Great Western Hospitals NHS
NHS Foundation Trust

Great Western Hospitals NHS Foundation Trust
Annual Report and Accounts
2010/2011

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Act 2006

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ANNUAL ACCOUNTS

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Chair and Chief Executive's report

We continue to focus our energies on improving safety and patient and carer satisfaction by providing the highest quality care. The past year has been an extremely positive one and we have improved care in a number of areas and delivered some significant service improvements and developed our services.

On safety we made a number of changes and we have seen our Hospital Standard Mortality Rates (HSMR) fall from 95 in 2009/10 to 88.2 in 2010/11. We now undertake regular Methicillin-Resistant Staphylococcus Aureus (MRSA) screening for emergency and elective patients and through rigorous attention to hygiene, hand washing and antibiotic prescribing, we have seen a fall in hospital acquired infection rates – both MRSA and Clostridium Difficile. For MRSA we saw a fall from 5 hospital acquired cases in 2009/10 to 3 in 2010/11 and for Clostridium Difficile a fall from 49 to 40. Our staff have led improvements in many other areas of safety and improved care, including Venus Thromboembolisis (VTE), Ventilator Acquired Infections, patient falls and a significant reduction in pressure ulcers. All of these have contributed to better patient outcomes and experience.

Delivering safe, high quality care relies on a clean and fit for purpose environment and good equipment. We were delighted that we were scored "excellent" again by an external assessment of the hospital by the Patient Environment Action Team (PEAT). The hospital design means that we can deliver single sex accommodation and bathrooms. Our nursing teams have eliminated mixed sex bays and all ward areas are compliant with this important aspect of privacy and dignity. Further work is underway to segregate the sexes in our Acute Assessment Unit (AAU), which cares for patients requiring urgent medical treatment

We are still seeing the benefits of the Dragon's Den initiative which we set up in 2009. Following bids from staff, money was invested in services and equipment to help improve safety, patient care and provide more cost effective services. Evaluation of the schemes funded showed demonstrable improvements, for example investing in avoiding Musculoskeletal Disorder injuries to staff has helped to significantly reduce the number of work days lost to injuries and our staff sickness rates fell so that more nurses were able to work during the year, providing invaluable care to patients. In the Breast Centre the Trust was one of the first places in the Europe where patients can now be tested to assess their risk of Lymphodaema prior to Breast Surgery which is helping improve their quality of life after their operation. These examples, and many more, were the result of the creativity and innovation of staff and something which grows ever more important as we tackle the financial challenges of the years ahead.

As a Foundation Trust not only do we ensure that we provide consistently safe, high quality care but we also have to meet the terms of our authorisation which are set out by Monitor (the Regulator of Foundation Trusts) through its Compliance Framework. This covers a range of areas including national requirements such as ensuring patients with cancer receive their diagnosis and treatment in a timely manner and people are seen promptly for both emergency and elective treatment. We are delighted that each quarter we were "Green" for all these important indicators.

We also have to make sure that we are using public money wisely and manage within the resources that we have obtained through our contracts with Primary Care Trusts (PCTs). Once again this year we saw more patients than we were contracted to see. This is a very important issue for us going forward as we need to support Primary Care in ensuring that patients referred to the hospital are similar to the numbers of patients we are commissioned to treat. If we do not do this then it causes both operational and financial problems for the hospital. We ended the year with

a breakeven position. Further information on these issues is provided in the annual accounts at the back of this annual report.

The year has been very significant in that we are proud to have been selected as preferred provider for Wiltshire Community Health Services and we plan to take on the responsibility for management of these services. Not only will these services increase the population we serve from 340,000 to approximately 750,000 but it will mean we have delivered an important element of our strategic aim which is to increase the population we serve.

Through our Governors, our members have said they wanted us to improve the patient experience from General Practitioner, hospital and community and social care services. We believe that in becoming responsible for Community Services we have a unique opportunity, not only to improve patient and carer satisfaction, but to reduce duplication and cost. We will continue to work effectively with other health, local authority and voluntary provider services to ensure that we use public funding wisely and provide the best services we can.

None of the above would have been possible without the hard work and dedication of our staff and volunteers, along with colleagues working in other allied organisations. Change is needed and is inevitable if we are to continue to improve what we do both inside and outside hospitals and deliver better care for the population we serve at lower cost. However, we are confident that our staff will continue to meet the challenges ahead.

Yours sincerely

Bruce Laurie
Chairman
6 June 2011

Lyn Hill-Tout
Chief Executive
6 June 2011

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Our Trust

Vision - Your health our passion

The Trust's Strategy for 2010-15 was developed through an iterative process during 2009/10 which involved discussions with the four clinical directorates within the Trust, the Trust Board and the Governors, and through them our membership. The input of all of these groups helped shaped the final strategy and defined the final vision for 2015 which is:

"We will provide healthcare services that delight patients and satisfy commissioners by meeting, or exceeding, all local and national standards and providing convenient, local services so that people enjoy the best state of health and will have access to first class services when they need them."

A key theme of the vision has been for the Trust to provide 'healthcare services' not solely acute hospital services. As part of the work that took place in 2010/11 towards achieving the 2015 vision, the Trust entered a competitive process and submitted a proposal to run a range of community health services and community maternity services across Wiltshire and surrounding areas which were previously provided by Wiltshire Community Health Services (WCHS).

This merger is a key step towards achieving the vision as we will work even more closely with key local partners including the Local Authority, GPs and the third sector to deliver better care, closer to home.

Our aims and values

To achieve our Vision we have the following aims, also known as strategic objectives: -

1. To provide consistently high quality, safe services which deliver desired patient outcomes and we will perform in the top 25% (upper quartile) of comparable acute trusts in delivering Hospital Standardised Mortality Rates (HSMR), patient satisfaction and staff satisfaction.

2. To improve the patient and carer experience of every aspect of the service and care that we deliver.

3. To ensure that staff are proud to work for the Trust and would recommend the Trust as a place to work and to receive treatment.

4. To secure the long term financial health of the Trust.

5. To adopt new approaches and innovate to promote health and improve services as healthcare changes whilst continuing to become even more efficient.

6. To work in partnership with others so that we provide seamless care for patients, more systematically identifying and supporting those individuals at most risk of ill health and delivering closer to home in rural areas.

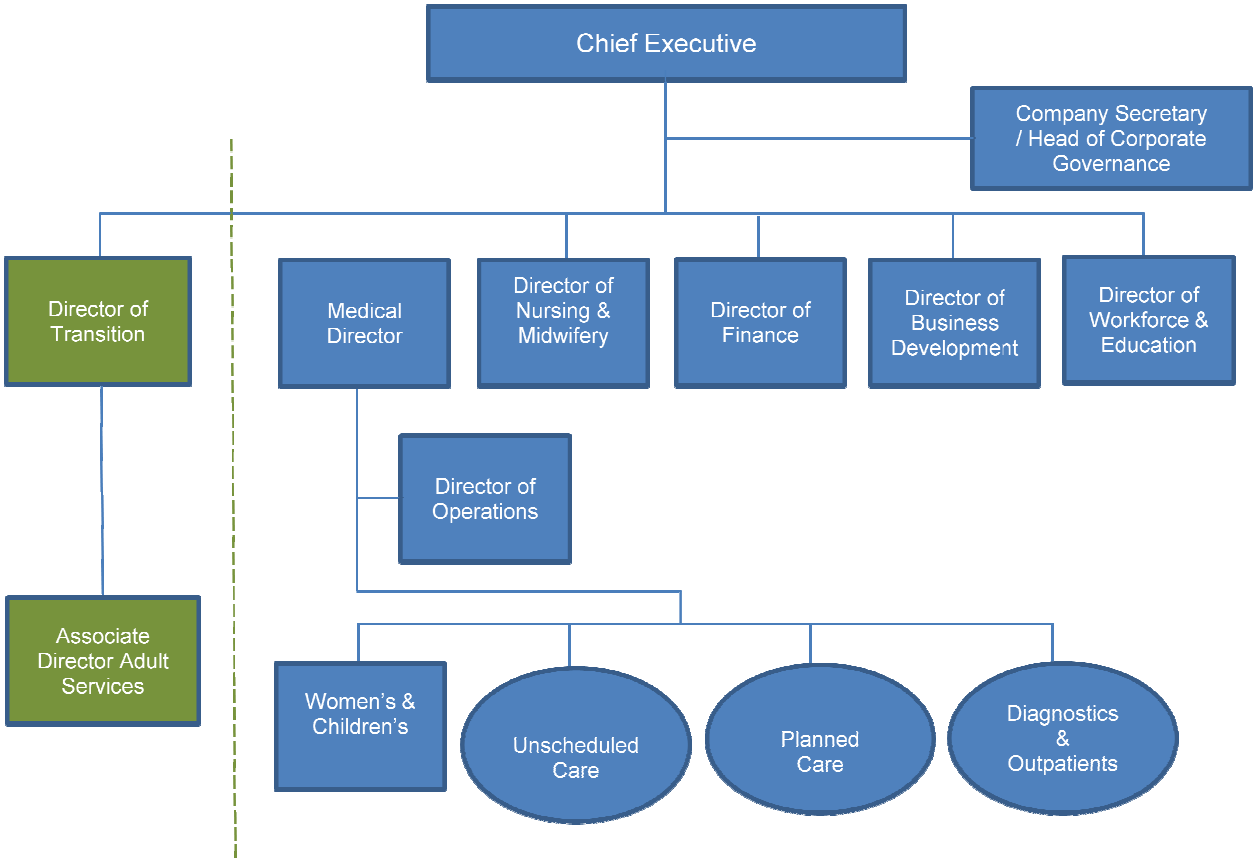
Underpinning this, our values are to: -

1. always listen to our patients, local people, commissioners and staff;

2. be a good collaborator, working effectively with colleagues and with external stakeholders with mutual respect; and

3. work honestly, openly and with integrity to encourage innovation and bold decisions, striving to be an exemplary employer.

Organisational structure



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Director's Report

General Companies Act Disclosures

Directors of Great Western Hospitals NHS Foundation Trust

Directors of Great Western Hospital NHS Foundation Trust during 2010/11: -

Bruce Laurie	Chairman
Helen Bourner	Director Business Development
Roberts Burns	Non-Executive Director
Rowland Cobbold	Non-Executive Director, Deputy Chairman and Senior Independent Director
Liam Coleman	Non-Executive Director
Oonagh Fitzgerald	Director Workforce and Education
Angela Gillibrand	Non-Executive Director
Roger Hill	Non-Executive Director
Lyn Hill-Tout	Chief Executive
Maria Moore	Director Finance
Sue Rowley	Director Nursing and Midwifery
Kevin Small	Non-Executive Director
Alf Troughton	Medical Director

In addition in January 2011 Jenny Barker, the Managing Director of Wiltshire Community Health Services was appointed as a Director Designate (Transition).

Principle activities of the Trust

Great Western Hospitals NHS Foundation Trust, located in Swindon, provides services to 340,000 people living in Wiltshire, Gloucestershire, Oxfordshire and West Berkshire with a workforce of 3,300. The Trust has an annual income of £203m. The history of the Trust is referred to elsewhere in this report (page 48 refers).

The regulated activities that GWH is currently registered to provide are as follows: -

- Treatment of disease, disorder or injury;
- Assessment of medical treatment for persons detained under the 1983 (Mental Health) Act;
- Surgical Procedures;
- Diagnostic and screening procedures;
- Management of the supply of blood & blood derived products;
- Maternity and midwifery services;

- Termination of pregnancy

The Trust secured a licence to operate from the Care Quality Commission in March 2010 without any conditions attached to it.

The Trust provides emergency and acute services to the local population through the following sites:

Great Western Hospital

The Great Western Hospital (GWH) is a purpose built District General Hospital providing emergency care, elective (planned) surgery, diagnostics, paediatrics, maternity (both midwife and consultant led), outpatient and day case services.

GWH opened in December 2002, replacing the Princess Margaret Hospital in Old Town, Swindon. The hospital has just under 502 beds and is designed and equipped to offer a first-class environment for patients, visitors and staff, with over 30% of beds provided in single rooms with en-suite facilities. The remainder are in single sex four bedded bays.

The Brunel Treatment Centre

On the GWH site there is a purpose built centre for elective (planned) surgery called the Brunel Treatment Centre. The centre has enabled the Trust to separate emergency from elective (planned) surgery. All patients admitted to the Treatment Centre are screened for MRSA prior to their admission. The Centre includes the Shalbourne Suite, which is a private patient unit.

Within the Community

The Trust also provides a number of services closer to patients' homes in the local community as follows: -

Location	Primary Care Trust (PCT)	Outpatient clinics in community settings
Savernake Hospital, Marlborough, Wiltshire	NHS Wiltshire	Trust outpatient clinics, X-Ray services and medical support to the inpatient beds which are operated by Wiltshire PCT
Fairford Hospital, Fairford, Gloucestershire	NHS Gloucestershire	Trust outpatient clinics and X-Ray service into the facility run by Gloucestershire PCT
Devizes Community Hospital, Wiltshire	NHS Wiltshire	Trust outpatient clinics
Chippenham Hospital, Chippenham, Wiltshire	NHS Wiltshire	Trust outpatient clinics
Malmesbury Primary Care Centre, Malmesbury, Wiltshire	NHS Wiltshire	Trust outpatient clinics
Melksham Hospital, Melksham, Wiltshire	NHS Wiltshire	Trust outpatient clinics
Tetbury Hospital, Gloucestershire	NHS Gloucestershire	Trust outpatient clinics
Trowbridge Hospital, Wiltshire	NHS Wiltshire	Orthopaedics outpatients
GP Practices	NHS Swindon	Community midwives attached to practices in Swindon and North Wiltshire
Various clinics in Swindon	NHS Swindon	Sexual Health

Further Companies Act Disclosures

Business Review - Operating and financial review

The Trust's Annual Plan submitted to Monitor (the regulator of Foundation Trusts) set out the organisation's priorities for delivery during the year. Listed below are some of the important issues which the Trust dealt with and improvements that the Trust has made over the course of the last year.

The Trust has made steady progress to achieving its six main objectives outlined elsewhere in this report *(page 13 refers).* Highlights of progress are as follows: -

1. **To provide consistently high quality, safe services which deliver desired patient outcomes and we will perform in the top 25% (upper quartile) of comparable acute trusts in delivering Hospital Standardised Mortality Rates (HSMR), patient satisfaction and staff satisfaction.**

   Key developments during the year towards achieving this objective:

   Quality and safety are our top priorities and during the course of the year we have made further progress in strengthening our quality and safety processes to provide the best care possible. Highlights include:

   - The Trust is a member of the South West Quality and Patient Safety Improvement Programme which is a patient safety initiative carried out in collaboration with the Institute for Healthcare Improvement (IHI). The programme aims to achieve a 30% reduction in adverse events and a 15% reduction in mortality by September 2014 and consists of five works streams:

     1. Leadership - The introduction of Chief Executive led patient safety walk rounds helps ensure senior leadership scrutiny of safety issues and gives front line staff the opportunity to raise concerns direct with Executive Directors. The walk rounds are a success as they give staff the opportunity to talk openly about patient safety topics, their concerns and ideas for improvements.

     2. General Ward - The Introduction of safety briefings and files on all wards ensuring that all staff at the start of the shift are aware of potential safety problems and concerns. These files ensure that this information is available to all staff creating a culture of safety and improvement of quality of care. The Implementation of SBAR (a communication tool) as a standardised clinical communication format was introduced Trust wide in April 2011. This will reduce the incidence of miscommunication and thereby increase patients' safety.

     3. Medicines Management - The team have continued to expand on the action plan developed for the NPSA alert Reducing Harm from Omitted and Delayed Medication (2010), a critical medication list has been now developed and implemented across the Trust. The team have commenced twice monthly audits and have been working with ward managers to implemented actions to resolve the issues as they are identified. In addition, as part of the patient safety programme, during 2011/12 the team will be sharing expertise and working jointly with the peri-operative team to identify the incidence and reduce occurrence of missed doses of beta blockers in surgical patients.

     4. Peri-operative and Critical Care - The team have been working on improving

compliance with the WHO safer surgical checklist first implemented in 2009/10, the two pilot areas identified have successfully demonstrated sustained compliance of 100%. The team will now be validating these results before spreading the improvement process across all theatres in the department. In addition the maternity safer surgical checklist has been introduced to the maternity theatre.

5. Critical care - The intensive care team have successfully implemented multidisciplinary ward rounds and daily goal setting for their patients, helping to improve communication between all team members, patients, carers and relatives.

- Each work stream covers a number of topics, for example preventing Venous Thromboembolism (VTE), use of a surgical safety checklist and reducing complications from ventilators in intensive care.

- Over the past year the Trust has consistently performed well in relation to Hospital Standardised Mortality Rate (HSMR) with the end of year position for HSMR at 88.2 which is below the level of mortality which would be expected (100) against the standardised figure.

A more detailed report on our performance against a range of quality and safety indicators can be found elsewhere in this report (page 30 refers).

2. To improve the patient and carer experience of every aspect of the service and care that we deliver.

Key developments during the year towards achieving this objective:

To support improvements in patient and carer experience, in 2010 the Trust commissioned a new quarterly patient experience survey conducted by an independent organisation called Picker which provides a range of patient experience research services to the NHS. The quarterly survey allows the trust to more robustly track patient experience and identify areas for improvement on a more regular basis providing opportunities for swift action to be taken where necessary.

The results of the survey, along with the results of other indicators of patient and carer experience are routinely reported to the Trust Board and to the Council of Governors Patient Experience Working Group to oversee the delivery of action plans designed to improve patient care.

Notable achievements during the year in improving patients and carer experience include:

- GWH being named as second best amongst all other Acute Trusts in the South West for care provided to people with learning disabilities according to an independent review carried out by South West SHA.

- The Trust has again achieved an excellent rating across all three indicators measured by the Patient Environment Action Team who independently assess the standard of the hospital estate, quality of food for patients and the level of privacy and dignity afforded to them.

- The Trust also scored highly in an independent survey carried out by Picker to assess the experience of women who have used our maternity services.

- The introduction of a standardised ward timetable across the majority of wards covering visiting hours, cleaning schedules and meal times to ensure patients have protected time in which they can relax and recover from their treatment ensuring a more consistent standard of care across the Trust.

- The continuing implementation of the Productive Ward timetable which is helping Nurses spend more time with their patients.

Patient and carer experience will continue to be a key indicator against which we will measure the success of our services, particularly as the Trust begins to provide a wider range of services across a larger area.

More detail of patient experience can be found elsewhere in this report (page 31 refers).

3. To ensure that staff are proud to work for the Trust and would recommend the Trust as a place to work and to receive treatment.

Key developments during the year towards achieving this objective:

A key development during the year has been the launch of a three year Organisation Development (OD) programme. The programme is designed to create a strong customer service culture within the organisation so that patients are provided with consistent high quality care no matter where or how they access our services.

- In 2011/12 the programme will see a range of developments. Most importantly each of these new developments has been developed and led by staff. These will include: the launch of new values which staff have developed and which all staff will be expected to uphold. The values are based around the STAR – Service, Teamwork, Ambition and Respect.

  Management standards which will look at the skills that each line manager or supervisor should have including the leadership and effective management of staff together with responsibilities of patient and staff satisfaction, planning, and budget management. The staff group will recommend how the Trust implements these qualities, provides training for staff and ensures they are used everyday.

- A new performance management process will be introduced which will help identify the best performers in the Trust and put in place a monthly staff awards process which recognises their contribution acting as role models for others. The process will also identify those who need further support in improving their skills with the aim of raising standards across the Trust.

- In July 2010 the Trust also held the first annual GWH Staff Excellence Awards at a ceremony in Swindon. The evening event included over 270 members of staff who were invited to celebrate the achievements of colleagues across the Trust. Following the success of the evening, the ceremony will become an annual event supported by an 'Employee of the Month' scheme which will be launched in 2011/12.

A significant achievement was the Trust being awarded a national occupational health and safety award for the reduction in the number of days lost due to musculoskeletal injuries. The Award for Excellence in Improving Employee Health and Well-being was part of the national Human Resources Management Excellence Awards 2010 and the work that has taken place to focus on tackling potential causes for these injuries has led to a 25% reduction in the number of

sick days caused by these types of injury – this is the equivalent of an extra 7.5 nurses available each month for patient care. Since the award the team have reduced the number of these injuries by a further 20%, demonstrating a clear commitment to improving work life quality for staff.

The independent Staff Survey Carried out by the Care Quality Commission each year will be a key measure of the success of the programme. An overview of 2010 Staff Survey results is contained elsewhere in this report (page 177 refers).

4. To secure the long term financial health of the Trust.

Key developments during the year towards achieving this objective:

Whilst the financial environment continues to be extremely challenging the Trust has sought to create a stronger financial basis by taking on responsibility for Wiltshire Community Health Services. This will increase the Trust's income from £200m a year to £280m and through the work that the Trust will undertake in redesigning and improving patient pathways the ultimate goal will be to secure these services when they are retendered by GPs in three years time.

The Trust was also successful in its submissions to manage a range of other services which were previously provided by other organisations. This has expanded the services we provide and is contributing towards a stronger financial foundation. These services include:

- In July 2010, the Trust took on responsibility for Physiotherapy and Occupational Therapy services previously provided by NHS Swindon. The value of the contract is £1.1m covering a range of outpatient specialties including hands, chronic pain, gym, general outpatients, amputees, hydrotherapy and rheumatology along with acute physiotherapy services.

- In October 2010 the Community Paediatric Service previously managed by NHS Swindon provider arm was transferred to the Trust. The value of this contract was circa £800k and a total of three medical staff were transferred along with one specialist nurse and six support staff. This will allow more joined up care for children both in the acute setting and out in the community.

- The transfer of NHS Swindon Sexual Health Services under the management of GWH took place from 1 April 2011. The new services amount to a total value of circa £700k and involve Community Contraception and Sexual Health (CASH) services and Chlamydia Screening from NHS Swindon's provider arm.

5. To adopt new approaches and innovate to promote health and improve services as healthcare changes whilst continuing to become even more efficient.

Key developments during the year towards achieving this objective:

The Trust continues to be amongst the more efficient Acute Trusts as measured by national Reference Costs which are published annually. The latest information indicates that the Trust Reference Cost Index is 95 which means the Trust is 5% more efficient than the average. We recognise that it is not just about being more efficient but also about doing things differently and innovating.

An example of how we are actively seeking to do things differently is the work taking place to reduce the time patients spend in hospital. We are achieving this in a number of areas by changing clinical practice so that so procedures which previously required an overnight stay can now be carried out as a day case.

We also continue to implement the Productive Ward programme which is designed to release more time for Nurses to spend on direct patient care and less on things such as paperwork. In some areas this has resulted in Nurses now spending twice as much time with patients as they were able to previously by transforming the way they do their job. This programme was extended to the Emergency Department and Theatres during the year and we hope to see similar efficiency gains in those areas.

We have also reduced the amount of waste generated by the Trust, details are referred to elsewhere in this report (page 170 refers). This not only makes sense from a financial point of view (disposing of material in clinical waste bags when it could have been disposed on in general waste, is expensive), but it also makes sense from an environmental perspective as more of the waste we produce can then be recycled. This work has included looking at how we use electricity and other utilities. As a result we have installed automatic lights in some areas of the hospital.

6. To work in partnership with others so that we provide seamless care for patients, more systematically identifying and supporting those individuals at most risk of ill health and delivering closer to home in rural areas.

Key developments during the year towards achieving this objective:

As previously mentioned, in November 2010 the Trust was named by NHS Wiltshire as the preferred provider for Wiltshire Community Health Services (WCHS). Since being named as the preferred provider the Trust has been involved in discussions with key partners including colleagues in primary care, the Local Authority and third sector to explore ways we can work together.

The Trust will become responsible for providing care in the community, in people's homes as well as hospitals. Discussions have already taken place with colleagues already providing these services to identify how we can improve the service. These discussions culminated in a series of three 'Working Together' events, the output of which has been used to inform the development of the Business Plan for the year ahead. The Trust has also presented an overview of the merger to a number of the Wiltshire Local Area Boards and key stakeholder groups to seek input into how we can improve pathways in the future. This work will continue throughout 2011/12.

Management commentary

Additional activity creating pressure on finances

The Trust continues to experience significant additional demand for services, over and above the levels we are contracted to provide by our Commissioners. This creates significant pressure on the Trust finances as every additional operation or treatment the Trust provides which is over the level we are paid to provide costs money. This means that, funds need to be found from other areas which reduce the money available to invest in other services and capital projects.

Point of Delivery	Contract	Actual	(Under)/ Over performance against contract	Variance %
New Outpatients	81,648	96,456	14,808	15.35%
Follow Up Outpatients	185,435	212,887	27,452	12.89%
Planned Same Day	19,969	27,813	7,844	28.20%
Emergency Inpatients	34,547	35,210	663	1.88%
Elective Inpatients	6,790	7,269	479	6.60%
Emergency Department Attendances	66,543	68,618	2,075	3.02%
Total	394,933	448,253	53,320	11.90%

To tackle this challenge the Trust had discussions with NHS Swindon, our main Commissioner, to agree payment for the additional patients that we have treated, which is above the levels they contracted us to provide at the start of 2010/11. After prolonged negotiations payment was secured from NHS Swindon and NHS Wiltshire of £7.5m and £3.5m respectively. This has impacted on the Trust's ability to deliver a surplus over the course of the year which was originally forecast to be £1.4m. A surplus is vital to us because as a Foundation Trust we receive no funding from any other sources and this money is used to invest in equipment which allows us to keep pace with changes in technology. As a result of these pressures, the Trust ended the year in a breakeven position.

Despite the financial challenges the Trust continued to invest in improved services for patients

During the year the Trust officially opened, or began work on, a number of significant capital projects which are helping the Trust provide better, safer care for patients. These include:

- A £0.35m Pharmacy Robot launched in July 2010 which reduces the time patients need to wait for their medicines and reduces the potential for prescribing errors. The new robot allows the Pharmacist to request a drug and it is automatically dispensed (and restocked) by the robot. This also helps reduce the amount of time patients spend in hospital so patients can go home more quickly.

- A £1.5m investment in the redevelopment of the Wiltshire Breast Screening Centre at GWH which has been in use since October 2010. This investment is helping the Trust meet increased demand for breast screening services which are as a result of the expansion in the

National Breast Screening Programme, the investment included the latest technology which allows for more accurate and speedier diagnoses, two mobile screening units based in the community in Wiltshire and a Stereo Biopsy Unit which was the first of its kind outside of the United States.

- £0.66m investment in a new Midwife-led Birth Centre at GWH called the White Horse Birth Centre, which opened in March and is providing women with more choice of where to give birth. The centre is designed to offer more personalised care in a 'home from home' environment allowing for a more natural birth experience. Facilities at the centre include:

  - Four en-suite birthing rooms
  - Two birthing pools
  - A Family room and a quiet room

- A £2.7m investment began in October on the refurbishment of the existing Cardiac Catheter Laboratory and the building of a second Cath Lab at GWH. The new laboratory will help the Trust to meet the demand for cardiac procedures such as angiographies, angioplasties and pacemakers and treat patients more quickly in a state of the art environment. The new laboratory opened in April 2011.

Good performance across the range of healthcare indicators which we are measured against

During the year, despite treating more patients than were planned by the Primary Care Trust, the Trust continued to deliver against the indicators on which we are measured by our Regulators Monitor and the Care Quality Commission. In 2009/10 there were some areas where the Trust had under performed, in particular the time patients spent on the Stroke Unit and the time it took the Trust to share clinical correspondence with GPs following a patient's discharge. However, following a sustained focus during 2010/11 which included detailed action plans to improve performances (which were monitored at Trust Board level) we delivered significant improvements in these areas.

These improvements mean patients are receiving better care, improving outcomes and patient experience. The Trust met the target for 80% of patients to spend 90% of their time on the Stroke Unit in quarter 4. This indicator is important as the more time a patient spends on the Stroke Unit the better their recovery.

During the year the Trust established a Clinical Correspondence Project Group to improve the speed with which clinical correspondence is shared with GPs following a patient's clinic appointment. The National target i.e. 95% of clinical correspondence is sent to GPs within 48 hours following clinic appointment. Previously, performance in some areas of the hospital in sending clinical correspondence in a timely manner was below standard and the project group has been looking at both administrative and clinical functions which could be improved to meet this target.

Performance in this area was also the subject of discussions at the Swindon Health Overview and Scrutiny Committee (HOSC) during the year, and following a significant amount of work by the project group, which has included new IT solutions; more GPs are able to receive clinical correspondence electronically within 48 hours after discharge which will improve continuity of care. Work continues to address IT issues within GP practices and the PCT are currently enabling GP patient administration systems in Swindon in particular to receive the correspondence directly into

these systems. We anticipate that these issues will be addressed early in 2011/12 and the 95% target will be met.

The Trust has a strong track record of delivering both financial stability and good performance. It will be essential in the challenging financial years ahead that the Trust continues to deliver in both respects – to live within the funds we have available to us and at the same time continue to deliver improvements in patient care. This will require the coordinated effort of staff across the organisation to think and do things differently and ultimately look at the way we provide services in the future.

A more detailed performance report is provided elsewhere in this report (pages 92 – 153 refer).

Looking for opportunities to get the most out of our resources

During the year we have invested significant time and energy into looking at ways we can use our resources more effectively so that we get the most out of every pound we spend. This grows ever more important as the financial environment gets increasingly challenging. This has included looking at ways we can prevent unnecessary hospital admissions and reduce the amount of time patients spend in hospital for example by transferring operations where patients would have stayed in overnight to day case procedures and preparing patients for their operation so they can be admitted on the day of the scheduled operation not days before.

This work is already contributing towards improved patient care and better use of resources with the number of beds in some wards being reduced over the second half of 2010. These areas were:

- Beech Ward (Gynaecology) = Four beds were removed in January due to changes in working practices which will result in a greater number of day cases being performed reducing the need for the previous number of beds in that area.

- Aldbourne (Orthopaedics) = Ten beds were removed at the end of October due to increased efficiency resulting in reduced length of stay for patients.

- Shalbourne Suite (Private Patients Unit) = The plan was for ten beds to close to reflect private patient activity, increasing day case rates and reductions in length of stay. The ten closed beds have been used over the winter period for NHS patients as part of the Trust's operational escalation plan.

During the second half of the year the Trust also began a programme of refurbishing all wards to maintain a high quality environment. Due to the size of the hospital this programme will take five years however, two wards have already been completely refurbished - Saturn Ward (Acute and Chronic Respiratory) and Kingfisher Ward (Trauma and Orthopaedics). Each ward takes approximately three months to refurbish and to enable the work to take place; wards are decanted to other areas generally during the summer months when the hospital is less busy.

To create this additional space a decision was made in January 2011 to close Linnet Ward (Diabetes) from the beginning of April 2011 removing 34 beds. Linnet Ward was selected as increasingly more and more Diabetes patients are being treated in the community and there is less demand for in patient beds for this specialty. Diabetes patients requiring acute hospital care will receive specialist care elsewhere in the hospital. The space created by closing Linnet Ward will be used to support the refurbishment of other areas of the hospital and during particularly busy periods such as winter, allows the Trust to be much more flexible with the way we use our resources by

opening up beds in this area as demand dictates. Staff working in all these areas have been redeployed to vacancies in other areas of the hospital.

Looking ahead – the main trends likely to impact on the Trust

Like other public sector organisations, the Trust is experiencing unprecedented financial challenges which mean that as a healthcare provider we will have to radically change the way we provide care in the future. Nationally the NHS is required to find £20bn of efficiency savings under a programme called QIPP (Quality, Innovation, Productivity, and Prevention), for GWH this means savings of £8m are needed in 2011/12 and a similar level of savings each year up until 2015 as PCTs reduce the money they spend with Acute Trusts under the QIPP programme and to cope with rising costs.

Nationally there continues to be a shift in moving care out of hospital and into the community and as a Trust we will not be immune to what these changes will mean for our organisation. This will mean over the coming years as more services will be provided in the community and less in acute hospitals, the Trust will need fewer beds to treat patients. In turn this means that fewer posts will be needed working in the hospital, although some of these roles may be transferred into the community. It is therefore essential that we have a clear workforce plan, if we are to try to avoid redundancies.

Redundancy would always be a last resort as we seek to maximise the use of vacancy freezes and retirement along with an array of other measures to reduce costs whilst ensuring changes do not impact on safety or quality. We will plan these workforce changes in close discussion with our primary care and Trade Union colleagues.

A national change, which will impact on the Trust, is the planned changes to commissioning which will transfer responsibility for commissioning from Primary Care Trusts to General Practitioner Consortia. Transitional arrangements for the GP Consortia are being established by the PCTs and the Trust is engaging with emerging ten GP Consortia across our catchment area. We will be agreeing our approach to how we will engage with Consortia and General Practitioners – both as commissioners who 'buy' our services and as fellow providers of healthcare services. A GP Engagement Plan has been approved by the Trust Executive Committee. Its aim is to strengthen relationships with GPs so that a strong foundation is in place when they take on commissioning responsibilities.

The NHS is changing significantly including national plans for greater competition from the private and third sectors. This will mean that we need to stay competitive. The Government's plans for "Any Qualified Provider" will mean more providers seek to provide NHS commissioned services and the Trust will need to work hard to compete in this environment. Above all, the Trust will continue to focus on offering local, high quality services to our patients and services which are cost effective for our commissioners.

The merger with Wiltshire Community Health Services which will enable true integration of community health services within the existing structure of the Trust. A key focus of our energy in the year ahead will be to maximise the benefits of being an acute and community health provider by integrating community services within the GWH structure to help share best practice, deliver seamless pathways and provide opportunities for staff both in the hospital and in the community to develop news skills.

Below is a table which contains the description of each service the Trust will become responsible for and where responsibility for those services will sit within the organisation on 1st June followed by where those services will eventually rest once full integration takes place.

TABLE – Description of Services

Description of services	Destination at point of merger
Maternity	Women and Children's Directorate
Community Midwifery Obstetrics (consultant led)	
Children and young people	Women and Children's Directorate
Children's LD Service Children's Medical Services Community Child Health Complex care Health visiting LD respite care (Children) Safeguarding Vulnerable Children (South) School Health Service School Nursing Paediatric Diabetes Speech and Language Child and Adult OHP (Oral Health Promotion)	
Miscellaneous	5th temporary Directorate
Community teams for people with Learning Disabilities LD Day care Community LD	
Wheelchair service	5th temporary Directorate
Community Dentistry • Dental Access Service • Special Dental Service (including screening and epidemiology)	Planned Care Orthodontics Department
Decontamination Service	Planned Care
Prison Health	5th temporary Directorate
Independent Living Centre	5th temporary Directorate
Adult Services	5th temporary Directorate
<u>In patients and long term care (delivered by Community Nursing Teams)</u> • Inpatient beds • Adult Diabetes • Neurology and stroke • Cardiac and respiratory	
<u>Ambulatory Care</u> • Minor Injury services • Outpatients • Fracture clinic (GP)	
<u>Clinical services (delivered by specialist nurses and Community Nursing Teams)</u> • Continence Specialist Nurse • Tissue viability Specialist Nurse • Dietetics	

Description of services	Destination at point of merger
• Physiotherapy • Physiotherapy OPD • Podiatry • Orthotics	
Facilities and Estates	Estates and Facilities Management GWH

Research and development

The Trust carries out its own research within the Academy, principally in the areas of Cancer studies, Paediatrics, Orthopaedics, Anaesthetics, Rheumatology, Dermatology, Haematology and two pandemic flu studies. The Trust follows the research governance standards set out by the Department of Health.

Within the Academy, the Trust has a small Research and Development Team with responsibility for providing advice, support and leadership on matters relating to R&D. The team comprises a clinical lead, R&D Manager and a R&D Coordinator. Detailed below are some of areas where significant progress has been made in 2009/10:

1483 patients were recruited during 2010/11 to participate in research approved by a research ethics committee. This is a slight increase from last year. The following have been areas of priority for Research and Development over the last 12 months:-

- Increasing the breadth of the portfolio within the Trust to include ICU, Diabetes, Stroke, Rheumatology, Cancer, Orthopaedics, Dermatology, and Sexual Health. We continue to pursue quality research projects for the area of Cardiology.

- Research and Development fund research posts within Cancer, Rheumatology, Dermatology, Orthopaedics, ICU, Sexual Health and Stroke to support the research activity, increased the recruitment and set up new projects.

- Funding research roles in support departments such as Pharmacy, Pathology, Day Therapy and Radiology to enable them to support research activity within the Trust.

- Support for these research roles is key. We are developing a set of competencies for the research nurses and an induction pack for all new staff. Holding team meetings and training sessions where necessary.

- Developing our processes to further support Trust-Sponsored activity following our first Good Clinical Practice Inspection from the Medicines and Healthcare products Regulatory Agency (MHRA).

- Working closely with our Comprehensive Local Research Network to streamline our processes, utilise their training packages and for general support and advice.

- Monitoring our funding allocation closely to ensure financial probity and targeted spending in key areas.

Please note that the Trust has disclosed information on the above as required under the Companies Act that is relevant to its operations.

Quality governance reporting

Patient care and stakeholder relations

Number of patients seen, treated or admitted during 2010/11

We treat thousands of patients every year as follows: -

TABLE – Patients seen, treated or admitted 2007/08 – 2010/11

	2007/08	2008/09	2009/10	2010/11	Variance from 2009/10
New outpatients	87,441	90,852	94,587	96,456	**1.98%**
Follow up appointments	179,466	195,846	198,244	212,887	**7.39%**
Day cases	26,102	28,508	28,053	27,813	**-0.86%**
Emergency inpatients	34,075	36,658	39,202	35,210	**-10.18%**
Elective inpatients	7,438	7,345	7,004	7,269	**3.78%**
Emergency Department attendances	60,583	62,628	66,262	68,618	**3.27%**

Total number of patients, seen, treated or admitted in 2010/11 was **448,253** with a total variance of 3.40% from 2009/10.

Performance against key indicators

TABLE – Performance against key indicators

Indicator	Target	Q1	Q2	Q3	Q4	YTD
Incidence of MRSA bacteraemia	5 a yr	0	0	2	1	3
Incidence of Clostridium difficile	69	14	9	10	7	40
All cancers - two week wait	93%	97.0%	95.7%	96.9%	97.9%	96.9%
Symptomatic Breast two week wait	93%	97.1%	98.1%	97.5%	96.2%	97.2%
31 day wait from diagnosis to first treatment for all cancers	96%	98.7%	99.4%	99.7%	98.9%	99.2%
31 day wait for second or subsequent treatment - Surgery	94%	98.0%	99.4%	100%	100%	99.4%
31 day wait for second or subsequent treatment - Drug Treatment	98%	100%	100%	100%	100%	100%
62 day wait for first treatment from Urgent GP Referral to treatment for all cancers	85%	93.7%	90.6%	91.1%	93.9%	92.2%
62 day wait for first treatment from Consultant/Screening Service to treatment for all cancers	90%	100%	100%	100%	100%	100%
% of patients who stay max of 4 hours in A&E inc MIU's	95%	99.4%	98.9%	97.7%	97.5%	98.4%
Patients suffering heart attack to receive thrombolysis within 60 minutes of call	68%	80.00%	100%	-	-	-
Patients suffering heart attack to receive Primary PCI within 150 minutes of call	TBC	100%	88.9%	100%	92.3%	94.8%
Elective MRSA Screening	100%	96.4%	95.7%	98.1%	98.5%	97.2%

Notes

Patients suffering heart attack to receive thrombolysis within 60 minutes of call - we no longer use thrombolysis within the Trust and have not done so since October, so the September data is the last data relating to thrombolysis. Instead, we apply “Patients suffering heart attack to receive Primary PCI within 150 minutes of call”. This has been included in the table.

MRSA screening targets – The table below includes Monitor targets. Set out in the table below are the PCT, Gateway, Quality Accounts (QA) targets instead.

TABLE – Further MRSA Screening Targets

Elective MRSA Screening	95.2%	Monitor	**100%**
Elective MRSA Screening	95.2%	PCT, Gateway, QA	**95%**
Emergency MRSA Screening	89.0%	Monitor	**100% end December 2010**
Emergency MRSA Screening	89.0%	PCT, Gateway, QA	**95% end December 2010**

Patient experience

For the Trust to continue to improve its' services it needs to continue to actively gather, listen and act upon patient feedback to ensure we that we are getting services and care right first time for our service users, which will ultimately result in giving a high standard of care and being the provider of choice.

The Patient Advice and Liaison Service (PALS) is led by the Head of Patient Experience and Director of Nursing and Midwifery. PALS are at the forefront of gaining feedback and being a point of contact for our patients and their carers to seek advice and give their views.

The Trust's Strategic Objectives for the next five years incorporate three elements that feed directly into patient experience:

- To improve the patient and carer experience of every aspect of the service and care that we deliver
- To ensure that staff are proud to work at GWH and would recommend the Trust as a place to work, or to receive treatment
- To work in partnership with others so that we provide seamless care for patients

During 2010/11, the post of PALS Administrator was made substantive and a Formal Complaints PALS Officer was recruited within the Department, with a focus on guiding the Directorates through the Formal Complaints process.

2010/11 saw an increase in the collection of patient feedback through surveys and over the next financial year, the Trust will be looking at raising the profile of gaining feedback locally at ward level.

The merging of GWH and the Wiltshire Community Health Service and Maternity Services will raise the number of contacts with the PALS Service and a service review of PALS is underway to ensure that GWH has the appropriate staffing level to meet the needs of our new remit of patients.

The Patient Experience Business Plan 2011/12 will incorporate DSSA and Essence of Care. Patients have reported a high level of satisfaction with DSSA and Privacy and Dignity during 2010/11.

The Head of Patient Experience and Director of Nursing and Midwifery have been identifying and actively engaging with patients who have raised multiple concerns and complaints with the Trust. These patients are invited into the Trust to tell us about their experience and give us the opportunity to discuss the work that we are doing across various departments across the Hospital.

Patient Advice and Liaison Service (PALS)

The Head of Patient Experience and PALS team lead on patient surveys, patient forums, logging complaints and compliments, signposting, translation and interpreting, overseas patients, bereavement and Patient Recorded Outcome Measures (PROMS).

Members of the team also provide valuable input with groups around the Trust (including Essence of Care, Productive Ward and Values Project), maintaining a focus on patient experience and assisting Directorates with complaint resolution.

The table below shows the breakdown in PALS contacts during 2010/11 in comparison with 2009/10. There was a marked increase in the number of PALS contacts during quarter four 2010/11 (289). There was a decrease in contacts from quarter three to four of 170 during 2009/10. This increase correlates with the national trend of an increase in patients accessing PALS and Complaints departments.

TABLE - PALS contacts

	201011	200910	201011	200910	201011	200910	201011	200910	201011	200910
	Qtr 1	Qtr 1	Qtr 2	Qtr 2	Qtr3	Qtr3	Qtr 4	Qtr 4	Total	Total
Information and Signposting	65	66	7	54	38	75	37	61	147	256
Compliment	60	87	78	77	44	91	61	82	243	337
Overseas	60	115	40	41	32	57	23	31	155	244
Stage 1	94	226	78	224	37	310	86	222	295	982
Stage 2	246	202	255	266	227	204	297	211	1025	883
Bereavement	307	180	293	296	351	358	514	318	1465	1152
Total	832	876	751	958	729	1095	1018	925	3330	3854

The Bereavement Service has been reconfigured and from 1st April 2011 will be managed operationally to improve alignment with internal and external services.

New software for monitoring complaints and compliments was installed in April 2010 and from April 2011 data will be extracted from this system to inform the monthly ward dashboards.

Following feedback from our patients through PALS, the Deputy Head of PALS has led a project to set up a drop-in facility for patients to exchange used hearing aid batteries for new ones. This is in collaboration with the Hearing and Vision Group, Audiology Department and Voluntary Services.

Formal complaints

Following the introduction of the Formal Complaints PALS Officer during quarter three 2010/11, there has been an improvement in the response times for Formal Complaints.

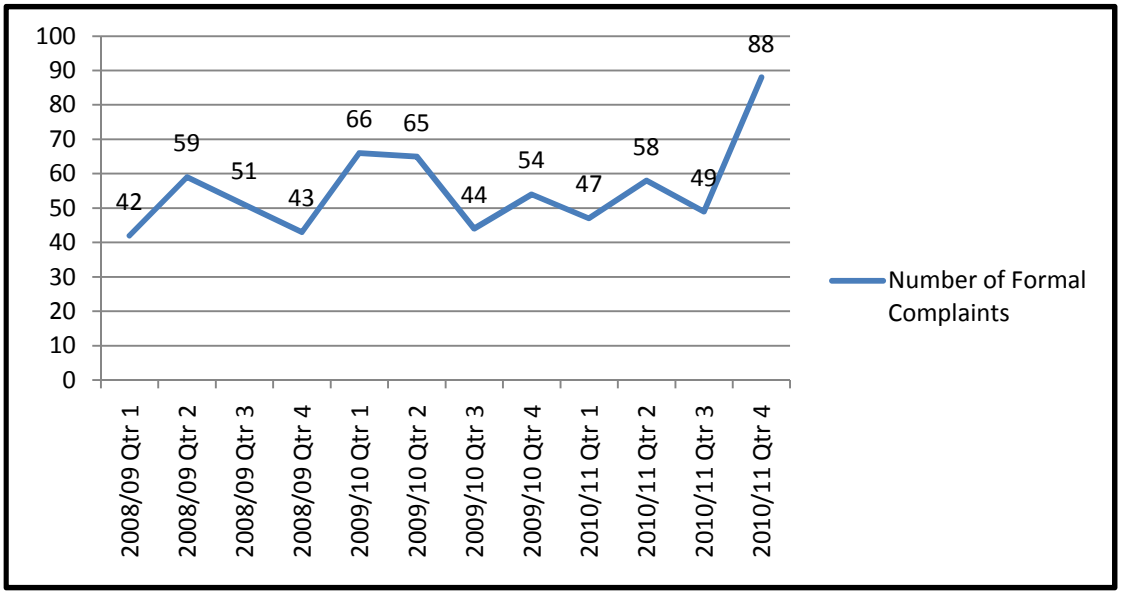
During 2010/11, 242 Formal Complaints were made to the Trust compared with 229 during 2009/10. The number of Formal Complaints received by the Trust represents 0.04% of the total number of patients seen, treated or admitted during 2010/11.

There were 88 Formal Complaints received during four, which is an increase in of 39 compared with quarter three. Of the 88 Formal Complaints, 50 of those received were classified in the Harry Cayton Category of Safe, High Quality Co-Ordinated Care. 23 of these were in the Planned Care Directorate and 19 were in the Unscheduled Care Directorate. The increase in complaints coincided with the publication of the Parliamentary and Health Service Ombudsman Report titled 'Care and Compassion?' which highlighted the investigations into the NHS care of ten older people.

The Trust encourages a culture of being open with patients, which incorporates acknowledging, apologising and offering an explanation when things go wrong. Reports published nationally about care standards can often trigger a reflection into care that has been received, which can be followed by an increase in people contacting the Trust for confirmation and clarification about their treatment.

The graph below compares the number of Formal Complaints received during 2010/11.

GRAPH - Number of Formal Complaints received during 2010/11



The Formal Complaints Response Training has continued during 2010/11 and the format will be reviewed over the next financial year. It is anticipated that the Head of Patient Experience will meet with the Academy to make this training Mandatory for all managers who have a responsibility for complaint investigation and responding to the complainant.

In line with the changes to the Complaint Regulations 2009, deadlines are negotiated with the complainant. The Trust has continued to measure complaint response times to a maximum of 25 working days, unless otherwise agreed with the complainant.

Compliments

There were 243 compliments received during 2010/11 and the three highest areas with compliments raised through PALS were:

1. A&E
2. AAU
3. Breast Screening

Compliments are also recorded at ward level through the Productive Ward and on the patient comment cards.

Bereavement service

The compassionate administration service which co-ordinates the completion and collection of internal and external paperwork associated with Bereavement has had 1465 contacts during 2010/11 compared with 1152 contacts in 2009/10.

The Bereavement Officer is the main point of contact between the Mortuary and Funeral Directors. PALS staff assisted the Bereavement Officer with meeting with families to return property belonging to the patient and the Medical Cause of Death Certificate, which is needed to formally register the death.

The Bereavement Officer works closely with the Coroner's Officers and the Head of Patient Experience has met with the Detective Sergeant of Wiltshire Constabulary who oversees their office to strengthen working relationships. There is a dedicated volunteer who assists with Bereavement two mornings a week.

A Consultant led Mortality and Morbidity Group has been established and the information captured from the Bereavement Database is used to inform this group. This information has also been used to assist in an audit of Death Certification in the Trust.

From April 2011, the Bereavement Service will be transferred under the Directorate of Diagnostics and Outpatients to facilitate a more joined up service.

Translation and interpreting services

The Trust provides Translation and Interpreting for patients who are deaf, partially sighted or do not speak or read English. This is to ensure that our services remain accessible and to remove any potential barriers of communication.

The Translation and Interpreting Contracts are being reviewed and will be awarded under tender from quarter one 2011/12.

The top four languages accessed to meet patient communication needs during 2010/11 are:

Mandarin
Polish
Bengali
Turkish

Using patient experience information to drive further improvements

Comment Cards

The 'Tell us how we're doing' comment cards capture four elements of patient feedback:

- What was good about your visit?
- Was there anything we could do better?
- Would you recommend us to a friend?
- Please tell us about any person or team who provided you with excellent care

The results are reported in the quarterly patient experience report.

There has been an increase in the number of completed comment cards over 2010/11 and the number of patients who would recommend the Trust to a friend (in February 2011, 97.3% of patients would recommend us).

During 2010/11 there have been a number of volunteers who have visited wards and departments to get feedback from the patients using the comment cards.

NHS Choices

The Communications Team monitor feedback from the NHS Choices website and there has been an increase in positive comments about the Trust.

Surveys carried out

Patient Surveys

The PICKER Institute is a not-for-profit organisation which undertakes a range of qualitative and quantitative research into patient experience. The Trust has historically commissioned PICKER to undertake the Mandatory Surveys issued by the Care Quality Commission (CQC).

The internal inpatient surveys were removed from circulation in 2010/11, as they were not user friendly and the number of completed surveys did not give a representative view of our patients. The surveys have been replaced with a quarterly inpatient survey commissioned through the PICKER Institute.

During 2010/11, the PICKER Institute has carried out the following surveys:

Quarterly Inpatient
Maternity Services
Paediatric Inpatient
Paediatric Outpatient
Annual Inpatient – results from this survey are used for national benchmarking purposes by the CQC

Action plans are developed and monitored through the Directorate Groups and the Patient Experience Working Group (a working group of the Council of Governors).

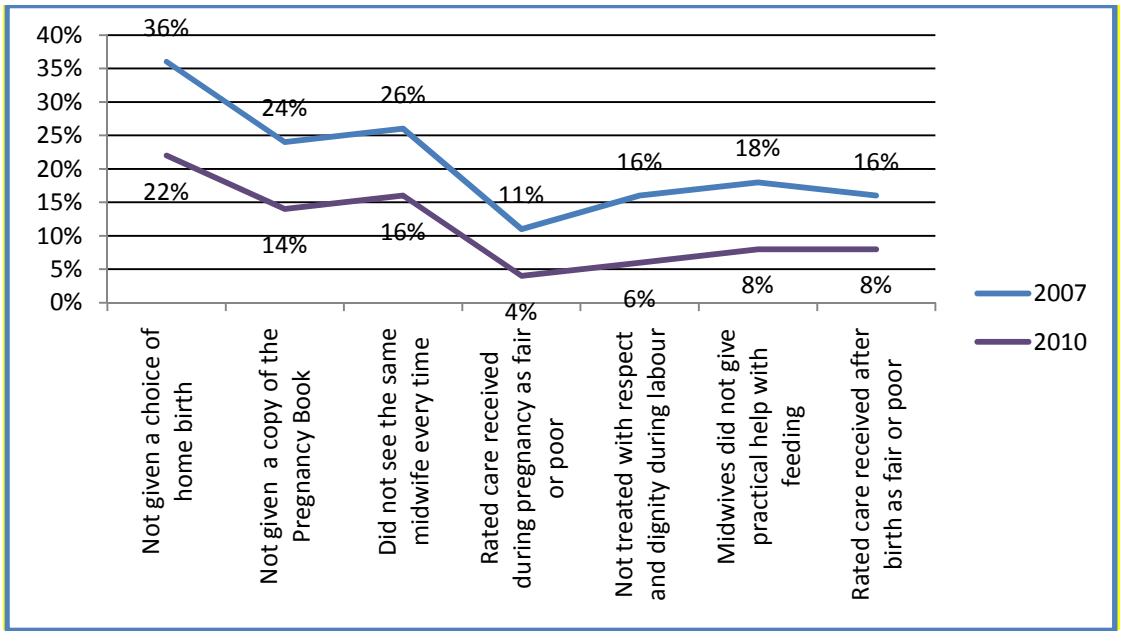
Maternity Services Survey

The Trust last carried out the Maternity Services Survey in 2007. The response rate for the Trust was 61.1% compared to the PICKER average of 49.8%.

The Trust was one of only five Acute Hospital Foundation Trusts in the South West Region who commissioned this survey through PICKER.

The graph below demonstrates areas where the Trust has improved significantly in comparison to the results of the survey carried out in 2007. Lower percentages are better.

GRAPH - Areas of significant improvement



Paediatric Inpatient and Outpatient Surveys

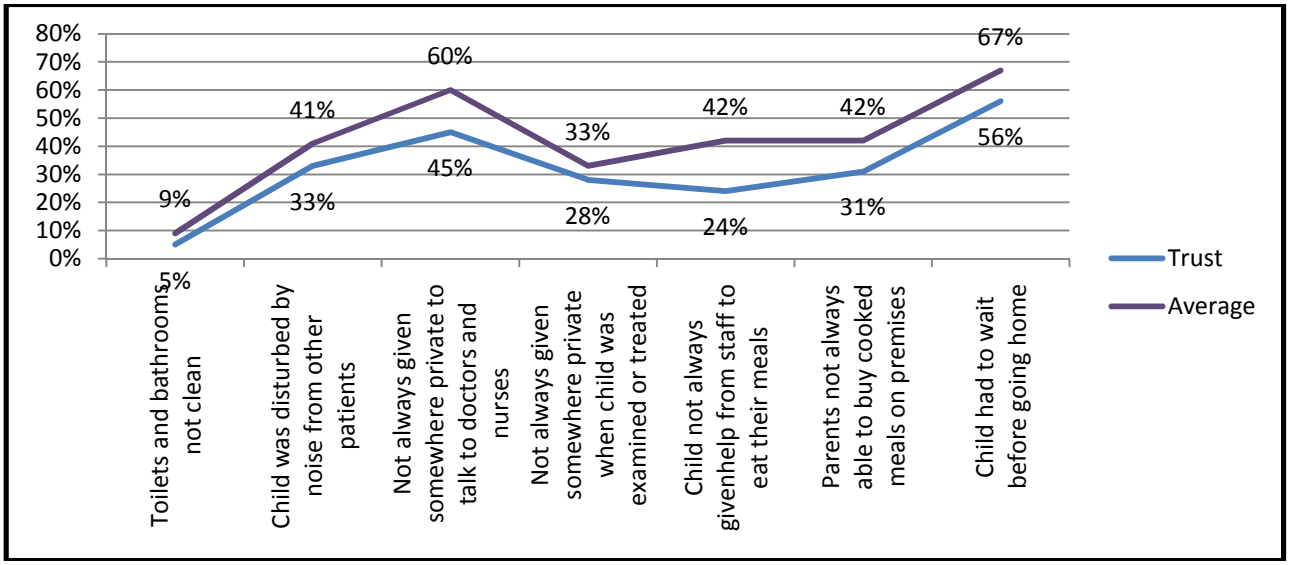
The Paediatric Inpatient Survey was last carried out in 2004 and the 2010 survey had a response rate of 34%.

Two areas identified for focused improvement are:

- Access to tea and coffee making facilities on the ward for parents
- Parent's rating of overnight facilities

The graph below shows areas where the Trust scored better than the PICKER average in the Paediatric Inpatient Survey. Lower percentages are better.

GRAPH – Areas where the Trust scored better that the PICKER average in Paediatric Inpatient Survey



The Trust Paediatric Outpatient Survey was commissioned for the first time, which meant that there were no previous Trust results for comparison. The response rate was 38%.

An area for focused improvement identified from the survey results is around the choice of appointment dates.

The table below shows the areas where the Trust results are significantly better than the PICKER average. Lower percentages are better.

