Great Western Hospitals NHS
NHS Foundation Trust

Great Western Hospitals NHS Foundation Trust
Annual Report and Accounts
2011/2012

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Schedule 7, paragraph 25(4) of the National Health Service
Act 2006

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1 CHAIR AND CHIEF EXECUTIVE'S REPORT

During the course of the year there have been a number of changes within the Trust which have altered the shape of the organisation and the way care is provided. The most significant of these was the merger with Wiltshire Community Health Services (WCHS) in June 2011. Our successful bid was the culmination of a substantial amount of work which has given us the opportunity to think radically about how we can combine the acute and community resources in the best interests of patients.

The first six months following the merger were spent getting to know the services, the staff and the stakeholders in the local area. Having done so, the Trust is now in a position to begin delivering the benefits of the merger including more joined up care for patients. One project that has begun in this area is the work to improve patient flow across the Trust seven days a week. This work involves acute staff based at the Great Western Hospital (GWH), community staff, social services and GPs and is designed to remove the blockages that exist and which can get in the way of giving patients the right care, in the right place and getting them back home swiftly. In the year ahead we hope to see this project begin to deliver real changes to practices and processes, which in turn will make a real difference to patients.

During the course of the year former Chief Executive, Lyn Hill-Tout left the Trust to take up another post in the NHS. We would like to put on record the thanks of this Trust for the work undertaken by Lyn, first as Operations Director and then as Chief Executive, in providing over 13 years of dedicated service. She oversaw the move from the Princess Margaret Hospital to the new Great Western Hospital and the licensing of ourselves as a foundation trust. However, above all Lyn demonstrated a total commitment to high standards of patient care which she has taken forward in her new role as Chief Executive of Mid Staffordshire NHS Foundation Trust.

Work to find a high calibre replacement began prior to Lyn's departure and Nerissa Vaughan joined the Trust in October from the Queen Elizabeth Hospital Foundation Trust in King's Lynn. Work has since begun on the development of a new Trust strategy to reflect the new reality of an integrated healthcare organisation operating in a financially difficult and political environment.

The Trust is pleased to report very good performance across the majority of the key indicators we are measured against. A significant amount of work takes place in the Trust, on the front line and behind the scenes, to deliver the best care possible for our patients and our performance against the 200 indicators we are measured against provides reassurance to those patients and service users about the standards we strive to achieve. Our Trust was the only Trust in the South West to score a green rating for all our comparable targets.

Our work on infection control over recent years has meant we have had consistently low rates of MRSA and *Clostridium difficile* with just two cases of MRSA across the entire Trust and just 19 cases of *C.diff* - 50 fewer cases than the threshold we are measured against. The Trust was cited as one of the best performing Trusts in the country on our performance to tackle *C.diff* which is thanks to the combined efforts of all staff in adhering to the strict infection control practices we have in place.

At the GWH we have changed the way we care for ambulatory (walk in) patients so they are seen, treated and discharged without the need for hospital admission. At a time of rising attendances to the Emergency Department, this change has helped us reduce the number of admissions. This is particularly crucial during the busy winter months. Due to the success of this initial pilot, the new model for Ambulatory Care, which also saw an increase in the number of beds on the Linnet Acute Medical Unit, will become a permanent feature and we will be looking at ways to expand the service across the whole week.

The Great Western Hospital became a designated Trauma Unit in two regional Trauma Networks in April 2012. Due to its geographical location, the Great Western Hospital is part of both the Severn Network to the West and the Thames Valley Network to the North-East. This is a commendable achievement due to the hard work of dedicated staff.

With a larger organisation, we are using our experience of rolling out the Productive Ward Programme at the GWH to implement the same initiative in the community hospitals. The programme is designed to release more nursing time to spend on direct patient care and Wiltshire residents will start to see the benefits of our experience in this area during 2012/13.

Our staff, who are at the core of the Trust, have also shared their views on what it is like to work within the Trust via the annual independent staff survey. The results, published in March, place the Trust in the top five Trusts in the South West in terms of overall scores. The Trust was placed in the top 20% nationally on many of the key measures and generally our staff are engaged. These results are important not only for staff, but also for patients as more engaged staff means better patient care. We will be building on these results in the year ahead and have identified four priorities for focus to deliver improvements.

The year has also been challenging. The expanded programme of unannounced inspections by the Care Quality Commission (CQC) has been felt across the Trust. During the course of the year there several inspections looking at different aspects of care including dignity, nutrition and hydration and theatres. One of the inspections resulted in moderate concerns. Action plans have been developed with the concerns raised now addressed. Plans to manage any remaining issues are being rolled out.

One area that is already being managed is the removal of a number of the Extra Bed Spaces in use on some wards. These are additional regular beds intended for use when demand from patients is high. The Trust has recognised that a number of these beds have compromised patient dignity on occasions and we are taking proactive steps to remove them and reduce their use.

From a financial perspective the Trust ended a difficult financial year with £0.5m surplus. The challenges going forward will grow, so it is vital we maintain a strong financial discipline. This is particularly important when looked at in the context of falling demand for some services currently provided in a hospital environment. With fewer patients comes less money to invest in services. The Trust therefore needs to be flexible in ensuring we have the beds, staff and resources in the right areas for the demand we are experiencing. Further information on the Trust's accounts is provided in the annual accounts at the back of this annual report.

We continue to work with our Governors to deliver the aspirations of our 12,000 members and have valued their input in shaping our priorities. Governors have contributed to the workings of the Trust by adding valuable feedback and helping us to focus on improvements in areas such as patient experience. The Trust hosted a successful Open Day in September, with many staff from across the Trust giving up their time to showcase their work. Staff hosted behind the scenes tours of different areas of the hospital and a number of partner agencies were represented at the event including Wiltshire Fire and Rescue, Wiltshire Air Ambulance, Wiltshire Involvement Network, Swindon LINk and Prospect Hospice. A total of 50 people (staff and public) safely abseiled off the hospital building with the money raised going to the Trust's Charitable Fund.

We are very grateful for the efforts our 5,500 staff and volunteers who work with us everyday to save and change lives. Despite the challenges and difficult times ahead, we know we are better placed to meet them because of their hard work, professionalism and dedication to the Trust.

Yours sincerely

Bruce Laurie
Chairman
24 May 2012

Nerissa Vaughan
Chief Executive
24 May 2012

2 OUR TRUST

2.1 Vision - Your health our passion

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

A key theme of the vision has been for the Trust to provide 'healthcare services' and not solely acute hospital services. Towards achieving the 2015 vision, in June 2011 the Trust took over the running of a range of community health services and community maternity services across Wiltshire and surrounding areas, which were previously provided by Wiltshire Community Health Services (WCHS).

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

2.2 Our aims and values

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

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

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

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

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

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

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

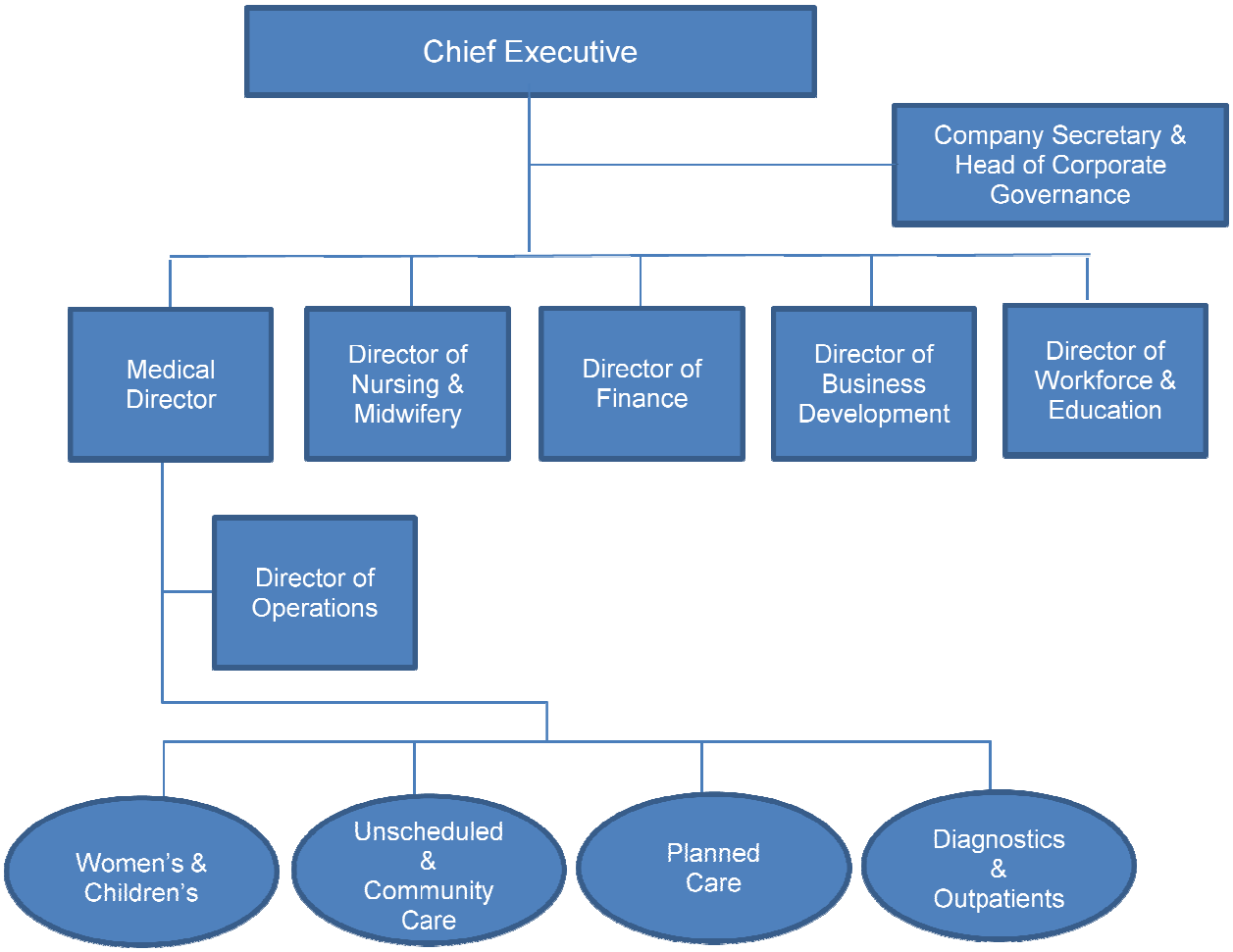
Underpinning this, our values are to: -

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

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

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

2.3 Organisational structure 2011/12



3 DIRECTOR'S REPORT

General Companies Act Disclosures

3.1 Directors of Great Western Hospitals NHS Foundation Trust

Directors of Great Western Hospital NHS Foundation Trust during 2011/12: -

Bruce Laurie	Chairman
Nerissa Vaughan	Chief Executive *(from 1 October 2011)*
Rowland Cobbold	Non-Executive Director, Deputy Chairman *(up until 31 December 2011)* Senior Independent Director
Angela Gillibrand	Non-Executive Director Deputy Chairman *(from 1 January 2012)*
Roberts Burns	Non-Executive Director
Liam Coleman	Non-Executive Director
Roger Hill	Non-Executive Director
Kevin Small	Non-Executive Director
Lyn Hill-Tout	Chief Executive *(until 12 June 2011)*
Alf Troughton	Medical Director Interim Chief Executive *(1 June – 30 September 2011)*
Guy Rooney	Interim Medical Director *(1 June – 30 September 2011)*
Maria Moore	Director Finance
Oonagh Fitzgerald	Director Workforce and Education
Sue Rowley	Director Nursing and Midwifery
Helen Bourner	Director Business Development *(until 5 April 2012)*
Jenny Barker	Director of Transition (designate) *(until 31 May 2011)* Director of Transition *(from 1 June – 31 December 2011)*

Lyn Hill Tout resigned as Chief Executive for this Trust taking up the post of Chief Executive of Mid Staffordshire NHS Foundation Trust in June 2011. Between the time of her leaving and the starting of a new Chief Executive, Alf Troughton the Medical Director acted as the interim Chief Executive and Guy Rooney acted as the interim Medical Director. Nerissa Vaughan joined the Trust as Chief Executive on 1 October 2011.
In January 2011 Jenny Barker, the Managing Director of Wiltshire Community Health Services was appointed as a Director Designate (Transition). She became a substantive Director of the Board on 1 June 2011 and left the Trust returning to NHS Wiltshire on 31 December 2011.

3.2 Principal activities of the Trust

Great Western Hospitals NHS Foundation Trust has its main headquarters at the Great Western Hospital (GWH) in Swindon. In addition to this, the Trust also provides a range of community health and maternity services across Wiltshire and parts of Bath and North East Somerset covering a population of approximately 1,300,000 people. This includes providing services to residents of parts of Oxfordshire, West Berkshire and Gloucestershire.

Since the merger with WCHS in June 2011 the Trust's workforce grew from circa 3,300 to 5,500 and the Trust's income grew from £203m to £282m in 2012/13. In 2011/12 the additional income due to WCHS was £64m for ten months. The history of the Trust is referred to elsewhere in this report (section 3.32.2 refers).

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

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

The Trust secured a licence to operate from the Care Quality Commission in March 2010 without any conditions attached to it. As part of the merger with Wiltshire Community Health Services (WCHS), the Trust altered the conditions of its existing registration from 1 June 2011 with the Care Quality Commission (CQC). This included nursing care as an additional community based activity and the addition of 21 community sites/locations. All registered sites/locations and activities have since been reviewed post merger and registration variation applications are currently underway to reflect the changes. A full copy of our licence can be found at: www.gwh.nhs.uk.

3.3 Location of services

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

3.3.1 Great Western Hospital

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

GWH opened in December 2002, replacing the Princess Margaret Hospital in Old Town, Swindon. The hospital has approximately 500 beds and is designed and equipped to offer a first-class environment for patients, visitors and staff, with over 30% of beds provided in single rooms with en-suite facilities. The remainder are in single sex four bedded bays.

3.3.2 The Brunel Treatment Centre

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

3.3.3 Within the Community

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

Location	Type of service
Chippenham Community Hospital	Acute and community services, Minor Injuries Unit, dentistry and Birthing Centre
Trowbridge Community Hospital	Acute and community services, Birthing Centre, Minor injuries Unit and outpatients clinics
Savernake Community Hospital	Acute and community - Inpatients
Warminster Community Hospital	Acute and community – Inpatients and dentistry
Melksham Community Hospital	Community/Out patients
Westbury Community Hospital	Dentistry
Southgate House	Neighbourhood Team base. Community specialist services
Hillcote	Care home
Paulton Memorial Hospital	Birth Centre and Outpatients Clinic
Princess Anne Wing, Royal United Hospital, Bath	Acute Maternity and Inpatients
Shepton Mallet Community Hospital	Birthing Centre
Frome Victoria Hospital	Birth Centre and outpatients clinic
Erlstoke Prison	Dentistry and nursing
Amesbury Health Clinic	Dentistry and podiatry
Nunton Unit, Salisbury District Hospital	Physiotherapy
Malmesbury Primary Care Centre	Podiatry/MSK
Devizes Community Hospital	Maternity/MSK Physio/Out patients/dentistry
Salisbury Central Health Clinic	Dentistry and podiatry
Swindon Health Centre (Carfax Street)	Dentistry and sexual health
Tidworth Clinic	Dentistry
West Swindon Health Centre	Dentistry
Devizes Health Centre	Dentistry
Fairford Community Hospital	Outpatient services
GP practices	The Trust provides a range of clinics in various GP practices throughout our catchment area

Further Companies Act Disclosures

3.4 Regulation Disclosures

1 Where any market values of fixed assets are known to be significantly different from the values at which those assets are held in the Trust's financial statements, and the difference is, in the directors' opinion, of such significance that readers of the accounts should have their attention drawn to it, the difference in values will be stated with as much precision as is practical and reported in the notes to the accounts.

2 There are no political or charitable donations to disclose.

3 Any important events since the end of the financial year affecting the Trust will be recorded as a post balance sheet event and noted in the accounts.

4 An indication of likely future developments at the Trust is included in the Trust's Annual Plan.

5 An indication of any significant activities in the field of research and development is reported elsewhere in this report (section 3.8 refers).

6 The Trust does not have branches outside the UK.

7 Details of policies applied during the financial year for giving full and fair consideration to applications for employment made by disabled persons, having regard to their particular aptitudes and abilities are available on request to the Trust.

8 Details of policies applied during the financial year for continuing the employment of, and for arranging appropriate training for, employees who have become disabled persons during the period are available on request to the Trust.

9 Details of policies applied during the financial year for the training, career development and promotion of disabled employees are available on request to the Trust.

10 The circulation of a "Team Brief" (an electronic site communication) is one regular action taken in the financial year to provide employees systematically with information on matters of concern to them as employees.

11 To enable consultation with employees, following on from the merger with Wiltshire Community Health Services on 1 June 2011, a new employee partnership agreement was drawn up which covered the new organisation. The Employee Partnership Forum is made up of representatives from the trades unions and management. The agenda covers Trust developments and financial information, as well as consultation on policies and change programmes.

12 Actions taken in the financial year to encourage the involvement of employees in the Trust's performance include regular all staff briefings by the Chief Executive. Staff are encouraged to ask questions and seek further information directly.

13 Actions taken in the financial year to achieve a common awareness on the part of all employees of the financial and economic factors affecting the performance of the Trust include site communication with staff and Team Brief circulation.

14 In relation to the use of financial instruments, an indication of the financial risk management objectives and policies of the Trust and the exposure of the entity to price risk, credit risk, liquidity risk and cash flow risk, unless such information is not material for the assessment of the assets, liabilities, financial position and results of the entity are included in the account notes.

15 Disclosures in respect of policy and payment of creditors are included in the notes to the accounts.

Business Review / Management Commentary / Operating and Financial Review

3.5 Review of the Trust's Business

The Trust's Annual Plan submitted to Monitor (the regulator of Foundation Trusts) sets out the organisation's priorities for delivery during the year. Listed below are some of the important issues which the Trust dealt with 2011/12 and improvements that the Trust has made over the course of the last year.

The Trust continues to make progress towards the six strategic objectives which guide the direction of the Trust. Key developments during the year towards achieving each objective are as follows:

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

   Quality and safety remain our top priorities as we want patients to be confident they will receive the best care possible, whether they access the Emergency Department at the GWH or are cared for at Warminster Community Hospital or at home. The Trust continues to focus on ensuring that there is a consistently high standard of care provided across all wards and departments to improve patient experience and remove the variability in standards that sometimes exist.

   During the course of the year the Trust has:

   - Expanded the Productive Ward Programme to include all Community Hospitals in Wiltshire. The first phase of this work began at Savernake Hospital at the end of January and the programme is designed to 'buddy' a community ward with a ward at the GWH to share experience and learning from the wider Productive Ward Initiative which has been in place at the GWH since 2009. Details of the benefits of the Productive Ward are included elsewhere in this report (section 3.22.1 refers).

     The Trust has also expanded the programme to cover Theatres and will see more nursing time released through improvements in ward and theatre working, time which can be reinvested back into direct patient care.

   - The Medical Director has introduced a regular safety briefing aimed at Junior Doctors but relevant to all clinical staff featuring important 'calls to action' around specific safety issues. The first issue was published in March 2012 and has been well received therefore it will become a regular tool to engage clinical staff on the safety agenda.

   - Overall our safety performance through the year has been good showing strong improvements in many areas. As evidence, at a meeting of NHS Chief Executives in the South West in January, the Trust and the wider NHS in Swindon was commended as one of the best performing places in the country for infection control, as a result of the significant efforts to tackle *Clostridium difficile* in particular.

   - Following three Never Events during the course of the year, the Trust invited Plymouth Hospitals to visit the Trust to share their learning from similar experiences so that safety practices could be strengthened. This work has led to the re-launch of a Safer Surgical

Checklist, a World Health Organisation (WHO) initiative across our 15 theatres to ensure greater consistency for how these checks are carried out. A Consultant Orthopaedic Surgeon, Mr Adam Brooks, is championing this initiative across the Theatres Team. He has direct accountability for ensuring the checks are carried out properly. Ensuring that staff are engaged in the pre-operative safety briefings, now rests with each surgeon.

- Over the past year the Trust has performed well in relation to Hospital Standardised Mortality Rate (HSMR) with the end of year position being below the level of mortality expected against the standardised figure. A more detailed report on our performance against a range of quality and safety indicators can be found elsewhere in this report (section 6.2.1 refers).

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

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

- Taking part in a Dementia Peer Review to assess how well the Trust cares for dementia patients in an acute setting. This has led to the early stages of development of a Dementia Plan to assist the Trust in managing how we will provide care for people with dementia in the years ahead, given the expected rise in the numbers of older people nationally. This work includes the rolling out of the use of the 'This is me' booklet which people with dementia fill out with their families prior to admission. The booklet is a useful tool to tell staff what the patient does and does not like so that care can be tailored to their individual needs.

- Following concerns about how patient fluid intake is monitored on some wards, the Trust piloted the use of a new device called the Hydrant on Jupiter Ward. The Hydrant helps monitor fluid intake and gives assurance that patients are getting the right level of fluids they need to support their recovery. Following this successful trial the Trust will become the first in the country to roll out this device in a large scale way.

- The GWH has again achieved an excellent rating across all three indicators measured by the Patient Environment Action Team who independently assess the standard of the hospital estate, quality of food for patients and the level of privacy and dignity afforded to them. This is the third year running this rating has been given. The results also show generally positive results across the community, with the exception of the Princess Anne Wing at the Royal United Hospital in Bath, which the Trust took on responsibility for in June. As part of a wider maternity review, the Trust is looking at how the patient environment can be improved for patients given the lack of investment in that area over previous years.

- Towards the end of 2011 the Trust eliminated mixed sex accommodation for the first time following changes to the way we care for ambulatory (walk in) patients. Due to restrictions on space there had been a small but significant number of patients who would occasionally be cared for in mixed sex areas. This work has now led to the elimination of mixed sex accommodation across the Trust.

More detail of patient experience can be found elsewhere in this report (section 3.22 refers).

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

- Over the summer the Trust launched new values, as part of a three year Organisational Development Programme to embed a strong customer service culture within the Trust. The new values were developed by staff as the key characteristics and traits they felt the Trust embodies and that all staff should aspire to.

  The values are represented by four simple but powerful words: **Service, Teamwork, Ambition and Respect (STAR)** and as part of the process to embed these values across the enlarged Trust, a new employee of the month scheme was launched in August. The STAR of the Month scheme has been well received and the Trust receives a wide variety of nominations from across the organisation.

  The Trust host an annual Staff Excellence Award in June each year which was established to recognise, reward and celebrate the achievements of staff. This event is well supported by staff.

  In the future the values will underpin management standards, recruitment processes, induction and appraisals to ensure the Trust has the right calibre of staff delivering not only the best clinical care, but the best customer service too.

- Towards the end of 2011 the Trust took part in the annual national NHS Staff Survey. The results, published in March 2012 place the Trust in the top five Acute Trusts in the South West in terms of overall performance and the best response rate in the region. The results show that overall staff consider the Trust to be a good place to work. As a comparison to the previous survey in 2010 when GWH NHS FT was in the top 20% of Trusts in 12/38 of the measures, this year the Trust is in the top 20% of Trusts in 17/38 of the indicators.

  With staff being more engaged than before, this has clear benefits for patients as research suggests that a well engaged workforce leads to better care. Despite the good results, we are not complacent and recognise there is more work to do on some of the indicators to see further improvements in the year ahead, such we would like to see a bigger improvement in staff recommending the Trust as a place to receive treatment.

  The Executive Committee has set four priorities for 2012/13 and plans are being worked up to achieve them: -
  - ensuring staff feel that patient care is the Trust's priority;
  - staff feeling happy with the standard of care if their relatives needed treatment;
  - improving staff satisfaction with the way the Trust values their work; and
  - ensuring staff feel involved in decisions on changes that affect work.

An overview of 2011 Staff Survey results is contained elsewhere in this report (section 9.3 refers).

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

The financial environment remains challenging and this challenge is set to grow in the years ahead as the Trust seeks to reduce costs and maintain a high standard of care.

The merger with WCHS in June 2011 provides a good opportunity to be more in control of some of the changes. Being a Trust which provides both acute and community services, as more care is transferred out into the community, we will be better placed than most

organisations to adapt to these changes and the massive reorganisation that is taking place in the NHS.

Aside from the merger, the Trust did not win any further significant tenders during the year. The Trust was involved with was an unsuccessful bid for a Medicines Management service for the Bath area which was a significant tender.

In the coming year the new legislation allowing "Any Qualified Provider" to deliver healthcare will become a significant feature of the local health market. The Trust aims to ensure that we are in the best position possible to bid for services that are put out through this policy. This preparation has included investing in bid preparation training session towards the end of the year to share skills and learning around what it takes to prepare a successful tender. This was supplemented by a learning session to feedback on the experience of bidding for WCHS as learning points for future bids.

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

Whilst the Trust, which is already more efficient than the average according to the Trust Reference Cost, the financial difficulties facing the NHS nationally, means that we have to become more efficient, delivering more with less. We have to be radical in how we approach the way we provide care.

An example of our innovative approach has been the changes to Ambulatory Care which were launched in November 2011. The aim of the initiative was to reduce the number of admissions, eliminate mixed sex accommodation and improve how we care for ambulatory (walk in) patients. Through an internal reconfiguration and streamlined processes, the Acute Assessment Unit (AAU) was expanded to create more space to see and treat patients who may not require hospital admission. More space means that we are able to put patients in the most appropriate bay removing the risk of accommodating patients in bays with people of the opposite sex.

These changes were part of a six month pilot to see what impact they would have in improving admission rates. As the impact has been so positive, the changes will become permanent within the hospital.

In January 2012, the Trust began rolling out the Productive Ward Programme to the Wiltshire Community Hospitals. This will see those hospitals benefiting from efficiencies, added improvements and more time for nurses to spend on direct patient care.

The Trust has begun work to improve the Older People's Pathway. This is aimed at streamlining the way older people are cared for; reducing reliance on acute hospitals and reducing the risk of older people becoming institutionalised through long stays in hospital. This work involves a wide range of stakeholders including commissioners and social care, and through smarter working will improve care and reduce costs.

Allied to this work is a large project aimed at improving patient flow. The project is designed to remove potential blockages for staff and patients so that whatever point they access the NHS they have a clear patient journey and are supported through discharge back to where they came from.

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

With the effects of the national reorganisation of the NHS beginning to be seen during the year, the Trust has established embryonic relationships with the various GP Commissioning organisations that will soon take on full commissioning responsibilities from the Primary Care Trusts (PCTs). Whilst these relationships are in the early stages pending the abolition of PCTs, time and effort have been invested in exploring areas of joint interest and understanding future commissioning priorities. The Trust holds regular meetings with Wiltshire Clinical Commissioning Groups to discuss relevant issues.

The new NHS landscape will be more complex than previously and the Trust will need to interact with many more groups with commissioning interests. This presents the Trust with the difficulty of adapting the way we interact with our stakeholders and will require investment in understanding their issues and concerns.

In Swindon, for example, the Trust has been working with the lead of the Transitional Leadership Group (Dr Peter Crouch) on a new IT initiative called Optimise. Optimise is a GP decision making referral tool, which has been developed locally by elected GPs and hospital consultants in Swindon. It replicates many of the useful features of the previous e-referral system and combines this with modern care pathways (e.g. Map of Medicine).

The Trust has also been a regular attendee at the Wiltshire Involvement Network (WIN) since June building better relationships with patient representatives in that area.

3.6 Additional activity creating pressure on finances

The Trust continues to experience additional demand for services, over and above the levels we are contracted to provide by our Commissioners. The following tables highlight activity levels vs contracts by point of delivery for the GWH Acute and Community and Maternity contracts.

TABLE - GWH Acute Activity

Point of Delivery	Contract	Actual	(Under)/ Over performance against contract	Variance %
GWH - New Outpatients	136,442	137,504	1,062	0.78%
GWH - Follow Up Outpatients	250,411	263,066	12,655	5.05%
GWH - Planned Same Day	22,654	27,320	4,666	20.60%
GWH - Emergency Inpatients	32,224	35,804	3,580	11.11%
GWH - Elective Inpatients	6,610	6,723	113	1.71%
GWH - Emergency Department Attendances	63,006	70,731	7,725	12.26%
Total	511,348	541,148	29,800	5.83%

TABLE - Wiltshire Community Activity

Point of Delivery	Contract	Actual	(Under)/ Over performance against contract	Variance %
Community - A&E	44,336	46,507	2,171	4.90%
Community - Contacts	855,948	803,545	(52,403)	-6.12%
Community - Emergency Inpatients	7,857	7,445	(412)	-5.24%

In year the Trust secured from NHS Swindon and NHS Wiltshire £3.6m and £5.26m respectively in terms of contract over performance for both the Acute and Community contracts.

3.7 Continued investment in improved services for patients

Following a significant £2.7m investment, a second Cardiac Cath Lab was opened in April 2011. The work, which included refurbishment of the previous Cath Lab, was a significant capital project designed to improve waiting times and overall experience of users of the service. The investment also means that some of the more complex pacemaker procedures previously carried out in Oxford can now be carried out at the GWH reducing the need for some patients to travel further afield.

In future years it will become more challenging to invest in large capital projects of this scale. As a Foundation Trust there are no other sources of funding and therefore we rely on delivering ambitious savings programmes to free up money to invest in new equipment and services. This becomes more pressing as the Great Western Hospital approaches its 10th anniversary when some of the equipment purchased at the time of opening is now coming to the stage where it needs to be replaced.

Moving forward the Trust will focus on generating a surplus to allow investment in services and equipment thus ensuring that we continue to improve care for our patients both at the GWH, out in the community and in the home.

3.8 Research and development

The Trust carries out its own research within our Academy. The Trust follows the Research Governance Standards set out by the Department of Health.

Within the Academy, the Trust has a Research and Development Team with responsibility for providing advice, support and leadership on matters relating to research and development (R&D). Under the direction of the R&D Director and Academic Dean, the R&D Department continues to increase research activity at Great Western Hospitals NHS Foundation Trust. The Team has increased to include a R&D Administrator to ensure that tight deadlines for approval of research projects are met.

Cancer research remains our largest topic area, accounting for approximately 50% of our activity. However substantial progress has been made in other key topic areas such as Rheumatology and Orthopaedics. Cardiology is now participating in a commercially funded research project and further projects are being considered. Commercially funded research has grown within the Trust which will allow us to self-fund some research posts in the coming year.

With funding received from the Department of Health through our Comprehensive Local Research Network (CLRN), Research and Development have been able to continue funding key research posts across the Trust in Cancer, Rheumatology, Dermatology, Sexual Health, Orthopaedics and ICU. Support departments continue to receive funding for posts to allow them to carry out any additional tests that a research project may require.

All research staff in the Trust are supported with training and guidance through Research and Development and the CLRN's. All research nurses receive an induction pack and competency pack in addition to their standard induction information.

R&D also fund a part time trainee accountant to ensure funding allocated to the Team is utilised effectively and the department can offer transparent accounting. R&D and Finance are always looking for smarter and more efficient ways of working to ensure our funding allocation and income is used in key areas to support research activity, allowing the Team to offer patient choice in as many areas as possible.

All standard operating procedures created within the Research Support Services National Initiative are being implemented to ensure the Trust is compliant with all governance standards.

Recruitment of patients into research studies has decreased this year from 1680 in 2010/11 to approximately 700 this year. This is due to the closure of an observational study that recruited over 800 patients last year. Recruitment into more complex research projects has increased by 5% this year which is an excellent achievement.

3.9 Main risks and uncertainties facing the Trust in the future

Main risks and uncertainties facing the Trust are included in the Trust's Annual Plan, together with proposed actions to mitigate those risks. A summary of the risks to the Trust for 2012/13 onwards is included in the Annual Governance Statement set out elsewhere in this report (section 14.4.5refers).

3.10 Trends likely to impact on the Trust 2012/13

The NHS faces significant challenges in the coming year with the impact of the Health Act, recently enacted, confirming the establishment of Clinical Commissioning Groups (CCGs), the abolition of Primary Care Trusts (PCTs), and Strategic Health Authorities (SHAs) and the creation of the National Commissioning Board.

This will change the way that our services are commissioned (purchased) and it will be important that we work closely with the CCGs across Swindon, Wiltshire and the wider catchment area to ensure that we can understand each CCG's priorities for the patients and communities. Giving such local focus to the requirements of local communities was a key plank of the health reforms, and we are looking forward to this new way of working, aware that it will require some changes to way we do business.

Scrutiny of the services that we deliver will also change with local LINKs groups being abolished and local Healthwatch groups being created, housed in the local authority. These will feed into the national Health and Wellbeing Boards and it will be important that as a Trust we form strong links with these new organisations as early as possible.

The Trust is currently reviewing its strategy 2010-2015 and will launch this later in the year after suitable engagement with staff and the communities we serve. At a time when there is so much change, we will continue to focus on delivering high quality patient care, and ensuring that we have the right staff in post across our enlarged organisation able to deliver the high standards of care that we demand.

As well as the structural changes that will be made to the wider NHS during this and next year, the NHS is in the midst of the delivery of £20bn savings. Such sums cannot be found through small transactional changes, and as a result the Trust is working very closely with the local commissioning organisations (PCTs and CCGs) to identify services and schemes where there are efficiencies and productivities to be found. Such scales of change will be disconcerting to the communities that we serve, and we will seek to engage local interest groups, members and other stakeholders throughout the change process so that with commissioners, we make the right decisions for our patients. In some cases, services may be taken over by other NHS providers or private sector companies as the government seeks to open up the NHS to more providers to ensure greater choice for patients.

As part of the drive to find the huge savings, we will continue to work with colleagues nationally on initiatives to bring down the length of time a patient stays in hospital, and where possible, to find opportunities to treat more patients outside the hospital setting closer to home and friends and family.

This will mean as more services are provided in the community and the home and less in acute hospitals, the Trust will need fewer beds to treat patients. In turn this means that fewer posts will be needed working in the hospital, although some of these roles may be transferred into the community. It is therefore essential that we have a clear workforce plan, as we will do everything we can to avoid redundancies. Any workforce changes that need to be made will be done in close discussion with our primary care and Trade Union colleagues.

3.11 Impact of the Trust's business

Details of the impact of the Trust's business on the environment, social and community issues and on employees, including information about policies in relation to those matters and the effectiveness of those policies are referred to elsewhere in this report under the sustainability report (section 7 refers) and in the staff survey report (section 9 refers).

3.12 Consultations

During 2011/12 there was a staff consultation regarding a back office restructure aimed at streamlining management.

A formal consultation with staff commenced in May 2012 on one ward regarding support to changes relating to bed reconfiguration.

There were no formal public or stakeholder consultations during 2011/12. However, the Trust regularly engages with local stakeholders regarding issues relevant to the Trust.

3.13 Contractual arrangements

The Trust does not have any contractual arrangements with individual persons.

3.14 Performance across the range of healthcare indicators which we are measured against

A detailed performance report is provided elsewhere in the quality report (section 6.4 refers).

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

Enhanced Quality Governance Reporting

Quality governance is combination of structures and processes at and below Board level to lead on trust-wide quality performance including:

- ensuring required standards are achieved;
- investigating and taking action on sub-standard performance;
- planning and driving continuous improvement;
- identifying, sharing and ensuring delivery of best-practice; and
- identifying and managing risks to quality of care.

Arrangements in place to ensure quality governance and quality are discussed in more detail within the annual governance statement (section14 refers) and the quality report (section 6 refers).

3.15 Monitor's Quality Governance Framework

The Trust has had regard to Monitor's quality governance framework in arriving at its overall evaluation of the organisation's performance, internal control and board assurance framework. In June 2011 and again in September 2011, the Trust undertook an evaluation of its strategy; capabilities and culture; processes and structure and measurements mapping them against Monitor's Quality Governance Framework. In addition, the Trust commissioned an independent audit which provided substantial assurance regarding the Trust's quality governance arrangements.

The Trust has not developed one specific action plan to improve the governance of quality. However, throughout the Trust there are plans or ongoing processes which contribute to its improvement. Examples of this include: -

- Development of the Trust's business strategy with particular emphasis on quality.
- Monthly reporting to the Board on risks and potential risks to quality, with action plans in place to address any gaps in assurance.
- Ongoing Board development with the Institute for Innovation and Improvement and refreshment of the Board to ensure that the Board has the necessary skills and qualities to manage the Trust and deliver the quality agenda.
- Promotion of a quality focused culture throughout the Trust evidenced by the roll of staff values and improved communication and feedback mechanisms. Quality is considered in developing policies and procedures for the Trust with consideration given to the impact on clinical effectiveness, patient experience and the quality of care.
- There are clear processes for escalating quality performance issues to the board. These are documented, with agreed rules determining which issues should be escalated. These rules cover, amongst other issues, escalation of serious untoward incidents and complaints. Robust action plans are put in place to address quality performance issues.
- Quality information is analysed and challenged in a number or areas. The board reviews a monthly 'dashboard' of the most important metrics.

Patient care

3.16 Development of services to improve patent care

We treat thousands of patients every year as follows: -

TABLE – Patients seen, treated or admitted 2007/08 – 2011/12

	2007/08	2008/09	2009/10	2010/11	2011/12	Variance from 2010/11
New outpatients	87,441	90,852	94,587	96,456	137504	5.4
Follow up appointments	179,466	195,846	198,244	212,887	263066	14.3
Day cases	26,102	28,508	28,053	27,813	27320	-1.9
Emergency inpatients	34,075	36,658	39,202	35,210	35804	1.6
Elective inpatients	7,438	7,345	7,004	7,269	6723	-7.8
Emergency Department attendances	60,583	62,628	66,262	68,618	70731	3.1

The table above is for GWH acute activity only. 2008/09 onwards includes GUM/HIV, A&E, Anti-coagulation in outpatient figures. 2011/12 outpatient activity includes former Swindon PCT therapies activity.

Table – Patients seen, treated or admitted 2011/12 by former WCHS Community Services

	2011/12
Minor Injuries Unit	46,507
Admitted Patients	7,445
Community contacts including outpatient	803,545

The Trust is using its foundation trust status to develop its services and improve patient care. An example of this is that the Trust was able to use retained cash surpluses to provide a new Cath Lab.

3.17 Performance against key healthcare targets

Details of performance against key healthcare indicators is set out elsewhere in this report (section 6.4 refers).

3.18 Arrangements for monitoring improvements in the quality of healthcare

Continuous monitoring of the Quality Account and Improvement Plan and National Targets is observed monthly. The improvement indicators and national targets inform the Safety and Performance Dashboard and are reported through to our Commissioners and Trust Board via an Executive Committee. The Quality Account improvement indicators also inform a Patient Safety and Quality Committee each month.

Compliance Monitoring of the CQC regulations is undertaken through a Clinical Standards Group, the Patient Safety and Quality Committee and Executive Committee up to Trust Board. Compliance monitoring is informed by the CQC Quality and Risk Profile. Exceptions in compliance or risks identified inform the Trust's 15+ Risk Register (a register of top risks) and actions plans are developed and progress monitored to ensure any evidence of compliance or strengthened where appropriate.

3.19 Progress towards targets

Progress with national targets informs the Trust Safety and Performance dashboard which is shared and monitored by our commissioners, as well as monitored through the Executive Committee and Trust Board. Monthly directorate performance meetings are held to monitor performance at directorate level. Quarterly reporting on compliance with the national targets informs Monitor quarterly.

Progress towards targets as agreed with local commissioners, together with details of other key quality improvements are included elsewhere in this report (section 6.4 refers).

3.20 New or significantly revised services

Wiltshire Community Health Services – As referred to elsewhere in this report (section 1 refers) with effect from 1 June 2011 the Trust took over the provision of Wiltshire Community Health Services.

Improving the way we care for ambulatory patients - Acute Assessment Unit (AAU) and Ambulatory Care Unit pilot - At the beginning of November the Trust began a six month pilot to relocate the Acute Assessment Unit (AAU) and opened an Ambulatory Care Unit at GWH. Ambulatory patients are those who are capable of walking and who require acute hospital medical attention.

These changes were designed to:

- Increase the size of AAU, which is re-named the Acute Medical Unit (AMU) and will better match the demand from the number of daily medical admissions into the hospital. It will continue to be a specialist area providing care for patients requiring admission for up to 72 hours or needing acute medical assessment and treatment prior to referral to specialty teams.
- Set up a fast track Assessment and Diagnostic area in the current AAU space close to the Emergency Department to treat patients without having to admit them overnight to hospital, called the Ambulatory Care Unit.

There is clear evidence from elsewhere in the NHS that this way of providing care for AAU and ambulatory patients improves their care and experience in hospital and the initial pilot proved successful therefore the Ambulatory model will become a permanent feature in the Trust acting as a bridge between primary care, community and acute services.

3.21 Improvement in patient / carer information

The Trust has established a Patient Information Group with a view to improving the quality and range of patient information available. This has included a more standardised approach to patient literature.

Towards the end on 2011/12, the Trust began work on a new patient bedside booklet which will provide a range of patient information and advice for patients when admitted. This is being trialled on a couple of wards and reviewed by patient representatives before roll out across Great Western Hospital. The Trust will then look to prepare a version for community hospitals.

In July 2011, the Trust launched a new website to provide more accurate and timely information to patients and visitors regarding Trust services. The website has thousands of visitors each month and it is kept up to date, with information being presented in new formats such as video, and these are proving popular.

3.22 Focusing on the patient

3.22.1 Productive Ward

The Productive Ward initiative was introduced at GWH in 2008/09. The aim of the project is to increase direct patient care. The roll out has continued and now all 21 wards are at varying stages

of implementing the programme. Included in this number are Maternity, Neonatal Unit and the Children's Ward. The project is also being rolled out to the community Hospitals in Wiltshire. To share expertise and enhance collaborative working, the community hospital wards will be supported by a buddy system approach with a ward at the Great Western Hospital.

There are 11 modules of the programme that are designed to enable ward managers and their teams to free up time to deliver direct patients' care. Successful implementation of the programme and embedding good practices is reliant on good multidisciplinary team working and outcome measures are determined from patient's experience, safety and clinical risks indicators.

The following outlines achievements since implementing the Productive Ward Programme:

- Patient status on glance boards has increased patient safety through better communication amongst members of the Multidisciplinary Team. It has also contributed to a reduction in the average length of stay by up to 2 days, demonstrating efficiency through the patients' pathway.

- The introduction of standardised shift handover reduces clinical risk through better communication of information that is essential to the seamless care of a patient throughout their inpatient stay. There is ongoing work occurring to ensure that handovers are embedded in all clinical areas and are working effectively to support the patient experience and safety agenda.

- The introduction of a menu free approach has enabled patients to be more involved in selecting their meal of choice on a daily basis. The other benefit is that food is served at the right temperature because of the ability to serve meals in a timelier manner.

- The trialing of red tabs and poster campaign aimed at reducing interruptions to nurses' during the administration of medication reduces medication incidents. This work is done in collaboration with members of the pharmacy team.

- Patients' privacy and dignity is enhanced by the introduction of 'privacy pegs'. This involves raising awareness of staff to consider the issues around maintaining privacy and dignity within a hospital environment.

- The introduction of intentional rounding will support the delivery of holistic nursing care. It is envisage that all wards including community hospitals will implement this concept through a roll out programme.

- Innovative work such as the pilot of 'water hydrant' on Jupiter ward has been successful. The hydrants support suitable patients in promoting their hydration and independence. The project is currently being implemented on 4 other wards.

3.23 Examples

The Trust focuses on the patient by making improvement in their nutrition. The Trust aims to reduce pressure ulcers; the number of our patients who fall and the incidence of Venous Thromboembolism (VTE). In addition the Trust seeks to ensure that patients with dementia are cared for in such a way that is suitable to their needs. These are just a few examples of focussing on the patients.

3.24 Complaints Handling

For the Trust to continue to improve its' services we need to continue to actively gather, listen and act upon feedback from patients and service users. In seeking feedback we are able to assure ourselves whether the services we are providing meet the needs of those who use them. Where we fall short of the high standards we aspire to, we look to make changes to the way we deliver care. This journey of continual improvement means that we are always looking at ways we can deliver a better service for people now and in the future.

Within the Trust there is a dedicated team responsible for leading on all aspects of patient experience, working with the clinical directorates to support improvements and respond to feedback. The Patient Advice and Liaison Service (PALS) is led by the Head of Patient Experience and Director of Nursing and Midwifery. PALS is at the forefront of gaining feedback and being a point of contact for our patients and their carers to seek advice and give their views.

The Trust's strategic objectives incorporate three elements that feed directly into patient experience:

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

- To ensure that staff are proud to work at GWH and would recommend the Trust as a place to work, or to receive treatment.

- To work in partnership with others so that we provide seamless care for patients.

The vast majority of patients who use Trust services have a positive experience. They are cared for by caring staff, using the best technology, with treatment by skilled and dedicated professionals. With over 540,000 patient interactions a year, unfortunately there is a small number that are dissatisfied with their care or treatment. Whilst the number is small, the emphasis we place on them is big, so that we can learn how to do things better.

A proactive approach is taken to handling any concerns and complaints. The Head of Patient Experience and Director of Nursing and Midwifery liaise with patients who have raised multiple concerns and complaints with the Trust. These patients are invited into the Trust to tell us about their experience and give us the opportunity to discuss the work that we are doing.

To provide a more visible service to patients and the public, the PALS office moved into a refurbished and extended office in January 2012 situated close to the main entrance to the Great Western Hospital (GWH). This extension created two meeting rooms, one informal room and one formal room for holding complaint meetings. The Trust was successful in a One Swindon bid, a scheme to raise the visibility of the Police within public services and encourage joint working. The scheme contributed towards the cost of the PALS extension and the Police are actively using PALS as a base when they are on site.

Demonstrating how patient experience is a key focus for the senior management of the Trust, during 2011/12 the Patient Experience Report increased to monthly instead of quarterly. This increase in reporting gives the Directorate management and Executive Team a more frequent measure of patient satisfaction and enables monitoring of service improvements. Since the end of the year a 'patient story' has been included detailing the experience of an individual patient from the previous month. This has been put in place to allow the Executive to look beyond the numbers and the written feedback to truly reflect on individual experience – the good and the bad. This is providing a useful way to share lessons learned in one directorate across the rest of the organisation.

As part of the corporate back office, PALS is undergoing a restructure which will be completed during quarter one 2012/13. The restructure gives an opportunity to review the process of informal and formal complaint management, with a clear separation between the two. A clinical post is being introduced to oversee the formal complaint process which will strengthen the level of clinical understanding within PALS with the aim of improving response times. As part of the restructure, a training specification for PALS staff is also being introduced.

3.24.1 Formal complaints

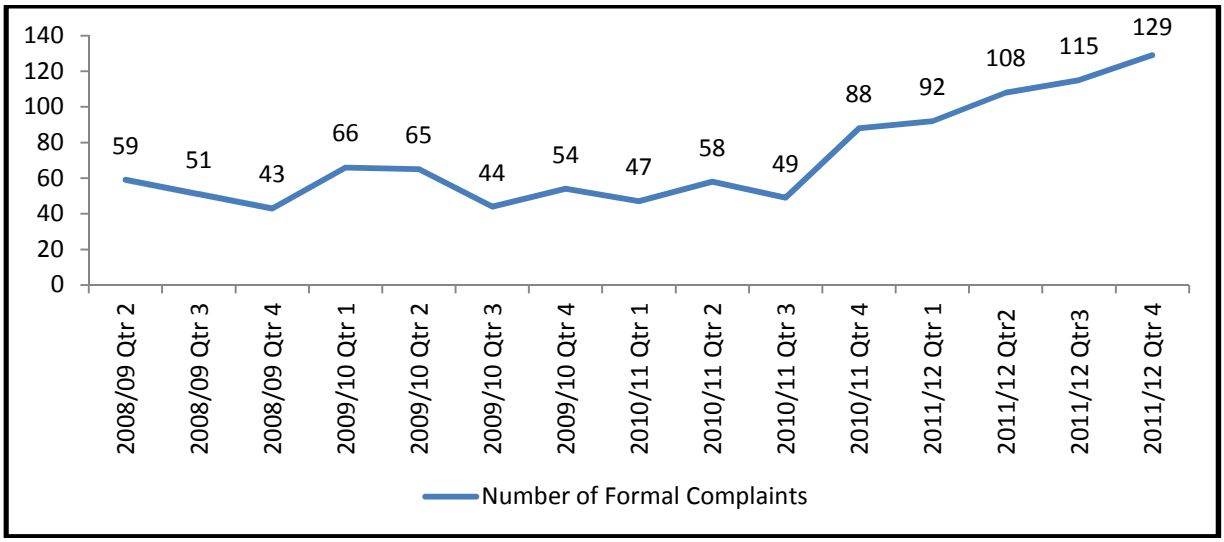
During 2011/12, 444 formal complaints were made to the Trust compared with 242 during 2010/11. The number of formal complaints received by the Trust represents 0.08% of the total number of patients seen, treated or admitted during 2011/12.

When the Trust merged with Wiltshire Community Health Services in June 2011, PALS at GWH became the point of contact for patients and their carers with queries or concerns from across the Wiltshire Services. This in turn has resulted in an increase in the number of contacts with the PALS.

Nationally there is an increase in the number of complaints being made to Trusts. The Trust uses complaints as a resource and opportunity to review services and to identify areas for improvement. A lot of work has been undertaken across the organisation to raise the patient and public awareness of PALS and the importance of gathering feedback. This is also reflected in the increase of contacts with the service as the Trust embraces the culture of seeking continuous patient feedback.

The graph below compares the number of Formal Complaints received during 2011/12 with 2010/11, 2009/10 and 2008/09.

Chart - Number of Formal Complaints received



The Trust actively responds to feedback from our patients and their carers, and the top three complaint themes during 2011/12 and actions taken to address these are as follows: -:

1. Safe, High Quality Co-ordinated Care

   - All wards are rolling out posters which detail who the Matron and Ward Manager are for that area and how they can be contacted if anyone has a concern about their care.
   - A review of the Enhanced Recovery Pathway (an initiative to support patients in making a swift recovery following a procedure) is being re-launched in 2012/13.

2. Access and Waiting

   - The process of weighing patients prior to arranging an angioplasty appointment has reduced the number of cancellations in this area.
   - We have reviewed the way that we manage duplicate referrals to the triage referrals in the Ophthalmology Department to reduce the number of appointment letters that are sent to patients.
   - We have reviewed the pathway for referrals to the Sleep Clinic to try to ensure patients who wish to come to GWH are able to.

3. Better information, communication and choice

   - We have made changes in the information that is given by our Booking Service and are introducing a customer service desk for patient queries.
   - We have introduced telephone calls where appointments are made within seven days of the appointment date.
   - A review of the Clinical Nurse Specialist in Cancer Services has taken place to ensure that patients know who to contact and how to access this support.
   - A review of the appointment system within Community Podiatry Service has taken place.

3.24.2 Learning from patient experience

What patients and service users have told us	What change have been made as a result of this feedback
Some service users have expressed concerns about the way their discharge was handled in 'joining up' their discharge with services in the community.	In response to this feedback, the Trust has introduced a Discharge Pathway Facilitator who is reviewing patient pathways and the discharge planning process. This is raising the profile of, and strengthening, the links between hospital departments and services in the community to ensure a joined up, patient centred approach. The Trust is rolling out handovers at the bedside to involve patients in discussions about their care and to keep them informed.
Patients have also told us they want to be more involved with decisions about their care and they would like more of an opportunity to ask questions during Outpatient Appointments.	A campaign will be launched by the Diagnostics and Outpatient Directorate called 'able to ask' to empower patients to feel able to ask questions during their outpatient appointment and to encourage staff if there is anything else that the patient would like to know.

What patients and service users have told us	What change have been made as a result of this feedback
Service users have asked for a range of alternative ways they would like to be kept in touch with.	The Trust is reviewing the way that we link with patients and a text reminder service is currently being trialled. The Trust has also launched a number of different ways patients can confirm, cancel or rearrange appointments to make it as easy as possible for them change an appointment.
Patients and their families have asked for more opportunities to speak with ward staff when patients and their carers have concerns or questions about their care.	Ward Manager Surgeries are being rolled out to enable patients and their carers to meet with the Ward Manager to discuss any issues.
Patients who suffer with visual impairment shared with us concerns about the difficulty they have in reading some of the signage at the GWH.	We invited the RNIB in to help us understand what issues they had and as a result changes will be carried out during 2012/13.
People arriving in the emergency Department and who may require a British Sign Language Interpreter fed back to the Trust how they often faced delays waiting for an interpreter to arrive.	A new Translating and Interpreting provider was introduced from February 2012 and as part of the criteria for awarding the contract, the Trust included that British Sign Language (BSL) interpreters must have a swift response time for attending the Emergency Department.
Hard of hearing patients told us that they had problems with accessing the hearing loop system and ins some cases it was not working.	The Trust has reviewed the hearing loop systems across the Great Western Hospital and all hearing loops are being replaced and additional loops are being placed in convenient locations around the hospital.
Inpatients would like more information about the hospital, routines and the ward to read and refer to during their stay.	The Trust is reviewing the bedside folders to give patients the most accurate, up to date information. Ward specific information will also be included.

The Trust has continued to measure complaint response times to a maximum of 25 working days, unless otherwise agreed with the complainant. However, it has proved a challenge for the organisation to routinely meet this response time and significant focus and effort during 2012/13 will be placed on improving in this area. To address concerns with the response times for formal complaints and to improve the standard of complaint responses, each Directorate has a designated Executive Lead who reviews complaint responses prior to them being signed by the Chief Executive.

The Complaints Policy was reviewed and updated to incorporate community services into the process for managing complaints. Following the merger with Wiltshire Community Services in June 2011, there has been an increase in PALS activity.

The Formal Complaints Response Training has been reviewed following the appointment of our new Chief Executive and monthly sessions are scheduled throughout 2012/13.

3.25 Using patient experience to drive service improvements

3.25.1 Comment Cards

Across the Trust we use 'Tell us how we're doing' comment cards to capture four elements of patient feedback:

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

A measure of satisfaction regularly used in the commercial industry is recommendation to a friend, which is included within the comment cards. It has proved challenging to generate enough responses via these comment cards to confidently track performance, particularly in relation to the patient recommendation question. Towards the end of the year each directorate was set a monthly target of returning 100 completed cards to enable a statistically reliable comparison to be made each month.

The response rate is reported by Directorates in the monthly patient experience report to the Executive Committee and Trust Board. Due to low response rates, the last reliable indicator of patient recommendation was in January 2012 tracking at 97%. During the other months when the response rate was large enough for a statistically significant response, the recommendation rate ranged from 84% to 97% showing a high level of satisfaction.

3.25.2 Online Feedback

The Communications Team monitors and interacts with patients through feedback through online channels. The Trust is experiencing a rapid growth in online feedback and user interaction through relatively new websites such as PatientOpinion.org. This site has been established as a 'Trip Advisor' style site for users of the health service and is likely to become more widely used by patients in the future. During the course of the year, the site established formal links with NHS Choices and information posted on Patient Opinion is automatically linked to the NHS Choices website (and vice versa). Several thousand people view the GWH sections of these sites on a monthly basis, so it is important to be actively engaged with users through these channels.

Sites such as this present both an opportunity for the Trust in providing a rich vein of user feedback, and at the same time they present a challenge as typically, people posting on these sites expect a response within 48 hours. This means the Trust needs to be much more responsive than we have been previously and we need to ensure responses (as they are in the public domain) not only respect confidentiality but also are actually useful to the user and those viewing the site in the future.

Patients and the public are also able to 'follow' the Trust on Twitter and Facebook. There are over 450 followers at present. In the year ahead PALS will be looking at alternative ways to seek feedback such as using a dedicated children's PALS website aimed at engaging and sharing information with children and young people.

3.25.3 Patient Surveys

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

During 2011/12, the PICKER Institute has carried out the following surveys:

- Quarterly Inpatient
- Annual Inpatient - *results from this survey are used for national benchmarking purposes by the CQC*
- Annual Outpatient

3.25.4 Quarterly Inpatient Surveys

Quarterly Inpatient Surveys give the Trust an opportunity to monitor service improvements and exceptions reports are presented to a Patient Safety and Quality Committee on a quarterly basis.

The results of the PICKER Inpatient survey are used to monitor five elements of Commissioning for Quality and Innovation (CQUIN) relating to patient experience at GWH. The table below shows the CQUIN results gathered from the quarterly Inpatient Surveys. Lower percentages are better.

TABLE - Great Western Hospital Quality Account results on patient experience

Indicator	Regulator	Target 2011/12	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Wanted to be more involved with decisions about care GWH	QA, PCT, CQUIN	<=50%	45.1%	46.6%	46.8%	52%
Could not always find staff to discuss concerns with GWH	QA, PCT, CQUIN	<=59%	40.7%	54.5%	61.6%	37%
Not enough privacy when discussing care or treatment GWH	QA, PCT, CQUIN	<=31%	27.4%	24.8%	29.1%	28%
Side effects of medication not fully explained GWH	QA, PCT, CQUIN	<=49%	30.8%	42.9%	65%	52%
Not told who to contact after discharge if worried GWH	QA, PCT, CQUIN	<=26%	34.5%	21.8%	23.2%	26%

Satisfaction surveys are given to all patients upon discharge from the Trust's Community Inpatient areas. Community inpatient services are provided from four wards across three sites, Longleat Ward - Warminster Hospital, Ailesbury Ward - Savernake Hospital, and two wards at Chippenham Community Hospital, Cedar Ward and Mulberry Ward which is a Stroke rehabilitation Unit. There are currently low numbers of participants in the surveys. This problem will be resolved when the Trust incorporates these surveys within our survey contract.

The table below shows the CQUIN results gathered through the internal surveys.

TABLE - Community Services Quality Account results on patient experience

Indicator	Regulator	Target 2011/12	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Wanted to be more involved with decisions about care WCHS	QA, PCT, CQUIN	<=35%	31%	31%	4%	10%
Could not always find staff to discuss concerns with. WCHS	QA, PCT, CQUIN	<=3%	10.1%	6.2%	9%	5%
Not enough privacy when discussing care or treatment. WCHS	QA, PCT, CQUIN	<=20%	6.3%	3.2%	1%	8%
Side effects of medication not fully explained WCHS	QA, PCT, CQUIN	<=10%	7.3%	21.5%	21%	20.5%
Not told who to contact after discharge if worried WCHS	QA, PCT, CQUIN	<=20%	30%	23.7%	25%	19%

As a result of the feedback from patients, the Trust is introducing Ward Managers Surgeries, which give patients and their carers an opportunity to meet with the Ward Manager if they have any queries or concerns. As an organisation, the Trust recognises the importance of raising issues at the time to resolve them swiftly and photographs of the Ward Managers and Matrons are in the process of being displayed in the ward areas. The Bedside Folders are in the process of being reviewed and will include ward specific information such as the name of the Ward Manager. Bedside Handovers as part of the Productive Ward are a further example of involving patients in discussions about their care.

There are a number of initiatives that have been put in place to improve medication information being given to patients, these include

- Information leaflets included with all discharge medicines
- Patient information available via the internet Provision of medicine reminder card with all discharges via pharmacy
- A patient medicines information helpline which is publicised via Outpatients and the discharge medicines reminder card.

Further work is required to ensure that a clear process is in place to share information with patients and their carers, and this is a targeted area for improvement for 2012/13.

During 2011/12, the Trust recruited a Pathway Discharge Facilitator. A review if the Discharge Pathway has been undertaken and the Unscheduled Care Directorate are facilitating workshops for staff and a revised Admission, Discharge and Transfer Policy. This is being integrated across both the Acute Hospital site and community services.

3.25.5 Annual Inpatient Survey

The Annual Inpatient Survey was sent to a sample of patients who were admitted in June, July or August 2011. The results of this survey are used to inform the quarter two update of the PICKER Action Plan and are used by the CQC to collate a benchmarking report of Acute Trusts which is due to be published in May 2012.

The Trust response rate for the Annual Inpatient Survey was 53.4%, in comparison with the PICKER average of 49.6%. The Trust made significant improvements in comparison with the 2010 Inpatient Survey in four areas and scored significantly better than average on eight questions.

The graphs below show the areas of significant improvement in the 2011 Annual Inpatient Survey and the areas significantly better than the PICKER average.

CHART - Areas of significant improvement

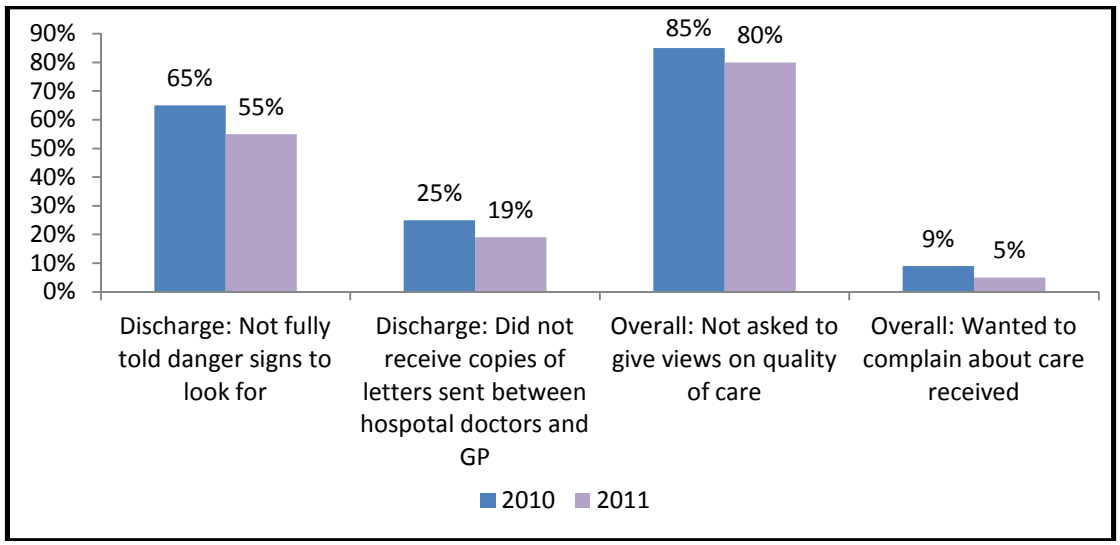
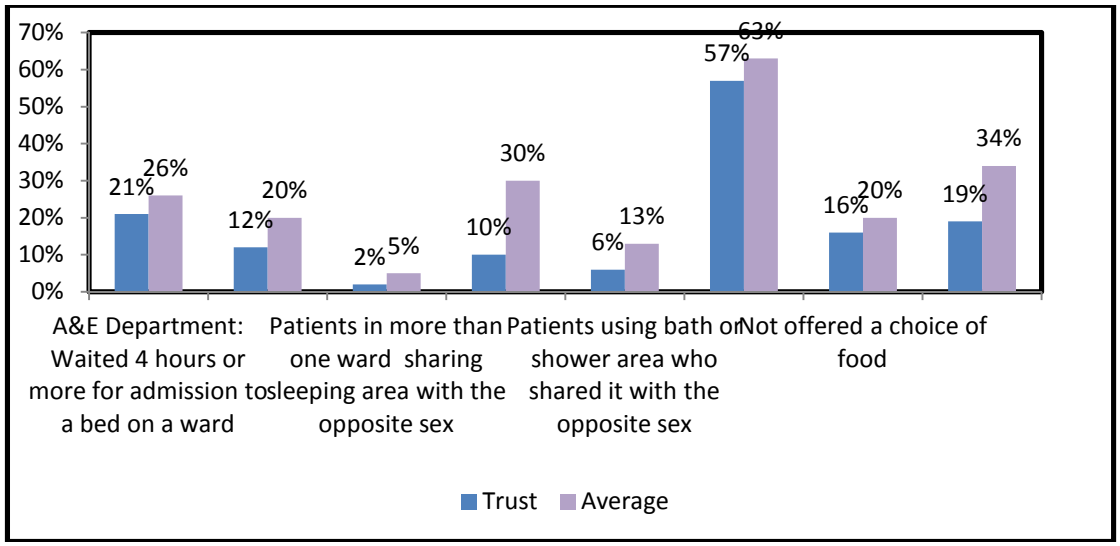


CHART - Areas significantly better than PICKER average



Action plans based on the Quarterly and Annual Inpatient Surveys are developed and monitored through the Patient Safety and Quality Committee, Executive Committee, Trust Board and Patient Experience Governors Group.

Specific areas of focus for 2012/13 are the review of the bedside booklets, medication information, information given to patients on discharge and prompts to use hand gel.

3.25.6 Other

Call bell response times and Patient Reported Outcome Measures (PROMs) which measure the quality of care provided in hospitals from the perspective of the patient are

Call bells

Call bell response times are monitored by the Director of Nursing and Midwifery. During 2011/12 the target for responding to call bell activations within five minutes was 85%. Over the forthcoming year, the target is 90%. Weekly call bell reports have been introduced which enable Matrons to monitor call bell activations in their clinical areas more closely.

Monthly call bell response times are monitored on the ward performance boards as part of the Productive Ward. As the Productive Ward is rolled out into the community inpatient areas, a review of call bells will be undertaken to record and monitor Trust wide response times.

Patient Reported Outcome Measures (PROMs)

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

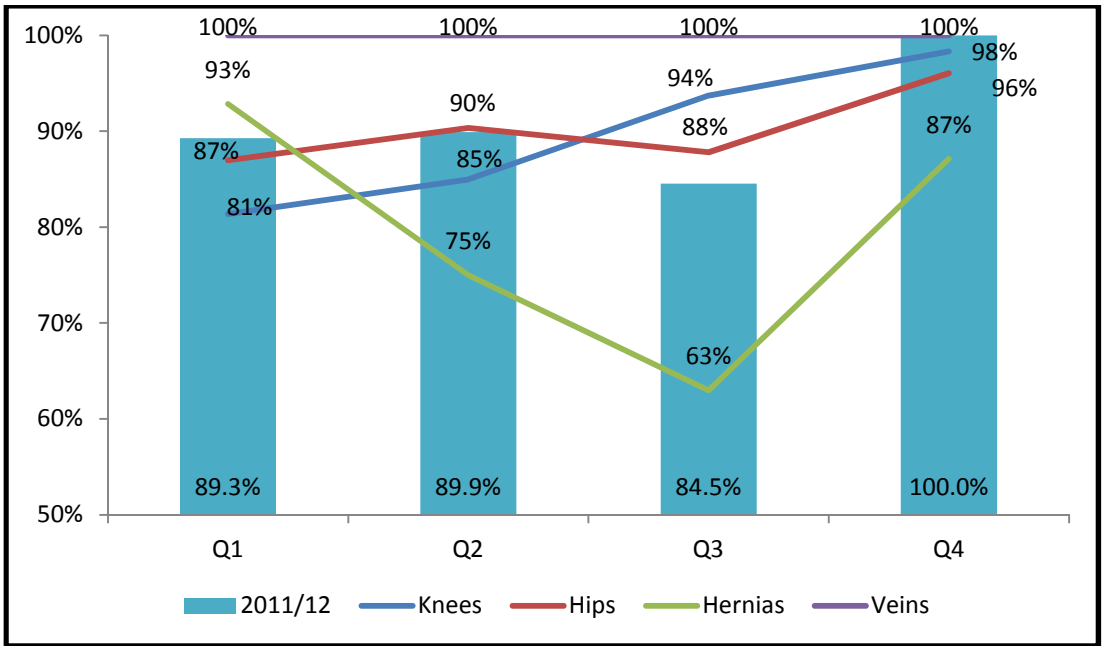
A PROMs assistant is managed within the PALS Department and currently collects the data for the following procedures within the Cherwell Unit:

- Hip
- Knee
- Hernia
- Varicose Veins

Completed surveys are sent to the National PROMS team for analysis. They monitor the feedback against the number of historic procedures recorded on the HES (Hospital Episode Statistics) system. As this information is historic, it gives an indication on performance rather than up to date information. There is work underway nationally to improve the information that is gathered through these questionnaires to ensure that meaningful data is available for Trusts to use to improve services.

The PROMS Assistant monitors the number of completed surveys through the clinic lists of the Cherwell Pre-Assessment Unit. The graph below shows the percentage of completed surveys in the Cherwell Unit.

CHART - Percentage of patients who completed a PROMS questionnaire



Stakeholder Relations

3.26 Partnerships and alliances

To facilitate the delivery of improved healthcare the Trust took over the provision of Wiltshire Community Health Services, the purpose being to provide joined up and stream lined services for patients across a wider geographical area. The Trust aims to achieve improvements in the quality of care through shared learning and to have a closer working relationship with partners in primary care, social care and the third sector.

The Trust works in partnership with Carillion our Private Finance Initiative (PFI) partners who provides security; catering; house-keeping; cleaning; portering and switchboard services. A formal contract is in place for this.

Since December 2011, Carillion and the GMB (a general trade union) have been in dispute regarding employment matters around annual leave and allegations of bullying, racism and bribery from members of the house-keeping staff (cleaners and ward hostesses). The Trust has been liaising with Carillion to ensure robust investigations are carried out and the concerns raised by staff are treated in an open and transparent manner. The dispute has involved 19 days of strike action by these staff but robust plans by Carillion have meant that there has been minimal disruption to patients and services. The Trust has encouraged both partied to reach a resolution as soon as possible.

3.27 Development of services with others

The Trust is in the process of reviewing community and acute pathways between Great Western Hospital and its boarder counties. The aim is to establish a single process of referral between acute and community to ensure that patients are in the right place, at the right time, with the right skills to meet their needs. This includes proactive planning of care from the point of admission and the development of pathways between community services and the front door (Emergency Department, Ambulatory Care and Linnet Assessment Medical Unit). This will enable patients to be returned directly home when feasible.

3.28 Working with our partners to strengthen the service we provide

During the course of the year significant effort has gone in to focussing on how the Trust can achieve its objectives through better working in partnership with local key stakeholders. The merger with Wiltshire Community Health services (WCHS) in June 2011 presented a unique opportunity to shift from being an acute hospital provider to being an integrated healthcare provider with much closer links to GPs, Local Authorities and the Third Sector in particular.

This shift has also seen the Trust operate across a much wider geographical area and has required us to build greater knowledge of the surrounding area and an understanding of the partnerships there so we can tap into the effective relationships that already exist on the ground.

As evidence of our commitment to working in partnership, work has taken place with our partners to:

- Redesign the Older People's Pathway with the aim of making the best use of providing both acute and community services under a single organisation so that the various stages of clinical care for an elderly patient are provided in the appropriate setting and in a timely fashion.
  To be successful this project involves a wide variety of local stakeholders including our commissioners, Clinical Commissioning Group, and Acute Geriatric Medicine Consultants, Social Care, and Community Hospital representatives.
  The group aims to reduce reliance on the acute sector to provide clinical care, support more care in the community or at home and reduce the risk of elderly patient becoming institutionalised in hospital due to the challenges of getting social care and other support services in place following long stays in hospital.

- Instigating a project to improve patient flow not only to reduce the amount of time patients spend in our hospitals but to improve their overall NHS experience whether they come to us through their GP or through the Emergency Department. This work relies on close working with our partners in social care to support patients and users in getting back to where they originally came from and then working closely together to develop effective plans to prevent unnecessary readmission. The work of our Discharge Liaison Nurses is instrumental in this area in working with social care to help ease the transition from hospital back into the community.

- Engage more with the emerging Clinical Commissioning Groups to secure early GP input into discussions around pathways and potential future commissioning intentions so that services are built around our customers – patients and GPs.

  Over the coming year the Trust will be engaging with GPs to secure their input into the development of the Trust strategy running from 2012 – 2017. This is to ensure that our new strategy reflects future commissioning intentions and is responsive to the rapid changes in the local health economy.

- Regular attendance at Wiltshire Involvement Network (WIN) to discuss key developments in the community and at the GWH which is helping establish more productive working relationships in an area that the Trust had not previously engaged with.
  This relationship will continue to develop as we engage with them on changes to local community services in the years ahead.

3.29 Health and Overview Scrutiny Committees (HOSCs)

HOSCs (known as the Adult Social Care Select Committee in Wiltshire) are a statutory function of Local Authorities comprising elected representatives whose role it is to scrutinise decisions and changes that impact on health services in the area.

The Chief Executive of the Trust, along with other senior officers, routinely attends both Swindon HOSC and Wiltshire AHSC to provide updates and respond to issues. During the course of the year a formal report is now provided to Swindon HOSC and presented at each meeting which has been well received.

Key topics covered at Swindon HOSC during the course of the year include:

- Changes to patient, public and staff car parking at the GWH
- Overview of the Hydrant project to improve the way patients are kept hydrated
- Progress on the development of a local Radiotherapy service
- The Development of Quality Accounts

The Trust welcomes the input of the HOSC in our work and towards the end of the year began working with the HOSC as part of a small review group which includes Swindon LINk to look at the action plan that has been developed in response to the various unannounced inspections carried out by the CQC across the Trust during the year. This input is important in providing assurance to the HOSC and LINks about the robustness of our plans and is a good model for joint work in the future.

3.30 Swindon and Wiltshire LINks

Since the merger with WCHS the Trust has been a regular attendee at Wiltshire Involvement Network meetings presenting on a range of topics concerning the Trust. This includes providing advance notice of changes and developments in the local NHS.

As a Trust we have sought to ensure the LINks, as statutory bodies, are kept fully informed of developments at the Trust and good links have been developed with key members of the respective groups.

In December 2011 the Trust invited members of both groups to attend a food tasting session to hear about the ‘menu less meals’ initiative that is being rolled out and planned changes to the lunchtime meal offering. This session provided a useful opportunity to hear from users of our service about their experience of hospital food. The senior team from Carillion, the catering provider, were also in attendance to take on board the feedback and look at how the service may be adapted to reflect the comments of those present.

Outside of more formal meetings, the Trust receives a regular flow of questions and feedback from users through the LINks which are responded to. This open communication is useful to understand the issues that are ‘reaching up to the surface’ and becoming a local concern which may need to be addressed.

In Swindon the development of the Swindon LINk website has been a useful source of user feedback through postings by service users. The Trust responds to all of the issues raised through this site and shares with relevant teams and department for action where necessary.

3.31 Statement as to disclosures to auditors

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

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

3.32 Additional disclosures

3.32.1 Preparation of accounts

The accounts for the period ended 31st March 2012 have been prepared in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006 in the form that Monitor (the Independent Regulator of NHS Foundation Trusts) with the approval of the Treasury, has directed.

3.32.2 History of the Trust

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

As a Foundation Trust the organisation has greater freedom to run its own affairs, which offers financial advantages to invest in services for the future. The principle activities of the Trust are referred to elsewhere in this report (section 3.2 refers).

3.32.3 Going concern

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

3.32.4 Accounting policies for pensions and other retirement benefits

Accounting policies for pensions and other retirement benefits are set out in note 1.3 to the accounts and details of senior employees' remuneration can be found elsewhere in this report in the remuneration report section (section 4.8 refers).

3.32.5 Interests held by Directors and Governors

Details of company directorships and other significant interests held by directors or governors which may conflict with their management responsibilities are registered. The Trust maintains two registers one each for directors and one for governors which are open to the public. Both registers are available from the Company Secretary.

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

4 REMUNERATION REPORT

Information not subject to audit

4.1 Remuneration Committee

The Trust has a Remuneration Committee which has responsibility to put in place formal, rigorous and transparent procedures for the appointment of a new Chief Executive and other Executive Directors and to develop, maintain and implement a remuneration policy that will enable the Trust to attract and retain the best candidates. The Committee regularly reviews the structure, size and composition (including the skills, knowledge and experience) required of the Board and gives consideration to and make plans for succession planning.

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

4.2 Membership of the Remuneration Committee

Membership of the Committee in 2011/12 was as follows: -

Rowland Cobbold	Chairman
Robert Burns	Member
Liam Coleman	Member
Angela Gillibrand	Member
Kevin Small	Member
Roger Hill	Member
Bruce Laurie	Member
Lyn Hill –Tout	Member *(part year until 12 June 2011)*
Alf Troughton	Member *(part year 1 June – 30 September 2011)*
Nerissa Vaughan	Member *(part year from 1 October 2011)*

4.3 Attendance at meetings of the Remuneration Committee during 2011/12

There have been 8 meetings of the Remuneration Committee during 2011/12.

	Record of attendance at each meeting (✓ = attended × = did not attend)							
	08/04/11	**28/04/11**	**04/05/11**	**24/06/11**	**21/09/11**	**15/02/12**	**12/03/12**	**21/03/12**
Rowland Cobbold (Chair)	✓	✓	✓	✓	✓	✓	✓	✓
Robert Burns	✓	✓	✓	✓	✓	✓	✓	✓
Liam Coleman	×	×	×	✓	✓	✓	×	✓
Angela Gillibrand	×	✓	✓	✓	✓	✓	✓	✓
Kevin Small	✓	✓	×	✓	✓	×	✓	✓
Roger Hill	✓	✓	✓	✓	✓	✓	×	✓
Bruce Laurie	✓	✓	✓	✓	✓	✓	×	✓
Lyn Hill-Tout	✓	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Alf Troughton	n/a	n/a	*	*	×	n/a	n/a	n/a
Nerissa Vaughan	n/a	n/a	n/a	n/a	n/a	✓	✓	✓

* considering Chief Executive appointment so not permitted to attend

4.4 Policy and guidance

In exercising its responsibilities, the Committee: -

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

4.5 Remuneration of senior managers (Executive Directors)

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

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

Having regard to the future the Committee has considered recent developments in remuneration practice in the public sector, advice from Hay Group and the recommendations of the Hutton Report, particularly the proposition that a proportion of executives' pay should be at risk. The opportunity was taken to introduce the concept with the appointment of a new Chief Executive. A basic salary was approved with the opportunity to earn an additional 20% if agreed performance measures are met. The Committee has a clear view that there must be a vigorous threshold to be achieved before payment of all or part of the variable element can be considered. It is intended to introduce variable pay for Executive Directors from April 2013.

The Committee recognises that Directors' remuneration does not in all cases reflect current market levels and therefore to ensure the Trust can continue to recruit and retain high calibre Directors, the Committee plans to undertake a fundamental review of Executive Director remuneration during 2012/13. The Committee aspires to offer top quartile remuneration for top quartile performance.

4.6 Performance of senior managers

The appraisal process adopted in 2009/10 for the Chief Executive and Executive Directors involves a 360 degree assessment of each Director against a range of competencies based on those devised by Hay Group for Foundation Trust Directors and an assessment of performance against a set of objectives agreed with each individual. This provides an effective system for setting individual objectives and performance measures each year. The process has been used to assess performance in 2011/12 and to set objectives for 2012/13. In the case of the Chief Executive the review is carried out by the Chair and for other Directors by the Chief Executive. The Committee receives a summary report into the performance of each Director.

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

4.7 Board of Directors' employment terms

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

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

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

Information subject to audit

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

4.8 Pension Benefits and Remuneration

Pensions Benefits

Name	Title	Real Increase in Pension 2011-12 (Bands of £2500)	Real Increase in Lump Sum 2011-12 (Bands of £2500)	Total accrued pension at 31st March 2012 (Bands of £5000)	Total accrued related lump sum at 31st March 2012 (Bands of £5000)	Cash Equivalent Transfer Value at 31st March 2012	Cash Equivalent Transfer Value at 31st March 2011	Real Increase in Cash Equivalent Transfer Value	*Employers Contribution to Stakeholder Pensions*
		£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	***£000***
Lyn Hill-Tout	Chief Executive	7.5 - 10	27.5 - 30	50 - 55	155 -160	1,065	826	239	0
Nerissa Vaughan	Chief Executive	n/a	n/a	30 - 35	100 - 105	517	n/a	n/a	0
Oonagh Fitzgerald	Director of Workforce and Education	0 – 2.5	0 – 2.5	10 - 15	40 - 45	187	140	47	0
Maria Moore	Director of Finance	0 – 2.5	2.5 - 5	15 - 20	55 - 60	282	217	64	0
Alf Troughton	Medical Director and Interim Chief Executive	5 – 7.5	15 – 17.5	60 - 65	180 - 185	1,377	1,215	162	0
Guy Rooney	Interim Medical Director	n/a	n/a	35 - 40	105 - 110	620	n/a	n/a	0
Sue Rowley	Director of Nursing and Midwifery	0 – 2.5	2.5 – 5	30 - 35	90 - 95	594	530	64	0
Helen Bourner	Director of Business Development	0 – 2.5	2.5 - 5	10 - 15	40 - 45	257	207	50	0

Note. J Barker was seconded from NHS Wiltshire as Director of Transition for the period 1 June – 31 December 2011. Her remuneration for the period was £81k and her pension information is as follows:
Pension £33k, Lump Sum £10k, CETV £623k.

Note. Accrued Pension and Lump Sum relate to benefits accrued to date and are not a projection of future benefits. They will include any additional pension benefits that have been purchased to date
Note membership of the Board during 2011/12 is referred to elsewhere in this report (section 3.1 refers)

Remuneration

		2011/12					2010/11				
Name	**Title**	**Salary (Bands of £5000)**	**Other Remuneration (Bands of £5000)**	**Performance Related Bonuses (Bands of £5,000)**	**Compensation for Loss of Office**	**Benefits in Kind Rounded to the Nearest £100**	***Salary (Bands of £5000)***	***Other Remuneration (Bands of £5000)***	***Performance Related Bonuses (Bands of £5,000)***	***Compensation for Loss of Office***	***Benefits in Kind Rounded to the Nearest £100***
Bruce Laurie	Chair	35-40		-	-	0	35-40	0	-	-	0
Kevin Small	Non Executive Director	10-15		-	-	0	10-15	-	-	-	0
Rowland Cobbold	Non Executive Director	10-15		-	-	0	10-15	-	-	-	0
Angela Gillibrand	Non Executive Director	10-15		-	-	0	10-15	-	-	-	0
Roger Hill	Non Executive Director	10-15		-	-	0	10-15	-	-	-	0
Robert Burns	Non Executive Director	10-15		-	-	0	10-15	-	-	-	0
Liam Coleman	Non Executive Director	10-15		-	-	0	10-15	-	-	-	0
Lyn Hill-Tout	Chief Executive	30-35		-	-	0	120-125	-	0-5	-	0
Alf Troughton	Interim Chief Executive Medical Director	45-50 80-85	15-20 35-40	-	-	0	80-85	100-105	0-5	-	0
Nerissa Vaughan	Chief Executive	70-75		-	-	0	-	-	-	-	-
Oonagh Fitzgerald	Director of Workforce and Education	80-85		-	-	0	80-85	-	0-5	-	0
Maria Moore	Director of Finance	100-105		-	-	0	100-105	-	0-5	-	0
Guy Rooney	Interim Medical Director	25-30	20-25	-	-	0	-	-	-	-	-
Sue Rowley	Director of Nursing and Midwifery	80-85		-		0	80-85	-	0-5	-	0
Helen Bourner	Director of Business Development	80-85		-	-	0	80-85	-	0-5	-	0

Notes: Salary includes employer NI and pension contributions. The above figures do not include any final bonus/performance related pay increase which is subject to agreement by Remuneration Committee

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

4.8.1 Notes to Pension and Remuneration Tables

Non-Executive Directors do not receive pensionable remuneration.
No executive directors serve elsewhere as non-executive directors and therefore there is no statement on retention of associated earnings.

4.8.2 Cash Equivalent Transfer Value

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

A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme, or arrangements when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures show the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of the scheme at their own cost. CETV's are calculated within the guidelines and frameworks prescribed by the Institute and Faculty of Actuaries. The CETV is based on actual contributions to 31st March 2012.

4.8.3 Real Increase in CETV

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

4.8.4 Additional disclosures

The Trust is required to disclose the median remuneration of its staff and the ratio between this and the mid-point of the banded remuneration of the highest paid director; whether or not this is the Accounting Officer or Chief Executive. The calculation is based on full-time equivalent staff of the Trust at the year end on an annualised basis. This information is set out below together with an explanation of the calculation, including the causes of significant variances where applicable.

Extract of the accounts: -

7.4 Highest Paid Director

Executive Name & Title Salary	Total remuneration	
	2011/12	**2010/11**
Dr A F Troughton, Medical Director	£194,218	£184,726

The above remuneration is on an annualised basis and is that of the highest paid director. This includes salary, performance related pay, severance payments and benefits in kind where applicable but excludes employer pension contributions. The Medical Director was Acting Chief Executive for the period May to September 2011.

7.5 Multiple Statement

	2011/12	**2010/11**	**% change**
Highest paid director's total remuneration	£194,218	£184,726	5.1%
Median total remuneration	£28,702	£26,146	9.8%
Ratio	6.77	7.07	-4.2%

All NHS Foundation Trusts are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisations workforce. The median total remuneration above is the total remuneration of the staff member lying in the middle of the linear distribution of staff employed in the Trust, excluding the highest paid director. This is based on an annualised full time total staff equivalent remuneration as at the reporting period date.The movement in the above ratio of -4.2% is due to the increased staff numbers through the merger with Wiltshire Community Services.

Signed.....

Nerissa Vaughan
Chief Executive

24 May 2012

5 NHS FOUNDATION TRUST CODE OF GOVERNANCE

5.1 Council of Governors

5.1.1 Governors

The Council of Governors consists of 19 elected and nominated governors who provide an important link between the Trust, local people and key stakeholders by sharing information and views that can be used to develop and improve health services.

Four public constituencies exist to cover the Trust's catchment area namely: -
Swindon;
Wiltshire;
West Berkshire and Oxfordshire; and
Gloucestershire and Bath and North East Somerset.

Governors for these areas are elected by members of those constituencies in accordance with the election rules stated in the Trust's Constitution using the "first past the post" voting system. Elections are carried out on behalf of the Trust by the independent Electoral Reform Services Ltd. There are 10 public governor positions (Swindon – 5, Wiltshire – 3, West Berkshire and Oxfordshire - 1, and Gloucestershire and Bath and North East Somerset – 1). In addition there are 3 elected staff governors and 6 governors nominated by organisations that have an interest in how the Trust is run. The number of public governors must be more that half of the total membership of the Council of Governors.

In 2011/12 the Trust reviewed its public constituencies based on its new geographical area as a result of taking on board Wiltshire Community Health Services. The West Berkshire, Gloucestershire and Oxfordshire constituency was initially expanded in June 2011 to incorporate Bath and North East Somerset and then split out in August 2011 to create the two constituencies referred to above.

In 2012/13 it is planned that the Wiltshire Constituency will be split into three constituencies with an increase in the number of public governors. This will provide better local representation of the Wiltshire area. Furthermore, the Trust has a wide range of staff undertaking a variety of roles and professions. In 2011/12 the Trust supported the establishment of classes within the staff constituency to reflect occupational areas. This amendment is proposed to be implemented in 2013.

During 2011 the Trust considered its other partner governors and whether there should be representation from third sector organisations reflecting the Trust's involvement in this area. It was agreed that the Thames Valley Chamber of Commerce should be replaced with Prospect Hospice as a partner organisation for the purposes of nominating a governor to the Council of Governors.

The names of governors during the year, including where governors were elected or appointed and their length of appointments are set out in the following tables. The Trust held elections in all constituencies during the year for governors whose terms of office expired. There was an average turnout of 35% across all constituencies which is a 6% increase on last year. The re-elected and newly elected Governors were formally appointed to office at the Council of Governors meeting held on 23 November 2011.

5.1.2 Elected Governors – Public Constituencies

Name	Constituency	Date elected	Term of Office	End of current term	Attendance at meetings during 2011/12	Notes
Ros Thomson	Swindon	10/11/11	2 years	Nov 2013	6 of 7	Ros Thomson was initially elected 01/12/08
Katherine Usmar	Swindon	01/02/08	3 years	Ended Nov 2011	1 of 5	Katherine Usmar did not stand for re-election at the end of her term of office in November 2011
Kevin Parry	Swindon	10/11/11	2 years	Nov 2013	1 of 3	Kevin Parry was elected in November 2011 filling the seat previously held by Katherine Usmar
Harry Dale	Swindon	04/11/10	3 years	Nov 2013	5 of 7	Harry Dale was initially elected 01/12/08
Geraint Day	Swindon	12/01/11	Rest of 3 years	Nov 2012	4 of 7	Geraint Day took up the position in January 2011 being a Reserve Governor
Phil Prentice	Swindon	20/11/09	3 years	Nov 2012	7 of 7	Phil Prentice was initially elected 01/12/08
Margaret Toogood	Wiltshire	01/12/08	3 years	Ended Apr 2011	1 of 1	Resigned 28/04/11 – She is prevented from standing to become a governor for 5 years from the date of her resignation
Margaret White	Wiltshire	10/11/11	1 year	Nov 2012	6 of 6	Margaret White took up the position on 03/06/11 being a Reserve Governor following the resignation of Margaret Toogood. She was the second place candidate at the election for Wiltshire in November 2010 with 27.29% of the vote. Margaret served the remainder of a 3 year term and was subsequently re-elected at the elections in November 2011.
Godfrey Fowler	Wiltshire	04/11/10	3 years	Nov 2013	7 of 7	Godfrey Fowler was initially elected 01/12/08
Janet Jarmin	Wiltshire	04/11/09	3 years	Nov 2012	5 of 7	Janet Jarmin was initially elected 01/12/08
Srini Madhavan	West Berkshire, and Oxfordshire	10/11/11	3 years	Dec 2014	6 of 7	Srini Madhavan was initially elected 01/12/08. At the beginning of 2011/12, there was one Constituency known as the West Berkshire, Gloucestershire and Oxfordshire Constituency. It was then expanded to include Bath and North East Somerset before being split out to form these constituencies.

There is currently a vacancy for the governor position in respect of the Gloucestershire and Bath and North East Somerset Constituency. No candidates stood at the last elections in November 2011. Elections are planned for the summer 2012.

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

5.1.3 Elected Governors – Staff Constituency

Name	Constituency	Date elected	Term of Office	End of current term	Attendance at meetings during 2011/12	Notes
Vicki Barnett	Staff	10/11/11	2 years	Nov 2013	3 of 3	Vicki Barnett was elected in November 2011 filling the seat previously held by Rachel Cross
Rachel Cross	Staff	01/12/08	3 years	Ended	5 of 5	Rachel Cross did not stand for re-election at the end of her term of office in November 2011
Peter Hanson	Staff	04/11/10	3 years	Dec 2013	5 of 7	
Marcus Galea	Staff	20/11/09	3 years	Dec 2012	5 of 7	

5.1.4 Nominated Governors

Name	Nominating Partner Organisation	Date nominated	Term of Office	End of current term	Attendance at meetings during 2011/12	Notes
David Stevens	PCT – Wiltshire PCT	23/11/11	3 years	Nov 2014		David Stevens was initially nominated 01/12/08
Bill Fishlock	PCT – Swindon PCT	23/11/11	3 years	Nov 2014		Bill Fishlock was initially nominated 01/12/08
David Renard	Local Authority – Swindon Borough Council	01/12/08	3 years	Ended Dec 2011		
Brian Mattock	Local Authority – Swindon Borough Council	23/11/11	3 years	Nov 2014		
Carole Soden	Local Authority – Wiltshire Council	01/12/08	3 years	Ended Jun 2011		Carole Soden resigned 17/06/11
Jemima Milton	Local Authority – Wiltshire Council	23/11/11	3 years	Nov 2014		
Andy Cresswell	Other Partnerships – Thames Valley Chamber of Commerce	01/12/08	3 years	Ended Sep2011		Andy Cresswell resigned 12/09/11
Clive Bassett	Other Partnerships – Prospect Hospice	23/11/11	3 years	Nov 2014		
Lesley Donovan	Other Partnerships – Swindon and North Wiltshire Health and Social Care Academy	01/12/08	3 years	Ended Dec 2011		
Jon Elliman	Other Partnerships – Swindon and North Wiltshire Health and Social Care Academy	23/11/11	3 years	Nov 2014		

5.1.5 Attendance at meetings of the Council of Governors during 2011/12

There were 7 meetings of the Council of Governors in 2011/12, one of which was a joint meeting with the Annual Members Meeting and another being a joint meeting with the Board of Directors. The table below shows governor and director attendance at those meetings: -

Attendee (✓ = attended X = did not attend)	**11/04/11**	**24/06/11**	**21/07/11**	**22/09/11** *1	**23/11/11**	**26/01/11**	**12/03/12** *2
Governors							
Vicki Barnett	n/a	n/a	n/a	n/a	✓	✓	✓
Clive Bassett	n/a	n/a	n/a	n/a	✓	✓	✓
Andy Cresswell	×	×	×	n/a	n/a	n/a	n/a
Rachel Cross	✓	✓	✓	✓	✓	n/a	n/a
Harry Dale	✓	✓	✓	×	✓	×	✓
Geraint Day	✓	×	✓	✓	×	×	✓
Lesley Donovan	✓	×	n/a	n/a	n/a	n/a	n/a
Jon Elliman	n/a	n/a	n/a	n/a	✓	✓	×
Bill Fishlock	✓	✓	✓	×	×	×	✓
Godfrey Fowler	✓	✓	✓	✓	✓	✓	✓
Marcus Galea	✓	✓	×	✓	×	✓	✓
Peter Hanson	✓	✓	✓	✓	✓	×	×
Janet Jarmin	✓	×	✓	×	✓	✓	✓
Srini Madhavan	✓	×	✓	✓	✓	✓	✓
Brian Mattock	n/a	n/a	n/a	n/a	×	✓	×
Jemima Milton	n/a	n/a	n/a	n/a	✓	✓	×
Kevin Parry	n/a	n/a	n/a	n/a	✓	×	×
Phil Prentice	✓	✓	✓	✓	✓	✓	✓
David Renard	✓	✓	×	×	×	n/a	n/a
Carole Soden	×	n/a	n/a	n/a	n/a	n/a	n/a
David Stevens	✓	✓	✓	✓	✓	✓	✓
Ros Thomson	✓	✓	✓	✓	×	✓	✓
Margaret Toogood	✓	n/a	n/a	n/a	n/a	n/a	n/a
Katherine Usmar	×	×	×	×	✓	n/a	n/a
Margaret White	n/a	✓	✓	✓	✓	✓	✓
Directors							
Jenny Barker	×	×	×	×	×	n/a	n/a
Helen Bourner	✓	×	×	✓	×	×	✓
Robert Burns	×	✓	×	✓	×	×	✓
Rowland Cobbold	✓	✓	✓	✓	×	✓	✓
Liam Coleman	×	✓	×	✓	×	×	×
Oonagh Fitzgerald	×	✓	×	✓	×	×	×
Angela Gillibrand	×	×	×	✓	×	✓	✓
Roger Hill	×	✓	×	✓	×	×	×
Lyn Hill-Tout	✓	×	×	n/a	n/a	n/a	n/a
Guy Rooney	✓	✓	×	×	n/a	n/a	n/a
Bruce Laurie (Chair)	✓	✓	✓	✓	✓	✓	✓
Maria Moore	✓	×	×	✓	×	×	✓
Sue Rowley	×	×	×	✓	×	×	×
Kevin Small	×	×	×	✓	×	✓	×
Alf Troughton	×	✓	✓	✓	×	×	✓
Nerissa Vaughan	n/a	n/a	n/a	n/a	✓	✓	✓

*1 Joint Council of Governors meeting with Annual Members Meeting
*2 Joint Council of Governors meeting with the Board of Directors

5.1.6 Lead and Deputy Lead Governors

In November 2011, Harry Dale, previously the Deputy Lead Governor, was nominated as the Lead Governor for one year replacing Godfrey Fowler and Ros Thomson was nominated as the Deputy Lead Governor. The Lead Governor is responsible for receiving from governors and communicating to the Chair any comments, observations and concerns expressed by governors other than at meeting of the Council of Governors regarding the performance of the Trust or any other serious or material matter relating to the Trust or its business. The Deputy Lead Governor is responsible for supporting the lead governor in his role and for performing the responsibilities of the lead governor if he is unavailable. The Lead Governor regularly meets with the Chair of the Trust both formally and informally. In addition the Lead Governor communicates with other governors by way of regular email correspondence.

5.1.7 Biography of individual governors

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

5.1.8 Role and function of the Council of Governors

The Council of Governors has a duty under the National Health Services Act 2006 to represent the views of foundation trust members and stakeholders, to the Board of Directors and the management of the Trust. The Trust keeps the Council of Governors fully informed on all aspects of the Trust's performance. This is done through formal Council meetings, and through working groups set up by the Council of Governors. These are explained in detailed elsewhere in this report (section 5.1.11 refers).

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

The overall responsibility for running the Trust lies with the Board of Directors and the Council of Governors is the collective body through which the directors explain and justify their actions. The Board has a scheme setting out which decisions it will make itself, known as the Reservation of Powers to the Board (section 5.2.7 elsewhere in this report refers) and there is a Scheme of Delegation which sets out powers delegated to staff.

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

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

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

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

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

Referred to elsewhere in this report (section 5.2.7 refers) are the powers reserved to the Board of Directors which provides details of the types of decisions made by the Board. In addition the Board has agreed a Scheme of Delegation which sets out those decisions which are delegated to management. A copy of the Scheme is available from the Company Secretary.

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

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

Non-Executive Director attendance at Council of Governors Meetings – During 2011/12 Non-Executive Directors attended Council of Governor meetings which enabled them to listen to Governor's concerns.

