Great Western Hospitals NHS
NHS Foundation Trust

Great Western Hospitals NHS Foundation Trust
Annual Report and Accounts
2009/2010

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Chair's report

I am delighted to present our Annual Report for the Trust's first full year as a Foundation Trust.

Through our business plan for 2009/10 we reaffirmed our focus on the delivery of high quality, safe patient care and have a number of projects underway which are bringing about improvements across a range of clinical areas and more details of these can be found in the body of this report. We have considered carefully the Francis Report into the failures of care at Mid Staffordshire Hospitals and have acted upon the recommendations that it makes. Staff have developed detailed action plans that they are working together to deliver, so that in every area of the hospital, there is a continued commitment to further improving both patient safety and patient experience.

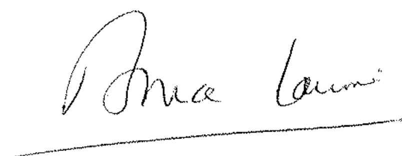
The Care Quality Commission (CQC) published their Annual Health Check in October for the full year 2008/9 and we were pleased to be awarded 'Good' for quality of services and 'Good' for quality of financial management for the second year in a row. The assessment standards become more challenging each year (and rightly so) and therefore NHS organisations have to improve their performance to maintain the same rating.

During what was the coldest winter in 30 years we experienced unprecedented demand for our services, and at the same time the weather conditions presented real challenges in getting staff to and from work to maintain essential services. This came at the same time as one of the longest community outbreaks of Norovirus, and I would like to pay tribute to the dedication of all our staff who worked so hard during these months to keep our services open for our patients.

As a Foundation Trust our funding is dependent on the income we earn through our contracts with the commissioners NHS Swindon and Wiltshire. It is therefore vital that we make a modest operational surplus in order to re-invest in services and replace equipment. I am delighted to report that surpluses to date have been used to increase nursing levels and to provide a second CT scanner which was opened in March this year.

We recognise that there are challenges ahead for all NHS organisations with the need to deliver financial savings whilst delivering high quality, safe care to our patients. We are working with our partners across the health community to develop joint initiatives that will enable us to demonstrate greater efficiencies, and even more joined up care for our patients.

Great Western Hospitals NHS Foundation Trust has been a Foundation Trust since December 2008 and we take our responsibilities to our members seriously. Through our Governors, we are directly accountable to you, and value the benefits that this relationship brings. It is still early days on this journey, but, on your behalf, I am delighted to report that our Governors are making a real contribution to improving the patient experience as well as developing their role of holding the Board to account. If you are not yet a Member of the Trust can I encourage you to join and take an active part in shaping the future of health services in your local community.



Bruce Laurie
Chairman

Directors Report

Directors of Great Western Hospital NHS Foundation Trust during 2009/10

Bruce Laurie	Chairman
Helen Bourner	Director Business Development
Roberts Burns	Non-Executive Director
Rowland Cobbold	Non-Executive 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 & Midwifery
Kevin Small	Non-Executive Director
Alf Troughton	Medical Director

Our Trust

Principle activities and overview 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 £201m.

Great Western Hospitals NHS Foundation Trust was authorised as a Foundation Trust on 1st 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 Trust provides emergency and acute services to the local population through the following sites:

Great Western Hospital

The Great Western Hospital (GWH) is a modern 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. GWH 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.

With just under 542 beds, the GWH offers a full range of services and facilities normally found in a District General Hospital including a busy Emergency Department.

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. It has 128 beds and all patients admitted to the Treatment Centre are screened for MRSA prior to their admission. The Centre includes the Shalbourne Suite, which is a 20 bed private patient unit and outpatient suite.

Marlborough House
Up until the end of the financial year (2009/10), the Trust provided Child and Adolescent Mental Health Service (CAMHS) including inpatient services from 12 beds (all single rooms, plus a two bed high dependency area) in the Old Town area of Swindon. Up to six places for young people to attend on a daily basis were provided along with a comprehensive outpatient service. The service was tendered by the PCTs in 2009 and staff and services transfer to a new provider (Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust) in April 2010.

The Great Western Hospital site
Elsewhere on the GWH hospital site there is:

- A 60 bed Intermediate Care Centre – Swindon Intermediate Care Centre (operated by NHS Swindon) for slow stream rehabilitation.
- An older peoples' mental health unit – the Victoria Centre (operated by Avon and Wiltshire Partnership NHS Trust).
- The Swindon and North Wiltshire Health and Social Care Academy. This provides local training for medical students, nursing students, junior doctors, GP trainees, PCT staff, staff from the independent sector (local care home staff) and Great Western Hospital staff. The Trust also provides facilities to train dental nurses, private nursing agencies and Great Western Ambulance Service staff.

Services currently provided by the Trust in the community
Great Western Hospitals NHS Foundation Trust also provides a number of services closer to patients' homes in the local community:

Hospital	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
GP Practices	NHS Swindon	Community midwives attached to practices in Swindon and North Wiltshire
Various clinics in Swindon	NHS Swindon	Sexual Health.

The Vision for Great Western Hospitals NHS Foundation Trust
Your health our passion

The Trust's Strategy for 2010-15 has been developed through an iterative process throughout 2009/10 which has 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 has helped shape the final strategy and defining 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.

Six strategic objectives
From this Vision fall six key strategic objectives which must be delivered:

1. To provide consistently high quality, safe services which deliver desired patient outcomes and we will perform in the top 25% 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 at GWH and would recommend the Trust as a place to work, or to receive treatment
4. To secure the long term financial health of the Trust
5. To adopt new approaches and innovation so that we 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

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

These values will be refreshed over the coming year with the input of staff across the Trust as part of an Organisation Development process which will commence in 2010/11.

The Trust has established six work streams (that will deliver the six strategic objectives) each of these identifies work that must be done and are identified in the diagram below. The milestones and targets against which Trust performance can be measured are in the process of being developed so that performance can be monitored and corrective action taken when necessary.

The strategy has been developed with the national drivers in mind, in particular it is aligned with the national Quality, Innovation, Productivity and Prevention (QIPP) agenda, and whilst wholly owned by the organisation will be shaped and influenced by a range of external bodies over the five years, and the connections between these is clearly set out in the diagram below.

Statements of compliance wit h Companies Act

Research and Development

The Trust carries out its own research within the Academy, principally in the areas of 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.

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 require 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 who 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 who 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.

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.

Business 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 we tackled and improvements that the Trust made in 2009/10.

Bringing infection rates down

Over recent years the Trust has had a sustained focus on reducing the level of Healthcare Associated Infections (HCAIs) acquired whilst in our hospital. Since 2005 there has been an 80% drop in the number of cases of *Clostridium difficile* (C.diff) and MRSA. In 2009/10 we had six hospital acquired MRSA bacteraemias (an infection in the blood) with no deaths attributable to this infection, in the previous year there were two. The number of cases of C.diff was 29% below trajectory in 2009/10 and fell from 75 to 49 from the previous year. Despite these huge improvements the Trust continues to focus on maintaining high infection control standards and eliminating hospital acquired infections and has shared the lessons we have learned with other Trusts in the South West. Further details are provided in the Quality Report on page 31.

A year of increased demand for Trust services

Throughout the year, referrals to the Trust from primary care and through emergency admissions have been greater than the level our commissioners contracted for. The number of GP referrals received in 2009/10 totalled 69,067. This represents an increase of 1.8% on the 2008/9 total of 67,815 which was also the contracted level of referrals in 2009/10. Whilst the Trust has welcomed this additional activity it created pressures in terms of staff, capacity and ensuring delivery of the nationally set waiting time targets. The Trust experienced a greater number of attendances at the Emergency Department (A&E) than expected which was 5.8% higher than 2008/09. To ensure the financial impact on the Trust was mitigated, during the year discussions took place between the Trust, NHS Swindon and NHS Wiltshire (who commission health care services) to reach agreement on payment for the increase in demand for Trust services. Total extra demand equalled £4.5m and agreement was reached towards the end of the financial year with the commissioners contributing £4m towards the increase in activity experienced. The Trust delivered an in year deficit of £6.8m, this includes a non-cash technical accounting adjustment relating to a net impairment loss of £7.9m arising from a decrease in market valuation of land and buildings in 2009/10. The Trust delivered a cash surplus for the year of £1.1m, which will be used to invest in key services and equipment and prepare for the challenging financial times ahead.

Independent Sector Treatment Centres and the impact on the Trust

In November 2009 two Independent Sector Treatment Centres (ISTCs) opened nearby in Cirencester and Devizes to offer patients a choice for non-complex elective day surgery. The ISTCs are part of the national system reform to create more capacity and choice for patients in the Bristol, Gloucestershire, Somerset and Wiltshire areas. The two commissioning Primary Care Trusts (NHS Swindon and NHS Wiltshire) developed plans to ensure that patients were offered the choice of these centres, and the Trust reduced its income projections by £5.4m (full year effect).

To support the commissioners, the Trust closed an operating theatre, and revised its theatre workforce requirements to allow for the reduction in activity. However, the number of patients choosing the ISTC has been lower than expected, and patients eligible for treatment at the ISTCs have expressed a wish to come to the Great Western Hospital for their treatment. This too has resulted in activity exceeding the anticipated level.

Service developments

In 2009/10 we changed and expanded our endoscopy service which led to accreditation by the Joint Advisory Group which meant that we could provide a local bowel screening service. Plans to build a second cardiac catheter laboratory are well advanced, and we have a mobile cardiac catheter laboratory on site, two days each week whilst the building work is being undertaken and this *means we can now treat more patients locally* reducing the need for patients to travel for treatment.

We are also progressing our plans to develop a birth centre at the Great Western Hospital. This will enable us to provide expectant mothers with more choice in terms of where to give birth, meeting the requirements around choice as part of "Maternity Matters", the national strategy for maternity services. We plan to allocate capital funding for this exciting project and work will start during 2010.

Implementing stroke pathways

Towards the end of 2008/09 the Trust opened a dedicated stroke ward to ensure we met the best national practice for the care of stroke patients. Unfortunately it was not possible to transfer as many stroke patients for their rehabilitation care elsewhere as had been planned. The Trust received its license to provide health services (without any conditions attached to it) from the Care Quality Commission in March 2010. At the same time the Trust proactively declared non-compliance in relation to stroke care. To ensure full compliance the changes we need to make will be completed by October 2010.

Using the surplus which the Trust had made, in March 2010 the Trust installed a second CT scanner investing £1.2m which has increased our capacity and improved diagnostic waiting times. The second scanner will also provide CT scanning for stroke patients seven days a week for the first time.

Child and Adolescent Mental Health Services (CAMHS) moving to a new provider

During 2008/09 the Trust submitted a bid to run the Child and Adolescent Mental Health Services (CAMHS) for NHS Wiltshire and NHS Bath & North East Somerset. The Trust was advised during the first quarter of 2009/10 that it had not been successful, and as a result it was decided that the Trust would not submit a bid for the Swindon CAMHS tender.

We have worked closely with Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust (OBMH), the new provider for both services, to ensure smooth transition arrangements are in place for patients, staff and stakeholders. The Trust will lose the income from this contract from 2010/11 although the costs associated with it will be transferred to the new provider. Managing the service throughout this period of uncertainty could not have been achieved without the commitment of the staff to their patients and the service.

Focusing on 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 uses to assess whether targets are being met. The KPIs monitored by the Trust are the same as those used by Monitor and the Care Quality Commission (CQC). Overall, the Board has been satisfied with performance. However, there are two areas which require greater scrutiny and focus which include patients waiting more than four hours in A&E before admission or discharge and delays in ambulance handovers. Delivery of both of these important quality indicators have suffered during Quarter 4, where the extreme winter conditions and prolonged outbreak of diarrhoea and vomiting (Norovirus) created additional pressures. Staff worked tirelessly to continue to provide care during this challenging time.

The Trust is pleased with its performance in treating patients who may have cancer, within the national timescales. In some areas of cancer care we have been able to exceed the national standards. We will be working more closely with GPs during 2010/11 to ensure that patients continue to receive timely, high quality care in both primary and secondary care.

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 the number of operations cancelled on the day. Improving on cancelled operations and appointments will improve our patient's experience, reducing inconvenience for them and cost to the Trust.

A table setting out the Trust's performance across a number of key targets can be found on page 29.

A continuing focus on the patient

The roll out of the Productive Ward initiative which started in 2008/09 has continued. All wards have completed at least two of the modules and already the benefits for patients and staff are clear. The programme, developed by the Institute for Innovation and Improvement, is designed to help release more time for nursing staff to spend on direct patient care. National research shows on average nursing staff spend only 40% of their time with patients. The results from the first year of activity are impressive and show that patients feel more involved with their care and treatment resulting in a better patient experience. At the same time, complaints relating to nursing care have fallen by 45% and the project has contributed towards improved job satisfaction for staff.

Since we started the initiative in February 2008, the average time nursing staff are spending with patients has increased from 42.9% to 55.5%. On one ward the time spent with patients has doubled. So far 14 of our wards at GWH have started the programme and we aim for all wards to begin the 18 month programme by May 2010, helping to continue to increase the time spent with patients even further.

The Trust's success in reducing its length of stay has been partly due to work undertaken as part of the Productive Ward roll out. Last year the Trust also invested a further £700,000 in ward nurses and this investment together with the work undertaken as part of the productive ward is producing tangible benefits.

During 2009/10 the Trust recruited an experienced Marketing and Communications team to lead the development of a comprehensive communications programme to engage staff and ensure that the Trust delivers its vision statement to *" … delight our patients and commissioners …",* and raise its profile in the communities we serve through improved media relations. Work to redesign the Trust's websites (public facing internet, staff facing intranet, GP portal and access for members and governors) is now in the final planning stages.

With the Trust's PALS and Marketing and Communication teams now fully recruited, different ways of collecting patient experience information are being considered to ensure that there is a real focus on delivering the care that patients expect. A new short feedback card with four simple questions for all patients to complete is currently in use.

Working with suppliers

The Trust has a number of contracts with external suppliers ranging from the Great Western Hospital Private Finance Initiative (PFI) agreement to contracts for smaller services. The PFI contract is due to expire in 2029 and covers the construction and facilities management of the hospital (cleaning, catering, building maintenance and security and switchboard). GWH staff work closely with the 400 staff employed by Carillion Plc helping to provide services that make the hospital environment as good as it should be.

The Trust also has a number of smaller contracts for periods up to four years and these are regularly reviewed to ensure that quality improves whilst value for money is also achieved.

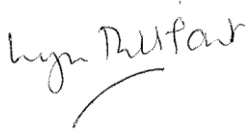
Main trends likely to affect the future development performance and position

The UK economy has experienced its longest recession since the Great Depression and its impact has been felt by the private sector for some time. With funding for the NHS guaranteed during this recent period, Trusts like GWH have been relatively sheltered from some of the problems faced by other sectors.

As we move forward over the next three to five years the impact of the economic problems will be felt more strongly by NHS organisations and the Trust will remain resolute in the way in which it tackles the challenges that lie ahead. After a long period of increased investment in the NHS it is clear that the next few years will require us to work even harder to continue to deliver safe, high quality services within the money available and to innovate and change services so that quality and patient experience improves, whilst costs are reduced. This will mean the Trust will need to engage with staff

and other stakeholders to ensure that we deliver increased productivity, improve efficiency and deliver savings.

During this time the Trust's focus will continue to be on the quality of care and delivering value for money. The Trust recognises without the co-operation, hard work and innovation of all staff, overcoming these future challenges will not be possible. We will therefore work closely with our staff to discuss these issues and secure their support and engagement.



Lyn Hill-Tout
Chief Executive
4th June 2010

Statement explaining how the Board of Directors and the Council of Governance operate, including a high level statement of which type of decisions are delegated to the management by the Board of Directors.

The Board of Directors (Trust Board)

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

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.

Biography of individual Board members

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 also attends the Workforce Strategy Committee, is Chair of the Mental health Act Committee, sits on the Remuneration Committee and on Consultant Appointment Panels. Bruce has been Chair of the Trust since 1st 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, and latterly developing the NHS Customer Care programme. She joined Barnsley Hospital NHS Foundation Trust in 2005, where she worked in Patient Safety, Accident and Emergency before taking up the role of Acting Director of Strategy and Business Development. 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 17 years in a complex multinational responsible for budgetary control, accounting and reporting, tax and treasury operations, fiscal and legal compliance and internal audit. He has worked for Cisco Systems as a Director Internal Control Services and with implementing e-procurement technologies. He is a Fellow of the Institute of Chartered Accountants in England and Wales (FCA), a Fellow of the Chartered Management Institute (FCMI) and an Independent Board Member of Gloucester Probation Area (GPA), a statutory body within the National Offender Management Service. He joined the Board on 1st August 2008. Robert Chairs the Finance Committee and attends the Audit Committee, Remuneration Committee and Charitable Funds Committee.

Rowland Cobbold, Non-Executive Director & Deputy Chair

Rowland has 40 years commercial experience in the aviation and tourism industry including seven years on the Board of Cathay Pacific Airways Ltd (His responsibilities included marketing, customer

service, corporate communications and IT). He is currently Chairman of Ecco Tours Ltd which he helped to set up 15 years ago and 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, Senior Independent Director and chairs the Remuneration Committee, the Integrated Governance and Risk Committee and is a member of the Mental Health Act Committee.

Liam Coleman, Non-Executive Director
Liam Coleman is 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 a member of the Remuneration Committee, Finance Committee and Workforce Strategy Committee.

Oonagh Fitzgerald, Director of Workforce & Education
Oonagh joined the Trust in February 2008. Oonagh had previously worked as Director of Human Resources & 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 Chairs the Audit Committee, Academy Strategic Board and the Charitable Funds Committee and is a member of the Remuneration Committee. Angela has been a member of the Board since 1st 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. Since 2002 he has been serving as a Governor of Newbury College. Roger chairs the Business Advisory Development Group and is a member of the Audit Committee, Integrated Governance and Risk Committee, Finance Committee, Workforce and Strategy Committee and the Remuneration Committee.

Lyn Hill-Tout, Chief Executive
Lyn has been an Executive Director since November 1997 and Chief Executive of the Trust for seven 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 Chair of NHS Elect.

Maria Moore, Director of Finance
Maria was appointed as Director of Finance on 29th September 2008. She had previously held the Deputy Director of Finance post at the Trust having joined in March 2003. Maria has over 16 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 qualified as a nurse in 1982 and subsequently specialised in trauma and orthopaedics. After working as a ward sister and senior nurse, Sue moved into general management in 2000. She was appointed Director of Operations in August 2003. Sue undertook the Kings Fund National Nursing Leadership programme (1999–2001). She is registered with Kings College London to undertake MSc in Health Services Management.

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 date.

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 Workforce Strategy Committee and is a member of the Integrated Governance and Risk Committee, the Finance Committee, and the Remuneration Committee. Kevin has been a member of the Board since 1st November 2003

Dr Alf Troughton, Medical Director
Alf has been a consultant radiologist at the Trust since 1994 and was the Clinical Director of Radiology for five years. Alf was the Radiology President at the Royal Society of Medicine between 2003 and 2005. He is currently Regional Chair in the South West Region for the Royal College of Radiologists. 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. Alf has been Medical Director at the Trust since 1st April 2006.

Length of appointments for Non-Executive Directors

Listed below are details of the length of appointments for the Non-Executive Directors. Incumbent Non-Executive Directors, whose term of office began prior to the Trust becoming a Foundation Trust on the 1st December 2008, had their appointment confirmed by the Council of Governors. However, Liam Coleman was appointed by the Council of Governors as a new Non-Executive Director in anticipation of authorisation.

Name	First Term	Second Term
Rowland Cobbold	01.01.03 – 31.12.06	01.01.07 – 31.12.10
Kevin Small	01.11.03 – 31.10.07	01.11.07 – 31.10.11
Angela Gillibrand	01.07.04 – 30.06.08	01.07.08 – 30.06.12
Bruce Laurie	01.02.08 – 31.01.12	
Roger Hill	01.05.08 – 30.04.12	
Robert Burns	01.08.08 – 31.07.12	
Liam Coleman	01.11.08 – 31.10.12	

The Trust's Constitution determines that the appointment of a Non-Executive Director is as determined by the Council of Governors in General meeting of 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 appear on the Disqualified Directors Register as of 10 March 2010.

Attendance at meetings of the Trust Board held during 2009/10

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 X = Did not attend											
Name	**01/05/09**	**20/05/09**	**29/05/09**	**26/06/09**	**31/07/09**	**28/08/09**	**16/09/09**	**30/10/09**	**27/11/09**	**18/12/09**	**28/01/10**	**25/02/10**	**25/03/10**
Attendees													
Helen Bourner	✓	X	✓	✓	✓	✓	✓	✓	X	✓	✓	✓	✓
Robert Burns	✓	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	X	✓
Rowland Cobbold	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	✓
Liam Coleman	X	✓	✓	✓	✓	X	X	✓	✓	✓	✓	✓	✓
Oonagh Fitzgerald	✓	X	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Angela Gillibrand	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Roger Hill	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	✓	✓	✓
Lyn Hill-Tout	X	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Bruce Laurie	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	✓
Maria Moore	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sue Rowley	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Kevin Small	✓	✓	✓	✓	✓	✓	✓	X	✓	✓	X	✓	✓
Dr Alf Troughton	✓	✓	✓	X	✓	✓	X	✓	✓	✓	✓	✓	✓

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 dealing with all matters relating to the standing orders of the Trust, delegating powers to and receiving reports from sub-committees, any directors and officers' interests which may conflict with the interests of the Trust, certain disciplinary matters, complaints, and setting the organisation structure.

Appointments
This provision relates to appointing the Vice Chairman of the Board, appointing Executive Directors and approving the proposals for remuneration packages of the Directors, Senior Employees and the Chief Executive.

Strategy, Business Plans and Budget
This provision means defining the strategic aims and objectives of the Trust, ensuring quality and developing clinical governance in Trust services, managing risk and approving budgets.

Annual Report and Accounts
The Board of Directors receives the Annual Report and Accounts and delegates their approval to the Audit Committee.

Monitoring
This provision entails receiving reports from committees to which the Board have delegated power, continually appraising the affairs of the Trust, receiving reports on financial performance against the set budget and business plan and also receiving reports from the Chief Executive.

Audit Arrangements
The Board of Directors will approve the audit arrangements and receive reports from the Audit Committee, receive the annual audit letter from the external auditors and agree actions for any recommendations made by the External Auditors. They will also receive the annual report from the Internal Auditor and agree actions for any recommendations given.

Council of Governors

The Council of Governors consists of elected Governors who represent their members and nominated Governors who represent key stakeholder organisations. 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 work 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 have certain statutory powers and duties including:

- appointing and, if necessary, removing the Chair
- appointing and, if necessary, removing the Non-Executive Directors
- deciding the remuneration of the Chair and Non-Executive Directors
- approving the appointment of the Chief Executive
- appointing and, if necessary, removing the Trust's auditor
- receiving the Trust's annual accounts, any report of the auditor on them and the annual report.

Statement setting out the steps that the Members of the Board, in particular the Non-Executives have taken to understand the views of the Governors and Members

In order to ensure meaningful engagement between the Board of Directors and the Council of Governors, the Trust holds at least two joint meetings per year. These meetings are public meetings allowing the Board the opportunity to hear the view of the Governors and the Members first hand.

During the planning for the Trust's five year strategy, four joint strategy planning workshops were held. At least one Executive Director and one Non-Executive Director were present at each meeting to give all Directors the opportunity to work with the Governors and listen to their views on the future strategy of the Trust. A final planning meeting was held which included the Governor Chair of each workshop, the Chair of the Board of Directors and the Council of Governors, the Chief Executive and a Non-Executive Director to go through all the workshop findings. The Governors were present throughout which enabled a thorough discussion to take place in relation to the issues that came out of the workshops.