TABLE – Areas where the Trust results are significantly better than the PICKER average - Paediatric Outpatient

	Trust	Average
Waited more than three months for an appointment	7%	13%
Could not find a convenient place to park	25%	38%
Not easy to find way to the right department	23%	30%
Unable to immediately find a place to sit in waiting area	2%	7%
Appointment started more than 15 minutes after stated time	28%	36%
Toilets at the outpatient department not clean	3%	8%
Parent not clearly told why their child needed tests	9%	18%
Not told when the child could carry on their usual activities	24%	31%
Not told what to do or who to contact if worried after the appointment	19%	25%
Child not given enough privacy when being treated or examined	13%	18%
Staff contradict one another	16%	22%
Overall - child's care rated as fair or poor	1%	4%

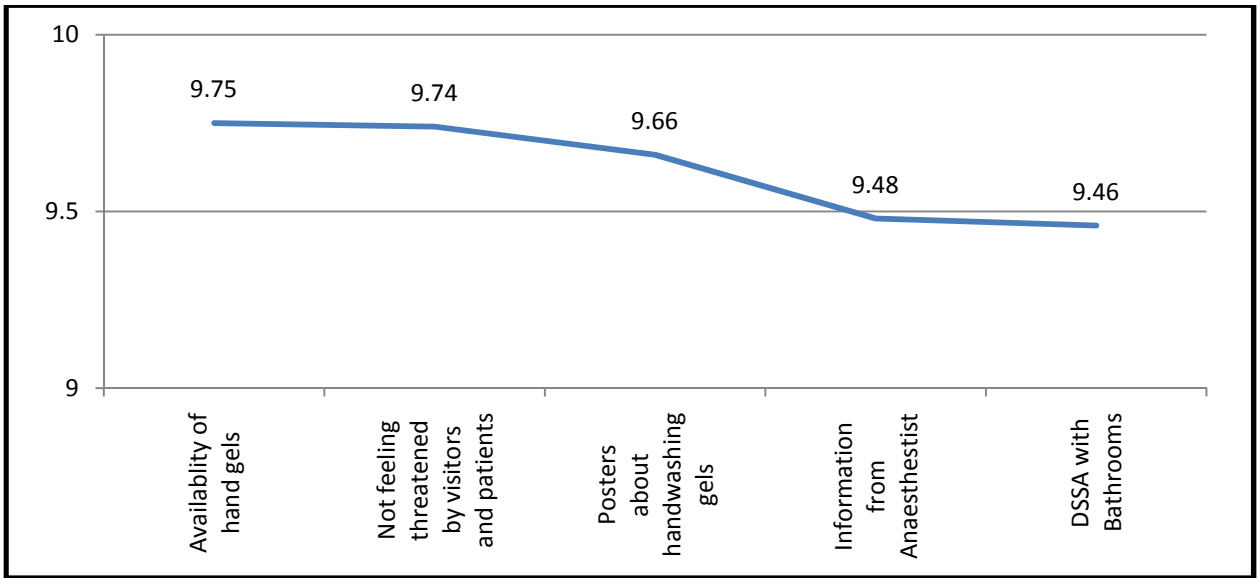
Annual Inpatient Survey

The Annual Inpatient Survey, results are reviewed by the Care Quality Commission (CQC) to benchmark Trusts nationally and will be used over the forthcoming financial years for Commissioning for Quality and Innovation (CQUIN) and measuring patient satisfaction as part of the NHS Outcomes Framework. The Annual Inpatient Survey is commissioned through the PICKER Institute.

The CQC rate Trusts scores out of ten. The Trust achieved a score of greater than 8/10 in 30 out of 63 areas.

The graph below shows the five highest scoring areas by the CQC.

GRAPH – Highest scoring patient satisfaction areas as scored by CQC



The table below shows where the Trust scored significantly higher than the PICKER average. Lower scores are better.

TABLE – Where the Trust has scored significantly higher than the PICKER average

	Trust	Average
Did not receive copies of letters sent between GWH and GP	25%	40%
Not offered a choice of food	14%	21%
Patients sharing bath or shower area with the opposite sex	6%	16%
Patients in more than one ward, sharing sleeping area with the opposite sex	2%	11%

The Head of Patient Experience and Essence of Care Lead review results against the quarterly report action plan. A Governor from the Patient Experience Working Group is invited to participate in this.

Call bells

Call bell response times appeared as an emerging theme within complaints, which are monitored by the Director of Nursing and Midwifery. The Quarterly Inpatient Surveys also reported an increase in the number of patients who reported waiting longer than five minutes for their call bell to be answered. Ward level call bell monitoring reports are available and will be displayed on the ward Performance Boards as part of the 'knowing how we're doing' module of the Productive Ward.

Comfort Rounds have been introduced across the Trust which allows Ward staff to ask patients if they require anything. This increases non clinical interaction between staff and patients, whilst reducing the need for patients to use the call bells.

Patient Reported Outcome Measures (PROMs)

PROMS are a national initiative which measure the quality of care provided in hospitals from the perspective of the patient. They help to measure improvement experienced by a patient following an operation, and this is captured through surveys being completed before and after surgery.

A PROMs assistant (funded by Department of Health) is managed within the PALS Department and currently collects the data for the following procedures within the Cherwell Unit:

- Hip
- Knee
- Hernia
- Varicose Veins

The figures collected by the Information Centre during 2010/11 showed that the Trust response rate for knee and hip surgery was above the national average.

Improvements in Stroke Care 2010/11

The Trust has a dedicated stroke ward to ensure that the best national practice for the care of stroke patients is achieved. The Trust obtained its licence to provide health services (without any conditions attached to it) from the Care Quality Commission in March 2010, but at the same time the Trust proactively declared non-compliance in relation to stroke care and undertook to ensure full compliance by implementing changes before October 2010.

The Trust has completed the changes required by the Care Quality Commission in the last year, delivering significant improvements in the quality of care provided for stroke patients. Patients receive dedicated treatment and rehabilitation in line with national standards, which enables a quicker and better recovery in the majority of cases. In the year ending 1 April 2011, 73.6% of all stroke patients spent 90% or more of their stay in the hospital on the Acute Stroke Unit. This represented a significant improvement on the previous year (34.5%). The Trust also commenced a 24 hours a day, 7days per week Thrombolysis service in April 2011.

The South West Stroke Review Team undertook a second inspection of the service in July 2010. The Review Team complimented the Trust and staff involved in stroke care, on the work that had been undertaken supporting the creation of a service that was unrecognisable from their previous visit.

Focusing on business performance

The Trust has kept a strong focus on its performance during the year and has a range of key performance indicators (KPIs) that it monitors. When appropriate, improvement plans are implemented and then reviewed to ensure the Trust's performance is within or exceeds target thresholds. The KPIs monitored by the Trust include those used by Monitor and the Care Quality Commission. Overall, the Board has been satisfied with performance. However, one Monitor KPI requiring improvement during 2009/10 was achieving 100% elective and emergency MRSA screening. The Trust has sustained over 95% compliance and actions have been put in place to achieve 100%. The KPI is not included within Monitors 2011/12 compliance framework and the DH is undertaking a study during 2011 to determine the effectiveness of screening all patients for MRSA on admission. The Trust is participating in this study.

The Trust reports MRSA screening on a 1:1 basis, as opposed to number of patients admitted against number of screens obtained within a set time frame. Although 100% MRSA screening for both elective and emergency patients has not been achieved by this method, measures have been introduced to address this. Twice daily an automatic report is generated on samples, which have been sent to the pathology laboratory, but not labelled appropriately. The wards are then notified and asked to repeat the specimen. Through an IT interface, a report which can be run as and when required is in the test phase. This report will show patients that have not been screened and allow screening to be prompted. MRSA screens, both elective and emergency, which have been missed, are investigated by the Infection Prevention and Control Practice Nurses. This information is fed back to the Ward Managers, Matrons and Infection Control Forum.

The Trust treats patients who may have cancer, within the national timescales. In all areas of cancer care we have been able to meet or exceed the national standards. National targets are important and we believe these "targets" are integral to delivering high quality clinical care. We are determined to maintain and improve our performance against the national and local targets, including reducing ambulance handover delays, reducing numbers of falls in hospital, increasing the number of patients who have a nutritional assessment completed.

Focusing on the patient

Productive Ward

The roll out of the Productive Ward initiative was introduced at GWH in 2008/09. The aim of the project is to increase direct patient care. This roll out has continued and now all 22 wards are at varying stages of implementing the programme. Included in this number are Maternity, Neonatal Unit and the Children's Ward. Only a very few hospitals have achieved this. In addition GWH is breaking new ground by adapting the programme and introducing in the Emergency Department, Day Surgery and Pathology.

There are 11 modules to the Productive Ward and with 22 wards this equates to 242 modules in total trust wide. Of this number 87 have been completed with a further 43 being implemented.

Since starting the initiative in February 2009:

- the average time nursing staff are spending with patients has increased from 43.1% to 59.3%;

- improved communication between the Multi Disciplinary Team using Patient status at a Glance boards has increased patient safety and has demonstrated a reduction in average length of stay of up to 2 days, which is a positive outcome for our patients;

- the introduction of a standardized handover to include safety briefings and bed side handover now ensures the safe transfer of patient information reducing risk and achieving patient satisfaction and involvement in their care; and

- innovative working has reduced food wastage by the introduction of protected mealtimes, trialing a menu free approach, red lids and red trays for our vulnerable patients. Food is hotter at point of delivery to the patient increasing patient satisfaction in our service.

Nutrition

Good nutrition and hydration are fundamental to well-being and recovery from illness or trauma. A high proportion of individuals admitted to hospital are vulnerable to malnutrition.

- 70% of those admitted are elderly
- 40 - 50% of all hospital in-patients may be malnourished.

In hospital, nutritional status and hence general health and well-being can rapidly deteriorate for a variety of reasons often with serious consequences.

There have been significant improvements in a number of areas at GWH as follows: -

- Nationally validated screening tool (MUST) has been customised for local use and implemented in all appropriate areas along with supporting information e.g. user guide and patient record forms.

- A training programme is in place which includes Volunteers and Nursing Assistants. On-going training of staff to use MUST continues with ward based Nutrition Resource Nurses and MUST champions cascading training.

- E-learning version of MUST is now available.

- MUST average compliance has increased from 33% to 75%.

- There have been improvements to meal quality (portion sizes, presentation, temperature and patient satisfaction).

- A new allergy aware menu and green tray system has been introduced for people with food intolerance/coeliac disease.

- A new children's menu has been introduced.

- Positive Patient Environment Action Team (PEAT) feedback regarding food provision in 2010 and again 2011 has been received.

- There is a positive Essence of Care as evidence in the internal audit report August 2010.

- A recent Care Quality Commission (CQC) spot check has shown that GWH is providing appropriate nutritional care to the patients.

Pressure Ulcers

Our objectives for the period 2010/2011 were to reduce all hospital acquired grade 3 and grade 4 pressure ulcers by 10%.

- The Trust has made a dramatic improvement of 91% to the target for Grade 3 pressure ulcers and 59% improvement to the number of Grade 4 pressure ulcers.
- The overall combined mean average reduction for 2010/2011 is 75%.
- Through aggregated analysis, the Pressure Ulcer Focus Forum has focused upon best practice actions to improve the care delivered to our patients.
- The introduction of comfort rounds/intentional rounding; education; ward safety briefings and auditing can also be attributed to this year's success.

Reducing the number of our patients who fall in hospital

This year we have seen a 38% improvement in reducing falls resulting in severe harm as categorised by the National Patient Safety Agency (NPSA). This has exceeded the 10% target set for 2010/11. This has been achieved through a focus group using aggregated analysis to form an action plan for all the wards involved. It has raised awareness and brought focus and support for wards to reduce the risk factors resulting in harm from falls. The following has been achieved: -

- There have been patient safety initiatives as a result of the productive ward which have assisted in the reduction of falls risk factors. These initiatives have included patient boards focussing on fall risks and ward safety briefings. Communication with staff and awareness of risk has improved.
- The organisation has developed a Trust wide electronic auditing system for falls risk assessments in partnership with clinical audit, enabling support to be given to those wards in need.
- GWH has held the first regional falls study day providing vital training and networking opportunities to all trust staff and the wider South West.
- The Patient Safety First Campaign in conjunction with work from the Quality and Patient Safety Improvement Programme is progressing well with the first two wards completing a successful trial of the new inpatient falls care pathway. This will contribute to helping develop an effective falls pathway document.

Venous Thromboembolism (VTE)

Following the report from the All-Party Parliamentary Thrombosis group in November 2007, the Trust identified the reduction in hospital acquired VTE as an area for local improvement and an action plan was formulated. Over the last 12 months the development of a local policy for VTE has been established and individual points from the action plan have been either achieved or are working towards completion.

Accomplishments so far include:

- Development of a multi-disciplinary thrombosis implementation group with membership from the Primary Care Trust commissioner, provider and the Trust.
- Appointment of a VTE nurse to lead on education and implementation of strategy (this commenced in January 2010).
- The VTE policy has been amended to include changes from the National Institute for Health and Clinical Excellence (NICE) guidelines.
- Establishing a risk assessment tool for VTE to be used for all adult in-patients. (This was incorporated into the Trust's new drug chart in July 2010).
- Development of a separate Obstetric risk assessment tool.
- Development of a robust audit trail to check compliance with the risk assessment tool, appropriate prescribing of Thromboprophylaxis and any Hospital Acquired Thrombosis (HAT).
- The Orthopaedic department is now fully compliant with NICE guidelines for recommended Thromboprophylaxis following elective Total Hip Replacement (THR) and Total Knee Replacement (TKR).
- An education programme for nurses and medical staff is on going and will be incorporated into training tracker for 2011/12.
- A patient information leaflet has been developed. A separate discharge leaflet for patients who are going home on VTE prophylaxis medication is also available and has been drawn up as a joint leaflet with Swindon PCT.

Over the past 12 months we have seen a significant improvement in patients receiving a risk assessment for VTE. In March 2010 we were achieving 33% and through lots of hard work on everyone's part managed to reach more than 90% by the end of November which we have continued to sustain over the last 4 months. This means that we reached our Commissioning for Quality and Innovation (CQUIN) goal for 2010/11.

This work has been recognised by "Lifeblood" the thrombosis charity and we received an award at the House of Commons in January this year.

Working with carers

Carers play a key role in the care of the patients at GWH. The Trust recognises that carers are the experts in the care of a patient and therefore are partners in care. In supporting Carers GWH ensures that they have input in advice and guidance for our staff, and are encouraged to be part of the team during that care if they wish to. Carers are offered parking permits and food vouchers to make the time spent at the Trust as less stressful as possible. A protocol has been developed with partners both statutory and voluntary to ensure Carers needs are met at GWH.

The support we offer Carers has been recognised by the 'Princess Trust' and the Trust has been awarded a 'Recognition Award' and 'Champions Award' by the Swindon Carers Centre/Demonstrator Site. Carers are also members of the Carers Committee to ensure we continue to meet the needs of Carers and their voices are heard and all in patient areas have dedicated link staff that support Carers at the ward level.

Caring for our patients with Learning Disabilities

The NHS South West in partnership with Commissioners facilitated peer reviews to assess acute hospitals' ability to meet the needs of people with a learning disability. The key drivers informing the review were:

- Death by Indifference Report, Mencap (2007)
- Independent Enquiry, Healthcare for All (2008)
- Joint Ombudsman Report, Six Lives (2009)
- Equal Access, Department of Health (DOH) (2009)

The review for GWH took place on the 30 September 2010. The findings of the review showed areas of strength and areas for attention for which a working plan is in place.

Areas of strength:

- High level of commitment at GWH
- Clear policy, intranet web site and passport in place
- Partnership working
- Organisational Learning regarding risks and incidents
- Innovative training methods
- Link nurses on each ward with a special interest in learning disability

Areas for improvement:

- Further development of Easy Read Documentation
- Development of Safe Swallow Guidelines for people with Learning Disabilities
- Hospital Discharge requires some refinement
- Training for effective communication including Makaton methods
- Patient Comment Cards – Learning Disability needs to be considered

Work is progressing to address the areas for improvement.

Caring for patients with Dementia

The development and introduction of the Living Well with Dementia, A National Dementia Strategy (2009) has set clear expectations for the development of:

- improved knowledge about dementia for professionals;
- improvements in assessment and diagnosis;
- developing a range of services that meet the changing needs of people with dementia over time.

The implementation of the national strategy has given GWH clear direction to ensure that people with dementia and their carers receive services that are appropriate and timely. GWH has completed a self assessment and improvement plan with partners and users to ensure we meet current and future needs; develop new roles and build on established effective partnerships to ensure the whole system works effectively and efficiently.

Working with our partners to strengthen the service we provide

The main development in relation to partnership working between GWH and key stakeholders during the year has been the Trust's selection as 'preferred provider' for Wiltshire Community Health Services (WCHS). This development means that moving forward the Trust will need to adopt a different approach to partnership working as the organisation moves from being an acute hospital provider to healthcare provider offering acute, community and maternity services across a much larger geographical area.

As part of the work taking place to ensure a smooth and safe merger of these services, there has been a strong focus on establishing and strengthening relationships with key local stakeholders such as GPs, Local Authorities, Social Care and the Third Sector across Wiltshire. As an organisation with long standing roots in the Swindon and Wiltshire community the Trust already has strong relationships with many of these groups in the immediate local area. As the merger widens the geographical area across which the Trust will be providing services (across Wiltshire and into Bath and parts of North East Somerset), work has been taking place in the second part of the year to build links with partners in these areas.

The Trust recognises that it is only by working effectively with partners both inside and outside the NHS that GWH will be able to provide truly seamless, integrated care for patients and their communities. This improvement is a key driver behind the merger with Wiltshire Community Health Services and will be an important measure of the Trust's success in improving the care provided to patients in the years ahead.

Through the merger the Trust aims to deliver the following benefits:

- Redesigned care pathways across acute and community care, enabling greater joined up working between acute and community care teams which will remove some of the artificial boundaries that patients experience, and can lead to patients feeling lost in the system.

- The opportunity to work even more closely as a health community with our GP, social care and Local Authority partners in improving patient care and experience.

- Keeping people out of hospital and close to home which has clear links to tackling hospital readmissions and supporting the re-enablement of patients and services users so they can lead an independent life (supported by social care where appropriate).

- Reducing duplication where it exists as currently some services are offered in both the Acute setting and Community which is not sustainable given the financial challenges facing the NHS.

- To deliver cost savings through implementation of IT solutions that enable 'smarter' working and less staff mileage

As part of the work that has been taking place to support the merger of services, representatives from the Trust have attended meetings of the Wiltshire Local Area Boards as part of a planned stakeholder engagement to present on the merger and to set the tone for ongoing relationships with these important partners once the merger takes place.

Additionally, the Trust has been actively engaging with GPs, Local Authority partners through Area Boards and with colleagues in Social Care. The Trust has also attended Third Sector forums which exist, recognising the important role these groups will play in helping the Trust fully realise the benefits of the merger.

In June 2010 the Trust published the first edition of a new quarterly magazine called 'Horizon' which is distributed to all members (both staff and public) and to local key stakeholders including GP practices and local libraries. The magazine is designed to keep people informed and up to date on developments at the Trust including important information from the governors on membership matters. A large focus of the content for the magazine centres on developments that are improving patient care and experience. The magazine has been well received. The content for Horizon will be expanded to include articles and topics covering community services in Wiltshire when the Trust takes on responsibility for these services from June 2011. The magazine is available to view on the Trust website.

Health and Overview Scrutiny Committees (HOSCs)

HOSCs (also known as Adult Social Care Select Committees) provide an external voice and work in partnership with public service providers to improve the quality of life and services for the residents in their area. They monitor proposals and service changes to ensure that they have been made in accordance with protocol and act in the best interest of the community.

The Trust liaises regularly with representatives of the HOSC and where appropriate, gives briefings to the committees. Briefings have included topics such as the Epilepsy Service for patients in Swindon, Car Parking and correspondence with GPs. During 2010/11 there has been representation at both the Swindon HOSC and Wiltshire Adult Social Care Select Committee and in addition to this, there will be Governor representation from April 2011.

A visit is being arranged for the members of the HOSC to come to The Great Western Hospital to see the different projects that are underway.

Swindon and Wiltshire LINks

The Trust works closely with the Swindon LINk and continues to develop its relationship with the Wiltshire Involvement Network. The Trust has a duty to:

- Respond to requests to enter and view the organization
- Respond to requests for information made by a LINk
- Address reports and recommendations made by a LINk
- Address reports or recommendations from a LINk that have been made by another services provider

The Trust is committed to looking at ways of reaching out to the broader community beyond our existing membership. Through working closely with LINk, the Trust looks at areas to pool resources and share knowledge to access hard to reach groups.

Statement as to disclosures to auditors

For each individual director, so far as the director is aware, there is no relevant information of which the Great Western Hospitals NHS Foundation Trust's auditor is unaware and that each director has taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the Great Western Hospitals Foundation Trust's auditor is aware of that information.

Relevant audit information means information needed by the auditor in connection with preparing their report. In taken all steps the directors have made such enquiries of their fellow directors and of the Trust's auditors for that purpose and they have taken such other steps for that purpose as are required by their duty as a director of the Trust to exercise reasonable care, skill and diligence.

Additional disclosures

Preparation of accounts

The accounts for the period ended 31st March 2011 have been prepared in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006 in the form that Monitor (the Independent Regulator of NHS Foundation Trusts) with the approval of the Treasury, has directed.

History of the Trust

Great Western Hospitals NHS Foundation Trust was authorised as a Foundation Trust on 1 December 2008 and established as a public benefit corporation under the NHS Act 2006. On becoming a Foundation Trust the name of the organisation was changed from Swindon and Marlborough NHS Trust to the name we have now.

As a Foundation Trust the organisation has greater freedom to run its own affairs, which offers financial advantages to invest in services for the future. The principle activities of the Trust are referred to elsewhere in this report *(page 15 refers).*

Going concern

After making enquiries the directors have a reasonable expectation that the Great Western Hospitals NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing for the accounts.

Accounting policies for pensions and other retirement benefits

Accounting policies for pensions and other retirement benefits are set out in note 1.3 to the accounts and details of senior employees' remuneration can be found elsewhere in this report in the remuneration report section *(page 53 - 55 refers).*

Interests held by Directors and Governors

Details of company directorships and other significant interests held by directors or governors which may conflict with their management responsibilities are registered. The Trust maintains two registers one each for directors and one for governors which are open to the public. Both registers are referred to elsewhere in this report *(pages 65 - 66 and 74 refer).*

Each Director and Non-Executive Director is required to declare their interests on an ongoing basis and to ensure that their registered interests are up to date. The registers of interests are maintained by the Company Secretary. The Directors are reminded at the beginning of each Trust Board meeting that they must declare any interest which may conflict with the business of the Trust and excuse themselves from any discussion where such conflict may arise. The Trust is satisfied with the independence of the Board for the entire year.

4
Remuneration Report

Information not subject to audit

Remuneration Committee

The Trust has a Remuneration Committee known as the Nominations and Remuneration Committee. This is a committee of the Trust Board and its responsibilities are to:

- Regularly review the structure, size and composition (including the skills, knowledge and experience) required of the Board and make recommendations to the Board with regard to any changes.
- Give full consideration to and make plans for succession planning for the Chief Executive and other Executive Board Directors taking into account the challenges and opportunities facing the Trust and the skills and expertise needed, in particular on the board in future.
- Be responsible for identifying and nominating for appointment candidates to fill posts within its remit as and when they arise.
- Be responsible for identifying and nominating for appointment a candidate, for approval by the Council of Governors, to fill the position of Chief Executive.
- Before an appointment is made evaluate the balance of skills, knowledge and experience on the Board, and, in the light of this evaluation, prepare a description of the role and capabilities required for a particular appointment. In identifying suitable candidates the Committee shall:

  i. use open advertising or the services of external advisers to facilitate the search
  ii. consider candidates from a wide range of backgrounds
  iii. consider candidates on merit against objective criteria

- Consider any matter relating to the continuation in office of any Board Executive Director at any time including the suspension or termination of service of an individual as an employee of the Trust.
- To consider the engagement or involvement of any suitably qualified third party or advisers to assist with any aspects of its responsibilities.
- To determine and agree with the Board the framework on broad policy for the remuneration of the Trust's Chief Executive, Executive Directors and other such members of the Executive Management Team and staff as it is designated to consider as listed below:

  1 Annual pay review
  2 Executive Directors' remuneration
  3 Chief Executive remuneration
  4 Consultant Discretionary Awards (scale of award, points and recommendations)
  5 Special cases on variation of conditions
  6 Senior Managers' pay

- The annual pay review will be delegated to the Committee for approval. Items 2, 3, 4 and 5 above will be delegated to the Committee to resolve, with power to establish a Sub-Committee to make recommendations in the cases of 4 and 5. In the case of 4 prior

approval of the Committee will be sought on the points to be awarded and the process to be followed to determine the allocation of points.

Senior managers' pay (6) will be recommended by the Executive Committee for approval by the Committee. The Committee will monitor senior managers' pay, ensuring it is in line with corporate policy.

- In carrying out this duty, the Committee will:

  (a) take into account all factors which it deems necessary. The objective of such policy shall be to ensure that members of the executive management of the Trust are provided with appropriate incentives to encourage enhanced performance and are, in a fair and responsible manner, rewarded for their individual contributions to the success of the Trust;
  (b) judge where to position the Trust in relation to other NHS Trusts, being aware of what these organisations are paying;
  (c) focus on the wider scene, including pay and conditions elsewhere in the NHS, especially when determining salary increases and outside the NHS where the market so determines;
  (d) consider what compensation commitments (including pension contributions) the Directors' contracts of service will entail, if any, in the event of early termination;
  (e) consider whether Directors should be eligible for annual bonuses and what the criteria should be for such schemes.

- To review the ongoing appropriateness and relevance of the Trust's remuneration policy.
- To approve the design of, and determine targets for, any performance related pay schemes operated by the Trust and approve the total annual payments made under such schemes.
- To request the Audit, Risk and Assurance Committee to adopt a 'quality of earnings' approach to reviewing the achievement of a budget surplus where this forms part of the Executive remuneration scheme.
- To review the design of all incentive plans for approval by the Board. In respect of such plans, to determine each year whether awards will be made and if so, the overall amount of such awards, the individual.

The responsibility for carrying out these duties rests with the Nominations and Remuneration Committee whilst the accountability for the actions of the Committee remains with the full Board.

Membership of the Nominations and Remuneration Committee

Membership of the Committee in 2010/11 was as follows: -

Rowland Cobbold	Chairman
Robert Burns	Member
Liam Coleman	Member
Angela Gillibrand	Member
Kevin Small	Member
Roger Hill	Member
Bruce Laurie	Member
Lyn Hill –Tout	Chief Executive

Attendance at meetings of the Nominations and Remuneration Committee during 2010/11

	Record of attendance at each meeting (✓ = attended X = did not attend)		
Name	**29/04/10**	**17/11/10**	**31/03/11**
Rowland Cobbold (Chair)	✓	✓	✓
Robert Burns	✓	✓	✓
Liam Coleman	✓	✓	X
Angela Gillibrand	X	✓	✓
Kevin Small	✓	✓	✓
Roger Hill	✓	✓	✓
Bruce Laurie	✓	✓	✓
Lyn Hill-Tout	✓	✓	X

Policy and guidance

In exercising its responsibilities, the Committee: -

- has regard for each individual's performance and contribution to the Trust and the performance of the Trust itself;
- takes into account any applicable guidance from Hay Group (appointed by the Trust to advise on all aspects of executive remuneration on an ongoing basis) or other external bodies, that may from time to time be issued relating to remuneration of Executive Directors; and
- seeks professional advice from the Chief Executive, Director of Workforce and Education, Director of Finance or other professionals.

The Nominations and Remuneration Committee reviewed the performance and salaries of the Executive Directors of the Trust. Advice was obtained from the Chief Executive and the Director of Workforce and Education and its advisors.

In 2009/10, a new appraisal process for the Chief Executive and Executive Directors was designed which included an 360 degree assessment of each Executive Director against a range of competencies and a more effective system for setting individual objectives and performance measures for 2010/11. This method was again followed in setting objectives in 2011/12 and in reviewing 2010/11 contribution and performance.

The Committee had charged the Executive team with developing a more formal framework for identifying and managing talent, and reports were provided during the year of progress made. The Committee approved the approach to succession planning and talent management.

The individual performance of the Executive Directors was assessed against their objectives and their achievements, which had previously been approved by the Committee. Individual

performance review meetings were held for each Executive Director with the Chief Executive (or the Chairman in the case of the Chief Executive), and each Executive Director.

In May 2010 the Nominations and Remuneration Committee received benchmark information on Executive salaries. The Committee considered market dynamics, internal relativities and the risk to the organisation of losing key staff. Pay increases were therefore agreed in respect of 2010/11 for three Executive Directors following assessment of the pay market within the South West. There were no inflationary increases for Executive Directors.

In April 2011 the Nominations and Remuneration Committee decided not to agree an inflationary increase for Executive Directors pending a further review of those salaries against the market, but resolved to pay a non-pensionable and non-recurring uplift of 4% in recognition of hard work in delivering the Trust strategy.

The Committee reviewed approaches to Board assessment and development and commissioned the Institute for Innovation and Development, who had developed a Board Development Tool (BDT) for Foundation Trusts to undertake a review of its effectiveness in 2011/12. The Committee was also keen to ensure that the Trust established a longer term relationship with an organisation as members felt that this would be beneficial in the Board's ongoing development.

Board of Directors' employment terms

The appointment of the Chief Executive is made by the Non-Executive Directors and approved by the Council of Governors. The Chief Executive and Executive Directors have a contract with no time limit, and the contract can be terminated by either party with three months' notice. These contracts are subject to usual employment legislation.

Executive Directors are nominated for re-appointment by a committee comprising the Chairman and Non-Executive Directors with the Chief Executive invited to attend and the Trust's Constitution sets out the circumstances under which a Director may be disqualified from office. New Executive Directors are nominated for appointment by a Joint Committee of Governors and Non-Executive Directors. The Board agrees the Executive Director appointments.

The Committee recognises that Executive pay does not reflect market levels and therefore in order to recruit and retain high calibre Executives, the Committee is actively exploring ways of redressing this balance.

Information subject to audit

The information subject to audit, which includes senior manager's salaries, compensations, non cash benefits, pension, compensations and retention of earnings for non-executive directors, is set out in the table below.

Nominations and Remuneration Committee report

Pensions Benefits

Name	Title	Real Increase in Pension 2010-11 (Bands of £2500)	Real Increase in Lump Sum 2010-11. (Bands of £2500)	Total accrued pension at 31st March 2011. (Bands of £5000)	Total accrued related lump sum at 31st March 2011. (Bands of £5000)	Cash Equivalent Transfer Value at 31st March 2011	Cash Equivalent Transfer Value at 31st March 2010	Real Increase in Cash Equivalent Transfer Value	*Employers Contribution to Stakeholder Pensions*
		£000	£000	£000	£000	£000	£000	£000	*£000*
L. Hill-Tout	Chief Executive	0-2.5	2.5-5	40-45	125-130	826	858	-31	*0*
O Fitzgerald	Director of Workforce and Education	0-2.5	5-7.5	10-15	35-40	140	142	-3	*0*
M. Moore	Director of Finance	0-2.5	2.5-5	15-20	50-55	217	238	-21	*0*
A. Troughton	Medical Director	10-12.5	30-32.5	55-60	165-170	1,215	1,047	168	*0*
S Rowley	Director of Nursing	0-2.5	5-7.5	30-35	90-95	530	540	-11	*0*
H Bourner	Director of Business Development & Performance	0-2.5	5-7.5	10-15	35-40	207	194	14	*0*

Note. Accrued Pension and Lump Sum relate to benefits accrued to date and are not a projection of future benefits. They will include any additional pension benefits that have been purchased to date.

Remuneration

		2010/11					2009/10					
Name	**Title**	**Salary (Bands of £5000)**	**Other Remuneration (Bands of £5000)**	**Performance Related Bonuses (Bands of £5,000)**	**Compensation for Loss of Office**	**Benefits in Kind Rounded to the Nearest £100**	***Salary (Bands of £5000)***	***Arrears for 08-09 paid in 09-10***	***Other Remuneration (Bands of £5000)***	***Performance Related Bonuses (Bands of £5,000)***	***Compensation for Loss of Office***	***Benefits in Kind Rounded to the Nearest £100***
B Laurie	Chair	35-40	-	-	-	0	*35-40*	*05-10*	*0*	*0*	*0*	*0*
K Small	Non Executive Director	10-15	-	-	-	0	*10-15*	*0-5*	*0*	*0*	*0*	*0*
R Cobbold	Non Executive Director	10-15	-	-	-	0	*10-15*	*0-5*	*0*	*0*	*0*	*0*
A Gillibrand	Non Executive Director	10-15	-	-	-	0	*10-15*	*0-5*	*0*	*0*	*0*	*0*
R Hill	Non Executive Director	10-15	-	-	-	0	*10-15*	*0-5*	*0*	*0*	*0*	*0*
R Burns	Non Executive Director	10-15	-	-	-	0	*10-15*	*0-5*	*0*	*0*	*0*	*0*
L Coleman	Non Executive Director	10-15	-	-	-	0	*10-15*	*0*	*0*	*0*	*0*	*0*
L. Hill-Tout	Chief Executive	120-125	-	0-5	-	0	*120-125*	*05-10*	*0*	*0*	*0*	*0*
O Fitzgerald	Director of Workforce and Education	80-85	-	0-5	-	0	*75-80*	*0-5*	*0*	*0*	*0*	*0*
M Moore	Director of Finance	100-105	-	0-5	-	0	*100-105*	*0-5*	*0*	*0*	*0*	*0*
A. Troughton	Medical Director	80-85	100-105	0-5	-	0	*95-100*	*0-5*	*80-85*	*0*	*0*	*0*
S Rowley	Director of Nursing	80-85	-	0-5	-	0	*80-85*	*0-5*	*0*	*0*	*0*	*0*
H Bourner	Director of Business Development & Performance	80-85	-	0-5	-	0	*75-80*	*0-5*	*0*	*0*	*0*	*0*

The accounting policies for pensions and other retirement benefits are set out in the notes 1.3 to the accounts and key management compensation is set out in note 7.3 to the accounts.

Notes to Remuneration and Pension Tables

Non-Executive Directors do not receive pensionable remuneration.

No executive directors serve elsewhere as non-executive directors and therefore there is no statement on retention of associated earnings.

Cash Equivalent Transfer Value

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at any one time. The benefits valued are the members' accrued benefits and any contingent spouse's pension payable from the scheme.

A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme, or arrangements when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures show the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of the scheme at their own cost. CETV's are calculated within the guidelines and frameworks prescribed by the Institute and Faculty of Actuaries. The CETV is based on actual contributions to 31st March 2011.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation and contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses the common market valuation factors from the start and end of the period.

Signed……..

Lyn Hill-Tout
Chief Executive 6 June 2011

5
NHS Foundation Trust Code of Governance

Council of Governors

Council of Governors

The Council of Governors consists of elected and nominated governors who provide an important link between the hospital, local people and key stakeholder organisations by sharing information and views that can be used to develop and improve hospital services.

Three public constituencies have been created to cover the Trust's catchment area namely, Swindon, Wiltshire, and West Berkshire, Gloucestershire and Oxfordshire. Governors for these areas are elected by members of those constituencies in accordance with the election rules stated in the Trust's Constitution using the "first past the post" voting system. Elections are carried out on behalf of the Trust by the independent Electoral Reform Services Ltd. There are 10 public governor positions (Swindon – 5, Wiltshire – 3, and West Berkshire, Gloucestershire and Oxfordshire – 2). In addition there are elected staff governors and governors nominated by organisations that have an interest in how the Trust is run. There are 3 staff governor positions and 6 nominated governor positions (2 PCT governors; 2 local authority governors and 2 other partner governors). There are 19 governor positions in total on the Council of Governors.

The Trust is currently reviewing its public constituencies based on its new geographical area as a result of taking on board Wiltshire Community Health Services. It is an anticipated that the constituencies will be reviewed in the longer term and there will be an increase in the number of public governors to reflect this. Furthermore, the Trust has a wide range of staff undertaking a variety of roles and professions. Consideration is currently being given to establishing classes within the staff constituency to reflect occupational areas. In addition, consideration is being given to other partner governors and whether there should be representation from third sector organisations reflecting the Trust's involvement in this area.

The number of public governors must be more that half of the total membership of the Council of Governors.

There were 3 meetings of the Council of Governors in 2010/11. In addition there was a joint meeting of the Board of Directors and the Council of Governors and an annual members meeting.

The names of governors during the year, including where governors were elected or appointed during the year and their length of appointments are set out in the following tables. The Trust held elections in all constituencies during the year for governors whose terms of office expired. There was an average turnout of 29% across all constituencies. The re-elected and newly elected Governors were formally appointed to office at the Council of Governors meeting held on 29 November 2010.

Elected Governors – Public Constituency

Name	Constituency	Term of Office	Date Elected	End of term	Attendance from 3 meetings
Ros Thomson	Swindon	3 years	01/12/08	Dec 2011	3
Katherine Usmar	Swindon	3 years	01/02/08	Dec 2011	2
Harry Dale 1	Swindon	3 years	04/11/10	Nov 2013	1 from 1
John Brown - Reserve Governor *2	Swindon	Remainder of 3 years	03/02/10	Resigned 23/11/10	1 from 2
Geraint Day – Reserve Governor *3	Swindon	Remainder of 3 years	12/01/11	Nov 2012	0 from 0
Phil Prentice *4	Swindon	3 years	20/11/09	Nov 2012	3
Margaret Toogood*6	Wiltshire	3 years	01/12/08	Resigned 28/04/11	2
Godfrey Fowler*4	Wiltshire	3 years	04/11/10	Nov 2013	3
Janet Jarmin*4	Wiltshire	3 years	04/11/09	Nov 2012	2
Srini Madhavan	West Berkshire, Gloucestershire and Oxfordshire	3 years	01/12/08	Dec 2011	2
*Graham Chisholm*5	West Berkshire, Gloucestershire and Oxfordshire	2 years	01/12/08	Resigned 05/05/10	0 from 1

*1 Harry Dale was elected initially in December 2008 for a 2 year term. He was re-elected for a second term of 3 years in November 2010.

*2 John Brown was elected as a governor taking up the position in February 2010 following the resignation of Emma Neilson in January 2010. John Brown received 12.12% of the votes at the November 2009 elections coming third (note that the second place candidate was elected to a seat). However, John Brown subsequently resigned in November 2010. He is prevented from standing to become a governor for 5 years from the date of his resignation.

*3 Geraint Day was elected as a governor taking up the position in January 2011 following the resignation of John Brown in November 2010. Geraint Day received 35.53% of the votes at the November 2010 elections.

*4 Phil Prentice, Godfrey Fowler and Janet Jarmin are serving second terms.

*5 Graham Chisholm resigned in May 2010. He is prevented from standing to become a governor for 5 years from the date of his resignation.

*6 Margaret Toogood has recently resigned. The vacancy has yet to be filled.

There is currently a vacancy for the governor position in respect of the West Berkshire, Gloucestershire and Oxfordshire constituency. No candidates stood at the last elections in November 2010.

In the event of an elected governor's seat falling vacant for any reason before the end of a term of office, it shall be filled by the second (or third) placed candidate in the last held election for that seat provided at least five percent of the vote and they are known as reserve governors.

Elected Governors – Staff Constituency

Name	Constituency	Term of Office	Date Elected	End of term	Attendance from 3 meetings
Rachel Cross	Staff	3 years	01/12/08	Dec 2011	2
Mike Carvell *1	Staff	2 years	01/12/08	Dec 2010	1 from 2
Peter Hanson	Staff	3 years	04/11/10	Dec 2013	0 from 1
Marcus Galea	Staff	3 years	20/11/09	Dec 2012	3

*1 Mike Carvell was not re-elected at the elections held in December 2010. He was replaced by Peter Hanson.

Nominated Governors

Name	Constituency	Term of Office	Date Elected	End of term	Attendance from 3 meetings
David Stevens	PCT – Wiltshire PCT	3 years	01/12/08	Dec 2011	3
Bill Fishlock	PCT – Swindon PCT	3 years	01/12/08	Dec 2011	3
David Renard	Local Authority – Swindon Borough Council	3 years	01/12/08	Dec 2011	2
Carole Soden	Local Authority – Wiltshire Council	3 years	01/12/08	Dec 2011	1
Andy Cresswell	Other Partnerships – Thames Valley Chamber of Commerce	3 years	01/12/08	Dec 2011	1
Lesley Donovan	Other Partnerships – Swindon and North Wiltshire Health and Social Care Academy	3 years	01/12/08	Dec 2011	1

Attendance at meetings of the Council of Governors during 2010/11

The table below shows governor and director attendance at meetings of the Council of Governors and a joint meeting of the Council of Governors and Board of Directors: -

Attendee	05/05/10	08/09/10	08/09/10*	29/11/10
			(✓ = attended X = did not attend)	
Governors				
John Brown	√	x	x	n/a
Mike Carvell	√	x	x	n/a
Graeme Chisholm	x	n/a	n/a	n/a
Andy Cresswell	x	√	√	x
Rachel Cross	√	x	x	√
Harry Dale	x	x	x	√
Geraint Day	n/a	n/a	n/a	n/a
Lesley Donovan	x	√	√	x
Bill Fishlock	√	√	√	√
Godfrey Fowler	√	√	√	√
Marcus Galea	√	√	√	√
Peter Hanson	n/a	n/a	n/a	x
Janet Jarmin	x	√	√	√
Srini Madhavan	√	x	x	√
Phil Prentice	√	√	√	√
David Renard	x	√	√	√
Carole Soden	x	√	√	x
David Stevens	√	√	√	√
Ros Thomson	√	√	√	√
Margaret Toogood	√	x	x	√
Katherine Usmar	x	√	√	√
Directors				
Helen Bourner	√	x	√	x
Robert Burns	x	x	√	x
Rowland Cobbold	√	√	√	√
Liam Coleman	x	x	√	x
Oonagh Fitzgerald	x	x	√	x
Angela Gillibrand	x	x	√	x
Roger Hill	x	x	√	x
Lyn Hill-Tout	√	√	√	√
Bruce Laurie (Chair)	√	√	√	√
Maria Moore	x	x	√	x
Sue Rowley	x	x	√	x
Kevin Small	x	x	√	x
Alf Troughton	x	x	√	x

*This was a joint meeting of the Council of Governors with the Board of Directors.

Lead and Deputy Lead Governors

In November 2010, Godfrey Fowler was nominated as the lead governor for another year and Harry Dale was nominated as the deputy lead governor. The lead governor is responsible for receiving from governors and communicating to the Chair any comments, observations and concerns expressed by governors other than at meeting of the Council of Governors regarding the performance of the Trust or any other serious or material matter relating to the Trust or its business. The deputy lead governor is responsible for supporting the lead governor in his role and for performing the responsibilities of the lead governor if he is unavailable. The lead governor regularly meets with the Chair of the Trust both formally and informally. In addition the lead governor communicates with other governors by way of regular email correspondence.

Biography of individual governors

A biography of each governor is included on the Trust's website.

Role and function of the Council of Governors

The Council of Governors has a duty under the National Health Services Act 2006 to represent the views of foundation trust members and stakeholders, to the Board of Directors and the management of the Trust. The Trust keeps the Council of Governors fully informed on all aspects of the Trust's performance. This is done through formal Council meetings, and through working groups set up by the Council of Governors. These are explained in detailed elsewhere in this report (*page 63 refers).*

In addition to discussions and presentations at the formal Council meetings and meetings of the working groups, a monthly report from the Chair is sent to Governors after each Trust Board meeting providing a summary of key performance and organisational issues. The Governors are also consulted on forward plans and on our compliance with Standards for Better Health and our Quality Accounts. During the year the Trust has continued to strengthen the links between the Board of Directors and the Council of Governors to enable a better understanding of the views of Trust members. This has involved, amongst other initiatives, joint workshops, further details of which can also be found elsewhere in this report *(page 61 refers)*.

Statement setting out how the Council of Governors and the Board of Directors operate

The overall responsibility for running the Trust lies with the Board of Directors and the Council of Governors is the collective body through which the directors explain and justify their actions.

It is the responsibility of the Council of Governors to represent the views and interests of the members, to hold the Board of Directors to account for the performance of the NHS Foundation Trust and to ensure the Trust acts within the terms of its authorisation. The Council of Governors also works with the Board of Directors to shape the future strategy of the organisation. It is the role of the Governors to ensure that information about the performance and strategy of the Trust is disseminated to members.

The Council of Governors has specific statutory powers and duties including:

- appointing and, if appropriate, removing the chair
- appointing and, if appropriate, removing the non-executive directors

- deciding the remuneration and allowances and the other terms and conditions of office of the chair and the other non-executive directors
- approving the appointment of the chief executive
- appointing and, if appropriate, removing the Trust's auditor
- receiving the Trust's annual accounts, any report of the auditor on them and the annual report

In addition, in preparing the Trust's annual plan, the Board of Directors must have regard to the views of the Council of Governors. Furthermore, the Council of Governors receives the quality reports.

The Chairman of the Council of Governors is also the Chairman of the Board of Directors and he provides a link between the two, supported by the Company Secretary.

Referred to elsewhere in this report *(pages 72 – 73 refer)* are the powers reserved to the Board of Directors which provides details of the types of decisions made by the Board. In addition the Board has agreed a Scheme of Delegation which sets out those decisions which are delegated to management. A copy of the Scheme is available from the Company Secretary.

Statement setting out the steps that members of the Board of Directors, in particular the Non-Executive Directors have taken to understand the views of governors and members

The Board of Directors Board has taken the following steps to understand the views of governors and members: -

Joint Board of Directors and Council of Governor Meeting - In order to ensure meaningful engagement between the Board of Directors and the Council of Governors, the Trust holds at least one joint meeting per year. These meetings are public meetings allowing the Board the opportunity to hear the view of the Governors and the Members first hand. It also provides an opportunity for the Directors to advise the governors directly of any issues or answer any questions or concerns or enquiries. The governors are able to hold the Board of Directors to account for its actions.

Joint Board of Director and Council of Governor Workshop – To allow an open discussion about the proposed take over of Wiltshire Community Health Services a joint Board of Directors and Council of Governors workshop was held. Directors sought the views of governors on the proposals.

Chair / Governors Workshop – A workshop was held in November 2010 between the Chair of the Board of Directors and the Council of Governors to discuss and considered the roles of the governors, those of the directors and better ways of working. This provided an opportunity for the Chair on behalf of the non-executive directors to engage with the governors and to better understand their views. It was agreed that as the workshop had been so successful, a similar event should be hosted in 2011.

"Eyes and Ears" – An initiative known as "eyes and ears" is in place whereby the governors identify any issues of concern regarding the provision of services. The governors' feedback issues they have witnessed for themselves or those which have been reported to them by members or the wider public generally. Compliments and comments on activities working well are also fed in. A report is co-ordinated on issues raised together with responses and proposed action where necessary to those issues. The idea is to identify themes for improvement / action. "Eyes and ears" are raised and considered at both the Patient Experience Working Group and the Council of

Governors meetings. “Eyes and Ears” are submitted by the Governors before the meetings and the Chief Executive distributes the concerns/ comments to the relevant Executive Lead for consideration. Feedback on the submitted “eyes and ears” is then fed back to the governors by the Chief Executive.

Governor Working Groups – As referred to elsewhere in this report, there are a number of working groups of the Council of Governors, the work of which is supported by staff and directors. The joint working results in effective communication between the staff, directors and governors. Governors have an opportunity to input directly into the workings of the Trust.

Constituency meetings – To provide a forum for members to meet the governors, the Trust hosts meetings in each constituency. These are held throughout the year in publicly accessible local venues, where all members for the respective constituency area are invited to attend to discuss relevant issues or topics of specific interest. The Chairman and Deputy Chairman of the Board of Directors attend these meetings to listen to the debate, take on board the comments made and answer any questions or add any additional information.

Annual Members Meeting – This is held once per year, although consideration is being given to hosting two of these meetings in 2011/12 due to the success of the event in 2010 and the high attendance of members. The annual report and accounts are presented and a briefing given on the overall performance of the Trust in the previous year. The governors provide feedback to the Board of Directors.

Chairman – The Chairman of the Trust attends most meetings of the working groups of the Council of Governors. He listens to the comments raised at these meetings and he feeds them back to the Board of Directors. In addition the Chairman often meets with the Lead and Deputy Lead Governors to sound out their views on any matters currently being considered. The Lead and Deputy Lead Governors are representatives of the Council of Governors. Their advice and input is incorporated into the decision making process via the Chairman.

Event invitations to governors / governor volunteers / governor views generally – Governors are invited to attend a number of events throughout the year. These provide an opportunity for governors to understand the workings of the Trust. Any comments arising out of these events are fed back to the directors via the “eyes and ears” initiative. For many projects, initiatives and schemes governor volunteers are sought to take part. In addition governors are specifically invited to input their views. This is normally by way of a direct request from the Chairman. Governors are able to provide feedback to the directors and influence any decision making. Also this provides a mechanism for the governors’ to check and challenge directors. A few examples in 2010/11 include the following: -

- Birthing Centre and Stroke Unit Visit
- Breast Screening Unit Opening
- White Horse Birth Centre Opening
- Patient safety walkabouts by the non-executive directors and governors;
- Views sought on organisational values
- Picker Institute Survey Group governor volunteer sought
- Open Day / Annual Members Meeting governor volunteer sought
- Membership development governor volunteer sought

Meeting Structure

The Council of Governors has established the following working groups: -

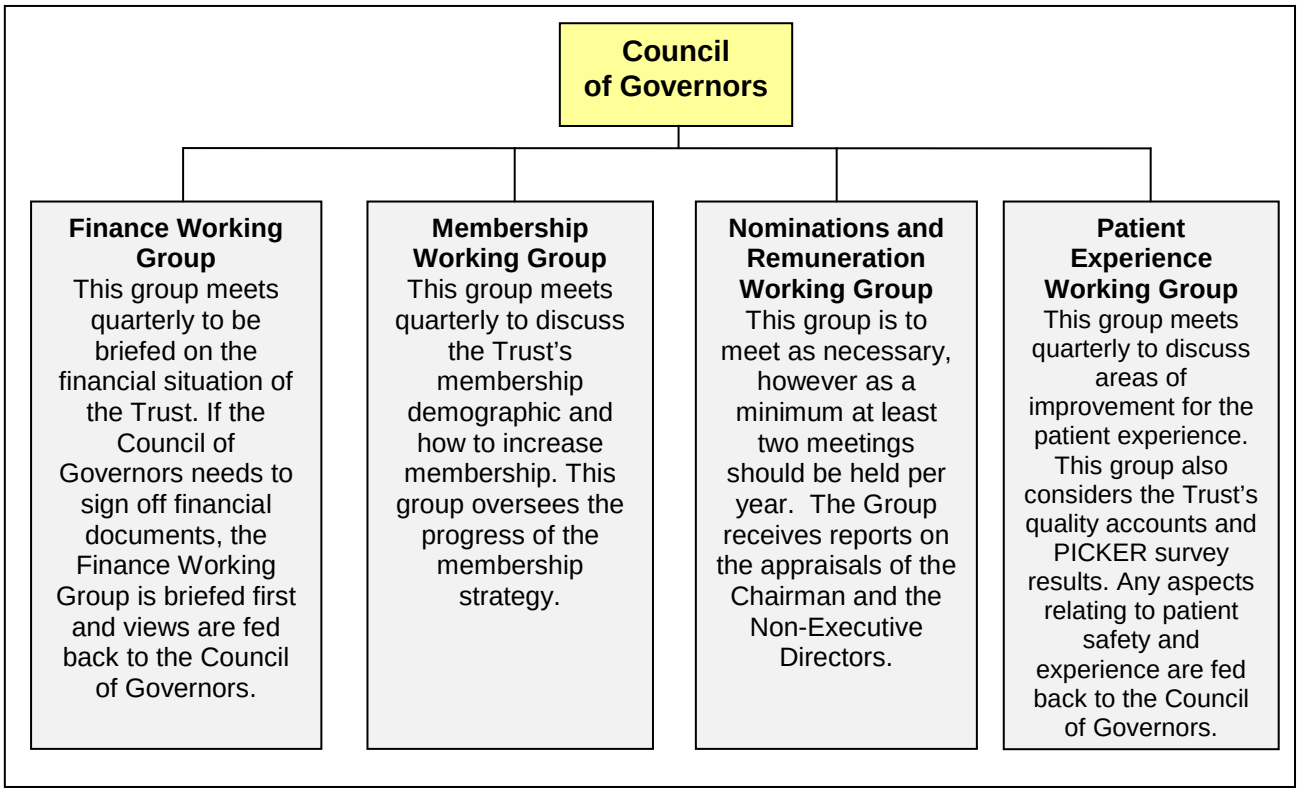
- Finance Working Group
- Membership Working Group
- Nominations and Remuneration Working Group
- Patient Experience Working Group

The purpose of the working groups is to inform governors about activities and issues relevant to each area; provide an opportunity for governors to seek further information and a better understanding of those areas. Furthermore they allow governors a means of influencing into the development of those areas and their activities and they provide a mechanism for challenge and scrutiny of action and activities.

As referred to elsewhere in this report *(page 62 refers)*, there are Constituency meetings, where all members for the respective constituency area are invited to meet governors to discuss relevant issues or topics of specific interest. In addition there is an Annual Members Meeting where the annual report and accounts are presented. At this meeting the governors are briefed on the overall performance of the Trust in the previous year and the governors provide feedback to the Board of Directors.

The meeting structure was reviewed in 2008 in preparation of becoming a Foundation Trust is kept under review in line with emerging guidance from Monitor. The meeting structure is shown below.

TABLE - Meeting structure



Nominations and Remuneration Working Group

It is the role of the Nominations and Remuneration Working Group to evaluate the effectiveness of the Trust Board as a whole, to assess the performance of the chairman and the non-executive directors and to determine their level of remuneration. The working group makes recommendations to the Council of Governors on the suitability of either the chairman or any non-executive directors wishing to undertake a second terms of office.

The Working Group agrees the process for evaluation with the chairman and the non-executive directors. The outcome of the evaluation process is considered by the working group with reports from the Chairman and the Senior Independent Director being presented and recommendations are then made to the Council of Governors. There is an annual review of the level of remuneration paid to the chairman and the non-executive directors and at least every three years there is market testing of those remuneration levels. The working group makes recommendations to the Council of Governors on the suitability of the Chairman and any non-executive directors wishing to serve a second term of office. When a non-executive director reaches the end of their current term, and if they are still eligible and wish to be reappointed, the working group may nominate the individual for such reappointment without competition. This will be subject to the working group taking into account the result of any review of the individual's performance during their term of office and the balance of skills required for the Board. Should the working group choose not to nominate an individual for reappointment, appointment to the office of non-executive director should be by way of open competition. A formal, rigorous and transparent procedure to identify and select a suitable candidate for nomination must be in place. The Joint Nominations Committee is responsible for nominating suitable candidates to the Council of Governors for appointment to the Chairmanship or to the office of non-executive director.

The Nominations and Remuneration Working Group is comprised of five governors (three elected, one nominated and one staff). The Chairman is appointed by the Chairman of the Council of Governors who attends as appropriate with the Senior Independent Director attending as requested.

The Council of Governors has the power to remove a non-executive director before their term of office comes to an end and any such action requires the support of three quarters of the Council of Governors.

The Nominations and Remuneration Working Group met twice in 2010/11. The current pay arrangements for non-executive directors were fixed at Authorisation in December 2008 to reflect foundation trust responsibilities. No salary increases were awarded to the Non-Executive Directors in 2010/11. Further information about the salaries of the Non-Executive Directors can be found elsewhere in this report (*pages 53 – 55 refer).*

Terms and conditions of appointment of non-executive directors are included in the Trust's Constitution.

Interests of Governors

The Regulatory Framework requires each governor to declare any interests which are relevant and material to the business of the Trust; pecuniary interests in any contract, proposed contract or other matter concerning the Trust; and family interests of which the governor is aware, irrespective of whether the interests are actual and potential, direct or indirect.

A register of those interests is maintained, details of which are set out in the table below as at 31 March 2011.