Presentation by Non-Executive Directors to Governors - Three Non-Executive Directors, being the Chair's of Board Committees have each made a presentation to the Council of Governors on the role and work of the Committee and this has provided an opportunity for Governors to express their views and question the Non-Executive Directors.

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

Joint Board of Directors and Council of Governor Workshop – To allow an open discussion about future strategy a joint workshop was held in September 2011. Directors sought the views of governors on what role they could play in the development and delivery of strategy. This was further expanded upon with a presentation to a Council of Governor's meeting in March 2012 and further discussion is planned in April 2012.

Joint Board of Directors and Council of Governors Training – A training session was held in January 2012 for the Board of Directors and the Council of Governors to discuss and considered the roles of the governors, those of the directors and future working in the light of pending legislation. This provided an opportunity for the whole Board, including the Non-Executive Directors to engage with the governors and to better understand their views and concerns about future roles and responsibilities.

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

"Eyes and Ears" – An initiative known as "eyes and ears" is in place whereby the Governors identify any issues of concern regarding the provision of services. Governors' feedback issues they have witnessed for themselves or those which have been reported to them.

Governor Working Groups – As referred to elsewhere in this report, there are a number of working groups of the Council of Governors, the work of which is supported by staff and directors. The joint working results in effective communication between the staff, directors and governors. Governors have an opportunity to input directly into the workings of the Trust. On request, Non-Executive Directors may attend meetings of working groups to provide information and receive feedback from Governors directly.

Annual Members Meeting – This is formally held once per year, although in 2011/12 an informal Annual Members Meeting was also hosted. The annual report and accounts are presented and a briefing given on the overall performance of the Trust in the previous year. The Governors provide feedback to the Board of Directors.

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

Governor involvement in events / activities – Governors are invited to attend a number of events throughout the year. This provides an opportunity for Governors to be directly involved in the workings of the Trust and to influence the decisions being made. Any comments arising out of these events are fed back to the Directors. A few examples in 2011/12 are: -

- Weekly food tasting
- Menu less meals Ward visit
- Patient safety walkabouts by the Non-Executive Directors and Governors;
- Open Day / Annual Members Meeting Governor volunteer sought
- Membership development Governor volunteer sought
- Governor representative on Car Parking Advisory Group looking at car parking at the Great Western Hospital site
- Governor representative on Nutrition Steering Group looking at hydration and nutrition
- Local study days
- Sensory Awareness Drop in Day
- Tour of community services and neighbourhood teams
- Governor Blog

5.1.11 Council of Governors Meetings Structure

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

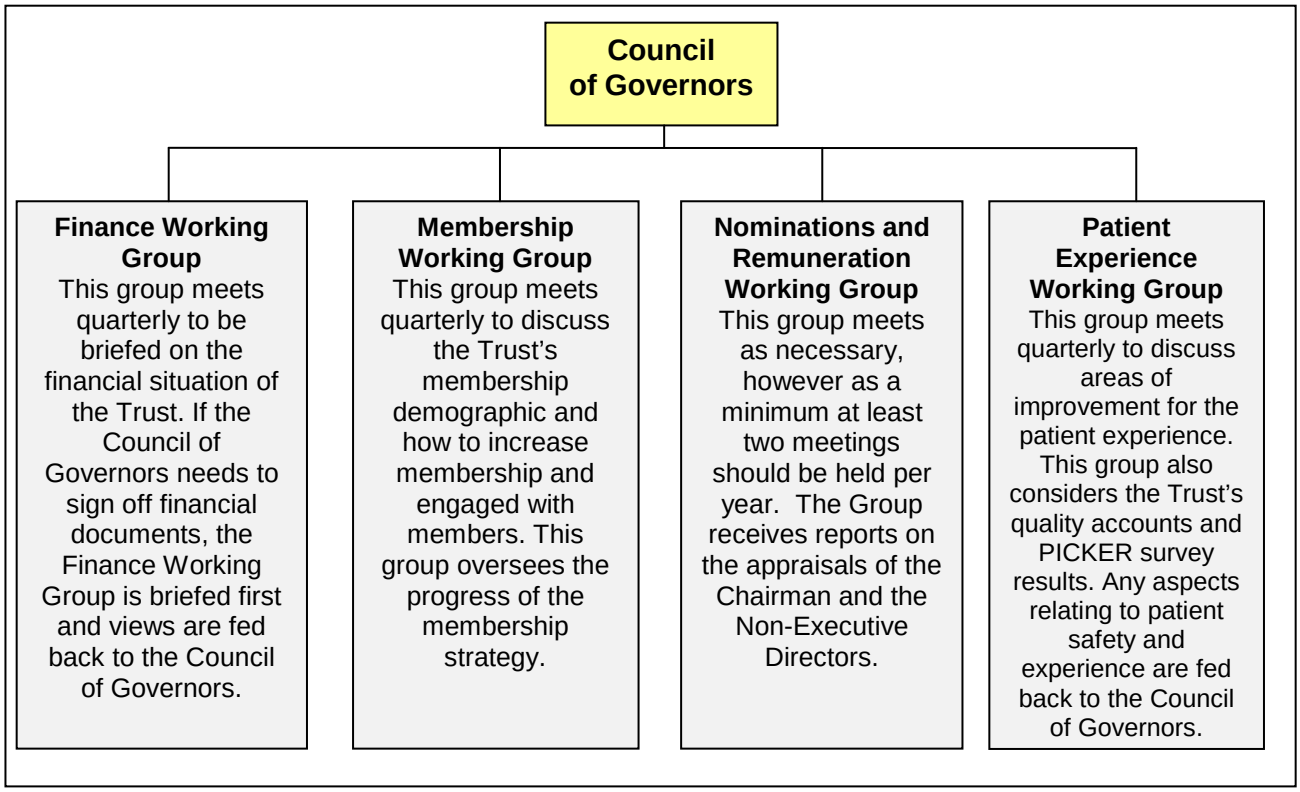
- Finance Working Group
- Membership Working Group
- Nominations and Remuneration Working Group
- Patient Experience Working Group

The purpose of the working groups is to inform governors about activities and issues relevant to each area and provide an opportunity for governors to seek further information. They allow governors a means of influencing decisions and provide a vehicle for challenge and scrutiny of action and activities by the Board.

In addition there is an Annual Members Meeting where the annual report and accounts are presented. At this meeting governors are briefed on the overall performance of the Trust in the previous year and the governors provide feedback to the Board of Directors.

The meetings structure of the Council of Governors is shown below.

TABLE - Meeting structure



5.1.12 Nominations and Remuneration Working Group

It is the role of the Nominations and Remuneration Working Group to assess the performance of the chairman and the non-executive directors and to determine their level of remuneration. Working with a Joint Nominations Committee, the Working Group makes recommendations to the Council of Governors on the suitability of either the chairman or any non-executive directors wishing to be re-appointed.

The Working Group agrees the process for appraisal of the chairman and the non-executive directors. The outcome of the appraisal process is considered by the working group with reports from the Chairman and the Senior Independent Director being presented and recommendations are then made to the Council of Governors.

There is an annual review of the level of remuneration paid to the Chairman and the non-Executive Directors and at least every three years there is market testing of those remuneration levels. The current pay arrangements for Non-Executive Directors were fixed at Authorisation in December 2008 to reflect foundation trust responsibilities. No salary increases were awarded to the Non-Executive Directors in 2011/12. Further information about the salaries of the Non-Executive Directors can be found elsewhere in this report (section 4.8 refers).

During 2011/12, with the Joint Nominations Committee, the Working Group made recommendations to the Council of Governors on the suitability of re-appointing the Chairman and five Non-Executive Directors wishing to be re-appointed. The considerations are referred to under Non-Executive Director appointments elsewhere in this report (section 5.2.3 refers).

During 2012/13 the Non-Executive Director salaries will be market tested, the results of which will be considered by the Working Group.

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

The Working Group met five times in 2011/12.

5.1.13 Interests of Governors

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

A register of those interests is maintained, a copy of which can be obtained from the Company Secretary.

5.2 Board of Directors

5.2.1 The Board of Directors

The Board of Directors or Trust Board, is the decision making body for strategic direction and the overall allocation of resources. It has delegated decision making for the operational running of the Trust to the Executive Directors. The Board takes decisions consistent with the approved strategy. Brief biographies for the Non-Executive and Executive Directors on the Board in 2011/12 are given below.

5.2.2 Biography of individual Directors

Bruce Laurie, Chairman

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 University of West London where he leads a Masters Course in Managing Technological Innovation. Bruce joined the Trust in February 2008 and led it successfully to Foundation Trust status and is proud to be associated with the acquisition of Wiltshire Community Health Services in June 2011.
Prior to being involved in the NHS he was Group Services Director of BG plc having held a number of board level positions in the gas regions and in the international business.
Bruce is Chair of the Mental Health Act / Mental Capacity Act Committee and is a member of the Remuneration Committee. Bruce has been Chair of the Trust since 1 February 2008. In 2011 Bruce was re-appointed Chairman of the Trust for a further term of two years ending 31 January 2014.

Nerissa Vaughan, Chief Executive *(from 1 October 2011)*

Nerissa Vaughan joined the NHS in 1991 as a Graduate National Management trainee. She trained in Birmingham and after completing the Training Scheme took up her first post in Birmingham Family Health Services authorising developing GP commissioning.

After a few years in commissioning at Birmingham Health Authority, she took up her first hospital management job in Dudley Road Hospital in Birmingham as Divisional Manager for Clinical Support Services, which included A&E, Pharmacy, Theatres, ICU, Therapies and a range of other support services.

Nerissa became Project Director for the Wolverhampton Heart Centre, setting up a new Cardiac Tertiary Centre from scratch. Following this, she became interested in capital development and moved to Hull as Director of Planning. She oversaw a £200m capital programme which included a cardiac development and oncology PFI scheme.

Keen to return to the Midlands, she took up post as Deputy Chief Executive at Kettering General Hospital. Moving to her first CEO role at King's Lynn nearly four years ago, she led the Trust to Foundation Trust status. Nerissa became Chief Executive of this Trust in October 2011. Nerissa originates from Llanelli and holds a BA Degree in Theology and a Master of Science Degree in Health Service Management from Birmingham University.

Rowland Cobbold, Non-Executive Director, Deputy Chair *(until 31 December 2011)* **and Senior Independent Director**

Rowland has over 40 years commercial experience in the aviation and tourism industry including seven years on the Board of Cathay Pacific Airways Ltd where his responsibilities included marketing, customer service, corporate communications and IT. He is currently Chairman of Ecco Tours Ltd which he helped to set up 17 years ago and he has also served as a Non-Executive Director on the Boards of Air Partner PLC (1996 to 2004) and Groundstar Ltd (1999 to 2004). Rowland holds a masters degree in law and attended the London Business School's Executive Programme. Rowland was the Deputy Chairman of the Trust up until 31 December 2011. Rowland is the Trust's Senior Independent Director being re-appointed to this position by the Board in 2011/12. Rowland was re-appointed as a Non-Executive Director in July 2011 for a further term of one year ending 31 December 2012.
In 2011/12 Rowland was Chair of the Patient Safety and Quality Committee and the Remuneration Committee and is a member of the Audit, Risk and Assurance Committee and Vice-Chair of the Mental Health Act/Mental Capacity Act Committee. In 2012/13 Rowland will become Chair of a new Clinical Governance Committee. He will stand down as a member of the Mental Health Act/Mental Capacity Act Committee, but will continue to Chair the Remuneration Committee until 30 September 2012 to coincide with his Senior Independent Director appointment.

Angela Gillibrand, Non-Executive Director and Deputy Chair *(from 1 January 2012)*

Between 1984 and 1999 Angela was the Finance Director at the University of Cranfield's Shrivenham Campus, and helped set up one of the first PFIs - the academic contract between the University and the Ministry of Defence. More recently Angela was the Head of Finance, Planning and Company Secretary at U.K. Nirex Ltd, the U.K.'s radioactive waste management company. Since 2003 Angela has combined a career as a Non-Executive Director in the NHS, Government and a Housing Association with work for a family company. Angela holds a degree in Physiology and Psychology from Somerville College, Oxford and a MBA from INSEAD, Fontainebleau, France. Angela has been a member of the Board since 1 July 2004. Angela was re-appointed as a Non-Executive Director in January 2012 for a further term of two years ending 30 June 2014. In 2011/12 Angela was Chair of the Audit, Risk and Assurance Committee, the Academy Strategic Board and the Charitable Funds Committee and was a member of the Remuneration Committee. Angela was also appointed Deputy Chairman of the Trust with effect from 1 January 2012, initially until 30 June 2012 and this was subsequently extended until 2014 coinciding with her re-appointment. In 2012/13 Angela will stand down as Chair of the Audit, Risk and Assurance Committee and will no longer be a member of that Committee, noting that she is now Deputy Chairman of the Trust. Angela will also stand down as Chair of the Charitable Funds Committee and the Academy Strategic Board respectively, but she will remain as a member on those Committees. Angela will become a member of the Mental Health Act / Mental Capacity Act Committee and also a member and later Chair of the Clinical Governance Committee.

Liam Coleman, Non-Executive Director

Liam Coleman is currently Deputy Group Treasurer of the Royal Bank of Scotland Group. Prior to that Liam was Group Director - Treasury at Nationwide Building Society. Prior to joining Nationwide, Liam worked in banking roles at Mitsubishi Bank, Hambros Bank and National Westminster Bank. Liam holds a BA Honours degree from the University of Manchester and an MBA from Warwick Business School; he is also a member of the Chartered Institute of Bankers and the Association of Corporate Treasurers. In 2011/12 Liam was Chair of the Workforce Strategy Committee and was a member of the Remuneration Committee and the Finance and Investment Committee. In 2012/13 Liam will stand down as Chair of the Workforce Strategy Committee but remain as a Committee member. However, he will take on the role of Chair of the Finance and Investment 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. Until 2008 he had been serving as a Governor of Newbury College. Roger was re-appointed as a Non-Executive Director in January 2012 for a further term of three years ending 30 April 2015.

During 2011/12 Roger was Chair of the Business Development and Advisory Group and was a member of the Patient Safety and Quality Committee; the Workforce Strategy Committee and the Remuneration Committee. In 2012/13 Roger will stand down from the Patient Safety and Quality Committee but will become a member of the Finance and Investment Committee. He will also take over as Chair of the Remuneration Committee to coincide with his appointment as Senior Independent Director which was agreed in January 2012 with effect from 1 October 2012.

Robert Burns, Non-Executive Director

Robert Burns' career has been largely focused on financial disciplines and financial management roles. Having trained as an accountant most of his career has been spent in complex multinationals ultimately in various senior Finance, and Sales Management roles. He is a Fellow of the Institute of Chartered Accountants in England and Wales (FCA) and a Fellow of the Chartered Management Institute (FCMI). He was also a Board Member of Gloucester Probation Trust, part of the National Offender Management Service but resigned in June 2011 to enable him to dedicate more time to this Trust following the transition of Community Services. He joined the Board on 1 August 2008 since when Robert has been Chair of the Finance and Investment Committee. He is also a member of the Audit, Risk and Assurance Committee; the Patient Safety and Quality Committee; the Remuneration Committee and the Charitable Funds Committee.
Robert was re-appointed as a Non-Executive Director in January 2012 for a further term of three years ending 31 July 2015. In April 2012 he will stand down as a member of the Patient, Safety and Quality Committee and and as Chair of the Finance and Investment Committee respectively, taking on the role of Chair of the Audit, and Risk Assurance Committee.

Kevin Small, Non-Executive Director

Kevin was appointed to the Board on 1 November 2003. Kevin is an experienced Board member having been involved in a wide range of organisations. Kevin was Chair of Wiltshire Ambulance Service NHS Trust from 1998 to 2002 and Director of the New Swindon Company between 2003 and 2004 and again from 2005 to 2010. Kevin has also been a Non-Executive Director for the British Railways Board/Strategic Rail Authority (2000 to 2002), Chair of Western England Rail Passenger Committee (1998 to 2000), a member of Wiltshire Police Authority (1999 to 2003) and Leader of Swindon Borough Council (Aug 2002 to May 2003). In July 2011, Kevin was re-appointed as a Non-Executive Director for a further term of one year ending 31 October 2012.

During 2011/12 Kevin was a member of the Finance and Investment Committee, the Workforce Strategy Committee and the Remuneration Committee. In 2012/13 Kevin will stand down as a member of the Finance and Investment Committee but will become Chair of the Workforce Strategy Committee. He will also become a member of the Audit, Risk and Assurance Committee and the Clinical Governance Committee.

Lyn Hill-Tout, Chief Executive *(until 12 June 2011)*

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

Lyn left the Trust in June 2011 to take up the position of Chief Executive of Mid Staffordshire NHS Foundation Trust.

Dr Alf Troughton, Medical Director *(interim Chief Executive - 1 June – 30 September 2011)*

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

During 2011/12 Alf Troughton was appointed interim Chief Executive following the resignation of Lyn Hill-Tout who left the Trust in June 2011. He returned to his substantive post in October 2011 when Nerissa Vaughan joined the Trust as Chief Executive.

Maria Moore, Director of Finance

Maria was appointed as Director of Finance on 29 September 2008. She had previously held the Deputy Director of Finance post at the Trust having joined in March 2003. Maria has over 18 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).

Oonagh Fitzgerald, Director of Workforce and Education

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

Sue Rowley, Director of Nursing and Midwifery

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

Helen Bourner, Director of Business Development *(until 5 April 2012)*

Helen spent a number of years working in the hotel sector, latterly as Regional Director of Sales for the North of England and Scotland for Hilton Hotels. She worked for NHS Estates (an executive agency of the Department of Health) and NHSU (the NHS University) from 2000 – 2005 providing advice and guidance on the Consumerism agenda arising out of the NHS Plan in 2000. She entered the NHS through the Gateway to Leadership Scheme, joining Barnsley Hospital NHS Foundation Trust in 2005. Helen has been Director of Business Development since August 2008. Helen left the Trust at the beginning of April 2012 to take up the position of Director of Commercial and Corporate Development at Warrington and Halton Hospitals NHS Foundation Trust.

Guy Rooney, Interim Medical Director *(1 June – 30 September 2011)*

Dr Guy Rooney joined the Board as interim Medical Director in May 2011 when the Medical Director acted up as Chief Executive pending the appointment of a substantive post holder. Dr Guy Rooney is a consultant in Sexual health and HIV and has been working for the Trust as a consultant since 1999. For the last few years he has been one of the Associate Medical Directors with responsibility for the Diagnostics and Outpatients directorate. In addition he provided the clinical input into the bid for Wiltshire community services. Guy returned to his post as an Associate Medical Director in October 2011.

Jenny Barker, Director of Transition *(1 June - 31 December 2011)*

Jenny was a Managing Director at Wiltshire Community Health Services since the reconfiguration of the Primary Care Trusts in Wiltshire in October 2006. She began her career in nursing at the Royal London Hospital in 1978. She then held a series of senior nursing appointments within the NHS and the private sector, rising to become BUPA Health Services' Director of Nursing. Jenny returned to the NHS in 1994 as a Directorate Manager in a university teaching hospital in London. She was seconded to work as the Project Director for the reconfiguration of hospital services in South West London and masterminded the reduction in services at Queen Mary University Hospital and the increase in services to St George's Tooting and Kingston Hospital Trusts. She relocated the Regional Burns Unit from Queen Mary to Chelsea and Westminster Hospital. Jenny has a wealth of experience in senior NHS roles including Deputy Chief Executive at Dorset County Hospital, the challenging role of Recovery Director for the Bath and Wiltshire Health Community, Director of Operations & Acting Chief Executive at the Royal United Hospital in Bath. Jenny gained an MBA in 1997. Since GWH became the preferred provider for Wiltshire Community Health Services, Jenny was seconded to this Trust, assisting the Board of Directors as the Director Transition (designate). Jenny became the Director of Transition on 1 June 2011 coinciding with the formal transfer of Wiltshire Community Services to this Trust. Jenny left the Trust in December 2011 having completed the transitional work, returning to NHS Wiltshire.

5.2.3 Length of appointments of Non-Executive Directors

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

Name	First Term	Second Term	Third Term
Bruce Laurie (Chair)	01.12.08 – 31.01.12	01.02.12 – 31.01.14*	
Rowland Cobbold	01.12.08 – 31.12.10	01.01.11 – 31.12.11	01.01.12 – 31.12.12*
Angela Gillibrand	01.12.08 – 30.06.12	01.07.12 – 30.06.14*	
Kevin Small	01.12.08 – 31.10.11	01.11.11 – 31.10.12*	
Roger Hill	01.12.08 – 30.04.12	01.05.12 – 30.04.15*	
Robert Burns	01.12.08 – 31.07.12	01.08.12 – 31.07.15*	
Liam Coleman	01.12.08 – 31.10.12		

Note that the date of first term appointment is the date of becoming a Foundation Trust. However, with the exception of Liam Coleman, all had been appointed before this date and hence there is variation in their first terms of office.

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

As recommended by the Local Counter Fraud Service (LCFS), the names of all Trust Directors (Executive and Non-Executive) are cross-referenced with the Disqualified Directors Register on the Companies House website on an annual basis. No Trust Directors appeared on the Disqualified Directors Register (as of 14 March 2012).

*These six Non-Executive Directors were re-appointed during 2011/12. The process involved assessment by a Joint Nominations Committee and the Governor Nomination and Remuneration Working Group. The following considerations were taken into account and matched against a job description and person specification in respect of each re-appointment: -

- Skills and qualities identified as required;
- Composition of the Board mapped against Directors;
- Statutory and Code of Governance requirements;
- Governors' duties in considering re-appointments;
- Views of the Chairman and Governors;
- Independence;
- Qualifications and experience requirements;
- Annual performance appraisals feedback;
- Board development feedback;
- Refreshment of the Board;
- Changes in significant commitments which could be relevant;
- Time commitment for the role; and
- Term of appointment.

The re-appointments were approved by the Council of Governors.

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

The Non-Executive Directors are all considered to be independent of the Foundation Trust and the Trust Board believes it has the correct balance, completeness and appropriateness in its composition to meet the requirements of an NHS Foundation Trust. Three Non-Executive Directors have served more than 6 years from the date of their first appointment but in each case, on re-appointment the Trust considered that they remained independent in that, amongst other things, they continued to have a willingness to probe and challenge and there were no relationships which might create a conflict of interest.

The Board is committed to reviewing its balance and composition in order to maintain its effectiveness. During 2011, the Trust mapped the refreshment of the Board, looking in detail at the skills and qualities needed now and in the future and mapped the composition of the Board against desired experience and knowledge on the Board.

In addition, the Board recognised that Board development tools provide a framework for objectively assessing performance and in meeting our responsibilities. In 2011 an external agency was recruited to undertake development of the Board using the National Institute for Innovation and Improvement Board Development Tool for Foundation Trusts. Board development will continue in 2012/13.

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

In 2011/12 the Trust commissioned an independent formal review of its performance and effectiveness. This review involved an independent advisor attending and observing Board meetings, interviews with each Director and the Company Secretary and 360 degree questionnaires and feedback. The review looked at the performance of the Board and that of its collective and individual Directors with recommendations being made relating to the operation of the Board; Director's roles; functions of the Board; Board engagement; strategy development and development generally. The Trust is continuing to use the independent advisor with further Board Development planned during 2012/13.

For individual Non-Executive Directors, the Trust has in place a framework for their appraisal based on elements of the Hay Group work and best practice from other Foundation Trusts. In June 2011 a formal appraisal process for the Chairman and the Non-Executive Directors was undertaken by the Council of Governors. The evaluation of the Chair's performance was led by the Senior Independent Director with input from the Lead Governor and the Chief Executive on behalf of the Executive Directors and having regard to the views of the other Non-Executive Directors. The Chief Executive and Non-Executive Directors' performance was evaluated by the Chairman taking account of Governors and other Directors' input. The Executive Directors' appraisals were led by the Chief Executive in April 2012, through the Board Remuneration Committee following a formal appraisal process using Hay Group's leadership competencies. All appraisals involve 360 degree evaluation and feedback.

5.2.6 Attendance at meetings of the Board of Directors during 201/12

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

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

	28.04.11	Extra 16.05.11 meeting	26.05.11	26.05.11	30.06.11	28.07.11	29.09.11	27.10.11	24.11.11	22.12.11	26.01.12	23.02.12	12.03.12 – Joint Board & Council of Governors	29.03.12
Jenny Barker (up until 31.12.11)	✓	✓	×	✓	✓	×	✓	✓	×	✓	n/a	n/a	n/a	n/a
Helen Bourner	✓	✓	×	×	✓	×	✓	✓	✓	✓	✓	✓	✓	✓
Robert Burns	✓	×	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rowland Cobbold	✓	✓	×	×	✓	✓	✓	✓	✓	✓	✓	×	✓	✓
Liam Coleman	×	×	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	✓
Oonagh Fitzgerald	✓	×	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	✓
Angela Gillibrand	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Roger Hill	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	✓
Bruce Laurie	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Maria Moore	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Guy Rooney (from 01.05.11 – 03.10.11)	✓	×	✓	✓	✓	✓	✓	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Sue Rowley	✓	✓	×	×	✓	✓	✓	✓	✓	✓	✓	✓	×	✓
Kevin Small	✓	×	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	✓
Alf Troughton	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Lyn Hill-Tout (until 31.05.11)	✓	×	×	×	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Nerissa Vaughan (from 03.10.11)	n/a	n/a	n/a	n/a	n/a	n/a	✓	✓	✓	✓	✓	✓	✓	✓

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

5.2.7 Decisions reserved for the Board of Directors

There are certain matters which are reserved for the Board of Directors to decide relating to regulation and control; appointments; strategic and business planning and policy determinations; direct operational decisions; financial and performance reporting arrangements; audit arrangements and investment policy.

The Reservation of Powers to the Board was reviewed in January 2012. A copy of the full reservation of powers to the Board document can be obtained from the Company Secretary.

5.2.8 Interests of Directors

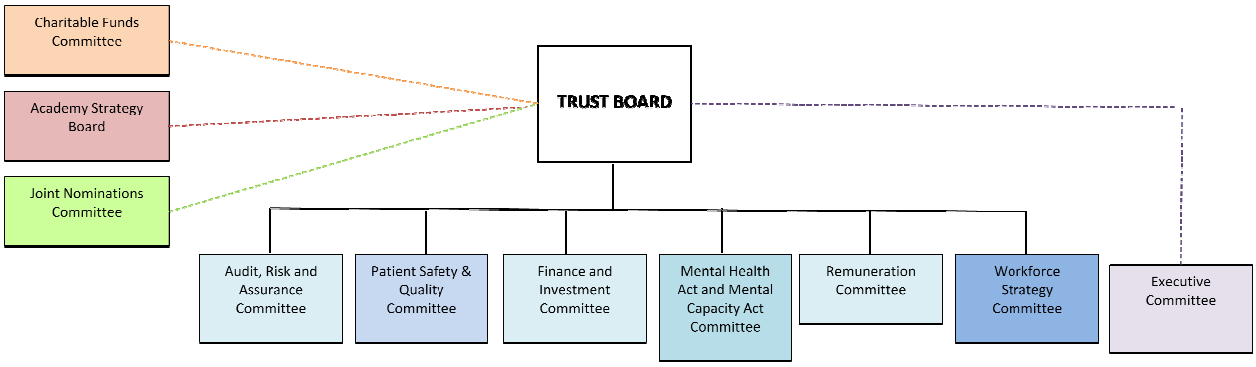
A Register of Interests of Directors is maintained, a copy of which can be obtained from the Company Secretary.

5.2.9 Significant Commitments of the Chairman

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

5.2.10 Committee structure

The Board of Directors reviewed its committees during 2010/11, which remained in place during 2011/12 as follows: -



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

5.2.11 Key Committees

The Board recognises the importance of organisational governance such as executive structures, annual and service plans, performance management and risk management arrangements to deliver the Trust's strategic objectives. The Trust has therefore developed a meetings structure to support these and to provide assurance to the Board.

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

- Audit, Risk and Assurance Committee*
- Charitable Funds Committee
- Executive Committee
- Finance and Investment Committee
- Mental Health Act and Mental Capacity Act Committee*
- Remuneration Committee*
- Patient Safety and Quality Committee
- Workforce Strategy Committee.

* Statutory Committees

Each year the committees evaluate their effectiveness by way of a discussion or questionnaire. This informs any amendment to their Terms of Reference.

5.3 Audit Committee

5.3.1 The Audit, Risk and Assurance Committee

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

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

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

Internal Control

The Committee assures the Board that the system of internal control is operating effectively. The Committee monitors internal control systems and the External Auditor provides an independent view of the overall management arrangements.

Internal Audit

The Committee evaluates 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 Parkhill.

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; 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 Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The external audit function for Great Western Hospitals NHS Foundation Trust is carried out by KPMG.

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

In 2011/12 the Audit, Risk and Assurance Committee discharged the responsibilities delegated to it in the following way:

- The Committee has Board approved Terms of Reference.
- The minutes of the Committee meetings are submitted to the Board.
- The Chair of the Committee gives regular verbal updates at the Board meetings.
- The internal audit plan was reviewed and approved, ensuring that there is consistency with the audit needs of the organisation as identified in the Assurance Framework, Organisational Risk registers and the plan supports the work of the external auditors.
- A review of the Committee effectiveness is undertaken annually.
- The trust-wide risk register is reviewed at each meeting, a directorate risk register is considered in detail at each meeting and the Board Assurance Framework is scrutinised and challenged at each meeting.
- Progress reports from the external auditor are received.
- All internal audit and Local Counter Fraud Service reports are reviewed.
- The Annual Governance Statement is reviewed.
- Single tender actions are reviewed.
- Any losses and compensation payments are approved.

5.3.3 Attendance at the Audit, Risk and Assurance Committee Meetings during 2011/12

Audit, Risk and Assurance Committee Members	Record of attendance at each meeting ✓ = Attended × = Did not attend						
	4 April 2011	3 June 2011	7 July 2011	15 September 2011	17 November 2011	19 January 2012	22 March 2012
Rowland Cobbold	✓	✓	✓	✓	✓	✓	✓
Robert Burns	✓	✓	✓	✓	✓	✓	✓
Angela Gillibrand (Chair)	✓	✓	✓	✓	✓	✓	✓

The Chair of the Committee is Angela Gillibrand, a Non-Executive Director.

5.4 Directors' responsibility for preparing the accounts

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

The Directors are aware of their responsibilities for preparing the accounts and are satisfied that they meet the requirements as reflected in the Statement of Chief Executive's responsibilities as the Accounting Officer at Great Western Hospital NHS Foundation Trust also as referred to elsewhere in this report (section 12.1 refers).

5.5 Statement from the auditors about their reporting responsibilities

This included in the auditor's report (section 5.5 refers).

5.6 Nominations Committee

5.6.1 The Joint Nominations Committee

The Trust has a Joint Nominations Committee which is responsible for nominating suitable candidates to the Council of Governors for appointment to the Chairmanship or office of Non-Executive Director; and for nominating suitable candidates to the Non-Executive Directors for appointment as the Chief Executive.

5.6.2 The work of the Joint Nominations Committee in discharging its responsibilities

In 2011/12 the Committee met on three occasions, once to consider nominating suitable candidates to the Non-Executive Directors for appointment as Chief Executive and thereafter on two further occasions to consider the re-appointment of the Chairman and five Non-Executive Directors. When the Chairman or a Non-Executive Director reaches the end of their current term and being eligible wishes to be reappointed, the Joint Nominations Committee may nominate the individual for such reappointment without competition, subject to the Committee taking into account the result of any review of the individual's performance during their term of office and the balance of skills required on the Board of Directors. An external search agency was engaged for the Chief Executive appointment.

The Joint Nominations Committee worked closely with the Governor Nominations and Remuneration Working Group, to ensure that nominations for re-appointment were made by a majority of governors.

Before making any nomination for re-appointment, the Committee evaluated the performance of the individual seeking re-appointment during their term, the balance of qualifications, skills, knowledge and experience on the Board of Directors and, in light of this evaluation, prepares a description of the role and capabilities required. When considering the Chairman's re-appointment, the Committee took into consideration the time commitment required.

5.6.3 Attendance at the Joint Nominations Committee Meetings during 2011/12

Joint Nominations Committee Members	Record of attendance at each meeting ✓ = Attended × = Did not attend		
	10 June 2011	27 July 2011	25 January 2012 Joint meeting with the Governor Nomination and Remuneration Working Group
Rowland Cobbold	✓	✓	✓
Angela Gillibrand	✓	✓	✓
Bruce Laurie (Chair)	✓	✓	✓
Harry Dale	✓	✓	✓
Godfrey Fowler	✓	✓	✓
Marcus Galea	✓	✓	✓
			Plus 3 other Governors

Note: Angela Gillibrand and Rowland Cobbold are Non-Executive Directors appointed to the Committee by the Chairman Bruce Laurie also a Non-Executive Director and Godfrey Fowler, Harry Dale and Marcus Galea are Governors appointed by the Council of Governors.

The Chair of the Committee is Bruce Laurie, Chairman of the Trust.

Note that in addition to the Joint Nominations Committee, there is a Remuneration Committee authorised by the Trust Board to oversee a formal, rigorous and transparent procedure for the appointment of the Chief Executive and other Board Executive Directors and to keep under review the composition size and structure of the Executive, leading on succession planning, appointing candidates to Board level positions. The Remuneration Committee reviews senior manager (Executive Director) remuneration and has delegated authority for agreeing any annual pay review for these staff only.

5.7 Mental Health Act / Mental Capacity Act Committee

5.7.1 The Mental Health Act / Mental Capacity Act Committee

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

The Trust must:

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

Membership of the Mental Health Act and Mental Capacity Act Committee

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

5.7.2 Meetings during 2010/11 and attendance

The Mental Health Act / Mental Capacity Act Committee members		Jun 2011	Sep 2011	Dec 2011 Cancelled	Mar 2012
Bruce Laurie (Chair)	Chairman of the Trust	√	√		√
Rowland Cobbold (Deputy Chair)	Non Executive Director	x	√		√
Sue Rowley	Director of Nursing and Midwifery	x	√		√
Carole Crocker	Deputy Director of Nursing	√	Left the Trust		
Joy Gobey	Mental Health Act Administrator	√	√		√
Teresa Harding Joanne Smith, Senior Nurse Paediatrics - deputy	General Manager, Women and Children's' Department	x	x		√ Joanne Smith
Dick Eyre Attendance as either / both with Amanda Cadder	Child Psychiatrist	x	√		√
Amanda Cadder Attendance as either/both with Dick Eyre	Nurse Manager	x	x		x

The Mental Health Act / Mental Capacity Act Committee members		Jun 2011	Sep 2011	Dec 2011 Cancelled	Mar 2012
Neil Mason (deputy for Gill McKinnon)	Community Service Manager and Adults Service Manager AWP (Liaison)	x	x		x
Gill McKinnon	Service Manager (Specialist Services) Older People's SBU	√	√		√
Jane Higgins for Joi Demery	AMHP		√		
Kieran Holland (deputy for Jenny MacDonald)	Modern Matron, Sandalwood Court	x	√		x
Anthony Harrison	Consultant Nurse (Liaison Psychiatry) AWP	-	-		√
Donna Bosson	Senior Nurse Unscheduled Care	x	√		x
Julie Dart	Mental Capacity Act Programme Manager Joint appointment with Swindon Borough Council and Swindon Primary Care Trust, Adult Social Care	x	√		x

GWH and Avon and Wiltshire Mental Health Partnership (AWP) have a two way service level agreement (SLA) signed off. The provision of mental health liaison psychiatry has been extended to include out of hours and weekends. The provision of older people liaison psychiatry service for Wiltshire was withdrawn in April 2011 but extended to September 2011 has not been in place following the extension. The reinstatement of this service has been high on the agenda and it is envisage that this will be resolved in the first quarter of 2012.

With regards to section 12 of the Act the Trust continues to have delays in accessing a psychiatrist as the responsible clinician. The Deputy Director of Nursing is having discussions with AWP and commissioners in order that the issues are resolved as early as possible.

5.7.3 Application of the Mental Health Act (MHA) in the Trust

The Mental Health Act Administrator provides a three monthly report on the application of the Mental Health Act in the Trust. The report is considered by the Mental Health Act and Mental Capacity Act Committee at each meeting.

From April 2011 – 7th March 2012, the use of the Mental Health Act was applied on 75 occasions in regard of 30 patients. The 75 occasions relate to 30 inpatients at the Great Western Hospital which include those patients on Section 17 authorisation of leave from other organisations.

5.8 Membership

5.8.1 Membership

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

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

5.8.2 Public Members

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

Public members are placed in constituencies based on where they live. Originally there were three constituencies created on Authorisation as a Foundation Trust in 2008 to reflect the Trust's catchment area. However, as the area of the Trust expanded in 2011/12 following the transition of community services in Wiltshire, the West Berkshire, Gloucester and Oxfordshire constituency was enlarge to accommodate the additional areas, becoming the West Berkshire, Oxfordshire, Gloucestershire and Bath and North East Somerset Constituency on 1 June 2011. That constituency was subsequently split out on 8 August 2011 to better reflect local communities, resulting in the following public constituencies: -

- Swindon,
- Wiltshire,
- West Berkshire and Oxfordshire,
- Gloucestershire, Bath and North East Somerset.

The Trust is continuing to review its public constituencies. In 2012/13 the Wiltshire Constituency will be split out into three constituencies (northern, central and southern Wiltshire constituencies).

5.8.3 Staff Members

Staff members include Trust employees, Carillion Health employees and volunteers. The Trust has strong links with the local community, with over 500 volunteers. These persons automatically become members when:

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

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

The Trust has a wide range of staff undertaking a variety of roles and professions. In 2011/12 consideration was given to establishing classes within the staff constituency to reflect occupational areas. This was supported by the Trust and changes to the staff constituency are planned for implementation in November 2013, the details of which will be finalised in early 2013.

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

5.8.4 Membership analysis

During the year, the Trust sought to increase membership numbers. As at 31 March 2012, the membership of the Great Western HNS Foundation Trust was as follows: -

	Number of Members
Swindon Public Constituency	2870
Wiltshire Public Constituency	1473
West Berkshire and Oxfordshire Public Constituency	325
Gloucestershire and Bath and North East Somerset Public Constituency	156
Affiliated	217
Staff Constituency	7222
TOTAL	**12263**

Public Constituency	**2011/12**	**2012/13 (estimated)**
At year start (1 April)	5007	5041
New Members	187	250
Members leaving	153	150
At year end (31 March)	5041	5141

Staff constituency	**2011/12**	**2012/13 (estimated)**
At year start (1 April)	4916	7222
New Members	2438	200
Members leaving	132	200
At year end (31 March)	7222	7222

The estimates for 2012/13 are based on a best prediction having regard to this year's increase and the number of members leaving.

The groupings of the members in the public constituency are as follows: -

Public constituency	Number of members
Age (years)	
0-16	86
17-21	168
22+	4740
Not specified	47
Ethnicity:	
White	3927
Mixed	25
Asian or Asian British	130
Black or Black British	49
Other	25
Not specified	885
Gender analysis	
Male	2155
Female	2796
Not specified	90

The Trust uses information from the Office of National Statistics (Census 2011) to build up a picture of the population size and ethnicity for each constituency. This helps the Trust in it aims to make the membership reflective of its population. The Trust has also determined the socio-economic breakdown of its membership and the population from its catchment area.

5.8.5 Building a strong relationship with our members

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

The Trust fulfils this aim by communicating and engaging with members via the Trust's quarterly magazine Horizon, hosting member focus groups and events such as open days. The Trust's website has been redeveloped to provide more regular updates and information and there are plans to allow more interaction between members and Governors in the form of Blogs and web chats. The Trust also has a full time Governance Officer responsible for membership, to answer any questions from members or provide additional information.

5.8.6 Membership Strategy

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

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

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

5.8.7 Membership development in 2011/12

In order to build a representative membership during 2011/12 the Trust undertook the following: -

- Attended 6 parish council meetings throughout Wiltshire to explain membership and encourage participation in Trust activities;
- The Governance Officer hosts monthly recruitment drives in the hospital atrium;
- Revised the membership application form so that it is easier for applicant members to return to the Trust
- Hosted 6 Constituency meetings, including at community hospital venues
- The planning of a larger scale member's event planned for the summer of 2012
- Hosted an hospital Open Day

Youth membership continues to be the least represented age category. In order to encourage membership amongst the young, the Governance Officer is working closely with the Academy to plan and deliver two experience events for GCSE and A Level students interested in healthcare. It is envisaged that one of these events will be held at a community hospital. These events are planned for autumn 2012.

In the last twelve months the Trust has worked on increasing its members as well as engaging its' members. The membership application form has been revised to incorporate a method of return delivery, making it easier for people to return to the Trust. The Open Day hosted over 30 stalls and was well attended. The Governance Officer has attended Parish Council and forum meetings in order to talk about the structures of Foundation Trusts and the opportunities to get involved. The Governance Officer hosts a stall in the atrium of the GWH on a monthly basis talking to visitors and patients and recruiting members.

The Trust acknowledges that the number of new members has not increased by the estimated numbers projected in the Annual Plan 2010/11. Membership levels appear to have levelled off, with new recruited members replacing leaving members.

5.8.8 Membership development proposed for 2012/13

Engagement with existing forums
The Governance Officer will continue to engage with existing forums, such as Patient Participation Groups, parish and town councils, carers groups etc. by attending meetings and presenting to them about membership and recruiting new members.

Member's Event
Constituency meetings have not been well attended by Members and consequently the Trust is looking to organise a larger event for all Members which will offer the opportunity to engage with Governors, offer feedback and attend focus groups, in addition to attending clinician led lectures. It is envisaged that this event will be held in the summer of 2012 and depending on success will be repeated in the community.

Youth Membership Drive
The Governance Officer is working with the Academy to plan and deliver two schools days aimed at GCSE and A Level students, which will take place in the autumn of 2012. Students will receive a presentation on the structure of foundation trusts, tied in with the politics and funding of healthcare. There will also be opportunities for students to watch operations via video link, use the SIM man and other activities. This will be an opportunity to increase our membership amongst the under 18s.

Governor Blog
The Trust has launched a blog written by Governors, seeking the views of local service users and existing members on the Trust and healthcare more generally. The Trust aims to develop this over the next 12 months.

Horizon Newsletter
The Trust's quarterly magazine Horizon is sent to every member, either electronically or in the post. The newsletter contains dedicated membership pages, with a word from the Governors.

Contacting the Governors and Directors

If any constituency member or member of the public generally wishes to communicate with a Governor or a Director they can do so by emailing the Foundation Trust email address: foundation.trust@gwh.nhs.uk. This email address is checked daily by the Governance Officer who will forward the email to the correct Governor and/or Director. Alternatively a message can be left for a Governor by ringing the Governance Officer on 01793 604185 or for a Director by ringing the Company Secretary on 01793 6047151 or by sending a letter to:

Company Secretary, The Great Western Hospital, FREEPOST (RRKZ-KAYR-YRRU), Swindon, SN3 6BB.

5.9 Code of Governance Disclosure Statement

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

Monitor, the independent regulator for Foundation Trusts, published the NHS Foundation Trusts Code of Governance. The way in which the Trust applies the principles within the Code of Governance are set out in this report, and the Directors consider that in 2011/12, the Trust has been compliant with the Code with the exception of the following: -

A.3.1 – Based on the recommendations of a Joint Nominations Committee comprising Directors and Governors, the Council of Governors rather than the Board determined whether non-executive directors seeking re-appointment were independent in character and judgment and whether there were relationships or circumstances which were likely to affect, or could appear to affect, the director's judgement. The Council of Governors determined that the non-executive directors were independent, notwithstanding that they had served on the Board of the NHS Foundation Trust for more than six years from the date of their first appointment, the reasons for which are stated elsewhere in this report (section 5.2.3 refers).

B.1.7 – Practices and procedures are in place for engagement by Council of Governors with the Board of Directors for those circumstances when there are concerns about the performance of the Board, compliance with the terms of authorisation or other matters related to the general wellbeing of the Trust. Provisions are also included within the Constitution and role descriptions for the Lead and Deputy Lead Governor. The intention is to capture this in one policy document for consideration by the Council of Governor in 2012/13.

C.1.5 – The Trust has a Joint Nominations Committee responsible for nominating Non-Executive Directors for appointment and re-appointment. At present there is an equality of membership of Directors and Governors. Therefore in 2011/12, to ensure a majority of governors made nominations, the Joint Nominations Committee met with the Governor Nominations and Remuneration Working Group. Going forward into 2012/13, it has already been supported that the membership of the Joint Nominations Committee, which is in accordance with Constitutional provisions, will be amended to increase the number of Governor members.

C.2.2 – One Non-Executive Director is currently in the last year of a four year term. All new appointments and re-appointments are at intervals of no more than 3 years.

F.3.9 – The audit committee did not review arrangements by which staff of the NHS foundation trust may raise in confidence concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. However, the Trust has in place a Whistle Blowing policy which was highlighted to staff by the Senior Independent Director. Furthermore, guidance was issued to governors on how to handle matters referred to them. In addition the Trust has in place a counter fraud policy. Annually the Local Counter Fraud officer undertakes a staff fraud awareness survey. In 2011/12 456 members of staff answered the survey a ten fold increase compared with the previous year. The survey demonstrates that a high proportion (60%) of respondents knew the Trust had a Local Counter Fraud Specialist and how to contact them. The work conducted by the Local Counter Fraud Specialist can also be demonstrated by the increase of referrals and general assistance during 2011/12, which resulted in five investigations taking place.

G.1.1 – The Trust should have a public document setting out the Trust's policy on the involvement of members, patients and the local community at large including a description of the kind of issues it will consult. This is being drafted and will be considered by the Board later in 2012/13. The Trust's approach is outlined in a number of documents and the intention is to capture this in one policy.

G.1.2 – The Board should clarify in writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between governors and any local consultative forums already in place. This is being drafted and will be considered by the Board later in 2012/13.

6 QUALITY REPORTS

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

6.1 Statement on quality from the Chief Executive of the Great Western Hospitals NHS Foundation Trust

Patient safety continues to be at the heart of everything we do. We continue to focus our energies on improving safety and patient and staff satisfaction by providing the highest quality care.

The past year has been extremely challenging due to the mergence with Wiltshire Community Health Services on 1st June 2011. However, it has also been an extremely positive and rewarding year and provided opportunity for us to develop and improve the quality of care provided for the new enlarged organisation.

We have regularly monitored our quality improvement plans during 2011/12 via our Patient Safety and Quality Committee through to Trust Board and through our external reporting and monitoring arrangements with our commissioners and key stake holders including LINks and local Hospital Overview Scrutiny Committees.

The priorities for quality improvement set out in the quality Accounts have been chosen to reflect our goals to improve patient safety, clinical effectiveness and the experiences of our patients. We have improved care in many areas and delivered some significant service improvements and continued to develop our services.

We have seen our Hospital Standard Mortality Rates (HSMR) remain below (better than) 100. We have continued to reduce hospital acquired infections and more specifically we have achieved our MRSA and *Clostridium difficile* improvement (reduction) targets. Our staff have led improvements in many other areas of safety and improved care, including Venus Thromboembolisis (VTE), Ventilator Acquired Infections and shown a significant reduction in pressure ulcers and harm associated with patient falls. All of these have contributed to better patient outcomes and experience.

Delivering safe, high quality care relies on a clean and fit for purpose environment and good equipment. We were delighted that we have received excellent verbal feed back again following our external assessments of all of our hospital (inpatient sites) by the Patient Environment Action Teams (PEAT). Formal written reports are awaited. The hospital design and reconfiguration of ambulatory care and transfer of the AAU department onto Linnet ward has also enabled us to achieve ZERO mixed sex breaches since December 2011.

We consistently aim to follow and implement best practice in accordance with national recommendations and alerts and I am delighted to say that we are over 95% compliant with all published NICE guidance and Central Alert System (CAS) alerts.

We have used the published annual inpatient (PICKER) survey results to focus on improving the experiences of our patients and we have used our day to day reporting processes to ensure we learn from complaints, incidents, clinical audits and claims.

We have progressed with the implementation of the regional acute patient safety programme and we have implemented Executive led quality and safety walkabouts as part of the leadership module within this programme. These walkabouts now include representation from Non Executive Directors

and Governors. We have also commenced implementation of the community patient safety programme.

I am delighted with our recent 2011/12 staff survey result. GWH's position (including WCHS) has improved significantly and no indicators are in the bottom 20% and nearly 50% are in the top 20%.

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

Signed

Nerissa Vaughan
Chief Executive
24 May 2012

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

6.2 Priorities for improvement

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

The Trusts aim is to set out a clear quality improvement plan building on current local and national quality improvement initiatives to meet its patient quality and **safety** objectives and provide the safest and most **effective** care to enhance the experiences of our patients.

6.2.1 Priorities 2011/12:

Safe care

To reduce harm through the monitoring and reducing:

1. Healthcare Associated Infections (HCAIs)
2. Medication errors
3. Patients falls
4. Pressure ulcers
5. Blood transfusion errors
6. Reducing preventable hospital mortalities year on year i.e. hospital standardised mortality rates (HMSR)
7. Participating on the Regional Patient Safety Programme

Effective care

1. Complying with best practice guidance (NICE) and Central Alert Bulletins
2. Reviewing the clinical care of patients who need to return to theatre within a two week period
3. Ensuring that patients who have sustained a fractured neck of femur are operated upon within 36 hours of sustaining their injury if medically fit
4. Ensuring patients are assessed for the risk of developing Venousthromboembolisms and managing the risk appropriately
5. Undertaking nutritional assessments on patients on admission to hospital to ensure we meet their nutritional and hydration needs
6. Achieving the sentinel stoke audit indicators

Patient Experience

1. To involve patients more in decisions about their care
2. To ensure privacy when discussing treatment and care with patients
3. To improve upon the information given to patients on medication and it side effects
4. To ensure patients know who to contact after discharge if they have concerns

Regulation

1. To sustain compliance with the CQC regulations
2. To sustain NHSLA and Maternity Standards and develop longer term plans to achieve Level 3
3. To implement plans to improve results of the national staff survey
4. To sustain compliance with the Mental Health Capacity Act
5. To sustain compliance with Safeguarding Children

6.2.2 Priorities 2012/13

Our commitment to quality will continue through a number of priorities for 2012/13 which have been agreed in accordance with the views and comments from clinical staff commissioners, the Trust Governors and key external stake holders and the PSQC. Our priorities will be:

Safe Care

- Continue to reduce healthcare associated infections including MRSA and *Clostridium difficile (CQUIN)*
- Continue to reduce harm associated with patient falls
- Continue to reduce hospital and community acquired pressure ulcers
- Continue to reduce avoidable mortality, disability and chronic health through improved assessment and management of venous thromboembolism *(CQUIN)*

Effective Care

- Improve the care and management of patients through implementation of the Trust Nutrition and Hydration strategy
- Improve our Hospital Standardised Mortality Ratio (HSMR) year on year (100 or below)
- Improve the management of the deteriorating patient by full completion of the Early Warning Score

Patient Experience

- Continue to improve the quality of end of life care for patients and improve access to palliative care services (CQUIN)
- Improve care and access to services for patients with dementia *(CQUIN)*
- Improve patient satisfaction by improving upon the Trusts outcome measures within the National Patient Experience (PICKER) survey *(CQUIN)*

6.3 Statements of assurance from the Board

During 2011/12 the Great Western Hospitals NHS Foundation Trust provided and/or sub-contracted 7 NHS services.

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

The income generated by the NHS services reviewed in 2011/12 represents 100 per cent of the total income generated from the provision of NHS services by the Great Western Hospitals NHS Foundation Trust for 2011/12.

6.3.1 Review of services and participation in clinical audits and national confidential enquiries

During 2011/12 42 national clinical audits and 4 national confidential enquiries covered NHS services that Great Western Hospitals NHS Foundation Trust provides.

During 2011/12 Great Western Hospitals NHS Foundation Trust participated in 86% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Great Western Hospitals NHS Foundation Trust was eligible to participate in during 2011/12 and those that Great Western Hospitals NHS Foundation Trust participated in are as follows: -

Audit / confidential enquiry title	Eligible	Participated
Peri-and Neo-natal		
Perinatal mortality (MBRRACE-UK)	Yes	No
Neonatal intensive and special care (NNAP)	Yes	Yes
Children		
Paediatric pneumonia (British Thoracic Society)	Yes	Yes
Paediatric asthma (British Thoracic Society)	Yes	Yes
Pain management (College of Emergency Medicine)	Yes	Yes
Childhood epilepsy (RCPH National Childhood Epilepsy Audit)	Yes	Yes
Paediatric intensive care (PICANet)	No	NA
Paediatric cardiac surgery (NICOR Congenital Heart Disease Audit)	No	NA
Diabetes (RCPH National Paediatric Diabetes Audit)	Yes	Yes
Acute care		
Emergency use of oxygen (British Thoracic Society)	Yes	Yes
Adult community acquired pneumonia (British Thoracic Society)	Yes	Yes
Non invasive ventilation -adults (British Thoracic Society)	Yes	Yes
Pleural procedures (British Thoracic Society)	Yes	Yes
Cardiac arrest (National Cardiac Arrest Audit)	Yes	No
Severe sepsis & septic shock (College of Emergency Medicine)	Yes	No
Adult critical care (ICNARC CMPD)	Yes	Yes
Potential donor audit (NHS Blood & Transplant)	Yes	Yes
Seizure management (National Audit of Seizure Management)	Yes	No
Long term conditions		
Diabetes (National Adult Diabetes Audit)	Yes	No
Heavy menstrual bleeding (RCOG National Audit of HMB)	Yes	Yes
Chronic pain (National Pain Audit)	Yes	Yes
Ulcerative colitis & Crohn's disease (UK IBD Audit)	Yes	Yes
Parkinson's disease (National Parkinson's Audit)	Yes	Yes
Adult asthma (British Thoracic Society)	Yes	Yes
Bronchiectasis (British Thoracic Society)	Yes	No

Audit / confidential enquiry title	Eligible	Participated
Elective procedures		
Hip, knee and ankle replacements (National Joint Registry)	Yes	Yes
Elective surgery (National PROMs Programme)	Yes	Yes
Intra-thoracic transplantation (NHSBT UK Transplant Registry)	No	NA
Liver transplantation (NHSBT UK Transplant Registry)	No	NA
Coronary angioplasty (NICOR Adult cardiac interventions audit)	Yes	Yes
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	Yes	Yes
Carotid interventions (Carotid Intervention Audit)	Yes	Yes
CABG and valvular surgery (Adult cardiac surgery audit)	No	NA
Cardiovascular disease		
Acute Myocardial Infarction & other ACS (MINAP)	Yes	Yes
Heart failure (Heart Failure Audit)	Yes	Yes
Acute stroke (SINAP)	Yes	Yes
Cardiac arrhythmia (Cardiac Rhythm Management Audit)	Yes	Yes
Renal disease *		
Renal replacement therapy (Renal Registry)	No	NA
Renal transplantation (NHSBT UK Transplant Registry)	No	NA
Cancer		
Lung cancer (National Lung Cancer Audit)	Yes	Yes
Bowel cancer (National Bowel Cancer Audit Programme)	Yes	Yes
Head & neck cancer (DAHNO)*	Yes	Yes
Oesophago-gastric cancer (National O-G Cancer Audit)	Yes	Yes
Trauma		
Hip fracture (National Hip Fracture Database)	Yes	Yes
Severe trauma (Trauma Audit & Research Network)	Yes	Partly
Psychological conditions		
Prescribing in mental health services (POMH)	No	NA
Schizophrenia (National Schizophrenia Audit)	No	NA
Blood transfusion		
Bedside transfusion (National Comparative Audit of Blood Transfusion)	Yes	Yes
Medical use of blood (National Comparative Audit of Blood Transfusion)	Yes	Yes
Health promotion		
Risk factors (National Health Promotion in Hospitals Audit)	Yes	No
End of life		
Care of dying in hospital (NCDAH)	Yes	Yes
National Confidential Enquiries into Patient Outcome & Death		
Cardiac arrest	Yes	Yes

GWHFT is not currently participating in the National Cardiac Arrest Audit project; however the Trust has subscribed and made arrangements to participate in the next round of the National Audit.

The trust chose not to contribute to the repeat audit of National Health Promotion in Hospitals as the trust was compliant with the standards audited in the initial project and has other internal measures in place to monitor compliance.

In addition the trust has now signed up to participate in severe trauma (Trauma Audit & Research Network).

The Trust participated in a number of other National Audits during 2011-2012 that were considered vital in promoting the quality and effectiveness of patient care. A few of these are outlined below:

Other National Clinical Audits
National Cancer Patient Survey (as mandated by the National Cancer Reform Strategy)
College of Emergency Medicine (CEM) - Fractured Neck of Femur's (NOF) in Emergency Department
College of Emergency Medicine (CEM) - Asthma in Emergency Department
CEM - National Audit of Emergency Department Discharge Data on GP Letters
Inpatient Audit of Children with Diabetes (SWPDN)
National Mastectomy and Breast Reconstruction Audit-(4th Round-Final)
National Comparative Audit of the use of Red Cells in Neonates & Children
National Diabetes Inpatient Day Audit
Major Complications of Airway Management

The national clinical audits and national confidential enquiries that Great Western Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2011/12, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Audit Title	**Submitted/Required (%)**
Peri-and Neo-natal	
Perinatal mortality (MBRRACE-UK)	Ongoing internal review
Neonatal intensive and special care (NNAP)	100%
Children	
Paediatric pneumonia (British Thoracic Society)	Ongoing- data submission deadline- Mar 2012
Paediatric asthma (British Thoracic Society)	100%
Pain management (College of Emergency Medicine)	100%
Childhood epilepsy (RCPH National Childhood Epilepsy Audit)	100%
Diabetes (RCPH National Paediatric Diabetes Audit)	100%
Acute care	
Emergency use of oxygen (British Thoracic Society)	100%
Adult community acquired pneumonia (British Thoracic Society)	Ongoing- data submission deadline- May 2012
Non invasive ventilation -adults (British Thoracic Society)	Ongoing- data submission deadline- May 2012
Pleural procedures (British Thoracic Society)	100%
Adult critical care (ICNARC CMPD)	100%
Potential donor audit (NHS Blood & Transplant)	100%

Audit Title	Submitted/Required (%)
Long term conditions	
Heavy menstrual bleeding (RCOG National Audit of HMB)	100%
Chronic pain (National Pain Audit)	100%
Ulcerative colitis & Crohn's disease (UK IBD Audit)	100%
Parkinson's disease (National Parkinson's Audit)	100%
Adult asthma (British Thoracic Society)	100%
Elective procedures	
Hip, knee and ankle replacements (National Joint Registry)	100%
Elective surgery (National PROMs Programme)	100%
Coronary angioplasty (NICOR Adult cardiac interventions audit)	100%
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	100%
Carotid interventions (Carotid Intervention Audit)	100%
Cardiovascular disease	
Acute Myocardial Infarction & other ACS (MINAP)	100%
Heart failure (Heart Failure Audit)	100%
Acute stroke (SINAP)	100%
Cardiac arrhythmia (Cardiac Rhythm Management Audit)	100%
Cancer	
Lung cancer (National Lung Cancer Audit)	100%
Bowel cancer (National Bowel Cancer Audit Programme)	100%
Head & neck cancer (DAHNO)	100%
Oesophago-gastric cancer (National O-G Cancer Audit)	100%
Trauma	
Hip fracture (National Hip Fracture Database)	100%
Blood transfusion	
Bedside transfusion (National Comparative Audit of Blood Transfusion)	100%
Medical use of blood (National Comparative Audit of Blood Transfusion)	100%
End of life	
Care of dying in hospital (NCDAH)	100%

The reports of 21 national clinical audits were reviewed by the provider in 2011/12 and Great Western Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided: -

No.	Audit Title	Learning From The Project
1.	*National Cancer Patient Survey*	*Actions include- Focussed survey to assess service opportunities in Day therapy centre. Local survey was undertaken and the report is covered under "Local Audits".*
2.	National Audit of Dementia 2010	The Trust performed in the middle quartile. The audit demonstrated a few areas of good practice. The action plan has been incorporated into the Trust Dementia Strategy. The Trust has signed up to participate in the next round of National Audit of Dementia.
3.	National Mastectomy and Breast	The Trust performance is in the upper 25% centiles in terms of satisfaction. The time that the clinical nurse specialists take with these patients needs to be recognised for future increase in caseload. The trust must continue to provide patients with

No.	Audit Title	Learning From The Project
	Reconstruction Audit	sufficient time in their consults to discuss reconstructive issues. It is recommended that those involved in the development of future guidelines on mastectomy and breast reconstruction should refer to the results of high achieving organisations.
4.	College of Emergency Medicine (CEM) - Asthma in Emergency Department (ED)	The audit demonstrated that there is a great improvement with the performance. Areas that need to improve are recording of peak flow, better recording of discharge plans, use of proforma and promote local education and training.
5.	College of Emergency Medicine (CEM) - Fractured Neck Of Femur's in Emergency Department (ED)	The pain scores are not always recorded on NOF proforma and there are delays in analgesia, X-Rays & fast tracking admission. Improvement plan focuses on better recording/education, improvements in ED flow.
6.	College of Emergency Medicine (CEM) - Pain in Children in Emergency Department (ED)	There is improvement in pain scoring, analgesia recording & reassessment.
7.	National Pleural Procedures Audit 2010	The results reflect that 40% of chest drains with pleural effusions are being carried out by Ultrasound guidance. There is no bedside ultrasound is being carried out. High numbers of drains are being put in for undiagnosed effusions. Ultrasound machine has been purchased, local pleural effusion guidelines have been developed, pneumothorax guidelines updated. Teaching and education is done regularly. Other plans include producing a chest drain proforma.
8.	Myocardial Ischaemia National Audit Project-2010	The Trust has demonstrated high compliance with the key performance indicators. The area that needs to improve is time of transfer of patients with nSTEMI (acute coronary syndrome) to cardiac beds on admission.
9.	NCEPOD- An Age Old Problem- Elective and Emergency Surgery in the Elderly	Current practice is in line with most of the national recommendations. There are no recommendations to implement,
10.	College of Emergency Medicine CEM – National Audit of Emergency Department Discharge Data on GP Letters.	The project organisers have not provided individual hospital reports. Local actions include implementation of recommendations from the college.
11.	Data for Head and Neck – DAHNO 6th Round	The Trust is compliant with the majority of the criteria and has shown significant improvement since the last audit in intervals from referral to established diagnosis. Areas for improvement include documentation of chest imaging onto the local database.
12.	Inpatient Audit of Children with Diabetes (SWPDN)	Participation rates were low, however positive with regard to paediatric diabetes staff but critical of other health professional's knowledge. Patients and parents were happy with amount of contact with Dr, paediatric diabetes specialist nurse (PDSN) and

No.	Audit Title	Learning From The Project
		Dieticians. Patients and parents felt there was a need for psychological services to be made available (particularly at diagnosis). Over half of the Parents and patients said they visited the clinic 4+ times. Majority of patients and parents felt they had enough choice re: insulin regime. Over 80% of patients and parents felt they could contact their PDSN or Dr outside of their appointment, and this that service was valued and useful.
13.	The National Oesophago-Gastic Cancer Audit (NOGCA)	The aim of the audit is to look at the diagnosis, staging, and treatment planning process, curative treatment outcomes, palliative oncological treatment (chemotherapy / radiotherapy) and endoscopic / radiological palliative therapies. The Trust is compliant with the recommendations made by the national audit. The surgical treatment is offered in Oxford. The Trust aims to continue with the current practice and participate in the next round of the national audit.
14.	National Lung Cancer Audit (LUCADA) - 2009/10	The Trust is compliant with all the standards covered under this project in 2009/10.
15.	Consultant Sign Off – College of Emergency Medicine (CEM) Audit 2011	This audit was to review of selected patient groups by a consultant in Emergency Medicine prior to discharge from the Emergency Department (ED) or admission to hospital. The results showed that there is limited consultant availability in ED in the evenings and at night. Consultants in the department have started to cover shifts from 3pm to 7pm. There should be teaching of all ED staff to underline the importance of review of these patients prior to discharge. Results of the national audit will be taken forward by the College to look at national guidance on staffing levels in emergency departments.
16.	Major Complications of Airway Management	The project aimed at focusing on the complications of airway management in the NHS hospitals across the UK. Although the Trust did not have any eligible patients for the audit, the trust is compliant with the recommendations made by the Royal College of Anaesthetists.
17.	Carotid Interventions Audit 2010	The trust has demonstrated excellent clinical outcomes. The next steps include, a planned patient experience questionnaire from August 2011, further joint working with stroke team to streamline pathway, and improved data submission.
18.	National Diabetes Inpatient Day Audit-2010	This Audit was to assess the care received by diabetic patients. Actions include raising awareness of the Think Glucose Initiative across the whole of the trust to improve patient care.
19.	National Comparative Audit of the use of Red Cells in Neonates & Children - 2010	Participation in the National Audit reflected that the Trust is compliant with the majority of the recommendations. Action plans include drawing up new guidelines and policies for the use of red cell transfusions to all children and not just neonatal groups, promote education about safe prescribing and administration of transfusions. Re-audit with a focus on pre and post transfusions Hb levels and the recommendations around documentation and prescriptions.
20.	College of Emergency Medicine (CEM)- Paediatric Fever	There is a need for training and supervision for medical and nursing staff so that the guideline is both understood and becomes part of the normal practice of our departments. Actions include: Dissemination of the results and revision of paediatric proforma to capture all elements required on admission with fever.
21.	National Paediatric Diabetes Audit 2010	This National report is two years out of date and changes have already been made to the service. Recent data suggests that the Trust is performing equal to or above the National Average. Actions that have been completed include increase in diabetes support nurse.

The reports of 273 local clinical audits were reviewed by the provider in 2011/12 and Great Western Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

No.	Audit Title	Audit Summary/Learning and Action
1.	Antibiotic Missed Doses	The audit was aimed identify the reasons behind missed antibiotic doses and to try to see any trends or educational issues with an aim to address these issues and look at the need for a possible change in procedure or for further education. The results demonstrated partial compliance. Actions include- Antibiotic working group to promote training for staff groups. Look into possibility of adding a feature to the antibiotic newsletter. Ward stock lists to be made available on the pharmacy intranet.
2.	Image Guides Musculo-Skeletal Injection Review	The overall patient experience is good and results demonstrate patient satisfaction with information provided regarding the procedure in majority of cases. Actions include- Continue with the practice and work on improved explanations of procedure and re-survey.
3.	Surviving Sepsis	The results demonstrate that there are areas for improvement Trust wide. Actions include- Developing & implementing sepsis proforma, change in practice with first dose of antibiotic, information dissemination and education.
4.	Compliance to In-Patient Consent Policy	Audit results demonstrate that there is a high level of compliance in areas of practice i.e. stating demographics, intended benefits, risks. However lower levels of compliance can be seen in respect of consenting children compared both to consenting adults. Actions include inserting “check box” into Consent Form 1-4 to require a positive affirmation from the health professional that they are either competent to do the procedure or have undertaken procedure specific training. Raising targeted awareness amongst paediatric surgeons to improve compliance with consenting children. These actions have been implemented and the re-audit is planned in June 2012.
5.	Compliance to Out Patient Clinic Letters (10-11)	Audit results demonstrate that there are only a few areas for improvement pertaining to quality of Outpatient Clinic letters. Areas of good practice include secretaries within the directorates are now pooling the work to enable speedier transcription, voice recognition has proved really successful although cost implications if taken forward for all specialties, letters being sent ‘unsigned to hasten delivery’ to speed up the process. Actions include monthly monitoring on timeliness of clinic letter; continue work on improving timeliness of clinic letters and re- audit.
6.	Compliance with In- Patient discharge letters (10-11)	Audit results demonstrate that there are only a few areas for improvement pertaining to quality of Discharge Summaries. The area that needs to be largely improved is the time frame the discharge summary is sent to the general practitioner. Actions include appropriate changes to eDS system to allow automatic population of ‘source of admission’, colour coding to inspire timely completion, monthly monitoring on timeliness of eDS, education for junior doctors. Encourage clinical engagement within Directorates at each stage of the audit, review data collection proforma and re-audit.
7.	Stem Cell Transplant-Patient Satisfaction Survey	The survey was designed to obtain information about the patient experience of stem cell transplantation, including follow-up support. 100% of patients felt involved in decisions about their treatment and felt comfortable to ask questions. They were all able to meet the dietician prior to their transplant. There were positive responses with regard to the role of clinical nurse specialist. 50% of patients felt they would benefit

No.	Audit Title	Audit Summary/Learning and Action
		from seeing a clinical psychologist. There were some issues with cleanliness and standard of meals. Extremely positive results received for standard of care post discharge. Actions include changes to patient information leaflet to emphasise the details of support available for the relatives. A clinical psychologist is now in post. Cleaning is being monitored by the ward and fed back to Carillion.
8.	Diabetes Ketoacidosis (DKA) Management	Majority of patients are managed according to the guidelines however capillary ketone measurement to confirm diagnosis is not done well and there is lack of awareness and over reliance on urinary ketones. Actions include: To add a new sheet to the DKA protocol for nurses to check, as well as clear indication for stopping insulin infusion .To ask Emergency Department Assistants to ensure that ketones strips are always available.
9.	Re-Audit Use of Troponin Test	The re-audit illustrated a large improvement in performance. The initial audit results showed poor compliance with only 28% of test fully complying with guidelines. The guidelines were updated in order to clarify when the tests should be used. After a period of education the re-audit showed 94% of patients now fully complying with guidelines. This process has saved the trust over £4000 per year. Updated guidelines have clarified usage; this is reflected in a reduction in the number of tests ordered. Action Summary-Ward troponin education needs to be incorporated into the induction program for Acute Assessment Unit and Emergency Department.
10.	NICE Self Harm in Emergency Department	Performance is significantly short of NICE guidelines Action Summary- Dissemination of results to encourage better documentation and referral rate for this group of patients. Work with the Mental Health Service to identify what is achievable and to ensure this group of patients is receiving adequate care. Re-Audit following implementation.
11.	Laparoscopic Cholecystectomy (LC)- Patient satisfaction - Important factors to patients	The review aimed at assessing the importance of cosmesis v's other factors in gall bladder surgery.93% of patients were happy or extremely happy with the current procedure. 48% experienced some wound related issues (pain, infection) and 65% of those were at the umbilicus. Cosmesis was rated less important than other factors in gall bladder surgery. Action Summary-Given patients are generally satisfied by the current procedure, the aim is to invest in improving day case rates for LC.
12.	Obstetric Haemorrhage (Midwifery Led Unit)	This audit demonstrated good compliance with the correct management of Post Partum Haemorrhage within the setting of the midwifery led unit or if transfer to an acute unit was required, however it highlighted some areas for improvement in documentation. Actions include - All staff to be made aware of the need to: - Document discussion of events and discussion with parents of reasons for transfer and consent. Respirations and fluid balance charts should be documented where appropriate and revise audit tool.
13.	Client Identification at Hillcote	The audit demonstrated 100% compliance. Hillcote have improved greatly on recording the NHS number or any appropriate number of their photo pages. The service will aim to continue with this high level of performance.
14.	Provision of Information about Prescribed Medicines	The audit aimed to gather baseline data on patient's perceptions of the quality and quantity of information they received about medicines newly started at GWH. Majority of patients reported being given information on what medicine was prescribed, why it was prescribed and how to take it, during their hospital stay. Furthermore, the results demonstrate a very low compliance around information provided on what side effects patients

No.	Audit Title	Audit Summary/Learning and Action
		might experience and what to do in that case. A large proportion of patients did not know how long to continue new medicines for. 70% patients were satisfied or very satisfied with the surveyed aspects of information given. This represents a mis-match between what Health Care Professionals and patients believe constitutes appropriate information. Action plan includes developing a "Provisions of Medicines Policy" detailing a list of MUST and SHOULD actions for provision of information. "Patient information leaflet" must be given with all supplied medicines. Electronic discharge summaries to be standardised. Implementation of "Patient Medicines Information Helpline". Ward Pharmacists to use available opportunities to speak to patients about newly prescribed medicines and relevant information in a timely manner. Re-audit is planned when actions have been implemented.
15.	Non Invasive Ventilation (NIV)	In general, NIV is being used appropriately. The key learning is to modify NIV Nursing chart to include record of blood gases.
16.	Vaginal Birth after C- Section	The audit has demonstrated excellent performance in the implementation of recommendations for intrapartum care and antenatal records. The works needs to focus on improvement in documentation of counselling, management and planning required.
17.	The time taken by Emergency Department X-ray to complete X-ray requests made by Acute Assessment Unit (AAU)	A low number (23%) of cases had a delay in having the X-rays performed. The main reasons identified were- No nurse escort and/or Patient not ready. There are discussions planned at inter-departmental steering group and the results will be referred to AAU.
18.	Service Improvement: Chemotherapy treatment on Day Therapy Centre (DTC)	The key actions to improve service include- Promote patient information regarding avoiding same day bloods unless there is a clinical reason to do so, Poster to be produced, Proposal to separate out different chemotherapy types to streamline process and C-PORT chemotherapy capacity tool to be introduced to streamline pathway and increase efficiency to maximise DTC capacity.
19.	Prescribing of Oral Nutritional Supplements (ONS) for Adults at Three Swans Surgery.	There are identified areas for improvement around “advice given to the patients, recording of BMI’s, and documentation of treatment plan. Use of ONS has risen since 2008. Targeted work around each individual patient with recording of essential information and timely periodic review of patients to ascertain continuation of ONS.
20.	Compliance to Patient Group Directions (PGD)	Areas for improvement include amalgamation of PGD policies and agreement on training and competency for PGD’s across the merged Trusts.
21.	Audit of the Prescribing, Monitoring and Administration of Therapeutically Monitored Antibiotics	Overall, the results demonstrate improvements (of various magnitudes) in the indicators of interest relating to antibiotic level monitoring. The plans are to continue with the service and re-audit using the same methodology.
22.	Evaluation of Sedation Practice on Intensive Care Unit	Actions include analgesia and sedation protocol discussion by a multi-disciplinary working group.

No.	Audit Title	Audit Summary/Learning and Action
23.	Hip Resurfacing	This Review was undertaken following Medicines and Healthcare products Regulatory Agency (MHRA) Alert- Revision of MoM (Metal on Metal) hip replacements. The concerns involved soft tissue reactions which may be associated with unexplained hip pain. The Orthopaedic Department categorised the affected patients with plans to follow-up patients.
24.	NICE CG56 - Ordering of Scans in Paediatrics Incorporating Head Injury	Results demonstrate compliance with the NICE guidance and that there is appropriate ordering and undertaking of CT Scans.
25.	Neonatal Readmissions to the Children's Ward 0-28 Days of Age	Results reflect good communication of breastfeeding care. Actions include- Infant coordinator to continue in-house training. Use of Breastfeed observation charts to pick up ineffective feeding at an earlier stage.
26.	SALT (Speech and Language Therapy) - Service Evaluation of the interface between agencies supporting children with Autistic Spectrum Disorders (ASD).	Actions include improved sharing of information using Communication Assessment Form and better communication between the SALT Service and other multi-agencies.
27.	Venous Thromboembolism (VTE)	The results demonstrated that overall compliance was very high. Actions include possibility of using a sticker stating the VTE assessment at each ante natal admission.
28.	Induction of Labour	There was low compliance with documentation of the discussion with the mother about induction of labour in the maternal records. Actions include- Remind all midwives of the importance of discussion of prolonged pregnancy and induction of labour and giving leaflet to supplement these discussions.
29.	VTE Assessment of Screening Prophylaxis	The results reflected very high compliance with the majority of criterion.
30.	Delayed and Omitted Medicines Audit	Actions include all blank missed doses to be reported to the Ward Manager and investigated.
31.	Death Certificate Completion	Areas for improvement identified were recording of Doctor’s grade and name, training and education and guidance notes that include clarification on confirmation and certifying deaths.
32.	End of Life	Base line audit results demonstrate that the Trust performance is better that the nationally published data. Actions include- discussion of results with the Commissioners to agree a CQUIN target.
33.	Compliance with Joint Guidelines in Regard to	Overall compliance is excellent. Further actions include educating prescribers to ensure patients are switched from Intravenous to oral antibiotics.

No.	Audit Title	Audit Summary/Learning and Action
	Antibiotic Prescribing	
34.	Health Records Audit Q2 – Warminster Neighbourhood Team.	Audit demonstrates a very high compliance.
35.	Health Records Audit Q2 – Bradford on Avon, Trowbridge and Melksham Neighbourhood Team's	Audit demonstrates compliance with majority of standards. Areas for improvement include encouraging recording of name and designation of each signatory.
36.	NICE CG124 – Hip Fracture	Audit demonstrated an improvement since 2008. Actions include further teaching sessions to improve further compliance. There is ongoing monitoring of this practice to monitor compliance.
37.	Audit on Causes of Delays in Theatre Start Times	There is considerable room for improvement. This includes identification of poor risk patients in advance and receiving the patients into a dedicated holding bay.
38.	Parenthood Education with WCHS	The re-audit demonstrates high satisfaction rates.
39.	Privacy and Dignity at Hillcote	There is improvement since the previous audit in 2009/10. Further actions include checks on induction process and protocol review to promote this further.
40.	Health Records Audit – Minor Injury Unit (MIU) Health Records Audit – Wilton and Amesbury Neighbourhood teams	There are some areas for improvement including improving documentation, recording NHS numbers and ensuring that there are no spaces between entries.
41.	Omitted and Delayed Medicines Audit – Beech Omitted and Delayed Medicines Audit - Longleat	Areas for action include reporting of blank missed doses and drug availability appropriately.
42.	Privacy and Dignity Mixed Sex Accommodation	Majority of criteria was compliant. Only action was to ensure staff wear ID badges visible on their uniforms and are easily identified by patients. .

No.	Audit Title	Audit Summary/Learning and Action
	Neighbourhood Teams	
43.	Services in the Swindon Community for Children with Continuing Healthcare Needs	Excellent practice demonstrated around identifying acting upon and documenting the children's clinical need. Further work includes improved documentation of care for children with complex healthcare needs and development of local guidelines.
44.	Management of Suspected Cardiac Chest Pain in the Emergency Department	Very high compliance. Actions include changes to a few sections of the "Chest Pain Proforma".
45.	Compliance with Discharge Summaries Audit Report-Quality & Timeliness 2011-12	The re-audit showed that the Trust has demonstrated high compliance with the vast majority of the standards. ALL electronic discharge summaries currently submitted now have values for the data on: Action by GP requested / For GP info, Urgent / Routine, Medication Changed (Y/N). Finally, compliance with the timeliness of inpatient discharge summaries to be with GPs within 1 working day of discharge was 73% (Target-90%). Actions include: dissemination of results, weekly monitoring on timeliness of eDS and educating all clinicians to ensure discharge summaries include all relevant information.
46.	Compliance with Out Patient Clinic Letters-2011-12	The re-audit demonstrated that the vast majority (94%) of the patient records checked reflect a high standard of compliance. Considering that changes to the OP clinic template were implemented on 12th Jan 2012, the compliance with data on: Action by GP requested / For GP info, Urgent / Routine, Medication Changed (Y/N), is 80% (Target-98%).Furthermore, it was observed that the actions in the boxes did match the content/sense of the OP clinic letter. Even though there is some improvement with the availability of clinic letter on Medway within 2 working days, there is further improvement required to achieve compliance (% Achieved- 71%, Target-90%). Actions include: Dissemination of results, continue work on improving timeliness of clinic letters and re-evaluate the effectiveness of the mandatory boxes.
47.	Continuing Health Care (CHC) Review Process	Audit identified that, although improvements have been made, further work is required in order that all documents are completed ensuring that all areas of patient need are being met.
48.	Community Patients have an Estimated Date of Discharge (EDD) in their Care Plans (Re-Audit)	7 Neighbourhood Teams have achieved 100% compliance with EDD set and documented within 24 hours. Action includes, non-compliance NT's to benchmark against each other to improve compliance.
49.	Congenital Hypothyroidism	There is clear evidence of good documentation and institution of treatment and investigation in children born with CHD. In addition, the follow-up is also managed regularly.

No.	Audit Title	Audit Summary/Learning and Action
50.	NICE CG111 – Nocturnal Enuresis	Although the Children's Continence Service has achieved 100% compliance against the majority of the criteria, the Care Pathway needs to be revised to include the latest published NICE Guidance.
51.	Readmission Review – Unscheduled Care	The review results demonstrate that there is no evidence that suggests any gaps in delivery of care. None of the readmissions were preventable or avoidable.
52.	Readmission Review –Planned Care	The review results demonstrate that there is no evidence that suggests any gaps in delivery of care. Relevant information was provided to all of the patients on discharge. Furthermore, there is no evidence of failure to communicate between acute care and primary care. 100% of patients reviewed showed no evidence of any issues concerning community care prior to readmission. It is recommended that further audits are undertaken to raise any clinical areas of concern and to ensure appropriate financial credits with commissioners. It is also recommended that this work links in with the ongoing Surgical Site Infection (SSI) audit work to identify and potential areas of concern regarding infection rates.

6.3.2 Participation in Clinical Research

The number of patients receiving NHS services provided or sub-contracted by Great Western Hospitals NHS Foundation Trust that were recruited during that period to participate in research approved by a research ethics committee was 793.

6.3.3 Use of the CQUIN Framework

A proportion of Great Western Hospitals NHS Foundation Trust income in 2011/12 was conditional upon achieving quality improvement and innovation goals agreed between Great Western Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2011/12 and for the following 12 month period are available online at:
http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275

6.3.4 Registration with Care Quality Commission and periodic / special reviews

Great Western Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions. Great Western Hospitals NHS Foundation Trust has the following conditions on registration - none.

The Care Quality Commission has not taken enforcement action against Great Western Hospitals NHS Foundation Trust during 2011/12.

Great Western Hospitals NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2011/12: -

1. Great Western Hospital 12th April 2011 (Privacy and Dignity focus)
2. Warminster Hospital 20th May 2011 (Longleat Ward pre merger)
3. Trowbridge 29th June 2011 (Minor Injuries Unit and Birthing Centre)
4. Great Western Hospital 12th & 13th July 2011 (Full review)
5. Savernake 19th October 2011 (Ailsbury Ward)
6. Chippenham 8th November 2011 (Beech now Mulberry Ward)
7. Great Western Hospital 12th December 2011 (Theatres specialist review)
8. Great Western Hospital 12th December 2011 (Privacy and Dignity follow up)
9. Great Western Hospital 8th February 2012 (IR(ME)R Radiology specialist review-announced inspection)
10. Great Western Hospital 21st March 2012 (Termination of Pregnancy)

Great Western Hospitals NHS Foundation Trust intends to take the following action to address the conclusions or requirements reported by the Care Quality Commission – comply with specific and measurable actions plans developed after each inspection to address any issues raised in the inspection reports. In all cases internal assurance that all actions have been met will be sought and internal CQC compliance monitoring processes are in place.

Great Western Hospitals NHS Foundation Trust has made the following progress by 31 March 2012 in taking such action – none.

6.3.5 Quality Data

Great Western Hospitals NHS Foundation Trust submitted records during 2011/12 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patient's valid NHS Number was: 99.5% for admitted patient care; 99.8% for outpatient care; and 92.2% for accident and emergency care. The lower performance in accident and emergency care is attributed to the completeness of this data item at the minor injury units in Wiltshire and the Trust data quality group is working on improving this.

- which included the patient's valid General Practitioner Registration Code was 99.6% for admitted patient care; 99.5% for outpatient care; and 100% for accident and emergency care.

Great Western Hospitals NHS Foundation Trust Information Governance Assessment Report overall score for 2011/12 was 77% and was graded satisfactory / green.

Great Western Hospitals NHS Foundation Trust will be taking the following actions to improve data quality:

- The Trust Data Quality Group will continue to manage and monitor a work programme that targets identified areas of poor data quality and progress will be reported to the Trust's Information Governance Steering Group
- The actions from internal and external audits and benchmark reports associated with data quality will be acted on and monitored by the Trust Data Quality Group
- Development of refresher training programmes for staff involved in data collection and data entry will continue

Great Western Hospitals NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission. The summary results of the audit were

Auditor	Primary Diagnosis	Secondary Diagnosis	Primary Procedure	Secondary Procedure
PbR Audit Commission	91.5%	91.0%	91.1%	94.7%

These results achieved level 2 in the Information Governance Toolkit. The audit identified areas for improvement and these have been included in an action plan that will be implemented in the course of the year.

The Trust continues to work towards developing compliance with the pseudonymisation initiative and has re-audited patient identifiable data flows from key departments. The audit serves both to log the flows and to audit their compliance with pseudonymisation and data protection rules. This work will maintain its level of focus as changes to data flows are requested by Clinical Care Commissioning Groups as they become established as Commissioners.

Information governance

Information is a key asset, both in terms of the clinical management of individual patients and the management of services and resources throughout the Trust. It is therefore of utmost importance that appropriate policies, procedures and management accountability provide a robust governance framework for the efficient management of information. There is corporate leadership of information governance, the Finance Director having overall responsibility. The Information Governance Steering Group oversees information governance issues, with responsibilities delegated from the Audit, Risk & Assurance Committee on behalf of the Trust Board.

The Information Governance Management Framework is documented within the Information Governance Strategy and Policy. The four key principles are openness, information quality, information security and legal compliance. Confidentiality, security, and data quality play an important role in the safeguarding of information within the Trust. This includes organisational and staff information as well as patient information. The Trust has agreements for the sharing of patient information with healthcare organisations and other agencies in a controlled manner, which ensures the patients' and public interests are upheld. It is essential for the delivery of the highest quality health care that accurate, timely and relevant information is recorded and maintained. As such it is the responsibility of all staff to promote data quality and confidentiality.

The Trust's Information Governance Steering Group undertakes an Information Governance Work Programme covering the full range of information governance elements, and ensures that appropriate policies and management arrangements are in place. The Data Quality Group, which reports to the

Steering Group, provides a quarterly data quality and completeness report, including the results of data accuracy tests. The Data Quality Group also undertakes a Data Quality Work Programme, which includes data quality reporting, training and awareness, clinical coding, and policies and procedures. These corporate and operational arrangements ensure that information governance and data quality are prioritised at all levels of the Trust.

Each year the Trust completes a comprehensive self-assessment of its information governance arrangements by means of the NHS Information Governance Toolkit. The main Toolkit headings are:

- Information Governance Management
- Confidentiality and Data Protection Assurance
- Information Security Assurance
- Clinical Information Assurance – Health Records and Information Quality
- Secondary Use Assurance
- Corporate Information Assurance – Records Management and Freedom of Information.

These assessments and the information governance measures themselves are regularly validated through independent internal audit. The Trust's Information Governance Assessment Report overall score for 2011/12 was 77% and was graded Green/Satisfactory, with a satisfactory rating in every heading of the Information Governance Toolkit.

6.3.6 Explanatory Note for clinical Coding

The Clinical Coding Audit carried out by the Audit Commission takes a sample of 100 patients from a selected specialty, in this years audit Trauma and Orthopaedics, as well as 100 patients randomly selected across all specialties. The samples are therefore small and the results of the audit should not be extrapolated further than the actual sample audited.

Part 3 - Other Information

6.4 Overview of the quality of care offered 2011/12

Safe Care

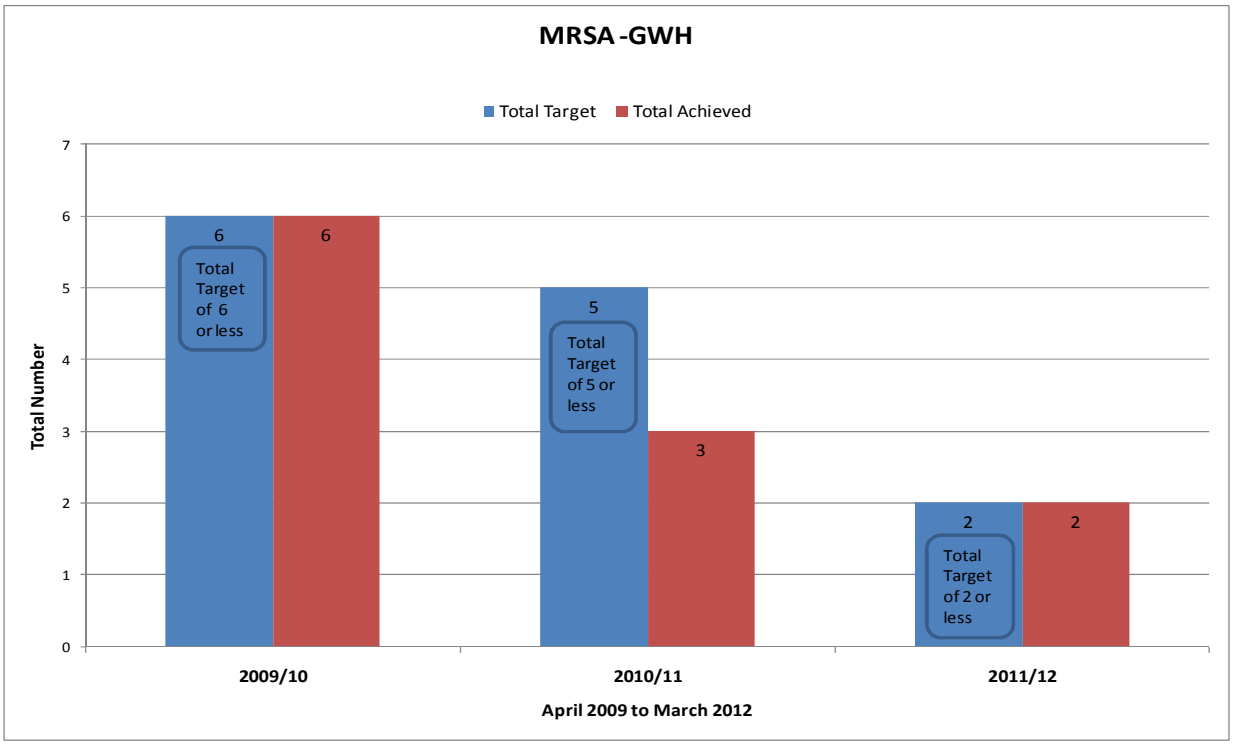
Priority 1: To reduce our numbers of Healthcare Associated Infections

MRSA: The goal to reduce the number for 2011/12 was achieved with only two cases reported as Trust attributed. No cases of MRSA bacteraemia (MSRAB) were reported within WCHS following its merger with GWH on 1st June 2012.

Local initiatives to ensure MRSA infection remain minimal have included:

- Sustained improvement with care bundles for peripheral lines and urinary catheters
- Ensuring admission risk assessments are completed on all patients and acted upon
- Daily monitoring of MRSA admission screening of elective and emergency patients
- Development of a core training programmes for nurses, doctors and pharmacists which has included key information on antibiotic prescribing
- Improving care for diabetic patients in Swindon thus helping to reduce the complications that are often associated in MRSABs

GRAPH – MRSA – GWH

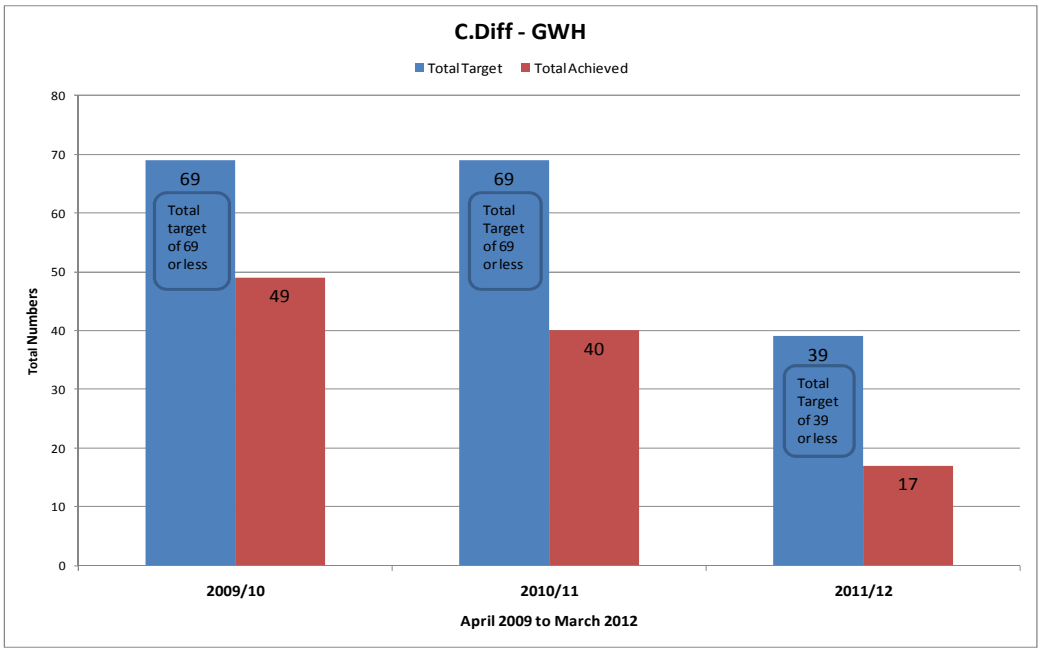


Clostridium Difficile: The goal for 2011/12 was to report no more than 39 Acute Trust apportioned cases and no more than 30 WCHS apportioned cases. We reported 17 GWH *Clostridium difficile* infections within GWH and two within WCHS

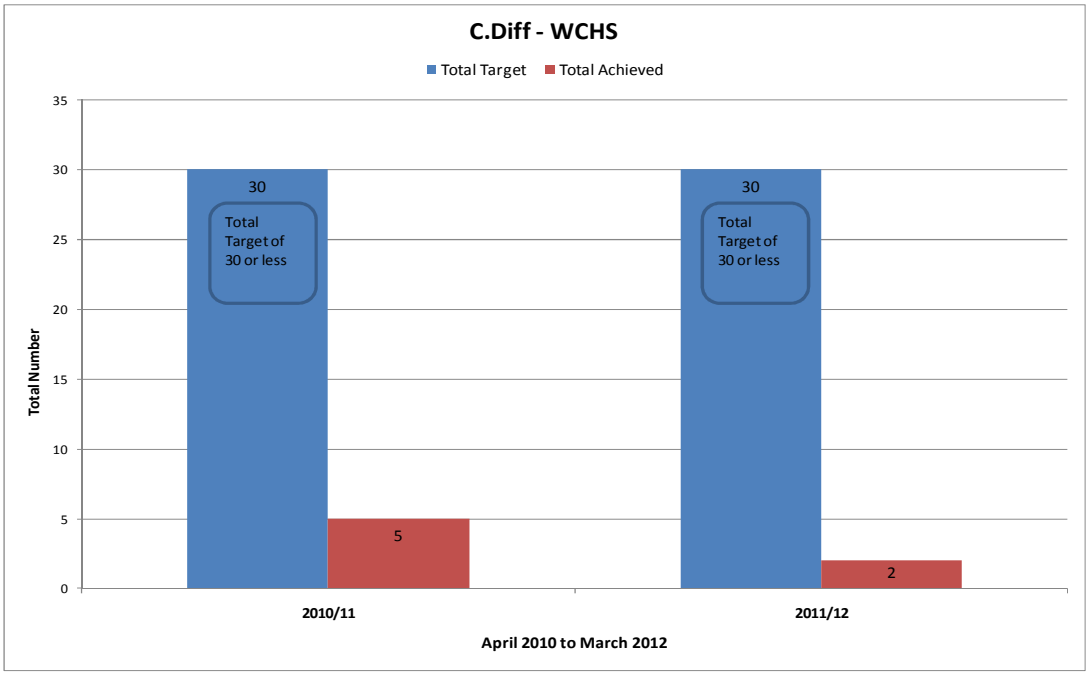
Local initiatives to ensure we continue to reduce these infections have included:

- Promotion of prompt isolation of patients with suspected infective diarrhoea
- Rapid testing of suspected norovirus (GWH only), which allows early identification of norovirus outbreaks and aids prompt management of outbreaks of diarrhoea
- Inclusion of a gastroenterologist and dietician to the weekly ward round for patients with *Clostridium difficile* infections
- Review and harmonisation of GWH and WCHS *Clostridium difficile* policy
- Increased surveillance and investigation of inpatients with a history of *Clostridium difficile*

GRAPH - Clostridium Difficile GWH 2009/10 – 2011/12



GRAPH - Clostridium Difficile WCHS2011/11 – 2011/12



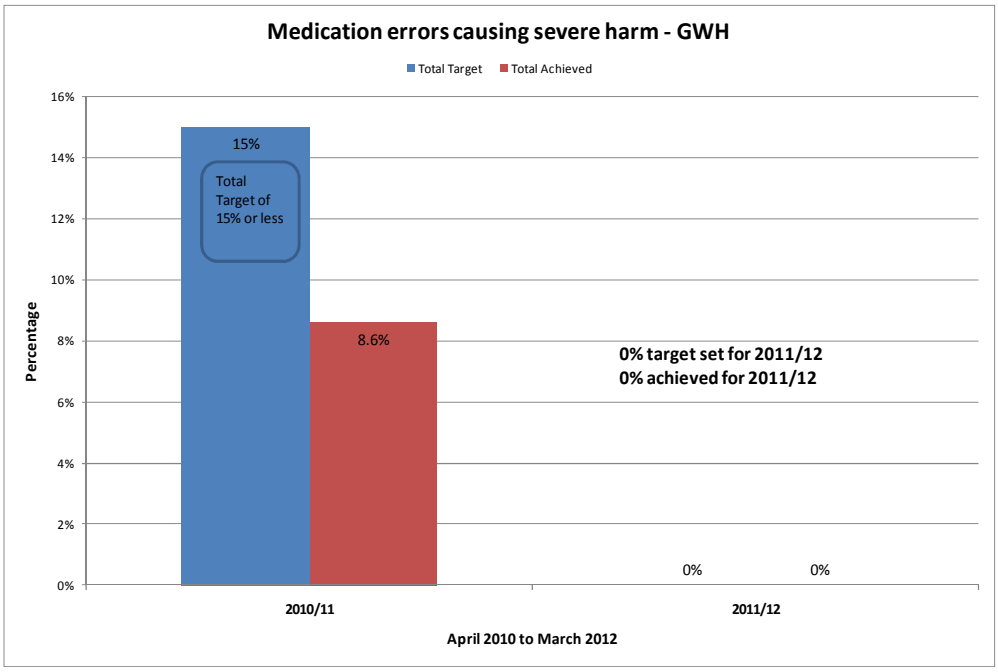
In January 2012's volume of the Journal of Hospital Infection, an article was published by the *Clostridium difficile* ward round team from GWH. The ward round is attended by a Consultant Microbiologist, Antibiotic Pharmacist or Technician, an Infection Prevention and Control Nurse, a Consultant Gastroenterologist and a Dietician. The article concluded that the *Clostridium difficile* ward rounds have helped improve patient care by enabling expertise in management to be brought to the patient. Audit results show that despite the fact that a *Clostridium difficile* protocol was in place, additional interventions were made during the majority of team visits, which further improved the quality of patient care and also provided educational opportunities for ward staff.