Board members also attend working group meetings of the Council of Governors to offer support and allow discussion between the Board and the Council of Governors. An example of joint working came in the Governor Finance Working Group where the Non-Executive Directors who Chair the Audit

Committee and the Finance Committee respectively, participated in the appointment process for the Trust's External Auditor. This joint collaboration resulted in effective communication from both sides and allowed a smooth appointment process to take place.

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

The Board commissioned a whole Board review of its performance against best practice models, using board observation and a questionnaire focusing on the differing emphasis of role between Executive and Non-Executive Directors. The general feedback from that process was that the Board had made significant strides in adapting to the new responsibilities of a Foundation Trust, both in holding the Executive Directors to account and in developing meaningful strategy as a whole board. The review also clearly demonstrated that patient safety was central to the Board agenda and there was the right balance between clinical quality and financial discussions. The Council of Governors intends to further this work through its Nominations and Remuneration Committee.

The Chairman and Non-Executive Directors of the Trust are appointed by the Council of Governors for a term of office of up to three years. This can be renewed for a second three year term with the agreement of both parties. Evaluation of the Chair's performance was led by the Senior Independent Director. The Chief Executive and Non-Executive Directors' performance was evaluated by the Chairman. There has been less development of Non-Executive Director appraisal systems both in the NHS and in wider industry. The Council of Governors has therefore agreed that the Board Remuneration Committee and the Governor Nominations and Remuneration Committee will work together to develop a framework for Non-Executive Directors based on adapting elements of the Hay Group work and best practice from other Foundation Trusts.

There has been no increase in Chair or Non-Executive remuneration as a two year review period was agreed in 2008-9.

Director's responsibilities for preparing the Accounts

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. This can be found in the Annual Accounts of the Trust (see page 82).

After making enquiries, the directors have a reasonable expectation that the 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 the accounts.

Executive Director’s Register of Interests

Register of Interests - Board of Directors (*changed from last entry)		
Name of Director	**Interest Disclosed**	**Role within Interest Disclosed**
Helen Bourner*	Arts in Health, South West	Trustee
Robert M Burns*	Gloucestershire Probation Service	Independent Board Member
Rowland Cobbold	Ecco Tours Ogbourne St. George Parochial Church Council	Chairman Honorary Treasurer
Liam Coleman *	First Nationwide Nationwide Lease Finance Limited Nationwide Investments (No1) Limited Moulton Finance Overseas BV	Director Director Director Director
Oonagh Fitzgerald	None	N/A
Angela Gillibrand	Lotmead Company Hanover Housing Prospect Hospice Lloyds of London enforcement Board Holborn Estate Charity	Shareholder Group Director Trustee Member Trustee
Roger Stephen 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 Thames Valley University	Management Consultancy MD Trustee and NED Trustee Church Warden Member Trustee Fellow
Maria Moore	None	N/A
Sue Rowley	None	N/A
Kevin David Small*	Swindon Borough Council Swindon and District Referees Association Even Swindon WMC Mid Counties Co-operative Society Wiltshire County Football Association	Councillor Member Member Shareholder Hon County Referees Secretary and Referee Development Officer
Dr Alf Troughton	None	N/A

Governance and Risk arrangements

Council of Governors

The Council of Governors has a duty under the NHS 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 working groups are:

- Patient Experience
- Membership
- Finance

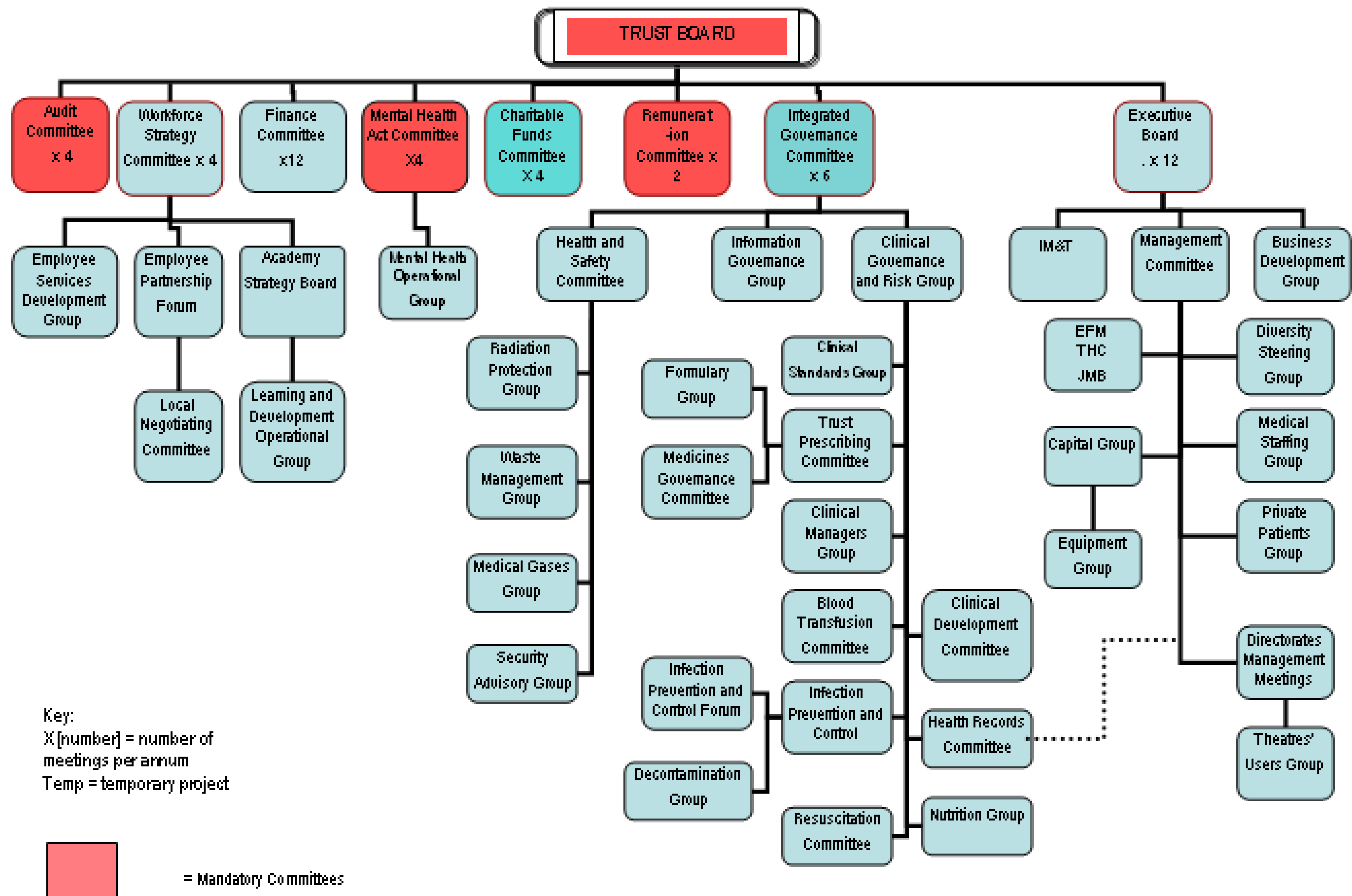
In addition to discussions and presentations at the formal Council meetings and meetings of the working groups, a monthly report from the Chair is sent to Governors after each Trust Board meeting providing a summary of key performance and organisational issues. The Governors are also consulted on forward plans and on our compliance with Standards for Better Health and our new Quality Accounts. During the year the Trust has further strengthened 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 Strategy Planning Workshops, further details of which can be found later in this report.

The Council of Governors has two formal sub-committees, remuneration for Non-Executive Directors and the nominations committee for the appointment of Non-Executive Directors, including the Chairman of the board. The Non-Executive Remuneration Committee met twice in 2009 and its recommendations were ratified by the Council of Governors. No further salary increases were awarded to the Non-Executive Directors in 09/10 as a two year review period was agreed in 2008/9. Further information about the salaries of the Non-Executive Directors can be found on Page 72.

Committee structure

The committee structure was reviewed in 2008 in preparation of becoming a Foundation Trust and will be kept under review in line with emerging guidance from Monitor. The delegated sub-committees are shown overleaf.

Trust committee structure



Key Committees

In addition to the Trust Board there are three other mandatory committees - the Audit Committee, Mental Health Act Committee and Remuneration Committee and their work is described below.

Audit Committee

The Audit Committee's Terms of Reference are available on request from the Secretary of the Trust and are also available on the Trust's website (www.gwh.nhs.uk). The members of the Audit Committee are Angela Gillibrand, (Chair), Robert Burns and Roger Hill.

The main objectives of NHS Audit Committees 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 Audit 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 Audit 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 now 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 Committee on such matters.

Internal Audit

Internal Audit is an important resource that assists the Audit Committee to meet its internal control responsibilities. The Audit 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.

Members of the Audit Committee

Listed below is a list of the members of the Audit Committee and their attendance at each committee meeting held during the course of 2009/10.

Audit Committee members	Record of attendance at each meeting ✓ **= Attended, x = Did not attend**				
	08/04/2009	04/06/2009	10/07/2009	29/10/2009	21/01/2010
Angela Gillibrand	✓	✓	✓	✓	✓
Robert Burns	✓	✓	✓	✓	✓
Roger Hill	✓	✓	✓	x	✓

Mental Health 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 2009/10 and attendance

Mental Health Act Committee members	11/06/2009	02/12/2009
Bruce Laurie	✓	✓
Rowland Cobbold	✓	x
Carole Crocker	✓	✓
Teresa Harding	✓	x
Amanda Cadder	✓	**x**
Julie Dart	✓	✓
Maggie Jordan	✓	**x**
Neil Mason	✓	✓
Jenny MacDonald	**x**	✓
Joshua Orisago	**x**	✓
Malcolm Stewart	**x**	x

Remuneration Committee
The Remuneration Committee is a Committee of the Trust Board. It determines the remuneration and conditions of service of Executive Directors, ensuring that these properly support the objectives of the Trust, represent value for money, comply with statutory and NHS requirements and can, as necessary, be effectively communicated to the public.

All Non-Executive Directors are members of the Remuneration Committee and a report of the Remuneration Committee can be found on page 72.

Appointments Committee
It is the role of the Appointments Committee to appoint suitable candidates to Executive Director posts, to approve the terms and conditions on which the candidates to the role of Executive Director shall be appointed and to remove candidates as Executive Directors if the need arises. Any decisions made by the committee are taken on a majority basis with the Chair holding the casting vote in the event of equality of voting.

The Appointments Committee comprises of the Chair, the Chief Executive and at least three Non-Executive Directors. For this group to have a quorum the Chair or Deputy Chair and at least two other members must be present.

The Committee should meet when it is necessary to appoint an Executive Director but in any case should meet at least once in every calendar year. In 2009 the Appointments Committee did not hold a meeting due to no appointments for Executive Director posts being advertised during the year.

Performance Assurance

Monitor – the independent regulator of NHS Foundation Trusts
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, on:

Governance *(rated red, amber, green).* The Trust's rating of amber for Governance. The term governance is used to describe the effectiveness of an NHS Foundation Trust's leadership. An amber rating means there are concerns about one or more aspects of governance, the Trust is addressing this through the appointment of an experienced Board Secretary to provide expert advice on governance issues.

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. We have published for the first time our quality accounts from page 19;
- **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.

Finance *(rated 1-5, where 1 represents the highest risk and 5 the lowest).* The Trust has been rated as 4 for Finance which means there are no regulatory concerns.

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
- 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.

Mandatory services *(rated red, amber or green).* The Trust has been rated as green for 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. A green rating means that for mandatory services the Trust complies with authorisation.

Further details about the risk ratings issues by Monitor can be found on their website at: www.monitor-nhsft.gov.uk

NHS Foundation Trust 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 is set out in the following sections of the report, and the Directors consider that, in 2009/10, the Trust has been compliant with the Code with the exception of the following:

C.2.2 – Re-appointment of Executive Directors at intervals of no more than 5 years

The Remuneration Committee of the Trust Board decided not to reflect this requirement in the terms and conditions of the Executive Directors.

This element of the Code has since been retracted for 2010-11.
A.1.1 – The Reservation of Powers to the Board policy to be reviewed

The Trust will review and approve Reservation of Powers to the Board policy in 2010/11 and an action plan is in place to remedy this.

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.

As part of the Annual Health Check carried out by the Care Quality Commission, all NHS organisations are required to comply with 24 Core Standards which make up the Standards for Better Health Declaration. As part of this declaration the Board of Directors is required to make a statement of compliance with the Hygiene Code. These standards cover the full range of healthcare services and provide the general public with information on the quality of services by the Trust. The full statement of compliance and Standards of Better Health declaration is available on the Trust's website www.gwh.nhs.uk.

The Care Quality Commission (formerly the Healthcare Commission) publishes national rating for every healthcare organisation based on declarations made by the Trust. The CQC published its rating for 2008/09 in October 2009. This Trust was, like others nationally, assessed on its performance during the previous financial year.

The most recent results demonstrate that the Trust has strengthened its position as an organisation that uses its resources well at the same time as providing high quality services. Each year the

assessments get tougher and for the Trust to show a consistent rating with the previous year, staff at the Trust have had to work harder to deliver these scores.

Year	Quality of Services Score	Use of Resources Score
2005/06	Good	Weak
2006/07	Fair	Good
2007/08	Good	Good
2008/09	Good	Good

(The range is weak, fair, good or excellent.)

From 2009/2010 onwards a new system of 'periodic review' by the CQC will replace the Annual Health Check Rating. A key component of the periodic review will be the registration process which all healthcare providers are required to go through.

Registration with the Care Quality Commission (CQC)

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
- 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. During the second part of 2009/10 the Trust looked at the new system of compliance to see whether GWH is compliant with the new regulations. Following a thorough review the Trust chose to register as compliant with the CQC across all areas with the exception of stroke service. It is clear that more needs to be done to raise the standard of stroke care and as part of this process has a robust action plan has been implemented which will help ensure patients are provided with the right level of stroke care by the end of 2010.

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.

Number of patients seen, treated or admitted during 2009/10

	2007-08	2008-09	2009-10	Variance from 08-09
New outpatients	87,441	90,852	94,587	4.11%
Follow-up appointments	179,466	152,462	152,627	0.11%
Day cases	26,102	28,508	28,053	-1.60%
Emergency inpatients	34,075	36,658	39,202	6.90%
Elective inpatients	7,438	7,345	7,004	-4.60%
Emergency Department (A&E) attendances	60,583	62,628	66,262	5.80%

Trust performance against key indicators

Provided below are details are the Trust's performance against key indicators during 2009/10.

Indicator	Target (2008/09)	Overall performance (2008/09)	Target (2009/10)	Q1	Q2	Q3	Q4	Overall performance (2009/10)	Commentary
18 Weeks Referral to Treatment waiting time									This target for 2009/10 was changed by the Care Quality Commission. Trusts were required to pass both admitted and non-admitted targets in every speciality for Quarter 4 (Q4) only and as a Trust pass the targets every month of the year. Every speciality passed the admitted target in Q4. For the non-admitted target the only specialities to miss this was Oral Surgery and Plastic Surgery. Both specialities have action plans in place to deliver this aim by the end of Q1 in 2010/11.
Admitted	90.0%	95.1%	90.0%	98.6%	98.6%	92.3%	94.3%	95.0%	
Non-Admitted	95.0%	98.4%	95.0%	97.9%	99.0%	97.5%	97.4%	97.5%	
Cancer									In 2009/10 the rules for measuring performance against all cancer indicators were changed. This now means that any patient that declines an appointment(s) within the target dates is counted as a breach of target. The Trust is encouraging patients to accept the earliest opportunity for an appointment to help improve their outcome.
31 day Diagnosis to Treatment	96.0%	99.0%	96.0%	94.7%	97.2%	97.3%	97.6%	97.4%	
62 day Referral to Treatment	86.0%	96.9%	85.0%	86.8%	90.1%	92.4%	91.6%	90.4%	
2 Week wait for a cancer referral for first appointment	93.0%	99.3%	93.0%	85.2%	92.4%	95.8%	97.3%	92.6%	
A&E – 4 Hours maximum waiting time to admission or discharge.	98.0%	99.1%	98.0%	99.0%	99.3%	98.7%	96.6%	98.2%	The whole health community (which includes local Walk-in Centres) achieved this indicator. As a stand alone organisation the Trust failed to achieve this target (97.3%).
Infection control									
Number of Clostridium Difficile cases	220	75	69	9	11	14	15	49	
Number of MRSA cases	10	6	6	3	0	2	1	6	

Thrombolysis (Time from the ambulance call to injection in 60 minutes for eligible heart attack patients)	68.0%	74.0%	68.0%	76.9%	80.0%	92.9%	75.0%	80.0%	
Genito Urinary Medicine (Appointment offered within two weeks)	98.0%	99.9%	98.0%	100%	100%	100%	100%	100.0%	
Delayed Transfers of Care – patients who no longer require acute hospital care but are unable to be discharged due to other support that the patient may require post-discharge.	3.5%	2.2%	3.5%	1.01%	1.20%	1.22%	1.09%	1.1%	
Operations cancelled on the day for non-clinical reasons.	0.8%	1.4%	0.8%	1.67%	1.24%	1.02%	1.04%	1.2%	This continues to be an area of under performance for the Trust and, whilst there has been an improvement in performance compared to 2008/09, the Trust remains above threshold. An action plan is in place to continue to deliver improvements against this indicator in 2010/11.
Stroke patients spending 90% time on the Stroke Unit.	60.0%	45%	60.0%	39.2%	31.1%	37.0%	33.3%	34.2%	As indicated elsewhere in the Annual Report the Trust has an action plan in place to improve on this indicator.

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 2009/10 provides a narrative of progress toward achieving the quality improvement indicators agreed by Management Committee, the Clinical Governance and Risk Committee and the Integrated Governance and Risk Committee.

Overview of Safety, Effectiveness and Experience Initiatives and Improvements

The top safety priorities have been to reduce our number of MRSA Bacteraemias and *Clostridium Difficile* infections and to reduce medication errors and patients falls. We also agreed zero tolerance of blood transfusion errors and incorrect clinical procedures.

The Trust is particularly proud of the achievements made in reducing hospital acquired infections, remaining within the trajectories set by the Department of Health 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 hard work and dedication of staff has led to a further reduction in the MRSA Bacteraemia rate from 0.59 to 0.33 per 10,000 hospital bed days with no increase in the number of reported cases. There have been no deaths during 2009/10 where MRSA Bacteraemia was recorded on the death certificate. We have further reduced our annual *Clostridium Difficile* infections to 49 against our locally agreed trajectory of 69 or less.

Following the Trust's involvement in the South West Quality Improvement programme there have been significant developments in advancing the activity around patient safety in the use of medicines, focusing on actual and potential harm to patients. The Trust is pleased to have reduced the number of patient falls, exceeding our target of 1156 with 952 falls reported.

The Trust is proud to have sustained zero blood transfusion errors and also to have achieved zero incorrect clinical procedures following implementation of the WHO surgical checklist.

Clinical Effectiveness

The top clinical effectiveness priorities for the Trust have been to reduce hospital acquired Grade 3 and Grade 4 pressure ulcers, to develop a local policy for the risk assessment and management of venous thrombo-embolism (VTE) and to maintain the Hospital Standardised Mortality Rate (HSMR) below the 100 benchmark described by Dr Foster (Dr Foster Intelligence is a public/private partnership that aims to improve the quality and efficiency of health and social care through better use of information).

The Trust is pleased to have met the targets for the reduction of both Grade 3 and Grade 4 hospital acquired pressure ulcers. Instrumental in this achievement has been the sustained undertaking of patients' skin status/pressure ulcer assessment on admission and use of the adapted Department of Health Root Cause Analysis Data Gathering Tool.

Over the last year a local policy for VTE has been established and a VTE nurse has been recruited to lead on education and implementation of strategy, resulting in considerable progress towards compliance with national standards.

Introduction of several key initiatives to reduce hospital mortalities during 2008/09 resulted in the mortality rate consistently falling below the 100 HSMR threshold. In spite of the 100 mark being re-calibrated during 2009, the Trust has succeeded in maintaining a rate consistently below the 100 mark.

The Trust has also made progress in other areas of clinical effectiveness with maternity services maintaining a sustained reduction in assisted deliveries and almost full participation in the Department of Health Patient Reported Outcomes Measures programme.

The quality indicator of time to surgery for patients with fractured neck of femur is to be amended from 24 hours to 36 hours in accordance with best practice tariff.

Patient Experience

The top patient experience priorities have been developed using information that patients have fed back to us through the Picker survey (undertaken in June 2009) and from local complaints and Patient Advice and Liaison Service (PALS) data. The Picker Institute is a research charity and a leading authority and advocate for patient-centred health care. The focus for the Trust has been on increasing patient satisfaction by giving patients enough privacy and dignity and effort has also been made to reduce response times to patient call bells. There have been problems obtaining accurate call bell response time data for the Great Western Hospital and this remains an area where further improvement is needed but the latest data for the Brunel Treatment Centre is encouraging with 74% of call bells being responded to within five minutes. There has also been a significant increase in the number of patients receiving copies of all letters sent between the hospital doctors and GPs.

Changes in the national regulations on complaints management mean that the deadline of 25 working days is flexible with the agreement of the complainant. Although the Trust has continued to aim towards a 25 working day target, this will be adjusted in the 2010/2011 Quality Account.

Further details on the work taking place to improve how the Trust captures patient experience information can be found on page 57.

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.

Patient Safety Outcomes and Objectives

To reduce our number of MRSA Bacteraemias

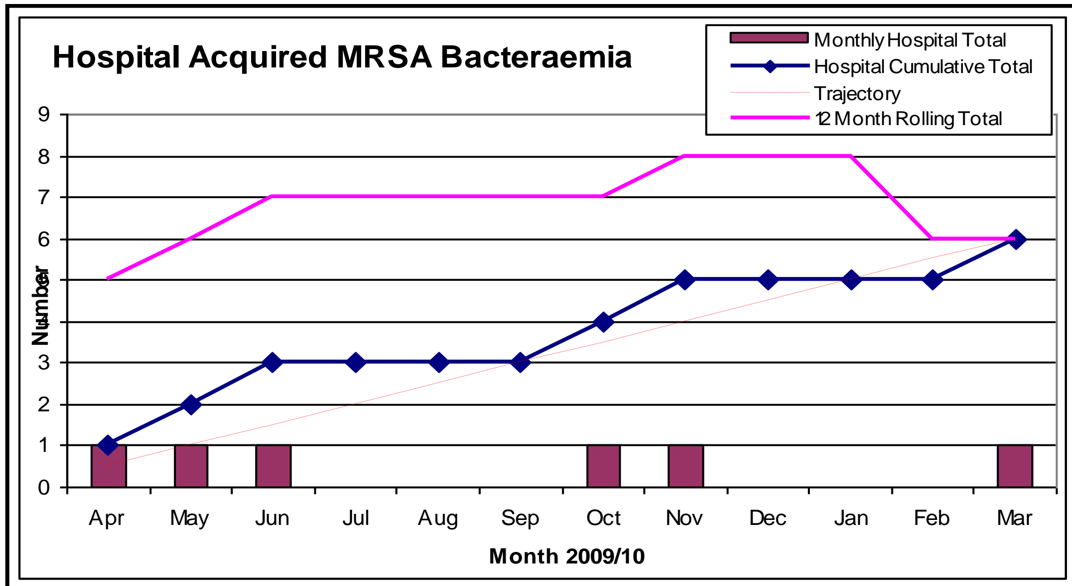
During 2008/09 the number and rate of our MRSA bacteraemias was already low, however the Trust believed that measures could be introduced to reduce these further in line with national priorities. The goal for 2009/10 was to reduce the number of hospital acquired MRSA bacteraemias to six or less.