TABLE - Governors' Register of Interests
(Key - † = Changed from previous register; * = new Governor)

Register of Interests – Council of Governors (as at 01.02.11)		
Name of Governor	**Interest Disclosed**	**Role within Interest Disclosed**
Andy Cresswell †	Midcounties Co-operative – contracted service provider to Buffer Bear Nurseries	Executive Officer
Rachel Cross †	Broadtown School Association	Treasurer
Harry Dale	None	N/A
Geraint Day *	Swindon Civic Trust Co-operative Press Limited CAREIF (Centre for Applied Research & Evaluation International Foundation) Steering Group, Swindon Local Involvement Network (LINk) Gloucester & Swindon Branch Committee, the Benenden Healthcare Society Limited Gloucestershire and Swindon Branch Committee, the Midcounties Co-operative Party Royal College of Surgeons of England	Trustee and Vice Chair Non-Executive Director Non-Executive Director and Trustee Steering Group Member Committee Member Committee Member and Vice Chair Regional Co-ordinator
Lesley Donovan †	University of West of England within Faculty of Health and Social Care	Employee
Bill Fishlock †	Morris Owen Chartered Accountants Oakus Estates Swindon Primary Care Trust Wiltshire Police Authority Greensquare Group Westlea Housing Association Prospect Foundation Ltd The Green Hut Registered Charity United Swindon Charities (Almshouses) Institute of Chartered Accountants in England and Wales	Employee Chairman Non-Executive Director Board Member Director and Board Member Member Member and Vice President Management team member Charity Trustee Member

Register of Interests – Council of Governors (as at 01.02.11)		
Name of Governor	**Interest Disclosed**	**Role within Interest Disclosed**
Godfrey Fowler	None	N/A
Marcus Galea	None	N/A
Peter Hanson *	Hanson Medical Ltd Grasshopper Publishing Ltd DG Hanson Ltd	Director (main shareholder) Director Director
Janet Jarmin	Wiltshire Involvement Network (WIN)	Core Member
Srini Madhavan	None	N/A
Phil Prentice	Vision for Wroughton	Treasurer
David Renard	Swindon Borough Council 1st Swindon Sea Scouts Haydonleigh Primary School Swindon Conservatives Cancer and Leukaemia Movement (CALM)	Councillor Chairman and Trustee Governor Member Member
Carole Soden	Wiltshire Council Wiltshire Police Authority William 'Doc' Couch Trust Malmesbury Community Trust	Councillor Vice-Chairman Chairman Chairman
David Graham Stevens	Judiciary of England and Wales NHS Wiltshire	Magistrate - Swindon Bench Nominated Governor
Rosalind A Thomson	None	N/A
Margaret Toogood	Malmesbury League of Friends Diocese of Bristol Malmesbury Centre for Physically Handicapped	Trustee Committee Member Lay Assessor President
Katherine Usmar	Clinimax	Family company - no personal interest

Board of Directors

The Board of Directors

The Board of Directors or Trust Board, is the decision making body for strategic direction and the overall allocation of resources. It has delegated decision making for the operational running of the Trust to the Executive Directors. The Board takes decisions consistent with the approved strategy. Brief biographies for the Non-Executive and Executive Directors are given below.

Biography of individual Directors

Bruce Laurie, Chair

Bruce was Chair of Newbury and Community PCT from 2001 until 2006 where he established the new West Berkshire Community Hospital working closely with West Berkshire Council. He was appointed a Non-Executive Director of Berkshire Healthcare NHS Foundation Trust, leading on commercial matters and saw the transition to Foundation Trust. He is also a Trustee Director of Connexions Berkshire, working with young people on employment, education, training and support and is a Fellow of the Institute of IT at Thames Valley University where he leads a Masters Course in Managing Technological Innovation. Bruce joined the Trust in February 2008 and led it successfully to Foundation Trust status.
Bruce is Chair of the Mental Health Act / Mental Capacity Act Committee and is a member of the Nominations and Remuneration Committee. Bruce has been Chair of the Trust since 1 February 2008.

Helen Bourner, Director of Business Development

Helen spent a number of years working in the hotel sector, latterly as Regional Director of Sales for the North of England and Scotland for Hilton Hotels. She worked for NHS Estates (an executive agency of the Department of Health) and NHSU (the NHS University) from 2000 – 2005 providing advice and guidance on the Consumerism agenda arising out of the NHS Plan in 2000. She entered the NHS through the Gateway to Leadership Scheme, joining Barnsley Hospital NHS Foundation Trust in 2005. Helen has been Director of Business Development since August 2008.

Robert Burns, Non-Executive Director

Robert Burns' career has been largely focused on financial disciplines and financial management roles. Having trained as an accountant, he spent 19 years in a complex multinational ultimately in various senior Finance, and Sales Management roles. He worked for Cisco Systems setting up an Internal Audit and Fraud Investigation function supporting over 60 countries and also implemented e-Procurement Technologies within Europe. He is a Fellow of the Institute of Chartered Accountants in England and Wales (FCA), a Fellow of the Chartered Management Institute (FCMI). He is also an Independent Board Member of Gloucester Probation Trust, a statutory body within the National Offender Management Service but has recently resigned with effect from end of June 2011. He joined the Board on 1 August 2008. Robert is Chair of the Finance and Investment Committee and is a member of the Audit, Risk and Assurance Committee; the Patient Safety and Quality Committee; the Nominations and Remuneration Committee and the Charitable Funds Committee.

Rowland Cobbold, Non-Executive Director and Deputy Chair

Rowland has over 40 years commercial experience in the aviation and tourism industry including seven years on the Board of Cathay Pacific Airways Ltd where his responsibilities included marketing, customer service, corporate communications and IT. He is currently Chairman of Ecco Tours Ltd which he helped to set up 16 years ago and he has also served as a Non-Executive Director on the Boards of Air Partner PLC (1996 to 2004) and Groundstar Ltd (1999 to 2004). Rowland holds a masters degree in law and attended the London Business School's Executive Programme. He is the Deputy Chairman and Senior Independent Director. Rowland is Chair of the Patient Safety and Quality Committee and the Nominations and Remuneration Committee and is a member of the Audit, Risk and Assurance Committee and Vice-Chair of the Mental Health Act/Mental Capacity Act Committee.

Liam Coleman, Non-Executive Director

Liam Coleman is currently Deputy Group Treasurer of the Royal Bank of Scotland Group. Prior to that Liam was Group Director - Treasury at Nationwide Building Society. Prior to joining Nationwide, Liam worked in banking roles at Mitsubishi Bank, Hambros Bank and National Westminster Bank. Liam holds a BA Honours degree from the University of Manchester and an MBA from Warwick Business School; he is also a member of the Chartered Institute of Bankers and the Association of Corporate Treasurers. Liam is Chair of the Workforce Strategy Committee and is a member of the Nominations and Remuneration Committee and the Finance and Investment Committee.

Oonagh Fitzgerald, Director of Workforce & Education

Oonagh joined the Trust in February 2008. Oonagh had previously worked as Director of Human Resources and Organisation Development at Kingston Hospital, South West London and prior to that she was Deputy Director of Human Resources at Mayday Healthcare NHS Trust in Croydon, South London. She is a Fellow of the Chartered Institute of Personnel and Development. She originally studied law at university and gained a Masters in HR Leadership in 2005.

Angela Gillibrand, Non-Executive Director

Between 1984 and 1999 Angela was the Finance Director at the University of Cranfield's Shrivenham Campus, and helped set up one of the first PFIs - the academic contract between the University and the Ministry of Defence. More recently Angela was the Head of Finance, Planning and Company Secretary at U.K. Nirex Ltd, the U.K.'s radioactive waste management company. Since 2003 Angela has combined a career as a Non-Executive Director in the NHS, Government and a Housing Association with work for a family company. Angela holds a degree in Physiology and Psychology from Somerville College, Oxford and a MBA from INSEAD, Fontainebleau, France. Angela is Chair of the Audit, Risk and Assurance Committee, the Academy Strategic Board and the Charitable Funds Committee and is a member of the Nominations and Remuneration Committee. Angela has been a member of the Board since 1 July 2004.

Roger Hill, Non-Executive Director

Roger was appointed to the Board in April 2008. Until 1999 he had been both the Chairman and Managing Director of the UK subsidiary of Intergraph Corporation, a large American computer company. Subsequently he has been a Board Director of a number of IT services companies, both in the UK and Ireland. Until 2008 he had been serving as a Governor of Newbury College. Roger is Chair of the Business Development and Advisory Group and is a member of the Patient Safety and Quality Committee; the Workforce Strategy Committee and the Nominations and Remuneration Committee.

Lyn Hill-Tout, Chief Executive

Lyn has been an Executive Director since November 1997 and Chief Executive of the Trust for eight years. Lyn's background is in operational general management. Lyn is a graduate of the Institute of Personnel and Development (1994) and holds a HNC in Business Studies and Public Administration (1988). Until March 2008 she was a Trustee of Age Concern (Swindon) and is currently Chair of NHS Elect.

She will be leaving the Trust in June 2011 to take up the position of Chief Executive of Mid Staffordshire NHS Foundation Trust.

Maria Moore, Director of Finance

Maria was appointed as Director of Finance on in 29 September 2008. She had previously held the Deputy Director of Finance post at the Trust having joined in March 2003. Maria has over 17 years experience in the NHS which she joined as a Regional Finance Management Trainee in 1994. Since completing her training, she has worked in several acute Trusts. Maria graduated from London University with a degree in Mathematics and is a member of the Chartered Institute of Management Accountants (ACMA).

Sue Rowley, Director of Nursing & Midwifery

Sue registered as a General Nurse in 1982. Undertook her diploma of nursing, registering as a clinical tutor in 1987. Sue specialised in trauma and orthopaedics as a Ward Sister and Senior Nurse before moving into General Management. Sue was successful in applying for the Kings Fund Leadership Programme (1999–2001) and studied leadership in healthcare nationally and internationally spending time in both Hong Kong and China. Sue was appointed Director of Operations in August 2003, then to Director of Nursing & Midwifery as a statutory Board member in September 2006. Sue is currently completing her MSc in Strategic Management at Bristol University.

Kevin Small, Non-Executive Director

Kevin is an experienced Board member having been involved in a wide range of organisations. Kevin was Chair of Wiltshire Ambulance Service NHS Trust from 1998 to 2002 and Director of the New Swindon Company between 2003 and 2004 and again from 2005 to 2010. Kevin has also been a Non-Executive Director for the British Railways Board/Strategic Rail Authority (2000 to 2002), Chair of Western England Rail Passenger Committee (1998 to 2000), a member of Wiltshire Police Authority (1999 to 2003) and Leader of Swindon Borough Council (Aug 2002 to May 2003).

Kevin is a member of the Finance and Investment Committee, the Workforce Strategy Committee and the Nominations and Remuneration Committee. Kevin has been a member of the Board since 1 November 2003

Dr Alf Troughton, Medical Director

Alf has been Medical Director at the Trust since 1 April 2006. He has been a consultant radiologist at the Trust since 1994 and was the Clinical Director of Radiology for five years. He was the Radiology President at the Royal Society of Medicine between 2003 and 2005. Alf obtained his degree in medicine in 1978 from the University of Bristol and became a member of the Royal College of Physicians (MRCP) in 1984. Subsequently Alf became a fellow of the Royal College of Radiologists (FRCR) in 1989 and a fellow of the Royal College of Physicians (FRCR) in 1997. Despite his managerial commitments Alf continues to practice as a Radiology consultant part time as this helps him to keep in touch first hand with the clinical services provided by the Trust.

Alf Troughton has recently been appointed interim Chief Executive following the resignation of Lyn Hill-Tout who leaves the Trust in June 2011.

Jenny Barker, Managing Director Wiltshire Community Health Services (designated director of GWH transition)

Jenny has been Managing Director at Wiltshire Community Health Services since the reconfiguration of the Primary Care Trusts in Wiltshire in October 2006. She began her career in nursing at the Royal London Hospital in 1978. She then held a series of senior nursing appointments within the NHS and the private sector, rising to become BUPA Health Services' Director of Nursing. Jenny returned to the NHS in 1994 as a Directorate Manager in a university teaching hospital in London. She was seconded to work as the Project Director for the reconfiguration of hospital services in South West London and masterminded the reduction in services at Queen Mary University Hospital and the increase in services to St George's Tooting and Kingston Hospital Trusts. She relocated the Regional Burns Unit from Queen Mary to Chelsea and Westminster Hospital. Jenny has a wealth of experience in senior NHS roles including Deputy Chief Executive at Dorset County Hospital, the challenging role of Recovery Director for the Bath and Wiltshire Health Community, Director of Operations & Acting Chief Executive at the Royal United Hospital in Bath. Jenny gained an MBA in 1997. Since GWH became the preferred provider for Wiltshire Community Health Services, Jenny has assisted the Board of Directors as the Director Transition (designate).

Length of appointments of Non-Executive Directors

Listed below are details of the length of appointments of the Non-Executive Directors. Appointments are shown from 1 December 2008, being the date of Authorisation as a Foundation Trust.

Name	First Term	Second Term	Note that the date of first term appointment is the date of becoming a Foundation Trust. However, with the exception of Liam Coleman, all had been appointed before this date and hence there is variation in the terms.
Rowland Cobbold	01.12.08 – 31.12.10	01.01.11 – 31.12.11*	
Kevin Small	01.12.08 – 31.10.11		
Angela Gillibrand	01.12.08 – 30.06.12		
Bruce Laurie (Chair)	01.12.08 – 31.01.12		
Roger Hill	01.12.08 – 30.04.12		
Robert Burns	01.12.08 – 31.07.12		
Liam Coleman	01.12.08 – 31.10.12		

Non-Executive Directors are appointed by the Council of Governors. A Non-Executive Director or Chairman may be removed from office with approval of three-quarters of the members of the Council of Governors.

As recommended by the Local Counter Fraud Service (LCFS), the names of all Trust Directors (Executive and Non-Executive) are cross-referenced with the Disqualified Directors Register on the Companies House website on an annual basis. No Trust Directors appeared on the Disqualified Directors Register (as of 7 March 2011).

*This non-executive director was re-appointed during 2010/11 for a term of one year. The process involved interview and assessment by the governor Nominations and Remuneration Working Group, having regard to the views of the Chairman and the re-appointment was approved by the Council of Governors.

Statement about the balance, completeness and appropriateness of the Board of Directors

The Non-Executive Directors are all considered to be independent of the Foundation Trust and the Trust Board believes it has the correct balance, completeness and appropriateness in its composition to meet the requirements of an NHS Foundation Trust.

However, the Board is committed to reviewing its effectiveness. In 2009 the Folio Partnership was commission to undertake an assessment process that culminated in a formal report presented to the Board in March 2010. Board development tools provide a framework for objectivity assessing performance and in meeting our responsibilities. Research was conducted in October and November 2010 regarding research companies specialising in supporting Board assessment and in November 2010, the use of the Institute for Innovations and Improvement Board Development Tool for Foundation Trusts was approved. The review of effectiveness is continuing into 2011/12.

Statement setting out that the Board of Directors undertakes a formal and rigorous evaluation of its own performance and that of its collective and individual directors

The Chairman and Non-Executive Directors of the Trust are appointed by the Council of Governors for a term of office of up to four years.

In 2009/10, the Council of Governors agreed that the Nominations and Remuneration Committee (a committee of the Board of Directors) and the Nominations and Remuneration Working Group (a working group of the Council of Governors) worked together to develop a framework for Non-Executive Directors' appraisal based on adapting elements of the Hay Group work and best practice from other Foundation Trusts. In 2010/11 a formal appraisal process for the Chairman and the Non-Executive Directors was agreed by the Council of Governors. Accordingly the evaluation of the Chair's performance was led by the Senior Independent Director with input from the Lead Governor and the Chief Executive on behalf of the Executive Directors and having regard to the views of the other Non-Executive Directors. The Chief Executive and Non-Executive Directors' performance was evaluated by the Chairman taking account of governors and other directors' input. The Executive Directors' appraisals were led by the Chief Executive through the Board Nominations and Remuneration Committee.

There was no increase in Chair or Non-Executive Director remuneration in 2010/11.

Attendance at meetings of the Board of Directors during 2010/11

Listed below are the Directors and Non-Executive Directors of GWH and their attendance record at the meetings of the Trust Board held during the past year.

Record of attendance at each meeting
✓ = Attended
× = Did not attend

Board of Directors' Members	29.04.10	27.05.10	24.06.10	29.07.10	30.09.10	07.10.10 Extra ordinary	14.10.10 Extra ordinary	28.10.10	10.11.10 Extra ordinary	25.11.10	27.01.11 Private	27.01.11 Public	24.02.11	31.03.11 Private	31.03.11 Public
Jenny Barker (from January 2011)	-	-	-	-	-			-		-	✓	✓	✓	✓	×
Helen Bourner	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Robert Burns	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rowland Cobbold (Deputy Chairman and Senior Independent Director)	✓	✓	✓	✓	✓	✓	×	✓	✓	✓	✓	✓	✓	✓	✓
Liam Coleman	✓	✓	×	✓	✓	×	✓	✓	✓	✓	✓	✓		✓	✓
Oonagh Fitzgerald	✓	×	✓	✓	✓	✓	×	✓	✓	✓	✓	✓	✓	✓	✓
Angela Gillibrand	×	✓	×	✓	×	×	✓	✓	✓	✓	✓	✓	✓	✓	✓
Roger Hill	✓	✓	×	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Lyn Hill-Tout (Chief Executive)	✓	✓	✓	×	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Bruce Laurie (Chairman)	✓	✓	✓	✓	×	✓	✓	✓	✓	✓	✓	✓	×	✓	✓
Maria Moore	✓	✓	✓	✓	✓	✓	✓	✓	×	✓	✓	✓	✓	✓	✓
Sue Rowley	✓	✓	×	×	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Kevin Small	✓	✓	✓	✓	✓	×	×	✓	✓	✓	✓	✓	×	✓	✓
Alf Troughton	✓	✓	✓	✓	✓	✓	×	✓	✓	✓	✓	✓	✓	✓	✓

Details of the number of meetings of committees and individual attendance by Executive and Non-Executive Directors is available on request to the Trust.

Decisions reserved for the Board of Directors

There are certain matters which are reserved for the Board of Directors to manage including:

Regulation and Control
This includes approval of Standing Orders (SOs) and Standing Financial Instructions (SFIs) for the regulation of Trust proceedings and business; approval of a scheme of delegation of powers from the Board to employees; requiring and receiving the declaration of directors' and employees' interests; disciplining directors; approval of the disciplinary procedure for employees; approval of arrangements for dealing with complaints; adoption of the director level organisational structures, processes and procedures; the appointment of committees and sub-committees and receiving reports and considering recommendations from them; ratification of any urgent decisions; approval of arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee and as a bailee for patients' property.

Appointments
This provision relates to the establishment, appointment, terms of reference, reporting arrangements and dismissal of all sub committees acting on behalf of the Board; the appointment, appraisal, disciplining and dismissal of executive directors and the appointment of members of any committee of the Trust or the appointment of representatives on outside bodies.

Policy Determination
This provision relates to the approval of strategy and policy as outlined in the Scheme of Delegation.

Strategy, Business Plans and Budget
This provision means defining the strategic aims and objectives of the Trust, approval of plans in respect of the application of available financial resources and approval and monitoring of the Trust's policies and procedures for the management of risk.

Direct Operational Decisions
This provision relates to the acquisition, disposal or change of use of land and/or buildings (including leases and licences) and approval of the associated financial limits; the introduction or discontinuance of any significant activity or operation (an activity or operation shall be regarded as significant if it has a gross annual income or expenditure (that is before any set off) in excess of £500k0; approval of individual compensation payments over limits set out; and to agree action on litigation against or on behalf of the Trust.

Financial and Performance Reporting Arrangements
This provision relates to the continuous appraisal of the affairs of the Trust by means of the receipt of reports as it sees fit from directors, committees and employees of the Trust as set out in management policy statements. All monitoring returns required by Monitor, the Care Quality Commission, NHSLA and the Charity Commission will be reported, at least in summary, to the Trust. This provision also covers approval of the opening or closing of any bank or investment account; the requirement for the consideration and approval of the Trust's Annual Report including the annual accounts and the receipt and approval of the Annual Report(s) for funds held on trust.

Audit Arrangements
This provision relates to the approval of audit arrangements (including arrangements for the separate audit of funds held on trust) and to receive reports of the Audit, Risk and Assurance Committee meetings and take appropriate action. The provision also covers the receipt of the annual management letter received from the external auditor and agreement of action on the recommendation where appropriate of the Audit, Risk and Assurance Committee.

Investment Policy
This related to the approval of the investment policy for exchequer funds and discharge of trustee responsibilities in relation to non-exchequer funds

A copy of the full reservation of powers to the Board document can be obtained from the Company Secretary.

Interests of Directors

Interests of directors as at 31 March 2011 are set out in the table below.

TABLE - Directors' Register of Interests
(Key - † = Changed from previous register
* = new Director)

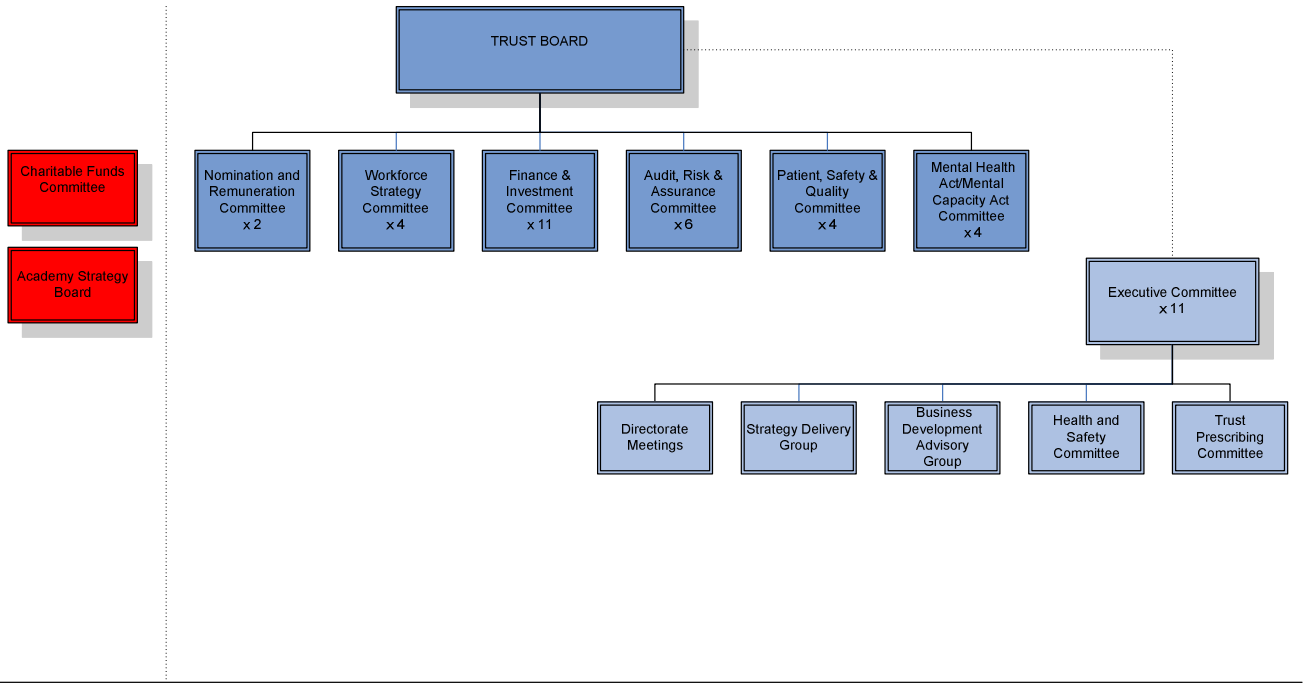
Register of Interests – Board of Directors (as at 31.03.11)		
Name of Director	**Interest Disclosed**	**Role within Interest Disclosed**
Jenny Barker *	Wiltshire Community Health Services	Director
Helen Bourner	Arts in Health, South West	Trustee
Robert Burns	Gloucestershire Probation Trust	Board Member
Rowland Cobbold	Ecco Tours Ogbourne St George Parochial Church Council	Chairman Honorary Treasurer
Liam Coleman †	Royal Bank of Scotland Group	Deputy Group Treasurer
Oonagh Fitzgerald	None	N/A
Angela Gillibrand †	Lotmead Company Prospect Hospice	Shareholder 20% Trustee
Roger Hill	None	N/A
Lyn Hill-Tout	NHS Elect	Chair
Bruce Laurie	Changology Ltd Connexions Berkshire Charity of William Chowles Lambourn Parish Church Lambourn Parish Council Lambourn Sexton's Charity Connexions Berkshire	Management Consultancy Ltd Trustee and NED Trustee Church Warden Member Trustee Trustee
Maria Moore	None	N/A
Sue Rowley	None	N/A
Kevin Small	Swindon Borough Council Swindon and District Referees Association Even Swindon WMC Mid Counties Co-operative Society Wiltshire County Football Association Limited	Councillor Member Member Shareholder Hon County Referees Secretary & Referee Development Officer
Alf Troughton	None	N/A

Significant Commitments of the Chairman

There have been no substantial changes to commitments during the year and the Chairman is able to devote the appropriate time commitment to this role.

Committee structure

The Board of Directors reviewed its committees during 2010/11 and now has a revised committee structure in place as follows: -



Sitting below this top level structure are a number of working groups and other meetings.

Key Committees

The Board recognises that it is important that organisational governance and executive structures, annual and service plans, performance management and risk management arrangements are focussed on actions to deliver the Trust's strategic objectives alongside the Board Assurance Framework. The Trust has therefore developed a committee and meeting structure to support the delivery of these objectives and to give assurance to the Board. The review focused on the role and organisation of the Board committees taking into account the statutory minimum committees required by a Foundation Trust, in accordance with Monitor requirements, Charity Commission requirements, Health and Safety Act requirements and the Mental Health Act Code of Practice, and a review of other applicable regulation and law). Committee were established as set out in the Committee structure above.

In formulating a revised structure, which focussed on improving board scrutiny and assurance views were taken into account from executive and non-executive directors and it was agreed that a formal review of effectiveness would be undertaken in 2011/12.

The Board delegated authority, on its behalf, to the following committees: -

- Audit Committee (disbanded January 2011)
- Audit, Risk and Assurance Committee (replaced Audit and Integrated Governance Risk Committees)*
- Charitable Funds Committee
- Clinical Governance and Risk Committee (disbanded January 2011)
- Executive Committee
- Finance and Investment Committee
- Integrated Governance and Risk Committee (disbanded in January 2011)
- Mental Health Act and Mental Capacity Act Committee*
- Nominations and Remuneration Committee*
- Patient Safety and Quality Committee (replaced Clinical Governance and Risk Committee)
- Workforce Strategy Committee.

* Statutory Committees

Audit Committee

The Audit Committee

The Trust has an audit committee known as the Audit, Risk and Assurance Committee is responsible for overseeing the establishment and maintenance of an effective system of internal control, and management reporting; ensuring that there are robust processes in place for the effective management of clinical and corporate risk to underpin the delivery of the Trust's principal objectives; overseeing the effective operation and use of Internal Audit; encouraging and enhancing the effectiveness of the relationship with External Audit; overseeing the corporate governance aspects that cover the public service values of accountability, probity and openness and overseeing the information governance arrangements of the Trust.

The Audit, Risk and Assurance Committee's Terms of Reference are available on request from the Company Secretary. The members of the Audit, Risk and Assurance Committee and their attendance at meetings during the year are set out below.

The main objectives of a committee with responsibility for audit are to ensure that the NHS Board activities are within the law and regulations governing the NHS and that an effective internal control system is maintained. These objectives can be achieved through the committee's judgement, independent and objective review and through its relationships with the various parties involved. Through these it is able to draw assurance as to whether an appropriate system of internal control has been established and maintained.

Internal Control

The committee must be able to assure the Board that the system of internal control is operating effectively. Internal control systems therefore need to be monitored. While the External Auditor provides an independent view of the overall management arrangements, Internal Audit is required to provide a clear statement of assurance regarding the adequacy and effectiveness of internal controls.

The Director of Finance is professionally responsible for implementing systems of internal financial control and is able to advise the Audit, Risk and Assurance Committee on such matters.

Internal Audit

Internal Audit is an important resource that assists the Audit, Risk and Assurance Committee to meet its internal control responsibilities. The Committee must therefore evaluate the extent to which the internal audit service complies with the mandatory audit standards and agreed performance measures. The internal audit function for Great Western Hospitals NHS Foundation Trust is carried out by RSM Tenon.

External Audit

In auditing the accounts of an NHS Foundation Trust the auditors must, by examination of the accounts and otherwise, satisfy themselves:

- that they are prepared in accordance with directions under paragraph 25(2) of Schedule 7 of the 2006 Act;
- that they comply with the requirements of all other provisions contained in, or having effect under, any enactment which is applicable to the accounts;
- that proper practices have been observed in the compilation of the accounts; and

- that the NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

The work of the Audit, Risk and Assurance Committee in discharging its responsibilities

In 2010/11 the Audit, Risk and Assurance Committee discharges the responsibilities delegated to it by the in the following way:

- the Committee has Board approved terms of reference;
- the minutes of the Committee meetings are submitted to the Board;
- the Chair of the Committee gives regular verbal updates at the Board meetings;
- reviewed and approved the internal audit plan, ensuring that there is consistency with the audit needs of the organisation as identified in the Assurance Framework, Organisational Risk registers and supports the work of the external auditors;
- developed and agreed with the council of Governors, the criteria for appointment of the external auditors, which resulted in the recommendation to the Council of Governors the appointment of KPMG as the Trust's external auditors; and
- a review of the Committee effectiveness was completed in July 2010.

The Council of Governors accepted the Audit, Risk and Assurance Committee's recommendation on the appointment of an external auditor.

Attendance at the Audit / Audit, Risk and Assurance Committee Meetings during 2010/11

Audit Committee / Audit, Risk and Assurance Committee Members	Record of attendance at each meeting ✓ = Attended × = Did not attend				
	14.04.10	15.07.10	14.10.10	17.01.11	16.02.11
Rowland Cobbold (member from January 2011)	-	-	-	✓	✓
Robert Burns	✓	✓	✓	✓	✓
Angela Gillibrand (Chair)	✓	✓	✓	✓	✓
Roger Hill (member until January 2011)	✓	✓	✓	-	-

Note the Audit Committee changed to Audit, Risk and Assurance Committee (ARAC) in January 2011 (with revised membership). The Chair of the Committee is Angela Gillibrand, a Non-Executive Director.

Directors' responsibility for preparing the accounts

So far as the directors are aware, there is no relevant audit information of which the auditors are unaware. The directors have taken all of the steps that they ought to have taken as directors in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

The Directors are aware of their responsibilities for preparing the accounts and are satisfied that they meet the requirements as reflected in the Statement of Chief Executive's responsibilities as the Accounting Officer at Great Western Hospital NHS Foundation Trust also as referred to elsewhere in this report (*page 192 – 200 refers).*

Statement from the auditors about their reporting responsibilities

This included in the auditor's report.

Nominations and Remuneration Committee

The Nominations and Remuneration Committee

As referred to elsewhere in this report *(pages 49 - 55 refer),* the Trust has a Nominations and Remuneration Committee. Details of the chair and members of the committee, the number of meetings and individual attendance by directors at each, together with a description of the work of the committee are included in that section.

In summary the committee is authorised by the Trust Board to oversee a formal, rigorous and transparent procedure for the appointment of the Chief Executive and other Board Executive Directors and to keep under review the composition size and structure of the Executive, leading on succession planning, nominating candidates for Board level position. The committee advises and makes recommendations to the Trust Board on Executive and Senior Management remuneration and has delegated authority for agreeing any annual pay review.

Mental Health Act / Mental Capacity Act Committee

The Mental Health Act / Mental Capacity Act Committee

Under the terms of the Mental Health Act 1983, (MHA) the Trust has a key responsibility for looking after patients who come to the hospital with problems associated with their mental health and to ensure that that the requirements of the Act are followed.

The Trust must:

- ensure that patients are detained only as the MHA allows;
- ensure that patients' treatment and care accords fully with the provision of the Act;
- patients are fully informed of, and supported in, exercising their rights;
- patients' cases are dealt with in line with other relevant statutory legislation including the Mental Capacity Act 2005, Human Rights Act 1998, The Race Relations Act, Disability Discrimination Act 1995 or Data Protection Act 1998.

Membership of the Mental Health Act and Mental Capacity Act Committee

- Non-Executive Directors x two
- Director of Nursing - Executive Lead for Mental Health Services
- Deputy Director of Nursing – Trust Lead for Mental Health Services
- Mental Health Act Administrator
- Representatives from the Child and Adolescent Mental Health Service (CAMHS) x three (General Manager/Clinician/Nurse)
- Senior Representative from the Adult Mental Health Services (AWP)
- Senior Representative from Older People's Mental Health Services (AWP)
- Senior Nurse/Matron (Great Western Hospital)
- Representative from Swindon Primary Care Trust.

Meetings during 2010/11 and attendance

The Mental Health Act / Mental Capacity Act Committee members		June 2010	September 2010	December 2010	March 2011
Bruce Laurie (Chair)	Chairman of the Trust	x	√	√	√
Rowland Cobbold (Deputy Chair)	Non Executive Director	√	√	√	√
Sue Rowley As from March 2011 the Committee agreed that Sue Rowley only needed to attend as a Board member when there was a subject of interest.	Director of Nursing and Midwifery	X	X	X	X
Carole Crocker	Deputy Director of Nursing	√	√	√	√
Joy Gobey	Mental Health Act Administrator	√	√	√	√
Teresa Harding Joanne Smith, Matron for Paediatrics - deputy	General Manager, Women and Children's' Department	X	√	X	√

The Mental Health Act / Mental Capacity Act Committee members		June 2010	September 2010	December 2010	March 2011
Dick Eyre Attendance as either/both with Amanda Cadder.	Child Psychiatrist	X	√	X	X
Amanda Cadder Attendance as either/both with Dick Eyre.	Nurse Manager	X	X	X	X
Neil Mason (deputy for Gill McKinnon)	Community Service Manager and Adults Service Manager AWP (Liaison)	X	X	X	X
Gill McKinnon	Service Manager (Specialist Services) Older People's SBU	-	-	-	√
Gill Tertois deputy for Gill McKinnon x 1 (Neil Mason confirmed deputy)	Mental Health Liaison Nurse	-	-	√	-
Jennifer MacDonald	Area Manager, Banes and Swindon. AWP	-	-	-	-
Kieran Holland (deputy for Jenny MacDonald)	Modern Matron, Sandalwood Court	√	√	√	√
Anthony Harrison	Consultant Nurse (Liaison Psychiatry) AWP	-	-	√	√
Donna Bosson	Senior Nurse Unscheduled Care	X	X	X	√
Malcolm Stewart (Deputy for Donna Bosson)	Matron, Unscheduled Care	X	√	√	√
Judith Blackstock	Judith Blackstock Assistant Director of Quality & Clinical Governance, NHS Swindon	√	√	X	√
Julie Dart	Mental Capacity Act Programme Manager Joint appointment with Swindon Borough Council and Swindon Primary Care Trust, Adult Social Care	X	√	X	√

During 2010/11 the following activity has occurred: -

- The Committee has continued to meet and the operational group has continued its functions to support the committee.

- Marlborough House has been transferred to Oxford and Buckingham Mental Health Trust and the service level agreement (SLA) has been developed and signed off.

GWH and Avon and Wiltshire Mental Health Partnership (AWP) have a two way service level agreement (SLA) signed off with the exception of specifications 1 (**Liaison Psychiatry**), 2 (**Crisis Resolution Out of Hours Services**) and 3 (**Treatment and Care for Older People with Mental Health needs**). There has been a delay in agreeing these specifications due to the re-structure of AWP. They have now been agreed within the contract with Commissioning and awaiting funding transfer to AWP.

- All mental health sections through 2010 have been within the legal framework and have been scrutinised accordingly.

The Service model which includes specifications 1, 2 and 3 has been agreed by Swindon Mental Health Development Board including filling the funding gap; therefore this part of the SLA will be in place within the first quarter of 2011/12.

Membership

Membership

The Trust is accountable to local people who can become members of the Trust. Members share their views and influence the way in which the Trust is run.

The Trust's membership is made up of local people, patients and staff who have an interest in healthcare and their local health care services and these are broken down into two groups with different criteria.

Public Members

Public members include patients, carers and interested members of the public. Public members are aged 12 and over who live in the geographical area of the Trust.

Public members are placed in constituencies based on where they live. Three constituencies have been created to reflect the Trust's catchment area, namely: -

- Swindon,
- Wiltshire,
- West Berkshire, Gloucestershire and Oxfordshire.

The Trust is currently reviewing its public constituencies based on its new geographical area as a result of its intention to take on board Wiltshire Community Health Services.

Staff Members

Staff members include Trust employees, Carillion Health employees and volunteers. The Trust has strong links with the local community, with over 300 volunteers. These persons automatically become members when:

- they are employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or
- they have been continuously employed by the Trust under a contract of employment for at least 12 months; or
- they are employed by a designated subcontractor (i.e. Carillion Health) who otherwise exercise functions for the purpose of the Trust provided they have exercised these functions continuously for a period of 12 months; or
- they are designated volunteers who assist the Trust on a voluntary basis and have been doing so for at least 12 months.

Trust staff may opt-out of membership if they wish.

The Trust has a wide range of staff undertaking a variety of roles and professions. Consideration is currently being given to establishing groups within the staff constituency to reflect occupational areas.

Public members can only be a member of one constituency. Staff can only be members of the staff constituency. Members are able to vote and stand in elections for the Council of Governors.

Membership Strategy

During the year, the Trust sought to increase membership numbers. As at 31 March 2011, the membership of the Great Western HNS Foundation Trust was as follows: -

	Number of Members
Swindon Public Constituency	2865
Wiltshire Public Constituency	1429
West Berkshire, Gloucestershire and Oxfordshire Public Constituency	462
Affiliated	225
Staff Constituency	5156
TOTAL	**10,137**

To encourage membership, the Trust has in place a Membership Strategy which is reviewed annually to ensure that it reflects the needs of the members. The latest Membership Strategy approved in January 2011, focuses on three key areas:

- How the Trust hopes to engage and offer more to our existing members.
- The future change in membership demographic due to the adoption of Wiltshire Community Health Services and the mechanisms GWH will use to increase membership in the new territories.
- The changes to the Trust's Constitution in order for the Trust to be fully representative of the new areas it will serve.

The Council of Governors has established a sub-group known as the Membership Working Group, whose remit is to aim to increase and promote membership. The group meets quarterly and deliberates mechanisms to increase membership, as well as how to market membership, including tangible benefits that can be offered.

In order to build a representative membership, the Trust has attended local community events, as well as attending hospital open days and recruitment days. The Governors and the Membership Officer have also attended community health forums to listen to the views and to encourage membership from a wider community.

The youth membership is the least represented age category of members. In order to encourage membership amongst the younger population the Trust is looking into developing specific material with the youth in mind, such as a youth membership form, youth newsletter and youth section on the Trust website. The Trust also offers work experience placements for pupils interested in the healthcare profession, in return for membership. The Membership Officer is planning to give a series of presentations in 2011/12 to local schools on becoming a member and the benefits of membership.

The Trust uses information from the Office of National Statistics (Census 2001) to build up a picture of the population size and ethnicity for each constituency. This helps the Trust in it aims to make the membership reflective of its population. The Trust has also determined the socio-economic breakdown of its membership and the population from its catchment area.

Membership size and movements

Public Constituency	2010/2011	2011/2012 (estimated)
At year start (1 April 2010)	4940	5500
New Members	530	700
Members leaving	218	200
At year end (31March 2011)		

Staff constituency	2010/11	2011/2012 (estimated)
At year start (1 April 2010)	4423	7000
New Members	326	1800
Members leaving	206	200
At year end (31 March 2010)		

Analysis of current membership

Public constituency	Number of members
Age (years)	
0-17	128
18-21	140
22+	4681
Ethnicity:	
White	3897
Mixed	25
Asian or Asian British	135
Other (including not known)	942
Gender analysis	
Male	2265
Female	2736

The Trust has considered broadly the socio-economic grouping in its area.

Membership development in 2010/11

In the last twelve months the Trust has worked on increasing its members as well as engaging its' members. The Annual Members Meeting last September was a huge success and combined the formal requirements of an Annual General Meeting with a 'Healthy Living Event' for members. The members welcomed and complimented the 'Healthy Living Event' which boasted over 30 stalls and provided medical and lifestyle advice. In addition, the Membership Officer proactively encouraged membership by meeting with various groups and committees to explain what membership is and the benefits of being a member. These included Women's Institute meetings and GP forums.

Membership development proposed for 2011/12

With the recent implementation of the new Membership Strategy the Trust has an action plan in place to increase membership across Wiltshire and Bath and North East Somerset, as well as providing more activities to engage with members. Membership material is being written and designed to be distributed in local venues such as GP surgeries and libraries. The Membership Officer will also present to Patient Participation Groups on what being a member actually means and what the benefits are. Furthermore plans are being established for stalls at various health events across Wiltshire to promote membership of GWH. The Trust also plans on holding an Open Day in September 2011 to give members and other people in the local community the chance to look behind the scenes at the hospital.

Also, a reciprocal membership arrangement with Avon and Wiltshire Mental Health Trust has been established, so that both Trusts will offer membership of the other on their application forms. This will help the Trust to increase its membership remit, particularly in the targeted areas of central and southern Wiltshire.

Building a strong relationship with our members

It is the aim of the Trust to have a membership which will allow the Trust to develop a more locally accountable organisation, delivering healthcare services that reflect the needs of the local communities. Membership supports the Trust in increasing local accountability through communicating directly with current and future service users. In turn services are developed which reflect the needs of our local communities and loyalty within the local communities is encouraged.

The Trust fulfils this aim by communicating and engaging with members via the Trust's quarterly magazine Horizon, hosting member focus groups and events such as open days. The Trust's website will be redeveloped over the summer to provide more regular updates and information and allow for more interaction between members and Governors in the form of Blogs, Web Chats and Forums. The Trust also has a full time Membership Officer to answer any questions, compliments or concerns from members.

Constituency meetings

The Trust holds two meetings per annum in each of the following Constituencies: Staff, Swindon and Wiltshire. The Constituency meetings are hosted in a variety of locations including going out into the community, to ensure that the meetings are well attended and easily accessible. Previously there were separate meetings for the Gloucestershire, West Berkshire and Oxfordshire Constituency but these have now been merged with the Swindon Constituency meetings.

Constituency meetings provide a regular forum for members to meet the Governors of the Trust. All the meetings are held in public and members are provided with the opportunity to submit questions in advance of the meeting so that answers can be given in full at the meeting.

The Trust is looking to reshape these meetings to provide opportunities for Members to find out about specific subject matter i.e. Cancer Research, Stroke and Patient Safety. These will give Members greater insight into key developments taking place in the Trust. Furthermore, these meetings will be open to all governors and members to attend and not just those within the constituency.

Contacting the Governors and Directors

If any constituency member or member of the public generally wishes to communicate with a Governor or a Director they can do so by emailing the Foundation Trust email address: foundation.trust@gwh.nhs.uk. This email address is checked daily by the Membership Officer who will forward the email to the correct Governor and/or Director. Alternatively a message can be left for a Governor by ringing the Membership Officer on 01793 604185 or for a Director by ringing the Company Secretary on 01793 6047151 or by sending a letter to:
Company Secretary, The Great Western Hospital, FREEPOST (RRKZ-KAYR-YRRU), Swindon, SN3 6BB.

Code of Governance Disclosure Statement

The Trust Board has overall responsibility for the administration of sound corporate governance throughout the Trust and recognises the importance of a strong reputation

Monitor, the independent regulator for Foundation Trusts, published the NHS Foundation Trusts Code of Governance. The way in which the Trust applies the principles within the Code of Governance are set out in this report, and the Directors consider that in 2010/11, the Trust has been compliant with the Code with the exception of the following: -

F.3.9 – The audit committee did not review arrangements by which staff of the NHS foundation trust may raise in confidence concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. However, the Trust has in place a Whistle Blowing policy which was circulated to all staff by the Senior Independent Director. Furthermore, guidance was issued to governors on how to handle matters referred to them. In addition the Trust has in place a counter fraud policy. Annually the Local Counter Fraud officer undertakes a staff fraud awareness survey. In 10/11 the survey clearly demonstrates that a high proportion (98%) of respondents knew the Trust had a Fraud and Corruption policy and knew where to get access to it. It was also pleasing that 71% of respondents have read the policy.

The effectiveness of the Fraud and Correction policy can also be demonstrated by the increase of referrals since implementation. Prior to implementation the Trust received three referrals (2007/08). In 2008/09 the Trust received 6 referrals increasing to 11 referrals in 2009/10 and ten in 2010/11. Referrals and general fraud queries made in 2010/11 have been slightly lower with ten requests for help of which three resulted in investigations.

G.1.1 – The Trust does not currently have a public document setting out its policy on the involvement of members, patients and the local community at large including a description of the kind of issues it will consult on. Such a document will be prepared during 2011/12. However, our approach is outlined in a number of documents. The Trust has mechanisms in place through the Council of Governors to actively engage members in key issues relating to Trust business, for example a working group focussed on patient experience has looked at issues such as food quality and hospital signage during the year. Also there is a membership working group which has given consideration to involvement of members, patients and the local community at large and is influencing our approach to engagement. The Trust has a marketing and Communications Strategy approved by the Trust Board which sets out how we aim to open up lines of communication with staff, patients and the local community via key stakeholders such as the Health Overview and Scrutiny Committees, Local Involvement Networks and other groups.

6
Quality reports

Part 1 - Statement on quality from the Chief Executive of the Great Western Hospitals NHS Foundation Trust

We continue to focus our energies on improving safety and patient and carer satisfaction by providing the highest quality care. The past year has been an extremely positive one and we have improved care in a number of areas and delivered some significant service improvements and developed our services.

On safety we made a number of changes and we have seen our Hospital Standard Mortality Rates (HSMR) fall from 95 in 2009/10 to 88.2 in 2010/11. We now undertake regular Methicillin-Resistant Staphylococcus Aureus (MRSA) screening for emergency and elective patients and through rigorous attention to hygiene, hand washing and antibiotic prescribing, we have seen a fall in hospital acquired infection rates – both MRSA and Clostridium Difficile. For MRSA we saw a fall from 5 hospital acquired cases in 2009/10 to 3 in 2010/11 and for Clostridium Difficile a fall from 49 to 40. Our staff have led improvements in many other areas of safety and improved care, including Venus Thromboembolisis (VTE), Ventilator Acquired Infections, patient falls and a significant reduction in pressure ulcers. All of these have contributed to better patient outcomes and experience.

Delivering safe, high quality care relies on a clean and fit for purpose environment and good equipment. We were delighted that we were scored “excellent” again by an external assessment of the hospital by the Patient Environment Action Team (PEAT). The hospital design means that we can deliver single sex accommodation and bathrooms. Our nursing teams have eliminated mixed sex bays and all ward areas are compliant with this important aspect of privacy and dignity. Further work is underway to segregate the sexes in our Acute Assessment Unit (AAU), which cares for patients requiring urgent medical treatment.

We are still seeing the benefits of the Dragon’s Den initiative which we set up in 2009. Following bids from staff, money was invested in services and equipment to help improve safety, patient care and provide more cost effective services. Evaluation of the schemes funded showed demonstrable improvements, for example investing in avoiding Musculoskeletal Disorder injuries to staff has helped to significantly reduce the number of work days lost to injuries and our staff sickness rates fell so that more nurses were able to work during the year, providing invaluable care to patients. In the Breast Centre the Trust was one of the first places in the Europe where patients can now be tested to assess their risk of Lymphodaema prior to Breast Surgery which is helping improve their quality of life after their operation. These examples, and many more, were the result of the creativity and innovation of staff and something which grows ever more important as we tackle the financial challenges of the years ahead.

As a Foundation Trust not only do we ensure that we provide consistently safe, high quality care but we also have to meet the terms of our authorisation which are set out by Monitor (the Regulator of Foundation Trusts) through its Compliance Framework. This covers a range of areas including national requirements such as ensuring patients with cancer receive their diagnosis and treatment in a timely manner and people are seen promptly for both emergency and elective treatment. We are delighted that each quarter we were “Green” for all these important indicators.

We also have to make sure that we are using public money wisely and manage within the resources that we have obtained through our contracts with Primary Care Trusts (PCTs). Once again this year

we saw more patients than we were contracted to see. This is a very important issue for us going forward as we need to support Primary Care in ensuring that patients referred to the hospital are similar to the numbers of patients we are commissioned to treat. If we do not do this then it causes both operational and financial problems for the hospital. We ended the year with a b*reakeven* position. Further information on these issues is provided in the annual accounts at the back of this annual report.

The year has been very significant in that we are proud to have been selected as preferred provider for Wiltshire Community Health Services and we plan to take on the responsibility for management of these services. Not only will these services increase the population we serve from 340,000 to approximately 750,000 but it will mean we have delivered an important element of our strategic aim which is to increase the population we serve.

Through our Governors, our members have said they wanted us to improve the patient experience from General Practitioner, hospital and community and social care services. We believe that in becoming responsible for Community Services we have a unique opportunity, not only to improve patient and carer satisfaction, but to reduce duplication and cost. We will continue to work effectively with other health, local authority and voluntary provider services to ensure that we use public funding wisely and provide the best services we can.

None of the above would have been possible without the hard work and dedication of our staff and volunteers, along with colleagues working in other allied organisations. Change is needed and is inevitable if we are to continue to improve what we do both inside and outside hospitals and deliver better care for the population we serve at lower cost. However, we are confident that our staff will continue to meet the challenges ahead.

Signed

Lyn Hill-Tout
Chief Executive
6 June 2011

Part 2 - Priorities for improvement and statements of assurance from the Board

Priorities for improvement

Within its business plan, the Great Western Hospitals NHS Foundation Trust sets out that the provision of safe, high quality, patient care, is its number one priority.

This quality and safety strategy explains the key measures against which the Trust will assess that this objective is met and the detailed plans for how these measures will be delivered. Delivery of this strategy will provide both internal and external assurances that robust clinical governance structures and systems are in place, monitored and appropriately managed and that there is a continuous drive to improve the quality of care provided for our patients.

The Trusts aim is to set out a clear quality improvement plan building on current local and national quality improvement initiatives to meet its patient quality and safety objectives and provide the safest and most effective care to enhancing the patient experience.

The Trust proposes four priorities for quality improvement:

1. To improve patient safety and reduce harm.
2. To deliver effective, evidence based care.
3. To improve the patient experience.
4. To comply with governance and regulatory obligations.

The Trust proposes the following areas for reporting on quality performance and improvement within the four priorities identified:

Priority Area for Quality Improvement	Quality Matrix for measuring and monitoring quality performance	Primary Drivers
1. To improve patient safety and reduce harm	**1.1** Reduce hospital acquired infection • MRSA bacteraemias • *Clostridium difficile* infection	DH CQC regulations Monitor Health Act Commissioning contract Local priority QRP
	1.2 Reduce harm associated with incidents • drug errors • blood transfusion • patient falls	SW Quality and Patient Safety Improvement Programme CQC Monitor Commissioning Contract SHOT NSFs Local priority
	1.3 Reduce Grade 3 and Grade 4 pressure ulcers	CQC Regulations Local priority
	1.4 NPSA – reducing avoidable harm to patients using the key risk categories advised by the NPSA	NPSA – never events Commissioning contract Local priority CQC regulations

Priority Area for Quality Improvement	Quality Matrix for measuring and monitoring quality performance	Primary Drivers
	1.5 Reduce preventable hospital mortalities	CQC regulation Commissioning Contract Local priority Patient Safety First campaign
2. To deliver effective, evidence based care	**2.1** Compliance with VTE guidance and action plan	CQC regulations Regional and commissioning contract National priority QRP
	2.2 Improvement in Nutritional assessments and care	CQC regulations Regional and commissioning contract National priority QRP
	2.2 Implementation of the Stroke action plan to ensure compliance with the stroke care pathway	CQC regulations Regional and commissioning contract National priority QRP
	2.3 Review hospital readmissions within 14 days	Commissioning Contract Local priority
	2.4 18 weeks RTT (also defined within the national performance targets).	CQC regulations Regional and commissioning contract National priority QRP Monitor
	2.5 Cancer national priorities (also defined within the national performance targets).	CQC regulations Regional and commissioning contract National priority QRP Monitor
	2.6 Review patient return to theatres within 2 weeks	Commissioning Contract Local priority
	2.7 #NOF – review and monitor timescales to theatre	National and local priority CQC regulations Commissioning contract
	2.8 Compliance with NICE guidance	National and local priority CQC regulations Commissioning contract
	2.9 Compliance with CAS	National and local priority CQC regulations Commissioning contract
3. To improve the patient experience	**3.1** Patients who would recommend the hospital to family and friends	CQC regulations Regional and commissioning contract National priority QRP Picker survey

Priority Area for Quality Improvement	Quality Matrix for measuring and monitoring quality performance	Primary Drivers
	3.2 Patients treated with dignity and respect	CQC regulations Regional and commissioning contract National priority QRP Picker survey
	3.3 Patient information on discharge	CQC regulations QRP Picker survey
	3.4 Response times to call bells	QRP Picker survey
4. To comply with governance and regulatory obligations	**4.1** Compliance with CGC regulations and CQC registration	CQC regulations and registration Monitor
	4.2 Improve the Trusts Quality and Risk profile	CQC regulations and registration Monitor
	4.3 NHSLA acute standards – work toward Level 3	CQC regulations QRP Commissioning contract
	4.4 NHSLA maternity standards – sustain Level 3	CQC regulations QRP Commissioning contract
	4.5 Staff survey	CQC regulations QRP Commissioning contract
	4.6 Mental Health/Capacity	CQC regulations QRP Commissioning contract
	4.7 Vulnerable children/adults	CQC regulations QRP Commissioning contract

1 To reduce our number of MRSA Bacteraemias

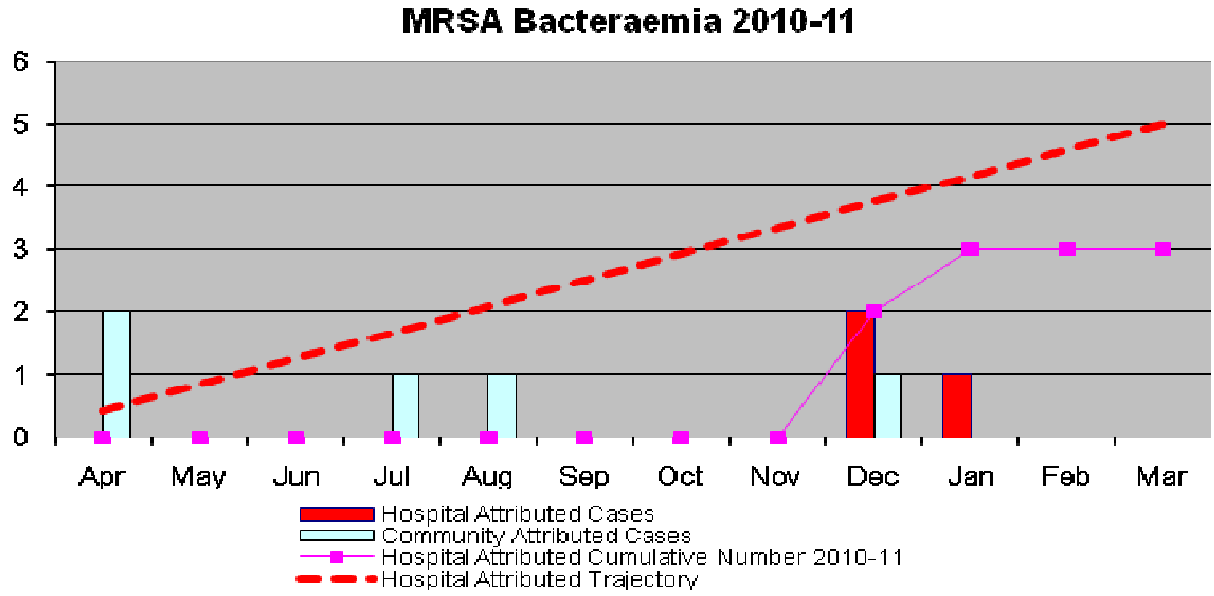
Monitoring	Monthly	**09/10 Target**	6 or less
Target Requirement	CQC,M,	**10/11 Target**	5 or less
PC Contract	Yes	**Target achieved**	**Yes (3)**
Leads	Dr Alf Troughton – Medical Director Dr Susan Dawson – Consultant Microbiologist Lisa Hocking – Lead Nurse Practitioner for Infection Prevention & Control		

During 2008/09 and 2009/10 rates of MRSA bacteraemias continued to be low, however the Trust still felt that further measures could be implemented to continue to reduce these numbers in line with national priorities. The goal for 2010/11 was to reduce the number of hospital acquired MRSA bacteraemias to five or less.

Although our MRSA bacteraemia rate per 10,000 bed days was 0.33 during 2009/10, this has increased to 0.59 (October to December 2010), this is because Non-Acute Trust apportioned MRSA bacteraemias are included with Acute Trust data to calculate this rate.

This Trust reported three MRSA bacteraemias for 2010/11, thus showing a 50% reduction in Acute Trust reported MRSA bacteraemias when compared to 2009/10.