Priority 2: To reduce harm associated with medication errors

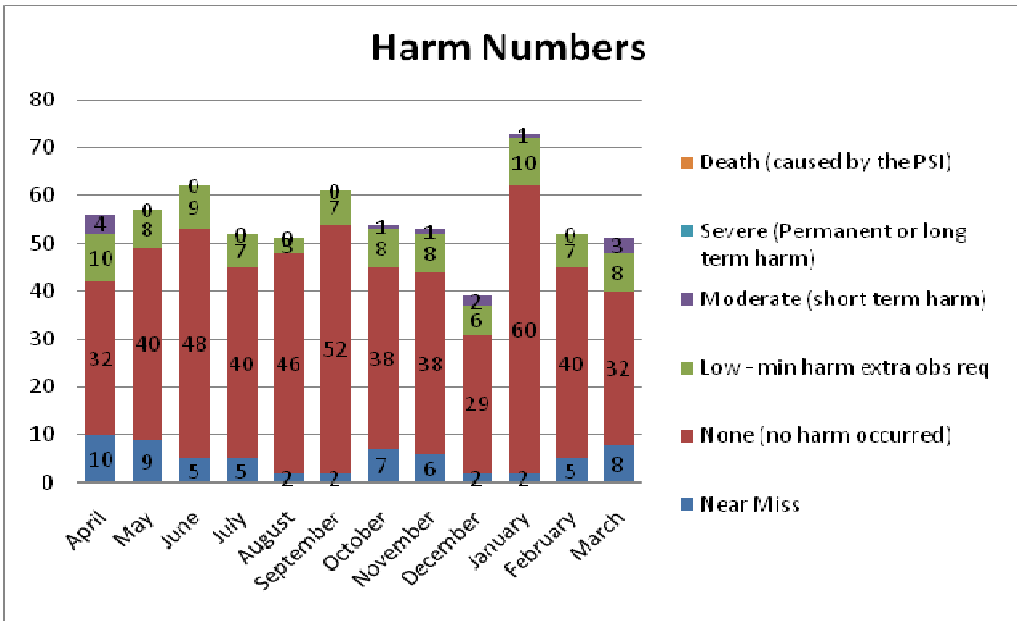
Medication errors - In 2011/12 there were a total of 661 medicine related incidents. Of these 12 (1.8%) were classified as causing moderate harm. No medicines incidents caused severe harm or worse.

The number of reported incidents has increased from 514 in the previous year. This is a positive indication of increased reporting and also reflects the assimilation of the Wiltshire Community Unit incident reporting system.

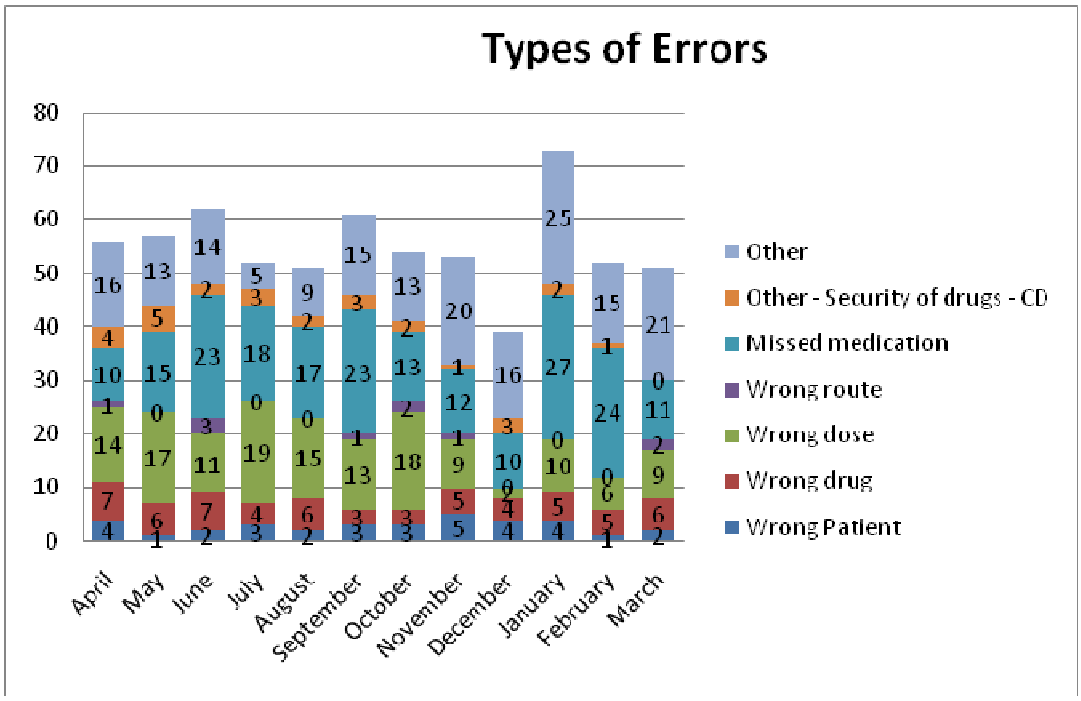
GRAPH – Medication errors causing severe harm GWH2010/11 - 2011/12



GRAPH - Medicine incidents by harm 2011/12



GRAPH - Medicine incidents by type 2011/12



Medicine incident trends and types are reviewed as part of the work program of the Medicines Governance Group. The main incident type is missed doses, and this reflects the increased awareness around this issue. The number of missed doses is audited on a regular basis and there are workplans in place for several areas.

All medicine related incidents were seen and reviewed by a Medicines Governance Pharmacist and assessed for severity and further investigated when necessary. Trends and reoccurring incidents were discussed at the Medicines Governance Group. This group was significantly changed in 2011/12. The membership was extended to include Wiltshire Community representation and also to widen the membership to all directorates and to include both senior and junior medical staff. The Medicines Governance Group also added membership from the training department to ensure safety messages were integrated as part of Trust training.

During the year, the Pharmacy Medicines Governance Team produced a series of medicines safety bulletins to highlight particular issues within the Trust. Training was provided at induction to nursing and medical staff and this was modified to include learning from recent incidents and near misses.

Further information about medicines management, notably the areas listed below, is included in the Trust's Quality Account: -

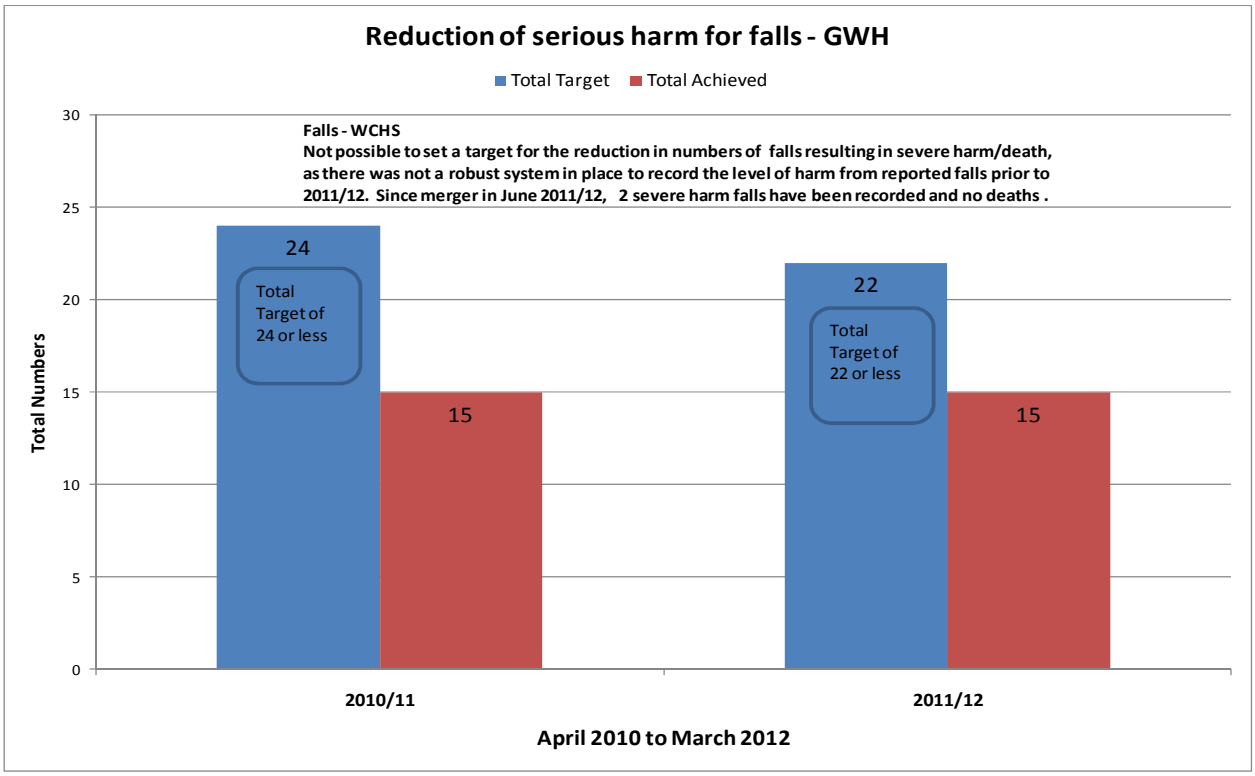
- Regional Quality Improvement Programme
- Medicines security audits
- Medical Gas Cylinder Management
- Discharge information and improved patient medicine information.
- Patient's own medicine 'Green Bag'
- Pharmacy Robot
- Pharmacy Training
- Clinical Pharmacy Services and Key Performance Indicators
- Amalgamation with Wiltshire Community Health Service Units

Priority 3: To reduce harm associated with patient falls

Harm from falls GWH: This year the Trust has focused on a 10% reduction in severe harm and death from falls in the acute setting, as categorised by the NPSA (National Patient Safety Agency) guidance. The figures indicate that the Trust's performance exceeded the target by 32% for the year.

The acute Trust has an implementation programme for rolling out a new falls care bundle to all adult wards by April 2012, supported by a training workbook. The care bundle named by the Trust as "SAFE" (Stratification and Avoidance of Falls in the Environment) is in line with the latest evidence based guidance on falls prevention in hospitals, as produced by the Royal College of Physicians in 2011. As part of the implementation programme there is a monitoring tool developed by April 2012 to audit compliance of the falls care bundle across the Trust. The focus going forward in 2012/13 will be to facilitate the acute wards to effectively implement this new care bundle, working towards 95% or greater compliance by November 2012. This aims to ensure we are providing the best possible standards of care for patient at risk of falls.

GRAPH – Reduction of serious harm from falls GWH



Harm from falls WCHS: It was not possible to set a target for the reduction in numbers falls resulting in severe harm and death, as there was not a robust system in place to record the level of harm from reported falls prior to 2011/12. Since Wiltshire community services merged with GWH in June 2011, there have been two recorded severe harm incidents across the four community wards. There has not been any death directly caused by falls in the same period of time.

The previous Community Falls Policy has been updated; it now shares much of its contents with the revised acute falls policy, this is prior to the proposed full integration of both the community and acute polices later this year. **Across the community hospital wards, the SAFE care bundle is being introduced.**

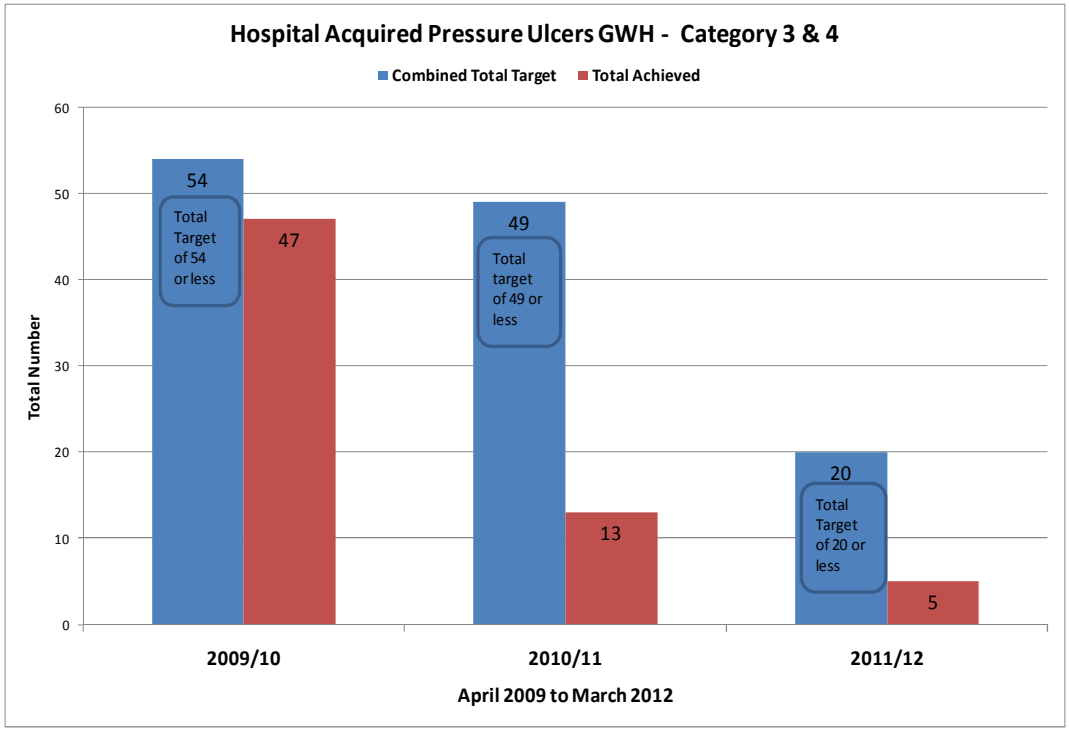
Priority 4: To reduce healthcare acquired pressure ulcers

Pressure ulcers GWH: The combined target of both Category 3 and Category 4 hospital acquired pressure ulcers was 20 or less. The actual total number reported during 2011/12 was 5 (Grade 4 = 1; Grade 3 = 4).

Comparing the total numbers for 2010/11 Category 4 and Category 3 hospital acquired pressure ulcers (13) with 2011/12 figures we have a 61.5% reduction on the previous year's total number.

Our greatest improvement is on the actual total numbers of pressure ulcers that have developed year on year. This year our strongest achievement has been in the reduction of Category 4s.

GRAPH – Hospital Acquired Pressure Ulcers GWH – Category 3 and 4



Pressure ulcers are key quality care indicators within the Essence of Care patient-focused framework for clinical effectiveness and are included in the South West Key driver programme. Further information about pressure ulcers, including planned reductions, assessment tools, support, training and equipment can be found in the Trust's Quality Account 2011/12.

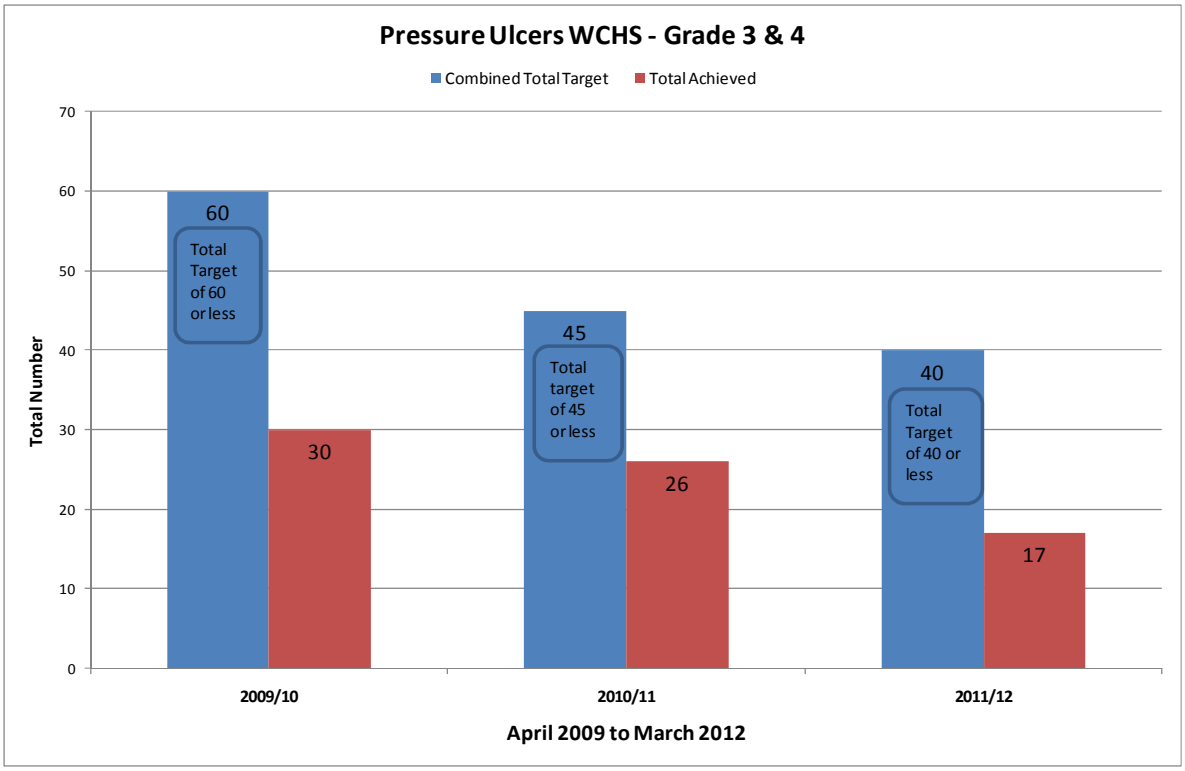
Pressure ulcers Community: The community Tissue Viability Team has a monthly reporting mechanism in which all patients who develop a pressure ulcer, while in the care of the community nursing team, are reported, using a paper based audit tool to the tissue viability office. There has been 100% reporting for the last 12 months.

The data is formatted into a quarterly report which is then distributed to all of the Neighbourhood team Co-ordinators and has been presented at the Quality Meetings with managers and commissioners.

The pressure ulcer risk assessment tool used within community teams is the Pressure Ulcer Risk Assessment Tool (PURAT) and has been used successfully for five years and has won a national award for innovation. The pressure ulcers are put into Categories in accordance with the 2009 European Pressure Ulcer Advisory Panel which advises NICE and the Department of Health.

The target combined number of category 3 and 4 pressure ulcers is 40 and the number developed is 23. This is 17 below target (57%).

GRAPH – Hospital Acquired Pressure Ulcers WCHS – Category 3 and 4



The reduction in pressure ulcers has been achieved through some of the following initiatives:

- Provision of pressure relieving alternating air mattresses to high risk community patients within 4 hours of referral
- Community in-patient units use the white board and handover sheets for every shift to highlight patients at high risk. There has been one category IV pressure ulcer developed on the community hospital ward in the last 12 months
- The tissue viability team respond to referral regarding a patient with a category 3 or 4 within one working day

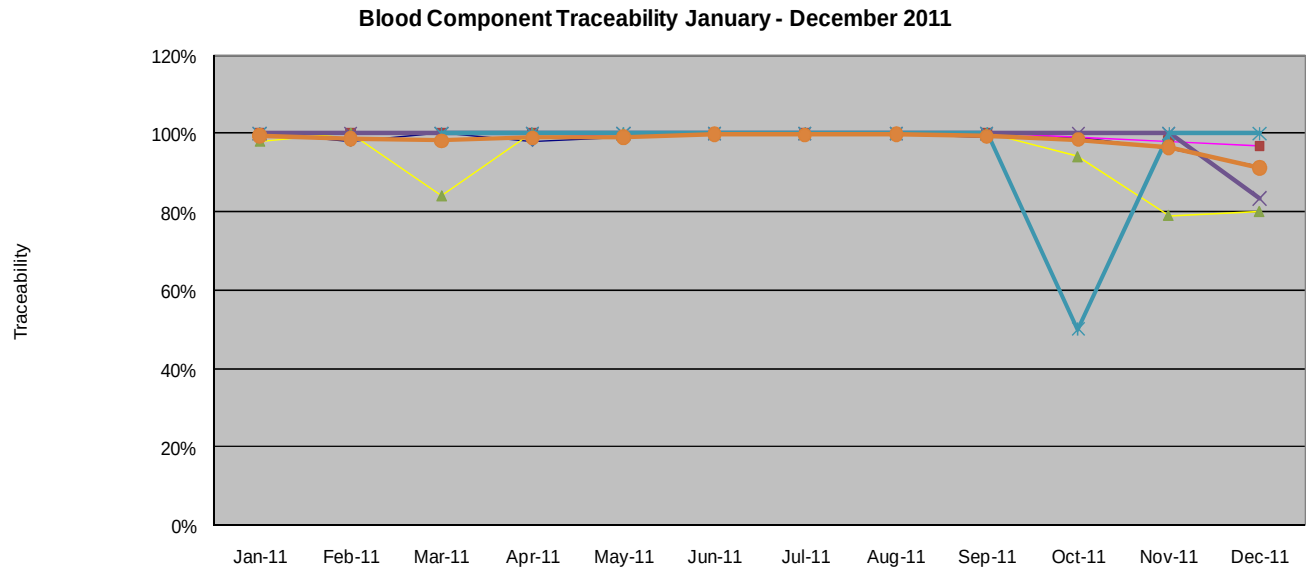
- Rolling educational programme with community staff to which all staff attend
- Developed link nurse group (33% of qualified nurses within each team) who have regular pressure ulcer educational updates and training with equipment
- Development of the RCA's investigation form in line with the NPSA Investigation report to identify any patient focused learning outcomes
- Completion of RCA's for every Category 3 and 4 pressure ulcer with regular feedback given to the NT's at all staffing levels and the Community Operations meeting. This feedback is patient focused and informs the educational program
- Educational program with social service and agency staff working with patients within Wiltshire community to ensure that all new and existing staff can recognise and respond appropriately to their client group who are at risk of developing pressure ulcer and the early signs of pressure damage

Priority 5: To Provide Safe Blood Transfusions

Safe Blood Transfusions - During 2011/12 there have been no 'wrong blood to wrong patient' incidents within the Great Western Hospital, Savernake, Chippenham and Warminster Community Hospitals.

Under the Blood Safety and Quality Regulations 2005 there is a legislative requirement for all blood and blood components to be fully traceable from donor to recipient. The Great Western Hospital uses the Blood Audit and Release System (BARS) which is an electronic blood tracking system. We are also responsible for the traceability of blood components at SwICC, Prospect Hospice and Savernake Hospital. For these areas we use a paper system. Blood component traceability is constantly monitored on a monthly basis and has on average been running at 98.2%. Chippenham and Warminster community hospitals and the Princess Anne Wing have their blood provided by the Royal United Hospital, Bath which is responsible for the traceability.

CHART - Blood Component Traceability Jan 2011 – Dec 2011



	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11
RBC	100%	98%	100%	98%	99%	100%	100%	100%	99.08%	99.00%	96.00%	91%
Platelets	100%	100%	100%	100%	99%	100%	100%	100%	100.00%	99.00%	98.00%	97%
FFP	98%	100%	84%	100%	100%	100%	100%	100%	100.00%	94.00%	79.00%	80%
Cryo	100%	100%	100%	100%	100%	100%	100%	100%	100.00%	100.00%	100.00%	83%
Octaplas	100%		100%	100%	100%	100%	100%	100%	100.00%	50.00%	100.00%	100.00%
Overall Percentage	99.44%	98.65%	98.15%	98.86%	98.95%	99.75%	99.62%	99.74%	99.21%	98.35%	96.46%	91.21%

Safe care of the patient receiving blood component transfusions has been regularly monitored via audit of transfusion observations. Minimum monitoring of the patient should include temperature, pulse, blood pressure and respiration rate. These should be recorded no more than 60 minutes prior to commencing the unit, 15 minutes into the unit (this includes observations undertaken within a 5 minute window either side of the 15 minutes) and no more than 60 minutes after completion of the unit. This is stipulated within the Trust's transfusion guidelines and will be monitored via audit at least once a year.

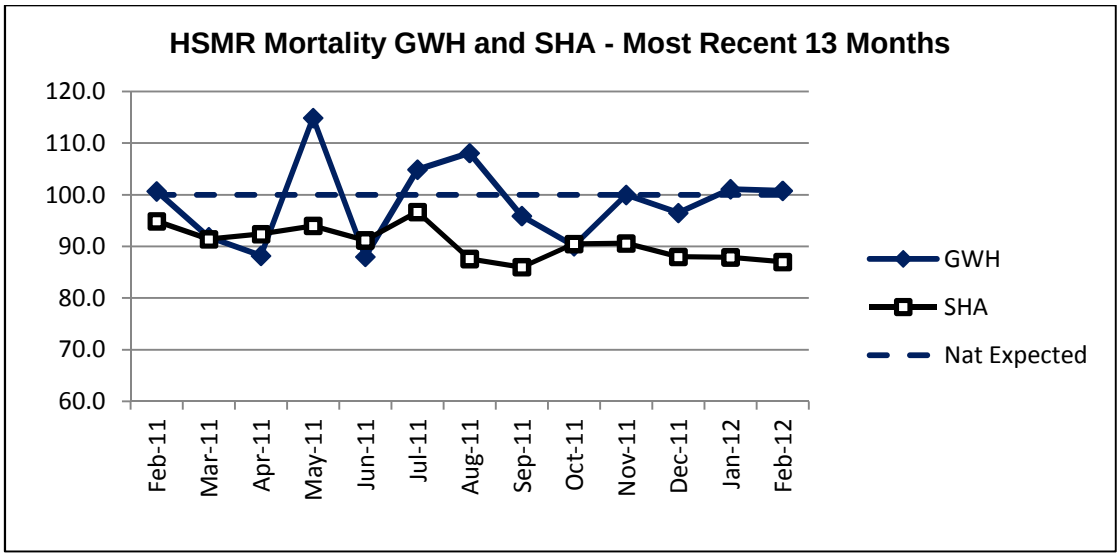
The National Patient Safety Agency (NPSA) competency based training for blood administration and venepuncture continues. The Trust is working towards achieving the set target of 100% for all staff involved in transfusion. However this is a very fluid process due to staff leaving and joining the organisation, maternity leave, long term sick leave etc. Staff who do not have a current relevant competency can no longer perform the procedure. Work is ongoing to monitor transfusion related competencies. A clear process of action was approved utilising the Matrons actively in policing and managing staff competencies. A 'transfusion breech form' is generated whenever blood is administered by someone who, according to our records, does not have the relevant competency. The number of breaches is falling month on month which shows that we are making good progress.

Priority 6: To Reduce Preventable Hospital Mortalities

Hospital Standardised Mortality Rate - The Trust has maintained an aggregate 98.7 Hospital Standardised Mortality Rate (HSMR) below (better than) 100 for the year to date (April – February).

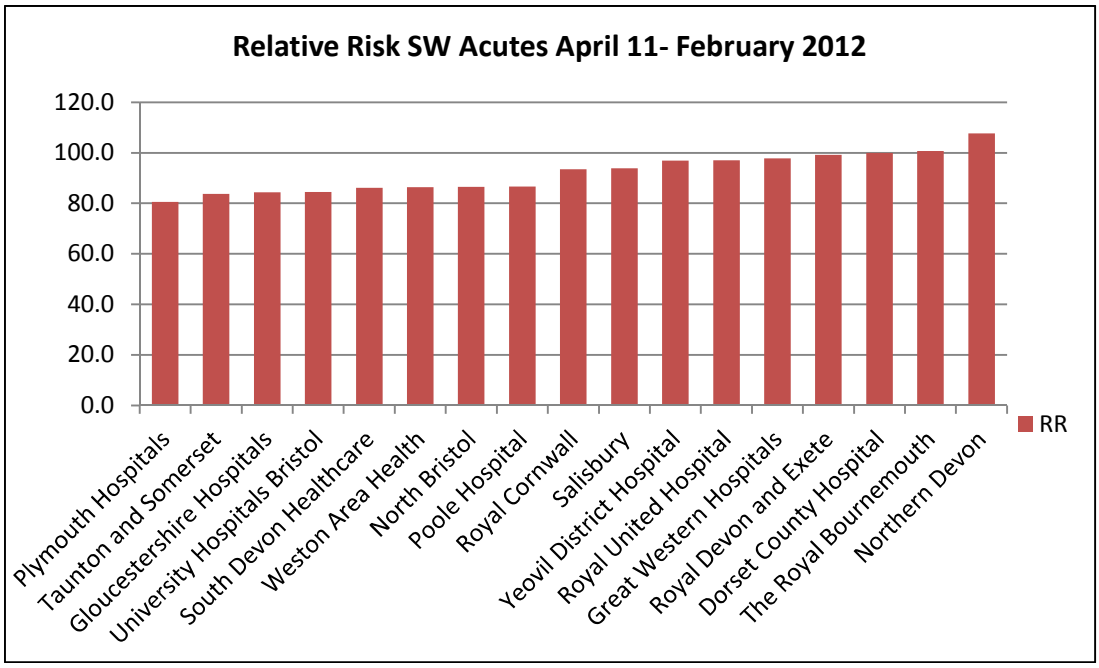
The graph below shows how the Trust is performing when compared to the average for the South West SHA and against the national expected level of 100. It can be seen that over the last 13 months the Trust's trend has broadly followed that of the SHA average although at a higher level with some peaks.

CHART – Hospital Standardised Mortality Rate GWH and SHA most recent 13 months



The graph below shows in more detail how the Trust compares against the other Acute Trusts in the SHA for HSMR relative risk for the current year. It can be seen that performance is generally good in the SHA.

CHART - Relative risk SW Acute Trusts April 2011 – February 2012



The Trust has an established Trust Mortality Group that meets on a monthly basis and includes clinician representation from each Clinical Directorate as well as representatives from Quality, Clinical Audit, Risk, Informatics and Clinical Coding. The work of this group includes monthly reports on mortality produced by the information department and centred on Dr Foster tools. Red bell alerts from Dr Foster are investigated with review of coding and clinical care. CUSUM reports also produced by Dr Foster are being used to identify areas for proactive investigation where mortality appears to be increasing prior to a red bell alert. This tool has also been introduced to monitor areas which have previously alerted to give assurance that improved performance is maintained. Audits have been presented back to the Patient Safety and Quality Committee. Action plans arising from these audits which have the potential to improve patient care, reduce the risk of preventable deaths.

Further information is contained in the Quality Account 2011/12.

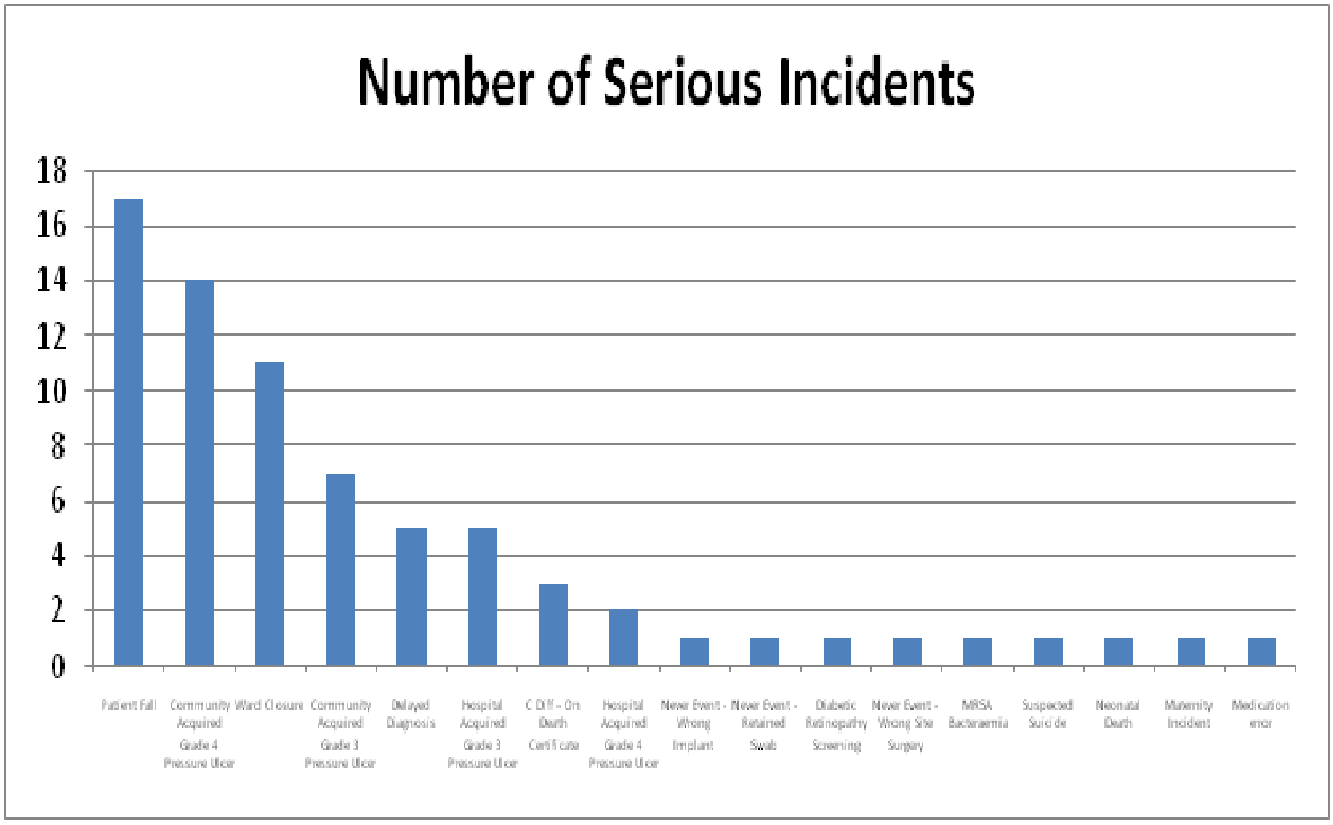
Clinical Incidents – Never Events, Serious Incidents and Incidents

Never Events: A total of three never events have been recorded in the Trust between April 2011 to March 2012. All three were surrounding surgery;

1. Wrong site surgery
2. Wrong implant/prosthesis
3. Retained foreign object post-operation

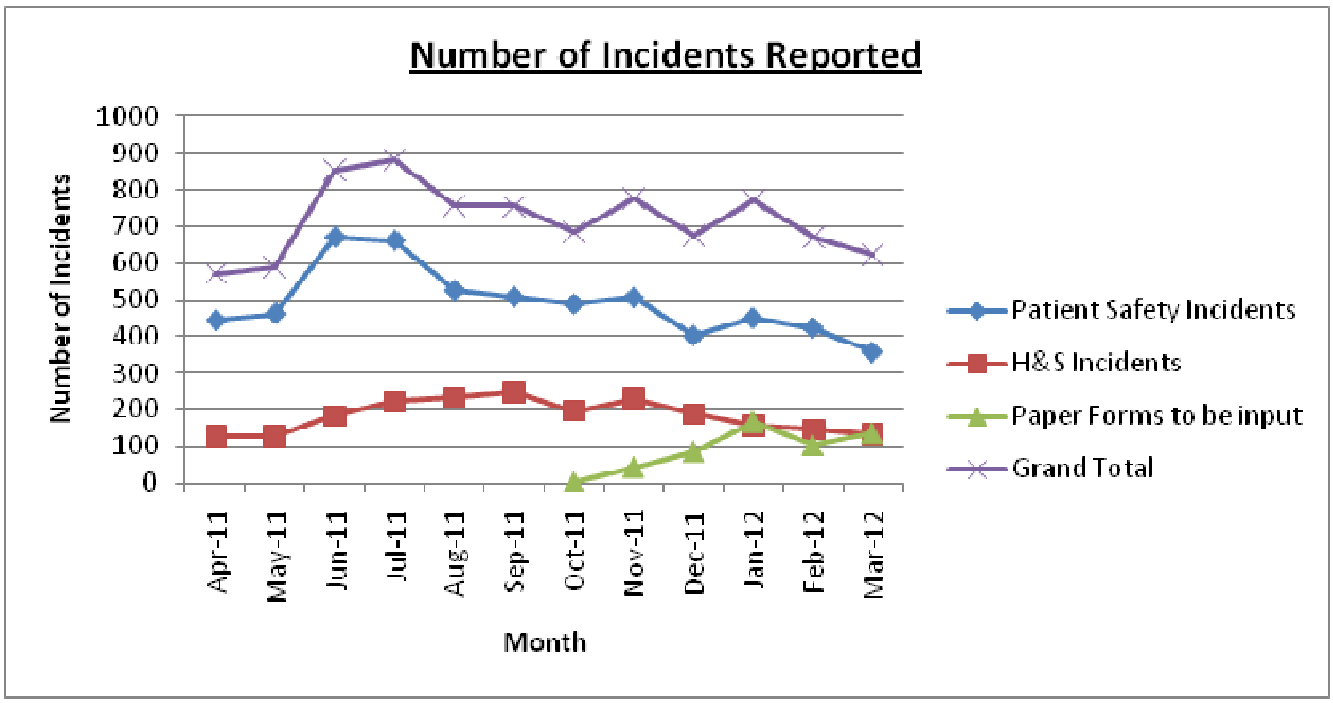
Serious Incidents: All serious incidents are investigated to identify the care and service delivery problems which contributed to the root cause of the incident. These are addressed in an action plan which is then communicated within Directorate meetings and reports across the Trust to ensure learning is shared. 71 serious incidents were reported and investigated across the merged Trust during the period April 2011 to March 2012. This was a decrease from the previous year April 2010 to March 2011 of 100 (44 GWH and 56 WCHS incidents added to quantify the figures). The graph below demonstrates the number of Serious Incidents grouped by type of incident.

CHART - Serious Incidents grouped by type of incident



Incidents: The Clinical Risk Team was responsible for managing 84% of incidents which occurred at the Trust over the last year. The Health and Safety Team investigate the non-clinical incidents. The graph below demonstrates the numbers of incidents reported.

GRAPH - numbers of incidents reported



Following the Trust's merge in June, the community arm of GWH is still reporting a large quantity of their incidents on paper incident reporting forms which are subsequently input to the GWH electronic system. Whilst all incidents reported in this manner are reviewed and reported within accepted timescales, there is currently a three month backlog of inputting the data from these forms which is reflected in the graph above. There is an ongoing community rollout of access, and training to the GWH electronic reporting system. Wiltshire community users will be integrated onto the GWH incident reporting system by September 2012.

TABLE - Top five clinical incident causes 2011-2012

Incident Cause	Grand Total
Fall - Found On Floor	933
Pressure Ulcer	607
Fall - Slip Or Trip	418
Equipment/Device - Contamination	258
Med Error - Missed Medication	226

Note - *Equipment/Device – Contamination* relates to damaged packaging on sterile equipment stored for use. These are mainly '*near miss'* incidents where the damaged packaging was found on routine checks and alternative sets supplied for use.

Patient Falls and Pressure Ulcers are included in the ***South West SHA Patient Safety and Quality Improvement Programme,*** which the Trust is currently participating in order to embed processes focussed on reducing harm from these events.

Last year it was reported that there had been an increase in documentation errors but this trend does not appear to have continued in 2011/12. The previous rise may have been due to the increase in total reporting figures; the NPSA agree that organisations reporting more incidents generally have a better and more effective safety culture. In the most recent *NPSA Organisation Patient Safety Incident Report*, the GWH was in the highest 25% of reporters. Timeliness of reporting is also an indication that the organisation is able to identify and act efficiently on incidents. The NPSA Report from April to September 2011 recognised the Trust continued to submit 50% of incidents fewer than 20 days after the incident occurred, ahead of the average of fifty percent of all incidents submitted more than 36 days after the incident occurred.

The volume of reporting within the Trust has continued to increase year on year:

- 3759 reported during 2009/10
- 4613 reported during 2010/11
- 5547 reported during 2011/12* *this includes the merged organisation from June 2011.

The NPSA Organisation Patient Safety Incident Report demonstrates that our rate of moderate harm, severe harm and incidents resulting in death is over 50% lower than that of comparable trusts.

The three top serious incident causes and their report recommendations are;

- Patient Falls
    - Variance on audit compliance - Falls risk assessment and SAFE tool. Monthly audits undertaken to monitor compliance;
    - Reinforcement of the importance of implementing care plans following identification of at risk patients;
    - Improving and cascading information to all members of the Multidisciplinary team
- Community acquired grade 4 pressure ulcer
    - Immobile patients to receive multi-disciplinary care planning;
    - Regular review of nutritional status;
    - Improve recognition, and subsequent referral when patients current pain-relief regime is not sufficient;
    - Patients identified as being at risk of or who have pressure ulcers will have core care plans that are implemented and regularly evaluated;
    - Monitoring accuracy of assessments; additional training identified and accessed
- Ward Closure
    - Improve staff awareness of procedure and policy surrounding isolation, control and investigative procedures of possible outbreaks of infection;
    - When outbreak identified, check possibility of cross contamination of patients exposed and discharged from affected area;
    - Ensure full and accurate patient details are given when transfers are planned.
    - Hand hygiene audit completed weekly
    - Personal protective equipment to be available and staff reminded of when to wear.

Presentations of the reports of these investigations are made to Directorate Leads at the monthly Patient Safety and Quality Committee meeting; learning from this, including action plans is then cascaded to directorate teams to share good practice. Utilising this system of reporting enables the Trust to learn from incidents, complaints and claims and act in a proactive way to try and prevent similar events occurring.

National Patient Safety Thermometer.

During 2012/13 the Trust will adopt the NHS Safety Thermometer; developed for the NHS by the NHS as a point of care survey instrument. The survey allows teams to measure harm and the proportion of patients that are ‘harm free’ within their care. Survey measurements will be uploaded onto a national monitoring tool to allow organisations to benchmark against others.
The four areas being measured are:

- Pressure ulcers;
- Falls;
- Urinary catheters and associated infections;
- VTE assessments.

Priority 7: Participation on the Regional Patient Safety Programme

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

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

Following the merger of acute and community service in June 2011 between the Great Western Hospital NHS Foundation Trust and Wiltshire Community Health, the acute and community programmes now run in parallel.

The community programme consists of six measures and one work stream package for the community programme: Average length of stay for inpatients, Patients with Observations complete, patient falls, pressure ulcers, urinary catheters, venous thromboembolism and leadership. Each measure and workstream has a Trust Lead.

Leadership - As part of the SW SHA Quality and Patient Safety Programme, GWH has been conducting patient safety walk rounds within the acute services, visiting various areas to establish first hand patient safety concerns from frontline staff. The walk rounds for the community are planned to be rolled out during 2012/13. Non Executive Directors (NEDs) and Governors are now actively involved in this process, the first NED joined the executive team walk round for the visit to the mortuary in January 2011 helping to develop actions and solutions to concerns raised. A NED or Governor now takes part in a patient safety walk round on a monthly basis. Since implementing patient safety walk rounds within the Trust executive teams have visited 18 clinical areas, most having had two visits; with up to a further 16 programmed for 2012/13.

During the walk round, actions are identified to resolve issues that are raised by staff, the Patient Safety Coordinator within the Clinical Risk Team monitors completion of actions, of the 90 actions raised to date 67 have now been completed and resolved. The most common themes that have been identified are communication, treatment/care delivery problems and equipment related issues. In continuing to develop the process, themes that are being identified are now being incorporated into the Trusts aggregated analysis and improvement report which is produced on an annual basis alongside incidents, claims and complaints data.

As a method of providing assurance that change is taking place, NEDs and Governors will be undertaking bi- annual meetings to review progress, discuss common themes and resolution of actions that have been identified. In addition the Chief Executive's report will include the key themes schedule which identifies key and common concerns raised on the walk rounds, this ensures that patient safety concerns are raised directly to the Trust Board.

General Ward – During 2011/12 the general ward teams have successfully implemented and rolled out the hydro bottles across the Trust in conjunction with the productive ward handover module. The bottles aid with hydrating patients and help to provide more independence to those who are less able.

The Tissue Viability Nurse Specialist (TVNS) presented on Pressure Ulcers at the SW SHA learning session in June 2011. The work undertaken to reduce the Trust's pressure ulcers was so inspirational that she was invited by the SHA and Improvement for Healthcare Improvement (IHI) to host a South

West conference call in August 2011 on pressure ulcers. The conference call was a success and the pressure ulcer tools have made available for other SW NHS Trusts to use.

The community have commenced developing an EWS (Early Warning System) in the community settings. It entails utilising the observation chart (currently used at GWH) for Wiltshire (to replace their current Obs Chart).

The process is split into 3 phases: trailing chart on a community ward, roll out to inpatient areas and roll out to neighbourhood teams.

Medicines Management –The team has worked across the Trust with omitting the abbreviations for insulin prescribing. The prescribing will now be written as 'unit' rather than 'u, this will help to reduce the number of errors associated with insulin prescribing.

Peri operative – The team has been working on improving compliance with normothermia to ensure that the patient's body temperature is normal throughout the operation. A traffic light system has been introduced by the team to help identify patients who are at risk of becoming cold. The system scores the patient and identifies what the risk is of the patient not being able to maintain a normal body temperature. The theatre team is able to proactively provide interventional methods to keep the patients warm.

Critical Care – The intensive care team is now successfully collating data and recording Ventilated Acquired Pneumonia (VAP) rates in patients. A lot of hard work and effort has been invested in this project (measure) and the team is now investigating specific trends in the VAP rates.

Institute Multi-Disciplinary Rounds where introduced during 2011 and are now embedded into practice, there is regular attendance by the physio, pharmacy and dietician. Multi-disciplinary ward rounds are taking place on a daily basis (Monday – Friday) and are helping to improve communication between all team members, patients, carers and relatives.

As part of the SW SHA programme the Trust are involved a number of improvement projects which includes, improving the use of the surgical safety check list, patient falls protocol, patient comfort rounds, theatre pre list meetings, medication reconciliation and many more.

Effective Care

Priority 8: Compliance with best practice guidance (NICE) and Central Alert Bulletins

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

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

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

NICE published 82 guidelines during 2011/12.

All the guidelines have been disseminated to the relevant clinicians and directorates including Wiltshire Community Health Services. A response rate of 96 % or above has been maintained throughout the year.

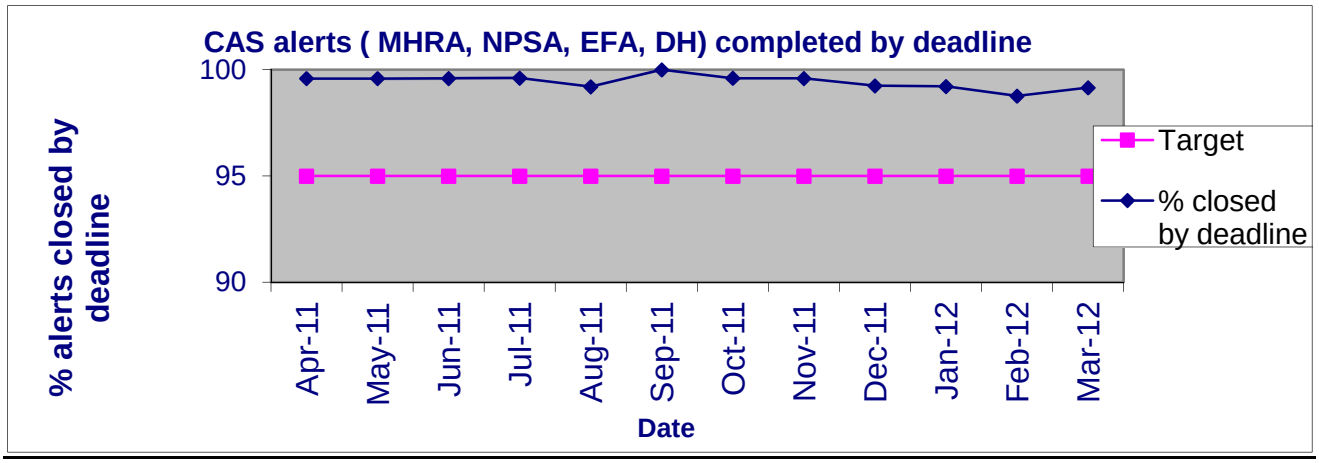
35/82 (41.5%) of the publications have been confirmed they are relevant to the Trust.
Out of this 35 -

- 22 guidance have been assured of full compliance
- 4 guidance's are currently being implemented
- 6 have only recently been published and are within time frame to respond
- 1 Technology Appraisal is under discussion
- 2 guidance's have been reported as an exception as the Trust has other provisions to implement the guidance.

Thus Trust wide compliance of 98-100 % has been attained this year.

CAS: The CAS (Central Alerting System) publishes Safety Alerts, emergency alerts, Dear Doctor letters and Medical Device Alerts on behalf of the Medicines and Healthcare products Regulatory Agency, the National Patient Safety Agency, and the Department of Health. These relate to medical devices, hospital facilities, equipment and clinical incidents. Responses and actions are monitored to defined deadlines via a web based system. Between April 2011 and March 2012 the Trust received 112 alerts from the CAS system.

CHART – Central Alerting System Alerts 2011/12



The standard of at least 95% compliance with no significant exceptions has been maintained throughout the 2011/12. Any alert that has failed to achieve full compliance within the prescribed deadline is reviewed monthly at the PSQ meeting to ensure that progress is being made to address outstanding actions and that no significant risks exist.

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

The NPSA alert, 2010 RRR019: Safer ambulatory syringe drivers, is outstanding, awaiting confirmation of a training programme in the community. Clinical Risk assesses the risk of non completion to be low. There is one Estates alert past its deadline, EFA 2011/002, concerning the management of refilling liquid Oxygen VIE plants. The outstanding actions concern approval of documentation. Estates and Facilities Management assess the risk to be low.

Priority 9: To review the clinical care of patients who need to return to theatre within a two week period

The aim for 2011/12 was to establish baseline figures for patient returns to Theatre within 2 weeks.

Total returns to Theatre for YTD = 41
Total cases YTD = 18.468
Overall % YTD = 0.2%

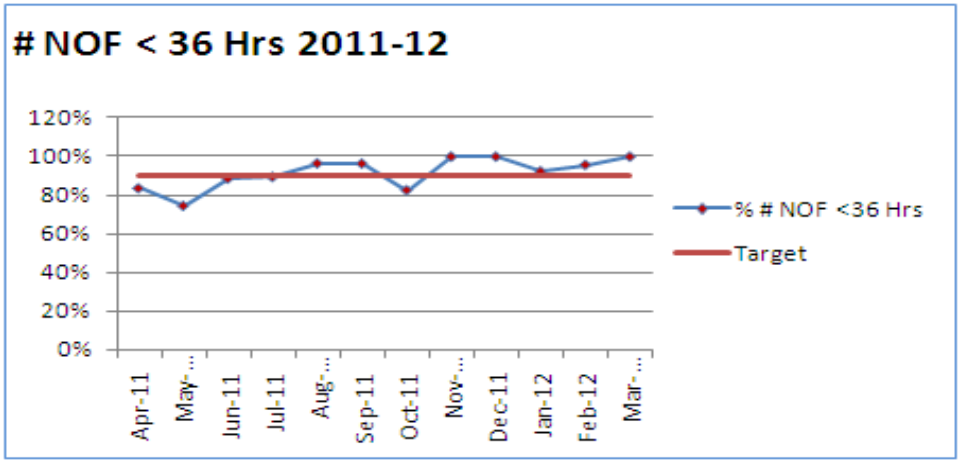
- There continues to be monthly monitoring of specialty trends. Theatre Coordinating Managers validate the monthly figures collated by the Informatics Team.
- 2012/13 we will continue to collate, monitor and validate on a monthly basis.
- We will continue to highlight any trends and report these to the appropriate specialty Clinical lead in the first instance.
- Any trends or areas of concern will be discussed at the Directorate & Clinical Governance meeting on a monthly basis where appropriate.

Priority 10: To ensure that patients who have sustained a fractured neck of femur are operated upon within 11 hrs of sustaining their injury if medically fit

Hip fracture is a common, costly and well-defined injury, which occurs mainly in older people. As the number of elderly people and age-specific incidence of hip fracture continue to rise, orthopaedic and rehabilitation services face growing pressures and a multidisciplinary working group meets bi-monthly to review all aspects of care for these patients.

Early surgical intervention is associated with better patient outcome. In accordance with best practice tariff, the quality indicator contract time to theatre is 36 hours. The Trust indicator requires that 90% of patients who are deemed medically fit require surgery within 36 hours of admission. The average percentage of patients who achieve this is 91% for the year.

CHART – Fractured Neck of Femur – Patients going to theatre with 36 hours if medically fit



This has been achieved by:

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

Priority 11: To ensure patients are assessed for the risk of developing Venousthromboembolisms and that these risks are managed appropriately

Compliance with completing VTE risk assessment has been maintained at over 90%. This achievement includes data from Wiltshire since June 2011.

This has been achieved with:

- Continued education sessions at Trust Induction.
- VTE update training now available on Training tracker and via a workbook.
- VTE sessions provided specifically for Health Care assistants which was very successful and enabled recruitment of additional VTE link HCA's who have made significant improvements to the quality of VTE assessments in their areas. This is also being rolled out in Wiltshire to enable VTE link staff to have the same level of access.
- Implementation of an audit trail through the nursing crescendo system and daily reports provided by Informatics to each ward area which allows them to easily identify any patients who have not been risk assessed.
- Raising awareness with patients and relatives by means of information boards and displays during national thrombosis week, the winner of last year's event is permanently displayed in Cherwell, pre-assessment unit.
- A second patient information leaflet developed specifically for patients who are being discharged home with VTE prophylaxis which gives information for the patient and also the community health care provider.
- We have also worked closely with Swindon PCT to establish VTE risk assessment in the community for patients who are discharged home with VTE prophylaxis. This will also enable patients who deteriorate at home to be assessed and for them to receive appropriate VTE prophylaxis if at risk.

Administer appropriate VTE thromboprophylaxis

Compliance with VTE prophylaxis has been maintained between 88%-100% for the last 12 months. Audits are proposed to evaluate the quality of the risk assessments and ensure appropriate thromboprophylaxis is prescribed and that patients who require extended prophylaxis in the community receive it.

Priority 12: To undertake nutritional assessments on patients on admission to hospital to ensure we meet their nutritional and hydration needs

Good nutrition and hydration are fundamental to well being and recovery from illness or trauma. A high proportion of individuals admitted to hospital or requiring support via the neighbourhood teams are vulnerable to malnutrition

Targets, compliance and audit methodology & frequency for the 3 key locations vary:

- **GWH site: Target 95%; compliance 86.9%** Jan 2012
- **Community Hospitals: Target 100%; Compliance 77.5%**
- **NHT: Target 100%; compliance 44.4%**

Despite not yet meeting the target significant improvements in other aspects of nutritional care have been achieved. At GWH site "MUST" (Malnutrition Universal Screening Tool) completion is assessed via Crescendo (electronic system) on a daily basis to provide weekly and monthly compliance rates. Wiltshire Community conducts a qualitative audit 6 monthly. For the purposes of this report an average of all wards is used for the key parameters of the audit.

GWH site:

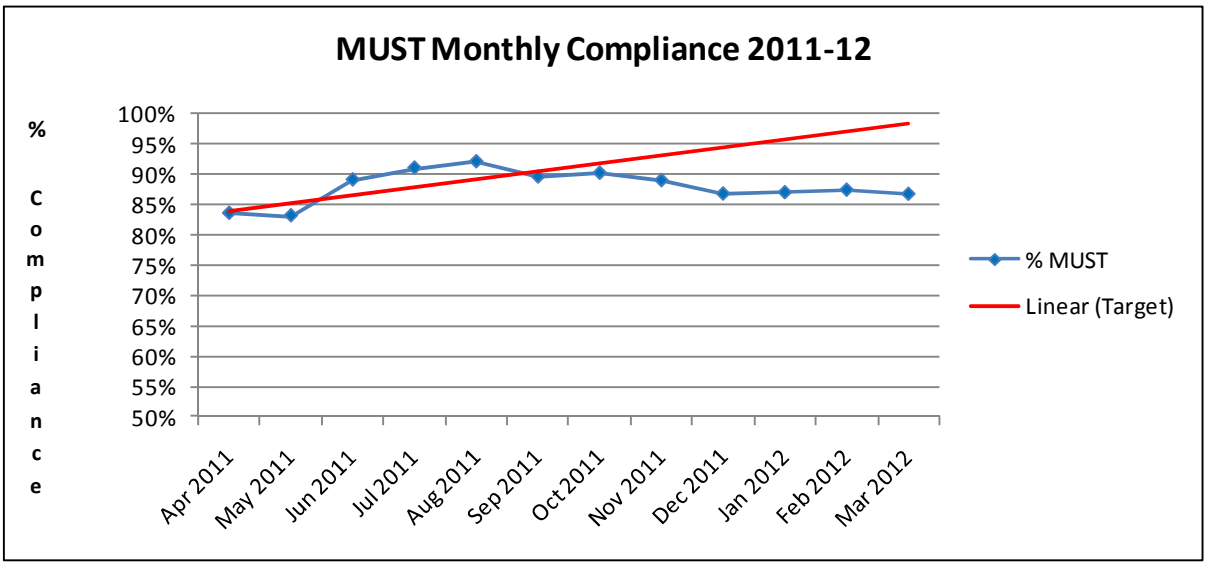
- Prior to MUST implementation there was no consistent or validated screening tool in place and compliance was measured at 33%.
- In 2010 MUST was implemented with a training programme carried out by the dietetic team. Compliance was improved to 75% by February 2011.
- The improved MUST compliance resulted in a >100% increase in referrals to the dietetic team resulting in a lack of time available for on-going training.
- During 2011 refinements were made to compliance audits, including improving the identification of exclusions and supporting wards with lower levels of compliance.
- Compliance has further improved to 87% with 3 areas achieving 95%; 6 areas 85 – 94% and 5 areas at or below 84% (range 78 – 84%).
- An on-going training programme is in place for NAs and volunteers including MUST and nutrition care.

Additional and existing activities to improve MUST accuracy and compliance are being introduced and strengthened.

- To support accurate MUST completion a new E- learning package and workbook for MUST are being introduced via the academy. The Nursing Auxiliary and volunteer training programme is to be updated to incorporate the needs of Wiltshire Community staff and changes to meals service such as the menu-less meals project.
- An additional dietician has now been funded by industry (commenced in post 20th Feb 2012 until March 2013) to support the MUST and nutrition care plan programme and to identify ways of managing the resultant referral demand. The post holder will be required to identify and pilot alternative ways of working to achieve this once the funding ceases.
- Ward dieticians will be targeting their lower compliance wards with additional training and support Regular comfort rounds (intentional rounding) instituted to provide more proactive and timely care.
- Matron's weekly inspections have recently started with a more specific and consistent approach to monitoring and improving compliance issues with MUST, nutrition care pans and documentation of fluid balance.

- As a result of complaints and concerns regarding meals' quality on-going weekly checks of meals service is carried out. This has improved resulting in positive PEAT (Patient Environment Action Team) reports
- A pilot project to improve patient's meals experience and reduce wastage was introduced in 2010 through the Productive ward meals module. Due its success the menu-less meals programme is being rolled out to the rest of GWH site, as appropriate.
- Dieticians identified a significant amount of food wastage and dissatisfaction from patients with diabetes and ward staff regarding the diabetic snack provision. Subsequently a new snack choice has been introduced which has been well received by patients and staff and is predicted to reduce wastes and produce some cost savings.
- The Productive ward team identified a system designed to improve patients' hydration needs. The trial of the "Hydrant" in 2011 was so successful it is being rolled out to other areas
- It was identified mid 2011 that the menus did not fully cater for patients with dysphagia. The dieticians, Speech and Language Therapists and Carillion are working on the development of a separate soft menu to improve choice and suitability of texture for these patients. An interim menu is currently in place prior to introduction of the finalised version
- Women and Children's directorate and paediatric dieticians identified that MUST is not appropriate for children and no other equivalent screening tool exists. The paediatric dieticians have developed a nutritional screening tool for 0-5 year olds.
- Update of pictorial menu completed.

CHART - GWH Site – MUST (Malnutrition Universal Screening Tool) 2011/12



Wiltshire Community Sites*:*

Wiltshire Community Services were being integrated with the Trust throughout 2011. Both elements of the Trust were using MUST but training programmes, targets and audit methodology have been different. The Nutrition Steering Groups have been merged and a new integrated Trust Nutrition and Hydration Steering Group has been established which is developing a comprehensive work plan. This should ensure more consistent reporting and activity in the coming year

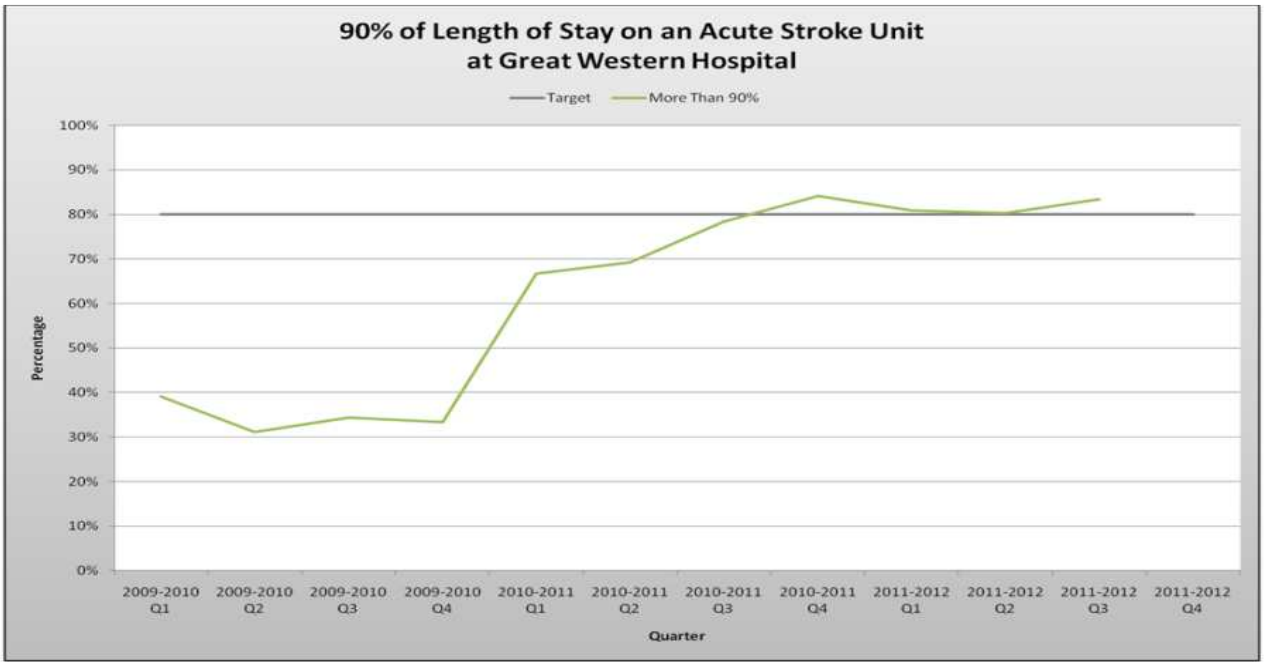
Wiltshire conducts a qualitative audit 6 monthly. For the purposes of this report an average of all wards is used for the key parameters of the audit.

- A regular ongoing training programme ("MUST" & nutrition action planning) for all Neighbour Hood teams and community Hospitals to ensure accuracy and improve compliance rates.
- Overarching action plan developed for NHT to support local planning
- 6 monthly audits undertaken for NHT and community hospitals
- Introduction of Nutrition Link Workers; role to include audits
- Development of matrons observational audit
- On-going review of "MUST" screening documentation across all localities
- Review of "Food First" nutrition information booklet
- "MUST" training provided in care homes

Priority 13: To attain the national Sentinel Stroke Targets

The Acute Stroke Unit at the Great Western Hospital has consistently delivered quality care for stroke patients over the last year. The quarterly target for 80% of patients to spend at least 90% of their length of stay in hospital on an Acute Stroke Unit was first achieved in the last quarter of 2010-2011, and has been achieved for all quarters of 2011-2012.

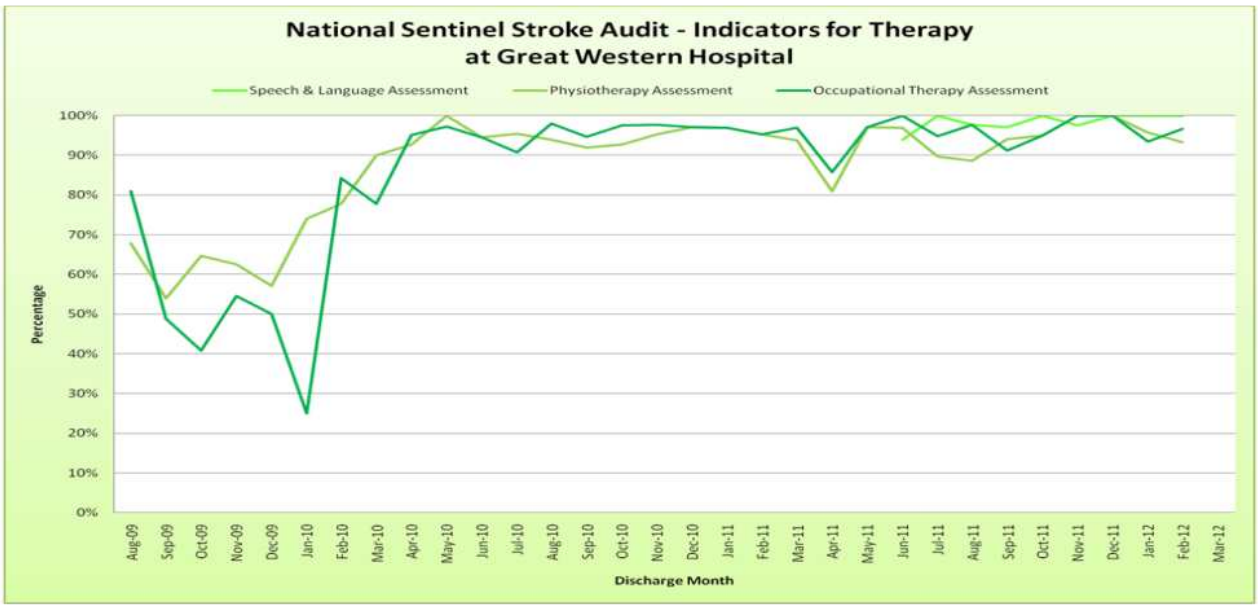
CHART – 90% Length of Stay on an Acute Stroke Unit at Great Western Hospital



Patients treated on the Acute Stroke Unit received dedicated treatment and rehabilitation from a multidisciplinary team with specialist stroke skills, patients are consistently:

- assessed within 72 hours of admission, if required, by the Speech and Language Therapist
- assessed within 72 hours of admission by the Physiotherapists
- assessed within 4 working days of admission by the Occupational Therapists

CHART – National Sentinel Stroke Audit – Indicators for Therapy at Great Western Hospital



The Great Western Hospital has delivered significant improvements for stroke patients with the 24/7 thrombolysis service. Since the extended service was introduced this financial year in April 2011, 47 patients have been thrombolysed compared to 7 patients in the previous financial year; this is an increase or 600% on than the number of patients thrombolysed during the limited working hours service (09:00 to 17:00, Monday to Friday). In addition, the door-to-needle times (from the moment a patient enters A&E to assessment and receiving treatment) are continuing to decrease with less variability between patients.

Patient Experience

Priority 14: To involve patients more in decisions about their care

GWH:

- Q1 Performance April to June 2011: 45.1% - Achieved
- Q2 Performance July to September 2011: 46.6% - Achieved
- Q3 Performance October to December 2011: 46.8% - Achieved
- Q4 Performance January to March 2012: Data not yet available

The Great Western Hospital collects the views of patients about information on discharge from the quarterly inpatient survey. The National Inpatient Survey 2010 showed that 50% of patients wanted to be more involved with decisions about their care, which demonstrates a slight improvement during 2011/12.

Further actions required:

- Roll out of ward managers surgeries to encourage patients and their carers to ask questions and query care whilst on the ward
- Bedside handovers to keep patients aware of their care and to be informed of any tests or procedures to be carried out during that shift

Community:

- Q1 Performance April to June 2011: 31% - Achieved
- Q2 Performance July to September 2011: 31% - Achieved
- Q3 Performance October to December 2011: 4% - Achieved
- Q4 Performance January to March 2012: Data not yet available

Satisfaction surveys are given to all patients upon discharge from the Trust's Community Inpatient areas. Community inpatient services are provided from four wards across three sites, Longleat Ward - Warminster Hospital, Aylesbury Ward - Savernake Hospital, and two wards at Chippenham Community Hospital, Cedar Ward and Beech Ward which is a Stroke rehabilitation Unit. There are currently low numbers of participants in the surveys. The Community Inpatient Survey will be incorporated within the patient survey tender in quarter one 2012/13.

The Community Inpatient Survey results demonstrate that the Community Inpatient areas are consistently achieving this measure.

Priority 15: To ensure staff are available to discuss care concerns with patients and their carers

GWH:

- Q1 Performance April to June 2011: 40.7% - Achieved
- Q2 Performance July to September 2011: 54.5% - Achieved
- Q3 Performance October to December 2011: 61.6% - Not achieved
- Q4 Performance January to March 2012: Data not yet available

The National Inpatient Survey 2010 showed that 59% of patients could not always find a member of staff to discuss concerns with. During quarters one and two 2011/12, there has been an increase in patient satisfaction in this measure, which decreased in quarter three. Posters showing photographs of the Ward Managers and Matrons have been displayed during March 2012, to inform patients of the clinical managers in the ward should they wish to speak with some one. The introduction of bedside handovers will also increase the availability of nursing staff to speak with patients about their care.

Community:

- Q1 Performance April to June 2011: 10.1% - Not achieved
- Q2 Performance July to September 2011: 6.2% - Not Achieved
- Q3 Performance October to December 2011: 9% - Not achieved
- Q4 Performance January to March 2012: Data not yet available

The results of the Community Inpatient Survey show that there is further work required to improve patient satisfaction in this area.
Further actions required:

- Roll out of ward managers surgeries to encourage patients and their carers to ask questions and query care whilst on the ward
- Bedside handovers to keep patients aware of their care and to be informed of any tests or procedures to be carried out during that shift
- Posters showing photographs of the Ward Manager and Matron to be displayed

Priority 16: To ensure patients are given sufficient privacy when discussing care and concerns

GWH:

- Q1 Performance April to June 2011: 27.4% - Achieved
- Q2 Performance July to September 2011: 24.8% - Achieved
- Q3 Performance October to December 2011: 29.1% - Achieved
- Q4 Performance January to March 2012: Data not yet available

The National Inpatient Survey 2010 showed that 31% of patients felt that there was not enough privacy when discussing their care or treatment. The quarterly survey results for 2011/12 show an increase in patient satisfaction in this area.

A matron within the Planned Care Directorate carried out a privacy audit in November 2011 to collect information on the different ways that privacy notices are used when discussions are taking place around the bedside. As part of the bedside handover, confidential information about patients is discussed away from the bedside. Safety briefings have also been introduced to share information with staff on handover and are carried out away from the bedside.

Further actions required:

- Standardised privacy notices to be rolled out to wards as part of the hygiene module of the Productive Ward

Community:

- Q1 Performance April to June 2011: 6.3% - Achieved
- Q2 Performance July to September 2011: 3.2% - Achieved
- Q3 Performance October to December 2011: 1% - Achieved
- Q4 Performance January to March 2012: Data not yet available

There has been an improvement of patient satisfaction in this area during 2011/12.

Further actions required:

- Audit of curtain peg and privacy notice use across community inpatient areas with a view to introducing the Trust wide standardised privacy notices

Priority 17: To improve upon the information given to patients on medication and it side effects

GWH:

- Q1 Performance April to June 2011: 30.8% - Achieved
- Q2 Performance July to September 2011: 42.9% - Achieved
- Q3 Performance October to December 2011: 65% - Not achieved
- Q4 Performance January to March 2012: Data not yet available

There are a number of ways that side effect information could be provided, and a number of developments have been made over the last year by the Pharmacy department to enable this information to be given to patients. These include, information leaflets included with all discharge medicines, patient information available via the internet and a patient medicines information helpline which is publicised via Outpatients.

The survey results demonstrate that clear guidance needs to be given to both staff and patients.

Further actions required:

- Provision of medicine reminder card with all discharges via pharmacy
- A multidisciplinary meeting including nursing and medical representation to review the process and information sharing of medication on discharge

Community:

- Q1 Performance April to June 2011: 7.3% - Achieved
- Q2 Performance July to September 2011: 21.5% - Not achieved
- Q3 Performance October to December 2011: 21% - Not achieved
- Q4 Performance January to March 2012: Data not yet available

As with the measure for GWH, there is work around information of medication to be undertaken in Community Inpatient areas. The Community Inpatient areas receive their discharge medication in a different way, however the way that this information is shared with patients can be replicated from GWH.

Further actions required:

- Review of the way medications are given to patients discharged from Community Inpatient areas

Priority 18: To ensure patients know who to contact after discharge if they have concerns about their care

GWH:

- Q1 Performance April to June 2011: 34.5% - Not achieved
- Q2 Performance July to September 2011: 21.8% - Achieved
- Q3 Performance October to December 2011: 23.20% - Achieved
- Q4 Performance January to March 2012: Data not yet available

The National Inpatient Survey 2010 showed that 26% of patients were not told who to contact if they were worried after they were discharged. The Unscheduled Care Directorate has led on the discharge policy review and the introduction of discharge leaflets. This links with the work that Pharmacy has been undertaking to improve patient information on discharge. The Unscheduled Care Directorate have facilitated a number of workshops on improving the pathway to discharge

Community:

- Q1 Performance April to June 2011: 30% - Not achieved
- Q2 Performance July to September 2011: 23.7% - Not achieved
- Q3 Performance October to December 2011: 25% - Not achieved
- Q4 Performance January to March 2012: Data not yet available

Community Inpatient areas are managed by the Unscheduled Care Directorate. As the Directorate are leading the work on discharge, it gives an ideal opportunity for good practice to be replicated.

6.5 Care Quality Commission (CQC) Inspections

There have been a total of 9 external inspections by the CQC and a schedule of work has been developed to monitor progress with the action plans arising following each inspection.

Following 8 of those inspections (noting the ninth inspection happening in mid May, the outcome of which is awaited), a CQC judgement of not fully compliant for the following three outcomes at Great Western Hospital site has been made:

- **Outcome 1 Respecting and Involving people who use services**
  In April 2011, the Trust was judged as none compliant with Outcome 1 due to its inability to demonstrate the provision of adequate and consistent patient privacy and dignity. An action plan was developed and completed by September 2011. In December 2011 a follow up inspection by the CQC deemed the trust as compliant with some improvement actions.

- **Outcome 4 (Care & Welfare of people who use services**
  On December 8th 2011, the CQC specialist inspection for Theatres judged the site as non compliant due to inconsistency of WHO checklist completion.
  Completion of action plan and subsequent regular internal audits and inspections for assurance has provided clear evidence of compliance and the Trust has declared compliance with Outcomes four as from 30th April 2012 with the CQC.

- **Outcome 5 (Meeting nutritional needs)**
  On December 8th 2011, the CQC inspectors focussed on hydration and after finding 3 incomplete fluid charts on one ward, judged the site as non compliant.
  Completion of action plans, a hydration strategy internal review, Productive Ward improvements and subsequent weekly internal audits and inspections has provided clear evidence of compliance and the Trust has declared compliance with Outcomes five as from 30th April 2012 with the CQC.

Other External Reviews

A dynamic database system has been created to enable tracking of all external reviews and inspections. This system enables the Trust to track progress, actions and compliance status and is reported to the Patient Safety and Quality Committee.

6.6 Performance against key national priorities

An overview of performance in 2011/12 against the key national priorities from the Department of Health's Operating Framework is set out below. Performance against the relevant indicators and performance thresholds are provided.

TABLE – Performance against key indicators

	2009-2010	2010-11	Annual 2011-12				
	GWH	GWH	Merged	Merged Target	GWH	WCHS	Achieved / Not Met
Clostridium Difficile year on year reduction^	49	40	19	69	17	2	Achieved
Incidence of MRSA bacteraemia	6	3	2	2 or less	2	0	Achieved
Two week wait from urgent GP referral to date first seen for all cancers	92.6%	97.0%	97.1%	93%	97.1%	N/A	Achieved
Symptomatic Breast two week wait	96.0%	97.2%	97.1%	93%	97.1%	N/A	Achieved
31 day wait from decision to treat to first treatment for all cancers	97.4%	99.0%	98.7%	96%	98.7%	N/A	Achieved
31 day wait for second or subsequent treatment - Surgery	94.7%	98.5%	98.4%	94%	98.4%	N/A	Achieved
31 day wait for second or subsequent treatment - Anti Cancer Drug treatments	99.8%	100%	100.0%	98%	100%	N/A	Achieved
62 day wait for first treatment from Urgent GP Referral to treatment for all cancers	90.3%	92.4%	89.3%	85%	89.3%	N/A	Achieved
62 day wait for first treatment from Screening Service to treatment for all cancers	98.9%	100%	98.4%	90%	98.4%	N/A	Achieved
For admitted patients - Referral to treatment 18 weeks maximum waiting time	95.0%	95.1%	96.1%	90%	96.1%	N/A	Achieved
For non admitted patients - Referral to treatment 18 weeks maximum waiting time	97.5%	97.9%	98.2%	95%	98.2%	99.8%	Achieved
Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge	95.3%	97.4%	97.0%	95%	95.5%	99.9%	Achieved
The Trust has fully met the National core standards	Compliant	Compliant	Not Fully Compliant	CQC Compliance	Not fully Meeting Outcomes 4 and 5	Compliant	Not Fully Met
Self certification against compliance with requirements regarding access to healthcare for people with a learning disability	Not measured	Not measured	Compliant	Maintain compliance	Compliant	Compliant	Achieved

6.7 Statement of Directors' responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 as amended to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2011/12;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2011 to May 2012
  - Papers relating to Quality reported to the Board over the period April 2011 to May 2012
  - Feedback from the commissioners dated 18/05/2012
  - Feedback from Governors dated 18/05/2012
  - Feedback from LINks dated 18/05/2012
  - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 15 May 2012
  - The national patient survey dated April 2012
  - The national staff survey March 2012
  - The Head of Internal Audit's annual opinion over the trust's control environment dated 14 May 2012
  - Care Quality Commission quality and risk profiles dated September 2011 – March 2012
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual)).

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

24-5-12 Date ..... Chairman

24-5-12 Date ..... Chief Executive

6.8 Statements from Primary Care Trusts, Local Involvement Networks and Overview and Scrutiny Committee

6.8.1 Health Overview and Scrutiny Committee Statements

The Swindon Health Overview & Scrutiny Committee is encouraged by the work that is already being undertaken to improve services amongst the priority areas for quality improvement.

The Health Overview & Scrutiny Committee is committed to having a good working relationship with the Great Western Hospital NHS Foundation Trust and, based on the Committee's knowledge, endorses the Quality Account for 2011/12.

The Committee is grateful to the Chief Executive and her team for the regular updates at Committee meetings on what is working well, and in some cases, what is not working so well within the Foundation Trust. The Foundation Trust has been open and transparent throughout the overview and scrutiny process and the committee hopes that this continues through to the next municipal year.

The Committee looks forward to continuing to work with The Great Western Hospital NHS Foundation Trust to continue to improve acute hospital care and community care for the residents of Swindon and the region.

6.8.2 Governors Statement

Over the course of the past year the Governor Group have had the opportunity to receive regular Quality updates at both the Council of Governors Meetings and in the more focused Patient Experience Working Group, which has an open invitation to the local CQC officials,

This group has the opportunity to feed in on a regular basis on matters of Patient Care and is regularly updated on new initiatives. It also on occasions, calls for reports on areas that have been highlighted which are of potential concern. It is a highly motivated group which helps to keep Patient Experience at the top of the Hospitals agenda.

This Quality Report presents a balanced and accurate account of the performance of the Trust over the period 2011/12"

6.8.3 LINks Statements

Local Involvement Network commentary on the Great Western Hospitals NHS Foundation Trust (GWH) draft Quality Account 2011/12
Local Involvement Network (LINks) welcome the opportunity to comment on the draft Quality Account from Great Western Hospital. Swindon has responsibility for co-ordinating responses from other LINks because the Trust's head office is in Swindon. The first draft QA was circulated to LINks in Gloucestershire, Oxfordshire, West Berkshire and Wiltshire. The Trust responded to the initial comments made by LINks and this commentary has been amended accordingly.

Combined LINk comments
In making this composite response we have considered the Department of Health published guidance which includes this statement, "year-round stakeholder engagement during the process of producing

a Quality Account and the opportunity for local scrutiny is seen as an important feature to ensure that Quality Accounts are locally meaningful and reflect local priorities."
There is an expectation that GWH will demonstrate in this QA that patients and the public have been involved in its production. The Chief Executive's statement clarifies this point as does the Governors' statement.

Ruth Lockwood, GWH Associate Director for Quality and Patient Safety attended the October 2011 Swindon LINk steering group to present information to the group about service improvements at GWH mid-year.

Specifically referring to the published draft Quality Account,
The QA appears to reflect the priorities of the local population in broad terms, – patient care, safety, involvement, dignity and nutrition. It was not apparent that any important issues have been missed out. However many of the graphs in the original draft were felt to be confusing particularly with the added dimension of the merger of GWH with WCHS. We understand that the graphs will be clearer in the final version of the QA.

The use of abbreviations and jargon is often a major problem for people not familiar with the language regularly used in health and care services. We hope that some significant editing between draft and final versions will have added to the document's clarity for a wider readership; as will the addition of the glossary.

The three month backlog of data transfer from paper to electronic systems (incident reporting) may cause doubt over the accuracy of some of the other performance data. However we understand from GWH that the backlog should now be in the process of being cleared and that all data is readily available.

We refer to the 2011/12 priority about patient experience "to ensure privacy when discussing treatment and care with patients". People with hearing loss tend to talk and need to listen to people who talk a little louder than normal. We understand that patients are asked if they are happy for their treatment or care to be discussed at the bedside and that they will be moved to a private area if they have concerns about the privacy.

Whilst there are references to end of life care, there are no specific references to the Liverpool Pathway (LCP) being used when appropriate. We understand that the LCP will be included in the 2012/13 QA.

Care Quality Commission (CQC)
We noted in their October 2011 report on Dignity at 100 UK hospitals the CQC reported that they had moderate concerns at GWH. We are pleased to hear that the Annual Report clarifies the position.

Review of Priorities
We are pleased to note that GWH have developed the 2012/13 plan to continue to improve in key patient areas such as falls, ulcer and infection. We also welcome the information that the Trust has considered important patient improvement measures where it is felt there is local need and priority and is including dementia as a key quality measure. This also links with the CQC's quality and risk profile.

Jo Osorio
Swindon LINk development officer josorio@swindon.gov.uk 01793 497777
22 May 2012
/LINk/GWH

6.8.4 Wiltshire Primary Care Trust

NHS Wiltshire, as lead commissioner for Wilshire Community Health Services is pleased to assure the merged Wiltshire Community Health Services second annual Quality Account. The document is clearly presented in the format required by the Department of Health Toolkit and the information it contains accurately represents the Trust's quality profile.

This has been a year of transition for Wiltshire Community Health Services on 1 June 2011 Great Western Hospitals NHS Foundation Trust acquired Wiltshire Community Health Services and became a merged organisation. The Wiltshire Community Health Services have joined the Unscheduled and Community Care directorate, Children's and the Bath Clinical Area Maternity Services have joined the Directorate of Women and Children's Services.

Wiltshire Community Health services provides a range of general and specialist services, and it is right that these services should aspire to make year on year improvements in the standards of care they can achieve. We believe the specific priorities for 2012/13 which the trust has highlighted in the report are appropriate areas to target for continued improvement.

NHS Wiltshire's strategy for improving health and health care services in Wiltshire set out clear priorities for ensuring that wherever possible patients can be looked after in their own home and that they have access to services which offer excellence in terms of clinical outcomes and patient experience. The Quality Account acknowledges the level of the challenge posed in some 2011/12 priorities, particularly in relation to patient falls. We support the Trust's decision to continue to improve patient safety, ensure effective care and continue to improve the patient experience.

We welcome the inclusion of success measures within the Quality Account, providing a gauge upon which service users, carers and commissioners can appraise the Trust's achievements in the coming year. NHS Wiltshire looks forward to continuing to work with Great Western Foundation Trust as they fulfil their commitment to continuously improve the quality of care for our local health service users, their families and carers.

6.8.5 Swindon Primary Care Trust

NHS Swindon as lead commissioner has reviewed GWFT Quality Accounts report for 2011/12. The Quality Accounts were reviewed by the Commissioning for Quality group which includes Clinical Commissioning group representation. NHS Swindon can confirm that, in their view, the Quality Accounts complies with the guidelines for application for the trust QA report.

Commissioners monitor performance and the quality of services routinely each month with the Trust. Commissioners can confirm that, to the best of our knowledge, the Trust QA 2011/12 contains accurate information in relation to the services provided.

The Trust has set their priorities by exploring multiple sources ranging from patient feedback to local intelligence collected via incident reporting and complaints, as well as consulting staff and commissioners. The approach to setting priorities is commended by NHS Swindon and we are happy to endorse the targets that have been set. The monitoring of each priority is deemed to be set at appropriately timed intervals for each priority, allowing a timely response to address issues that may cause the target to be missed.

It is good to see the improvements for quality of end of life care for patients and improve access to palliative care services. NHS Swindon would encourage the further integration and collaboration of health and social care community services as a driver to achieve this improvement.

Overall, the Trust has good plans to improve quality during 2012/13, and with the impending transition from Primary Care Trusts to Clinical Commissioning Groups we look forward to working together to ensure that quality of care and services remains key.

6.9 Independent Assurance Report to the Council of Governors of Great Western Hospitals NHS Foundation Trust on the Annual Quality Report

Independent Auditor's Report to the Council of Governors of Great Western Hospitals NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of Great Western Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Great Western Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2012 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2012 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Clostridium difficile – all cases of Clostridium Difficile positive diarrhoea in patients aged two years or over that are attributed to the Trust and
- 62 Day cancer waits – the percentage of patients treated within 62 days of referral from GP.

We refer to these national priority indicators collectively as the "indicators".

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;
- the Quality Report is not consistent in all material respects with the sources specified below; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports*.

We read the Quality Report and considered whether it addresses the content requirements of the *NHS Foundation Trust Annual Reporting Manual*, and considered the implications for our report if we became aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the sources specified below:

The sources with which we shall be required to form a conclusion as to the consistency of the Quality Report are limited to:

- Board minutes for the period April 2011 to May 2012;
- Papers relating to Quality reported to the Board over the period April 2011 to May 2012;
- Feedback from the Commissioners dated 18 May 2012;
- Feedback from LINKs dated 18 May 2012;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 15 May 2012;
- The national outpatient survey, dated November 2011 and national inpatient survey dated April 2012;
- The national staff survey dated March 2012;
- Care Quality Commission quality and risk profiles dated September 2011 – March 2012;
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 14 May 2012 and
- Feedback from Governors dated 18 May 2012

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents. We refer to those sources, (collectively the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Great Western Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting Great Western Hospitals NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2012, to enable the Council of Governors to demonstrate that is has discharged its governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Great Western Hospitals NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – "Assurance Engagements other than Audits or Reviews of Historical Financial Information" issued by the International Auditing and Assurance Standards Board ("ISAE 3000"). Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- Making enquiries of management;
- Testing key management controls;
- Analytical procedures;
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- Comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* to the categories reported in the Quality Report; and
- Reading the documents.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual.*

The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts/organisations/entities. In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Great Western Hospitals NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2012:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;
- the Quality Report is not consistent in all material respects with the sources specified above; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports.*

KPMG LLP

KPMG LLP, Statutory Auditor

100 Temple Street
Bristol
BS1 6AG

29 May 2012

7 SUSTAINABILITY REPORTING

7.1 Strong focus on sustainability

The Great Western Hospitals NHS Foundation Trust recognises that there are many benefits of having a strong focus on all aspects of sustainability, which means we continue to meet the needs of the present without compromising the needs of future generations. There are short, medium and long term advantages to making sure that we are able to continue to provide healthcare of the highest standard in a sustainable way.

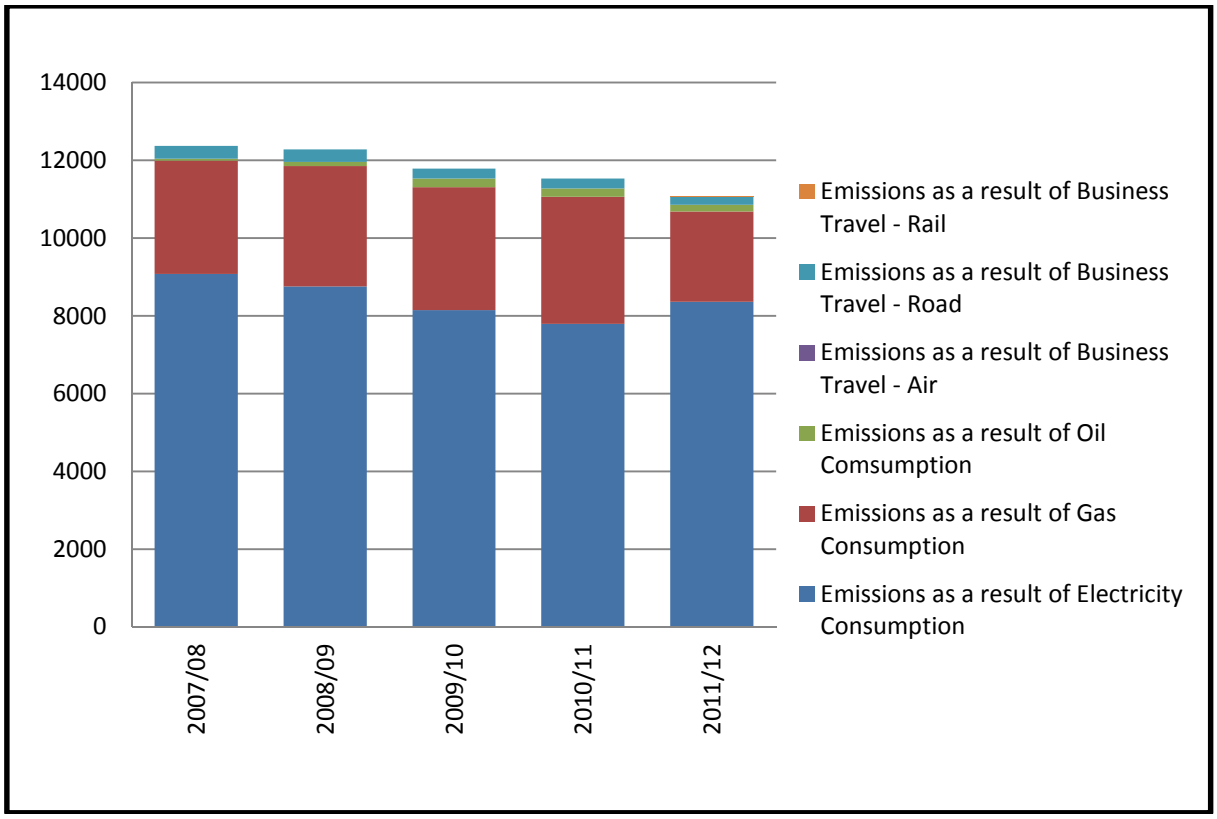
In June 2011 the Great Western Hospitals NHS Foundation Trust merged with Wiltshire Community Health Services (WCHS), to form a much larger Trust. As part of the merger the Trust took over responsibility for several properties and services previously managed by WCHS. Since the merger planned closures of two health centres have been completed and admin services being centralised ending the lease on a further two buildings. Through out this report information is shown separately for the Great Western Hospital and WCHS. WCHS data for previous years has been taken from estate reports, but it could not be verified. In next year's report the data for 2011/12 will be combined so that a clear comparison on performance can be shown. Where possible the WCHS data has been benchmarked as changes in the organisation make direct comparisons difficult.

7.2 Energy

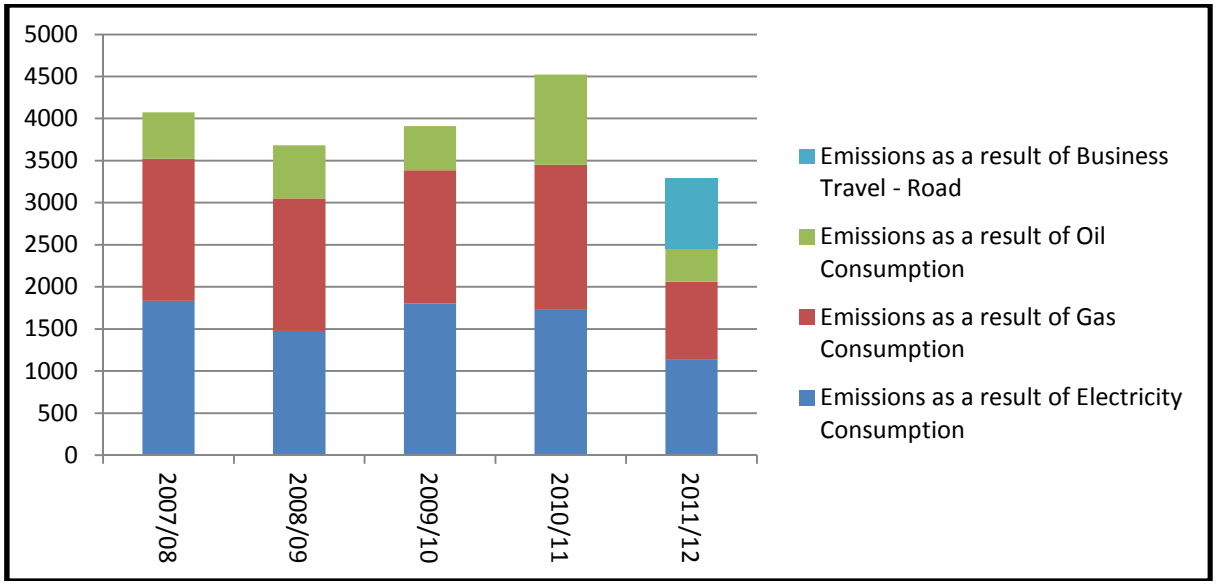
Carbon reduction is one area where the Trust has specific targets that it is required to achieve. The target being focused on currently is achieving a 10% reduction in CO_2e emissions from a 2007 baseline by 2015. Achieving this target will assist the NHS as a whole with reaching the overall target of reducing 80% CO_2e emission by 2050. These targets are tough and require careful management if we are to achieve our share of reductions. However, there are very good business reasons to undertake our activities in a sustainable way. Reduction in unnecessary consumption almost always means reduced costs and management. This in turn means that the Trust can dedicate more time and resources on frontline patient care.

Graphs 1 and 2 show the total measured emissions produced by each organisation. At GWH carbon emissions from air and rail travel have only been measured in 2011/12, this information is not available in WCHS. Mechanisms are being put in place to capture all staff business travel to increase the accuracy of scope 2 emissions data next year. At present there is no mechanisms for measuring or controlling emissions from scope 3 activities, however, as part of our focus on carbon we are committed to reducing the wider environmental and social impacts associated with the procurement of goods and services. Part of our sustainability procurement policy will outline how the Trust will start to work with suppliers and other third parties to assist with reducing these emissions.