Local initiatives to reduce numbers included:

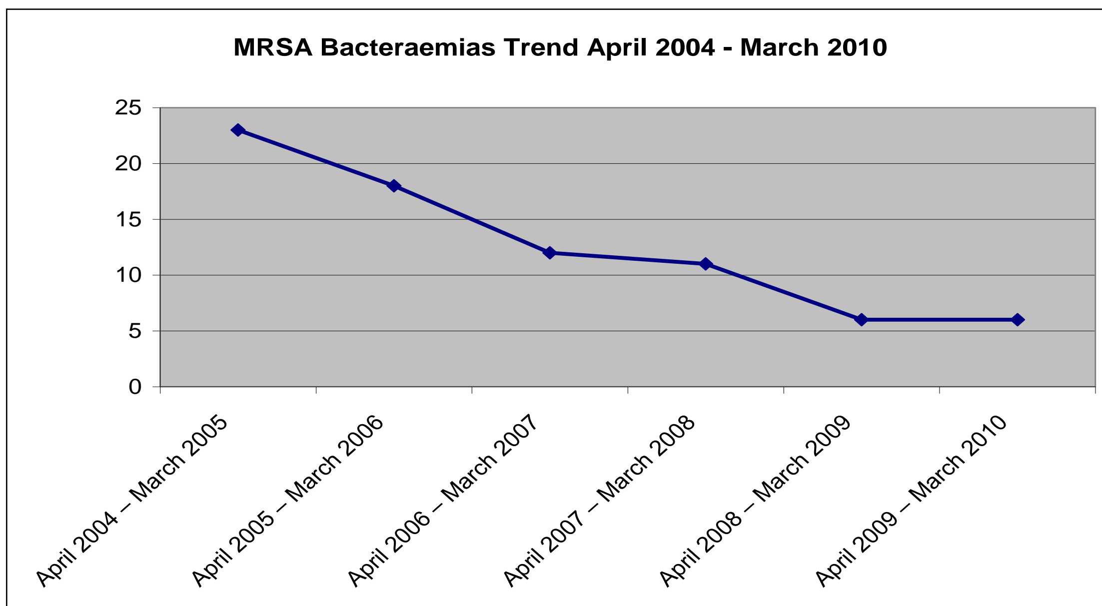
- Improved compliance with the care bundles for peripheral lines and urinary catheters aiming for 100%.
- Undertaking IP&C risk assessments on all patients admitted to the GWH aiming for 100%.
- Introduction of screening of all elective and emergency patients, aiming for 100%.
- All results from the above are reported and monitored monthly via the IP&C Forum and the Clinical Governance and Risk Committee.
- Developing a process for rapid MRSA screening of patients (PCR).

- Including antibiotic prescribing in core training programmes for nurses, doctors and pharmacists.

The Trust reported six hospital acquired MRSA bacteraemia during 2009/10, the same number that was reported for 2008/09. One sample was noted to be a contaminant. There have been no deaths with MRSA bacteraemia recorded on the death certificate for 2009/10, down from two for 2008/09.



The MRSA bacteraemia rate per 10,000 bed days has reduced further to 0.33 over the last 12 months being the lowest for GWH since robust reporting by the Health protection Agency began in 2004.



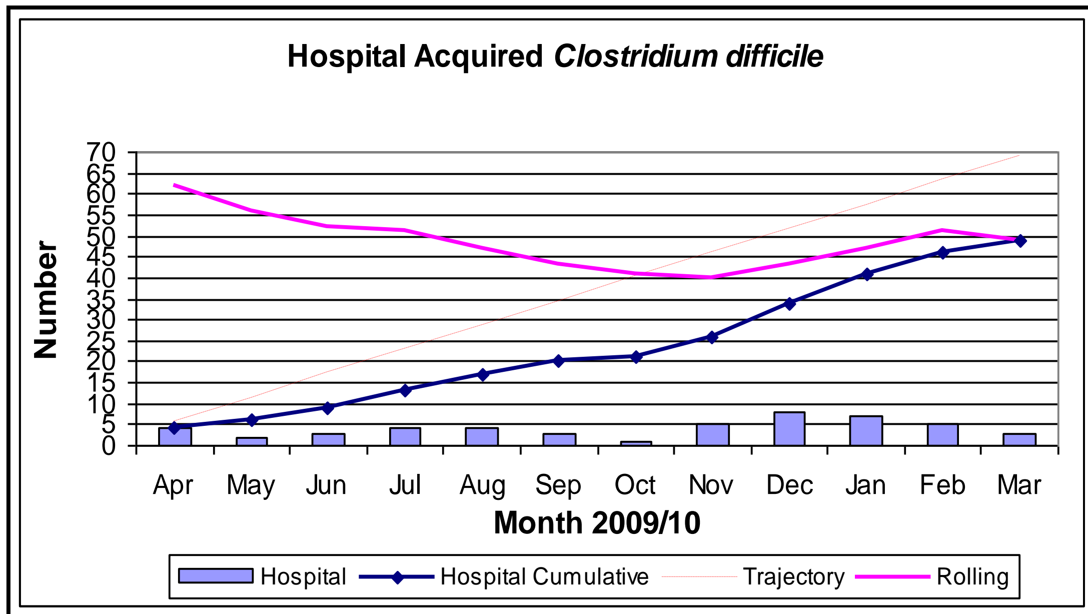
2. To reduce our number of *Clostridium difficile* infections

The goal for 2009/10 was to report 69 hospital cases or less, a locally agreed trajectory with the commissioning PCTs and the SHA. The total numbers of hospital cases reported to year end is 49.

Local initiatives to attain this reduction include:

- Prompt isolation of patients with suspected infective diarrhoea within four hours.

- Developing a protocol for rapid testing of patients for Norovirus. This process has been very successful in early identification of Norovirus outbreaks to aid appropriate management of outbreaks of diarrhoea.

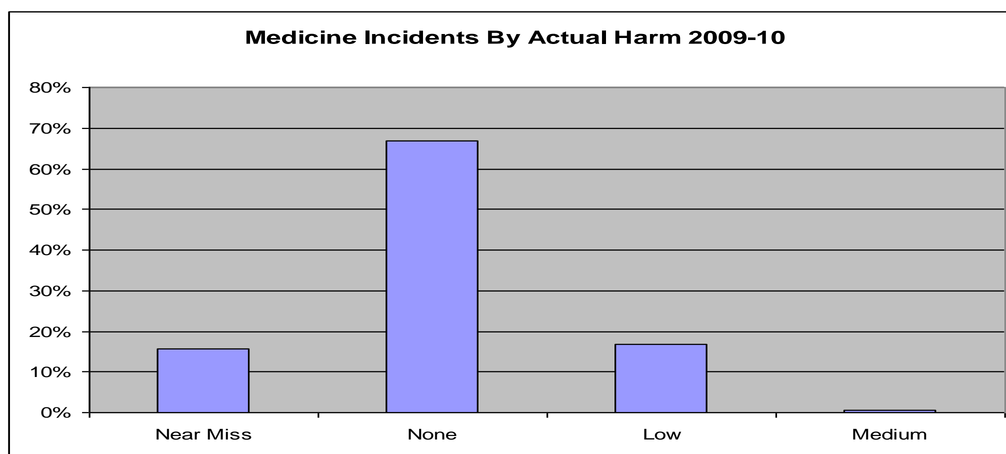


3. To reduce the number of reported medication errors.
Following the Trust involvement in the South West Quality Improvement program the Trust has started work on the work streams linked to this initiative. Within medicine safety the main pieces of work are:-

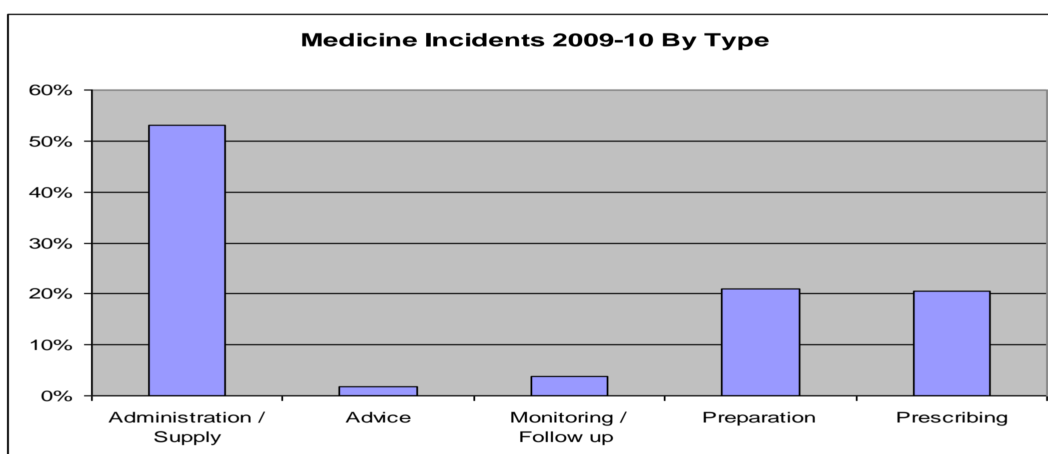
- Completion of a baseline assessment
- Collection and recording of regular audit data
- Systematic review of areas of high risk medicine usage using Failure Mode Effect Analysis (FMEA) with implementation of any actions arising
- A program of quality improvement cycles linked to medicines safety.

Priorities for 2009/10 were to undertake more detailed analysis of the errors that occur in order to understand the causes more readily and hence focus on reducing those errors that have the potential for causing the greatest harm to our patients. In addition action plans were developed and implemented around other significant areas including missed doses, medical gas safety, prescribing of high risk medicines such as anticoagulation and insulin.

The analysis of medicine related incidents for 2009/10 showed that there were no incidents of severe or worse harm reported, and two cases of moderate harm.



An analysis of these incidents by type showed that the most common area where incidents were reported was around administration and supply.



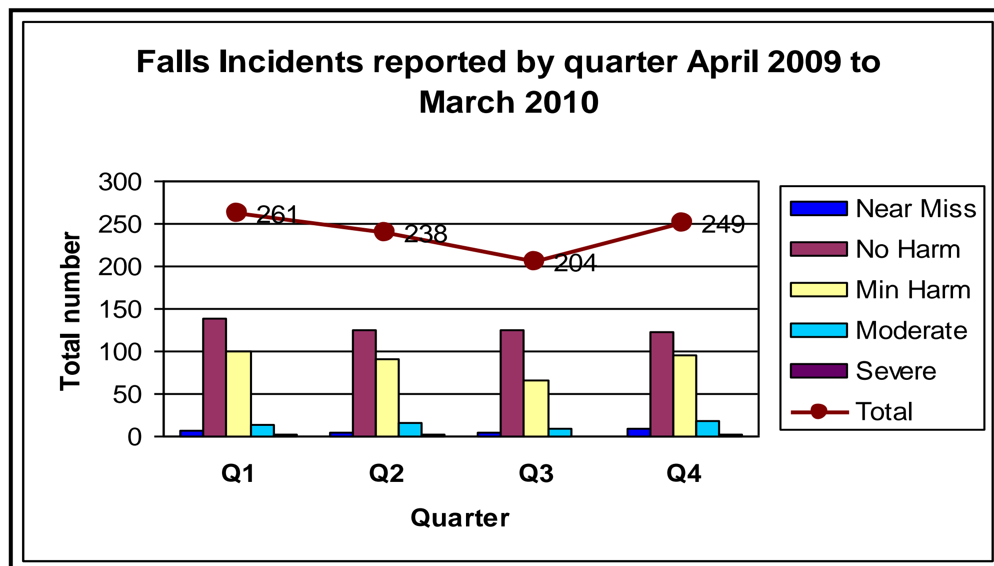
The pharmacy automated dispensing system (robot) was successfully introduced and will be operational by the end of May 2010. This and other initiatives will allow improved safety and efficiency in dispensing and allow more pharmacy staff to be involved at ward level.

4. To reduce the number of our patients who fall in hospital.

A patient falling is the most common patient safety incident reported to the National Patient Safety Agency (NPSA) from inpatient services. The majority of falls result in no injury, but even these falls can result in loss of confidence, increased length of stay and increased likelihood of the patient being discharged to residential care. The Falls Working Group continues to be committed to the needs of patients who require falls and bone management. The group has worked in partnership with Swindon and Wiltshire to inform a review of services, delivery and recommendations across the boroughs.

At ground level in the Trust, there is a well co-ordinated multi-professional/agency falls team at the Betjeman Centre and are building on Acute Therapy links within the hospital to increase referrals to the service.

The Trust's aims during 2009/10 was to achieve a 6% reduction in the number of falls and to reduce the number of patients who acquire a fracture associated with a fall in hospital by improved compliance with falls risk assessment, further training for falls link nurses and increased availability of ultra-low beds within the Trust. The Trust is pleased to report that the target for reduction in falls was exceeded and it is hoped that further reduction will take place during 2010/11.



5. To perform the correct site surgery and procedures on our patients.
Performing the correct site surgery and procedures on patients is recognised nationally by the NPSA and WHO as a significant element of patient safety. During 2009/10, use of the pre-operative checklist was rolled out across all surgical specialties and zero errors of incorrect site surgery were reported.

The Trust is continuing to audit the pre-operative checklist on a monthly basis and this will become a daily audit to ensure compliance with the South West Health Authority, Quality and Patient Safety Improvement programme.

6. To transfuse our patients with the correct blood transfusion products.
There is a national drive by the Department of Health, NPSA and Serious Hazards of Transfusion to reduce incorrect blood component transfusions. Locally, the number of transfusion errors has been low or zero and the Trust has sustained this during 2009/10 with zero transfusion errors reported. The National Patient Safety Agency (NPSA) has a target of 100% competency based training and assessment for all relevant staff involved in blood transfusion by November 2010 and the Trust is currently working to achieve this.

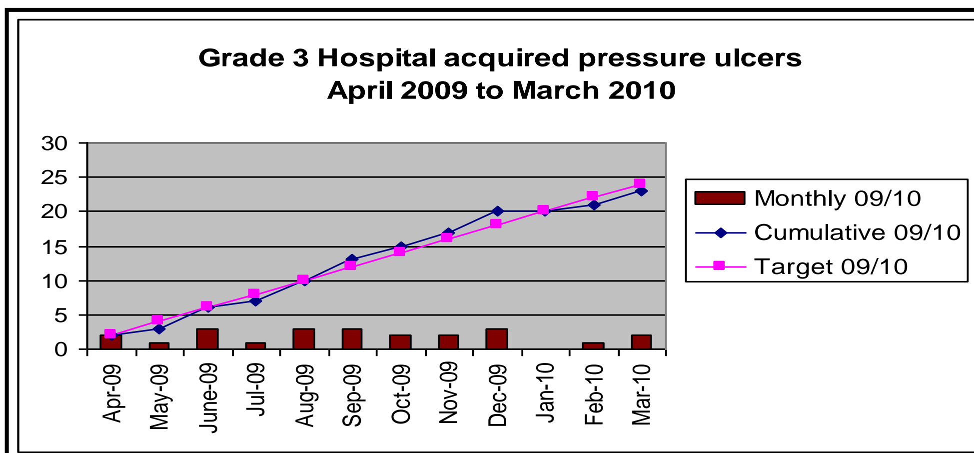
Under the Blood Safety & Quality Regulations (2005) there is a legislative requirement for all blood and blood components to be fully traceable from donor to recipient. The Great Western Hospitals NHS Foundation Trust uses the Blood Audit & Release System (BARS) which is an electronic blood tracking system. Traceability is monitored monthly and has improved significantly since IT software upgrades in January 2010. Electronic blood tracking still needs to be fully utilised at the bedside which will help with improving traceability data further.

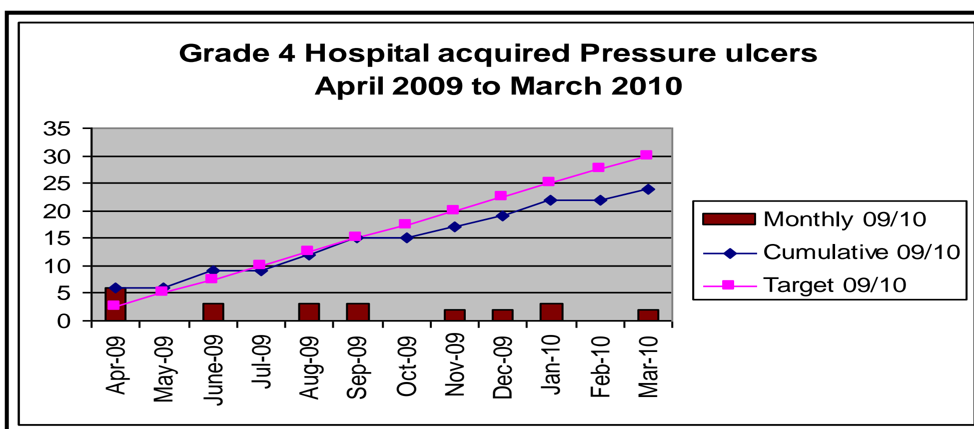
Following on from the Trust's successful NHSLA Level II assessment, safe care of the patient receiving blood transfusion is being monitored via monthly auditing of transfusion observations.

7/8. To reduce our hospital acquired Grade 3 and Grade 4 pressure ulcers. Pressure ulcers are key quality care indicators within the Essence of Care patient-focused framework for clinical effectiveness. During 2009/10, the Trust has again been successful in achieving a 10% year on year reduction in both Grade 3 and Grade 4 hospital acquired pressure ulcers. Indeed there has been a significant reduction in Grade 4 ulcers and the target for the reduction in Grade 3 ulcers has been met. Local initiatives to attain this reduction included:

- Grade 4 pressure ulcers being formally investigated using an adapted Department of Health Root Cause Analysis Data Gathering Tool.
- Increased compliance with skin status assessments of all patients on admission

- Sustained compliance with the skin status assessments weekly using the electronic nursing record, crescendo.



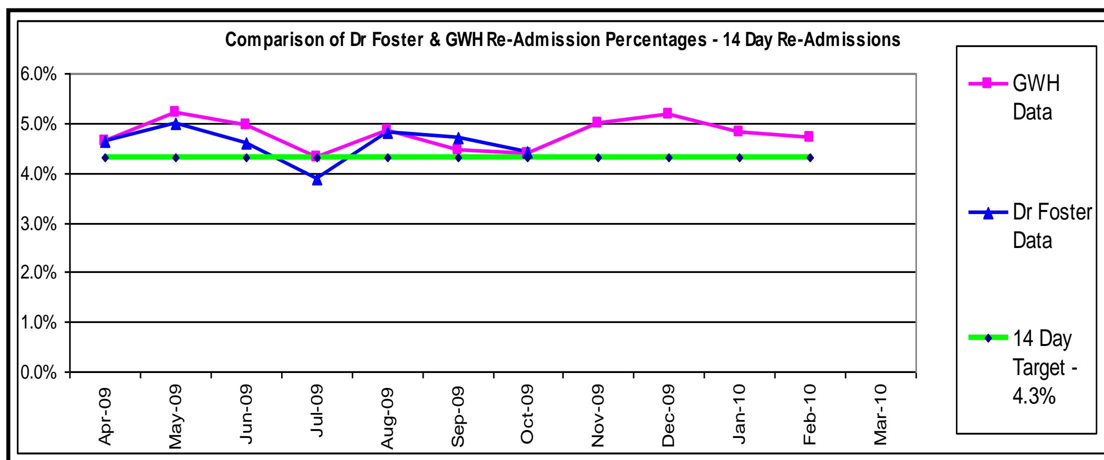


9. Re-admission rates within 14 days

The rate of readmission is an important monitoring tool to review delivery of care provided locally. Information extracted from Dr Foster data shows the percentage of patients re-admitted as emergencies within 14 days of discharge. However, it does not differentiate between re-admissions related and unrelated to the original episode, it is also only available with a five month time lag and cannot be replicated locally because of differences in data methodology. Dr Foster is currently developing the facility for Trusts to access National and SHA data for comparison of re-admissions within 14 days.

In order to reduce the rate of emergency re-admissions, local data is being produced monthly by the Informatics Team at the Trust and is circulated to the Associate Medical Directors who review and provide analysis of their re-admission data to the CGRC, allowing areas for audit to be identified within a month of the readmission.

The percentage of patients readmitted with 14 days remains very close to the trajectory with average performance this year as 4.8% (target-4.3% by end of year.



Further plans to reduce hospital readmission include;

- Setting up a monitoring programme for readmission rates for all specialities.
- Develop systematic review of unplanned related readmissions in specialities.

10. Venous Thromboembolism (VTE) – Development of Local Policy

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 either been achieved or are working towards completion.

Accomplishments so far include:

- Development of a multi-disciplinary thrombosis implementation group with membership from PCT commissioner and the Trust
- Appointment of a VTE nurse to lead on education and implementation of strategy (commenced January 2010)
- VTE policy amended to include changes from NICE guidelines 92 and care of patients transferred to other clinical settings
- Establishing a risk assessment tool for VTE to be used for all adult in-patients
- Development of a separate Obstetric risk assessment tool
- Developing a robust audit trail to check compliance with risk assessment tool and appropriate prescribing of Thromboprophylaxis
- Orthopaedic department now fully compliant with NICE guidelines for recommended Thromboprophylaxis following elective THR and TKR
- Education programme for nurses and medical staff on going
- Patient information leaflet developed and available on intranet.

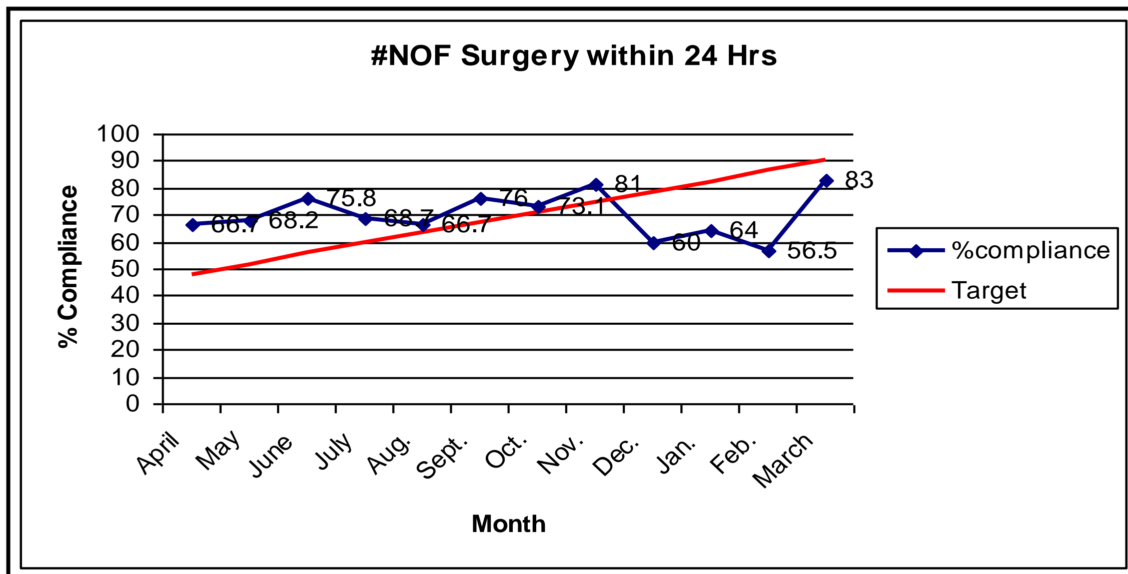
11. Fractured Neck of Femur – Less than 24 hour wait for surgery.

Fractured neck of femur (or hip) 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 has been formed which meets monthly to review all aspects of care for these patients. Early surgical intervention is associated with better patient outcome. The Trust set an improvement indicator to work toward 90% of patients waiting less than 24 hours for surgery.

Local initiatives to attain this improvement included:

- Monthly reporting from fracture NOF database.
- Peer review of all fracture NOF admissions weekly/monthly.
- Monthly trend analysis to close any gaps identified.
- Amend fracture NOF guidelines as identified from audit report.
- Ensuring these patients have a priority on the daily theatre lists.

Compliance remains reasonably close to the trajectory with 69% average performance this year. This was adversely influenced by poor weather conditions resulting in an overall increase in trauma admissions and increased pressure on operating theatres between December 2009 and February 2010.



