GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST

REPORT AND ACCOUNTS
1ST DECEMBER 2008 – 31ST MARCH 2009

Presented to Parliament pursuant to schedule 7, paragraph 25(4) of the National Health Service Act 2006

Chair's Report

The Great Western Hospitals NHS Foundation Trust was authorised on 1st December 2008 as the successor to the Swindon & Marlborough NHS Trust. Separate Accounts have been prepared for the 8 months as an NHS Trust and this is the first Annual Report as a Foundation Trust for the part year. On the 1st December, we ceased to report directly to the Department of Health via the South West Strategic Health Authority and are now responsible to Parliament via our Regulator, Monitor, and locally to our patients as Members through our Council of Governors elected by the Members. While we are still part of the family of the NHS, we hope that this increased local accountability and flexibility to operate within our Authorisation will enable us to meet the national NHS objectives in ways that are attuned to the needs of the people of Swindon, Wiltshire and the surrounding areas.

Although only established for a short while, our Governors have made a distinctive contribution to the work of the Trust ensuring that we remain focussed as a good district general hospital for the communities we serve, establish good links with other healthcare providers of specialist services in Oxford and Bristol and above all ensure that improving the patient experience is central to all we do.

2008/09 was an exceptionally strong year for the Trust with significant reductions in hospital acquired infections, improvements in mortality rates, improved scores in the National Patient Experience Survey and staff surveys and more beds open. We are proud of being one of the very few hospitals in the country offering 13 week referral to treatment times in all specialties. Finally, and no less importantly, there were significant improvements in waiting times for diagnostic tests and provision of hearing aids.

Our top priority is, and always will be, to provide safe healthcare of the highest quality and we are committed to the National Patient Safety First Campaign. We were able to make a surplus and to apply that surplus to invest in more nurses and doctors and replacement equipment to support our activities.

The process of achieving Foundation Trust status is rigorous and balances sound financial and clinical governance. You will have read elsewhere of hospitals that "took their eye off the ball" during this time and I am delighted to confirm that we achieved Foundation Trust status whilst making the significant improvements in patient outcomes identified above and more fully detailed in this report. I would like to give my thanks to the whole Board for their continued focus on our core task of delivering high standards of clinical care. However, the real thanks need to go to the dedicated staff at every level who have worked so hard to give these exceptional results. I would also like to pay tribute to the work of our many volunteers who do so much to put the human face on this hospital. We are increasingly getting teenage volunteers and our oldest volunteer is in their 80's. If you are interested, we can always find an outlet for your time.

As we look forward to more troubled financial times ahead, the Trust is in a sound position to do our best to maintain and improve both the levels and quality of activity in the years ahead.

Bruce Laurie
Chair

Directors' Report

The directors appointed to membership of the Board who were in post from 1st December 2008 to 31st March 2009 were:

Bruce Laurie	Chair
Lyn Hill-Tout	Chief Executive
Helen Bourner	Director of Business Development
Oonagh Fitzgerald	Director of Workforce and Education
Maria Moore	Director of Finance
Sue Rowley	Director of Nursing
Alf Troughton	Medical Director
Robert Burns	Non Executive Director
Rowland Cobbold	Non Executive Director
Liam Coleman	Non Executive Director
Angela Gillibrand	Non Executive Director
Roger Hill	Non Executive Director
Kevin Small	Non Executive Director

Principal activities and overview of Trust

Great Western Hospitals NHS Foundation Trust was established on 1st December 2008 as a public benefit corporation under the National Health Service Act 2006. Its predecessor was the Swindon and Marlborough NHS Foundation Trust

The principal purpose of the trust is the provision of goods and services for the purposes of the health service in England. The Trust's activities are governed by the terms of authorisation agreed by Monitor (the independent regulator of NHS Foundation Trusts) and by legislation.

The Trust provides general acute and emergency services to the local populations from the following sites.

The **Great Western Hospital** (GWH) opened in December 2002. It is a medium sized acute district general hospital providing a very high standard of modern accommodation with one third of the beds in single en suite rooms. GWH provides general and acute medical and surgery, critical care, coronary care, diagnostics, paediatric medicine and surgery, trauma and orthopaedics and midwifery and obstetric services.

The **Brunel Treatment Centre**, opened in April 2005, adjoins GWH. This centre is designed specifically for elective surgery and has enabled the separation of elective patients from emergency and urgent patients, who are treated in the Great Western Hospital. The centre also includes the **Shalbourne Suite**, a 20-bed private patient unit.

In addition to GWH and the adjoining Brunel Treatment Centre the site comprises:

- A 60 bed **Intermediate Care Centre** (operated by Swindon Primary Care Trust) for slow stream rehabilitation.

- An **older peoples' mental health unit** operated by the Avon and Wiltshire Partnership NHS Trust (relocated from the old Victoria Hospital in Swindon and opened in December 2007).

- Child and Adolescent Mental Health Services (CAMHS) including Tier 4 (inpatient and day care services) from **Marlborough House**, a modern, purpose built facility in Old Town Swindon.

- Outpatient clinics in community settings, supporting these, where possible, with radiology services and electronic communications. Outpatient clinics are currently held at the community hospitals listed in the box below and in various GP surgeries. In addition, orthopaedics outreach clinics are offered at a number of sites including Trowbridge in Wiltshire.

Services Currently Provided by the Trust in the Community

Hospital	PCT	Outpatient Clinics in Community Settings
Savernake Hospital Marlborough, Wiltshire	Wiltshire PCT	Trust outpatient clinics, X-Ray services and medical support to the inpatient beds which are operated by Wiltshire PCT.
Fairford Hospital Fairford, Gloucestershire	Gloucestershire PCT	Trust outpatient clinics and X-Ray service into the facility run by Gloucestershire PCT.
Chippenham Hospital Chippenham, Wiltshire	Wiltshire PCT	Trust outpatient clinics.
Malmesbury Hospital Malmesbury, Wiltshire	Wiltshire PCT	Trust outpatient clinics.
Melksham Hospital Melksham, Wiltshire	Wiltshire PCT	Trust outpatient clinics.
GP practices	Swindon PCT	Community midwives attached to practices in Swindon and North Wiltshire.
Various clinics in Swindon	Swindon PCT	Sexual health.

The campus from where the hospital operates also provides the following services for our staff.

- The **Swindon and North Wiltshire Health & Social Care Academy** - one of seven across the South West providing a multi-professional, multi-disciplinary educational environment, staffed by educational professionals from a number of different organisations (including higher education).

- A **crèche**, operated by Buffer Bear Nurseries.

- **Staff accommodation** operated by Unite.

Aims and Objectives

Trust Vision.

The Trust's vision is to be:

"The provider of choice by delivering high quality specialist services, within the resources available, which delight our patients and commissioners and to establish sound, viable business partnerships by forming strategic alliances with our primary care trusts and other key partners".

Our Objectives

1. To provide safe healthcare of the highest quality.
2. To continually improve patients' experience of our care.
3. To provide better access to healthcare services.
4. To become the provider of choice for patients and commissioners.
5. To maximise the contribution and potential of our staff.
6. To improve the cost effectiveness of our services.
7. To become a beacon of excellence in leadership, governance and financial management.
8. To work in partnership to provide an effective network of care which improves health and reduces health inequalities.
9. To play a leading role in our community.

Our Values

We will:

- Always listen to our patients, local people, commissioners and staff.
- Be a good collaborator and partner.
- Work honestly, openly and with integrity to encourage innovation and take bold decisions, striving to be an exemplary employer.

Strategy

National and local context

Recent guidance has put a clear focus on quality being at the centre of the healthcare provision. In June 2008 the Department of Health published the Darzi Report 'High Quality Care for All'. It describes an NHS that gives the patient more information and choice, works in partnership and has quality of care at its heart. A service where people have more control and influence over their health care and where care is more personalised.

In May 2008 the NHS South West published a draft Strategic Framework for Improving Health 2008/09 to 2010/11. This recognised that "people expect high quality services in the context of world wide comparisons… not just in the health outcomes but also in the broader experience of using services, including respect, dignity, responsiveness and convenience" and that "The NHS needs to offer the consistent delivery of high quality services that promote independence and health…"

These principles are supported by local commissioners who are developing plans for how they wish to see local services improve. We share this strong commitment to the provision of high quality services and as part of the wider local health community are putting quality of care and service to patients at the centre of all we do.

Trust Strategic Intent

Patient expectations are increasing; new health technologies, lifestyle diseases and a society which is able to access information about health will all drive the pace of change. The environment in which we operate is also changing with more choice available to patients. As a Trust with an excellent performance and a sound financial base we are focusing on the quality of the individual patient experience and improving health outcomes. We intend to play our part in delivering the aims of the NHS, working closely with our community partners (both public and private sector) and engage even more with the public and patients through our membership and Governors.

To us one of the important benefits of becoming a Foundation Trust is the direct engagement with and accountability to, our local population. Engaging local people, as members and governors, in discussions about health priorities will help shape the services we provide and how we deliver them. We want the community to have confidence, trust and pride in their local health services. We intend to grow our membership base and use this for the benefit of wider public services

Our intentions about quality and patient satisfaction

Our aim is to provide specialist healthcare services to patients, carers and referrers which exceed their expectations and deliver clinical outcomes which are in the top quartile of similar trusts and increasingly we will benchmark our services against the best in the United Kingdom. We will deliver on all the national standards and where possible exceed them. Our first quality accounts are included in this annual report.

Our key strategies are to:

Provide safe, high quality care

Our aim is to provide specialist healthcare services to patients, carers and referrers which exceed their expectations and deliver clinical outcomes which are in the top quartile of similar trusts and increasingly we will benchmark our services against the best in Europe. We will deliver on all the national standards and where possible exceed them by providing care:

- Which is right first time
- Which uses best clinical practice and embraces the latest technology
- Which exceeds the patient's expectation – every time
- Which our staff are proud to provide and in which our patients have confidence.
- That is the first choice for local people and our commissioners - offering a range of services and choice to patients with personalised care, shorter waiting times and care closer to home where possible.

Play a key part in the network of care for patients
We will play our part in adding life to years and years to life by:

- Using our expertise and infrastructure to support the delivery of healthcare across the whole care pathway
- Providing acute health treatment when necessary
- Linking with specialist centres – we will repatriate patient care locally where we safely can and ensure effective pathways where we cannot
- Delivering all, or elements of, the care pathway as effectively and quickly as we can.

Support our commissioners in improving health and reducing health inequalities
We will continue to work with public sector partners through the Local Area Agreements to deliver health and public services around the needs of our localities. In so doing we will support the delivery of the "vision for Swindon" and the aims of Wiltshire which will improve health and reduce health inequalities by:

- Providing useful information and health education to patients who use our services
- As an employer, support staff in their health and welfare
- Ensuring our policies support public health
- Enabling clinical teams to work across traditional boundaries
- Supporting primary care in the management of long term conditions and maintaining independence for people in the community
- Providing services targeted to the different needs of different localities.

Play a leading role in our community
We will fully participate with public and private sector partners to shape the development of the local community. We believe that one of the benefits of becoming a Foundation Trust is the direct engagement with and accountability to, our local population. Engaging local people, as members and governors, in discussions about health priorities will help shape the services we provide and how we deliver them. This will increase our community's confidence, trust and pride in their local health services. We will work closely with other partners to:

- Develop services in a way that meets the needs of the growing and diverse community
- Foster existing community partnerships and fully contribute to innovative and first class public services
- Use our site proactively to enable the current wide range of services to be developed further as a 'health campus' for patients
- Develop the role of the Trust as an important economic influence locally.

Performance Management

Council of Governors
The Trust aims to keep 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:

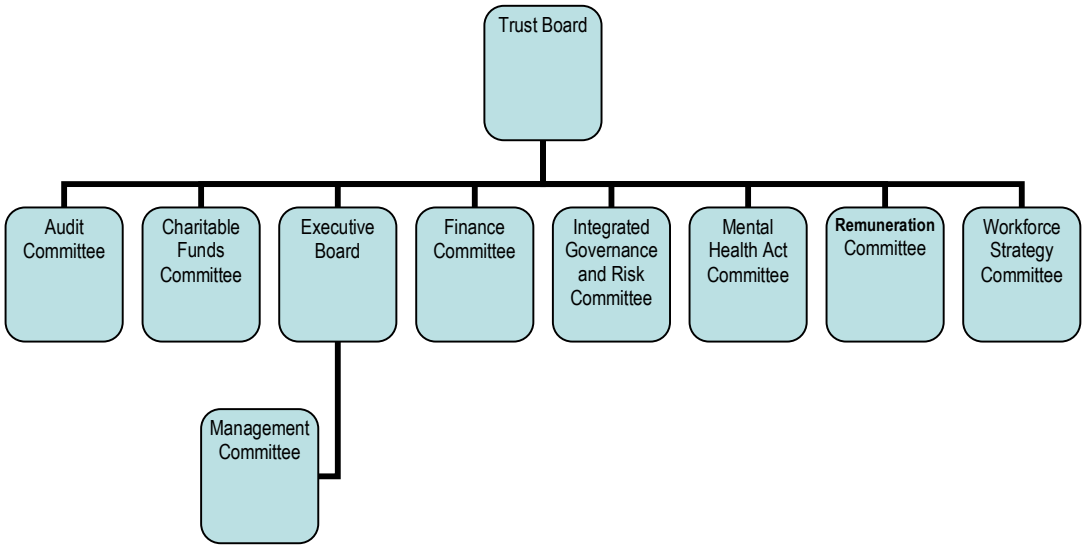
- Patient Experience
- Membership
- Finance, and
- Nominations and Remuneration.

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 with a summary of key performance issues. The Governors are also consulted on forward plans and on our compliance with Standards for Better Health and our new Quality Accounts. We receive excellent feedback from the Governors about the views of the members and we will strengthen the working relationship between the Board of Directors, the Council of Governors and the members during 2009/10.

Board of Directors
To assist in monitoring delivery against key objectives, the Board receives regular reports on performance in the following key areas:

- Infection Control
- Patient experience, quality and safety
- Finance
- Activity and access
- Workforce
- Risk Management
- Operational efficiency.

During the year and in preparation for the Foundation Trust application the Board has reviewed the governance structure and reviewed the work of various committees. The delegated sub-committees are shown below.



The Audit Committee, Mental Health Act Committee and Remuneration Committee are three mandatory Committees 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 Bentley Jennison.

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.

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.

They 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.

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.

Performance Assurance

Monitor
Monitor requires each Foundation Trust board to submit an annual plan and 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**. The Trust's rating of amber for Governance improved to green for the fourth quarter of 2008/09. The scale is red (lowest), amber and green (highest). The term governance is used to describe the effectiveness of an NHS foundation trust's leadership. 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 3 for Finance. When assessing financial risk, Monitor will assign quarterly and annual risk ratings using a system which looks at four criteria:

- Achievement of plan
- Underlying performance
- Financial efficiency
- 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 goods and services** (rated red, amber or green). The Trust has been rated as green for mandatory services. Mandatory goods and services are defined in a foundation trust's terms of authorisation. These are the services the trust is contracted to supply to its commissioners.

Healthcare Commission.

As part of the Annual Health Check 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 Healthcare Commission assesses declarations from Trusts and published in October 2008 published their national ratings for Trusts' returns for 2007/08. This Trust was, like others nationally, assessed on its performance during the previous financial year. We are delighted to report improved performance.

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

The scores range from weak, fair, good or excellent. The Directors are working closely with the clinical and corporate teams to manage and measure all the relevant indicators to ensure that the Trust maintains and improves these scores. These results are expected to be published by the Care Quality Commission (successor to the Healthcare Commission) in October 2009.

A Review of GWH Business

Since authorisation as a Foundation Trust on 1st December 2008, one of the main priorities for the Great Western Hospitals NHS Foundation Trust (GWH NHS FT) has been the delivery of the 13 week referral-to-treatment target in all specialties. This was achieved in March 2009 and we were the first trust in the South West region to do so. This major accomplishment was the result of clinical and management teams working more closely together.

Through continuing effort and rigorous control, the level of healthcare associated infections (HCAIs) has dramatically reduced throughout the year. This effort was recognised by the Strategic Health Authority and GWH NHS FT was awarded the HCAI Technical Innovation Award 2009 for being the most improved trust in reducing HCAIs, which was accompanied by a cash sum of £150,000. The overall number of Hospital acquired MRSA Bacteraemias and *Clostridium difficile* infections was 58% less than the previous year. This is described in the quality accounts from page 21.

Alongside this we achieved the Accident & Emergency 4 hour target; the hospital saw 98.26% of its patients within 4 hours and the whole health community achieved 99.1%.

The Trust began a detailed assessment during the final quarter of the year of the referrals that originate from GP practices to understand and develop a marketing programme for 2009/10. A series of six forums per year for referring GPs and Trust consultants and doctors has been established. The purpose of these is to establish a regular opportunity where referring GPs and hospital consultants and doctors can meet and network together thereby improving clinical links and ultimately patient care. The fora are neither purely didactic nor purely social but an opportunity to share knowledge and expertise.

Recognising the need to create more time for nurses to spend more direct time with their patients and improve patient experience, and supported by our Governors, we started in 2008/09 a national project called the "Productive Ward". National studies indicate that ward-based nurses spend less than 40% of their time on direct patient care and valuable time is spent looking for equipment, keys, linen, medicines and information. The Productive Ward Project has 11 modules that jointly encompass all aspects of the patient care delivery and experience while in hospital. Working through these modules allows the Ward Managers and their teams to identify where the other 60% of time is being spent, to look at it objectively, to streamline and use that time more effectively thus freeing up time for direct patient care.

Analysis and development of the Trust's business during the year

Increasing GP referrals throughout the year (circa 17%) across both Swindon PCT and NHS Wiltshire created pressure from increased emergency admissions and this occurred at the same time as the Trust was working to deliver the 13 week referral-to-treatment target. Joint work will take place in 2009/10 to ensure that demand management protocols take effect.