Graph 1 – GWH carbon footprint (tonnes of Carbon Dioxide equivalent)

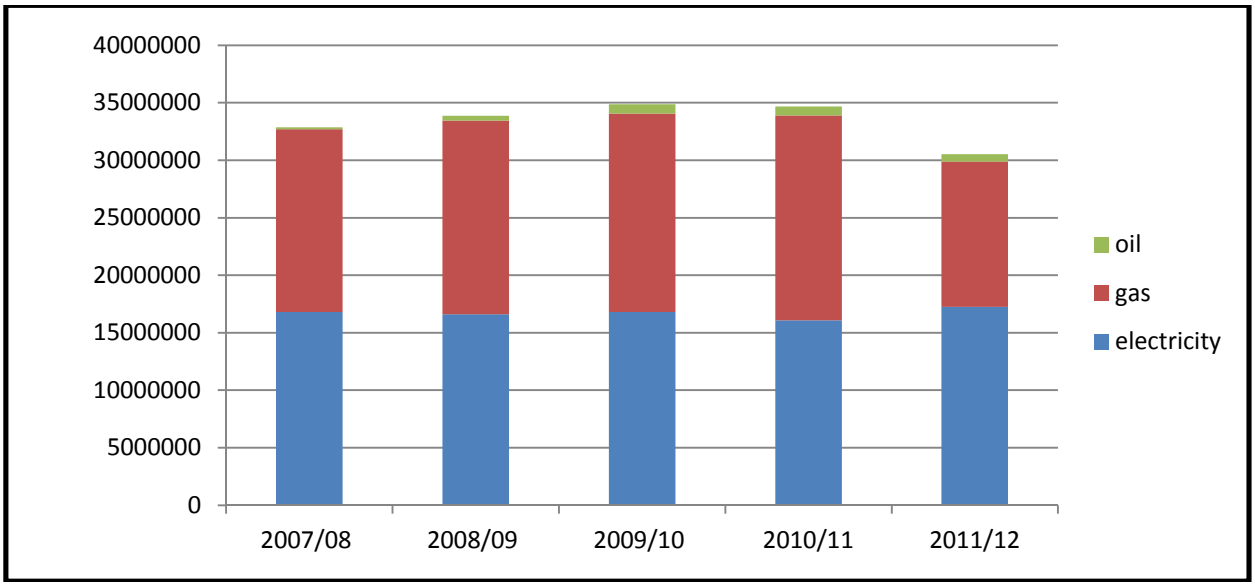


Graph 2 – WCHS carbon footprint (tonnes of carbon dioxide equivalent)

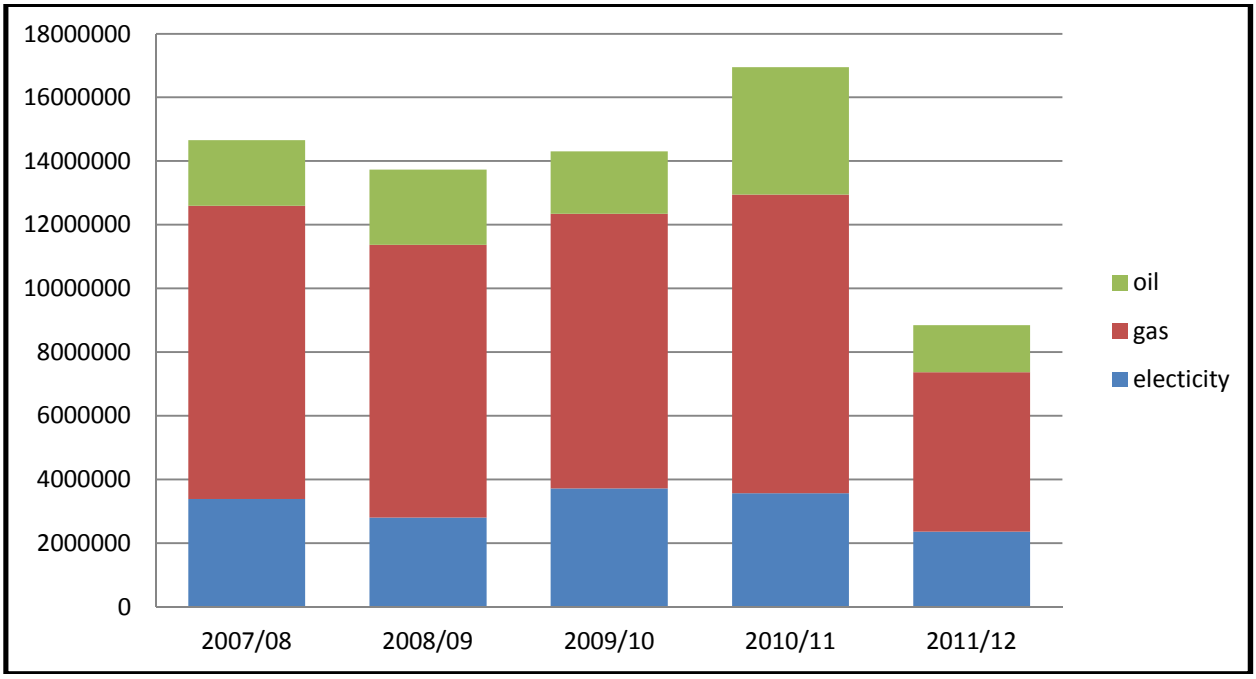


Graphs 3 and 4 show energy consumption in kwH at the Great Western Hospital and WCHS sites since 2007/08 respectively. Spend on energy has reduced in Wiltshire with the closure of buildings, but increased at the Great Western Hospital in this financial year. The reason for this is being investigated at the moment, but is likely to be due in part to increasing the amount of cardiac diagnostic equipment. Over the next year the Trust has plans to spend over £330,000 on capital schemes that will continue to reduce the amount of energy being consumed. Other projects such as LED lighting is being considered on all sites and smaller more visible changes such as the installation of PIR light switches in offices and store rooms has continued.

Graph 3 – Energy consumption at GWH in KwH



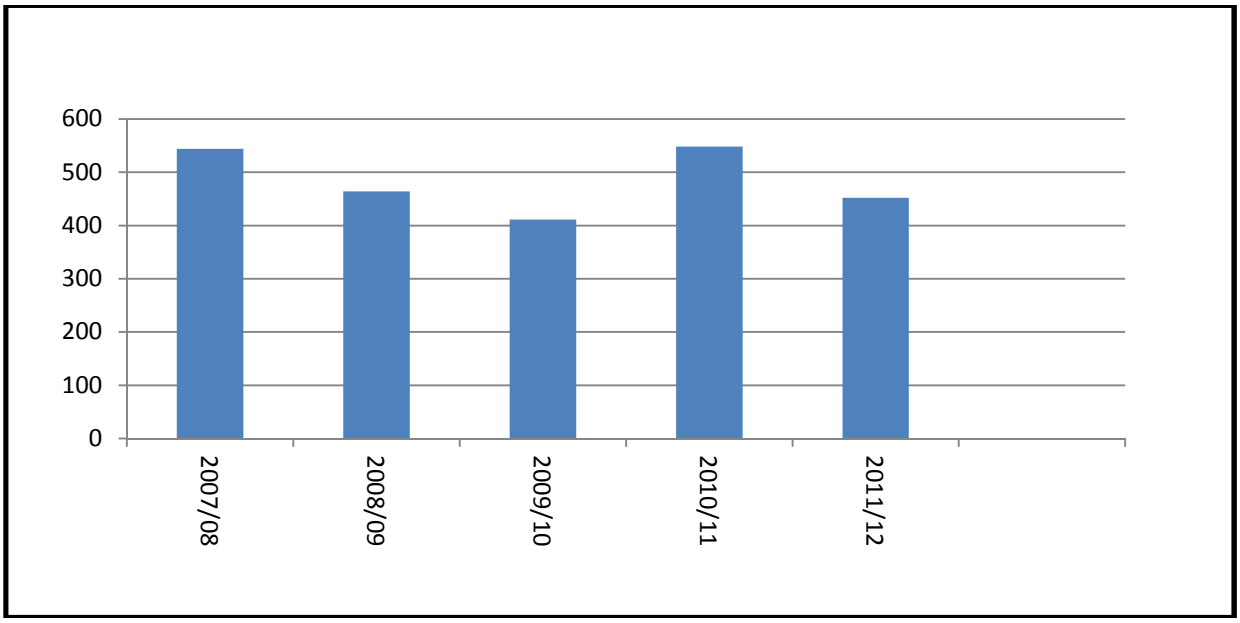
Graph 4 – Energy consumption by WCHS (KwH)



The Trust is working with local businesses and the Borough Council in Swindon to review the installation of CHP plants on site. This would if successfully built, help increase the Trust's energy security with on site generation and would allow the Trust to use renewable energy sources.

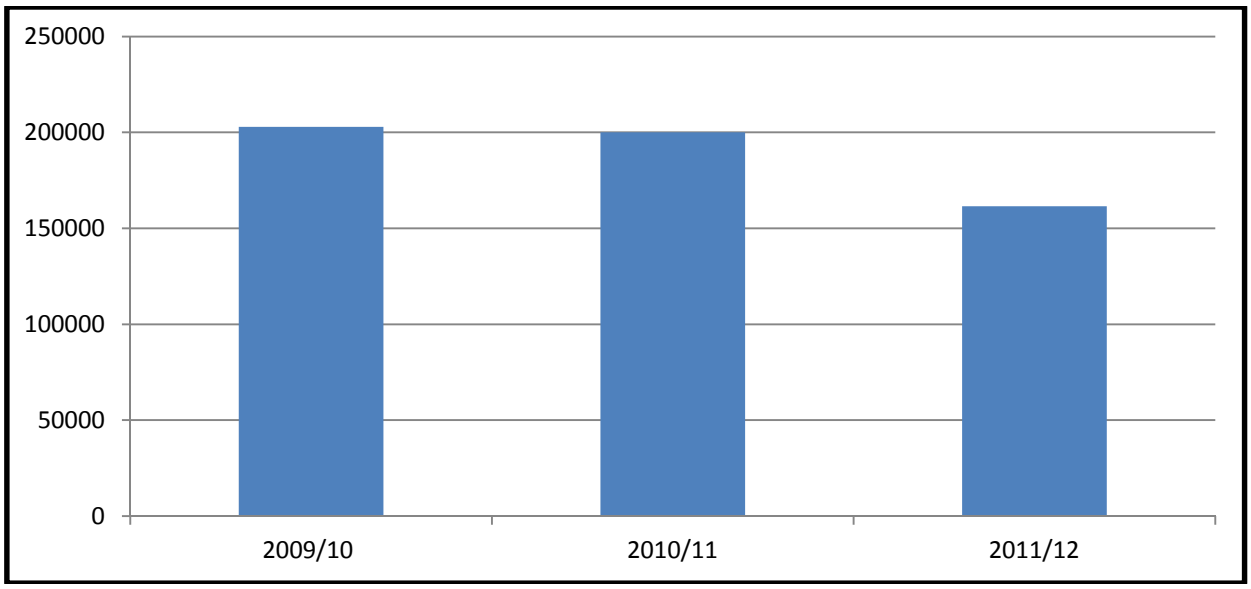
From 2007 to the present the occupied floor area at the Great Western Hospital has remained nominally static. Wards and other areas have been closed for short periods of time for redecoration or refurbishment only. In WCHS the occupied floor area has altered significantly over the same period. Graph 5 shows total energy consumption in kwH/occupied floor space in m^2 for WCHS.

Graph 5 – Energy Intensity (kwH/occupied floor area m^2)

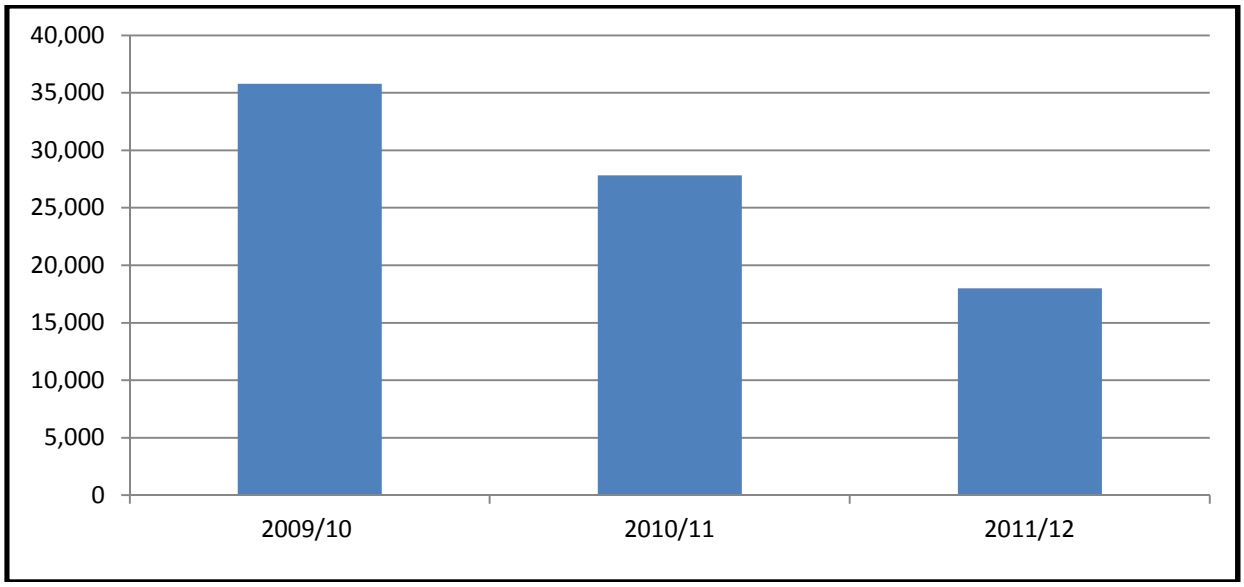


In the reporting period water usage has decreased by 16 percent at the GWH and 36 percent at WCHS from 2010/11. Graphs 6 and 7 show GWH and WCHS water consumption figures for the last three years respectively.

Graph 6 – Water consumption at GWH (m^3)



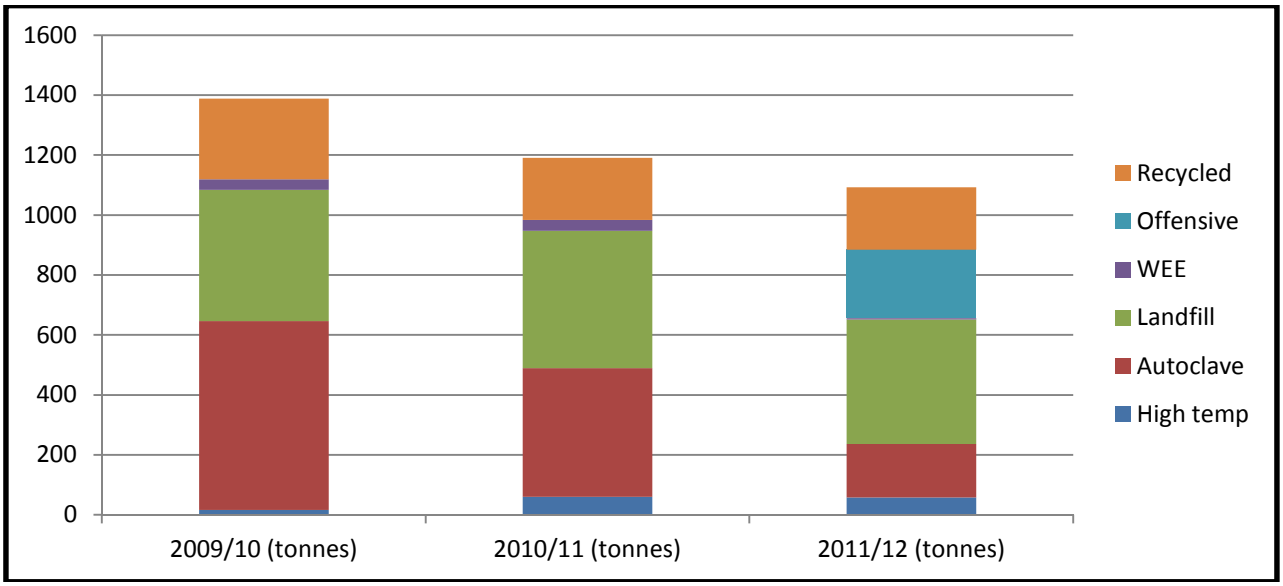
Graph 7 – Water consumption in WCHS (m^3)



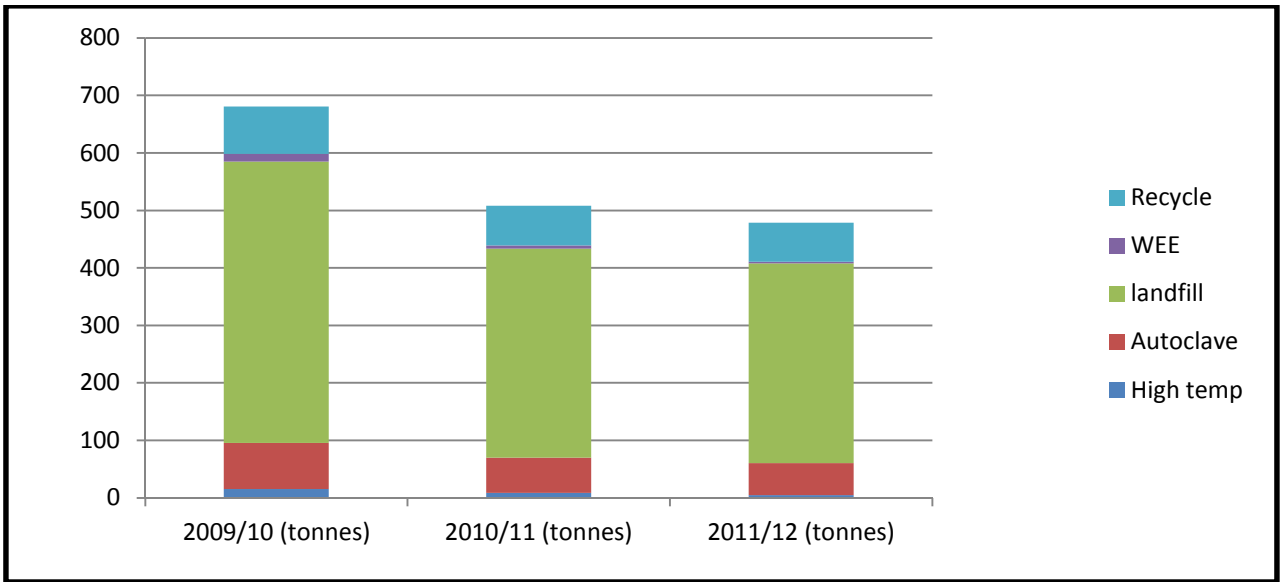
7.3 Waste

The weight of waste produced at GWH has decreased by 11% in 2011/12 from 2010/11. At WCHS sites the total weight of waste produced decrease by 6%. At GWH an offensive waste stream has been introduced and this waste is being sent to energy from waste plant for disposal. To date this by-product of the Trust's activities has produced 150990 kwH of electricity. In 2010/11 this waste was reported as landfill waste, but has been separated out in 2011/12 figures. On top of this 23% and 15% of the waste generated at GWH and WCHS properties respectively was sent for recycling in this financial year.

Graph 8 – Total tonnes of waste produced at GWH (tonnes)



Graph 9 – Total tonnes of waste produced by WCHS (tonnes)



The NHS Carbon Reduction Strategy requires all Trusts to have a board approved Sustainable Development Management Plan (SDMP). Our plan is due to go to the Board for approval early in financial year 2012/13. Once approved, a Sustainability Forum will be established to be chaired by the Director of Finance who has board level responsibility for sustainability. The Sustainability Forum will monitor the SDMP and ensures that the Trust fulfils its commitment to conducting all aspects of our activities with due consideration to sustainability, whilst providing high quality patient care. A board level lead for Sustainability ensures that issues have visibility and ownership at the highest level of the organisation.

The Trust has a statutory duty to assess the risks posed by climate change, and these are on the risk register. The Trust is also aware of the potential need to adapt the buildings and services to reflect changes in climate and illnesses in our locality.

A sustainable NHS can only be delivered through the efforts of all staff. Staff training is on going on all Trust sites. As part of the Trust's action for Sustainability Awareness day department managers were asked to participate in an energy audit for their area. This served to highlight equipment that could be switched off and increased awareness of usage. A smaller number of staff took part in a Good Corporate Citizen Workshop in September, where they evaluated the Trust's sustainability performance in six key areas against NHS targets. In three out of the six areas discussed the Trust was exceeding the 2012 target of having a minimum score of 37%. Another workshop will be held in the following year to ensure that this target is met across all six areas and that the Trust is on track to achieve 70% compliance by 2015.

Staff at GWH have changed their travel patterns and significantly reduced the number of commuting miles that are driven each day by staff, by increasing car sharing and decreasing car dependence. This in turn reduces the impact of the hospital activities on local air quality and greenhouse gas emissions, so it is important. This was part of the GWH sustainable transport plan, which is now being considered in WCHS. The Trust is also keen to work with other transport providers such as Great Western Ambulance Service to reduce the miles driven.

8 EQUALITY REPORTING

8.1 Equality duty

The Trust uses the Equality and Diversity System to help ensure the requirements of the public sector Equality Duty are met and that the Trust delivers services that are personal, fair and diverse.

The Equality and Diversity System (EDS) covers 18 outcomes grouped in to 4 objectives:

1. Better health outcomes for all
2. Improved patient access and experience
3. Empowered, engaged and included staff
4. Inclusive leadership

Guidance published by the Equality and Human Rights Commission states that public authorities must:

- Prepare and publish one or more objectives they think they should achieve to do any of the things mentioned in the aims of the general equality duty by 6th April 2012 and at least every 4 years thereafter.
- Ensure that those objectives are specific and measurable.
- Publish those objectives in such a manner that they are accessible to the public.

8.2 Our equality and diversity objectives

In 2012/13 the Trust will be working towards the following objectives to enhance equality and diversity across the Trust: -

Objectives
The Trust will develop positive attitudes towards equality and diversity by training and developing, Associate Medical Directors, General Managers, Matrons, Deputy General Managers and Ward Sister/Charge Nurses. Success will be measured through a baseline questionnaire pre programme and repeated post programme. Improvement will be fed back at the end of year 1 and areas for further work identified leading to a year 2 / phase 2 programme. This will be a joint venture working with the Royal College of Nursing with the intention of publishing the work so that best practice can be shared across the NHS.
The Trust will identify an EDS data set for patients and staff by the end of July 2012. Data collection will commence from September 2012 and analysed in March 2012 in order to inform 2013 / 2014 business planning process. EDS business planning objectives will be set by each Directorate for year 2013.
The Trust will complete its participation in a National Research Project identifying good and poor practice for people with learning difficulties in Acute Trusts by October 2012. The Trust will implement the research recommendation in 2013 once the research results are published.

The Trust will be working towards achieving these objectives over the next three years and will be reviewing our progress in this area annually. The Trust will publish updated objectives every three years to take into account changes in practice.

8.3 Policies for potential and existing disabled employees

The Trust has signed up to the national "two tick" symbol and supports the recruitment and development of disabled candidates/employees. The Trust interviews all disabled applicants who meet the minimum criteria for a job vacancy and to consider them on their abilities. The Trust makes every effort when employees become disabled to make sure they stay in Employment. HR works with Occupational Health to seek appropriate roles for staff following a change in circumstances. For staff that become disabled whilst in our employment, the Trust actively works with the Occupational Health Team to make reasonable adjustments to enable the member of staff to continue their employment with the Trust.

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

9 STAFF SURVEY REPORT

9.1 Our staff

The Trust is committed to being an exemplar employer and strives to ensure that all employees reach their full potential at work. We have also focused on ensuring that our staff have the right knowledge and skills to provide high standards of care to our patients and their carers but also the right behaviours so that we work as an effective team to get things done.

We have also been working towards improving how we recognise the hard work, loyalty, commitment and successes of our workforce and have put in place a number of mechanisms such as a monthly and annual award scheme as part of our strategy.

Our average headcount for 2011/12 was 4,800. This equated to an average whole time equivalent of 3,911.33. For the two months prior to the June merger our average was 3,332 staff (2,756.64 wte) and for the 10 months after the merger, our average was 5,094 staff (4,142.27 wte).

9.2 Staff satisfaction

It is recognised across the NHS that a more satisfied workforce provides better patient care and the Trust places a great deal of emphasis on exploring ways to improve and enhance motivation and morale so that staff are satisfied in their work. To help the Trust understand how staff are feeling, the results of the annual staff survey commissioned by the Care Quality Commission are examined to identify any areas for improvement.

In 2011, the Trust transferred 1,900 staff from Wiltshire Community Health Services, consequently the sample included employees who would have not worked for the Great Western Hospitals Foundation Trust the previous year. The transition and integration took a considerable amount of focus and it is positive to note that staff motivation at work increased over the previous year's results despite the organisational changes. The Trust is now in the best 20% for all acute trusts for staff motivation.

Our staff scores place the Trust as fifth across 20 Acute Trusts in the South West of England.

The 2011 survey results show that staff experience has improved in the following areas:-

- Staff motivation at work
- The percentage of staff agreeing that their role makes a difference to patients
- The percentage of staff experiencing discrimination at work in the last 12 months

Staff have reported no areas of deterioration since 2010.

Overall, the Trust is measured against the four staff pledges from the NHS Constitution with an additional theme of staff satisfaction. These indicators break down into 38 key findings and results show that GWH has improved on 4 key finding areas since 2010 and is average or above average for 31 areas as benchmarked against other Trusts. However, there are seven key findings areas where the Trust is below average. Last year we were below average in nine areas.

Detailed below is a summary of the Staff Survey scores for 2011 alongside the equivalent scores from the 2010 survey. Full details of the survey can be found on the Care Quality Commission website at www.cqc.org.uk.

9.3 Summary of staff survey results

	2010	2010	2011	2011	Improvement / Deterioration
	Trust	National Average	Trust	National Average	
Response rate	59%	51%	66%	53%	7% improvement
Top 4 ranking scores					
KF 23. Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months	8%	8%	4%	8%	4% improvement
KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	13%	15%	10%	15%	3% improvement
KF 16. Percentage of staff receiving health and safety training in last 12 months	92%	80%	92%	81%	No change
KF 38. Percentage of staff experiencing discrimination at work in last 12 months	13%	13%	9%	13%	4% improvement
Bottom 4 ranking scores					
KF 13. Percentage of staff having well structured appraisals in last 12 months	34%	33%	31%	34%	No change
KF 8. Percentage of staff working extra hours	70%	66%	68%	66%	2% improvement
KF 14. Percentage of staff appraised with personal development plans in last 12 months	66%	66%	66%	68%	No change
KF 10. Percentage of staff feeling there are good opportunities to develop their potential at work	39%	41%	37%	40%	2% deterioration

Following this year's staff survey results, the Trust received a presentation from Quality Health so that we could determine which areas to focus our efforts to sustain improvement for our workforce.

It was agreed that we would focus on improving the appraisal rates so that more staff reported receiving a well structured effective appraisal. A new policy and process with relevant training for line managers will be introduced over the course of the year.

It was also agreed that we could improve our staff's confidence so that they feel satisfied with the quality of work and patient care they are able to deliver. We will do this by reviewing how we design our jobs and teams and ensuring that improving patient experience is at the core of our actions.

We are also investing in improving our management capability so that our managers are well equipped to support staff through change as we improve pathways and efficiencies in the way we work.

The Trust is focussing on improving staff feedback through questionnaires and workshops, the results of which will be analysed and reported through the Executive Committee which will monitor performance.

9.4 Staff consultation and engagement / other consultations

The GWH has a strong relationship with the Employee Partnership Forum (EPF) and work on integration with the Wiltshire Workforce Partnership forum started in January 2011, so that a new agreement was in place and joint meetings being held from June 2011. All major change papers that affect organisational structures are presented to this forum before the organisation starts consultation, an example of the effectiveness of the process is that we have no appeals or employment tribunal claims as a result of the Corporate Back Office re-structure programme which was implemented in the last quarter of 2011.

During 2011 we introduced new organisation values. These are Service, Teamwork, Ambition and Respect (STAR). These values were launched with a series of road shows across our different localities. The Values have been embedded into the new annual recognition programme and monthly STAR awards. They have also been used to support recruitment decisions.

In October 2011, our new Chief Executive, Nerissa Vaughan joined the Trust. As part of her induction to the Trust she carried out a series of meetings to meet the staff. A feedback process called 'Ask Nerissa' was also established to enable staff to email her directly about their concerns and questions on issues affecting them.

In addition to the Staff survey feedback, in early 2012 the Trust asked for feedback in the form of a questionnaire from key employees involved in the pre and post transition phase and a workshop was held, facilitated by NHS Elect to understand what went well and what could have been done differently. A feedback questionnaire has also been designed which will go out to the wider community to understand key issues around the transition and what improvements can be introduced.

9.5 Communicating with staff

Since 2010 a range of new channels have been introduced to strengthen communication between senior management and Trust staff:

- Over the past year the Trust has built on the success of quarterly magazine Horizon by providing space for regular features on different areas within the organisation and highlighting the achievements of staff including educational attainment and awards. The magazine continues to be well read and its readership has grown since the launch and the merger with

Wiltshire Community Health Services. In each issue the Trust ensures there is a wide selection of features from across the Trust providing representation from both the acute and community settings. The magazine also provides a good source of news items for the local media.

- Launching the new Trust Intranet in February 2012 will provide greater opportunities to reach staff across the newly enlarged organisation. For the first time since the merger in June 2011, the Trust has a single intranet providing an accurate and timely source of information across the various departments and empowering staff to take control of their own areas of the site to share information with colleagues. The new intranet will feature web chat and video podcasts in the future to provide important information in a more easily digestible format.

- Establishing an 'Ask the Chief Executive' email address to provide an opportunity for staff to raise issues directly with Nerissa Vaughan and to receive a response direct.

- Hosting a number of Chief Executive 'road shows' across the Trust to provide staff with an opportunity to meet the new Chief Executive and ask questions. These events included sessions at a number of the community sites across Wiltshire. In addition a number of road shows were held to launch the Trust STAR values over the summer.

- The monthly Team Brief continues to be used as a key source of information for staff offering the Chief Executive's personal view on issues affecting the Trust. The Team Brief has grown to be a trusted source of information and we continue to look at ways to increase its readership.

For 2012/13 an updated internal communication plan has been developed which takes into account the enlarged organisation and aims to strengthen the channels the Trust already has in place for communicating with staff. Underpinning the plan will be a drive to improve some of the key scores in the latest staff survey. An internal communications staff survey will also be carried out to ensure we can measure the impact of the various mechanisms in place and make adjustments accordingly.

9.6 Workforce Key performance indicators (KPI's)

The Trust has a range of workforce KPI's which are monitored to understand the organisation's performance.

Sickness absence. The upper threshold for sickness absence was set at 3.5% for 2011/12 a 0.5% reduction on 2010/11. The sickness statistics are only available 6 weeks after the end of the month. The latest figures available are for January when the rolling 12 month total was 3.42%. This equates to 32860 days lost to the Trust. 3.42% absence represents an improvement for GWH and benchmarks well across the NHS.

Turnover. Voluntary turnover at the end of January was 8.92%. This has been increasing slightly due to the impact of the transition of WCHS on the data.

Vacancy levels. The difference between the budgeted headcount and actual in post is 7.62%, although the actual vacancies that we are recruiting to is 2.35% of our headcount. Some recruitment is being held in order to re-deploy clinical and non-clinical staff following on from bed re-configuration plans and other changes.

Appraisal rates. The overall rate for the Trust is 69.58%. The staff survey has highlighted a number of issues relating to appraisals. At present there are two different systems from GWH and Wiltshire Community Health Services. During 2012 we will be implementing a new process which will provide a clear link between the Trust's strategy and individual performance.

9.7 Workforce Development

The Trust continues to encourage and support staff with their development, placing emphasis on the safety of staff and service users. The Academy has been innovative in developing successful strategies to encourage staff to engage with mandatory elements of training, this has now been extended to reflect the changing age profile of service users and to embrace the needs to community services. During 2011-2012 the Academy has developed and delivered 24 clinical and non clinical mandatory training modules in consultation across the community and the acute settings and has developed a Training need analyses for all staff members enabling accurate capture of training statistics on ESR.

The Academy has extended its excellent training facilities in 2011. Not only does it boast an excellent suites of seminar rooms and lecture facilities in Swindon but has extended across the Wiltshire area improving facilities in Warminster and opening new, fully equipped training rooms at Chippenham and Savernake Hospitals.

Our Aim is to support the current and future workforce of all disciplines to gain knowledge, skills and understanding which will enable them to deliver empathetic care of the highest quality to our service users, now and in the future. The Academy listens to feedback from service users and inspectors and firmly links educational aims to service delivery, striving for excellence in both delivery of clinical care and overall patient experience.

The Academy has focussed on a number of improvements to education and development opportunities available for staff including:

- the course portfolio has been expanded to offer a wider range of clinical skills, suprapubic catheter care, 'in depth' infection control, and new pressure area courses;
- a range of new regional study days have been developed and delivered to prepare our staff new future challenges in healthcare including dementia, discharge planning, practical bariatric care and dignity;
- The successful development of support staff via new QCF, BTEC, Apprenticeships and NVQ qualifications has allowed development of unregistered role models who can deliver a more responsive service.
- All courses are reviewed twice annually against local and national benchmarks. Content and delivery are scrutinised by educational and subject experts to ensure relevance and quality.
- Learner experiences are continually measured after an educational event and to identify the impact of any education once they have returned to a service area. This feedback and that of the service user is used to inform future educational approaches.

Work continues to strengthen the education of junior doctors with the Postgraduate team securing agreement with the Deanery to provide and run additional courses with a GWH based Medical Ethics course attended by medical staff from across the UK.

The Academy continues to support our future workforce; the Academy recently reviewed and coordinated an audit from the SW SHA to determine whether their KPIs for healthcare professional programmes into the region has been met by both the University and the Trust as practice placement

providers. Feedback obtained across 12 different professions indicates good practice in student preparation within the Rust and local HEIs.

Experience support staff in acute and community settings were supported to successfully complete the Foundation Degree in Health and Social Care. The knowledge, skills and attitudes acquired allowed service areas to reassess the traditional staff skills mix to ensure service delivery which is responsive and flexible as well as producing role models for our students and support staff.

Research and Development throughout the Trust has developed well this year with increased recruitment into more complex studies with commercial research projects increasing from 100% to 8 with a further 4 within the set up process.

Generation of income from education clinical skills and resuscitation courses that can be reinvested within the Trust will be in excess of £120k this year and demonstrates the growth in Trust profile attracting nationally renowned keynote speakers such as Christine Beasley (Chief Nursing Officer).

Focussed customer service training for the Diagnostics and Outpatient directorate demonstrated fall in service user complaints in 2011 from January to March where 7 complaints were received to April to June where 3 complaints were received.

Undergraduate medical training provision has expanded this year to include 2nd years students from Bristol University. The faculty has expanded to support this with additional educational supervisor posts to deliver the expanding requirements of undergraduate curriculum, ensuring the quality of our future workforce.

9.8 Supporting our volunteers

The Great Western Hospital's Foundation Trust is extremely fortunate to have so many committed and enthusiastic volunteers. Each provides an extremely valuable service to patients and enormous support to staff. They form an essential part of the hospital team and are greatly appreciated.

For many, volunteering is a step on the ladder to employment; an opportunity to experience the hospital environment before going to University or having the courage to leave their current employment to follow a long held dream of working in the NHS. Of course, many of our volunteers stay with us for years with some having 5, 10, 15, 20 and even 25 years or more voluntary service and each volunteer has their own personal reason for offering their time.

There remains a constant interest in "volunteering within the Great Western Hospital", with an average of 40 enquiries received each month. Volunteers come through the same recruitment process as a member of staff. They are interviewed by the Voluntary Services Manager, have to have two references, Occupational Health and CRB clearance and then meet the relevant Placement Area Manager before attending the Trust induction and any other relevant training e.g. assisting patients at mealtimes and bed making. This process can often take up to three months to complete.

In addition, there is the opportunity to volunteer at the hospital via other organisations, such as British Red Cross, Hospital Radio, WRVS and the Friends of Savernake Hospital & Community.

Volunteers are called the Voluntary Services TEAM because with their assistance "**T**ogether **E**veryone **A**chieves **M**ore". Our volunteers now wear teal coloured polo shirts (with the exception of Chaplaincy Volunteers, Cancer Information Point and also Breastfeeding Support volunteers who wear lavender) which makes them stand out in their own right as a team within the hospital.

A quarterly “Voluntary Service Matters” newsletter is sent to all volunteers and twice a year we hold “Volunteer Social Events” (including Long Service Awards) to ensure that the volunteers are well communicated with and have an opportunity to share their ideas with us too.

Volunteer numbers			**Trust volunteer demographics**
We currently have **538** volunteers			22% Male 78% Female
389 **82** **30** **21** **16**	Trust Volunteers WRVS Volunteers Hospital Radio Volunteers British Red Cross Volunteers Friends of Savernake Hospital & Community	72% 15% 6% 4% 3%	18% of our volunteers are aged between 17-25, 31% of our volunteers are aged between 26-60, 46% of our volunteers are aged between 61-80, 5% of our volunteers are aged over 80.

9.8.1 Number of hours volunteered by Trust volunteers

During 2011/2012 (April ’11 to January ’12) our GWH based Trust volunteers helped us for 20,550 hours. This equates to an average of 2283 hours per month and 61 full time equivalent members of staff per month. This is an approximate 11% increase on the same period in the previous year.

In total, 3 volunteer leavers secured permanent roles as paid members of staff in the Trust, 1 as a Nursing Auxiliary and two as Bio Medical Scientists.

9.9 Occupational Health

The Occupational Health Department welcomed the introduction of the National Occupational Health Standards for Accreditation, published 2010, and is now working towards full accreditation by summer 2012.

The Boorman Review, published during 2009, which showed that being proactive and putting in place preventative measures will yield considerable benefits for individuals and for patients continues to be one of the main drivers for OH activity and during 2011/12 has seen the implementation of the Health & Wellbeing programme which is a new and innovative service, offered to all employees. This enables every member of staff to have an assessment to look at all aspects of their health and lifestyle and specialist advice is offered to design a bespoke programme to make changes which will improve and enhance their health and wellbeing both at work and at home.

The Occupational Health department continues to work closely with managers and HR to reduce time lost due to sickness absence. The two key areas that have been addressed are Musculoskeletal Disorder (MSD) issues and reducing stress related absence.

The Occupational Health team now has an OH nurse advisor who is also a Registered Mental Health Nurse. This nurse complements the nurses already in post who can offer Cognitive Behavioural Therapy, and also works alongside the Staff Support Service, who offer the full range of counselling and support therapies.

The Musculoskeletal Disorder team and the Occupational Health team including physiotherapy input have worked closely together to carry out workplace assessments along with early intervention treatment.

Over the past 12 months there has been a very clear correlation between the number of referrals received within Occupational Health from line managers and the number of staff off sick. For example in December there was a dramatic fall in referrals and a marked increase in sickness absence, compared to January, where there was a high number of OH interventions and a noted fall in sickness absence numbers.

9.10 Swine / Seasonal Flu Vaccinations

The seasonal Flu campaign obtained a 26% uptake across the Trust in 2010, but, with recent national media coverage featuring the Chief Medical Officer at the Department of Health 2011 resulted in 39.5%.

9.11 Health and Safety

During 2011 we commenced implementation of a suitable safety management system throughout the combined geographical area. Notable improvements are already being appreciated by staff, visitors and patients across the enlarged trust and a new governance structure has been implemented with monitoring via the Trust and Wiltshire Health and Safety Committees and regular progress reports to the Executive Committee.

Major targeted improvements have included:

- Implementation of new Safeguard Incident Management system across Wiltshire and commencement of an electronic incident reporting process across all sites within the enlarged Trust to speed up and improve quality of reports and investigations.

- Roll out of a comprehensive H&S Audit programme across all Wiltshire sites to benchmark current compliance with legal / Policy H&S requirements and to provide clear improvement advice to all departmental managers.

- Fire safety management improvements in reducing unwanted fire signals at GWH from 35 last year to 22 [against a target threshold of 32] in partnership with Carillion and also providing a comprehensive fire safety warden structure and training programme throughout the enlarged trust.
- Sustained performance in serious RIDDOR reportable accidents for GWH which remain at 9 for the year and introduction of a centralised RIDDOR reporting requirement across Wiltshire instead of manager self reporting. This has resulted in 7 RIDDOR incidents being reported by the H&S Department from Wiltshire over the past year.
- Introduction of a comprehensive H&S Representative training programme for the newly appointed department Reps and Department Managers throughout the Wiltshire sites.
- Amalgamation of Wiltshire and GWH Policies and procedures accessible via a new versatile H&S Intranet web page.

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

10 REGULATORY RATINGS REPORT

10.1 Monitor the Independent Regulator

As a Foundation Trust, GWH is regulated by Monitor, the independent regulator of all NHS Foundation Trusts. Monitor's relationship with GWH is to ensure that the Trust does not breach the terms of its authorisation which were agreed when GWH became a Foundation Trust in December 2008. The Terms of Authorisation are a set of detailed requirements covering how GWH will operate – in summary they include:

- the general requirement to operate effectively, efficiently and economically;
- requirements to meet healthcare targets and national standards; and
- the requirement to cooperate with other NHS organisations.

Monitor requires each Foundation Trust board to submit an annual plan, quarterly and ad hoc reports. Performance is monitored against these plans to identify where potential and actual problems might arise. Monitor publishes quarterly and annual reports on these submissions and assigns each Foundation Trust with an annual and quarterly risk rating. These risk ratings are designed to indicate the risk of a failure to comply with the terms of authorisation. Monitor publishes three risk ratings for each NHS Foundation Trust as follows: -

- financial rating; and
- governance risk rating.

The future role of Monitor and the regulatory regime is changing in light of new legislation. Providers of healthcare services will be licensed and Monitor will ensure that providers comply with licensing conditions.

10.2 Risk ratings from Monitor

10.2.1 Financial risk rating

The Trust has been rated as 3 for Finance (rated range from 1-5, where 1 represents the highest risk and 5 the lowest). This means that there are regulatory concerns in one or more components but significant breach is unlikely.

When assessing financial risk, Monitor will assign quarterly and annual risk ratings using a system which looks at four criteria, namely achievement of plan; underlying performance; financial efficiency; and liquidity.

The risk rating is forward-looking and is intended to reflect the likelihood of an actual or potential financial breach of the Foundation Trust's terms of authorisation.

10.2.2 Governance risk rating

The term governance is used to describe the effectiveness of an NHS Foundation Trust's leadership. The Trust has a rating of green for Governance (rating range from red, amber-red, amber-green, green with green being the best). A green rating means there are no material concerns surrounding the terms of Authorisation.

When assessing the annual and quarterly governance risk ratings Monitor considers the legality of the constitution; growing a representative membership; appropriate board roles and structures; xo-operation with NHS bodies and local authorities; clinical quality; service performance (healthcare targets and standards); and other risk management processes.

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

10.2.3 Mandatory services

Mandatory services are defined in a Foundation Trust's terms of authorisation and are the services the Trust is contracted to supply to its commissioners.

Trust Boards are required to provide a board statement certifying that they expect to be able to continue to provide the mandatory services required by Schedules 2 and 3 of their Authorisation and then by exception to declare in year if this risks not being the case. During 2011/12 no such declarations were made.

10.3 Risk Ratings 2011/12

10.3.1 Summary of rating performance throughout the year and comparison to prior year with analysis of actual quarterly rating performance compared with expectation in the annual plan and comparison to prior year

	Annual Plan 2010-11	Q1 2010-11	Q2 2010-11	Q3 2010-11	Q4 2010-11
Financial Risk Rating	**4**	3	3	3	3
Governance Risk rating	**Green**	Green	Green	Green	Green

	Annual Plan 2011/12	Q1 2011-12	Q2 2011-12	Q3 2011-12	Q4 2011-12
Financial Risk Rating	**3**	3	3	3	3
Governance Risk rating	**Amber Green**	Green	Green	Amber Red	Green

10.3.2 Explanation for differences in actual performance versus expected performance at the time of the annual risk assessment

Two CQC Outcome compliance risks were reported by the CQC in January 2012. These risks related to Outcomes 4 and 5 (Care and Welfare of people who use services and meeting nutritional needs). Since this time, the Trust has implemented and audited actions plans to ensure compliance is observed. The CQC was advised by the Trust that is compliant with these Outcomes as from 30th April 2012.

10.3.3 Details and actions from any formal interventions.

The Trust had no formal interventions during 2011/12.

10.4 The Care Quality Commission (CQC – formerly the Healthcare Commission)

Whereas Monitor's role is to assess and regulate the ability of an NHS Foundation Trust board to do their job properly and ensure their hospitals provide high quality care, the Care Quality Commission (CQC) is the independent regulator responsible for regulating the quality of health and adult social care services in England.

There are Core Standards which the Trust must comply with and which the Care Quality Commission periodically reviews the Trust against. These standards cover the full range of healthcare services and provide the general public with information on the quality of services provided by the Trust.

10.4.1 Care Quality Commission (CQC) registration

Health and social care organisations are required to register with the CQC through a registration system. This process is, in effect, a licence for Trusts like GWH to provide services.

To be registered, trusts must meet the standards, which cover important issues for patients such as treating people with respect; involving them in decisions about care; keeping clinical areas clean, and ensuring services are safe.

To register with the CQC the Trust has had to demonstrate that it meets the essential standards of quality and safety across all services being provided.

In March 2010 GWH was registered with the CQC without additional conditions attached to the registration.

11 OTHER DISCLOSURES IN PUBLIC INTEREST

11.1 Cost allocation and charging requirements

The Trust has complied with the cost allocation and charging requirement set out in HM Treasury and Office of Public Sector Information Guidance.

11.2 Serious incidents involving data loss or confidentiality breach

During 2011/12 there were no serious incidents involving data loss or confidentiality breach classified at a severity rating of 3-5. Accordingly, no incidents were required to be reported to the Information Commissioner's Office.

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

Summary of other personal data related incidents in 2011/12		
Category	**Nature of incident**	**Total**
I	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	0
II	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	0
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	0
IV	Unauthorised disclosure	2
V	Other	3

Severity rating 1 is a minor breach of confidentiality affecting only a single individual.

11.3 Working with suppliers

The Great Western Hospitals NHS Foundation Trust works with a large number of suppliers across a very diverse portfolio. Our aim is to work in partnership with our suppliers and to build strong relationships that enable us to obtain best value for money when purchasing the quality of goods and services the Trust needs to support patient care.

The Trust has developed its E-Procurement tools which enhances transparency of our contracting processes, gives visibility of the contracts the Trust is tendering for, makes it easier for suppliers to engage with us and reduces the paperwork suppliers have to complete during formal tendering processes.

12 STATEMENT OF ACCOUNTING OFFICER'S RESPONSIBILITIES

12.1 Statement of the Chief Executive's responsibilities as the accounting officer of Great Western Hospitals NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the Accounting Officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the NHS Act 2006, Monitor has directed Great Western Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Great Western Hospitals NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the *NHS Foundation Trust Annual Reporting Manual* and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgments and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements; and
- prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's NHS Foundation Trust Accounting Officer Memorandum.

Signed.....

Nerissa Vaughan
Chief Executive

24 May 2012

13 AUDITOR'S OPINION AND CERTIFICATE

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

We have audited the financial statements of Great Western Hospitals NHS Foundation Trust for the year ended 31 March 2012 on pages 176 to 209. These financial statements have been prepared under applicable law and the accounting policies set out in the Statement of Accounting Policies.

This report is made solely to the Council of Governors of Great Western Hospitals NHS Foundation Trust in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of Governors of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of the accounting officer and the auditor

As described more fully in the Statement of Accounting Officer's Responsibilities on page 160 the accounting officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practice's Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed, the reasonableness of significant accounting estimates made by the accounting officer and the overall presentation of the financial statements. In addition we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of Great Western Hospitals NHS Foundation Trust's affairs as at 31 March 2012 and of its income and expenditure for the year then ended; and
- have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2011/12.

Opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts

In our opinion the information given in the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

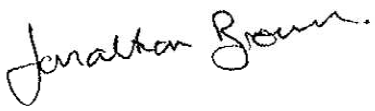
Matters on which we are required to report by exception

We have nothing to report where under the Audit Code for NHS Foundation Trusts we are required to report to you if, in our opinion, the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

We are not required to assess, nor have we assessed, whether all risks and controls have been addressed by the Annual Governance Statement or that risks are satisfactorily addressed by internal controls.

Certificate

We certify that we have completed the audit of the accounts of Great Western Hospitals NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.



Jonathan Brown for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
100 Temple Street
Bristol
BS1 6AG

29 May 2012

14 ANNUAL GOVERNANCE STATEMENT

14.1 Scope of responsibility

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

14.2 The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Great Western Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Great Western Hospitals NHS Foundation Trust for the year ended 31 March 2012 and up to the date of approval of the annual report and accounts.

14.3 Capacity to handle risk

Leadership is given to the risk management process by embedding responsibility within the executive director's job description and annual appraisal and personal development plans. Executive directors personally review assurances against their strategic objectives on a quarterly basis as part of the Board Assurance Framework. In December 2011, a workshop was held to provide training for Executive and Non-Executive Directors and senior managers on roles and responsibilities for leadership in risk management.

Staff education and training on risk management is carried out commensurate with their roles. All new employees receive corporate induction, which includes risk management and incident reporting, alongside health and safety, manual handling and infection control training appropriate to their duties. In addition during 2011/12, further training on risk management has been provided to all Associate Medical Directors, General Managers and other senior staff within directorates as part of the roll out of a new electronic system for compiling and managing risk.

14.4 The risk and control framework

14.4.1 Risk Management Strategy

The overall objective of the Risk Management Strategy is to ensure that robust risk management processes are in place which provide assurance to the Board that the Trust is discharging its responsibilities in ensuring good business and financial decision making leading to improvements in services and the quality of care provided.

To ensure that risk is identified, evaluated and controlled there are formal structures within the Trust. In 2011/12 the Risk Management Strategy was reviewed with the reporting process for risk being formalised. Whilst the Board has overall responsibility for risk management, it delegated the work to the Executive Committee and the Audit, Risk and Assurance Committee.

The three main tenets of our risk management strategy are:

- Risk assessment
- Risk Register
- Board Assurance Framework

14.4.2 Risk assessment

All trust staff are made responsible for identifying and managing risk. In addition there is a robust Incident Management Policy in place and at Corporate Induction staff are actively encouraged to utilise our web-based incident reporting system. A healthy incident reporting culture has been maintained for a number of years providing assurance that staff feel able to report incidents and risks. A Being Open Policy, based on National Patient Safety Agency guidance, is in place and regularly reviewed. An annual audit is undertaken by the Health and Safety Team of all wards and departments which demonstrates risk assessment and risk management in practice.

14.4.3 Risk Register

In 2011/12 it was agreed that the most significant risks to the Trust, being those which score 15 and above, should be reviewed monthly at the Executive Committee. A register containing 15 plus risks is scrutinised and challenged by the Executive Committee (to ensure risks are being managed) and the Audit, Risk and Assurance Committee (to ensure processes in place to manage risk are effective). This high-level register is informed both by those risks which scored 15 in the board assurance framework (top down) and risks identified from within the directorates (bottom up).

14.4.4 Board Assurance Framework

During 2011/12, the Trust undertook a fundamental review of its Board Assurance Framework. The Board Assurance Framework is set by the Executive Committee and approved by the Trust Board annually. The assurance framework sets out

- the principal objectives to achieving the Trust's overall goals,
- the principal risks to achieving those objectives,

- the key controls to mitigate against those risks,
- the assurances on those controls, and
- any gaps in assurances.

An internal audit undertaken in January 2012 granted the Trust substantial (green) assurance on the design and implementation of the board assurance framework.

14.4.5 Significant Risks

There are a number of risks identified in the board assurance framework and risk register. Examples of significant risks identified during 2011/12, together with the actions that have been taken to mitigate them as summarised as follows: -

Risk	How risk was mitigated
Directorate's forecasts deteriorate resulting in a deficit.	• Project management board to monitor delivery of savings; • Monthly monitoring of actions by the Executive Committee; • Monthly reporting to the Finance and Investment Committee;
Activity above proposed contract levels	• Risk framework agreed with Commissioners; • Appropriate contract values agreed with Commissioners.
Potential for quality of care to be compromised during transition phase of transfer of WCHS	• A project transition team created; • Governance arrangements strengthened; • A Transition Director of Community Services appointed.
Failure to achieve compliance with new NHSLA Level 2 Acute Standards	• Agreement with Wiltshire PCT to fund any deficit associated with reductions in NHSLA Levels for 1 year • Agreement with NHSLA for an extension to the normal assessment cycle.

No significant gaps in controls or assurances were identified during 2011/12. Where minor gaps in control were identified, these were acted upon within prescribed timescales.

New risks for 2012/13 will be identified through the annual plan process and will be added to the Assurance Framework. Major future risks, including significant clinical risks for 2012/13 have been identified and include the following: -

TABLE - Future risks

Risk	Actions to manage and mitigate, including how outcomes will be assessed
Establishment of Clinical Commissioning Groups with different approaches within Swindon and Wiltshire with risk of differential pathways	• Stakeholder engagement • Trust working with Wiltshire Council to develop partnership • Attendance at Community Change Programme Group (QIPP) in Swindon chaired by GP commissioning lead • Attendance at QIPP Board in Wiltshire, which clinical input • Partnership working with NHS Swindon and NHS Wiltshire to develop joint contract performance arrangements with input from Trust Clinicians and GPs • Monthly GP forum being used to as a vehicle to discuss future plans • Stakeholder engagement/consultation of the Trust 5 year Strategy enabling alignment of Trust plans with Commissioning intentions.

Risk	Actions to manage and mitigate, including how outcomes will be assessed
Licence to operate (compliance with CQC registration and regulatory regime)	• Plans implemented to address CQC compliance concerns, CQC notified with re-inspection by CQC outstanding • Programme of matron led CQC style visits to review practise, and staff response • Periodic Clinical Audit compliance reviews, with outcomes and action plans where required being presented and scrutinised by Governance Committee, providing assurance to the Board. • CQC compliance included in annual internal audit plan. The audit report/compliance being reported to both the Governance Committee and Audit Risk & Assurance Committee. Actions plans to resolve compliance issues will be presented and scrutinised by the Governance Committee. • Monthly reporting on compliance
Financial and reputation risk if non achievement of NHSLA level 2 – Acute standards in November 2012 and Maternity in May 2013	• Gap analysis completed and action plan in place, • Monitored monthly via Executive Committee and Patient Safety and Quality Group. • Informal Assessments completed by NHSLA prior to formal assessment with action plans updated to reflect outcome. • Included in work plan for Parkhill, Internal Auditors with out-come being presented to Audit Risk & Assurance Committee • Scrutiny of plans by the Governance Committee. • Clinical Governance Committee and Audit, Risk & Assurance Committee will provides assurance to Trust Board.
QIPP/Savings delivery, target is £16m which is 5.7% of turnover. Non delivery leading to a deficit, poor liquidity and reduction in Financial Risk Rating	• Programme Management Arrangements in place, including increased support to the Directorates • Clinical engagement and increased partnership working with other providers. • Targets included in Directorate Accountability Agreements implemented as part of the new performance management arrangements • Delivery monitored monthly via Directorate Performance meetings and Executive Committee. • Scrutiny of plans by the Finance & Investment Committee • External review of plans by Parkhill, these will take place in at end of quarter 1 and in quarter 3. Outcomes presented to Finance & Investment Committee and Audit Risk & Assurance Committee, with issues escalated to the Board • Multi-provider governance arrangements in place for delivery of QIPP, with representation Executive Directors and Associate Medical Directors of the Trust, reporting into the Community Change Programme Groups (QIPP) • Increase working capital facility, tender planned for August with new agreement in place by 1st December 2012

14.4.6 Organisation Culture

The Trust operates a Being Open Policy and has mechanisms in place to promote a culture in which staff are supported to be open with patients when things go wrong. The Trust also operates a Whistle Blowing Policy which encourages staff to come forward with concerns.

During 2011/12 the requirements for reports to the Board and its Committees were reviewed which included the introduction of quality impact assessments for all papers, with any areas of concern highlighted and addressed. Equality and quality impact assessments were also introduced for policies and Trust wide procedural documents, thus ensuring that equality and quality considerations are core to the Trust's overall policy framework and business.

14.4.7 Information Risk

Risks to information, including data confidentiality, integrity and availability, are managed and controlled through an Information Governance Steering Group, which reports into the Audit, Risk and Assurance Committee. The Trust has a Senior Information Risk Owner (SIRO) with responsibility for the Information Risk Policy which defines an overall structured approach to the management of information risk, in line with the Risk Management Strategy. A register of Information Assets is maintained with senior managers identified as asset owners with for operational management of the assets and ensuring the principal risks are identified, assessed and regularly reviewed, and they provide annual assurance reports of the satisfactory operation and security of the information assets.

Where assessed as appropriate, risk treatment plans are actioned, additional controls are implemented, and prioritised risks are escalated to the appropriate Risk Register. As Accounting Officer I am committed to ensuring that immediate actions are taken where significant risks have been highlighted.

A range of measures is used to manage and mitigate information risks, including: staff training, privacy impact assessments, physical security, data encryption, access controls, penetration testing, audit trail monitoring, departmental checklists and spot checks. In addition, a comprehensive assessment of information security is undertaken annually as part of the Information Governance Toolkit and further assurance is provided from Internal Audit and other reviews.

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

14.4.8 Stakeholder involvement

As a foundation trust our membership is a resource for supporting risk management in the Trust. The membership is represented by governors who attend regular formal meetings with the Board of Directors and Trust staff. In particular the governors hold the Trust to account via various working groups, such as the Patient Experience Working Group and the Finance Working Group which both meet quarterly.

The governors contributed to the development of the Trust's quality strategy through a patient safety, quality and satisfaction working group. The strategy was developed in 2009/10 and is for five years ending in 2015.

The governors and wider stakeholders are actively involved in the development of the Trust's Business Strategy for future years. During 2012/13 there will be further consultations and workshops with stakeholders to ensure that the Trust's strategy going forward matches the needs and wishes of the local community and that there is a full understanding of the risks, threats and opportunities facing the Trust in the years ahead.

14.4.9 Quality Governance Arrangements

During the 2011/12 financial year, the Trust remained at level 2 for the National Health Service Litigation Authority (NHSLA) Risk Management Standards for Acute Trusts and was level 2 for Clinical Negligence Scheme for Trusts (CNST) Risk Management Standards for maternity following the integration of community services into the Trust.

During 2011/12 revised arrangements were put in place to ensure that there is corporate governance overview of all policies and Trust wide procedural documents. As part of the revised requirements, authors are required to carry out an equality impact assessment and a quality impact assessment of the reviewed document to ensure that any issues of concern relating to equality and quality are highlighted and addressed.

14.4.10 Internal CQC Compliance Assessment arrangements

Internal processes for assessing compliance against the CQC regulations are led by the Clinical Standards Group which meets on a monthly basis. The compliance judgement is informed by the CQCs Quality and Risk Profile and other accessible sources of intelligence. Evidence supporting compliance is captured on the Trust's Provider Compliance Assessment Forms which are saved and managed centrally by the Quality Team. Gaps in compliance inform the Patient Safety and Quality Committee and actions plans are developed and monitored to ensure improvements are progressed. Risks identified from the internal compliance assessment and risks arising from within the directorates, inform the relevant risk registers and are linked to the CQC outcomes.

The Patient Safety and Quality Committee reports to the Executive Committee and Trust Board monthly on the Trust's regulatory compliance status.

The foundation trust is not fully compliant with the registration requirements of the Care Quality Commission.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

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

The foundation trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

14.5 Review of economy, efficiency and effectiveness of the use of resources

The Trust has robust arrangements in place for setting objectives and targets on a strategic and annual basis. These arrangements include ensuring Great Western Hospitals NHS Foundation Trust strategy is affordable, scrutiny of cost savings plans to ensure achievement (whilst maintaining and improving quality and safety), compliance with terms of authorisation and coordination of individual objectives with corporate objectives as identified in the Annual Plan 2011/12.

Performance against objectives is monitored and actions identified through a number of channels:

- approval of annual budgets by the Board of Directors;
- monthly reporting to the Patient Safety and Quality Committee on patient safety and quality indicators; patient safety and clinical risk; clinical effectiveness; regulation; patient experience and complaints;
- regular reporting to the Board on key performance indicators including finance, activity, patient safety and human resources targets;
- monthly review of financial targets and contract performance by the Finance and Investment Committee, which is a committee of the Board;
- monthly reporting to the Executive Committee on directorate and Trust performance; and
- quarterly reporting to Monitor, via the Finance and Investment Committee and compliance with the terms of authorisation.

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

- Use of the Institute of Innovation and Improvement data and subscribes to the Foundation Trust Network benchmarking data to ensure productivity;
- Achieving Level 2 in the NHS Litigation Authority's Risk Management Standards for Acute Trusts and Level 2 in maternity standards;
- Quarterly reporting to Monitor, via the Finance and Investment Committee and compliance with terms of authorisation.

Value for money is an important component of the internal and external audit plans. These provide assurance to the Trust that processes in place are effective and efficient in the use of resources.

The Trust has an assessment process for future annual plans to ensure value for money and full appraisal processes are employed when considering the effect on the organisation. Procedures are in place to ensure all strategic decisions are considered at Executive and Board level and there is wider consultation with governors and stakeholders.

The emphasis in Internal Audit work is providing assurances on internal controls, risk management and governance systems to the Audit, Risk and Assurance Committee and to the Board.

14.6 Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

Steps which have been put in place to assure the Board that the Quality Report presents a balanced view and that there are appropriate controls in place to ensure the accuracy of data include the following: -

- The Medical Director is the Executive lead for the Quality Account and there is a named Non Executive Director with designated personal leadership for patient safety and quality on behalf of the Trust Board. The Trust has a 3 year Quality Improvement Strategy which provides details on roles and responsibilities for quality and safety and defines the key focus for the Annual Quality Accounts.

- The Annual Quality Account Report 2011/12 provides a narrative of progress toward achieving the quality improvement indicators agreed by the Executive Committee, the Patient Safety and Quality Committee and the Trust Board.

- The Quality Account is compiled by a Clinical Governance Administrator following both internal and external consultation to inform the improvement indicators. Data is provided by nominated leads in the Trust. These leads are responsible for scrutinising the data they provide to ensure accuracy. Once compiled the Quality Account Report is scrutinised by the Associated Director of Quality and Patient Safety for challenging the veracity of data. The Medical Director is ultimately accountable to Trust Board and its committees for the accuracy of the Quality Account Report.

- The Quality Account is subject to robust challenge at a Patient Safety and Quality Committee on both substantive issues and also on data quality. Where variance against targets is identified the leads for individual metrics are held to account by the Patient Safety and Quality Committee. Following scrutiny at that committee, the Quality Account is reported to Trust Board which is required to both attest to the accuracy of the data and also ensure that improvements against the targets are maintained.

- Directors' responsibilities for the Quality Account Report are outlined separately in this report.

- The Quality Account Report has been prepared in accordance with Monitor's annual reporting guidance as well as the standards to support data quality for the preparation of the Quality Report. No material weaknesses in the control framework associated with Quality Accounts have been identified.

14.7 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, clinical audit and the executive managers within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board and the Audit, Risk and Assurance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The processes that have been applied in maintaining and reviewing the effectiveness of the system of internal control include the following: -

Process		Role and Conclusions
Board	-	The Board has continued to lead the organisation throughout the year with regular reporting on finance and clinical performance, It receives and reviews minutes of committees, with concerns and issues escalated by the Committee Chairs. In March 2012 the Board reviewed and updated the Governance Structure, approving new terms of references for Board Committees to ensure that the Trust's system of internal control reflects the current needs of the organisation and to ensure that appropriate reporting and decision making mechanisms are in place.
Audit, Risk and Assurance Committee	-	The Committee provides scrutiny of internal controls, including the review the Assurance Framework and Corporate Risk.
Internal audits	-	On the effectiveness of systems of internal control. Audit findings are presented to the Audit, Risk and Assurance Committee and the Board through the Audit, Risk and Assurance Committee minutes.
Clinical audits	-	The Trust Board is meticulous in keeping Clinical Audit as the key component of clinical governance in its efforts to promote patient safety, patient experience and to promote effectiveness of care delivered to the patients. The Trust is compliant with the Trust Clinical Audit plan. The NICE lead is responsible for actively disseminating and monitoring NICE compliance. Trust wide compliance of 96-100% has been attained throughout this year.
Other Committees	-	All committees have a clear timetable of meetings and a clear reporting structure to allow issues to be raised. Terms of reference for each Board Committee have been reviewed in 2011/12 to ensure ongoing effectiveness and ensure that an appropriate level of delegation and reference back to the Board is in place.
Assurance Framework	-	Provides assurance that the effectiveness of the controls to manage the risks to the organisation in achieving its principal objectives has been reviewed. An internal audit in January 2012 gave positive assurance to the risk management process of the Trust and the Assurance Framework has been commended by the Audit, Risk and Assurance Committee and external and internal auditors.
Self-assessment declaration against CQC standards	-	The Trust has self assessed compliance with the CQC regulations. There have moderate concerns with compliance with the CQC regulations for which is it registered, but action plans are in place to address moderate and minor concerns. External NHSLA Risk Management Standards (Acute) – level 2. External CNST Risk Management Standards (Maternity) – level 2.
Quarterly reporting to Monitor	-	Declarations are considered by the Executive Committee and Finance and Investment Committee and thereafter approved by the Board on a quarterly basis prior to submission to Monitor.

The Trust will continue to review all risks and where necessary will take approach actions to either reduce or eliminate these. Actions taken will be monitored through the appropriate committees of the Board, and where necessary the Chair of the committee will escalate concerns to Board.

14.8 Conclusion

I have not identified any material weaknesses in our systems for internal control as part of my review. My review confirms that Great Western Hospitals NHS Foundation Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives.

Signed.....

Nerissa Vaughan
Chief Executive

24 May 2012

15 GLOSSARY OF TERMS

BARS – Blood Audit and Release System

CETV - Cash Equivalent Transfer Value

Clostridium Difficile – Bacteria naturally present in the gut

CQC – Care Quality Commission

CQUIN – Commissioning for Quality and Innovation Payment

CUSUM – Cumulative Sum Control Chart

DSDU –

EDS – Electronic Discharge Summary

EPF – Employee Partnership Forum

GWH – Great Western Hospitals

HCAIs – Healthcare Associated Infections

HSMR – Hospital Standardised Mortality rate

JACIE – Joint Accreditation Committee

MTD –

MRSA – Methicillin- resistant Staphylococcus Aureus, which is a common skin bacterium that is resistant to a range of antibiotics

MUST – Malnutrition Universal Screening Tool

NEDs – Non executive Directors

NICE – National Institute for Health and Clinical Excellence

NHLSA – National Health Service Litigation Authority

NPSA – National Patient Safety Agency

PCT – Primary care Trust

PEAT – Patient Environment Action Team

PSQC – Patient Safety and Quality Committee

PURAT – Pressure Ulcer Risk Assessment Tool

RCA – Root Cause Analysis

SAFE – Stratification and Avoidance of Falls in the Environment

SHA – Strategic Health Authority

SWICC – South West Intermediate Care Centre

TVNS – Tissue Viability Nurse Specialist

VAP - Ventilated Acquired Pneumonia

VTE - Venous Thromboprophylaxis (Blood clot)

WCHS – Wiltshire Community Health Service

WHO – World Health Authority

16 FOREWORD TO THE ACCOUNTS

16.1 Foreword to the accounts for the year ending 31 March 2012

These accounts for the period ended 31st March 2012 have been prepared by Great Western Hospitals NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 of the National Service Act 2006 in the form than Monitor, the Independent Regulator of NHS Foundation Trusts, with the approval of the Treasury, has directed.

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2012

	Notes	Year Ended 31 March 2012 £000	Restated Year end 31 March 2011 £000
Operating Income from continued operations	3 - 4	**290,475**	202,712
Operating Expenses of continued operations	5	**(275,274)**	(187,835)
Operating surplus		**15,201**	14,877
Finance Costs			
Finance income	10	**333**	217
Finance expense - financial liabilities	11	**(13,834)**	(14,102)
Finance expense - unwinding of discount on provisions		**(44)**	(49)
Public Dividend Capital Dividends payable		**(1,120)**	(1,190)
Net finance costs		**(14,665)**	(15,124)
SURPLUS/(DEFICIT) FOR THE YEAR		**536**	(247)
Other comprehensive income			
Loss on Asset Disposal		**(22)**	0
Total comprehensive income/(expense) for the year		**514**	(247)

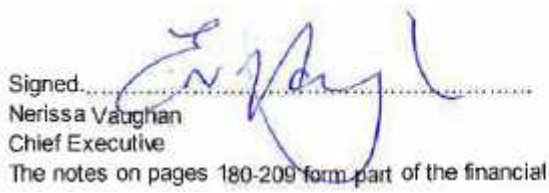
Note:

The Trust acquired the community services of NHS Wiltshire from 1 June 2011 under a Transfer of Community Services (TCS) agreement. As per Department of Health guidance, merger accounting has been used and as a result a full year of trading has been included within the above SoCI for the year ending 31 March 2012.

All income and expenditure is derived from continuing operations.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2012

	Notes	31 March 2012 £000	Restated 31 March 2011 £000	Restated 1 April 2010 £000
Non-Current Assets				
Intangible assets	13	**1,162**	1,170	612
Property, Plant and Equipment	14	**179,122**	183,018	182,725
Trade & Other Receivables	17			1,733
Total non-current assets		**180,284**	184,188	185,070
Current Assets				
Inventories	16	**4,839**	3,820	3,156
Trade and other receivables	17	**13,577**	8,335	11,095
Cash and cash equivalents	19	**14,482**	11,223	12,181
Total current assets		**32,898**	23,379	26,432
Current Liabilities				
Trade and Other Payables	20	**(22,970)**	(18,652)	(19,102)
Borrowings	22	**(4,533)**	(1,425)	(3,004)
Provisions	23	**(565)**	(350)	(1,434)
Tax Payable	21.1	**(1,788)**	(1,324)	
Other liabilities	21	**(1,425)**	(1,016)	(1,491)
Total current liabilities		**(31,281)**	**(22,766)**	**(25,031)**
Total assets less current liabilities		**181,901**	184,801	186,472
Non-Current Liabilities				
Trade and Other Payables	20	**(412)**	0	(593)
Borrowings	22.2	**(128,133)**	(132,036)	(133,118)
Provisions	23	**(4,686)**	(4,495)	(4,132)
Other Liabilities	21	**(1,816)**	(1,930)	(2,044)
Total non-current liabilities		**(135,047)**	(138,461)	(139,886)
Total assets employed		**46,854**	46,340	46,586
Financed by Taxpayers' Equity				
Public dividend capital		**27,111**	27,111	27,111
Revaluation reserve		**18,529**	18,551	18,551
Income and expenditure reserve		**1,214**	678	925
Total taxpayers' equity		**46,854**	46,340	46,586



Note:

The Balance Sheet has been restated from 1st April 2010 following a change in accounting treatment for Donated Asset Reserve and Government Grant Reserve.

These Reserves were previously held separately in Taxpayers Equity and were released over the life of the assets to which they related.

The revised accounting treatment is to charge the costs to the Statement of Comprehensive Income in the year in which the asset/liability arises. The impact on the Statement of Financial Position is that any balances held in these reserves now form part of the Income and Expenditure Reserve.

Great Western Hospitals NHS Foundation Trust
Accounts for the year ended 31 March 2012

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	Public Dividend Capital	Revaluation Reserve - Tangible assets	Donated Asset Reserve	Other Reserves	Income and Expenditure Reserve	**Total**
	£000	£000	£000	£000	£000	**£000**
Taxpayers' Equity at 1 April 2010 as previously stated	27,111	18,551	895	264	(235)	46,586
Prior period adjustment	**0**	**0**	**(895)**	**(264)**	**1,160**	**0**
Taxpayers' Equity at 1 April 2010 - restated	**27,111**	**18,551**	**(0)**	(0)	**925**	**46,586**
Surplus/(deficit) for the year	0	0	0	0	(247)	(247)
Transfers in respect of assets disposed of	0	0	0	0	0	0
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of on donated assets	0	0	0	0	0	0
Receipt of donated assets	0	0	0	0	0	0
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of on donated assets	0	0	0	0	0	0
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve	0	0	0	0	0	0
Public Dividend Capital received/paid	0	0	0	0	0	0
Additions/(reduction) in Other reserves	0	0	0	0	0	0
Taxpayers' Equity at 31 March 2011	**27,111**	**18,551**	**(0)**	**(0)**	**678**	**46,340**
TCS and merger adjustments	0	0	0	0	0	0
Surplus/(deficit) for the year	0	0	0	0	536	536
Transfers in respect of assets disposed of	0	(22)	0	0	0	(22)
Revaluation gains/(losses) and impairment losses property, plant and equipment	0	0	0	0	0	0
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of on donated assets	0	0	0	0	0	0
Receipt of donated assets	0	0	0	0	0	0
Transfers in respect of depreciation, impairment and disposal of donated assets	0	0	0	0	0	0
Public Dividend Capital received	0	0	0	0	0	0
Additions/(reduction) in Other reserves	0	0	0	0	0	0
Taxpayers' Equity at 31 March 2012	**27,111**	**18,529**	**(0)**	**(0)**	**1,214**	**46,854**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2012

	Notes	Year Ended 31 March 2012 £000	Restated Year Ended 31 March 2011 £000
Cash flows from operating activities			
Operating surplus from continuing operations		**15,201**	14,877
Depreciation and amortisation		**7,872**	7,536
Amortisation of PFI credit		**114**	0
Increase in inventories		**(1,019)**	(664)
(Increase) / decrease in trade and other receivables		**(5,242)**	4,491
Increase in trade and other payables		**5,195**	281
Increase / (decrease) in other liabilities		**180**	(633)
Increase / (decrease) in provisions		**406**	(721)
NET CASH GENERATED FROM OPERATIONS		**22,706**	25,167
Cash flows from investing activities			
Interest received		**333**	87
Purchase of Property, Plant and Equipment		**(3,337)**	(8,452)
Net cash used in investing activities		**(3,004)**	(8,365)
Cash flows from financing activities			
Capital element of Private Finance Initiative Obligations		**(1,425)**	(2,595)
Interest paid		**(57)**	(100)
Interest element of Finance Leases		**(39)**	0
Interest element of Private Finance Initiative Obligations		**(13,738)**	(14,002)
PDC dividends paid		**(1,185)**	(1,063)
Net cash generated (used in) financing activities		**(16,443)**	**(17,760)**
Increase/(decrease) in cash and cash equivalents		**3,259**	**(958)**
Cash and cash equivalents at 1 April 2011		**11,223**	12,181
Cash and cash equivalents at 31 March 2012	19	**14,482**	11,223

ACCOUNTING POLICIES

1 Basis of Preparation

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the FT ARM 2011/12 issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered in relation to the accounts.

1.1 Accounting Convention

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

1.1.1 **Subsidiaries**

Subsidiary entities are those over which the Trust has the power to exercise control or a dominant influence so as to gain economic or other benefits. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

Until 31st March 2013, NHS Charitable Funds considered to be subsidiaries are excluded from consolidation in accordance with the accounting direction issued by Monitor.

1.1.2 TCS Merger Note

The Trust acquired the contract to run Wiltshire Community Health Services (WCHS) from NHS Wiltshire with effect from 1st June 2011. This is operated under two commissioning contracts - one for Adult and Community Services and one for Maternity Services.

The Foundation Trust Annual Reporting Manual requires that all transfers of functions between public sector bodies will be accounted for using full merger accounting. As a result a full 12 months of WCHS has been included within the SOCI. The Department of Health has considerd it impracticable to restate the comparative information.

The Department of Health does not require Trusts to include prior year comparators for transfers under TCS (Transferring Community Services) and the amendments to the 2011/12 Opening Balances are shown by an adjustment to 1 April 2011 opening balances in the line 'Adjustment for transfer of functions' The following current and non-current assets were transferred to the Trust at book value, which also reflects their fair value, are included in the opening balances.

	At 1 April 2011	At 1 June 2011
	£'000	£'000
Non-Curent Assets	0	0
Current Assets	1,492	0
Non-current liabilities	0	0
Current liabilities	(1,492)	94

It should be noted that the information in the annual accounts includes 12 months results for WCHS, even though it was only unde the Operational management of the Trust for 10 months of the year. The actual value of the contract from the date of transfer (1st June 2011) for 2011/12 is £66.2m.

The current year reported results of the Trust can be analysed as follows:

	1 April 2011- 31 May 2011		1 June - 31 March 2012	
	Great Western Hospitals NHS FoundationTrust	Wiltshire Community Health Services	Total Combined Organisation	Total for the Year
	£'000	£'000	£'000	£'000
Operating Income	33,854	12,964	243,657	290,475
Operating Expenses	(31,397)	(12,954)	(230,923)	(275,274)
Finance Costs	(2,442)	0	(12,223)	(14,665)
Surplus/Deficit for the period	**15**	**10**	**511**	**536**
Other Comprehensive Income		-		
Total comprehensive income for the period	**15**	**10**	**511**	**536**

1.2 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services.

Income relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

1.3 Expenditure on Employee Benefits

1.3.1 Short term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from the employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that the employees are permitted to carry forward leave into the following period.

ACCOUNTING POLICIES (continued)

1.3.2 Pension Costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under direction of the Secretary of State, in England and Wales. 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.

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

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement regardless of the method of payment.

The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised in the income and expenditure reserve and reported in the
. Statement of Comprehensive Income as an item of 'other comprehensive income'

Local Government Superannuation Scheme

Some employees are members of the Local Government Superannuation Scheme which is a defined benefit pension scheme. The scheme assets and liabilities attributable to these employees can be identified and are recognised in the Trust accounts. The assets are measured at fair value, and the liabilities at the present value of future obligations.

1.4 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.5 Property, plant and equipment

1.5.1 Recognition

Property, plant and equipment is capitalised where:

- they are held for use in delivering services or for administrative purposes.
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust.
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- individually have a cost of at least £5,000; or
- form a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial equipping and setting-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

ACCOUNTING POLICIES (continued)

1.5.2 Measurement

Valuation

All property, plant and equipment are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Land and Property assets are valued every 5 years with a 3 yearly interim valuation also carried out. Annual impairment reviews are carried out in other years. The 3 and 5 yearly interim revaluations are carried out by a professionally qualified valuer in accordance with the Royal Chartered Institute of Surveyors (RICS) Appraisal and Valuation Manual. The valuations are carried out on the basis of a Modern Equivalent Asset as required by HM Treasury. The annual reviews are carried out using the most appropriate information available at the date of the review. A revaluation was carried out on 31 March 2010.

Equipment assets values are reviewed annually internally to determine the remaining life based on past and forecasted consumption of the economic useful life of the asset.

Property used for the Trust's services or for administrative purposes are stated in the Statement of Financial Position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the Trust and the cost of the item can be determined reliably.

Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been classified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Leasehold properties are depreciated over the primary lease term.

Equipment is capitalised at current cost and depreciated evenly over the estimated lives of the asset.

	Years
Medical equipment and engineering plant and equipment	5 to 15
Furniture	10
Information technology equipment	5
Transport	6

ACCOUNTING POLICIES (continued)

Revaluation Gains and Losses
Revaluation gains are recognised in the revaluation reserve , except where, and to the extent that, they reverse a revaluation decrease that has been previously recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
In accordance with the FT ARM, impairments that are due to a loss of economic benefit or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charges to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'Held for Sale' once all the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales
- the sale must be highly probable i.e.

  management are committed to a plan to sell the asset

  an active programme has begun to find a buyer and complete the sale.
  the asset is being actively marketed at a reasonable price.
  the sale is expected to be completed in within 12 months of the date of classification as 'Held for Sale' and
  the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the assets economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

ACCOUNTING POLICIES (continued)

1.6 Donated, government grant and other grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor imposes a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

This change in accounting treatment was effective from a April 2010 and has resulted in the restatement of the 2010/11 balances.

The donated and grant funded assets are subsequently accounted for in the same manner as other property, plant and equipment.

1.7 Private Finance Initiative (PFI) Transactions

PFI Transactions that meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. The underlying assets are recognised as property, plant and equipment at their fair value. An equivalent financial liability is recognised in accordance with IAS 17.

The annual contractual payments are apportioned between the repayment of the liability, a finance cost and the charges for services.

The service charge is recognised in operating expenses and the finance cost is charged to the Statement of Comprehensive Income.

1.7.1 Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

1.8 Intangible assets

1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

ACCOUNTING POLICIES (continued)

1.8.2 Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.
Expenditure on research is not capitalised.
Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development

1.8.3 Software

Software which is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of the hardware e.g. application software is capitalised as an intangible asset.

1.8.4 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at fair value. Revaluation gains and losses and impairments are treated in the same manner as for Property, Plant and Equipment.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.8.5 Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.8.6 Revenue Grants and other Grants

Government grants are grants from Government Bodies other than income from Primary Care Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. Pharmacy stocks are valued at average cost, other inventories are valued on a first-in first-out basis. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks. Work-in-progress comprises goods and services in intermediate stages of production.

ACCOUNTING POLICIES (continued)

1.10 Financial instruments and financial liabilities

1.10.1 Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

1.10.2 Classification

Financial assets are classified as fair value through income and expenditure, loans and receivables. Financial liabilities are classified as fair value through income and expenditure, or as other financial liabilities.

Financial assets and financial liabilities at 'fair value through the income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short term. Derivatives are also categorised as held for trading unless they are designated as hedges. Assets and liabilities in this category are classified as current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains and losses in the Statement of Comprehensive Income.

1.10.3 Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets. The Trust's loans and receivables comprise current investments, cash and cash equivalents, NHS debtors, accrued income and other debtors.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial assets or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

1.10.4 Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or to intangible assets is not capitalised as part of the cost of those assets.

1.10.5 Determination of Fair Value

For Financial assets and financial liabilities carried at fair value, the carrying amounts are determined from current market prices.

ACCOUNTING POLICIES (continued)

1.10.6 Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

1.10.7 Accounting for derivative financial instruments

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through income and expenditure. They are held at fair value, with any subsequent movement recognised as gains or losses in the Statement of Comprehensive Income.

1.11 Trade receivables

Trade receivables are recognised and carried at original invoice amount less provision for impairment. A provision for impairment of trade receivables is established when there is objective evidence that the Trust will not be able to collect all amounts due according to the original terms of receivables. The amount of the provision is recognised in the Statement of Comprehensive Income.

1.12 Deferred income

Deferred income represents grant monies and other income received where the expenditure has not occurred in the current financial year. The deferred income is included in current liabilities unless the expenditure, in the opinion of management, will take place more than 12 months after the reporting date, which are classified in non-current liabilities.

1.13 Borrowings

The Trust can borrow within the limits set by Monitor's Prudential Borrowing Code. The Trust's position against its prudential borrowing limit is disclosed in note 22.1 on Page 28. The PFI non-current lease liability counts as part of the Trust's Prudential Borrowing Limit.

1.14 Leases

1.14.1 Finance Leases

Where substantially all of the risks and rewards of ownership of a lease asset are borne by the Trust the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present minimum value of the lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property, plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

1.14.2 Operating Leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

1.14.3 Lease of Land and Buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

ACCOUNTING POLICIES (continued)

1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2% in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 2.8% in real terms.

1.15.1 Clinical Negligence Costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed in note 23 on page 29 but is not recognised in the Trust's accounts.

1.15.2 Non-Clinical Risk Pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 25 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 25, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.17 Public Dividend Capital

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not an equity financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), and (ii) net cash balances with the Government Banking Services (GBS), excluding any cash balances held in GBS accounts that relates to a short term working capital facility and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the accounts.

ACCOUNTING POLICIES (continued)

1.18 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.19 Corporation Tax

The Trust does not have a corporation tax liability for the year 2011/12. Tax may be payable on activities as described below:

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

1.20 Foreign exchange

The functional and presentational currencies of the Trust is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the date of the transaction. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Statement of Comprehensive Income in the period in which they arise.

1.21 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

1.22 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However, the note on losses and special payments is compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

ACCOUNTING POLICIES (continued)

1.23 Critical Accounting Estimates and Judgements

International accounting standard IAS1 requires estimates, assumptions and judgements to be continually evaluated and to be based on historical experience and other factors including expectation of future events that are believed to be reasonable under the circumstances. Actual results may differ from these estimates. The purpose of the evaluation is to consider whether there may be a significant risk of causing a material adjustment to the carrying value of assets and liabilities within the next financial year, compared to the carrying value in these accounts. The following significant assumptions and areas of estimation and judgement have been considered in preparing these financial statements. Value of land, buildings and dwellings £159m: This is the most significant estimate in the accounts and is based on the professional judgement of the Trust's independent valuer with extensive knowledge of the physical estate and market factors. The value does not take into account potential future changes in market value which cannot be predicted with any certainty.

Income for an inpatient stay can start to be recognised from the day of admission, but cannot be precisely calculated until after the patient is discharged. For patients occupying a bed at the 2011/12 financial year end, the estimated value of partially completed spells is shown in the table below.

Untaken annual leave: salary costs include an estimate for the annual leave earned but not taken by employees at 31 March 2012, to the extent that staff are permitted to carry up to 5 days leave forward to the next financial year. This shown below:

	As at 31 March 2012	As at 31 March 2011
	£'000	£'000
Partially Completed Spells	1,284	720
Untaken Annual Leave	645	521

Provisions: Assumptions around the timing of the cash flows relating to provisions are based upon information from the NHS Pensions Agency and expert opinion within the Trust and from external advisers regarding when legal issues may be settled.

1.24 New Accounting Standards

Accounting standards that have been issued but have not yet been adopted

The following accounting standards, amendments and interpretations have been issued by the IASB and IFRIC but are not yet required to be adopted:

Effective for the next financial year ending 31 March 2013:	**Effective Date**
IFRS 7 Financial Instruments Disclosure Amendments Transfer of Financial Assets	1 January 2013
IAS 12 Income Taxes Amendment	1 January 2013
Effective for future financial years:	
IFRS 10 Consolidated Financial Statements	1 January 2013
IFRS 11 Joint Arrangements	1 January 2013
IFRS 12 Disclosure of Interests in Other Entities	1 January 2013
IFRS 13 Fair Value Measurement	1 January 2013
IAS 1 Presentation of Financial Statements on other Comprehensive Income	1 July 2012
IAS 27 Separate Financial Statements	1 January 2013
IAS 28 Associates and Joint Ventures	1 January 2013
IFRS 9 Financial Instruments Financial Assets, Financial Liabilities	1 January 2013
Financial Assets	
Financial Liabilities	

The Trust has considered the above new standards, interpretations and amendments to published standards that are not yet effective and concluded that they are either not relevant to the Trust or that they would not have a significant impact on the Trust's financial statements, apart from some additional disclosures.

The Trust has not early adopted any new accounting standards, amendments or interpretations.

2. Segmental Analysis

The Trust's Board has determined that the Trust operates in two material segments which is Great Western Hospitals and Wiltshire Community Health Services. This is reflected in the Trusts' Contracts.

	GWH	WCHS	Total
Operating Income	**£'000**	**£'000**	**£'000**
NHS Clinical Income	185,747	75,860	261,607
Private Patients	3,797		3,797
Other Non Mandatory/Non Protected Revenue	3,079	512	3,591
Research & Development Income	700	(44)	656
Education and Training Income	6,839	16	6,855
Misc Other Operating Income	9,615	4,354	13,969
Total Income	**209,777**	**80,699**	**290,475**

3. Income from Activities (by Type)

	Year Ended 31 March 2012	Restated Year Ended 31 March 2011
	£000	£000
NHS Foundation Trusts	**324**	0
NHS Trusts	**448**	13
Primary Care Trusts	**259,332**	179,172
Local Authorities	**1,503**	1,347
Private Patients	**3,797**	3,040
Non-NHS: Overseas patients (non-reciprocal)	**320**	74
NHS Injury Cost Recovery scheme	**1,565**	1,515
	267,289	185,161

NHS Injury Cost Recovery scheme income is shown gross and is subject to a provision for doubtful debts of 10.5% (2010/11 9.6%) to reflect expected rates of collection.

The increase in income from NHS Foundation Trusts and NHS Trusts relates to income for services provided by Wiltshire Community Services.

3.1 Income from Activities (by Class)

	Year Ended 31 March 2012	Restated Year Ended 31 March 2011
	£000	£000
Elective income	**39,919**	41,367
Non elective income	**73,366**	64,218
Outpatient income	**38,643**	36,824
A & E income	**7,783**	7,433
Other NHS clinical income	**38,189**	32,279
Community contract income	**65,593**	0
Private patient income	**3,797**	3,040
	267,289	185,161

3.2 Private Patient Income

	Year Ended 31 March 2012	Base Year 2002/3
	£000	£000
Private patient income	**3,797**	1,587
Total patient related income	**267,289**	99,359
Proportion (as percentage)	**1.4%**	1.6%

Please note: The proportion of Private Patient Income to the total patient related income of the Trusts should not exceed its proportion whilst the body was an NHS Trust in 2002/03 (the base year).

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

4. Other Operating Income	**Year ended 31 March 2012 £000**	Year ended 31 March 2011 £000
Research and Development	**656**	573
Education and Training	**6,855**	6,512
Charitable and other contributions to expenditure	**805**	644
Non-patient care services to other bodies	**2,448**	2,215
Staff recharges	**2,065**	1,532
Other Income	**10,356**	6,075
	23,185	17,551

Analysis of Other Operating Income

Charitable and Other Contributions to Expenditure		
Macmillan Nurses	108	108
Prospect Hospice	98	77
Contributions from suppliers to support staff posts	584	449
Charitable Funds Recharge	15	10
Total	805	644

Non-patient care services to other bodies		
Mortuary	31	27
Renal	381	289
Sterile Services	377	663
Drugs provided to other NHS bodies	587	675
Bowel Screening Programme	223	68
Other Misc amounts	849	493
Total	2,448	2,215

Other Income includes		
Car Parking (Staff & Patients)	1,090	993
Estates recharges	1,548	329
IT recharges	47	47
Pharmacy sales	6	7
Clinical Excellence Awards	177	176
Catering	232	25
Property Rentals	2,655	1,101
Payroll & Procurement Services	214	78
Occupational Health Service	168	163
Dietetics	77	72
Ultrasound Photo Sales	51	32
Heart Improvement Programme	942	1,426
Transport services	282	
Other	2,867	1,626
Total	10,356	6,075

The increase in Estates recharges relates to management services relating to community sites rented to other bodies £900K

The increase in Property rentals relates to £1.5m income from sites within the Wiltshire Health Community Servcies contract which transferred in 2011/12

The increase in Payroll & Procurement services relates to the provision of these services to NHS Swindon , NHS Wiltshire and Royal National Hospital for Rheumatic Diseases.
The increase in Catering relates to services provided through the Wiltshire Community Health Services contract.

The increase in Transport services relates to the take on of this service with the transfer of Wiltshire Community Health Services in 2011/12

5. Operating Expenses	**Year Ended 31 March 2012 £000**	Restated Year ended 31 March 2011 £000
Services from Foundation Trusts	**1,575**	441
Services from other NHS Trusts	**10,001**	135
Services from PCTs	**4,650**	1,189
Services from other NHS bodies	**13**	0
Purchase of healthcare from non NHS bodies	**133**	72
Employee Expenses - Executive Directors	**855**	711
Employee Expenses - Non-Executive Directors	**126**	127
Employee Expenses - Staff	**171,129**	118,719
Drug Costs	**17,811**	13,011
Supplies and services - clinical	**22,377**	18,416
Supplies and services - general	**2,604**	1,689
Consultancy services	**259**	44
Establishment	**4,442**	2,173
Research and development	**656**	564
Transport	**337**	205
Premises	**7,942**	5,154
Increase / (decrease) in bad debt provision	**541**	(387)
Depreciation on property, plant and equipment	**7,620**	7,385
Amortisation on intangible assets	**252**	152
Loss on disposal of property, plant and equipment	**73**	0
Audit services (Statutory audit)	**63**	59
Audit services (Other Assurance Services)	**13**	17
Clinical negligence	**5,723**	3,842
Patient travel	**1,509**	909
Car parking and security	**177**	26
Insurance	**187**	97
Hospitality	**68**	67
Legal Fees	**854**	439
Training courses and conferences	**596**	551
Other Services	**11,519**	11,473
Losses, ex gratia & special payments	**7**	35
Other	**1,163**	521
	275,274	187,835

Staff Exit Packages
The Trust has not agreed any staff exit packages in 2011/12 (31 March 2011: £nil).

Limitation on auditor's liability
The limitation on the auditor's liability is £1,000,000

Other Services

Other Services - includes cleaning, catering, portering, housekeeping and estates services.
The increase in Clinical Negligence relates to the additional contributions for Wiltshire Community Health Services.

Services Provided by Foundation Trusts

The increase in Services provided by Foundation Trust's relates to payments to Salisbury NHSFT (£1,017k) for accommodation for Wiltshire Community Health Services.

Services Provided by Other NHS Trusts

The increase in Services from other NHS Trust's relates to payments to the Royal United Hospital for accommodation and medical cover (£7,017k) and Clinical Negligence (£1,935k) for Wiltshire Maternity Services which are operated from that site.

Services Provided by PCTs

The increase in Services provided by PCTs relates to payments to Bath & North East Somerset PCT (£134k), Somerset PCT (£226k) and Wiltshire PCT (£2,945k) relating to accommodation for Wiltshire Community Health Services.

The increase in Employee Expenses, Drugs Costs, Clinical and Non Clinical Supplies, Establishment Expenses, Costs and Patient Travel relate to the increase in expenditure in providing Wilthire Community and Maternity Services.

Bad Debt Provision

The increase in Bad Debt Provision is due to the Injury Recovery Scheme (£114k) and Overseas Visitors (£67k).

6. Operating leases - as Lessee

	Year Ended 31 March 2012	Year ended 31 March 2011
	£000	£000
Minimum lease payments	**5,599**	251
Contingent rents	**0**	0
Less sublease payments received	**0**	0
	5,599	251

Total future minimum lease payments	**Year Ended 31 March 2012**	Year Ended 31 March 2011
Payable:	**£000**	£000
Not later than one year	**4,203**	231
Between one and five years	**4,371**	193
After 5 years	**52**	0
Total	**8,626**	424

The increase in minimum lease payments is due to the merger with Wiltshire Community Services and relate to building and equipment utilised in the delivering of these services at a total cost of £5,011k.

7. Employee costs and numbers

7.1 Employee Expenses

	Year Ended 31 March 2012			Year Ended 31 March 2011		
	Total	**Permanently Employed**	**Other incl agency**	Total	Permanently Employed	Other incl agency
	£000	**£000**	**£000**	£000	£000	£000
Salaries and wages	**144,146**	**140,338**	**3,808**	100,119	96,515	3,604
Social security costs	**10,810**	**10,810**	**0**	7,711	7,711	0
Pension costs - defined contribution plans Employers contributions to NHS pensions	**17,028**	**17,028**	**0**	11,600	11,600	0
	171,984	**168,176**	**3,808**	119,430	115,826	3,604

7.2 Average number of employees

	Year Ended 31 March 2012			Year ended 31 March 2011		
	Total	**Permanently Employed**	**Other incl agency**	Total	Permanently Employed	Other incl agency
	Number	**Number**	**Number**	Number	Number	Number
Medical and dental	**473**	**464**	**9**	465	437	28
Administration and estates	**1,216**	**1,181**	**35**	764	739	25
Healthcare assistants and other support staff	**901**	**900**	**1**	607	573	34
Nursing, midwifery and health visiting staff	**1,892**	**1,797**	**95**	1,208	1,166	42
Nursing, midwifery and health visiting learners	**5**	**5**	**0**	2	2	0
Scientific, therapeutic and technical staff	**680**	**667**	**13**	395	391	4
	5,168	**5,014**	**154**	3,441	3,308	133

As part of Transforming Community Services Agreement 2,100 staff transferred form NHS Wiltshire on 1 June 2011.

7.3 Key Management Compensation

	Year Ended 31 March 2012	Year Ended 31 March 2011
	£000	£000
Salaries and short term benefits	**785**	687
Social Security Costs	**81**	72
Employer contributions to NHSPA	**82**	79
	948	838

Key management compensation consists entirely of the emoluments of the Board of Directors of the NHS Foundation Trust. Full details of Directors' remuneration and interests are set out in the Directors' Remuneration Report which is a part of the annual report and accounts.

There are currently six Directors to whom pension benefits are accruing under defined benefit schemes.

7.4 Highest Paid Director

Executive Name & Title Salary	**Total remuneration**	
	2011/12	**2010/11**
Dr A F Troughton, Medical Director	£194,218	£184,726

The above remuneration is on an annualised basis and is that of the highest paid director. This includes salary, performance related pay, severance payments and benefits in kind where applicable but excludes employer pension contributions. The Medical Director was Acting Chief Executive for the period May to September 2011.