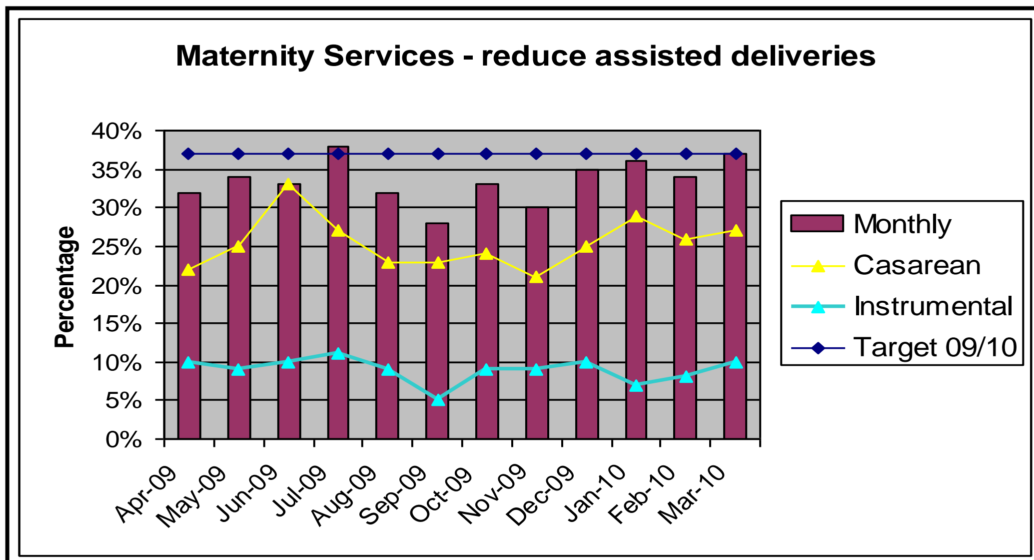
Further plans for early surgical intervention for fractured NOF include:

- Close monitoring of this service delivery will enable us to identify any issues at early stages
- All day weekend Trauma list instead of current half day operating
- In accordance with best practice tariff, the quality indicator contract time to theatre has been amended from 24 hours to 36 hours.

12. To reduce the number of women who require an assisted delivery during childbirth

Over the last twelve months maternity services have regularly reported interventions during delivery in line with nationally agreed drive to promote normality during childbirth. During last decade, nationally there has been a gradual increase in caesarean section rate. The causes for increasing interventions during labour and delivery have been multifaceted. A changing demographic profile with increasing maternal age at first pregnancy, rising rate of obesity, increasing successful pregnancy in women with maternal disorders and availability of sophisticated fertility treatment have all contributed to rise in high risk pregnancies. There is also increasing acceptance of caesarean section as a safe mode of delivery by both women and health care professionals.

However there is a need to stabilise this trend and this remains our philosophy of care at Great Western Hospital. The Maternity Unit statistics for 2008/09 show a caesarean section rate of 25.72% and an instrumental rate of 12.45%. The annual statistics for 2009/10 has shown a caesarean section rate of 26.24% and an instrumental delivery rate of 8.9%. Overall the assisted delivery rate is slightly better than the trajectory 0f 37%. The Trust plans to maintain focus on reducing both operative and instrumental deliveries.



13. To reduce hospital mortality

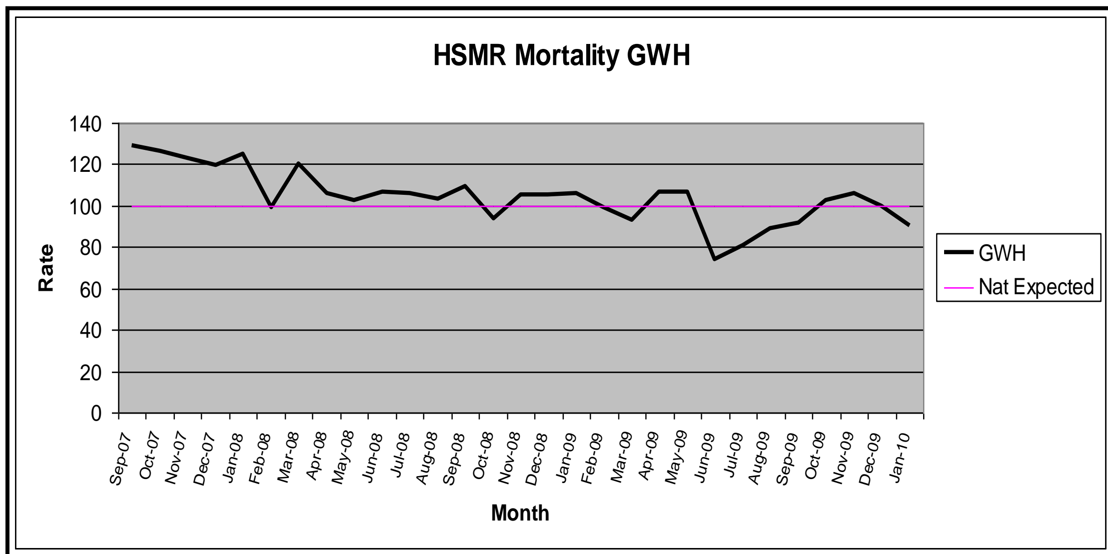
Hospital mortality and morbidity is recognised nationally as a key indicator of the effectiveness of care provided. National reports published and available to the public reflect just how important this information is and how much it affects the confidence of our patients and the public in our ability to provide high quality and safe care.

The Trust continues to achieve an aggregate HSMR below 100 for the year to date although some individual months have exceeded this nationally expected level. The Trust is currently at a rate of 95.0 for the year which shows a significant improvement on the previous year's levels of 122.7 in 2007/08 and 103.1 in 2008/09 (note these levels are all based on 2008/09 national benchmark data).

Dr Foster recalibrates its benchmark following the end of the year and when this was done for the 2008/09 year the HSMR increased from being below 100 to 103.1. Dr Foster anticipate that as HSMRs are continuing to drop the recalibration at the end of this financial year will again reduce the national expected level and the Trust should not assume it will remain below 100.

A number of Trusts have recently completed reviews of HSMR and identified coding errors and absence of co morbidity data. This exercise is being undertaken locally.

The Clinical Audit Department is actively involved in facilitating peer reviews and conducting investigations in areas showing lower performance than expected. In addition, the directorates are reviewing mortality rates and data per speciality and the Trust is developing a Trust wide mortality group which will work closely with the patient safety initiative leads to implement the "reducing mortalities" element of this programme.



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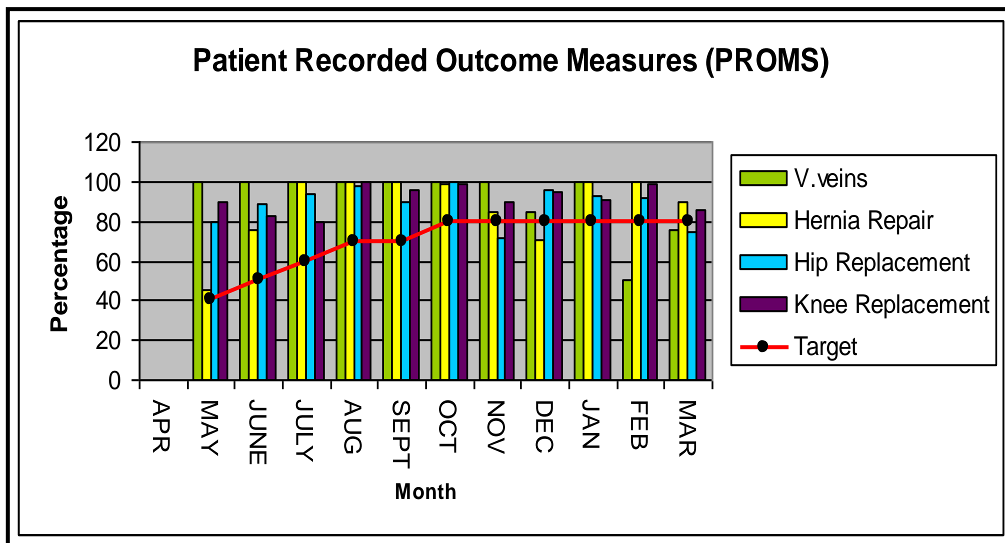
14. To obtain Patient Reported Outcome Measures (PROMs)

For most of the year, completion of the PROMs questionnaire was above target. Occasional dips in compliance have been identified to be at times when the PROMs assistant has been absent. The agreement between Planned Care and PALS that was set up when the service was initially implemented will be reviewed during 2010/11.

The graph below shows the reporting of PROMS began in May 2009 and shows the number of patients who have been seen in clinic and consented to take part in the PROMS initiative. The target for the year was 80% to be achieved by October 2009.



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 Risk Registers.

An Integrated Governance & Risk Committee has delegated responsibility for risk management within the organisation which includes holding the Executive Directors to account for managing risks within their directorates. The committee has regularly scrutinised the Assurance Framework and Corporate Risk Register.

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 in September 2009. It was awarded a pass in nine out of a possible 10 criteria under the "Governance" standard.

As part of the annual business planning cycle, the following risks have been identified against the Trust's objectives for 2010/11:

- Financial implications contained as penalties in the NHS standard contract
- Delivery of productivities in the contract
- Delivery of CIPs (cost improvements)
- Partnership working to deliver the changes demanded by the new financial climate
- Staff recruitment and retention
- Changes in NHS policy as a result of the impending general election.

A detailed analysis of external impacts and regulatory risks can be found overleaf.

The Chief Executive has confidence in the risk management and control processes within the Trust as confirmed in the Statement of Internal Control.

Key external impacts

Key external impact	Risk to the plan	Mitigating actions and residual risk	Overall expected outcome	Measures of progress and accountability
Greater reduction in spending on the NHS than forecast and a consequent impact on the health economy	• Reduction in funding available to commissioners of our services • A focus on cost may distract from the service improvement quality & innovation agenda • Change in relationship with commissioners • Dissatisfaction amongst patients	The Trust is working to reduce expenditure and raise efficiency savings to mitigate future income reductions Opportunity to look at alternative commissioning models and sources of income Focus on opportunity of integration to increase activity and reduce costs Remain focused on quality and service improvement levering cost savings through efficiencies and good practice Addressing poor performance; picking up informal complaints and resolving (MED)	Reduction in costs [over the life of the plan	Director of Finance, CEO, Trust Board Director of Business Development CEO Medical Director/Director of Ops Directors of Workforce & Nursing/Midwifery
PCT delivery of demand management protocols and ISTC transfers	More activity than contract agreement	"Early warning" system to be established to flag high risk specialties /interventions • Joint appointment between commissioners and GWH to manage internal transfers off PTL. • Consider closing C&B for some specialties (MED)	Some activity will reduce through (a) applied demand management (b) the Trust will return referrals when contract activity levels are reached	Monthly report to commissioners on activity Accountability is with Directors of Finance, and Business Development

Political change leading to NHS restructure and reconfiguration which changes the shape of the NHS; i.e. SHA and PCTs	• Significantly more or less activity either of which will be uncontrolled or unplanned in relation to the Trust's current strategy	• "Early warning" system to be established to flag high risk specialties /interventions • Responsive approach at the Board to environmental factors and changes brought about my restructuring (HIGH)	Ability to respond to changing requirements to ensure GWH is a strong player in the health economy	CEO, Directors of Finance & Business Development, Trust Board
NHS Constitution and "High Quality Care for All" agendas – increased competition	Private sector encroachment into territory through commissioning or other; increased competition leading to fewer referrals	Quality strategy and focus on delivering safe high quality care,& improving patient experience to ensure patients want to use GWH (MED) Focus on increasing the Trust's catchment in targeted areas. (HIGH)	Patient experience and safety levels maintained, or improved Patient harm reduced	Sustain compliance with CQC quality and safety standards and NICE guidelines Directors of Nursing & Midwifery, and Business Development & Medical Director,
Changing populations and demographic representation of our communities – (Wiltshire's population is predicted to rise at a greater rate than the national average, (a) 1450 new homes planned for Swindon alone in 2010-11. (b) Wiltshire inhabitants have a higher life expectancy than average (c) General ageing in the population)	The Trust could be faced with increased uptake of services from an increasing and ageing population Increased population levels may contribute to further draws on already finite budgets on the part of commissioners Changing nature of demand for services as the population ages	The Trust will work with commissioners to manage demand for its services, and to promote care outside the hospital where appropriate and focus on changing care pathways to reduce non-elective admissions. Work with primary care to develop integrated pathways Improve the mechanisms for the management of long term conditions in the ageing population in the community (MED)	Partnership working with GWH staff and services working more closely in community settings	Activity and performance reports and early warning mechanisms to flag 'over performance' against contracted levels Director s of Nursing & Midwifery, Operations and Medical Director

Key regulatory risks

Key regulatory risks	Nature of risk	Actions to rectify / mitigate and responsibilities	Measures 2010/11 2011/12 2012/13
Clinical quality/governance	• Not learning from patient safety incidents • Safety compromised by excess activity/demand	• Monthly reports to CGRC/TB • Monthly SUI reports • Monthly activity reports with 'early warning' flag • Lessons learned reported through the Clinical Governance committee structure, • Trust News Bulletin in development Responsibility: Medical Director	• Fewer claims year on year • Continued strong reputation for reporting • Improved score on specific question in staff survey
Delivery of national performance targets	• Annual health Check score compromised by failure to meet 2WW Cancer target	• Performance improvement sustained • Cancer Group close monitoring • Reported internally and externally monthly Responsibility: Director of Operations	• Excellent in AHC (or equivalent) Quality of Services in 10/11
Compliance with Monitor regulatory requirements	• Failure to achieve required levels of compliance may result in de-authorisation	• Ensure regulatory arrangements within the Trust allow effective monitoring and assurance of compliance • Further develop the performance management arrangements to ensure timely information is available to return to Monitor at appropriate times. • Manage a programme of development to ensure compliance with current requirements and responsive to changes as anticipated Reponsibility: Company Secretary	Achievement of compliance statements from Monitor at quarterly and Annual basis

Terms of authorisation and CQC registration	Vertical integration or other major service change through significant transaction (e.g. PCT provider arm)	External advice commissioned Responsibility: CEO	Trust Board ratification of fully worked up plan for possible M&A
Compliance with and delivery of pledges and commitment within the NHS Constitution	Financial (failure to deliver RTT) Reputational (failure to deliver RTT)	Trust has assessed its compliance and has an action plan to ensure continued delivery Responsibility: Director of Business Development	Twice yearly update report to Executive Board
Financial stability jeopardised and Terms of authorisation (mandatory services) and CQC registration will require amendment	• Loss of services put out to tender that Trust fails to win	• Bid process developed • Commercial focus through OD strategy • Bid training under investigation • Resource implication to ensure bids are effectively supported Responsibility: Director of Business Development and Director of Finance	Identified Bid/tender won in 2010/11

Governors and members

Composition of the Council of Governors
The following table shows the composition of the Council of Governors and any changes which occurred throughout this financial year:

Governor	Constituency	Nominated/ Elected	Term of Office	From	To
John Brown	Swindon	Elected	3 years	25/01/10	Present
Mike Carvell	Staff	Elected	2 years	01/12/08	Present
Graeme Chisholm	West Berks/ Glos/Oxon	Elected	2 years	01/12/08	Present
Andy Cresswell	Thames Valley Chamber of Commerce	Nominated	3 years	01/12/08	Present
Rachel Cross	Staff	Elected	3 years	01/12/08	Present
Harry Dale	Swindon	Elected	2 years	01/12/08	Present
Lesley Donovan	The Academy	Nominated	3 years	01/12/08	Present
Sue Doyle	Swindon	Elected	1 year	01/12/08	20/11/09
Bill Fishlock	Swindon PCT	Nominated	3 years	01/12/08	Present
Godfrey Fowler	Wiltshire	Elected	2 years	01/12/08	Present
Marcus Galea	Staff	Elected	3 years	03/12/09	Present
Janet Jarmin	Wiltshire	Elected Re-elected	I year 3 years	01/12/08 03/12/09	20/11/09 Present
Srini Madhavan	West Berks/ Glos/Oxon	Elected	3 years	01/12/08	Present
Emma Neilson	Swindon	Elected Re-elected	I year 3 years	01/12/08 03/12/09	20/11/09 18/01/10
Phil Prentice	Swindon	Elected Re-elected	1 year 3 years	01/12/08 03/12/09	20/11/09 Present
David Renard	Swindon Borough Council	Nominated	3 years	01/12/08	Present
Carole Soden	Wiltshire Council	Nominated	3 years	01/12/08	Present
David Stevens	NHS Wiltshire	Nominated	3 years	01/12/08	Present
Ros Thomson	Swindon	Elected	3 years	01/12/08	Present

Margaret Toogood	Wiltshire	Elected	3 years	01/12/08	Present
Katherine Usmar	Swindon	Elected	3 years	01/12/08	Present

In the 2009/10 financial year, there was a Governor election held in the Swindon, Wiltshire and Staff constituencies, in the election, Sue Doyle, Staff Governor, failed to win re-election and was replaced by Marcus Galea. Emma Neilson was re-elected but resigned the post in January 2010.

The election process was managed by the Electoral Reform Services on behalf of Great Western Hospitals NHS Foundation Trust in accordance with the Model Rules for Elections contained within the Trust's constitution. The election closed at 12 noon on Friday 20th November 2009 and had an average turnout of 33% across the three constituencies. The re-elected and newly elected Governors were formally appointed to office at the Council of Governors meeting held on 3rd December 2009.

Council of Governor meeting and attendance
There have been three Council of Governor meetings and three Joint Board of Director and Council of Governor meetings this financial year. The table below shows the dates of these meetings as well as Governor and Director attendance at each of those meetings. The meeting dates *underlined in italics* are the ones which were joint meetings between the Governors and Trust Board.

Name	***18/05/09***	**16/07/09**	***16/09/09***	**03/12/09**	**25/01/10**	***24/03/10***
Council of Governors						
John Brown	N/A	N/A	N/A	N/A	√	√
Mike Carvell	√	√	√	√	√	√
Graeme Chisholm	√	√	√	x	√	x
Andy Cresswell	x	√	√	√	√	√
Rachel Cross	√	x	√	√	x	√
Harry Dale	√	√	√	√	√	√
Lesley Donovan	x	x	√	x	x	√
Sue Doyle	√	√	√	N/A	N/A	N/A
Bill Fishlock	x	√	√	x	x	x
Godfrey Fowler	√	√	√	√	√	√
Marcus Galea	N/A	N/A	N/A	√	√	√
Janet Jarmin	x	√	√	√	√	√
Srini Madhavan	√	x	√	√	√	√
Emma Neilson	√	√	x	√	N/A	N/A
Phil Prentice	√	√	√	√	√	√
David Renard	x	√	√	x	x	x
Carole Soden	x	√	x	x	x	√
David Stevens	√	x	√	√	√	√
Ros Thomson	√	√	√	√	√	√
Margaret Toogood	x	√	√	√	x	√
Katherine Usmar	√	√	√	√	√	√
Board of Directors						
Helen Bourner	√	N/A	√	N/A	N/A	√
Robert Burns	√	N/A	x	N/A	N/A	√
Rowland Cobbold	√	√	√	N/A	√	√
Liam Coleman	x	N/A	√	N/A	N/A	√
Oonagh Fitzgerald	√	N/A	√	N/A	N/A	√
Angela Gillibrand	√	N/A	√	N/A	N/A	√
Roger Hill	√	N/A	√	N/A	N/A	√
Lyn Hill-Tout	√	√	√	√	√	√
Bruce Laurie (Chair)	√	√	√	√	√	√
Maria Moore	√	N/A	√	N/A	N/A	√
Sue Rowley	√	N/A	√	N/A	N/A	x
Kevin Small	√	N/A	√	N/A	N/A	√
Dr Alf Troughton	√	N/A	√	N/A	N/A	√

Governor Nominations and Remuneration Committee

It is the role of the Governor Nominations and Remuneration Committee to recommend suitable candidates for the roles of Chairman and Non-Executive Directors (NED) to the Council of Governors. The Committee will also make recommendations to the Council of Governors regarding the remuneration packages for these positions. In making recommendations to the Council of Governors for suitable candidates and remuneration packages, the Committee must ensure that a formal, rigorous and transparent procedure is followed. Any decisions of the committee are taken on a majority basis with the Chair holding the casting vote in the event of equality of voting.

The Nominations and Remuneration Committee comprises of the Chairman of the Council of Governors, three Governors (at least two of which must be public) and two Non-Executive Directors. For this group to have a quorum the Chair or the Deputy Chair must be present along with two other members, one of which must be an elected Governor.

When a NED reaches the end of their current term, and if they are still eligible and wish to be reappointed, the Committee may nominate the individual for such reappointment without competition. This will be subject to the Committee 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 Committee choose not to nominate an individual for reappointment, they must conduct an open competition ensuring the existence of a formal, rigorous and transparent procedure to identify and select a suitable candidate for nomination.

Before the Committee make any recommendation, whether it is a reappointment or an initial appointment, the committee should evaluate the performance of the individual seeking reappointment during their term and also the balance of qualifications, skills, knowledge and experience which the Board of Directors already has. From this evaluation a job description should be formed describing the role and capabilities required for the particular appointment. The Committee may seek advice and/or use the services of firms or individuals who have expertise in this area.

Once a candidate has been selected, they will be appointed for a period of office determined by the Council of Governors at a general meeting. The group should meet at least once per calendar year. In 2009 this Committee met in February and March. The following table shows the members of the Committee and their attendance at meetings to date:

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

Name and Position	16/02/09	05/03/09
Graeme Chisholm - Governor	x	✓
Rowland Cobbold – Non-Executive Director	✓	x
Harry Dale - Governor	✓	x
Godfrey Fowler - Governor	✓	✓
Bruce Laurie - Chair	✓	✓

Governor Register of Interests
(Key - † = Changed from previous register)

Register of Interests - Council of Governors (as at 05/01/10)		
Name of Governor	**Interest Disclosed**	**Role within Interest Disclosed**
Mike Carvell	MFM Software Consultants LTD	Director
Graeme Chisholm †	Headway Swindon and District	Director
Andy Cresswell	None	N/A
Rachel Cross	Unison Guiding Association	Lead Steward Brownie Leader
Harry Dale	None	N/A
Lesley Donovan	None	None
Bill Fishlock	Morris Owen Chartered Accountants Oakus Estates Swindon Primary Care Trust Wiltshire Police Authority Greensquare Group Taurus Employment Development Ltd Westlea Housing Association The Green Hut Registered Charity Institute of Chartered Accountants in England and Wales	Employee Chairman Non-Executive Director Board Member Director Director Member Management team member Member
Godfrey Fowler	None	N/A
Marcus Galea	None	N/A
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 Non-Executive Director
Rosalind A Thomson	None	N/A
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

Building a strong relationship with our members

As a Foundation Trust, the Trust is accountable to the local population through its members. In order to become a public member of Great Western Hospitals NHS Foundation Trust a person must be aged 12 or over and live in Swindon, Wiltshire, West Berkshire, Gloucestershire or Oxfordshire. Any member of Trust staff, Carillion staff or the volunteers of the Trust, automatically become members of the Trust 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
- Have been continuously employed by the Trust under a contract of employment for at least 12 months; or
- 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
- 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.