During 2008/09 the Trust was advised that its two main commissioning primary care trusts (PCTs) were putting their Children and Adolescent Mental Health Services (CAMHs) out for tender with service change to take effect from 1st April 2010. The income and contribution from this service is significant and the Trust Board agreed that the Trust should enter into the tender process. Regretfully, the Trust's proposal for the joint NHS Wiltshire and Bath and North East Somerset PCT bid was declined. The Trust conducted a financial assessment of the CAMH service that it delivers for Swindon, and concluded that without

the element of service delivered to users in east Wiltshire, the remaining service would not be financially viable. It therefore withdrew from the Swindon PCT tender process. In both cases, the Trust will continue as the provider of services until the end of the financial year 2009/10, and is working with both PCTs to ensure a seamless handover of care for patients users and bidders, and that appropriate arrangements are made for staff in the transfer process.

During the final quarter of 2008/09, the Trust held a 'Dragon's Den' event to encourage innovative ideas from clinical and corporate directorates and 50 projects were approved, with a total value of circa £400K. As we had a firm control on costs we had sufficient income to invest creatively in ideas that would improve patient satisfaction, quality or efficiency. It is hoped that this event, which was very well received by staff, will be run regularly.

KPMG was commissioned to undertake a review of the Trust's cost improvement programme (CIPs) with a particular focus on plans for 2010/11 onwards. The Board will review the recommendations during 2009/10.

Trends and factors likely to affect the future development, performance and position of business

The Trust faces a new challenge in 2009/10 with the opening of the independent sector treatment centres (ISTC) at Cirencester and Devizes. Both Swindon PCT and NHS Wiltshire will be contracting activity with these two centres and it is estimated that the full year effect of this will be a loss of £4.7m of activity.

As part of the contract negotiations for 2009/10 there has been a gap identified in the funding that the PCTs have available for secondary care and the activity that they wish to commission. In an effort to close the gap, and ensure that the local health economy is better able to withstand the reduced funding streams that are anticipated from 2011/12 onwards, the Trust will be working with its PCT partners on a set of clinical productivities. To ensure delivery of this work and our demanding cost improvement programme, the Trust has invested in a programme management office to monitor and ensure delivery of this work and other major projects.

The Trust will continue in 2009/10 to offer clinics in peripheral locations such as Fairford, Savernake, Chippenham and Malmesbury and will seek further opportunities to bring services closer to patients. While this has been a successful way to encourage more patients to use GWH NHS FT, the competitive climate in future is likely to bring more players into the community market especially as the PCTs pursue the world class commissioning agenda. To ensure that the Trust retains and develops market share against NHS and private sector healthcare providers, it will continue to develop its staff to improve the patient experience. The Trust will invest circa £100,000 in its organisational development programme starting in 2009/10.

Risk Management

The risk management processes in place at the Trust ensure that a safe and secure environment exists for patient care and for the workforce. The Board of Directors has overall responsibility for risk management and delegates responsibility to the Integrated Governance and Risk Committee, which monitors the risk management arrangements through the Trust. The operational leads are invited to the Committee to inform the debate on the nature of the risk, the controls in place and any mitigating actions or plans.

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

As a business, the Trust also maintains a strategic risk register. The strategic risk register is assessed on a regular basis and the following significant risks that could impact on the business in 2009/10 have been extracted from the risk register to inform the annual plan. These are listed below, and provided in tabular format with detail of the mitigating actions.

- Commissioners' financial position.
- Delivery of productivities linked to contract.
- Delivery of efficiencies and service changes related to cost improvement programmes.
- Maintaining and delivering CAMHs in 2009/10 after losing the Wiltshire bid and withdrawal from Swindon bid.
- Major Incident (MAJAX), or catastrophe (which may or may not be H1N1 flu outbreak).
- Staff Recruitment and retention.
- Outstanding case and potential for Health and Safety Prosecution.

Risk	Potential Impact	Likelihood	Mitigating Action	Residual Risk
Financial				
Commissioners' financial position	PCTs' financial situation means that payment for over performance is not available, and neither Swindon PCT nor NHS Wiltshire have a track record of effective demand management, so current high levels of referrals from GPs is a key risk for 2009/10.	High	o Two senior clinicians from GWH will be working with the Locality /PBC leads at PCT to encourage engagement and adherence to agreed principles. o Project Group (re productivities) with regular review. o Regular 1:1s and updates between key personnel within all organisations. o 'Flag' system to alert GWH to higher than planned activity levels versus profiling	Medium
Delivery of productivities linked to contract.	Delivery of productivities requires partnership working with PCTs and some elements will not be deliverable without their active participation.	High	o Project Group established between PCTs and GWH to ensure updates and regular reporting. o Revised performance management arrangements between PCTs and GWH for the year will ensure focus on productivity. o Regular communication at management level at GWH to ensure focus in maintained. o Monthly update for management committee demonstrating progress. o Quarterly report to Board.	Medium
Delivery of efficiencies and	Significant CIPs programme agreed	Medium	o Trust has invested in establishing a	Low

Risk	Potential Impact	Likelihood	Mitigating Action	Residual Risk
service changes contained in CIPs.	for 2009/10; failure to deliver in full will have negative impact on overall Trust performance and year end profitability.		programme office to oversee reporting of efficiencies so focus is maintained. o Thorough review of efficiency opportunities has been carried out (KPMG) so in the event of agreed work becoming undeliverable, an alternative scheme can be adopted.	
Governance				
Commissioner relationships.	Risk that relationship could shift to a transactional level if GWH and PCTs cannot work better together	Medium	o Revised performance meeting structure to facilitate review and dialogue between PCTs and GWH	Low
Major Incident (MAJAX), or catastrophe (which may or may not be H1N1 flu outbreak)	Major incident or catastrophe may create staff shortages through sick leave and carers leave, and requirement for increased number of emergency beds will risk delivery of elective activity. Such an incident may have a major impact on infrastructure outside our control	High	o New Business Continuity Lead in place (Director of EFM) and actively reviewing processes o Pandemic flu plan in place which contains operational contingency arrangements for predicted events. o The plan has been assessed as fit for purpose by the Local Resilience forum and SHA. o Phased reductions in elective activity are incorporated within the plan.	Medium
Staff Recruitment and retention.	Inability to deliver services. High usage of agency staffing.	High	o Proactive vacancy management. o International recruitment for difficult to recruit medical posts. o Process overseen by the medical	Medium

Risk	Potential Impact	Likelihood	Mitigating Action	Residual Risk
			staffing group.	
Outstanding decision on prosecution by HSE	Reputation risk to the Trust regarding media coverage of a prosecution. Financial risk if sum of potential fine exceeds that estimated by Trust solicitors.	Medium	o The Trust solicitors have advised the Trust that an HSE prosecution has the potential to result in a fine to the estimated maximum sum of £200k. o Positive recommendation by CMO representative (Prof Jim Reason) that Trust has learnt from this incident and has changed procedure and processes o Lessons from case shared nationally through NPSA	Medium
Mandatory Services				
Maintaining and delivering CAMHs in 2009/10 after losing in Wiltshire bid and withdrawal from Swindon bid.	Trust is contracted to deliver CAMHs to Wiltshire and Swindon until March 31st 2010; keeping and motivating staff during this period of uncertainty will be challenging.	Medium	o Regular and informed HR support for staff and managers. o Regular briefing for staff o Close working with both PCTs and their bidders to ensure a smooth handover of services and TUPE transfer.	Low

Sustainability
The Trust is a major entity in the local community and we take great care in the impact that we have on our environment. We carefully monitor our consumption of energy and water and we also monitor how much waste the Trust produces. We aim to reduce the amount of carbon we are responsible for producing while recognising the need to provide services to patients to meet their needs. The Trust regularly meets with public transport operators to ensure that the services available to access the hospital are as user friendly as possible.

Business Continuity Management
The Trust has started a comprehensive review of its business continuity management arrangements. Considerable work has been undertaken in the past to ensure that the hospital has the ability to continue to function in the event that challenging incidents or circumstances arise. These arrangements are still in place and provide the guidance and instructions necessary to continue to provide healthcare services when events make normal functioning more challenging.

The Trust recognises its legal obligations to comply with the Civil Contingencies Act 2004 and we will continue to monitor our arrangements and amend when appropriate to suit changes as they arise.

The site was recently short listed for the Better Healthcare Sustainability Awards in recognition of the hard work that has gone into driving improvements in environmental performance.

Quality Report

Organisational Overview

Our quality improvement activities have been driven locally from the feedback of our patients and their experiences, from our Governors and staff, from national data provided from the Picker survey 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 our quality agenda and progress with our quality improvement plan we have developed our Clinical Governance structures, committees, monitoring and reporting processes with quality improvement embedded within the culture of all directorates. Organisationally, some of our key regulatory achievements have been obtaining compliance with the revised NHSLA Acute Standards at Level 1 during October 2008 and we were one of only two Trusts to receive the new NHSLA Maternity Standards at Level 3 during November 2008. The Trust successfully registered with the Care Quality Commission as a provider of Health Care Services in February 2009 with no conditions attached. A full declaration of compliance with the Care Quality Commissions Standards for Better Health was submitted during April 2009.

Overview of Safety, Effectiveness and Experience Initiatives and Improvements

Patient Safety

Our top safety priorities have been to reduce the numbers of hospital acquired MRSA and *Clostridium difficile* infections and to reduce drug errors, patient falls and associated fractures. We also agreed zero tolerance of any blood transfusion errors and incorrect clinical procedures.

We are particularly proud of our achievements in reducing our hospital acquired infections both in numbers and rates. This has been achieved through rigorous monitoring of and changes to antibiotic prescribing protocols, the implementation of infection control risk assessments on all patients admitted to hospital and the phased introduction of MRSA screening of all patients admitted to hospital for both elective and emergency admissions. The hard work and dedication of all staff has led to a reduction in annual MRSA infections from 10 to 6 which is 4 below the trajectory set by the Department of Health. We have reduced our annual *Clostridium difficile* infections from 221 to 75 which is significantly below the trajectory set by the Department of Health of 220.

The Trust has reduced drug errors from 184 to 145 (-22%) and patient falls have reduced from 1260 to 1230 (-3%). Although the 6% reduction in patient falls was not fully achieved, there continues to be a notable reduction and improvement which will be progressed as a priority 2009/10.

We are proud that we have sustained zero blood transfusion errors. We are disappointed that one error was reported regarding an incorrect site surgery procedure being performed. However we are confident that through progressing with the correct site surgery module within the National Patient Safety Campaign further errors will not occur.

Clinical Effectiveness

Our top clinical effectiveness priorities have been to reduce hospital acquired Grade 3 and Grade 4 pressure ulcers and to reduce hospital standardized mortality ratio (HSMR) to 94, below the 100 benchmark described by Dr Foster (Dr Foster Intelligence is a public-private partnership launched in February 2006 that aims to improve the quality and efficiency of health and social care through better use of information).

We are proud of our achievement in reducing both Grade 3 and 4 hospital acquired pressure ulcers. Instrumental toward this achievement has been the increased undertaking of skin status assessments on patients admitted to hospital and the ability to report on compliance with these assessments regularly.

The national Dr Foster reports show our reported mortality rates during previous years have been higher than those expected. During 2008/09, the Trust introduced several key initiatives to reduce mortalities which have shown the rate to have improved (reduced) and consistently fallen below the 100 HMSR threshold. These initiatives include reducing *Clostridium difficile* infections, the undertaking of Preoperative Cardio Pulmonary Exercise Testing (CPET) for patients undergoing major abdominal surgery and a strengthened process for and greater input into palliative care and “end of life” pathway

Patient Experience

Our top patient experience priorities have been developed using information that patients have fed back to us through the Picker survey (undertaken in June 2008) and from local complaints and Patient Advice and Liaison (PALs) data. The Picker Institute, based in Oxford, is a research charity which is a leading authority and advocate for patient-centred healthcare. Our focus has been on improving privacy and dignity, demonstration of improved patient satisfaction increasing the numbers of patients who recommend our services and shortening our response times to patient call bells.

Overall, we are pleased that over 95% of patients would recommend the Trust's services to other patients and improvements have been noted with regard to patients being treated with privacy and dignity. While improvements to responses in call bells have improved there is still some way to go to ensure this element of our patients' experience is at an acceptable level. Improving the patient experience has been led by the Matrons and Essence of Care leads, although we regard this as every member of staff's responsibility.

Also, following recent publication of the Picker report we are very aware of the need to review and improve upon the local capture of patient experiences and satisfaction and to improve upon elements of the patient discharge process. This includes a particular emphasis on the provision of discharge letters following outpatient department appointments and admission to hospital.

Summary
We would like to pay tribute to and congratulate all the staff for their achievements throughout the past year. Our quality improvement strategy has been a shared priority and focus through which we can demonstrate real improvements in the provision of safe and effective care thus enhancing the experiences of our patients.

In conclusion, we want to emphasise the continuing commitment throughout the entire Trust to deliver a patient focused quality service that will deliver and 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.

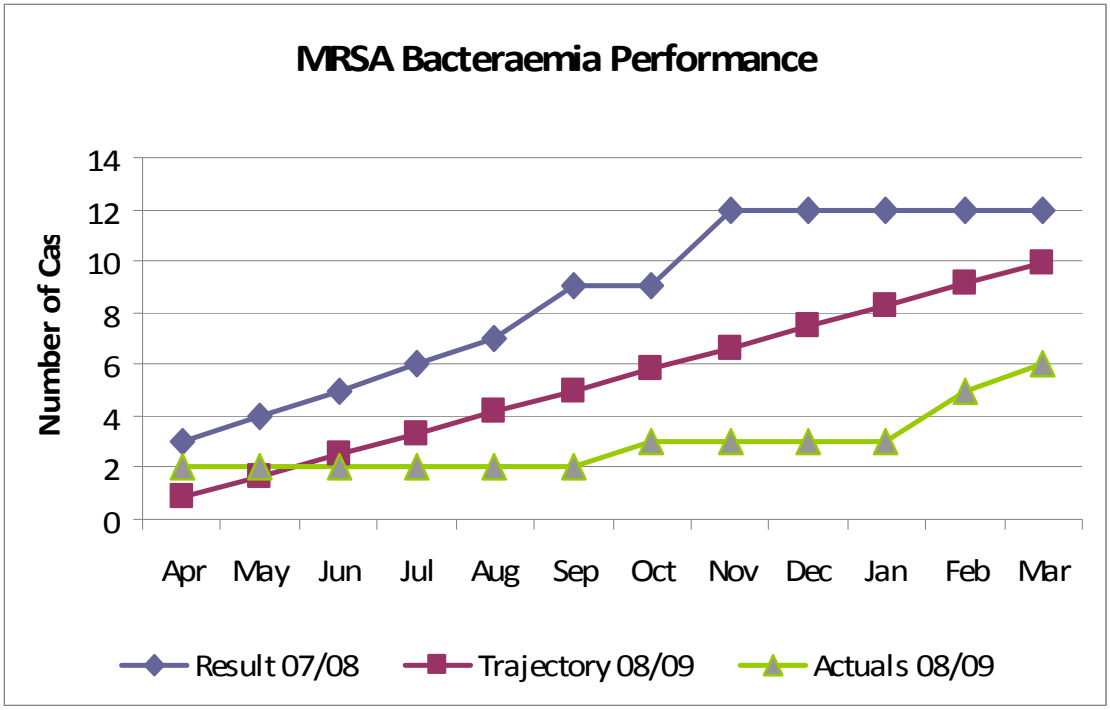
Patient Safety Outcomes and Objectives

1. To reduce our number of MRSA Bacteraemias
Our 2007/08 the number and rate of MRSA bacteraemias was already low however we believe that we could introduce measures to reduce the number of these infections further in line with national priorities. Our goal for 2008/09 was to reduce our number of hospital acquired MRSA bacteraemias to 10 or less.

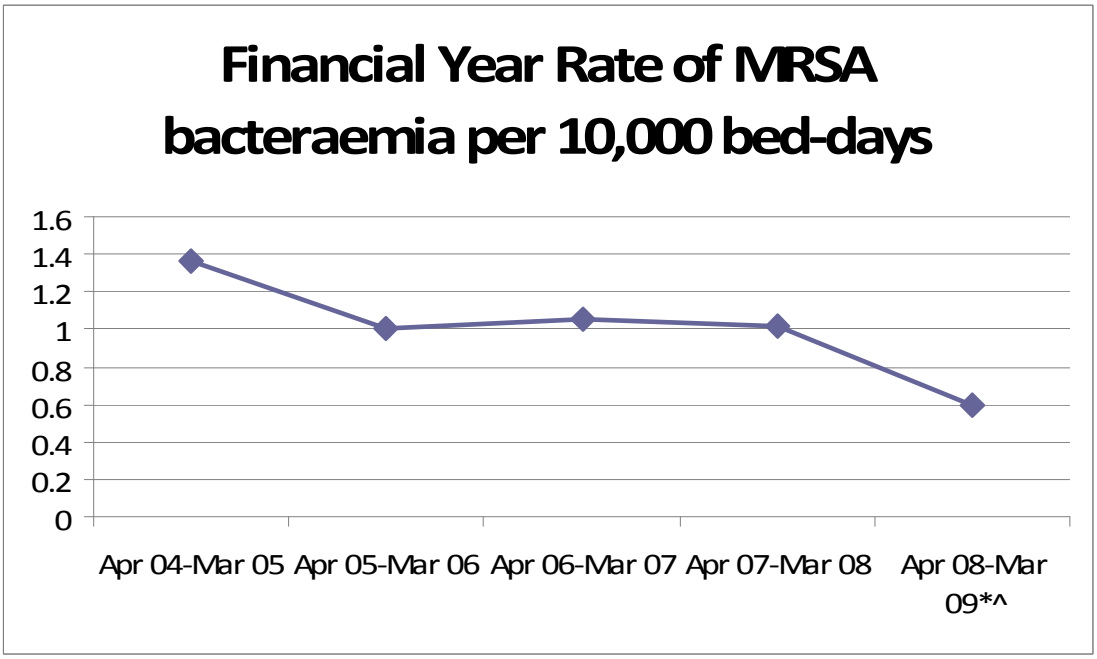
Local initiatives to achieve this reduction included:

- The regular undertaking of audit and care bundles in all clinical areas to ensure staff are adhering to best practice for care of invasive devices;
- To monitor all results and report monthly via the Infection Control Forum and the Clinical Governance and Risk Committee;
- To report and investigate MRSA bacteraemias as Serious Untoward Incidents;
- To undertake MRSA risk assessments on all patients admitted to hospital;
- To phase in MRSA admission screening on all patients admitted to hospital;
- To closely monitor isolation practices and appropriate use of single rooms; and
- To appoint IP&C practice nurses within the directorates to monitor and develop practice.