7.5 Multiple Statement

	2011/12	**2010/11**	**% change**
Highest paid director's total remuneration	£194,218	£184,726	5.1%
Median total remuneration	£28,702	£26,146	9.8%
Ratio	6.77	7.07	-4.2%

All NHS Foundation Trusts are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisations workforce. The median total remuneration above is the total remuneration of the staff member lying in the middle of the linear distribution of staff employed in the Trust, excluding the highest paid director. This is based on an annualised full time total staff equivalent remuneration as at the reporting period date.The movement in the above ratio of -4.2% is due to the increased staff numbers through the merger with Wiltshire Community Services.

8. Retirements due to ill-health

During the year to 31 March 2012 there were 5 early retirements from the Trust agreed on the grounds of ill-health (31 March 2010 - 4 early retirements). The estimated additional pension liabilities of these ill-health retirements will be £368,490 (31 March 2011 - £113,566). The cost of these ill-health retirements will be borne by the NHS Pensions Agency.

9. Better Payment Practice Code

9.1 Better Payment Practice Code - measure of compliance

	Year Ended 31 March 2012		Year ended 31 March 2011	
	Number	**£000**	Number	£000
Total trade bills paid in the year	**41,617**	**77,899**	36,766	106,952
Total trade bills paid within target	**35,101**	**67,917**	34,578	103,129
Percentage of trade bills paid within target	**84.34%**	**87.19%**	94.05%	96.43%
Total NHS bills paid in the year	**2,078**	**25,585**	2,045	22,927
Total NHS bills paid within target	**1,038**	**12,426**	1,518	19,952
Percentage of NHS bills paid within target	**49.95%**	**48.57%**	74.23%	87.02%

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

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

The Trust was charged £558.51 in the year for late payment of commercial debts (31 March 2011 £2,833.79).

10. Finance Income

	Year Ended 31 March 2012	Year Ended 31 March 2011
	£000	£000
Interest on loans and receivables	**333**	217
	333	217

11. Finance Expense

	Year Ended 31 March 2012	Year Ended 31 March 2011
	£000	£000
Working Capital Facility Fee	**56**	97
Interest on late payment of commercial debt	**1**	3
Interest on obligations under Finance leases	**39**	0
Interest on obligations under PFI	**13,738**	14,002
	13,834	14,102

12. Taxation

The activities of the Trust have not given rise to any corporation tax liability in the year (31st March 2011- £nil).

13. Intangible Assets

13.1 2011/12:	Computer software - purchased	Licences and trademarks	Total
	£000	£000	£000
Gross cost at 1 April 2011	895	1,329	2,224
Additions purchased	244	0	244
Additions donated		0	0
Reclassifications	0	0	0
Gross cost at 31 March 2012	**1,139**	**1,329**	**2,468**
Amortisation at 1 April 2011	72	982	1,054
Provided during the year	141	111	252
Amortisation at 31 March 2012	**213**	**1,093**	**1,306**
Net book value			
Purchased	927	235	1,162
Donated	0	0	1
Total at 31 March 2012	**927**	**235**	**1,162**

13.2 2010/11:	Computer software - purchased	Licences and trademarks	Total
	£000	£000	£000
Gross cost at 1 April 2010	186	1,329	1,515
Additions purchased	283	0	283
Additions donated	0	0	0
Reclassifications	426	0	426
Gross cost at 31 March 2011	**896**	**1,329**	**2,225**
Amortisation at 1 April 2010	31	872	903
Provided during the year	41	110	151
Amortisation at 31 March 2011	**72**	**982**	**1,054**
Net book value			
Purchased	824	347	1,171
Donated	0	0	1
Total at 31 March 2011	**824**	**347**	**1,171**

Reclassification relates to transfer of assets from tangible assets.

13.3 Valuation and economic useful lives

The valuation basis is described in note 1.5 to the accounts. There is no active market for the Trust's intangible assets and there is no revaluation reserve.

The economic useful lives of intangible assets are finite and are described in note 1.8 to the accounts.

PFI Intangible Assets are depreciated over the life of the PFI Contract.
Economic useful lives of intangible assets are finite and amortisation is charged on a straight line basis:

	Minimum useful life Years	Maximum useful life Years
Software	5	5
Licences and trademarks	5	12

14. Property, plant and equipment

14.1 2011/12:	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Gross cost at 1 April 2011	21,049	153,375	5,206	5,299	30,999	58	11,180	2,952	230,118
Additions Purchased	0	629	0	1,405	956	0	759	48	3,797
Additions donated	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluation gains	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	(73)	0	0	0	(73)
Gross cost at 31 March 2012	**21,049**	**154,004**	**5,206**	**6,704**	**31,882**	**58**	**11,939**	**3,000**	**233,842**
Depreciation at 1 April 2011	0	16,561	308	0	21,011	58	7,475	1,687	47,100
Provided during the year	0	4,516	135	0	1,557	0	1,126	286	7,620
Impairments	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Depreciation at 31 March 2012	**0**	**21,077**	**443**	**0**	**22,568**	**58**	**8,601**	**1,973**	**54,720**
Net book value									
- Purchased at 31 March 2012	21,049	132,927	4,763	6,704	8,915	0	3,338	1,017	178,713
- Donated at 31 March 2012	0	0	0	0	399	0	(0)	10	409
Total at 31 March 2012	**21,049**	**132,927**	**4,763**	**6,704**	**9,314**	**0**	**3,338**	**1,027**	**179,122**
Analysis of property, plant and equipment									
Net book value									
- Protected assets at 31 March 2012	21,049	132,927	4,763	0	0	0	0	0	158,739
- Unprotected assets at 31 March 2012	0	0	0	6,704	9,314	0	3,338	1,027	20,383
Total at 31 March 2012	**21,049**	**132,927**	**4,763**	**6,704**	**9,314**	**0**	**3,338**	**1,027**	**179,122**
Asset Financing									
Net book value									
- Owned	21,049	132,927	4,763	6,704	9,314	0	3,338	1,027	179,122
- Finance Leased	0	0	0	0	0	0	0	0	0
Total at 31 March 2012	**21,049**	**132,927**	**4,763**	**6,704**	**9,314**	**0**	**3,338**	**1,027**	**179,122**

14. Property, plant and equipment

14.2 Prior year 2010/11:	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Gross cost at 1 Dec 2010	21,049	149,803	5,206	1,837	42,994	58	11,111	2,851	234,909
Additions Purchased	0	3,572	0	3,462	803	0	227	40	8,104
Additions donated	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	(329)	0	(158)	61	(426)
Revaluation gains	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	(12,469)	0	0	0	(12,469)
Gross cost at 31 March 2011	**21,049**	**153,375**	**5,206**	**5,299**	**30,999**	**58**	**11,181**	**2,952**	**230,119**
Depreciation at 1 Dec 2010	0	12,530	173	0	31,623	58	6,393	1,407	52,184
Provided during the year	0	4,031	135	0	1,857	0	1,082	280	7,385
Impairments	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	(12,469)	0	0	0	(12,469)
Depreciation at 31 March 2011	**0**	**16,561**	**308**	**0**	**21,011**	**58**	**7,475**	**1,687**	**47,100**
Net book value									
- Purchased at 31 March 2011	21,049	136,814	4,898	5,299	9,365	0	3,705	1,239	182,369
- Donated at 31 March 2011	0	0	0	0	623	0	(0)	26	649
Total at 31 March 2011	**21,049**	**136,814**	**4,898**	**5,299**	**9,988**	**0**	**3,705**	**1,265**	**183,018**
Analysis of property, plant and equipment									
Net book value									
- Protected assets at 31 March 2011	21,049	136,814	4,898	0	0	0	0	0	162,761
- Unprotected assets at 31 March 2011	0	0	0	5,299	9,988	0	3,705	1,265	20,257
Total at 31 March 2011	**21,049**	**136,814**	**4,898**	**5,299**	**9,988**	**0**	**3,705**	**1,265**	**183,018**
Asset Financing									
Net book value									
- Owned	21,049	136,814	4,898	5,299	9,988	0	3,705	1,265	183,018
- Finance Leased	0	0	0	0		0	0	0	0
Total at 31 March 2011	**21,049**	**136,814**	**4,898**	**5,299**	**9,988**	**0**	**3,705**	**1,265**	**183,018**

Reclassification relates to transfer of assets from intangible assets.

14. Property, plant and equipment (cont.)

14.3 Revaluation

The Trust has not revalued land, buildings and dwellings in 2011-12 as there has not been a significant change in asset values. All other assets are valued at depreciated replacement cost with no indexation in year due to the current economic climate.

14.4. Non-current assets held for sale

The Trust has no non-current assets held for sale (31 March 2011: £nil).

15. Capital commitments

There are no commitments under capital expenditure contracts at the end of the period (31st March 2011: £300K), not otherwise included in these financial statements.

16. Inventories

16.1 Inventories	**31 March 2012**	31 March 2011
	£000	£000
Materials	**4,839**	3,820
	4,839	3,820

Inventories carried at fair value less costs to sell where such value is lower than cost are nil (31 March 2011 - £nil).

16.2 Inventories recognised in expenses	**31 March 2012**	31 March 2011
	£000	£000
Inventories recognised as an expense	**42,500**	33,109
Write-down of inventories recognised as an expense	**0**	37
	42,500	33,146

17. Trade and other receivables

	Current	
	31 March 2012	31 March 2011
	£000	£000
NHS receivables	**2,455**	2,926
Other receivables with related parties	**1,018**	0
Provision for impaired receivables	**(940)**	(399)
Prepayments	**1,023**	1,009
Lifecycle prepayment	**3,426**	0
Accrued Income	**3,170**	2,734
Other receivables	**3,310**	2,016
PDC receivable	**114**	49
	13,577	8,336

18.1 Provision for impairment of receivables

	31 March 2012	31 March 2011
	£000	£000
Balance at 1 April	**399**	786
Increase in provision	**541**	0
Amounts utilised	**0**	0
Unused amounts reversed	**0**	(387)
Balance at 31 March	**940**	399

18.2 Analysis of Impaired Receivables

	31 March 2012	31 March 2011
	£'000	£'000
Ageing of impaired receivables		
0-30 days	**40**	15
30-60 days	**12**	7
60-90 days	**75**	8
90-180 days	**386**	157
over 180 days	**427**	212
	940	399
Ageing of non-impaired receivables past their due date		
0-30 days	**1,752**	1,460
30-60 days	**625**	217
60-90 days	**458**	343
90-180 days	**237**	413
over 180 days	**2,417**	1,536
	5,489	3,969

19. Cash and cash equivalents	**31 March 2012 £000**	31 March 2011 £000
Balance at 1 April	**11,223**	12,181
Net change in year	**3,259**	(958)
Balance at 31 March	**14,482**	11,223
Made up of		
Cash with Government Banking Service	**14,473**	11,216
Commercial banks and cash in hand	**9**	7
Cash and cash equivalents as in statement of financial position	**14,482**	11,223
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**14,482**	11,223

20. Trade and other payables	**Current**		**Non-Current**	
	31 March 2012 £000	31 March 2011 £000	**31 March 2012 £000**	31 March 2011 £000
NHS payables	**2,947**	2,496	**0**	0
Trade payables - capital	**1,350**	1,857	**0**	0
Other trade payables	**3,631**	1,523	**288**	0
Other payables	**8,798**	4,172	**0**	0
Accruals	**5,030**	4,413	**0**	0
Receipts in advance	**3,002**	5,516	**124**	0
	24,758	19,976	**412**	0

Other payables include outstanding pension contributions of £2,053,755. (31 March 2011: £1,453,927).

Receipts in advance include the PFI advance payment from NHS Wiltshire.
The increase in accruals as at 31 March 2012 is due to an increase in the accrual for annual leave and salary enhancements £526k still outstanding at 31/3/12 and the aquisition of Wiltshire Community Health Services £1,241k

The increase in NHS Payables as at 31 March 2012 is due to an increase in services purchased from other NHS organisations as a result of the acquisition of Wiltshire Community Health Services.

21. Other liabilities	**Current**		**Non-current**	
	31 March 2012 £000	31 March 2011 £000	**31 March 2012 £000**	31 March 2011 £000
Deferred income	**1,425**	1,016	**1,816**	1,930
	1,425	1,016	**1,816**	1,930

21.1 Tax Payable
Tax payable of £1,788,001.64 (31 March 2011: £1,324,016.28) consists of employment taxation only (Pay As You Earn), owed to Her Majesty's Revenue and Customs at the period end.

22. Borrowings

22.1 Prudential borrowing limit	**31 March 2012 £000**	31 March 2011 £000
Prudential borrowing limit set by Monitor	**133,100**	135,700
Working capital facility	**14,000**	14,000
Actual borrowing in year - long term	**132,666**	133,461
Actual borrowing in year - working capital	**0**	0

The Trust is required to comply and remain within a prudential borrowing limit. This is made up of two elements:

- the maximum cumulative amount of long term borrowing. This is set by reference to the four ratios test set out in Monitor's Prudential Borrowing Code. The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact on the long term borrowing limit.

- the amount of any working capital facility approved by Monitor.

Further information on the NHS Foundation Trust Prudential Borrowing Code and Compliance Framework can be found on the website of Monitor, the Independent Regulator of NHS Foundation Trusts.

There has been no necessity to use its overdraft facility. The actual long term borrowing relates to the Trust's PFI Lease Liability and Finance Leases. These are both within this limit.

22.2 PFI lease obligations

Amounts payable under PFI on SoFP obligations:	**31 March 2012 £000**	31 March 2011 £000
Gross PFI liabilities	262,969	275,673
Of which liabilities are due		
Within one year	15,489	12,579
Between one and five years	52,263	52,152
After five years	195,217	210,942
Less future finance charges	(130,934)	(142,212)
	132,035	133,461
Net PFI liabilities		
Of which liabilities are due		
Within one year	4,430	1,425
Between one and five years	10,762	9,729
After five years	116,843	122,307
	132,035	133,461
Included in:		
Current borrowings	4,430	1,425
Non-current borrowings	127,605	132,036
	132,035	133,461

22.3 Finance lease obligations

Amounts payable under Finance lease obligations:	**31 March 2012 £000**	31 March 2011 £000
Gross Finance lease liabilities	768	0
Of which liabilities are due		
Within one year	139	0
Between one and five years	506	0
After five years	122	0
Less future finance charges	(137)	0
	631	0
Net Finance lease liabilities		
Of which liabilities are due		
Within one year	103	0
Between one and five years	447	0
After five years	81	0
	631	0
Included in:		
Current borrowings	103	0
Non-current borrowings	528	0
	631	0

No finance leases were held in 2010-11.

22.4 Charges to expenditure

The total charged in the year to expenditure in respect of the service element of On-Statement of Financial Position PFI contracts was £11,352k (£11,162k 2010/11)

The Trust is committed to the following annual charges

	31 March 2012	31 March 2011
PFI commitments in respect of service element:	**£000**	£000
Not later than one year	**12,327**	11,979
Later than one year, not later than five years	**50,428**	48,247
Later than five years	**195,212**	203,531
Total	**257,967**	263,757
PFI commitments present value in respect of service element:		
Not later than one year	**11,910**	11,387
Later than one year, not later than five years	**43,938**	42,798
Later than five years	**128,723**	131,983
Sub total	**184,571**	186,168

The estimated annual payments in future years are expected to be materially different from those which the Trust is committed to make during the next year as the service payment is increased annually in accordance with the increase in the Retail Price Index (RPI).

23. Provisions

	Current		**Non current**	
	31 March 2012	31 March 2011	**31 March 2012**	31 March 2011
	£000	£000	**£000**	£000
Pensions relating to other staff	**119**	117	**1,292**	1,082
Legal claims	**100**	0	**0**	0
Other	**346**	233	**3,394**	3,413
	565	350	**4,686**	4,495

	Pensions relating to other staff	**Legal claims**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**
At 1 April 2011	1,199	0	3,646	**4,845**
Arising during the year	298	100	161	**559**
Used during the year	(116)	0	(57)	**(173)**
Reversed unused	0	0	(24)	**(24)**
Unwinding of discount	30	0	14	**44**
At 31 March 2012	**1,411**	**100**	**3,740**	**5,251**
Expected timing of cash flows:				
Within one year	119	100	346	**565**
Between one and five years	424	0	3,017	**3,441**
After five years	868	0	377	**1,245**
	1,411	100	3,740	**5,251**

The provision under 'legal claims' relates to an outstanding Employment Tribunal Claim (31 March 2011: £nil). The provisions under 'other' includes s106 Agreement of £2,900k (31st March 2011 £2,900k) and AGW Cardiac Network Redundancy provision £161,000 (31st March 2011: £137,000)

Provisions within the annual accounts of the NHS Litigation Authority at 31 March 2012 include £31,653,683 in respect of clinical negligence liabilities of the Trust (31 March 2011 - £26,974,277).

The Trust has not made a provision under the Carbon Emissions Scheme as the Trust is not required to be registered in 2011/12 as the properties managed by the Trust are below the threshold. This is not anticipated to change in 2012/13.

24. Events after the reporting period

There are no events after the reporting period

25. Contingencies

There are no contingent assets and liabilities for the period ended 31 March 2012

26. Related party transactions

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

The Trust is under the common control of the Board of Directors. During the year none of the Board Members or members of the key management staff or parties related to them, has undertaken any material transactions with the Great Western Hospitals NHS Foundation Trust.

It should be noted that the Trust has a Non- Executive Director, Cllr Kevin Small, who is also a Councillor for Swindon Borough Council with whom the Trust has had material transactions relating mainly to the Section 106 agreement (£2.9m) and our Pooled Budget (£936k)

The Department of Health is regarded as a related party. During 2011/12 the Trust has had a significant number of material transactions with other entities for which the Department is regarded as the Parent Department. These entities are listed below.

.	Receivables	Payables	Revenue	Expenditure
	£000	**£000**	**£000**	**£000**
NHS South West	30	0	6,188	5
NHS Swindon	992	216	112,486	687
NHS Wiltshire	715	5,583	118,563	3,805
NHS Bath & North East Somerset	16	59	7,424	134
NHS Berkshire	45	0	6,049	0
NHS Bristol	49	0	5,130	9
NHS Gloucester	83	83	6,658	83
Royal United Hospital NHS Trust	520	1,479	1,055	8,774
NHS Litigation Authority	0	385	0	5,676
NHS Pension Scheme	0	2,055	0	17,028
Total	2,450	9,860	263,553	36,201

The Trust has also received revenue payments from a number of charitable funds, certain of the Trustees for which are also members of the Trust Board. The audited accounts of these Funds held on Trust are not included in this annual report and accounts and will be audited and published at a later date. A copy of these will be available on the Trusts' internet site.

27. Private Finance Initiative contracts

27.1 PFI schemes on-Statement of Financial Position

The Trust has 3 PFI schemes which are deemed to be on-Statement of Financial Position at the period end. These are the Main Hospital and Brunel Treatment Centre (treated as one agreement), Downsview Residences and the agreement in place with Systems C.

Great Western Hospital

The contract commenced on 5 October 1999 for a period of 30 years until 4 October 2029. In terms of the contract the operator company was obliged to build the Great Western Hospital, which was completed in November 2002, for subsequent occupation and use by the Trust. The Trust pays the operator company a quarterly availability fee for the occupation of the hospital and a quarterly service fee for the services provided by the operator such as portering and catering. In October 2003 the Trust entered into a variation of the original agreement for the construction of the Brunel Treatment Centre which is an extension to the original hospital. The construction of the Treatment Centre has resulted in increased availability and service charges, however, the main terms of the contract including the termination date remain unchanged. Subsequently, in September 2006, the Trust entered into a refinancing agreement which resulted in a reduction in the annual availability payment again with no change to the contract term. The amount of the availability payment is determined annually and increased based on a combination of the annual increase in the Retail Price Index (RPI) and a fixed percentage increase of 2.5%. The operator is obliged to maintain the buildings and replace lifecycle elements of the buildings where necessary. At the end of the contract term the hospital buildings revert back to the Trust for Nil consideration. The nature of the contract meets the criteria for treatment as a service concession under IFRIC 12. Accordingly the hospital buildings are treated as an asset under property, plant and equipment with the resultant liability being treated as a finance lease under IAS 17.

Downsview Residences

The contract commenced on 5 October 1999 for a period of 30 years until 4 October 2029. In terms of the contract the operator company was obliged to build the Downsview staff residences on the Hospital site for the provision of housing to hospital staff. At commencement of the contract the Trust made a capital contribution of £649k towards the construction cost of the building. The residences are managed by the operator company who rent the accommodation units to, primarily, Trust staff. The Trust does not pay the operator company an availability fee, however, a monthly service fee is paid for the servicing of the units which is based on usage. The operator is responsible for maintaining the buildings over the contract term. At the end of the contract term the accommodation buildings revert back to the Trust for Nil consideration. The nature of the contract meets the criteria for treatment as a service concession under IFRIC 12. Accordingly the residences are recognised as an asset under property, plant and equipment. The cost of the building less the capital contribution has been accounted for as deferred income and is released to income equally over the entire contract term.

Systems C

The Trust has a PFI contract in respect of the Integrated Clinical Information System which meets the criteria for recognition as a service concession agreement as envisaged under IFRIC 12 and has, accordingly, been treated as on statement of financial position. The contract is dated 27 May 2002 with an effective date of 13 November 2001. The contract is for 12 years and is due to expire on 12 November 2013. The contract is for the supply of computer hardware and software together with the provision of ongoing support and system management services.

28 Financial instruments and related disclosures

The key risks that the Trust has identified relating to its financial instruments are as follows:-

28.1 Financial risk

Because of the continuing service provider relationship that the Trust has with Primary Care Trusts (PCTs) and the way those PCTs are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Finance & Investment Committee.

28.2 Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

28.3 Credit risk

The majority of the Trust's income comes from contracts with other public sector bodies, resulting in a low exposure to credit risk. The maximum exposures as at 31 March 2012 are in receivables from customers, as disclosed in note 17 to the accounts. The Trust mitigates its exposure to credit risk through regular review of debtor balances and by calculating a bad debt provision at the period end.

The following shows the age of such financial assets that are past due and for which no provision for bad or doubtful debts has been raised:

	31 March 2012	31 March 2011
	£000	£000
By up to three months	**2,835**	2,020
By three to six months	**237**	413
By more than six months	**2,417**	1,536
	5,489	3,969

The Trust has not raised bad or doubtful debt provisions against these amounts as they are considered to be recoverable based on previous trading history.

The increase in the amounts is primarily due to an increase in income from the Injury Recovery Scheme for both GWH and Wiltshire Community Health Services (£1,321k) and Non-NHS Debtors (£272k)

28.4 Liquidity risk

The NHS Trust's net operating costs are incurred under annual service agreements with local PCTs, which are financed from resources voted annually by Parliament. The Trust also largely finances its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks. It should also be noted that the Trust has a Working Capital Facility of £14 million available within its terms of authorisation as an NHS Foundation Trust which reduces its liquidity risk still further.

28.5 Fair Values of Financial Instruments

All the financial assets and all the financial liabilities of the Trust are measured at fair value on recognition and subsequently at amortised cost.

The following table is a comparison by category of the carrying amounts and the fair values of the Trust's financial assets and financial liabilities at 31 March 2012 and 31 March 2011.

	Carrying Value 31 March 2012 £000	**Fair Value 31 March 2012 £000**	Carrying Value 31 March 2011 £000	Fair Value 31 March 2011 £000
Current financial assets				
Cash and cash equivalents	**14,482**	**14,482**	11,216	11,216
Loans and receivables:				
Trade and receivables	**7,540**	**7,540**	12,141	12,141
	22,022	**22,022**	23,357	23,357
Non-current financial assets				
Loans and receivables:				
Trade and receivables	**0**	**0**	0	0
Total financial assets	**22,022**	**22,022**	23,357	23,357
Current financial liabilities				
Financial liabilities measured at amortised cost:				
Obligations under PFI	**4,430**	**4,430**	1,425	1,425
Obligations under Finance Leases	**103**	**103**	0	0
Trade and other payables	**22,917**	**22,917**	12,704	12,704
Provisions under contract				
	27,450	**27,450**	14,129	14,129
Non-current financial liabilities				
Financial liabilities measured at amortised cost:				
Obligations under PFI	**127,605**	**127,605**	132,036	132,036
Obligations under Finance Leases	**528**	**528**	0	0
Provisions under contract	**2,900**	**2,900**	2,900	2,900
	131,033	**131,033**	134,936	134,936
Total financial liabilities	**158,483**	**158,380**	149,065	149,065
Net financial assets	**(136,461)**	**(136,358)**	(125,708)	(125,708)

The fair value on all these financial assets and financial liabilities approximate to their carrying value.

The following table reconciles the financial assets and financial liabilities that fall within the scope of IAS 39 to the relevant on-Statement of Financial Position amounts. Cash and cash equivalents and finance lease liabilities fall wholly within the scope of IAS 39.

	Current		**Non-current**	
	31 March 2012 £000	31 March 2011 £000	**31 March 2012 £000**	31 March 2011 £000
Trade and other receivables:	**1,474**	347	**0**	0
Non-financial assets	**114**	49	**0**	0
Prepayments	**4,450**	1,009	**0**	1,733
	6,038	1,406	**0**	1,733
Trade and other payables:				
Taxes payable	**3,430**	2,056	**0**	0
Non-financial liabilities	**0**	0	**0**	0
	3,430	2,056	**0**	0
Provisions:				
Financial liabilities	**0**	206	**0**	0
Provisions under legislation	**147**	144	**1,783**	1,732
	147	350	**1,783**	1,732

The provisions under legislation are for personal injury pensions £519,266 (31 March 2011: £538,845) and early retirement pensions £1,411,343 (31 March 2011: £1,199,428). These liabilities are not contracted, but are defined by legislation and are owed to the NHS Pensions Agency.

29. Third Party Assets

The Trust held £8,617 cash at bank and in hand at 31 March 2012 (31 March 2011: £10,161) which relates to monies held by the NHS Trust on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts.

30. Losses and Special Payments

There were 1,017 cases of losses and special payments totalling £47,744.40 approved in the year. (2010/11 - 1,712 cases totalling £71,621)

There were no clinical negligence, fraud, personal injury, compensation under legal obligation or fruitless payment cases where the net payment or loss for the individual case exceeded £100,000. (2010/11 - nil cases).

Losses and special payments are compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

31. Pooled Budget - Integrated Community Equipment Service

	31 March 2012	31 March 2011
Income:	**£000**	**£000**
Swindon Borough Council	517	537
Paediactrics	29	0
NHS Swindon	238	231
Great Western Hospitals NHS Foundation Trust	153	153
Total Income	**936**	920
Expenditure	936	1,078
Total Surplus/(Deficit)	**0**	(158)
Share of Surplus (Deficit):		
Swindon Borough Council	0	(84)
Swindon Borough Council De Minus level	0	(10)
NHS Swindon	0	(40)
Great Western Hospitals NHS Foundation Trust	0	(25)
Total Surplus/(Deficit)	**0**	(158)

The above disclosure is based on month 12 management accounts provided by Swindon Borough It should be noted that these figures are un-audited.

Great Western Hospitals NHS

NHS Foundation Trust

Great Western Hospitals NHS
NHS Foundation Trust

Great Western Hospitals NHS Foundation Trust
Annual Report and Accounts
2011/2012

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

CONTENTS

1 CHAIR AND CHIEF EXECUTIVE'S REPORT

During the course of the year there have been a number of changes within the Trust which have altered the shape of the organisation and the way care is provided. The most significant of these was the merger with Wiltshire Community Health Services (WCHS) in June 2011. Our successful bid was the culmination of a substantial amount of work which has given us the opportunity to think radically about how we can combine the acute and community resources in the best interests of patients.

The first six months following the merger were spent getting to know the services, the staff and the stakeholders in the local area. Having done so, the Trust is now in a position to begin delivering the benefits of the merger including more joined up care for patients. One project that has begun in this area is the work to improve patient flow across the Trust seven days a week. This work involves acute staff based at the Great Western Hospital (GWH), community staff, social services and GPs and is designed to remove the blockages that exist and which can get in the way of giving patients the right care, in the right place and getting them back home swiftly. In the year ahead we hope to see this project begin to deliver real changes to practices and processes, which in turn will make a real difference to patients.

During the course of the year former Chief Executive, Lyn Hill-Tout left the Trust to take up another post in the NHS. We would like to put on record the thanks of this Trust for the work undertaken by Lyn, first as Operations Director and then as Chief Executive, in providing over 13 years of dedicated service. She oversaw the move from the Princess Margaret Hospital to the new Great Western Hospital and the licensing of ourselves as a foundation trust. However, above all Lyn demonstrated a total commitment to high standards of patient care which she has taken forward in her new role as Chief Executive of Mid Staffordshire NHS Foundation Trust.

Work to find a high calibre replacement began prior to Lyn's departure and Nerissa Vaughan joined the Trust in October from the Queen Elizabeth Hospital Foundation Trust in King's Lynn. Work has since begun on the development of a new Trust strategy to reflect the new reality of an integrated healthcare organisation operating in a financially difficult and political environment.

The Trust is pleased to report very good performance across the majority of the key indicators we are measured against. A significant amount of work takes place in the Trust, on the front line and behind the scenes, to deliver the best care possible for our patients and our performance against the 200 indicators we are measured against provides reassurance to those patients and service users about the standards we strive to achieve. Our Trust was the only Trust in the South West to score a green rating for all our comparable targets.

Our work on infection control over recent years has meant we have had consistently low rates of MRSA and *Clostridium difficile* with just two cases of MRSA across the entire Trust and just 19 cases of *C.diff* - 50 fewer cases than the threshold we are measured against. The Trust was cited as one of the best performing Trusts in the country on our performance to tackle *C.diff* which is thanks to the combined efforts of all staff in adhering to the strict infection control practices we have in place.

At the GWH we have changed the way we care for ambulatory (walk in) patients so they are seen, treated and discharged without the need for hospital admission. At a time of rising attendances to the Emergency Department, this change has helped us reduce the number of admissions. This is particularly crucial during the busy winter months. Due to the success of this initial pilot, the new model for Ambulatory Care, which also saw an increase in the number of beds on the Linnet Acute Medical Unit, will become a permanent feature and we will be looking at ways to expand the service across the whole week.

The Great Western Hospital became a designated Trauma Unit in two regional Trauma Networks in April 2012. Due to its geographical location, the Great Western Hospital is part of both the Severn Network to the West and the Thames Valley Network to the North-East. This is a commendable achievement due to the hard work of dedicated staff.

With a larger organisation, we are using our experience of rolling out the Productive Ward Programme at the GWH to implement the same initiative in the community hospitals. The programme is designed to release more nursing time to spend on direct patient care and Wiltshire residents will start to see the benefits of our experience in this area during 2012/13.

Our staff, who are at the core of the Trust, have also shared their views on what it is like to work within the Trust via the annual independent staff survey. The results, published in March, place the Trust in the top five Trusts in the South West in terms of overall scores. The Trust was placed in the top 20% nationally on many of the key measures and generally our staff are engaged. These results are important not only for staff, but also for patients as more engaged staff means better patient care. We will be building on these results in the year ahead and have identified four priorities for focus to deliver improvements.

The year has also been challenging. The expanded programme of unannounced inspections by the Care Quality Commission (CQC) has been felt across the Trust. During the course of the year there several inspections looking at different aspects of care including dignity, nutrition and hydration and theatres. One of the inspections resulted in moderate concerns. Action plans have been developed with the concerns raised now addressed. Plans to manage any remaining issues are being rolled out.

One area that is already being managed is the removal of a number of the Extra Bed Spaces in use on some wards. These are additional regular beds intended for use when demand from patients is high. The Trust has recognised that a number of these beds have compromised patient dignity on occasions and we are taking proactive steps to remove them and reduce their use.

From a financial perspective the Trust ended a difficult financial year with £0.5m surplus. The challenges going forward will grow, so it is vital we maintain a strong financial discipline. This is particularly important when looked at in the context of falling demand for some services currently provided in a hospital environment. With fewer patients comes less money to invest in services. The Trust therefore needs to be flexible in ensuring we have the beds, staff and resources in the right areas for the demand we are experiencing. Further information on the Trust's accounts is provided in the annual accounts at the back of this annual report.

We continue to work with our Governors to deliver the aspirations of our 12,000 members and have valued their input in shaping our priorities. Governors have contributed to the workings of the Trust by adding valuable feedback and helping us to focus on improvements in areas such as patient experience. The Trust hosted a successful Open Day in September, with many staff from across the Trust giving up their time to showcase their work. Staff hosted behind the scenes tours of different areas of the hospital and a number of partner agencies were represented at the event including Wiltshire Fire and Rescue, Wiltshire Air Ambulance, Wiltshire Involvement Network, Swindon LINk and Prospect Hospice. A total of 50 people (staff and public) safely abseiled off the hospital building with the money raised going to the Trust's Charitable Fund.

We are very grateful for the efforts our 5,500 staff and volunteers who work with us everyday to save and change lives. Despite the challenges and difficult times ahead, we know we are better placed to meet them because of their hard work, professionalism and dedication to the Trust.

Yours sincerely

Bruce Laurie
Chairman
24 May 2012

Nerissa Vaughan
Chief Executive
24 May 2012

2 OUR TRUST

2.1 Vision - Your health our passion

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

A key theme of the vision has been for the Trust to provide 'healthcare services' and not solely acute hospital services. Towards achieving the 2015 vision, in June 2011 the Trust took over the running of a range of community health services and community maternity services across Wiltshire and surrounding areas, which were previously provided by Wiltshire Community Health Services (WCHS).

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

2.2 Our aims and values

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

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

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

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

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

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

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

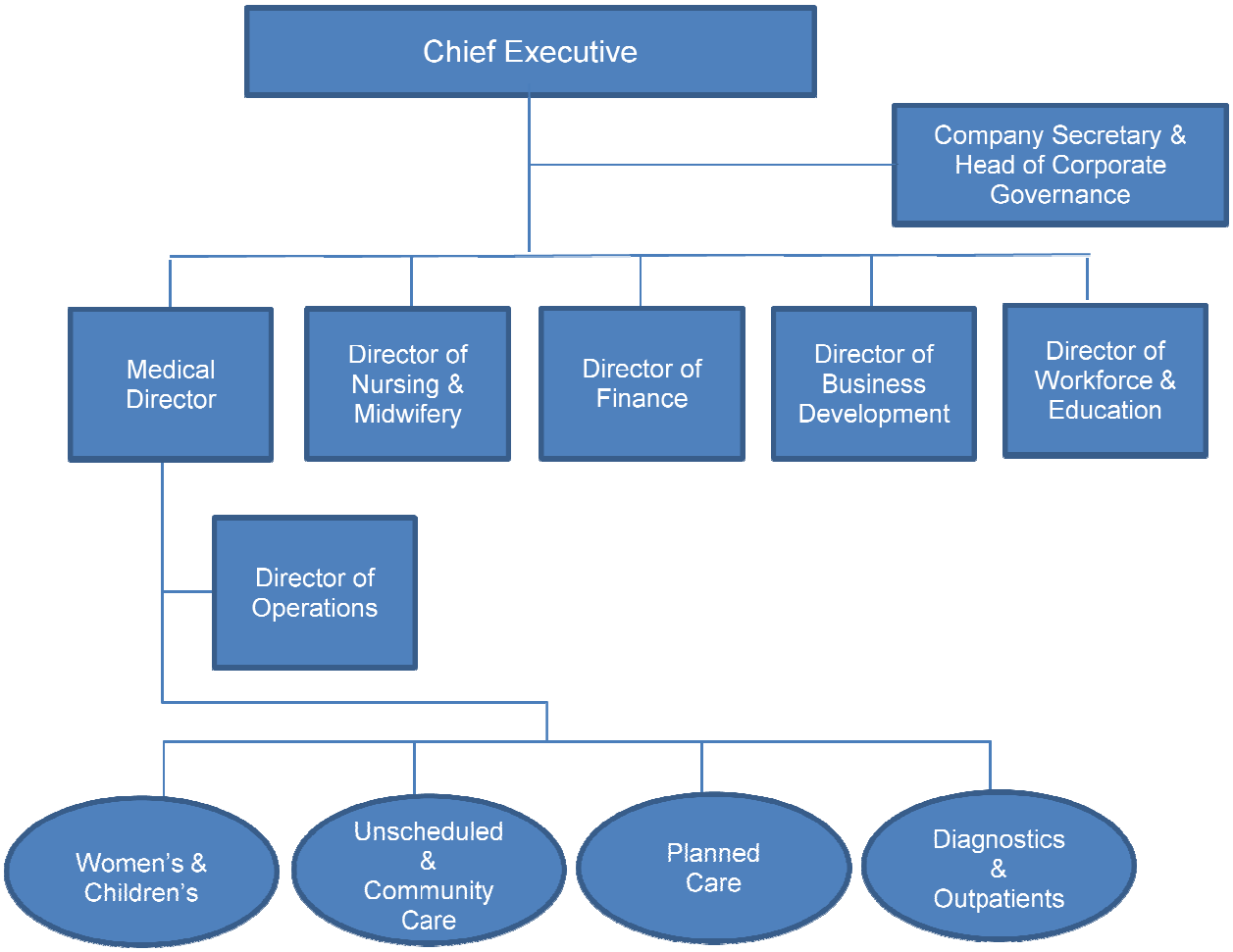
Underpinning this, our values are to: -

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

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

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

2.3 Organisational structure 2011/12



3 DIRECTOR'S REPORT

General Companies Act Disclosures

3.1 Directors of Great Western Hospitals NHS Foundation Trust

Directors of Great Western Hospital NHS Foundation Trust during 2011/12: -

Bruce Laurie	Chairman
Nerissa Vaughan	Chief Executive *(from 1 October 2011)*
Rowland Cobbold	Non-Executive Director, Deputy Chairman *(up until 31 December 2011)* Senior Independent Director
Angela Gillibrand	Non-Executive Director Deputy Chairman *(from 1 January 2012)*
Roberts Burns	Non-Executive Director
Liam Coleman	Non-Executive Director
Roger Hill	Non-Executive Director
Kevin Small	Non-Executive Director
Lyn Hill-Tout	Chief Executive *(until 12 June 2011)*
Alf Troughton	Medical Director Interim Chief Executive *(1 June – 30 September 2011)*
Guy Rooney	Interim Medical Director *(1 June – 30 September 2011)*
Maria Moore	Director Finance
Oonagh Fitzgerald	Director Workforce and Education
Sue Rowley	Director Nursing and Midwifery
Helen Bourner	Director Business Development *(until 5 April 2012)*
Jenny Barker	Director of Transition (designate) *(until 31 May 2011)* Director of Transition *(from 1 June – 31 December 2011)*

Lyn Hill Tout resigned as Chief Executive for this Trust taking up the post of Chief Executive of Mid Staffordshire NHS Foundation Trust in June 2011. Between the time of her leaving and the starting of a new Chief Executive, Alf Troughton the Medical Director acted as the interim Chief Executive and Guy Rooney acted as the interim Medical Director. Nerissa Vaughan joined the Trust as Chief Executive on 1 October 2011.
In January 2011 Jenny Barker, the Managing Director of Wiltshire Community Health Services was appointed as a Director Designate (Transition). She became a substantive Director of the Board on 1 June 2011 and left the Trust returning to NHS Wiltshire on 31 December 2011.

3.2 Principal activities of the Trust

Great Western Hospitals NHS Foundation Trust has its main headquarters at the Great Western Hospital (GWH) in Swindon. In addition to this, the Trust also provides a range of community health and maternity services across Wiltshire and parts of Bath and North East Somerset covering a population of approximately 1,300,000 people. This includes providing services to residents of parts of Oxfordshire, West Berkshire and Gloucestershire.

Since the merger with WCHS in June 2011 the Trust's workforce grew from circa 3,300 to 5,500 and the Trust's income grew from £203m to £282m in 2012/13. In 2011/12 the additional income due to WCHS was £64m for ten months. The history of the Trust is referred to elsewhere in this report (section 3.32.2 refers).

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

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

The Trust secured a licence to operate from the Care Quality Commission in March 2010 without any conditions attached to it. As part of the merger with Wiltshire Community Health Services (WCHS), the Trust altered the conditions of its existing registration from 1 June 2011 with the Care Quality Commission (CQC). This included nursing care as an additional community based activity and the addition of 21 community sites/locations. All registered sites/locations and activities have since been reviewed post merger and registration variation applications are currently underway to reflect the changes. A full copy of our licence can be found at: www.gwh.nhs.uk.

3.3 Location of services

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

3.3.1 Great Western Hospital

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

GWH opened in December 2002, replacing the Princess Margaret Hospital in Old Town, Swindon. The hospital has approximately 500 beds and is designed and equipped to offer a first-class environment for patients, visitors and staff, with over 30% of beds provided in single rooms with en-suite facilities. The remainder are in single sex four bedded bays.

3.3.2 The Brunel Treatment Centre

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

3.3.3 Within the Community

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

Location	Type of service
Chippenham Community Hospital	Acute and community services, Minor Injuries Unit, dentistry and Birthing Centre
Trowbridge Community Hospital	Acute and community services, Birthing Centre, Minor injuries Unit and outpatients clinics
Savernake Community Hospital	Acute and community - Inpatients
Warminster Community Hospital	Acute and community – Inpatients and dentistry
Melksham Community Hospital	Community/Out patients
Westbury Community Hospital	Dentistry
Southgate House	Neighbourhood Team base. Community specialist services
Hillcote	Care home
Paulton Memorial Hospital	Birth Centre and Outpatients Clinic
Princess Anne Wing, Royal United Hospital, Bath	Acute Maternity and Inpatients
Shepton Mallet Community Hospital	Birthing Centre
Frome Victoria Hospital	Birth Centre and outpatients clinic
Erlstoke Prison	Dentistry and nursing
Amesbury Health Clinic	Dentistry and podiatry
Nunton Unit, Salisbury District Hospital	Physiotherapy
Malmesbury Primary Care Centre	Podiatry/MSK
Devizes Community Hospital	Maternity/MSK Physio/Out patients/dentistry
Salisbury Central Health Clinic	Dentistry and podiatry
Swindon Health Centre (Carfax Street)	Dentistry and sexual health
Tidworth Clinic	Dentistry
West Swindon Health Centre	Dentistry
Devizes Health Centre	Dentistry
Fairford Community Hospital	Outpatient services
GP practices	The Trust provides a range of clinics in various GP practices throughout our catchment area

Further Companies Act Disclosures

3.4 Regulation Disclosures

1 Where any market values of fixed assets are known to be significantly different from the values at which those assets are held in the Trust's financial statements, and the difference is, in the directors' opinion, of such significance that readers of the accounts should have their attention drawn to it, the difference in values will be stated with as much precision as is practical and reported in the notes to the accounts.

2 There are no political or charitable donations to disclose.

3 Any important events since the end of the financial year affecting the Trust will be recorded as a post balance sheet event and noted in the accounts.

4 An indication of likely future developments at the Trust is included in the Trust's Annual Plan.

5 An indication of any significant activities in the field of research and development is reported elsewhere in this report (section 3.8 refers).

6 The Trust does not have branches outside the UK.

7 Details of policies applied during the financial year for giving full and fair consideration to applications for employment made by disabled persons, having regard to their particular aptitudes and abilities are available on request to the Trust.

8 Details of policies applied during the financial year for continuing the employment of, and for arranging appropriate training for, employees who have become disabled persons during the period are available on request to the Trust.

9 Details of policies applied during the financial year for the training, career development and promotion of disabled employees are available on request to the Trust.

10 The circulation of a "Team Brief" (an electronic site communication) is one regular action taken in the financial year to provide employees systematically with information on matters of concern to them as employees.

11 To enable consultation with employees, following on from the merger with Wiltshire Community Health Services on 1 June 2011, a new employee partnership agreement was drawn up which covered the new organisation. The Employee Partnership Forum is made up of representatives from the trades unions and management. The agenda covers Trust developments and financial information, as well as consultation on policies and change programmes.

12 Actions taken in the financial year to encourage the involvement of employees in the Trust's performance include regular all staff briefings by the Chief Executive. Staff are encouraged to ask questions and seek further information directly.

13 Actions taken in the financial year to achieve a common awareness on the part of all employees of the financial and economic factors affecting the performance of the Trust include site communication with staff and Team Brief circulation.

14 In relation to the use of financial instruments, an indication of the financial risk management objectives and policies of the Trust and the exposure of the entity to price risk, credit risk, liquidity risk and cash flow risk, unless such information is not material for the assessment of the assets, liabilities, financial position and results of the entity are included in the account notes.

15 Disclosures in respect of policy and payment of creditors are included in the notes to the accounts.

Business Review / Management Commentary / Operating and Financial Review

3.5 Review of the Trust's Business

The Trust's Annual Plan submitted to Monitor (the regulator of Foundation Trusts) sets out the organisation's priorities for delivery during the year. Listed below are some of the important issues which the Trust dealt with 2011/12 and improvements that the Trust has made over the course of the last year.

The Trust continues to make progress towards the six strategic objectives which guide the direction of the Trust. Key developments during the year towards achieving each objective are as follows:

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

   Quality and safety remain our top priorities as we want patients to be confident they will receive the best care possible, whether they access the Emergency Department at the GWH or are cared for at Warminster Community Hospital or at home. The Trust continues to focus on ensuring that there is a consistently high standard of care provided across all wards and departments to improve patient experience and remove the variability in standards that sometimes exist.

   During the course of the year the Trust has:

   - Expanded the Productive Ward Programme to include all Community Hospitals in Wiltshire. The first phase of this work began at Savernake Hospital at the end of January and the programme is designed to 'buddy' a community ward with a ward at the GWH to share experience and learning from the wider Productive Ward Initiative which has been in place at the GWH since 2009. Details of the benefits of the Productive Ward are included elsewhere in this report (section 3.22.1 refers).

     The Trust has also expanded the programme to cover Theatres and will see more nursing time released through improvements in ward and theatre working, time which can be reinvested back into direct patient care.

   - The Medical Director has introduced a regular safety briefing aimed at Junior Doctors but relevant to all clinical staff featuring important 'calls to action' around specific safety issues. The first issue was published in March 2012 and has been well received therefore it will become a regular tool to engage clinical staff on the safety agenda.

   - Overall our safety performance through the year has been good showing strong improvements in many areas. As evidence, at a meeting of NHS Chief Executives in the South West in January, the Trust and the wider NHS in Swindon was commended as one of the best performing places in the country for infection control, as a result of the significant efforts to tackle *Clostridium difficile* in particular.

   - Following three Never Events during the course of the year, the Trust invited Plymouth Hospitals to visit the Trust to share their learning from similar experiences so that safety practices could be strengthened. This work has led to the re-launch of a Safer Surgical

Checklist, a World Health Organisation (WHO) initiative across our 15 theatres to ensure greater consistency for how these checks are carried out. A Consultant Orthopaedic Surgeon, Mr Adam Brooks, is championing this initiative across the Theatres Team. He has direct accountability for ensuring the checks are carried out properly. Ensuring that staff are engaged in the pre-operative safety briefings, now rests with each surgeon.

- Over the past year the Trust has performed well in relation to Hospital Standardised Mortality Rate (HSMR) with the end of year position being below the level of mortality expected against the standardised figure. A more detailed report on our performance against a range of quality and safety indicators can be found elsewhere in this report (section 6.2.1 refers).

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

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

- Taking part in a Dementia Peer Review to assess how well the Trust cares for dementia patients in an acute setting. This has led to the early stages of development of a Dementia Plan to assist the Trust in managing how we will provide care for people with dementia in the years ahead, given the expected rise in the numbers of older people nationally. This work includes the rolling out of the use of the 'This is me' booklet which people with dementia fill out with their families prior to admission. The booklet is a useful tool to tell staff what the patient does and does not like so that care can be tailored to their individual needs.

- Following concerns about how patient fluid intake is monitored on some wards, the Trust piloted the use of a new device called the Hydrant on Jupiter Ward. The Hydrant helps monitor fluid intake and gives assurance that patients are getting the right level of fluids they need to support their recovery. Following this successful trial the Trust will become the first in the country to roll out this device in a large scale way.

- The GWH has again achieved an excellent rating across all three indicators measured by the Patient Environment Action Team who independently assess the standard of the hospital estate, quality of food for patients and the level of privacy and dignity afforded to them. This is the third year running this rating has been given. The results also show generally positive results across the community, with the exception of the Princess Anne Wing at the Royal United Hospital in Bath, which the Trust took on responsibility for in June. As part of a wider maternity review, the Trust is looking at how the patient environment can be improved for patients given the lack of investment in that area over previous years.

- Towards the end of 2011 the Trust eliminated mixed sex accommodation for the first time following changes to the way we care for ambulatory (walk in) patients. Due to restrictions on space there had been a small but significant number of patients who would occasionally be cared for in mixed sex areas. This work has now led to the elimination of mixed sex accommodation across the Trust.

More detail of patient experience can be found elsewhere in this report (section 3.22 refers).

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

- Over the summer the Trust launched new values, as part of a three year Organisational Development Programme to embed a strong customer service culture within the Trust. The new values were developed by staff as the key characteristics and traits they felt the Trust embodies and that all staff should aspire to.

  The values are represented by four simple but powerful words: **Service, Teamwork, Ambition and Respect (STAR)** and as part of the process to embed these values across the enlarged Trust, a new employee of the month scheme was launched in August. The STAR of the Month scheme has been well received and the Trust receives a wide variety of nominations from across the organisation.

  The Trust host an annual Staff Excellence Award in June each year which was established to recognise, reward and celebrate the achievements of staff. This event is well supported by staff.

  In the future the values will underpin management standards, recruitment processes, induction and appraisals to ensure the Trust has the right calibre of staff delivering not only the best clinical care, but the best customer service too.

- Towards the end of 2011 the Trust took part in the annual national NHS Staff Survey. The results, published in March 2012 place the Trust in the top five Acute Trusts in the South West in terms of overall performance and the best response rate in the region. The results show that overall staff consider the Trust to be a good place to work. As a comparison to the previous survey in 2010 when GWH NHS FT was in the top 20% of Trusts in 12/38 of the measures, this year the Trust is in the top 20% of Trusts in 17/38 of the indicators.

  With staff being more engaged than before, this has clear benefits for patients as research suggests that a well engaged workforce leads to better care. Despite the good results, we are not complacent and recognise there is more work to do on some of the indicators to see further improvements in the year ahead, such we would like to see a bigger improvement in staff recommending the Trust as a place to receive treatment.

  The Executive Committee has set four priorities for 2012/13 and plans are being worked up to achieve them: -
  - ensuring staff feel that patient care is the Trust's priority;
  - staff feeling happy with the standard of care if their relatives needed treatment;
  - improving staff satisfaction with the way the Trust values their work; and
  - ensuring staff feel involved in decisions on changes that affect work.

An overview of 2011 Staff Survey results is contained elsewhere in this report (section 9.3 refers).

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

The financial environment remains challenging and this challenge is set to grow in the years ahead as the Trust seeks to reduce costs and maintain a high standard of care.

The merger with WCHS in June 2011 provides a good opportunity to be more in control of some of the changes. Being a Trust which provides both acute and community services, as more care is transferred out into the community, we will be better placed than most

organisations to adapt to these changes and the massive reorganisation that is taking place in the NHS.

Aside from the merger, the Trust did not win any further significant tenders during the year. The Trust was involved with was an unsuccessful bid for a Medicines Management service for the Bath area which was a significant tender.

In the coming year the new legislation allowing "Any Qualified Provider" to deliver healthcare will become a significant feature of the local health market. The Trust aims to ensure that we are in the best position possible to bid for services that are put out through this policy. This preparation has included investing in bid preparation training session towards the end of the year to share skills and learning around what it takes to prepare a successful tender. This was supplemented by a learning session to feedback on the experience of bidding for WCHS as learning points for future bids.

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

Whilst the Trust, which is already more efficient than the average according to the Trust Reference Cost, the financial difficulties facing the NHS nationally, means that we have to become more efficient, delivering more with less. We have to be radical in how we approach the way we provide care.

An example of our innovative approach has been the changes to Ambulatory Care which were launched in November 2011. The aim of the initiative was to reduce the number of admissions, eliminate mixed sex accommodation and improve how we care for ambulatory (walk in) patients. Through an internal reconfiguration and streamlined processes, the Acute Assessment Unit (AAU) was expanded to create more space to see and treat patients who may not require hospital admission. More space means that we are able to put patients in the most appropriate bay removing the risk of accommodating patients in bays with people of the opposite sex.

These changes were part of a six month pilot to see what impact they would have in improving admission rates. As the impact has been so positive, the changes will become permanent within the hospital.

In January 2012, the Trust began rolling out the Productive Ward Programme to the Wiltshire Community Hospitals. This will see those hospitals benefiting from efficiencies, added improvements and more time for nurses to spend on direct patient care.

The Trust has begun work to improve the Older People's Pathway. This is aimed at streamlining the way older people are cared for; reducing reliance on acute hospitals and reducing the risk of older people becoming institutionalised through long stays in hospital. This work involves a wide range of stakeholders including commissioners and social care, and through smarter working will improve care and reduce costs.

Allied to this work is a large project aimed at improving patient flow. The project is designed to remove potential blockages for staff and patients so that whatever point they access the NHS they have a clear patient journey and are supported through discharge back to where they came from.

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

With the effects of the national reorganisation of the NHS beginning to be seen during the year, the Trust has established embryonic relationships with the various GP Commissioning organisations that will soon take on full commissioning responsibilities from the Primary Care Trusts (PCTs). Whilst these relationships are in the early stages pending the abolition of PCTs, time and effort have been invested in exploring areas of joint interest and understanding future commissioning priorities. The Trust holds regular meetings with Wiltshire Clinical Commissioning Groups to discuss relevant issues.

The new NHS landscape will be more complex than previously and the Trust will need to interact with many more groups with commissioning interests. This presents the Trust with the difficulty of adapting the way we interact with our stakeholders and will require investment in understanding their issues and concerns.

In Swindon, for example, the Trust has been working with the lead of the Transitional Leadership Group (Dr Peter Crouch) on a new IT initiative called Optimise. Optimise is a GP decision making referral tool, which has been developed locally by elected GPs and hospital consultants in Swindon. It replicates many of the useful features of the previous e-referral system and combines this with modern care pathways (e.g. Map of Medicine).

The Trust has also been a regular attendee at the Wiltshire Involvement Network (WIN) since June building better relationships with patient representatives in that area.

3.6 Additional activity creating pressure on finances

The Trust continues to experience additional demand for services, over and above the levels we are contracted to provide by our Commissioners. The following tables highlight activity levels vs contracts by point of delivery for the GWH Acute and Community and Maternity contracts.

TABLE - GWH Acute Activity

Point of Delivery	Contract	Actual	(Under)/ Over performance against contract	Variance %
GWH - New Outpatients	136,442	137,504	1,062	0.78%
GWH - Follow Up Outpatients	250,411	263,066	12,655	5.05%
GWH - Planned Same Day	22,654	27,320	4,666	20.60%
GWH - Emergency Inpatients	32,224	35,804	3,580	11.11%
GWH - Elective Inpatients	6,610	6,723	113	1.71%
GWH - Emergency Department Attendances	63,006	70,731	7,725	12.26%
Total	511,348	541,148	29,800	5.83%

TABLE - Wiltshire Community Activity

Point of Delivery	Contract	Actual	(Under)/ Over performance against contract	Variance %
Community - A&E	44,336	46,507	2,171	4.90%
Community - Contacts	855,948	803,545	(52,403)	-6.12%
Community - Emergency Inpatients	7,857	7,445	(412)	-5.24%

In year the Trust secured from NHS Swindon and NHS Wiltshire £3.6m and £5.26m respectively in terms of contract over performance for both the Acute and Community contracts.

3.7 Continued investment in improved services for patients

Following a significant £2.7m investment, a second Cardiac Cath Lab was opened in April 2011. The work, which included refurbishment of the previous Cath Lab, was a significant capital project designed to improve waiting times and overall experience of users of the service. The investment also means that some of the more complex pacemaker procedures previously carried out in Oxford can now be carried out at the GWH reducing the need for some patients to travel further afield.

In future years it will become more challenging to invest in large capital projects of this scale. As a Foundation Trust there are no other sources of funding and therefore we rely on delivering ambitious savings programmes to free up money to invest in new equipment and services. This becomes more pressing as the Great Western Hospital approaches its 10th anniversary when some of the equipment purchased at the time of opening is now coming to the stage where it needs to be replaced.

Moving forward the Trust will focus on generating a surplus to allow investment in services and equipment thus ensuring that we continue to improve care for our patients both at the GWH, out in the community and in the home.

3.8 Research and development

The Trust carries out its own research within our Academy. The Trust follows the Research Governance Standards set out by the Department of Health.

Within the Academy, the Trust has a Research and Development Team with responsibility for providing advice, support and leadership on matters relating to research and development (R&D). Under the direction of the R&D Director and Academic Dean, the R&D Department continues to increase research activity at Great Western Hospitals NHS Foundation Trust. The Team has increased to include a R&D Administrator to ensure that tight deadlines for approval of research projects are met.

Cancer research remains our largest topic area, accounting for approximately 50% of our activity. However substantial progress has been made in other key topic areas such as Rheumatology and Orthopaedics. Cardiology is now participating in a commercially funded research project and further projects are being considered. Commercially funded research has grown within the Trust which will allow us to self-fund some research posts in the coming year.

With funding received from the Department of Health through our Comprehensive Local Research Network (CLRN), Research and Development have been able to continue funding key research posts across the Trust in Cancer, Rheumatology, Dermatology, Sexual Health, Orthopaedics and ICU. Support departments continue to receive funding for posts to allow them to carry out any additional tests that a research project may require.

All research staff in the Trust are supported with training and guidance through Research and Development and the CLRN's. All research nurses receive an induction pack and competency pack in addition to their standard induction information.

R&D also fund a part time trainee accountant to ensure funding allocated to the Team is utilised effectively and the department can offer transparent accounting. R&D and Finance are always looking for smarter and more efficient ways of working to ensure our funding allocation and income is used in key areas to support research activity, allowing the Team to offer patient choice in as many areas as possible.

All standard operating procedures created within the Research Support Services National Initiative are being implemented to ensure the Trust is compliant with all governance standards.

Recruitment of patients into research studies has decreased this year from 1680 in 2010/11 to approximately 700 this year. This is due to the closure of an observational study that recruited over 800 patients last year. Recruitment into more complex research projects has increased by 5% this year which is an excellent achievement.

3.9 Main risks and uncertainties facing the Trust in the future

Main risks and uncertainties facing the Trust are included in the Trust's Annual Plan, together with proposed actions to mitigate those risks. A summary of the risks to the Trust for 2012/13 onwards is included in the Annual Governance Statement set out elsewhere in this report (section 14.4.5refers).

3.10 Trends likely to impact on the Trust 2012/13

The NHS faces significant challenges in the coming year with the impact of the Health Act, recently enacted, confirming the establishment of Clinical Commissioning Groups (CCGs), the abolition of Primary Care Trusts (PCTs), and Strategic Health Authorities (SHAs) and the creation of the National Commissioning Board.

This will change the way that our services are commissioned (purchased) and it will be important that we work closely with the CCGs across Swindon, Wiltshire and the wider catchment area to ensure that we can understand each CCG's priorities for the patients and communities. Giving such local focus to the requirements of local communities was a key plank of the health reforms, and we are looking forward to this new way of working, aware that it will require some changes to way we do business.

Scrutiny of the services that we deliver will also change with local LINKs groups being abolished and local Healthwatch groups being created, housed in the local authority. These will feed into the national Health and Wellbeing Boards and it will be important that as a Trust we form strong links with these new organisations as early as possible.

The Trust is currently reviewing its strategy 2010-2015 and will launch this later in the year after suitable engagement with staff and the communities we serve. At a time when there is so much change, we will continue to focus on delivering high quality patient care, and ensuring that we have the right staff in post across our enlarged organisation able to deliver the high standards of care that we demand.

As well as the structural changes that will be made to the wider NHS during this and next year, the NHS is in the midst of the delivery of £20bn savings. Such sums cannot be found through small transactional changes, and as a result the Trust is working very closely with the local commissioning organisations (PCTs and CCGs) to identify services and schemes where there are efficiencies and productivities to be found. Such scales of change will be disconcerting to the communities that we serve, and we will seek to engage local interest groups, members and other stakeholders throughout the change process so that with commissioners, we make the right decisions for our patients. In some cases, services may be taken over by other NHS providers or private sector companies as the government seeks to open up the NHS to more providers to ensure greater choice for patients.

As part of the drive to find the huge savings, we will continue to work with colleagues nationally on initiatives to bring down the length of time a patient stays in hospital, and where possible, to find opportunities to treat more patients outside the hospital setting closer to home and friends and family.

This will mean as more services are provided in the community and the home and less in acute hospitals, the Trust will need fewer beds to treat patients. In turn this means that fewer posts will be needed working in the hospital, although some of these roles may be transferred into the community. It is therefore essential that we have a clear workforce plan, as we will do everything we can to avoid redundancies. Any workforce changes that need to be made will be done in close discussion with our primary care and Trade Union colleagues.

3.11 Impact of the Trust's business

Details of the impact of the Trust's business on the environment, social and community issues and on employees, including information about policies in relation to those matters and the effectiveness of those policies are referred to elsewhere in this report under the sustainability report (section 7 refers) and in the staff survey report (section 9 refers).

3.12 Consultations

During 2011/12 there was a staff consultation regarding a back office restructure aimed at streamlining management.

A formal consultation with staff commenced in May 2012 on one ward regarding support to changes relating to bed reconfiguration.

There were no formal public or stakeholder consultations during 2011/12. However, the Trust regularly engages with local stakeholders regarding issues relevant to the Trust.

3.13 Contractual arrangements

The Trust does not have any contractual arrangements with individual persons.

3.14 Performance across the range of healthcare indicators which we are measured against

A detailed performance report is provided elsewhere in the quality report (section 6.4 refers).

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

Enhanced Quality Governance Reporting

Quality governance is combination of structures and processes at and below Board level to lead on trust-wide quality performance including:

- ensuring required standards are achieved;
- investigating and taking action on sub-standard performance;
- planning and driving continuous improvement;
- identifying, sharing and ensuring delivery of best-practice; and
- identifying and managing risks to quality of care.

Arrangements in place to ensure quality governance and quality are discussed in more detail within the annual governance statement (section14 refers) and the quality report (section 6 refers).

3.15 Monitor's Quality Governance Framework

The Trust has had regard to Monitor's quality governance framework in arriving at its overall evaluation of the organisation's performance, internal control and board assurance framework. In June 2011 and again in September 2011, the Trust undertook an evaluation of its strategy; capabilities and culture; processes and structure and measurements mapping them against Monitor's Quality Governance Framework. In addition, the Trust commissioned an independent audit which provided substantial assurance regarding the Trust's quality governance arrangements.

The Trust has not developed one specific action plan to improve the governance of quality. However, throughout the Trust there are plans or ongoing processes which contribute to its improvement. Examples of this include: -

- Development of the Trust's business strategy with particular emphasis on quality.
- Monthly reporting to the Board on risks and potential risks to quality, with action plans in place to address any gaps in assurance.
- Ongoing Board development with the Institute for Innovation and Improvement and refreshment of the Board to ensure that the Board has the necessary skills and qualities to manage the Trust and deliver the quality agenda.
- Promotion of a quality focused culture throughout the Trust evidenced by the roll of staff values and improved communication and feedback mechanisms. Quality is considered in developing policies and procedures for the Trust with consideration given to the impact on clinical effectiveness, patient experience and the quality of care.
- There are clear processes for escalating quality performance issues to the board. These are documented, with agreed rules determining which issues should be escalated. These rules cover, amongst other issues, escalation of serious untoward incidents and complaints. Robust action plans are put in place to address quality performance issues.
- Quality information is analysed and challenged in a number or areas. The board reviews a monthly 'dashboard' of the most important metrics.

Patient care

3.16 Development of services to improve patent care

We treat thousands of patients every year as follows: -

TABLE – Patients seen, treated or admitted 2007/08 – 2011/12

	2007/08	2008/09	2009/10	2010/11	2011/12	Variance from 2010/11
New outpatients	87,441	90,852	94,587	96,456	137504	5.4
Follow up appointments	179,466	195,846	198,244	212,887	263066	14.3
Day cases	26,102	28,508	28,053	27,813	27320	-1.9
Emergency inpatients	34,075	36,658	39,202	35,210	35804	1.6
Elective inpatients	7,438	7,345	7,004	7,269	6723	-7.8
Emergency Department attendances	60,583	62,628	66,262	68,618	70731	3.1

The table above is for GWH acute activity only. 2008/09 onwards includes GUM/HIV, A&E, Anti-coagulation in outpatient figures. 2011/12 outpatient activity includes former Swindon PCT therapies activity.

Table – Patients seen, treated or admitted 2011/12 by former WCHS Community Services

	2011/12
Minor Injuries Unit	46,507
Admitted Patients	7,445
Community contacts including outpatient	803,545

The Trust is using its foundation trust status to develop its services and improve patient care. An example of this is that the Trust was able to use retained cash surpluses to provide a new Cath Lab.

3.17 Performance against key healthcare targets

Details of performance against key healthcare indicators is set out elsewhere in this report (section 6.4 refers).

3.18 Arrangements for monitoring improvements in the quality of healthcare

Continuous monitoring of the Quality Account and Improvement Plan and National Targets is observed monthly. The improvement indicators and national targets inform the Safety and Performance Dashboard and are reported through to our Commissioners and Trust Board via an Executive Committee. The Quality Account improvement indicators also inform a Patient Safety and Quality Committee each month.

Compliance Monitoring of the CQC regulations is undertaken through a Clinical Standards Group, the Patient Safety and Quality Committee and Executive Committee up to Trust Board. Compliance monitoring is informed by the CQC Quality and Risk Profile. Exceptions in compliance or risks identified inform the Trust's 15+ Risk Register (a register of top risks) and actions plans are developed and progress monitored to ensure any evidence of compliance or strengthened where appropriate.

3.19 Progress towards targets

Progress with national targets informs the Trust Safety and Performance dashboard which is shared and monitored by our commissioners, as well as monitored through the Executive Committee and Trust Board. Monthly directorate performance meetings are held to monitor performance at directorate level. Quarterly reporting on compliance with the national targets informs Monitor quarterly.

Progress towards targets as agreed with local commissioners, together with details of other key quality improvements are included elsewhere in this report (section 6.4 refers).

3.20 New or significantly revised services

Wiltshire Community Health Services – As referred to elsewhere in this report (section 1 refers) with effect from 1 June 2011 the Trust took over the provision of Wiltshire Community Health Services.

Improving the way we care for ambulatory patients - Acute Assessment Unit (AAU) and Ambulatory Care Unit pilot - At the beginning of November the Trust began a six month pilot to relocate the Acute Assessment Unit (AAU) and opened an Ambulatory Care Unit at GWH. Ambulatory patients are those who are capable of walking and who require acute hospital medical attention.

These changes were designed to:

- Increase the size of AAU, which is re-named the Acute Medical Unit (AMU) and will better match the demand from the number of daily medical admissions into the hospital. It will continue to be a specialist area providing care for patients requiring admission for up to 72 hours or needing acute medical assessment and treatment prior to referral to specialty teams.
- Set up a fast track Assessment and Diagnostic area in the current AAU space close to the Emergency Department to treat patients without having to admit them overnight to hospital, called the Ambulatory Care Unit.

There is clear evidence from elsewhere in the NHS that this way of providing care for AAU and ambulatory patients improves their care and experience in hospital and the initial pilot proved successful therefore the Ambulatory model will become a permanent feature in the Trust acting as a bridge between primary care, community and acute services.

3.21 Improvement in patient / carer information

The Trust has established a Patient Information Group with a view to improving the quality and range of patient information available. This has included a more standardised approach to patient literature.

Towards the end on 2011/12, the Trust began work on a new patient bedside booklet which will provide a range of patient information and advice for patients when admitted. This is being trialled on a couple of wards and reviewed by patient representatives before roll out across Great Western Hospital. The Trust will then look to prepare a version for community hospitals.

In July 2011, the Trust launched a new website to provide more accurate and timely information to patients and visitors regarding Trust services. The website has thousands of visitors each month and it is kept up to date, with information being presented in new formats such as video, and these are proving popular.

3.22 Focusing on the patient

3.22.1 Productive Ward

The Productive Ward initiative was introduced at GWH in 2008/09. The aim of the project is to increase direct patient care. The roll out has continued and now all 21 wards are at varying stages

of implementing the programme. Included in this number are Maternity, Neonatal Unit and the Children's Ward. The project is also being rolled out to the community Hospitals in Wiltshire. To share expertise and enhance collaborative working, the community hospital wards will be supported by a buddy system approach with a ward at the Great Western Hospital.

There are 11 modules of the programme that are designed to enable ward managers and their teams to free up time to deliver direct patients' care. Successful implementation of the programme and embedding good practices is reliant on good multidisciplinary team working and outcome measures are determined from patient's experience, safety and clinical risks indicators.

The following outlines achievements since implementing the Productive Ward Programme:

- Patient status on glance boards has increased patient safety through better communication amongst members of the Multidisciplinary Team. It has also contributed to a reduction in the average length of stay by up to 2 days, demonstrating efficiency through the patients' pathway.

- The introduction of standardised shift handover reduces clinical risk through better communication of information that is essential to the seamless care of a patient throughout their inpatient stay. There is ongoing work occurring to ensure that handovers are embedded in all clinical areas and are working effectively to support the patient experience and safety agenda.

- The introduction of a menu free approach has enabled patients to be more involved in selecting their meal of choice on a daily basis. The other benefit is that food is served at the right temperature because of the ability to serve meals in a timelier manner.

- The trialing of red tabs and poster campaign aimed at reducing interruptions to nurses' during the administration of medication reduces medication incidents. This work is done in collaboration with members of the pharmacy team.

- Patients' privacy and dignity is enhanced by the introduction of 'privacy pegs'. This involves raising awareness of staff to consider the issues around maintaining privacy and dignity within a hospital environment.

- The introduction of intentional rounding will support the delivery of holistic nursing care. It is envisage that all wards including community hospitals will implement this concept through a roll out programme.

- Innovative work such as the pilot of 'water hydrant' on Jupiter ward has been successful. The hydrants support suitable patients in promoting their hydration and independence. The project is currently being implemented on 4 other wards.

3.23 Examples

The Trust focuses on the patient by making improvement in their nutrition. The Trust aims to reduce pressure ulcers; the number of our patients who fall and the incidence of Venous Thromboembolism (VTE). In addition the Trust seeks to ensure that patients with dementia are cared for in such a way that is suitable to their needs. These are just a few examples of focussing on the patients.

3.24 Complaints Handling

For the Trust to continue to improve its' services we need to continue to actively gather, listen and act upon feedback from patients and service users. In seeking feedback we are able to assure ourselves whether the services we are providing meet the needs of those who use them. Where we fall short of the high standards we aspire to, we look to make changes to the way we deliver care. This journey of continual improvement means that we are always looking at ways we can deliver a better service for people now and in the future.

Within the Trust there is a dedicated team responsible for leading on all aspects of patient experience, working with the clinical directorates to support improvements and respond to feedback. The Patient Advice and Liaison Service (PALS) is led by the Head of Patient Experience and Director of Nursing and Midwifery. PALS is at the forefront of gaining feedback and being a point of contact for our patients and their carers to seek advice and give their views.

The Trust's strategic objectives incorporate three elements that feed directly into patient experience:

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

- To ensure that staff are proud to work at GWH and would recommend the Trust as a place to work, or to receive treatment.

- To work in partnership with others so that we provide seamless care for patients.

The vast majority of patients who use Trust services have a positive experience. They are cared for by caring staff, using the best technology, with treatment by skilled and dedicated professionals. With over 540,000 patient interactions a year, unfortunately there is a small number that are dissatisfied with their care or treatment. Whilst the number is small, the emphasis we place on them is big, so that we can learn how to do things better.

A proactive approach is taken to handling any concerns and complaints. The Head of Patient Experience and Director of Nursing and Midwifery liaise with patients who have raised multiple concerns and complaints with the Trust. These patients are invited into the Trust to tell us about their experience and give us the opportunity to discuss the work that we are doing.

To provide a more visible service to patients and the public, the PALS office moved into a refurbished and extended office in January 2012 situated close to the main entrance to the Great Western Hospital (GWH). This extension created two meeting rooms, one informal room and one formal room for holding complaint meetings. The Trust was successful in a One Swindon bid, a scheme to raise the visibility of the Police within public services and encourage joint working. The scheme contributed towards the cost of the PALS extension and the Police are actively using PALS as a base when they are on site.

Demonstrating how patient experience is a key focus for the senior management of the Trust, during 2011/12 the Patient Experience Report increased to monthly instead of quarterly. This increase in reporting gives the Directorate management and Executive Team a more frequent measure of patient satisfaction and enables monitoring of service improvements. Since the end of the year a 'patient story' has been included detailing the experience of an individual patient from the previous month. This has been put in place to allow the Executive to look beyond the numbers and the written feedback to truly reflect on individual experience – the good and the bad. This is providing a useful way to share lessons learned in one directorate across the rest of the organisation.

As part of the corporate back office, PALS is undergoing a restructure which will be completed during quarter one 2012/13. The restructure gives an opportunity to review the process of informal and formal complaint management, with a clear separation between the two. A clinical post is being introduced to oversee the formal complaint process which will strengthen the level of clinical understanding within PALS with the aim of improving response times. As part of the restructure, a training specification for PALS staff is also being introduced.

3.24.1 Formal complaints

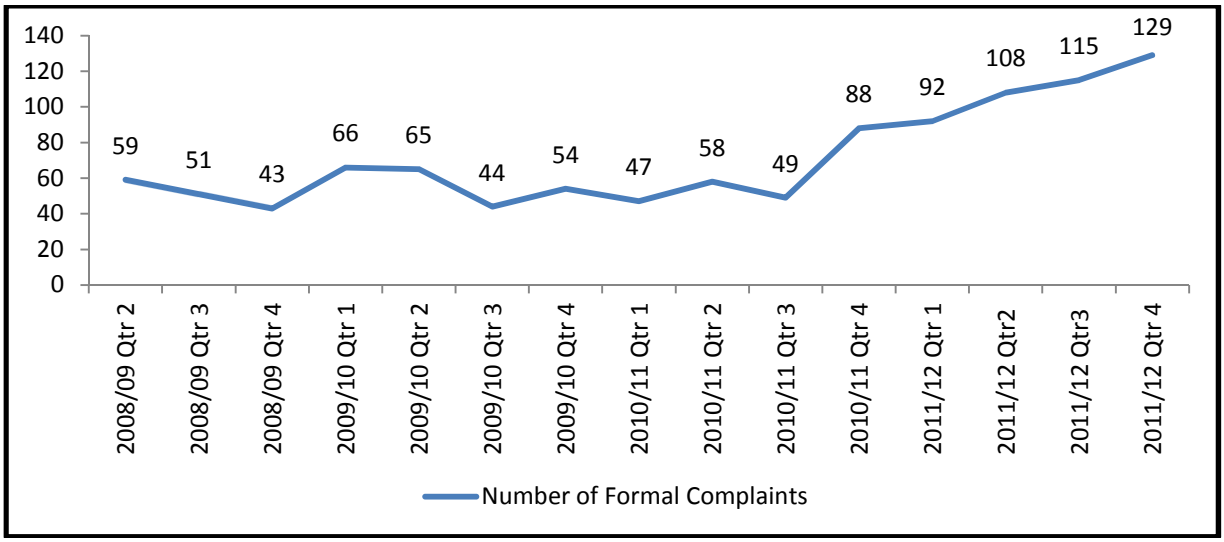
During 2011/12, 444 formal complaints were made to the Trust compared with 242 during 2010/11. The number of formal complaints received by the Trust represents 0.08% of the total number of patients seen, treated or admitted during 2011/12.

When the Trust merged with Wiltshire Community Health Services in June 2011, PALS at GWH became the point of contact for patients and their carers with queries or concerns from across the Wiltshire Services. This in turn has resulted in an increase in the number of contacts with the PALS.

Nationally there is an increase in the number of complaints being made to Trusts. The Trust uses complaints as a resource and opportunity to review services and to identify areas for improvement. A lot of work has been undertaken across the organisation to raise the patient and public awareness of PALS and the importance of gathering feedback. This is also reflected in the increase of contacts with the service as the Trust embraces the culture of seeking continuous patient feedback.

The graph below compares the number of Formal Complaints received during 2011/12 with 2010/11, 2009/10 and 2008/09.

Chart - Number of Formal Complaints received



The Trust actively responds to feedback from our patients and their carers, and the top three complaint themes during 2011/12 and actions taken to address these are as follows: -:

1. Safe, High Quality Co-ordinated Care

   - All wards are rolling out posters which detail who the Matron and Ward Manager are for that area and how they can be contacted if anyone has a concern about their care.
   - A review of the Enhanced Recovery Pathway (an initiative to support patients in making a swift recovery following a procedure) is being re-launched in 2012/13.

2. Access and Waiting

   - The process of weighing patients prior to arranging an angioplasty appointment has reduced the number of cancellations in this area.
   - We have reviewed the way that we manage duplicate referrals to the triage referrals in the Ophthalmology Department to reduce the number of appointment letters that are sent to patients.
   - We have reviewed the pathway for referrals to the Sleep Clinic to try to ensure patients who wish to come to GWH are able to.

3. Better information, communication and choice

   - We have made changes in the information that is given by our Booking Service and are introducing a customer service desk for patient queries.
   - We have introduced telephone calls where appointments are made within seven days of the appointment date.
   - A review of the Clinical Nurse Specialist in Cancer Services has taken place to ensure that patients know who to contact and how to access this support.
   - A review of the appointment system within Community Podiatry Service has taken place.

3.24.2 Learning from patient experience

What patients and service users have told us	What change have been made as a result of this feedback
Some service users have expressed concerns about the way their discharge was handled in 'joining up' their discharge with services in the community.	In response to this feedback, the Trust has introduced a Discharge Pathway Facilitator who is reviewing patient pathways and the discharge planning process. This is raising the profile of, and strengthening, the links between hospital departments and services in the community to ensure a joined up, patient centred approach. The Trust is rolling out handovers at the bedside to involve patients in discussions about their care and to keep them informed.
Patients have also told us they want to be more involved with decisions about their care and they would like more of an opportunity to ask questions during Outpatient Appointments.	A campaign will be launched by the Diagnostics and Outpatient Directorate called 'able to ask' to empower patients to feel able to ask questions during their outpatient appointment and to encourage staff if there is anything else that the patient would like to know.

What patients and service users have told us	What change have been made as a result of this feedback
Service users have asked for a range of alternative ways they would like to be kept in touch with.	The Trust is reviewing the way that we link with patients and a text reminder service is currently being trialled. The Trust has also launched a number of different ways patients can confirm, cancel or rearrange appointments to make it as easy as possible for them change an appointment.
Patients and their families have asked for more opportunities to speak with ward staff when patients and their carers have concerns or questions about their care.	Ward Manager Surgeries are being rolled out to enable patients and their carers to meet with the Ward Manager to discuss any issues.
Patients who suffer with visual impairment shared with us concerns about the difficulty they have in reading some of the signage at the GWH.	We invited the RNIB in to help us understand what issues they had and as a result changes will be carried out during 2012/13.
People arriving in the emergency Department and who may require a British Sign Language Interpreter fed back to the Trust how they often faced delays waiting for an interpreter to arrive.	A new Translating and Interpreting provider was introduced from February 2012 and as part of the criteria for awarding the contract, the Trust included that British Sign Language (BSL) interpreters must have a swift response time for attending the Emergency Department.
Hard of hearing patients told us that they had problems with accessing the hearing loop system and ins some cases it was not working.	The Trust has reviewed the hearing loop systems across the Great Western Hospital and all hearing loops are being replaced and additional loops are being placed in convenient locations around the hospital.
Inpatients would like more information about the hospital, routines and the ward to read and refer to during their stay.	The Trust is reviewing the bedside folders to give patients the most accurate, up to date information. Ward specific information will also be included.

The Trust has continued to measure complaint response times to a maximum of 25 working days, unless otherwise agreed with the complainant. However, it has proved a challenge for the organisation to routinely meet this response time and significant focus and effort during 2012/13 will be placed on improving in this area. To address concerns with the response times for formal complaints and to improve the standard of complaint responses, each Directorate has a designated Executive Lead who reviews complaint responses prior to them being signed by the Chief Executive.

The Complaints Policy was reviewed and updated to incorporate community services into the process for managing complaints. Following the merger with Wiltshire Community Services in June 2011, there has been an increase in PALS activity.

The Formal Complaints Response Training has been reviewed following the appointment of our new Chief Executive and monthly sessions are scheduled throughout 2012/13.

3.25 Using patient experience to drive service improvements

3.25.1 Comment Cards

Across the Trust we use 'Tell us how we're doing' comment cards to capture four elements of patient feedback:

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

A measure of satisfaction regularly used in the commercial industry is recommendation to a friend, which is included within the comment cards. It has proved challenging to generate enough responses via these comment cards to confidently track performance, particularly in relation to the patient recommendation question. Towards the end of the year each directorate was set a monthly target of returning 100 completed cards to enable a statistically reliable comparison to be made each month.

The response rate is reported by Directorates in the monthly patient experience report to the Executive Committee and Trust Board. Due to low response rates, the last reliable indicator of patient recommendation was in January 2012 tracking at 97%. During the other months when the response rate was large enough for a statistically significant response, the recommendation rate ranged from 84% to 97% showing a high level of satisfaction.

3.25.2 Online Feedback

The Communications Team monitors and interacts with patients through feedback through online channels. The Trust is experiencing a rapid growth in online feedback and user interaction through relatively new websites such as PatientOpinion.org. This site has been established as a 'Trip Advisor' style site for users of the health service and is likely to become more widely used by patients in the future. During the course of the year, the site established formal links with NHS Choices and information posted on Patient Opinion is automatically linked to the NHS Choices website (and vice versa). Several thousand people view the GWH sections of these sites on a monthly basis, so it is important to be actively engaged with users through these channels.

Sites such as this present both an opportunity for the Trust in providing a rich vein of user feedback, and at the same time they present a challenge as typically, people posting on these sites expect a response within 48 hours. This means the Trust needs to be much more responsive than we have been previously and we need to ensure responses (as they are in the public domain) not only respect confidentiality but also are actually useful to the user and those viewing the site in the future.

Patients and the public are also able to 'follow' the Trust on Twitter and Facebook. There are over 450 followers at present. In the year ahead PALS will be looking at alternative ways to seek feedback such as using a dedicated children's PALS website aimed at engaging and sharing information with children and young people.

3.25.3 Patient Surveys

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

During 2011/12, the PICKER Institute has carried out the following surveys:

- Quarterly Inpatient
- Annual Inpatient - *results from this survey are used for national benchmarking purposes by the CQC*
- Annual Outpatient

3.25.4 Quarterly Inpatient Surveys

Quarterly Inpatient Surveys give the Trust an opportunity to monitor service improvements and exceptions reports are presented to a Patient Safety and Quality Committee on a quarterly basis.

The results of the PICKER Inpatient survey are used to monitor five elements of Commissioning for Quality and Innovation (CQUIN) relating to patient experience at GWH. The table below shows the CQUIN results gathered from the quarterly Inpatient Surveys. Lower percentages are better.

TABLE - Great Western Hospital Quality Account results on patient experience

Indicator	Regulator	Target 2011/12	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Wanted to be more involved with decisions about care GWH	QA, PCT, CQUIN	<=50%	45.1%	46.6%	46.8%	52%
Could not always find staff to discuss concerns with GWH	QA, PCT, CQUIN	<=59%	40.7%	54.5%	61.6%	37%
Not enough privacy when discussing care or treatment GWH	QA, PCT, CQUIN	<=31%	27.4%	24.8%	29.1%	28%
Side effects of medication not fully explained GWH	QA, PCT, CQUIN	<=49%	30.8%	42.9%	65%	52%
Not told who to contact after discharge if worried GWH	QA, PCT, CQUIN	<=26%	34.5%	21.8%	23.2%	26%

Satisfaction surveys are given to all patients upon discharge from the Trust's Community Inpatient areas. Community inpatient services are provided from four wards across three sites, Longleat Ward - Warminster Hospital, Ailesbury Ward - Savernake Hospital, and two wards at Chippenham Community Hospital, Cedar Ward and Mulberry Ward which is a Stroke rehabilitation Unit. There are currently low numbers of participants in the surveys. This problem will be resolved when the Trust incorporates these surveys within our survey contract.

The table below shows the CQUIN results gathered through the internal surveys.

TABLE - Community Services Quality Account results on patient experience

Indicator	Regulator	Target 2011/12	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Wanted to be more involved with decisions about care WCHS	QA, PCT, CQUIN	<=35%	31%	31%	4%	10%
Could not always find staff to discuss concerns with. WCHS	QA, PCT, CQUIN	<=3%	10.1%	6.2%	9%	5%
Not enough privacy when discussing care or treatment. WCHS	QA, PCT, CQUIN	<=20%	6.3%	3.2%	1%	8%
Side effects of medication not fully explained WCHS	QA, PCT, CQUIN	<=10%	7.3%	21.5%	21%	20.5%
Not told who to contact after discharge if worried WCHS	QA, PCT, CQUIN	<=20%	30%	23.7%	25%	19%

As a result of the feedback from patients, the Trust is introducing Ward Managers Surgeries, which give patients and their carers an opportunity to meet with the Ward Manager if they have any queries or concerns. As an organisation, the Trust recognises the importance of raising issues at the time to resolve them swiftly and photographs of the Ward Managers and Matrons are in the process of being displayed in the ward areas. The Bedside Folders are in the process of being reviewed and will include ward specific information such as the name of the Ward Manager. Bedside Handovers as part of the Productive Ward are a further example of involving patients in discussions about their care.

There are a number of initiatives that have been put in place to improve medication information being given to patients, these include

- Information leaflets included with all discharge medicines
- Patient information available via the internet Provision of medicine reminder card with all discharges via pharmacy
- A patient medicines information helpline which is publicised via Outpatients and the discharge medicines reminder card.

Further work is required to ensure that a clear process is in place to share information with patients and their carers, and this is a targeted area for improvement for 2012/13.

During 2011/12, the Trust recruited a Pathway Discharge Facilitator. A review if the Discharge Pathway has been undertaken and the Unscheduled Care Directorate are facilitating workshops for staff and a revised Admission, Discharge and Transfer Policy. This is being integrated across both the Acute Hospital site and community services.

3.25.5 Annual Inpatient Survey

The Annual Inpatient Survey was sent to a sample of patients who were admitted in June, July or August 2011. The results of this survey are used to inform the quarter two update of the PICKER Action Plan and are used by the CQC to collate a benchmarking report of Acute Trusts which is due to be published in May 2012.

The Trust response rate for the Annual Inpatient Survey was 53.4%, in comparison with the PICKER average of 49.6%. The Trust made significant improvements in comparison with the 2010 Inpatient Survey in four areas and scored significantly better than average on eight questions.

The graphs below show the areas of significant improvement in the 2011 Annual Inpatient Survey and the areas significantly better than the PICKER average.

CHART - Areas of significant improvement

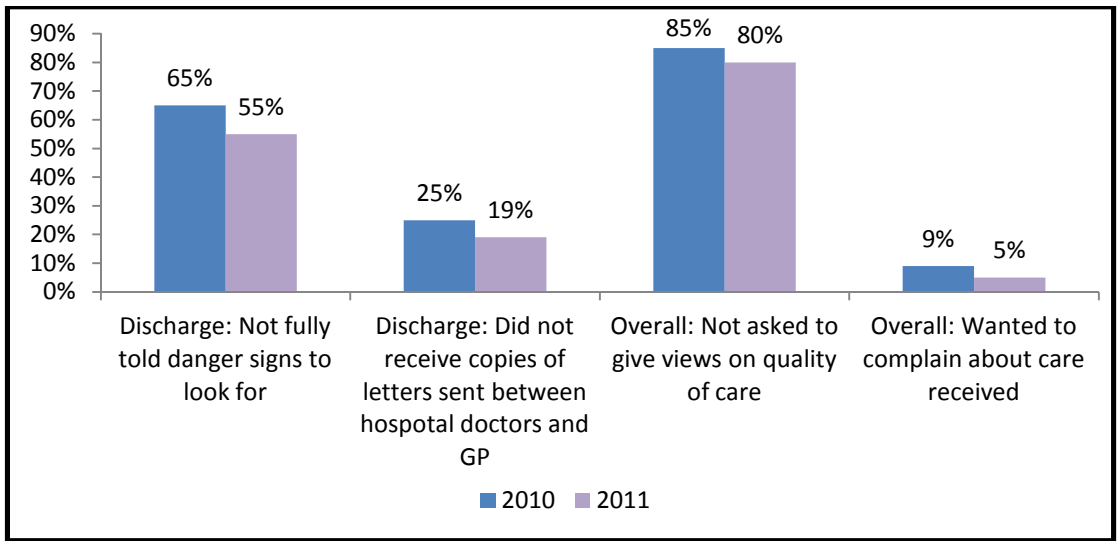
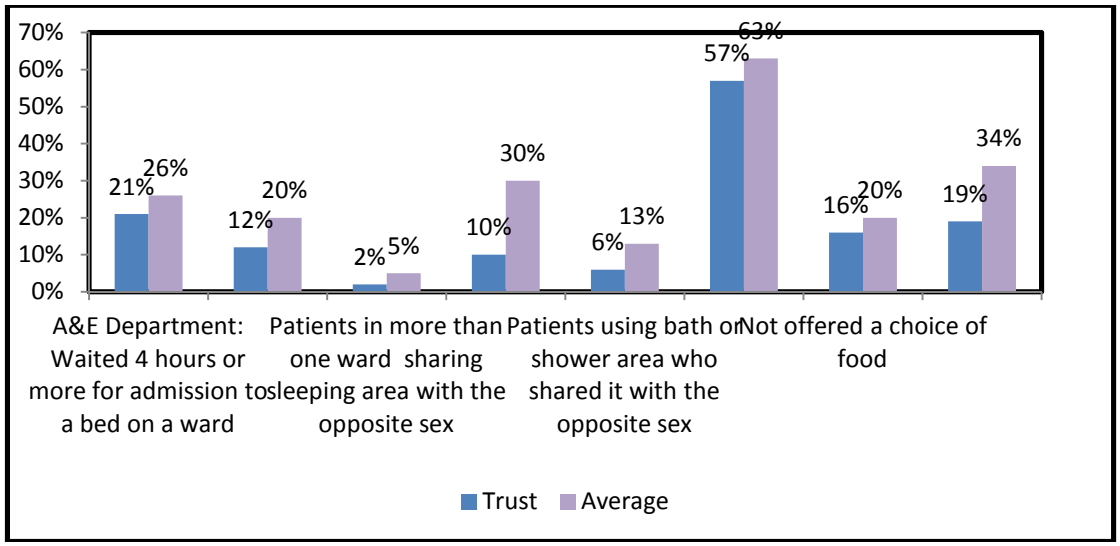


CHART - Areas significantly better than PICKER average



Action plans based on the Quarterly and Annual Inpatient Surveys are developed and monitored through the Patient Safety and Quality Committee, Executive Committee, Trust Board and Patient Experience Governors Group.

Specific areas of focus for 2012/13 are the review of the bedside booklets, medication information, information given to patients on discharge and prompts to use hand gel.

3.25.6 Other

Call bell response times and Patient Reported Outcome Measures (PROMs) which measure the quality of care provided in hospitals from the perspective of the patient are

Call bells

Call bell response times are monitored by the Director of Nursing and Midwifery. During 2011/12 the target for responding to call bell activations within five minutes was 85%. Over the forthcoming year, the target is 90%. Weekly call bell reports have been introduced which enable Matrons to monitor call bell activations in their clinical areas more closely.

Monthly call bell response times are monitored on the ward performance boards as part of the Productive Ward. As the Productive Ward is rolled out into the community inpatient areas, a review of call bells will be undertaken to record and monitor Trust wide response times.

Patient Reported Outcome Measures (PROMs)

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

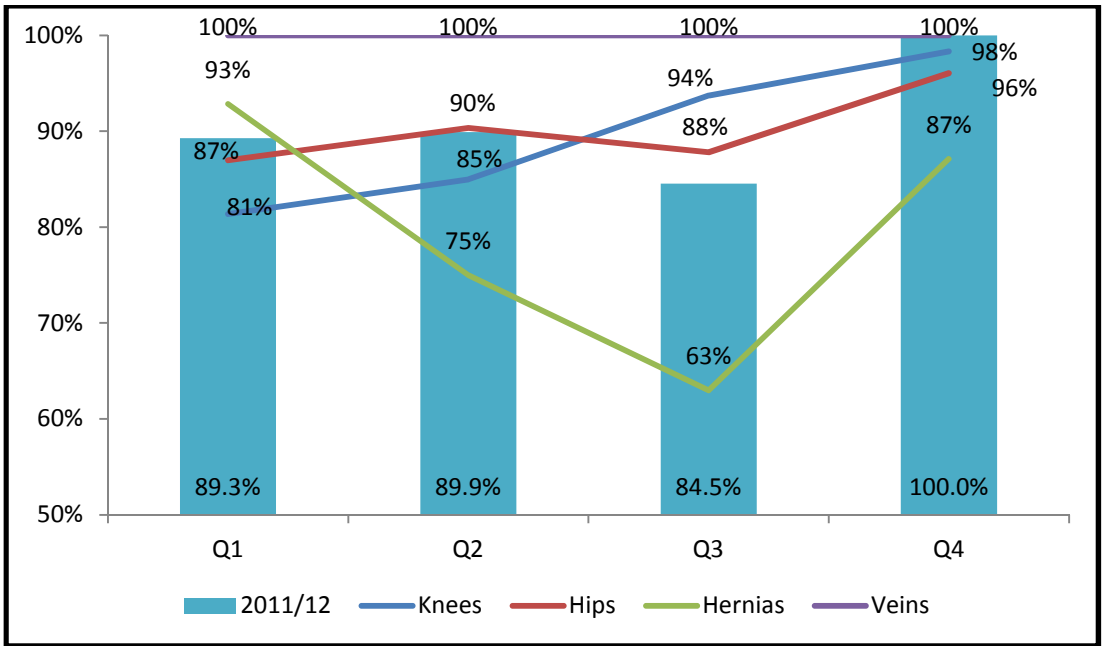
A PROMs assistant is managed within the PALS Department and currently collects the data for the following procedures within the Cherwell Unit:

- Hip
- Knee
- Hernia
- Varicose Veins

Completed surveys are sent to the National PROMS team for analysis. They monitor the feedback against the number of historic procedures recorded on the HES (Hospital Episode Statistics) system. As this information is historic, it gives an indication on performance rather than up to date information. There is work underway nationally to improve the information that is gathered through these questionnaires to ensure that meaningful data is available for Trusts to use to improve services.

The PROMS Assistant monitors the number of completed surveys through the clinic lists of the Cherwell Pre-Assessment Unit. The graph below shows the percentage of completed surveys in the Cherwell Unit.

CHART - Percentage of patients who completed a PROMS questionnaire



Stakeholder Relations

3.26 Partnerships and alliances

To facilitate the delivery of improved healthcare the Trust took over the provision of Wiltshire Community Health Services, the purpose being to provide joined up and stream lined services for patients across a wider geographical area. The Trust aims to achieve improvements in the quality of care through shared learning and to have a closer working relationship with partners in primary care, social care and the third sector.

The Trust works in partnership with Carillion our Private Finance Initiative (PFI) partners who provides security; catering; house-keeping; cleaning; portering and switchboard services. A formal contract is in place for this.

Since December 2011, Carillion and the GMB (a general trade union) have been in dispute regarding employment matters around annual leave and allegations of bullying, racism and bribery from members of the house-keeping staff (cleaners and ward hostesses). The Trust has been liaising with Carillion to ensure robust investigations are carried out and the concerns raised by staff are treated in an open and transparent manner. The dispute has involved 19 days of strike action by these staff but robust plans by Carillion have meant that there has been minimal disruption to patients and services. The Trust has encouraged both partied to reach a resolution as soon as possible.

3.27 Development of services with others

The Trust is in the process of reviewing community and acute pathways between Great Western Hospital and its boarder counties. The aim is to establish a single process of referral between acute and community to ensure that patients are in the right place, at the right time, with the right skills to meet their needs. This includes proactive planning of care from the point of admission and the development of pathways between community services and the front door (Emergency Department, Ambulatory Care and Linnet Assessment Medical Unit). This will enable patients to be returned directly home when feasible.

3.28 Working with our partners to strengthen the service we provide

During the course of the year significant effort has gone in to focussing on how the Trust can achieve its objectives through better working in partnership with local key stakeholders. The merger with Wiltshire Community Health services (WCHS) in June 2011 presented a unique opportunity to shift from being an acute hospital provider to being an integrated healthcare provider with much closer links to GPs, Local Authorities and the Third Sector in particular.

This shift has also seen the Trust operate across a much wider geographical area and has required us to build greater knowledge of the surrounding area and an understanding of the partnerships there so we can tap into the effective relationships that already exist on the ground.