Table 1 – MRSA Bacteraemia 2010-11



Local initiatives included:

- Sustained improvement whilst striving for increased compliance with care bundles for peripheral lines and urinary catheters.
- Undertake risk assessments for all patients admitted to GWH aiming for 100% compliance.
- MRSA screening of elective and emergency patients aiming for 100%
- All results reported through the IP&C Forum and the Clinical Governance and Risk Committee (now the Patient Safety and Quality Committee).
- Utilise a rapid process for MRSA screening.
- Core training programmes for nurses, doctors and pharmacists to include antibiotic prescribing

2 To reduce our number of Clostridium difficile infections

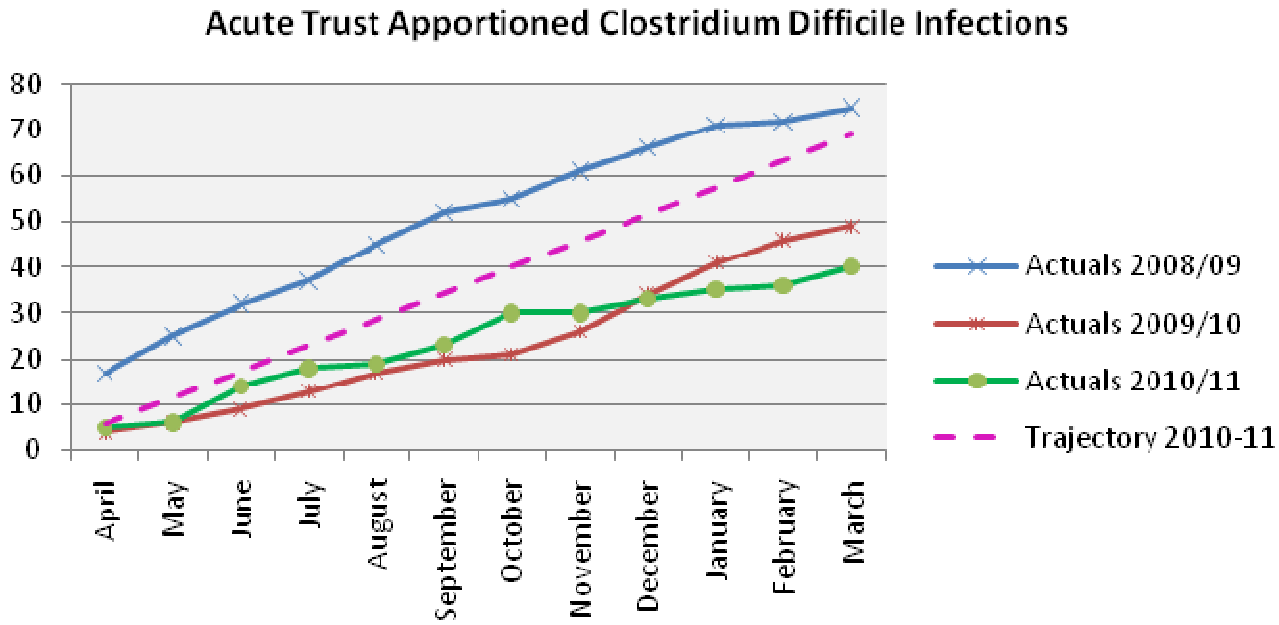
Monitoring	Monthly	**09/10 Target**	69 or less
Target Requirement	CQC,M,	**10/11 Target**	69 or less
PC Contract	Yes	**Target achieved**	**Yes (40)**
Leads	Dr Alf Troughton – Medical Director Dr Susan Dawson – Consultant Microbiologist Lisa Hocking – Lead Nurse Practitioner for Infection Prevention & Control		

The goal for 2010/11 was to report 69 Acute Trust apportioned cases or less. This is a locally agreed trajectory with the commissioning PCT and the SHA. The total number of cases reported during 2010/11 was 40, thus showing a reduction of 18% when compared to 2009/10.

Local initiatives to maintain our reduction included:

- Prompt isolation of patients with suspected infective diarrhoea within two hours.
- Rapid testing of suspected norovirus, which allows early identification of norovirus outbreaks and aid appropriate management of outbreaks of diarrhoea.
- Introduction of a weekly ward round for patients with Clostridium difficile.

Table 2 – Acute Trust Apportioned Clostridium Difficile Infections



During October to December 2010 the rate of Acute Trust apportioned cases per 1000 bed days for GWH was 0.21, which is lower than both the national (0.27) and regional rates (0.24).

Health & Social Care Act 2008

Following the unannounced visit in 2009 the Trust has the action plan has been satisfactorily been completed and the Trust continues to audit, review and sustain improvements made and collated as evidence against the Health and Social Care Act.

3 Medication errors – Reduce harm associated with medication errors

Monitoring	Monthly	**09/10 Target**	N/A
Target Requirement	Regional	**10/11 Target**	15% or less
PC Contract	Yes	**Target achieved**	**Yes (8.6%)**
Leads	Dr Alf Troughton – Medical Director Jane Coleborn – Chief Pharmacist Mike Lewis – Deputy Chief Pharmacist		

In 2010 – 11 there were a total of 514 medicine related incidents, and of these 7.8% were reported as causing low harm, 0.5% moderate harm and the remainder (91.7%) with no harm or a near miss. There were no medicine incidents causing severe harm or worse. An increase in number of reports in 2010-2011 is a positive sign as the need to report near miss incidents is widely promoted at staff induction and other training as a means of improving safety.

All medicine related incidents were reviewed by a medicines governance pharmacist, assessed for severity, and further investigated when necessary. Where appropriate action plans were put in place to reduce the risk of reoccurrence. Trends around medicines were investigated and reported to the Medicines Governance Group.

Table 3 – Medicine incidents by harm 2010-2011

Medicine Incidents by Harm 2010 – 2011

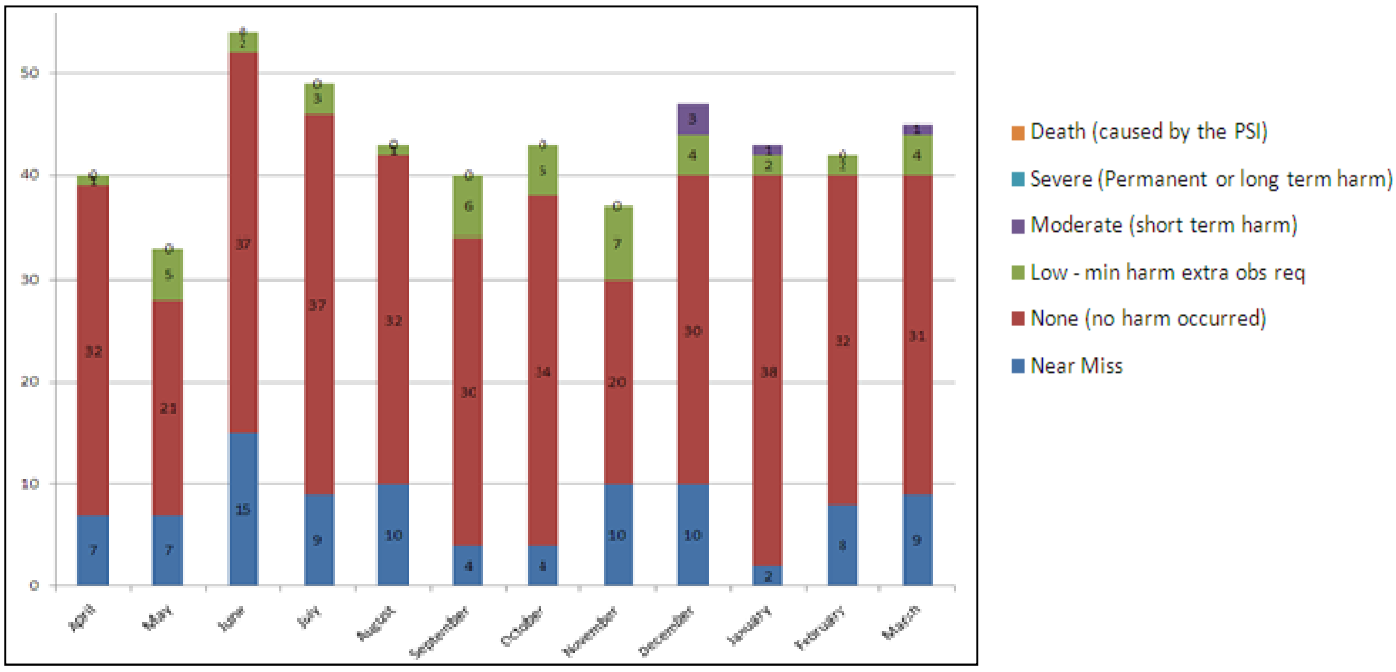
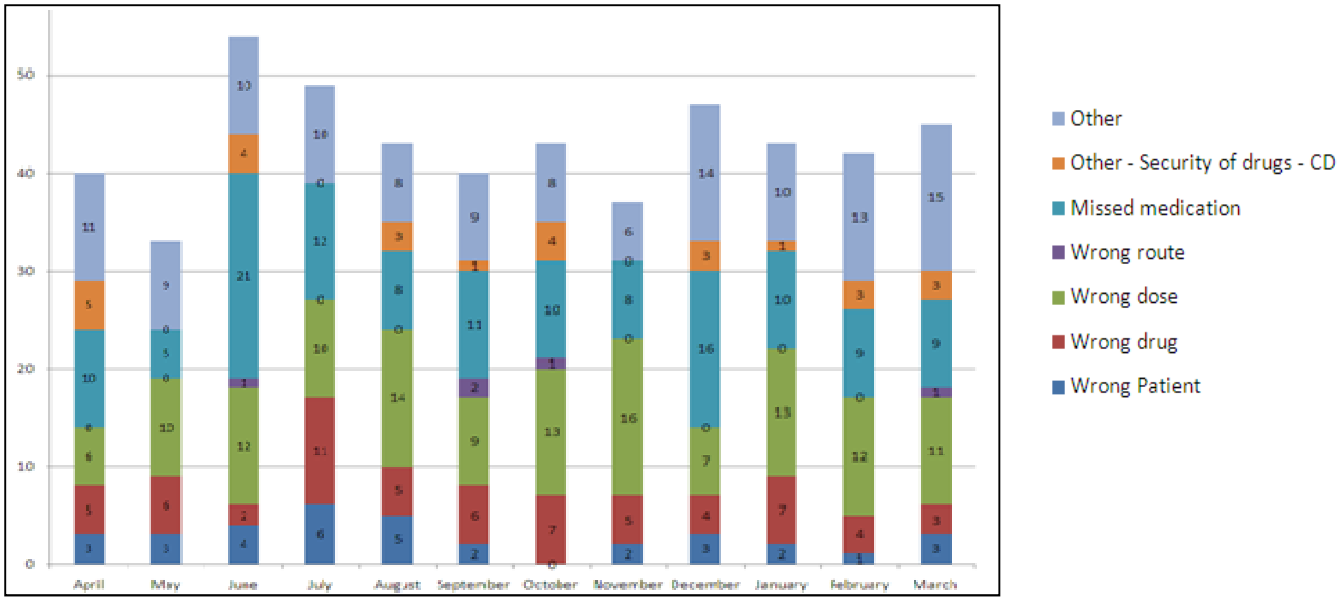


Table 4 – Medicine incidents by type 2010-2011

Medicine Incidents by Type 2010 – 2011



Regional Quality Improvement Program

Work continued as part of active involvement with the Regional Quality improvement program. A weekly rolling audit program using a sample of charts was initiated and this information was fed into the Regional program dataset. In addition many changes were made as part of this program to progress the NPSA alert on missed doses.

These activities included:

- two wards receiving more intensive intervention with cycles of change and review
- a more comprehensive monthly audit program of missed doses to cover all wards over a 12 month period
- the development of a critical list to guide staff in identifying medicines that must not be missed
- review of all incidents of over-anticoagulation with warfarin with an INR greater than 6
- a redesign of the pharmacy intranet front page with a particular emphasis on missed doses and the development of a set of tools to aid nursing staff – see illustration below. This front page was accessed approximately 50,000 times in 2010.

Missed dose resources on the pharmacy Intranet

Discharge Team

In 2010-2011 the pharmacy further developed a discharge team service to wards. This is an afternoon senior pharmacist led process involving an experienced pharmacist visiting unscheduled care wards and planned care wards, and clinically screening discharge prescriptions at ward level. This allows the pharmacist to process discharge prescriptions whilst on the ward and resolve any queries on the prescription (medication missed off, incorrect doses etc) in a timely manner using both the patient's medical notes and asking the patients doctor hence improving patient safety. This service has enabled the pharmacy department to process TTA (To Take Away) prescriptions in faster turnaround time's thus improving patient satisfaction.

Discharge Process

The discharge process has been further streamlined throughout 2010-2011 in a number of ways. Pharmacists and pharmacy technicians are now able to upload medication on to the patients electronic discharge summary (EDS) provided the drug chart has a doctor's signature to state drug is to continue on discharge. This has allowed the medication on TTA prescriptions to be dispensed in a much timelier manner. By providing each ward with a one stop dispensing service (supplying all medication for each patient with directions for discharge), there is often no need for prescriptions to be sent to pharmacy for dispensing as the patient already has all items on the ward thus again improving discharge time. The pharmacy robot has also allowed a more streamline dispensing process which has further improved the turnaround time of TTAs.

Medical Gases

Safety issues around medical gases were addressed by the development of new ward based storage racks for oxygen cylinders to ensure appropriate storage and labelling, and by the start of a medical gas cylinder 'milk round' that topped up wards to an agreed level every night to ensure cylinders were always available and to reduce the amount of clinical time needed to manage cylinders.

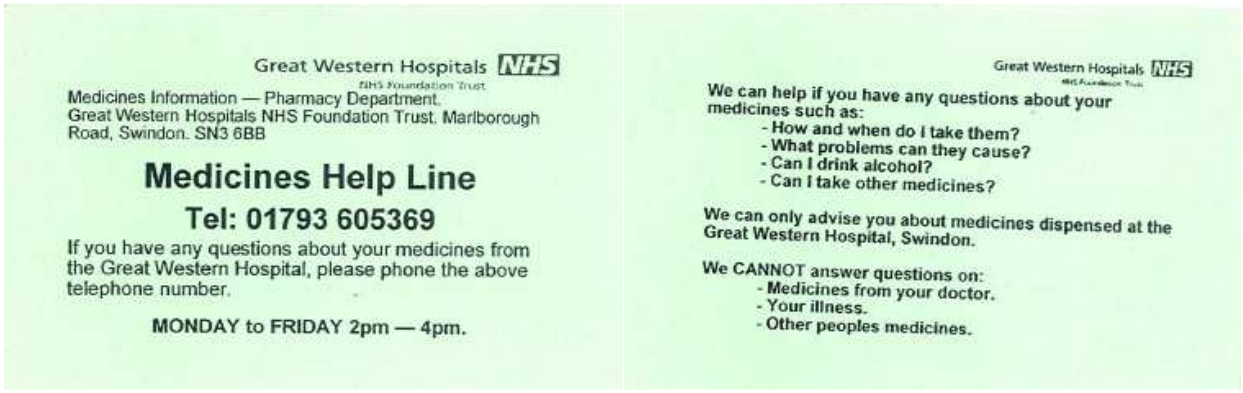
New Medicine Chart

In June 2010 after extensive trials and consultation, a new inpatient medicine prescribing chart was introduced to the Trust. This chart was a 16 sided 'booklet' style and replaced the old 'blue' six side charts. It drew together many of existing additional charts and forms which were often present as loose pages stapled to the main blue chart. It also allowed several clinical guidelines to be included as an integral part of all inpatient stays notably venous thromboembolic prophylaxis. The chart also created a structured approach to short and long term antibiotic prescribing and review, and created more space for regular and when required medicines, so that fewer patients required a second chart.

Patient helpline and information

In 2010 a patient medicine information helpline was trialled and then introduced fully to the Trust. This consists of a dedicated telephone number which is staffed by an experienced medicines Information pharmacist or pharmacy technician during certain hours to answer patients' questions about their outpatient or discharge medications. A copy of the card advertising the service is shown in the illustration below. This information will also be included in the enhanced discharge information given to inpatients.

Medicine Helpline Information Card



Training

Training is an important part of medicine safety, and in 2010 – 11 there was further development of the training program.

- Induction of clinical staff consisted of workbooks or face to face training on the major issues related to medicines safety. In addition all junior medical staff coming in to the Trust received additional sessions on safe prescribing and antibiotic prescribing, and the good principles associated with the provision of information to patients about their medicines (Medicines Adherence).

- Medical Students had a significant amount of extra training around medicines safety including shadowing of pharmacy staff and preparation for practice sessions looking at prescribing issues with worked examples and problem solving.

Medicine Reconciliation

Pharmacy led medicine reconciliation (recording an accurate medicine history on admission) continued in 2010-11 and this was audited on a rolling basis as part of the Regional Quality Improvement Program. Overall compliance was 90% with an increased pharmacy input into the Acute Admissions Unit at weekends and bank holidays, although further work is needed in the surgical admission unit.

Pharmacy Robot

The pharmacy 'robot' (an automated dispensing system) was installed in April to May 2010 and commissioned in June 2010. This system has several advantages from a patient safety point of view

- Reallocation of staff to ward based activities
- Bar coded issue of medicines for dispensing, reducing the risk of wrong drug / wrong dose errors
- A redesign of the dispensary, allowing more efficient and safer workflow

After 6 months of usage the robot has had a major effect on workflow in pharmacy, leading to a more efficient, better structured process.

Antibiotic Team

Throughout the year April 2010 - 11 the antibiotic management team (pharmacists, microbiologists and IC nurses) have been continuing to see an improvement in the quality of antibiotic prescribing. The team continuously monitors the use of antibiotics by auditing prescribing on every ward each week and regularly discusses these results with nursing and medical staff on the wards and feed this information back formally to prescribers every three months.

There has been a further reduction in numbers of *C.difficile* associated diarrhoea (CDAD) cases in the Trust this year. The team manages care of all patients with CDAD and has introduced a weekly antibiotic team ward round which also includes a dietician and a consultant gastroenterologist. The team also visits selected patients with severe infections who benefit the specialist advice. The antibiotic pharmacists have launched an antibiotic blood level monitoring service this year which aims to ensure safer use of certain antibiotics.

We continue to ensure all of our antibiotic usage policies are updated regularly and are available on our hospital intranet for easy access by prescribers.

Air Tube

The hospital air tube transport system was extended to all wards in 2010. This allows a rapid transit of prescription requests from wards to pharmacy, and return of items from pharmacy to ward. The system is in place and working, and pharmacy is working with the Productive Ward initiative to develop standard ways of using the air tubes most effectively and ensuring that medicines are available and doses are not missed.

National Patient Safety Agency (NPSA) Alerts

In 2010 action plans were developed and followed for all NPSA alerts. In addition the NPSA identified to Trusts an increased number of ‘Never’ events and also developed ‘Signals’ designed to highlight safety issues, many related to medication. The Trust medicines Governance team has started to develop work plans around these notifications.

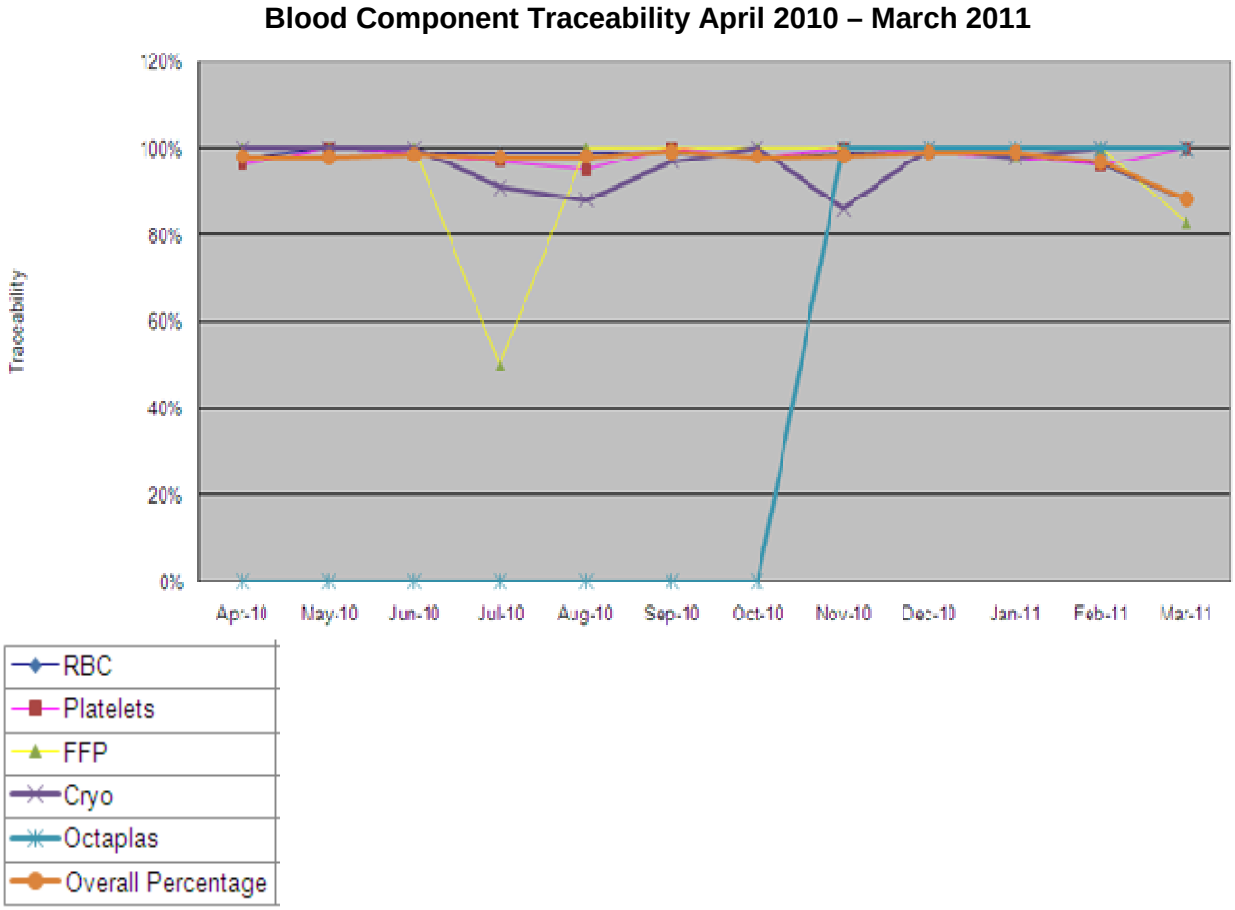
4 Zero patients receive incorrect blood transfusions and safer transfusions

Monitoring	Monthly	**09/10 Target**	0 errors
Target Requirement		**10/11 Target**	0 errors
PC Contract	No	**Target achieved**	**Yes**
Leads	Sue Rowley – Director of Nursing and Midwifery Dr Alex Sternberg – Consultant Haematologist Sally Caldwell – Blood transfusion Practitioner		

During the 2010 - 2011 reporting year there have been no 'wrong blood to wrong patient' incidents and no 'near miss' incidents within this category. There have also been no 'handling & storage' incidents this year. There have been two delayed haemolytic transfusion reactions due to immunological complications, **not** human error. One has been reported to SABRE (Serious Adverse Blood Reactions & Events) and SHOT (Serious Hazards of Transfusion) and one is about to be reported.

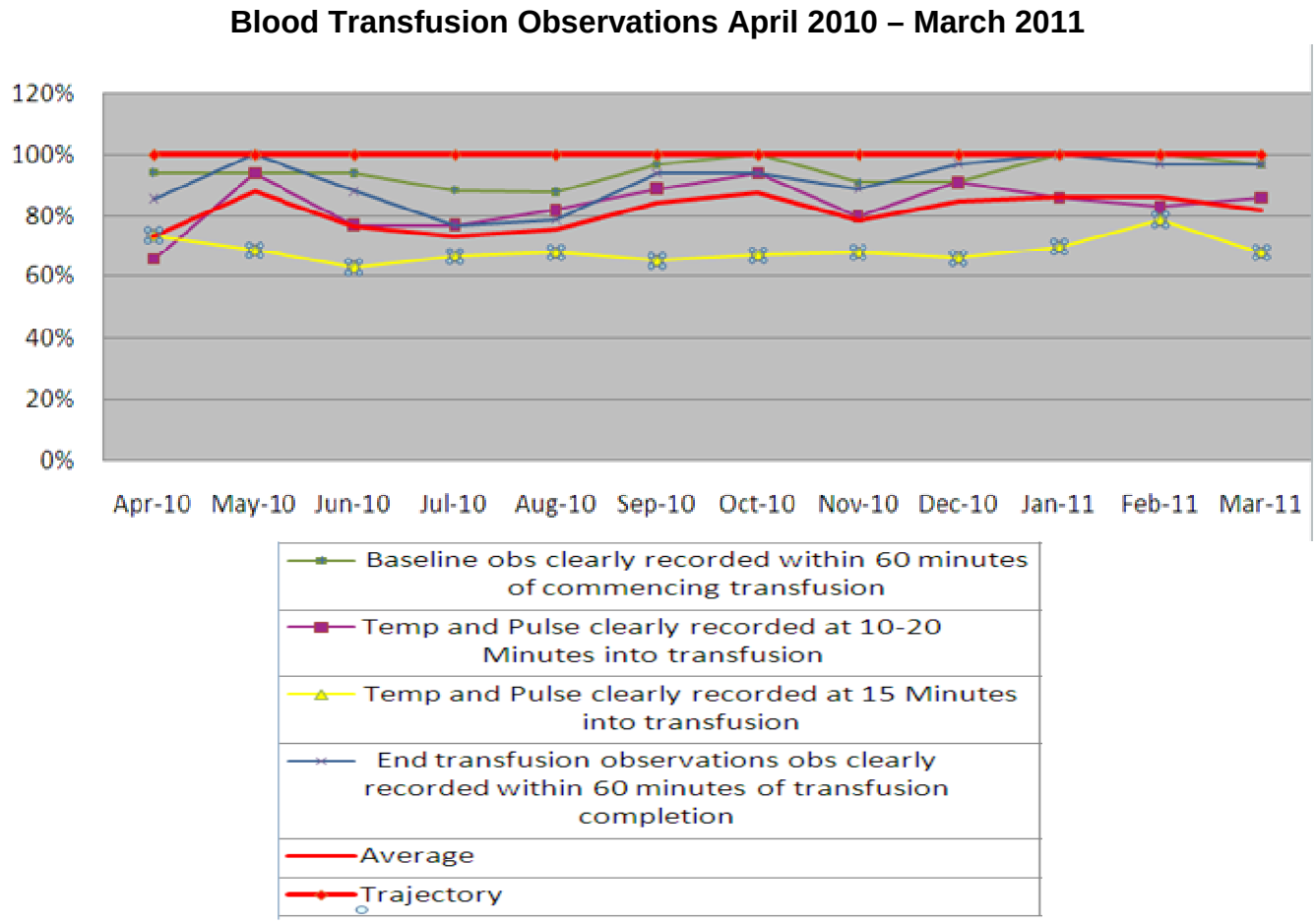
Under the Blood Safety & Quality Regulations (2005) there is a legislative requirement for **all** blood and blood components to be fully traceable from donor to recipient. The Great Western Hospitals NHS Foundation Trust uses the Blood Audit & Release System (BARS) which is an electronic blood tracking system. Traceability is constantly monitored and month by month has on average been running at 98.041% with a mode of 98.59%. There has been a marked improvement over the last two years. Traceability for January, February and March 2011 is still to be completed.

Table 5 – Blood Component Traceability April 2010- March 2011



Safe care of the patient receiving blood component transfusions is regularly monitored via monthly auditing of transfusion observations. Minimum monitoring of the patient should include temperature, pulse, blood pressure and respiration rate. These should be recorded no more than 60 minutes prior to commencing the unit, 15 minutes into the unit (this includes observations undertaken within a 5 minute window either side of the 15 minutes) and no more than 60 minutes after completion of the unit.

Table 6 – Blood transfusion observations April 2010 – March 2011



The National Patient Safety Agency (NPSA) competency based training for blood administration and venepuncture continues. The Trust is working towards achieving the set target of 100% for all staff involved in this process. The Trust is currently at 79.8% (not including doctors). All staff undertaking these tasks must hold a current Trust competency, any staff without the relevant competencies are no longer permitted to take part in the blood transfusion process. A clear process of action was approved at February's Clinical Managers meeting utilising the Matrons actively in policing and managing this; a transfusion breech form has been devised to identify any concerns. Any concerns or issues regarding staff competencies will be monitored through the Clinical Managers Group held monthly.

5a Reduce patients' falls in hospital

Monitoring	Monthly	**09/10 Target**	1156 or less
Target Requirement	Local	**10/11 Target**	909 or less
PC Contract	Yes	**Target achieved**	**No (1090)**
Leads	Sue Rowley – Director of Nursing and Midwifery Dr Attoti – Consultant Physician (DOME) Amy Walsh – Falls Co-ordinator		

5b Reduce associated harm

Monitoring	Monthly	**09/10 Target**	NA
Target Requirement	Local	**10/11 Target**	24 or less incidents of severe harm
PC Contract	Yes	**Target achieved**	**Yes (15)**
Leads	Sue Rowley – Director of Nursing and Midwifery Dr Attoti – Consultant Physician (DOME) Amy Walsh – Falls Co-ordinator		

The Trusts aim for falls reduction during 2010/11 has not been achieved. The 6% decrease in reported falls was exceeded by 17% to a total of 1090. We have however surpassed the 10% reduction aim in severe harm falls by 38% from our target of 24 to our total of 15 reported incidents. The falls investigation group commenced at the beginning of last year have worked together in reducing this number through learning from the serious incident investigation process and sharing their learning between wards. This work will continue through the GWH falls working group.

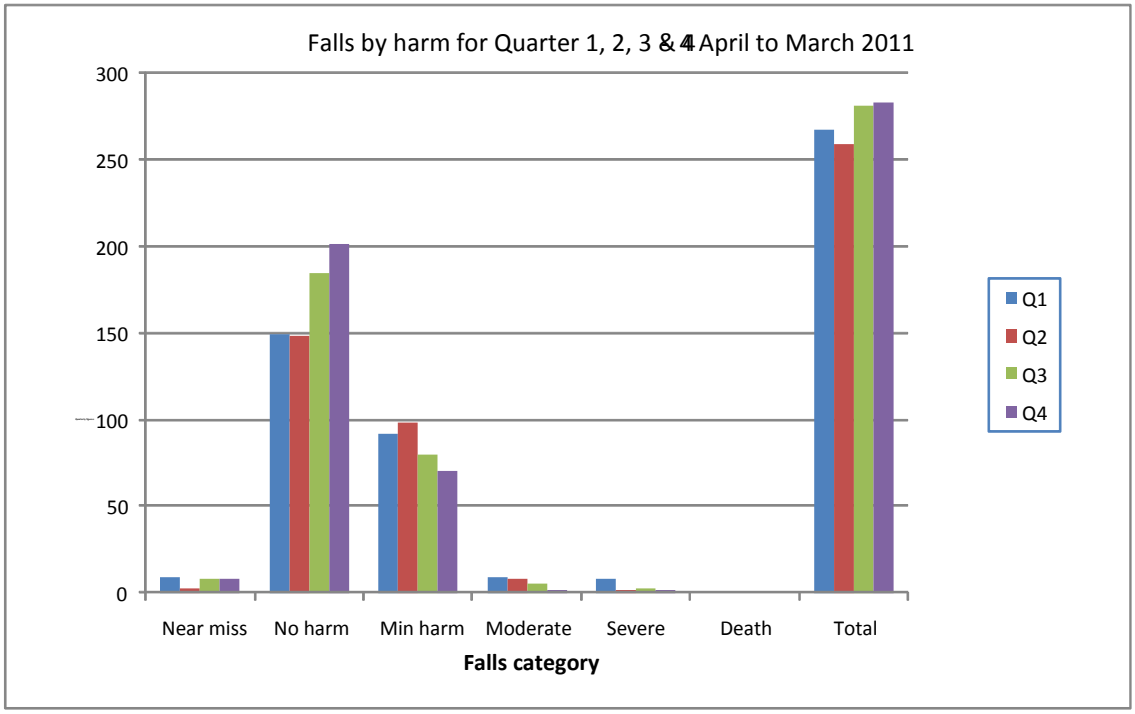
The Swindon falls and bone health strategic group work together across council services and primary and secondary care organisations. The action plan from this group have enabled us to work together to review and improve the integrated falls and bone health pathway, to ensure a seamless journey of service delivery to all service users. As a result of this we have audited the first stage of the inpatient falls pathway to measure its effectiveness and drawn up improvement measures to be re audited in 2011/12. We have also taken part in the second national falls and bone health audit from the Royal College of physicians, the results of which will be released soon. This information will further aid us in reviewing and progressing within our service.

Within the integrated falls and bone health team over the last year there has been new key professionals welcomed. Dr Ipe is the new Falls consultant lead, Amy Walsh is the new Clinical nurse – falls avoidance and Julia Bradbury is the new Community falls and bone health lead for care and support partnership in Swindon.

Weekly audit reports show that on average 60% of patients over 65 years old have the current falls risk assessment completed within 24 hours of admission. Those wards in the transitional period of using new the new risk assessment audit their compliance manually, for which they are achieving 80% on average.

The patient safety campaigns aim to improve staff compliance with the care pathway continues this year. Through efforts to ensure the inpatient falls pathway is accessible and easy to use in practice. The trial of the new tool in two adult wards will become the new pathway and will be implemented throughout the hospital during the coming year.

Table 7 – Falls by harm April 2010 – March 2011



6 To reduce our hospital acquired Grade 3 Pressure Ulcers

Monitoring	Monthly	**09/10 Target**	24
Target Requirement	Local	**10/11 Target**	22
PC Contract	Yes	**Target achieved**	**Yes (2)**
Leads	Sue Rowley – Director of Nursing and Midwifery Dr Hocken – Vascular Surgeon Stephanie Carpenter – Tissue Viability Nurse Specialist		

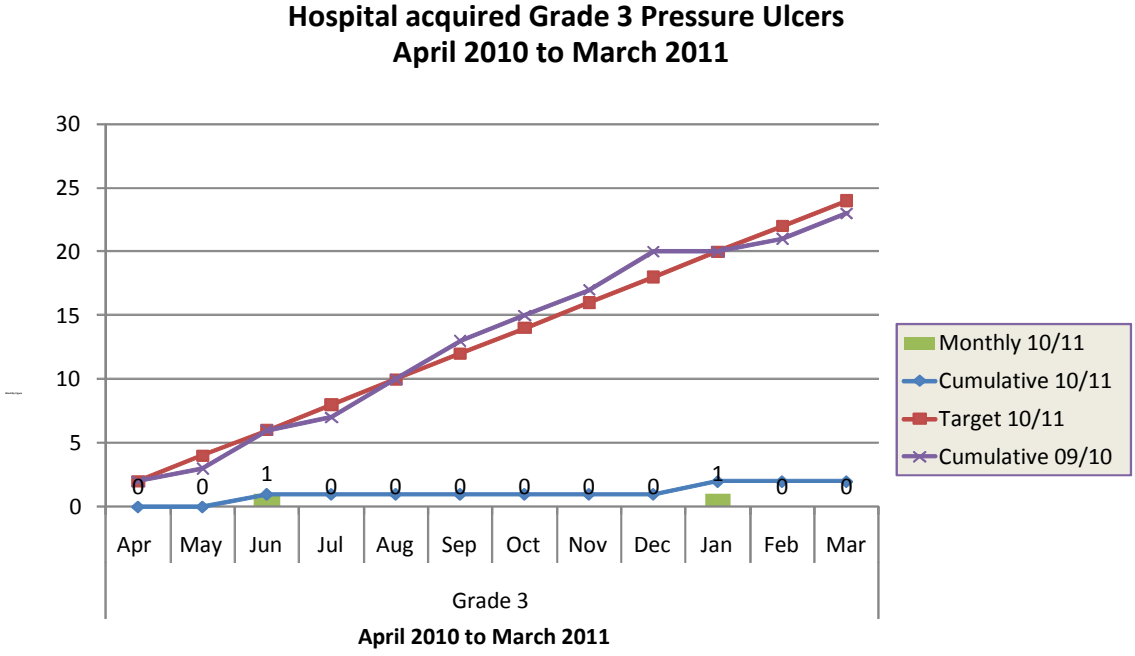
With the introduction of the Pressure Ulcer Focus Forum (PUFF) we have targeted areas where it has been identified through RCA, the learning outcomes to improve on patient care. This year focusing upon the learning outcomes has resulted in a combined improvement by 75% in the number of Grade 3 and Grade 4 hospital acquired pressure ulcers.

The Trust has made a dramatic improvement of 91% to the target for Grade 3 pressure ulcers and 59% improvement to the number of Grade 4 pressure ulcers. An audit tool has been developed for the designated areas to take ownership of these patient focused outcomes.

Pressure ulcers are key quality care indicators within the Essence of Care patient-focused framework for clinical effectiveness and are included in the South West Key driver programme; the aim 80% reduction in hospital acquired pressure ulcers by 2014. The planned reduction of both Grade 3 and Grade 4 hospital acquired pressure ulcers has been exceeded.

The reduction in grade 3 and 4 pressure ulcers has been achieved through the employment of a specialist nurse who reports fortnightly to the Deputy Director of Nursing and Midwifery. A specialist assessment tool "waterlow" is used on admission and throughout a patient's stay. The results sit on the ward dashboard so that they are visible at all times. This is particularly important during ward handover so that staff are aware of who is at risk. Specialist equipment is used depending on the outcome of the assessment such as mattresses, negative pressure ulcer machines, gels, protectors and dressings. Photographs are taken of any ulcers to observe how they improve or worsen. There is a pressure ulcer forum which monitors activity.

Table 8 – Hospital acquired Grade 3 pressure ulcers April 2010 – March 2011

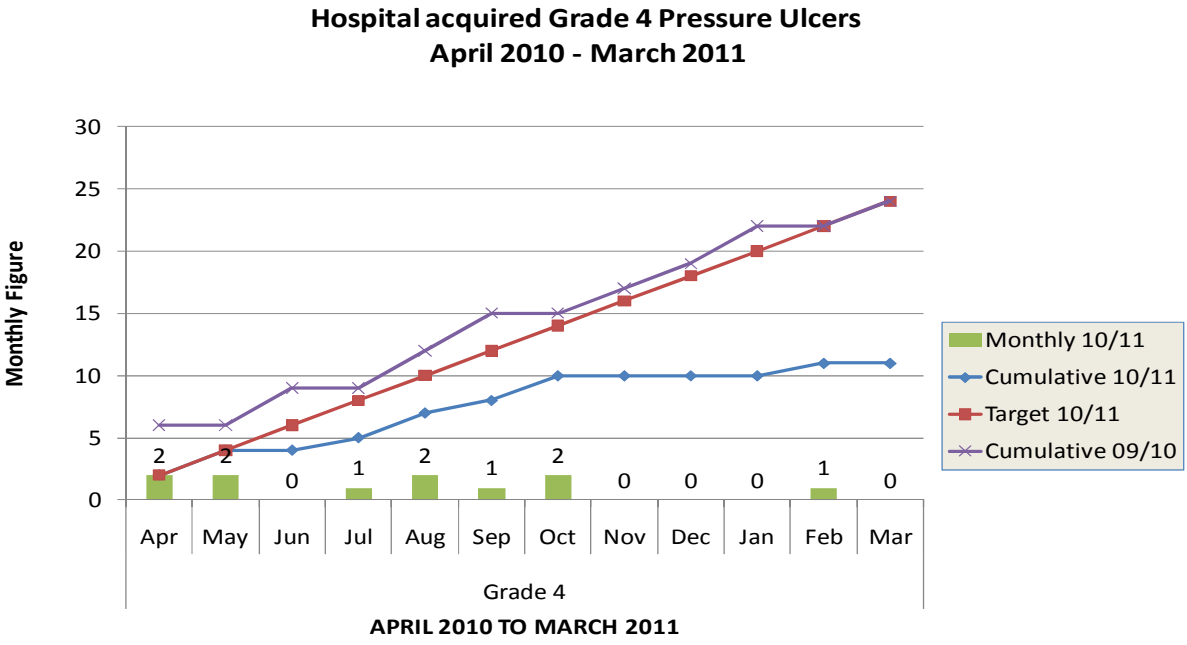


7 To reduce our hospital acquired Grade 4 Pressure Ulcers

Monitoring	Monthly	**09/10 Target**	30
Target Requirement	Local	**10/11 Target**	27
PC Contract	Yes	**Target achieved**	**Yes (11)**
Leads	Sue Rowley – Director of Nursing and Midwifery Dr Hocken – Vascular Surgeon Stephanie Carpenter – Tissue Viability Nurse Specialist		

- Grade 4 pressure ulcers to be formally investigated using an adapted Department of Health RCA Data Gathering Tool
- Increase compliance with skin status assessments of all patients on admission
- Sustained compliance with the skin status assessments weekly using the electronic nursing record, crescendo
- Probably the most influential elements for this achievement has been sustained compliance of the skin status/pressure ulcer risk assessments via Crescendo and the use of the adapted Department of Health Root Cause Analysis Data Gathering Tool to identify any learning outcomes
- From April 2010, Grade 3 pressure ulcers were formally investigated using the RCA information collection tool and reported as serious incidents.
- The findings assisted the PUFF action plans and reviews. All patients will also have a re-assessment of skin status/Water low score on a weekly basis.
- All Grade 4 pressure ulcers were formally investigated using the RCA information collection tool; and reported as serious incidents. Ward Managers are able to identify the numbers of pressure ulcers within their areas using the daily/weekly pressure ulcer audit tool. This can be completed on a daily basis and a copy forwarded to the Tissue Viability Nurse Specialist (TVNS).
- Wards have had educational sessions by the TVNS and comfort rounds have been implemented.

Table 9 – Hospital acquired Grade 4 pressure ulcers April 2010 – March 2011



8 NPSA – reducing harm – never events.

Monitoring	Monthly	**09/10 Target**	NA
Target Requirement	National	**10/11 Target**	0 errors
PC Contract	Yes	**Target achieved**	**Yes**
Leads	Dr Alf Troughton – Medical Director Associate Medical Directors Rachel Jefferies – Clinical Risk Manager		

The Trust has reported no never events from April 2010 to March 2011. In February 2011, the Department of Health published an updated list of never events for 2012. The list has expanded from a previous set of 8 never events to 25. Leads have been identified for each never event to ensure that an action plan is in place to reduce the risk of an event occurring.

9 HSMR – reduce reduce preventable hospital mortalities

Monitoring	Monthly	**09/10 Target**	100 or less
Target Requirement	National	**10/11 Target**	100 or less
PC Contract	Yes	**Target achieved**	**88.2% YTD (data 3 months in arrears)**
Leads	Dr Alf Troughton – Medical Director Mark Juniper Consultant respiratory Medicine Ruth McCarthy – Associate Director for Clinical Governance Peter 'O' Driscoll – Head of Informatics		
Monitoring	Monthly	**09/10 Target**	N/A
Source	Local	**10/11 Target**	To monitor and progress our plan to reduce mortalities
PC Contract	No	**Target achieved**	
Leads	Dr Alf Troughton – Medical Director Mark Juniper Consultant respiratory Medicine Ruth McCarthy – Associate Director for Clinical Governance Peter 'O' Driscoll – Head of Informatics		

The Trust has maintained an aggregate Hospital Standardised Mortality Rate (HSMR) below 100 for the year to date (April – January). The rate of 88.2 is a significant improvement on the previous year.

As reported previously Dr Foster updates its benchmark following the end of year and when this was done for the year 2009/10 performance the HSMR increased from being 95.0 to a final rebased position of 106.4. Dr Foster's explanation is that the in-hospital mortality rates are declining rapidly and so that HSMRs fall accordingly. As a result the national average expected level would no longer be 100 and that recalibration when actual annual data is available is necessary to re-baseline performance. Dr Foster currently predicts that the re-based outturn for the Trust would be 97.0, which would be a significant improvement on 2009/10 final position.

Table 10 shows how the Trust is performing when compared to the average for the South West SHA and against the national expected level of 100. It can be seen that over the last four years the Trust has reduced its HSMR and in the current year is broadly tracking around the SHA average (89.2 April – January) with two months where higher peaks are seen.

Table 10 – HSMR Mortality GWH and SHA

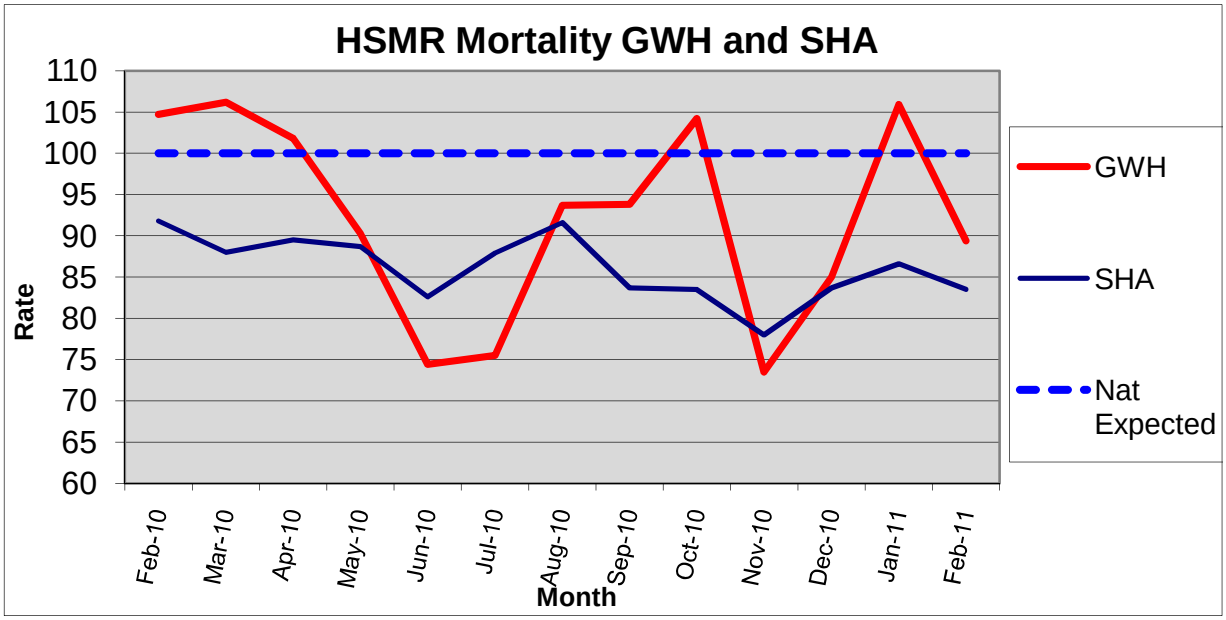
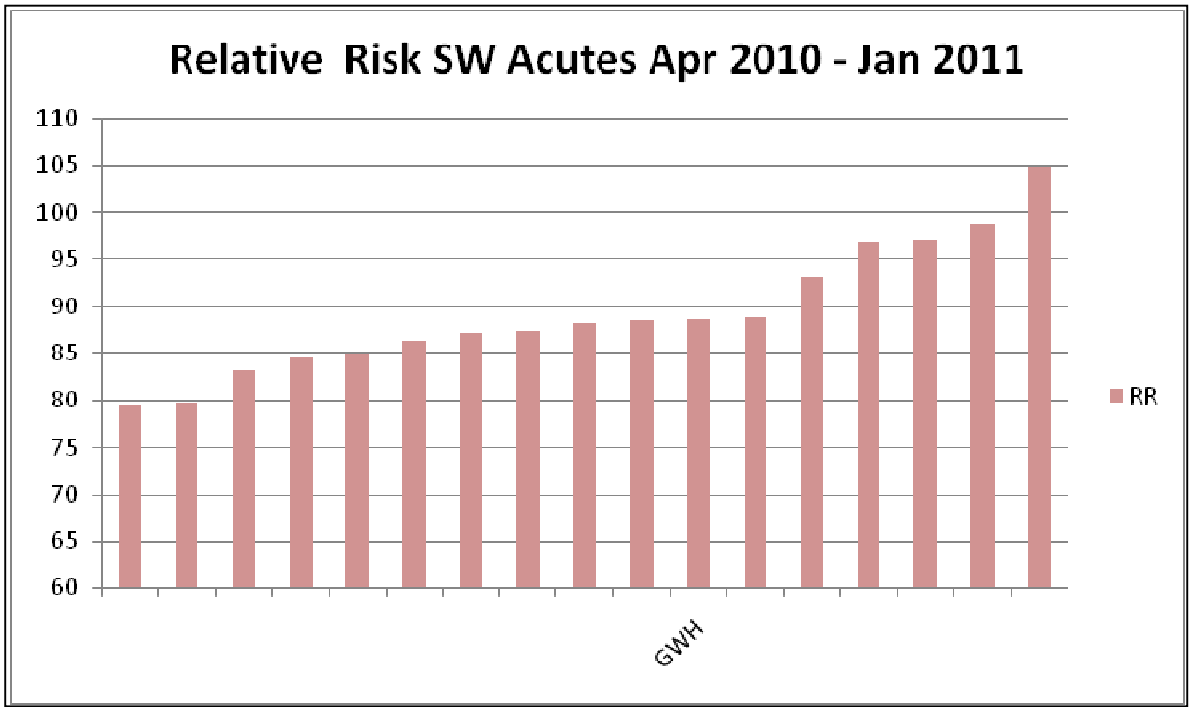


Table 11 shows in more detail how the Trust compares against the other Acute Trusts in the SHA for HSMR relative risk for the current year. It can be seen that performance is good and significantly better than several Trusts in the SHA.

Table 11 – Relative risk SW Acute Trusts April 2010 – January 2011



The Trust has developed a Trust Mortality Group that meets on a monthly basis and includes clinician representation from each Clinical Directorate as well as representatives from Quality, Clinical Audit, Risk, Information and Clinical Coding. The group receives monthly reports on mortality centred on Dr Foster analysis and investigates areas where performance is showing lower than expected, often including a clinical audit or review by the lead clinician of the area concerned. The results of investigations are reported back to the group and the group also reports regularly on its work to the Trust Quality Group. The Mortality Group also develops work strands on any issues concerned with mortality that are brought to it.

10 South West SHA Quality and Patient Safety Improvement Programme

A patient safety incident is any unintended or unexpected incident which could have or did lead to harm to one or more patients receiving NHS care (NPSA). The Trusts reports all incidents which relate to patient safety to the National Patient Safety Agency (NPSA) via the Reporting and Learning System (NRLS) on a weekly basis.

The NPSA is now required to send all incidents resulting in moderate harm, severe harm or death to the Care Quality Commission (CQC). Since February 2011, to comply with CQC regulatory requirements, the Trust includes the incident description and outcome of the investigation with all incidents uploaded to the NPSA.

Incidents reported to the NPSA during 2010/11

The NPSA encourages reporting of incidents and recognises that high reporting organisations usually have a better and more effective safety culture.

The number of patient safety incidents reported within the Trust has increased from 3759 incidents reported during 2009/10 to 4613 during 2010/11. The Trust's organisational report received from the NPSA for the period April 2010 to September 2010 confirmed this improvement, the Trust's reporting rate had increased to 5.45 per 100 admissions compared to 4.8 per 100 admissions for the period between October 2009 and March 2010. This indicates that awareness of the requirement to report patient safety incidents has improved and that staff feel confident to report incidents. The CQC 2010 staff survey supports this. The Trust was placed in the best 20% of Trusts for fairness and effectiveness of their incident reporting procedures.

The CQC staff survey results revealed that the Trust scored better than average for the percentage of staff who said they had witnessed a harmful error in the last month (fewer staff had witnessed a harmful error). Table 13 demonstrates that although incident reporting to the NPSA increased during 2010/11, a higher percentage of incidents reported than in 2009/10, were either a near miss incident or resulted in no harm to a patient, indicating that although a more incidents were reported this did not equate to higher numbers of incidents resulting in harm.

Table 12 - **Actual harm resulting from patient safety incidents**

Actual harm	Number of incidents 2009/10	% of incidents 2009/10	Number of incidents 2010/11	% of incidents 2010/11
Near miss	255	6.8%	345	7.5%
No harm	2095	55.7%	2859	62%
Low harm	1048	27.9%	1246	27%
Moderate harm	344	9.15%	139	3%
Severe harm	10	0.27%	20	0.4%
Death	7	0.19%	7	0.15%
Total	3759	100%	4613	100%

In April 2010 the Trust fully adopted the NPSA National *Framework* for Reporting and Learning from Serious *Incidents Requiring Investigation*. This may account for the slightly higher percentage of incidents resulting in severe harm, all Grade 4 pressure ulcers are now graded as severe harm, along with any fall which results in a fractured neck of femur, a number of these types of incident would previously have been reported as moderate harm.

Timeliness of reporting

The time between an incident occurring and being reported to the NPSA is important for the information to be useful for identifying and acting on patient safety incidents quickly. Year end 2009/10 the NPSA reported that fifty percent of all incidents reported from all organisations were submitted to the NRLS more than 44 days after the incident occurred, whilst in our organisation, 50% of incidents were submitted more than 20 days after the incident occurred. The Trust maintained a consistently good reporting time in 2010/11, with an average of 21 days from date of incident occurring to date of report to NPSA.

Table 13 - Type of incident reported

Cause Group	2008/09	2009/10	2010/11
Access, Admission, transfer, discharge	348	269	274
Clinical Assessment	281	222	206
Consent, Communication, Confidentiality	179	97	93
Disruptive, Aggressive Behaviour	37	26	9
Documentation (Inc Records, patient identification)	241	227	376
Fire	3	0	0
Implementation Of Care/ongoing	309	291	399
Infection Control Incident	96	91	320
Infrastructure (Incl. Staffing)	302	128	137
Manual Handling	16	9	15
Maternity incident	N/A	N/A	61
Medical Device, Equipment	268	165	322
Medication	302	447	512
Other Accident/incident	134	113	160
Physical Abuse	13	8	15
Security	26	9	13
Self-Harming Behaviour	34	32	16
Sexual Abuse	2	0	0
Slips, trips And Falls	1297	975	1108
Treatment/procedure	708	650	565
Verbal Abuse	3	0	4
Total	4599	3759	4613

Most notably an increase has been seen in the reporting of documentation and infection control related incidents. This is likely to be as a result of an improved reporting culture, a reduction in actual harm from Clostridium Difficile and MRSA has been consistently achieved during 2010/11, however further evaluation and monitoring of the increase in documentation errors will be required during 2011/12 to establish trends.

A new cause group for maternity specific errors was added by the NPSA in Quarter 3 of 2010/11, the Trust is now coding and uploading incidents to the NPSA against this new cause group. During 2011/12 analysis of themes, cause groups and learning will form part of developing trust wide aggregated analysis of incidents, claims and complaints data required for NHSLA assessment.

Serious Incidents

The Trust reported 44 serious incidents during the period April 2010 to March 2011, an increase from 27 reported during April 2009 to March 2010. In April 2010 the Trust fully adopted the NPSA National *Framework* for Reporting and Learning from Serious Incidents Requiring Investigation, which set clear criteria for the types of incident which should be reported as a serious incident. All Grade 3 and 4 pressure ulcer incidents and falls resulting in a fractured neck of femur are now classified as a serious incident, 21 incidents of this type were reported by the Trust in 2010/11, increasing our total number of serious incidents.

All serious incidents were investigated following the principles of Root Cause Analysis, with progress monitored by the previous Clinical Governance and Risk Committee, the newly formed Patient Safety and Quality Committee and appraised by the Trust Board through the monthly Patient Safety and Quality report.

Learning from incidents this year has resulted in many recommendations to improve care and patient safety throughout the Trust. The completion of action plans to implement the advised recommendations has been monitored by the previous Clinical Governance and Risk Committee and now the Patient Safety and Quality Committee, 35 serious incident action plans have now been completed, out of the 44 incidents reported. Improvements in practice, systems and processes which are now either completely implemented or in the process of being implemented include:

- Clearly defined use of the discharge unit, with agreed plan for opening as an additional area to admit inpatients;
- Introduction of PCR Norovirus testing on site;
- Implementation of the South West Norovirus checklist;
- Current Intensive Care Unit practice of routine MRSA suppression for all patients included in Trust policy;
- All patients identified as having a pressure ulcer will have a clear preventative and management plan completed;
- Reassessment will be completed twice weekly on a Wednesday and Sunday for those patients who have been identified as at a high risk of development of pressure ulcers;
- Review of falls care plan and risk assessment process, to ensure a comprehensive record of interventions put in place to reduce risk of falls;
- Traceable and auditable programme for maternal screening programme, the screening team to implement a blood tracking form;
- Maternity bloods need to be identifiable - all maternity blood forms will be marked with a sticker until electronic requesting is implemented;
- In maternity, all out of area women will be attending GWH for their booking blood tests.

Quality and Patient Safety Improvement Programme

Since March 2010 the Great Western Hospital NHS Foundation Trust, alongside many of the acute Trusts in the South West region, has been actively involved in the Quality and Patient Safety Improvement Programme. The programme, led by the South West Strategic Health Authority (SHA) in collaboration with the Institute for Healthcare Improvement (IHI), aims to achieve a 30% reduction in adverse events and a 15% reduction in mortality by September 2014.

The programme consists of 5 work stream packages: leadership, general ward, medicines management, peri-operative care and critical care. Each incorporating a number of high risk topics, for example preventing venous thromboembolism, use of the Safer Surgical checklist, and reducing complications from ventilators in intensive care units. Work stream leads and teams have been established within the Trust to deliver improvement in each of these areas, supported by our recently appointed Patient Safety Project Coordinator.

Leadership Since June 2011, as part of the SW SHA Quality and Patient Safety Programme, GWH has been conducting patient safety walk rounds, visiting various areas throughout the Trust to establish first hand patient safety concerns from frontline staff.