The Trust reported 6 hospital acquired MRSA bacteraemias during 2008/09 achieving a reduction of 6 from the previous year and 4 below the 2008/09 Department of Health trajectory. One sample was noted to be a contaminant. There was no common route of entry for these bacteraemias showing a notable improvement in the management of peripheral venous line management.



The MRSA bacteraemia rate per 10,000 beds days has also reduced significantly over the last 12 months being the lowest for GWH since robust reporting by the Health Protection Agency began in 2004. The current annual rate is 0.59, below 1.0 for the first time.



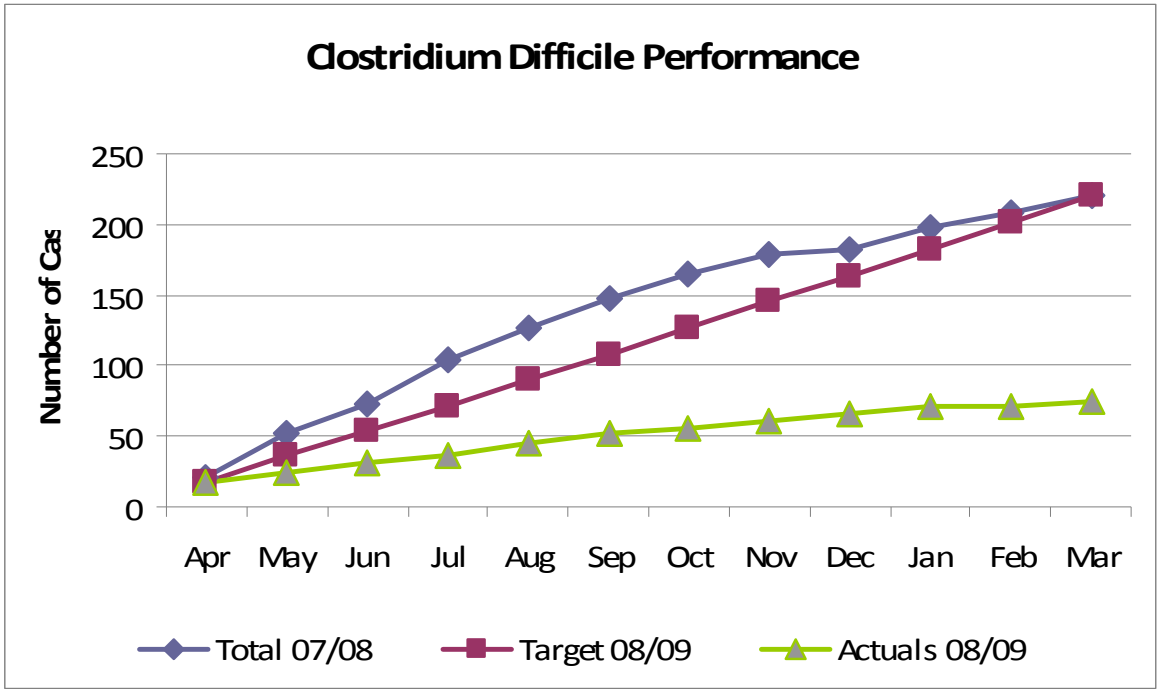
2. To reduce our number of *Clostridium difficile* infections

Our 2007/08 number and rate of *Clostridium difficile* infections have been high and we intend to introduce measures to reduce the number of these infections in line with national priorities. Our improvement goal 2008/09 was to reduce our *Clostridium difficile* infections to 18 or less per month, and to 220 or less for the whole year.

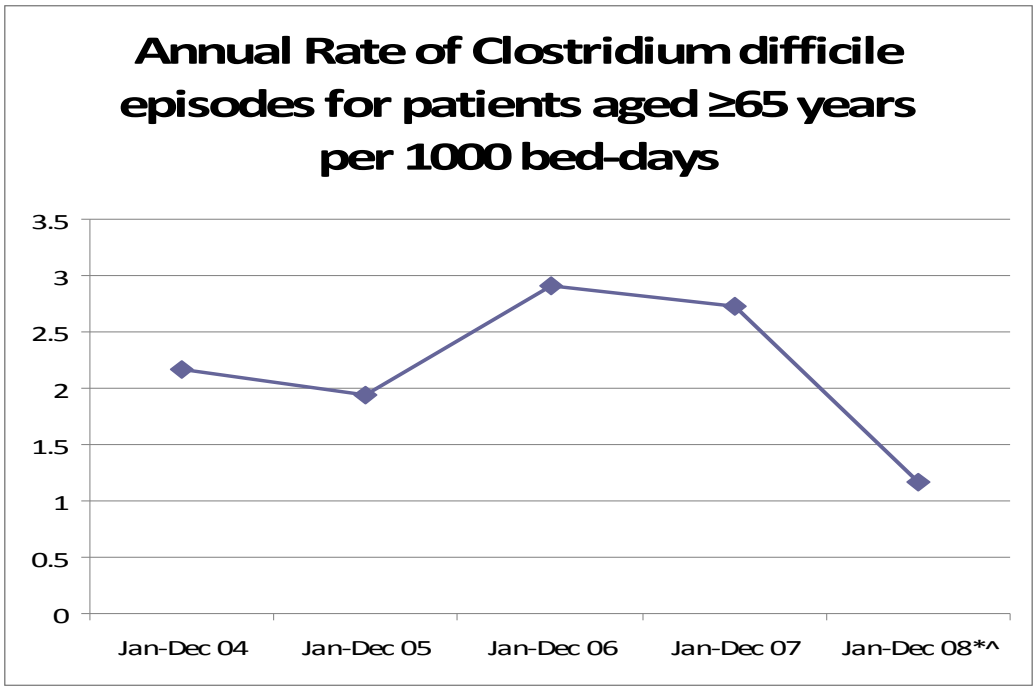
Local initiatives to attain this reduction included:

- To review antibiotic prescribing policies and reduce use of Cephalosporins;
- To develop and implement *Clostridium difficile* patient care management pathway;
- To undertake more regular antibiotic prescribing audits;
- To set up a proactive antibiotic prescribing group who would also have high profiles on the wards monitoring and reviewing prescribing practices;
- To ensure *Clostridium difficile* care bundles were undertaken on the wards; and
- To appoint Infection Prevention and Control practice nurses within the directorates to monitor and develop practice.

The Trust reported 75 hospital acquired *Clostridium difficile* infections during 2008/09 achieving a reduction of 146 from the previous year (75/221, over 60% reduction) and 145 below the 220 2008/09 Department of Health trajectory.



The *Clostridium difficile* rate per 1000 beds days has also reduced significantly over the last 12 months being the lowest ever since robust reporting by the Health Protection Agency began in 2004. The current annual rate is 1.17 compared to 2.73 during 2007/08.

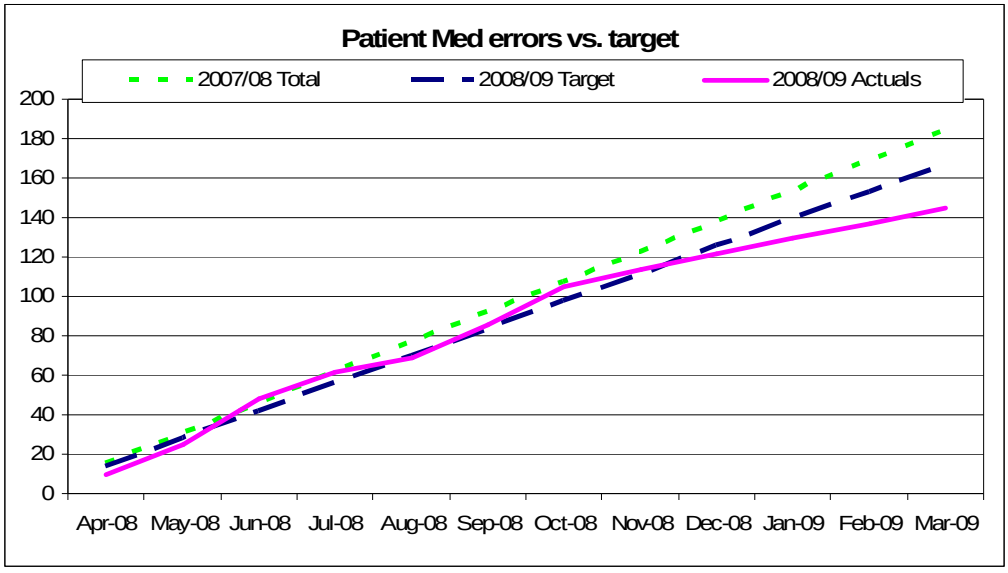


3. To reduce our number of reported medication errors.
Reducing medication errors is a key priority of the National Patient Safety Agency and Department Of Health. Locally, we aimed to reduce these errors in line with national priorities by 10%.

Local initiatives to attain this reduction included:

- Introduce competency assessment and mandatory training on medicines management for all relevant staff;
- Review and update the policy for the control and administration of medicines; and
- Reform the medicines governance group.

Overall we have exceeded our planned reduction of reported drug errors reducing them by just over 20%. While we are proud of this achievement we recognise that there is still substantial room for further improvements. Priorities for 2009/10 are 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 greatest harm to our patients.



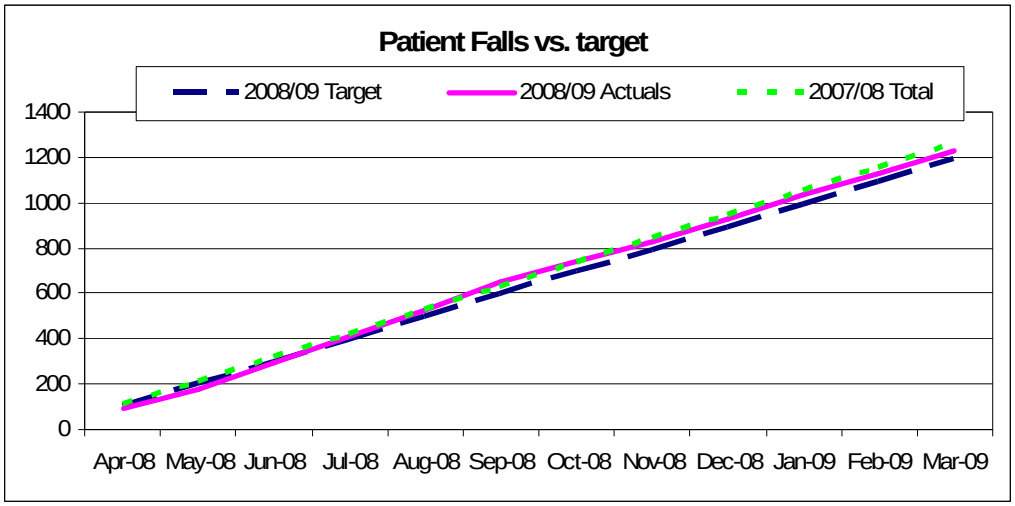
4. To reduce the number of our patients who fall in hospital and acquire associated fractures.

A patient falling is the most common patient safety incident reported to the National Patient Safety Agency (NPSA) from inpatient services. Although the majority of falls result in no harm, even falls without injury can be life changing leading to loss of confidence, increased length of stay and increase likelihood of discharge to residential or nursing home care. We want to reduce the number of falls by 18% over the next 3 years in line with NPSA recommendations and during 2008/09 to reduce these falls by 6%. The NPSA also estimates that there are over 530 patients every year who fracture a hip following a fall in hospital and a further 440 patients who sustain other fractures. The Trust's aim during 2008/09 was to reduce the number of patients who acquire a fracture associated with a fall in hospital by 10% (26 or less per year). Local initiatives to attain this reduction included:

- Improve and increase compliance with falls risk assessments;
- Increase mandatory training for falls link nurses;
- Reform the falls working group; and
- Increase the number of ultra-low beds available within the Trust.

Overall we did not achieve our planned 6% reduction in numbers of patient falls; however a reduction of 3% was achieved. A notable reduction in the number of patients fractures associated with in-patient falls was achieved.

This significant element of patient safety is noted as a key priority for 2009/10 and one of the most important practices to progress is to improve compliance with the completion of falls risk assessments on our patients on admission to hospital.



5. 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 reported transfusion errors has been low or zero however we wanted to continue introducing initiatives to help us sustain this. Local initiatives to sustain this excellent area of practice included:

- To implement electronic blood tracking;
- To provide 2 yearly mandatory blood transfusion training for all relevant staff; and
- To implement 3 yearly competency assessments for all relevant staff.

The above initiatives have been progressed and electronic blood tracking has been implemented. Training and competency assessments have improved however there is still some way to go before this programme of work is fully on target

During 2008/09 no blood transfusion errors were reported hence sustaining the excellent standard of practices embedded within the Trust associated with these procedures.

During 2009/10, a significant priority for the Trust to improve its blood traceability systems in line with the MHRA guidance and progress will be monitored through our Clinical Governance systems.

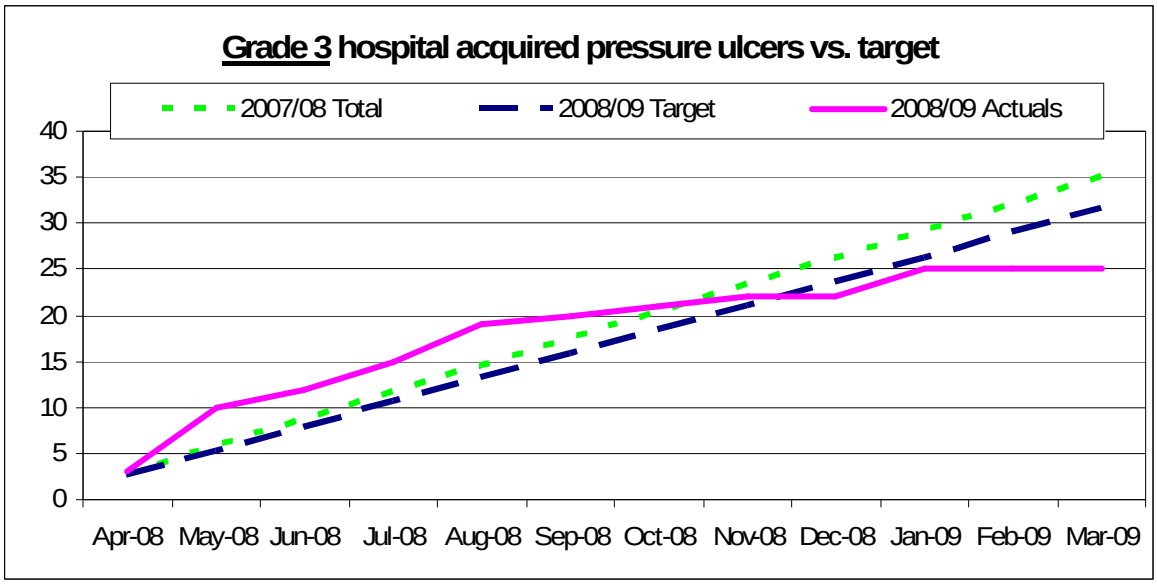
6 To perform the correct site surgery and procedures on our patients.
Performing the correct site surgery and clinical procedures on our patients is recognised nationally by the NPSA and WHO as a significant element of patient safety. During 2007/08, 3 incorrect operations/procedures were performed locally and our aim was to reduce this to zero during 2008/09.

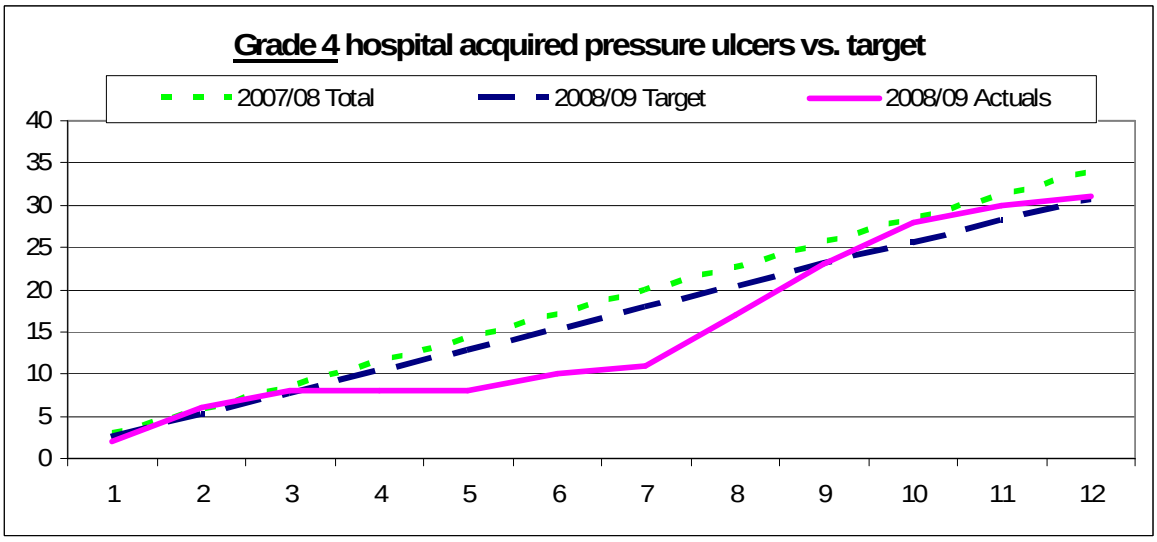
During December 2008, one incorrect operation was reported and this was investigated as a very serious untoward incident. The shared learning from this incident has been to review the pre operative check list and audit compliance with pre operative checks more regularly. In addition, the Trust has signed up to the National Patient Safety First campaign and more specifically the correct site surgery module which will also help ensure practices for all patients associated with pre operative checks are safe on every occasion.

7 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. Having reviewed the numbers of pressure ulcers reported locally during 2007/08, we believed we could introduce initiatives to reduce them by 10%. Local initiatives to attain this reduction included:

- Grade 4 pressure ulcers to be formally investigated as serious untoward incidents (SUIs);
- Implementation of learning outcomes following investigation of SUIs;
- Increase compliance with skin status assessments of all patients on admission;
- To audit and report upon compliance with the skin status assessments weekly using the electronic nursing record.