As evidence of our commitment to working in partnership, work has taken place with our partners to:

- Redesign the Older People's Pathway with the aim of making the best use of providing both acute and community services under a single organisation so that the various stages of clinical care for an elderly patient are provided in the appropriate setting and in a timely fashion.
  To be successful this project involves a wide variety of local stakeholders including our commissioners, Clinical Commissioning Group, and Acute Geriatric Medicine Consultants, Social Care, and Community Hospital representatives.
  The group aims to reduce reliance on the acute sector to provide clinical care, support more care in the community or at home and reduce the risk of elderly patient becoming institutionalised in hospital due to the challenges of getting social care and other support services in place following long stays in hospital.

- Instigating a project to improve patient flow not only to reduce the amount of time patients spend in our hospitals but to improve their overall NHS experience whether they come to us through their GP or through the Emergency Department. This work relies on close working with our partners in social care to support patients and users in getting back to where they originally came from and then working closely together to develop effective plans to prevent unnecessary readmission. The work of our Discharge Liaison Nurses is instrumental in this area in working with social care to help ease the transition from hospital back into the community.

- Engage more with the emerging Clinical Commissioning Groups to secure early GP input into discussions around pathways and potential future commissioning intentions so that services are built around our customers – patients and GPs.

  Over the coming year the Trust will be engaging with GPs to secure their input into the development of the Trust strategy running from 2012 – 2017. This is to ensure that our new strategy reflects future commissioning intentions and is responsive to the rapid changes in the local health economy.

- Regular attendance at Wiltshire Involvement Network (WIN) to discuss key developments in the community and at the GWH which is helping establish more productive working relationships in an area that the Trust had not previously engaged with.
  This relationship will continue to develop as we engage with them on changes to local community services in the years ahead.

3.29 Health and Overview Scrutiny Committees (HOSCs)

HOSCs (known as the Adult Social Care Select Committee in Wiltshire) are a statutory function of Local Authorities comprising elected representatives whose role it is to scrutinise decisions and changes that impact on health services in the area.

The Chief Executive of the Trust, along with other senior officers, routinely attends both Swindon HOSC and Wiltshire AHSC to provide updates and respond to issues. During the course of the year a formal report is now provided to Swindon HOSC and presented at each meeting which has been well received.

Key topics covered at Swindon HOSC during the course of the year include:

- Changes to patient, public and staff car parking at the GWH
- Overview of the Hydrant project to improve the way patients are kept hydrated
- Progress on the development of a local Radiotherapy service
- The Development of Quality Accounts

The Trust welcomes the input of the HOSC in our work and towards the end of the year began working with the HOSC as part of a small review group which includes Swindon LINk to look at the action plan that has been developed in response to the various unannounced inspections carried out by the CQC across the Trust during the year. This input is important in providing assurance to the HOSC and LINks about the robustness of our plans and is a good model for joint work in the future.

3.30 Swindon and Wiltshire LINks

Since the merger with WCHS the Trust has been a regular attendee at Wiltshire Involvement Network meetings presenting on a range of topics concerning the Trust. This includes providing advance notice of changes and developments in the local NHS.

As a Trust we have sought to ensure the LINks, as statutory bodies, are kept fully informed of developments at the Trust and good links have been developed with key members of the respective groups.

In December 2011 the Trust invited members of both groups to attend a food tasting session to hear about the ‘menu less meals’ initiative that is being rolled out and planned changes to the lunchtime meal offering. This session provided a useful opportunity to hear from users of our service about their experience of hospital food. The senior team from Carillion, the catering provider, were also in attendance to take on board the feedback and look at how the service may be adapted to reflect the comments of those present.

Outside of more formal meetings, the Trust receives a regular flow of questions and feedback from users through the LINks which are responded to. This open communication is useful to understand the issues that are ‘reaching up to the surface’ and becoming a local concern which may need to be addressed.

In Swindon the development of the Swindon LINk website has been a useful source of user feedback through postings by service users. The Trust responds to all of the issues raised through this site and shares with relevant teams and department for action where necessary.

3.31 Statement as to disclosures to auditors

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

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

3.32 Additional disclosures

3.32.1 Preparation of accounts

The accounts for the period ended 31st March 2012 have been prepared in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006 in the form that Monitor (the Independent Regulator of NHS Foundation Trusts) with the approval of the Treasury, has directed.

3.32.2 History of the Trust

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

As a Foundation Trust the organisation has greater freedom to run its own affairs, which offers financial advantages to invest in services for the future. The principle activities of the Trust are referred to elsewhere in this report (section 3.2 refers).

3.32.3 Going concern

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

3.32.4 Accounting policies for pensions and other retirement benefits

Accounting policies for pensions and other retirement benefits are set out in note 1.3 to the accounts and details of senior employees' remuneration can be found elsewhere in this report in the remuneration report section (section 4.8 refers).

3.32.5 Interests held by Directors and Governors

Details of company directorships and other significant interests held by directors or governors which may conflict with their management responsibilities are registered. The Trust maintains two registers one each for directors and one for governors which are open to the public. Both registers are available from the Company Secretary.

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

4 REMUNERATION REPORT

Information not subject to audit

4.1 Remuneration Committee

The Trust has a Remuneration Committee which has responsibility to put in place formal, rigorous and transparent procedures for the appointment of a new Chief Executive and other Executive Directors and to develop, maintain and implement a remuneration policy that will enable the Trust to attract and retain the best candidates. The Committee regularly reviews the structure, size and composition (including the skills, knowledge and experience) required of the Board and gives consideration to and make plans for succession planning.

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

4.2 Membership of the Remuneration Committee

Membership of the Committee in 2011/12 was as follows: -

Rowland Cobbold	Chairman
Robert Burns	Member
Liam Coleman	Member
Angela Gillibrand	Member
Kevin Small	Member
Roger Hill	Member
Bruce Laurie	Member
Lyn Hill –Tout	Member *(part year until 12 June 2011)*
Alf Troughton	Member *(part year 1 June – 30 September 2011)*
Nerissa Vaughan	Member *(part year from 1 October 2011)*

4.3 Attendance at meetings of the Remuneration Committee during 2011/12

There have been 8 meetings of the Remuneration Committee during 2011/12.

	Record of attendance at each meeting (✓ = attended × = did not attend)							
	08/04/11	**28/04/11**	**04/05/11**	**24/06/11**	**21/09/11**	**15/02/12**	**12/03/12**	**21/03/12**
Rowland Cobbold (Chair)	✓	✓	✓	✓	✓	✓	✓	✓
Robert Burns	✓	✓	✓	✓	✓	✓	✓	✓
Liam Coleman	×	×	×	✓	✓	✓	×	✓
Angela Gillibrand	×	✓	✓	✓	✓	✓	✓	✓
Kevin Small	✓	✓	×	✓	✓	×	✓	✓
Roger Hill	✓	✓	✓	✓	✓	✓	×	✓
Bruce Laurie	✓	✓	✓	✓	✓	✓	×	✓
Lyn Hill-Tout	✓	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Alf Troughton	n/a	n/a	*	*	×	n/a	n/a	n/a
Nerissa Vaughan	n/a	n/a	n/a	n/a	n/a	✓	✓	✓

* considering Chief Executive appointment so not permitted to attend

4.4 Policy and guidance

In exercising its responsibilities, the Committee: -

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

4.5 Remuneration of senior managers (Executive Directors)

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

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

Having regard to the future the Committee has considered recent developments in remuneration practice in the public sector, advice from Hay Group and the recommendations of the Hutton Report, particularly the proposition that a proportion of executives' pay should be at risk. The opportunity was taken to introduce the concept with the appointment of a new Chief Executive. A basic salary was approved with the opportunity to earn an additional 20% if agreed performance measures are met. The Committee has a clear view that there must be a vigorous threshold to be achieved before payment of all or part of the variable element can be considered. It is intended to introduce variable pay for Executive Directors from April 2013.

The Committee recognises that Directors' remuneration does not in all cases reflect current market levels and therefore to ensure the Trust can continue to recruit and retain high calibre Directors, the Committee plans to undertake a fundamental review of Executive Director remuneration during 2012/13. The Committee aspires to offer top quartile remuneration for top quartile performance.

4.6 Performance of senior managers

The appraisal process adopted in 2009/10 for the Chief Executive and Executive Directors involves a 360 degree assessment of each Director against a range of competencies based on those devised by Hay Group for Foundation Trust Directors and an assessment of performance against a set of objectives agreed with each individual. This provides an effective system for setting individual objectives and performance measures each year. The process has been used to assess performance in 2011/12 and to set objectives for 2012/13. In the case of the Chief Executive the review is carried out by the Chair and for other Directors by the Chief Executive. The Committee receives a summary report into the performance of each Director.

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

4.7 Board of Directors' employment terms

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

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

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

Information subject to audit

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

4.8 Pension Benefits and Remuneration

Pensions Benefits

Name	Title	Real Increase in Pension 2011-12 (Bands of £2500)	Real Increase in Lump Sum 2011-12 (Bands of £2500)	Total accrued pension at 31st March 2012 (Bands of £5000)	Total accrued related lump sum at 31st March 2012 (Bands of £5000)	Cash Equivalent Transfer Value at 31st March 2012	Cash Equivalent Transfer Value at 31st March 2011	Real Increase in Cash Equivalent Transfer Value	*Employers Contribution to Stakeholder Pensions*
		£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	***£000***
Lyn Hill-Tout	Chief Executive	7.5 - 10	27.5 - 30	50 - 55	155 -160	1,065	826	239	0
Nerissa Vaughan	Chief Executive	n/a	n/a	30 - 35	100 - 105	517	n/a	n/a	0
Oonagh Fitzgerald	Director of Workforce and Education	0 – 2.5	0 – 2.5	10 - 15	40 - 45	187	140	47	0
Maria Moore	Director of Finance	0 – 2.5	2.5 - 5	15 - 20	55 - 60	282	217	64	0
Alf Troughton	Medical Director and Interim Chief Executive	5 – 7.5	15 – 17.5	60 - 65	180 - 185	1,377	1,215	162	0
Guy Rooney	Interim Medical Director	n/a	n/a	35 - 40	105 - 110	620	n/a	n/a	0
Sue Rowley	Director of Nursing and Midwifery	0 – 2.5	2.5 – 5	30 - 35	90 - 95	594	530	64	0
Helen Bourner	Director of Business Development	0 – 2.5	2.5 - 5	10 - 15	40 - 45	257	207	50	0

Note. J Barker was seconded from NHS Wiltshire as Director of Transition for the period 1 June – 31 December 2011. Her remuneration for the period was £81k and her pension information is as follows:
Pension £33k, Lump Sum £10k, CETV £623k.

Note. Accrued Pension and Lump Sum relate to benefits accrued to date and are not a projection of future benefits. They will include any additional pension benefits that have been purchased to date
Note membership of the Board during 2011/12 is referred to elsewhere in this report (section 3.1 refers)

Remuneration

		2011/12					2010/11				
Name	**Title**	**Salary (Bands of £5000)**	**Other Remuneration (Bands of £5000)**	**Performance Related Bonuses (Bands of £5,000)**	**Compensation for Loss of Office**	**Benefits in Kind Rounded to the Nearest £100**	***Salary (Bands of £5000)***	***Other Remuneration (Bands of £5000)***	***Performance Related Bonuses (Bands of £5,000)***	***Compensation for Loss of Office***	***Benefits in Kind Rounded to the Nearest £100***
Bruce Laurie	Chair	35-40		-	-	0	35-40	0	-	-	0
Kevin Small	Non Executive Director	10-15		-	-	0	10-15	-	-	-	0
Rowland Cobbold	Non Executive Director	10-15		-	-	0	10-15	-	-	-	0
Angela Gillibrand	Non Executive Director	10-15		-	-	0	10-15	-	-	-	0
Roger Hill	Non Executive Director	10-15		-	-	0	10-15	-	-	-	0
Robert Burns	Non Executive Director	10-15		-	-	0	10-15	-	-	-	0
Liam Coleman	Non Executive Director	10-15		-	-	0	10-15	-	-	-	0
Lyn Hill-Tout	Chief Executive	30-35		-	-	0	120-125	-	0-5	-	0
Alf Troughton	Interim Chief Executive Medical Director	45-50 80-85	15-20 35-40	-	-	0	80-85	100-105	0-5	-	0
Nerissa Vaughan	Chief Executive	70-75		-	-	0	-	-	-	-	-
Oonagh Fitzgerald	Director of Workforce and Education	80-85		-	-	0	80-85	-	0-5	-	0
Maria Moore	Director of Finance	100-105		-	-	0	100-105	-	0-5	-	0
Guy Rooney	Interim Medical Director	25-30	20-25	-	-	0	-	-	-	-	-
Sue Rowley	Director of Nursing and Midwifery	80-85		-		0	80-85	-	0-5	-	0
Helen Bourner	Director of Business Development	80-85		-	-	0	80-85	-	0-5	-	0

Notes: Salary includes employer NI and pension contributions. The above figures do not include any final bonus/performance related pay increase which is subject to agreement by Remuneration Committee

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

4.8.1 Notes to Pension and Remuneration Tables

Non-Executive Directors do not receive pensionable remuneration.
No executive directors serve elsewhere as non-executive directors and therefore there is no statement on retention of associated earnings.

4.8.2 Cash Equivalent Transfer Value

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

A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme, or arrangements when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures show the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of the scheme at their own cost. CETV's are calculated within the guidelines and frameworks prescribed by the Institute and Faculty of Actuaries. The CETV is based on actual contributions to 31st March 2012.

4.8.3 Real Increase in CETV

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

4.8.4 Additional disclosures

The Trust is required to disclose the median remuneration of its staff and the ratio between this and the mid-point of the banded remuneration of the highest paid director; whether or not this is the Accounting Officer or Chief Executive. The calculation is based on full-time equivalent staff of the Trust at the year end on an annualised basis. This information is set out below together with an explanation of the calculation, including the causes of significant variances where applicable.

Extract of the accounts: -

7.4 Highest Paid Director

Executive Name & Title Salary	Total remuneration	
	2011/12	**2010/11**
Dr A F Troughton, Medical Director	£194,218	£184,726

The above remuneration is on an annualised basis and is that of the highest paid director. This includes salary, performance related pay, severance payments and benefits in kind where applicable but excludes employer pension contributions. The Medical Director was Acting Chief Executive for the period May to September 2011.

7.5 Multiple Statement

	2011/12	**2010/11**	**% change**
Highest paid director's total remuneration	£194,218	£184,726	5.1%
Median total remuneration	£28,702	£26,146	9.8%
Ratio	6.77	7.07	-4.2%

All NHS Foundation Trusts are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisations workforce. The median total remuneration above is the total remuneration of the staff member lying in the middle of the linear distribution of staff employed in the Trust, excluding the highest paid director. This is based on an annualised full time total staff equivalent remuneration as at the reporting period date.The movement in the above ratio of -4.2% is due to the increased staff numbers through the merger with Wiltshire Community Services.

Signed.....

Nerissa Vaughan
Chief Executive

24 May 2012

5 NHS FOUNDATION TRUST CODE OF GOVERNANCE

5.1 Council of Governors

5.1.1 Governors

The Council of Governors consists of 19 elected and nominated governors who provide an important link between the Trust, local people and key stakeholders by sharing information and views that can be used to develop and improve health services.

Four public constituencies exist to cover the Trust's catchment area namely: -
Swindon;
Wiltshire;
West Berkshire and Oxfordshire; and
Gloucestershire and Bath and North East Somerset.

Governors for these areas are elected by members of those constituencies in accordance with the election rules stated in the Trust's Constitution using the "first past the post" voting system. Elections are carried out on behalf of the Trust by the independent Electoral Reform Services Ltd. There are 10 public governor positions (Swindon – 5, Wiltshire – 3, West Berkshire and Oxfordshire - 1, and Gloucestershire and Bath and North East Somerset – 1). In addition there are 3 elected staff governors and 6 governors nominated by organisations that have an interest in how the Trust is run. The number of public governors must be more that half of the total membership of the Council of Governors.

In 2011/12 the Trust reviewed its public constituencies based on its new geographical area as a result of taking on board Wiltshire Community Health Services. The West Berkshire, Gloucestershire and Oxfordshire constituency was initially expanded in June 2011 to incorporate Bath and North East Somerset and then split out in August 2011 to create the two constituencies referred to above.

In 2012/13 it is planned that the Wiltshire Constituency will be split into three constituencies with an increase in the number of public governors. This will provide better local representation of the Wiltshire area. Furthermore, the Trust has a wide range of staff undertaking a variety of roles and professions. In 2011/12 the Trust supported the establishment of classes within the staff constituency to reflect occupational areas. This amendment is proposed to be implemented in 2013.

During 2011 the Trust considered its other partner governors and whether there should be representation from third sector organisations reflecting the Trust's involvement in this area. It was agreed that the Thames Valley Chamber of Commerce should be replaced with Prospect Hospice as a partner organisation for the purposes of nominating a governor to the Council of Governors.

The names of governors during the year, including where governors were elected or appointed and their length of appointments are set out in the following tables. The Trust held elections in all constituencies during the year for governors whose terms of office expired. There was an average turnout of 35% across all constituencies which is a 6% increase on last year. The re-elected and newly elected Governors were formally appointed to office at the Council of Governors meeting held on 23 November 2011.

5.1.2 Elected Governors – Public Constituencies

Name	Constituency	Date elected	Term of Office	End of current term	Attendance at meetings during 2011/12	Notes
Ros Thomson	Swindon	10/11/11	2 years	Nov 2013	6 of 7	Ros Thomson was initially elected 01/12/08
Katherine Usmar	Swindon	01/02/08	3 years	Ended Nov 2011	1 of 5	Katherine Usmar did not stand for re-election at the end of her term of office in November 2011
Kevin Parry	Swindon	10/11/11	2 years	Nov 2013	1 of 3	Kevin Parry was elected in November 2011 filling the seat previously held by Katherine Usmar
Harry Dale	Swindon	04/11/10	3 years	Nov 2013	5 of 7	Harry Dale was initially elected 01/12/08
Geraint Day	Swindon	12/01/11	Rest of 3 years	Nov 2012	4 of 7	Geraint Day took up the position in January 2011 being a Reserve Governor
Phil Prentice	Swindon	20/11/09	3 years	Nov 2012	7 of 7	Phil Prentice was initially elected 01/12/08
Margaret Toogood	Wiltshire	01/12/08	3 years	Ended Apr 2011	1 of 1	Resigned 28/04/11 – She is prevented from standing to become a governor for 5 years from the date of her resignation
Margaret White	Wiltshire	10/11/11	1 year	Nov 2012	6 of 6	Margaret White took up the position on 03/06/11 being a Reserve Governor following the resignation of Margaret Toogood. She was the second place candidate at the election for Wiltshire in November 2010 with 27.29% of the vote. Margaret served the remainder of a 3 year term and was subsequently re-elected at the elections in November 2011.
Godfrey Fowler	Wiltshire	04/11/10	3 years	Nov 2013	7 of 7	Godfrey Fowler was initially elected 01/12/08
Janet Jarmin	Wiltshire	04/11/09	3 years	Nov 2012	5 of 7	Janet Jarmin was initially elected 01/12/08
Srini Madhavan	West Berkshire, and Oxfordshire	10/11/11	3 years	Dec 2014	6 of 7	Srini Madhavan was initially elected 01/12/08. At the beginning of 2011/12, there was one Constituency known as the West Berkshire, Gloucestershire and Oxfordshire Constituency. It was then expanded to include Bath and North East Somerset before being split out to form these constituencies.

There is currently a vacancy for the governor position in respect of the Gloucestershire and Bath and North East Somerset Constituency. No candidates stood at the last elections in November 2011. Elections are planned for the summer 2012.

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

5.1.3 Elected Governors – Staff Constituency

Name	Constituency	Date elected	Term of Office	End of current term	Attendance at meetings during 2011/12	Notes
Vicki Barnett	Staff	10/11/11	2 years	Nov 2013	3 of 3	Vicki Barnett was elected in November 2011 filling the seat previously held by Rachel Cross
Rachel Cross	Staff	01/12/08	3 years	Ended	5 of 5	Rachel Cross did not stand for re-election at the end of her term of office in November 2011
Peter Hanson	Staff	04/11/10	3 years	Dec 2013	5 of 7	
Marcus Galea	Staff	20/11/09	3 years	Dec 2012	5 of 7	

5.1.4 Nominated Governors

Name	Nominating Partner Organisation	Date nominated	Term of Office	End of current term	Attendance at meetings during 2011/12	Notes
David Stevens	PCT – Wiltshire PCT	23/11/11	3 years	Nov 2014		David Stevens was initially nominated 01/12/08
Bill Fishlock	PCT – Swindon PCT	23/11/11	3 years	Nov 2014		Bill Fishlock was initially nominated 01/12/08
David Renard	Local Authority – Swindon Borough Council	01/12/08	3 years	Ended Dec 2011		
Brian Mattock	Local Authority – Swindon Borough Council	23/11/11	3 years	Nov 2014		
Carole Soden	Local Authority – Wiltshire Council	01/12/08	3 years	Ended Jun 2011		Carole Soden resigned 17/06/11
Jemima Milton	Local Authority – Wiltshire Council	23/11/11	3 years	Nov 2014		
Andy Cresswell	Other Partnerships – Thames Valley Chamber of Commerce	01/12/08	3 years	Ended Sep2011		Andy Cresswell resigned 12/09/11
Clive Bassett	Other Partnerships – Prospect Hospice	23/11/11	3 years	Nov 2014		
Lesley Donovan	Other Partnerships – Swindon and North Wiltshire Health and Social Care Academy	01/12/08	3 years	Ended Dec 2011		
Jon Elliman	Other Partnerships – Swindon and North Wiltshire Health and Social Care Academy	23/11/11	3 years	Nov 2014		

5.1.5 Attendance at meetings of the Council of Governors during 2011/12

There were 7 meetings of the Council of Governors in 2011/12, one of which was a joint meeting with the Annual Members Meeting and another being a joint meeting with the Board of Directors. The table below shows governor and director attendance at those meetings: -

Attendee (✓ = attended X = did not attend)	**11/04/11**	**24/06/11**	**21/07/11**	**22/09/11** *1	**23/11/11**	**26/01/11**	**12/03/12** *2
Governors							
Vicki Barnett	n/a	n/a	n/a	n/a	✓	✓	✓
Clive Bassett	n/a	n/a	n/a	n/a	✓	✓	✓
Andy Cresswell	×	×	×	n/a	n/a	n/a	n/a
Rachel Cross	✓	✓	✓	✓	✓	n/a	n/a
Harry Dale	✓	✓	✓	×	✓	×	✓
Geraint Day	✓	×	✓	✓	×	×	✓
Lesley Donovan	✓	×	n/a	n/a	n/a	n/a	n/a
Jon Elliman	n/a	n/a	n/a	n/a	✓	✓	×
Bill Fishlock	✓	✓	✓	×	×	×	✓
Godfrey Fowler	✓	✓	✓	✓	✓	✓	✓
Marcus Galea	✓	✓	×	✓	×	✓	✓
Peter Hanson	✓	✓	✓	✓	✓	×	×
Janet Jarmin	✓	×	✓	×	✓	✓	✓
Srini Madhavan	✓	×	✓	✓	✓	✓	✓
Brian Mattock	n/a	n/a	n/a	n/a	×	✓	×
Jemima Milton	n/a	n/a	n/a	n/a	✓	✓	×
Kevin Parry	n/a	n/a	n/a	n/a	✓	×	×
Phil Prentice	✓	✓	✓	✓	✓	✓	✓
David Renard	✓	✓	×	×	×	n/a	n/a
Carole Soden	×	n/a	n/a	n/a	n/a	n/a	n/a
David Stevens	✓	✓	✓	✓	✓	✓	✓
Ros Thomson	✓	✓	✓	✓	×	✓	✓
Margaret Toogood	✓	n/a	n/a	n/a	n/a	n/a	n/a
Katherine Usmar	×	×	×	×	✓	n/a	n/a
Margaret White	n/a	✓	✓	✓	✓	✓	✓
Directors							
Jenny Barker	×	×	×	×	×	n/a	n/a
Helen Bourner	✓	×	×	✓	×	×	✓
Robert Burns	×	✓	×	✓	×	×	✓
Rowland Cobbold	✓	✓	✓	✓	×	✓	✓
Liam Coleman	×	✓	×	✓	×	×	×
Oonagh Fitzgerald	×	✓	×	✓	×	×	×
Angela Gillibrand	×	×	×	✓	×	✓	✓
Roger Hill	×	✓	×	✓	×	×	×
Lyn Hill-Tout	✓	×	×	n/a	n/a	n/a	n/a
Guy Rooney	✓	✓	×	×	n/a	n/a	n/a
Bruce Laurie (Chair)	✓	✓	✓	✓	✓	✓	✓
Maria Moore	✓	×	×	✓	×	×	✓
Sue Rowley	×	×	×	✓	×	×	×
Kevin Small	×	×	×	✓	×	✓	×
Alf Troughton	×	✓	✓	✓	×	×	✓
Nerissa Vaughan	n/a	n/a	n/a	n/a	✓	✓	✓

*1 Joint Council of Governors meeting with Annual Members Meeting
*2 Joint Council of Governors meeting with the Board of Directors

5.1.6 Lead and Deputy Lead Governors

In November 2011, Harry Dale, previously the Deputy Lead Governor, was nominated as the Lead Governor for one year replacing Godfrey Fowler and Ros Thomson was nominated as the Deputy Lead Governor. The Lead Governor is responsible for receiving from governors and communicating to the Chair any comments, observations and concerns expressed by governors other than at meeting of the Council of Governors regarding the performance of the Trust or any other serious or material matter relating to the Trust or its business. The Deputy Lead Governor is responsible for supporting the lead governor in his role and for performing the responsibilities of the lead governor if he is unavailable. The Lead Governor regularly meets with the Chair of the Trust both formally and informally. In addition the Lead Governor communicates with other governors by way of regular email correspondence.

5.1.7 Biography of individual governors

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

5.1.8 Role and function of the Council of Governors

The Council of Governors has a duty under the National Health Services Act 2006 to represent the views of foundation trust members and stakeholders, to the Board of Directors and the management of the Trust. The Trust keeps the Council of Governors fully informed on all aspects of the Trust's performance. This is done through formal Council meetings, and through working groups set up by the Council of Governors. These are explained in detailed elsewhere in this report (section 5.1.11 refers).

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

The overall responsibility for running the Trust lies with the Board of Directors and the Council of Governors is the collective body through which the directors explain and justify their actions. The Board has a scheme setting out which decisions it will make itself, known as the Reservation of Powers to the Board (section 5.2.7 elsewhere in this report refers) and there is a Scheme of Delegation which sets out powers delegated to staff.

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

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

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

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

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

Referred to elsewhere in this report (section 5.2.7 refers) are the powers reserved to the Board of Directors which provides details of the types of decisions made by the Board. In addition the Board has agreed a Scheme of Delegation which sets out those decisions which are delegated to management. A copy of the Scheme is available from the Company Secretary.

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

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

Non-Executive Director attendance at Council of Governors Meetings – During 2011/12 Non-Executive Directors attended Council of Governor meetings which enabled them to listen to Governor's concerns.

Presentation by Non-Executive Directors to Governors - Three Non-Executive Directors, being the Chair's of Board Committees have each made a presentation to the Council of Governors on the role and work of the Committee and this has provided an opportunity for Governors to express their views and question the Non-Executive Directors.

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

Joint Board of Directors and Council of Governor Workshop – To allow an open discussion about future strategy a joint workshop was held in September 2011. Directors sought the views of governors on what role they could play in the development and delivery of strategy. This was further expanded upon with a presentation to a Council of Governor's meeting in March 2012 and further discussion is planned in April 2012.

Joint Board of Directors and Council of Governors Training – A training session was held in January 2012 for the Board of Directors and the Council of Governors to discuss and considered the roles of the governors, those of the directors and future working in the light of pending legislation. This provided an opportunity for the whole Board, including the Non-Executive Directors to engage with the governors and to better understand their views and concerns about future roles and responsibilities.

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

"Eyes and Ears" – An initiative known as "eyes and ears" is in place whereby the Governors identify any issues of concern regarding the provision of services. Governors' feedback issues they have witnessed for themselves or those which have been reported to them.

Governor Working Groups – As referred to elsewhere in this report, there are a number of working groups of the Council of Governors, the work of which is supported by staff and directors. The joint working results in effective communication between the staff, directors and governors. Governors have an opportunity to input directly into the workings of the Trust. On request, Non-Executive Directors may attend meetings of working groups to provide information and receive feedback from Governors directly.

Annual Members Meeting – This is formally held once per year, although in 2011/12 an informal Annual Members Meeting was also hosted. The annual report and accounts are presented and a briefing given on the overall performance of the Trust in the previous year. The Governors provide feedback to the Board of Directors.

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

Governor involvement in events / activities – Governors are invited to attend a number of events throughout the year. This provides an opportunity for Governors to be directly involved in the workings of the Trust and to influence the decisions being made. Any comments arising out of these events are fed back to the Directors. A few examples in 2011/12 are: -

- Weekly food tasting
- Menu less meals Ward visit
- Patient safety walkabouts by the Non-Executive Directors and Governors;
- Open Day / Annual Members Meeting Governor volunteer sought
- Membership development Governor volunteer sought
- Governor representative on Car Parking Advisory Group looking at car parking at the Great Western Hospital site
- Governor representative on Nutrition Steering Group looking at hydration and nutrition
- Local study days
- Sensory Awareness Drop in Day
- Tour of community services and neighbourhood teams
- Governor Blog

5.1.11 Council of Governors Meetings Structure

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

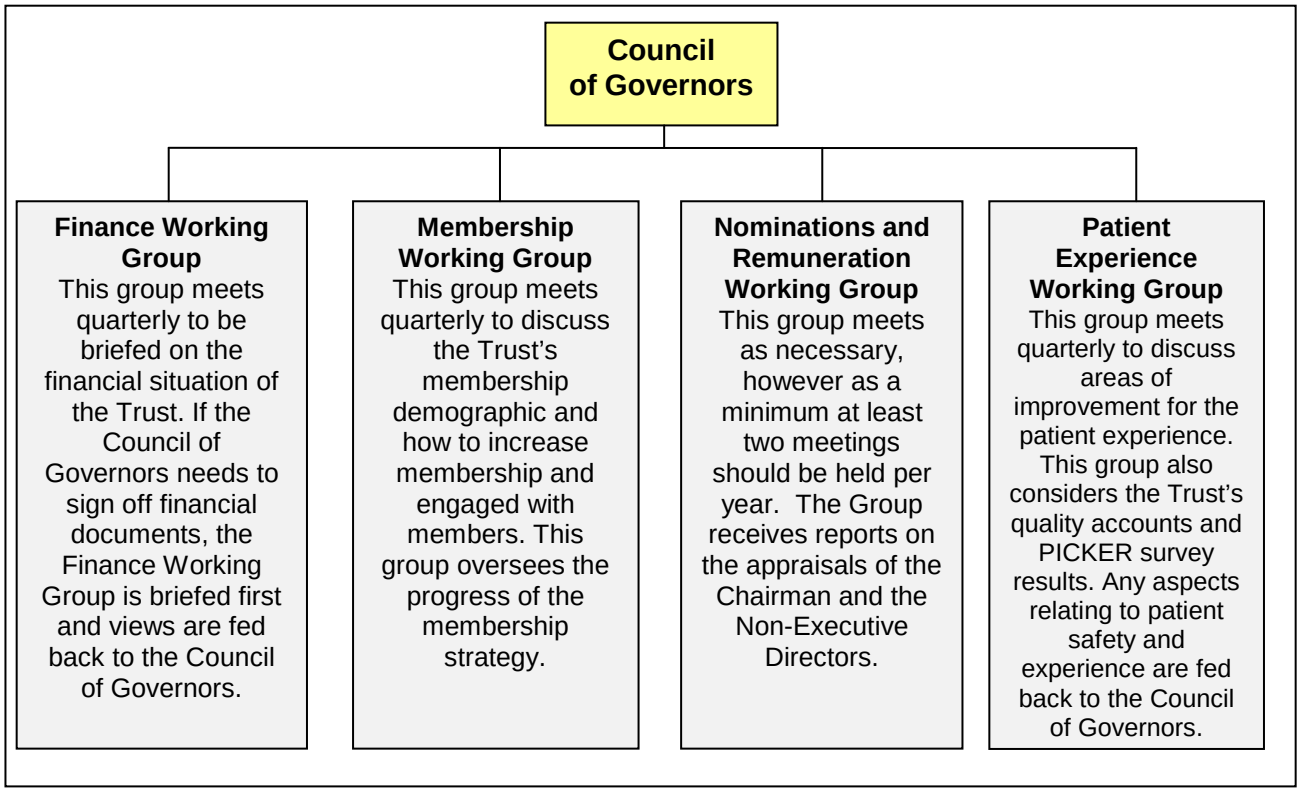
- Finance Working Group
- Membership Working Group
- Nominations and Remuneration Working Group
- Patient Experience Working Group

The purpose of the working groups is to inform governors about activities and issues relevant to each area and provide an opportunity for governors to seek further information. They allow governors a means of influencing decisions and provide a vehicle for challenge and scrutiny of action and activities by the Board.

In addition there is an Annual Members Meeting where the annual report and accounts are presented. At this meeting governors are briefed on the overall performance of the Trust in the previous year and the governors provide feedback to the Board of Directors.

The meetings structure of the Council of Governors is shown below.

TABLE - Meeting structure



5.1.12 Nominations and Remuneration Working Group

It is the role of the Nominations and Remuneration Working Group to assess the performance of the chairman and the non-executive directors and to determine their level of remuneration. Working with a Joint Nominations Committee, the Working Group makes recommendations to the Council of Governors on the suitability of either the chairman or any non-executive directors wishing to be re-appointed.

The Working Group agrees the process for appraisal of the chairman and the non-executive directors. The outcome of the appraisal process is considered by the working group with reports from the Chairman and the Senior Independent Director being presented and recommendations are then made to the Council of Governors.

There is an annual review of the level of remuneration paid to the Chairman and the non-Executive Directors and at least every three years there is market testing of those remuneration levels. The current pay arrangements for Non-Executive Directors were fixed at Authorisation in December 2008 to reflect foundation trust responsibilities. No salary increases were awarded to the Non-Executive Directors in 2011/12. Further information about the salaries of the Non-Executive Directors can be found elsewhere in this report (section 4.8 refers).

During 2011/12, with the Joint Nominations Committee, the Working Group made recommendations to the Council of Governors on the suitability of re-appointing the Chairman and five Non-Executive Directors wishing to be re-appointed. The considerations are referred to under Non-Executive Director appointments elsewhere in this report (section 5.2.3 refers).

During 2012/13 the Non-Executive Director salaries will be market tested, the results of which will be considered by the Working Group.

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

The Working Group met five times in 2011/12.

5.1.13 Interests of Governors

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

A register of those interests is maintained, a copy of which can be obtained from the Company Secretary.

5.2 Board of Directors

5.2.1 The Board of Directors

The Board of Directors or Trust Board, is the decision making body for strategic direction and the overall allocation of resources. It has delegated decision making for the operational running of the Trust to the Executive Directors. The Board takes decisions consistent with the approved strategy. Brief biographies for the Non-Executive and Executive Directors on the Board in 2011/12 are given below.

5.2.2 Biography of individual Directors

Bruce Laurie, Chairman

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 University of West London where he leads a Masters Course in Managing Technological Innovation. Bruce joined the Trust in February 2008 and led it successfully to Foundation Trust status and is proud to be associated with the acquisition of Wiltshire Community Health Services in June 2011.
Prior to being involved in the NHS he was Group Services Director of BG plc having held a number of board level positions in the gas regions and in the international business.
Bruce is Chair of the Mental Health Act / Mental Capacity Act Committee and is a member of the Remuneration Committee. Bruce has been Chair of the Trust since 1 February 2008. In 2011 Bruce was re-appointed Chairman of the Trust for a further term of two years ending 31 January 2014.

Nerissa Vaughan, Chief Executive *(from 1 October 2011)*

Nerissa Vaughan joined the NHS in 1991 as a Graduate National Management trainee. She trained in Birmingham and after completing the Training Scheme took up her first post in Birmingham Family Health Services authorising developing GP commissioning.

After a few years in commissioning at Birmingham Health Authority, she took up her first hospital management job in Dudley Road Hospital in Birmingham as Divisional Manager for Clinical Support Services, which included A&E, Pharmacy, Theatres, ICU, Therapies and a range of other support services.

Nerissa became Project Director for the Wolverhampton Heart Centre, setting up a new Cardiac Tertiary Centre from scratch. Following this, she became interested in capital development and moved to Hull as Director of Planning. She oversaw a £200m capital programme which included a cardiac development and oncology PFI scheme.

Keen to return to the Midlands, she took up post as Deputy Chief Executive at Kettering General Hospital. Moving to her first CEO role at King's Lynn nearly four years ago, she led the Trust to Foundation Trust status. Nerissa became Chief Executive of this Trust in October 2011. Nerissa originates from Llanelli and holds a BA Degree in Theology and a Master of Science Degree in Health Service Management from Birmingham University.

Rowland Cobbold, Non-Executive Director, Deputy Chair *(until 31 December 2011)* **and Senior Independent Director**

Rowland has over 40 years commercial experience in the aviation and tourism industry including seven years on the Board of Cathay Pacific Airways Ltd where his responsibilities included marketing, customer service, corporate communications and IT. He is currently Chairman of Ecco Tours Ltd which he helped to set up 17 years ago and he has also served as a Non-Executive Director on the Boards of Air Partner PLC (1996 to 2004) and Groundstar Ltd (1999 to 2004). Rowland holds a masters degree in law and attended the London Business School's Executive Programme. Rowland was the Deputy Chairman of the Trust up until 31 December 2011. Rowland is the Trust's Senior Independent Director being re-appointed to this position by the Board in 2011/12. Rowland was re-appointed as a Non-Executive Director in July 2011 for a further term of one year ending 31 December 2012.
In 2011/12 Rowland was Chair of the Patient Safety and Quality Committee and the Remuneration Committee and is a member of the Audit, Risk and Assurance Committee and Vice-Chair of the Mental Health Act/Mental Capacity Act Committee. In 2012/13 Rowland will become Chair of a new Clinical Governance Committee. He will stand down as a member of the Mental Health Act/Mental Capacity Act Committee, but will continue to Chair the Remuneration Committee until 30 September 2012 to coincide with his Senior Independent Director appointment.

Angela Gillibrand, Non-Executive Director and Deputy Chair *(from 1 January 2012)*

Between 1984 and 1999 Angela was the Finance Director at the University of Cranfield's Shrivenham Campus, and helped set up one of the first PFIs - the academic contract between the University and the Ministry of Defence. More recently Angela was the Head of Finance, Planning and Company Secretary at U.K. Nirex Ltd, the U.K.'s radioactive waste management company. Since 2003 Angela has combined a career as a Non-Executive Director in the NHS, Government and a Housing Association with work for a family company. Angela holds a degree in Physiology and Psychology from Somerville College, Oxford and a MBA from INSEAD, Fontainebleau, France. Angela has been a member of the Board since 1 July 2004. Angela was re-appointed as a Non-Executive Director in January 2012 for a further term of two years ending 30 June 2014. In 2011/12 Angela was Chair of the Audit, Risk and Assurance Committee, the Academy Strategic Board and the Charitable Funds Committee and was a member of the Remuneration Committee. Angela was also appointed Deputy Chairman of the Trust with effect from 1 January 2012, initially until 30 June 2012 and this was subsequently extended until 2014 coinciding with her re-appointment. In 2012/13 Angela will stand down as Chair of the Audit, Risk and Assurance Committee and will no longer be a member of that Committee, noting that she is now Deputy Chairman of the Trust. Angela will also stand down as Chair of the Charitable Funds Committee and the Academy Strategic Board respectively, but she will remain as a member on those Committees. Angela will become a member of the Mental Health Act / Mental Capacity Act Committee and also a member and later Chair of the Clinical Governance Committee.

Liam Coleman, Non-Executive Director

Liam Coleman is currently Deputy Group Treasurer of the Royal Bank of Scotland Group. Prior to that Liam was Group Director - Treasury at Nationwide Building Society. Prior to joining Nationwide, Liam worked in banking roles at Mitsubishi Bank, Hambros Bank and National Westminster Bank. Liam holds a BA Honours degree from the University of Manchester and an MBA from Warwick Business School; he is also a member of the Chartered Institute of Bankers and the Association of Corporate Treasurers. In 2011/12 Liam was Chair of the Workforce Strategy Committee and was a member of the Remuneration Committee and the Finance and Investment Committee. In 2012/13 Liam will stand down as Chair of the Workforce Strategy Committee but remain as a Committee member. However, he will take on the role of Chair of the Finance and Investment 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. Until 2008 he had been serving as a Governor of Newbury College. Roger was re-appointed as a Non-Executive Director in January 2012 for a further term of three years ending 30 April 2015.

During 2011/12 Roger was Chair of the Business Development and Advisory Group and was a member of the Patient Safety and Quality Committee; the Workforce Strategy Committee and the Remuneration Committee. In 2012/13 Roger will stand down from the Patient Safety and Quality Committee but will become a member of the Finance and Investment Committee. He will also take over as Chair of the Remuneration Committee to coincide with his appointment as Senior Independent Director which was agreed in January 2012 with effect from 1 October 2012.

Robert Burns, Non-Executive Director

Robert Burns' career has been largely focused on financial disciplines and financial management roles. Having trained as an accountant most of his career has been spent in complex multinationals ultimately in various senior Finance, and Sales Management roles. He is a Fellow of the Institute of Chartered Accountants in England and Wales (FCA) and a Fellow of the Chartered Management Institute (FCMI). He was also a Board Member of Gloucester Probation Trust, part of the National Offender Management Service but resigned in June 2011 to enable him to dedicate more time to this Trust following the transition of Community Services. He joined the Board on 1 August 2008 since when Robert has been Chair of the Finance and Investment Committee. He is also a member of the Audit, Risk and Assurance Committee; the Patient Safety and Quality Committee; the Remuneration Committee and the Charitable Funds Committee.
Robert was re-appointed as a Non-Executive Director in January 2012 for a further term of three years ending 31 July 2015. In April 2012 he will stand down as a member of the Patient, Safety and Quality Committee and and as Chair of the Finance and Investment Committee respectively, taking on the role of Chair of the Audit, and Risk Assurance Committee.

Kevin Small, Non-Executive Director

Kevin was appointed to the Board on 1 November 2003. Kevin is an experienced Board member having been involved in a wide range of organisations. Kevin was Chair of Wiltshire Ambulance Service NHS Trust from 1998 to 2002 and Director of the New Swindon Company between 2003 and 2004 and again from 2005 to 2010. Kevin has also been a Non-Executive Director for the British Railways Board/Strategic Rail Authority (2000 to 2002), Chair of Western England Rail Passenger Committee (1998 to 2000), a member of Wiltshire Police Authority (1999 to 2003) and Leader of Swindon Borough Council (Aug 2002 to May 2003). In July 2011, Kevin was re-appointed as a Non-Executive Director for a further term of one year ending 31 October 2012.

During 2011/12 Kevin was a member of the Finance and Investment Committee, the Workforce Strategy Committee and the Remuneration Committee. In 2012/13 Kevin will stand down as a member of the Finance and Investment Committee but will become Chair of the Workforce Strategy Committee. He will also become a member of the Audit, Risk and Assurance Committee and the Clinical Governance Committee.

Lyn Hill-Tout, Chief Executive *(until 12 June 2011)*

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

Lyn left the Trust in June 2011 to take up the position of Chief Executive of Mid Staffordshire NHS Foundation Trust.

Dr Alf Troughton, Medical Director *(interim Chief Executive - 1 June – 30 September 2011)*

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

During 2011/12 Alf Troughton was appointed interim Chief Executive following the resignation of Lyn Hill-Tout who left the Trust in June 2011. He returned to his substantive post in October 2011 when Nerissa Vaughan joined the Trust as Chief Executive.

Maria Moore, Director of Finance

Maria was appointed as Director of Finance on 29 September 2008. She had previously held the Deputy Director of Finance post at the Trust having joined in March 2003. Maria has over 18 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).

Oonagh Fitzgerald, Director of Workforce and Education

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

Sue Rowley, Director of Nursing and Midwifery

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

Helen Bourner, Director of Business Development *(until 5 April 2012)*

Helen spent a number of years working in the hotel sector, latterly as Regional Director of Sales for the North of England and Scotland for Hilton Hotels. She worked for NHS Estates (an executive agency of the Department of Health) and NHSU (the NHS University) from 2000 – 2005 providing advice and guidance on the Consumerism agenda arising out of the NHS Plan in 2000. She entered the NHS through the Gateway to Leadership Scheme, joining Barnsley Hospital NHS Foundation Trust in 2005. Helen has been Director of Business Development since August 2008. Helen left the Trust at the beginning of April 2012 to take up the position of Director of Commercial and Corporate Development at Warrington and Halton Hospitals NHS Foundation Trust.

Guy Rooney, Interim Medical Director *(1 June – 30 September 2011)*

Dr Guy Rooney joined the Board as interim Medical Director in May 2011 when the Medical Director acted up as Chief Executive pending the appointment of a substantive post holder. Dr Guy Rooney is a consultant in Sexual health and HIV and has been working for the Trust as a consultant since 1999. For the last few years he has been one of the Associate Medical Directors with responsibility for the Diagnostics and Outpatients directorate. In addition he provided the clinical input into the bid for Wiltshire community services. Guy returned to his post as an Associate Medical Director in October 2011.

Jenny Barker, Director of Transition *(1 June - 31 December 2011)*

Jenny was a Managing Director at Wiltshire Community Health Services since the reconfiguration of the Primary Care Trusts in Wiltshire in October 2006. She began her career in nursing at the Royal London Hospital in 1978. She then held a series of senior nursing appointments within the NHS and the private sector, rising to become BUPA Health Services' Director of Nursing. Jenny returned to the NHS in 1994 as a Directorate Manager in a university teaching hospital in London. She was seconded to work as the Project Director for the reconfiguration of hospital services in South West London and masterminded the reduction in services at Queen Mary University Hospital and the increase in services to St George's Tooting and Kingston Hospital Trusts. She relocated the Regional Burns Unit from Queen Mary to Chelsea and Westminster Hospital. Jenny has a wealth of experience in senior NHS roles including Deputy Chief Executive at Dorset County Hospital, the challenging role of Recovery Director for the Bath and Wiltshire Health Community, Director of Operations & Acting Chief Executive at the Royal United Hospital in Bath. Jenny gained an MBA in 1997. Since GWH became the preferred provider for Wiltshire Community Health Services, Jenny was seconded to this Trust, assisting the Board of Directors as the Director Transition (designate). Jenny became the Director of Transition on 1 June 2011 coinciding with the formal transfer of Wiltshire Community Services to this Trust. Jenny left the Trust in December 2011 having completed the transitional work, returning to NHS Wiltshire.

5.2.3 Length of appointments of Non-Executive Directors

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

Name	First Term	Second Term	Third Term
Bruce Laurie (Chair)	01.12.08 – 31.01.12	01.02.12 – 31.01.14*	
Rowland Cobbold	01.12.08 – 31.12.10	01.01.11 – 31.12.11	01.01.12 – 31.12.12*
Angela Gillibrand	01.12.08 – 30.06.12	01.07.12 – 30.06.14*	
Kevin Small	01.12.08 – 31.10.11	01.11.11 – 31.10.12*	
Roger Hill	01.12.08 – 30.04.12	01.05.12 – 30.04.15*	
Robert Burns	01.12.08 – 31.07.12	01.08.12 – 31.07.15*	
Liam Coleman	01.12.08 – 31.10.12		

Note that the date of first term appointment is the date of becoming a Foundation Trust. However, with the exception of Liam Coleman, all had been appointed before this date and hence there is variation in their first terms of office.

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

As recommended by the Local Counter Fraud Service (LCFS), the names of all Trust Directors (Executive and Non-Executive) are cross-referenced with the Disqualified Directors Register on the Companies House website on an annual basis. No Trust Directors appeared on the Disqualified Directors Register (as of 14 March 2012).

*These six Non-Executive Directors were re-appointed during 2011/12. The process involved assessment by a Joint Nominations Committee and the Governor Nomination and Remuneration Working Group. The following considerations were taken into account and matched against a job description and person specification in respect of each re-appointment: -

- Skills and qualities identified as required;
- Composition of the Board mapped against Directors;
- Statutory and Code of Governance requirements;
- Governors' duties in considering re-appointments;
- Views of the Chairman and Governors;
- Independence;
- Qualifications and experience requirements;
- Annual performance appraisals feedback;
- Board development feedback;
- Refreshment of the Board;
- Changes in significant commitments which could be relevant;
- Time commitment for the role; and
- Term of appointment.

The re-appointments were approved by the Council of Governors.

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

The Non-Executive Directors are all considered to be independent of the Foundation Trust and the Trust Board believes it has the correct balance, completeness and appropriateness in its composition to meet the requirements of an NHS Foundation Trust. Three Non-Executive Directors have served more than 6 years from the date of their first appointment but in each case, on re-appointment the Trust considered that they remained independent in that, amongst other things, they continued to have a willingness to probe and challenge and there were no relationships which might create a conflict of interest.

The Board is committed to reviewing its balance and composition in order to maintain its effectiveness. During 2011, the Trust mapped the refreshment of the Board, looking in detail at the skills and qualities needed now and in the future and mapped the composition of the Board against desired experience and knowledge on the Board.

In addition, the Board recognised that Board development tools provide a framework for objectively assessing performance and in meeting our responsibilities. In 2011 an external agency was recruited to undertake development of the Board using the National Institute for Innovation and Improvement Board Development Tool for Foundation Trusts. Board development will continue in 2012/13.

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

In 2011/12 the Trust commissioned an independent formal review of its performance and effectiveness. This review involved an independent advisor attending and observing Board meetings, interviews with each Director and the Company Secretary and 360 degree questionnaires and feedback. The review looked at the performance of the Board and that of its collective and individual Directors with recommendations being made relating to the operation of the Board; Director's roles; functions of the Board; Board engagement; strategy development and development generally. The Trust is continuing to use the independent advisor with further Board Development planned during 2012/13.

For individual Non-Executive Directors, the Trust has in place a framework for their appraisal based on elements of the Hay Group work and best practice from other Foundation Trusts. In June 2011 a formal appraisal process for the Chairman and the Non-Executive Directors was undertaken by the Council of Governors. The evaluation of the Chair's performance was led by the Senior Independent Director with input from the Lead Governor and the Chief Executive on behalf of the Executive Directors and having regard to the views of the other Non-Executive Directors. The Chief Executive and Non-Executive Directors' performance was evaluated by the Chairman taking account of Governors and other Directors' input. The Executive Directors' appraisals were led by the Chief Executive in April 2012, through the Board Remuneration Committee following a formal appraisal process using Hay Group's leadership competencies. All appraisals involve 360 degree evaluation and feedback.

5.2.6 Attendance at meetings of the Board of Directors during 201/12

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

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

	28.04.11	Extra 16.05.11 meeting	26.05.11	26.05.11	30.06.11	28.07.11	29.09.11	27.10.11	24.11.11	22.12.11	26.01.12	23.02.12	12.03.12 – Joint Board & Council of Governors	29.03.12
Jenny Barker (up until 31.12.11)	✓	✓	×	✓	✓	×	✓	✓	×	✓	n/a	n/a	n/a	n/a
Helen Bourner	✓	✓	×	×	✓	×	✓	✓	✓	✓	✓	✓	✓	✓
Robert Burns	✓	×	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rowland Cobbold	✓	✓	×	×	✓	✓	✓	✓	✓	✓	✓	×	✓	✓
Liam Coleman	×	×	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	✓
Oonagh Fitzgerald	✓	×	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	✓
Angela Gillibrand	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Roger Hill	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	✓
Bruce Laurie	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Maria Moore	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Guy Rooney (from 01.05.11 – 03.10.11)	✓	×	✓	✓	✓	✓	✓	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Sue Rowley	✓	✓	×	×	✓	✓	✓	✓	✓	✓	✓	✓	×	✓
Kevin Small	✓	×	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	✓
Alf Troughton	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Lyn Hill-Tout (until 31.05.11)	✓	×	×	×	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Nerissa Vaughan (from 03.10.11)	n/a	n/a	n/a	n/a	n/a	n/a	✓	✓	✓	✓	✓	✓	✓	✓

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

5.2.7 Decisions reserved for the Board of Directors

There are certain matters which are reserved for the Board of Directors to decide relating to regulation and control; appointments; strategic and business planning and policy determinations; direct operational decisions; financial and performance reporting arrangements; audit arrangements and investment policy.

The Reservation of Powers to the Board was reviewed in January 2012. A copy of the full reservation of powers to the Board document can be obtained from the Company Secretary.

5.2.8 Interests of Directors

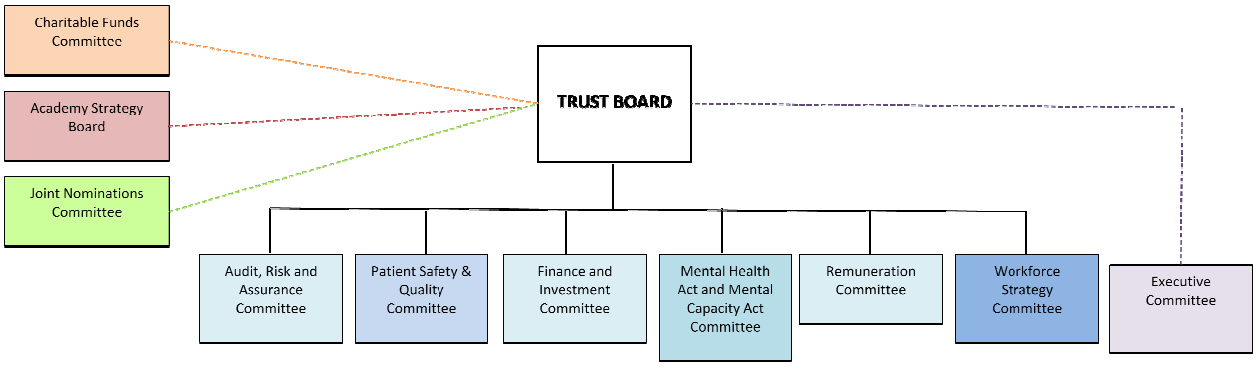
A Register of Interests of Directors is maintained, a copy of which can be obtained from the Company Secretary.

5.2.9 Significant Commitments of the Chairman

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

5.2.10 Committee structure

The Board of Directors reviewed its committees during 2010/11, which remained in place during 2011/12 as follows: -



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

5.2.11 Key Committees

The Board recognises the importance of organisational governance such as executive structures, annual and service plans, performance management and risk management arrangements to deliver the Trust's strategic objectives. The Trust has therefore developed a meetings structure to support these and to provide assurance to the Board.

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

- Audit, Risk and Assurance Committee*
- Charitable Funds Committee
- Executive Committee
- Finance and Investment Committee
- Mental Health Act and Mental Capacity Act Committee*
- Remuneration Committee*
- Patient Safety and Quality Committee
- Workforce Strategy Committee.

* Statutory Committees

Each year the committees evaluate their effectiveness by way of a discussion or questionnaire. This informs any amendment to their Terms of Reference.

5.3 Audit Committee

5.3.1 The Audit, Risk and Assurance Committee

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

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

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

Internal Control

The Committee assures the Board that the system of internal control is operating effectively. The Committee monitors internal control systems and the External Auditor provides an independent view of the overall management arrangements.

Internal Audit

The Committee evaluates 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 Parkhill.

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; 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 Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The external audit function for Great Western Hospitals NHS Foundation Trust is carried out by KPMG.

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

In 2011/12 the Audit, Risk and Assurance Committee discharged the responsibilities delegated to it in the following way:

- The Committee has Board approved Terms of Reference.
- The minutes of the Committee meetings are submitted to the Board.
- The Chair of the Committee gives regular verbal updates at the Board meetings.
- The internal audit plan was reviewed and approved, ensuring that there is consistency with the audit needs of the organisation as identified in the Assurance Framework, Organisational Risk registers and the plan supports the work of the external auditors.
- A review of the Committee effectiveness is undertaken annually.
- The trust-wide risk register is reviewed at each meeting, a directorate risk register is considered in detail at each meeting and the Board Assurance Framework is scrutinised and challenged at each meeting.
- Progress reports from the external auditor are received.
- All internal audit and Local Counter Fraud Service reports are reviewed.
- The Annual Governance Statement is reviewed.
- Single tender actions are reviewed.
- Any losses and compensation payments are approved.

5.3.3 Attendance at the Audit, Risk and Assurance Committee Meetings during 2011/12

Audit, Risk and Assurance Committee Members	Record of attendance at each meeting ✓ = Attended × = Did not attend						
	4 April 2011	3 June 2011	7 July 2011	15 September 2011	17 November 2011	19 January 2012	22 March 2012
Rowland Cobbold	✓	✓	✓	✓	✓	✓	✓
Robert Burns	✓	✓	✓	✓	✓	✓	✓
Angela Gillibrand (Chair)	✓	✓	✓	✓	✓	✓	✓

The Chair of the Committee is Angela Gillibrand, a Non-Executive Director.

5.4 Directors' responsibility for preparing the accounts

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

The Directors are aware of their responsibilities for preparing the accounts and are satisfied that they meet the requirements as reflected in the Statement of Chief Executive's responsibilities as the Accounting Officer at Great Western Hospital NHS Foundation Trust also as referred to elsewhere in this report (section 12.1 refers).

5.5 Statement from the auditors about their reporting responsibilities

This included in the auditor's report (section 5.5 refers).

5.6 Nominations Committee

5.6.1 The Joint Nominations Committee

The Trust has a Joint Nominations Committee which is responsible for nominating suitable candidates to the Council of Governors for appointment to the Chairmanship or office of Non-Executive Director; and for nominating suitable candidates to the Non-Executive Directors for appointment as the Chief Executive.

5.6.2 The work of the Joint Nominations Committee in discharging its responsibilities

In 2011/12 the Committee met on three occasions, once to consider nominating suitable candidates to the Non-Executive Directors for appointment as Chief Executive and thereafter on two further occasions to consider the re-appointment of the Chairman and five Non-Executive Directors. When the Chairman or a Non-Executive Director reaches the end of their current term and being eligible wishes to be reappointed, the Joint Nominations Committee may nominate the individual for such reappointment without competition, subject to the Committee taking into account the result of any review of the individual's performance during their term of office and the balance of skills required on the Board of Directors. An external search agency was engaged for the Chief Executive appointment.

The Joint Nominations Committee worked closely with the Governor Nominations and Remuneration Working Group, to ensure that nominations for re-appointment were made by a majority of governors.

Before making any nomination for re-appointment, the Committee evaluated the performance of the individual seeking re-appointment during their term, the balance of qualifications, skills, knowledge and experience on the Board of Directors and, in light of this evaluation, prepares a description of the role and capabilities required. When considering the Chairman's re-appointment, the Committee took into consideration the time commitment required.

5.6.3 Attendance at the Joint Nominations Committee Meetings during 2011/12

Joint Nominations Committee Members	Record of attendance at each meeting ✓ = Attended × = Did not attend		
	10 June 2011	27 July 2011	25 January 2012 Joint meeting with the Governor Nomination and Remuneration Working Group
Rowland Cobbold	✓	✓	✓
Angela Gillibrand	✓	✓	✓
Bruce Laurie (Chair)	✓	✓	✓
Harry Dale	✓	✓	✓
Godfrey Fowler	✓	✓	✓
Marcus Galea	✓	✓	✓
			Plus 3 other Governors

Note: Angela Gillibrand and Rowland Cobbold are Non-Executive Directors appointed to the Committee by the Chairman Bruce Laurie also a Non-Executive Director and Godfrey Fowler, Harry Dale and Marcus Galea are Governors appointed by the Council of Governors.

The Chair of the Committee is Bruce Laurie, Chairman of the Trust.

Note that in addition to the Joint Nominations Committee, there is a Remuneration Committee authorised by the Trust Board to oversee a formal, rigorous and transparent procedure for the appointment of the Chief Executive and other Board Executive Directors and to keep under review the composition size and structure of the Executive, leading on succession planning, appointing candidates to Board level positions. The Remuneration Committee reviews senior manager (Executive Director) remuneration and has delegated authority for agreeing any annual pay review for these staff only.

5.7 Mental Health Act / Mental Capacity Act Committee

5.7.1 The Mental Health Act / Mental Capacity Act Committee

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

The Trust must:

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

Membership of the Mental Health Act and Mental Capacity Act Committee

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

5.7.2 Meetings during 2010/11 and attendance

The Mental Health Act / Mental Capacity Act Committee members		Jun 2011	Sep 2011	Dec 2011 Cancelled	Mar 2012
Bruce Laurie (Chair)	Chairman of the Trust	√	√		√
Rowland Cobbold (Deputy Chair)	Non Executive Director	x	√		√
Sue Rowley	Director of Nursing and Midwifery	x	√		√
Carole Crocker	Deputy Director of Nursing	√	Left the Trust		
Joy Gobey	Mental Health Act Administrator	√	√		√
Teresa Harding Joanne Smith, Senior Nurse Paediatrics - deputy	General Manager, Women and Children's' Department	x	x		√ Joanne Smith
Dick Eyre Attendance as either / both with Amanda Cadder	Child Psychiatrist	x	√		√
Amanda Cadder Attendance as either/both with Dick Eyre	Nurse Manager	x	x		x

The Mental Health Act / Mental Capacity Act Committee members		Jun 2011	Sep 2011	Dec 2011 Cancelled	Mar 2012
Neil Mason (deputy for Gill McKinnon)	Community Service Manager and Adults Service Manager AWP (Liaison)	x	x		x
Gill McKinnon	Service Manager (Specialist Services) Older People's SBU	√	√		√
Jane Higgins for Joi Demery	AMHP		√		
Kieran Holland (deputy for Jenny MacDonald)	Modern Matron, Sandalwood Court	x	√		x
Anthony Harrison	Consultant Nurse (Liaison Psychiatry) AWP	-	-		√
Donna Bosson	Senior Nurse Unscheduled Care	x	√		x
Julie Dart	Mental Capacity Act Programme Manager Joint appointment with Swindon Borough Council and Swindon Primary Care Trust, Adult Social Care	x	√		x

GWH and Avon and Wiltshire Mental Health Partnership (AWP) have a two way service level agreement (SLA) signed off. The provision of mental health liaison psychiatry has been extended to include out of hours and weekends. The provision of older people liaison psychiatry service for Wiltshire was withdrawn in April 2011 but extended to September 2011 has not been in place following the extension. The reinstatement of this service has been high on the agenda and it is envisage that this will be resolved in the first quarter of 2012.

With regards to section 12 of the Act the Trust continues to have delays in accessing a psychiatrist as the responsible clinician. The Deputy Director of Nursing is having discussions with AWP and commissioners in order that the issues are resolved as early as possible.

5.7.3 Application of the Mental Health Act (MHA) in the Trust

The Mental Health Act Administrator provides a three monthly report on the application of the Mental Health Act in the Trust. The report is considered by the Mental Health Act and Mental Capacity Act Committee at each meeting.

From April 2011 – 7th March 2012, the use of the Mental Health Act was applied on 75 occasions in regard of 30 patients. The 75 occasions relate to 30 inpatients at the Great Western Hospital which include those patients on Section 17 authorisation of leave from other organisations.

5.8 Membership

5.8.1 Membership

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

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

5.8.2 Public Members

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

Public members are placed in constituencies based on where they live. Originally there were three constituencies created on Authorisation as a Foundation Trust in 2008 to reflect the Trust's catchment area. However, as the area of the Trust expanded in 2011/12 following the transition of community services in Wiltshire, the West Berkshire, Gloucester and Oxfordshire constituency was enlarge to accommodate the additional areas, becoming the West Berkshire, Oxfordshire, Gloucestershire and Bath and North East Somerset Constituency on 1 June 2011. That constituency was subsequently split out on 8 August 2011 to better reflect local communities, resulting in the following public constituencies: -

- Swindon,
- Wiltshire,
- West Berkshire and Oxfordshire,
- Gloucestershire, Bath and North East Somerset.

The Trust is continuing to review its public constituencies. In 2012/13 the Wiltshire Constituency will be split out into three constituencies (northern, central and southern Wiltshire constituencies).

5.8.3 Staff Members

Staff members include Trust employees, Carillion Health employees and volunteers. The Trust has strong links with the local community, with over 500 volunteers. These persons automatically become members when:

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

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

The Trust has a wide range of staff undertaking a variety of roles and professions. In 2011/12 consideration was given to establishing classes within the staff constituency to reflect occupational areas. This was supported by the Trust and changes to the staff constituency are planned for implementation in November 2013, the details of which will be finalised in early 2013.

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

5.8.4 Membership analysis

During the year, the Trust sought to increase membership numbers. As at 31 March 2012, the membership of the Great Western HNS Foundation Trust was as follows: -

	Number of Members
Swindon Public Constituency	2870
Wiltshire Public Constituency	1473
West Berkshire and Oxfordshire Public Constituency	325
Gloucestershire and Bath and North East Somerset Public Constituency	156
Affiliated	217
Staff Constituency	7222
TOTAL	**12263**

Public Constituency	**2011/12**	**2012/13 (estimated)**
At year start (1 April)	5007	5041
New Members	187	250
Members leaving	153	150
At year end (31 March)	5041	5141

Staff constituency	**2011/12**	**2012/13 (estimated)**
At year start (1 April)	4916	7222
New Members	2438	200
Members leaving	132	200
At year end (31 March)	7222	7222

The estimates for 2012/13 are based on a best prediction having regard to this year's increase and the number of members leaving.

The groupings of the members in the public constituency are as follows: -

Public constituency	Number of members
Age (years)	
0-16	86
17-21	168
22+	4740
Not specified	47
Ethnicity:	
White	3927
Mixed	25
Asian or Asian British	130
Black or Black British	49
Other	25
Not specified	885
Gender analysis	
Male	2155
Female	2796
Not specified	90

The Trust uses information from the Office of National Statistics (Census 2011) to build up a picture of the population size and ethnicity for each constituency. This helps the Trust in it aims to make the membership reflective of its population. The Trust has also determined the socio-economic breakdown of its membership and the population from its catchment area.

5.8.5 Building a strong relationship with our members

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

The Trust fulfils this aim by communicating and engaging with members via the Trust's quarterly magazine Horizon, hosting member focus groups and events such as open days. The Trust's website has been redeveloped to provide more regular updates and information and there are plans to allow more interaction between members and Governors in the form of Blogs and web chats. The Trust also has a full time Governance Officer responsible for membership, to answer any questions from members or provide additional information.

5.8.6 Membership Strategy

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

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

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

5.8.7 Membership development in 2011/12

In order to build a representative membership during 2011/12 the Trust undertook the following: -

- Attended 6 parish council meetings throughout Wiltshire to explain membership and encourage participation in Trust activities;
- The Governance Officer hosts monthly recruitment drives in the hospital atrium;
- Revised the membership application form so that it is easier for applicant members to return to the Trust
- Hosted 6 Constituency meetings, including at community hospital venues
- The planning of a larger scale member's event planned for the summer of 2012
- Hosted an hospital Open Day

Youth membership continues to be the least represented age category. In order to encourage membership amongst the young, the Governance Officer is working closely with the Academy to plan and deliver two experience events for GCSE and A Level students interested in healthcare. It is envisaged that one of these events will be held at a community hospital. These events are planned for autumn 2012.

In the last twelve months the Trust has worked on increasing its members as well as engaging its' members. The membership application form has been revised to incorporate a method of return delivery, making it easier for people to return to the Trust. The Open Day hosted over 30 stalls and was well attended. The Governance Officer has attended Parish Council and forum meetings in order to talk about the structures of Foundation Trusts and the opportunities to get involved. The Governance Officer hosts a stall in the atrium of the GWH on a monthly basis talking to visitors and patients and recruiting members.

The Trust acknowledges that the number of new members has not increased by the estimated numbers projected in the Annual Plan 2010/11. Membership levels appear to have levelled off, with new recruited members replacing leaving members.

5.8.8 Membership development proposed for 2012/13

Engagement with existing forums
The Governance Officer will continue to engage with existing forums, such as Patient Participation Groups, parish and town councils, carers groups etc. by attending meetings and presenting to them about membership and recruiting new members.

Member's Event
Constituency meetings have not been well attended by Members and consequently the Trust is looking to organise a larger event for all Members which will offer the opportunity to engage with Governors, offer feedback and attend focus groups, in addition to attending clinician led lectures. It is envisaged that this event will be held in the summer of 2012 and depending on success will be repeated in the community.

Youth Membership Drive
The Governance Officer is working with the Academy to plan and deliver two schools days aimed at GCSE and A Level students, which will take place in the autumn of 2012. Students will receive a presentation on the structure of foundation trusts, tied in with the politics and funding of healthcare. There will also be opportunities for students to watch operations via video link, use the SIM man and other activities. This will be an opportunity to increase our membership amongst the under 18s.

Governor Blog
The Trust has launched a blog written by Governors, seeking the views of local service users and existing members on the Trust and healthcare more generally. The Trust aims to develop this over the next 12 months.

Horizon Newsletter
The Trust's quarterly magazine Horizon is sent to every member, either electronically or in the post. The newsletter contains dedicated membership pages, with a word from the Governors.

Contacting the Governors and Directors

If any constituency member or member of the public generally wishes to communicate with a Governor or a Director they can do so by emailing the Foundation Trust email address: foundation.trust@gwh.nhs.uk. This email address is checked daily by the Governance Officer who will forward the email to the correct Governor and/or Director. Alternatively a message can be left for a Governor by ringing the Governance Officer on 01793 604185 or for a Director by ringing the Company Secretary on 01793 6047151 or by sending a letter to:

Company Secretary, The Great Western Hospital, FREEPOST (RRKZ-KAYR-YRRU), Swindon, SN3 6BB.

5.9 Code of Governance Disclosure Statement

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

Monitor, the independent regulator for Foundation Trusts, published the NHS Foundation Trusts Code of Governance. The way in which the Trust applies the principles within the Code of Governance are set out in this report, and the Directors consider that in 2011/12, the Trust has been compliant with the Code with the exception of the following: -

A.3.1 – Based on the recommendations of a Joint Nominations Committee comprising Directors and Governors, the Council of Governors rather than the Board determined whether non-executive directors seeking re-appointment were independent in character and judgment and whether there were relationships or circumstances which were likely to affect, or could appear to affect, the director's judgement. The Council of Governors determined that the non-executive directors were independent, notwithstanding that they had served on the Board of the NHS Foundation Trust for more than six years from the date of their first appointment, the reasons for which are stated elsewhere in this report (section 5.2.3 refers).

B.1.7 – Practices and procedures are in place for engagement by Council of Governors with the Board of Directors for those circumstances when there are concerns about the performance of the Board, compliance with the terms of authorisation or other matters related to the general wellbeing of the Trust. Provisions are also included within the Constitution and role descriptions for the Lead and Deputy Lead Governor. The intention is to capture this in one policy document for consideration by the Council of Governor in 2012/13.

C.1.5 – The Trust has a Joint Nominations Committee responsible for nominating Non-Executive Directors for appointment and re-appointment. At present there is an equality of membership of Directors and Governors. Therefore in 2011/12, to ensure a majority of governors made nominations, the Joint Nominations Committee met with the Governor Nominations and Remuneration Working Group. Going forward into 2012/13, it has already been supported that the membership of the Joint Nominations Committee, which is in accordance with Constitutional provisions, will be amended to increase the number of Governor members.

C.2.2 – One Non-Executive Director is currently in the last year of a four year term. All new appointments and re-appointments are at intervals of no more than 3 years.

F.3.9 – The audit committee did not review arrangements by which staff of the NHS foundation trust may raise in confidence concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. However, the Trust has in place a Whistle Blowing policy which was highlighted to staff by the Senior Independent Director. Furthermore, guidance was issued to governors on how to handle matters referred to them. In addition the Trust has in place a counter fraud policy. Annually the Local Counter Fraud officer undertakes a staff fraud awareness survey. In 2011/12 456 members of staff answered the survey a ten fold increase compared with the previous year. The survey demonstrates that a high proportion (60%) of respondents knew the Trust had a Local Counter Fraud Specialist and how to contact them. The work conducted by the Local Counter Fraud Specialist can also be demonstrated by the increase of referrals and general assistance during 2011/12, which resulted in five investigations taking place.

G.1.1 – The Trust should have a public document setting out the Trust's policy on the involvement of members, patients and the local community at large including a description of the kind of issues it will consult. This is being drafted and will be considered by the Board later in 2012/13. The Trust's approach is outlined in a number of documents and the intention is to capture this in one policy.

G.1.2 – The Board should clarify in writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between governors and any local consultative forums already in place. This is being drafted and will be considered by the Board later in 2012/13.

6 QUALITY REPORTS

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

6.1 Statement on quality from the Chief Executive of the Great Western Hospitals NHS Foundation Trust

Patient safety continues to be at the heart of everything we do. We continue to focus our energies on improving safety and patient and staff satisfaction by providing the highest quality care.

The past year has been extremely challenging due to the mergence with Wiltshire Community Health Services on 1st June 2011. However, it has also been an extremely positive and rewarding year and provided opportunity for us to develop and improve the quality of care provided for the new enlarged organisation.

We have regularly monitored our quality improvement plans during 2011/12 via our Patient Safety and Quality Committee through to Trust Board and through our external reporting and monitoring arrangements with our commissioners and key stake holders including LINks and local Hospital Overview Scrutiny Committees.

The priorities for quality improvement set out in the quality Accounts have been chosen to reflect our goals to improve patient safety, clinical effectiveness and the experiences of our patients. We have improved care in many areas and delivered some significant service improvements and continued to develop our services.

We have seen our Hospital Standard Mortality Rates (HSMR) remain below (better than) 100. We have continued to reduce hospital acquired infections and more specifically we have achieved our MRSA and *Clostridium difficile* improvement (reduction) targets. Our staff have led improvements in many other areas of safety and improved care, including Venus Thromboembolisis (VTE), Ventilator Acquired Infections and shown a significant reduction in pressure ulcers and harm associated with patient falls. All of these have contributed to better patient outcomes and experience.

Delivering safe, high quality care relies on a clean and fit for purpose environment and good equipment. We were delighted that we have received excellent verbal feed back again following our external assessments of all of our hospital (inpatient sites) by the Patient Environment Action Teams (PEAT). Formal written reports are awaited. The hospital design and reconfiguration of ambulatory care and transfer of the AAU department onto Linnet ward has also enabled us to achieve ZERO mixed sex breaches since December 2011.

We consistently aim to follow and implement best practice in accordance with national recommendations and alerts and I am delighted to say that we are over 95% compliant with all published NICE guidance and Central Alert System (CAS) alerts.

We have used the published annual inpatient (PICKER) survey results to focus on improving the experiences of our patients and we have used our day to day reporting processes to ensure we learn from complaints, incidents, clinical audits and claims.

We have progressed with the implementation of the regional acute patient safety programme and we have implemented Executive led quality and safety walkabouts as part of the leadership module within this programme. These walkabouts now include representation from Non Executive Directors

and Governors. We have also commenced implementation of the community patient safety programme.

I am delighted with our recent 2011/12 staff survey result. GWH's position (including WCHS) has improved significantly and no indicators are in the bottom 20% and nearly 50% are in the top 20%.

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

Signed

Nerissa Vaughan
Chief Executive
24 May 2012

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

6.2 Priorities for improvement

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

The Trusts aim is to set out a clear quality improvement plan building on current local and national quality improvement initiatives to meet its patient quality and **safety** objectives and provide the safest and most **effective** care to enhance the experiences of our patients.

6.2.1 Priorities 2011/12:

Safe care

To reduce harm through the monitoring and reducing:

1. Healthcare Associated Infections (HCAIs)
2. Medication errors
3. Patients falls
4. Pressure ulcers
5. Blood transfusion errors
6. Reducing preventable hospital mortalities year on year i.e. hospital standardised mortality rates (HMSR)
7. Participating on the Regional Patient Safety Programme

Effective care

1. Complying with best practice guidance (NICE) and Central Alert Bulletins
2. Reviewing the clinical care of patients who need to return to theatre within a two week period
3. Ensuring that patients who have sustained a fractured neck of femur are operated upon within 36 hours of sustaining their injury if medically fit
4. Ensuring patients are assessed for the risk of developing Venousthromboembolisms and managing the risk appropriately
5. Undertaking nutritional assessments on patients on admission to hospital to ensure we meet their nutritional and hydration needs
6. Achieving the sentinel stoke audit indicators

Patient Experience

1. To involve patients more in decisions about their care
2. To ensure privacy when discussing treatment and care with patients
3. To improve upon the information given to patients on medication and it side effects
4. To ensure patients know who to contact after discharge if they have concerns

Regulation

1. To sustain compliance with the CQC regulations
2. To sustain NHSLA and Maternity Standards and develop longer term plans to achieve Level 3
3. To implement plans to improve results of the national staff survey
4. To sustain compliance with the Mental Health Capacity Act
5. To sustain compliance with Safeguarding Children

6.2.2 Priorities 2012/13

Our commitment to quality will continue through a number of priorities for 2012/13 which have been agreed in accordance with the views and comments from clinical staff commissioners, the Trust Governors and key external stake holders and the PSQC. Our priorities will be:

Safe Care

- Continue to reduce healthcare associated infections including MRSA and *Clostridium difficile (CQUIN)*
- Continue to reduce harm associated with patient falls
- Continue to reduce hospital and community acquired pressure ulcers
- Continue to reduce avoidable mortality, disability and chronic health through improved assessment and management of venous thromboembolism *(CQUIN)*

Effective Care

- Improve the care and management of patients through implementation of the Trust Nutrition and Hydration strategy
- Improve our Hospital Standardised Mortality Ratio (HSMR) year on year (100 or below)
- Improve the management of the deteriorating patient by full completion of the Early Warning Score

Patient Experience

- Continue to improve the quality of end of life care for patients and improve access to palliative care services (CQUIN)
- Improve care and access to services for patients with dementia *(CQUIN)*
- Improve patient satisfaction by improving upon the Trusts outcome measures within the National Patient Experience (PICKER) survey *(CQUIN)*

6.3 Statements of assurance from the Board

During 2011/12 the Great Western Hospitals NHS Foundation Trust provided and/or sub-contracted 7 NHS services.

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

The income generated by the NHS services reviewed in 2011/12 represents 100 per cent of the total income generated from the provision of NHS services by the Great Western Hospitals NHS Foundation Trust for 2011/12.

6.3.1 Review of services and participation in clinical audits and national confidential enquiries

During 2011/12 42 national clinical audits and 4 national confidential enquiries covered NHS services that Great Western Hospitals NHS Foundation Trust provides.

During 2011/12 Great Western Hospitals NHS Foundation Trust participated in 86% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Great Western Hospitals NHS Foundation Trust was eligible to participate in during 2011/12 and those that Great Western Hospitals NHS Foundation Trust participated in are as follows: -

Audit / confidential enquiry title	Eligible	Participated
Peri-and Neo-natal		
Perinatal mortality (MBRRACE-UK)	Yes	No
Neonatal intensive and special care (NNAP)	Yes	Yes
Children		
Paediatric pneumonia (British Thoracic Society)	Yes	Yes
Paediatric asthma (British Thoracic Society)	Yes	Yes
Pain management (College of Emergency Medicine)	Yes	Yes
Childhood epilepsy (RCPH National Childhood Epilepsy Audit)	Yes	Yes
Paediatric intensive care (PICANet)	No	NA
Paediatric cardiac surgery (NICOR Congenital Heart Disease Audit)	No	NA
Diabetes (RCPH National Paediatric Diabetes Audit)	Yes	Yes
Acute care		
Emergency use of oxygen (British Thoracic Society)	Yes	Yes
Adult community acquired pneumonia (British Thoracic Society)	Yes	Yes
Non invasive ventilation -adults (British Thoracic Society)	Yes	Yes
Pleural procedures (British Thoracic Society)	Yes	Yes
Cardiac arrest (National Cardiac Arrest Audit)	Yes	No
Severe sepsis & septic shock (College of Emergency Medicine)	Yes	No
Adult critical care (ICNARC CMPD)	Yes	Yes
Potential donor audit (NHS Blood & Transplant)	Yes	Yes
Seizure management (National Audit of Seizure Management)	Yes	No
Long term conditions		
Diabetes (National Adult Diabetes Audit)	Yes	No
Heavy menstrual bleeding (RCOG National Audit of HMB)	Yes	Yes
Chronic pain (National Pain Audit)	Yes	Yes
Ulcerative colitis & Crohn's disease (UK IBD Audit)	Yes	Yes
Parkinson's disease (National Parkinson's Audit)	Yes	Yes
Adult asthma (British Thoracic Society)	Yes	Yes
Bronchiectasis (British Thoracic Society)	Yes	No

Audit / confidential enquiry title	Eligible	Participated
Elective procedures		
Hip, knee and ankle replacements (National Joint Registry)	Yes	Yes
Elective surgery (National PROMs Programme)	Yes	Yes
Intra-thoracic transplantation (NHSBT UK Transplant Registry)	No	NA
Liver transplantation (NHSBT UK Transplant Registry)	No	NA
Coronary angioplasty (NICOR Adult cardiac interventions audit)	Yes	Yes
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	Yes	Yes
Carotid interventions (Carotid Intervention Audit)	Yes	Yes
CABG and valvular surgery (Adult cardiac surgery audit)	No	NA
Cardiovascular disease		
Acute Myocardial Infarction & other ACS (MINAP)	Yes	Yes
Heart failure (Heart Failure Audit)	Yes	Yes
Acute stroke (SINAP)	Yes	Yes
Cardiac arrhythmia (Cardiac Rhythm Management Audit)	Yes	Yes
Renal disease *		
Renal replacement therapy (Renal Registry)	No	NA
Renal transplantation (NHSBT UK Transplant Registry)	No	NA
Cancer		
Lung cancer (National Lung Cancer Audit)	Yes	Yes
Bowel cancer (National Bowel Cancer Audit Programme)	Yes	Yes
Head & neck cancer (DAHNO)*	Yes	Yes
Oesophago-gastric cancer (National O-G Cancer Audit)	Yes	Yes
Trauma		
Hip fracture (National Hip Fracture Database)	Yes	Yes
Severe trauma (Trauma Audit & Research Network)	Yes	Partly
Psychological conditions		
Prescribing in mental health services (POMH)	No	NA
Schizophrenia (National Schizophrenia Audit)	No	NA
Blood transfusion		
Bedside transfusion (National Comparative Audit of Blood Transfusion)	Yes	Yes
Medical use of blood (National Comparative Audit of Blood Transfusion)	Yes	Yes
Health promotion		
Risk factors (National Health Promotion in Hospitals Audit)	Yes	No
End of life		
Care of dying in hospital (NCDAH)	Yes	Yes
National Confidential Enquiries into Patient Outcome & Death		
Cardiac arrest	Yes	Yes

GWHFT is not currently participating in the National Cardiac Arrest Audit project; however the Trust has subscribed and made arrangements to participate in the next round of the National Audit.

The trust chose not to contribute to the repeat audit of National Health Promotion in Hospitals as the trust was compliant with the standards audited in the initial project and has other internal measures in place to monitor compliance.

In addition the trust has now signed up to participate in severe trauma (Trauma Audit & Research Network).

The Trust participated in a number of other National Audits during 2011-2012 that were considered vital in promoting the quality and effectiveness of patient care. A few of these are outlined below:

Other National Clinical Audits
National Cancer Patient Survey (as mandated by the National Cancer Reform Strategy)
College of Emergency Medicine (CEM) - Fractured Neck of Femur's (NOF) in Emergency Department
College of Emergency Medicine (CEM) - Asthma in Emergency Department
CEM - National Audit of Emergency Department Discharge Data on GP Letters
Inpatient Audit of Children with Diabetes (SWPDN)
National Mastectomy and Breast Reconstruction Audit-(4th Round-Final)
National Comparative Audit of the use of Red Cells in Neonates & Children
National Diabetes Inpatient Day Audit
Major Complications of Airway Management

The national clinical audits and national confidential enquiries that Great Western Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2011/12, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Audit Title	**Submitted/Required (%)**
Peri-and Neo-natal	
Perinatal mortality (MBRRACE-UK)	Ongoing internal review
Neonatal intensive and special care (NNAP)	100%
Children	
Paediatric pneumonia (British Thoracic Society)	Ongoing- data submission deadline- Mar 2012
Paediatric asthma (British Thoracic Society)	100%
Pain management (College of Emergency Medicine)	100%
Childhood epilepsy (RCPH National Childhood Epilepsy Audit)	100%
Diabetes (RCPH National Paediatric Diabetes Audit)	100%
Acute care	
Emergency use of oxygen (British Thoracic Society)	100%
Adult community acquired pneumonia (British Thoracic Society)	Ongoing- data submission deadline- May 2012
Non invasive ventilation -adults (British Thoracic Society)	Ongoing- data submission deadline- May 2012
Pleural procedures (British Thoracic Society)	100%
Adult critical care (ICNARC CMPD)	100%
Potential donor audit (NHS Blood & Transplant)	100%

Audit Title	Submitted/Required (%)
Long term conditions	
Heavy menstrual bleeding (RCOG National Audit of HMB)	100%
Chronic pain (National Pain Audit)	100%
Ulcerative colitis & Crohn's disease (UK IBD Audit)	100%
Parkinson's disease (National Parkinson's Audit)	100%
Adult asthma (British Thoracic Society)	100%
Elective procedures	
Hip, knee and ankle replacements (National Joint Registry)	100%
Elective surgery (National PROMs Programme)	100%
Coronary angioplasty (NICOR Adult cardiac interventions audit)	100%
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	100%
Carotid interventions (Carotid Intervention Audit)	100%
Cardiovascular disease	
Acute Myocardial Infarction & other ACS (MINAP)	100%
Heart failure (Heart Failure Audit)	100%
Acute stroke (SINAP)	100%
Cardiac arrhythmia (Cardiac Rhythm Management Audit)	100%
Cancer	
Lung cancer (National Lung Cancer Audit)	100%
Bowel cancer (National Bowel Cancer Audit Programme)	100%
Head & neck cancer (DAHNO)	100%
Oesophago-gastric cancer (National O-G Cancer Audit)	100%
Trauma	
Hip fracture (National Hip Fracture Database)	100%
Blood transfusion	
Bedside transfusion (National Comparative Audit of Blood Transfusion)	100%
Medical use of blood (National Comparative Audit of Blood Transfusion)	100%
End of life	
Care of dying in hospital (NCDAH)	100%

The reports of 21 national clinical audits were reviewed by the provider in 2011/12 and Great Western Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided: -

No.	Audit Title	Learning From The Project
1.	*National Cancer Patient Survey*	*Actions include- Focussed survey to assess service opportunities in Day therapy centre. Local survey was undertaken and the report is covered under "Local Audits".*
2.	National Audit of Dementia 2010	The Trust performed in the middle quartile. The audit demonstrated a few areas of good practice. The action plan has been incorporated into the Trust Dementia Strategy. The Trust has signed up to participate in the next round of National Audit of Dementia.
3.	National Mastectomy and Breast	The Trust performance is in the upper 25% centiles in terms of satisfaction. The time that the clinical nurse specialists take with these patients needs to be recognised for future increase in caseload. The trust must continue to provide patients with

No.	Audit Title	Learning From The Project
	Reconstruction Audit	sufficient time in their consults to discuss reconstructive issues. It is recommended that those involved in the development of future guidelines on mastectomy and breast reconstruction should refer to the results of high achieving organisations.
4.	College of Emergency Medicine (CEM) - Asthma in Emergency Department (ED)	The audit demonstrated that there is a great improvement with the performance. Areas that need to improve are recording of peak flow, better recording of discharge plans, use of proforma and promote local education and training.
5.	College of Emergency Medicine (CEM) - Fractured Neck Of Femur's in Emergency Department (ED)	The pain scores are not always recorded on NOF proforma and there are delays in analgesia, X-Rays & fast tracking admission. Improvement plan focuses on better recording/education, improvements in ED flow.
6.	College of Emergency Medicine (CEM) - Pain in Children in Emergency Department (ED)	There is improvement in pain scoring, analgesia recording & reassessment.
7.	National Pleural Procedures Audit 2010	The results reflect that 40% of chest drains with pleural effusions are being carried out by Ultrasound guidance. There is no bedside ultrasound is being carried out. High numbers of drains are being put in for undiagnosed effusions. Ultrasound machine has been purchased, local pleural effusion guidelines have been developed, pneumothorax guidelines updated. Teaching and education is done regularly. Other plans include producing a chest drain proforma.
8.	Myocardial Ischaemia National Audit Project-2010	The Trust has demonstrated high compliance with the key performance indicators. The area that needs to improve is time of transfer of patients with nSTEMI (acute coronary syndrome) to cardiac beds on admission.
9.	NCEPOD- An Age Old Problem- Elective and Emergency Surgery in the Elderly	Current practice is in line with most of the national recommendations. There are no recommendations to implement,
10.	College of Emergency Medicine CEM – National Audit of Emergency Department Discharge Data on GP Letters.	The project organisers have not provided individual hospital reports. Local actions include implementation of recommendations from the college.
11.	Data for Head and Neck – DAHNO 6th Round	The Trust is compliant with the majority of the criteria and has shown significant improvement since the last audit in intervals from referral to established diagnosis. Areas for improvement include documentation of chest imaging onto the local database.
12.	Inpatient Audit of Children with Diabetes (SWPDN)	Participation rates were low, however positive with regard to paediatric diabetes staff but critical of other health professional's knowledge. Patients and parents were happy with amount of contact with Dr, paediatric diabetes specialist nurse (PDSN) and

No.	Audit Title	Learning From The Project
		Dieticians. Patients and parents felt there was a need for psychological services to be made available (particularly at diagnosis). Over half of the Parents and patients said they visited the clinic 4+ times. Majority of patients and parents felt they had enough choice re: insulin regime. Over 80% of patients and parents felt they could contact their PDSN or Dr outside of their appointment, and this that service was valued and useful.
13.	The National Oesophago-Gastic Cancer Audit (NOGCA)	The aim of the audit is to look at the diagnosis, staging, and treatment planning process, curative treatment outcomes, palliative oncological treatment (chemotherapy / radiotherapy) and endoscopic / radiological palliative therapies. The Trust is compliant with the recommendations made by the national audit. The surgical treatment is offered in Oxford. The Trust aims to continue with the current practice and participate in the next round of the national audit.
14.	National Lung Cancer Audit (LUCADA) - 2009/10	The Trust is compliant with all the standards covered under this project in 2009/10.
15.	Consultant Sign Off – College of Emergency Medicine (CEM) Audit 2011	This audit was to review of selected patient groups by a consultant in Emergency Medicine prior to discharge from the Emergency Department (ED) or admission to hospital. The results showed that there is limited consultant availability in ED in the evenings and at night. Consultants in the department have started to cover shifts from 3pm to 7pm. There should be teaching of all ED staff to underline the importance of review of these patients prior to discharge. Results of the national audit will be taken forward by the College to look at national guidance on staffing levels in emergency departments.
16.	Major Complications of Airway Management	The project aimed at focusing on the complications of airway management in the NHS hospitals across the UK. Although the Trust did not have any eligible patients for the audit, the trust is compliant with the recommendations made by the Royal College of Anaesthetists.
17.	Carotid Interventions Audit 2010	The trust has demonstrated excellent clinical outcomes. The next steps include, a planned patient experience questionnaire from August 2011, further joint working with stroke team to streamline pathway, and improved data submission.
18.	National Diabetes Inpatient Day Audit-2010	This Audit was to assess the care received by diabetic patients. Actions include raising awareness of the Think Glucose Initiative across the whole of the trust to improve patient care.
19.	National Comparative Audit of the use of Red Cells in Neonates & Children - 2010	Participation in the National Audit reflected that the Trust is compliant with the majority of the recommendations. Action plans include drawing up new guidelines and policies for the use of red cell transfusions to all children and not just neonatal groups, promote education about safe prescribing and administration of transfusions. Re-audit with a focus on pre and post transfusions Hb levels and the recommendations around documentation and prescriptions.
20.	College of Emergency Medicine (CEM)- Paediatric Fever	There is a need for training and supervision for medical and nursing staff so that the guideline is both understood and becomes part of the normal practice of our departments. Actions include: Dissemination of the results and revision of paediatric proforma to capture all elements required on admission with fever.
21.	National Paediatric Diabetes Audit 2010	This National report is two years out of date and changes have already been made to the service. Recent data suggests that the Trust is performing equal to or above the National Average. Actions that have been completed include increase in diabetes support nurse.

The reports of 273 local clinical audits were reviewed by the provider in 2011/12 and Great Western Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

No.	Audit Title	Audit Summary/Learning and Action
1.	Antibiotic Missed Doses	The audit was aimed identify the reasons behind missed antibiotic doses and to try to see any trends or educational issues with an aim to address these issues and look at the need for a possible change in procedure or for further education. The results demonstrated partial compliance. Actions include- Antibiotic working group to promote training for staff groups. Look into possibility of adding a feature to the antibiotic newsletter. Ward stock lists to be made available on the pharmacy intranet.
2.	Image Guides Musculo-Skeletal Injection Review	The overall patient experience is good and results demonstrate patient satisfaction with information provided regarding the procedure in majority of cases. Actions include- Continue with the practice and work on improved explanations of procedure and re-survey.
3.	Surviving Sepsis	The results demonstrate that there are areas for improvement Trust wide. Actions include- Developing & implementing sepsis proforma, change in practice with first dose of antibiotic, information dissemination and education.
4.	Compliance to In-Patient Consent Policy	Audit results demonstrate that there is a high level of compliance in areas of practice i.e. stating demographics, intended benefits, risks. However lower levels of compliance can be seen in respect of consenting children compared both to consenting adults. Actions include inserting “check box” into Consent Form 1-4 to require a positive affirmation from the health professional that they are either competent to do the procedure or have undertaken procedure specific training. Raising targeted awareness amongst paediatric surgeons to improve compliance with consenting children. These actions have been implemented and the re-audit is planned in June 2012.
5.	Compliance to Out Patient Clinic Letters (10-11)	Audit results demonstrate that there are only a few areas for improvement pertaining to quality of Outpatient Clinic letters. Areas of good practice include secretaries within the directorates are now pooling the work to enable speedier transcription, voice recognition has proved really successful although cost implications if taken forward for all specialties, letters being sent ‘unsigned to hasten delivery’ to speed up the process. Actions include monthly monitoring on timeliness of clinic letter; continue work on improving timeliness of clinic letters and re- audit.
6.	Compliance with In- Patient discharge letters (10-11)	Audit results demonstrate that there are only a few areas for improvement pertaining to quality of Discharge Summaries. The area that needs to be largely improved is the time frame the discharge summary is sent to the general practitioner. Actions include appropriate changes to eDS system to allow automatic population of ‘source of admission’, colour coding to inspire timely completion, monthly monitoring on timeliness of eDS, education for junior doctors. Encourage clinical engagement within Directorates at each stage of the audit, review data collection proforma and re-audit.
7.	Stem Cell Transplant-Patient Satisfaction Survey	The survey was designed to obtain information about the patient experience of stem cell transplantation, including follow-up support. 100% of patients felt involved in decisions about their treatment and felt comfortable to ask questions. They were all able to meet the dietician prior to their transplant. There were positive responses with regard to the role of clinical nurse specialist. 50% of patients felt they would benefit

No.	Audit Title	Audit Summary/Learning and Action
		from seeing a clinical psychologist. There were some issues with cleanliness and standard of meals. Extremely positive results received for standard of care post discharge. Actions include changes to patient information leaflet to emphasise the details of support available for the relatives. A clinical psychologist is now in post. Cleaning is being monitored by the ward and fed back to Carillion.
8.	Diabetes Ketoacidosis (DKA) Management	Majority of patients are managed according to the guidelines however capillary ketone measurement to confirm diagnosis is not done well and there is lack of awareness and over reliance on urinary ketones. Actions include: To add a new sheet to the DKA protocol for nurses to check, as well as clear indication for stopping insulin infusion .To ask Emergency Department Assistants to ensure that ketones strips are always available.
9.	Re-Audit Use of Troponin Test	The re-audit illustrated a large improvement in performance. The initial audit results showed poor compliance with only 28% of test fully complying with guidelines. The guidelines were updated in order to clarify when the tests should be used. After a period of education the re-audit showed 94% of patients now fully complying with guidelines. This process has saved the trust over £4000 per year. Updated guidelines have clarified usage; this is reflected in a reduction in the number of tests ordered. Action Summary-Ward troponin education needs to be incorporated into the induction program for Acute Assessment Unit and Emergency Department.
10.	NICE Self Harm in Emergency Department	Performance is significantly short of NICE guidelines Action Summary- Dissemination of results to encourage better documentation and referral rate for this group of patients. Work with the Mental Health Service to identify what is achievable and to ensure this group of patients is receiving adequate care. Re-Audit following implementation.
11.	Laparoscopic Cholecystectomy (LC)- Patient satisfaction - Important factors to patients	The review aimed at assessing the importance of cosmesis v's other factors in gall bladder surgery.93% of patients were happy or extremely happy with the current procedure. 48% experienced some wound related issues (pain, infection) and 65% of those were at the umbilicus. Cosmesis was rated less important than other factors in gall bladder surgery. Action Summary-Given patients are generally satisfied by the current procedure, the aim is to invest in improving day case rates for LC.
12.	Obstetric Haemorrhage (Midwifery Led Unit)	This audit demonstrated good compliance with the correct management of Post Partum Haemorrhage within the setting of the midwifery led unit or if transfer to an acute unit was required, however it highlighted some areas for improvement in documentation. Actions include - All staff to be made aware of the need to: - Document discussion of events and discussion with parents of reasons for transfer and consent. Respirations and fluid balance charts should be documented where appropriate and revise audit tool.
13.	Client Identification at Hillcote	The audit demonstrated 100% compliance. Hillcote have improved greatly on recording the NHS number or any appropriate number of their photo pages. The service will aim to continue with this high level of performance.
14.	Provision of Information about Prescribed Medicines	The audit aimed to gather baseline data on patient's perceptions of the quality and quantity of information they received about medicines newly started at GWH. Majority of patients reported being given information on what medicine was prescribed, why it was prescribed and how to take it, during their hospital stay. Furthermore, the results demonstrate a very low compliance around information provided on what side effects patients

No.	Audit Title	Audit Summary/Learning and Action
		might experience and what to do in that case. A large proportion of patients did not know how long to continue new medicines for. 70% patients were satisfied or very satisfied with the surveyed aspects of information given. This represents a mis-match between what Health Care Professionals and patients believe constitutes appropriate information. Action plan includes developing a "Provisions of Medicines Policy" detailing a list of MUST and SHOULD actions for provision of information. "Patient information leaflet" must be given with all supplied medicines. Electronic discharge summaries to be standardised. Implementation of "Patient Medicines Information Helpline". Ward Pharmacists to use available opportunities to speak to patients about newly prescribed medicines and relevant information in a timely manner. Re-audit is planned when actions have been implemented.
15.	Non Invasive Ventilation (NIV)	In general, NIV is being used appropriately. The key learning is to modify NIV Nursing chart to include record of blood gases.
16.	Vaginal Birth after C- Section	The audit has demonstrated excellent performance in the implementation of recommendations for intrapartum care and antenatal records. The works needs to focus on improvement in documentation of counselling, management and planning required.
17.	The time taken by Emergency Department X-ray to complete X-ray requests made by Acute Assessment Unit (AAU)	A low number (23%) of cases had a delay in having the X-rays performed. The main reasons identified were- No nurse escort and/or Patient not ready. There are discussions planned at inter-departmental steering group and the results will be referred to AAU.
18.	Service Improvement: Chemotherapy treatment on Day Therapy Centre (DTC)	The key actions to improve service include- Promote patient information regarding avoiding same day bloods unless there is a clinical reason to do so, Poster to be produced, Proposal to separate out different chemotherapy types to streamline process and C-PORT chemotherapy capacity tool to be introduced to streamline pathway and increase efficiency to maximise DTC capacity.
19.	Prescribing of Oral Nutritional Supplements (ONS) for Adults at Three Swans Surgery.	There are identified areas for improvement around “advice given to the patients, recording of BMI’s, and documentation of treatment plan. Use of ONS has risen since 2008. Targeted work around each individual patient with recording of essential information and timely periodic review of patients to ascertain continuation of ONS.
20.	Compliance to Patient Group Directions (PGD)	Areas for improvement include amalgamation of PGD policies and agreement on training and competency for PGD’s across the merged Trusts.
21.	Audit of the Prescribing, Monitoring and Administration of Therapeutically Monitored Antibiotics	Overall, the results demonstrate improvements (of various magnitudes) in the indicators of interest relating to antibiotic level monitoring. The plans are to continue with the service and re-audit using the same methodology.
22.	Evaluation of Sedation Practice on Intensive Care Unit	Actions include analgesia and sedation protocol discussion by a multi-disciplinary working group.