As at 31st March 2010 the Trust has 9,249 members. The membership per constituency is as follows:

Public constituency	**2009/10**	**2010/11 (estimated)**
At year start (1st April 2009)	4,628	5,031
New members	553	2,520
Members leaving	150	150
At year end (31st March 2010)	5,031	7,401

Staff constituency	**2009/10**	**2010/11 (estimated)**
At year start (April 1)	3,891	4,218
New members	328	400
Members leaving	1	1
At year end (31 March)	4,218	4,617

Constituency	**Number of members**
Swindon	2,883
Wiltshire	1,456
West Berks/Glos/Oxon	464
Affiliate	228

The following table show the membership figures that were predicted in the 2008/09 Annual Report:

Constituency	**Figure as at 31st March 2009**	**Predicted figure for 31st March 2010**
Public	4,151	6,426
Staff	4,232	4,232

Unfortunately the membership figures in the public constituency are lower than predicted. This has been due to focus being placed on the improving the relationship between Governors and

Members and actually engaging with the current membership as opposed to focusing primarily on recruitment. The Trust does however write to former patients inviting them and their relatives to become members, as well as a host of other activities as outlined below to continually develop a representative membership.

Membership Strategy

It is the aim of Great Western Hospitals NHS Foundation Trust to have a membership which will allow the Trust to develop as a locally accountable organisation which delivers health care services that reflect the needs of our local communities. In turn this will support the Trust in achieving its key aims and objectives. The membership will support the Trust to increase local accountability, communicate directly to current and future service users, develop services that reflect the needs of our local communities and build loyalty to the Trust within our local communities. The Trust fulfils this aim by communicating and engaging with members via the quarterly membership newsletter, member focus groups and events such as open days, the Trust website where members can go to for updates and information and also via the Trust's Membership Officer, who is a full time member of staff and is available to answer any questions, compliments or concerns from members.

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

In order to encourage membership amongst some of the younger members of the community, the Trust has initiated a schools programme with one of the local senior schools. Pupils from the school have joined up to become members and have even set up their own Council of Governors. In return the Trust has been able to offer work experience placements and careers advice to the pupils. It is the aim of the Trust to build upon this schools programme and introduce a Young Members Council in conjunction with the main Council of Governors.

The Council of Governors has a sub-committee dedicated to Membership and how the Trust can improve membership for all of our members. This group is currently assessing the Trust's membership strategy to see what improvements could be made in order to increase membership and to encourage further membership engagement.

If a member wishes to communicate with their Governors or Directors they can do so via any of the following channels:
E-mail: foundation.trust@gwh.nhs.uk,
Phone: 01793 604185
Post: FT Membership
The Great Western Hospital
FREEPOST (RRKZ-KAYR-YRRU)
Swindon
SN3 6BB

Constituency meetings

To provide a regular forum for members to meet the Governors the Trust holds regular meetings in each constituency across the local. All meetings were held in public halls within the relevant constituency to ease travelling distances for members. In response to feedback received from members to have more opportunities to meet with their Governors, the Trust will hold two constituency meetings per constituency in 2010.

In order to improve engagement with the membership, the Trust has recently undertaken a survey of members to see how their membership experience can be improved. This survey has also given information about how the Trust can improve communication between members not only from the Trust, but between members and their Governors also. Based on the feedback the Trust will be hosting a series of events on various themes during 2010.

Environment and sustainability

As such a large organisation, the activities of the Trust in providing high quality care for patients 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 at least achieving NHS carbon reduction targets.

Over the past year the Trust has embarked on a number of projects to reduce the amount of waste and energy used in the Trust. During the year an appointment was made to the post of Head of Sustainability, Accommodation and Transport, whose role is to ensure that resources are used efficiently and continuing efforts are made to reduce the Trust's carbon footprint.

In line with the Trust's environmental policy which forms part of the sustainability work plan various projects have been carried out over the year to reduce the environmental impact of the Trust. Last year a rolling programme of installing light sensors in offices to reduce electricity use was implemented along with food audits to reduce wastage. The next phase of this project will investigate alternative disposal methods including composting.

During the year the Trust also undertook a consultation with staff on a draft Fair Transport Scheme, the aim of which is to provide clear and sustainable solutions to manage transport to and from the hospital site for our staff. The scheme set out proposals on car parking for the future along with measures for supporting staff to use more environmentally friendly forms of transport such as subsidised bus travel. Further work will be taking place with our staff in 2010/2011 to identify a suitable transport scheme which delivers these aims and reduces demand for parking over time.

Over the next year the Trust aims to measure its carbon footprint providing a clear baseline against which the Trust can measure progress against and to assist with raising awareness of the impact the Trust has on the environment.

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.

Waste type	**Amount of waste produced (tonnes)**		**Cost of waste disposal**	
	2008/09	**2009/10**	**2008/09**	**2009/10**
Incineration	46.2	51.18	£29,100	£32,282
Alternative treatment	480.1	484.12	£209,693	£211,749
Landfill	389.86	391.53	£30,884	£31,060

Energy type	**Amount of energy used**		**Cost of energy usage**	
	2008/09	**2009/10**	**2008/09**	**2009/10**
Electricity (Giga Joules - GJ)	59,765.49	55,371.51	£1,766,948	£1,219,177
Gas/GJ	60,636.76	55,243.88	£544,517	£301,040
Oil/GJ	1,670.69	2,533.46	£31,957	£40,866
Water/m^3	214,383	199,962	£323,185	£330,564

The sustainability agenda in the year ahead

The following projects have all been approved, and subject to business case approval will be introduced in the next twelve months:

- The Trust aims to continue to reduce energy consumption of the hospital by reducing the air temperature by one degree in areas where this will not have a clinical impact. It is estimated that this will reduce gas consumption by around 6%.
- Towards the end of the financial year the Trust consulted with staff about a proposed Fair Transport Scheme. The aim of the Fair Transport Scheme was to reduce the number of individuals driving to the site in their own vehicles and reduce demand for parking on the hospital site.
- Concessionco are now starting to replace electrical equipment in line with the lifecycle plan. The Trust is working closely to ensure that the energy efficiency of the products being purchased is being considered.
- At the moment all waste food is put into a waste disposal unit, which requires electricity and large amounts of water to run efficiently. A proposed change in future legislation may also make this a very expensive way of disposing of food. To overcome this, the Trust is investigating the option to build a composter on site. An application has been made to the South West Innovation Fund to support this new development, as it will reduce water and power usage on site, and turn waste food into a usable (possibly commercial) commodity.
- The Trust is also trialling the introduction of an offensive waste stream. It is estimated that the volume of clinical waste produced could drop by approximately 60% if successful. Offensive waste would be sent to a waste plant where it will be burnt at low temperatures to produce electricity.

Our patients

Patient experience and public engagement at GWH

The Patient Advice and Liaison Service (PALS), under the leadership of the Head of Patient Experience and the Director of Nursing and Midwifery, take the lead on the patient experience and engagement agenda at GWH. From 2011 up to 10% of Trust income will be linked to patient experience and therefore the need to always listen and respond to patients continues to grow.

Following staff shortages in the PALS team, 2009/10 saw the recruitment of additional personnel, including a Head of Patient Experience, who has been appointed to lead the team to raise the profile of patient experience within the organisation. It is anticipated that 2010/11 will see a greater focus on patient experience with new methods of collecting patient experience data to inform service developments and changes to the way the Trust provides care.

Patient Advice and Liaison Service (PALS)

The Head of Patient Experience and the PALS team lead on the following issues on behalf of the Trust: Patient and Public Involvement (PPI); patient surveys; patient forums; complaints; translation and interpreting; overseas patients; bereavement and Patient Reported Outcome Measures (PROMS). Members of the team also provide valuable input into various working groups around the hospital to ensure a focus on patient experience is maintained.

During 2009/10 there have been 3,882 contacts by patients, relatives or members of the public with the PALS Service in comparison to 2,815 within 2008/2009.

Formal Complaints

The Trust experienced a historic backlog of complaints due to staffing and capacity issues in the PALS department which had significantly delayed the speed with which the Trust was able to respond to complainants. This backlog was significantly reduced towards the end of 2009/10 and with capacity issues now being resolved the Trust expects an improvement in response times during 2010/11.

During 2009/10, 229 formal complaints were made to the Trust compared with 197 formal complaints during 2008/09. The number of complaints received by the Trust represents 0.06% of the total number of patients seen, treated or admitted during the course of the year. The complaints covered a range of issues including: Coordination of care between departments, delays in treatment, the quality of information and communication provided to patients and waiting times for appointments.

The Trust’s target is to respond to all formal complaints within 25 days however; due to the capacity issues highlighted earlier the response rate for 2009/10 was 38%. Formal complaint training commenced in September 2009 as a joint project between the General Manager of Diagnostics and Outpatients, Deputy Head of PALS and the Chief Executive and it is anticipated that this will help improve response times.

Compliments

There have been 335 compliments received by PALS, which is in addition to the many cards, letters and gifts received directly by wards, departments and Consultants. This is in comparison to 141 compliments were received during 2008/09.

Bereavement Service

There have been 336 contacts with the Bereavement Service over the last financial year in comparison with 1,377 contacts for the previous financial year (2008/09). The Bereavement Service facilitates the Compassionate Administration Service within the Trust and co-ordinates the completion and collection of the internal and external paperwork associated with registering the death of a patient.

The Bereavement Officer also acts as the main liaison between the Mortuary and Funeral Directors and acts as the contact for the collection of patient property in the majority of cases where a patient has died in hospital. The Bereavement Officer also links with the Coroner's Officers where cases are reportable or if there are queries regarding an inquest. Towards the end of the 2009/10 financial year, a Bereavement Working Group was formed whose membership consists of:

- PALS
- Bereavement Officer
- Mortuary
- Manager for the Pathology Service
- Tissue and Organ Donation Lead
- Women and Children's Bereavement Support Service
- Chaplaincy
- Ward Staff.

The aim of this group is to ensure a consistent approach throughout the Trust to end of life care, and bereavement support. The group reviews and improves the processes, paperwork, inter-departmental working and policies relating to bereavement to ensure a better continuity of care.

Translation and Interpreting services

The Trust provides a translation and interpreting for patients who do not speak English. This is to ensure there are no barriers for patients from black and minority ethnic groups in accessing hospital services. The current Translation and Interpreting contracts are being reviewed and will be put out to European Tender in 2010/11.

Using patient experience information to drive further improvements

Comments and suggestion cards have continued to be used during 2009/10 as a way for the Trust to better understand the experiences of patients and visitors. In addition the Trust introduced the 'Tell us How We're Doing' feedback cards in December 2009 which have been rolled out across all wards and departments. The feedback cards ask the following questions:

- What was good about your visit?
- Was there anything we could do better?
- Would you recommend us to a friend? Yes, No and Why?
- Please tell us about any person or team who provided you with excellent care.

During the initial roll out of the cards the response rate has been low and further work is taking place to raise awareness of the cards and increase its use across the wards.

The current inpatient survey will be reviewed during 2010/11 to make it more user-friendly. The Trust will be liaising with local Learning Disability providers to ensure that the revised feedback mechanisms are available in a user-friendly format.

During 2010/11 alternative methods of gaining feedback about patient experience will be explored including the possible introduction of electronic handheld tablets to gain real-time data, post-discharge surveys and volunteer and staff engagement exercises with patients and lay user involvement.

Surveys carried out by the Picker Institute

The Picker Institute is a not-for-profit organisation that undertakes a range of quantitative and qualitative research into patient experience. The results from the 2009 inpatient and outpatient surveys conducted by Picker were received by the Trust in quarter four of 2009/10 and a summary of the results can be found overleaf.

Picker Inpatient Survey		
Of the 835 patients eligible to complete the survey, which was carried out towards the end of 2009, 441 questionnaires were returned which is a response rate of 53% (5% higher than the national average).		
The Trust has improved significantly upon the 2008 survey in the following areas:	2008	2009
Patients reporting that they shared a sleeping area with opposite sex	22%	11%
Patients reporting that in more than one ward, they shared a sleeping area with opposite sex	15%	6%
Patients reporting that they used a bath or shower area shared with the opposite sex	17%	4%
Patients reporting that their room or ward was not very or not at all clean	7%	3%
Patients reporting that they did not receive copies of letters sent between hospital doctors and GP	70%	43%
Patients reporting that they were not asked to give views on quality of care	86%	81%
Patients reporting that there were no posters/leaflets seen explaining how to complain about care	46%	39%
The Trust has worsened in the following areas:	2008	2009
Patients reporting that following a planned admission they were not given printed information about the hospital	13%	21%
Planned admission: not given printed information about the condition or treatment	10%	18%
Patients reporting that they were bothered by noise at night from other patients	31%	40%
Doctors: Some/none knew enough about condition/treatment	7%	12%
Nurses: Did not always get clear answers to questions	26%	34%
Surgery: What would be done during operation not fully explained	17%	24%
Discharge: Not given any written/printed information about what they should do or not do after leaving hospital	40%	47%
Discharge: Not fully told purpose of medications	18%	25%
Discharge: Not fully told side-effects of medications	42%	52%
Picker Outpatient Survey		
Of the 846 patients who were eligible to complete the outpatient survey carried out during quart two of 2009/10, 454 completed questionnaires were received which is a response rate of 53.7% (3.6% higher than the national average).		
The Trust has improved significantly upon the 2004 survey in the following areas:	2004	2009
Patients reporting that they had to wait more than five months for an appointment	8%	3%

Patients reporting that they did not receive copies of all letters sent between hospital doctors and family doctor (GP)	69%	44%
The Trust has worsened in the following areas:	2004	2009
Patients reporting that they waited for longer than they were told, or were not told how long the wait would be	65%	81%
Patients reporting that the Doctor did not explain reasons for treatment/action in an understandable way	20%	27%
Patients reporting that the Doctor did not fully listen to what the patient had to say	16%	23%

An action plan will be developed in early 2010/11 to address the issues identified through the inpatient and outpatient survey. The Trust Governors have also established Patient Experience Working Group to help drive forward improvements in patient experience and identify areas for further improvement.

During 2010/11 the Trust will gather more routine insight into patient experience through a quarterly survey of a sample of patients. This survey will be conducted following discharge from hospital and it will allow much more regular tracking of experience comparing trends over time and allowing quicker action to be taken where areas are identified as being in need of improvement.

Patient Reported Outcome Measures (PROMs)
PROMs are a national initiative which measure the quality of care provided in hospitals from the patient perspective. They help measure the health gain a person experiences after having an operation by using surveys before and after surgery.

From April 2009 all providers of NHS care have been required to collect PROM data on four procedures. To support the process of collecting this information, a PROMs assistant (funded by Department of Health) works in the Cherwell Unit on collecting data on the following four procedures:

- Hip
- Knee
- Hernia
- Varicose vein.

The data from this process is used to measure the clinical quality of care provided.

Working with carers
Carers play an invaluable role in supporting their loved ones. The Trust recognises that a greater focus was needed to support carers in the vital role they undertake. Towards the second half of 2009/10 a Carer's Task Group and Committee was set up to carry out this role. Nominated Carers Leads are being identified within directorates and wards over the forthcoming year to join the group which will look at:

- Barriers to identifying carers and carers identifying themselves
- The range of support available to carers (with support from the Hospital Carers Liaison Worker funded through Swindon Carers Centre).

Partnership working
Great Western Hospitals NHS Foundation Trust recognises how important partnership working is in helping to improve the lives of local people. The challenges of the years ahead are on such a scale that they can only be overcome by working closely with others in the Health and Social Care sector.

As part of this commitment in 2009/10 the Trust worked closely with partners in Wiltshire to develop the Wiltshire Health and Social Care Concordat setting out the key principles for Health and Social Care organisations in the area when working together. The principles cover issues such as how organisations will seek to collaborate on issues of strategic importance and how we will all work together to improve the experience that local people have of their local services.

During 2009/10 the Trust also began discussions separately with Community Health Oxfordshire and Wiltshire Community Health Services regarding the future of Community Hospitals, in Oxfordshire and Wiltshire. The Trust is keen to explore opportunities to work closely in partnership with other organisations to see how the services provided by GWH may be able to be provided closer to home in the future. The Trust is well placed to respond as it has a strong track record of good service delivery.

Health and Overview Scrutiny Committees (HOSCs)
Health Overview and Scrutiny Committees have a unique role to play in scrutinising the services provided by NHS organisations. During 2009/10 there has been representation of the Trust at both the Swindon and Wiltshire HOSC.

The Trust stays in regular dialogue with representatives of the HOSCs to ensure they are kept informed about key issues and where appropriate, are given briefings to inform their discussions.

Swindon and Wiltshire LINks

The Trust is working with the respective LINks in both Swindon and Wiltshire to meet both our statutory duties and to extend the way in which we engage with our communities. The Trust has a duty to:

- respond to requests for information made by a LINk;
- respond to requests to enter and view;
- deal with reports and recommendations made by a LINk; and
- deal with any reports or recommendations from a LINk that have been referred by another services provider.

Above and beyond this, the Trust continues to look at ways to pool resources to reach out to the broader community beyond our existing membership; to share intelligence to access specific hard to reach or seldom heard groups; to share workload on consultations and dissemination of information; and, to engage people in each others work and potentially to help to recruit new members to both the Trust and the LINks.

Our staff

The Trust employs a total head count of 3,263 members of staff – a total of 2,731.02 Whole Time Equivalents (WTE).

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 2009 survey results show that staff satisfaction levels continue to improve and currently stand at a score of 3.52 (out of five). This is higher than the national average for acute Trusts.

The 2009 staff survey results also shows the Trust performance against a range of other indicators and demonstrate that staff experience has improved in the following:

- The percentage of staff feeling satisfied with the quality of work and the patient care they are able to deliver has risen from 64% in 2008 to 73% in 2009.
- Staff report greater satisfaction with the quality of job design i.e. clear job content, feedback opportunities and staff involvement rising from a score of 3.32 in 2008 to 3.44 in 2009.
- Work pressure felt by staff has fallen from 3.27 in 2008 to 3.10 in 2009
- Staff job satisfaction has risen from 3.41 in 2008 to 3.52 in 2009.

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 40 key findings and the results show that GWH has improved on 13 key finding areas since the last survey in 2008. However there are a number of indicators where the Trust performs below the national average.

Detailed below is a summary of the Staff Survey scores for 2009 alongside some of the scores from the 2008 survey. Full details of the results of the survey can be found on the Care Quality Commission website at: www.cqc.org.uk

Summary of the Staff Survey results

	2008		2009		Improvement/Deterioration
Response rate	Trust	National Average	Trust	National Average	
	59%	55%	60%	55%	1% increase on the year before

	2008		2009		Improvement/Deterioration
Top 4 Ranking Scores	Trust	National Average	Trust	National Average	
KF 30 Percentage of staff feeling pressure in last 3 months to attend work when feeling unwell	NA	NA	22%	26%	The question was not asked in 2008
KF 38 Percentage of staff having equality and diversity training in last 12 months	44%	27%	56%	35%	12% increase on the year before
KF 28 Perceptions of effective action from employer towards violence and harassment	3.58	3.54	3.65	3.55	0.7 point increase on the year before
KF 15 Percentage of staff appraised with personal development plans in last 12 months	57%	55%	69%	59%	12% increase on the year before

	2008		2009		Improvement/Deterioration
Bottom 4 Ranking Scores	Trust	National Average	Trust	National Average	
KF 12 Percentage of staff receiving job-related training, learning or development in last 12 months	78%	72%	75%	78%	3% decrease on the year before
KF 39 Percentage of staff believing trust provides equal opportunities for career progression or promotion	NA	NA	86%	90%	The question was not asked in 2008
KF 29 Impact of health and well-being on ability to perform work or daily activities	NA	NA	1.61	1.57	The question was not asked in 2008
KF 25 Percentage of staff experiencing physical violence from staff in last 12 months	2%	2%	2%	2%	Same result as the year before

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 Trust's performance can be improved and issues of concern can be addressed.

Staff consultations and engagement
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.

At the beginning of 2010 the Trust formally consulted with staff on a draft Fair Transport Scheme which is designed to reduce demand for car parking. These proposals included increasing staff parking charges and encouraging staff to use more sustainable modes of transport to and from work. The Trust received a lot of responses to the consultation along with constructive suggestions as to how the scheme should be implemented and as a result the Trust decided not to implement the scheme on 1 April but allow more time for feedback to be reviewed and an alternative plan to be identified later in 2010.

The Trust is also exploring improvements as to how the Trust communicates with staff so that they have ready access to timely and relevant information about Trust affairs. In early 2010/11 a staff engagement programme rolled out across the Trust to provide further opportunities for staff to discuss issues of importance and to help shape the thinking of the Trust leadership. Opportunities for open forums, surveys, staff recognition schemes and suggestions schemes will all be explored.

Supporting our volunteers
The Trust regularly receives contact from members of the public wishing to volunteer at GWH to help support frontline services. 318 volunteers regularly give up their time to make an important contribution to the hospital and our community. Over the past 12 months the Trust, through a dedicated support function, has streamlined volunteer recruitment processes, reviewed their roles and extended their contribution to cover a wider range of areas. For example, in March the Trust launched a volunteer feeding project where volunteers assisted with the feeding of patients who were malnourished or at risk of malnourishment.

Volunteers contribute approximately 1,600 hours per month and to recognise the contribution they make, the Trust regularly organises events including long service awards and keeps them informed of developments at the Trust through a dedicated volunteers newsletter.

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 has in place the statutory requirements of a Race, Disability and Gender Equality Scheme and is in the process of developing a Single Equality Scheme which will also incorporate religion, age and sexuality.

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 who 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.

Occupational Health

The Trust welcomed 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.

The Occupational Health department continues to work closely with managers and HR to reduce time lost due to sickness absence. The two key projects began in 2009/10 to address Musculoskeletal Disorder (MSD) issues and reducing stress related absence.

The MSD team and the Occupational Health team including physiotherapy input have worked closely together to carry out work place assessments along with early intervention treatment. This has helped reduce time lost by 5%. With regard to stress related absence, the Occupational Health team have recruited two employees who are qualified in Cognitive Behavioural Therapy.

Over the past 12 months there has been an increase in the number of line managers requesting case conferences on employees with underlying conditions and this has enabled key stakeholders to plan for and support employees in an early return to work. These will increase with the implementation of the revised Med 3 (fit note) from April 2010.

Swine 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. The Occupational Health Department ran a successful Swine Flu vaccination programme from November 2009 and as a result over 60% of front line staff received the vaccine.

Health and Safety

Several management systems and governance improvements have been introduced during 2009/10, helping to develop an improved health and safety culture at GWH.

Health and Safety targets were set for 2009/10 in key areas where safety performance improvements were required. They include stress management, musculoskeletal injury/absence reduction, slips, trips and falls, sharps management, accident reduction and fire safety compliance.

Performance was monitored and measured in all areas via the Health and Safety Committee and Integrated Governance and Risk Committee and several key improvement initiatives were rolled out in order to help achieve these targets and to improve in future years.

These included:-

- Implementation of an Electronic IR1 reporting system throughout the Trust and training of staff to attain 85% of all IR1 reports in this format without any reduction in levels of

incidents reported. The electronic reporting system enables the Trust to report on investigation levels by department and ward level. The Trust is in the top 20% of Trusts in England for the levels of reporting of errors, near misses or incidents and also in the fairness and effectiveness of incident reporting procedures according to the 2009 CQC staff survey.

- Implementation and roll out of Managers Accident / Incident Investigation training to improve the quality and quantity of reports investigated in order to identify root causes, learn lessons and prevent recurrence.

- A series Working Groups on the following issues:
    - Stress Management, with good progress being made throughout the year culminating in the Health and Safety Executive publishing a Stress Management best practice case study at GWH on its website in January 2010
    - Latex Management, including an internal audit completed in November 2009 with good compliance results.
    - Ergonomics / MSD Reduction Project attained a 5% reduction in working days lost to MSD during the eight month period to January 2010.
    - An anticipated 20% or more reduction in unwanted fire signals and Fire Brigade call-outs during 2009/10 compared to the previous year.

An RSM Bentley Jennison Internal Audit of Trust wide Health and Safety compliance in July 2009 concluded that the Board can take substantial assurance that the controls upon which the organisation relies to manage health and safety risk are effective.