The planned reduction of both grade 3 and 4 pressure ulcers has been achieved. Probably the most influential element of this achievement has been the placement of the skin status risk assessments onto Crescendo, our patient care database, and hence the ability to monitor compliance and report back quickly to the wards and departments.



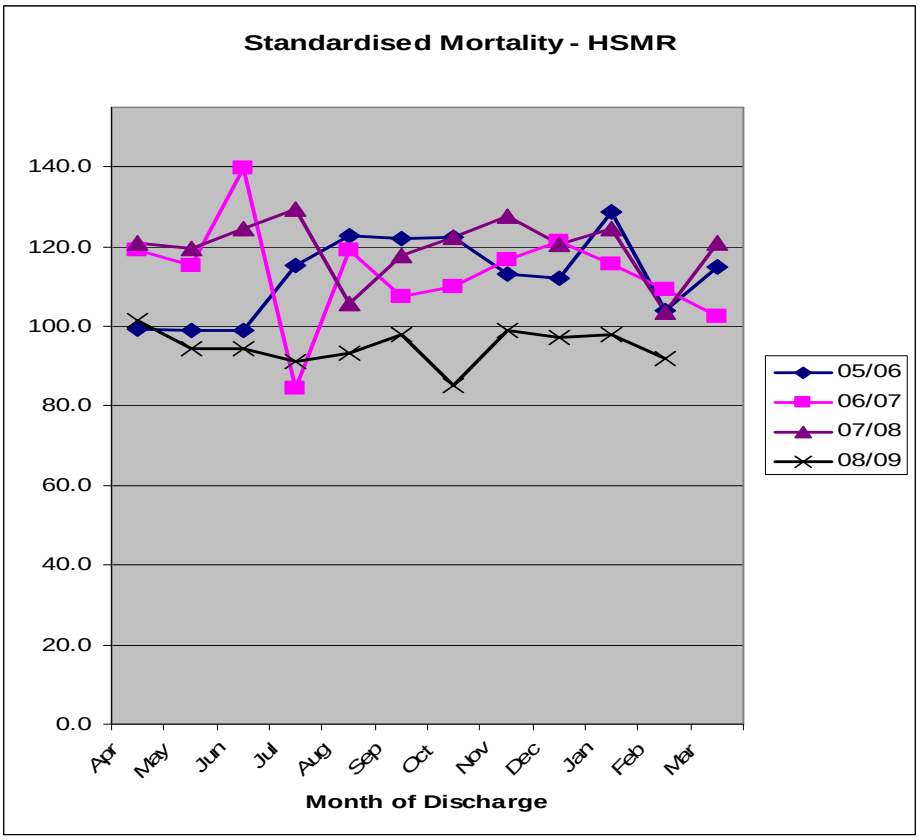


8 To reduce our hospital mortalities.

Our reported mortality rates during previous years have been higher than those expected. Hospital mortality and morbidity is recognised nationally as a key indicator of the effectiveness of care provided. National reports published and available to our patients and the public reflect the reality of 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. Locally we were determined to reduce our hospital mortality rate to below the standards HMSR of 100. Local initiatives to achieve this reduction have included:

- Reducing *Clostridium difficile* infections and hence associated mortalities
- The undertaking of Preoperative Cardio Pulmonary Exercise Testing (CPET) for patients undergoing major abdominal surgery
- Implementing a stronger process for and greater input into palliative care and "end of life" pathway.

The HMSR data provided by Dr Foster shows that we have made a remarkable reduction in hospital mortalities during 2008/09 and we have consistently reported below (better than) the acceptable standard HMSR of 100.



Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
05/06	99.4	98.9	98.9	115.3	122.8	122.0	122.4	113.2	112.2	128.8	104.1	114.8
06/07	119.2	115.2	139.8	84.4	119.3	107.4	109.8	116.7	121.4	115.6	109.3	102.6
07/08	120.8	119.6	124.5	129.4	105.8	117.8	122.3	127.6	120.6	124.4	103.7	120.9
08/09	101.4	94.3	94.5	91.1	93.3	97.9	85.2	99.0	97.3	98.0	91.8	n/a

9 To improve the experiences of our patients.

Our top patient experience priorities have been developed utilising the information that patients have fed back to us from the Picker survey and from local complaints and PALS data. As such, our focus has been on improving privacy and dignity, demonstration of improved patient satisfaction by increasing the numbers of patients who recommend our services and improving the timeliness of responding to call bells.

We are disappointed that our responses to formal patient complaints within 25 days has reduced over the latter quarter of the year. Actions have already been taken to address this within the PALS department and improvements will be demonstrated through the monthly reports to the CGRC.

The recently published Picker (reflecting patient experiences June 2008) survey report from the Care Quality Commission demonstrates that the Trust has performed significantly better in 34/80 questions (42%) and significantly worse in 0/80 (0%) when compared to the 2007 report. When benchmarked nationally, the Trust is in the top/best 20% of Trusts for the following areas of patient experience:

- Offered choice of hospital for 1st appointment
- Did not share bathroom/toilets with patients of opposite sex
- Was not disturbed by noise at night
- Was not threatened by other patients /visitors

- Personal belongings were kept safe
- Drs and nurses did not talk in front of me
- Understood information given to me
- Staff explained operations and procedures
- Anaesthetists explained how I would be put to sleep and how my pain would be controlled

We were in the lower 20% of Trusts for the following elements of the patient experience:

- Length of time waiting to be admitted (planned)
- Perception of sufficient nurses on duty
- Opportunity for family to talk to Drs
- Length of time to get help after ringing call bell, more than 5 minutes
- Involvement in decisions about discharge
- Given written information about what you should do after discharge
- Information about medication on discharge
- General information upon discharge
- Given copy of discharge letter sent between hospital and GP
- Asked to give a view on the quality of care received

The above information reflects an overview of the experiences of our patients during the latest Picker survey undertaken in June 2008. Since that time, many initiatives have been progressed to improve this important element of quality that include:

- Development of the ward dashboard to monitor and improve upon patients experiences. This facility includes local feedback on the quality of care provided and also provides an electronic facility for monitoring the times of responses to patient call bells
- Go the extra smile campaign
- Electronic discharge letters
- Re engineering of services to negate mixed sex accommodation
- Significant investment in additional nursing and medical staffing
- An increase in the numbers of volunteers to help patients at mealtimes
- Protected mealtimes on the wards
- Implementation of the national Productive Ward initiative.

Whilst the above initiatives will continue, the Trust recognises that it needs to really give priority to a more robust and timely method of capturing the patients experiences and to ensuring all patients are provided with discharge letters after their OPD appointments and discharge from hospital. Plans are being progressed to improve these key areas as a priority.

9 Regulatory Objectives

The Trust has continuously monitored compliance with all clinical quality regulation and/or nationally recognised standards and no significant lapses have been reported. A summary is provided in the table below:

Key	Regulation/Standards	Commentary	Monitoring/date
6.0	Hygiene Code – full compliance	Submitted fully complaint to the CQC February 2009 Registered as Health Care provider with no conditions attached	Quarterly and annual
6.1	Standards for Better Health – full compliance	Submitted fully compliant to the CQC April 2009	Quarterly and annual
6.2	NHSLA Acute Standards Level 1	Assessment October 2008 Attained	October 2008
6.3	NHSLA Maternity Standards – Level 3	Assessment November 2008 Attained	November 2008
6.4	NICE guidance – 95% compliance	Attained 95%. Risk assessments completed where not fully compliant. No significant risks identified	Monthly and annual
6.5	Central Alert Bulletins – 90% compliance	Attained 95%. Risk assessments completed where not fully compliant. No significant risks identified	Monthly and annual
6.6	National Priority Performance Indicators (Appendix 2)	These indicators are reported to Trust Board within the performance reports	Monthly

A compliance framework monitoring tool has been developed by the Trust and is shown at **Appendix 1**.

This tool provides a facility for monthly assessment of progress with the quality improvement plan. The tool incorporates a risk monitoring facility to enable any risks to achieving the improvement plan to be identified and inform the directorate and/or corporate risk registers. This monitoring tool will inform the Clinical Governance and Risk Committee on a monthly basis.

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Quality Improvement Plan 2009/10

In consultation with key stakeholders, clinical teams, the Council of Governors and Trust Board, the Trust has developed and agreed its quality improvement plan 2009/10. The plan describes the priorities for quality improvement, how these improvements will be achieved, and how the data will be measured, captured and monitored. In summary our plans for further improvement 2009/10 are as follows:

Safety

- To continue to reduce hospital acquired infections
- To continue to reduce preventable hospital mortalities
- To reduce medication errors
- To reduce patient falls in hospital
- To provide the correct site surgery and procedures on our patients
- To transfuse the correct blood products to our patients.

Effectiveness

- To reduce hospital acquired pressure ulcers
- To reduce emergency re admission rates
- To fully implement a trust wide Venous Thrombo-Embolism (VTE) policy and determine the current numbers of hospital acquired VTEs.
- To increase the percentage of patients with a fractured neck of femur who wait for 24 hours or less for surgery
- To increase the number of women who experience an unassisted delivery.
- To implement system for monitoring patient reported outcome measures as advised by the Department of Health.

Patient Experience

- To sustain the percentage of patients who would recommend the hospital to a friend or relative
- To sustain the percentage of patients who stated they were treated with dignity and respect
- To increase the % of complaints that are responded to within 25 days
- To increase the % of patients whose call bells are responded to within 5 minutes
- To review the local methodology for asking patients about their hospital experience with a view to increasing the number so patient responses.

Regulation

- Sustain full compliance with the Hygiene Code
- Sustain full compliance with the CQC's Standards for Better Health
- Attain NHSLA Acute Standards at Level 2
- Sustain NHSLA Maternity Standards at Level 3
- To comply with NICE guidance, no significant lapses
- To comply with Central Alert Bulletins, no significant lapses.

Quality Account Monitoring Tool - 2008 / 2009

No.	Indicator	Target 2008 / 2009		Month																Year End
		Year	Month	April	May	June	Q1	July	August	September	Q2	October	November	December	Q3	January	February	March	Q4	
Patient Safety																				
1	MRSA bacteraemias - Number reported 2007/08 = 18	10 or less	1 or less	2	0	0	**2**	0	0	0	**0**	1	0	0	**1**	0	2	1	**3**	**6**
2	Clostridium difficile - Number reported 2007/08 = 221	220 or less	18 or less	17	8	7	**32**	5	8	7	**20**	3	6	5	**14**	5	1	3	**9**	**75**
3	Correct patient, correct drug, correct route, correct dose: 10% reduction in errors. 2007/08 = 184	**167**	**14**	10	15	23	**48**	14	7	17	**38**	19	9	8	**36**	8	7	8	**23**	**145**
4	Reduction in patient falls: 6% reduction. 2007/08 = 1,260	**1189**	**99**	94	83	120	**297**	115	117	122	**354**	90	87	99	**276**	113	87	103	**303**	**1230**
5	Reduce patient fractures: 10% reduction. 2007/08 = 29	**26**	**2**	2	0	5	**7**	0	2	0	**2**	0	1	1	**2**	1	5	0	**6**	**17**
6	Corrent patient, correct blood transfusion (100%). 2007/08 = 0	**0 Errors**	**0 Errors**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	**0**
7	Correct patient, correct site surgery (100%). 2007/08 = 3	**0 Errors**	**0 Errors**	0	0	0	**0**	0	0	0	**0**	0	0	1	**1**	0	0	0	**0**	**1**

No.	Indicator	Target 2008 / 2009		Month																Year End
		Year	Month	April	May	June	Q1	July	August	September	Q2	October	November	December	Q3	January	February	March	Q4	
Clinical Effectiveness																				
8	Hospital acquired pressure ulcers - 10% reduction - Grade 4	31or less	3 or less	2	4	2	8	0	0	2	2	1	6	6	13	5	2	1	8	31
9	- Grade 3	32 or less	3 or less	3	7	2	12	3	4	1	8	1	1	0	2	3	0	0	3	25
10	Hospital Mortality Rates - to reduce preventable hospital mortalities	Yearly ave. of monthly total	HSMR = 100 or less	101	94	94	96	91	93	98	94	85	99	97	93	98	92	94	94*	95
Patient Experience																				
11	Patient Recommendation: 95% to be achieved by year end (Picker).Previous year = 90%	95%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	95%	95%
12	Patients treated with dignity & care: 80% by year end (Picker). Previous year = 72%	80%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	80%	80%
13	Complaints dealt with within 25 days (Picker).	75% per quarter	N/A	N/A	N/A	N/A	95%	N/A	N/A	N/A	71%	N/A	N/A	N/A	75%	N/A	N/A	N/A	39%	70%
14	Patient call bells responded to within 5 minutes (Picker). Previous year = 69%.	75%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	72%	72%

No.	Indicator	Target 2008 / 2009		Month																Year End
		Year	Month	April	May	June	Q1	July	August	September	Q2	October	November	December	Q3	January	February	March	Q4	
Regulatory Measures																				
15	Full compliance with the Hygiene Code with no significant lapses	Achieve Compliance each Quarter		N/A	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		
16	Full compliance with the Standards for Better Health with no significant lapses	Achieve Compliance each Quarter		N/A	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A		
17	Attain NHSLA Acute Standards at Level 1	Obtain by September		N/A	N/A	N/A	N/A	N/A	N/A											
18	Obtain NHSLA Maternity Pilot Standards at Level 3	Obtain by November		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A								
19	Compliance with NICE guidance within timescales (exceptions present no significant risks)	95%	95% per Quarter	N/A	N/A	N/A	96	N/A	N/A	N/A	98	N/A	N/A	N/A	96	N/A	N/A	N/A	97	97
20	Compliance with Central alert bulletins within timescales (exceptions present no significant risks)	90%	90% per Quarter	N/A	N/A	N/A	96%	N/A	N/A	N/A	95%	N/A	N/A	N/A	94%	N/A	N/A	N/A	96%	95%

Keys:

Risk Rating Key:	**3**	**Mandatory**
	2	**National Priority**
	1	**Local Priority**

* = Estimate. Actual data not yet available.

Key: **Significantly Below Target, and Risk Rating is deducted from score**

Below Target, and Risk Rating is deducted from score

On Target or Better, and Risk Rating is added to score

Working in Partnership

Patients are at the centre of our strategy and at the centre of our service. Therefore we aim to gather information about our service from a range of sources to bring about improvements for patients, their families and carers. These sources include:

- Our Governors and members
- Thank you letters
- Letters of complaint
- Patient advice and Liaison service
- Legal Claims
- Incident Reports
- National and Local surveys

Patient Advice and Liaison Service (PALS)

The Patient Advice and Liaison Service plays an important part in supporting patients, their carers and relatives. The Service can help in different ways, such as:

- Providing information and advice to make using our services as easy as possible
- Listening to questions, suggestions, concerns and complaints
- Working as an intermediary between patients, relatives and carers and our own staff to answer your questions, concerns and complaints
- Making sure comments and suggestions on how to improve our services are taken seriously
- Working with departments to make sure patients get information in the right way and at the right time
- Helping patients gain access to their medical health records
- Providing information on support groups, voluntary organisations and advocacy groups
- Helping guide patients through the different services provided by our Trust
- Providing information on local or national NHS services
- Actively seeking the views of patients and the public on the quality of services to help make sure that they are of the highest standards
- Working with staff throughout the organisation to make sure we act on the feedback we receive.

The Bereavement Office provides sympathetic support and assistance to bereaved relatives and carers by helping them through the procedures following the death of a patient at the hospital.

Equality and Diversity

The Trust is committed to the provision of a high quality service to all members of the community, within a culture where people are valued and respected for their individual differences. The Trust has a duty to protect service users, employees, job applicants, volunteers, students, contractors and agency staff from victimisation, harassment and discrimination and will apply a philosophy of zero tolerance in all circumstances.

Primary Care Trusts (PCTs)
Primary Care Trusts commission services from the Trust and good progress is being made to work constructively with our lead commissioner, Swindon PCT and our neighbouring PCTs. Regular meetings are held and we work together to achieve targets set by the government.

Health Overview and Scrutiny
We have a positive relationship with both Swindon and Wiltshire Local Authority Health Overview and Scrutiny Committees and our Trust is regularly represented at these meetings. We contribute to their work programme and have had a number of opportunities to attend the meetings and present on topics of interest or concern. We are included in wider policy issues through these forums (for example how we can improve our responsiveness to the treatment of patients with learning disabilities) and welcome the constructive challenge each of these forums provide.

Workforce

Our staff are our most valuable asset. We are committed to supporting our staff to ensure that they have a satisfying job and career in the hospital.

Our workforce information is monitored against national key performance indicators and agreed Trust targets to measure organisational performance, so that we can target areas for improvement. During 2008/09 the Trust overspent on its pay budget due to high spending on agency staff to deliver the 13 week referral-to-treatment target. The Trust also provided more services than expected to the PCT.

Workforce key –performance indicators

Directorate	Whole Time Equivalent	Headcount	Turnover	Vacancy levels	Sickness absence levels
Corporate Services	323	344	16.72	4.82	4.03
Diagnostics and Outpatients	538	637	12.24	3.69	4.04
Planned Care	780	918	11.9	-1.38	5.47
Private Patients	31	35	15.15	16.65	1.84
Unscheduled Care	604	674	14.29	8.11	4.45
Women's and Children's	392	456	9.28	8.62	5.07
Total	2671.72	3064	12.70%	4.22%	4.68%

Training and development

Academy teams with line managers reviewed our training provision to ensure what was being provided for our staff was more explicitly linked with team, departmental and Trust wide objectives. We also reviewed the variety of methods of delivery to ensure that time spent away from ward and department areas was worthwhile. A training prospectus was

developed as well as a review of mandatory training. One thousand and forty two staff including temporary staff and volunteers attended Trust induction.

Attendance at work

We continue to make progress in improving attendance at work and have focused our efforts on supporting staff with stress and musculo-skeletal disorders as these some of our highest areas of absence. We recruited two additional ergonomists to investigate problems and support our Occupational Health and Safety team and staff. We were also visited by the Health and Safety Inspector who was pleased with our progress in many key areas.