No.	Audit Title	Audit Summary/Learning and Action
23.	Hip Resurfacing	This Review was undertaken following Medicines and Healthcare products Regulatory Agency (MHRA) Alert- Revision of MoM (Metal on Metal) hip replacements. The concerns involved soft tissue reactions which may be associated with unexplained hip pain. The Orthopaedic Department categorised the affected patients with plans to follow-up patients.
24.	NICE CG56 - Ordering of Scans in Paediatrics Incorporating Head Injury	Results demonstrate compliance with the NICE guidance and that there is appropriate ordering and undertaking of CT Scans.
25.	Neonatal Readmissions to the Children's Ward 0-28 Days of Age	Results reflect good communication of breastfeeding care. Actions include- Infant coordinator to continue in-house training. Use of Breastfeed observation charts to pick up ineffective feeding at an earlier stage.
26.	SALT (Speech and Language Therapy) - Service Evaluation of the interface between agencies supporting children with Autistic Spectrum Disorders (ASD).	Actions include improved sharing of information using Communication Assessment Form and better communication between the SALT Service and other multi-agencies.
27.	Venous Thromboembolism (VTE)	The results demonstrated that overall compliance was very high. Actions include possibility of using a sticker stating the VTE assessment at each ante natal admission.
28.	Induction of Labour	There was low compliance with documentation of the discussion with the mother about induction of labour in the maternal records. Actions include- Remind all midwives of the importance of discussion of prolonged pregnancy and induction of labour and giving leaflet to supplement these discussions.
29.	VTE Assessment of Screening Prophylaxis	The results reflected very high compliance with the majority of criterion.
30.	Delayed and Omitted Medicines Audit	Actions include all blank missed doses to be reported to the Ward Manager and investigated.
31.	Death Certificate Completion	Areas for improvement identified were recording of Doctor’s grade and name, training and education and guidance notes that include clarification on confirmation and certifying deaths.
32.	End of Life	Base line audit results demonstrate that the Trust performance is better that the nationally published data. Actions include- discussion of results with the Commissioners to agree a CQUIN target.
33.	Compliance with Joint Guidelines in Regard to	Overall compliance is excellent. Further actions include educating prescribers to ensure patients are switched from Intravenous to oral antibiotics.

No.	Audit Title	Audit Summary/Learning and Action
	Antibiotic Prescribing	
34.	Health Records Audit Q2 – Warminster Neighbourhood Team.	Audit demonstrates a very high compliance.
35.	Health Records Audit Q2 – Bradford on Avon, Trowbridge and Melksham Neighbourhood Team's	Audit demonstrates compliance with majority of standards. Areas for improvement include encouraging recording of name and designation of each signatory.
36.	NICE CG124 – Hip Fracture	Audit demonstrated an improvement since 2008. Actions include further teaching sessions to improve further compliance. There is ongoing monitoring of this practice to monitor compliance.
37.	Audit on Causes of Delays in Theatre Start Times	There is considerable room for improvement. This includes identification of poor risk patients in advance and receiving the patients into a dedicated holding bay.
38.	Parenthood Education with WCHS	The re-audit demonstrates high satisfaction rates.
39.	Privacy and Dignity at Hillcote	There is improvement since the previous audit in 2009/10. Further actions include checks on induction process and protocol review to promote this further.
40.	Health Records Audit – Minor Injury Unit (MIU) Health Records Audit – Wilton and Amesbury Neighbourhood teams	There are some areas for improvement including improving documentation, recording NHS numbers and ensuring that there are no spaces between entries.
41.	Omitted and Delayed Medicines Audit – Beech Omitted and Delayed Medicines Audit - Longleat	Areas for action include reporting of blank missed doses and drug availability appropriately.
42.	Privacy and Dignity Mixed Sex Accommodation	Majority of criteria was compliant. Only action was to ensure staff wear ID badges visible on their uniforms and are easily identified by patients. .

No.	Audit Title	Audit Summary/Learning and Action
	Neighbourhood Teams	
43.	Services in the Swindon Community for Children with Continuing Healthcare Needs	Excellent practice demonstrated around identifying acting upon and documenting the children's clinical need. Further work includes improved documentation of care for children with complex healthcare needs and development of local guidelines.
44.	Management of Suspected Cardiac Chest Pain in the Emergency Department	Very high compliance. Actions include changes to a few sections of the "Chest Pain Proforma".
45.	Compliance with Discharge Summaries Audit Report-Quality & Timeliness 2011-12	The re-audit showed that the Trust has demonstrated high compliance with the vast majority of the standards. ALL electronic discharge summaries currently submitted now have values for the data on: Action by GP requested / For GP info, Urgent / Routine, Medication Changed (Y/N). Finally, compliance with the timeliness of inpatient discharge summaries to be with GPs within 1 working day of discharge was 73% (Target-90%). Actions include: dissemination of results, weekly monitoring on timeliness of eDS and educating all clinicians to ensure discharge summaries include all relevant information.
46.	Compliance with Out Patient Clinic Letters-2011-12	The re-audit demonstrated that the vast majority (94%) of the patient records checked reflect a high standard of compliance. Considering that changes to the OP clinic template were implemented on 12th Jan 2012, the compliance with data on: Action by GP requested / For GP info, Urgent / Routine, Medication Changed (Y/N), is 80% (Target-98%).Furthermore, it was observed that the actions in the boxes did match the content/sense of the OP clinic letter. Even though there is some improvement with the availability of clinic letter on Medway within 2 working days, there is further improvement required to achieve compliance (% Achieved- 71%, Target-90%). Actions include: Dissemination of results, continue work on improving timeliness of clinic letters and re-evaluate the effectiveness of the mandatory boxes.
47.	Continuing Health Care (CHC) Review Process	Audit identified that, although improvements have been made, further work is required in order that all documents are completed ensuring that all areas of patient need are being met.
48.	Community Patients have an Estimated Date of Discharge (EDD) in their Care Plans (Re-Audit)	7 Neighbourhood Teams have achieved 100% compliance with EDD set and documented within 24 hours. Action includes, non-compliance NT's to benchmark against each other to improve compliance.
49.	Congenital Hypothyroidism	There is clear evidence of good documentation and institution of treatment and investigation in children born with CHD. In addition, the follow-up is also managed regularly.

No.	Audit Title	Audit Summary/Learning and Action
50.	NICE CG111 – Nocturnal Enuresis	Although the Children's Continence Service has achieved 100% compliance against the majority of the criteria, the Care Pathway needs to be revised to include the latest published NICE Guidance.
51.	Readmission Review – Unscheduled Care	The review results demonstrate that there is no evidence that suggests any gaps in delivery of care. None of the readmissions were preventable or avoidable.
52.	Readmission Review –Planned Care	The review results demonstrate that there is no evidence that suggests any gaps in delivery of care. Relevant information was provided to all of the patients on discharge. Furthermore, there is no evidence of failure to communicate between acute care and primary care. 100% of patients reviewed showed no evidence of any issues concerning community care prior to readmission. It is recommended that further audits are undertaken to raise any clinical areas of concern and to ensure appropriate financial credits with commissioners. It is also recommended that this work links in with the ongoing Surgical Site Infection (SSI) audit work to identify and potential areas of concern regarding infection rates.

6.3.2 Participation in Clinical Research

The number of patients receiving NHS services provided or sub-contracted by Great Western Hospitals NHS Foundation Trust that were recruited during that period to participate in research approved by a research ethics committee was 793.

6.3.3 Use of the CQUIN Framework

A proportion of Great Western Hospitals NHS Foundation Trust income in 2011/12 was conditional upon achieving quality improvement and innovation goals agreed between Great Western Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2011/12 and for the following 12 month period are available online at:
http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275

6.3.4 Registration with Care Quality Commission and periodic / special reviews

Great Western Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions. Great Western Hospitals NHS Foundation Trust has the following conditions on registration - none.

The Care Quality Commission has not taken enforcement action against Great Western Hospitals NHS Foundation Trust during 2011/12.

Great Western Hospitals NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2011/12: -

1. Great Western Hospital 12th April 2011 (Privacy and Dignity focus)
2. Warminster Hospital 20th May 2011 (Longleat Ward pre merger)
3. Trowbridge 29th June 2011 (Minor Injuries Unit and Birthing Centre)
4. Great Western Hospital 12th & 13th July 2011 (Full review)
5. Savernake 19th October 2011 (Ailsbury Ward)
6. Chippenham 8th November 2011 (Beech now Mulberry Ward)
7. Great Western Hospital 12th December 2011 (Theatres specialist review)
8. Great Western Hospital 12th December 2011 (Privacy and Dignity follow up)
9. Great Western Hospital 8th February 2012 (IR(ME)R Radiology specialist review-announced inspection)
10. Great Western Hospital 21st March 2012 (Termination of Pregnancy)

Great Western Hospitals NHS Foundation Trust intends to take the following action to address the conclusions or requirements reported by the Care Quality Commission – comply with specific and measurable actions plans developed after each inspection to address any issues raised in the inspection reports. In all cases internal assurance that all actions have been met will be sought and internal CQC compliance monitoring processes are in place.

Great Western Hospitals NHS Foundation Trust has made the following progress by 31 March 2012 in taking such action – none.

6.3.5 Quality Data

Great Western Hospitals NHS Foundation Trust submitted records during 2011/12 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patient's valid NHS Number was: 99.5% for admitted patient care; 99.8% for outpatient care; and 92.2% for accident and emergency care. The lower performance in accident and emergency care is attributed to the completeness of this data item at the minor injury units in Wiltshire and the Trust data quality group is working on improving this.

- which included the patient's valid General Practitioner Registration Code was 99.6% for admitted patient care; 99.5% for outpatient care; and 100% for accident and emergency care.

Great Western Hospitals NHS Foundation Trust Information Governance Assessment Report overall score for 2011/12 was 77% and was graded satisfactory / green.

Great Western Hospitals NHS Foundation Trust will be taking the following actions to improve data quality:

- The Trust Data Quality Group will continue to manage and monitor a work programme that targets identified areas of poor data quality and progress will be reported to the Trust's Information Governance Steering Group
- The actions from internal and external audits and benchmark reports associated with data quality will be acted on and monitored by the Trust Data Quality Group
- Development of refresher training programmes for staff involved in data collection and data entry will continue

Great Western Hospitals NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission. The summary results of the audit were

Auditor	Primary Diagnosis	Secondary Diagnosis	Primary Procedure	Secondary Procedure
PbR Audit Commission	91.5%	91.0%	91.1%	94.7%

These results achieved level 2 in the Information Governance Toolkit. The audit identified areas for improvement and these have been included in an action plan that will be implemented in the course of the year.

The Trust continues to work towards developing compliance with the pseudonymisation initiative and has re-audited patient identifiable data flows from key departments. The audit serves both to log the flows and to audit their compliance with pseudonymisation and data protection rules. This work will maintain its level of focus as changes to data flows are requested by Clinical Care Commissioning Groups as they become established as Commissioners.

Information governance

Information is a key asset, both in terms of the clinical management of individual patients and the management of services and resources throughout the Trust. It is therefore of utmost importance that appropriate policies, procedures and management accountability provide a robust governance framework for the efficient management of information. There is corporate leadership of information governance, the Finance Director having overall responsibility. The Information Governance Steering Group oversees information governance issues, with responsibilities delegated from the Audit, Risk & Assurance Committee on behalf of the Trust Board.

The Information Governance Management Framework is documented within the Information Governance Strategy and Policy. The four key principles are openness, information quality, information security and legal compliance. Confidentiality, security, and data quality play an important role in the safeguarding of information within the Trust. This includes organisational and staff information as well as patient information. The Trust has agreements for the sharing of patient information with healthcare organisations and other agencies in a controlled manner, which ensures the patients' and public interests are upheld. It is essential for the delivery of the highest quality health care that accurate, timely and relevant information is recorded and maintained. As such it is the responsibility of all staff to promote data quality and confidentiality.

The Trust's Information Governance Steering Group undertakes an Information Governance Work Programme covering the full range of information governance elements, and ensures that appropriate policies and management arrangements are in place. The Data Quality Group, which reports to the

Steering Group, provides a quarterly data quality and completeness report, including the results of data accuracy tests. The Data Quality Group also undertakes a Data Quality Work Programme, which includes data quality reporting, training and awareness, clinical coding, and policies and procedures. These corporate and operational arrangements ensure that information governance and data quality are prioritised at all levels of the Trust.

Each year the Trust completes a comprehensive self-assessment of its information governance arrangements by means of the NHS Information Governance Toolkit. The main Toolkit headings are:

- Information Governance Management
- Confidentiality and Data Protection Assurance
- Information Security Assurance
- Clinical Information Assurance – Health Records and Information Quality
- Secondary Use Assurance
- Corporate Information Assurance – Records Management and Freedom of Information.

These assessments and the information governance measures themselves are regularly validated through independent internal audit. The Trust's Information Governance Assessment Report overall score for 2011/12 was 77% and was graded Green/Satisfactory, with a satisfactory rating in every heading of the Information Governance Toolkit.

6.3.6 Explanatory Note for clinical Coding

The Clinical Coding Audit carried out by the Audit Commission takes a sample of 100 patients from a selected specialty, in this years audit Trauma and Orthopaedics, as well as 100 patients randomly selected across all specialties. The samples are therefore small and the results of the audit should not be extrapolated further than the actual sample audited.

Part 3 - Other Information

6.4 Overview of the quality of care offered 2011/12

Safe Care

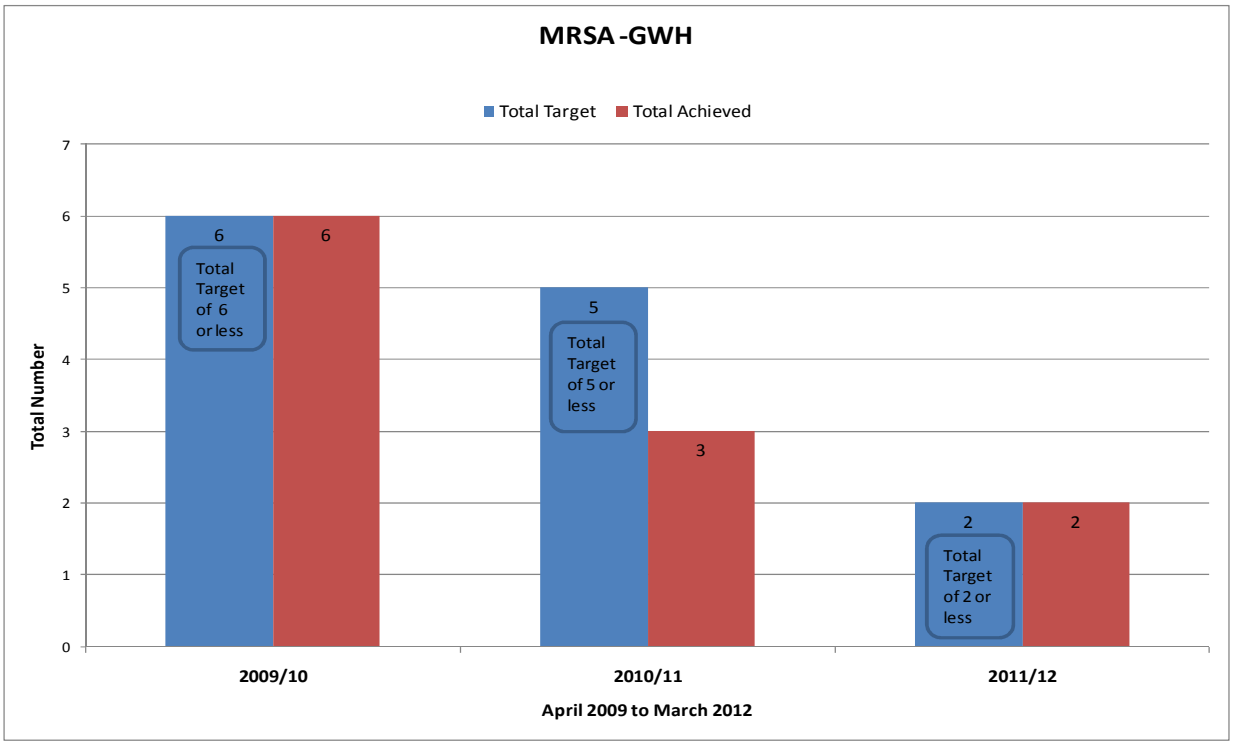
Priority 1: To reduce our numbers of Healthcare Associated Infections

MRSA: The goal to reduce the number for 2011/12 was achieved with only two cases reported as Trust attributed. No cases of MRSA bacteraemia (MSRAB) were reported within WCHS following its merger with GWH on 1st June 2012.

Local initiatives to ensure MRSA infection remain minimal have included:

- Sustained improvement with care bundles for peripheral lines and urinary catheters
- Ensuring admission risk assessments are completed on all patients and acted upon
- Daily monitoring of MRSA admission screening of elective and emergency patients
- Development of a core training programmes for nurses, doctors and pharmacists which has included key information on antibiotic prescribing
- Improving care for diabetic patients in Swindon thus helping to reduce the complications that are often associated in MRSABs

GRAPH – MRSA – GWH

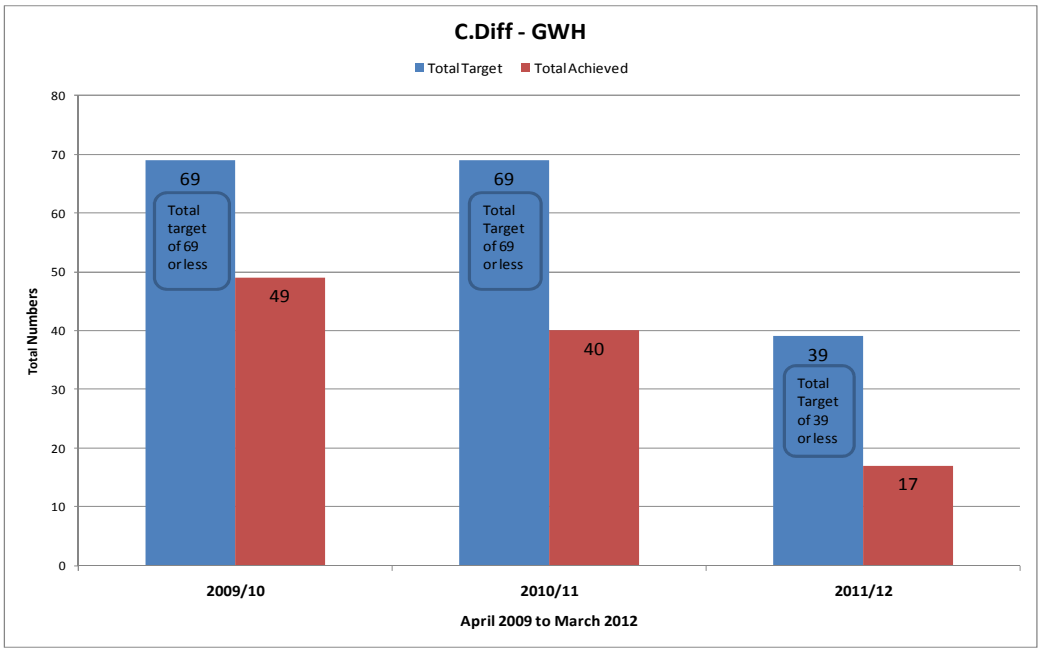


Clostridium Difficile: The goal for 2011/12 was to report no more than 39 Acute Trust apportioned cases and no more than 30 WCHS apportioned cases. We reported 17 GWH *Clostridium difficile* infections within GWH and two within WCHS

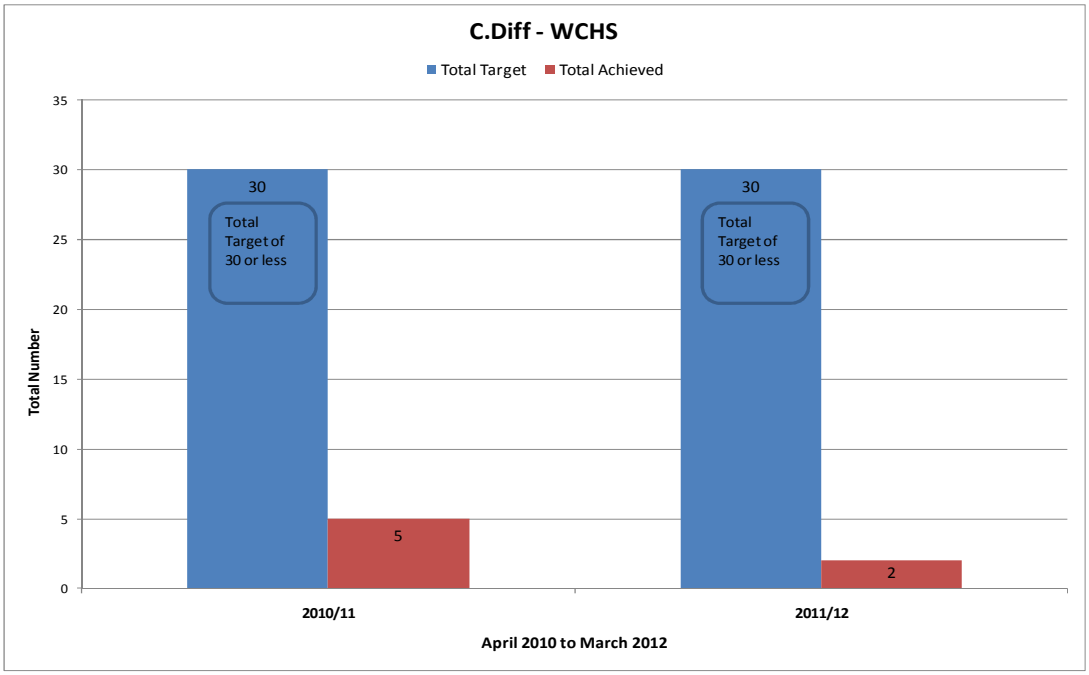
Local initiatives to ensure we continue to reduce these infections have included:

- Promotion of prompt isolation of patients with suspected infective diarrhoea
- Rapid testing of suspected norovirus (GWH only), which allows early identification of norovirus outbreaks and aids prompt management of outbreaks of diarrhoea
- Inclusion of a gastroenterologist and dietician to the weekly ward round for patients with *Clostridium difficile* infections
- Review and harmonisation of GWH and WCHS *Clostridium difficile* policy
- Increased surveillance and investigation of inpatients with a history of *Clostridium difficile*

GRAPH - Clostridium Difficile GWH 2009/10 – 2011/12



GRAPH - Clostridium Difficile WCHS2011/11 – 2011/12



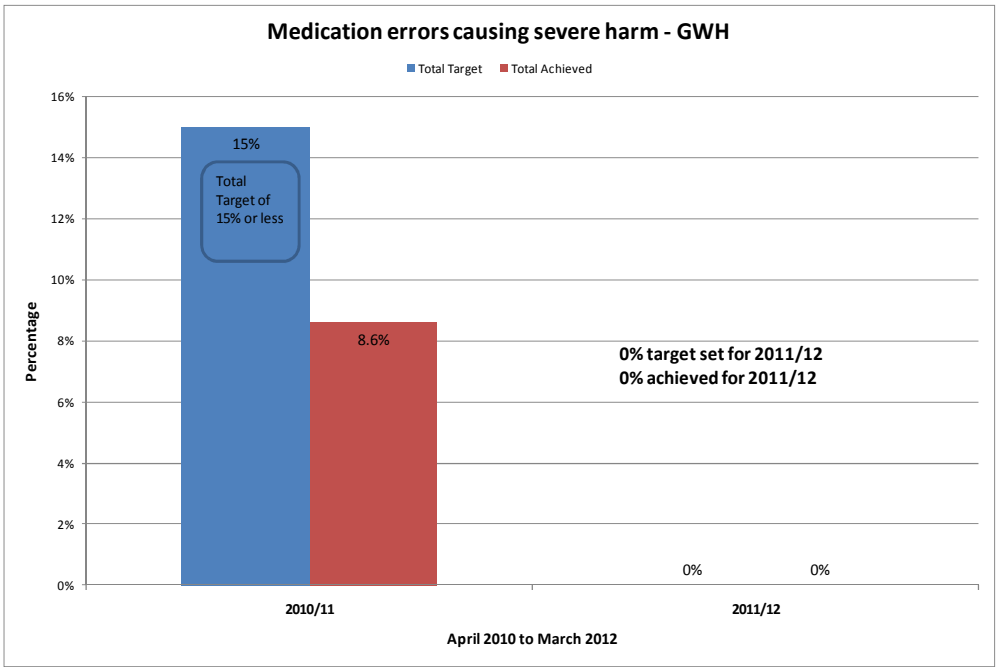
In January 2012's volume of the Journal of Hospital Infection, an article was published by the *Clostridium difficile* ward round team from GWH. The ward round is attended by a Consultant Microbiologist, Antibiotic Pharmacist or Technician, an Infection Prevention and Control Nurse, a Consultant Gastroenterologist and a Dietician. The article concluded that the *Clostridium difficile* ward rounds have helped improve patient care by enabling expertise in management to be brought to the patient. Audit results show that despite the fact that a *Clostridium difficile* protocol was in place, additional interventions were made during the majority of team visits, which further improved the quality of patient care and also provided educational opportunities for ward staff.

Priority 2: To reduce harm associated with medication errors

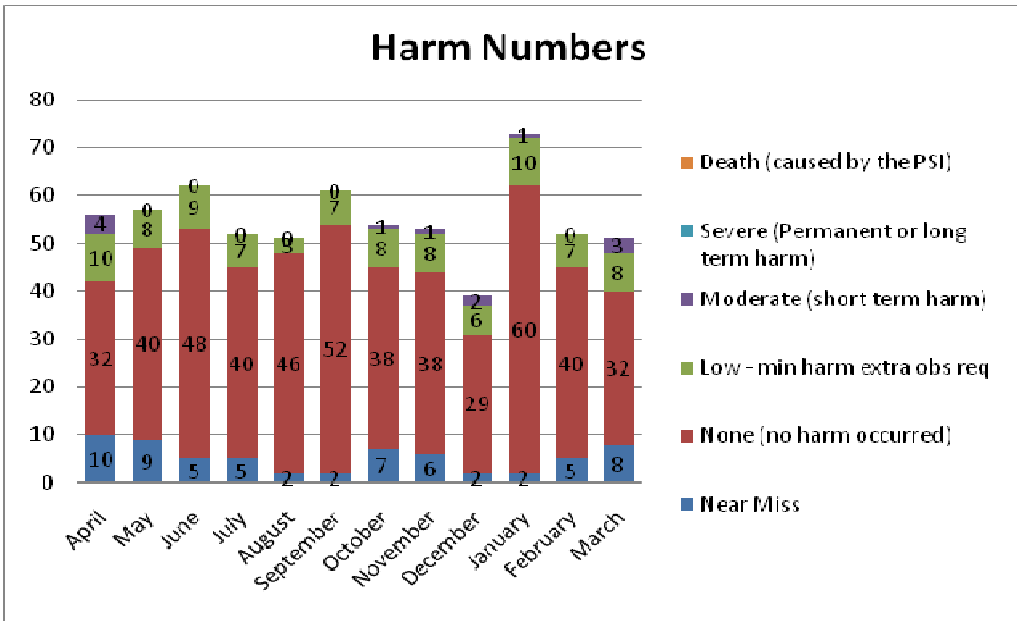
Medication errors - In 2011/12 there were a total of 661 medicine related incidents. Of these 12 (1.8%) were classified as causing moderate harm. No medicines incidents caused severe harm or worse.

The number of reported incidents has increased from 514 in the previous year. This is a positive indication of increased reporting and also reflects the assimilation of the Wiltshire Community Unit incident reporting system.

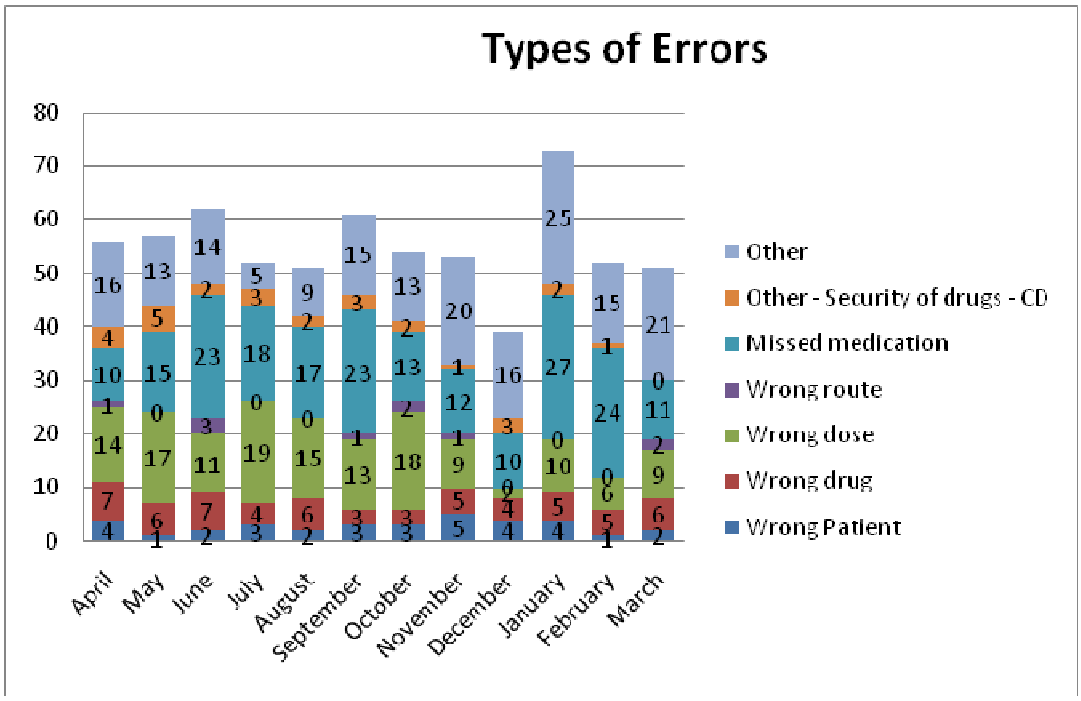
GRAPH – Medication errors causing severe harm GWH2010/11 - 2011/12



GRAPH - Medicine incidents by harm 2011/12



GRAPH - Medicine incidents by type 2011/12



Medicine incident trends and types are reviewed as part of the work program of the Medicines Governance Group. The main incident type is missed doses, and this reflects the increased awareness around this issue. The number of missed doses is audited on a regular basis and there are workplans in place for several areas.

All medicine related incidents were seen and reviewed by a Medicines Governance Pharmacist and assessed for severity and further investigated when necessary. Trends and reoccurring incidents were discussed at the Medicines Governance Group. This group was significantly changed in 2011/12. The membership was extended to include Wiltshire Community representation and also to widen the membership to all directorates and to include both senior and junior medical staff. The Medicines Governance Group also added membership from the training department to ensure safety messages were integrated as part of Trust training.

During the year, the Pharmacy Medicines Governance Team produced a series of medicines safety bulletins to highlight particular issues within the Trust. Training was provided at induction to nursing and medical staff and this was modified to include learning from recent incidents and near misses.

Further information about medicines management, notably the areas listed below, is included in the Trust's Quality Account: -

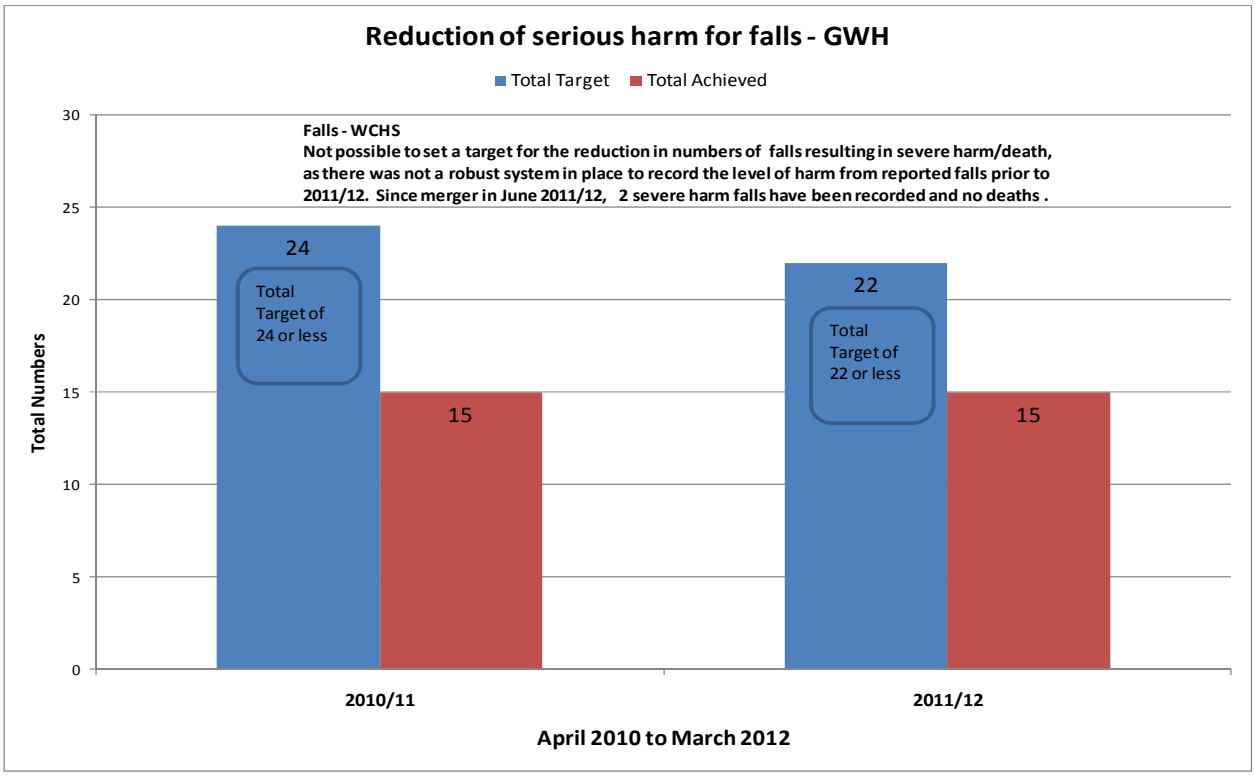
- Regional Quality Improvement Programme
- Medicines security audits
- Medical Gas Cylinder Management
- Discharge information and improved patient medicine information.
- Patient's own medicine 'Green Bag'
- Pharmacy Robot
- Pharmacy Training
- Clinical Pharmacy Services and Key Performance Indicators
- Amalgamation with Wiltshire Community Health Service Units

Priority 3: To reduce harm associated with patient falls

Harm from falls GWH: This year the Trust has focused on a 10% reduction in severe harm and death from falls in the acute setting, as categorised by the NPSA (National Patient Safety Agency) guidance. The figures indicate that the Trust's performance exceeded the target by 32% for the year.

The acute Trust has an implementation programme for rolling out a new falls care bundle to all adult wards by April 2012, supported by a training workbook. The care bundle named by the Trust as "SAFE" (Stratification and Avoidance of Falls in the Environment) is in line with the latest evidence based guidance on falls prevention in hospitals, as produced by the Royal College of Physicians in 2011. As part of the implementation programme there is a monitoring tool developed by April 2012 to audit compliance of the falls care bundle across the Trust. The focus going forward in 2012/13 will be to facilitate the acute wards to effectively implement this new care bundle, working towards 95% or greater compliance by November 2012. This aims to ensure we are providing the best possible standards of care for patient at risk of falls.

GRAPH – Reduction of serious harm from falls GWH



Harm from falls WCHS: It was not possible to set a target for the reduction in numbers falls resulting in severe harm and death, as there was not a robust system in place to record the level of harm from reported falls prior to 2011/12. Since Wiltshire community services merged with GWH in June 2011, there have been two recorded severe harm incidents across the four community wards. There has not been any death directly caused by falls in the same period of time.

The previous Community Falls Policy has been updated; it now shares much of its contents with the revised acute falls policy, this is prior to the proposed full integration of both the community and acute polices later this year. **Across the community hospital wards, the SAFE care bundle is being introduced.**

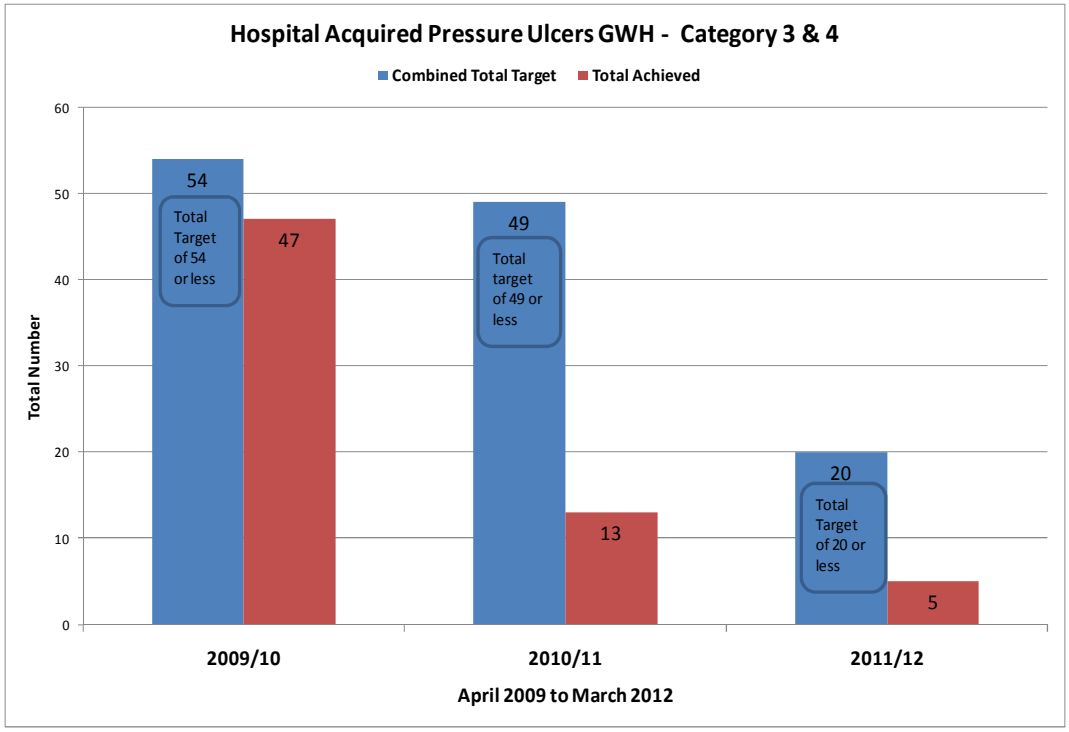
Priority 4: To reduce healthcare acquired pressure ulcers

Pressure ulcers GWH: The combined target of both Category 3 and Category 4 hospital acquired pressure ulcers was 20 or less. The actual total number reported during 2011/12 was 5 (Grade 4 = 1; Grade 3 = 4).

Comparing the total numbers for 2010/11 Category 4 and Category 3 hospital acquired pressure ulcers (13) with 2011/12 figures we have a 61.5% reduction on the previous year's total number.

Our greatest improvement is on the actual total numbers of pressure ulcers that have developed year on year. This year our strongest achievement has been in the reduction of Category 4s.

GRAPH – Hospital Acquired Pressure Ulcers GWH – Category 3 and 4



Pressure ulcers are key quality care indicators within the Essence of Care patient-focused framework for clinical effectiveness and are included in the South West Key driver programme. Further information about pressure ulcers, including planned reductions, assessment tools, support, training and equipment can be found in the Trust's Quality Account 2011/12.

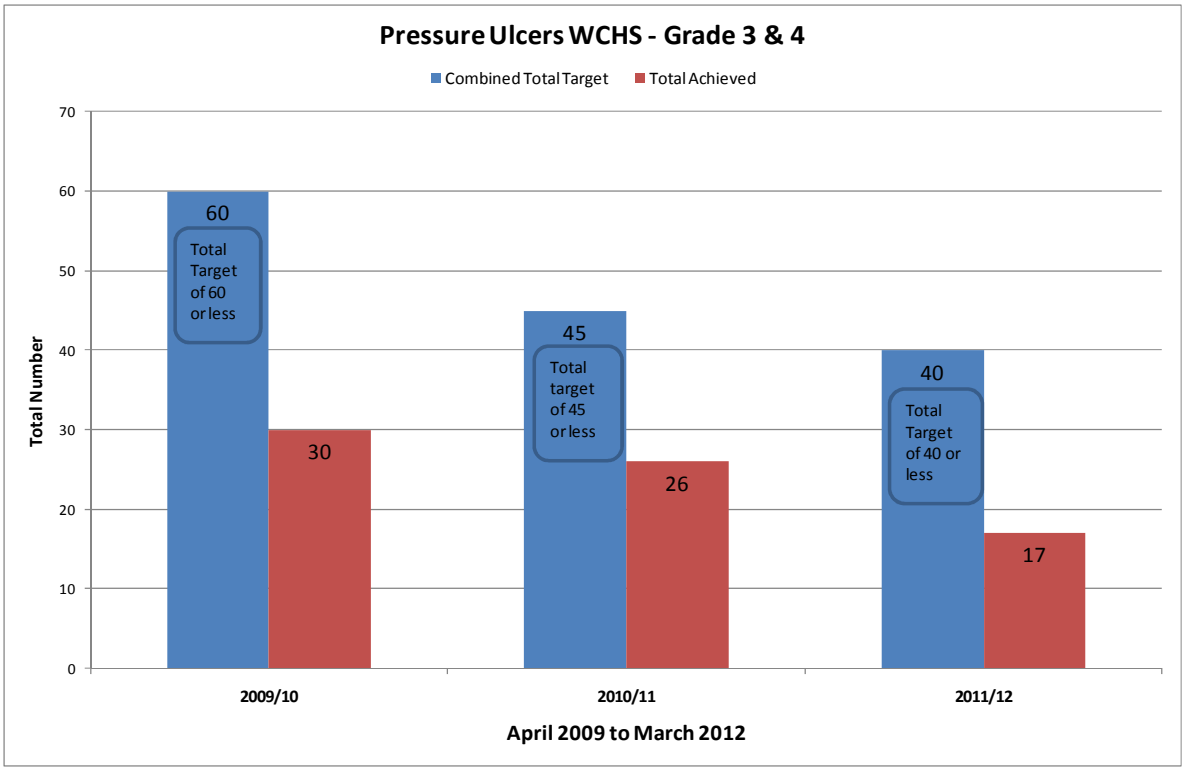
Pressure ulcers Community: The community Tissue Viability Team has a monthly reporting mechanism in which all patients who develop a pressure ulcer, while in the care of the community nursing team, are reported, using a paper based audit tool to the tissue viability office. There has been 100% reporting for the last 12 months.

The data is formatted into a quarterly report which is then distributed to all of the Neighbourhood team Co-ordinators and has been presented at the Quality Meetings with managers and commissioners.

The pressure ulcer risk assessment tool used within community teams is the Pressure Ulcer Risk Assessment Tool (PURAT) and has been used successfully for five years and has won a national award for innovation. The pressure ulcers are put into Categories in accordance with the 2009 European Pressure Ulcer Advisory Panel which advises NICE and the Department of Health.

The target combined number of category 3 and 4 pressure ulcers is 40 and the number developed is 23. This is 17 below target (57%).

GRAPH – Hospital Acquired Pressure Ulcers WCHS – Category 3 and 4



The reduction in pressure ulcers has been achieved through some of the following initiatives:

- Provision of pressure relieving alternating air mattresses to high risk community patients within 4 hours of referral
- Community in-patient units use the white board and handover sheets for every shift to highlight patients at high risk. There has been one category IV pressure ulcer developed on the community hospital ward in the last 12 months
- The tissue viability team respond to referral regarding a patient with a category 3 or 4 within one working day

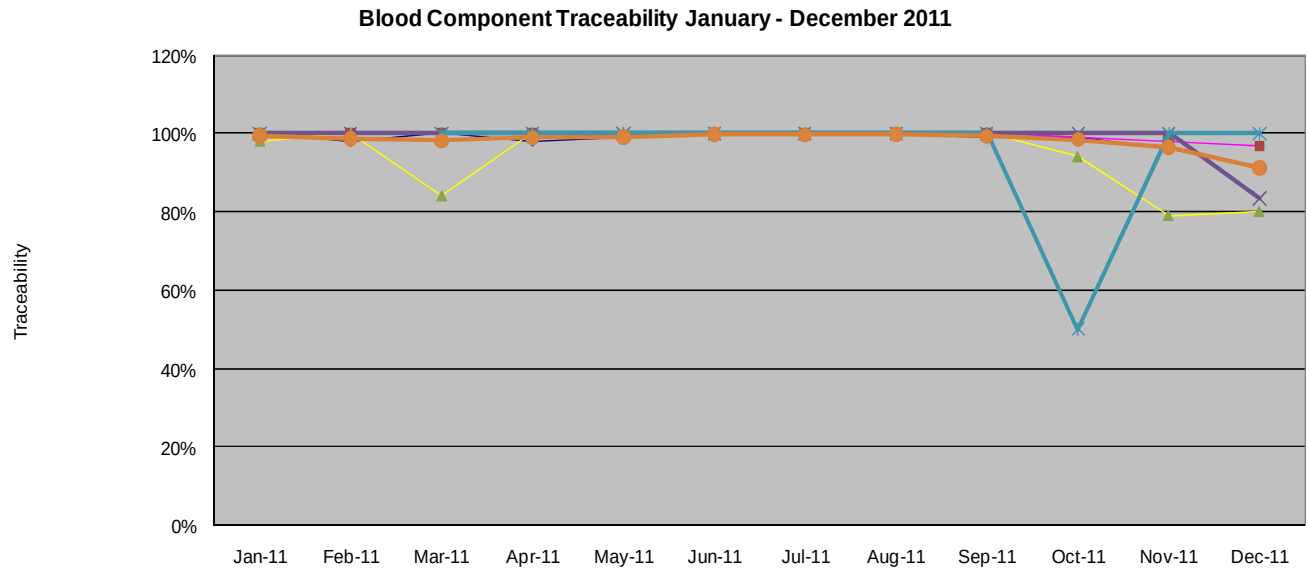
- Rolling educational programme with community staff to which all staff attend
- Developed link nurse group (33% of qualified nurses within each team) who have regular pressure ulcer educational updates and training with equipment
- Development of the RCA's investigation form in line with the NPSA Investigation report to identify any patient focused learning outcomes
- Completion of RCA's for every Category 3 and 4 pressure ulcer with regular feedback given to the NT's at all staffing levels and the Community Operations meeting. This feedback is patient focused and informs the educational program
- Educational program with social service and agency staff working with patients within Wiltshire community to ensure that all new and existing staff can recognise and respond appropriately to their client group who are at risk of developing pressure ulcer and the early signs of pressure damage

Priority 5: To Provide Safe Blood Transfusions

Safe Blood Transfusions - During 2011/12 there have been no 'wrong blood to wrong patient' incidents within the Great Western Hospital, Savernake, Chippenham and Warminster Community Hospitals.

Under the Blood Safety and Quality Regulations 2005 there is a legislative requirement for all blood and blood components to be fully traceable from donor to recipient. The Great Western Hospital uses the Blood Audit and Release System (BARS) which is an electronic blood tracking system. We are also responsible for the traceability of blood components at SwICC, Prospect Hospice and Savernake Hospital. For these areas we use a paper system. Blood component traceability is constantly monitored on a monthly basis and has on average been running at 98.2%. Chippenham and Warminster community hospitals and the Princess Anne Wing have their blood provided by the Royal United Hospital, Bath which is responsible for the traceability.

CHART - Blood Component Traceability Jan 2011 – Dec 2011



	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11
RBC	100%	98%	100%	98%	99%	100%	100%	100%	99.08%	99.00%	96.00%	91%
Platelets	100%	100%	100%	100%	99%	100%	100%	100%	100.00%	99.00%	98.00%	97%
FFP	98%	100%	84%	100%	100%	100%	100%	100%	100.00%	94.00%	79.00%	80%
Cryo	100%	100%	100%	100%	100%	100%	100%	100%	100.00%	100.00%	100.00%	83%
Octaplas	100%		100%	100%	100%	100%	100%	100%	100.00%	50.00%	100.00%	100.00%
Overall Percentage	99.44%	98.65%	98.15%	98.86%	98.95%	99.75%	99.62%	99.74%	99.21%	98.35%	96.46%	91.21%

Safe care of the patient receiving blood component transfusions has been regularly monitored via audit of transfusion observations. Minimum monitoring of the patient should include temperature, pulse, blood pressure and respiration rate. These should be recorded no more than 60 minutes prior to commencing the unit, 15 minutes into the unit (this includes observations undertaken within a 5 minute window either side of the 15 minutes) and no more than 60 minutes after completion of the unit. This is stipulated within the Trust's transfusion guidelines and will be monitored via audit at least once a year.

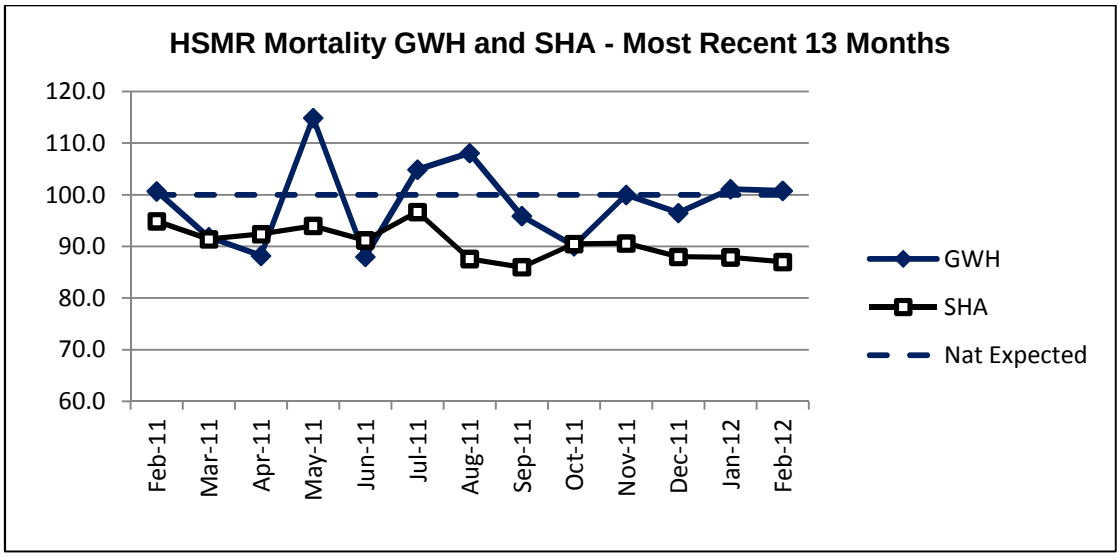
The National Patient Safety Agency (NPSA) competency based training for blood administration and venepuncture continues. The Trust is working towards achieving the set target of 100% for all staff involved in transfusion. However this is a very fluid process due to staff leaving and joining the organisation, maternity leave, long term sick leave etc. Staff who do not have a current relevant competency can no longer perform the procedure. Work is ongoing to monitor transfusion related competencies. A clear process of action was approved utilising the Matrons actively in policing and managing staff competencies. A 'transfusion breech form' is generated whenever blood is administered by someone who, according to our records, does not have the relevant competency. The number of breaches is falling month on month which shows that we are making good progress.

Priority 6: To Reduce Preventable Hospital Mortalities

Hospital Standardised Mortality Rate - The Trust has maintained an aggregate 98.7 Hospital Standardised Mortality Rate (HSMR) below (better than) 100 for the year to date (April – February).

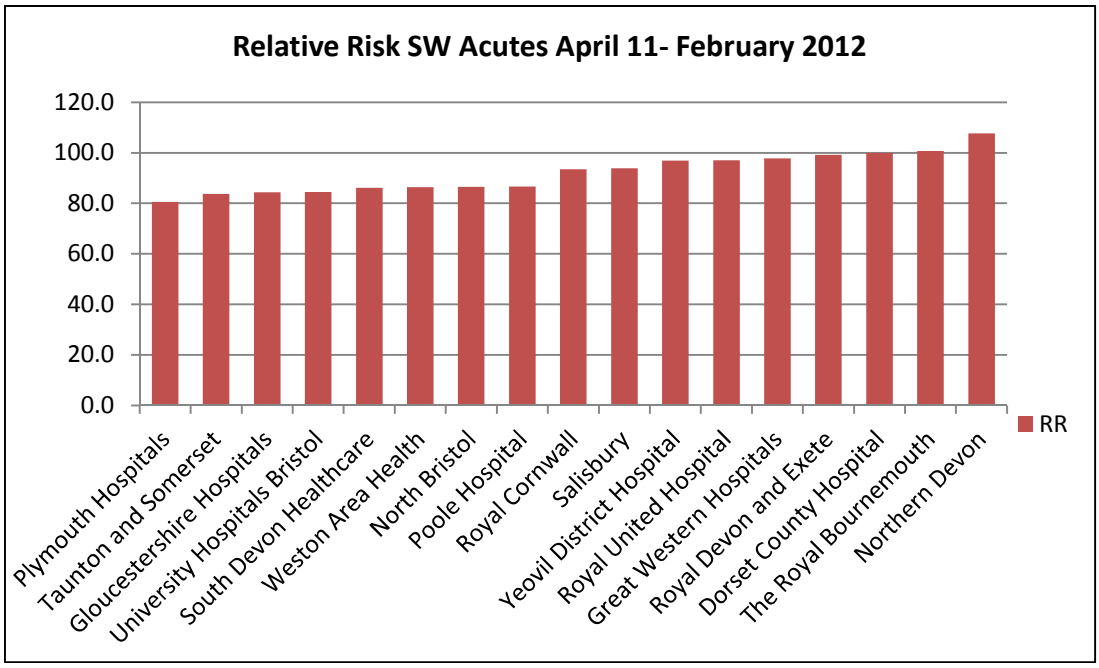
The graph below shows how the Trust is performing when compared to the average for the South West SHA and against the national expected level of 100. It can be seen that over the last 13 months the Trust's trend has broadly followed that of the SHA average although at a higher level with some peaks.

CHART – Hospital Standardised Mortality Rate GWH and SHA most recent 13 months



The graph below shows in more detail how the Trust compares against the other Acute Trusts in the SHA for HSMR relative risk for the current year. It can be seen that performance is generally good in the SHA.

CHART - Relative risk SW Acute Trusts April 2011 – February 2012



The Trust has an established Trust Mortality Group that meets on a monthly basis and includes clinician representation from each Clinical Directorate as well as representatives from Quality, Clinical Audit, Risk, Informatics and Clinical Coding. The work of this group includes monthly reports on mortality produced by the information department and centred on Dr Foster tools. Red bell alerts from Dr Foster are investigated with review of coding and clinical care. CUSUM reports also produced by Dr Foster are being used to identify areas for proactive investigation where mortality appears to be increasing prior to a red bell alert. This tool has also been introduced to monitor areas which have previously alerted to give assurance that improved performance is maintained. Audits have been presented back to the Patient Safety and Quality Committee. Action plans arising from these audits which have the potential to improve patient care, reduce the risk of preventable deaths.

Further information is contained in the Quality Account 2011/12.

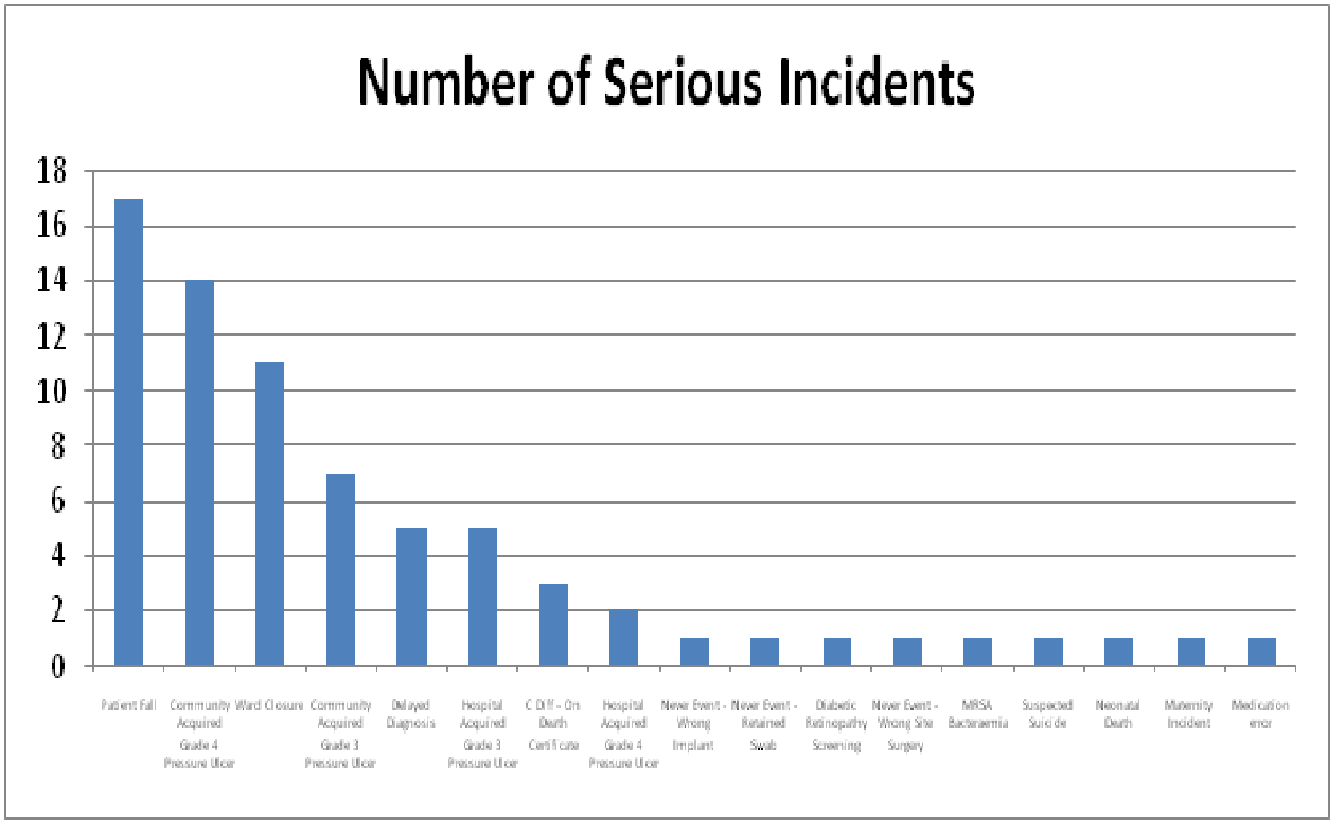
Clinical Incidents – Never Events, Serious Incidents and Incidents

Never Events: A total of three never events have been recorded in the Trust between April 2011 to March 2012. All three were surrounding surgery;

1. Wrong site surgery
2. Wrong implant/prosthesis
3. Retained foreign object post-operation

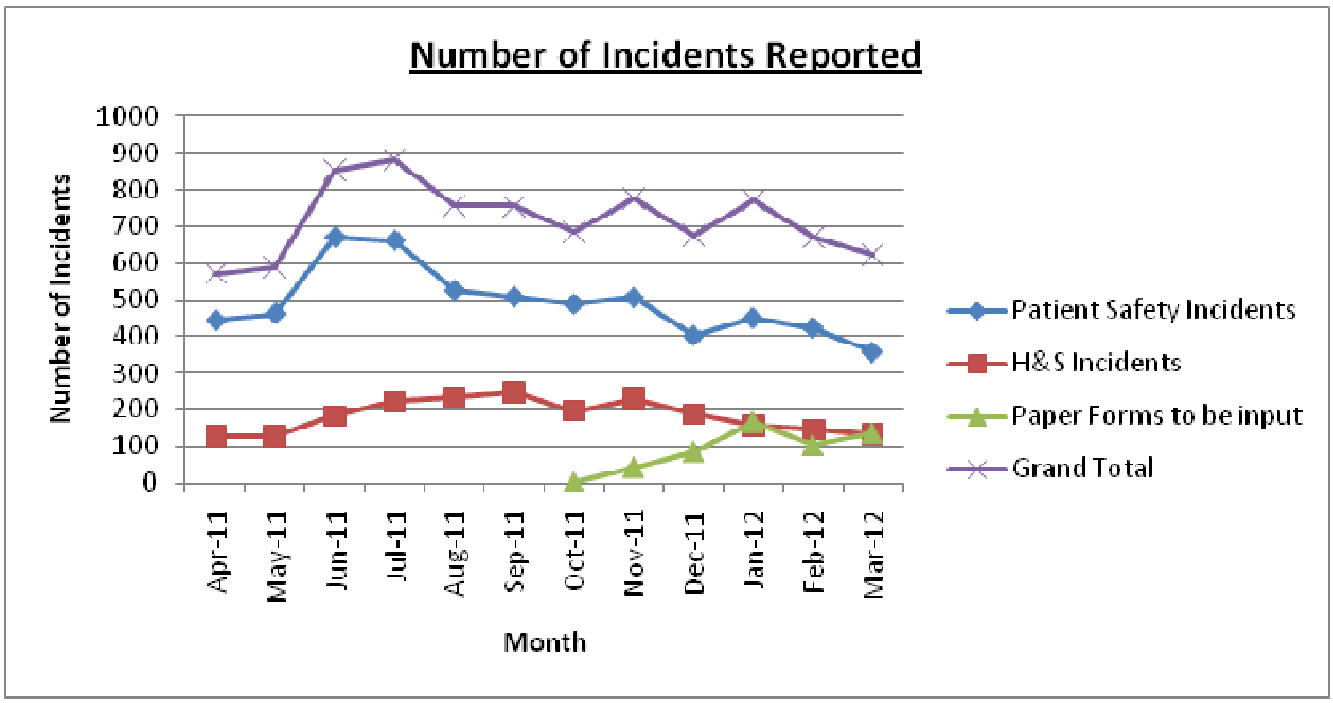
Serious Incidents: All serious incidents are investigated to identify the care and service delivery problems which contributed to the root cause of the incident. These are addressed in an action plan which is then communicated within Directorate meetings and reports across the Trust to ensure learning is shared. 71 serious incidents were reported and investigated across the merged Trust during the period April 2011 to March 2012. This was a decrease from the previous year April 2010 to March 2011 of 100 (44 GWH and 56 WCHS incidents added to quantify the figures). The graph below demonstrates the number of Serious Incidents grouped by type of incident.

CHART - Serious Incidents grouped by type of incident



Incidents: The Clinical Risk Team was responsible for managing 84% of incidents which occurred at the Trust over the last year. The Health and Safety Team investigate the non-clinical incidents. The graph below demonstrates the numbers of incidents reported.

GRAPH - numbers of incidents reported



Following the Trust's merge in June, the community arm of GWH is still reporting a large quantity of their incidents on paper incident reporting forms which are subsequently input to the GWH electronic system. Whilst all incidents reported in this manner are reviewed and reported within accepted timescales, there is currently a three month backlog of inputting the data from these forms which is reflected in the graph above. There is an ongoing community rollout of access, and training to the GWH electronic reporting system. Wiltshire community users will be integrated onto the GWH incident reporting system by September 2012.

TABLE - Top five clinical incident causes 2011-2012

Incident Cause	Grand Total
Fall - Found On Floor	933
Pressure Ulcer	607
Fall - Slip Or Trip	418
Equipment/Device - Contamination	258
Med Error - Missed Medication	226

Note - *Equipment/Device – Contamination* relates to damaged packaging on sterile equipment stored for use. These are mainly '*near miss'* incidents where the damaged packaging was found on routine checks and alternative sets supplied for use.

Patient Falls and Pressure Ulcers are included in the ***South West SHA Patient Safety and Quality Improvement Programme,*** which the Trust is currently participating in order to embed processes focussed on reducing harm from these events.

Last year it was reported that there had been an increase in documentation errors but this trend does not appear to have continued in 2011/12. The previous rise may have been due to the increase in total reporting figures; the NPSA agree that organisations reporting more incidents generally have a better and more effective safety culture. In the most recent *NPSA Organisation Patient Safety Incident Report*, the GWH was in the highest 25% of reporters. Timeliness of reporting is also an indication that the organisation is able to identify and act efficiently on incidents. The NPSA Report from April to September 2011 recognised the Trust continued to submit 50% of incidents fewer than 20 days after the incident occurred, ahead of the average of fifty percent of all incidents submitted more than 36 days after the incident occurred.

The volume of reporting within the Trust has continued to increase year on year:

- 3759 reported during 2009/10
- 4613 reported during 2010/11
- 5547 reported during 2011/12* *this includes the merged organisation from June 2011.

The NPSA Organisation Patient Safety Incident Report demonstrates that our rate of moderate harm, severe harm and incidents resulting in death is over 50% lower than that of comparable trusts.

The three top serious incident causes and their report recommendations are;

- Patient Falls
    - Variance on audit compliance - Falls risk assessment and SAFE tool. Monthly audits undertaken to monitor compliance;
    - Reinforcement of the importance of implementing care plans following identification of at risk patients;
    - Improving and cascading information to all members of the Multidisciplinary team
- Community acquired grade 4 pressure ulcer
    - Immobile patients to receive multi-disciplinary care planning;
    - Regular review of nutritional status;
    - Improve recognition, and subsequent referral when patients current pain-relief regime is not sufficient;
    - Patients identified as being at risk of or who have pressure ulcers will have core care plans that are implemented and regularly evaluated;
    - Monitoring accuracy of assessments; additional training identified and accessed
- Ward Closure
    - Improve staff awareness of procedure and policy surrounding isolation, control and investigative procedures of possible outbreaks of infection;
    - When outbreak identified, check possibility of cross contamination of patients exposed and discharged from affected area;
    - Ensure full and accurate patient details are given when transfers are planned.
    - Hand hygiene audit completed weekly
    - Personal protective equipment to be available and staff reminded of when to wear.

Presentations of the reports of these investigations are made to Directorate Leads at the monthly Patient Safety and Quality Committee meeting; learning from this, including action plans is then cascaded to directorate teams to share good practice. Utilising this system of reporting enables the Trust to learn from incidents, complaints and claims and act in a proactive way to try and prevent similar events occurring.

National Patient Safety Thermometer.

During 2012/13 the Trust will adopt the NHS Safety Thermometer; developed for the NHS by the NHS as a point of care survey instrument. The survey allows teams to measure harm and the proportion of patients that are ‘harm free’ within their care. Survey measurements will be uploaded onto a national monitoring tool to allow organisations to benchmark against others.
The four areas being measured are:

- Pressure ulcers;
- Falls;
- Urinary catheters and associated infections;
- VTE assessments.

Priority 7: Participation on the Regional Patient Safety Programme

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

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

Following the merger of acute and community service in June 2011 between the Great Western Hospital NHS Foundation Trust and Wiltshire Community Health, the acute and community programmes now run in parallel.

The community programme consists of six measures and one work stream package for the community programme: Average length of stay for inpatients, Patients with Observations complete, patient falls, pressure ulcers, urinary catheters, venous thromboembolism and leadership. Each measure and workstream has a Trust Lead.

Leadership - As part of the SW SHA Quality and Patient Safety Programme, GWH has been conducting patient safety walk rounds within the acute services, visiting various areas to establish first hand patient safety concerns from frontline staff. The walk rounds for the community are planned to be rolled out during 2012/13. Non Executive Directors (NEDs) and Governors are now actively involved in this process, the first NED joined the executive team walk round for the visit to the mortuary in January 2011 helping to develop actions and solutions to concerns raised. A NED or Governor now takes part in a patient safety walk round on a monthly basis. Since implementing patient safety walk rounds within the Trust executive teams have visited 18 clinical areas, most having had two visits; with up to a further 16 programmed for 2012/13.

During the walk round, actions are identified to resolve issues that are raised by staff, the Patient Safety Coordinator within the Clinical Risk Team monitors completion of actions, of the 90 actions raised to date 67 have now been completed and resolved. The most common themes that have been identified are communication, treatment/care delivery problems and equipment related issues. In continuing to develop the process, themes that are being identified are now being incorporated into the Trusts aggregated analysis and improvement report which is produced on an annual basis alongside incidents, claims and complaints data.

As a method of providing assurance that change is taking place, NEDs and Governors will be undertaking bi- annual meetings to review progress, discuss common themes and resolution of actions that have been identified. In addition the Chief Executive's report will include the key themes schedule which identifies key and common concerns raised on the walk rounds, this ensures that patient safety concerns are raised directly to the Trust Board.

General Ward – During 2011/12 the general ward teams have successfully implemented and rolled out the hydro bottles across the Trust in conjunction with the productive ward handover module. The bottles aid with hydrating patients and help to provide more independence to those who are less able.

The Tissue Viability Nurse Specialist (TVNS) presented on Pressure Ulcers at the SW SHA learning session in June 2011. The work undertaken to reduce the Trust's pressure ulcers was so inspirational that she was invited by the SHA and Improvement for Healthcare Improvement (IHI) to host a South

West conference call in August 2011 on pressure ulcers. The conference call was a success and the pressure ulcer tools have made available for other SW NHS Trusts to use.

The community have commenced developing an EWS (Early Warning System) in the community settings. It entails utilising the observation chart (currently used at GWH) for Wiltshire (to replace their current Obs Chart).

The process is split into 3 phases: trailing chart on a community ward, roll out to inpatient areas and roll out to neighbourhood teams.

Medicines Management –The team has worked across the Trust with omitting the abbreviations for insulin prescribing. The prescribing will now be written as 'unit' rather than 'u, this will help to reduce the number of errors associated with insulin prescribing.

Peri operative – The team has been working on improving compliance with normothermia to ensure that the patient's body temperature is normal throughout the operation. A traffic light system has been introduced by the team to help identify patients who are at risk of becoming cold. The system scores the patient and identifies what the risk is of the patient not being able to maintain a normal body temperature. The theatre team is able to proactively provide interventional methods to keep the patients warm.

Critical Care – The intensive care team is now successfully collating data and recording Ventilated Acquired Pneumonia (VAP) rates in patients. A lot of hard work and effort has been invested in this project (measure) and the team is now investigating specific trends in the VAP rates.

Institute Multi-Disciplinary Rounds where introduced during 2011 and are now embedded into practice, there is regular attendance by the physio, pharmacy and dietician. Multi-disciplinary ward rounds are taking place on a daily basis (Monday – Friday) and are helping to improve communication between all team members, patients, carers and relatives.

As part of the SW SHA programme the Trust are involved a number of improvement projects which includes, improving the use of the surgical safety check list, patient falls protocol, patient comfort rounds, theatre pre list meetings, medication reconciliation and many more.

Effective Care

Priority 8: Compliance with best practice guidance (NICE) and Central Alert Bulletins

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

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

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

NICE published 82 guidelines during 2011/12.

All the guidelines have been disseminated to the relevant clinicians and directorates including Wiltshire Community Health Services. A response rate of 96 % or above has been maintained throughout the year.

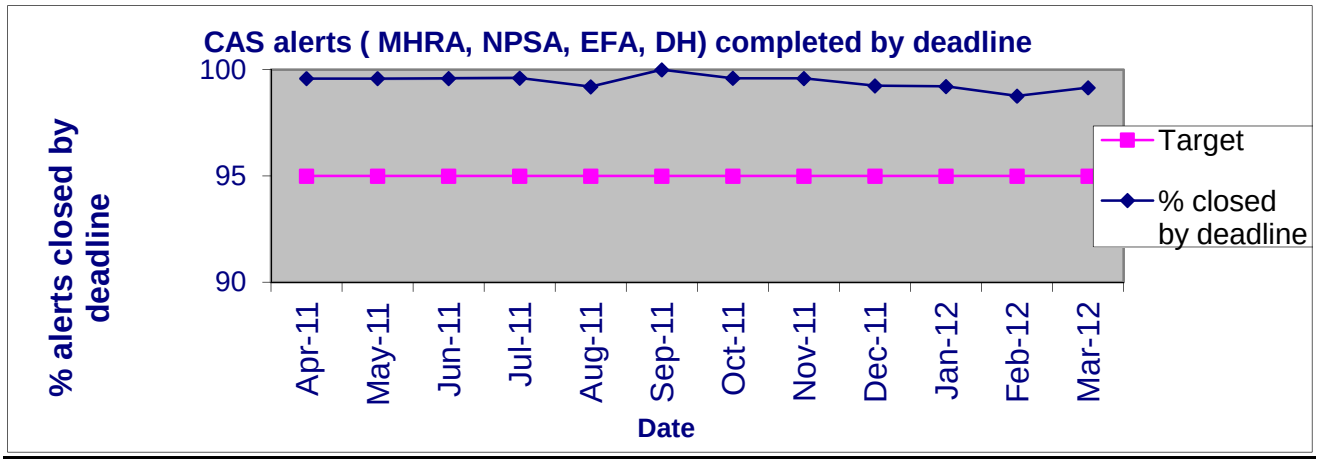
35/82 (41.5%) of the publications have been confirmed they are relevant to the Trust.
Out of this 35 -

- 22 guidance have been assured of full compliance
- 4 guidance's are currently being implemented
- 6 have only recently been published and are within time frame to respond
- 1 Technology Appraisal is under discussion
- 2 guidance's have been reported as an exception as the Trust has other provisions to implement the guidance.

Thus Trust wide compliance of 98-100 % has been attained this year.

CAS: The CAS (Central Alerting System) publishes Safety Alerts, emergency alerts, Dear Doctor letters and Medical Device Alerts on behalf of the Medicines and Healthcare products Regulatory Agency, the National Patient Safety Agency, and the Department of Health. These relate to medical devices, hospital facilities, equipment and clinical incidents. Responses and actions are monitored to defined deadlines via a web based system. Between April 2011 and March 2012 the Trust received 112 alerts from the CAS system.

CHART – Central Alerting System Alerts 2011/12



The standard of at least 95% compliance with no significant exceptions has been maintained throughout the 2011/12. Any alert that has failed to achieve full compliance within the prescribed deadline is reviewed monthly at the PSQ meeting to ensure that progress is being made to address outstanding actions and that no significant risks exist.

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

The NPSA alert, 2010 RRR019: Safer ambulatory syringe drivers, is outstanding, awaiting confirmation of a training programme in the community. Clinical Risk assesses the risk of non completion to be low. There is one Estates alert past its deadline, EFA 2011/002, concerning the management of refilling liquid Oxygen VIE plants. The outstanding actions concern approval of documentation. Estates and Facilities Management assess the risk to be low.

Priority 9: To review the clinical care of patients who need to return to theatre within a two week period

The aim for 2011/12 was to establish baseline figures for patient returns to Theatre within 2 weeks.

Total returns to Theatre for YTD = 41
Total cases YTD = 18.468
Overall % YTD = 0.2%

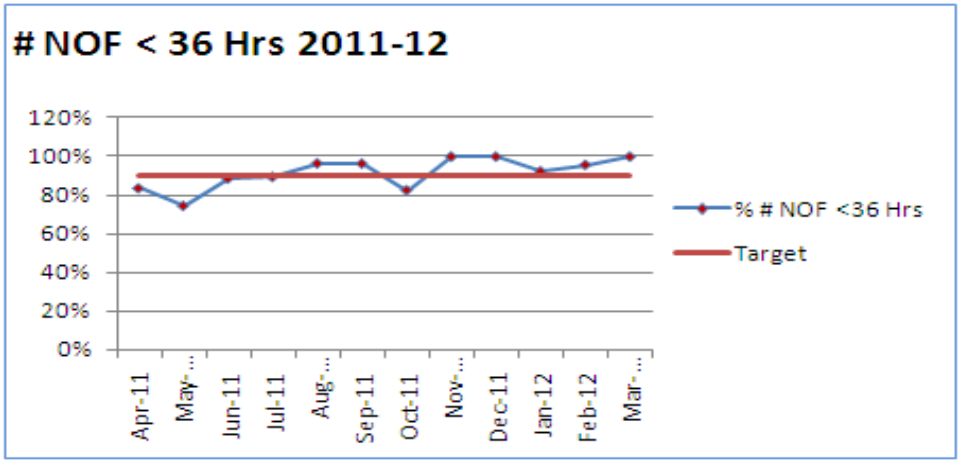
- There continues to be monthly monitoring of specialty trends. Theatre Coordinating Managers validate the monthly figures collated by the Informatics Team.
- 2012/13 we will continue to collate, monitor and validate on a monthly basis.
- We will continue to highlight any trends and report these to the appropriate specialty Clinical lead in the first instance.
- Any trends or areas of concern will be discussed at the Directorate & Clinical Governance meeting on a monthly basis where appropriate.

Priority 10: To ensure that patients who have sustained a fractured neck of femur are operated upon within 11 hrs of sustaining their injury if medically fit

Hip fracture is a common, costly and well-defined injury, which occurs mainly in older people. As the number of elderly people and age-specific incidence of hip fracture continue to rise, orthopaedic and rehabilitation services face growing pressures and a multidisciplinary working group meets bi-monthly to review all aspects of care for these patients.

Early surgical intervention is associated with better patient outcome. In accordance with best practice tariff, the quality indicator contract time to theatre is 36 hours. The Trust indicator requires that 90% of patients who are deemed medically fit require surgery within 36 hours of admission. The average percentage of patients who achieve this is 91% for the year.

CHART – Fractured Neck of Femur – Patients going to theatre with 36 hours if medically fit



This has been achieved by:

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

Priority 11: To ensure patients are assessed for the risk of developing Venousthromboembolisms and that these risks are managed appropriately

Compliance with completing VTE risk assessment has been maintained at over 90%. This achievement includes data from Wiltshire since June 2011.

This has been achieved with:

- Continued education sessions at Trust Induction.
- VTE update training now available on Training tracker and via a workbook.
- VTE sessions provided specifically for Health Care assistants which was very successful and enabled recruitment of additional VTE link HCA's who have made significant improvements to the quality of VTE assessments in their areas. This is also being rolled out in Wiltshire to enable VTE link staff to have the same level of access.
- Implementation of an audit trail through the nursing crescendo system and daily reports provided by Informatics to each ward area which allows them to easily identify any patients who have not been risk assessed.
- Raising awareness with patients and relatives by means of information boards and displays during national thrombosis week, the winner of last year's event is permanently displayed in Cherwell, pre-assessment unit.
- A second patient information leaflet developed specifically for patients who are being discharged home with VTE prophylaxis which gives information for the patient and also the community health care provider.
- We have also worked closely with Swindon PCT to establish VTE risk assessment in the community for patients who are discharged home with VTE prophylaxis. This will also enable patients who deteriorate at home to be assessed and for them to receive appropriate VTE prophylaxis if at risk.

Administer appropriate VTE thromboprophylaxis

Compliance with VTE prophylaxis has been maintained between 88%-100% for the last 12 months. Audits are proposed to evaluate the quality of the risk assessments and ensure appropriate thromboprophylaxis is prescribed and that patients who require extended prophylaxis in the community receive it.

Priority 12: To undertake nutritional assessments on patients on admission to hospital to ensure we meet their nutritional and hydration needs

Good nutrition and hydration are fundamental to well being and recovery from illness or trauma. A high proportion of individuals admitted to hospital or requiring support via the neighbourhood teams are vulnerable to malnutrition

Targets, compliance and audit methodology & frequency for the 3 key locations vary:

- **GWH site: Target 95%; compliance 86.9%** Jan 2012
- **Community Hospitals: Target 100%; Compliance 77.5%**
- **NHT: Target 100%; compliance 44.4%**

Despite not yet meeting the target significant improvements in other aspects of nutritional care have been achieved. At GWH site "MUST" (Malnutrition Universal Screening Tool) completion is assessed via Crescendo (electronic system) on a daily basis to provide weekly and monthly compliance rates. Wiltshire Community conducts a qualitative audit 6 monthly. For the purposes of this report an average of all wards is used for the key parameters of the audit.

GWH site:

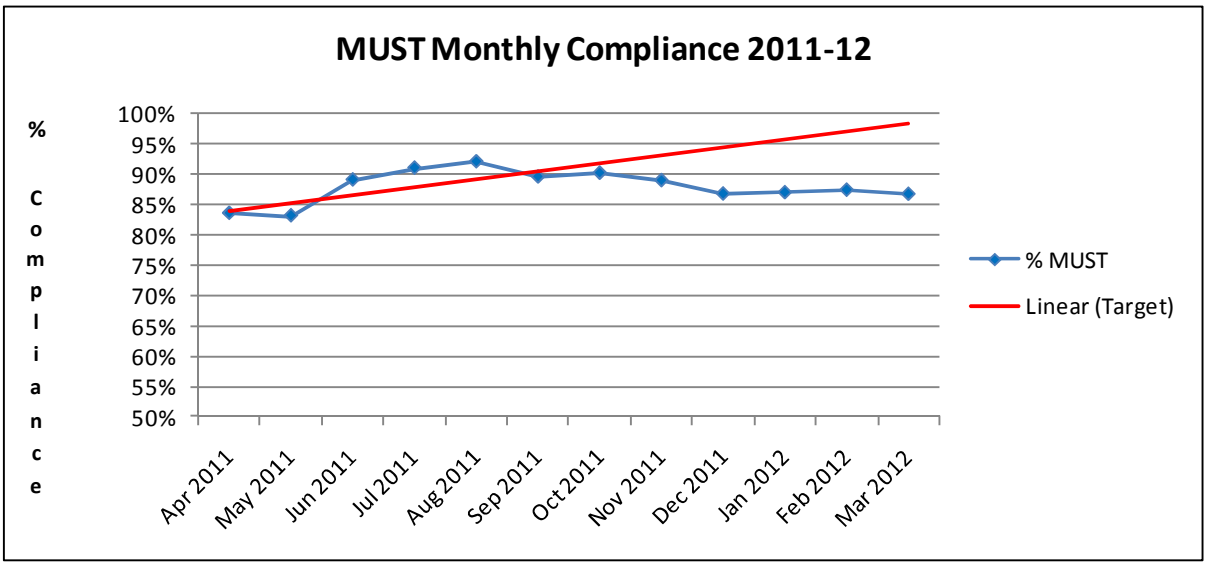
- Prior to MUST implementation there was no consistent or validated screening tool in place and compliance was measured at 33%.
- In 2010 MUST was implemented with a training programme carried out by the dietetic team. Compliance was improved to 75% by February 2011.
- The improved MUST compliance resulted in a >100% increase in referrals to the dietetic team resulting in a lack of time available for on-going training.
- During 2011 refinements were made to compliance audits, including improving the identification of exclusions and supporting wards with lower levels of compliance.
- Compliance has further improved to 87% with 3 areas achieving 95%; 6 areas 85 – 94% and 5 areas at or below 84% (range 78 – 84%).
- An on-going training programme is in place for NAs and volunteers including MUST and nutrition care.

Additional and existing activities to improve MUST accuracy and compliance are being introduced and strengthened.

- To support accurate MUST completion a new E- learning package and workbook for MUST are being introduced via the academy. The Nursing Auxiliary and volunteer training programme is to be updated to incorporate the needs of Wiltshire Community staff and changes to meals service such as the menu-less meals project.
- An additional dietician has now been funded by industry (commenced in post 20th Feb 2012 until March 2013) to support the MUST and nutrition care plan programme and to identify ways of managing the resultant referral demand. The post holder will be required to identify and pilot alternative ways of working to achieve this once the funding ceases.
- Ward dieticians will be targeting their lower compliance wards with additional training and support Regular comfort rounds (intentional rounding) instituted to provide more proactive and timely care.
- Matron's weekly inspections have recently started with a more specific and consistent approach to monitoring and improving compliance issues with MUST, nutrition care pans and documentation of fluid balance.

- As a result of complaints and concerns regarding meals' quality on-going weekly checks of meals service is carried out. This has improved resulting in positive PEAT (Patient Environment Action Team) reports
- A pilot project to improve patient's meals experience and reduce wastage was introduced in 2010 through the Productive ward meals module. Due its success the menu-less meals programme is being rolled out to the rest of GWH site, as appropriate.
- Dieticians identified a significant amount of food wastage and dissatisfaction from patients with diabetes and ward staff regarding the diabetic snack provision. Subsequently a new snack choice has been introduced which has been well received by patients and staff and is predicted to reduce wastes and produce some cost savings.
- The Productive ward team identified a system designed to improve patients' hydration needs. The trial of the "Hydrant" in 2011 was so successful it is being rolled out to other areas
- It was identified mid 2011 that the menus did not fully cater for patients with dysphagia. The dieticians, Speech and Language Therapists and Carillion are working on the development of a separate soft menu to improve choice and suitability of texture for these patients. An interim menu is currently in place prior to introduction of the finalised version
- Women and Children's directorate and paediatric dieticians identified that MUST is not appropriate for children and no other equivalent screening tool exists. The paediatric dieticians have developed a nutritional screening tool for 0-5 year olds.
- Update of pictorial menu completed.

CHART - GWH Site – MUST (Malnutrition Universal Screening Tool) 2011/12



Wiltshire Community Sites*:*

Wiltshire Community Services were being integrated with the Trust throughout 2011. Both elements of the Trust were using MUST but training programmes, targets and audit methodology have been different. The Nutrition Steering Groups have been merged and a new integrated Trust Nutrition and Hydration Steering Group has been established which is developing a comprehensive work plan. This should ensure more consistent reporting and activity in the coming year

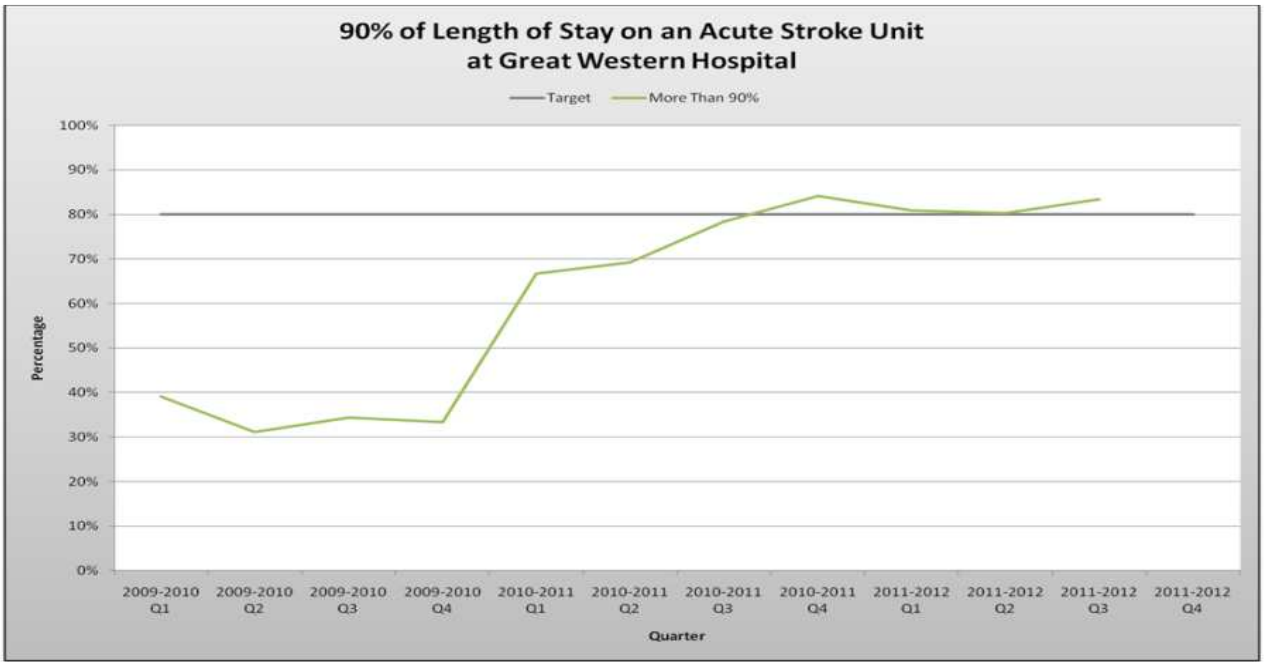
Wiltshire conducts a qualitative audit 6 monthly. For the purposes of this report an average of all wards is used for the key parameters of the audit.

- A regular ongoing training programme ("MUST" & nutrition action planning) for all Neighbour Hood teams and community Hospitals to ensure accuracy and improve compliance rates.
- Overarching action plan developed for NHT to support local planning
- 6 monthly audits undertaken for NHT and community hospitals
- Introduction of Nutrition Link Workers; role to include audits
- Development of matrons observational audit
- On-going review of "MUST" screening documentation across all localities
- Review of "Food First" nutrition information booklet
- "MUST" training provided in care homes

Priority 13: To attain the national Sentinel Stroke Targets

The Acute Stroke Unit at the Great Western Hospital has consistently delivered quality care for stroke patients over the last year. The quarterly target for 80% of patients to spend at least 90% of their length of stay in hospital on an Acute Stroke Unit was first achieved in the last quarter of 2010-2011, and has been achieved for all quarters of 2011-2012.

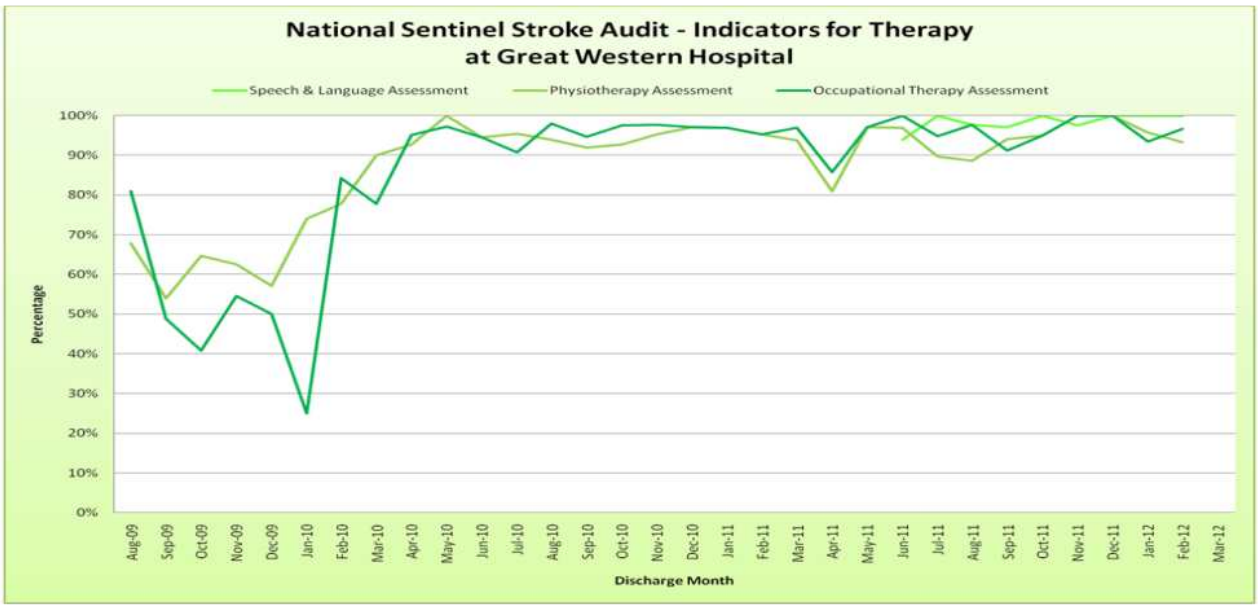
CHART – 90% Length of Stay on an Acute Stroke Unit at Great Western Hospital



Patients treated on the Acute Stroke Unit received dedicated treatment and rehabilitation from a multidisciplinary team with specialist stroke skills, patients are consistently:

- assessed within 72 hours of admission, if required, by the Speech and Language Therapist
- assessed within 72 hours of admission by the Physiotherapists
- assessed within 4 working days of admission by the Occupational Therapists

CHART – National Sentinel Stroke Audit – Indicators for Therapy at Great Western Hospital



The Great Western Hospital has delivered significant improvements for stroke patients with the 24/7 thrombolysis service. Since the extended service was introduced this financial year in April 2011, 47 patients have been thrombolysed compared to 7 patients in the previous financial year; this is an increase or 600% on than the number of patients thrombolysed during the limited working hours service (09:00 to 17:00, Monday to Friday). In addition, the door-to-needle times (from the moment a patient enters A&E to assessment and receiving treatment) are continuing to decrease with less variability between patients.

Patient Experience

Priority 14: To involve patients more in decisions about their care

GWH:

- Q1 Performance April to June 2011: 45.1% - Achieved
- Q2 Performance July to September 2011: 46.6% - Achieved
- Q3 Performance October to December 2011: 46.8% - Achieved
- Q4 Performance January to March 2012: Data not yet available

The Great Western Hospital collects the views of patients about information on discharge from the quarterly inpatient survey. The National Inpatient Survey 2010 showed that 50% of patients wanted to be more involved with decisions about their care, which demonstrates a slight improvement during 2011/12.

Further actions required:

- Roll out of ward managers surgeries to encourage patients and their carers to ask questions and query care whilst on the ward
- Bedside handovers to keep patients aware of their care and to be informed of any tests or procedures to be carried out during that shift

Community:

- Q1 Performance April to June 2011: 31% - Achieved
- Q2 Performance July to September 2011: 31% - Achieved
- Q3 Performance October to December 2011: 4% - Achieved
- Q4 Performance January to March 2012: Data not yet available

Satisfaction surveys are given to all patients upon discharge from the Trust's Community Inpatient areas. Community inpatient services are provided from four wards across three sites, Longleat Ward - Warminster Hospital, Aylesbury Ward - Savernake Hospital, and two wards at Chippenham Community Hospital, Cedar Ward and Beech Ward which is a Stroke rehabilitation Unit. There are currently low numbers of participants in the surveys. The Community Inpatient Survey will be incorporated within the patient survey tender in quarter one 2012/13.

The Community Inpatient Survey results demonstrate that the Community Inpatient areas are consistently achieving this measure.