Non Executive Directors (NEDs) and Governors are now actively involved in this process, the first NED joined the executive team walk round for the visit to the mortuary in January 2011 helping to develop actions and solutions to concerns raised. A NED or Governor will now be taking part in a patient safety walk round on a monthly basis.

Since implementing patient safety walk rounds within the Trust executive teams have visited 11 clinical areas, with a further 19 programmed for 2011. During the walk round actions are identified to resolve issues that are raised by staff, the Patient Safety Coordinator within the Clinical Risk Team monitors completion of actions, of the 45 actions raised 30 have now been completed and resolved. The most common themes that have been identified are communication, treatment/care delivery problems and equipment related issues. In continuing to develop the process, themes that are being identified will be incorporated into the Trusts developing aggregated analysis process alongside incidents, claims, complaints and Global Trigger tool (case note review) data.

As a method of providing assurance that change is taking place, NEDs and Governors will be undertaking biannual meetings to review progress, discuss common themes and resolution of actions that have been identified. In addition the Chief Executive's quarterly report will be including the main themes and actions identified, ensuring that patient safety concerns are raised directly to the Trust Board.

General Ward The general ward teams have successfully implemented daily safety briefings in ward areas across the Trust in conjunction with the Productive ward handover module. The safety briefing is delivered at handover to all ward staff at the start of each shift, ensuring that the team is fully aware of risks on the ward, such as patients at risk of falling, infection control issues or highly dependent patients. During 2011/12 the team will be continuing to monitor compliance with this new process and assessing its impact on the improvement of patient safety within the ward areas.

In February 2011 the team delivered a training programme and the launch of SBAR (Situation-Background-Assessment-Recommendation), a tool to improve communication between professionals in the healthcare setting. A plan is in place to roll out and monitor the effectiveness of the SBAR communication tool across the Trust in 2011/12.

Medicines Management The teams have continued to expand on the action plan developed for the NPSA alert Reducing Harm from Omitted and Delayed Medication (2010), a critical medication list has been now developed and implemented across the Trust. The teams have commenced twice monthly audits and have been working with ward managers to implemented actions to resolve the

issues as they are identified. In addition, as part of the patient safety programme, during 2011/12 the team will be sharing expertise and working jointly with the peri-operative team to identify the incidence and reduce occurrence of missed doses of beta blockers in surgical patients.

Peri operative The team have been working on improving compliance with the WHO safer surgical checklist first implemented in 2009/10; the two pilot areas identified have successfully demonstrated sustained compliance of 100%. The team will now be validating these results before spreading the improvement process across all theatres in the department. In addition the maternity safer surgical checklist has been introduced to the maternity theatre; audits of compliance will begin in April 2011.

Critical Care The intensive care team have successfully implemented multidisciplinary ward rounds and daily goal setting for their patients, helping to improve communication between all team members, patients, carers and relatives.

The Southwest SHA Patient Safety Team visited the hospital in September 2010 to assess the Trust's progress and commitment to implementing the Quality and Patient Safety Improvement Programme, the Trust was extremely pleased with the positive feedback that was received. The SHA felt that we had taken time to consider how to integrate the programme into the operational work of the trust, that each team was accelerating and demonstrating real enthusiasm, and that the programme was well linked with Trust objectives with progress reported to Clinical Governance meetings and Trust board.

11 Increase risk assessment completion for adult patients for VTE

Monitoring	Monthly	**09/10 Target**	45%
Target Requirement	National Local	**10/11 Target**	90% (end of year) 90%
PC Contract	Yes	**Target achieved**	**Yes (93%)**
Leads	Dr Alf Troughton – Medical Director Sue Rowley – Director of Nursing and Midwifery Dr Sarah Green – Consultant Haematologist Sue Rhodes – VTE Nurse		

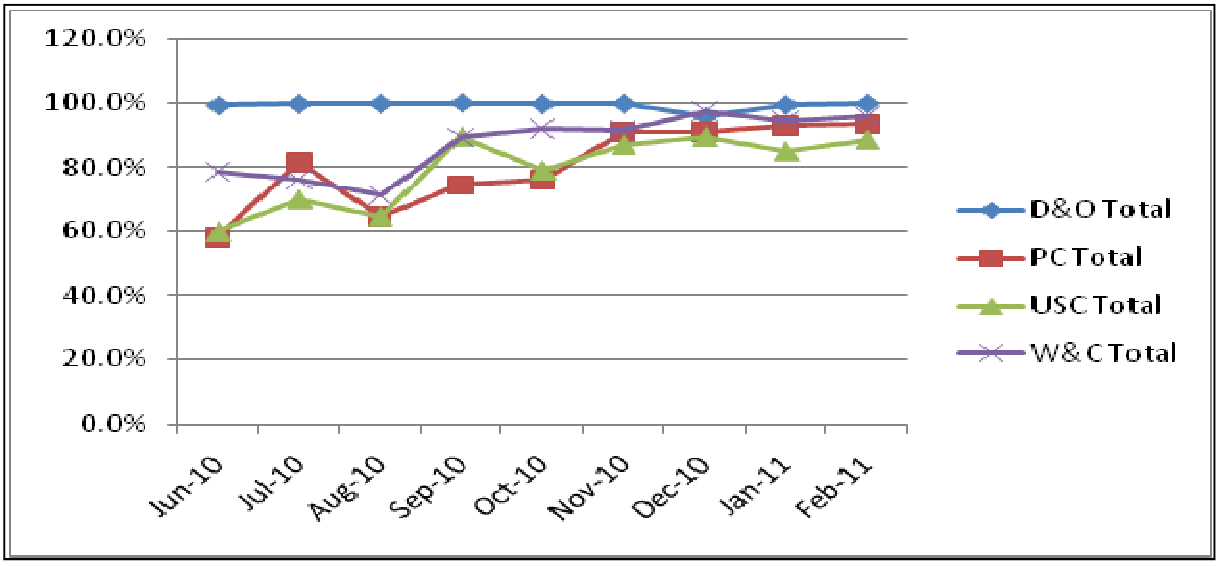
VTE risk assessment has continued to improve and we reached 92% for December 2010, 91.7% for January, 93% for February and 93% for March 2011. (To put this in context we were at 25% in February 2010 and 33% in March 2010) This is within trajectory and achieves the national target of >90% by end of Q3 and sustaining for Q4.

This has been achieved with:

- On-going training for both nursing and medical staff via Trust Induction, clinical skills framework, Training tracker workbook and E-learning available soon
- Implementation of an audit trail through the nursing crescendo system
- The incorporation of the risk assessment into the new drug chart which has significantly improved completion of the form.
- Raising awareness with patients and relatives by means of information boards and displays during national thrombosis week
- Patient information leaflet developed and available on intra-net, wards have copies and supply in discharge lounge. All patients to receive information either in pre-admission pack or on discharge from hospital

Note – The VTE measure started in June 2010. There is no data (as it was not a requirement) prior to June 2010.

Table 14 - % VTE Risk assessment completion by directorate since submission to DoH which commenced in June



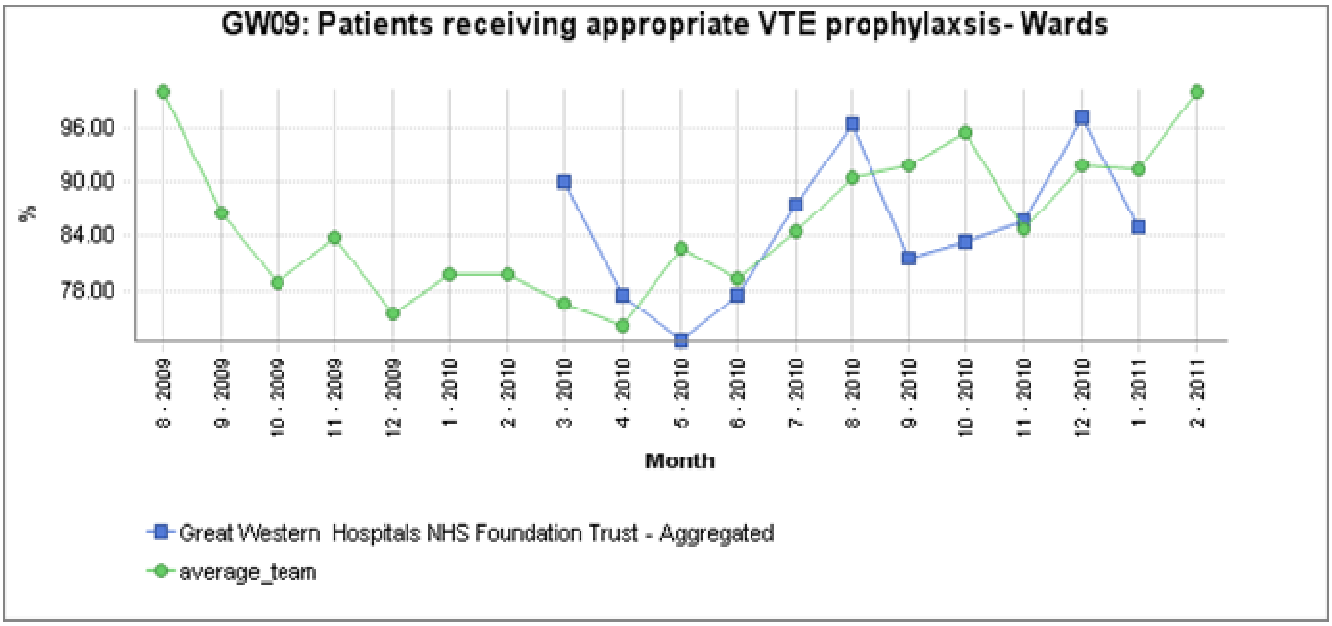
12 Administer appropriate VTE thrombophylaxis

Monitoring	Monthly	**09/10 Target**	45%
Target Requirement	National Local	**10/11 Target**	90%
PC Contract	Yes	**Target achieved**	**Yes (90%)**
Leads	Dr Alf Troughton – Medical Director Sue Rowley – Director of Nursing and Midwifery Dr Sarah Green – Consultant Haematologist Sue Rhodes – VTE Nurse		

The informatics team have been instrumental in ensuring that the data we submit to the DoH is robust and wards are notified daily of the number and names of patients without a VTE risk assessment to enable them to identify the patients more easily.

The administration of appropriate thromboprophylaxis is displayed in the chart below and shows compliance between 80%-90% for the last 6 months. We will continue to monitor compliance for both indicators and hope to sustain the levels achieved so far.

Table 15 – GW09 Patients receiving appropriate VTE prophylaxis – Wards



13 Nutritional assessments and care

Monitoring	Monthly	**09/10 Target**	NA
Target Requirement	Local	**10/11 Target**	95% compliance with completion of MUST tool by Mar 2011
PC Contract	Yes	**Target achieved**	**No (75%)**
Leads	Sue Rowley – Director of Nursing and Midwifery Carole Crocker- Deputy Director of Nursing Linda Webb – Dietetics and Service Manager		

Good nutrition and hydration are fundamental to well-being and recovery from illness or trauma. A high proportion of individuals admitted to hospital are vulnerable to malnutrition.

- 70% of those admitted are elderly
- 40 - 50% of all hospital in-patients may be malnourished

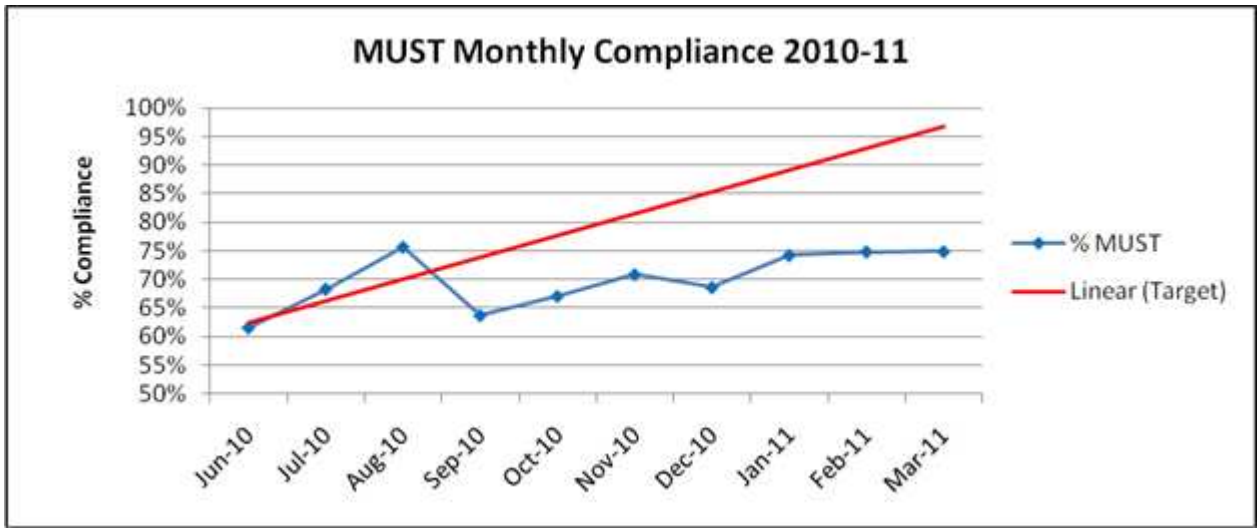
In hospital, nutritional status and hence general health and well-being can rapidly deteriorate for a variety of reasons often with serious consequences.

There have been significant improvements in a number of areas at GWH.

- Recent CQC spot check has shown at verbal feedback that GWH is providing appropriate nutritional care to the patients.
- Nationally validated screening tool (MUST) customised for local use and implemented in all appropriate areas along with supporting info e.g. user guide and patient record forms.
- Training programme includes Volunteers and Nursing Assistants and on-going training of staff to use MUST (& wards based Nutrition Resource Nurses & MUST champions cascade training).
- E-learning version of MUST now available.
- MUST average compliance has increased from 33% to 75%.
- Improvements to meal quality (portion sizes, presentation, temp & patient satisfaction).
- Introduction of new allergy aware menu & green tray system for people with food intolerance/coeliac disease. Complaints have reduced significantly.
- New Children's menu introduced.
- Positive PEAT feedback regarding food provision in 2010 and again 2011.
- Positive Essence of Care (RSM Tenon) audit report Aug 2010.

Overall there have been notable improvements with the numbers of patients receiving nutritional assessments on admission to hospital and the Trust has plans in place to further improve in this over the next 12 months. The 2010/11 Trust wide nutritional plan has been significantly progressed during the year as demonstrated above. A recent visit from the CQC and assessment of Outcome Five (meeting the nutritional needs of our patients) has resulted in the Trust being assessed as compliant in this important element of care. Suggestions for sustaining and further strengthening compliance will be included and implemented within the 2011/12 quality improvement plans.

Table 16 – MUST monthly compliance 2010 -11



14 New acute stroke patients spending 90% or more of their time in the Hospital on the Acute Stoke Ward (Falcon) – Q4 only

Monitoring	Monthly	**09/10 Target**	NA
Target Requirement	National	**10/11 Target**	Q1,2,3 - 60% Q4-80%
PC Contract	Yes	**Target achieved**	**Yes**
Leads	Dr Alf Troughton – Medical Director Dr Elizabeth Price – Consultant Rheumatologist Mark Canwell – DGM Unscheduled Care		

- Q1 Performance April to June 2010: 76 out of 114 patients (66.7%) spent 90% or more of their time on Falcon Acute Stroke Unit (vs target of 60%).
- Q2 Performance July to Sept 2010: 88 out of 127 patients (69.3%) spent 90% or more of their time on Falcon Acute Stroke Unit (vs target of 60%).
- Q3 Performance October to December 2010: 91 out of 116 patients (78.4%) spent 90% or more of their time on Falcon Acute Stroke Unit (vs target of 60%).
- Q4 Performance January to March 2011: 74 out of 87 patients (84.1%) have spent 90% or more of their time on Falcon Acute Stroke Unit (vs target of 80%).
- Annual Performance April 2010 to March 2010: 329 out of 445 patients (73.9%) have spent 90% or more of their time on Falcon Acute Stroke Unit.

The Trust has completed the changes required by the Care Quality Commission in the last year, delivering significant improvements in the quality of care provided for stroke patients. Patients receive dedicated treatment and rehabilitation in line with national standards, which enables a quicker and better recovery in the majority of cases. In the year ending 1 April 2011, 73.6% of all stroke patients spent 90% or more of their stay in the hospital on the Acute Stroke Unit. This represented a significant improvement on the previous year (34.5%).

The South West Stroke Review Team undertook a second inspection of the service in July 2010. The Review Team complimented the Trust and staff involved in stroke car, on the work that had been undertaken supporting the creation of a service that was unrecognisable from their previous visit.

Thrombolysis 24x7 was introduced in the early part of April 2011. This extended the service from 9-5 Monday to Friday.

The most significant current issue is maintaining direct admission particularly when there is significant pressure on beds.

Table 17A- Treatment

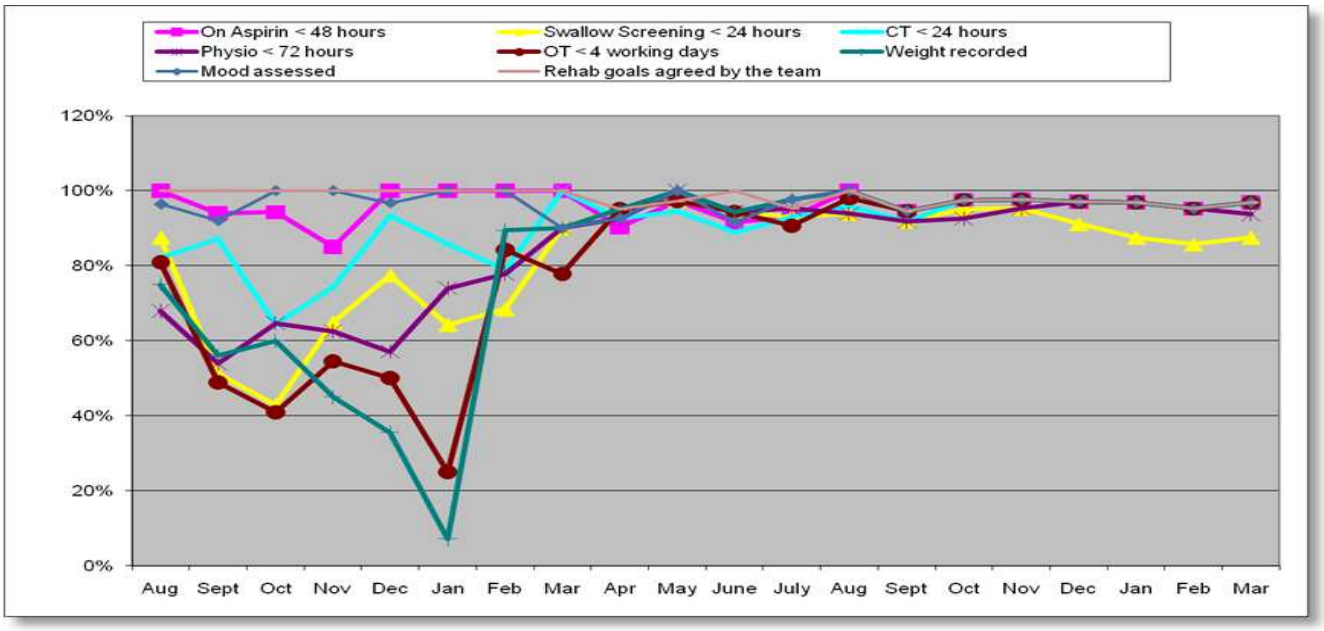


Table 17B – Percentage patients by percentage of time spent on Falcon Acute Stroke Unit

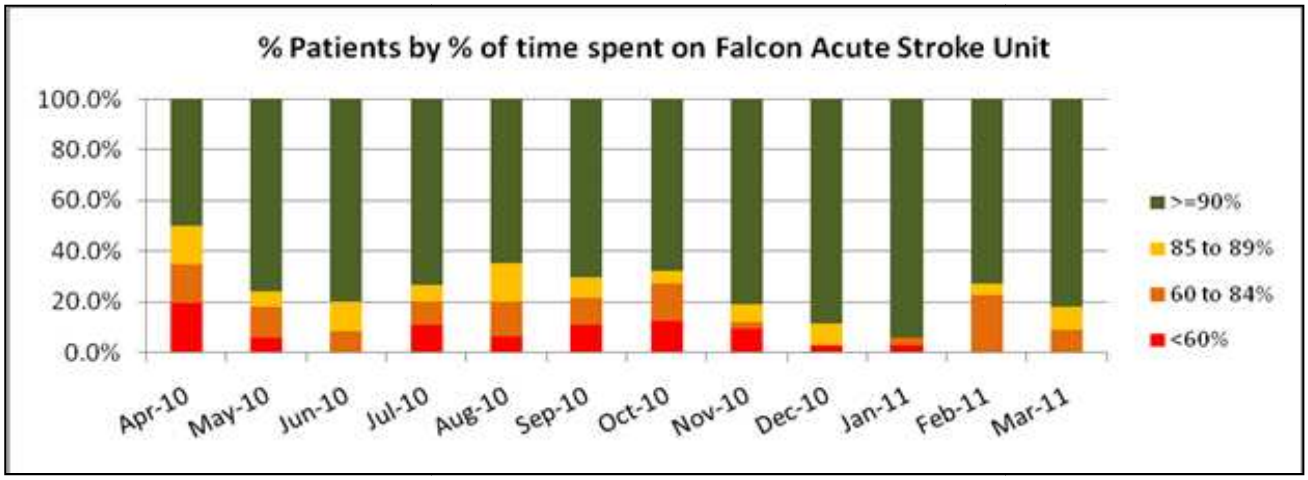
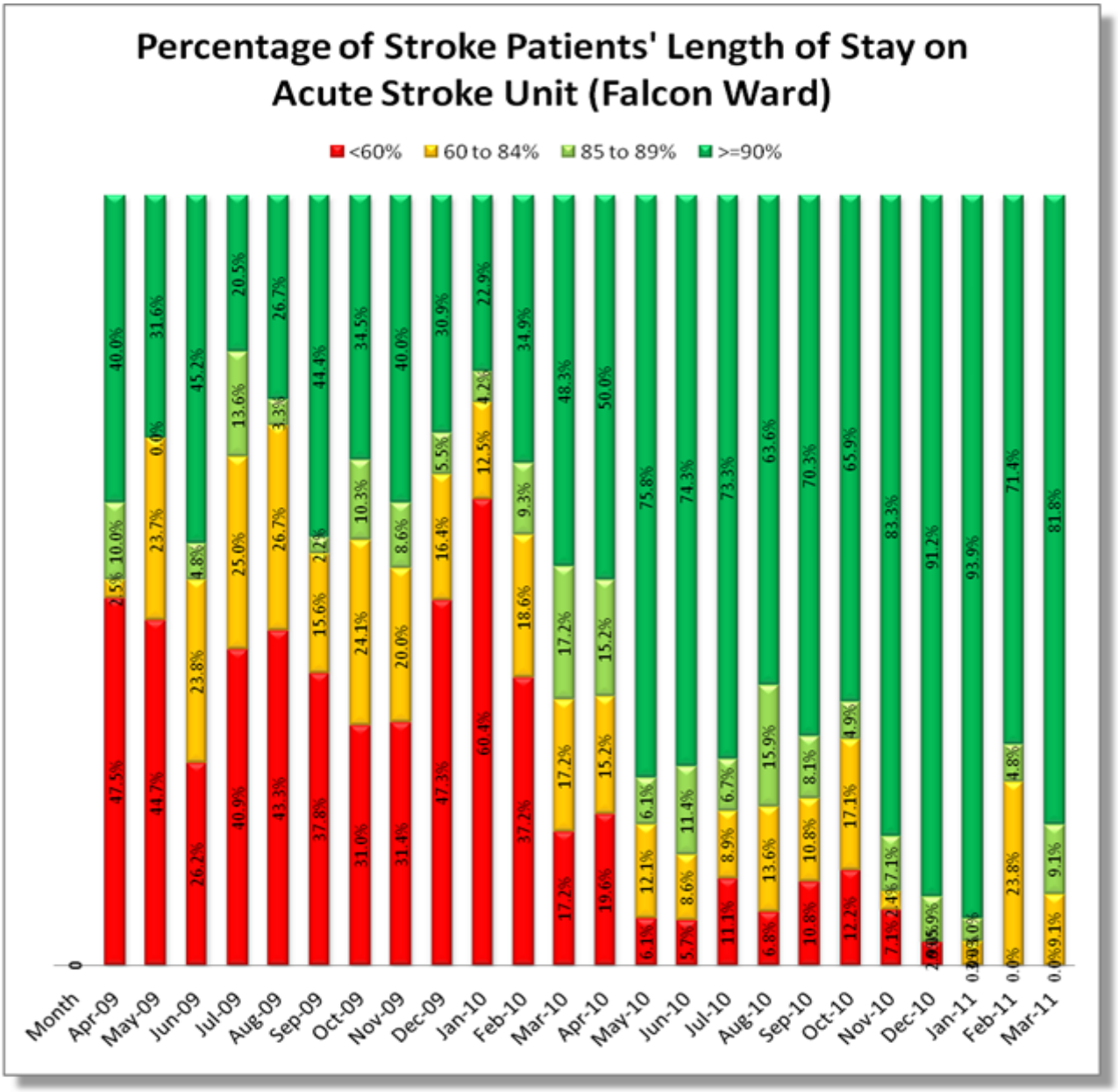


Table 18- Percentage of stroke patients' length of stay on acute stroke unit (Falcon Ward)



15 Reduce the rate of emergency re-admissions within 28 days of discharge and 14 days of discharge

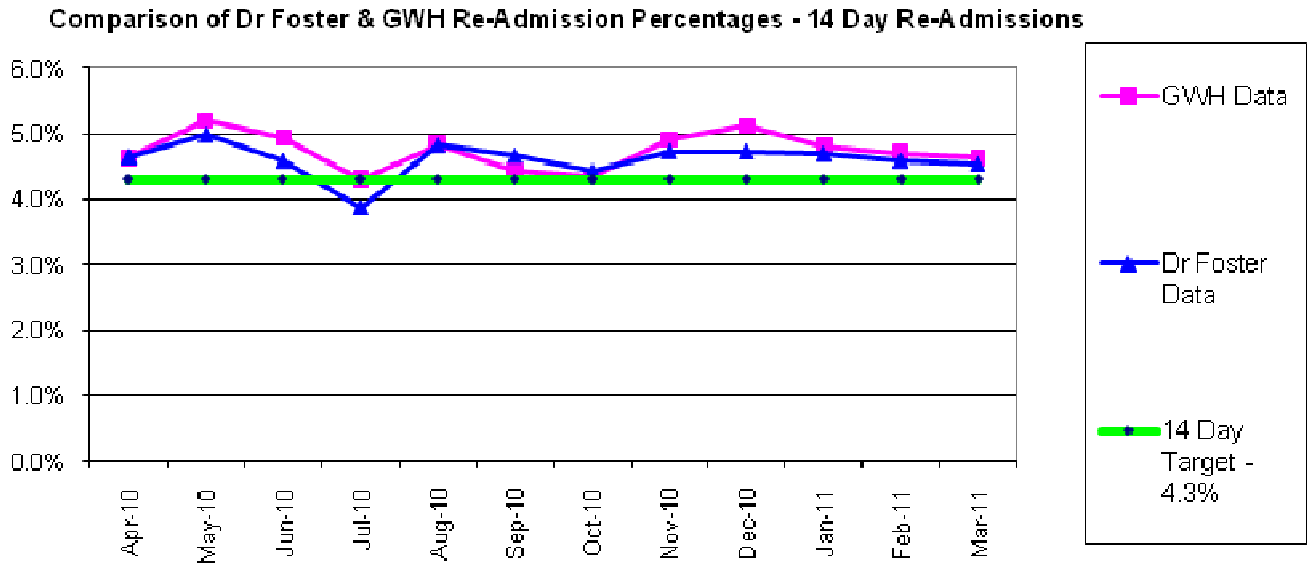
Monitoring	Monthly	**09/10 Target**	6.6% or less (28 days)
Target Requirement	Local	**10/11 Target**	6.6% or less (28 days)
PC Contract	Yes	**Target achieved**	**No**
Leads	Dr Alf Troughton – Medical Director Ranju Gopal – Clinical Audit & Effectiveness Manager John Palmer – Information Project Specialist		
Monitoring	Monthly	**09/10 Target**	4.3% or less (14 days)
Source	Local	**10/11 Target**	4.3% or less (14 days)
PC Contract	Yes	**Target achieved**	**No**
Leads	Dr Alf Troughton – Medical Director Associate Medical Directors Ranju Gopal – Clinical Audit & Effectiveness Manager John Palmer – Information Project Specialist		

The rate of readmission is a vital monitoring tool to review delivery of care provided locally. The information extracted from Dr Foster data (Imperial College) demonstrates the percentage of patients re-admitted as emergencies within 14 days of discharge. However, the data does not differentiate between related and unrelated re-admissions to the original episode. Furthermore the information is also only available with a five month time lag. The records cannot be replicated locally because of differences in data methodology.

Dr Foster is currently building the facility for Trusts to access National and SHA data for comparison of re-admission rates within 14 days.

In order to reduce the rate of emergency re-admissions, local data is being produced monthly by the Trust Informatics Team and is disseminated to the Associate Medical Directors and General Managers. The aim of the review is to capture facets of care that might influence the outcome and identify areas where delivery of care can be improved locally. This is shared with the Patient Safety & Quality Committee via the Trust Length of Stay Project Group. The percentage of patients readmitted with 14 days (April 2010- Jan 2011- Table 19) remains very close to the trajectory with an average performance this year of 4.9% (target-4.3% by end of year).

Table 19 – Comparison of Dr Foster and GWH re-admission percentages – 14 days re-admissions



Further plans to reduce hospital readmissions include:

- Develop a robust system of identifying related re-admissions.
- Set up audit as per specialities, prioritising according to highest related readmission rate.
- Set up regular reporting back to the Patient Safety & Quality Committee quarterly through Quality Accounts and the Trust Length of Stay Project Group.

16 18 Weeks Referral to Treatment (RTT)

Monitoring	Monthly	**09/10 Target**	90% admitted pathways, 95% non-admitted
Target Requirement	CQC, PCT	**10/11 Target**	90% admitted pathways, 95% non-admitted
PC Contract	Yes	**Target achieved**	**Yes**
Leads	Dr Alf Troughton – Medical Director		

Overall in 2010/11 the Trust has performed well in referral to treatment measures and consistently exceeded the overall all specialty targets of 90% for admitted patients being treated within 18 weeks, 95% for non-admitted patients and 95% for audiology patients. For admitted specialties each specialty has met or exceeded the target for each month. For non-admitted three specialties missed the target for individual months – Ophthalmology in February, Oral Surgery in April and May and Plastic Surgery in April and May.

17 Cancer National Priorities

Monitoring	Monthly	**09/10 Target**	Same as 2010/11 as below
Target Requirement	Monitor, PCT	**10/11 Target**	See Table below
PC Contract	Yes	**Target achieved**	**Yes**
Leads	Dr Alf Troughton – Medical Director Michael Wilson – Lead Manager Cancer services		

The National Institute for Health and Clinical Excellence (NICE) provides guidance and sets quality standards to improve people's health and prevent and treat ill health. NICE make recommendations to the NHS on new and existing medicines, treatments and procedures and NICE Technology Appraisals (TAs) are of significant importance within Cancer Services as they often introduce new chemotherapy drugs that require considerable resource to implement.

However, being able to demonstrate compliance with published NICE TAs is an indicator of a quality service and as a result of the robust NICE process that exists within Cancer Services we have successfully implemented each relevant new NICE TA that has been published during the financial year, these have included:

TA	Description	Fully Compliant?
TA129	Bortezomib monotherapy for relapsed multiple myeloma	✓
TA190	Pemetrexed for the maintenance treatment of non-small-cell lung cancer	✓
TA191	Capecitabine for the first-line treatment of inoperable advanced gastric cancer	✓
TA192	Gefitinib for the first-line treatment of locally advanced or metastatic non-small-cell lung cancer	✓
TA193	Rituximab for the treatment of relapsed or refractory chronic lymphocytic leukaemia	✓
TA202	Ofatumumab for the treatment of chronic lymphocytic leukaemia refractory to fludarabine and alemtuzumab	✓
TA208	Trastuzumab for HER2 positive metastatic gastric cancer	✓
TA209	Imatinib for the treatment of unresectable and/or metastatic gastrointestinal stromal tumours	✓
TA216	Bendamustine for the first-line treatment of chronic lymphocytic leukaemia	✓

Performance Indicators

The Trust has exceeded each of the various cancer operational standards for the 2010/11 financial year.

Table 20 – Cancer operational standards

	Operational Standard	2010/11
Two Week Wait	93%	96.9%
Symptomatic Breast Two Week Wait	93%	97.2%
31 Day First Treatment	96%	99.2%
62 Day First Treatment	85%	92.2%
62 Day First Treatment (Screening Service)	90%	100%
31 Day Subsequent Treatment (Surgery)	94%	99.4%
31 Day Subsequent Treatment (Drug)	98%	100%

During the 2010/11 financial year the Trust saw 7,230 patients being referred via the Two-Week Route (guaranteed first appointment with a responsible specialist within 14 calendar days of GP referral for a suspected cancer) – an increase of 11.5% on the previous year.

National Cancer Patient Experience Survey 2010
Certainly one of the largest to have been undertaken anywhere in the world, the national cancer patient experience survey provides insights into the care experienced by cancer patients across England who were treated as day cases or inpatients during the first three months of 2010. 158 NHS Trusts providing cancer services identified patients and 67,713 patients chose to respond. The high national response rate (67%) shows how willing patients are to report on their care and thereby help to improve future service quality.

The Great Western Hospitals NHS Foundation Trust fully embraced the National Survey and some 512 eligible patients from this Trust were sent a survey, and 352 questionnaires were returned completed. This represents a response rate of 72% (higher than the national response rate) once deceased patients and questionnaires returned undelivered had been accounted for.

Local Comparative Performance
The national report includes benchmark data that stratifies local responses into red, amber and green categories to represent local indicators in comparison with the lowest 20% of Trusts, the middle 60%, and the highest 20% of Trusts.

Local Cancer Patient Surveys
National Cancer Quality Indicators (National Peer Review Measures) first introduced by The Manual of Cancer Services establishes the requirement for providers of services to cancer patients to periodically survey relevant patient groups and to ensure observations made by patients are considered and acted upon by relevant multi-disciplinary cancer teams.

- A survey of patients attending Nurse-Led Clinical Trial Clinics, June 2010
- A survey of Paediatric Oncology Services, May 2010
- A TVCN survey of patients with Testicular Cancer, September 2010
- A survey of Stem Cell Transplant Services, December 2010
- A survey of Inpatient Environment, Dove Ward, February 2011
- A survey of patient experience, Two-Week Referral system, February 2011

18 Return to theatre within 2 weeks

Monitoring	Quarterly	**09/10 Target**	NA
Target Requirement	Local	**10/11 Target**	Establish baseline
PC Contract	Yes	**Target achieved**	**Yes**
Leads	Dr Alf Troughton – Medical Director Dr Helen Jones – AMD Planned Care Lucy Baker - GM Planned Care		

Outcome for 2010/11 was to establish baseline figures for patient returns to Theatre within 2 weeks.

Table 21 – Patient Returns

	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4	Total
Total returns to theatre	9	8	3	20	4	7	8	19	13	13	8	34	5	5	6	16	89
Total cases	1853	1619	1693	5165	1671	1532	1698	4901	1593	1792	1528	4913	1609	1477	1840	4926	19905
%	0.5	0.5	0.2	0.4	0.2	0.5	0.5	0.4	0.8	0.7	0.5	0.7	0.3	0.3	0.3	0.3	0.4

- There has been a significant reduction in returns from 2009/10.
- There continues to be monthly monitoring of specialty trends.
- 2011/12 we will continue to collate, monitor and validate on a monthly basis.
- We will continue to address any trends.

19 Time to theatre for patients with hip fracture

Monitoring	Monthly	**09/10 Target**	24hrs
Target Requirement	Regional	**10/11 Target**	36hrs (95% end of March 2011)
PC Contract	Yes	**Target achieved**	**No (89%)**
Leads	Dr Alf Troughton – Medical Director Dr Helen Jones – AMD Planned Care Gillian Taylor – DGM Trauma & Orthopaedics John Ivory – Consultant Orthopaedics		

Hip fracture is a common, costly and well-defined injury, which occurs mainly in older people. As the number of elderly people and age-specific incidence of hip fracture continue to rise, orthopaedic and rehabilitation services face growing pressures and a multidisciplinary working group meets bi-monthly to review all aspects of care for these patients. Early surgical intervention is associated with better patient outcome. In accordance with best practice tariff, the quality indicator contract time to theatre has been amended from 24 hours to 36 hours. The Trust set an indicator to work toward 95% of patients who are fit for surgery waiting less than 36 hours for surgery.

Local initiatives to attain this improvement have included:

- Monthly reporting of percentage of patients having surgery within 36 hours
- Monthly trend analysis to close any gaps identified
- Monthly reporting of reasons for non-operation within 36 hours
- Changes to processes to improve compliance
- Prioritisation of operating slots for patients with fractured NOF
- Increased bank holiday/weekend trauma lists

Compliance has improved during the year and in January, February and March 2011 the target was met or bettered. In December 2010 during the excessively bad weather 94% of patients with NOF fracture were operated on within 36 hours.

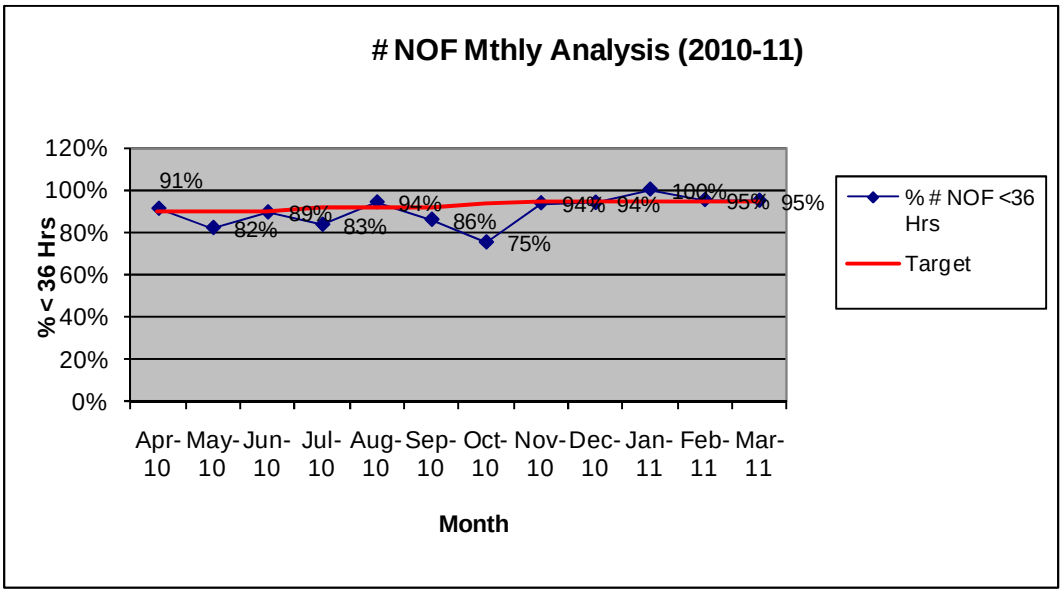
October was a particularly difficult month as the data shows we had 19 patients admitted in 1 week with a hip fracture. On average we would expect one patient per day to be admitted with a hip fracture. This led to delays in surgery due to time and availability of theatre equipment. Since then we have developed an escalation plan for such occurrences.

There was an improvement in quarter 4. We receive regular data on our time to theatre and analysis it carefully, putting plans in place to manage the process to provide the best outcome for patients.

The target will continue to be monitored closely.

Overall, the Trust has made noted improvements in this area and compares favourably benchmarked with other Trusts within the South and West.

Table 22 – Fractured Neck of Femur Monthly analysis 2010-11



20 Compliance with NICE guidance

Monitoring	Monthly	**09/10 Target**	95%
Target Requirement	Regional	**10/11 Target**	95%
PC Contract	Yes	**Target achieved**	**Yes**
Leads	Dr Alf Troughton – Medical Director Associate Medical Directors Ranju Gopal – Clinical Audit & Effectiveness Manager Sharon Edwards – Clinical Audit Facilitator & NICE Lead		

The National Institute for Health and Clinical Excellence (NICE) is an established organisation that publishes evidence based guidelines and recommendations for patients and healthcare organisations. Service providers are expected to consider and implement NICE guidelines where relevant, when developing and delivering their services for their patients. Regulatory bodies such as the Care Quality Commission (CQC) and the NHS Litigation Authority (NHSLA) can use these standards as a monitoring tool to measure the quality and safety the organisation provides.

At the Great Western Hospital, the Clinical Audit Department has been responsible for the dissemination pathway for National Institute for Clinical Excellence (NICE) Guidance since September 2007.

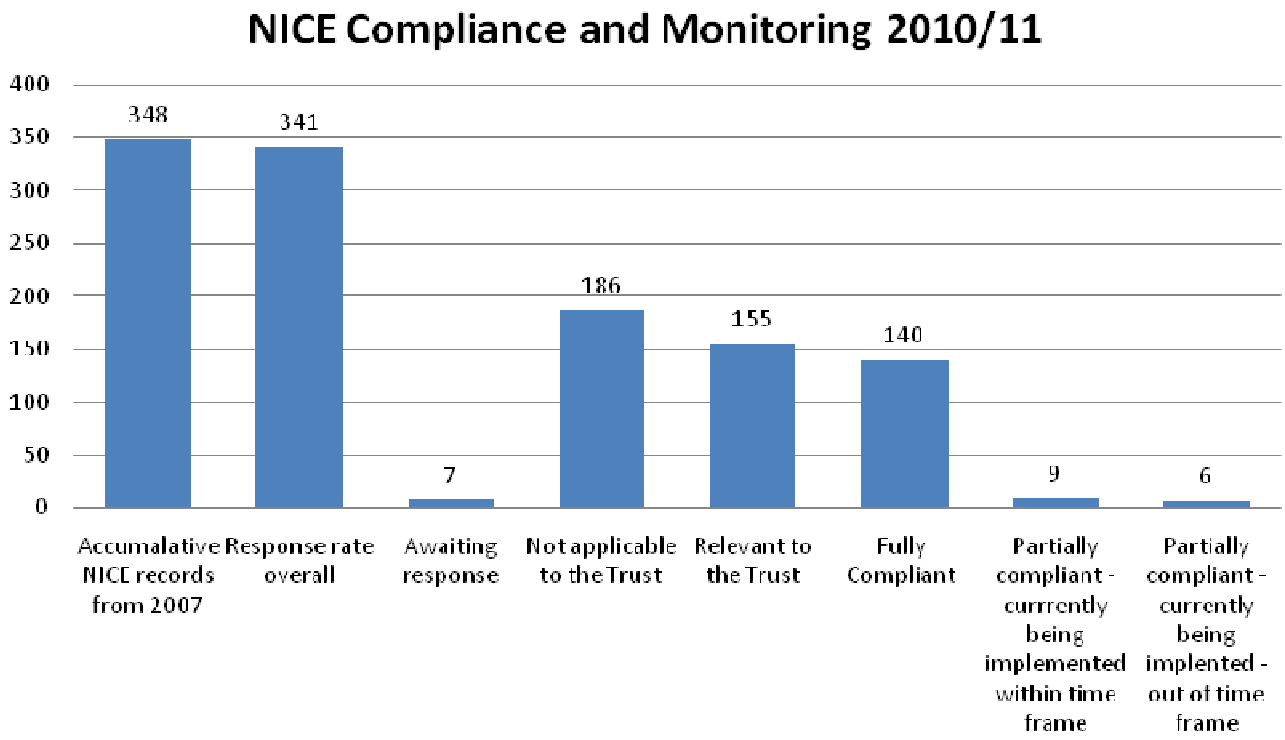
The NICE process includes identifying, disseminating, monitoring the implementation and reporting, of all NICE published guidance is managed by the NICE Lead, based in the Clinical Audit department.

The creation of dedicated database in 2010, has enable the accurate recording and monitoring of all 231NICE records, including the responses and progress with directorate and Trust wide compliance.

At the close of 2009/10 the trust demonstrated 100% compliance with 96/102 guidance fully implemented, and 6/102 that were partially compliant with actions to implement to attain full compliance.

During 2010/11, the Trust has been in receipt of an additional 117 published guidelines in the following areas; Technology Appraisals, Clinical Guidelines, Interventional Procedures, Public Health, and Cancer Services.

Table 23 – NICE compliance and monitoring 2010-11



All guidelines have been disseminated to the relevant clinicians and directorates. A response rate of 93% or above has been maintained throughout the year, which have confirmed that 60/117 (51%) of the publications are relevant to the Trust, of which, full compliance has been assured with 44/60 (73%).

Of the remaining guidance, 7 have only recently been published so are considered within the time frame, for assessment and responding.

To date, 9 guidance's are within the time frame allowed to become implemented and embedded within clinical practice. There are 6 guidances from 2009/10 which remain partially compliant, and are now out of time frame (pass the deadline for implementation).

Trust wide compliance of 96-100% has been attained throughout this year which meets the Trust's contractual obligation with NHS Swindon.

Table 24 – Relevant NICE guidance

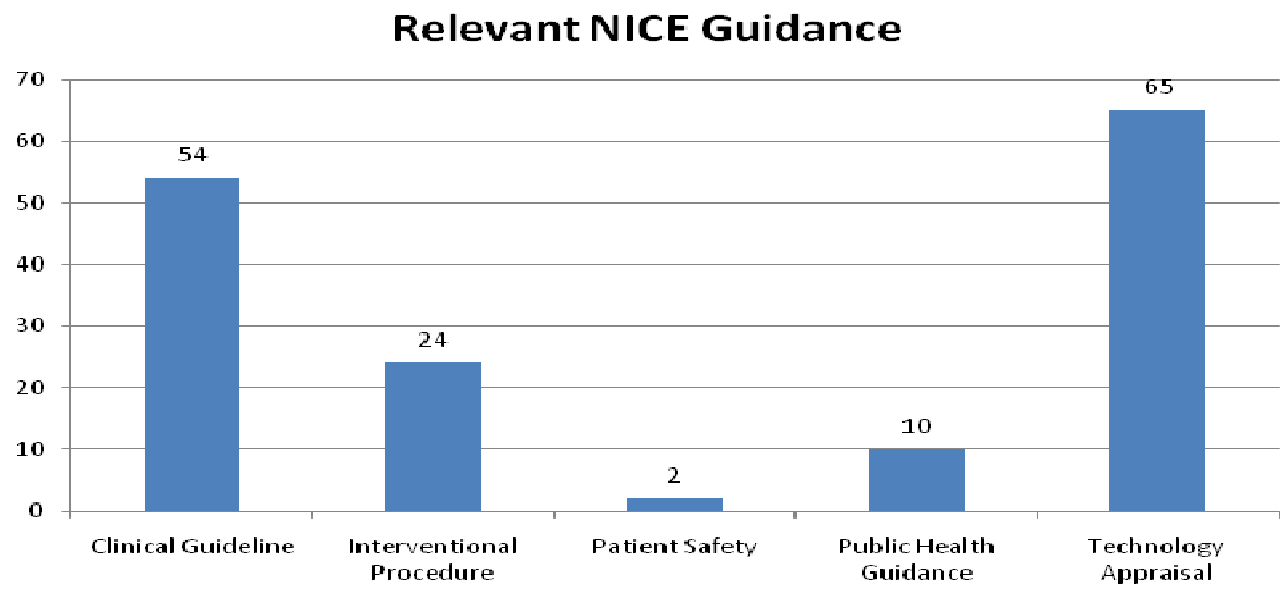
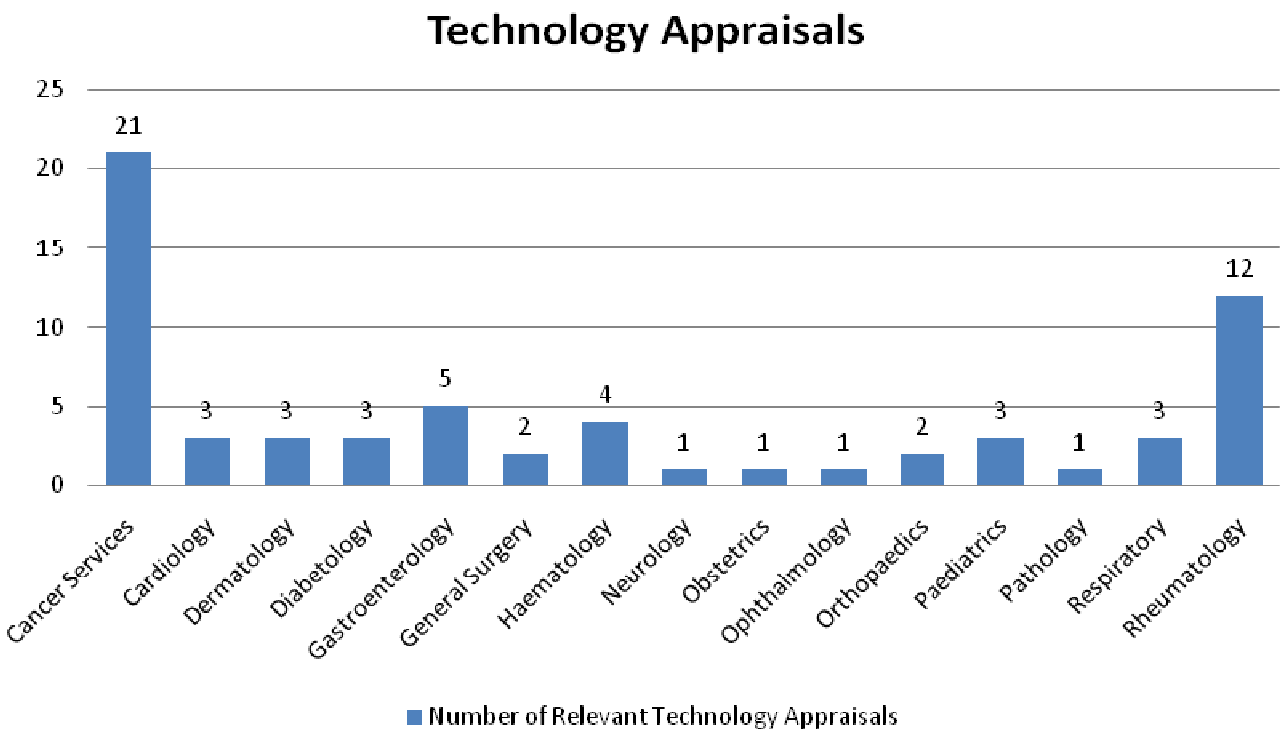


Table 25 – Technology appraisals

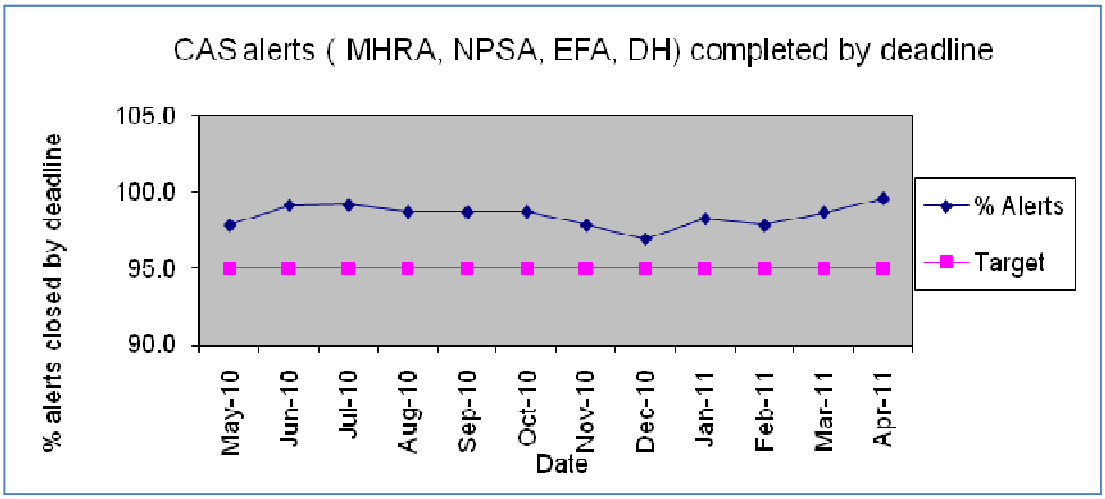


21 Compliance with CAS

Monitoring	Monthly	**09/10 Target**	95%
Target Requirement	National	**10/11 Target**	95%
PC Contract	Yes	**Target achieved**	**Yes**
Leads	Dr Alf Troughton – Medical Director John McGinty – Trust Equipment Manager Rachel Jefferies – Clinical Risk Manager		

The CAS (Central Alerting System) publishes medical device, hospital equipment and clinical alerts from the MHRA, the DH Estates and Facilities department and the NPSA. Responses and the completion of actions are monitored to defined deadlines via a web based system. Between April 2010 and the end of March 2011 the Trust received a total of 130 alerts from the CAS system.

Table 26 – CAS alerts (MHRA, NPSA, EFA, DH) completed by deadline



The standard of at least 95% compliance with no significant exceptions has been maintained throughout 2010/2011. Any alert that has failed to achieve full compliance within the prescribed deadline is reviewed monthly at the PSQ meeting to ensure that progress is being made to address outstanding actions and that no significant risks exist

All alerts that are past, or within one month of, their deadline have an allocated lead manager and associated responsible member of the executive, and outstanding actions are listed against expected resolve dates. These alerts are risk assessed to indicate the level of risk associated with non compliance.

Currently there is one alert outstanding, NPSA 2010/RRR015, concerning the prevention of over infusion of fluids in neonates. An action plan is in place, which is underway in Pharmacy and Paediatrics.

Table 27 – Outstanding alert

Date of deadline (in date order)	Reference and Alert description	Exec lead	Trust lead	Action awaited by, Directorate responsible	Estimated Date closing	Risk - to be completed by Trust lead
28/02/2011	**NPSA 2010-RRR015 Prevention of overinfusion of intravenous fluids and medicines in neonates**	AT	Rachel Jefferies	Mike Lewis/Joanne Smith	15/04/2011	8(4 x 2)

22 New and Revised Clinical Guidelines and Policies

The principal function of the Clinical Development Group (CDG) is to co-ordinate the assessment, implementation and monitoring of Clinical Guidelines and Policies within the Trust.

In September 2010, the way in which the Trust managed its policies and procedures changed with the introduction of EDRMS (Electronic Discharge and Record Management System). The new system provides a single store for all Trust wide policies and procedures. Document numbers are no longer required as EDRMS automatically controls the versioning of all the documents. Guidelines and competencies still remain on the intranet for the foreseeable future.

All staff are able to view all the documents but only the approved versions of these will be visible. The documents that have been ratified at the CDG from April 2010 to March 2011 (a total of 29) are listed in table 28 below:

Table 28 – Clinical guidelines and policies - April 2010 to March 2011

Document Name	Date ratified
Clinical Guideline for oxygen prescribing in adults	25.5.10
Clinical Guideline for the Management of Adult Patients At risk of re-feeding syndrome	22.6.10
Policy for the requesting of Clinical imaging procedures By non-medical referrers	22.7.10
Competency for the use of intra-aortic balloon counterpusation therapy (IABP) for nursing staff	22.7.10
Competency in the safe and appropriate use of temporary pacing single chamber external pulse generators for nursing staff	22.7.10
Clinical trials nurse led patient assessment protocol for patients receiving treatment or follow-up within the context of a breast cancer clinical trials	22.7.10
Guideline for the application of Transcutaneous nerve stimulation (TENS) machine for inpatients	22.7.10
Clinical Guideline for non-discordant radiographer only reading of mammograms	24.8.10
Clinical competency for the safe preparation and collection of venous blood sample – medical staff	28.9.10
Last Offices - Adults	30.9.10
Mortuary Viewing Policy	30.9.10
Nurse led supply of TTA Medication incorporating the use of TTA packs	26.10.10
Swindon Outreach Score (SOS)	26.10.10
Medical Devices Training Policy	26.10.10
Management of Acute pain in adult patients taking long-term opioids (non-obstetric)	26.10.10
Organ Donation Policy	23.11.10
Clinical Competency for the safe management of patients receiving blood component transfusions	23.11.10
Near Patient Testing Policy and Procedure	23.11.10
Policy Document for the Emergency plan for the Management of Blood and Platelet Shortages	23.11.10
Nutrition Policy for Infants, Children and Young People	23.11.10
Procurement of Medical Consumables Policy	25.1.11
Clinical Guideline for Elective Surgical Blood ordering Schedule	25.1.11
Clinical Competency for Laryngeal Mask airway insertion	22.3.11
Clinical Competency for automated external defibrillation	22.3.11
Clinical Competency for Defibrillation	22.3.11
Clinical Guideline for Massive Haemorrhage – Obtaining Blood and Blood products	22.3.11
Clinical Guideline for requesting a Blood Transfusion	22.3.11
Clinical Guideline for Blood issue and distribution from the Blood Transfusion Laboratory	22.3.11
Clinical Guideline for the Administration of Blood components and Blood products	22.3.11

The terms and conditions of the group are currently under revision. There has also been a change made to the meeting structure to ensure that the main focus of the group is the ratification of policies and procedures. A new draft ratification form is being developed which will ensure that all policies and procedures can be monitored more effectively throughout the Trust.