Temporary staff

Temporary staff are a key resource to the Trust as we continue to plan to match our capacity against the needs of our patients. We continue to expand our nurse bank (currently 500 staff) and administrative and clerical staff (150 staff). Our recruitment and induction processes were reviewed to ensure that are our temporary staff are fit for purpose.

Listening to our staff

In addition to Openness meetings which were held in all Directorates throughout the year, and provide valuable real time feedback from staff on issues affecting them, we received the annual staff survey results in March. Our staff told us that we were committed to their work-life balance and that staff felt they worked in a well structured team environment. However our staff told us that the level of work pressure they are experiencing is too high. In response we reviewed staffing levels in many areas and invested in key appointments. We have held recruitment fairs and are proactively managing our vacancies.
Staff also told us that the culture of health and safety was more embedded in the organisation and that staff satisfaction continues to be good. We continue to work with staff and managers to improve results in all key areas.

We also commenced work with the Partnership Institute to improve how we work with our trade union colleagues as we value our relationship and want to enhance its effectiveness for the benefit of all staff.

Our Volunteers

We have 258 volunteers in the hospital who provide a hugely valued service. During the year, we were delighted to welcome hospital radio on site and two of our volunteers Donna Reader and Beryl Bowles won awards at the Pride of Swindon Awards. We were also delighted to extend our volunteering Breastfeeding Service and services to the Eye Clinic. In November we recognised 15 long service awards including 1 volunteer Gordon Miles who had twenty years service as a volunteer and Ted Brewer who had twenty five years service.

Board of Directors

Trust Board Members

Our Trust is led by Bruce Laurie. Brief biographies for the Non-Executive and Executive Directors are given below. The Non Executive Directors are all considered to be independent of the Foundation Trust.

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 March 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.

Helen Bourner, Director of Business Development

Helen has 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.

Robert Burns, Non-Executive Director

Robert Burns' career has been largely focussed 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
Rowland has 30 years commercial experience in the aviation and tourism industry including seven years on the Board of Cathay Pacific Airways Ltd (Rowland's responsibilities included marketing, customer service, corporate communications and IT). Rowland is the Chair (founder investor) of Ecco Tours Ltd, a non-executive Director of Air Partner PLC (1996 to 2004) and a non-executive Director of Groundstar Ltd (1999 to 2004). Rowland holds a masters degree in law and undertook the London Business School's Executive Programme. He is the Deputy Chair and Senior Independent Director, chairs both the Integrated Governance and Risk Committee and is a member of the Finance Committee and Mental Health Act Committees.

Liam Coleman
Liam Coleman joined the Foundation Trust Board on 1st December 2008. He is a divisional director of the Nationwide Building Society.

Liam, who received a BA Honours in Geography from the University of Manchester, has also worked for the Mitsubishi Bank as manager of corporate finance and as loan manager at Hambros Bank Ltd.

Liam is a member of the Remuneration Committee and the Finance Committee.

Oonagh Fitzgerald, Director of Workforce & Education
Oonagh joined the Trust in February 2008. Oonagh had previously worked as Director of Human Resources & OD at Kingston Hospital, South West London and prior to that she was Deputy Director of HR 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 within 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.

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 six 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 14 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
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:
Chair of Wiltshire Ambulance Service NHS Trust from 1998 to 2002.
Director of the New Swindon Company between 2003 and 2004 and again from 2005 to date.
Non Executive Director British Railways Board/Strategic Rail Authority (2000 to 2002).
Chair of Western England Rail Passenger Committee (1998 to 2000).
Leader of Swindon Borough Council (Aug 2002 to May 2003).
A member of Employer's Side on the National Joint Negotiating Committee for Youth & Community Workers (1994 to date).
A member of Employer's Side on National Solbury Committee (1995 to date).
A member of the Employers Side National Joint Negotiating Committee for Teachers in Residential Establishments.
A member of Wiltshire Police Authority (1999 to 2003).
Kevin Chairs the Workforce Strategy Committee and is a member of the Integrated Governance and Risk Committee, the Finance Committee, and the Remuneration Committee.

Dr Alf Troughton, Medical Director
Alf has been a consultant radiologist at the Trust since 1994 and 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.

Membership of the Council of Governors

There are four constituencies that make up the Council of Governors: Swindon, Wiltshire, West Berkshire - Gloucestershire - Oxfordshire and the staff constituency. The elected members and their terms of office are shown below.

Elected Public Governors - Swindon

Harry Dale	2 years
Emma Neilson	1 year
Phil Prentice	1 year
Ros Thomson	3 years
Katherine Usmar	3 years

Elected Public Governors - Wiltshire

Godfrey Fowler	2 years
Janet Jarmin	1 year
Margaret Toogood	3 years

Elected Public Governors - West Berkshire / Gloucestershire / Oxfordshire

Graeme Chisholm	2 years
Srini Madhavan	3 years

Elected Staff Governors

Mike Carvell	2 years
Rachel Cross	3 years
Susan Doyle	1 year

Nominated Governors

Additionally there are 5 nominated Governors who serve for three years. They are:
Andy Creswell – Thames Valley Chamber of Commerce
Lesley Donovan – The Academy
Bill Fishlock – Swindon PCT
David Renard – Swindon Borough Council
Carole Soden – Wiltshire County Council
David Stevens – NHS Wiltshire

Governors are not remunerated for their work but are entitled to claim expenses for the costs incurred while undertaking duties for the Trust as a Governor. The total amount of expenses paid for the year from 1st December 2008 to 31st March 2009 was £0.

If there are any disagreements between the Council of Governors and the Board of Directors, the Constitution lays out the process of how these disagreements may be resolved. The Governors held two formal council meetings in the 4 month period.

Membership

The function of membership is to give our constituents and staff opportunities to influence the future development of the Trust and to make a real difference in the way it is run. We welcome members from outside the localities mentioned above as affiliate members. All members must be aged 12 or more.

The staff constituency consists of members of staff, volunteers and employees of Carillion (our PFI Contractor).

The number of members within each constituency is as follows:

Public constituency	Last year	Next year (estimated)
At year start (1 April or Authorisation)	1871	4151
New members	2438	2441
Members leaving	158	166
At year end (31 March)	4151	6426

Staff constituency	Last year	Next year (estimated)
At year start (1 April or Authorisation)	0	4232
New members	4246	400
Members leaving	14	400
At year end (31 March)	4232	4232

The Council of Governors, through its Membership Working Group, is responsible for ensuring that plans are in place for the implementation of the membership strategy.

Declarations of Interest

All members of the Council of Governors have a responsibility to declare relevant interests, as defined in the Trust's Constitution. These declarations are made known to the Secretary of the Trust and entered to a public register. Details are available from the Trust Secretary.

Committee Support

The Nominations and Remuneration Committee is a formal Committee of the Council of Governors. The Committee's function is to recommend to the Council of Governors the recruitment, appointment and terms and conditions of the Chair and Non Executive Directors. The Committee's members are

Godfrey Fowler
Graeme Chisholm
Harry Dale.

Support is offered to the Committee by the Chair, Director of Workforce and Education and the Trust Secretary. During the year the Committee recommended to the Council of Governors the remuneration of the Non Executive Directors. Full details of directors' remuneration is available in the remuneration report (page 47 onwards.)

Related Party Transactions

The Trust is required to disclose, in the annual accounts, any material transactions between the Trust and members of the Council of Governors. There were no such transactions for the period from 1st December 2008 to 31st March 2009.

Statement of Compliance with the NHS Foundation Trust Code of Governance 2008/09

The Board of Directors and the Council of Governors of the Great Western Hospitals NHS Foundation Trust recognises the importance of good corporate governance as described in the NHS Foundation Trust Code of Governance published by Monitor.

Work has been undertaken by the Trust during the year to ensure compliance against the Code and to determine action to address any areas on non-compliance.

As at 31st March 2009, the Trust was compliant with the code provisions with the following exceptions.

- A.1.3 - Process for evaluating the Chairs' performance. The arrangements for evaluating the Chair's performance will be led by the Senior Independent Director before 1st December 2009.
- C 2 1 - All other Executive Directors should be appointed by a committee or the chief executive, the chairman and the non executive directors and subject to reappointment at intervals of no more than five years. The Remuneration Committee has considered the issue of 5 year contracts and took into the account that the executive directors hold substantive contracts and are not subject to re-appointment at 5 year intervals for the following reasons:
  - (a) Executive Directors are subject to regular review of performance and existing procedures allow for appointment to be terminated if the performance is not satisfactory without the need for formal reappointment;
  - (b) The scope for refreshing the Board exists as executive posts turnover, and the board restructures the Executive Directors' responsibilities through organisation change; and
  - (c) Fixed term appointments create a short term focus and may be detrimental to the engagement of clinicians, this being vital to the success of any Foundation Trust.
- D 2.1 - The Chair with the assistance of the Secretary if applicable should use performance evaluations as the basis for determining individual and collective professional development programmes for directors relevant to their duties as Board members**.** The development of Executive Directors is delegated to the Chief Executive Officer and is measured through the Trust's appraisal process.

Remuneration Committee Report

The Board has established a Remuneration Committee under the Chairmanship of the Trust Deputy Chairman/Senior Independent Director. Other members are the Chair of the Trust and all other Non-Executive Directors.

The members may request the attendance of the Chief Executive and/or any other Directors as required for information and advice.

Terms of Reference

Duties

- Determine the appropriate remuneration, terms of service and contracts of employment for the Chief Executive and other 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 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 of these actions rests with the Remuneration Committee, the accountability of the actions of the Committee remains with the full Board.

Policy and Guidance

In exercising its duties, the Committee:

- Has regard for each individual's own performance and contribution to the Trust, the performance of the Trust itself and the provisions of any national arrangements for such staff that may be applicable;
- Takes into account any applicable guidance that may from time to time be issued by the Department of Health, the Chief Executive of the NHS or any other relevant person or body;
- Seeks professional advice from the Chief Executive, the Director of Workforce and Education and the Director of Finance and may, where appropriate, consult any other Director or other employee of the Trust;
- Obtains external advice from suitably qualified organisations, individuals or professional firms.

Meetings

Meetings in 2008/09 were held on 29th August and 16th October 2008 and details of members' attendance is shown below:

Attendees: 29th August 2008
Rowland Cobbold (Chair)
Robert Burns
Angela Gillibrand
Roger Hill
Bruce Laurie
Kevin Small

Attendees: 16th October 2008
Rowland Cobbold (Chair)
Robert Burns
Bruce Laurie
Kevin Small

The Committee keeps full minutes of all meetings together with all papers presented to the Committee and these are made available to the Trust's internal and external auditors. Any such papers and documents may be required for the proper scrutiny of their duties.

The Chairman of the Committee makes a verbal report to the Board following each meeting.

Statement of the policy on the remuneration of senior managers for current and future financial years

The Chief Executive and all Executive Directors are on permanent NHS Very Senior Managers' Contracts with notice periods of three or six months. The Medical Director has a continuing Clinical commitment to Radiology of 17 hours per week in addition to his Managerial Duties.

In determining remuneration for 2008/09 the Committee had regard to:

- National guidelines relating to Very Senior Managers' pay;
- The individual performance of the Chief Executive and other executive directors as assessed by an annual appraisal;
- The performance of the Trust;
- The annual report produced by Capita Consulting PLC on the remuneration of chief executives and directors across the NHS; and
- The current economic position.

In addition to an increase of 2.75%, the Committee also agreed in the light of the Trust's exceptional performance in 2008/09 to a non-pensionable, non recurring bonus of 5% payable to all Directors.

In setting remuneration for newly appointed directors, the Committee had regard to the size of the job, the need to offer competitive terms and the levels of remuneration currently on offer in similarly sized NHS organisations.

For the future the Committee intends to appoint an external consultant to provide advice on all aspects of performance measurement and remuneration with a view to establishing an effective and objective appraisal system and a system of remuneration that will enable the Trust to attract and retain the best possible candidates and reward excellent performance. A preferred supplier has been identified and a programme of work is under discussion.

Senior Managers Remuneration

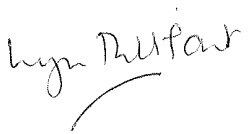
				2008/09 (4 months to 31st March 2009)		
Name	**Title**	**Start Date**	**Leaving Date**	**Salary (bands of £5000)**	**Other Remuneration (bands of £5000)**	**Benefits in Kind (Rounded to the nearest £100)**
B Laurie	Chair	1/2/2008		10-15	0	0
K Small	Non Executive Director	1/11/2003		0-5	0	0
R Cobbold	Non Executive Director	1/1/2003		0-5	0	0
A Gillibrand	Non Executive Director	1/7/2004		0-5	0	0
R Hill	Non Executive Director	1/5/2008		0-5	0	0
R Burns	Non Executive Director	1/8/2008		0-5	0	0
L. Coleman	Non Executive Director	1/12/2008		0-5	0	0
L. Hill-Tout	Chief Executive	17/2/2003		50-55	0	0
O Fitzgerald	Director of Workforce and Education	11/2/2008		40-45	0	0
M. Moore	Director of Finance	29/9/2008		40-45	0	0
A. Troughton	Medical Director	1/9/2006		25-30	30-35	0
S Rowley	Director of Nursing	1/1/2007		30-35	0	0
H Bourner	Director of Business Development	4/8/2008		35-40	0	0

Senior Managers Pension

		2008/09 (as @ 31st March 2009)						
		Real Increase in pension at age 60 (bands of £2500)	Real Increase in related lump sum at age 60 (bands of £2500)	Total accrued pension at age 60 (bands of £5000)	Lump sum at age 60 related to accrued pension (bands of £5000)	Cash Equivalent Transfer Value at 31 Mar 2009	Cash Equivalent Transfer Value at 30 Nov 2008	Real Increase in Cash Equivalent transfer Value
		£000	£000	£000	£000	£000	£000	£000
Name	**Title**							
L. Hill-Tout	Chief Executive	0-2.5	0-2.5	39	116	780	783	(3)
O Fitzgerald	Director of Workforce & Education	0-2.5	0-2.5	10	29	122	118	4
M. Moore	Director of Finance	0-2.5	0-2.5	38	113	637	595	42
A. Troughton	Medical Director	0-2.5	0-2.5	56	167	1248	1143	105
S Rowley	Director of Nursing & Performance	0-2.5	0-2.5	27	81	493	459	34
H Bourner	Director of Business Development & Performance	0-2.5	2.5-5.0	9	28	155	127	28

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's 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 arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in the former scheme. The pension figures shown relate to 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 their purchasing additional years of pension in the scheme at their own costs. CETV's are calculated within the guidelines and framework 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, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.



Signed
Lyn Hill-Tout
Chief Executive

4th June 2009

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STATEMENT OF ACCOUNTING OFFICER'S RESPONSIBILITIES

Statement of the chief executive's responsibilities as the accounting officer of Great Western NHS Foundation Trust

The National Health Service 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").

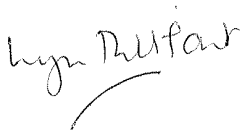
Under the National Health Service Act 2006, Monitor has directed the Great Western NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair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

Signed 

Lyn Hill-Tout

Chief Executive 4th June 2009

STATEMENT ON INTERNAL CONTROL

1. Scope of responsibility

The Board is accountable for internal control. As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum

Great Western Hospitals NHS Foundation Trust was incorporated as a Foundation Trust on 1st December 2008. This statement covers the period from that date to the 31st March 2009. The period from 1st April 2008 to 30th November 2008 has been covered by the Statement on Internal Control for Swindon and Marlborough NHS Trust.

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 Directors 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 4 months ended 31 March 2009 and up to the date of approval of the annual report and accounts.

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 regulations 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

3. Capacity to handle risk

Leadership is provided to the risk management process by ensuring clarity within each Executive Director's job description and annual appraisals with personal development plans. Staff training on risk management is commensurate with their roles. All new employees receive induction, which includes risk management and incident reporting, together with health and safety, manual handling and infection control training appropriate to their duties. Learning from incidents and good practice is encouraged within departments and directorates by means of specific incident reports, root causes analysis and trend analysis and these are shared widely. External and internal good practice is shared throughout the organisation and we have mechanisms in place to promote a culture encouraging 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 & Risk Committee, which is chaired by a Non Executive Director and has additional Non-Executive and Executive Director membership. The Clinical Governance and Risk Committee supports the Integrated Governance & Risk Committee, which regularly reviews the Trust's risk register, which is used to inform priorities. Risks are also identified at Directorate level and each Directorate inputs to the risk register. The Clinical Governance team and the Health & Safety Department support staff in the identification and management of risk.

The Trust's Risk Management Strategy describes the Trust's approach to risk management and outlines the formal structures in place to support this approach. The Strategy was reviewed and updated in April 2008

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

- the Trust strategic objectives;
- the strategic risks;
- the controls in place;
- the assurances in place; and
- records the actions to be taken to strengthen both controls and assurances.

The Trust is assured that it was compliant with all the Standards for Better Health as at 31st March 2009 and has been compliant throughout the year with these standards.

The Trust shares with patients and families outcomes and lessons from our investigations and complaints. This work will be strengthened as we enhance our compliance with the Standards for Better Health core standards and through consultation with our Governors, partner organisations including Swindon and Wiltshire Overview and Scrutiny Committees and the newly established Local Involvement Networks (LINks).

Key risks highlighted through the Business Plan included:

- Failure to provide joined up patient care in a complex system;
- Failure to meet and understand our Commissioner's needs and our patient's requirements;

- Transfer of service and income to other providers. Where appropriate, plans are in place to address these risks.

Risks to information are being managed and controlled. This has been particularly relevant from December 2007 as part of the work we have done on person identifiable data flows which underpin our Information Governance Assurance Statements. Actions have been taken in accordance with the Department of Health guidance and advice provided in the NHS Chief Executives letter dated 4 December 2007. As Accountable Officer I am committed to ensuring that immediate actions are taken where significant risks have been highlighted. A system of monitoring information governance risks is established and monitored through the Information Governance Steering Group.

I have received confirmation from NHS Connecting for Health that the Trust has completed its declaration of the version 4 information governance statement of compliance. An action plan has been developed to address progress in our compliance of the information governance toolkit standards and to monitor further enhancements to our information governance systems.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

5. Review of economy, efficiency and effectiveness of 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 the 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 Integrated Business Plan dated September 2008 and the Annual Plan 2009/10.