Workforce Key Performance Indicators (KPIs)

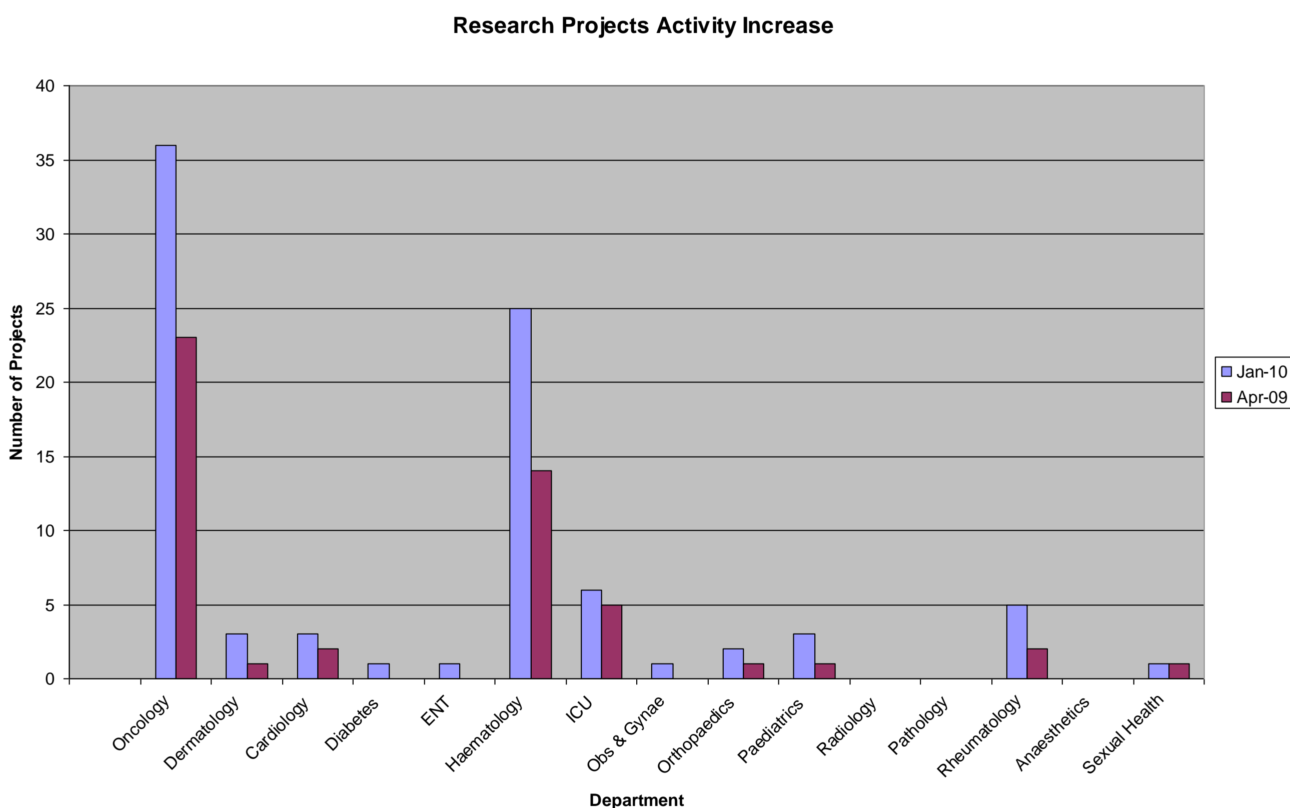
The Trust has a range of workforce KPIs against which the performance of the organisation can be measured. These are:

- An upper threshold limit of 4% for sickness absence in 2009/10. Year to date our levels are 4.64%. The variance is due to higher than expected levels of flu and diarrhoea and vomiting, which has been particularly prevalent in 2010.
- An upper threshold limit of 12% for turnover. Year to date our levels are 12.76%. This figure is slightly higher than the upper threshold due to the transfer of 76 staff from Marlborough House to Oxfordshire and Buckinghamshire Mental Health Trust as part of the transfer of responsibility for the provision of Child and Adolescent Mental Health Services at the end of the financial year.
- An upper threshold level of 6% for vacancy levels and the year end figure was 5.32%. The Trust has achieved this by introducing improved recruitment processes and delegating more responsibility to budget holders to replace leavers.
- The Trust is also in the top 20% of Trusts in England for the percentage of our staff who have received an appraisal and personal development plan.

Research and Development during 2009/10

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:

- A large number of new studies have been approved across Paediatrics, Orthopaedics, Anaesthetics, Rheumatology, Dermatology, Haematology and two pandemic flu studies. The graph below details the increase in the number of research projects during 2009/10 when compared with 2008/09. Some of these studies are from the government approved (portfolio) and therefore attract funding through the Western Comprehensive Local Research Network (WLCRN) who distribute funding to the Trust from the Department of Health.



- During 2009/10 additional hours/posts have been funded within Rheumatology, Dermatology, Stroke, Cancer and Sexual Health to support the portfolio research activity in these areas and to assist in setting up new projects. There are future plans to support Cardiology in setting up research projects.

- Providing research support services such as Day Therapy, Pathology, Pharmacy and Radiology with funding to ensure they can continue to support portfolio research activity across the Trust.

- Effort has been made to improve liaison with clinical staff across the Trust to assist them in engaging in research activity with diabetes being a particular area of interest.

- Work has now taken place to create/update/ratify Trust-wide Standard Operating Procedures for research to establish more robust governance arrangements in this area.

The R&D team continues to progress in these areas and aims to increase the number of patients joining studies by 20% over the course of 2010/11.

SUIs involving Data Loss or Confidentiality Breach

During 2009/10 there were no Serious Untoward Incidents (SUIs) involving data loss or confidentiality breach classified at a severity rating of 3-5. Accordingly, no incidents required reporting to the Information Commissioner.

Five incidents of severity rating 1-2 are aggregated and reported below in the specified format:

Summary of other personal data related incidents in 2008/09		
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	0
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	0
IV	Unauthorised disclosure	4
V	Other	1

Level 1 is a minor breach of confidentiality where only a single individual affected.
Level 2 is a potentially serious breach but with less than 5 people affected or it has been assessed as a low risk.

Remuneration Committee

Membership of the Remuneration Committee

Rowland Cobbold	Chairman
Robert Burns	Member
Liam Coleman	Member
Angela Gillibrand	Member
Kevin Small	Member
Roger Hill	Member
Bruce Laurie	Member

The Remuneration Committee is a sub committee of the Trust Board and its responsibilities are to:

- Determine the appropriate remuneration, terms of service and contracts of employment for the Chief Executive and other Executive Directors including, but not limited to;
  - all aspects of salary, including any performance related elements and bonuses;
  - the provision of other benefits, including pensions and cars where relevant;
  - the arrangements for the termination of employment.
- Ensure there is effective evaluation and monitoring of the performance of the Chief Executive by the Chair and of other Executive Directors by the Chief Executive.
- Determine the terms of any severance agreement between the Trust and the Chief Executive or between the Trust and any other Executive Director, including the calculation of any payment that may be contractually due, and/or any ex-gratia payment which the Committee may believe to be appropriate.
- Set, for new appointments, a salary range for each post prior to recruitment on the understanding that in the event that the Chief Executive advises that to secure the best candidate it may be necessary to offer a higher salary than originally agreed, he/she may seek the agreement of the Chair who in his/her sole discretion may act on this advice or refer it to the Committee for further consideration.

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

Policy and Guidance

In exercising its responsibilities, the Committee:

- Has regard for each individual's performance and contribution to the Trust, the performance of the Trust itself
- Takes into account any applicable guidance from suitably qualified organisations or external bodies, that may from time to time be issued relating to remuneration of Executive Directors
- Seeks professional advice from the Chief Executive, Director of Workforce and Education, Director of Finance or other professionals

The Remuneration Committee reviewed the performance and salaries of the Executive Directors of the Trust. Advice was obtained from Lyn Hill-Tout, Chief Executive and Oonagh Fitzgerald, Director of Workforce & Education.

During the year the Committee tendered for external advice and subsequently appointed Hay Group. Hay Group were selected based on their experience of working with Foundation Trusts and had developed competences relevant for Executive Directors of Foundation Trusts. Hay Group were commissioned to design a new appraisal process for the Chief Executive and Executive Directors 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.

The Committee has 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 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.

For 2009/10 an inflationary pay increase of 1.5% of salary was agreed for all Executive Directors and no other payments were made. In determining pay awards, the Remuneration Committee sought to ensure pay awards were consistent with those given to other staff groups.

For the coming year (2010/11) salary levels will be reviewed against market rates and the economic position generally.

Executive 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 appointed by a committee comprising the Chairman, Chief Executive and Non-Executive Directors and the Trust's Constitution sets out the circumstances under which a Director may be disqualified from office.

Attendance at Remuneration Committee meetings held during 2009/10

	Record of attendance at each meeting (✓ = attended X = did not attend)		
Name	**15/04/09**	**18/11/09**	**11/02/10**
Attendees			
Rowland Cobbold	✓	✓	✓
Robert Burns	✓	✓	✓
Liam Coleman	✓	✓	X
Angela Gillibrand	✓	✓	X
Kevin Small	X	✓	✓
Roger Hill	✓	✓	✓
Bruce Laurie	✓	✓	✓

Remuneration Committee Report – information subject to audit

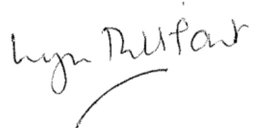
B Pensions Benefits

Name	Title	Real Increase in Pension at age 60. (Bands of £2500)	Real Increase in Lump Sum at age 60. (Bands of £2500)	Total accrued pension at age 60. (Bands of £5000)	Total accrued related lump sum at age 60. (Bands of £5000)	Cash Equivalent Transfer Value at 31st March 2010	Cash Equivalent Transfer Value at 31st March 2009	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	0-2.5	40-45	120-125	858	780	39	*0*
O Fitzgerald	Director of Workforce and Education	0-2.5	0-2.5	10-15	30-35	142	122	14	*0*
M. Moore	Director of Finance	2.5-5	7.5-10	15-20	50-55	238	177	52	*0*
A. Troughton	Medical Director	0-2.5	0-2.5	40-45	130-135	1,047	903	98	*0*
S Rowley	Director of Nursing	0-2.5	0-2.5	25-30	80-85	540	493	23	*0*
H Bourner	Director of Business Development & Performance	0-2.5	2.5-5	10-15	30-35	194	155	31	*0*

A Remuneration

		2009/10				*2008/09 Dec-Mar*		
Name	**Title**	**Salary (Bands of £5000)**	**Arrears for 08-09 paid in 09-10**	**Other Renumeration (Bands of £5000)**	**Benefits in Kind Rounded to the Nearest £100**	***Salary (Bands of £5000)***	***Other Renumeration (Bands of £5000)***	***Benefits in Kind Rounded to the Nearest £100***
B Laurie	Chair	35-40	05-10	-	0	*10-15*	*0*	*0*
K Small	Non Executive Director	10-15	0-5	-	0	*0-5*	*0*	*0*
R Cobbold	Non Executive Director	10-15	0-5	-	0	*0-5*	*0*	*0*
A Gillibrand	Non Executive Director	10-15	0-5	-	0	*0-5*	*0*	*0*
R Hill	Non Executive Director	10-15	0-5	-	0	*0-5*	*0*	*0*
R Burns	Non Executive Director	10-15	0-5	-	0	*0-5*	*0*	*0*
L Coleman	Non Executive Director	10-15	-	-	0	*0-5*	*0*	*0*
L. Hill-Tout	Chief Executive	120-125	05-10	-	0	*50-55*	*0*	*0*
O Fitzgerald	Director of Workforce and Education	75-80	0-5	-	0	*40-45*	*0*	*0*
M Moore	Director of Finance	100-105	0-5	-	0	*40-45*	*0*	*0*
A. Troughton	Medical Director	95-100	0-5	80-85	0	*25-30*	*30-35*	*0*
S Rowley	Director of Nursing	80-85	0-5	-	0	*30-35*	*0*	*0*
H Bourner	Director of Business Development & Performance	75-80	0-5	-	0	*35-40*	*0*	*0*

Lyn Hill-Tout



Chief Executive, 4th June 2010

The accounting policies for pensions and other retirement benefits are set out in note 1.3.1 to 1.3.2 in the accounts and key management compensation is set out in note 7.3.

Notes to Remuneration and Pension Tables

Non-Executive Directors do not receive pensionable remuneration.

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.

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.

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 accounting officers' Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

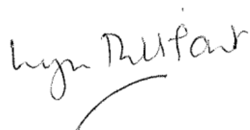
Under the NHS Act 2006, Monitor has directed the Great Western Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of 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 Financial 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



Signed…………………………………...

Chief Executive: Mrs Lyn Hill-Tout

Date: 4th June 2010

Statement on internal control

Statement on internal control

1. Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of Great Western Hospitals NHS Foundation Trust's policies, aims and objectives, whilst safeguarding 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 Board delegated authority, on its behalf, to the following committees:

- Audit Committee
- Integrated Governance and Risk Committee
- Finance Committee
- Remuneration Committee
- Charitable Funds Committee
- Mental Health Act Committee
- Workforce Strategy Committee.

Scrutiny by the Non-Executive Director within these committees provided assurance of internal control, including probity, in the application of public funds and in the conduct of the organisation's responsibilities. The Board reviewed minutes and reports from these groups to ensure that an integrated approach is taken to governance and risk management. Both internal and external audit were represented on the Audit Committee.

2. 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 2010 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

Leadership is provided 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 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 Untoward Incident (SUI) investigation the learning from which is disseminated through the Trust via the Clinical Governance and Risk 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.

4. The risk and control framework

To ensure that risk is identified, evaluated and controlled there are formal structures within the Trust. Whilst the Board has overall responsibility, it delegates the work to the Integrated Governance and Risk Committee, which is chaired by a Non-Executive Director and has addition Non-Executive and Executive Director membership. The Clinical Governance and Risk Committee supports the Integrated Governance and Risk Committee. The Audit Committee has an overarching role in oversight of the Assurance Framework.

In December 2009 internal audit submitted a draft report on Risk Management and the Assurance Framework which gave limited assurance on the Trust's processes for managing risk. In response to the report, the executive team made a number of changes to the way risk is managed. In recognition of the steps the Trust has taken, the final internal audit report on Risk Management and the Assurance Framework gave substantial assurance to the Trust.

The Trust's Risk Management Strategy (which was reviewed in August 2009 and in March 2010) describes the Trust's approach to risk management and outlines the formal structures in place to support our approach. The Trust operates an Assurance Framework, Corporate Risk Register and Directorate Risk Registers to support the management of risk across the organisation.

The Assurance Framework is built around the Trust's objectives and covers all of the organisation's main activities. It identifies:

- The Trust's **objectives**;
- **Risks** against achieving those objectives;
- **Controls** in place to manage the risks;
- **Assurances** on the effectiveness of controls; and
- **Actions** to be taken to strengthen both controls and assurances.

Each Directorate Risk Register identifies the high level risks within the Directorate based on systematic risk assessment and scoring. The Directorate 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 Governance team 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). The Integrated Governance and Risk Committee is reviewed for accuracy and currencybut the Integrated Governance and Risk Committee on a 2-monthly basis,and by Trust Board on a 6-monthly basis.

Significant risks identified and managed during 2009/10 include:

- The potential for care to be compromised due to significant seasonal pressures resulting from prolonged cold weather and higher than expected demand;
- Financial risk associated with non payment of over performance by PCTs;
- Reputation risk associated with impending HSE prosecution;
- Regulatory risk associated with potential failure to meet national targets on stroke.

Actions that have been taken throughout the year to mitigate these risks:

- The appointment of a Emergency Planning Coordinator and wholesale revision of the Trust Escalation Policy;
- High-level contract resolution meetings with Commissioning PCTs and taking formal legal advice;
- Communication handling plan implemented and regularly reviewed during the run up to HSE prosecution;

- A stroke action plan has been produced and will be implemented and monitored via the Clinical Governance and Risk Committee.

No significant gaps in controls or assurances were identified during 2009/10.

New risks have been identified as part of our 2010/11 business planning cycle and will be added to the Assurance Framework as follows:

- Financial implications contained as penalties in the NHS standard contract
- Delivery of productivities in the contract
- Delivery of CIPs (cost improvements)
- Partnership working to deliver the changes demanded by the new financial climate
- Staff recruitment and retention
- Changes in NHS policy as a result of the impending general election.

These risks will be actively managed through its 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.

The Trust was fully compliant with the core Standards for Better Health throughout 2009/10.

During the 2009/10 financial year, the Trust received external assurance on its risk management when it was awarded Level 2 of the NHSLA Risk Management Standards (Acute).

As a foundation trust our membership is a resource for supporting risk management in the Trust. The membership is represented by our Governors who attend regular formal meetings with the Board of Directors and Trust staff. In particular the Governors hold the Trust to account at the Patient Experience Working Group which meets quarterly. The Governors also have also contributed to the development of the Trust five-year quality strategy through a patient safety, quality and satisfaction working group.

Risks to information including data security are being managed and controlled. As Accountable Officer I am committed to ensuring that immediate actions are taken where significant risks have been highlighted. As a starting point we have identified the principal risks to data security as part of the overall approach to risk management within the Trust. Where assessed as appropriate, and in line with the Risk Management Strategy, these have been escalated to the relevant Risk Register. These principal risks accordingly reviewed and prioritised with appropriate controls and mitigations identified and outcomes actioned.

A range of measures are used to manage and mitigate the 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 data security is undertaken annually as part of the Information Governance Toolkit, and further assurance is provided from Internal Audit and other reviews.

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 Integrated Governance and Risk Committee, a sub committee of the Trust Board. The Trust Board has a Senior Information Risk Owner (SIRO) with responsibility for information risk policy.

The effectiveness of these measures is reported to the Information Governance Steering Group. This includes details of any personal-data-related Serious Untoward Incidents (SUIs), the Trust's annual Information Governance Toolkit score, and reports of other information governance incidents, audit reviews and spot checks.

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.

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 2009/10 provides a narrative of progress toward achieving the quality improvement indicators agreed by Management Committee, the Clinical Governance and Risk Committee and the Integrated Governance and Risk Committee.

The Quality Account is compiled by a Clinical Governance Administrator using data 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 Clinical Quality who is responsible 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 Clinical Governance and Risk 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 Clinical Governance and Risk Committee. Following scrutiny at the Clinical Governance and Risk Committee the Quality Account is reported to Trust Board who are required to both attest to the accuracy of the data and also ensure that improvement against the targets is 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.

The Quality Account is a new requirement from 1 April 2010. No material weakness in the control framework associated with Quality Accounts have been identified.

5. 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;
- A quarterly IM&T report;
- Monthly review of financial targets and contract performance by the Finance Committee, which is a sub committee of the Board;
- Monthly reporting to the Management Committee on directorate and Trust performance; and
- Quarterly reporting to Monitor, via the Finance Committee, and compliance with the terms of authorisation.

The Trust also participates in initiatives to ensure value of money, for example:

- Uses the Institute of Innovation & 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 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 business 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 Committee and to the Board.

6. Review of effectiveness

As Accountable 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 directors within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework, and 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, the audit committee and integrated Governance and Risk Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Assurance Framework also provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

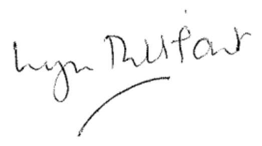
My review is informed by:

- Self-assessment declaration against CQC standards;
- External NHSLA Risk Management Standards (Acute) – Level 2 pass;
- Signed Statements on Internal Control from each Executive Director which identify material weaknesses;
- Quarterly reporting to Monitor;
- Internal audit reports on governance and risk.

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.

Lyn Hill-Tout



Chief Executive
4th June 2010

Additional declarations

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.

Each Director and Non-Executive Director is required to declare their interests on an annual basis. This formal declaration informs the Register of Directors Interests which is maintained by the Company Secretary and can be found on page 19 of this report. 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.

FOREWORD TO THE ACCOUNTS

These accounts for the period ended 31st March 2010 have been prepared by Great Western Hospitals NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to National Health Service Act 2006 in the form with Monitor, the Independent Regulator of NHS Foundation Trusts, with the approval of the Treasury, has directed.

Great Western Hospitals NHS Foundation Trust was formed on 1st December 2008, therefore in line with the FT Financial Reporting Manual comparators have only been included for the period 1st December 2008 - 31st March 2009.

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2010

	Notes	Year Ended 31 March 2010 £000	4 mths ended 31 March 2009 £000
Operating Income from continued operations	3 - 4	**200,882**	64,281
Operating Expenses of continued operations	5	**(192,344)**	(58,878)
Operating surplus		**8,538**	5,403
Finance Costs			
Finance income	10	**151**	64
Finance expense - financial liabilities	11	**(13,867)**	(4,485)
Finance expense - unwinding of discount on provisions		**(41)**	(41)
PDC Dividends payable		**(1,598)**	(742)
Net finance costs		**(15,355)**	(5,204)
DEFICIT FOR THE YEAR		**(6,817)**	198
Other comprehensive income			
Revaluation gains / (impairment losses) on property, plant & equipment	14.5	**(23,758)**	0
Increase in the donated asset reserve due to receipt of donated assets		**0**	0
Reduction in the donated asset reserve in respect of depreciation		**(247)**	(33)
Other recognised gains & losses		**0**	(2)
Total comprehensive income/(expense) for the year		**(30,822)**	164

Note:

Operating expenses includes a non-cash technical accounting adjustment due to an impairment loss of £7958K arising from a decrease in market valuation of land and buildings in 2009-10. The table below shows the surplus for the year prior to this adjustment

	£000
Deficit for the year	**(6,817)**
Add back net impairment loss charged to Operating Expenses	**7,958**
Surplus for the year prior to the technical accounting adjustment above	**1,141**

All income and expenditure is derived from continuing operations.