23 Patient Recommendations

Monitoring	Monthly	**09/10 Target**	95%
Target Requirement	National	**10/11 Targets**	Q1 70%, Q2 75%, Q3 80%, Q4 90%
PC Contract	Yes	**Target achieved**	**No**
Leads	Sue Rowley – Director of Nursing and Midwifery Kevin Mcnamara – Head of Marketing & Communications Liz Daly – Head of Patient Experience		

- Q1 Performance April to June 2010: 77.3% vs target of 60% - Achieved
- Q2 Performance July to September 2010: 73.7% vs target of 75% - Not Achieved
- Q3 Performance October to December 2010: 77.4% vs target of 80% - Not Achieved
- Q4 Performance January to March 2011: 90.5% vs target of 80% - Achieved (Notable improvement)
- Annual Performance April 2010 to March 2010: 83.5%

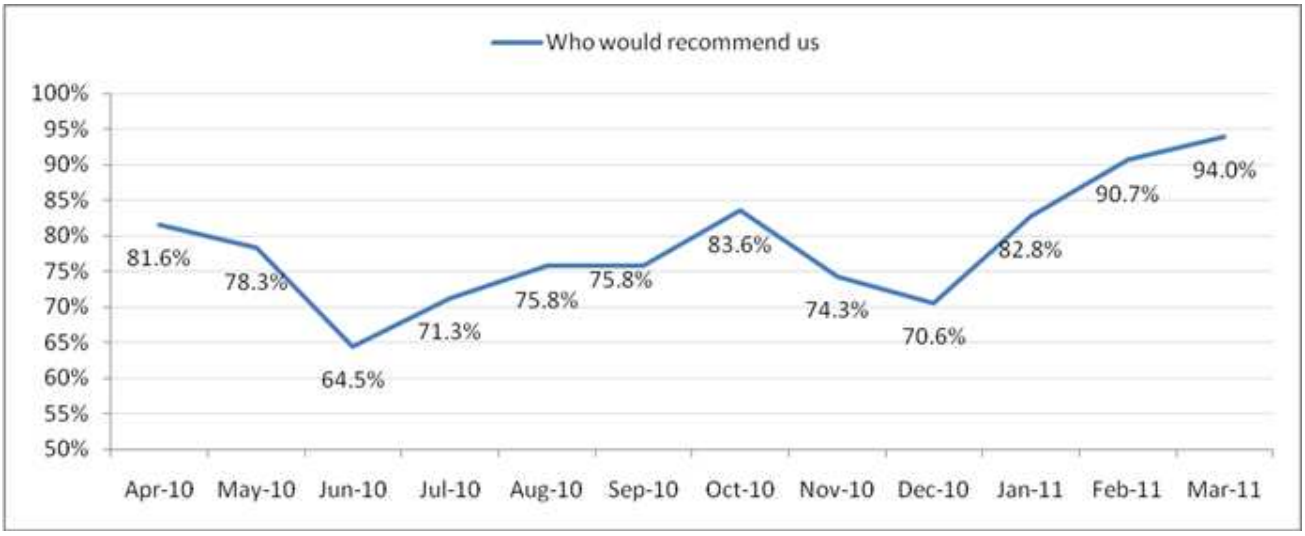
'Tell us how we're doing' comment cards are available throughout the hospital and ask four questions to gain a snapshot into the satisfaction of our service users and their relatives.

These questions are:

- What was good about your visit?
- Was there anything that we could do better?
- Would you recommend us to a friend and why?
- Please tell us about any person or team who provided you with excellent care

Table 29 below shows the number of patients who would recommend the organisation to a friend for 2010/11.

Table 29- Number of patients who would recommend the organisation to a friend for 2010/11



During 2010/11 there have been a number of volunteers who have visited wards and departments to get feedback from the patients using the comment cards.

Patient feedback is also actively collected from the NHS Choices website and during 2010/11 the following surveys were commissioned by the Trust:

Quarterly Inpatient
Maternity Services
Paediatric Inpatient
Paediatric Outpatient

Annual Inpatient – results from this survey are used for national benchmarking purposes by the CQC.

24 Patients treated with Dignity and Care

Monitoring	Quarterly	**09/10 Target**	90%
Target Requirement	National	**10/11 Target**	80%
PC Contract	Yes	**Target achieved**	**No (75.4% - Q1 - Q3 data)**
Leads	Sue Rowley – Director of Nursing and Midwifery Carol Black – Matron Planned Care		

The Trust commissioned quarterly in-patient surveys during 2010/11 from the PICKER Institute.

Question 72 in the questionnaire asks 'Overall, did you feel you were treated with respect and dignity while you were in hospital?' This question has also been adopted as a question for monitoring purposes from 2012/13 under the NHS Outcomes Framework.

22% of patients felt that they were not treated with dignity and care compared with 23% of patients who completed the 2009 survey.

25 Patient Information on discharge

Monitoring	Quarterly	**09/10 Target**	NA
Target Requirement	National	**10/11 Target**	80%
PC Contract	Yes	**Target achieved**	**No (59.9% - Q1 – Q3 data)**
Leads	Sue Rowley – Director of Nursing and Midwifery Liz Daly – Head of Patient Experience		

The Trust collects the views of patients about information on discharge from the quarterly inpatient survey. Q42 asks 'How much information about your condition or treatment was given to you?' The Trust measures the response rate for 'the right amount' for reporting.

23% of patients felt that they were not given enough (or given too much) information about their condition or treatment. In 2009 22% felt this way which means that there has been a slight decrease in the number of patients who were given the right amount of information.

The NHS Outcomes Framework and CQUIN highlight the importance of effective discharge planning and communication with patients.

The General Manager of Unscheduled Care is leading the Trust lead on discharge and a Discharge Lead Nurse was recruited during 2010/11 with a focus on reviewing and improving the discharge process. A discharge pack is being formulated in collaboration with the Pharmacy team and the comment cards will be included within this pack.

It is important to note that the number of comment cards completed by patients each month is quite low only representing feedback from approximately 75 – 100 patients each month. The Trust has been seeking more reliable and robust methods of capturing feedback from the experiences of our patients and this is now being obtained by undertaking internal PICKER surveys quarterly. Hence, future reports will be considered more reliable and informative.

26 Patient call bells responded to within 5 minutes

Monitoring	Monthly	**09/10 Target**	80%
Target Requirement	National	**10/11 Target**	80%
PC Contract	No	**Target achieved**	**Yes (80% Feb/March data only)**
Leads	Sue Rowley – Director of Nursing and Midwifery Liz Daly – Head of Patient Experience		

Responding promptly to call bells is really important to our patients. As such we have worked very closely with our partners in health care provision. Carillion Health Care to determine an effective way of monitoring this element of care. Carillion are now able to monitor response times to call bells using an electronic system which is robust and reliable. We are an organisation that is leading the way in capturing this data and are proud that we have been able to focus on and demonstrate some real improvements in this area.

27 Compliance with CQC

Monitoring	Quarterly	**09/10 Target**	100%
Target Requirement	National	**10/11 Target**	100% by October 2010
PC Contract	Yes	**Target achieved**	**Yes**
Leads	Dr Alf Troughton – Medical Director Ruth McCarthy – Associate director of Clinical Governance & IP&C		

Regulatory Monitoring

The Clinical Standards Group was set up by the Trust to specifically monitor performance against a variety of regulatory standards. The Group acts as a scrutinizing body and therefore provides assurance to the Trust Board.

It is tasked with enabling the Trust to meet its responsibilities in complying with the Care Quality Commission's essential standards of quality and safety as well as other regulations such as the Hygiene Code, the NHSLA risk management standards and others.

The Group meets monthly and draws upon a membership of Trust wide senior staff, reporting any perceived risks to its parent body the Patient Safety and Quality Committee.

Compliance with the various regulations is monitored at the Clinical Standards Group via an agreed rolling monitoring programme, with attendance of the appropriate regulation leads invited to aid the discussion. Monthly and quarterly summaries of the regulations discussed are fed back to the Executive Committee and Trust Board via the Patient Safety and Quality Report.

CQC Compliance

Table 30 - Health & Social Care Act 2008 / (CQC Registration Regulations 2009) Regulations Assessed for Compliance as at March 2011

Reg. No.	Outcome No.	Regulation Title	Compliance
17	1	Respecting & Involving People Who Use Services	Fully Compliant
18	2	Consent to Care & Treatment	Fully Compliant
(19)	3	Fees	Fully Compliant
9	4	Care & Welfare of People Who Use Services	Fully Compliant
14	5	Meeting Nutritional Needs	Fully Compliant
24	6	Co-operating With Other Providers	Fully Compliant
11	7	Safeguarding People Who Use Services From Abuse	Fully Compliant
12	8	Cleanliness & Infection Control	Fully Compliant
13	9	Management of Medicines	Fully Compliant
15	10	Safety & Suitability of Premises	Fully Compliant
16	11	Safety, Availability & Suitability of Equipment	Fully Compliant
21	12	Requirements Relating to Workers	Fully Compliant
22	13	Staffing	Fully Compliant
23	14	Supporting Workers	Fully Compliant
(12)	15	Statement of Purpose	Fully Compliant
10	16	Assessing & Monitoring the Quality of Service Provision	Fully compliant
19	17	Complaints	Fully Compliant
(16)	18	Notification of Death of a Person Who Uses Services	Fully Compliant
(17)	19	Notification of Death or Unauthorised Absence of a Person Who Is Detained or Liable to be Detained Under the Mental Health Act 1983	Fully Compliant
(18)	20	Notification of Other Incidents	Fully Compliant
20	21	Records	Fully Compliant
5	23	Requirement Where the Service Provider is a Body Other Than a Partnership	Fully Compliant
7	25	Registered Person: Training	Fully Compliant
(13)	26	Financial Position	Fully Compliant
(15)	28	Notifications: Notice of Changes	Fully Compliant

A concern was raised at the Clinical Standards Group with regard to providing sufficient detailed analysis of reporting trends for claims. Following the merger with WCHS from the 1st of June 2011 some additional resources for this area of work will become available, so further feedback with regard to this will be available.

With regard to the other parts of the regulation such as risk management, serious incident investigation, analysis and learning, the Group felt that the Trust can be confident that it has robust processes in place and is compliant with the regulation.

This concern and the overall compliance with the regulations were presented to the April meeting of the Patient Safety and Quality Committee. The PSCQ agreed the internal review of full compliance with all CQC regulations and outcomes.

CQC Registration

The following summary applies to the registration of the enlarged organisation as from June 1st 2011.

As part of the merger with Wiltshire Community Health Services (WCHS), the Trust is required to apply to the Care Quality Commission (CQC) to alter the conditions of its existing registration as from June 1st 2011. The CQC require 120 days notice of any variance to an organisation's registration.

The Trust has applied to be registered as the provider of an additional regulated activity, namely nursing care, which is carried out at two locations within WCHS. The cost of this variance is a one-off flat fee of £5,000 which is payable on application.

The Trust has also applied to the CQC to vary its registration in relation to locations at which the regulated activities will be carried out from June 2011. In total the Trust has submitted to register 21 sites, (20 additional sites). This has involved declaring compliance in relation to all the CQC essential standards of quality and safety, and details relating to the security of records and premises, any other business carried out and compliance with the Disability Discrimination Act 2005 in relation to access. As these locations were previously registered with the CQC by WCHS, we have been advised that there is no charge for this change to our registration, although we await confirmation.

All the applications required an updated version of the Trust's Statement of Purpose, detailing all services and locations that will be part of the enlarged organisation post 1st of June 2011. Once finalised, this will be accessible on the Trust's website.

28 NHSLA Acute standards

Monitoring	Quarterly	**09/10 Target**	Level 2
Target Requirement	Local	**10/11 Target**	Work toward level 3
PC Contract	Yes	**Target achieved**	**Yes**
Leads	Dr Alf Troughton – Medical Director Rachel Jefferies - Clinical Risk Manager		

Since March 2010 the Great Western Hospital NHS Foundation Trust has recruited an NHSLA project co-ordinator.

The co-ordinator has been helping the trust to prepare for NHSLA assessment level 3, this has involved:

- Revised and aligned policies to reflect the revised assessment standards for 2010/2011
- Completed a gap analysis
- Produced a programme of the works for each criterion lead for progression towards level 3
- Provided guidance on implementation of monitoring systems
- Assisted in revising audit criterions for level 3 evidence
- Prepared and undertook an informal assessment during 2010

During the 3rd quarter of 2010 GWH were successful in their bid in acquiring the Wiltshire Community Health Services (WCHS). This meant that GWH and WCHS would become a merge organisation and would be assessed as one.

The NHSLA standards stipulated that organisations undergoing significant restructuring will be allocated an assessment level by the NHSLA immediately post event.

New organisations and those which have undergone significant restructuring must choose either a formal assessment or an informal visit within the first twelve months of their establishment or the restructuring. The acute merge was classified as large but not significant, therefore NHSLA as a compromise in February 2011 allowed the merged organisation to retain its current NHSLA acute Level 2 accreditation following the merger but the date of its next assessment must take place within 1 calendar year of the merge.

To determine which level the organisation should next be assessed at the NHSLA project co-ordinator has been undertaking an options appraisal, this will be presented to the Trust's Clinical Standards Group and Patient Safety Quality Committee with recommendations of the preferred option of assessment at level 1 or 2.

GWH have been liaising with WCHS to establish their current position and to help build relations prior to the merger.

The NHSLA project co-ordinator is working with the GWH criterion leads establishing what work is required, community leads and understanding of processes ahead of the forthcoming assessment. Over the forthcoming months the NHSLA project co-ordinator will be helping the trust to prepare for its next assessment for 2012.

Statements of assurance from the Board

During 2010/11 the Great Western Hospitals NHS Foundation Trust provided and/or sub-contracted 7 NHS services.

The Great Western Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 7 of these NHS services.

The income generated by the NHS services reviewed in 2010/11 represents 100 per cent of the total income generated from the provision of NHS services by the Great Western Hospitals NHS Foundation Trust for 2010/11.

During 2010/11 38 national clinical audits and 3 national confidential enquiries covered NHS services that Great Western Hospitals NHS Foundation Trust provides.

During 2010/11 Great Western Hospitals NHS Foundation Trust participated in 82% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Great Western Hospitals NHS Foundation Trust was eligible to participate in during 2010/11 are as follows:

Audit Title	Eligible	Participated
Adult Asthma	Yes	Yes
Adult Cardiac Surgery	Not Eligible	NA
Adult Community Acquired Pneumonia	Yes	No
British Cardiovascular Intervention Society	Yes	Yes
Bronchietasis	Not Eligible	NA
Cardiac arrest (National Cardiac Arrest Audit)	Yes	No
Cardio- Thoracic NHS Blood & Transplant: UK Transplant Registry	Not Eligible	NA
Carotid Interventions Audit	Yes	Yes
DAHNO - Data for Head and Neck Oncology	Yes	Yes
Depression & anxiety (National Audit of Psychological Therapies)	Not Eligible	NA
Emergency use of Oxygen	Yes	No
European Chronic Obstructive Pulmonary Disease audit	Yes	No
Familial Hypercholesterolemia	Not Eligible	NA
Heart Failure Audit	Yes	Yes
Heavy Menstrual Bleeding	Yes	Yes
Intensive Care National Audit & Research (ICNARC) 2010	Yes	Yes
Liver Transplantation NHSBT UK Transplant Registry	Not Eligible	NA
LUCADA - National Lung Cancer Audit-2010	Yes	Yes
Myocardial Ischemia National Audit Project 2010	Yes	Yes

Audit Title	Eligible	Participated
National Audit of Pharmacological Treatment of Schizophrenia	Not Eligible	NA
National Childhood Epilepsy Audit	Yes	Yes
National Comparative Re-Audit of the use of Platelets	Yes	Yes
National Elective Surgery PROMs - Four Operations	Yes	Yes
National Inflammatory Bowel Disease 3rd Round-2010	Yes	Yes
National Joint Registry	Yes	Yes
National Neonatal Audit Programme 2010	Yes	Yes
National Paediatric Diabetes Audit	Yes	Yes
National Pain Database Audit	Yes	Yes
National Pleural Procedures Audit	Yes	Yes
National Re-audit of Falls and Bone Health	Yes	Yes
National Sentinel Stroke Audit - Round 7	Yes	Yes
National Vascular: Peripheral Vascular Surgery	Yes	Yes
NBOCAP - National Bowel Cancer Audit Project-2010	Yes	Yes
NHFD (National Hip Fracture Database)	Yes	Yes
Non Invasive Ventilation (NIV)	Yes	No
Paediatric Asthma	Not Eligible	NA
Paediatric Cardiac Surgery & Congenital Heart Disease	Not Eligible	NA
Paediatric Fever	Yes	Yes
Paediatric High Dependency Audit	Yes	Yes
Paediatric Pneumonia	Yes	Yes
Parkinson’s UK - National Parkinson’s Audit	Yes	No
POMH: Prescribing Topics in Mental Health Services	Not Eligible	NA
Potential Donor Audit	Yes	Yes
Prescribing in mental health services (POMH)	Not Eligible	NA
Pulmonary Hypertension Audit	Not Eligible	NA
Re-Audit of the use of Group ORh D Neg Red Cells-2010	Yes	Yes
Renal Colic	Yes	Yes
Renal replacement therapy (Renal Registry)	Not Eligible	NA
Renal Services (Vascular Assess: Patient Transport)	Not Eligible	NA
Renal transplantation (NHSBT UK Transplant Registry)	Not Eligible	NA
Stroke Improvement National Audit Programme	Yes	No
TARN: Severe Trauma	Yes	Yes
CEMACH-Peri natal Mortality	Yes	Yes
Vital Signs in Majors	Yes	Yes
NCEPOD - Cardiac Arrest Procedures Study	Yes	Yes
NCEPOD - Peri-operative Care Study	Yes	Yes

The national clinical audits and national confidential enquiries that Great Western Hospitals NHS Foundation Trust participated in during 2010/11 are as follows:

Other National Clinical Audits
Asthma in Emergency Department
BRONJ - National study on avascular necrosis of the jaw including bisphosphonate related osteo necrosis
Care Feedback Following Antenatal Clinic Restructuring
Diabetes Pump Audit
Efficiency of Outpatient Appointments
Fractured NOF's in ED
Incidences of problematic stomas
Information Giving in Antenatal Clinics
Inpatient Audit of Children with Diabetes
National Audit of Cardiac Rehabilitation
National Audit of Emergency Department Discharge Data on GP Letters
National Audit of Services for People with Multiple Sclerosis 2011 - Service Providers
National Cancer Patient Survey (as mandated by the National Cancer Reform Strategy)
National Care of Dying Audit - 3rd Round 2011
National Comparative Audit of the use of Red Cells in Neonates & Children
National Confidential Enquiry Head Injury in Children
National Diabetes Inpatient Day Audit-2010
Negative Wound Pressure Therapy
Paediatric Consent - Are we following the guidelines
Pain in Children in Emergency Department
UK wide audit of all colonoscopies
UKONS 24 hour Triage Assessment Tool

The national clinical audits and national confidential enquiries that Great Western Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2010/11, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Audit Title	Submitted/Required (%)
Adult Asthma	10/10 (100%)
British Cardiovascular Intervention Society	368/368 (100%)
Carotid Interventions Audit	22/22 (100%)
DAHNO - Data for Head and Neck Oncology	18/ 18 (100%)
Heart Failure Audit	207/207 (100%)
Heavy Menstrual Bleeding	Ongoing submission
Intensive Care National Audit & Research (ICNARC) 2010/11	818/818 (100%)
LUCADA - National Lung Cancer Audit-2010	155/155 (100%)
Myocardial Ischaemia National Audit Project 2010	518/700 (74%)
National Childhood Epilepsy Audit	In planning stages-awaiting data submission.
National Comparative Re-Audit of the use of Platelets	20/20 (100%)
National Elective Surgery PROMs - Four Operations	1223/1223 (100%)
National Inflammatory Bowel Disease 3rd Round-2010	40/40 (100%) -Ongoing
National Joint Registry	1178/1178 (100%)
National Neonatal Audit Programme 2010	366/366 (100%)
National Paediatric Diabetes Audit	148/148 (100%)
National Pain Database Audit	25/25 (100%)
National Pleural Procedures Audit	30/30 (100%)
National Re-audit of Falls and Bone Health	60/60 (100%)
National Sentinel Stroke Audit - Round 7	30/30 (100%)
National Vascular: Peripheral Vascular Surgery	22/22 (100%)
NBOCAP - National Bowel Cancer Audit Project-2010	17/ 17 (100%)
NHFD (National Hip Fracture Database)	382/382 (100%)
Paediatric Fever	50/50 (100%)
Paediatric High Dependency Audit	169/300 (63%) (Approx figures)
Paediatric Pneumonia	32/32 (100%)
CEMACH-Perinatal Mortality	28/28 (100%)
Potential Donor Audit	276/276 (100%)
Re-Audit of the use of Group ORh D Neg Red Cells-2010	29/29 (100%)
Renal Colic	50/50 (100%)
TARN: Severe Trauma	179/179 (100%)
Vital Signs in Majors	50/50 (100%)
NCEPOD - Peri-operative Care Study	3/3 (100%)
NCEPOD - Cardiac Arrest Procedures Study	2/2 (100%)

The reports of 12 national clinical audits were reviewed by the provider in 2010/11 and Great Western Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided: -

Adult Asthma

The audit aims to identify areas around the early management of asthma, assessment of severity of the condition and more particularly discharge arrangements. Audit results demonstrate the need for a Respiratory Specialist Nurse. Although most of the results are comparable, the outcome shows poor performance when taking peak flow readings and doing unnecessary blood gases. Improvement plan includes presentation of results to Unscheduled Care Clinical Governance and Respiratory Meeting, highlighting importance of non-compliant areas.

British Cardiovascular Intervention Society 2009

The results demonstrate increase in number of procedures performed locally and good care quality reflected by reduction in mortality. There is high compliance with data completeness. Actions include continue with delivery of high standard of care and ongoing participation in the national audit.

DAHNO - Data for Head and Neck Oncology 2009

The trust participated in this national audit, submitting > 85% of expected cases. 95% of patients were seen at multi disciplinary team (MDT). Internal validation reflected that 52% of patients to have interval of less than 21 days from referral to diagnosis and 67 % to have interval of less than 30days between diagnosis & MDT. Most of the key data items relate to treatment activity that takes place in Oxford. Our patients' treatment is recorded under Oxford's audit submission. To facilitate improved data contribution, the Trust is looking into the possibility of promoting data input on our behalf. Clinical Nurse Specialists contact is now routinely recorded on our Cancer Database and is projected to be around 95% for next audit period. Trust will continue to participate in the national audit.

Intensive Care National Audit & Research 2009

Results demonstrate good accurate data input with local performance comparable to national benchmarking and reflects clear improvement in some areas e.g. Night discharge. The trust aims to sustain and monitor performance.

National Lung Cancer Audit 2009

Trust demonstrates high compliance to data completeness & quality, processes of care in place and clinical outcomes. It was apparent from the 2008 report that the figures did not include patients who have not been diagnosed in person. These figures are picked up through other pathways where scans have shown abnormalities. In these cases the results are sent to GPs asking them to re-refer the patient as appropriate.

Myocardial Ischemia National Audit Project 2009

The Trust performance is better than or in line with the national targets. Results demonstrate that the Trust is compliant with the national standards i.e. administering clot busting drugs within 60 minutes (of calling for professional help) in over 86% of patients and within 30 minutes in 100% of arriving through the hospital doors. Percentage of patients discharged on secondary prevention medication is >90%. The trust endeavours to maintain high quality performance, with close monitoring of service delivery including primary percutaneous coronary intervention by reviewing each case on an individual basis.

National Neonatal Audit Programme 2009

The aim of this audit is to assess whether babies requiring neonatal care received consistent care across England and Wales. Results show that our neonatal intensive care unit has achieved high rates of compliance in a number of areas. 100% of all infants with gestational ages 26-28 weeks received surfactant (allowing them to breathe more easily). 100% of all infants with a birth weight of <1250g, underwent 1st Retinopathy of Prematurity (ROP) screening whilst still an inpatient and between 42 and 49 days after birth.100% of babies born < 33 weeks gestation receive their mother's milk whilst an inpatient. 57% of babies <28 weeks gestation (up to 27+6) had their blood pressure is measured within 1 hour of birth.71% of babies <28 weeks gestation (up to 27+6) had their temperature measured within 1 hour of birth. We aim to improve data quality.

UK Inflammatory Bowel Disease 2009

The UK Inflammatory Bowel Disease (IBD) Audit is performed within gastroenterology and seeks to improve the quality and safety of care for IBD patients in hospitals throughout the UK. The audit investigates individual patient care, service resources and organisation against national standards. Report demonstrates that the Trust performs above average in nearly all aspects audited.

The reports of 126 local clinical audits were reviewed by the provider in 2010/11 and Great Western Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Productive Theatres

Improve efficiency and effectiveness within Theatres - part of the productive ward initiative. There are no agreed procedures in place for preparing patients for operating theatres or regular process for communicating with wards to allow them to know that specific patients will be collected for operating theatres. Implementation of a flow chart of the process, education to all ward and theatre staff, liaising with all ward staff to agree on realistic patient transfer times will help promote efficiency. Re-audit is planned for this year.

Parkinson's disease NICE-CG35

Outcome of this audit has shown that, whilst we are compliant with most of the criteria, we fail to provide adequate continuing support for patients once they have been discharged from hospital and in between outpatient appointments. Key recommendations include the design and introduction of patient information leaflets and the introduction of a dedicated Parkinson's Nurse to provide support for patients and families on the ward, outpatients department and on the telephone. Re-audit is anticipated in 1yr.

Primary Percutaneous Coronary Intervention

GWH PPCI service has performed well in 2010 – robust 9-5 service timings improved with learning curve. Ongoing changes have been made on a rolling basis throughout the year. We will continue to monitor action when necessary.

Prescribing & Complications of Fondaparinux

Prescribing of Fondaparinux is a safe method and demonstrates good clinical outcomes. Education of indications and contra-indications has been given to all staff in Cardiology at Clinical Governance.

Time to Surgery for Fracture Neck of Femur (#NOF)

In February and March 2010, 75% of hip fractures presenting to Great Western Hospital received surgery within 36hrs from arrival in Accident & Emergency, or time of diagnosis in an inpatient, to the start of anaesthesia. An anaesthetic flow chart was introduced for patients with hip fractures with operation slots and the option to cancel elective surgery to avoid delay in hip fracture surgery. The reasons for delay and targeted improvements are discussed at the monthly hip fracture care meeting.

Uni-compartmental - Knee replacement - Rapid Recovery
The rapid recovery programme for patients undergoing uni-knee replacement has not been effective as pathway not followed. As a result of the audit, the anaesthetic protocol has been reviewed with a dedicated theatre slot agreed. Patients will be better informed prior to surgery by being offered the opportunity to discuss the procedure individually with the surgeon and physiotherapist and also by having access to a video currently being produced.

Management of Cord Prolapse after Viable Age of Gestation at GWH
Results show 74% compliance to Royal College Obstetricians & Gynaecologists guidelines for the management of Cord Prolapsed. Action Plan include improve documentation of attending team, avoidance of artificial ruptures, new protocol for management cord prolapsed with normal continuous electronic fetal monitoring to avoid general anaesthesia, increase paired cord blood samples. Re-audit.

Outcomes in Macular Hole Surgery
The results show that combined procedure of Phaco/Intra-ocular Lenses (IOL)/Vitrectomy/Internal Limiting Membrane (ILM) peel/Gas for macular hole repair has comparative benefits over vitrectomy alone of: Improved visual outcome and shorter hospital in-patient stay. Monitor compliance.

Lumbar Puncture Documentation
To ensure that when a lumbar puncture is performed it is documented in the patients clinical case notes and includes a minimum data set of criteria as outlined in the standards. The results show that we are compliant for indication for the procedure but showed poor compliance with documentation guidelines in the health record. The department has enrolled use of stickers to assist with including all necessary information in the health record when doing lumbar puncture.

Service Provision in Surgical Assessment Unit (SAU)
This was a patient satisfaction survey with the service and care they receive in SAU. The improvements will focus on promoting patient dignity and produce a patient information leaflet which patients would be given on admission to the unit. Re-audit to take place in 6 months after implementation of above results.

Re-audit of Patients Re-admitted to Acute Assessment Unit (AAU) within 30 days of discharge
The review demonstrated that 70% admissions were related and 14% were avoidable. Measures include improving communication of management with patients, families/carers & GPs, improve documentation, clarify services provided by AAU with GPs, and ensure adequate outpatient support available and education of results to AAU staff.

Audit of step 3 of the baby friendly initiative. 'Giving information to pregnant women'
The baseline audit aimed to check if the correct breastfeeding information has been given to women by 34 weeks of pregnancy. Women demonstrate poor retention of information regarding breastfeeding and there was poor documentation regarding completed information about breastfeeding checklist in notes. Improvement aims at educating each midwife in the Trust to ensure they are delivering effective information to expectant mothers.

Alvarado Score a useful tool in the diagnosis of acute appendicitis?
Aim to assess the validity of the Alvarado score in the diagnosis of acute appendicitis. Implementing or educating doctors about the modified Alvarado score is recommended to aid diagnosis of acute appendicitis. The different aspects of the modified Alvarado score should all be included when clerking a patient presenting with right iliac fossa pain.

Audit of the Blood Collection Process

The GWH NHS Foundation Trust is required to show compliance with the Trust's Blood Transfusion Guidelines for all staff who have received training and competency assessment in the blood administration process. Although almost compliant, transfusion training is now incorporated in the mandatory Trust induction and standing agenda item at Clinical Managers Meeting. The transfusion team will raise and monitor incidents and report on any exceptions.

Re-Audit -Compliance to Health Records Keeping Policy

Aim was to determine the Trust's current compliance to Medical Record Keeping/filing Policy. Generally most areas are not compliant and need to be improved. Actions include stamps printed with the Name and Grade of each clinician when taking post at the Trust. The wards need to ensure addressograph labels are always available for use in medical records. Provide education sessions to all clinical staff to highlight the importance of maintaining the health record. Re-audit in one year to allow time for action plans to become embedded in practice.

Re-Audit of New GWH Drug Charts

To audit aimed to ensure that the new drug charts are being used safely and appropriately. Partial compliance led to improvements in the new drug chart. It will be re-audited with the up dated version of the new drug charts.

Surviving Sepsis Campaign First Six Hours Compliance

To determine the extent to which the Trust emergency and acute medical departments adhere to international guidelines in the resuscitation of the septic patient - admitted to Intensive Care with sepsis. Trust compliance for the elements audited reflects areas for improvement. A proforma approach to managing these patients may be beneficial that would ensure these bundle criteria are adhered to in a timely manner. This approach should include the doctor giving the first does of the antibiotics.

Summary

The Trust Clinical Audit Department, with the support of Trust PSQC, ensures that the full cycle of clinical audit is maintained, a particular focus is ensured on improving the quality of care to patients. The aim is to affect real change and improvement and not just the provision of unutilised data. The Trust promotes participation in clinical audit and quality improvement initiatives. Members of the different health care professions are encouraged to undertake audits. Patients and other service users are engaged in this undertaking. This optimises the impact of clinical audit in creating partnership between multidisciplinary teams.

The results are actively disseminated to relevant governance groups. Action plans are addressed to facilitate change and identify those tasked to implement service improvement. Re-audits are ensured to ascertain whether improvements in care have been implemented as a result of clinical audit activity.

For areas showing compliance or sustainability of implemented changes, systems are put in place to monitor service improvements once the clinical audit cycle has been completed.

Dr Foster Reviews

Local Audits including reviews flagged as "Red bells" by Imperial College (Dr Foster) are vital in measuring and benchmarking clinical practice against agreed national and local standards. The alerts are investigated to identify areas for improvement and explain the reason for deviation in clinical care or processes at GWHFT beyond apparent.

The following list outlines Dr Foster investigation summary with actions implemented:

Day Case Rates - Termination of Pregnancy

Cohort of 17 patients reviewed and no cause of concern identified. The Trust aims to monitor & sustain performance.

Extended Length of Stay (LOS)- Coronary Angiography
There is a higher level of acute cases as opposed to elective cases. The results reflect that extended LOS was justified in majority of patients. LOS will be monitored via Myocardial Ischemia National Audit Project database. Furthermore, the performance will improve with the opening of second Catheter lab.

Extended Length of Stay - Normal Pregnancy/Delivery
No cause of concern was identified in the care of these cases. Delayed discharges due to Neonatal complications will be addressed.

Extended Length of Stay - Pneumonia
No instance of prolonged LOS was identified due to delay in diagnosis or delay in institution of medical treatment.

Extended Length Of Stay - Hip Replacement
Most patients in high risk group – complex co-morbidities. No common themes found. The Trust aims to monitor & sustain practice.

Extended Length Of Stay - Endoscopic Resection of Male Bladder
57 % patients were Trial without Catheter (TWOC'd) successfully and went home the following day, 43% either failed TWOC or had medical issues. The improvement plans include development of guidelines for improving processes to facilitate TWOC and discharge of patients with potential of catheter removal in the community.

Day Case Rates - Operation on Vitreous body
The investigation report suggested that it is a complex surgery with high risk of visual disability. No cause of concern identified. Continue monitoring. Discuss with the ophthalmologist the proposal of ways to reduce post operative stay and coding to improve data input.

Day Case Rates - Other destruction of haemorrhoid
The investigation report suggested that the patients are not discharged because of surgery performed in afternoon list and indication to surgery not clearly indicated in operation notes. Improvement plans include discussion with the surgeons the proposal of clearly annotating the indication to discharge on the operation notes and admitting patients for am theatre list.

Mortality outlier for Acute and Unspecified Renal Failure
Having carried out this review with recommendations made by Care Quality Commission, there do not appear to be concerns regarding the clinical care of these patients and areas where quality of clinical care could be improved. The cohorts of patients were elderly with multiple co-morbidities that appeared to be managed appropriately during the patient's admission. This review has provided evidence that clinical care has not been compromised.

Length of Stay - Cardiac Pacemaker
The main preventable delay was from referral to implantation. There are actions in progress. Length of Stay will decrease when the new Catheter lab is open. It is expected that the new cardiology database will, with IT support, allow electronic referral and listing for these patients.

Maternal Re-Admissions following Normal Delivery
The majority of re-admissions were attendances. No clinical concerns were identified in the management of the patients. The plans include working with NHS Swindon to encourage attendance at walk in centre's rather than emergency department, ensure better signposting at delivery to encourage patients to see their family doctor and review coding at point of entry to hospital.

Readmissions within 28 days - Transurethral Resection of Bladder Tumour (TURBT).
No trends identified as a result of the review.

Readmissions within 28 days - Cancer of Breast
Following a triggered alert from Dr Foster, the following area was investigated to ascertain the reason for high readmission rate. The results of the review demonstrated that re-admissions was unrelated, therefore, no cause of concern was identified.

Readmissions within 28 days - Inguinal Hernia Repair
Following a triggered alert from Dr Foster, the following area was investigated to ascertain the reason for high readmission rate. The results of the review demonstrated that re-admissions was unrelated, therefore, no cause of concern was identified.

Mortality Review - Operation on Peptic Ulcer
This review has provided evidence that clinical care has not been compromised.

Conclusion

Other activities include promoting work-based learning and support to healthcare professionals. This promotes learning from the best audits and encourages participation in audits in areas of reduced audit activity.

The Trust provides support to enhance the audit network. It has a wide range of resources, including books, web site links, and skills to set up databases and guidance to help local teams deliver local audit activity.

The number of patients receiving NHS services provided or sub-contracted by Great Western Hospitals NHS Foundation Trust that were recruited during that period to participate in research approved by a research ethics committee was 1483.

A proportion of Great Western Hospitals NHS Foundation Trust income in 2010/11 was conditional upon achieving quality improvement and innovation goals agreed between Great Western Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2010/11 and for the following 12 month period are available online at:
http://www.monitornhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275
The total CQUIN available in 2010/11 was £2.048m of which the Trust received £2m.

Expected financial value of Scheme £2.3m (approx).

The payment of 1.5% CQUIN in 2011/12 will be linked to locally agreed quality improvement schemes. CQUIN enables commissioners to reward excellence by paying a quality increment to providers using NHS Standard Contracts if they achieve agreed quality improvement goals.

Further detail of the agreed goals for 2009/10 and new goals agreed for 2010/11 is available on request from the Director of Business Development, Great Western Hospitals NHS Foundation Trust.

Great Western Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions. Great Western Hospitals NHS Foundation Trust has the following conditions on registration - none.

The Care Quality Commission has not taken enforcement action against Great Western Hospitals NHS Foundation Trust during 2010/11.

Great Western Hospitals NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2010/1 - review of support for families with disabled children (Acute Services) and also undertook a case note review on a CQC "Outlier Alert" for maternal re-admissions. Great Western Hospitals NHS Foundation Trust intends to take the following action to address the conclusions or requirements reported by the Care Quality Commission – none.

Great Western Hospitals NHS Foundation Trust has made the following progress by 31 March 2011 in taking such action – none.

Great Western Hospitals NHS Foundation Trust submitted records during 2010/11 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:
- which included the patient's valid NHS Number was: 99.2% for admitted patient care; 99.6% for outpatient care; and 97% for accident and emergency care.
- which included the patient's valid General Practitioner Registration Code was 99.1% for admitted patient care; [percentage] for outpatient care; and 100% for accident and emergency care.

Great Western Hospitals NHS Foundation Trust Information Governance Assessment Report overall score for 2010/11 was 77% and was graded green.

Great Western Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

Part 3 - Other Information

Directors' comment on quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place for the preparation of the Quality Report.

In preparing the Great Western Hospitals NHS Foundation Trust's 2010/11 Quality Report, the directors have satisfied themselves that:

- The Quality Report presents a balanced picture of the Foundation Trust's performance over the period covered;
- The performance information reported in the Quality Report is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions subject to appropriate scrutiny and review;
- The Quality Report has been prepared in accordance with Monitor's annual reporting guidance as well as the standards to support data quality for the preparation of the quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

Organisational overview

Our quality improvement activities have been driven locally from the feedback of patients and their experiences, from Governors and staff, from national data provided from the Picker surveys and local themes from complaints, both formal and informal. We have also considered information from incidents to inform our patient safety improvement plans and data from national centres and regulatory bodies to ensure our progress is comparable and improved upon.

To further strengthen the quality agenda and progress with the Trust's quality improvement plan we have further developed our clinical governance structures, committees, monitoring and reporting processes with quality improvement embedded within the culture of all directorates. The Trust successfully registered with the Care Quality Commission in February 2010 with no conditions attached.

The Annual Quality Account 2010/11 provides a narrative of progress toward achieving the quality improvement indicators agreed by the Executive Committee and the Patient Safety and Quality Committee (PSQ), previously known as the Clinical Governance Committee. The PSQ now has three non executive director members, one of whom is the chair.

Safety

Our top patient safety priorities 2010/11 have been:

- To reduce our number of MRSA Bacteraemias and Clostridium Difficile infections.
- To reduce harm associated with medication errors and patients falls.
- To reduce our number of hospital acquired pressure ulcers
- To continue to reduce our Hospital Standard Mortality Rate (HSMR)
- To fully participate on the South West regional Patient Safety and Improvement Programme.

The Trust is particularly proud of the achievements made in reducing hospital acquired infections, remaining within the trajectories set by the Department of Health and PCTs for both MRSA and Clostridium Difficile infections. This has been achieved through the rigorous monitoring of antibiotic regimes and by the implementation of infection control risk assessments and MRSA screening on all patients admitted to hospital.

The Trust is pleased to have met the targets for the reduction of both Grade 3 and Grade 4 hospital acquired pressure ulcers. Measuring harm associated with falls and drug errors has been introduced this year and has significantly reduced.

Clinical effectiveness

The top clinical effectiveness priorities for the Trust have been

- To fully implement our Venous Thromboembolism (VTE) Policy and increase VTE risk assessments
- To monitor and reduce hospital readmissions
- To increase the number of patients with fracture hips attending theatre within 36 hours of the fracture occurring

Compliance with the VTE policy has been progressed and significant improvements have been made with the completion of VTE risk assessments. Further commentary on some improvements we have made regarding VTE can be found elsewhere in this report (pages 116 - 117 refer).

The introduction of several key initiatives to reduce hospital mortalities during 2010/11 has resulted in the mortality rate consistently falling below the 100 HSMR threshold. In spite of the 100 mark being re-calibrated during 2010, the Trust has succeeded in maintaining a rate consistently below the 100 mark. The Trust has also been extremely focused on improving the care provided to patients who have suffered a fractured neck of femur. Clinical outcomes are improved if these patients attend theatre within 36 hrs of sustaining the fracture and the Trust has improved to lower 90% in this key are of quality. Details of the different initiatives that have helped reduce the hospital mortalities can be found elsewhere in this report (pages 108 - 110 refer).

Patient experience

The Trust continues to improve services by listening and acting upon patient feedback for improvements to be made to ensure that a high standard of care is provided to patients.

The Trust's strategic objective for Patient Experience is to incorporate elements that feed directly into patient care by improving patient and carer experience, ensuring that staff recommend the Trust as a place to work or receive treatment and to work in partnership with others. This information is obtained through annual/monthly inpatient and outpatient surveys, patient forums,

logging complaints and compliments to identify trends and themes for improvement. The number of patients who would recommend the Trust to a friend in February 2011 was 97.3%.

Formal Complaints received by the Trust represents 0.04% of the total number of patients seen, treated or admitted during 2010/11. Learning from these complaints is acted on to help to improve standard of care and communication. Links throughout the Trust including Essence of Care, Productive Ward and Values Project, maintains a focus on patient experience and assists directorates with successful timely complaint resolution.

Patient recommendation to a friend

The information recorded on the dashboard is extracted at a point in time after month end. There are instances where further cards are received after that date, which are included in the aggregate figures for the end of the quarter.

Late during Q4, PALS took complete control in the collection and entering of the cards to reduce delays and we are reviewing the method of their receipt into PALS.

Patient Information on Discharge

During 2011/12, Patient Information on Discharge is being actively monitored in the Patient Experience Action plan, which is based on the results of the PICKER survey. It has been identified as an area for targeted improvement both through local monitoring and National results reported in the CQC report published during quarter four 2010/11. Patient satisfaction and the effectiveness of a well facilitated discharge process are also measured within two areas of CQUIN:

- Being informed about the side effects of medication
- Being informed who to contact if worried about condition after leaving hospital

The Action Plan links in with existing work streams within the organisation and a target of the end of July 2011 has been agreed for a discharge pack to be rolled out across the organisation which specifically includes information on danger signs for the patient and their carers to look out for and a contact within the hospital if they have any concerns.

Patients treated with dignity and care

Within the PICKER survey, there is a specific question which asks if the patient felt as though they were treated with dignity and care. As an organisation, we recognise that there are many factors within their care and treatment which contribute towards this. The Call Bell data has been analysed and is reported on a monthly basis to the ward managers. Based on the feedback from our patients, by the end of July 2011 there will be matron/ward manager clinics held on each ward which will give patients and their families the opportunity to discuss aspects of care and treatment, and any concerns which they may have.

Matrons walkabouts are being introduced which aims are for:

- Visibility and perception of the Matron
- Monitoring practice/standards/projects
- Patient and staff interaction/feedback
- Validating practice
- Providing assurances to Trust Board/Director of Nursing

By the end of August 2011, there will be a consistency with privacy notices on wards and around the bedside. Currently some wards operate a curtain peg system and others place curtain signs.

The Secretary of State for Health requested a review of the quality of care for older people in the NHS, which was to be delivered by CQC.

The CQC made an unannounced visit to the Trust in April 2011 and whilst the finalised report has not been published, it indicates that staff are aware of the importance of maintaining the privacy and dignity of our patients, and that there are areas where a targeted improvement can be made, particularly with the use of extra bed spaces.

The Patient Environment Action Team (PEAT) assessment in 2010 showed that the Trust scored well in maintaining the privacy and dignity of patients and was rated as excellent overall.

Regulatory Monitoring

A Clinical Standards Group (CSG) is now fully established to specifically monitor performance against a variety of regulatory standards comprising:

- CQC regulations
- NHSLA and CNST Standards
- Staff satisfaction
- Mental health Capacity Act
- Safeguarding and Children

The CSG is tasked with assessing the Trusts ability to evidence compliance with its regulatory requirements. This process has been scrutinised by internal audit and found to be robust with no recommendations noted.

Compliance is monitored following an agreed rolling programme, with attendance from the appropriate regulatory. Monthly and quarterly reports inform the PSQ and Trust Board.

Summary

The Trust's quality improvement strategy has been a shared priority and focus through which the organisation can demonstrate real improvements in the provision of safe and effective care.

In conclusion, we want to emphasise the continuing commitment throughout the entire Trust to deliver a patient focused quality service that will improve the experiences of our patients, their families and friends. We will continue to evolve our quality plans in response to benchmarking and direct feedback from our governors and members to ensure we deliver an ever improving service.

Risk management

The Trust recognises that actively managing risk is a key component of an effective governance framework.

The Trust operates an Assurance Framework and a Corporate Risk Register. In the Assurance Framework, controls are identified against the Trust's strategic and business objectives and assurances are taken against those controls throughout the year. Where gaps are identified these are acted upon within agreed timescales by a nominated lead, supported by an Executive Director. The Corporate Risk Register is informed by risks identified both within the Assurance Framework and by risks identified by the Directorates within Directorate and specific area Risk Registers.

An Integrated Governance and Risk Committee was delegated responsibility for risk management within the organisation which included holding the Executive Directors to account for managing risks within their directorates. The Committee regularly scrutinised the Assurance Framework and Corporate Risk Register. However, during 2010/11 this Committee was strengthened when it was decided by the Trust Board that this Committee should be combined with the Trust's Audit Committee, creating a new Audit, Risk and Assurance Committee. This Committee became and remains accountable to the Board for ensuring that robust processes for risk management are in place and are effective.

The Trust received external assurance on its risk management processes in 2009/10 when it was awarded Level 2 of the NHS Litigation Authority's Risk Management Standards for Acute Trusts. It was awarded a pass in nine out of a possible 10 criteria under the "Governance" standard. Throughout 2010/11, the Trust has remained at Level 2. Furthermore, the Trust has remained at Level 3 against Clinical Negligence Scheme for Trusts (CNST) risk management standards for maternity services since being awarded this level in November 2008.

The Trust has also received an internal assurance in that it was rated "green" following an internal audit of assurance and risk management in March 2011. Notwithstanding this, in March 2011 the Trust conducted a review of the effectiveness of the system of internal controls to improve reporting lines further.

As part of the annual business planning cycle, the main risks to achieving the Trust's strategic objectives will be identified and will be incorporated into the Assurance Framework and risk registers for 2011/12.

The Chief Executive has confidence in the risk management and control processes within the Trust.

Key external impacts

These are detailed in the table below

Key regulatory risks

These are detailed in the table below.

Key external impacts

Key external impact	Risk to the plan	Mitigating actions and residual risk	Overall expected outcome	Measures of progress and accountability
Health Bill - policy slowdown/change (inc. any decision to leave the private patient (PP) cap in place)	(1)Uncertainty creates difficulty securing staff and stakeholder buy in to changes needed to services/pathways/ways of working (2)If PP cap not lifted opportunity lost to fully exploit growing PP market as a result in changes to services delivered on NHS (3)Lack of strategic commissioning by GP consortia/PCTs, leading to services lacking critical mass	(1)Emphasise need for Trust to make changes in line with the national picture and gather staff and local support and buy in to change Run regular staff, and stakeholder briefings on work in hand and progress against objectives (2) Management restructure aligning PP unit with planned care will enable capture of work for PPs through decommissioning of elective work. Action plan in place to drive increased income to cap limit for enlarged organisation (c. £4.3m full year) (3) Ensure effective working relationships established with emerging GP consortia	(1)Staff (and Employee Partnership Forum) have been kept informed and are accepting of changes that need to be made. Stakeholders are kept briefed, reducing possibility of negative media coverage (2) Delivery of minimum PP cap target and contribution to bottom line to be transferred to GWH (support marginal surplus) (3 Shift of activity to community setting	(1)Performance Management Office (PMO) will manage delivery of Cost Improvement Programme/ Cash Releasing Efficiency Savings (CIPs/CRES). Assurance through Finance and Investment Committee monthly and Trust Board quarterly Tangible changes in patient pathways by end of 11/12 (Lead: Director of Business Development) (2) PP action plan and income achieved reviewed monthly and reported to Finance and Investment Committee (3) Maintenance of Financial Risk Rating (FRR) (Leads: Director of Business Development and Director of Finance)

Key external impact	Risk to the plan	Mitigating actions and residual risk	Overall expected outcome	Measures of progress and accountability
Establishment of GP commissioning consortia	(1) Emerging consortia are taking different approaches in Swindon than in Wiltshire; risk is twofold: (a) different commissioning strategies may mean specialties become unsustainable (b) specialties may be required to provide different pathways which will challenge Trust's ability to improve satisfaction levels	(c) CEO and Director of Transition have met with all Wiltshire GP consortia (d) Trust working with Wiltshire Council to create strategy for joint working (first meeting with GPs July) (e) Attendance at Swindon Quality Innovation Productivity and Intervention (QIPP) meeting (now chaired by GP commissioning lead) (f) Regular GP forum being used as vehicle to discuss future plans (g) GP relationship manager formulating visit schedule	Reduction in activity (Swindon) Shift in activity (Wiltshire) to community settings	Activity/referrals report quarterly (Lead Director of Finance) Stakeholder survey indicating GP feedback on working with GWH (Lead: Director of Business Development)
NHS Swindon commissioning intentions	Financial gap for 11/12	External review of contract levels and deliverability of QIPP will enable development of Risk Framework and will support application of similar solution in the future Joint working with PCTs through community change programme, with monthly monitoring GWH action plan, reporting through programme board to monitor progress against PCT aspirations in addition to activity reductions within agreed schedule of QIPP/clinical productivities	Agreed risk framework in place with assessment of financial risk for each organisation	Close monthly scrutiny of activity to enable Trust to manage/close out to activity as necessary Monthly reporting to Finance & Investment Committee and to and Trust Board (Lead: Director of Finance)

Key external impact	Risk to the plan	Mitigating actions and residual risk	Overall expected outcome	Measures of progress and accountability
Inability to influence emergency activity at Salisbury Foundation Trust (SFT) and Royal Untied Hospital Bath (RUH)	Financial risk of 20% of additional activity 11/12, and 30% thereafter	Using county wide forum (Wiltshire System and Strategy group) to work with two acute hospitals and other NHS partners to agree pathways in and out of community care	Indications at Y/E 10/11 is an overall reduction in Emergency Activity across all three acute which will lead to no penalty and potentially net benefit for GWH	Monitoring through validated activity reports from the two Trusts Reporting will be through monthly directorate performance meeting for operational recovery if required, and through Finance and Investment Committee for any financial repercussions (Lead: Director of Business Development)
PCT clustering	Positive opportunity to create strong commissioning relationships; more experience in wider clusters will enable sharing of best practice	Through CEOs, establish relationships with new lead Directors and agree ways of working	Stronger relations based on more decisive and timely commissioning in Swindon that will enable planned, clinically based response for service changes	Through monthly review meeting structure (still to be confirmed) (Lead; Director of Business Development)
Any Qualified Provider (AQP)	Strategic intent is to redesign patient care to provide improved pathways at less cost, and AQP can be a lever to ensure appropriate preparation takes place in directorates (1) Review service provision/patient pathway and secure	Review service provision/patient pathway to ensure maximum efficiency, and best outcomes, and good patient experience; use basis to create new products to respond to AQP opportunities	Specialties to use service line reporting to review profitability as start of process to develop new models of care to prepare for re commissioning of services through AQP	Schedule of reviews to be agreed, based on commissioning intentions of NHS Swindon, and confirmation of QIPP reinvestment plans (Lead: Director of Business Development)

Key external impact	Risk to the plan	Mitigating actions and residual risk	Overall expected outcome	Measures of progress and accountability
	new activity (or retain existing on different terms) (2)Reduction in activity; Trust will need to be able to respond by taking out costs			
NHS Swindon/Swindon Council Social Enterprise	Swindon Social Enterprise has "pathfinder" status (government support and funding) and its success may be at the detriment of GWH core activity as activity moves into community settings	Review service provision/patient pathway to ensure maximum efficiency, and best outcomes, and good patient experience; use basis to create new products to respond to Any Qualified Provider (AQP) opportunities	Reduction in activity in agreed specialties through joint working	Measured through Programme Board monthly (Lead Director of Business Development)
National agreement on pay and conditions	Any national or local agreement on terms and conditions may impact our strategic intent for staff to want to work at GWH and recommend it as an organisation of choice to provide care for friends/relatives	Continue to work with Employee Partnership Forum (EPF) on all issues relating to terms and conditions. Roll out 'values survey' to enable 'temperature' of organisation to be taken and understood Establish senior staff forum group for quarterly briefings to ensure positive cascade of information from Executive Committee Reinforce Team Brief as regular cascade for information from CEO and Trust Board on change plans resulting from local and national drivers Maintain strong media relations to ensure appropriate coverage of any changes in terms and conditions.	Redundancies will always be a last resort for the Trust, but EPF have been advised that there is the potential for redundancies over the three years 11/12 – 13/14	Workforce changes will be reported though project reports to Programme Board Scrutiny of workforce changes through Workforce Strategy Group and Trust Board (Lead: Director of Workforce and Education)

Key regulatory risks

Key regulatory risks	Nature of risk	Actions to rectify / mitigate and responsibilities	Measures 2011/12 2012/13 2013/14
Inadequate assurance framework and risk registers and lack of resources to support a robust process	Trust not assured that risks are identified and managed	Review of risk management strategy and assurance framework	Strategy in place 2012. Harmonised assurance framework in place 2012. Annual reviews of effectiveness.
Non compliance with authorisation and constitutional documents	Constitution out of date, not relevant to the workings of the Trust, non compliant with emerging legislation. Decision making mechanism unclear and bureaucratic. Lack of transparency and public accountability.	Programme of ongoing review of constitutional documents established. Systems and processes to support compliance set up and compliance monitored. Responsibility: Chief Executive	Review implementation against agreed timetable. Clear decision making structures in place. Evidence of compliance maintained. Achievement of levels of compliance through Monitor at quarterly and Annual reporting points.
Failure to achieve compliance with new NHSLA Level 2 Acute Standards	Drop from Acute Level 2 to Level 1 corresponding to a financial deficit of £240K	Options appraisal, action plan, gap analysis against standards, decision regarding level of assessment Responsibility: Medical Director	Action plan in place 2011; review against action plan.
Licence to operate (compliance with CQC registration and regulatory regime)	Not learning from safety incidents Safety compromised by excess activity / demand CQC unannounced inspection leads to minor/moderate concerns Financial and reputational risk through inability to deliver commitments	Governance structure Achievement of NHSLA levels Participation in regional Patient Safety Programme Responsibility: Medical Director Programme of matron led CQC style visits to review practice, and staff response at all sites Responsibility: Director of Nursing Assessment of compliance and action plan to ensure continued delivery Responsibility: Director of Business Development	Fewer claims year on year Continued strong reputation for reporting Improved score on specific questions in staff survey Twice yearly update to Executive Committee

Key regulatory risks	Nature of risk	Actions to rectify / mitigate and responsibilities	Measures 2011/12 2012/13 2013/14
Health and Safety	Catastrophic incident relating to patient care, staff and / or equipment Failure to comply with H&S Act could lead to reputational and financial penalties	High reporting levels with HSE. Strong internal focus on H&S and scrutiny by Board. Staff mandatory training. Responsibility: Director of Workforce and Education	Pass any unscheduled inspections through the life of the plan. Take on board and implement learning from any spot inspections during the timeframe to enhance practice.

Care Quality Commission (CQC) registration

Health and social care organisations are required to register with the CQC through a registration system. To be registered, trusts must meet the standards, which cover important issues for patients. Further information on CQC is included under the performance assurance section of this report *(page 184 refers)*.

Data quality

Good data quality is essential to support patient care and to monitor the quality and efficiency of the services provided by the Trust. The Trust has established structures in place to ensure data quality is monitored and proactively addressed. The Senior Information Risk Owner is the Director of Finance who has Board level responsibility for data quality. The Head of Information Management chairs the Trust data Quality Group which has Corporate and Clinical Directorate representation and which develops and delivers a data quality work programme in the Trust. The Data Quality Group reports to the Trust's Information Governance Steering Group on which the Head of Information and Director of Finance are members and issues and progress against the work programme is reported.