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 terms of authorisation.

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

- Uses the Institute of Innovation & Improvement data and subscribes to the Foundation Trust Network benchmarking data to ensure productivity;
- Achieved the NHS Litigation Authority risk management standards, achieving level 2 in the general and level 3 in maternity standards in 08/09;
- Healthcare Commission information that identifies key performance indicators and measures these over time to focus attention on areas for improvement.

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.

The Trust was also assessed by the Audit Commission under the Auditors Local Evaluation (ALE) which reviews internal control and value for money. The overall assessment for 2008/09 was level 3.

5. Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework, 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.

My review is also informed by:

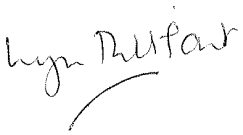
- External and Internal Audit Reports;
- CNST Assessment and report;
- NHSLA Assessment and report
- Department of Health and Healthcare Commission inspections and reports;
- SHA opinion on the Assurance Framework;
- Clinical audit and governance reports;
- Health and Safety Executive Reports;
- Ongoing self-assessment against the Standards for Better Health with the development/monitoring of the action plans to address identified gaps, including comments from the our partner organisations;
- Ongoing development of the risk register linking it into the assurance framework whilst maintaining the operations process; and
- Feedback from staff during regular open sessions and weekly walkabouts Performance, finance and workforce 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 Audit, Clinical Governance and Integrated Governance & Risk Committees. Plans to address weaknesses and ensure continuous improvement of systems are in place and are regularly monitored by these groups. The Trust has in place arrangements to monitor, as part of its risk identification and management processes, compliance with other key standards, including Standards for Better Health covering areas of potentially significant organisation risk. The report from the Head of Internal Audit on the effectiveness of the system of internal control stated that “the Board has significant assurance that there is a generally sound system of control designed to meet the organisation’s objectives”.

Whilst I am confident that controls are in place, I acknowledge that these can be further improved. We have reviewed our governance and committee structures to ensure integrated governance, overview and greater scrutiny and ensure compliance with the new Audit Committee Handbook and Integrated Governance framework. These proposals, approved by the Trust Board at the start of the year, have been implemented successfully.

As part of the Audit Plan, Internal Audit will continue to review the effectiveness of these arrangements.

Conclusion
As Accounting Officer I have reviewed the system of internal control and no significant internal control issues have been identified.



Signed: Date 4th June 2009

Chief Executive
(On behalf of the Board)

Independent auditor's report to the Council of Governors of Great Western Hospitals NHS Foundation Trust

I have audited the financial statements of Great Western Hospitals NHS Foundation Trust for the period ended 31 March 2009 under the National Health Service Act 2006. The financial statements comprise the Income and Expenditure Account, the Balance Sheet, the Cash Flow Statement, the Statement of Total Recognised Gains and Losses and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration Report that is described as having been audited.

This report is made solely to the Council of Governors of Great Western Hospitals NHS Foundation Trust as a body in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. My work was undertaken so that I might state to the Council of Governors those matters I am required to state to it in an auditor's report and for no other purpose. In those circumstances, to the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the Foundation Trust as a body, for my audit work, for the audit report or for the opinions I form.

Respective responsibilities of the Accounting Officer and auditor

The Accounting Officer's responsibilities for preparing the financial statements in accordance with directions made by the Independent Regulator of NHS Foundation Trusts (Monitor) are set out in the Statement of Accounting Officer's Responsibilities.

My responsibility is to audit the financial statements in accordance with statute, the Audit Code for NHS Foundation Trusts and International Standards on Auditing (UK and Ireland).

I report to you my opinion as to whether the financial statements give a true and fair view in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts. I report whether the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts. I also report to you whether, in my opinion, the information which comprises the Directors' Report, included in the Annual Report, is consistent with the financial statements.

I review whether the Accounting Officer's statement on internal control reflects compliance with the requirements of Monitor contained in the NHS Foundation Trust Financial Reporting Manual 2008/09. I report if it does not meet the requirements specified by Monitor or if the statement is misleading or inconsistent with other information I are aware of from my audit of the financial statements. I am not required to consider, nor have I considered, whether the Accounting Officer's statement on internal control covers all risks and controls. Neither am I required to form an opinion on the effectiveness of the Trust's corporate governance procedures or its risk and control procedures.

I read the other information contained in the Annual Report and consider whether it is consistent with the audited financial statements. This other information comprises the Chair's Report, Directors' report, Quality report, the sections on Working in partnership, Patient Advice and Liaison Service, Equality and Diversity, Workforce, the Board of Directors, Membership of the Council of Governors, Statement of Compliance with the NHS Foundation Trust Code of Governors 2008/09, and the un-audited part of the Remuneration

Report. I consider the implications for my report if I become aware of any apparent misstatements or material inconsistencies with the financial statements. My responsibilities do not extend to any other information.

Basis of audit opinion

I conducted my audit in accordance with the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor, which requires compliance with International Standards on Auditing (United Kingdom and Ireland) issued by the Auditing Practices Board. An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the financial statements and the part of the Remuneration Report to be audited. It also includes an assessment of the significant estimates and judgments made by the directors in the preparation of the financial statements, and of whether the accounting policies are appropriate to the Trust's circumstances, consistently applied and adequately disclosed.

I planned and performed my audit so as to obtain all the information and explanations which I considered necessary in order to provide me with sufficient evidence to give reasonable assurance that:

- the financial statements are free from material misstatement, whether caused by fraud or other irregularity or error; and
- the financial statements and the part of the Remuneration Report to be audited have been properly prepared.

In forming my opinion I also evaluated the overall adequacy of the presentation of information in the financial statements and the part of the Remuneration Report to be audited.

Opinion

In my opinion:

- the financial statements give a true and fair view of the state of affairs of Great Western Hospitals NHS Foundation Trust as at 31 March 2009 and of its income and expenditure for the period then ended in accordance with the accounting policies adopted by the Trust;
- the part of the Remuneration Report to be audited has been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts; and
- information which comprises the Directors' Report included in the annual report, is consistent with the financial statements.

Certificate

I certify that I have completed the audit of the accounts in accordance with the requirements of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Richard Lott
Engagement Lead
Audit Commission
Westward House
Stoke Gifford
Bristol
BS34 8SR

8 June 2009

Statement as to disclosure to auditors

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

MONITOR METRICS – Financial Risk Rating (FRR)

Financial Criteria	Weight (%)	Metric to be Scored	Metric	Rating	Rating Categories				
					5	4	3	2	1
Achievement of plan	10%	EBITDA achieved (%)	101.2%	5	100%	85%	70%	50%	<50%
Underlying performance	25%	EBITDA margin (%)	3.6%	2	11%	9%	5%	1%	<1%
Financial efficiency (i)	20%	Return on Assets excluding dividend (%)	5.2%	4	6%	5%	3%	-2%	<-2%
Financial efficiency (ii)	20%	I&E surplus margin (%)	1.0%	3	3%	2%	1%	-2%	<-2%
Liquidity	25%	Liquidity ratio in days	23.7	3	35	25	15	10	<10
Overall Financial Risk Rating				**3.2**					

Great Western Hospital NHS Foundation Trust Accounts

For the period 1st December 2008 to 31st March 2009

FOREWORD TO THE ACCOUNTS

These accounts for the four month period ended 31 March 2009 have been prepared by Great Western Hospitals NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006 in the form in which 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 NHS Foundation Trust Financial Reporting Manual only comparators relating to the 4 months that the Trust was a Foundation Trust have been included where required.

Signed:

Lyn Hill-Tout
Chief Executive

Date: 4th June 2009

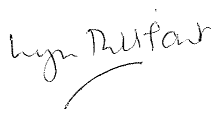
INCOME AND EXPENDITURE ACCOUNT FOR THE FOUR MONTH PERIOD ENDED 31 MARCH 2009

	Note	4 months ended 31/3/09 £000
Income from activities	3	60,017
Other operating income	4	4,224
Operating expenses	5-6	(62,857)
OPERATING SURPLUS		**1,384**
Cost of fundamental reorganisation / restructuring		0
Profit / (Loss) on disposal of fixed assets	11	0
SURPLUS BEFORE INTEREST		**1,384**
Finance Income	9	64
Finance costs - interest expense		0
Other net gains/(losses) on financial instruments		0
Other finance costs - unwinding of discount		(41)
Other finance costs - change in discount rate on provisions		0
SURPLUS FOR THE FINANCIAL YEAR		**1,407**
Public Dividend Capital dividends payable	18.2.1	(742)
RETAINED SURPLUS FOR THE YEAR		**665**

BALANCE SHEET AS AT 31 MARCH 2009

	Note	31 March 2009 £000	1 December 2008 £000
FIXED ASSETS			
Intangible assets	10	157	165
Tangible assets	11	61,228	59,098
Investments		0	0
		61,385	**59,263**
CURRENT ASSETS			
Stocks and work in progress	13	2,534	2,553
Debtors	14	14,668	20,403
Investments		0	0
Cash at bank and in hand	19.2	20,379	14,244
		37,581	**37,200**
TOTAL CURRENT ASSETS			
CREDITORS: Amounts falling due within one year	16	(22,918)	(19,763)
NET CURRENT ASSETS		**14,663**	**17,437**
TOTAL ASSETS LESS CURRENT (LIABILITIES)		**76,048**	**76,700**
CREDITORS: Amounts falling due after more than one year	16	(593)	(593)
PROVISIONS FOR LIABILITIES AND CHARGES	17	(6,157)	(7,442)
TOTAL ASSETS EMPLOYED		**69,298**	**68,665**
FINANCED BY:			
TAXPAYERS' EQUITY			
Public dividend capital		27,111	27,111
Revaluation reserve	18.3	28,191	28,190
Available for sale investments reserve		0	0
Donated asset reserve	18.3	1,142	1,175
Other reserves		0	0
Income and expenditure reserve	18.3	12,854	12,189
TOTAL TAXPAYERS EQUITY		**69,298**	**68,665**

Signed:



Lyn Hill-Tout
Chief Executive

Date: 4th June 2009

The financial statements on pages 63 to 97 were approved by the Board and accepted by the Audit Committee on 4 June 2009 and then signed by the Chief Executive

STATEMENT OF TOTAL RECOGNISED GAINS AND LOSSES FOR THE FOUR MONTH PERIOD ENDED 31 MARCH 2009

	4 months ended 31/3/09 £000
Surplus / (deficit) for the financial year before dividend payments	1,407
Fixed asset impairment losses	0
Unrealised surplus / (deficit) on fixed asset revaluations/indexation	0
Net gains / (losses) on available for sale investments	0
Increases in the donated asset reserve due to receipt of donated assets	0
Reduction in the donated asset reserve due to the depreciation, impairment and disposal of donated assets	(34)
Additions / (reductions) in "Other reserves"	0
Other recognised gains & (losses)	0
Total recognised gains & (losses) for the financial year	**1,373**
Prior period adjustments	0
Total recognised gains and losses	**1,373**

CASH FLOW STATEMENT FOR THE FOUR MONTH PERIOD ENDED 31 March 2009

	NOTE	4 months ended 31/3/09 £000
OPERATING ACTIVITIES		
Net cash inflow from operating activities	19	**8,158**
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:		
Interest received		64
Interest paid		0
Interest element of finance leases		0
Net cash inflow from returns on investments and servicing of finance		**64**
TAXATION PAID/RECEIVED		0
CAPITAL EXPENDITURE:		
(Payments) to acquire tangible fixed assets		(974)
Receipts from sale of tangible fixed assets		0
(Payments) to acquire intangible assets		0
Receipts from sale of intangible assets		0
(Payments to acquire)/receipts from sale of fixed asset investments		0
Net cash (outflow) from capital expenditure		**(974)**
DIVIDENDS PAID		(1,113)
Net cash inflow/(outflow) before management of liquid resources and financing		**6,135**
MANAGEMENT OF LIQUID RESOURCES:		
Purchase of current asset investments		0
Sale of current asset investments		0
Net cash inflow/(outflow) from management of liquid resources		0
Net cash (outflow) before financing		**6,135**
FINANCING:		
New Public dividend capital received		0
Public dividend capital repaid		0
Foundation Trust Financing Facility loans received		0
Other Loans received		0
FT Financing Facility loans repaid		0
Other Loans repaid		0
Other capital receipts		0
Capital element of finance lease rental payments		0
Net cash inflow from financing		**0**
Increase/(Decrease) in Cash		**6,135**

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Financial Reporting Manual which has been agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2008/2009 NHS FReM (Foundation Trust Financial Reporting Manual) issued by Monitor. The accounting policies contained in that manual follow UK Generally Accepted Accounting Practice for companies (UK GAAP) 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 material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of tangible fixed assets at their value to the business by reference to their current costs. NHS Foundation Trusts, in compliance with HM Treasury's Financial Reporting Manual, are not required to comply with the FRS 3 requirements to report "earnings per share" or historical profits and losses.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'discontinued' where they meet all of the following conditions:

a) the sale (this may be at nil consideration for activities transferred to another public sector body) or termination is completed either in the period or before the earlier of three months after the commencement of the subsequent period and the date on which the financial statements are approved;

b) if a termination, the former activities have ceased permanently;

c) the sale or termination has a material effect on the nature and focus of the reporting Trust's operations and represents a material reduction in its operating facilities resulting either from its withdrawal from a particular activity or from a material reduction in income in the Trust's continuing operations; and

d) the assets, liabilities, results of operations and activities are clearly distinguishable, physically, operationally and for financial reporting purposes.

Operations not satisfying all of these conditions are classified as continuing.

Activities are considered to be 'acquired' whether or not they are acquired from outside the public sector.

1.3 Income Recognition

Income is accounted for by applying the accruals convention. The main source of income for the Trust is under contracts from commissioners in respect of healthcare services. Income is recognised in the period in which services are provided. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

1.4 Impairment

Fixed asset impairments resulting from losses in 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 recognised gains and losses to the extent that there is a balance on the revaluation reserve in respect of the particular asset.

1.5 Expenditure

Expenditure is accounted for by applying the accruals convention.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.6 Intangible fixed 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.

1.7 Tangible fixed assets

Capitalisation

Tangible assets 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.

Valuation

Tangible fixed assets are stated at the lower of replacement cost and recoverable amount. On initial recognition they are measured at cost (for leased assets, fair value) including any costs such as installation directly attributable to bringing them into working condition. The carrying values of tangible fixed assets are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable.

All land and buildings are revalued using professional valuations in accordance with FRS15 every five years. A three yearly interim valuation is also carried out.

Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. Asset valuations were undertaken in 2004 as at the prospective valuation date of 1 April 2005. The revaluation undertaken at that date was accounted for on 31 March 2005.

The valuations are carried out primarily on the basis of depreciated replacement cost for specialised operational property and existing use value for non-specialised operational property. The value of land for existing use purposes is assessed at existing use value. For non-operational properties including surplus land, the valuations are carried out at open market value.

Additional alternative open market value figures have only been supplied for operational assets scheduled for imminent closure and subsequent disposal.

Assets in the course of construction are valued at current cost and are valued by professional valuers as part of the five or three yearly valuation or when they are brought into use.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.7 Tangible fixed assets (continued)

Residual interests in off-balance sheet private finance initiative properties are included in assets under construction within tangible fixed assets at the amount of unitary charge allocated for the acquisition of the residual with an adjustment. The adjustment is the net present value of the change in the fair value of the residual as estimated at the start of the contract and at the balance sheet date.

Depreciation, amortisation and impairments

Tangible fixed assets 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 and residual interests in off-balance sheet PFI contract assets 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 recognised gains and losses to the extent that there is a balance on the revaluation reserve in respect of the particular asset.

1.8 Donated fixed assets

Donated fixed assets are capitalised at their current value on receipt and this value is credited to the donated asset reserve. Donated fixed assets are depreciated as described above for purchased assets. Gains and losses on revaluation are also taken to the donated asset reserve and, each year, an amount equal to the depreciation charge on the asset is released from the donated asset reserve to the income and expenditure account. Similarly, any impairment on donated assets charged to the income and expenditure account is matched by a transfer from the donated asset reserve. On sale of donated assets, the net book value of the donated asset is transferred from the donated asset reserve to the income and expenditure reserve.

1.9 Government Grants

The Foundation Trust has no Government Grants

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.10 Stocks and work-in-progress

Stocks and work-in-progress are valued at the lower of cost and net realisable value. This is considered to be a reasonable approximation to current cost due to the high turnover of stocks.

1.11 Research and development

Expenditure on research is not capitalised. Expenditure on development is capitalised if it meets the following criteria:

- there is a clearly defined project;
- the related expenditure is separately identifiable;
- the outcome of the project has been assessed with reasonable certainty as to:
    - its technical feasibility;
    - its resulting in a product or service which will eventually be brought into use;
- adequate resources exist, or are reasonably expected to be available to enable the project to be completed and to provide any consequential increases in working capital.

Expenditure so deferred is limited to the value of future benefits expected and is amortised through the income and expenditure account on a systematic basis over the period expected to benefit from the project. It is revalued on the basis of current cost. Expenditure which does not meet the criteria for capitalisation is treated as an operating cost in the year in which it is incurred. Where possible the Trust will disclose the total amount of research and development expenditure charged in the income and expenditure account separately. However, where research and development activity cannot be separated from patient care activity it cannot be identified and is therefore not separately disclosed.

Fixed assets acquired for use in research and development are amortised over the life of the associated project.

1.12 Provisions

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the balance sheet 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 the HM Treasury's discount rate of 2.2% in real terms.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

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 at Note 17.1.

Non-clinical risk pooling

The Trust participates in the Liabilities to Third Parties Scheme. This is a risk pooling scheme 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 as and when the liability arises.

1.13 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. As a consequence it is not possible for the Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme under FRS17.

The Scheme is subject to a full actuarial investigation 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 FRS17 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.nhspa.gov.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.

Employers pension cost contributions are charged to operating expenses as and when they become due. Employer contribution rates are reviewed every four years following the scheme valuation on advice from the actuary. At the last valuation it was recommended that employer contributions should remain at 14% of pensionable pay. Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the income and expenditure account at the time the Trust commits itself to the retirement.