Great Western Hospitals NHS Foundation Trust
Accounts for the year ended 31 March 2010

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2010

.	Notes	31 March 2010 £000	31 March 2009 £000	1 Dec 2008 £000
Non-Current Assets				
Intangible assets	13	**613**	711	756
Property, Plant and Equipment	14	**182,725**	215,943	215,756
Trade and other receivables	17	**1,733**	2,703	2,439
Total non-current assets		**185,071**	219,356	218,951
Current Assets				
Inventories	16	**3,156**	2,534	2,553
Trade and other receivables	17	**11,094**	6,711	12,324
Cash and cash equivalents	19	**12,181**	20,379	14,244
Total current assets		**26,431**	29,624	29,121
Current Liabilities				
Trade and Other Payables	21	**(17,090)**	(18,652)	(17,729)
Borrowings	23.2	**(3,004)**	(3,418)	(3,379)
Provisions	24	**(1,424)**	(4,303)	(3,156)
Tax Payable	22.1	**(2,012)**	(2,222)	(2,148)
Other liabilities	22	**(1,491)**	(2,158)	0
Total current liabilities		**(25,020)**	(30,753)	(26,412)
Total assets less current liabilities		**186,482**	218,227	221,660
Non-Current Liabilities				
Trade and Other Payables	21	**(593)**	(593)	(2,789)
Borrowings	23.2	**(133,118)**	(136,213)	(137,340)
Provisions	24	**(4,142)**	(1,854)	(4,286)
Other Liabilities	22	**(2,044)**	(2,158)	
Total non-current liabilities		**(139,895)**	(140,818)	(144,415)
Total assets employed		**46,586**	77,409	77,245
Financed by Taxpayers' Equity				
Public dividend capital		**27,111**	27,111	27,111
Revaluation reserve		**18,551**	42,309	42,521
Donated asset reserve		**895**	1,142	1,175
Other reserves		**264**	264	6,172
Income and expenditure reserve		**(235)**	6,582	266
Total taxpayers' equity		**46,586**	77,409	77,245

Signed.. Date.............................
L Hill-Tout
Chief Executive
The notes on pages 5 to 49 form part of the financial statements

Great Western Hospitals NHS Foundation Trust
Accounts for the year ended 31 March 2010

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**
At start of period for new FT's	27,111	42,521	1,175	266	6,172	**77,245**
Surplus/(deficit) for the year	0	0	0	0	198	**198**
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	(33)	0	0	**(33)**
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve	0	(212)	0	0	212	**(0)**
Public Dividend Capital received/paid	0	0	0	0	0	**0**
Additions/(reduction) in Other reserves	0	0	0	(2)	0	**(2)**
Taxpayers' Equity at 31 March 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 year 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

Great Western Hospitals NHS Foundation Trust
Accounts for the year ended 31 March 2010

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2010

	Notes	Year Ended 31 March 2010 £000	4 mths ended 31 March 2009 £000
Cash flows from operating activities			
Operating surplus/(deficit) from continuing operations		8,538	5,403
Depreciation and amortisation		7,809	2,711
Impairment of tangible assets		7,958	0
Transfer from donated asset reserve		(247)	(36)
Amortisation of PFI credit		(114)	0
(Increase) / decrease in inventories		(622)	19
(Increase) / decrease in trade and other receivables		(3,235)	5,351
Increase / (decrease) in trade and other payables		(2,032)	1,275
Increase / (decrease) in other liabilities		(877)	0
Increase / (decrease) in provisions		(592)	(1,285)
NET CASH GENERATED FROM/(USED IN) OPERATIONS		16,586	13,437
Cash flows from investing activities			
Interest received		189	64
Purchase of Property, Plant and Equipment		(5,735)	(679)
Receipts from sale of property, plant and equipment		0	0
Payments to acquire intangible assets		0	0
Net cash used in investing activities		(5,546)	(615)
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		(3,509)	(1,089)
Interest paid		(105)	0
Interest element of finance leases		0	0
Interest element of Private finance Initiative Obligations		(13,851)	(4,485)
PDC dividends paid		(1,774)	(1,113)
Other capital receipts		0	
Net cash generated from/(used in) financing activities		(19,239)	(6,687)
Increase/(decrease) in cash and cash equivalents	19	(8,199)	6,135
Cash and cash equivalents at 1 April 2009		20,379	14,244
Cash and cash equivalents at 31 March 2010	19	12,181	20,379

ACCOUNTING POLICIES

1 Basis of Preparation

Monitor has directed that the financial statements of the 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 2009/10 NHS Foundation Trust Annual Reporting Manual 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 Transition to IFRS

The financial statements have been prepared in accordance with IFRSs and International Finance Reporting Interpretation Committee (IFRIC) interpretations as endorsed by the European Union, applicable at 31 March 2010 and appropriate to this Foundation Trust as noted above. This is the first set of full year results prepared in accordance with IFRS accounting policies. Its previously reported 2008/2009 financial statements for the 4 month accounting period December to March, have accordingly been restated to comply with IFRS, with the date of transition to IFRS being 1st April 2008, which is the beginning of the comparative period for the year to 31 March 2010. The Trust gained Foundation Trust status on 1st December 2008 and therefore the comparatives for the Statement of Comprehensive Income will be taken from this date.

The principal effects of the adoption of IFRS are detailed in the reconciliation of taxpayers' equity (assets employed) and retained surplus under UK GAAP to IFRS stated in note 33 on page 46-49.

Accounting Convention

These accounts have been prepared under the historical cost convention, on a going concern basis, except where modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

ACCOUNTING POLICIES (continued)

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 from 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 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

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.pensions.nhsbsa.nhs.uk. The Scheme is an unfunded, defined benefit scheme that covers NHS employers general practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The Scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying Scheme assets and liabilities. Therefore, the Scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the Scheme is taken as equal to the contributions payable to the Scheme for the accounting period.

Employers pensions cost contributions are charged to the operating expenses as and when they become due.

The Scheme is subject to a full actuarial investigation approximately every four years. The main purpose of which is to assess the level of liability in respect of the benefits due under the Scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and Scheme members. The last such investigation, on the conclusions of which Scheme contribution rates are currently based, had an effective date of 31 March 2004 and covered the period from 1 April 1999 to that date. Between the full actuarial valuations the Government Actuary provides an annual update of the Scheme liabilities for IAS19 purposes. The latest assessment of the liabilities of the Scheme is contained in the Scheme Actuary report, which forms part of the NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the Business Service Authority - Pensions Division website at www.nhsbsa.nhs.uk. Copies can also be obtained from the Stationery Office.

The conclusion of the 2004 investigation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004. This is after making some allowance for the one-off effects of pay modernisation, but before taking into account any of the scheme changes which come into effect on 1 April 2008. Taking into account the changes in the benefit and contribution structure effective from 1 April 2008, employer contributions could continue at the existing rate of 14% of pensionable pay. On advice from the actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities. Up to 31 March 2008 employees paid contributions at the rate of 6% (manual staff 5%) of their pensionable pay. From 1 April 2008, employees will pay contributions according to a tiered scale from 5% up to 8.5% of their pensionable pay.

Voluntary early retirements under scheme rules are discounted at the pensions rate.
Additional pensions 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 expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment (see note 24 of these accounts on page 37.

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.

ACCOUNTING POLICIES (continued)

1.5 Property, plant and equipment

1.5.1 Recognition

Capitalisation

Property, plant and equipment are capitalised if they are capable of being used for a period which exceeds one year and they:

- 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 Valuation

All property, plant and equipment are measured initially at cost, representing the cost 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.

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. Fair values are determined as follows:

Land and non specialised buildings - Modern Equivalent Asset (MEA)
Specialised buildings - MEA

ACCOUNTING POLICIES (continued)

Until 31 March 2008, the depreciated replacement cost of specialised buildings has been estimated for an exact replacement of the asset in its present location. HM Treasury, and confirmed by Monitor, has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. HM Treasury, and confirmed by Monitor has agreed that NHS FTs must apply these new valuation requirements by 1 April 2010 at the latest. A full valuation was undertaken in respect of the land and buildings accounted for as at 31 March 2010.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historical cost as this is not considered to be materially different from the fair value of assets which have a low value and / or short useful lives.

1.5.3 Revaluation

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset’s carrying value, derecognised. Where subsequent expenditure is simply restoring the asset to the specification assumed by its economic useful life then the expenditure is charged to operating expenses. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the recognition above. The carrying amount of the part replaced is derecognised.

1.6 Intangible assets

Intangible assets are capitalised when they are capable of being used in the Trust's activities for more than one year; they can be valued; and they have a cost of at least £5,000.

Intangible fixed assets held for operational use are valued at historical cost and are depreciated over the estimated life of the asset on a straight line basis. The carrying value of intangible assets is reviewed for impairment at the end of the first full year following acquisition and in other periods if events or changes in circumstances indicate the carrying value may not be recoverable.

Purchased computer software licences are capitalised as intangible fixed assets where expenditure of at least £5,000 is incurred and amortised over the shorter of the term of the licence and their useful economic lives.

These intangible assets are stated at cost less accumulated amortisation and impairment losses. Amortisation is charged to the Statement of Comprehensive Income on a straight line basis.

1.7 Depreciation and Amortisation and Impairments

Freehold land and properties under construction are not depreciated.

Property, plant and equipment are depreciated at rates calculated to write them down to estimated residual value on a straight-line basis over their estimated useful lives. No depreciation is provided on freehold land or assets surplus to requirements.

Assets in the course of construction are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as advised by the Trust's professional valuers. 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

Fixed asset impairments resulting from losses of economic benefits are charged to the income and expenditure account. All other impairments are taken to the revaluation reserve and reported in the statement of total changes in equity to the extent that there is a balance on the revaluation reserve in respect of the particular

If there has been an impairment loss, the asset is written down to its recoverable amount, with the loss charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to the income statement. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to the Statement of Comprehensive Income to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.8 Donated assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to the donated asset reserve. Donated assets are valued, depreciated and impaired as described for purchased assets. Gains and losses on revaluations and impairments are 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 offset the expenditure. On the sale of donated assets, the net book value is transferred from the donated asset reserve to retained earnings.

ACCOUNTING POLICIES (continued)

1.9 Government grants

Government grants are grants from government bodies other than revenue from NHS bodies or the MOD for the provision of services. Revenue grants are treated as deferred income initially and credited to income to match the expenditure to which they relate. Capital grants are recognised as a 'non-current liability' and are released to the Statement of Comprehensive Income over the life of the asset in a manner consistent with the depreciation and impairment charges for that asset. Assets purchased from government grants are valued, depreciated and impaired as described above for purchased assets.

1.10 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.10.1 The Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are charged directly to the Statement of Comprehensive Income.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated. Leased land is treated as an operating lease. Leased buildings are assessed as to whether they are operating or finance leases.

1.10.2 The Trust as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.11 Private Finance Initiatives (PFI) transactions

1.11.1 Recognition

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes following the principles of the requirements of IFRIC 12. Where the government body (the Grantor) meets the following conditions the PFI scheme falls within the cope of a 'service concession' under IFRIC 12:

- The grantor controls the use of the infrastructure and regulates the services to be provided to whom and at what price; and
- The grantor controls the residual interest in the infrastructure at the end of the arrangement as service concession arrangements.

The Trust therefore recognises the PFI asset as an item of property, plant and equipment on the Statement of Financial Position together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

1.11.2 Valuation

The PFI assets are recognised as property, plant and equipment, when they come into use, see the accounting policy 'Standards, amendments and interpretations applicable to the Trust for future accounting periods'. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

A PFI liability is recognised at the same time as the PFI asset is recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

1.11.3 Subsequent expenditure

The annual contract payments are apportioned, using appropriate estimation techniques between the repayment of the liability, a finance cost, lifecycle replacement and the charge for services.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term. The annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

1.11.4 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.

1.11.5 Other assets contributed by the Trust to the operator

Where existing Trust Buildings are to be retained as part of the PFI scheme, a deferred asset will be created at the point that the Trust transfers those buildings to the PFI partner. The deferred asset will be written off through the Statement of Comprehensive Income over the life of the concession.

Where current estate will be retained in use and maintained by the PFI provider but the risks and rewards will not pass to the provider, that part of the estate will remain on balance sheet and refurbishment costs which are included in the PFI will also be capitalised.

ACCOUNTING POLICIES (continued)

1.12 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.

1.13 Cash and cash equivalents

Cash and cash equivalents includes cash in hand, deposits held at call with banks, other short-term highly liquid investments with original maturities of three months or less and bank overdrafts. Account balances are only set off where a formal agreement has been made with the bank to do so. In all other cases bank overdrafts are shown within borrowings in 'current liabilities' on the Statement of Financial Position. In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. These balances exclude monies held in the Trust's bank accounts belonging to patients, see accounting policy note 1.26 for third party assets.

1.14 Finance income and costs

Interest earned on bank accounts and interest charged on overdrafts is recorded as, respectively, 'interest receivable' and 'interest payable' in the periods to which they relate. Bank charges are recorded as operating expenditure in the periods to which they relate.

1.15 Financial instruments and financial liabilities

1.15.1 Recognition and de-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.

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.

ACCOUNTING POLICIES (continued)

1.15.2 Classification

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.

1.15.3 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 cash at bank and in hand, 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 income and expenditure account.

1.15.4 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 balance sheet 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 the income and expenditure account.

ACCOUNTING POLICIES (continued)

1.15.5 Impairment of financial assets

At the end of the reporting period, 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.

1.15.6 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.

1.16 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.

1.17 Deferred income

Deferred income represents grant monies 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.

1.18 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 36. To date the Trust has not utilised any of its available prudential borrowing.

ACCOUNTING POLICIES (continued)

1.19 Provisions

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the reporting date on the basis of the best estimate of the expenditure 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.

1.19.1 Clinical Negligence Costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the 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 Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed in note 24 on page 37.

1.19.2 Non-Clinical Risk Pooling

The 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.

ACCOUNTING POLICIES (continued)

1.20 Public Dividend Capital

Public Dividend Capital (PDC) represents taxpayers' equity in the Trust. At any time the Secretary of State can issue new PDC to, and require repayments of, PDC from the Trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, 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. From the 1 April 2009, the dividend payable is calculated at the rate set by HM Treasury (currently 3.5%) on the actual relevant net assets of the Trust during the financial year, instead of forecast relevant net assets. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for donated assets and cash with the Office of the Paymaster General.

1.21 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.

1.22 Corporation Tax

The Trust is a Health Service Body within the meaning of s519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for the Treasury to disapply the exemption in relation to specified activities of a Foundation Trust (s519A (3) to (8) ICTA 1988). Accordingly, the Trust is potentially within the scope of corporation tax in respect of activities where income is received from a non public sector source. HM Treasury have stated that corporation tax will be applied to Foundation Trusts from the financial year commencing 1 April 2011.

ACCOUNTING POLICIES (continued)

1.23 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.

1.24 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the 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.

1.25 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.

1.26 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

The judgements and key sources of estimation uncertainty that have a significant effect on the amounts recognised in the financial statements are detailed below:

a) Determination of useful lives for property, plant and equipment and intangible assets

Buildings, dwellings and fittings not scheduled for disposal / demolition, are depreciated on their current value over the estimated remaining life of the asset as assessed by the Trust's professional valuer.

Depreciation is provided so as to write down the other assets on a straight line basis over the estimated life:

Short life medical equipment	5 years
Medium life medical equipment	10 years
Long life medical equipment	15 years
IT and intangible assets	5 years

b) Provisions

Provisions have been made for pension and legal liabilities based on information received from the NHS Pensions Agency, NHS Litigation Agency and the Trust's own solicitors. Trust management has also made provisions for legal and constructive obligations where past events are known, settlement by the Trust is probable and a reliable estimate can be made. These provisions are estimates of the actual costs of future cash flows and are dependent on future events. Any difference between expectations and the actual future liability will be accounted for in the period when such determination is made.

The holiday pay accrual represents management's best estimate of the cost of annual leave entitlement earned but not taken by employees at the period end.

The carrying amounts of the Trust's provisions are detailed in note 24 on page 37.

ACCOUNTING POLICIES (continued)

1.27 New Accounting Standards

1.27.1 The standards, amendments and interpretations effective as at 31 March 2010

The Trust has applied International Financial Reporting Standards for the first time in preparing its financial statements for the year ended 31 March 2010. All standards, amendments and interpretations effective in the year to 31 March 2010 which are relevant to the Trust's operations have been adopted.

2. Segmental Analysis

The 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 internal reporting structure.

3. Income from Activities

	Year Ended 31 March 2010 £000	4 mths ended 31 March 2009 £000
Foundation Trusts	**76**	143
NHS Trusts	**746**	114
Strategic Health Authorities	**0**	2,080
Primary Care Trusts	**180,073**	50,464
Department of Health - other	**0**	6,162
NHS Other	**0**	6
Private Patients	**2,607**	757
Non-NHS: Overseas patients (non-reciprocal)	**0**	47
NHS Injury Cost Recovery scheme	**1,124**	35
Non NHS: Other	**0**	209
	184,626	60,017

There is no Department of Health income in 2009/10 as the balance of £6162K in 2008/09 relates to the MFF payment which was paid by PCTs in this financial year. All income received from the Strategic Health Authority in 2009/10 relates to education and training.
NHS Injury Cost Recovery scheme income is subject to a provision for impairment of receivables of 19.25% to reflect expected rates of collection.

Non NHS:Other income is now included within Non-patient care services to other bodies in 2009/10.

3.1 Income from Activities

	Year Ended 31 March 2010 £000	4 mths ended 31 March 2009 £000
Elective income	**42,392**	14,014
Non elective income	**65,102**	21,200
Outpatient income	**36,009**	11,389
A & E income	**6,291**	1,898
Other NHS clinical income	**32,225**	10,468
Private patient income	**2,607**	757
Other non-protected clinical income	**0**	291
	184,626	60,017

With the exception of private patient and other non-protected clinical income, all of the above income from activities arises from mandatory services as set out in the Trust's Terms of Authorisation from Monitor.

3.1.1 Income from Mandatory and Non-Mandatory services

All income from activities included above relates to Mandatory services provided as set out in the Foundation Trusts Terms of Authorisation.

3.2 Private Patient Income	**Year Ended 31 March 2010 £000**	Base Year 2002/3 £000
Private patient income	**2,607**	1,587
Total patient related income	**185,185**	99,359
Proportion (as percentage)	**1.4%**	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 2010 £000**	4 mths ended 31 March 2009 £000
Research and Development	**426**	134
Education and Training	**7,117**	2,050
Charitable and other contributions to expenditure	**697**	214
Transfer from donated asset reserve in respect of depreciation on donated assets	**247**	36
Non-patient care services to other bodies	**1,884**	471
Other Income	**5885**	1,359
	16,256	4,264

Analysis of Other Operating Income

Charitable and Other Contributions to Expenditure		
a Macmillan Nurses	137	40
b Prospect Hospice	89	23
c Contributions from suppliers to support posts	464	136
d Charitable Funds Recharge	7	15
Total	697	214

Non-patient care services to other bodies		
a Mortuary	43	61
b Renal	304	87
c Sterile Services	127	36
d Drugs provided to other NHS bodies	855	131
e Other Misc amounts	555	156
Total	1,884	471

Other Income includes		
a Car Parking	1,016	333
b Estates Recharges	85	198
c Staff Recharges	1,317	311
d Property Rentals	442	128
e Cardiac Network	970	132
f Maternity amenity beds	107	34
g HCAI allocation	81	0
h Ultrasounds photo sales	31	7
i IT recharges	13	4
j Catering	25	6
f Other	1,798	206
Total	5,885	1,359

Revenue is almost totally from the supply of services. Revenue from the sale of goods is immaterial.

5. Operating Expenses

	Year Ended 31 March 2010 £000	4 mths ended 31 March 2009 £000
Services from Foundation Trusts	**752**	210
Services from other NHS Trusts	**2,488**	857
Services from other NHS bodies	**10,168**	613
Purchase of healthcare from non NHS bodies	**47**	421
Employee Expenses - Executive Directors	**717**	246
Employee Expenses - Non-Executive Directors	**148**	17
Employee Expenses - Staff	**116,213**	35,656
Drug Costs	**12,170**	3,457
Supplies and services - clinical	**8,814**	6,719
Supplies and services - general	**1,918**	659
Consultancy services	**142**	216
Establishment	**2,268**	971
Research and development	**426**	132
Transport	**170**	158
Premises	**4,741**	2,094
Increase / (decrease) in bad debt provision	**(2)**	(14)
Depreciation on property, plant and equipment	**7,711**	2,711
Amortisation on intangible assets	**98**	0
Impairment on property, plant and equipment	**7,958**	0
Audit services - statutory audit	**49**	58
Audit services - other	**36**	10
Clinical negligence	**3,613**	389
Legal Fees	**64**	58
Training courses and conferences	**586**	0
Other Services, e.g. Soft FM	**10,736**	3,243
Losses, ex gratia & special payments	**16**	(8)
Other	**297**	5
	192,344	58,878

The Trust's contract with its external auditors, The Audit Commission, provides for a limitation of the auditors liability of £0

Employee Expenses - Non Executive Director expenses in 2009/10 includes £17k related to back pay for 2008/09.

6. Operating leases

6.1 As lessee

	Year Ended 31 March 2010 £000	4 mths ended 31 March 2009 £000
Minimum lease payments	**256**	240
Contingent rents	**0**	0
	0	0
	256	240

Total future minimum lease payments	Year Ended 31 March 2010 £000	4 mths ended 31 March 2009 £000
Payable:		
Not later than one year	**441**	424
Between one and five years	**241**	736
After 5 years	**1**	4
Total	**683**	1,164

7. Employee costs and numbers

7.1 Employee Expenses

	Year Ended 31 March 2010			4 mths ended 31 March 2009		
	Total	**Permanently Employed**	**Other**	Total	Permanently Employed	Other
	£000	**£000**	**£000**	£000	£000	£000
Salaries and wages	**92,227**	**92,227**	**0**	28,861	28,861	
Social security costs	**7,345**	**7,345**	**0**	2,151	2,151	
Pension costs - defined contribution plans Employers contributions to NHS pensions	**11,009**	**11,009**	**0**	3,415	3,415	
	0	**0**	**0**	0		
Agency/contract staff	**6,349**	**0**	**6,349**	1,475		1,475
	116,930	**110,581**	**6,349**	35,902	34,427	1,475

7.2 Average number of employees (WTE Basis)

	Year Ended 31 March 2010			4 mths ended 31 March 2009		
	Total	**Permanently Employed**	**Other**	Total	Permanently Employed	Other
	Number	**Number**	**Number**	Number	Number	Number
Medical and dental	**408**	**408**	**0**	383	383	
Administration and estates	**688**	**688**	**0**	649	649	
Healthcare assistants and other support staff	**467**	**467**	**0**	422	422	
Nursing, midwifery and health visiting staff	**1,103**	**1,103**	**0**	1,072	1,072	
Nursing, midwifery and health visiting learners	**3**	**3**	**0**	3	3	
Scientific, therapeutic and technical staff	**398**	**398**	**0**	398	398	
Bank and agency staff	**171**	**0**	**171**	138		138
	3,238	**3,067**	**171**	3,065	2,927	138

7. Employee costs and numbers (cont.)

7.3 Key Management Compensation

	Year Ended 31 March 2010 £000	4 mths ended 31 March 2009 £000
Salaries and short term benefits	**714**	214
Social Security Costs	**74**	23
Employer contributions to NHSPA	**77**	26
Compensation for loss of office	**0**	0
	865	263

Key management compensation consists entirely of the emoluments of the Board of Directors of the 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 benefits are accruing under defined benefit schemes.

7.4 Management costs

	Year ended 31 March 2010 **000s**	Year ended 31 March 2009 **000s**
Managements Costs	£ 7,482	£ 6,732
Income	£ 200,882	£ 189,524
Percentage %	**3.7%**	**3.6%**

8. Retirements due to ill-health

During the year to 31 March 2010 there were 4 early retirements from the Trust agreed on the grounds of ill-health (31 March 2009 - 3). The estimated additional pension liabilities of these ill-health retirements will be £218,064 (31 March 2009 - £128,783). 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 2010**		Year ended 31 March 2009	
	Number	**£000**	Number	£000
Total trade bills paid in the year	**38,915**	**45,728**	35,414	38,050
Total trade bills paid within target	**36,295**	**42,070**	31,194	33,168
Percentage of trade bills paid within target	**93.27%**	**92.00%**	88.08%	87.17%
Total NHS bills paid in the year	**1,722**	**46,961**	1,580	36,620
Total NHS bills paid within target	**1,384**	**40,559**	1,380	34,599
Percentage of NHS bills paid within target	**80.37%**	**86.37%**	87.34%	94.48%

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 £25.55 in the year for late payment of commercial debts.

10. Finance Income

	Year Ended 31 March 2010 £000	4 mths ended 31 March 2009 £000
Interest on loans and receivables	**151**	64
	151	64

11. Finance Expense

	Year Ended 31 March 2010 £000	Year Ended 31 March 2009 £000
Interest relating to WCF	**16**	0
Interest on obligations under PFI	**13,851**	4,485
	13,867	4,485

12. Taxation

The activities of the Trust have not given rise to any corporation tax liability in the year (year ended 31 March 2009- £nil).

13. Intangible Assets

13.1 2009/10:

	Computer software - purchased £000	Licences and trademarks £000	Total £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. Intangible Assets (cont.)

13.2 Prior year 2008/09:

	Computer software - purchased	Licences and trademarks	Total
	£000	£000	£000
Gross cost at start of new FT period	186	1,329	1,515
Additions purchased	0	0	0
Additions donated	0	0	0
Gross cost at 31 March 2009	**186**	**1,329**	**1,515**
Amortisation at start of new FT period	21	739	760
Provided during the year	8	37	45
Amortisation at 31 March 2009	**29**	**776**	**805**
Net book value			
Purchased	157	554	711
Donated	0	0	0
Total at 31 March 2009	**157**	**554**	**711**

13.3 Valuation and economic useful lives

The valuation basis is described in note 1.6 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 1.29 to the accounts.