The Data Quality work programme is developed in response to identified data quality issues, whether picked up from regular internal and external monitoring, internal and external audits, commissioner queries, data collection initiatives or issues that arise from regular reporting. The Work Programme is developed with milestones and deliverables and progress is tracked by the Information Governance Steering Group on a regular basis through the year.

The Trust participates in regular internal and external audits and where these raise any issues associated with data quality an action plan is developed and incorporated and monitored through the Data Quality Work Programme.

Each year the Trust assesses its performance on Data Quality against the requirements of the Information Governance Toolkit and this includes an external audit of the quality and accuracy of admitted patient clinical coding and the quality of patient activity submissions to the Secondary User Service (SUS). Three components of the Toolkit relate closely to data quality and consist of several measures in each. The Trust's performance was rated as satisfactory in each (two ratings exist – unsatisfactory or satisfactory, with 70% being the attainment level for satisfactory). The performance levels were:

- Information Quality and Health Records Management – 80%
- Secondary Use Assurance – 83%
- Corporate Information assurance – 77%

The Trust submits patient level data to the Secondary Users Service (SUS) for inclusion in Hospital Episode Statistics and data quality reports are published on a monthly basis from this submitted data and made available to Providers and Commissioners. Performance is generally very good. One of the key data items is NHS Number which is included as an NHS priority data item. In the SUS flows for April – January 2010/11 the completeness for valid NHS number was:

- 99.2% for admitted care (compared to 98.5% nationally)
- 99.6 for outpatient care (98.6 nationally)
- 97.0 for accident and emergency care (91.1 nationally)

A further NHS data quality priority during 2010/11 has been the Psuedonymisation Project. The project aims to reduce access to patient identifiable data to NHS staff using data and information for "secondary use" which is broadly defined as not being for direct patient care. The Trust has a project that is developing better compliance with the requirements and has included work on reviewing data flows and data use not connected to direct patient care (for example Commissioning) and also reviewing the use of identifiable data within data made available within the Trust for, for example, management and review of performance. The Project reports to the Information Governance Steering Group.

Information governance

Information is a key asset, both in terms of the clinical management of individual patients and the efficient management of services and resources throughout the Trust. It is therefore of utmost importance that information is efficiently managed, and that appropriate policies, procedures and management accountability provide a robust governance framework for information management. There is corporate leadership of information governance, the Finance Director having overall responsibility. The Information Governance Steering Group oversees information governance issues, with responsibilities delegated from the Audit, Risk & Assurance Committee on behalf of the Trust Board.

The Information Governance Management Framework is documented within the Information Governance Strategy and Policy. The four key principles are openness, information quality, information security and legal compliance. The importance of confidentiality, security, and data quality plays a role in the safeguarding of information within the Trust. This includes patient and staff information as well as organisational information. The Trust has agreements to share patient information with other healthcare organisations and other agencies in a controlled manner, which ensures the patients' and public interests. It is essential for the delivery of the highest quality health care that accurate, timely and relevant information is recorded and maintained. As such it is the responsibility of all staff to promote data quality and confidentiality.

The Trust's Information Governance Steering Group undertakes an Information Governance Work Programme covering the full range of information governance elements, and ensures that appropriate policies and management arrangements are in place. The Data Quality Group, which reports to the Steering Group, provides a quarterly data quality and completeness report, including the results of data accuracy tests. The Data Quality Group also undertakes a Data Quality Work Programme, which includes data quality reporting, training and awareness, clinical coding, and policies and procedures. These corporate and operational arrangements ensure that information governance and data quality are prioritised at all levels of the Trust.

Each year the Trust completes a comprehensive self-assessment of its information governance arrangements by means of the NHS Information Governance Toolkit. The main Toolkit headings are:

- Information Governance Management
- Confidentiality and Data Protection Assurance
- Information Security Assurance
- Clinical Information Assurance – Health Records and Information Quality
- Secondary Use Assurance
- Corporate Information Assurance – Records Management and Freedom of Information

These assessments and the information governance measures themselves are regularly validated through independent internal audit. The Trust's Information Governance Assessment Report overall score for 2010/11 was 77% and was graded Green, with a satisfactory rating in every aspect of the Information Governance Toolkit.

Annex 2010/11 Statement of Directors' responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2010 to June 2011;
  - Papers relating to Quality reported to the Board over the period April 2010 to June 2011;
  - Feedback from the commissioners dated 03/06/11;
  - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated June 2011 (draft to Executive Committee);
  - The national patient survey January 2011;
  - The national staff survey April 2011;
  - The Head of Internal Audits annual opinion over the trusts control environment dated 03/06/2011;
  - Care Quality Commission quality and risk profiles dated 16/05/2011;
- the Quality Report presents a balanced picture of the NHS foundation trusts performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual)).

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

6/6/2011 ..... Date ..... Chairman

6/6/2011 ..... Date ..... Chief Executive

Independent Assurance Report to the Council of Governors of Great Western Hospitals NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of Great Western Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of the content of Great Western Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2011 (the "Quality Report").

Scope and subject matter

We read the Quality Report and considered whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and consider the implications for our report if we become aware of any material omissions.

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual 2010/11 issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual or is inconsistent with the documents.

We read the other information contained in the Quality Report and considered whether it is inconsistent with:

- Board minutes and papers for the period April 2010 to June 2011;
- Papers relating to Quality reported to the Board over the period April 2010 to June 2011;
- Feedback from the commissioners dated 03/06/11;
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated June 2011 (draft to Executive Committee);
- The national patient survey January 2011;
- The national staff survey April 2011;
- The Head of Internal Audits annual opinion over the trusts control environment dated 03/06/2011;
- Care Quality Commission quality and risk profiles dated 16/05/2011;

We considered the implications for our report if we became aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

This report, including the conclusion, has been prepared solely for the Council of Governors of Great Western Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting Great Western Hospitals NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2011, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the Quality Report. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Great Western Hospitals NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- Making enquiries of management;
- Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- Reading the documents.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual dated 31 March 2011.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2011, the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual.

Neil Thomas, for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
15 Canada Square
London
E14 5GL
21 June 2011

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Sustainability reporting

Commentary

Environment and sustainability

As a large and growing organisation, the activity of the Trust has an impact on the environment. The Trust therefore takes seriously its responsibility to minimise its effect on the environment seeking, wherever possible, to develop in a sustainable manner.

Sustainable development is about making sure we meet the needs of the present without compromising the needs of future generations. It is about energy efficiency, carbon reduction and recycling and also ensuring social justice and equity, and integrating environmental, health, social, political and economic issues into decision making. As sustainability covers so many aspects of the hospitals work it is important that the Trust monitors its progress through regular reports to the Board. The Director of Finance takes overall responsibility for ensuring that the Trust is achieving NHS carbon reduction targets.

During 2010/11 the Trust has continued to implement a number of projects to reduce the amount of waste produced and energy used in the Trust.

This year an additional two hundred motion sensitive lights have been installed in offices and toilets to turn the lights off when the room is not is use. These switches are now being installed routinely in any refurbishment work that is carried out where appropriate. Reducing energy use and therefore carbon will become more important moving forward as in September 2010 the Trust registered as a participant with the Carbon Reduction Commitment Scheme.

In December 2010 the Trust started to segregate out offensive waste, from the clinical waste stream. Offensive waste does not have any hazardous properties and can therefore be treated differently to infectious clinical waste. Our waste is sent to be burnt at low temperatures to produce electricity. In January 2011 13% of the hospital waste was consigned as offensive waste and this volume will increase as this is rolled out to more and more departments and ultimately to Wiltshire. It is estimated that when this project is complete over 60% of the hospital waste will be classified as offensive waste.

Unfortunately the Trust was not successful in securing funding for an on site composter for food waste, however, this option will continue to be explored if other funding streams are identified.

Following consultation with staff in early 2010 on the Fair Transport Scheme, further consultation has taken place with staff and Members to change parking arrangements at the hospital. The Trust now has a comprehensive Travel Choices policy which provides clear and sustainable solutions to manage transport to and from the hospital site with most staff no longer being able to bring their own individual car on site everyday. The policy will be implemented in May 2011 and aims to reduce demand for parking over time.

In the Spring 2010, the Hospital Arts Committee ‘Arts for Health’ secured funding to build a footpath around the balancing pond in the hospital grounds. This provides a short walk through pleasant habitat and is popular with staff in the summer months. The design was delivered with the needs of cardiac patients in particular in mind. There are benches placed at frequent intervals, so patients can use this facility to aid recovery. Also a courtyard garden was opened in the maternity unit giving mothers access to a secure and pleasant external space.

We continue to co-operate with our Private Finance Initiative (PFI) partners by assisting with educational site visits for children in a local school which the PFI has forged links with. The children are shown for example how hospital waste is managed and complete their day by assisting with bio diversity surveys of the pond area. The Trust has expanded this theme and is currently planning a "bring your child to work day", where staff children will be shown different areas of the hospital and be able to practice skills such as putting people into the recovery position.

Comparative data

Sustainability agenda for the year ahead

The tables below provide details of the amount of waste produced and the cost of disposal. Also provided are details of the amount and cost of the energy used by the Trust. This information is compared with last year.

Waste Type	Amount of waste produced (tonnes)		Cost of waste disposal	
	2009/10	2010/11	2009/10	2010/11
Incineration	51.18	60.11	£32,282	£53,171
Alternative treatment	484.12	429.25	£211,749	£143,746
Offensive (started roll out Dec 2010)		20.99		£5,780
Landfill	391.53	436.45	£31,060	£54,908
TOTAL	**926.83**	**946.8**	**£275,091**	**£257,605**

Energy type	Amount of energy used		Cost of energy usage	
	2009/10	2010/11	2009/10	2010/11
Electricity (Giga Joules - GJ)	55371.51	**57924.11**	£1,219,177	**£1,067,726**
Gas/GJ	55243.88	**64080.00**	£301,040	**£399,805**
Oil/GJ	2533.46	**2820.45**	£40,866	**£54,479**
Water/m3	199962	**200000**	£330,564	**£276,538**
TOTAL			**£1,891,647**	**£1,798,548**

Short Term Operating Reserve (STOR) this will allow the Trust to export electricity to the National Grid using our on site generators if not required by the hospital when the grid is stretched for

capacity. On a national level this will help reduce carbon emissions as the need to fire up additional power stations to meet short term high demand for electricity will be reduced. Assuming the final details can be agreed it is anticipated that this will commence in the summer.

In the next year large items of plant will be replaced under the lifecycle programme. We will continue to work closely with Concessionco to ensure that plant is upgraded to the most energy efficient appropriate. Other projects are under way to review the street lighting type and use on the hospital site, and the use of improved controls on air handling plant.

The Trust will be implementing the Travel Choices policy as discussed above in May 2011, by promoting car sharing the Trust will reduce the amount of congestion on site and local roads and reduce the level of carbon associated with staff commuting. As part of the policy the Trust will be providing a fleet of pool cars, these will all be fuel efficient cars so this will help monitor and control the CO_2 from business travel.

In the next year the Trust will be working alongside Wiltshire Community Health Services. This will present many different challenges and opportunities to integrate the two organisations and deliver sustainable healthcare across the whole of Wiltshire.

Climate change

The Trust has registered for the carbon reduction commitment as part of our obligations towards reducing our contribution to climate change. The Trust has also adopted our responsibilities in terms of adapting to climate change and we have participated in a number of regional events in order to ensure that the Trust can cope with the future consequence of changes in weather associated with global climate change.

This work is closely linked with the work we are doing on business continuity, however it incorporates the risk based approach advocated by the Department of Energy and Climate Change

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Equality reporting

Equality and diversity

As a public sector employer, equality and diversity is important to the Trust, not only because the workforce should reflect the local community but also so that patients are not disadvantaged in accessing the health services in any way. The Trust had in place the statutory requirements of a Race, Disability and Gender Equality Scheme and now has an Equality and Diversity Strategy which will also incorporate religion, age and sexuality.

What have we done?

The Trust has continued the development and raised the profile of Equality & Diversity (E&D) throughout the year. The Equality Act 2010 was implemented in October 2010. The Act simplified the current laws and applied further protection from discrimination. The Equality Act captures the individual groups that were protected by existing equality legislation – age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage, civil partnership, pregnancy and maternity. These are now called 'protected characteristics and are covered by the one Equality Act 2010. Over 90% of the Act has now been implemented. The provisions of the Act apply to the public sector from April 2011 and Trusts will be inspected to ensure compliance.

Equality Strategy

The Trust Strategy provides the framework for the Equality Act 2010, its implementation and our regulatory position. The paper describes the promotion and education of E&D in the Trust and how the Act links with existing Trust Policies and Strategy. We must ensure that the policies and measures meet the diverse needs of our health care services, population and workforce, ensuring that none are placed at a disadvantage. The Trust adopted an Equality and Diversity Strategy in March 2011.

Patient Care

A number of initiatives have been implemented to continue to improve our patient care. We have a successful programme of training for healthcare assistants and volunteers to assist with feeding in ward areas. We are working with our facilities provider to ensure that the specialist dietary needs of our population are considered. We continue to raise awareness of the needs of patients with sensory loss through our support of the Sensory Loss Group. The Group is introducing practices for ensuring these patients are identified on the ward and possible visual indication on their case notes.

Communication, Engagement and Information

E&D team representatives have been building relationships with 'harder to reach' community groups. Members regularly attend the local Black and Minority Ethnic (BME) group and a good relationship is being developed. The community group raises concerns from its members regarding the Trust services. These issues are brought to the attention of the relevant GWH service leads and are actioned. Key areas of concern related to communication and dietary requirements. The Patient Information Project is underway with representation from all directorates. The project's objective is standardisation of patient information to be available in different formats and languages.

NHS Swindon and Swindon Borough Council have excellent community involvement. The E&D team are currently exploring ways of being involved with joint programmes of work which will benefit our patients and staff.

Data Collection

Accurate data collection is required to ensure that we are meeting the needs of our health community and staff. We reviewed how we collect patient information and have implemented a demographic form which patients complete on each attendance. Patients prefer to provide this information in writing rather than verbal discussions at the reception desk. Staff data on disability, ethnicity and gender will be collected via the Electronic Staff record system and staff will be encouraged to share this information with us.

Staff Education

The E&D team recognised that education was key to ensure staff were aware of their role in E&D within the Trust. We commenced with the training of managers in the utilisation of the Impact Assessment Tool. All Trust policies are screened for adverse impact to ensure the E&D requirements have been met.

With the implementation of the new Act, it was essential that we had staff awareness of their responsibilities in ensuring that the Trust was embracing the Equality Act.

E- Learning training will be launched on 1 April and all staff will be required to undertake this initial training programme.

A short Equality Act 2010 presentation is available for Managers to present to their directorate teams which provide an overview of the Act and the Trust implementation requirements.

Recruitment

The Trust will no longer be allowed to ask general questions about health or disability prior to a job offer. Questions can be asked about tasks involved in the job role. If a new employee or existing member of staff is at a substantial disadvantage when compared with someone who isn't disabled, reasonable changes ('adjustments') will be made by the Trust. All Occupational Health referrals will meet the standards of Equality Act 2010. We will continue to be proactive in encouraging applicants from the BME community. This is being monitored via the Recruitment team, and Human Resources.

Policies for potential and existing disabled employees

The Trust has signed up to the national "two tick" symbol and supports the recruitment and development of disabled candidates/employees. By using the "two tick" symbol, GWH is required to make five disability commitments. These commitments are:

- to interview all disabled applicants who meet the minimum criteria for a job vacancy and to consider them on their abilities;
- to discuss with disabled employees, at any time but at least once a year, what both parties can do to make sure disabled employees can develop and use their abilities;
- to make every effort when employees become disabled to make sure they stay in employment;
- to take action to ensure that all employees develop the appropriate level of disability

awareness needed to make these commitments work;
- to review these commitments each year and assess what has been achieved, plan ways;
- to improve on them and let employees and Jobcentre Plus know about progress and future plans.

For staff that become disabled whilst in our employment, the Trust actively works with the Occupational Health team to make reasonable adjustments to enable the member of staff to continue their employment with the Trust. As a sign of the seriousness with which the Trust treats equality and diversity, the Trust is in the top 20% of trusts in England for the percentage of staff who receive equality and diversity training according to the annual staff survey commissioned by the Care Quality Commission (CQC).

The Trust is also part of a Pacesetters Programme to improve disability representation in our workforce and has also improved working relationships with local organisations that support employment of those with disabilities. The Trust has also taken part in a Positive Action Event on recruiting people with disabilities and is considering using "working interviews" as part of the recruitment process.

Our aims for 2011/12

- Improve Diversity within the E&D team
- Roll out of the Trust wide E&D training and ensure appraisals identify developmental needs around equality.
- Review policies to ensure that they meet the Equality Act 2010.
- Keep equality on the Trust agendas
- Develop the links with community groups through partnership working
- Plan a 'Diversity Day' for staff

Please note that the Trust has disclosed information on the above as required under the Companies Act that is relevant to its operations.

9
Staff survey report

Our staff

The Trust employed throughout 2010/11 an average headcount of 3356 members of staff – a total of 2,798.64 whole time equivalents (WTE).

The Trust places significant emphasis on the development of staff. All staff are supported to ensure they undertake annual Mandatory Training which assists in keeping patients and staff within the organisation safe. During the 2010-2011 the Trust continued to report a rise in such training, with compliance across the board now at 80 percent.

The Trust has an Academy which is a highly successful multi-professional education centre, situated within the Great Western Hospital. The Academy boasts state of the art education facilities including telemedicine, video conferencing, extensive IT, an excellent multi profession library as well as a full range of education rooms, clinical skills lab and lecture theatres.

Our aim is to increase the quality of care to our patients and meet the present and future education, training and development needs of all Trust staff and students. We strive to ensure that individuals are supported in obtaining the necessary knowledge, skills and behaviours; to provide an evolving and continually improving high quality standard of health care to patients and service users and to meet these needs within a multi-disciplinary and supportive environment providing a first class service at all times.

The Academy has focussed on a number of improvements to education and development opportunities available for staff including:

- the course portfolio has been expanded to offer a wider range of clinical skills, such as Stoma Care, Care of the Dying, and non clinical courses such as the Customer Service Programme;
- regional study days have been developed and delivered to support the education required to realise improvements in patient care set against national improvement drivers such as Stroke, Falls prevention and Dementia;
- Vocational training has been expanded to include NVQ in customer service delivered in house, an apprenticeship programme and a three module personal development course; and
- all courses are subject to a Quality Assessment process including national benchmarking and expert review, peer review of teaching staff, learner evaluation and six monthly evaluations of impact on patient care and assessment of review of return on investment.

The Academy continues to improve access to education and development via e-learning. This enables staff to keep up to date with best practice in an effective and efficient manner. In addition staff who traditionally have difficulty accessing educational and development opportunities such as night staff are better able to secure learning opportunities.

The continued drive to improve e-learning has seen all in-house material moved on to the National Learning management system, which will be piloted in April. This will see an improvement in quality of visual appeal of material and reporting of activity.

During the last year the Academy has been subject to a number of education inspections. A 'deep dive' visit by the Strategic Health Authority occurred in January to inspect educational provision as part of the learning and development agreement, which covers the education of doctors in training, continuing professional development of staff as well as the education provision for future workforce. The inspection reported a number of areas of best practice.

Furthermore an internal audit of mandatory training reported that the Trust could receive significant assurance that processes were in place to manage risk within the organisation. The report result was green with no recommendations and no suggestions

Work continues to strengthen the education of junior doctors. The Academy has placed significant emphasis on building the quality and quantity of education supervisors in the organisation. The result of this work is demonstrated in the improved General Medical Council (GMC) Post Graduate Medical Education and Training Board (PMETB) survey 2010.

The Academy continues to support our future workforce; the focus of this year has been to continue to strengthen the quality of nursing placements, seeing an improvement in the audits scores provided to the Trust by the University of the West of England and Oxford Brooks University. The clinical skills available to medical students placed in the organisation have been expanded and the Academy looks forward to the expansion of placements to include Bristol University 2nd year students.

Staff satisfaction

It is recognised across the NHS that a more satisfied workforce provides better patient care and the Trust places a great deal of emphasis on exploring ways to improve and enhance motivation and morale so that staff are satisfied in their work. To help the Trust understand how staff are feeling, the results of the annual staff survey commissioned by the Care Quality Commission are examined to identify any areas for improvement.

The Trusts overall scores position the Trust as seventh across 20 Trusts in the South West of England.

The 2010 survey results show that staff experience has improved in the following areas:-

- the percentage of staff believing the trust provides equal opportunities for career progression or promotion has risen from 86%in 2009 to 93% in 2010;
- the impact of health and well-being on ability to perform work or daily activities has reduced from 1.61 in 2009 to 1.54 in 2010;
- fairness and effectiveness of incident reporting procedures has increased from 3.49 in 2009 to 3.54 in 2010; and
- the percentage of staff receiving health and safety training in last 12 months has increased from 87% in 2009 to 92% in 2010.

Overall, the Trust is measured against the four staff pledges from the NHS Constitution with an additional theme of staff satisfaction. These indicators break down into 38 key findings and results show that GWH has improved on 5 key finding areas since 2009 and is average or above average for 29 areas as benchmarked against other Trusts. However, there are nine key findings areas where the Trust is below average.

Detailed below is a summary of the staff Survey scores for 2010 alongside the equivalent scores from the 2009 survey. Full details of the survey can be found on the Care Quality Commission website at www.cqc.org.uk.

Summary of staff survey results

	2009	2009	2010	2010	Improvement / Deterioration
	Trust	National Average	Trust	National Average	
Response rate	60%		59.44%		
Top 4 ranking scores					
%age of staff receiving health and safety training in the last 12 months	87%	78%	92%	80%	5% increase on last year
%age of staff having equality and diversity training in the last 12 months	56%	35%	63%	41%	7% increase on last year
Fairness and effectiveness of incident reporting procedures	3.49	3.42	3.54	3.45	0.05 point increase on last year
Perceptions of effective action from employer towards violence and harassment	3.65	3.55	3.65	3.56	No change
Bottom 4 ranking scores					
%age of staff receiving job-relevant training, learning or development in the last 12 months	75%	79%	73%	78%	2% decrease on last year
%age of staff feeling pressure in last 3 months to attend work when feeling unwell	22%	26%	31%	26%	9% increase on last year
%age of staff suffering a work-related injury in the last 12 months	16%	17%	19%	16%	3% increase on last year
Staff motivation at work	3.84	3.84	3.76	3.83	0.08 point decrease on last year

To encourage open dialogue and discussion with staff, the Trust hosts a programme of openness meetings throughout the year. These provide a framework for staff engagement and an opportunity for staff to feedback so that the Trusts performance can be improved and issues of concern can be addressed.

Staff consultation and engagement / other consultations

The Trust has a strong working relationship with the Employment Partnership Forum (EPF) which is the formal negotiating mechanism at GWH. Meetings between the Trust and the EPF take place on a monthly basis to discuss strategy, operational performance, service developments and patient and staff feedback. Members of the EPF have been involved in developing action plans as a result of staff survey results and in reviewing the Trusts policy framework as well as individual workforce policies.

In 2010 the Trust introduced a series of policies around conduct, capability and attendance which were fully consulted on. The emphasis was on encouraging the manager to tackle these issues. 'Triggers' were introduced for absence and the HR teams and line managers have been using these to manage absence; this may have resulted in the staff survey result that staff are feeling under more pressure to attend work.

Further consultation was undertaken around the new car parking policy and because of the strength of feedback; the implementation of the scheme was changed from February 2011 to May 2011. However, staff remain concerned about its effect on their work-life balance.

A change programme has been introduced is looking to tackle some of the key issues identified by the Staff survey results; this has been supported by a group which is representative of a cross-section of the organisation who are supporting management to define the changes that need to happen and help them to be delivered. Three specific work streams have been identified; Vision and Values; a Management standard and performance review. The work streams are headed up by senior clinical and line managers. In anticipation of the transition of staff from Wiltshire Community Health Services in June 2011, some of their staff have been invited to attend the groups.

Communicating with staff

A number of new initiatives have been implemented during the course of the year to help provide more information to staff on a regular basis and open up lines of communication.

- Horizon magazine: In June 2010 a Trust magazine was introduced on a quarterly basis to keep staff, members and stakeholders informed about key developments at the Trust. The magazine is distributed widely to staff and has received positive feedback from readers.
- Team Brief: A new monthly Team Brief was introduced in September 2010 with the aim of keeping staff informed about issues in the Trust including financial and performance information. Line Managers and Supervisors are encouraged to brief their teams on the contents of the Team Brief and encourage questions and discussion on key issues.
- Chief Executive Open meetings: At the end of each financial year the Chief Executive hosts a series of briefings for staff appraising staff of the performance of the Trust over the previous 12 months and highlighting the main challenges facing the Trust in the year ahead.

In the year ahead further opportunities to strengthen communication with staff.

Supporting our volunteers

The Great Western Hospital's Foundation Trust is extremely fortunate to have so many committed and enthusiastic volunteers. Each provides an extremely valuable service to patients and enormous support to staff. They form an essential part of the hospital team and are greatly appreciated.

For many, volunteering is a step on the ladder to employment; an opportunity to experience the hospital environment before going to University or having the courage to leave their current employment to follow a long held dream of working in the NHS. Of course, many of our volunteers stay with us for years with some having 5, 10, 15, 20 and even 25 years or more voluntary service and each volunteer has their own personal reason for offering their time.

There remains a constant interest in "volunteering within the Great Western Hospital", with an average of 29 enquiries received each month. Volunteers come through the same recruitment process as a member of staff. They are interviewed by the Voluntary Services Manager, have to have two references, Occupational Health and CRB clearance and then meet the relevant Placement Area Manager before attending the Trust induction and any other relevant training e.g. assisting patients at mealtimes and bed making. This process can often take up to three months to complete.

In addition, there is the opportunity to volunteer at the hospital via other organisations, such as British Red Cross, Hospital Radio and WRVS.

Volunteers are called the Voluntary Services TEAM because with their assistance "**T**ogether **E**veryone **A**chieves **M**ore". Our volunteers now wear teal coloured polo shirts (with the exception of Chaplaincy Volunteers, Cancer Information Point and also Breastfeeding Support volunteers who wear lavender) which makes them stand out in their own right as a team within the hospital.

A quarterly "Voluntary Service Matters" newsletter is sent to all volunteers and quarterly "Volunteer Social Events" (including Long Service Awards) are also held to ensure that the volunteers are well communicated with and have an opportunity to share their ideas with us too.

Volunteer numbers			**Trust volunteer demographics**
We currently have 375 volunteers			24% Male 76% Female
230	Trust Volunteers	61%	21% of our volunteers are aged between 17-25, 32% of our volunteers are aged between 26-60, 40% of our volunteers are aged between 61-80, 7% of our volunteers are aged over 80.
96	WRVS Volunteers	26%	
30	Hospital Radio Volunteers	8%	
19	British Red Cross Volunteers	6%	

Number of hours volunteered by Trust volunteers

2010/2011 (April '10 to January '11) our Trust volunteers helped us for 18,380 hours. This equates to an average of 1800 hours per month and 49 full time equivalent members of staff per month.

In total, 5 volunteer leavers secured permanent roles as paid members of staff in the Trust, four as Nursing Auxiliaries and one as a Bio Medical Scientist.

Occupational Health

The Occupational Health Department welcomed the introduction of the National Occupational Health Standards for Accreditation, published 2010, and is now working towards being an early implementer site for full accreditation by summer 2011.

The Boorman Review, published during 2009, which showed that being proactive and putting in place preventative measures will yield considerable benefits for individuals and for patients continues to be one of the main drivers for OH activity and during 2010/11 has seen the implementation of the Health & Wellbeing programme which is a new and innovative service, offered to all employees. This enables every member of staff to access an assessment to look at all aspects of their health and lifestyle and specialist advice is offered to design a bespoke programme to each to make changes which will improve and enhance their health and wellbeing both at work and at home.

The Occupational Health department continues to work closely with managers and HR to reduce time lost due to sickness absence. The two key areas that have been addressed are Musculoskeletal Disorder (MSD) issues and reducing stress related absence.

The Occupational Health team now has an OH nurse advisor who is also a Registered Mental Nurse and so is a specialist in the field of assessing and supporting individuals with mental health conditions and also stress related problems. This nurse complements the nurses already in post who can offer Cognitive Behavioural Therapy, and also works alongside the Staff Support Service, who offer the full range of counselling and support therapies.

The Musculoskeletal Disorder team and the Occupational Health team including physiotherapy input have worked closely together to carry out work place assessments along with early intervention treatment.

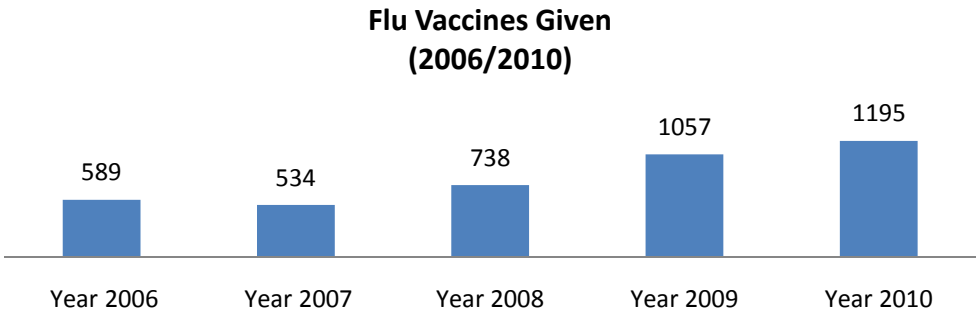
Over the past 12 months there has been a very clear correlation between the number of referrals received within Occupational Health from line managers and the number of staff off sick. For example in December there was a dramatic fall in referrals and a marked increase in sickness absence, compared to January, where there was a high number of OH interventions and a noted fall in sickness absence numbers.

Swine / Seasonal Flu Vaccinations

In 2009 all NHS organisations had to deal with the impact of Swine Flu and prepare and plan for the increase in admissions and staff absences that would arise from as a result of the pandemic. During the 2010 winter flu season, the vaccine that was offered contained both seasonal flu and swine flu vaccine and the OH team ran a very successful programme which ensured that all areas within the Trust were visited by the team and vaccines were given within the work place rather than mainly in the OH department.

This resulted in an extremely high uptake of vaccine by all groups of staff.

CHART – Flu vaccines 2006 – 2010



Health and Safety

Health and Safety performance during 2010/11 has continued to improve during the year as the safety culture from both staff and Managers alike at the GWH matures.

Health and Safety targets were set for 2010/11 around the main hazard areas and improvement levels were monitored via the Trust Health and Safety Committee and reports to the Executive Committee.

Major targeted improvements have included:

- Fire safety management improvements in reducing unwanted fire signals from 37 last year to 35 and also introducing regular practical fire evacuation exercises across 20 Departments in 2010/11. These evacuation exercises included Wards [after patients had been relocated prior to a planned Ward redecoration programme] and also incorporated the introduction of additional Ski Sheet vertical evacuation alternatives

- Year on year reduction in serious RIDDOR reportable accidents. Targeted reduction from previous year [16] was set at 13 for 2010/11 and only 9 incidents have been reported

- Staff Musculo skeletal injury incidents were targeted and an improvement of 20% reduction from previous year was set. The Trust has achieved this reduction in MSD incidents

- Implementation and roll out of managers' Health and Safety Training and also accident / incident investigation training to improve the quality and quantity of reports investigated in order to identify root causes, learn lessons and prevent recurrence.

- Stress Management and Latex Management Working Groups continue to work on reducing potential losses from these areas.

National HPMA Award Winners 2010

Great Western Hospitals NHS Foundation Trust was the winner of the HPMA Excellence Awards 2010 in the NHS Plus category for 'excellence in improving Health and Wellbeing' with our progress on Ergonomic MSD management at the GWH. The Trust's success was announced at an event in London on 17 June 2010 and a team from Medical Records, HSDU and Occupational Health and Safety attended to receive the award presented by Dr Steve Boorman. The judges praised the

Team's 'straightforward and highly effective approach which created an appetite within work groups to take control of their environment and to make real changes for the better'.

GWH was also one of the finalists in the Personnel Today and the Occupational Health Awards during 2010/11 for ergonomics improvements and staff musculoskeletal injury reduction initiatives.

Tackling fraud

The organisation works closely with the internal auditors in escalating issues which could be related to fraud. We also work with them to implement improvements to processes and systems where weaknesses have been identified as a result of internal audits.

Workforce key performance indicators (KPIs)

The Trust has a range of workforce KPI's which measure the performance of the organisation. These are:-

- The upper threshold for sickness absence was set at 4% for 2010/11. At the year end the actual rate of absence was 3.85%, this compares to a year end figure of 4.64% for 2009/10. The improvements are due to the implementation of a new sickness absence policy. As a result the Trust had an additional 7750 days available from its workforce: the equivalent of 21.23 whole time equivalents

- The upper threshold limit was 10% for voluntary turnover. In 2010/11 our voluntary turnover was 8.52%. This is primarily due to the economic climate as vacancies have decreased and individuals are reluctant to take the risk of moving to a new organisation.

- The upper threshold level was 6% for vacancy levels; and the year end figure was 1.29%. The number of vacancies has reduced considerably due in part to active recruitment campaigns and the careful management of internal resources to ensure that any restructuring has not resulted in redundancies

There were areas of concern and hence no requirement for action plans relating to the workforce KPIs.

Provision of information and involvement of employees

The Trust has a strong working relationship with the Employment Partnership Forum (EPF) which is the formal negotiating mechanism at GWH. Meetings between the Trust and the EPF take place on a monthly basis to discuss strategy, operational performance, service developments and patient and staff feedback. Members of the EPF have been involved in developing action plans as a result of staff survey results and in reviewing the Trust's policy framework as well as individual workforce policies.

Please note that the Trust has disclosed information on the above as required under the Companies Act that is relevant to its operations.

10
Regulatory ratings report

Performance Assurance

Monitor the Independent Regulator

As a Foundation Trust, GWH is regulated by Monitor, the independent regulator of all NHS Foundation Trusts. Monitor's relationship with GWH is to ensure that the Trust does not breach the terms of authorisation which were agreed when GWH became a Foundation Trust in December 2008. The Terms of Authorisation are a set of detailed requirements covering how GWH will operate – in summary they include:

- the general requirement to operate effectively, efficiently and economically;
- requirements to meet healthcare targets and national standards; and
- the requirement to cooperate with other NHS organisations.

Monitor requires each Foundation Trust board to submit an annual plan, quarterly and ad hoc reports. Performance is monitored against these plans to identify where potential and actual problems might arise. Monitor publishes quarterly and annual reports on these submissions and assigns each Foundation Trust with an annual and quarterly risk rating. These risk ratings are designed to indicate the risk of a failure to comply with the terms of authorisation. Monitor publishes three risk ratings for each NHS Foundation Trust as follows: -

- financial rating; and
- governance risk rating.

Risk ratings from Monitor

Risk rating definition: -

- Red - Likely or actual significant breach of terms of authorisation
- Amber-red - Breach of terms of authorisation
- Amber-green - Limited concerns surrounding terms of authorisation
- Green - No material concerns

Financial risk rating

Finance (rated 1-5, where 1 represents the highest risk and 5 the lowest)

The Trust has been rated as 3 for Finance.

When assessing financial risk, Monitor will assign quarterly and annual risk ratings using a system which looks at four criteria:

- achievement of plan;
- underlying performance;
- financial efficiency; and
- liquidity.

The risk rating is forward-looking and is intended to reflect the likelihood of an actual or potential financial breach of the Foundation Trust's terms of authorisation.

Governance risk rating

Governance (rated red, amber, green)

The Trust has a rating of green for Governance.

The term governance is used to describe the effectiveness of an NHS Foundation Trust's leadership. A green rating means there are no material concerns about any aspects of governance.

The following areas are considered when assessing the annual and quarterly governance risk ratings which Monitor publish for each trust:

- **Legality of constitution -** NHS Foundation Trust constitutions are legal documents that describe how each is governed;
- **Growing a representative membership -** NHS Foundation Trusts are accountable to their local communities and must have plans in place to develop and grow a representative membership. The Membership Strategy, overseen by the Membership Working Group of the Council of Governors, monitors the membership growth;
- **Appropriate board roles and structures -** NHS Foundation Trusts require appropriate board roles and an appropriate governance structure to be effective;
- **Co-operation with NHS bodies and local authorities -** NHS Foundation Trusts have a duty as part of their terms of authorisation to co-operate with a range of NHS bodies and with local authorities;
- **Clinical quality -** Boards must be satisfied, and certify to Monitor, that their NHS Foundation Trust has effective measures and arrangements in place to monitor and continually improve the quality of healthcare it provides. Quality reporting is referred to elsewhere in this report *(pages 90 – 169 refers)* and separate quality accounts are published.
- **Service performance (healthcare targets and standards)** - Boards have to confirm to Monitor that plans are in place to ensure that priority targets and standards will be met continually; and
- **Other risk management processes -** Boards must address and resolve any risks that have been identified. If issues are outstanding, the Board must demonstrate to Monitor that robust plans are in place to address them.

Further details about the risk ratings issues by Monitor can be found on their website at: www.monitor-nhsft.gov.uk

Regulatory Report Ratings

	Annual Plan 2009-10	Q1 2009-10	Q2 2009-10	Q3 2009-10	Q4 2009-10
Financial Risk Rating	4	4	4	4	3.8
Governance Risk rating	Green	Green	Green	Green	Green

	Annual Plan 2010-11	Q1 2010-11	Q2 2010-11	Q3 2010-11	Q4 2010-11
Financial Risk Rating	4	3	3	3	3
Governance Risk rating	Green	Green	Green	Green	Green

Mandatory services

Mandatory services are defined in a Foundation Trust's terms of authorisation and are the services the Trust is contracted to supply to its commissioners.

Trust Boards are required to provide a board statement certifying that they expect to be able to continue to provide the mandatory services required by Schedules 2 and 3 of their Authorisation and then by exception to declare in year if this risks not being the case. During 2010/11 not such declarations were made.

Other

The Care Quality Commission (CQC – formerly the Healthcare Commission)

Whereas Monitor's role is to assess and regulate the ability of an NHS Foundation Trust board to do their job properly and ensure their hospitals provide high quality care, the Care Quality Commission (CQC) is the independent regulator responsible for regulating the quality of health and adult social care services in England.

Up until 2008/09, as part of the Annual Health Check carried out by the Care Quality Commission, all NHS organisations were required to comply with 24 Core Standards which made up the Standards for Better Health Declaration. As part of this declaration the Board of Directors was required to make a statement of compliance with the Hygiene Code. These standards covered the full range of healthcare services and provided the general public with information on the quality of services by the Trust.

Since 2009/2010 a new system of 'periodic review' by the CQC has replaced the Annual Health Check Rating. A key component of the periodic review is the registration process which all healthcare providers are required to go through. The GWH FT registered as a healthcare provider with the CQC in April 2010 and was registered as fully compliant with no requirements.

A periodic review of compliance with the CQC regulations will be completed at the GWH FT by the CQC before 31 March 2012.

Care Quality Commission (CQC) registration

From April 2010, the way in which health and adult social care is regulated changed. Health and social care organisations are now required to register with the CQC through a new registration system. This new process is, in effect, a licence for Trusts like GWH to provide services.

To be registered, trusts must meet the standards, which cover important issues for patients such as:

- treating people with respect,
- involving them in decisions about care,
- keeping clinical areas clean, and
- ensuring services are safe.

To register with the CQC the Trust has had to demonstrate that it meets the new essential standards of quality and safety across all services being provided.

For some trusts, the licence granted by the CQC will be conditional on them taking further action to meet the standards. In March 2010 GWH was registered with the CQC without additional conditions attached to the registration.

Care Quality Commission (CQC) registration – planning for the future

The following summary applies to the registration of the enlarged organisation as from 1 June 2011.

As part of the merger with Wiltshire Community Health Services (WCHS), the Trust was required to apply to the Care Quality Commission (CQC) to alter the conditions of its existing registration as from 1 June 2011. The CQC required 120 days notice of any variance to an organisation's registration.

The Trust has applied to be registered as the provider of an additional regulated activity, namely nursing care, which is carried out at two locations within WCHS. The cost of this variance is a one-off flat fee of £5,000 which was payable on application.

The Trust has also applied to the CQC to vary its registration in relation to locations at which the regulated activities will be carried out from June 2011. In total the Trust has submitted to register 21 sites, (20 additional sites). This has involved declaring the level of compliance in relation to all the CQC essential standards of quality and safety and details relating to the security of records and premises, any other business carried out and compliance with the Disability Discrimination Act 2005 in relation to access. These locations were previously registered with the CQC by WCHS.

All the applications required an updated version of the Trust's Statement of Purpose, detailing all services and locations that will be part of the enlarged organisation post 1 June 2011. Once finalised, this will be accessible on the Trust's website.

11
Other disclosures in public interest

Serious incidents involving data loss or confidentiality breach

During 2010/11 there were no serious incidents involving data loss or confidentiality breach classified at a severity rating of 3-5. Accordingly, no incidents were required to be reported to the Information Commissioner's Office.

Three incidents of severity rating 1-2 are aggregated and reported below in the specified format:

Summary of other personal data related incidents in 2010-11		
Category	**Nature of incident**	**Total**
I	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	0
II	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	1
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	1
IV	Unauthorised disclosure	1
V	Other	0

Severity rating 1 is a minor breach of confidentiality affecting only a single individual.
Severity rating 2 is a potentially serious breach but which affects fewer than five people or which has been assessed as a low risk.

Working with suppliers

The Great Western Hospitals NHS Foundation Trust works with a large number of suppliers across a very diverse portfolio. Our aim is to work in partnership with our suppliers and to build strong relationships that enable us to obtain best value for money when purchasing the quality of goods and services the Trust needs to support patient care.

The Trust is also developing its E-Procurement tools which will enhance transparency of our contracting processes, give visibility of the contracts the Trust is tendering for, make it easier for suppliers to engage with us and reduce the paperwork suppliers have to complete during formal tendering processes.

12
Statement of accounting officer's responsibilities

Statement of the Chief Executive's responsibilities as the accounting officer of Great Western Hospitals NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the NHS Act 2006, Monitor has directed the Great Western Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Great Western Hospitals NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the *NHS Foundation Trust Annual Reporting Manual* and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements; and
- prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's NHS Foundation Trust Accounting Officer Memorandum.

Signed……..

Lyn Hill-Tout
Chief Executive 6 June 2011

13
Auditor's opinion and certificate

Independent auditor's report to the Council of Governors of Great Western Hospitals NHS Foundation Trust

We have audited the financial statements of Great Western Hospitals NHS Foundation Trust for the year ended 31 March 2011 on pages 1 to 35. These financial statements have been prepared under applicable law and the accounting policies set out in the Statement of Accounting Policies.

This report is made solely to the Council of Governors of Great Western Hospitals NHS Foundation Trust in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of the accounting officer and the auditor

As described more fully in the Statement of Accounting Officer's Responsibilities within the annual report the accounting officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practice's Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed, the reasonableness of significant accounting estimates made by the accounting officer and the overall presentation of the financial statements. In addition we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of Great Western Hospitals NHS Foundation Trust's affairs as at 31 March 2011 and of its income and expenditure for the year then ended; and

- have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual.

Opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts

In our opinion the information given in the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

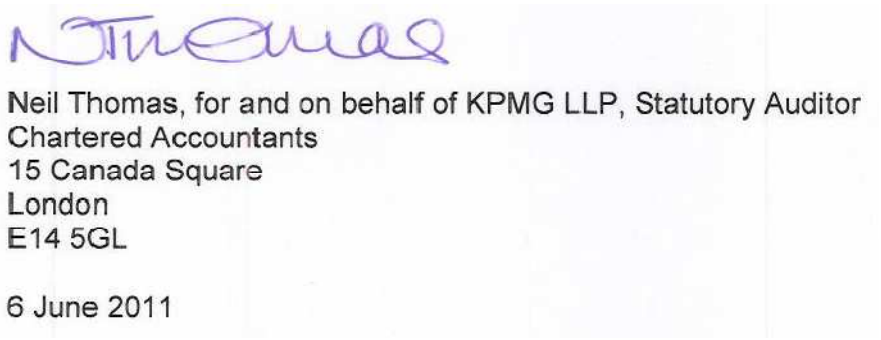
Matters on which we are required to report by exception

We have nothing to report where under the Audit Code for NHS Foundation Trusts we are required to report to you if, in our opinion, the Statement on Internal Control does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

We are not required to assess, nor have we assessed, whether all risks and controls have been addressed by the Statement on Internal Control or that risks are satisfactorily addressed by internal controls.

Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.



Neil Thomas, for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
15 Canada Square
London
E14 5GL

6 June 2011

Note: *pages 1 to 35 referred to in this letter are set out at pages 202 to 236 in this document*

14
Statement of Internal Control

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Great Western Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised, and the impact should they be realised and to manage them efficiently, effectively and economically. The system of internal control has been in place in Great Western Hospitals NHS Foundation Trust for the year ended 31 March 2011 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Leadership is given to the risk management process by embedding responsibility within the executive director's job description and annual appraisal and personal development plans.

Staff education and training on risk management is carried out commensurate with their roles. All new employees receive corporate induction, which includes risk management and incident reporting, alongside health and safety, manual handling and infection control training appropriate to their duties. Learning from incidents and sharing good practice is encouraged within directorates by means of risk assessment, incident reporting and serious incident investigation, the learning from which is disseminated through the Trust via the Clinical Governance and Risk Committee and latterly the Patient Safety and Quality Committee.

The Trust operates a Being Open policy and has mechanisms in place to promote a culture which encourages staff to come forward with concerns.

The risk and control framework

The overall objective of the Risk Management Strategy is to ensure that robust risk management processes are in place which provide assurance to the Board that the Trust is discharging its responsibilities as an NHS Foundation Trust in ensuring business and financial acumen, improving services and the quality of care provision, whilst operating as a model employer and service provider in achieving the Trust's operational and strategic objectives.

To ensure that risk is identified, evaluated and controlled there are formal structures within the Trust. Whilst the Board has overall responsibility, it has delegated the work to the Executive Committee and the Audit, Risk and Assurance Committee.

The Trust operates an assurance framework, corporate risk register and directorate and specific area risk registers to support the management of risk across the organisation.

The assurance framework is set by the Executive Committee and approved by the Trust Board annually. The assurance framework sets out

- the principal objectives to achieving the Trust's overall goals,
- the principal risks to achieving those objectives,
- the key controls to mitigate against those risks, and
- the assurances on those controls.

Each directorate and specific areas have a risk register which record the high level risks identified within the directorate based on systematic risk assessment and scoring. The directorate and other area risk registers are further divided into distinct registers for different service areas and departments. The departments are supported in the identification and management of risk by clinical risk and health and safety teams. The corporate risk register is informed both by those risks identified against Trust objectives in the assurance framework (top down) and risks identified within the directorates (bottom up).

During 2010/11 an overview of the assurance framework was undertaken on a monthly basis to check that the risks remained relevant and that control mechanisms remained adequate. In future this will take place on a quarterly basis. The Executive Committee determines if the arrangements in place to achieve the organisation's objectives and manage risks are effective and operating as intended. The Executive Committee scrutinises and challenges the design of the key controls and evaluates the assurance across all areas of principal risk. Positive assurances are identified along with any gaps in controls and / or assurances. Plans to take corrective action where gaps have been identified are put in place for principal risks. The Executive Committee scrutinises the assurance framework to ensure it is effective.

In addition each month the Executive Committee scrutinises and challenges the Corporate Risk Register. In the future on a rotational basis the directorate and specific area risk registers, will also be scrutinised and challenged by the Executive Committee so that it can be assured that the risks identified are being managed effectively by the respective directorate committees. The Executive Committee ensures that well founded risk registers are in place and that action to mitigate risk is being implemented and reviewed. There are directorate and specific area committees which are responsible for scrutinising and challenging their own risks at each of their monthly meetings. Any risks with a rating above 10 are added to the Corporate Risk Register.

The Executive Committee reports to the Audit, Risk and Assurance Committee which in turn provide assurances to the Trust Board. The Audit, Risk and Assurance Committee scrutinises and challenges the risk management process.

An internal audit of the risk management and assurance framework was undertaken in February 2011. The overall opinion was green and the Trust took substantial assurance that the controls upon which the Trust relies to manage this area are suitably designed, consistently applied and effective. However, recommendations in the report addressed application of the control framework. This prompted a review of the reporting process which has now been formalised and which will be fed into the risk management strategy currently being reviewed.

In January 2011 the committee structure was strengthened with the new Audit, Risk and Assurance Committee combining the existing Audit and Integrated Governance and Risk Committees responsibility for risk management. The Executive Committee has operational responsibility for the assurance framework and the risk registers.

There are a number of risks identified in the assurance framework. Three examples of significant risks identified during 2010/11, together with the actions that have been taken to mitigate them as summarised as follows: -

Risk	**Actions to mitigate**
Higher than average (hospital standardised mortality ratio (HSMR) reputation harm	• Monthly review and action of Dr Foster 'red bells' at Patient Safety and Quality Committee • Mortality group set up to review all deaths in the Trust • Monthly reporting of HSMR data to Trust
Potential for quality of care to be compromised during transitional phase of transfer of Wiltshire Health Care Services (WCHS)	• Project transition team set up • Transition Director of Community Services appointed • Risk log created with two-weekly reporting to the Project Oversight Group
Non-payment for over performance/commissioner's financial position	• Risk framework agreed as part of 2010/11 contract • Monthly contractual statements provided to PCT in line with contract • Agreement for part-payment of debt secured

No significant gaps in controls or assurances were identified during 2010/11.

New risks for 2011/12 will be identified through the annual plan process and will be added to the Assurance Framework. Major future risks, including significant clinical risks for 2011/12 have been identified as follows (note more detail is given in the key regulatory risks table in the quality report referred to elsewhere in this document *(pages 163 – 164 refer)*): -

Risk	**Actions to manage and mitigate, including how outcomes will be assessed**
Inadequate assurance framework and risk registers and lack of resources to support a robust process	Review of risk management strategy and assurance framework - Strategy in place 2012. Harmonised assurance framework in place 2012. Annual reviews of effectiveness.
Non compliance with authorisation and constitutional documents	Programme of ongoing review of constitutional documents established. Systems and processes to support compliance set up and compliance monitored - Review implementation against agreed

Risk	Actions to manage and mitigate, including how outcomes will be assessed
	timetable. Clear decision making structures in place. Evidence of compliance maintained. Achievement of levels of compliance through Monitor at quarterly and Annual reporting points.
Failure to achieve compliance with new NHSLA Level 2 Acute Standards	Options appraisal, action plan, gap analysis against standards, decision regarding level of assessment - Action plan in place 2011; review against action plan.
Health and Safety	High reporting levels with HSE. Strong internal focus on H&S and scrutiny by Board. Staff mandatory training - Pass any unscheduled inspections through the life of the plan. Take on board and implement learning from any spot inspections during the timeframe to enhance practice.
Activity above proposed contract levels	External review of contract levels and deliverability of QIPP will enable development of Risk Framework and will support application of similar solution in the future. The review will also provide an external risk assessment of the existing plans and identification of shortfall, this will enable encourage identification of additional schemes to cover the shortfall. Joint working with PCTs through community change programme, with monthly monitoring GWH action plan, reporting through programme board to monitor progress against PCT aspirations (inclusive of the income risk) in addition to activity reductions within agreed schedule of QIPP/clinical productivities. Identification of alternative income sources to offset the risk, this includes; • increasing private patient (PP) income to cap limit for enlarged organisation. additional repatriation of activity in 2012/13 and 2013/14

These risks will be actively managed through the assurance framework and corporate risk register throughout the year by putting control measures and taking assurances of the effectiveness of those control measures. A nominated executive director will be made accountable for each risk.

A robust Incident Management Policy is in place and staff are actively encouraged to utilise our web-based incident reporting system at Corporate Induction. A healthy incident reporting culture has been maintained in the Trust for a number of years providing assurance that staff feel able to report incidents and risks. A Being Open policy, based on National Patient Safety Agency guidance, is in place and regularly reviewed.

The Trust was fully compliant with the Care Quality Commission Regulations throughout 2010/11.

During the 2010/11 financial year, the Trust remained at level 2 for the National Health Service Litigation Authority (NHSLA) Risk Management Standards for Acute Trusts and level 3 for Clinical Negligence Scheme for Trusts (CNST) Risk Management Standards for maternity.

As a foundation trust our membership is a resource for supporting risk management in the Trust. The membership is represented by governors who attend regular formal meetings with the Board of Directors and Trust staff. In particular the governors hold the Trust to account via various working groups, notably the Patient Experience Working Group which meets quarterly. The governors also contributed to the development of the Trust's quality strategy through a patient safety, quality and satisfaction working group. The strategy was developed in 2009/10 and is for five years ending in 2015.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme are complied with. This includes ensuring that deductions from salary, employer's contributions and payments in to the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The foundation trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Information Risk

Risks to information, including data confidentiality, integrity and availability, are being managed and controlled. A system of monitoring and reporting on data security risks is established under delegated authority of the Trust Board through the Information Governance Steering Group, which reports into the Board's Audit, Risk and Assurance Committee. The Trust Board has a Senior Information Risk Owner (SIRO) with responsibility for information risk policy, who chairs the Steering Group.

The Information Risk Policy defines an overall structured approach to the management of information risk, in line with the Risk Management Strategy. A register of Information Assets is maintained. The business ownership of those assets is the responsibility of senior managers within the Trust, supported by staff with responsibility for operational management of the assets. These 'owners' and 'administrators' ensure that the principal risks are identified, assessed and regularly reviewed, and they provide annual assurance reports of the satisfactory operation and security of the information assets.

Where assessed as appropriate, risk treatment plans are actioned, additional controls are implemented, and prioritised risks are escalated to the relevant Risk Register. As Accounting Officer I am committed to ensuring that immediate actions are taken where significant risks have been highlighted.

A range of measures is used to manage and mitigate information risks, including: staff training, privacy impact assessments, physical security, data encryption, access controls, penetration testing,

audit trail monitoring and spot checks. In addition, a comprehensive assessment of information security is undertaken annually as part of the Information Governance Toolkit and further assurance is provided from Internal Audit and other reviews.

The effectiveness of these measures is reported to the Information Governance Steering Group. This includes details of any personal-data-related Serious Incidents (SIs), the Trust's annual Information Governance Toolkit score, and reports of other information governance incidents, audit reviews and spot checks.

Annual quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The Annual Quality Account Report 2010/11 provides a narrative of progress toward achieving the quality improvement indicators agreed by the Executive Committee, the Patient Safety and Quality Committee and Trust Board.

The Quality Account is compiled by our Clinical Governance Administrator following both internal and external consultation to inform the improvement indicators. Data is provided by nominated leads in the Trust. These leads are responsible for scrutinising the data they provide to ensure accuracy. Once compiled the Quality Account Report is scrutinised by the Associated Director of Quality and Patient Safety for challenging the veracity of data. The Medical Director is ultimately accountable to Trust Board and its sub-committees for the accuracy of the Quality Account Report.

The Quality Account is subject to robust challenge at the Patient Safety and Quality Committee on both substantive issues and also on data quality. Where variance against targets is identified the leads for individual metrics are held to account by the Patient Safety and Quality Committee. Following scrutiny at that committee, the Quality Account is reported to Trust Board which is required to both attest to the accuracy of the data and also ensure that improvements against the targets are maintained.

Directors' responsibilities for the Quality Account Report are outlined separately in this report.

The Quality Account Report has been prepared in accordance with Monitor's annual reporting guidance as well as the standards to support data quality for the preparation of the Quality Report. No material weaknesses in the control framework associated with Quality Accounts have been identified.

Review of economy, efficiency and effectiveness of the use of resources

The Trust has robust arrangements in place for setting objectives and targets on a strategic and annual basis. These arrangements include ensuring Great Western Hospitals NHS Foundation Trust strategy is affordable, scrutiny of cost savings plans to ensure achievement (whilst maintaining and improving quality and safety), compliance with terms of authorisation and coordination of individual objectives with corporate objectives as identified in the Annual Plan 2010/11.

Performance against objectives is monitored and actions identified through a number of channels:

- Approval of annual budgets by the Board of Directors;
- Regular reporting to the Board on key performance indicators including finance, activity, patient safety and human resources targets;
- Monthly review of financial targets and contract performance by the Finance and Investment Committee, which is a committee of the Board;
- Monthly reporting to the Management Committee on directorate and Trust performance; and
- Quarterly reporting to Monitor, via the Finance and Investment Committee and compliance with the terms of authorisation.

The Trust also participates in initiatives to ensure value of money, for example:

- Use of the Institute of Innovation and Improvement data and subscribes to the Foundation Trust Network benchmarking data to ensure productivity;
- Achieving Level 2 in the NHS Litigation Authority's Risk Management Standards for Acute Trusts and Level 3 in maternity standards;
- Quarterly reporting to Monitor, via the Finance and Investment Committee and compliance with terms of authorisation.