1.14 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 fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.15 Corporation Tax

The Trust does not have a corporation tax liability for period ended 2008/09. Tax may be payable on activities as described below:

- The activity is not related to the provision of core healthcare as defined under Section 14(1) of the HSCA. Private Healthcare falls under this legislation and is not therefore taxable.
- The activity is commercial in nature and competes with the private sector. In house trading activities are normally ancillary to the core healthcare objectives and are therefore not subject to tax. Canteen income and car park income falls under this legislation and is therefore not taxable.
- The activity must have annual profits of over £50,000

1.16 Foreign Exchange

Transactions that are denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses are taken to the income and expenditure account.

1.17 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 the HM Treasury Financial Reporting Manual, see note 19.3.

1.18 Leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as a tangible fixed asset and a debt is recorded to the lessor of the minimum lease payments discounted by the interest rate implicit in the lease. The interest element of the finance lease payment is charged to the income and expenditure account over the period of the lease at a constant rate in relation to the balance outstanding. Other leases are regarded as operating leases and the rentals are charged to the income and expenditure account on a straight-line basis over the term of the lease.

1.19 Public Dividend Capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities i.e. the net assets of a public benefit corporation.

A charge, reflecting the forecast cost of capital utilised by the Trust, is paid over as the public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average relevant assets of the Trust. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for donated assets and cash held at bank. Average relevant net assets are calculated as a simple mean of opening and closing relevant assets. A note to the accounts discloses the rate that the dividend represents as a percentage of the actual average carrying amount of assets less liabilities in the year, see note 18.2.1.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.20 Financial Instruments and financial liabilities

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.

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.

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.

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.

1.21 Partially Completed Spells

As a Foundation Trust we recognise partially completed spells as accrued income relating to the relevant PCTs.

1.22 Cash and bank

Cash and bank balances are recorded at the current values of these balances in the Great Western Hospitals NHS Foundation Trust's cash book. These balances exclude monies held in the Trust's bank account belonging to patients. Interest earned on bank accounts and is recorded as interest receivable in the periods to which they relate. Bank charges are recorded as operating expenditure in the periods to which they relate.

1.23 Private Finance Initiative (PFI) transactions

The NHS follows HM Treasury Technical Note 1 (Revised) "How to Account for PFI transactions" which provides definitive guidance for the application of note F to FRS 5.

Where the balance of the risks and rewards of ownership of the PFI property are borne by the PFI operator, the PFI payments are recorded as an operating expense. Where, at the end of the PFI contract a property reverts to the Trust, the difference between the expected fair value of the residual on reversion and any agreed payment on reversion is built up over the life of the contract by capitalising part of the unitary charge each year as a tangible fixed asset.

NOTES TO THE ACCOUNTS

2. SEGMENTAL ANALYSIS

All income and activities are for the provision of health and health related services in the UK.

3. INCOME FROM ACTIVITIES

3.1 Income from Activities

	4 months ended 31/3/09 £000
Acute Trusts:	
Elective Income	14,014
Non Elective income	21,200
Outpatient income	11,389
A&E income	1,898
Other NHS Clinical income	10,468
All Trusts:	
Private patient income	757
Other non-protected clinical income	291
Total Income	**60,017**

The Terms of Authorisation set out in the mandatory goods and services that the Trust is required to provide (protected services).

	4 months ended 31/3/09 £000
Income from Mandatory Services	58,969
Income from Non-mandatory Services	1,048
Total	**60,017**

3.2 Private Patient Income

	4 months ended 31/3/09 £000	Base year 2002/03 £000
Private patient income	757	1,587
Total patient related income	60,017	99,359
Proportion (as a percentage)	**1.3%**	**1.6%**

Section 44 of the 2006 NHS Act requires that 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 of 1.6%

3.3 Income from Activities - Provider analysis

	4 months ended 31/3/09 £000
NHS Foundation Trusts	143
NHS Trusts	114
Strategic Health Authorities	2,080
Primary Care Trusts	50,464
Local Authorities	0
Department of Health - grants	0
Department of Health - other	6,162
NHS Other	6
Non-NHS: Private patients	757
Non-NHS: Overseas patients (non-reciprocal)	47
NHS Injury Scheme (RTA)	35
Non NHS Other	209
Total	**60,017**

NHS Injury Scheme income (RTA) is subject to a provision for doubtful debts of 19.4% to reflect expected rates of collection.

NOTES TO THE ACCOUNTS

4. OTHER OPERATING INCOME	4 months ended 31/3/09 £000
Research and development	134
Education and training	2,050
Charitable and other contributions to expenditure	214
Transfers from donated asset reserve	34
Non-patient care services to other bodies	471
Other Income *	1,321
Total	**4,224**

Analysis of Other operating income:

Charitable and Other Contributions to expenditure includes:	**£000**
a Macmillan Nurses	40
b Prospect Hospice	23
c Contributions from Suppliers to support posts	136
d Charitable Funds Recharge	15
Total	**214**

Non-patient care services to other bodies includes:	**£000**
a. Mortuary	61
b. Renal	87
c. Sterile Services	36
d. Drugs provided to other NHS bodies	131
e. Other Misc Amounts	157
Total	**471**

Other income includes:	**£000**
Car Parking	333
Estates Recharges	198
Staff Recharges	311
Property rentals	128
Cardiac network	132
Other	219
Total	**1,321**

NOTES TO THE ACCOUNTS

5. OPERATING EXPENSES

5.1 Operating expenses comprise:	4 months ended 31/3/09 £000
Services from other NHS Foundation Trusts	210
Services from NHS Trusts	857
Services from other NHS bodies	613
Purchase of healthcare from non NHS bodies	421
Executive Director's costs	246
Non-Executive Director's costs	17
Staff costs	35,656
Drug costs	3,457
Supplies & services - clinical (excluding drug costs)	6,719
Supplies & services - general	659
Establishment	971
Research and development	132
Transport	158
Premises	2,094
Increase / (decrease) in bad debt provision	(112)
Other impairment of financial assets	0
Depreciation and amortisation	1,027
Fixed asset impairments	0
Fixed asset reversal of impairments	0
Audit fees:	
- audit services - statutory audit	58
- audit services - regulatory reporting	10
Other auditor's remuneration:	
- further assurance services	0
- other services	0
Clinical negligence	389
Exceptional items	0
Other *	9,275
Total	**62,857**

The total employer's pension contributions are disclosed in note 6.1.

Other Expenditure includes:	**£000**
Soft FM	8,931
Deferred Assets	120
VAT Adjustment	157
Other	67
Total Other	9,275

5.2 Operating leases

5.2.1 Operating lease rentals

	4 months ended 31/3/09 £000
Hire of plant and machinery	77
Other operating lease rentals	33
Total	**110**

5.2.2 Operating Lease Commitments

	Land & Buildings 31/3/09 £000	**Other leases 31/3/09 £000**
Annual commitments on lease expiring:		
Within 1 year	0	0
Between 1 and 5 years	147	158
After 5 years	0	78
Total	**147**	**236**

5.3 Limitation on auditors liability

	31/3/09 £000
Limitation on auditors liability	0

NOTES TO THE ACCOUNTS

6. STAFF COSTS AND NUMBERS

6.1 Staff costs

	4 months ended 31/3/09
	£000
Salaries and wages	28,861
Social Security Costs	2,151
Employer contributions to NHSPA	3,415
Other pension costs	0
Agency and contract staff	1,475
	35,902

6.2 Average number of persons employed WTE

	4 months to 31/3/09 Number
Medical and dental	383
Ambulance staff	0
Administration and estates	649
Healthcare assistants & other support staff	422
Nursing, midwifery & health visiting staff	1,072
Nursing, midwifery & health visiting learners	3
Scientific, therapeutic and technical staff	398
Social care staff	0
Bank and agency staff	138
Other	0
Total	**3,065**

Note: Employers pension contributions in the sum of £3415K were made for the period Dec 08 to Mar 09.

6.3 Employee benefits

There are no benefits in kind in the 4 month period.

6.4 Early Retirements due to ill-health

During the full 12 month period of 2008/09 there were 3 early retirements from the Trust agreed on the grounds of ill health. The estimated additional pension liabilities of these ill-health retirements will b**e** £128,783 These costs will be borne by the NHS Pensions Agency.

6.5 Management costs

		000s
Managements Costs	£	2,508
Income	£	64,241
Percentage %		**3.9%**

NOTES TO THE ACCOUNTS

7. BETTER PAYMENT POLICY CODE

7.1 Better Payment Practice Code - measure of compliance	4 months ended 31/3/09 Number	4 months ended 31/3/09 Value
Total Non-NHS trade invoices paid in the period	12,083	12,906
Total Non-NHS trade invoices paid within target	10,863	12,106
Percentage of Non-NHS trade invoices paid within target	**89.9%**	**93.8%**
Total NHS trade invoices paid in the period	501	13,180
Total NHS trade invoices paid within target	460	11,126
Percentage of NHS trade invoices paid within target	**91.8%**	**84.4%**

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date of within 30 days or receipt of valid invoices.

7.2 The Late Payment of Commercial Debts (Interest) Act 1998

There were no amounts included within Interest Payable arising from claims made by businesses under this legislation.

8. (LOSS) PROFIT ON DISPOSAL OF FIXED ASSETS

	4 months ended 31/3/09 £000
Profit on disposal of intangible fixed assets	0
Loss on disposal of intangible fixed assets	0
Profit on disposal of land and buildings	0
Loss on disposal of land and buildings	0
Profit on disposal of other tangible fixed assets	0
Loss on disposal of other tangible fixed assets	0
Total	**0**

9. FINANCE INCOME

	4 months ended 31/3/09 £000
Interest on loans & receivables	0
Interest on available for sale financial assets	0
Interest on held-to maturity financial assets	0
Other	64
Total Finance Income	**64**

NOTES TO THE ACCOUNTS

10. INTANGIBLE FIXED ASSETS

	Software licences	Licenses & trademarks	Patents	Development expenditure	Goodwill	Other	Total
	£000	£000	£000	£000	£000	£000	£000
Gross cost at 1 April 2008	0						0
Gross cost at start of period for new FT	186						186
Impairments	0						0
Reclassifications	0						0
Other Revaluations	0						0
Additions purchased	0						0
Additions donated	0						0
Disposals	0						0
Gross cost at 31 March 2009	**186**	**0**	**0**	**0**	**0**	**0**	**186**
Amortisation at 1 April 2008	0						0
Amortisation at start of period for new FT	21						21
Provided during the year	8						8
Impairments	0						0
Reversal of impairments	0						0
Reclassifications	0						0
Other Revaluations	0						0
Disposals	0						0
Amortisation at 31 March 2009	**29**	**0**	**0**	**0**	**0**	**0**	**29**
Net book value							
- Purchased at 1 April 2008	0						0
- Donated at 1 April 2008	0						0
- Total at 1 April 2008	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Net book value							
- Purchased at 31 March 2009	157						**157**
- Donated at 31 March 2009	**0**						**0**
- Total at 31 March 2009	**157**	**0**	**0**	**0**	**0**	**0**	**157**

NOTES TO THE ACCOUNTS

11. TANGIBLE FIXED ASSETS

11.1 Tangible fixed assets at the balance sheet date comprise the following elements:

	Freehold Land	Freehold Buildings excluding dwellings	Freehold Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2008	0	0	0	0	0	0	0	0	0
Cost or valuation at start of period for new FT's	23,910	9,336	99	11,910	39,131	58	5,712	2,778	92,934
Additions - purchased	0	261	0	834	667	0	1,387	0	3,149
Additions - donated	0	0	0	0	0	0	0	0	0
Impairment	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluation	0	0	0	0	552	0	0	0	552
Disposals	0	0	0	0	0	0	0	0	0
Cost or valuation at 31 March 2009	**23,910**	**9,597**	**99**	**12,744**	**40,349**	**58**	**7,099**	**2,778**	**96,634**
Depreciation at 1 April 2008	0	0	0	0	0	0	0	0	0
Depreciation at start of period for new FT's	0	343	5	0	28,900	58	3,528	1,003	33,837
Provided during the year	0	177	3	0	502	0	212	125	1,019
Impairments	0	0	0	0	0	0	0	0	0
Reversal of Impairments	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluation	0	0	0	0	552	0	0	0	552
Disposals	0	0	0	0	0	0	0	0	0
Accumulated depreciation at 31 March 2009	**0**	**520**	**8**	**0**	**29,954**	**58**	**3,740**	**1,128**	**35,407**
Net book value									
- Purchased at 1 December 2008	0	0	0	0	0	0	0	0	0
- Donated at 1 December 2008	0	0	0	0	0	0	0	0	0
Total at 1 December 2008	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
- Purchased at 31 March 2009	23,910	9,077	91	12,730	9,359	0	3,364	1,602	60,133
- Donated at 31 March 2009	0	0	0	14	1,037	0	(5)	49	1,095
Total at 31 March 2009	**23,910**	**9,077**	**91**	**12,744**	**10,396**	**0**	**3,359**	**1,651**	**61,228**

The build up of residual interest for the off balance sheet PFI Schemes is included in Assets Under Construction, and amounts to £12,169k. This figure is made up of £10,495k for the Great Western Hospital, £363k for Residences and £1,311k for the Brunel Treatment Centre.

11.2 Analysis of tangible Fixed Assets

Net book value									
Protected assets at 31 March 2009	23,910	9,077	91	0	0	0	0	0	33,078
Unprotected assets at 31 March 2009	0	0	0	12,744	10,396	0	3,359	1,651	28,150
Total at 31 March 2009	**23,910**	**9,077**	**91**	**12,744**	**10,396**	**0**	**3,359**	**1,651**	**61,228**

11.3 Assets held at open market value

	31 March 2009			
	Total	**Land**	**Buildings**	**Dwellings**
	£000	**£000**	**£000**	**£000**
Open market value at 31 March 2009	33,078	23,910	9,077	91

11.4 Assets held under finance leases & HP contracts

There were no assets held under Finance Leases or Hire Purchase contracts at the balance sheet date.

11.5 Impairment of Assets

There is no impairment of assets at the balance sheet date, as a full impairment review was carried out within the 8 month period as an NHS trust

NOTES TO THE ACCOUNTS

12. FIXED ASSET INVESTMENTS

The Foundation Trust has no fixed asset investments.

13. STOCKS AND WORK IN PROGRESS

	31 March 2009 £000
Raw materials and consumables	2,534
Work-in-progress	0
Finished goods	0
Total Stocks & WIP	**2,534**

14. DEBTORS

14.1 Debtors at the balance sheet date are made up of:	Total 31 March 2009 £000	Financial Assets 31 March 2009 £000	Non-Financial Assets 31 March 2009 £000
Amounts falling due within one year:			
NHS Debtors	2,646	2,646	0
Provision for impaired debtors	(788)	(788)	0
Prepayments	1,457	0	1,457
Accrued Income	1,694	1,694	0
Corporation Tax receivable	0	0	0
Other debtors	2,061	1,561	500
Debtors falling due within one year	**7,070**	**5,113**	**1,957**
Amounts falling due after more than one year:			
NHS debtors	0	0	0
Provision for irrecoverable debtors	0	0	0
Prepayments	7,598	0	7,598
Accrued income	0	0	0
Other debtors	0	0	0
Debtors due after more than one year	**7,598**	**0**	**7,598**
Total Debtors	**14,668**	**5,113**	**9,555**

14.2 Provision for Impairment of Debtors	31 March 2009 £000
At 1 April	0
At start of period for new FT's	801
Increase in provision	0
Amounts utilised	0
Unused amounts reversed	(14)
At 31 March 2009	**787**

14.3 Analysis of Impaired Debtors	31 March 2009 £000
Ageing of impaired debtors	
Up to three months	91
In three to six months	257
Over six months	440
Total Impaired Debtors	**788**
Ageing of non-impaired debtors past their due date	
Up to three months	8,421
In three to six months	349
Over six months	1,075
Total non-impaired debtors	**9,845**

15. CURRENT ASSET INVESTMENTS

The Foundation Trust has no current asset investments.

NOTES TO THE ACCOUNTS

16. CREDITORS

16.1 Creditors at the balance sheet date are made up of:

	Total	Financial Liabilities	Non-Financial Liabilities
	31 March 2009 £000	31 March 2009 £000	31 March 2009 £000
Amounts falling due within one year:			
Bank overdrafts	0	0	0
Loans	0	0	0
Payments received on account	0	0	0
NHS creditors	2,708	2,708	0
Corporation tax payable	0	0	0
Other Tax and social security costs	2,222	0	2,222
Obligations under finance leases and hire purchase contracts	0	0	0
Capital creditors	3,018	3,018	0
Other creditors	4,130	2,042	2,088
Accruals	8,796	8,796	0
Deferred income	2,044	0	**2,044**
Creditors falling due within one year	**22,918**	**16,564**	**6,354**
Amounts falling due after more than one year:			
Loans	0	0	**0**
Obligations under finance leases and hire purchase contracts	0	0	**0**
NHS Creditors	0	0	**0**
Other	593	0	**593**
Creditors falling due after more than one year	**593**	**0**	**593**
Total creditors	**23,511**	**16,564**	**6,947**

16.2 Loans

The Foundation Trust had no loans in the period.

NOTES TO THE ACCOUNTS

16.3 Prudential Borrowing Limit

	31 March 2009 £000
Maximum cumulative long term borrowing limit set by Monitor	18,500
Approved working capital facility: not to exceed	14,000
Total Prudential Borrowing Limit	**32,500**
Long term borrowing at start of period for new FT's	0
Net actual borrowing/(repayment) in year - long term	0
Long term borrowing at 31 March 2009	**0**
Working capital borrowing at start of period for new FT's	0
Net actual borrowing/(repayment) in year - long term	0
Working capital borrowing at 31 March 2009	**0**

Great Western Hospitals NHS Foundation Trust is required to comply and remain within a prudential borrowing limit. This is made up of two elements:

- the maximum cumulative amount of long-term borrowing. This is set by reference to the five ratio tests 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 Foundation Trusts

16.3.1 Financial Ratios

Financial Ratios	2008/09 Actual Ratios Ratios	2008/09 Approved PBL Ratios
Maximum Debt/Capital Ratio	N/A*	0
Minimum Dividend Cover	3.2	1 x
Minimum Interest Cover	N/A*	3 x
Minimum Debt Service Cover	N/A*	2 x
Maximum Debt Service to Revenue	N/A*	0

*Great Western Hospitals NHS Foundation Trust has no debt to service, therefore it is not applicable to calculate these borrowing

16.4 Finance Lease obligations

The Foundation Trust has no finance leases.