14. Property, plant and equipment

14.1 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 April 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 April 2009	0	0	0		29,953	58	5,376	1,128	36,515
Provided during the year	0	4,572	173	0	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	0
Revaluation	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	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	896
Total at 31 March 2010	**21,049**	**137,273**	**5,033**	**1,837**	**11,372**	**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	11,372	0	4,718	1,444	19,370
Total at 31 March 2010	**21,049**	**137,273**	**5,033**	**1,837**	**11,372**	**0**	**4,718**	**1,444**	**182,725**
Asset Financing									
Net book value									
- Owned	21,049	137,273	5,033	1,837	11,372	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**	**11,372**	**0**	**4,718**	**1,444**	**182,725**

Great Western Hospitals NHS Foundation Trust
Accounts for the year ended 31 March 2010

14. Property, plant and equipment

14.2 Prior year 2008/09:	**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 2008	23,910	191,286	6,821	188	39,131	58	9,351	2,778	273,523
Additions Purchased	0	402	0	387	667	0	1,397	0	2,852
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	0	0	0	0	0
Revaluation gains	0	0	0	0	552	0	0	0	552
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Gross cost at 31 March 2009	**23,910**	**191,688**	**6,821**	**575**	**40,349**	**58**	**10,748**	**2,778**	**276,927**
Depreciation at 1 Dec 2008	0	22,630	122		28,900	58	5,056	1,003	57,769
Provided during the year	0	1,656	61		501	0	321	125	2,664
Impairments	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0		0	0	0	0	0
Revaluation	0	0	0		552	0	0	0	552
Disposals other than by sale	0	0	0		0	0	0	0	0
Depreciation at 31 March 2009	**0**	**24,286**	**183**	**0**	**29,953**	**58**	**5,376**	**1,128**	**60,984**
Net book value									
- Purchased at 31 March 2009	23,910	167,402	6,638	528	9,360	0	5,372	1,592	214,801
- Donated at 31 March 2009	0	0	0	47	1,037	0	0	58	1,142
Total at 31 March 2009	**23,910**	**167,402**	**6,638**	**575**	**10,397**	**0**	**5,372**	**1,650**	**215,943**
Analysis of property, plant and equipment									
Net book value									
- Protected assets at 31 March 2009	23,910	167,402	6,638	0	0	0	0	0	197,950
- Unprotected assets at 31 March 2009	0	0	0	575	10,397	0	5,372	1,650	17,993
Total at 31 March 2009	**23,910**	**167,402**	**6,638**	**575**	**10,397**	**0**	**5,372**	**1,650**	**215,943**
Asset Financing									
Net book value									
- Owned	23,910	167,402	6,638	575	10,397	0	5,372	1,650	215,943
- Finance Leased	0	0	0	0		0	0	0	0
Total at 31 March 2009	**23,910**	**167,402**	**6,638**	**575**	**10,397**	**0**	**5,372**	**1,650**	**215,943**

14. Property, plant and equipment (cont.)

14.3 Revaluation

The Trust undertook a Modern Equivalent Asset revaluation as at 1st April 2009 on all land and buildings and also processed a subsequent impairment relating to this revaluation as at 31st March 2010. All other assets are valued at depreciated replacement cost with no indexation in year due to the current economic climate.

14.4 Economic useful lives

The economic useful lives of property, plant and equipment are described in note 1.29 to the accounts.

14.5 Impairments of property, plant and equipment

	31 March 2010 £000	31 March 2009 £000
Impairment on Land and Buildings relating to MEA valuation	**31,716**	0
	31,716	0

This impairment has been made relating to an MEA valuation given by the District Valuer dated 1st April 2009 and the subsequent decrease in the BCIS index from 245 to 210 by 31st March 2010 due to the current economic climate. This value is the value in existing use.

15. Capital commitments

There are no commitments under capital expenditure contracts at the end of the period (£1593K as at 31 March 2009), not otherwise included in these financial statements.

16. Inventories

16.1 Inventories

	31 March 2010 £000	31 March 2009 £000	1 Dec 2008 £000
Materials	**3,156**	2,534	2,553
Work in progress	**0**	0	0
Finished goods	**0**	0	0
	3,156	2,534	2,553

Inventories carried at fair value less costs to sell where such value is lower than cost are nil (31 March 2009 - £nil).

16.2 Inventories recognised in expenses

	31 March 2010 £000	31 March 2009 £000
Inventories recognised as an expense	**31,206**	10,835
Write-down of inventories recognised as an expense	**0**	0
	31,206	10,835

17. Trade and other receivables

17.1 Trade and other receivables

	Current			Non current		
	31 March 2010 £000	31 March 2009 £000	1 Dec 2008 £000	**31 March 2010 £000**	31 March 2009 £000	1 Dec 2008 £000
NHS receivables	**6,738**	2,647	5,146	**0**	0	0
Other receivables with related parties	**0**	0	0	**0**	0	0
Provision for impaired receivables	**(786)**	(788)	(801)	**0**	0	0
Prepayments	**359**	1,097	3,585	**0**	593	593
Lifecycle prepayment	**0**	0	0	**1,733**	2,110	1,846
Accrued Income	**1,818**	1,694	0	**0**	0	0
Other receivables	**2,788**	2,061	3,058	**0**	0	0
PDC receivable	**176**	0	0	**0**	0	0
	11,094	6,711	10,988	**1,733**	2,703	2,439

17.2 Provision for impairment of receivables

	31 March 2010 £000	31 March 2009 £000
Balance at 1 April	**788**	801
Increase in provision	**111**	0
Amounts utilised	**(113)**	(14)
Balance at 31 March	**786**	788

18. Other non financial assets

	Current			Non current		
	31 March 2010 £000	31 March 2009 £000	1 Dec 2008 £000	**31 March 2010 £000**	31 March 2009 £000	1 Dec 2008 £000
Tax Receivable	**393**	500	1,336	**0**	0	0
	393	500	1,336	**0**	0	0

There are no PFI deferred assets

19. Cash and cash equivalents	**31 March 2010 £000**	31 March 2009 £000
Balance at 1 Dec 2008		14,244
Balance at 1 April 2009	**20,379**	
Net change in year	**(8,198)**	6,135
Balance at 31 March 2010	**12,181**	20,379
Made up of		
Cash with Government Banking Service	**12,181**	18,878
Commercial banks and cash in hand	**0**	1,501
	0	0
Cash and cash equivalents as in statement of financial position	**12,181**	20,379
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**12,181**	20,379

20. Non-current assets held for sale

The Trust has no non-current assets held for sale (31 March 2009 - £nil).

21. Trade and other payables		**Current**			**Non-Current**	
	31 March 2010 £000	31 March 2009 £000	1 Dec 2008 £000	**31 March 2010 £000**	31 March 2009 £000	1 Dec 2008 £000
NHS payables	**3,750**	2,708	993	**0**	0	0
Amounts due to other related parties	**0**	0	0	**0**	0	0
Trade payables - capital	**3,492**	3,018	843	**0**	0	0
Other trade payables	**2,340**	0	5,213	**0**	0	0
Other payables	**2,201**	4,130	4,079	**593**	593	2,789
Accruals	**5,309**	8,796	8,749	**0**	0	0
Receipts in advance	**0**	0	0	**0**	0	0
PDC payable	**0**	0	0	**0**	0	0
	17,090	18,652	19,877	**593**	593	2,789

Other payables include pension contributions of £1,419,853 outstanding (31 March 2009: £2,140,974).

22. Other liabilities

	Current			Non-current		
	31 March 2010	31 March 2009	1 Dec 2008	**31 March 2010**	31 March 2009	1 Dec 2008
	£000	£000	£000	**£000**	£000	£000
Deferred income	**1,491**	2,158	0	**2,044**	2,158	0
	1,491	2,158	0	**2,044**	2,158	0

22.1 Tax Payable

Tax payable of £2,012,549 (31 March 2009: £2,221,974) 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 .

23. Borrowings

23.1 Prudential borrowing limit

	31 March 2010	31 March 2009
	£000	£000
Prudential borrowing limit set by Monitor	**137,300**	18,500
Working capital facility	**14,000**	14,000
Actual borrowing in year - long term	**0**	0
Actual borrowing in year - working capital	**0**	0
Minimum dividend cover	**0.7**	3.2
Minimum interest cover	**n/a**	n/a
Minimum debt service cover	**n/a**	n/a
Maximum debt/capital ratio	**n/a**	n/a
Maximum debt service to revenue	**n/a**	n/a

The 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 five 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.

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.

23.2 PFI lease obligations

Amounts payable under PFI on SoFP obligations:	**31 March 2010**	31 March 2009	1 Dec 2008
	£000	£000	£000
Gross PFI liabilities	**290,852**	305,922	310,944
of which liabilities are due			
Within one year	**15,967**	15,492	15,535
Between one and five years	**58,147**	58,622	58,731
After five years	**216,738**	231,808	236,679
Less future finance charges	**(154,731)**	(166,291)	(170,224)
	136,121	139,631	140,721
Net PFI liabilities			
of which liabilities are due			
Within one year	**3,004**	3,418	3,379
Between one and five years	**15,195**	13,501	13,286
After five years	**117,923**	122,712	124,056
	136,121	139,631	140,721
Included in:			
Current borrowings	**3,004**	3,418	3,379
Non-current borrowings	**133,118**	136,213	137,341
	136,121	139,631	140,721

23.3 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 £10736K (4 month period ended March 2009 £3243K).

The trust is committed to the following annual charges

	31 March 2010	31 March 2009	1 Dec 2008
	£000	£000	£000
[1]PFI scheme expiry date:			
Not later than one year	**0**	0	0
Later than one year, not later than five years	**1515**	1,515	1,515
Later than five years	**23754**	23,754	23,754
Total	**25269**	25,269	25,269

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).

24. Provisions

	Current			Non current		
	31 March 2010 £000	31 March 2009 £000	1 Dec 2008 £000	**31 March 2010 £000**	31 March 2009 £000	1 Dec 2008 £000
Pensions relating to other staff	**79**	52	109	**1,242**	1,358	1,322
Legal claims	**285**	340	380	**0**	0	0
Other - inc s106 Agreement	**1,060**	3,911	2,667	**2,900**	496	2,964
	1,424	4,303	3,156	**4,142**	1,854	4,286

	Pensions relating to former directors £000	Pensions relating to other staff £000	Legal claims £000	Other - inc s106 Agreement £000	Total £000
At 1 April 2009	0	1,410	340	4,407	**6,157**
Arising during the year	0	0	0	0	**0**
Used during the year	0	(120)	(55)	(457)	**(633)**
Reversed unused	0	0	0	0	**0**
Unwinding of discount	0	31	0	10	**41**
At 31 March 2010	**0**	**1,321**	**285**	**3,960**	**5,566**
Expected timing of cash flows:					
Within one year	0	89	285	1,060	**1,434**
Between one and five years	0	356	0	2,900	**3,256**
After five years	0	876	0	0	**876**

The provisions included under 'legal claims' are for personal injury £285,000 (31 March 2009: £340,000). The provisions under other including s106 Agreement include the S106 provision of £2,900,000 (31st March 2009 £2,900,000) and preceptorship provision £193,000 (31st March 2009: £160,728)

Provisions within the annual accounts of the NHS Litigation Authority at 31 March 2009 include £19,394,552 in respect of clinical negligence liabilities of the Trust (31 March 2009 - £12,637,208).

25. Events after the reporting period

There are no events after the reporting period for the Trust.

26. Contingencies

There are no contingent liabilities for the period ended 31 March 2010.

27. 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 of 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, Mr 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 2009/10 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
South West Strategic Health Authc	60	0	5,995	0
NHS Swindon	2,065	1,072	107,733	2,113
NHS Wiltshire	1,566	8	52,472	371
NHS Berkshire	37	0	5,616	0
NHS Bristol	24	0	3,043	0
NHS Gloucester	828	32	6,364	94
NHS Oxford	61	0	3,105	0
NHS Litigation Authority	0	0	0	3,614
NHS Blood and Transplant Agency	0	82	0	1,731
NHS PASA	0	648	0	6,215
NHS Business Services Authority	0	426	0	2,056
Total	4,641	2,268	184,328	16,194

The Trust has also received revenue and capital payments from a number of charitable funds, certain of the Trustees for which are also members of the NHS Foundation 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.

28. Private Finance Initiative contracts

28.1 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%. 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.

The key risks that the Trust has identified are as follows:-

29.1 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 Investment Committee.

29.2 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.

29. Financial instruments and related disclosures (cont.)

29.3 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 been raised:

	31 March 2010 £000	31 March 2009 £000
By up to three months	**883**	489
By three to six months	**903**	448
By more than six months	**57**	80
	1,843	1,017

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.

29.4 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 £14million available within its terms of authorisation as a Foundation Trust which reduces its liquidity risk still further.

29.5 Fair Values

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 2010 and 31 March 2009.

29. Financial instruments and related disclosures (cont.)

.	**Carrying Value 31 March 2010**	**Fair Value 31 March 2010**	Carrying Value 31 March 2009	Fair Value 31 March 2009	Carrying Value 1 Dec 2008	Fair Value 1 Dec 2008
	£000	**£000**	£000	£000	£000	£000
Current financial assets						
Cash and cash equivalents	**12,181**	**12,181**	20,379	20,379	14,244	14,244
Loans and receivables:						
Trade and receivables	**10,166**	**10,166**	5,113	5,113	6,067	6,067
	22,347	**22,347**	25,492	25,492	20,311	20,311
Non-current financial assets						
Loans and receivables:						
Trade and receivables	**0**	**0**	0	0	0	0
Total financial assets	**22,347**	**22,347**	25,492	25,492	20,311	20,311
Current financial liabilities						
Financial liabilities measured at amortised cost:						
Obligations under PFI	3004	3004	3,418	3,418	3,379	3,379
Trade and other payables	**17,090**	**17,090**	16,564	16,564	17,729	17,729
Provisions under contract			2,900	2,900	2,900	2,900
	20,094	**20,094**	22,882	22,882	24,008	24,008
Non-current financial liabilities						
Financial liabilities measured at amortised cost:						
Obligations under PFI	**133,118**	**133,118**	136,213	136,213	137,340	137,340
Provisions under contract	**2,900**	**2,900**				
	136,018	**136,018**	136,213	136,213	137,340	137,340
Total financial liabilities	**156,112**	**156,112**	159,095	159,095	161,348	161,348
Net financial assets	**(133,765)**	**(133,765)**	(133,603)	(133,603)	(141,037)	(141,037)

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.

29. Financial instruments and related disclosures (cont.)

	Current			Non current		
	31 March	31 March	1 Dec	**31 March**	31 March	1 Dec
.	**2010**	2009	2008	**2010**	2009	2008
	£000	£000	£000	**£000**	£000	£000
Trade and other receivables:	393					
Non-financial assets	**176**	500	1,336	**0**	0	0
Prepayments	**359**	1,097	3,585	**1,733**	2,703	2,439
	929	1,597	4,921	**1,733**	2,703	2,439
Trade and other payables:						
Taxes payable	**2,012**	2,222	2,148	**0**	0	0
Non-financial liabilities	**0**	2,088	0	**0**	593	0
	2,012	4,310	2,148	**0**	593	0
Provisions:						
Financial liabilities	**2,587**	3,195	4,433	**0**	0	0
Provisions under legislation	**79**	52	109	**0**	1,870	0
	2,666	3,247	4,542	**0**	1,870	0

The provisions under legislation are for personal injury pensions £491,068 (31 March 2009: £517,216) and early retirement pensions £1320,686 (31 March 2009: £1,405,974). These liabilities are not contracted, but are defined by legislation and are owed to the NHS Pensions Agency.

30. Third Party Assets

The Trust held £4,167 cash at bank and in hand at 31 March 2010 (31 March 2009: £6,004) 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.

31. Losses and Special Payments

There were 1,335 cases of losses and special payments (4 mths ended 31 March 2009 - 802 cases) totalling £37,805 (4 mths ended 31 March 2009 - £22,225) approved in the year.

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 (2008/09 - nil cases).

32. POOLED BUDGET - INTEGRATED COMMUNITY EQUIPMENT SERVICE

Great Western Hospitals NHS Foundation Trust and Swindon Primary Care Trust have entered into a pooled budget arrangement, hosted by Swindon Borough Council. Payments are made to the Council by the Swindon Community Equipment Service.

	Year ended 31/3/10 £	4 mths ended 31/03/2009 £
Income:		
Swindon Borough Council	469,100	204,183
Miscellaneous	600	51,276
Swindon Primary Care Trust	158,250	189,000
Great Western Hospitals NHS Foundation Trust	152,600	160,000
Total Income	**780,550**	604,459
Expenditure:		
Expenditure	**923,179**	414,960
Total Surplus/(Deficit) at 31/3/10	**(142,629)**	189,499
Share of Surplus (Deficit):		
Swindon Borough Council	(76,925)	2,473
Swindon Borough Council De Minus	(10,000)	0
Swindon Primary Care Trust	(30,505)	0
Great Western Hospitals NHS Foundation Trust	(25,199)	0
Total Surplus/(Deficit) at 31/3/10	**(142,629)**	2,473

Great Western Hospitals NHS Foundation Trust has a pooled budget arrangement with Swindon Borough Council and Swindon PCT. This is hosted by Swindon Borough Council.

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 the figures in the month 12 management accounts are un-audited.

33. Transition to IFRS

The Trust reported under UK GAAP in its published financial statements for the year ended 31 March 2009. The Trust has adopted International Financial Reporting Standards (IFRS) for these financial statements for the year ended 31 March 2010.

The main impacts of IFRS on the reported results of the Trust are listed below and are described in greater detail in the following sections.

- Recognition of PFI on SoFP (IFRIC12) - PFI leases must now be recognised as finance leases and so included as assets on the SoFP
  Intangible assets (IAS 38) - expenditure on software which is deemed not to be integral to the computer hardware and will generate economic benefits beyond one year is capitalised as an intangible asset.

The analysis below shows a reconciliation of tax payers' equity (assets employed) and comprehensive income reported under UK GAAP for the year to 31 March 2009 to the revised tax payers' equity and comprehensive income under IFRS as reported in these financial statements. There is a reconciliation of the tax payers' equity under UK GAAP to IFRS at the transition date for the Trust being 1 December 2008.

	4 mths ended 31 March 2009 £000
Retained surplus under UK GAAP as previously reported	**665**
Removal of PFI operating expenses	4,018
Finance charges relating to PFI	(4,485)
Surplus for the year under IFRS	**198**

	31 March 2009 £000
Tax payers' equity under UK GAAP as previously reported	**69,298**
Recognition of PFI on SoFP	8,111
Total taxpayers' equity (total assets employed) under IFRS	**77,409**

33. Transition to IFRS (cont.)

Reconciliation of the statement of comprehensive income for the year ended 31 March 2009

.	Ref	UK GAAP 4 mths ended 31 March 2009 £000	IFRS 4 mths ended 31 March 2009 £000	Difference £000
Operating Income		64,241	64,281	40
Operating expenses	1.1	(62,857)	(58,879)	3,978
				0
Operating surplus		**1,384**	**5,402**	**4,018**
Finance income		64	64	0
Finance expense - financial liabilities	1.2		(4,485)	(4,485)
Finance expense - unwinding of discount on provisions		(41)	(41)	0
PDC Dividends payable		(742)	(742)	0
Net finance costs		**(719)**	**(5,204)**	**(4,485)**
Surplus for the year		**665**	**198**	**(467)**

There is no change in the 'other comprehensive income' disclosures due to the adoption of international Financial Reporting Standards.

The differences are explained as follows:

	4 mths ended 31 March 2009 £000
Reference 1.1	
Operating Expenses	
Reduction of PFI operating expenses relating to finance charges	**3,978**
	3,978
Reference 1.2	
Finance expense - financial liabilities	
Finance expenses relating to recognition of PFI on SoFP	**(4,485)**
	(4,485)

33. Transition to IFRS (cont.)

Reconciliation of total tax payers' equity (total assets employed) at 31 March 2009 and 1 Dec 2008 (date of authorisation as a Foundation Trust and transition to IFRS)

.	Ref	UK GAAP 31 March 2009 £000	IFRS 31 March 2009 £000	Difference £000	UK GAAP 1 Dec 2008 £000	IFRS 1 Dec 2008 £000	Difference £000
Non-Current Assets							
Intangible assets	2.1	157	711	554	165	756	591
Property, Plant and Equipment	2.2	61,228	215,943	154,715	59,098	215,756	156,658
				0			0
Other assets			2,703	2,703	0	2,439	2,439
		61,385	219,356	157,972	59,263	218,951	159,688
Current Assets							
Inventories		2,534	2,534	0	2,553	2,553	0
Trade and other receivables		14,668	6,710	(7,958)	20,403	12,324	(8,079)
Other current assets				0	0	0	0
Cash at bank and in hand		20,379	20,379	0	14,244	14,244	0
		37,581	29,623	(7,958)	37,200	29,121	(8,079)
Current Liabilities							
Trade and Other Payables	2.3	(22,918)	(18,652)	4,266	(19,763)	(17,729)	2,034
Borrowings	2.4		(3,418)	(3,418)	0	(3,379)	(3,379)
Provisions	2.5		(4,303)	(4,303)	0	(3,156)	(3,156)
Tax Payable			(2,222)	(2,222)		(2,148)	(2,148)
Other liabilities	2.6		(2,158)	(2,158)	0		0
		(22,918)	(30,753)	(7,835)	(19,763)	(26,412)	(6,649)
Non-Current Liabilities							
Trade and Other Payables		(593)	(593)	0	(593)	(2,789)	(2,196)
Borrowings	2.4		(136,213)	(136,213)	0	(137,340)	(137,340)
Provisions		(6,157)	(1,854)	4,303	(7,442)	(4,286)	3,156
Other Liabilities	2.6		(2,158)	(2,158)	0	0	0
		(6,750)	(140,818)	(134,068)	(8,035)	(144,415)	(136,380)
Total assets employed		69,298	77,409	8,111	68,665	77,245	8,580
Financed by Taxpayers' Equity							
Public dividend capital		27,111	27,111	0	27,111	27,111	0
Revaluation reserve	2.7	28,191	42,309	14,118	28,190	42,521	14,331
Donated asset reserve		1,142	1,142	0	1,175	1,175	0
Income and expenditure reserve	2.8	12,854	6,583	(6,271)	12,189	6,172	(6,017)
Other reserves			264	264	0	266	266
Total taxpayers' equity		69,298	77,409	7,847	68,665	77,245	8,580

The differences are explained as follows:

	31 March 2009 £000	1 Dec 2008 £000
Reference 2.1		
Intangible assets		
Intangible assets (IAS 38) - requires the reclassification of capitalised expenditure on software from property, plant and equipment to intangible assets.	711	756

33. Transition to IFRS (cont.)

	31 March 2009 £000	1 Dec 2008 £000
Reference 2.2		
Property, plant and equipment		
PFI obligations (IFRIC 12) - previously off SoFP PFI scheme has now been recognised on SoFP.	**155,269**	156,658
	155,269	156,658
Reference 2.3		
Trade and Other Payables		
(IAS 1) - other payables reclassified as taxes payable	**(2,222)**	(2,148)
	(2,222)	(2,148)
Reference 2.4		
Borrowings		
PFI obligations (IFRIC 12) - previously off SoFP PFI scheme has now been recognised on SoFP. See reference 2.2 above. Liability due within one year -	**(3,418)**	(3,379)
PFI obligations (IFRIC 12) - previously off SoFP PFI scheme has now been recognised on SoFP. See reference 2.2 above. Liability due after one year -	**(136,213)**	(137,340)
	(139,631)	(140,719)
Reference 2.5		
Provisions		
(IAS 1) - provisions reclassified as current from non-current	**(4,303)**	(3,156)
	(4,303)	**(3,156)**

Reconciliation of the statement of cash flows for the year ended 31 March 2009

There is no change in the cash and cash equivalents of the Trust due to the adoption of International Financial Reporting Standards.