Value for money is an important component of the internal and external audit plans that provides assurance to the Trust of processes that are in place to ensure effective use of resources.

The Trust has an assessment process for future annual plans to ensure value for money and full appraisal processes are employed when considering the effect on the organisation. Procedures are in place to ensure all strategic decisions are considered at Executive and Board level.

The emphasis in Internal Audit work is providing assurances on internal controls, risk management and governance systems to the Audit, Risk and Assurance Committee and to the Board.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, and the executive managers within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board and the Audit, Risk and Assurance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The processes that have been applied in maintaining and reviewing the effectiveness of the system of internal control include the following: -

Process	**Role and Conclusions**
Board	- The Board has continued to lead the organisation throughout the year with regular reporting on finance and clinical performance, It receives and reviews minutes of sub-committees, with concerns and issues escalated by the Committee Chairs. The Board reviewed and updated the Governance Structure, and approved new terms of references to ensure that the Trust's system of internal control reflects the current needs of the organisation. In addition to the Board reviewing effectiveness, each Executive Director was required to undertake a review of the system of internal control within their directorate for 2010/1. As part of that review, each Executive Director provided assurances that: • an effective system of internal control was in place covering all aspects of the activity/function for which they are responsible; • the system of control has operated effectively during the full year to 31 March 2011; • that there were no matters of which they were aware of that may constitute a material weakness in the system of internal control; and • appropriate documentary evidence of the review process, and its results, were available on request. No material weaknesses to the Trust's system of Internal Control were identified as part of the review. Those declarations support the Chief Executive to sign the Statement of Internal Control.
Audit, Risk and Assurance Committee	- The Committee provides scrutiny of internal controls, including the review the Assurance Framework, Corporate Risk
Internal audits	- On the effectiveness of the systems of internal control. Audit findings are presented to the Audit, Risk and Assurance Committee and the Board through the Audit, Risk and Assurance Committee minutes.
Clinical audits	- The Trust Board is meticulous in keeping Clinical Audit as the key component of clinical governance in its efforts to promote patient safety, patient experience and to promote effectiveness of care delivered to the patients. The Trust is compliant with the Trust Clinical Audit plan. The NICE lead is responsible for actively disseminating and monitoring NICE compliance. Trust wide compliance of 96-100% has been attained throughout this year.

Other Committees	-	All committees have a clear timetable of meetings and a clear reporting structure to allow issues to be raised.
Assurance framework	-	Provides me with assurance that the effectiveness of the controls to manage the risks to the organisation in achieving its principal objectives has been reviewed.
Self-assessment declaration against CQC standards	-	The Trust has self assessed compliance with the CQC regulations. The Trust advises full compliance with the CQC regulations for which is it registered.
		External NHSLA Risk Management Standards (Acute) – level 2.
		External CNST Risk Management Standards (Maternity) – level 3.
Director declaration		Signed statements on internal control from each Executive Director which identify material weaknesses.
Quarterly reporting to Monitor		

The Trust will continue to review all risks and where necessary will take approach actions to either reduce or eliminate these. Actions taken will be monitored through the appropriate sub-committee of the Board, and where necessary the Chair of the sub-committee will escalate concerns to Board.

Conclusion

I have not identified any material weaknesses in our systems for internal control as part of my review. My review confirms that Great Western Hospitals NHS Foundation Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives.

Signed……...

Lyn Hill-Tout
Chief Executive 6 June 2011

15
Foreword to the accounts

Foreword to the accounts for the year ending 31 March 2011

These accounts for the period ended 31st March 2011 have been prepared by Great Western Hospitals NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006 in the form that Monitor, the Independent Regulator of NHS Foundation Trusts, with the approval of the Treasury, has directed.

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2011

	Notes	Year Ended 31 March 2011 £000	Year end 31 March 2010 £000
Operating Income from continued operations	3 - 4	**202,741**	200,882
Operating Expenses of continued operations	5	**(187,617)**	(192,344)
Operating surplus		**15,124**	8,538
Finance Costs			
Finance income	10	**217**	151
Finance expense - financial liabilities	11	**(14,102)**	(13,867)
Finance expense - unwinding of discount on provisions		**(49)**	(41)
PDC Dividends payable		**(1,190)**	(1,598)
Net finance costs		**(15,124)**	(15,355)
SURPLUS/(DEFICIT) FOR THE YEAR		**0**	(6,817)
Other comprehensive income			
Revaluation gains / (impairment losses) on property, plant & equipment	14.4	**0**	(23,758)
Reduction in the donated asset reserve in respect of depreciation		**(247)**	(247)
Total comprehensive expense for the year		**(247)**	(30,822)
Note:			
Deficit for the year		0	(6,817)
Add back net impairment loss charged to Operating Expenses		0	7,958
Surplus prior to the technical accounting adjustment		0	1,141

All income and expenditure is derived from continuing operations.

Great Western Hospitals NHS Foundation Trust
Accounts for the year ended 31 March 2011

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2011

	Notes	31 March 2011 £000	31 March 2010 £000
Non-Current Assets			
Intangible assets	13	**1,171**	613
Property, Plant and Equipment	14	**183,017**	182,725
Trade and other receivables	17	**0**	1,733
Total non-current assets		**184,188**	185,071
Current Assets			
Inventories	16	**3,820**	3,156
Trade and other receivables	17	**8,337**	11,094
Cash and cash equivalents	19	**11,223**	12,181
Total current assets		**23,380**	26,431
Current Liabilities			
Trade and Other Payables	21	**(17,920)**	(17,090)
Borrowings	23.2	**(1,425)**	(3,004)
Provisions	24	**(350)**	(1,424)
Tax Payable	22.1	**(2,056)**	(2,012)
Other liabilities	22	**(1,016)**	(1,491)
Total current liabilities		**(22,766)**	**(25,020)**
Total assets less current liabilities		**184,801**	186,482
Non-Current Liabilities			
Trade and Other Payables	21	**0**	(593)
Borrowings	23.2	**(132,036)**	(133,118)
Provisions	24	**(4,495)**	(4,142)
Other Liabilities	22	**(1,930)**	(2,044)
Total non-current liabilities		**(138,461)**	(139,895)
Total assets employed		**46,340**	46,586
Financed by Taxpayers' Equity			
Public dividend capital		**27,111**	27,111
Revaluation reserve		**18,551**	18,551
Donated asset reserve		**649**	895
Other reserves		**264**	264
Income and expenditure reserve		**(235)**	(235)
Total taxpayers' equity		**46,340**	46,586

Signed..... Date.....6/6/2011

L Hill-Tout
Chief Executive
The notes on pages 5 to 35 form part of the financial statements

Great Western Hospitals NHS Foundation Trust
Accounts for the year ended 31 March 2011

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	Public Dividend Capital	Revaluation Reserve - Tangible assets	Donated Asset Reserve	Other Reserves	Income and Expenditure Reserve	**Total**
	£000	£000	£000	£000	£000	**£000**
Tax Payers Equity at 1 April 2010	27,111	18,551	895	264	(235)	**46,586**
Surplus/(deficit) for the year	0	0	0	0	0	**0**
Transfers in respect of assets disposed of	0	0	0	0	0	**0**
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of on donated assets	0	0	0	0	0	**0**
Receipt of donated assets	0	0	0	0	0	**0**
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of on donated assets	0	0	(246)	0	0	**(246)**
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve	0	0	0	0	0	**0**
Public Dividend Capital received/paid	0	0	0	0	0	**0**
Additions/(reduction) in Other reserves	0	0	0	0	0	**0**
Taxpayers' Equity at 31 March 2011	**27,111**	**18,551**	**649**	**264**	**(235)**	**46,340**
Taxpayers' Equity at 1 April 2009	**27,111**	**42,309**	**1,142**	264	6,582	**77,409**
Surplus/(deficit) for the year	0	0	0	0	(6,817)	**(6,817)**
Transfers in respect of assets disposed of	0	0	0	0	0	**0**
Revaluation gains/(losses) and impairment losses property, plant and equipment	0	(23,758)	0	0	0	**(23,758)**
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of on donated assets	0	0	(247)	0	0	**(247)**
Receipt of donated assets	0	0	0	0	0	**0**
Transfers in respect of depreciation, impairment and disposal of donated assets	0	0	0	0	0	**0**
Public Dividend Capital received	0	0	0	0	0	**0**
Additions/(reduction) in Other reserves	0	0	0	0	0	**0**
Taxpayers' Equity at 31 March 2010	**27,111**	**18,551**	**895**	**264**	**(235)**	**46,586**

Note: The revaluation loss recognised above relates to the revaluation of property in 2009-10 to the amount held against these assets within the revaluation reserve, the net of this adjustment was recognised through operating expenses as detailed on page 1 of these accounts

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2011

	Notes	Year Ended 31 March 2011 £000	Year Ended 31 March 2010 £000
Cash flows from operating activities			
Operating surplus/(deficit) from continuing operations		**15,124**	8,538
Depreciation and amortisation		**7,536**	7,809
Impairment of tangible assets		**0**	7,958
Transfer from donated asset reserve		**(247)**	(247)
Amortisation of PFI credit		**0**	(114)
Increase in inventories		**(664)**	(622)
Decrease in trade and other receivables		**4,491**	(3,235)
Increase in trade and other payables		**237**	(2,032)
Decrease in other liabilities		**(589)**	(877)
Decrease in provisions		**(721)**	(592)
NET CASH GENERATED FROM/(USED IN) OPERATIONS		**25,167**	16,586
Cash flows from investing activities			
Interest received		**87**	189
Purchase of Property, Plant and Equipment		**(8,452)**	(5,735)
Receipts from sale of property, plant and equipment		**0**	0
Payments to acquire intangible assets		**0**	0
Net cash used in investing activities		**(8,365)**	(5,546)
Cash flows from financing activities			
Public dividend capital received		**0**	0
Public dividend capital repaid		**0**	0
Capital element of finance lease rental payments		**0**	0
Capital element of Private finance Initiative Obligations		**(2,595)**	(3,509)
Interest paid		**(100)**	(105)
Interest element of finance leases		**0**	0
Interest element of Private finance Initiative Obligations		**(14,002)**	(13,851)
PDC dividends paid		**(1,063)**	(1,774)
Other capital receipts		**0**	0
Net cash generated from/(used in) financing activities		**(17,760)**	**(19,239)**
Increase/(decrease) in cash and cash equivalents	19	**(958)**	**(8,199)**
Cash and cash equivalents at 1 April 2010		**12,181**	20,379
Cash and cash equivalents at 31 March 2011	19	**11,223**	**12,181**

ACCOUNTING POLICIES

1 Basis of Preparation

Monitor has directed that the financial statements of NHS Foundation trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the FT ARM 2010/11 issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered in relation to the accounts.

1.1 Accounting Convention

These accounts have been prepared under the historical cost convention, on a going concern basis modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.2 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services.

Income relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay.

Where income is received for a specific activity which is to be delivered in the following financial years, that income is deferred.

1.3 Expenditure on Employee Benefits

1.3.1 Short term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from the employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that the employees are permitted to carry forward leave into the following period.

1.3.2 Pension Costs

NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under direction of Secretary of State, in England and Wales. It is not possible for the NHS Foundation Trust to identify its share of the underlying scheme liabilities. Therefore the scheme is accounted for as a defined contribution scheme.

Employers pensions cost contributions are charged to the operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement regardless of the method of payment.

ACCOUNTING POLICIES (continued)

1.4 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.5 Property, plant and equipment

1.5.1 Recognition

Property, plant and equipment is capitalised if they are capable of being used for a period which exceeds one year and they:

- it is held for use in delivering services or for administrative purposes.
- it is probable that future economic benefits will flow to, or service potential be provided to, the trust.
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- individually have a cost of at least £5,000; or
- form a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial equipping and setting-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.5.2 Measurement

Valuation

All property, plant and equipment are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Land and Property assets are valued every 5 years with a 3 yearly interim valuation also carried out. Annual impairment reviews are carried out in other years. The 3 and 5 yearly interim revaluations are carried out by a professionally qualified valuer in accordance with the Royal Chartered Institute of Surveyors (RICS) Appraisal and Valuation Manual. The valuations are carried out on the basis of a Modern Equivalent Asset as required by HM Treasury. The annual reviews are carried out using the most appropriate information available at the date of the review. A revaluation was carried out on 31 March 2010.

Equipment assets values are reviewed annually internally to determine the remaining life based on past and forcasted consumption of the economic useful life of the asset.

Property used for the Trust's services or for administrative purposes are stated in the Statement of Financial Position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period.

ACCOUNTING POLICIES (continued)

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the Trust and the cost of the item can be determined reliably.

Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been classified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of constructuion and residual interest in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brough into use or reverts to the Trust, respectively.

Leaseholds are depreciated over the primary lease term.

Equipment is depreciated on current cost evenly over the estimated lives of the asset.

	Years
Medical equipment and engineering plant and equipment	5 to 15
Furniture	10
Information technology equipment	5
Transport	6

Revaluation Gains and Losses

Revaluation gains are recognised in the revaluation reserve , except where, and to the extent that, they reverse a revaluation decrease that has been previously recognised in operating expenses, in which case they are recognised in operating income

Revalutation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

ACCOUNTING POLICIES (continued)

Impairments

In accordance with the FT ARM, impairments that are due to a loss of economic benefit or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charges to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'Held for Sale' once all the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales
- the sale must be highly probable i.e.
- management are committed to a plan to sell the asset
- an active programme has begun to find a buyer and complete the sale.
- the asset is being actively marketed at a reasonable price.
- the sale is expected to be completed in within 12 months of the date of classification as 'Held for Sale' and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised whan all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the assets economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.6 Donated assets

Donated fixed assets are capitalised at their current value on receipt, and this value is credited to the donated asset reserve. Donated fixed assets are valued and depreciated as described above for purchased assets. Gains and losses on revaluations are also taken to the donated asset reserve and, each year, an amount equal to the depreciation charge on the asset is released from the donated asset reserve to the income and expenditure account. Similarly any impairment on donated assets charged to the income and expenditure account is matched by a transfer from the donated asset reserve. On sale of donated assets, the net book value is transferred from the donated asset reserve to the Income and Expenditure Reserve.

ACCOUNTING POLICIES (continued)

1.7 Private Finance Initiaitive (PFI) Transactions

PFI Transactions that meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. The underlying assets are recognised as property, plant and equipment at their fair value. An equivalent financial liability is recognised in accordance with IAS 17

The annual contractual payments are apportioned between the repayment of the liability, a finance cost and the charges for services.

The service charge is recognised in operating expenses and the finance cost is charged to the Statement of Comprehensive Income.

1.7.1 Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

1.8 Intangible assets

1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably

ACCOUNTING POLICIES (continued)

1.8.2 Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised

Expenditure on development is capitalised only where all of the following can be demonstrated:

the project is technically feasible to the point of completion and will result in an
- intangible asset for sale or use;
- the trust intends to complete the asset and sell or use it;
- the trust has the ability to sell or use the asset;

how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is used for internal
- use, the usefulness of the asset;

adequate financial, technical and other resources are available to the Trust to complete
- the development and sell or use the asset; and

the Trust can measure reliably the expenses attributable to the asset during
- development

1.8.3 Software

Software which is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of the hardware e.g. application software is capitalised as an intangible asset.

1.8.4 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at fair value. Revaluation gains and losses and impairments are treated in the same maner as for Property, Plant and Equipment.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.8.5 Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. Pharmacy stocks are valued at average cost, other inventories are valued on a first-in first-out basis. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks. Work-in-progress comprises goods and services in intermediate stages of production.

1.10 Financial instruments and financial liabilities

1.10.1 Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

1.10.2 Classification

Financial assets are classified as fair value through income and expenditure, loans and receivables. Financial liabilities are classified fair value through income and expenditure, or as other financial liabilities.

Financial assets and financial liabilities at 'fair value through the income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short term. Derivatives are also categorised as held for trading unless they are designated as hedges. Assets and liabilities in this category are classified as current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains and losses in the income and expenditure account.

1.10.3 Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets. The Trust's loans and receivables comprise current investments, cash and cash equivalents, NHS debtors, accrued income and other debtors.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial assets or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

1.10.4 Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or to intangible assets is not capitalised as part of the cost of those assets.

ACCOUNTING POLICIES (continued)

1.10.5 Impairment of financial assets

At the Statement of Financial Position date, the trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

1.10.6 Accounting for derivative financial instruments

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through income and expenditure. They are held at fair value, with any subsequent movement recognised as gains or losses in the Statement of Comprehensive Income.

1.11 Trade receivables

Trade receivables are recognised and carried at original invoice amount less provision for impairment. A provision for impairment of trade receivables is established when there is objective evidence that the Trust will not be able to collect all amounts due according to the original terms of receivables. The amount of the provision is recognised in the Statement of Comprehensive Income.

1.12 Deferred income

Deferred income represents grant monies and other income received where the expenditure has not occurred in the current financial year. The deferred income is included in current liabilities unless the expenditure, in the opinion of management, will take place more than 12 months after the reporting date, which are classified in non-current liabilities.

1.13 Borrowings

The Trust can borrow within the limits set by Monitor's Prudential Borrowing Code. The Trust's position against its prudential borrowing limit is disclosed in note 23.1 on Page 28. The PFI non-current lease liability counts as part of the Trust's Prudential Borrowing Limit.

1.14 Leases

1.14.1 **Finance Leases**
Where substantially all of the risks and rewards of ownership of a lease asset are borne by the NHS Foundation Trust the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present minimum value of the lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property, plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

1.14.2 **Operating Leases**
Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

1.14.3 **Lease of Land and Buildings**
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

ACCOUNTING POLICIES (continued)

1.15 Provisions

The NHS Foundation Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2% in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 2.9% in real terms.

1.15.1 Clinical Negligence Costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed in note 24 on page 29 but is not recognised in the NHS Foundation Trust's accounts.

1.15.2 Non-Clinical Risk Pooling

The NHS foundation trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity’s control) are not recognised as assets, but are disclosed in note 26 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 26, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity’s control; or

- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

ACCOUNTING POLICIES (continued)

1.17 Public Dividend Capital

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust . HM Treasury has determined that PDC is not an equity financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS Foundation Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets and (ii) net cash balances with the Government Banking Services (GBS), excluding any cash balances held in GBS accounts that relates to a short term working capital facility and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the accounts.

1.18 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.19 Corporation Tax

The NHS Foundation Trust does not have a corporation tax liability for the year 2010/11. Tax may be payable on activities as described below:

- the activity is not related to the provision of core healthcare as defined under Section 14(1) of the HSCA. Private healthcare falls under this legislation and is therefore not taxable

- the activity is commercial in nature and competes with the private sector. In house trading activities are normally ancillary to the core healthcare objectives and are therefore not subject to tax.
- the activity must have annual profits of over £50,000.

1.20 Foreign exchange

The functional and presentational currency of the Trust is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Statement of Comprehensive Income in the period in which they arise.

1.21 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS Foundation Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's Financial Reporting Manual.

ACCOUNTING POLICIES (continued)

1.22 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS Foundation Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However, the note on losses and special payments is compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

1.23 Critical Accounting Estimates and Judgements

International accounting standard IAS1 requires estimates, assumptions and judgements to be continually evaluated and to be based on historical experience and other factors including expectation of future events that are believed to be reasonable under the circumstances. Actual results may differ from these estimates. The purpose of the evaluation is to consider whether there may be a significant risk of causing a material adjustment to the carrying value of assets and liabilities within the next financial year, compared to the carrying value in these accounts. The following significant assumptions and areas of estimation and judgement have been considered in preparing these financial statements.

Value of land, buildings and dwellings £163.241m: This is the most significant estimate in the accounts and is based on the professional judgement of the Trust's independent valuer with extensive knowledge of the physical estate and market factors. The value does not take into account potential future changes in market value which cannot be predicted with any certainty.

Income for an inpatient stay can start to be recognised from the day of admission, but cannot be precisely calculated until after the patient is discharged. For patients occupying a bed at the 2010/11 financial year end, the estimated value of partially completed spells is £0.72m.

Untaken annual leave: salary costs include a £0.521m estimate for the annual leave earned but not taken by employees at 31 March 2011, to the extent that staff are permitted to carry leave forward to the next financial year.

Provisions: Assumptions around the timing of the cashflows relating to provisions are based upon information from the NHS Pensions Agency and expert opinion within the Trust and from external advisers regarding when legal issues may be settled.

1.24 New Accounting Standards

Accounting standards that have been issued but have not yet been adopted

The following accounting standards, amendments and interpretations have been issued by the IASB and IFRIC but are not yet required to be adopted:

Effective for the next financial year ending 31 March 2012:

IFRIC 19 Extinguishing financial liabilities with equity instruments	(effective 1 July 2010)
IFRS 1 (amendment) First time adoption of IFRS - limited exemptions for first	(effective 1 July 2010)
IAS 24 (amendment) Related party transactions - revised definition of a	(effective 1 January 2011)
IFRIC 14 (amendment) IAS 19 The limit on a defined benefit asset, minimum	(effective 1 January 2011)

Efffective for future financial years:

IFRS 9 Financial instruments - replacement of IAS 39	(effective 1 January 2013)

The Trust has considered the above new standards, interpretations and amendments to published standards that are not yet effective and concluded that they are either not relevant to the Trust or that they would not have a significant impact on the Trust's financial statements, apart from some additional disclosures.

The Trust has not early adopted any new accounting standards, amendments or interpretations.

2. Segmental Analysis

The NHS Foundation Trust Board has determined that the Trust operates in one material segment, which is healthcare, and one main geographical segment, which is the United Kingdom. The segmental reporting format reflects the Trust's management and reporting structure.

3. Income from Activities (by Type)

	Year Ended 31 March 2011 £000	Year Ended 31 March 2010 £000
NHS Foundation Trusts	**0**	76
NHS Trusts	**13**	746
Primary Care Trusts	**180,519**	180,073
Private Patients	**3,040**	2,607
Non-NHS: Overseas patients (non-reciprocal)	**74**	75
NHS Injury Cost Recovery scheme	**1,297**	1,124
	184,943	184,701

NHS Injury Cost Recovery scheme income is subject to a provision for impairment of receivables of 9.6% to reflect expected rates of collection. (Rate used at 31/03/2010 was 19.25%)

3.1 Income from Activities (by Class)

	Year Ended 31 March 2011 £000	Year Ended 31 March 2010 £000
Elective income	**41,367**	42,392
Non elective income	**64,218**	65,102
Outpatient income	**36,824**	36,009
A & E income	**7,433**	6,291
Other NHS clinical income	**32,061**	32,300
Private patient income	**3,040**	2,607
	184,943	184,701

With the exception of private patient all of the above income from activities arises from mandatory services as set out in the NHS Foundation Trust's Terms of Authorisation from Monitor.

3.2 Private Patient Income	**Year Ended 31 March 2011 £000**	Base Year 2002/3 £000
Private patient income	**3,040**	1,587
Total patient related income	**184,943**	99,359
Proportion (as percentage)	**1.6%**	1.6%

Please note: The proportion of Private Patient Income to the total patient related income of NHS Foundation Trusts should not exceed its proportion whilst the body was an NHS Trust in 2002/03 (the base year).

4. Other Operating Income	**Year ended 31 March 2011 £000**	Year ended 31 March 2010 £000
Research and Development	**573**	426
Education and Training	**6,512**	7,117
Charitable and other contributions to expenditure	**644**	697
Transfer from donated asset reserve in respect of depreciation on donated assets	**247**	247
Non-patient care services to other bodies	**2,215**	1,884
Other Income	**7,607**	5,885
	17,798	16,256

Analysis of Other Operating Income

Charitable and Other Contributions to Expenditure		
a Macmillan Nurses	108	137
b Prospect Hospice	77	89
c Contributions from suppliers to support staff posts	449	464
d Charitable Funds Recharge	10	7
Total	644	697

Non-patient care services to other bodies		
a Mortuary	27	43
b Renal	289	304
c Sterile Services	663	644
d Drugs provided to other NHS bodies	675	855
e Other Misc amounts	561	38
Total	2,215	1,884

Other Income includes		
a Car Parking	993	1,016
b Estates Recharges	329	85
c Staff Recharges	1,532	1,317
d Property Rentals	1,101	442
e Heart Improvement Programme	1,426	970
f Maternity Amenity beds	108	107
g HCAI allocation	32	81
h Ultrasound Photo Sales	32	31
i IT recharges	47	13
j Catering	25	25
f Other	1,982	1,798
Total	7,607	5,885

Revenue is almost totally from the supply of services. Revenue from the sale of goods is immaterial.

The increases in Estates Recharges and Property Rentals are due to the rental and maintenance charges of Marlborough House to Oxford and Buckinghanshire Mental Health Trust for the provision of CAMHS from 1st April 2010.

5. Operating Expenses

	Year Ended 31 March 2011 £000	Year ended 31 March 2010 £000
Services from Foundation Trusts	**0**	0
Services from other NHS Trusts	**135**	1,737
Services from other NHS bodies	**1,189**	1,746
Purchase of healthcare from non NHS bodies	**72**	47
Employee Expenses - Executive Directors	**711**	717
Employee Expenses - Non-Executive Directors	**127**	148
Employee Expenses - Staff	**118,719**	116,213
Drug Costs	**13,259**	12,389
Supplies and services - clinical	**18,416**	17,324
Supplies and services - general	**1,689**	1,918
Consultancy services	**44**	142
Establishment	**2,173**	2,268
Research and development	**564**	426
Transport	**205**	170
Premises	**5,154**	4,741
Increase / (decrease) in bad debt provision	**(387)**	(2)
Depreciation on property, plant and equipment	**7,386**	7,711
Amortisation on intangible assets	**152**	98
Impairment on property, plant and equipment	**0**	7,958
Audit services	**76**	85
Clinical negligence	**3,842**	3,613
Patient travel	**909**	751
Insurance	**97**	127
Hospitality	**67**	57
Legal Fees	**439**	64
Training courses and conferences	**551**	586
Other Services, e.g. Soft FM	**11,692**	11,182
Losses, ex gratia & special payments	**35**	16
Other	**302**	113
	187,617	192,344

Other Services e.g. Soft FM - Soft FM services include cleaning, catering, portering, housekeeping and estates services

Services from NHS Trusts in 2009-10 included £1.7m for Acute Therapy Services purchased NHS Swindon which was commisioned directly from the Trust from 1st July 2010.

Staff Exit Packages
The Trust has not agreed any staff exit packages in 31 March 2011 (31 March 2010 nil).

Audit Fees
Audit Fees are made up of the following:

	2010-11 £'000	2009-10 £'000
Audit Fees (Stautory Audit)	59	75
Audit Fees (Other Assurance Services)	17	10
Audit Fees (Other Services)	0	0
	76	85

Limitation on auditor's liability

The limitation on the auditor's liability is £1,000,000.

6. Operating leases

6.1 As lessee

	Year Ended 31 March 2011 £000	Year ended 31 March 2010 £000
Minimum lease payments	**251**	256
Contingent rents	**0**	0
	0	0
	251	256

Total future minimum lease payments	**Year Ended 31 March 2011 £000**	Year Ended 31 March 2010 £000
Payable:		
Not later than one year	**231**	441
Between one and five years	**193**	241
After 5 years	**0**	1
Total	**424**	683

7. Employee costs and numbers

7.1 Employee Expenses

	Year Ended 31 March 2011			Year Ended 31 March 2010		
	Total	**Permanently Employed**	**Other incl agency**	Total	Permanently Employed	Other incl agency
	£000	**£000**	**£000**	£000	£000	£000
Salaries and wages	**100,119**	**96,514**	**3,604**	98,576	92,227	6,349
Social security costs	**7,711**	**7,711**	**0**	7,345	7,345	0
Pension costs - defined contribution plans Employers contributions to NHS pensions	**11,600**	**11,600**	**0**	11,009	11,009	0
	119,430	**115,826**	**3,604**	116,930	110,581	6,349

7.2 Average number of employees

	Year Ended 31 March 2011			Year ended 31 March 2010		
	Total	**Permanently Employed**	**Other incl agency**	Total	Permanently Employed	Other incl agency
	Number	**Number**	**Number**	Number	Number	Number
Medical and dental	**454**	**426**	**28**	439	408	31
Administration and estates	**758**	**733**	**25**	716	688	28
Healthcare assistants and other support staff	**596**	**562**	**34**	520	467	53
Nursing, midwifery and health visiting staff	**1,162**	**1,120**	**42**	1,158	1,103	55
Nursing, midwifery and health visiting learners	**2**	**2**	**0**	3	3	0
Scientific, therapeutic and technical staff	**384**	**380**	**4**	402	398	4
	3,356	**3,223**	**133**	3,238	3,067	171

7. Employee costs and numbers (cont.)

7.3 Key Management Compensation

	Year Ended 31 March 2011	Year Ended 31 March 2010
	£000	£000
Salaries and short term benefits	**687**	714
Social Security Costs	**72**	74
Employer contributions to NHSPA	**79**	77
Compensation for loss of office	**0**	0
	838	865

Key management compensation consists entirely of the emoluments of the Board of Directors of the NHS Foundation Trust. Full details of Directors' remuneration and interests are set out in the Directors' Remuneration Report which is a part of the annual report and accounts.

There are currently 6 Directors to whom pension benefits are accruing under defined benefit schemes.

7.4 Management costs

	Year ended 31 March 2011	Year ended 31 March 2010
	£000	£000
Managements Costs	**7,476**	7,482
Income	**202,741**	200,882
Percentage %	**3.69%**	**3.72%**

8. Retirements due to ill-health

During the year to 31 March 2011 there were 4 early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £113,566 (31 March 2010 - £218,064). The cost of these ill-health retirements will be borne by the NHS Pensions Agency.

9. Better Payment Practice Code

9.1 Better Payment Practice Code - measure of compliance

	Year Ended 31 March 2011		Year ended 31 March 2010	
	Number	**£000**	Number	£000
Total trade bills paid in the year	**36,766**	**106,952**	38,915	45,728
Total trade bills paid within target	**34,578**	**103,129**	36,295	42,070
Percentage of trade bills paid within target	**94.05%**	**96.43%**	93.27%	92.00%
Total NHS bills paid in the year	**2,045**	**22,927**	1,722	46,961
Total NHS bills paid within target	**1,518**	**19,952**	1,384	40,559
Percentage of NHS bills paid within target	**74.23%**	**87.02%**	80.37%	86.37%

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

9.2 The Late Payment of Commercial Debts (Interest) Act 1998

The Trust was charged £2,833.79 in the year for late payment of commercial debts (31 March 2010 £25.55).

10. Finance Income	**Year Ended 31 March 2011 £000**	Year Ended 31 March 2010 £000
Interest on loans and receivables	**217**	151
	217	151

11. Finance Expense	**Year Ended 31 March 2011 £000**	Year Ended 31 March 2010 £000
Working Capital Facility Fee	**100**	16
Interest on obligations under PFI	**14,002**	13,851
	14,102	13,867

12. Taxation

The activities of the Trust have not given rise to any corporation tax liability in the year (ended 31 March 2010- £nil).

13. Intangible Assets

13.1 2010/11:	**Computer software - purchased £000**	**Licences and trademarks £000**	**Total £000**
Gross cost at 1 April 2010	186	1,329	1,515
Additions purchased	283	0	283
Additions donated	0	0	426
Reclassifications	426	0	
Gross cost at 31 March 2011	**896**	**1,329**	**2,225**
Amortisation at 1 April 2010	31	872	903
Provided during the year	41	111	152
Amortisation at 31 March 2011	**72**	**983**	**1,055**
Net book value			
Purchased	824	347	1,171
Donated	0	0	0
Total at 31 March 2011	**824**	**347**	**1,171**

Reclassification relates to transfer of assets from tangible assets.

13. Intangible Assets (cont.)

13.2 Prior year 2009/10:

	Computer software - purchased	Licences and trademarks	Total
	£000	£000	£000
Gross cost at 1 April 2009	186	1,329	1,515
Additions purchased	0	0	0
Additions donated	0	0	0
Gross cost at 31 March 2010	**186**	**1,329**	**1,515**
Amortisation at 1 April 2009	29	776	805
Provided during the year	2	96	98
Amortisation at 31 March 2010	**31**	**872**	**903**
Net book value			
Purchased	155	458	613
Donated	0	0	0
Total at 31 March 2010	**155**	**458**	**613**

13.3 Valuation and economic useful lives

The valuation basis is described in note 1.5 to the accounts. There is no active market for the Trust's intangible assets and there is no revaluation reserve.

The economic useful lives of intangible assets are finite and are described in note 1.8 to the accounts.

PFI Intangible Assets are depreciated over the life of the PFI Contract.

14. Property, plant and equipment

14.1 2010/11:	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Gross cost at 1 April 2010	21,049	149,803	5,206	1,837	42,994	58	11,111	2,851	234,909
Additions Purchased	0	3,572	0	3,462	803	0	227	40	8,104
Additions donated	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	(329)	0	(158)	61	(426)
Revaluation gains	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	(12,469)	0	0	0	(12,469)
Gross cost at 31 March 2011	**21,049**	**153,375**	**5,206**	**5,299**	**30,999**	**58**	**11,180**	**2,952**	**230,118**
Depreciation at 1 April 2010	0	12,530	173	0	31,623	58	6,393	1,407	52,184
Provided during the year	0	4,031	135	0	1,857	0	1,082	280	7,386
Impairments	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	(12,469)	0	0	0	(12,469)
Depreciation at 31 March 2011	**0**	**16,561**	**308**	**0**	**21,011**	**58**	**7,475**	**1,687**	**47,101**
Net book value									
- Purchased at 31 March 2011	21,049	136,814	4,898	5,299	9,365	0	3,705	1,239	182,369
- Donated at 31 March 2011	0	0	0	0	623	0	(0)	26	649
Total at 31 March 2011	**21,049**	**136,814**	**4,898**	**5,299**	**9,988**	**0**	**3,704**	**1,265**	**183,017**
Analysis of property, plant and equipment									
Net book value									
- Protected assets at 31 March 2011	21,049	136,814	4,898	0	0	0	0	0	162,761
- Unprotected assets at 31 March 2011	0	0	0	5,299	9,988	0	3,704	1,265	20,256
Total at 31 March 2011	**21,049**	**136,814**	**4,898**	**5,299**	**9,988**	**0**	**3,704**	**1,265**	**183,017**
Asset Financing									
Net book value									
- Owned	21,049	136,814	4,898	5,299	9,988	0	3,704	1,265	183,017
- Finance Leased	0	0	0	0	0	0	0	0	0
Total at 31 March 2011	**21,049**	**136,814**	**4,898**	**5,299**	**9,988**	**0**	**3,704**	**1,265**	**183,017**

Reclassification relates to transfer of assets from tangible assets to intangible assets.

14. Property, plant and equipment

14.2 Prior year 2009/10:	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Gross cost at 1 Dec 2009	23,910	167,402	6,638	575	40,349	58	10,748	2,778	252,458
Additions Purchased	0	1,866	0	1,262	2,645	0	363	73	6,209
Additions donated	0	0	0	0	0	0	0	0	0
Impairments	(2,861)	(19,465)	(1,432)	0	0	0	0	0	(23,758)
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluation gains	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Gross cost at 31 March 2010	**21,049**	**149,803**	**5,206**	**1,837**	**42,994**	**58**	**11,111**	**2,851**	**234,909**
Depreciation at 1 Dec 2009	0	0	0		29,953	58	5,376	1,128	36,515
Provided during the year	0	4,572	173		1,670	0	1,017	279	7,711
Impairments	0	7,958	0	0	0	0	0	0	7,958
Reclassifications	0	0	0		0	0	0	0	0
Revaluation	0	0	0		0	0	0	0	0
Disposals other than by sale	0	0	0		0	0	0	0	0
Depreciation at 31 March 2010	**0**	**12,530**	**173**	**0**	**31,623**	**58**	**6,393**	**1,407**	**52,184**
Net book value									
- Purchased at 31 March 2010	21,049	137,273	5,033	1,837	10,519	0	4,717	1,402	181,830
- Donated at 31 March 2010	0	0	0	(0)	853	0	1	42	895
Total at 31 March 2010	**21,049**	**137,273**	**5,033**	**1,837**	**11,371**	**0**	**4,718**	**1,444**	**182,725**
Analysis of property, plant and equipment									
Net book value									
- Protected assets at 31 March 2010	21,049	137,273	5,033	0	0	0	0	0	163,355
- Unprotected assets at 31 March 2010	0	0	0	1,837	11,371	0	4,718	1,444	19,370
Total at 31 March 2010	**21,049**	**137,273**	**5,033**	**1,837**	**11,371**	**0**	**4,718**	**1,444**	**182,725**
Asset Financing									
Net book value									
- Owned	21,049	137,273	5,033	1,837	11,371	0	4,718	1,444	182,725
- Finance Leased	0	0	0	0		0	0	0	0
Total at 31 March 2010	**21,049**	**137,273**	**5,033**	**1,837**	**11,371**	**0**	**4,718**	**1,444**	**182,725**

14. Property, plant and equipment (cont.)

14.3 Revaluation

The Trust has not revalued land, buildings and dwellings in 2010-11 as there has not been a significant change in asset values. All other assets are valued at depreciated replacement cost with no indexation in year due to the current economic climate.

14.4. Non-current assets held for sale

The Trust has no non-current assets held for sale (31 March 2010 - £nil).

14.5 Impairments of property, plant and equipment	31 March 2011 £000	31 March 2010 £000
Impairment on Land and Buildings relating to MEA valuation	**0**	31,716
	0	31,716

15. Capital commitments

Capital commitments under capital expenditure contracts at the end of the period are £300K (nil as at 31 March 2010), not otherwise included in these financial statements.

16. Inventories

16.1 Inventories	31 March 2011 £000	31 March 2010 £000
Materials	**3,820**	3,156
	3,820	3,156

Inventories carried at fair value less costs to sell where such value is lower than cost are nil (31 March 2010 - £nil).

16.2 Inventories recognised in expenses	31 March 2011 £000	31 March 2010 £000
Inventories recognised as an expense	**33,109**	31,206
Write-down of inventories recognised as an expense	**37**	0
	33,146	31,206

17. Trade and other receivables

17.1 Trade and other receivables

	Current		Non current	
	31 March 2011 £000	31 March 2010 £000	**31 March 2011 £000**	31 March 2010 £000
NHS receivables	**2,926**	6,738	**0**	0
Provision for impaired receivables	**(399)**	(786)	**0**	0
Prepayments	**1,009**	359	**0**	0
Lifecycle prepayment	**0**	0	**0**	1,733
Accrued Income	**2,734**	1,818	**0**	0
Other receivables	**2,016**	2,788	**0**	0
PDC receivable	**49**	176	**0**	0
	8,337	11,094	**0**	1,733

17.2 Provision for impairment of receivables

	31 March 2011 £000	31 March 2010 £000
Balance at 1 April	**786**	788
Increase in provision	**0**	111
Amounts utilised	**0**	(111)
Unused amounts reversed	**(387)**	(2)
Balance at 31 March	**399**	786

17.3 Analysis of Impaired Receivables

	31 March 2011 £'000	31 March 2010 £'000
Ageing of impaired receivables		
Up to three months	**26**	49
In three to six months	**172**	197
Over six months	**192**	540
	390	786
Ageing of non-impaired receivables past their due date		
Up to three months	**1,696**	1,157
In three to six months	**670**	1,201
Over six months	**691**	1,068
	3,057	3,426

19. Cash and cash equivalents	**31 March 2011 £000**	31 March 2010 £000
Balance at 1 April 2010	**12,181**	20,379
Net change in year	**(965)**	(8,198)
Balance at 31 March 2011	**11,216**	12,181
Made up of		
Cash with Government Banking Service	**11,216**	12,181
Commercial banks and cash in hand	**7**	0
Cash and cash equivalents as in statement of financial position	**11,223**	12,181
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**11,223**	12,181

20. Trade and other payables	**Current**		**Non-Current**	
	31 March 2011 £000	31 March 2010 £000	**31 March 2011 £000**	31 March 2010 £000
NHS payables	**2,496**	3,750	**0**	0
Trade payables - capital	**1,857**	3,492	**0**	0
Other trade payables	**1,523**	2,340	**0**	0
Other payables	**2,117**	2,201	**0**	593
Accruals	**4,413**	5,309	**0**	0
Receipts in advance	**5,516**	0	**0**	0
	17,920	17,090	**0**	593

Other payables include pension contributions of £1,453,927 outstanding (31 March 2010: £1,419,853).
Receipts in advance include the invoice for PFI advance payment from NHS Wiltshire and NHS Swindon, Cash received April 2011

21. Other liabilities

	Current		Non-current	
	31 March 2011	31 March 2010	**31 March 2011**	31 March 2010
	£000	£000	**£000**	£000
Deferred income	**1,016**	1,491	**1,930**	2,044
	1,016	1,491	**1,930**	2,044

21.1 Tax Payable

Tax payable of £2,056, 376 (31 March 2010: £2,012,549) consists of employment taxation only (Pay As You Earn and National Insurance contributions), owed to Her Majesty's Revenue and Customs at the period end .

22. Borrowings

22.1 Prudential borrowing limit

	31 March 2011	31 March 2010
	£000	£000
Prudential borrowing limit set by Monitor	**135,700**	137,300
Working capital facility	**14,000**	14,000
Actual borrowing in year - long term	**0**	0
Actual borrowing in year - working capital	**0**	0

	Actual Ratio 2010-11	**PBL Limit 2010-11**	Actual Ratio 2009-10	PBL Limit 2009-10
Minimum dividend cover	**0.86 x**	**1x**	1.65x	1x
Minimum interest cover	**1.07x**	**3x**	1.19x	3x
Minimum debt service cover	**0.88x**	**2x**	0.95x	2x
Maximum debt service to revenue	**8.4%**	**2.5x**	8.6%	2.5x

The NHS Foundation Trust is required to comply and remain within a prudential borrowing limit. This is made up of two elements:

- the maximum cumulative amount of long term borrowing. This is set by reference to the four ratios test set out in Monitor's Prudential Borrowing Code. The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact on the long term borrowing limit.

- the amount of any working capital facility approved by Monitor.

The Trust's variance on the Prudential Borrowing Limit is due to the PFI hospital which means that debt service costs are higher than a non-PFI hospital

Further information on the NHS Foundation Trust Prudential Borrowing Code and Compliance Framework can be found on the website of Monitor, the Independent Regulator of NHS Foundation Trusts.

There has been no necessity to make use of the Trust's Prudential Borrowing Limit or to use its overdraft facility.

22.2 PFI lease obligations

Amounts payable under PFI on SoFP obligations:	**31 March 2011**	31 March 2010
	£000	£000
Gross PFI liabilities	275,673	290,852
Of which liabilities are due		
Within one year	12,579	15,967
Between one and five years	52,152	58,147
After five years	210,942	216,738
Less future finance charges	(142,212)	(154,731)
	133,461	136,122
Net PFI liabilities		
Of which liabilities are due		
Within one year	1,425	3,004
Between one and five years	9,729	15,195
After five years	122,307	117,923
	133,461	136,122
Included in:		
Current borrowings	1,425	3,004
Non-current borrowings	132,036	133,118
	133,461	136,122

22.3 Charges to expenditure

The total charged in the year to expenditure in respect of the service element of On-Statement of Financial Position PFI contracts was £11,162K .

The trust is committed to the following annual charges

	31 March 2011	31 March 2010
	£000	£000
PFI commitments in respect of service element:		
Not later than one year	**11,979**	11,284
Later than one year, not later than five years	**48,247**	47,987
Later than five years	**203,531**	215,780
Total	**263,757**	275,050
PFI commitments PV in respect of service element:		
Not later than one year	**11,387**	10,902
Later than one year, not later than five years	**42,798**	42,571
Later than five years	**131,983**	136,326
Total	**186,168**	189,799

The estimated annual payments in future years are expected to be materially different from those which the Trust is committed to make during the next year as the service payment is increased annually in accordance with the increase in the Retail Price Index(RPI).

23. Provisions

	Current		Non current	
	31 March 2011 £000	31 March 2010 £000	**31 March 2011 £000**	31 March 2010 £000
Pensions relating to other staff	**117**	89	**1,082**	1,242
Legal claims	**0**	285	**0**	0
Other - inc s106 Agreement	**233**	1,060	**3,413**	2,900
	350	1,434	**4,495**	4,142

	Pensions relating to former directors £000	**Pensions relating to other staff £000**	**Legal claims £000**	**Other £000**	**Total £000**
At 1 April 2010	0	1,321	285	3,960	**5,566**
Arising during the year	0	0	0	44	**44**
Used during the year	0	(155)	(285)	(373)	**(813)**
Reversed unused	0	0	0	0	**0**
Unwinding of discount	0	34	0	15	**49**
At 31 March 2011	**0**	**1,199**	**(0)**	**3,646**	**4,845**
Expected timing of cash flows:					
Within one year	0	117	0	233	**350**
Between one and five years	0	403	0	3,013	**3,416**
After five years	0	679	0	400	**1,079**

The are no provisions included under 'legal claims'. (31 March 2010: £285,000). The provisions under other include a s106 Agreement of £2,900,000 (31st March 2010 £2,900,000) and AGW Cardiac Network Redundancy provision £137,000 (31st March 2010: £129,000)

Provisions within the annual accounts of the NHS Litigation Authority at 31 March 2011 include £26,974,277 in respect of clinical negligence liabilities of the Trust (31 March 2010 - £19,394,552).

24. Events after the reporting period

Community services are changing to provide better health outcomes for patients, families and communities and to become more efficient; by providing modern, personalised, and responsive care of a consistently high quality that is accessible to all. Community services also play an important part in changing the way in which the health system works as a whole, to enable truly integrated working between all services, and ensure seamless care with the most effective outcomes. Transforming Community Services (TCS) supports commissioners and providers of community services to effect these changes.

The Department of Health set out a clear requirement for every PCT to make significant decisions about the future governance of their in-house community service providers under the TCS agenda. Both the revised NHS Operating Framework 2010-11 and the White Paper made it clear that this is a vital step towards delivering the Government's vision; where front-line staff are empowered, and where patients have choice and control over their community care and treatment, and are able to choose from 'any willing provider'. The national TCS programme concluded in March 2011.

On 16th May 2011, the Board of Directors approved that the Trust proceed with the proposed transfer of Wiltshire Community Health Services, the provider arm of NHS Wiltshire, plus maternity services for Bath & North East Somerset and parts of Somerset, subject to the resolution of a number of issues around finance and risk transfer. The value of the services planned to transfer is expected to be in the region of £70m, and is planned to take place on 1 June 2011.

In the 2011-12 financial statement the transaction will be accounted for using the merger accounting requirements outlined in the ARM.

25. Contingencies

There are no contingent assets and liabilities for the period ended 31 March 2011.

26. Related party transactions

Great Western Hospitals NHS Foundation Trust is a body incorporated by the issue of a licence of authorisation from Monitor.
The Trust is under the common control of the Board of Directors. During the year none of the Board Members or members of the key management staff or parties related to them, has undertaken any material transactions with the Great Western Hospitals NHS Foundation Trust.

It should be noted that the Trust has a Non- Executive Director, Cllr Kevin Small, who is also a Councillor for Swindon Borough Council with whom the Trust has had material transactions relating mainly to the Section 106 agreement (£2.9m) and our Pooled Budget (£160k)

The Department of Health is regarded as a related party. During 2010/11 the trust has had a significant number of material transactions with other entities for which the Department is regarded as the Parent Department. These entities are listed below.

.	Receivables	Payables	Revenue	Expenditure
	£000	**£000**	**£000**	**£000**
Department of Health	0	0	0	0
NHS South West	60	0	5,982	0
NHS Swindon	875	394	111,335	1,833
NHS Wiltshire	925	5,209	52,562	451
NHS Berkshire	0	0	6,134	0
NHS Bristol	173	0	4,088	100
NHS Gloucester	0	32	6,661	180
NHS Oxford	0	0	2,767	0
NHS Litigation Authority	0	0	0	3,842
NHS Blood and Transplant Agency	0	0	0	1,393
NHS Business Services Authority	0	847	0	7,176
NHS Pension Scheme	0	0	0	11,600
Total	2,033	6,482	189,529	26,575

The NHS Foundation Trust has also received revenue payments from a number of charitable funds, certain of the Trustees for which are also members of the Trust Board. The audited accounts of these Funds held on Trust are not included in this annual report and accounts and will be audited and published at a later date. A copy of these will be available on the Trusts' internet site.

27. Private Finance Initiative contracts

27.1 PFI schemes on-Statement of Financial Position

The Trust has 3 PFI schemes which are deemed to be on-Statement of Financial Position at the period end. These are the Main Hospital and Brunel Treatment Centre (treated as one agreement), Downsview Residences and the agreement in place with Systems C.

Great Western Hospital
The contract commenced on 5 October 1999 for a period of 30 years until 4 October 2029. In terms of the contract the operator company was obliged to build the Great Western Hospital, which was completed in November 2002, for subsequent occupation and use by the Trust. The Trust pays the operator company a quarterly availability fee for the occupation of the hospital and a quarterly service fee for the services provided by the operator such as portering, catering etc. In October 2003 the Trust entered into a variation of the original agreement for the construction of the Brunel Treatment Centre which is an extension to the original hospital. The construction of the Treatment Centre has resulted in increased availability and service charges, however, the main terms of the contract including the termination date remain unchanged. Subsequently, in September 2006, the Trust entered into a refinancing agreement which resulted in a reduction in the annual availability payment again with no change to the contract term. The amount of the availability payment is determined annually and increased based on a combination of the annual increase in the Retail Price Index (RPI) and a fixed percentage increase of 2.5% (75% x RPI + 25% x 2.5%). The operator is obliged to maintain the buildings and replace lifecycle elements of the buildings where necessary. At the end of the contract term the hospital buildings revert back to the Trust for Nil consideration. The nature of the contract meets the criteria for treatment as a service concession under IFRIC 12. Accordingly the hospital buildings are treated as an asset under property, plant and equipment with the resultant liability being treated as a finance lease under IAS 17.

Downsview Residences
The contract commenced on 5 October 1999 for a period of 30 years until 4 October 2029. In terms of the contract the operator company was obliged to build the Downsview staff residences on the Hospital site for the provision of housing to hospital staff. At commencement of the contract the Trust made a capital contribution of £649k towards the construction cost of the building. The residences are managed by the operator company who rent the accommodation units to, primarily, Trust staff. The Trust does not pay the operator company an availability fee, however, a monthly service fee is paid for the servicing of the units which is based on usage. The operator is responsible for maintaining the buildings over the contract term. At the end of the contract term the accommodation buildings revert back to the Trust for Nil consideration. The nature of the contract meets the criteria for treatment as a service concession under IFRIC 12. Accordingly the residences are recognised as an asset under property, plant and equipment. The cost of the building less the capital contribution has been accounted for as deferred income and is released to income equally over the entire contract term.

Systems C
The Trust has a PFI contract in respect of the Integrated Clinical Information System which meets the criteria for recognition as a service concession agreement as envisaged under IFRIC 12 and has, accordingly, been treated as on statement of financial position. The contract is dated 27 May 2002 with an effective date of 13 November 2001. The contract is for 12 years and is due to expire on 12 November 2013. The contract is for the supply of computer hardware and software together with the provision of ongoing support and system management services.

28 Financial instruments and related disclosures

The key risks that the Trust has identified relating to its financial instruments are as follows:-

28.1 Financial risk

Because of the continuing service provider relationship that the Trust has with primary care trusts (PCTs) and the way those PCTs are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Finance & Investment Committee.

28.2 Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

28.3 Credit risk

The majority of the Trust's income comes from contracts with other public sector bodies, resulting in a low exposure to credit risk. The maximum exposures as at 31 March 2010 are in receivables from customers, as disclosed in note 17 to the accounts. The Trust mitigates its exposure to credit risk through regular review of debtor balances and by calculating a bad debt provision at the period end.

The following shows the age of such financial assets that are past due and for which no provision for bad or doubtful debts has

	31 March 2011 £000	31 March 2010 £000
By up to three months	**1,696**	1,157
By three to six months	**670**	1,201
By more than six months	**691**	1,068
	3,057	3,426

The Trust has not raised bad or doubtful debt provisions against these amounts as they are considered to be recoverable based on previous trading history.

28.4 Liquidity risk

The NHS Trust's net operating costs are incurred under annual service agreements with local Primary Care Trusts, which are financed from resources voted annually by Parliament. The Trust also largely finances its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks. It should also be noted that the Trust has a Working Capital Facility of £14 million available within its terms of authorisation as an NHS Foundation Trust which reduces its liquidity risk still further.

28.5 Fair Values of Financial Instruments

All the financial assets and all the financial liabilities of the Trust are measured at fair value on recognition and subsequently at amortised cost.

The following table is a comparison by category of the carrying amounts and the fair values of the Trust's financial assets and financial liabilities at 31 March 2011 and 31 March 2010.

.	**Carrying Value 31 March 2011 £000**	**Fair Value 31 March 2011 £000**	Carrying Value 31 March 2010 £000	Fair Value 31 March 2010 £000
Current financial assets				
Cash and cash equivalents	**11,216**	**11,216**	12,181	12,181
Loans and receivables:				
Trade and receivables	**12,141**	**12,141**	10,166	10,166
	23,357	**23,357**	22,347	22,347
Non-current financial assets				
Loans and receivables:				
Trade and receivables	**0**	**0**	0	0
Total financial assets	**23,357**	**23,357**	22,347	22,347
Current financial liabilities				
Financial liabilities measured at amortised cost:				
Obligations under PFI	**1,425**	**1,425**	3,004	3,004
Trade and other payables	**12,704**	**12,704**	17,090	17,090
Provisions under contract				
	14,129	**14,129**	20,094	20,094
Non-current financial liabilities				
Financial liabilities measured at amortised cost:				
Obligations under PFI	**132,036**	**132,036**	133,118	133,118
Provisions under contract	**2,900**	**2,900**	2,900	2,900
	134,936	**134,936**	136,018	136,018
Total financial liabilities	**149,065**	**149,065**	156,112	156,112
Net financial assets	**(125,708)**	**(125,708)**	(133,765)	(133,765)

The fair value on all these financial assets and financial liabilities approximate to their carrying value.

The following table reconciles the financial assets and financial liabilities that fall within the scope of IAS 39 to the relevant on-Statement of Financial Position amounts. Cash and cash equivalents and finance lease liabilities fall wholly within the scope of IAS 39.

	Current		**Non-current**	
.	**31 March 2011 £000**	31 March 2010 £000	**31 March 2011 £000**	31 March 2010 £000
Trade and other receivables:	**347**	393		0
Non-financial assets	**49**	176	**0**	0
Prepayments	**1,009**	359	**1,733**	0
	1,406	929	**1,733**	0
Trade and other payables:				
Taxes payable	**2,056**	2,012	**0**	0
Non-financial liabilities	**0**	0	**0**	0
	2,056	2,012	**0**	0
Provisions:				
Financial liabilities	**206**	2,587	**0**	0
Provisions under legislation	**144**	89	**1,594**	1,732
	350	2,676	**1,594**	1,732

The provisions under legislation are for personal injury pensions £538,845 (31 March 2010: £491,068) and early retirement pensions £1,199,428 (31 March 2010: £1,320,686). These liabilities are not contracted, but are defined by legislation and are owed to the NHS Pensions Agency.

29. Third Party Assets

The Trust held £10,161 cash at bank and in hand at 31 March 2011(31 March 2010: £4,167) which relates to monies held by the NHS Trust on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts.

30. Losses and Special Payments

There were 1,712 cases of losses and special payments totalling £71,621 approved in the year. (1,335 totalling £37,805 for year ended 31st March 2010)

There were no clinical negligence, fraud, personal injury, compensation under legal obligation or fruitless payment cases where the net payment or loss for the individual case exceeded £100,000 (2010/11 - nil cases).

Losses and special payments are compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

31. Pooled Budget - Integrated Community Equipment Service

Great Western Hospitals NHS Foundation Trust and NHS Swindon have entered into a pooled budget arrangement, hosted by Swindon Borough Council. Payments are made to the Council by the Swindon Community Equipment Service.

	31 March 2011 £000	31 March 2010 £000
Income:		
Swindon Borough Council	537,010	469,100
Miscellaneous	0	600
NHS Swindon	230,780	158,250
Great Western Hospitals NHS Foundation Trust	152,600	152,600
Total Income	**920,390**	780,550
Expenditure:		
Expenditure	**1,078,374**	923,179
Total Surplus/(Deficit) at 31/3/11	**(157,983)**	(142,629)
Share of Surplus (Deficit):		
Swindon Borough Council	(83,875)	(76,925)
Swindon Borough Council De Minus	(10,000)	(10,000)
NHS Swindon	(39,565)	(30,505)
Great Western Hospitals NHS Foundation Trust	(24,543)	(25,199)
Total Surplus/(Deficit) at 31/3/11	**(157,983)**	(142,629)

The above disclosure is based on month 12 management accounts provided by Swindon Borough Council, but have not yet provided a Pooled Budget Memorandum account.

It should be noted that these figures are un-audited.

Great Western Hospitals NHS
NHS Foundation Trust

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