NOTES TO THE ACCOUNTS

17. PROVISIONS FOR LIABILITIES AND CHARGES

	Pensions relating to other staff	Legal claims	Other	Total
	£000	£000	£000	**£000**
At 1 April 2008	0	0	0	**0**
At start of period for new FT's	1,431	380	5,631	**7,442**
Change in the discount rate	0	0	0	**0**
Arising during the year - Other	0	0	167	**167**
Utilised during the year	(51)	0	(21)	**(72)**
Reversed unused	0	(40)	(1,381)	**(1,421)**
Unwinding of discount	30	0	11	**41**
At 31 March 2009	**1,410**	**340**	**4,407**	**6,157**
Expected timing of cash flows:				
Within 1 year	52	340	3,911	4,303
1 - 5 years	206	0	84	290
Over 5 years	1,152	0	412	1,564
	1,410	**340**	**4,407**	**6,157**

17.1 Clinical Negligence Liabilities

	31 March 2009 £000
For NHS Foundation trusts within the NHSLA clinical negligence scheme, of which the Great Western Hospitals NHS Foundation Trust is one, all clinical negligence claims are recognised in the accounts of the NHSLA. Consequently, the Trust has no provision for clinical negligence claims. The amounts included in the provisions of the NHS Litigation Authority at 31 March 2009 in respect of clinical negligence for the Great Western Hospitals NHS Foundation Trust, as detailed in their schedule dated 20th April 2009, are:	12,637

NOTES TO THE ACCOUNTS

18.1 MOVEMENT IN TAXPAYERS' EQUITY

	4 months ended 31/3/09 £000
Taxpayers' equity at 1 April	0
Prior period Adjustments	0
Taxpayers' equity at 1 April, as restated	0
Taxpayers' equity at start of period for new FT	68,667
Surplus / deficit for the financial year	1,407
Public dividend capital dividends	(742)
Fixed asset impairments	0
Surplus / (deficit) from revaluations of fixed assets	0
Net gains /(losses) on available for sale investments	0
New public dividend capital received	0
Public dividend capital repaid in year	0
Public dividend capital repayable (creditor)	0
Public dividend capital written off	0
Other movements in public dividend capital in year	0
Additions / (reductions) in donated asset reserve	(34)
Additions/(reductions) in other reserves **	0
Taxpayers' equity at 31 March 09	**69,298**

18.2 MOVEMENTS IN PUBLIC DIVIDEND CAPITAL

	2008/09 £000
Public dividend capital at 1 April 08	0
Public dividend capital at start of period for new FT's	27,111
New public dividend capital received	0
Public dividend capital repaid in year	0
Public dividend capital repayable (creditor)	0
Public dividend capital written off	0
Other movements in public dividend capital in year *	0
Public dividend capital at 31 March 09	**27,111**

Note: The public dividend capital is of unlimited term.

18.2.1 PUBLIC DIVIDEND CAPITAL RATE

	4 months to 31/3/09 £000
Actual public dividend capital dividend incurred during the period	742
Average relevant net assets	61,215
	%
The actual dividend rate is	1.21%
The forecast dividend rate was	3.50%
Difference between actual and forecast rate	**-2.29%**

The Trust is required to absorb the cost of capital at a rate of 3.5% of average relevant net assets. The rate is calculated as the percentage of dividends paid on public dividend capital, totalling £2,226k bears to the average relevant net assets of £61,215k that is 3.6% for the full year. (The £742K in the above note is the dividend relating to our period as an FT 1st Dec 2008 to 31st March 2009)

The Variance to 3.6% from 3.5% is within the Department of Healths materiality range of 3% to 4%.

NOTES TO THE ACCOUNTS

18.3 Movements on Reserves

	Revaluation Reserve £000	Donation Reserve £000	Available for sale investments reserve £000	Other reserves £000	Income & Expenditure Reserve £000	Total £000
At 1 April 2008	0	0	0	0	0	**0**
Prior period adjustments	0	0	0	0	0	**0**
At 1 April 2008 as restated	0	0	0	0	0	**0**
As at start of period for new FT's	28,190	1,175	0	0	12,189	**41,555**
Transfer from the Income and Expenditure account	1	0	0	0	665	**666**
Fixed asset impairments	0	0	0	0	0	**0**
Surplus/(deficit on revaluations of fixed assets	0	0	0	0	0	**0**
Revaluations of available for sale investments - gross	0	0	0	0	0	**0**
Revaluations of available for sale investments - tax	0	0	0	0	0	**0**
Transfer of realised profits (losses) to the Income and Expenditure reserve	0	0	0	0	0	**0**
Net gains/(losses) on available for sale investments through the income and expenditure account	0	0	0	0	0	**0**
Receipt of donated assets	0	0	0	0	0	**0**
Transfer to the I&E account for Depreciation, impairment, and disposal of donated assets	0	(34)	0	0	0	**(34)**
Other transfers between reserves	0	0	0	0	0	**0**
Movements on other reserves	0	0	0	0	0	**0**
At 31 March 2009	28,191	1,141	0	0	12,854	**42,187**

NOTES TO THE ACCOUNTS

19.1 Reconciliation of operating surplus/(deficit) to net cash inflow/(outflow) from operating activities:

	4 months ended 31/3/09 £000
Total operating surplus / (deficit)	1,384
Depreciation and amortisation	1,027
Fixed assets impairments	0
Fixed asset reversal of impairments	0
Transfer from the donated asset reserve	(34)
Other movements	0
(Increase) / decrease in stocks	19
(Increase) / decrease in debtors	5,735
Increase / (decrease) in creditors	1,313
Increase / (decrease) in provisions	(1,285)
Net cash inflow / (outflow) from operating activities before restructuring costs	8,158
Payments in respect of fundamental reorganisation / restructuring	0
Net cash inflow / (outflow) from operating	**8,158**

19.2 Reconciliation of net cash flow to movement in net funds / (debt):

	4 months ended 31/3/09 £000
Increase/(decrease) in cash in the year	6,135
Cash (inflow) from new debt	0
Cash outflow from debt repaid and finance lease capital payments	0
Cash (inflow)/outflow from (decrease)/increase in liquid resources	0
Change in net funds / (debt) resulting from cash flows	**6,135**
Non-cash changes in debt	0
Change in net funds / (debt)	**6,135**
Net funds / (debt) at 1 April	0
Net funds / (debt) at start of period for new FT's	14,244
Net funds / (debt) at 31 March	**20,379**

19.3 Analysis of changes in net funds / (debt)

	At 1 April 2008 £000	At start of period for new FTs £000	Cash changes in year £000	Non-cash changes in year £000	At 31 March 2009 £000
Cash at commercial banks and in hand	0	3	1,498	0	1,501
Cash at OPG (Office of Paymaster General)	0	14,241	4,637	0	18,878
Bank overdrafts	0	0	0	0	0
Debt due within one year	0	0	0	0	0
Debt due after one year	0	0	0	0	0
Finance leases	0	0	0	0	0
Current asset investments	0	0	0	0	0
TOTAL	**0**	**14,244**	**6,135**	**0**	**20,379**
Third party assets held by the NHS Foundation Trust	0	3			1

This 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

NOTES TO THE ACCOUNTS

20. CONTRACTUAL CAPITAL COMMITMENTS

	31/3/09 £000
The commitments under capital expenditure contracts at the balance sheet date were:	1,593

This is in relation to the installation of a 2nd Cath Lab

21. POST BALANCE SHEET EVENTS

As part of the move to International Accounting Reporting Standards affecting the Annual Accounts from 2009/10 onwards Trusts PFI assets and liabilities will be recognised on the Balance Sheet.

22. CONTINGENT LIABILITIES

There were no contingent liabilities for the period ended 31 March 2009.

23. RELATED PARTY TRANSACTIONS

Great Western Hospitals NHS Foundation Trust is a body incorporated by the issue of a licence of authorisation from Monitor.

The Trust is under the common control of the Board of Directors. During the year none of the Board Members or members of the key management staff or parties related to them, has undertaken any material transactions with 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 Bus Subsidy (£2.9m) and our Pooled Budget (£160K).

The Department of Health is regarded as a related party. During the four month period 31 March 2009, Great Western Hospitals NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

	Income 4 months ended 31/3/09 £000	Expenditure 4 months ended 31/3/09 £000
Department of Health	6,162	0
South West Strategic Health Authority	1,975	0
Swindon Primary Care Trust	29,750	1,016
Wiltshire Primary Care Trust	15,058	166
Berkshire West Primary Care Trust	1,814	0
Bristol Primary Care Trust	970	0
Gloucester Primary Care Trust	2,068	82
Oxfordshire Primary Care Trust	866	0
NHS Litigation Authority	0	204
NHS Business Services Authority	0	520
NHS Blood and Transplant Agency	0	305
Total	**58,662**	**2,292**

	Debtors 4 months ended 31/3/09 £000	Creditors 4 months ended 31/3/09 £000
South West Strategic Health Authority	239	0
Swindon Primary Care Trust	3,725	1,509
Wiltshire Primary Care Trust	891	97
Berkshire West Primary Care Trust	99	0
Gloucester Primary Care Trust	543	82
Oxfordshire Primary Care Trust	90	0
NHS Litigation Authority	0	204
NHS Business Services Authority	0	292
NHS Blood and Transplant Agency	0	8
Total	**5,587**	**2,192**

In addition the Trust has entered into transactions with other Government Departments and other central and local Government bodies.

NOTES TO THE ACCOUNTS

24. PRIVATE FINANCE TRANSACTIONS

24.1 PFI schemes deemed to be off-balance sheet

	4 months 2009 Total £000	2009 PFI 1 £000	2009 PFI 2 £000	2009 PFI 3 £000
Gross charge to operating expenses in respect of off balance sheet PFI transaction's)	9425	8840	126	459
Amortisation of PFI deferred asset's)	0	0	0	0
Net charge to operating expenses in respect of off-balance sheet PFI transaction's)	**9425**	**8840**	**126**	**459**

The purpose of this PFI scheme was the building of a new hospital in partnership with The Hospital Company (Swindon) Ltd

24.2 PFI scheme which expires;

	4 months 2009 Total £000	2009 PFI 1 £000	2009 PFI 2 £000	2009 PFI 3 £000
Within one year	0	0	0	0
2nd to 5th years (inclusive)	0	0	0	0
6th to 10th years (inclusive)	1,341	0	0	1,341
11th to 15th years (inclusive)	0	0	0	0
16th to 20th years (inclusive)	27,005	26,640	365	0
21st to 25th years (inclusive)	0	0	0	0
26th to 30th years (inclusive)	0	0	0	0
31st to 35th years (inclusive)	0	0	0	0
Estimated capital value of project	**128,588**	**99,948**	**3,640**	**25,000**

24.3

The Trust has three PFI Schemes:	Contract Start Date	Contract End Date
1.The Great Western Hospital	5 October 1999	4 October 2029
1a.The Brunel Treatment Centre	20 October 2003	4 October 2029
2.Residences on the Great western Site	27 September 2001	4 October 2029
3.The Integrated Clinical Information System	13 November 2001	12 November 2013

The Estimated Capital Value & total length of Projects:	Estimated Capital Value £000's	Total Length of project Years	Number of Years Remaining
1.The Great Western Hospital	99,948	30	20
1a.The Brunel Treatment Centre	25,000	25	20
2.Residences on the Great western Site	3,640	28	20
3.The Integrated Clinical Information System	5,327	12	4
Total	**133,915**		

24.4 Service element of Private Finance schemes deemed to be On- Balance Sheet

The Trust had no on-balance sheet PFI transactions during the year ended 31 March 2009.

NOTES TO THE ACCOUNTS

25. FINANCIAL INSTRUMENTS

FRS 29, Financial Instruments disclosure, requires disclosure of the significance that financial instruments have had during the period on the financial position and performance of the entity and also of the exposure to risks arising from financial instruments. The main source of income for the Trust is under contracts from commissioners in respect of healthcare services. Due to the way that the Commissioners are financed, the Foundation 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 the listed companies to which FRS 29 mainly applies. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Foundation Trust in undertaking its activities.

As allowed by FRS 26 and FRS 29, debtors and creditors that are due to mature or become payable within 12 months from the balance sheet date have been omitted from all disclosures other than the currency profile.

Liquidity risk

The NHS Foundation Trust's net operating costs are incurred under contracts with commissioners, which are financed from resources voted annually by Parliament. Great Western Hospitals NHS Foundation Trust is not, therefore, exposed to significant liquidity risks.

Market risk / Interest rate risk

The interest on cash balances held by the Trust are subject to fluctuations based on the declared interest rates of the Bank of England. The Trust has no hedging contracts or future options as these are not deemed necessary based on our procurement profile.

Foreign Currency Risk

The Trust has negligible foreign currency income or expenditure.

Credit Risk

The Trust has set procedures on the collection of debtors and outstanding balances are regularly reviewed by management. There is a risk of non payment by overseas patients, however controls are in place to minimise the financial impact of this.

NOTES TO THE ACCOUNTS

25.1 Financial Assets by category

	Total £000	Loans and Receivables £000
Fixed asset investments	0	0
NHS Debtors (net of provision for irrecoverable debts)	2,646	2,646
Provision for irrecoverable debts	(788)	(788)
Accrued income	1,694	1,694
Other debtors	1,561	1,561
Current asset investments	0	0
Cash at bank and in hand	20,379	20,379
Total at 31 March 2009	**25,492**	**25,492**

25.2 Financial liabilities by category

	Other financial liabilities £000
Bank overdrafts	0
Loans	0
NHS Creditors	2,708
Other creditors	2,042
Accruals	8,796
Capital creditors	3,018
Finance lease obligations	0
Provisions under contract	2,900
Total at 31 March 2009	**19,464**

25.3 Fair value of financial assets

Currency	Book Value £000	Fair Value £000
At 31 March 2009		
Debtors over 1 year	0	0
Fixed asset investments	0	0
Other	25,492	25,492
Gross financial assets	**25,492**	**25,492**

25.4 Fair value of financial liabilities

Currency	Book Value £000	Fair Value £000
At 31 March 2009		
Creditors over 1 year - Finance lease obligations	0	0
Provisions under contract	2,900	2,900
Loans	0	0
Other	16,564	16,564
Gross financial liabilities	**19,464**	**19,464**

Fair value is not significantly different from book value since, in the calculation of book value, the expected cash flows have been discounted by the Treasury discount rate of 2.2% in real terms.

NOTES TO THE ACCOUNTS

26.1 LOSSES AND SPECIAL PAYMENTS	4 months ended 31/3/09 Number	4 months ended 31/3/09 Value £'000
Losses	799	22
Special payments	3	0
Total losses and special payments	**802**	**22**

There were no case payments that exceeded £100,000.
The above losses are calculated on an accruals basis.

27. 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.

	4 months ended 31/3/09 £
Income:	
Swindon Borough Council	204,183
Income Disposal	0
Refund Indepenedent Living Centre	18,194
Mainstream Paediatrics	33,082
Swindon Primary Care Trust	189,000
Great Western Hospitals NHS Foundation Trust	160,000
Total Income	**604,459**
Expenditure:	
Expenditure 4 months to 31/3/09	**414,960**
Surplus (Deficit) for 4 months	**189,499**
Deficit for 1/4/08 to 30/11/08	**(187,026)**
Total Surplus at 31/3/09	**2,473**
Share of Surplus (Deficit):	
Swindon Borough Council	2,473
Swindon Primary Care Trust	0
Great Western Hospitals NHS Foundation Trust	0
Total Surplus at 31/3/09	**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.

Glossary of Terms

AAU	Acute Assessment Unit
A&E	Accident & Emergency Unit (now known as ED – Emergency Department)
CaAMHS/ CAAHMs/CAMHS	Child and Adolescent Mental Health Services
CDiff	Clostridium Difficile
CF	Carried Forward
CIPs	Cost Improvement Programmes
CMO	Chief Medical Officer
DGH	District General Hospital
EBITDA	Earnings before interest, taxes, depreciation and amortisation
ED	Emergency Department
EFM	Estates & Facilities Management
EWTD	European Working Time Directive
FM	Facilities Management
FRR	Financial Risk Rating
FA	First appointment
FT	Foundation Trust
FU	Follow up appointment
HCAI	Health Care Associated Infections
HIT	Hit Infection Together
HRG	Healthcare Resource Group
HSE	Health & Safety Executive
HSMR	Hospital Standard Mortality Rate
IBP	Integrated Business Plan
I&E	Income & Expenditure
IFRS	International Finance Reporting Standards
IP	Inpatient
IR1	Incident Reference Form 1
ISTC	Independent Sector Treatment Centres
JAG	Joint Accreditation Group
KPMG	Project Company employed by the Trust to support delivery of CIPs
MAJAX	Major Incident
MFF	Market Forces Factor
MRSA	Methicillin Resistant Staphylococcus Aureus
N12	Financial code for births
NHSLA	NHS Litigation Authority
NICE	National Institute of Clinical Excellence
OD strategy	Organisational Development
OJEU	Official Journal of the European Union
OP	Outpatient
Over Performance	Achievement of activity above budgeted level
PBC	Practice Based Commissioning
PbR	Payment by Results
PCT	Primary Care Trust
PDC	Public Dividend Capital
PFI	Private Finance Initiative
PPI	Private Patients Income
PSD	Planned Same Day (treatment)
Q (1, 2, 3 or 4)	Quarters of the financial year
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
ROA	Return on Assets
RTT	Referral to Treatment Time
S22	Financial Code for a planned procedure not carried out
SLM	Service Line Management

SHA	Strategic Health Authority
SIC	Statement of Internal Control
SLAs	Service Level Agreements
SUI	Serious Untoward Incident
TIA	Transient Ischaemic Attack
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 2006
UK GAAP	UK General Accepted Accounting Principles
UKSH	UK Specialist Hospitals
VTE	Venous thrombo-embolism
WC	Working Capital

Copies of this annual report may be obtained from

Head of Governance & Board Secretary
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The annual report is available on the website www.gwh.nhs.uk. A summary report is also available.

The External Auditors to the Trust are:
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