Priority 15: To ensure staff are available to discuss care concerns with patients and their carers

GWH:

- Q1 Performance April to June 2011: 40.7% - Achieved
- Q2 Performance July to September 2011: 54.5% - Achieved
- Q3 Performance October to December 2011: 61.6% - Not achieved
- Q4 Performance January to March 2012: Data not yet available

The National Inpatient Survey 2010 showed that 59% of patients could not always find a member of staff to discuss concerns with. During quarters one and two 2011/12, there has been an increase in patient satisfaction in this measure, which decreased in quarter three. Posters showing photographs of the Ward Managers and Matrons have been displayed during March 2012, to inform patients of the clinical managers in the ward should they wish to speak with some one. The introduction of bedside handovers will also increase the availability of nursing staff to speak with patients about their care.

Community:

- Q1 Performance April to June 2011: 10.1% - Not achieved
- Q2 Performance July to September 2011: 6.2% - Not Achieved
- Q3 Performance October to December 2011: 9% - Not achieved
- Q4 Performance January to March 2012: Data not yet available

The results of the Community Inpatient Survey show that there is further work required to improve patient satisfaction in this area.
Further actions required:

- Roll out of ward managers surgeries to encourage patients and their carers to ask questions and query care whilst on the ward
- Bedside handovers to keep patients aware of their care and to be informed of any tests or procedures to be carried out during that shift
- Posters showing photographs of the Ward Manager and Matron to be displayed

Priority 16: To ensure patients are given sufficient privacy when discussing care and concerns

GWH:

- Q1 Performance April to June 2011: 27.4% - Achieved
- Q2 Performance July to September 2011: 24.8% - Achieved
- Q3 Performance October to December 2011: 29.1% - Achieved
- Q4 Performance January to March 2012: Data not yet available

The National Inpatient Survey 2010 showed that 31% of patients felt that there was not enough privacy when discussing their care or treatment. The quarterly survey results for 2011/12 show an increase in patient satisfaction in this area.

A matron within the Planned Care Directorate carried out a privacy audit in November 2011 to collect information on the different ways that privacy notices are used when discussions are taking place around the bedside. As part of the bedside handover, confidential information about patients is discussed away from the bedside. Safety briefings have also been introduced to share information with staff on handover and are carried out away from the bedside.

Further actions required:

- Standardised privacy notices to be rolled out to wards as part of the hygiene module of the Productive Ward

Community:

- Q1 Performance April to June 2011: 6.3% - Achieved
- Q2 Performance July to September 2011: 3.2% - Achieved
- Q3 Performance October to December 2011: 1% - Achieved
- Q4 Performance January to March 2012: Data not yet available

There has been an improvement of patient satisfaction in this area during 2011/12.

Further actions required:

- Audit of curtain peg and privacy notice use across community inpatient areas with a view to introducing the Trust wide standardised privacy notices

Priority 17: To improve upon the information given to patients on medication and it side effects

GWH:

- Q1 Performance April to June 2011: 30.8% - Achieved
- Q2 Performance July to September 2011: 42.9% - Achieved
- Q3 Performance October to December 2011: 65% - Not achieved
- Q4 Performance January to March 2012: Data not yet available

There are a number of ways that side effect information could be provided, and a number of developments have been made over the last year by the Pharmacy department to enable this information to be given to patients. These include, information leaflets included with all discharge medicines, patient information available via the internet and a patient medicines information helpline which is publicised via Outpatients.

The survey results demonstrate that clear guidance needs to be given to both staff and patients.

Further actions required:

- Provision of medicine reminder card with all discharges via pharmacy
- A multidisciplinary meeting including nursing and medical representation to review the process and information sharing of medication on discharge

Community:

- Q1 Performance April to June 2011: 7.3% - Achieved
- Q2 Performance July to September 2011: 21.5% - Not achieved
- Q3 Performance October to December 2011: 21% - Not achieved
- Q4 Performance January to March 2012: Data not yet available

As with the measure for GWH, there is work around information of medication to be undertaken in Community Inpatient areas. The Community Inpatient areas receive their discharge medication in a different way, however the way that this information is shared with patients can be replicated from GWH.

Further actions required:

- Review of the way medications are given to patients discharged from Community Inpatient areas

Priority 18: To ensure patients know who to contact after discharge if they have concerns about their care

GWH:

- Q1 Performance April to June 2011: 34.5% - Not achieved
- Q2 Performance July to September 2011: 21.8% - Achieved
- Q3 Performance October to December 2011: 23.20% - Achieved
- Q4 Performance January to March 2012: Data not yet available

The National Inpatient Survey 2010 showed that 26% of patients were not told who to contact if they were worried after they were discharged. The Unscheduled Care Directorate has led on the discharge policy review and the introduction of discharge leaflets. This links with the work that Pharmacy has been undertaking to improve patient information on discharge. The Unscheduled Care Directorate have facilitated a number of workshops on improving the pathway to discharge

Community:

- Q1 Performance April to June 2011: 30% - Not achieved
- Q2 Performance July to September 2011: 23.7% - Not achieved
- Q3 Performance October to December 2011: 25% - Not achieved
- Q4 Performance January to March 2012: Data not yet available

Community Inpatient areas are managed by the Unscheduled Care Directorate. As the Directorate are leading the work on discharge, it gives an ideal opportunity for good practice to be replicated.

6.5 Care Quality Commission (CQC) Inspections

There have been a total of 9 external inspections by the CQC and a schedule of work has been developed to monitor progress with the action plans arising following each inspection.

Following 8 of those inspections (noting the ninth inspection happening in mid May, the outcome of which is awaited), a CQC judgement of not fully compliant for the following three outcomes at Great Western Hospital site has been made:

- **Outcome 1 Respecting and Involving people who use services**
  In April 2011, the Trust was judged as none compliant with Outcome 1 due to its inability to demonstrate the provision of adequate and consistent patient privacy and dignity. An action plan was developed and completed by September 2011. In December 2011 a follow up inspection by the CQC deemed the trust as compliant with some improvement actions.

- **Outcome 4 (Care & Welfare of people who use services**
  On December 8th 2011, the CQC specialist inspection for Theatres judged the site as non compliant due to inconsistency of WHO checklist completion.
  Completion of action plan and subsequent regular internal audits and inspections for assurance has provided clear evidence of compliance and the Trust has declared compliance with Outcomes four as from 30th April 2012 with the CQC.

- **Outcome 5 (Meeting nutritional needs)**
  On December 8th 2011, the CQC inspectors focussed on hydration and after finding 3 incomplete fluid charts on one ward, judged the site as non compliant.
  Completion of action plans, a hydration strategy internal review, Productive Ward improvements and subsequent weekly internal audits and inspections has provided clear evidence of compliance and the Trust has declared compliance with Outcomes five as from 30th April 2012 with the CQC.

Other External Reviews

A dynamic database system has been created to enable tracking of all external reviews and inspections. This system enables the Trust to track progress, actions and compliance status and is reported to the Patient Safety and Quality Committee.

6.6 Performance against key national priorities

An overview of performance in 2011/12 against the key national priorities from the Department of Health's Operating Framework is set out below. Performance against the relevant indicators and performance thresholds are provided.

TABLE – Performance against key indicators

	2009-2010	2010-11	Annual 2011-12				
	GWH	GWH	Merged	Merged Target	GWH	WCHS	Achieved / Not Met
Clostridium Difficile year on year reduction^	49	40	19	69	17	2	Achieved
Incidence of MRSA bacteraemia	6	3	2	2 or less	2	0	Achieved
Two week wait from urgent GP referral to date first seen for all cancers	92.6%	97.0%	97.1%	93%	97.1%	N/A	Achieved
Symptomatic Breast two week wait	96.0%	97.2%	97.1%	93%	97.1%	N/A	Achieved
31 day wait from decision to treat to first treatment for all cancers	97.4%	99.0%	98.7%	96%	98.7%	N/A	Achieved
31 day wait for second or subsequent treatment - Surgery	94.7%	98.5%	98.4%	94%	98.4%	N/A	Achieved
31 day wait for second or subsequent treatment - Anti Cancer Drug treatments	99.8%	100%	100.0%	98%	100%	N/A	Achieved
62 day wait for first treatment from Urgent GP Referral to treatment for all cancers	90.3%	92.4%	89.3%	85%	89.3%	N/A	Achieved
62 day wait for first treatment from Screening Service to treatment for all cancers	98.9%	100%	98.4%	90%	98.4%	N/A	Achieved
For admitted patients - Referral to treatment 18 weeks maximum waiting time	95.0%	95.1%	96.1%	90%	96.1%	N/A	Achieved
For non admitted patients - Referral to treatment 18 weeks maximum waiting time	97.5%	97.9%	98.2%	95%	98.2%	99.8%	Achieved
Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge	95.3%	97.4%	97.0%	95%	95.5%	99.9%	Achieved
The Trust has fully met the National core standards	Compliant	Compliant	Not Fully Compliant	CQC Compliance	Not fully Meeting Outcomes 4 and 5	Compliant	Not Fully Met
Self certification against compliance with requirements regarding access to healthcare for people with a learning disability	Not measured	Not measured	Compliant	Maintain compliance	Compliant	Compliant	Achieved

6.7 Statement of Directors' responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 as amended to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2011/12;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2011 to May 2012
  - Papers relating to Quality reported to the Board over the period April 2011 to May 2012
  - Feedback from the commissioners dated 18/05/2012
  - Feedback from Governors dated 18/05/2012
  - Feedback from LINks dated 18/05/2012
  - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 15 May 2012
  - The national patient survey dated April 2012
  - The national staff survey March 2012
  - The Head of Internal Audit's annual opinion over the trust's control environment dated 14 May 2012
  - Care Quality Commission quality and risk profiles dated September 2011 – March 2012
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual)).

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

24-5-12 Date ..... Chairman

24-5-12 Date ..... Chief Executive

6.8 Statements from Primary Care Trusts, Local Involvement Networks and Overview and Scrutiny Committee

6.8.1 Health Overview and Scrutiny Committee Statements

The Swindon Health Overview & Scrutiny Committee is encouraged by the work that is already being undertaken to improve services amongst the priority areas for quality improvement.

The Health Overview & Scrutiny Committee is committed to having a good working relationship with the Great Western Hospital NHS Foundation Trust and, based on the Committee's knowledge, endorses the Quality Account for 2011/12.

The Committee is grateful to the Chief Executive and her team for the regular updates at Committee meetings on what is working well, and in some cases, what is not working so well within the Foundation Trust. The Foundation Trust has been open and transparent throughout the overview and scrutiny process and the committee hopes that this continues through to the next municipal year.

The Committee looks forward to continuing to work with The Great Western Hospital NHS Foundation Trust to continue to improve acute hospital care and community care for the residents of Swindon and the region.

6.8.2 Governors Statement

Over the course of the past year the Governor Group have had the opportunity to receive regular Quality updates at both the Council of Governors Meetings and in the more focused Patient Experience Working Group, which has an open invitation to the local CQC officials,

This group has the opportunity to feed in on a regular basis on matters of Patient Care and is regularly updated on new initiatives. It also on occasions, calls for reports on areas that have been highlighted which are of potential concern. It is a highly motivated group which helps to keep Patient Experience at the top of the Hospitals agenda.

This Quality Report presents a balanced and accurate account of the performance of the Trust over the period 2011/12"

6.8.3 LINks Statements

Local Involvement Network commentary on the Great Western Hospitals NHS Foundation Trust (GWH) draft Quality Account 2011/12
Local Involvement Network (LINks) welcome the opportunity to comment on the draft Quality Account from Great Western Hospital. Swindon has responsibility for co-ordinating responses from other LINks because the Trust's head office is in Swindon. The first draft QA was circulated to LINks in Gloucestershire, Oxfordshire, West Berkshire and Wiltshire. The Trust responded to the initial comments made by LINks and this commentary has been amended accordingly.

Combined LINk comments
In making this composite response we have considered the Department of Health published guidance which includes this statement, "year-round stakeholder engagement during the process of producing

a Quality Account and the opportunity for local scrutiny is seen as an important feature to ensure that Quality Accounts are locally meaningful and reflect local priorities."
There is an expectation that GWH will demonstrate in this QA that patients and the public have been involved in its production. The Chief Executive's statement clarifies this point as does the Governors' statement.

Ruth Lockwood, GWH Associate Director for Quality and Patient Safety attended the October 2011 Swindon LINk steering group to present information to the group about service improvements at GWH mid-year.

Specifically referring to the published draft Quality Account,
The QA appears to reflect the priorities of the local population in broad terms, – patient care, safety, involvement, dignity and nutrition. It was not apparent that any important issues have been missed out. However many of the graphs in the original draft were felt to be confusing particularly with the added dimension of the merger of GWH with WCHS. We understand that the graphs will be clearer in the final version of the QA.

The use of abbreviations and jargon is often a major problem for people not familiar with the language regularly used in health and care services. We hope that some significant editing between draft and final versions will have added to the document's clarity for a wider readership; as will the addition of the glossary.

The three month backlog of data transfer from paper to electronic systems (incident reporting) may cause doubt over the accuracy of some of the other performance data. However we understand from GWH that the backlog should now be in the process of being cleared and that all data is readily available.

We refer to the 2011/12 priority about patient experience "to ensure privacy when discussing treatment and care with patients". People with hearing loss tend to talk and need to listen to people who talk a little louder than normal. We understand that patients are asked if they are happy for their treatment or care to be discussed at the bedside and that they will be moved to a private area if they have concerns about the privacy.

Whilst there are references to end of life care, there are no specific references to the Liverpool Pathway (LCP) being used when appropriate. We understand that the LCP will be included in the 2012/13 QA.

Care Quality Commission (CQC)
We noted in their October 2011 report on Dignity at 100 UK hospitals the CQC reported that they had moderate concerns at GWH. We are pleased to hear that the Annual Report clarifies the position.

Review of Priorities
We are pleased to note that GWH have developed the 2012/13 plan to continue to improve in key patient areas such as falls, ulcer and infection. We also welcome the information that the Trust has considered important patient improvement measures where it is felt there is local need and priority and is including dementia as a key quality measure. This also links with the CQC's quality and risk profile.

Jo Osorio
Swindon LINk development officer josorio@swindon.gov.uk 01793 497777
22 May 2012
/LINk/GWH

6.8.4 Wiltshire Primary Care Trust

NHS Wiltshire, as lead commissioner for Wilshire Community Health Services is pleased to assure the merged Wiltshire Community Health Services second annual Quality Account. The document is clearly presented in the format required by the Department of Health Toolkit and the information it contains accurately represents the Trust's quality profile.

This has been a year of transition for Wiltshire Community Health Services on 1 June 2011 Great Western Hospitals NHS Foundation Trust acquired Wiltshire Community Health Services and became a merged organisation. The Wiltshire Community Health Services have joined the Unscheduled and Community Care directorate, Children's and the Bath Clinical Area Maternity Services have joined the Directorate of Women and Children's Services.

Wiltshire Community Health services provides a range of general and specialist services, and it is right that these services should aspire to make year on year improvements in the standards of care they can achieve. We believe the specific priorities for 2012/13 which the trust has highlighted in the report are appropriate areas to target for continued improvement.

NHS Wiltshire's strategy for improving health and health care services in Wiltshire set out clear priorities for ensuring that wherever possible patients can be looked after in their own home and that they have access to services which offer excellence in terms of clinical outcomes and patient experience. The Quality Account acknowledges the level of the challenge posed in some 2011/12 priorities, particularly in relation to patient falls. We support the Trust's decision to continue to improve patient safety, ensure effective care and continue to improve the patient experience.

We welcome the inclusion of success measures within the Quality Account, providing a gauge upon which service users, carers and commissioners can appraise the Trust's achievements in the coming year. NHS Wiltshire looks forward to continuing to work with Great Western Foundation Trust as they fulfil their commitment to continuously improve the quality of care for our local health service users, their families and carers.

6.8.5 Swindon Primary Care Trust

NHS Swindon as lead commissioner has reviewed GWFT Quality Accounts report for 2011/12. The Quality Accounts were reviewed by the Commissioning for Quality group which includes Clinical Commissioning group representation. NHS Swindon can confirm that, in their view, the Quality Accounts complies with the guidelines for application for the trust QA report.

Commissioners monitor performance and the quality of services routinely each month with the Trust. Commissioners can confirm that, to the best of our knowledge, the Trust QA 2011/12 contains accurate information in relation to the services provided.

The Trust has set their priorities by exploring multiple sources ranging from patient feedback to local intelligence collected via incident reporting and complaints, as well as consulting staff and commissioners. The approach to setting priorities is commended by NHS Swindon and we are happy to endorse the targets that have been set. The monitoring of each priority is deemed to be set at appropriately timed intervals for each priority, allowing a timely response to address issues that may cause the target to be missed.

It is good to see the improvements for quality of end of life care for patients and improve access to palliative care services. NHS Swindon would encourage the further integration and collaboration of health and social care community services as a driver to achieve this improvement.

Overall, the Trust has good plans to improve quality during 2012/13, and with the impending transition from Primary Care Trusts to Clinical Commissioning Groups we look forward to working together to ensure that quality of care and services remains key.

6.9 Independent Assurance Report to the Council of Governors of Great Western Hospitals NHS Foundation Trust on the Annual Quality Report

Independent Auditor's Report to the Council of Governors of Great Western Hospitals NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of Great Western Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Great Western Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2012 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2012 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Clostridium difficile – all cases of Clostridium Difficile positive diarrhoea in patients aged two years or over that are attributed to the Trust and
- 62 Day cancer waits – the percentage of patients treated within 62 days of referral from GP.

We refer to these national priority indicators collectively as the "indicators".

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;
- the Quality Report is not consistent in all material respects with the sources specified below; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports*.

We read the Quality Report and considered whether it addresses the content requirements of the *NHS Foundation Trust Annual Reporting Manual*, and considered the implications for our report if we became aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the sources specified below:

The sources with which we shall be required to form a conclusion as to the consistency of the Quality Report are limited to:

- Board minutes for the period April 2011 to May 2012;
- Papers relating to Quality reported to the Board over the period April 2011 to May 2012;
- Feedback from the Commissioners dated 18 May 2012;
- Feedback from LINKs dated 18 May 2012;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 15 May 2012;
- The national outpatient survey, dated November 2011 and national inpatient survey dated April 2012;
- The national staff survey dated March 2012;
- Care Quality Commission quality and risk profiles dated September 2011 – March 2012;
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 14 May 2012 and
- Feedback from Governors dated 18 May 2012

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents. We refer to those sources, (collectively the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Great Western Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting Great Western Hospitals NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2012, to enable the Council of Governors to demonstrate that is has discharged its governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Great Western Hospitals NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – "Assurance Engagements other than Audits or Reviews of Historical Financial Information" issued by the International Auditing and Assurance Standards Board ("ISAE 3000"). Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- Making enquiries of management;
- Testing key management controls;
- Analytical procedures;
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- Comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* to the categories reported in the Quality Report; and
- Reading the documents.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual.*

The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts/organisations/entities. In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Great Western Hospitals NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2012:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;
- the Quality Report is not consistent in all material respects with the sources specified above; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports.*

KPMG LLP

KPMG LLP, Statutory Auditor

100 Temple Street
Bristol
BS1 6AG

29 May 2012

7 SUSTAINABILITY REPORTING

7.1 Strong focus on sustainability

The Great Western Hospitals NHS Foundation Trust recognises that there are many benefits of having a strong focus on all aspects of sustainability, which means we continue to meet the needs of the present without compromising the needs of future generations. There are short, medium and long term advantages to making sure that we are able to continue to provide healthcare of the highest standard in a sustainable way.

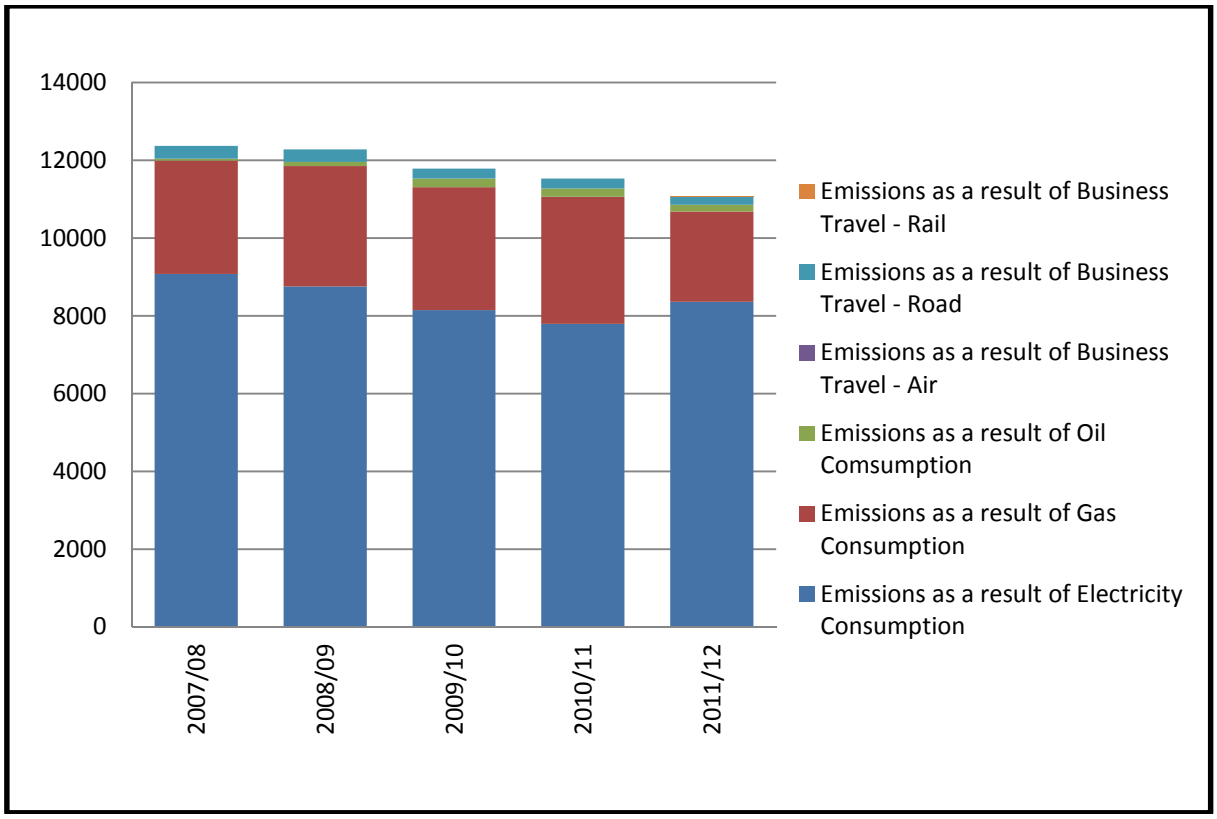
In June 2011 the Great Western Hospitals NHS Foundation Trust merged with Wiltshire Community Health Services (WCHS), to form a much larger Trust. As part of the merger the Trust took over responsibility for several properties and services previously managed by WCHS. Since the merger planned closures of two health centres have been completed and admin services being centralised ending the lease on a further two buildings. Through out this report information is shown separately for the Great Western Hospital and WCHS. WCHS data for previous years has been taken from estate reports, but it could not be verified. In next year's report the data for 2011/12 will be combined so that a clear comparison on performance can be shown. Where possible the WCHS data has been benchmarked as changes in the organisation make direct comparisons difficult.

7.2 Energy

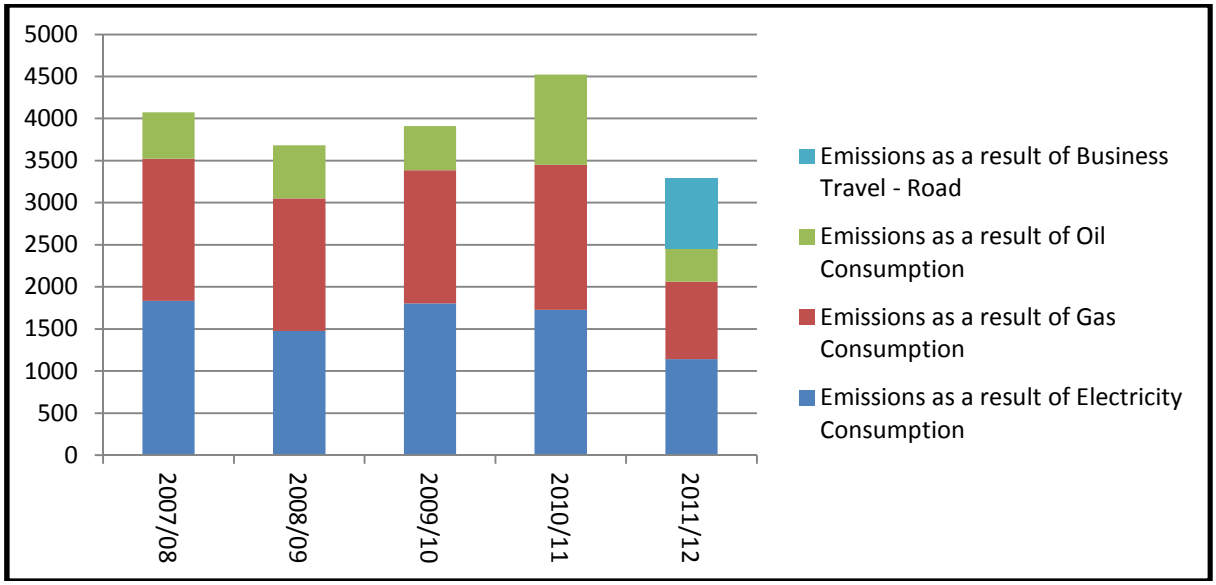
Carbon reduction is one area where the Trust has specific targets that it is required to achieve. The target being focused on currently is achieving a 10% reduction in CO_2e emissions from a 2007 baseline by 2015. Achieving this target will assist the NHS as a whole with reaching the overall target of reducing 80% CO_2e emission by 2050. These targets are tough and require careful management if we are to achieve our share of reductions. However, there are very good business reasons to undertake our activities in a sustainable way. Reduction in unnecessary consumption almost always means reduced costs and management. This in turn means that the Trust can dedicate more time and resources on frontline patient care.

Graphs 1 and 2 show the total measured emissions produced by each organisation. At GWH carbon emissions from air and rail travel have only been measured in 2011/12, this information is not available in WCHS. Mechanisms are being put in place to capture all staff business travel to increase the accuracy of scope 2 emissions data next year. At present there is no mechanisms for measuring or controlling emissions from scope 3 activities, however, as part of our focus on carbon we are committed to reducing the wider environmental and social impacts associated with the procurement of goods and services. Part of our sustainability procurement policy will outline how the Trust will start to work with suppliers and other third parties to assist with reducing these emissions.

Graph 1 – GWH carbon footprint (tonnes of Carbon Dioxide equivalent)

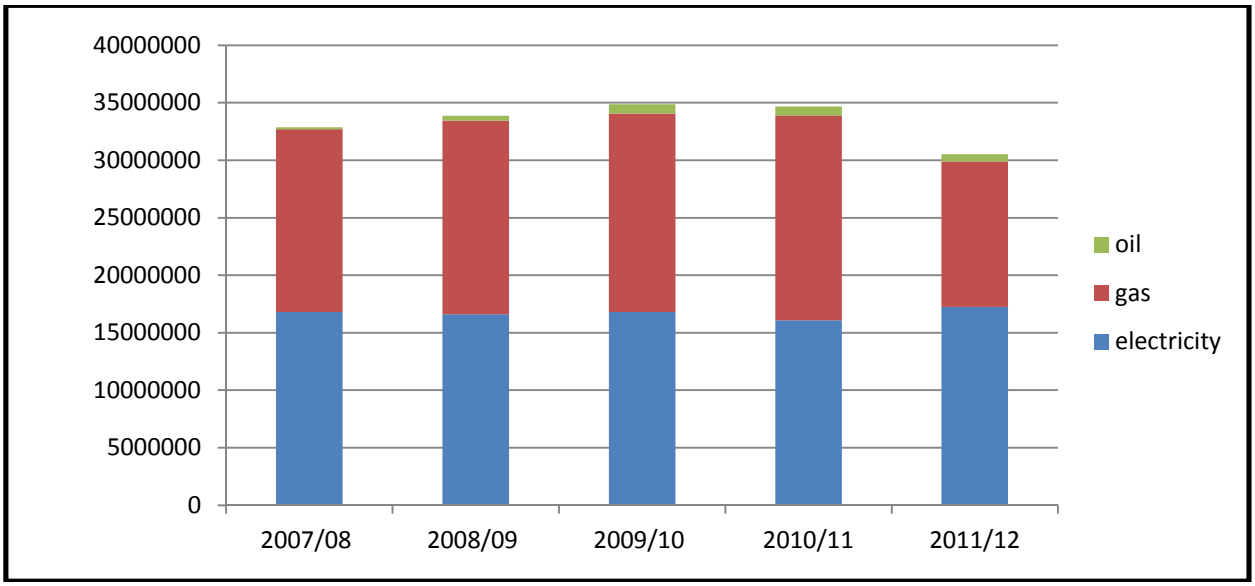


Graph 2 – WCHS carbon footprint (tonnes of carbon dioxide equivalent)

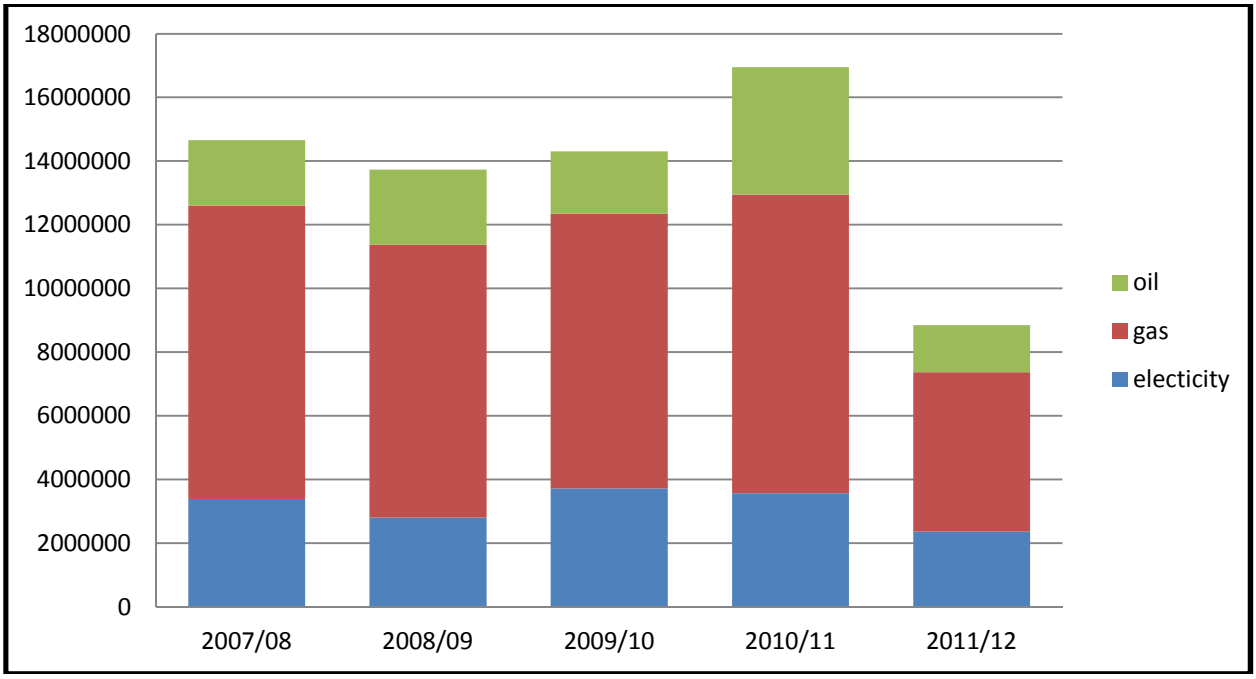


Graphs 3 and 4 show energy consumption in kwH at the Great Western Hospital and WCHS sites since 2007/08 respectively. Spend on energy has reduced in Wiltshire with the closure of buildings, but increased at the Great Western Hospital in this financial year. The reason for this is being investigated at the moment, but is likely to be due in part to increasing the amount of cardiac diagnostic equipment. Over the next year the Trust has plans to spend over £330,000 on capital schemes that will continue to reduce the amount of energy being consumed. Other projects such as LED lighting is being considered on all sites and smaller more visible changes such as the installation of PIR light switches in offices and store rooms has continued.

Graph 3 – Energy consumption at GWH in KwH



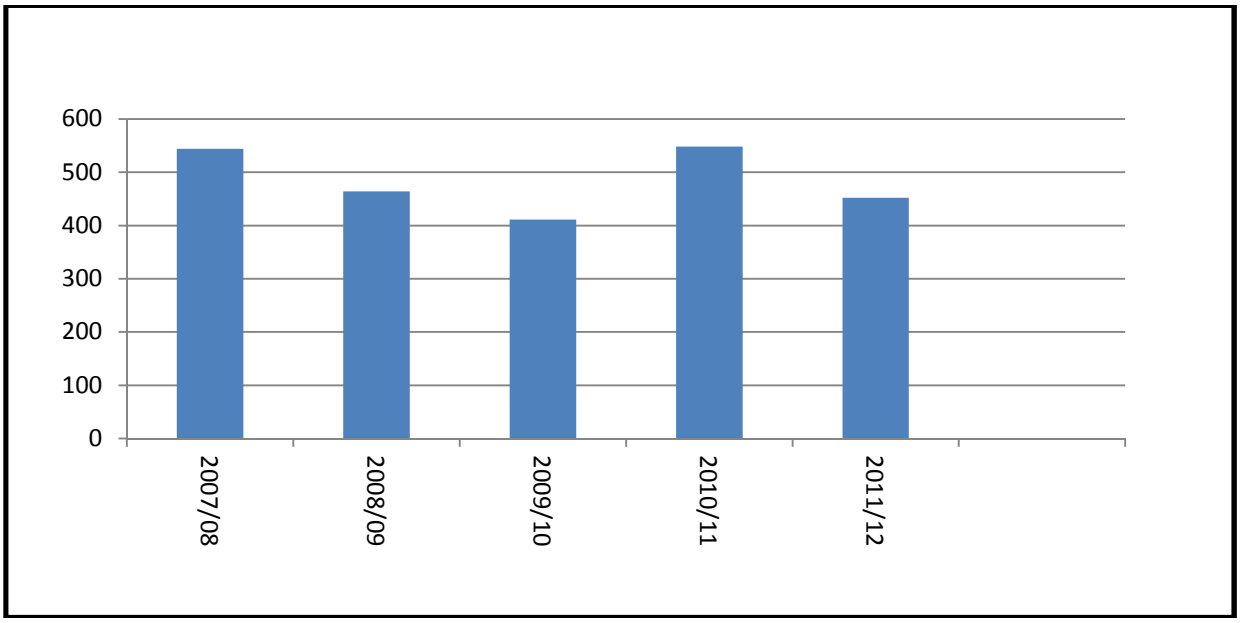
Graph 4 – Energy consumption by WCHS (KwH)



The Trust is working with local businesses and the Borough Council in Swindon to review the installation of CHP plants on site. This would if successfully built, help increase the Trust's energy security with on site generation and would allow the Trust to use renewable energy sources.

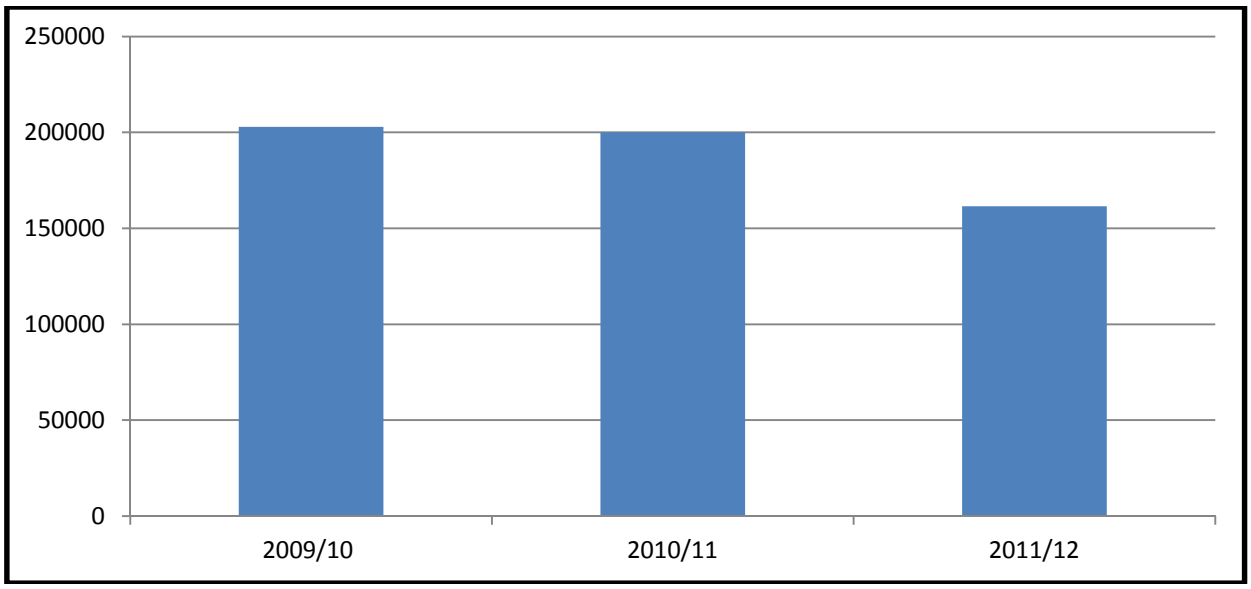
From 2007 to the present the occupied floor area at the Great Western Hospital has remained nominally static. Wards and other areas have been closed for short periods of time for redecoration or refurbishment only. In WCHS the occupied floor area has altered significantly over the same period. Graph 5 shows total energy consumption in kwH/occupied floor space in m^2 for WCHS.

Graph 5 – Energy Intensity (kwH/occupied floor area m^2)

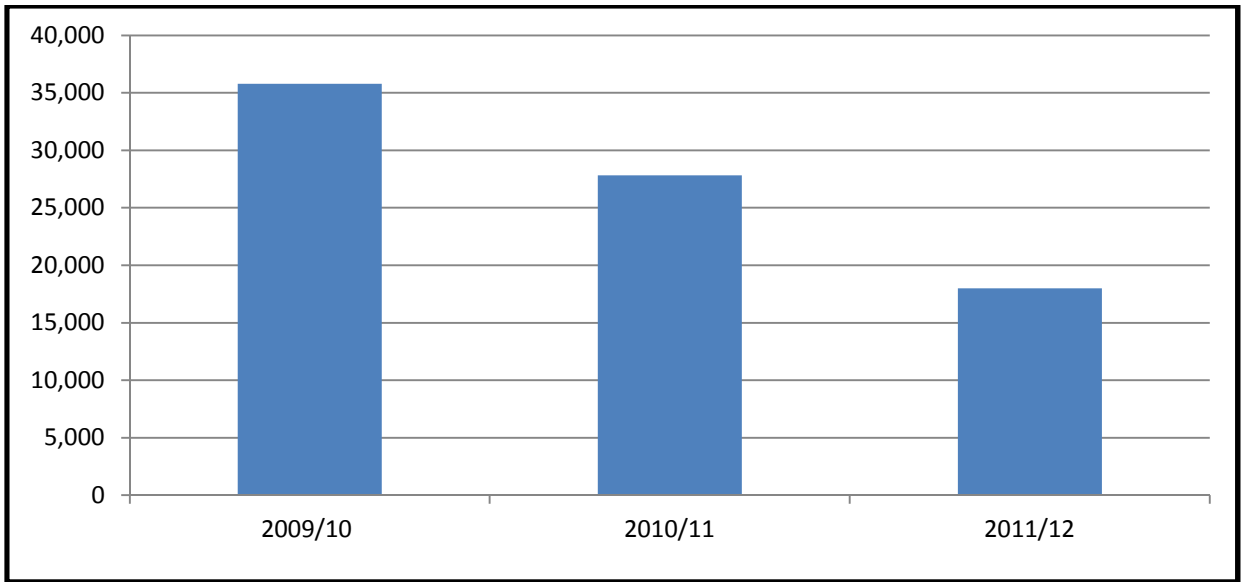


In the reporting period water usage has decreased by 16 percent at the GWH and 36 percent at WCHS from 2010/11. Graphs 6 and 7 show GWH and WCHS water consumption figures for the last three years respectively.

Graph 6 – Water consumption at GWH (m^3)



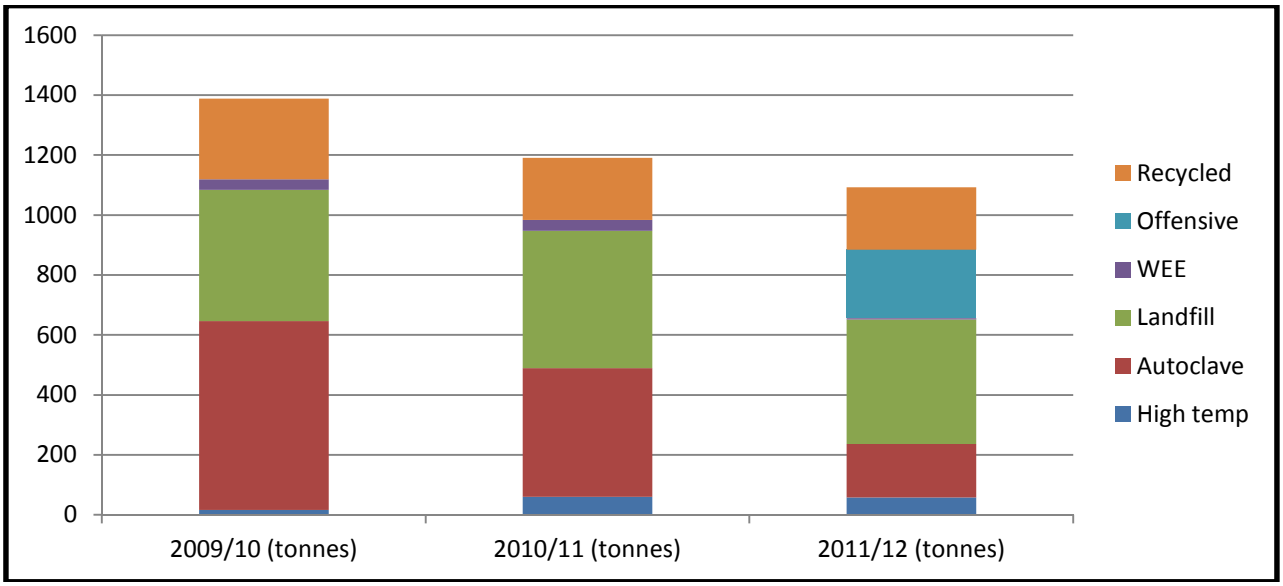
Graph 7 – Water consumption in WCHS (m^3)



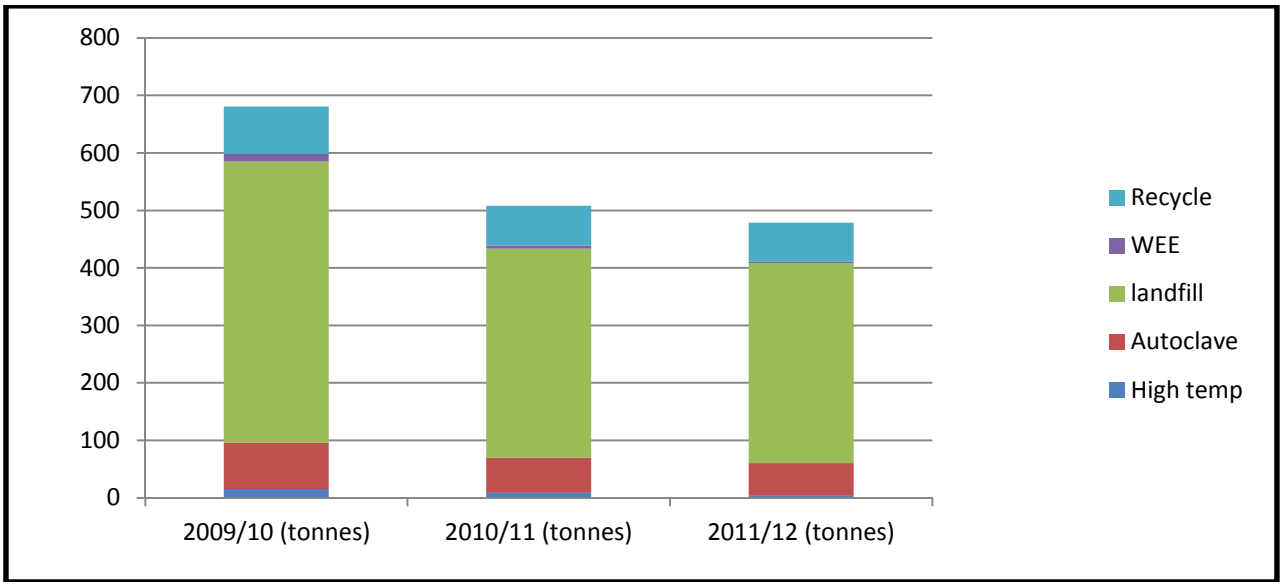
7.3 Waste

The weight of waste produced at GWH has decreased by 11% in 2011/12 from 2010/11. At WCHS sites the total weight of waste produced decrease by 6%. At GWH an offensive waste stream has been introduced and this waste is being sent to energy from waste plant for disposal. To date this by-product of the Trust's activities has produced 150990 kwH of electricity. In 2010/11 this waste was reported as landfill waste, but has been separated out in 2011/12 figures. On top of this 23% and 15% of the waste generated at GWH and WCHS properties respectively was sent for recycling in this financial year.

Graph 8 – Total tonnes of waste produced at GWH (tonnes)



Graph 9 – Total tonnes of waste produced by WCHS (tonnes)



The NHS Carbon Reduction Strategy requires all Trusts to have a board approved Sustainable Development Management Plan (SDMP). Our plan is due to go to the Board for approval early in financial year 2012/13. Once approved, a Sustainability Forum will be established to be chaired by the Director of Finance who has board level responsibility for sustainability. The Sustainability Forum will monitor the SDMP and ensures that the Trust fulfils its commitment to conducting all aspects of our activities with due consideration to sustainability, whilst providing high quality patient care. A board level lead for Sustainability ensures that issues have visibility and ownership at the highest level of the organisation.

The Trust has a statutory duty to assess the risks posed by climate change, and these are on the risk register. The Trust is also aware of the potential need to adapt the buildings and services to reflect changes in climate and illnesses in our locality.

A sustainable NHS can only be delivered through the efforts of all staff. Staff training is on going on all Trust sites. As part of the Trust's action for Sustainability Awareness day department managers were asked to participate in an energy audit for their area. This served to highlight equipment that could be switched off and increased awareness of usage. A smaller number of staff took part in a Good Corporate Citizen Workshop in September, where they evaluated the Trust's sustainability performance in six key areas against NHS targets. In three out of the six areas discussed the Trust was exceeding the 2012 target of having a minimum score of 37%. Another workshop will be held in the following year to ensure that this target is met across all six areas and that the Trust is on track to achieve 70% compliance by 2015.

Staff at GWH have changed their travel patterns and significantly reduced the number of commuting miles that are driven each day by staff, by increasing car sharing and decreasing car dependence. This in turn reduces the impact of the hospital activities on local air quality and greenhouse gas emissions, so it is important. This was part of the GWH sustainable transport plan, which is now being considered in WCHS. The Trust is also keen to work with other transport providers such as Great Western Ambulance Service to reduce the miles driven.

8 EQUALITY REPORTING

8.1 Equality duty

The Trust uses the Equality and Diversity System to help ensure the requirements of the public sector Equality Duty are met and that the Trust delivers services that are personal, fair and diverse.

The Equality and Diversity System (EDS) covers 18 outcomes grouped in to 4 objectives:

1. Better health outcomes for all
2. Improved patient access and experience
3. Empowered, engaged and included staff
4. Inclusive leadership

Guidance published by the Equality and Human Rights Commission states that public authorities must:

- Prepare and publish one or more objectives they think they should achieve to do any of the things mentioned in the aims of the general equality duty by 6th April 2012 and at least every 4 years thereafter.
- Ensure that those objectives are specific and measurable.
- Publish those objectives in such a manner that they are accessible to the public.

8.2 Our equality and diversity objectives

In 2012/13 the Trust will be working towards the following objectives to enhance equality and diversity across the Trust: -

Objectives
The Trust will develop positive attitudes towards equality and diversity by training and developing, Associate Medical Directors, General Managers, Matrons, Deputy General Managers and Ward Sister/Charge Nurses. Success will be measured through a baseline questionnaire pre programme and repeated post programme. Improvement will be fed back at the end of year 1 and areas for further work identified leading to a year 2 / phase 2 programme. This will be a joint venture working with the Royal College of Nursing with the intention of publishing the work so that best practice can be shared across the NHS.
The Trust will identify an EDS data set for patients and staff by the end of July 2012. Data collection will commence from September 2012 and analysed in March 2012 in order to inform 2013 / 2014 business planning process. EDS business planning objectives will be set by each Directorate for year 2013.
The Trust will complete its participation in a National Research Project identifying good and poor practice for people with learning difficulties in Acute Trusts by October 2012. The Trust will implement the research recommendation in 2013 once the research results are published.

The Trust will be working towards achieving these objectives over the next three years and will be reviewing our progress in this area annually. The Trust will publish updated objectives every three years to take into account changes in practice.

8.3 Policies for potential and existing disabled employees

The Trust has signed up to the national "two tick" symbol and supports the recruitment and development of disabled candidates/employees. The Trust interviews all disabled applicants who meet the minimum criteria for a job vacancy and to consider them on their abilities. The Trust makes every effort when employees become disabled to make sure they stay in Employment. HR works with Occupational Health to seek appropriate roles for staff following a change in circumstances. For staff that become disabled whilst in our employment, the Trust actively works with the Occupational Health Team to make reasonable adjustments to enable the member of staff to continue their employment with the Trust.

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

9 STAFF SURVEY REPORT

9.1 Our staff

The Trust is committed to being an exemplar employer and strives to ensure that all employees reach their full potential at work. We have also focused on ensuring that our staff have the right knowledge and skills to provide high standards of care to our patients and their carers but also the right behaviours so that we work as an effective team to get things done.

We have also been working towards improving how we recognise the hard work, loyalty, commitment and successes of our workforce and have put in place a number of mechanisms such as a monthly and annual award scheme as part of our strategy.

Our average headcount for 2011/12 was 4,800. This equated to an average whole time equivalent of 3,911.33. For the two months prior to the June merger our average was 3,332 staff (2,756.64 wte) and for the 10 months after the merger, our average was 5,094 staff (4,142.27 wte).

9.2 Staff satisfaction

It is recognised across the NHS that a more satisfied workforce provides better patient care and the Trust places a great deal of emphasis on exploring ways to improve and enhance motivation and morale so that staff are satisfied in their work. To help the Trust understand how staff are feeling, the results of the annual staff survey commissioned by the Care Quality Commission are examined to identify any areas for improvement.

In 2011, the Trust transferred 1,900 staff from Wiltshire Community Health Services, consequently the sample included employees who would have not worked for the Great Western Hospitals Foundation Trust the previous year. The transition and integration took a considerable amount of focus and it is positive to note that staff motivation at work increased over the previous year's results despite the organisational changes. The Trust is now in the best 20% for all acute trusts for staff motivation.

Our staff scores place the Trust as fifth across 20 Acute Trusts in the South West of England.

The 2011 survey results show that staff experience has improved in the following areas:-

- Staff motivation at work
- The percentage of staff agreeing that their role makes a difference to patients
- The percentage of staff experiencing discrimination at work in the last 12 months

Staff have reported no areas of deterioration since 2010.

Overall, the Trust is measured against the four staff pledges from the NHS Constitution with an additional theme of staff satisfaction. These indicators break down into 38 key findings and results show that GWH has improved on 4 key finding areas since 2010 and is average or above average for 31 areas as benchmarked against other Trusts. However, there are seven key findings areas where the Trust is below average. Last year we were below average in nine areas.

Detailed below is a summary of the Staff Survey scores for 2011 alongside the equivalent scores from the 2010 survey. Full details of the survey can be found on the Care Quality Commission website at www.cqc.org.uk.

9.3 Summary of staff survey results

	2010	2010	2011	2011	Improvement / Deterioration
	Trust	National Average	Trust	National Average	
Response rate	59%	51%	66%	53%	7% improvement
Top 4 ranking scores					
KF 23. Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months	8%	8%	4%	8%	4% improvement
KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	13%	15%	10%	15%	3% improvement
KF 16. Percentage of staff receiving health and safety training in last 12 months	92%	80%	92%	81%	No change
KF 38. Percentage of staff experiencing discrimination at work in last 12 months	13%	13%	9%	13%	4% improvement
Bottom 4 ranking scores					
KF 13. Percentage of staff having well structured appraisals in last 12 months	34%	33%	31%	34%	No change
KF 8. Percentage of staff working extra hours	70%	66%	68%	66%	2% improvement
KF 14. Percentage of staff appraised with personal development plans in last 12 months	66%	66%	66%	68%	No change
KF 10. Percentage of staff feeling there are good opportunities to develop their potential at work	39%	41%	37%	40%	2% deterioration

Following this year's staff survey results, the Trust received a presentation from Quality Health so that we could determine which areas to focus our efforts to sustain improvement for our workforce.

It was agreed that we would focus on improving the appraisal rates so that more staff reported receiving a well structured effective appraisal. A new policy and process with relevant training for line managers will be introduced over the course of the year.

It was also agreed that we could improve our staff's confidence so that they feel satisfied with the quality of work and patient care they are able to deliver. We will do this by reviewing how we design our jobs and teams and ensuring that improving patient experience is at the core of our actions.

We are also investing in improving our management capability so that our managers are well equipped to support staff through change as we improve pathways and efficiencies in the way we work.

The Trust is focussing on improving staff feedback through questionnaires and workshops, the results of which will be analysed and reported through the Executive Committee which will monitor performance.

9.4 Staff consultation and engagement / other consultations

The GWH has a strong relationship with the Employee Partnership Forum (EPF) and work on integration with the Wiltshire Workforce Partnership forum started in January 2011, so that a new agreement was in place and joint meetings being held from June 2011. All major change papers that affect organisational structures are presented to this forum before the organisation starts consultation, an example of the effectiveness of the process is that we have no appeals or employment tribunal claims as a result of the Corporate Back Office re-structure programme which was implemented in the last quarter of 2011.

During 2011 we introduced new organisation values. These are Service, Teamwork, Ambition and Respect (STAR). These values were launched with a series of road shows across our different localities. The Values have been embedded into the new annual recognition programme and monthly STAR awards. They have also been used to support recruitment decisions.

In October 2011, our new Chief Executive, Nerissa Vaughan joined the Trust. As part of her induction to the Trust she carried out a series of meetings to meet the staff. A feedback process called 'Ask Nerissa' was also established to enable staff to email her directly about their concerns and questions on issues affecting them.

In addition to the Staff survey feedback, in early 2012 the Trust asked for feedback in the form of a questionnaire from key employees involved in the pre and post transition phase and a workshop was held, facilitated by NHS Elect to understand what went well and what could have been done differently. A feedback questionnaire has also been designed which will go out to the wider community to understand key issues around the transition and what improvements can be introduced.

9.5 Communicating with staff

Since 2010 a range of new channels have been introduced to strengthen communication between senior management and Trust staff:

- Over the past year the Trust has built on the success of quarterly magazine Horizon by providing space for regular features on different areas within the organisation and highlighting the achievements of staff including educational attainment and awards. The magazine continues to be well read and its readership has grown since the launch and the merger with

Wiltshire Community Health Services. In each issue the Trust ensures there is a wide selection of features from across the Trust providing representation from both the acute and community settings. The magazine also provides a good source of news items for the local media.

- Launching the new Trust Intranet in February 2012 will provide greater opportunities to reach staff across the newly enlarged organisation. For the first time since the merger in June 2011, the Trust has a single intranet providing an accurate and timely source of information across the various departments and empowering staff to take control of their own areas of the site to share information with colleagues. The new intranet will feature web chat and video podcasts in the future to provide important information in a more easily digestible format.

- Establishing an 'Ask the Chief Executive' email address to provide an opportunity for staff to raise issues directly with Nerissa Vaughan and to receive a response direct.

- Hosting a number of Chief Executive 'road shows' across the Trust to provide staff with an opportunity to meet the new Chief Executive and ask questions. These events included sessions at a number of the community sites across Wiltshire. In addition a number of road shows were held to launch the Trust STAR values over the summer.

- The monthly Team Brief continues to be used as a key source of information for staff offering the Chief Executive's personal view on issues affecting the Trust. The Team Brief has grown to be a trusted source of information and we continue to look at ways to increase its readership.

For 2012/13 an updated internal communication plan has been developed which takes into account the enlarged organisation and aims to strengthen the channels the Trust already has in place for communicating with staff. Underpinning the plan will be a drive to improve some of the key scores in the latest staff survey. An internal communications staff survey will also be carried out to ensure we can measure the impact of the various mechanisms in place and make adjustments accordingly.

9.6 Workforce Key performance indicators (KPI's)

The Trust has a range of workforce KPI's which are monitored to understand the organisation's performance.

Sickness absence. The upper threshold for sickness absence was set at 3.5% for 2011/12 a 0.5% reduction on 2010/11. The sickness statistics are only available 6 weeks after the end of the month. The latest figures available are for January when the rolling 12 month total was 3.42%. This equates to 32860 days lost to the Trust. 3.42% absence represents an improvement for GWH and benchmarks well across the NHS.

Turnover. Voluntary turnover at the end of January was 8.92%. This has been increasing slightly due to the impact of the transition of WCHS on the data.

Vacancy levels. The difference between the budgeted headcount and actual in post is 7.62%, although the actual vacancies that we are recruiting to is 2.35% of our headcount. Some recruitment is being held in order to re-deploy clinical and non-clinical staff following on from bed re-configuration plans and other changes.

Appraisal rates. The overall rate for the Trust is 69.58%. The staff survey has highlighted a number of issues relating to appraisals. At present there are two different systems from GWH and Wiltshire Community Health Services. During 2012 we will be implementing a new process which will provide a clear link between the Trust's strategy and individual performance.

9.7 Workforce Development

The Trust continues to encourage and support staff with their development, placing emphasis on the safety of staff and service users. The Academy has been innovative in developing successful strategies to encourage staff to engage with mandatory elements of training, this has now been extended to reflect the changing age profile of service users and to embrace the needs to community services. During 2011-2012 the Academy has developed and delivered 24 clinical and non clinical mandatory training modules in consultation across the community and the acute settings and has developed a Training need analyses for all staff members enabling accurate capture of training statistics on ESR.

The Academy has extended its excellent training facilities in 2011. Not only does it boast an excellent suites of seminar rooms and lecture facilities in Swindon but has extended across the Wiltshire area improving facilities in Warminster and opening new, fully equipped training rooms at Chippenham and Savernake Hospitals.

Our Aim is to support the current and future workforce of all disciplines to gain knowledge, skills and understanding which will enable them to deliver empathetic care of the highest quality to our service users, now and in the future. The Academy listens to feedback from service users and inspectors and firmly links educational aims to service delivery, striving for excellence in both delivery of clinical care and overall patient experience.

The Academy has focussed on a number of improvements to education and development opportunities available for staff including:

- the course portfolio has been expanded to offer a wider range of clinical skills, suprapubic catheter care, 'in depth' infection control, and new pressure area courses;
- a range of new regional study days have been developed and delivered to prepare our staff new future challenges in healthcare including dementia, discharge planning, practical bariatric care and dignity;
- The successful development of support staff via new QCF, BTEC, Apprenticeships and NVQ qualifications has allowed development of unregistered role models who can deliver a more responsive service.
- All courses are reviewed twice annually against local and national benchmarks. Content and delivery are scrutinised by educational and subject experts to ensure relevance and quality.
- Learner experiences are continually measured after an educational event and to identify the impact of any education once they have returned to a service area. This feedback and that of the service user is used to inform future educational approaches.

Work continues to strengthen the education of junior doctors with the Postgraduate team securing agreement with the Deanery to provide and run additional courses with a GWH based Medical Ethics course attended by medical staff from across the UK.

The Academy continues to support our future workforce; the Academy recently reviewed and coordinated an audit from the SW SHA to determine whether their KPIs for healthcare professional programmes into the region has been met by both the University and the Trust as practice placement

providers. Feedback obtained across 12 different professions indicates good practice in student preparation within the Rust and local HEIs.

Experience support staff in acute and community settings were supported to successfully complete the Foundation Degree in Health and Social Care. The knowledge, skills and attitudes acquired allowed service areas to reassess the traditional staff skills mix to ensure service delivery which is responsive and flexible as well as producing role models for our students and support staff.

Research and Development throughout the Trust has developed well this year with increased recruitment into more complex studies with commercial research projects increasing from 100% to 8 with a further 4 within the set up process.

Generation of income from education clinical skills and resuscitation courses that can be reinvested within the Trust will be in excess of £120k this year and demonstrates the growth in Trust profile attracting nationally renowned keynote speakers such as Christine Beasley (Chief Nursing Officer).

Focussed customer service training for the Diagnostics and Outpatient directorate demonstrated fall in service user complaints in 2011 from January to March where 7 complaints were received to April to June where 3 complaints were received.

Undergraduate medical training provision has expanded this year to include 2nd years students from Bristol University. The faculty has expanded to support this with additional educational supervisor posts to deliver the expanding requirements of undergraduate curriculum, ensuring the quality of our future workforce.

9.8 Supporting our volunteers

The Great Western Hospital's Foundation Trust is extremely fortunate to have so many committed and enthusiastic volunteers. Each provides an extremely valuable service to patients and enormous support to staff. They form an essential part of the hospital team and are greatly appreciated.

For many, volunteering is a step on the ladder to employment; an opportunity to experience the hospital environment before going to University or having the courage to leave their current employment to follow a long held dream of working in the NHS. Of course, many of our volunteers stay with us for years with some having 5, 10, 15, 20 and even 25 years or more voluntary service and each volunteer has their own personal reason for offering their time.

There remains a constant interest in "volunteering within the Great Western Hospital", with an average of 40 enquiries received each month. Volunteers come through the same recruitment process as a member of staff. They are interviewed by the Voluntary Services Manager, have to have two references, Occupational Health and CRB clearance and then meet the relevant Placement Area Manager before attending the Trust induction and any other relevant training e.g. assisting patients at mealtimes and bed making. This process can often take up to three months to complete.

In addition, there is the opportunity to volunteer at the hospital via other organisations, such as British Red Cross, Hospital Radio, WRVS and the Friends of Savernake Hospital & Community.

Volunteers are called the Voluntary Services TEAM because with their assistance "**T**ogether **E**veryone **A**chieves **M**ore". Our volunteers now wear teal coloured polo shirts (with the exception of Chaplaincy Volunteers, Cancer Information Point and also Breastfeeding Support volunteers who wear lavender) which makes them stand out in their own right as a team within the hospital.

A quarterly “Voluntary Service Matters” newsletter is sent to all volunteers and twice a year we hold “Volunteer Social Events” (including Long Service Awards) to ensure that the volunteers are well communicated with and have an opportunity to share their ideas with us too.

Volunteer numbers			**Trust volunteer demographics**
We currently have **538** volunteers			22% Male 78% Female
389 **82** **30** **21** **16**	Trust Volunteers WRVS Volunteers Hospital Radio Volunteers British Red Cross Volunteers Friends of Savernake Hospital & Community	72% 15% 6% 4% 3%	18% of our volunteers are aged between 17-25, 31% of our volunteers are aged between 26-60, 46% of our volunteers are aged between 61-80, 5% of our volunteers are aged over 80.

9.8.1 Number of hours volunteered by Trust volunteers

During 2011/2012 (April ’11 to January ’12) our GWH based Trust volunteers helped us for 20,550 hours. This equates to an average of 2283 hours per month and 61 full time equivalent members of staff per month. This is an approximate 11% increase on the same period in the previous year.

In total, 3 volunteer leavers secured permanent roles as paid members of staff in the Trust, 1 as a Nursing Auxiliary and two as Bio Medical Scientists.

9.9 Occupational Health

The Occupational Health Department welcomed the introduction of the National Occupational Health Standards for Accreditation, published 2010, and is now working towards full accreditation by summer 2012.

The Boorman Review, published during 2009, which showed that being proactive and putting in place preventative measures will yield considerable benefits for individuals and for patients continues to be one of the main drivers for OH activity and during 2011/12 has seen the implementation of the Health & Wellbeing programme which is a new and innovative service, offered to all employees. This enables every member of staff to have an assessment to look at all aspects of their health and lifestyle and specialist advice is offered to design a bespoke programme to make changes which will improve and enhance their health and wellbeing both at work and at home.

The Occupational Health department continues to work closely with managers and HR to reduce time lost due to sickness absence. The two key areas that have been addressed are Musculoskeletal Disorder (MSD) issues and reducing stress related absence.

The Occupational Health team now has an OH nurse advisor who is also a Registered Mental Health Nurse. This nurse complements the nurses already in post who can offer Cognitive Behavioural Therapy, and also works alongside the Staff Support Service, who offer the full range of counselling and support therapies.

The Musculoskeletal Disorder team and the Occupational Health team including physiotherapy input have worked closely together to carry out workplace assessments along with early intervention treatment.

Over the past 12 months there has been a very clear correlation between the number of referrals received within Occupational Health from line managers and the number of staff off sick. For example in December there was a dramatic fall in referrals and a marked increase in sickness absence, compared to January, where there was a high number of OH interventions and a noted fall in sickness absence numbers.

9.10 Swine / Seasonal Flu Vaccinations

The seasonal Flu campaign obtained a 26% uptake across the Trust in 2010, but, with recent national media coverage featuring the Chief Medical Officer at the Department of Health 2011 resulted in 39.5%.

9.11 Health and Safety

During 2011 we commenced implementation of a suitable safety management system throughout the combined geographical area. Notable improvements are already being appreciated by staff, visitors and patients across the enlarged trust and a new governance structure has been implemented with monitoring via the Trust and Wiltshire Health and Safety Committees and regular progress reports to the Executive Committee.

Major targeted improvements have included:

- Implementation of new Safeguard Incident Management system across Wiltshire and commencement of an electronic incident reporting process across all sites within the enlarged Trust to speed up and improve quality of reports and investigations.

- Roll out of a comprehensive H&S Audit programme across all Wiltshire sites to benchmark current compliance with legal / Policy H&S requirements and to provide clear improvement advice to all departmental managers.

- Fire safety management improvements in reducing unwanted fire signals at GWH from 35 last year to 22 [against a target threshold of 32] in partnership with Carillion and also providing a comprehensive fire safety warden structure and training programme throughout the enlarged trust.
- Sustained performance in serious RIDDOR reportable accidents for GWH which remain at 9 for the year and introduction of a centralised RIDDOR reporting requirement across Wiltshire instead of manager self reporting. This has resulted in 7 RIDDOR incidents being reported by the H&S Department from Wiltshire over the past year.
- Introduction of a comprehensive H&S Representative training programme for the newly appointed department Reps and Department Managers throughout the Wiltshire sites.
- Amalgamation of Wiltshire and GWH Policies and procedures accessible via a new versatile H&S Intranet web page.

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

10 REGULATORY RATINGS REPORT

10.1 Monitor the Independent Regulator

As a Foundation Trust, GWH is regulated by Monitor, the independent regulator of all NHS Foundation Trusts. Monitor's relationship with GWH is to ensure that the Trust does not breach the terms of its authorisation which were agreed when GWH became a Foundation Trust in December 2008. The Terms of Authorisation are a set of detailed requirements covering how GWH will operate – in summary they include:

- the general requirement to operate effectively, efficiently and economically;
- requirements to meet healthcare targets and national standards; and
- the requirement to cooperate with other NHS organisations.

Monitor requires each Foundation Trust board to submit an annual plan, quarterly and ad hoc reports. Performance is monitored against these plans to identify where potential and actual problems might arise. Monitor publishes quarterly and annual reports on these submissions and assigns each Foundation Trust with an annual and quarterly risk rating. These risk ratings are designed to indicate the risk of a failure to comply with the terms of authorisation. Monitor publishes three risk ratings for each NHS Foundation Trust as follows: -

- financial rating; and
- governance risk rating.

The future role of Monitor and the regulatory regime is changing in light of new legislation. Providers of healthcare services will be licensed and Monitor will ensure that providers comply with licensing conditions.

10.2 Risk ratings from Monitor

10.2.1 Financial risk rating

The Trust has been rated as 3 for Finance (rated range from 1-5, where 1 represents the highest risk and 5 the lowest). This means that there are regulatory concerns in one or more components but significant breach is unlikely.

When assessing financial risk, Monitor will assign quarterly and annual risk ratings using a system which looks at four criteria, namely achievement of plan; underlying performance; financial efficiency; and liquidity.

The risk rating is forward-looking and is intended to reflect the likelihood of an actual or potential financial breach of the Foundation Trust's terms of authorisation.

10.2.2 Governance risk rating

The term governance is used to describe the effectiveness of an NHS Foundation Trust's leadership. The Trust has a rating of green for Governance (rating range from red, amber-red, amber-green, green with green being the best). A green rating means there are no material concerns surrounding the terms of Authorisation.

When assessing the annual and quarterly governance risk ratings Monitor considers the legality of the constitution; growing a representative membership; appropriate board roles and structures; xo-operation with NHS bodies and local authorities; clinical quality; service performance (healthcare targets and standards); and other risk management processes.

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

10.2.3 Mandatory services

Mandatory services are defined in a Foundation Trust's terms of authorisation and are the services the Trust is contracted to supply to its commissioners.

Trust Boards are required to provide a board statement certifying that they expect to be able to continue to provide the mandatory services required by Schedules 2 and 3 of their Authorisation and then by exception to declare in year if this risks not being the case. During 2011/12 no such declarations were made.

10.3 Risk Ratings 2011/12

10.3.1 Summary of rating performance throughout the year and comparison to prior year with analysis of actual quarterly rating performance compared with expectation in the annual plan and comparison to prior year

	Annual Plan 2010-11	Q1 2010-11	Q2 2010-11	Q3 2010-11	Q4 2010-11
Financial Risk Rating	**4**	3	3	3	3
Governance Risk rating	**Green**	Green	Green	Green	Green

	Annual Plan 2011/12	Q1 2011-12	Q2 2011-12	Q3 2011-12	Q4 2011-12
Financial Risk Rating	**3**	3	3	3	3
Governance Risk rating	**Amber Green**	Green	Green	Amber Red	Green

10.3.2 Explanation for differences in actual performance versus expected performance at the time of the annual risk assessment

Two CQC Outcome compliance risks were reported by the CQC in January 2012. These risks related to Outcomes 4 and 5 (Care and Welfare of people who use services and meeting nutritional needs). Since this time, the Trust has implemented and audited actions plans to ensure compliance is observed. The CQC was advised by the Trust that is compliant with these Outcomes as from 30th April 2012.

10.3.3 Details and actions from any formal interventions.

The Trust had no formal interventions during 2011/12.

10.4 The Care Quality Commission (CQC – formerly the Healthcare Commission)

Whereas Monitor's role is to assess and regulate the ability of an NHS Foundation Trust board to do their job properly and ensure their hospitals provide high quality care, the Care Quality Commission (CQC) is the independent regulator responsible for regulating the quality of health and adult social care services in England.

There are Core Standards which the Trust must comply with and which the Care Quality Commission periodically reviews the Trust against. These standards cover the full range of healthcare services and provide the general public with information on the quality of services provided by the Trust.

10.4.1 Care Quality Commission (CQC) registration

Health and social care organisations are required to register with the CQC through a registration system. This process is, in effect, a licence for Trusts like GWH to provide services.

To be registered, trusts must meet the standards, which cover important issues for patients such as treating people with respect; involving them in decisions about care; keeping clinical areas clean, and ensuring services are safe.

To register with the CQC the Trust has had to demonstrate that it meets the essential standards of quality and safety across all services being provided.

In March 2010 GWH was registered with the CQC without additional conditions attached to the registration.

11 OTHER DISCLOSURES IN PUBLIC INTEREST

11.1 Cost allocation and charging requirements

The Trust has complied with the cost allocation and charging requirement set out in HM Treasury and Office of Public Sector Information Guidance.

11.2 Serious incidents involving data loss or confidentiality breach

During 2011/12 there were no serious incidents involving data loss or confidentiality breach classified at a severity rating of 3-5. Accordingly, no incidents were required to be reported to the Information Commissioner's Office.

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

Summary of other personal data related incidents in 2011/12		
Category	**Nature of incident**	**Total**
I	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	0
II	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	0
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	0
IV	Unauthorised disclosure	2
V	Other	3

Severity rating 1 is a minor breach of confidentiality affecting only a single individual.

11.3 Working with suppliers

The Great Western Hospitals NHS Foundation Trust works with a large number of suppliers across a very diverse portfolio. Our aim is to work in partnership with our suppliers and to build strong relationships that enable us to obtain best value for money when purchasing the quality of goods and services the Trust needs to support patient care.

The Trust has developed its E-Procurement tools which enhances transparency of our contracting processes, gives visibility of the contracts the Trust is tendering for, makes it easier for suppliers to engage with us and reduces the paperwork suppliers have to complete during formal tendering processes.

12 STATEMENT OF ACCOUNTING OFFICER'S RESPONSIBILITIES

12.1 Statement of the Chief Executive's responsibilities as the accounting officer of Great Western Hospitals NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the Accounting Officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the NHS Act 2006, Monitor has directed Great Western Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Great Western Hospitals NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the *NHS Foundation Trust Annual Reporting Manual* and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgments and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements; and
- prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's NHS Foundation Trust Accounting Officer Memorandum.

Signed.....

Nerissa Vaughan
Chief Executive

24 May 2012

13 AUDITOR'S OPINION AND CERTIFICATE

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

We have audited the financial statements of Great Western Hospitals NHS Foundation Trust for the year ended 31 March 2012 on pages 176 to 209. These financial statements have been prepared under applicable law and the accounting policies set out in the Statement of Accounting Policies.

This report is made solely to the Council of Governors of Great Western Hospitals NHS Foundation Trust in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of Governors of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of the accounting officer and the auditor

As described more fully in the Statement of Accounting Officer's Responsibilities on page 160 the accounting officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practice's Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed, the reasonableness of significant accounting estimates made by the accounting officer and the overall presentation of the financial statements. In addition we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of Great Western Hospitals NHS Foundation Trust's affairs as at 31 March 2012 and of its income and expenditure for the year then ended; and
- have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2011/12.

Opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts

In our opinion the information given in the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

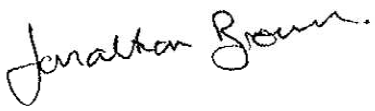
Matters on which we are required to report by exception

We have nothing to report where under the Audit Code for NHS Foundation Trusts we are required to report to you if, in our opinion, the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

We are not required to assess, nor have we assessed, whether all risks and controls have been addressed by the Annual Governance Statement or that risks are satisfactorily addressed by internal controls.

Certificate

We certify that we have completed the audit of the accounts of Great Western Hospitals NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.



Jonathan Brown for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
100 Temple Street
Bristol
BS1 6AG

29 May 2012

14 ANNUAL GOVERNANCE STATEMENT

14.1 Scope of responsibility

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

14.2 The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Great Western Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Great Western Hospitals NHS Foundation Trust for the year ended 31 March 2012 and up to the date of approval of the annual report and accounts.

14.3 Capacity to handle risk

Leadership is given to the risk management process by embedding responsibility within the executive director's job description and annual appraisal and personal development plans. Executive directors personally review assurances against their strategic objectives on a quarterly basis as part of the Board Assurance Framework. In December 2011, a workshop was held to provide training for Executive and Non-Executive Directors and senior managers on roles and responsibilities for leadership in risk management.

Staff education and training on risk management is carried out commensurate with their roles. All new employees receive corporate induction, which includes risk management and incident reporting, alongside health and safety, manual handling and infection control training appropriate to their duties. In addition during 2011/12, further training on risk management has been provided to all Associate Medical Directors, General Managers and other senior staff within directorates as part of the roll out of a new electronic system for compiling and managing risk.

14.4 The risk and control framework

14.4.1 Risk Management Strategy

The overall objective of the Risk Management Strategy is to ensure that robust risk management processes are in place which provide assurance to the Board that the Trust is discharging its responsibilities in ensuring good business and financial decision making leading to improvements in services and the quality of care provided.

To ensure that risk is identified, evaluated and controlled there are formal structures within the Trust. In 2011/12 the Risk Management Strategy was reviewed with the reporting process for risk being formalised. Whilst the Board has overall responsibility for risk management, it delegated the work to the Executive Committee and the Audit, Risk and Assurance Committee.

The three main tenets of our risk management strategy are:

- Risk assessment
- Risk Register
- Board Assurance Framework

14.4.2 Risk assessment

All trust staff are made responsible for identifying and managing risk. In addition there is a robust Incident Management Policy in place and at Corporate Induction staff are actively encouraged to utilise our web-based incident reporting system. A healthy incident reporting culture has been maintained for a number of years providing assurance that staff feel able to report incidents and risks. A Being Open Policy, based on National Patient Safety Agency guidance, is in place and regularly reviewed. An annual audit is undertaken by the Health and Safety Team of all wards and departments which demonstrates risk assessment and risk management in practice.

14.4.3 Risk Register

In 2011/12 it was agreed that the most significant risks to the Trust, being those which score 15 and above, should be reviewed monthly at the Executive Committee. A register containing 15 plus risks is scrutinised and challenged by the Executive Committee (to ensure risks are being managed) and the Audit, Risk and Assurance Committee (to ensure processes in place to manage risk are effective). This high-level register is informed both by those risks which scored 15 in the board assurance framework (top down) and risks identified from within the directorates (bottom up).

14.4.4 Board Assurance Framework

During 2011/12, the Trust undertook a fundamental review of its Board Assurance Framework. The Board Assurance Framework is set by the Executive Committee and approved by the Trust Board annually. The assurance framework sets out

- the principal objectives to achieving the Trust's overall goals,
- the principal risks to achieving those objectives,

- the key controls to mitigate against those risks,
- the assurances on those controls, and
- any gaps in assurances.

An internal audit undertaken in January 2012 granted the Trust substantial (green) assurance on the design and implementation of the board assurance framework.

14.4.5 Significant Risks

There are a number of risks identified in the board assurance framework and risk register. Examples of significant risks identified during 2011/12, together with the actions that have been taken to mitigate them as summarised as follows: -

Risk	How risk was mitigated
Directorate's forecasts deteriorate resulting in a deficit.	• Project management board to monitor delivery of savings; • Monthly monitoring of actions by the Executive Committee; • Monthly reporting to the Finance and Investment Committee;
Activity above proposed contract levels	• Risk framework agreed with Commissioners; • Appropriate contract values agreed with Commissioners.
Potential for quality of care to be compromised during transition phase of transfer of WCHS	• A project transition team created; • Governance arrangements strengthened; • A Transition Director of Community Services appointed.
Failure to achieve compliance with new NHSLA Level 2 Acute Standards	• Agreement with Wiltshire PCT to fund any deficit associated with reductions in NHSLA Levels for 1 year • Agreement with NHSLA for an extension to the normal assessment cycle.

No significant gaps in controls or assurances were identified during 2011/12. Where minor gaps in control were identified, these were acted upon within prescribed timescales.

New risks for 2012/13 will be identified through the annual plan process and will be added to the Assurance Framework. Major future risks, including significant clinical risks for 2012/13 have been identified and include the following: -

TABLE - Future risks

Risk	Actions to manage and mitigate, including how outcomes will be assessed
Establishment of Clinical Commissioning Groups with different approaches within Swindon and Wiltshire with risk of differential pathways	• Stakeholder engagement • Trust working with Wiltshire Council to develop partnership • Attendance at Community Change Programme Group (QIPP) in Swindon chaired by GP commissioning lead • Attendance at QIPP Board in Wiltshire, which clinical input • Partnership working with NHS Swindon and NHS Wiltshire to develop joint contract performance arrangements with input from Trust Clinicians and GPs • Monthly GP forum being used to as a vehicle to discuss future plans • Stakeholder engagement/consultation of the Trust 5 year Strategy enabling alignment of Trust plans with Commissioning intentions.

Risk	Actions to manage and mitigate, including how outcomes will be assessed
Licence to operate (compliance with CQC registration and regulatory regime)	• Plans implemented to address CQC compliance concerns, CQC notified with re-inspection by CQC outstanding • Programme of matron led CQC style visits to review practise, and staff response • Periodic Clinical Audit compliance reviews, with outcomes and action plans where required being presented and scrutinised by Governance Committee, providing assurance to the Board. • CQC compliance included in annual internal audit plan. The audit report/compliance being reported to both the Governance Committee and Audit Risk & Assurance Committee. Actions plans to resolve compliance issues will be presented and scrutinised by the Governance Committee. • Monthly reporting on compliance
Financial and reputation risk if non achievement of NHSLA level 2 – Acute standards in November 2012 and Maternity in May 2013	• Gap analysis completed and action plan in place, • Monitored monthly via Executive Committee and Patient Safety and Quality Group. • Informal Assessments completed by NHSLA prior to formal assessment with action plans updated to reflect outcome. • Included in work plan for Parkhill, Internal Auditors with out-come being presented to Audit Risk & Assurance Committee • Scrutiny of plans by the Governance Committee. • Clinical Governance Committee and Audit, Risk & Assurance Committee will provides assurance to Trust Board.
QIPP/Savings delivery, target is £16m which is 5.7% of turnover. Non delivery leading to a deficit, poor liquidity and reduction in Financial Risk Rating	• Programme Management Arrangements in place, including increased support to the Directorates • Clinical engagement and increased partnership working with other providers. • Targets included in Directorate Accountability Agreements implemented as part of the new performance management arrangements • Delivery monitored monthly via Directorate Performance meetings and Executive Committee. • Scrutiny of plans by the Finance & Investment Committee • External review of plans by Parkhill, these will take place in at end of quarter 1 and in quarter 3. Outcomes presented to Finance & Investment Committee and Audit Risk & Assurance Committee, with issues escalated to the Board • Multi-provider governance arrangements in place for delivery of QIPP, with representation Executive Directors and Associate Medical Directors of the Trust, reporting into the Community Change Programme Groups (QIPP) • Increase working capital facility, tender planned for August with new agreement in place by 1st December 2012

14.4.6 Organisation Culture

The Trust operates a Being Open Policy and has mechanisms in place to promote a culture in which staff are supported to be open with patients when things go wrong. The Trust also operates a Whistle Blowing Policy which encourages staff to come forward with concerns.

During 2011/12 the requirements for reports to the Board and its Committees were reviewed which included the introduction of quality impact assessments for all papers, with any areas of concern highlighted and addressed. Equality and quality impact assessments were also introduced for policies and Trust wide procedural documents, thus ensuring that equality and quality considerations are core to the Trust's overall policy framework and business.

14.4.7 Information Risk

Risks to information, including data confidentiality, integrity and availability, are managed and controlled through an Information Governance Steering Group, which reports into the Audit, Risk and Assurance Committee. The Trust has a Senior Information Risk Owner (SIRO) with responsibility for the Information Risk Policy which defines an overall structured approach to the management of information risk, in line with the Risk Management Strategy. A register of Information Assets is maintained with senior managers identified as asset owners with for operational management of the assets and ensuring the principal risks are identified, assessed and regularly reviewed, and they provide annual assurance reports of the satisfactory operation and security of the information assets.

Where assessed as appropriate, risk treatment plans are actioned, additional controls are implemented, and prioritised risks are escalated to the appropriate Risk Register. As Accounting Officer I am committed to ensuring that immediate actions are taken where significant risks have been highlighted.

A range of measures is used to manage and mitigate information risks, including: staff training, privacy impact assessments, physical security, data encryption, access controls, penetration testing, audit trail monitoring, departmental checklists and spot checks. In addition, a comprehensive assessment of information security is undertaken annually as part of the Information Governance Toolkit and further assurance is provided from Internal Audit and other reviews.

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

14.4.8 Stakeholder involvement

As a foundation trust our membership is a resource for supporting risk management in the Trust. The membership is represented by governors who attend regular formal meetings with the Board of Directors and Trust staff. In particular the governors hold the Trust to account via various working groups, such as the Patient Experience Working Group and the Finance Working Group which both meet quarterly.

The governors contributed to the development of the Trust's quality strategy through a patient safety, quality and satisfaction working group. The strategy was developed in 2009/10 and is for five years ending in 2015.

The governors and wider stakeholders are actively involved in the development of the Trust's Business Strategy for future years. During 2012/13 there will be further consultations and workshops with stakeholders to ensure that the Trust's strategy going forward matches the needs and wishes of the local community and that there is a full understanding of the risks, threats and opportunities facing the Trust in the years ahead.

14.4.9 Quality Governance Arrangements

During the 2011/12 financial year, the Trust remained at level 2 for the National Health Service Litigation Authority (NHSLA) Risk Management Standards for Acute Trusts and was level 2 for Clinical Negligence Scheme for Trusts (CNST) Risk Management Standards for maternity following the integration of community services into the Trust.

During 2011/12 revised arrangements were put in place to ensure that there is corporate governance overview of all policies and Trust wide procedural documents. As part of the revised requirements, authors are required to carry out an equality impact assessment and a quality impact assessment of the reviewed document to ensure that any issues of concern relating to equality and quality are highlighted and addressed.

14.4.10 Internal CQC Compliance Assessment arrangements

Internal processes for assessing compliance against the CQC regulations are led by the Clinical Standards Group which meets on a monthly basis. The compliance judgement is informed by the CQCs Quality and Risk Profile and other accessible sources of intelligence. Evidence supporting compliance is captured on the Trust's Provider Compliance Assessment Forms which are saved and managed centrally by the Quality Team. Gaps in compliance inform the Patient Safety and Quality Committee and actions plans are developed and monitored to ensure improvements are progressed. Risks identified from the internal compliance assessment and risks arising from within the directorates, inform the relevant risk registers and are linked to the CQC outcomes.

The Patient Safety and Quality Committee reports to the Executive Committee and Trust Board monthly on the Trust's regulatory compliance status.

The foundation trust is not fully compliant with the registration requirements of the Care Quality Commission.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

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

The foundation trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

14.5 Review of economy, efficiency and effectiveness of the use of resources

The Trust has robust arrangements in place for setting objectives and targets on a strategic and annual basis. These arrangements include ensuring Great Western Hospitals NHS Foundation Trust strategy is affordable, scrutiny of cost savings plans to ensure achievement (whilst maintaining and improving quality and safety), compliance with terms of authorisation and coordination of individual objectives with corporate objectives as identified in the Annual Plan 2011/12.

Performance against objectives is monitored and actions identified through a number of channels:

- approval of annual budgets by the Board of Directors;
- monthly reporting to the Patient Safety and Quality Committee on patient safety and quality indicators; patient safety and clinical risk; clinical effectiveness; regulation; patient experience and complaints;
- regular reporting to the Board on key performance indicators including finance, activity, patient safety and human resources targets;
- monthly review of financial targets and contract performance by the Finance and Investment Committee, which is a committee of the Board;
- monthly reporting to the Executive Committee on directorate and Trust performance; and
- quarterly reporting to Monitor, via the Finance and Investment Committee and compliance with the terms of authorisation.

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

- Use of the Institute of Innovation and Improvement data and subscribes to the Foundation Trust Network benchmarking data to ensure productivity;
- Achieving Level 2 in the NHS Litigation Authority's Risk Management Standards for Acute Trusts and Level 2 in maternity standards;
- Quarterly reporting to Monitor, via the Finance and Investment Committee and compliance with terms of authorisation.

Value for money is an important component of the internal and external audit plans. These provide assurance to the Trust that processes in place are effective and efficient in the use of resources.

The Trust has an assessment process for future annual plans to ensure value for money and full appraisal processes are employed when considering the effect on the organisation. Procedures are in place to ensure all strategic decisions are considered at Executive and Board level and there is wider consultation with governors and stakeholders.

The emphasis in Internal Audit work is providing assurances on internal controls, risk management and governance systems to the Audit, Risk and Assurance Committee and to the Board.

14.6 Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

Steps which have been put in place to assure the Board that the Quality Report presents a balanced view and that there are appropriate controls in place to ensure the accuracy of data include the following: -

- The Medical Director is the Executive lead for the Quality Account and there is a named Non Executive Director with designated personal leadership for patient safety and quality on behalf of the Trust Board. The Trust has a 3 year Quality Improvement Strategy which provides details on roles and responsibilities for quality and safety and defines the key focus for the Annual Quality Accounts.

- The Annual Quality Account Report 2011/12 provides a narrative of progress toward achieving the quality improvement indicators agreed by the Executive Committee, the Patient Safety and Quality Committee and the Trust Board.

- The Quality Account is compiled by a Clinical Governance Administrator following both internal and external consultation to inform the improvement indicators. Data is provided by nominated leads in the Trust. These leads are responsible for scrutinising the data they provide to ensure accuracy. Once compiled the Quality Account Report is scrutinised by the Associated Director of Quality and Patient Safety for challenging the veracity of data. The Medical Director is ultimately accountable to Trust Board and its committees for the accuracy of the Quality Account Report.

- The Quality Account is subject to robust challenge at a Patient Safety and Quality Committee on both substantive issues and also on data quality. Where variance against targets is identified the leads for individual metrics are held to account by the Patient Safety and Quality Committee. Following scrutiny at that committee, the Quality Account is reported to Trust Board which is required to both attest to the accuracy of the data and also ensure that improvements against the targets are maintained.

- Directors' responsibilities for the Quality Account Report are outlined separately in this report.

- The Quality Account Report has been prepared in accordance with Monitor's annual reporting guidance as well as the standards to support data quality for the preparation of the Quality Report. No material weaknesses in the control framework associated with Quality Accounts have been identified.

14.7 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, clinical audit and the executive managers within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board and the Audit, Risk and Assurance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The processes that have been applied in maintaining and reviewing the effectiveness of the system of internal control include the following: -

Process		Role and Conclusions
Board	-	The Board has continued to lead the organisation throughout the year with regular reporting on finance and clinical performance, It receives and reviews minutes of committees, with concerns and issues escalated by the Committee Chairs. In March 2012 the Board reviewed and updated the Governance Structure, approving new terms of references for Board Committees to ensure that the Trust's system of internal control reflects the current needs of the organisation and to ensure that appropriate reporting and decision making mechanisms are in place.
Audit, Risk and Assurance Committee	-	The Committee provides scrutiny of internal controls, including the review the Assurance Framework and Corporate Risk.
Internal audits	-	On the effectiveness of systems of internal control. Audit findings are presented to the Audit, Risk and Assurance Committee and the Board through the Audit, Risk and Assurance Committee minutes.
Clinical audits	-	The Trust Board is meticulous in keeping Clinical Audit as the key component of clinical governance in its efforts to promote patient safety, patient experience and to promote effectiveness of care delivered to the patients. The Trust is compliant with the Trust Clinical Audit plan. The NICE lead is responsible for actively disseminating and monitoring NICE compliance. Trust wide compliance of 96-100% has been attained throughout this year.
Other Committees	-	All committees have a clear timetable of meetings and a clear reporting structure to allow issues to be raised. Terms of reference for each Board Committee have been reviewed in 2011/12 to ensure ongoing effectiveness and ensure that an appropriate level of delegation and reference back to the Board is in place.
Assurance Framework	-	Provides assurance that the effectiveness of the controls to manage the risks to the organisation in achieving its principal objectives has been reviewed. An internal audit in January 2012 gave positive assurance to the risk management process of the Trust and the Assurance Framework has been commended by the Audit, Risk and Assurance Committee and external and internal auditors.
Self-assessment declaration against CQC standards	-	The Trust has self assessed compliance with the CQC regulations. There have moderate concerns with compliance with the CQC regulations for which is it registered, but action plans are in place to address moderate and minor concerns. External NHSLA Risk Management Standards (Acute) – level 2. External CNST Risk Management Standards (Maternity) – level 2.
Quarterly reporting to Monitor	-	Declarations are considered by the Executive Committee and Finance and Investment Committee and thereafter approved by the Board on a quarterly basis prior to submission to Monitor.

The Trust will continue to review all risks and where necessary will take approach actions to either reduce or eliminate these. Actions taken will be monitored through the appropriate committees of the Board, and where necessary the Chair of the committee will escalate concerns to Board.

14.8 Conclusion

I have not identified any material weaknesses in our systems for internal control as part of my review. My review confirms that Great Western Hospitals NHS Foundation Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives.

Signed.....

Nerissa Vaughan
Chief Executive

24 May 2012

15 GLOSSARY OF TERMS

BARS – Blood Audit and Release System

CETV - Cash Equivalent Transfer Value

Clostridium Difficile – Bacteria naturally present in the gut

CQC – Care Quality Commission

CQUIN – Commissioning for Quality and Innovation Payment

CUSUM – Cumulative Sum Control Chart

DSDU –

EDS – Electronic Discharge Summary

EPF – Employee Partnership Forum

GWH – Great Western Hospitals

HCAIs – Healthcare Associated Infections

HSMR – Hospital Standardised Mortality rate

JACIE – Joint Accreditation Committee

MTD –

MRSA – Methicillin- resistant Staphylococcus Aureus, which is a common skin bacterium that is resistant to a range of antibiotics

MUST – Malnutrition Universal Screening Tool

NEDs – Non executive Directors

NICE – National Institute for Health and Clinical Excellence

NHLSA – National Health Service Litigation Authority

NPSA – National Patient Safety Agency

PCT – Primary care Trust

PEAT – Patient Environment Action Team

PSQC – Patient Safety and Quality Committee

PURAT – Pressure Ulcer Risk Assessment Tool

RCA – Root Cause Analysis

SAFE – Stratification and Avoidance of Falls in the Environment

SHA – Strategic Health Authority

SWICC – South West Intermediate Care Centre

TVNS – Tissue Viability Nurse Specialist

VAP - Ventilated Acquired Pneumonia

VTE - Venous Thromboprophylaxis (Blood clot)

WCHS – Wiltshire Community Health Service

WHO – World Health Authority

16 FOREWORD TO THE ACCOUNTS

16.1 Foreword to the accounts for the year ending 31 March 2012

These accounts for the period ended 31st March 2012 have been prepared by Great Western Hospitals NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 of the National Service Act 2006 in the form than Monitor, the Independent Regulator of NHS Foundation Trusts, with the approval of the Treasury, has directed.

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2012

	Notes	Year Ended 31 March 2012 £000	Restated Year end 31 March 2011 £000
Operating Income from continued operations	3 - 4	**290,475**	202,712
Operating Expenses of continued operations	5	**(275,274)**	(187,835)
Operating surplus		**15,201**	14,877
Finance Costs			
Finance income	10	**333**	217
Finance expense - financial liabilities	11	**(13,834)**	(14,102)
Finance expense - unwinding of discount on provisions		**(44)**	(49)
Public Dividend Capital Dividends payable		**(1,120)**	(1,190)
Net finance costs		**(14,665)**	(15,124)
SURPLUS/(DEFICIT) FOR THE YEAR		**536**	(247)
Other comprehensive income			
Loss on Asset Disposal		**(22)**	0
Total comprehensive income/(expense) for the year		**514**	(247)

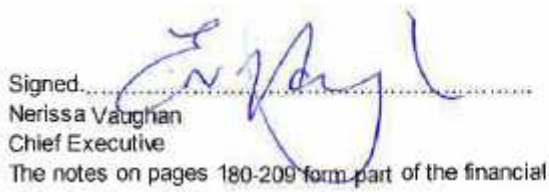
Note:

The Trust acquired the community services of NHS Wiltshire from 1 June 2011 under a Transfer of Community Services (TCS) agreement. As per Department of Health guidance, merger accounting has been used and as a result a full year of trading has been included within the above SoCI for the year ending 31 March 2012.

All income and expenditure is derived from continuing operations.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2012

	Notes	31 March 2012 £000	Restated 31 March 2011 £000	Restated 1 April 2010 £000
Non-Current Assets				
Intangible assets	13	**1,162**	1,170	612
Property, Plant and Equipment	14	**179,122**	183,018	182,725
Trade & Other Receivables	17			1,733
Total non-current assets		**180,284**	184,188	185,070
Current Assets				
Inventories	16	**4,839**	3,820	3,156
Trade and other receivables	17	**13,577**	8,335	11,095
Cash and cash equivalents	19	**14,482**	11,223	12,181
Total current assets		**32,898**	23,379	26,432
Current Liabilities				
Trade and Other Payables	20	**(22,970)**	(18,652)	(19,102)
Borrowings	22	**(4,533)**	(1,425)	(3,004)
Provisions	23	**(565)**	(350)	(1,434)
Tax Payable	21.1	**(1,788)**	(1,324)	
Other liabilities	21	**(1,425)**	(1,016)	(1,491)
Total current liabilities		**(31,281)**	**(22,766)**	**(25,031)**
Total assets less current liabilities		**181,901**	184,801	186,472
Non-Current Liabilities				
Trade and Other Payables	20	**(412)**	0	(593)
Borrowings	22.2	**(128,133)**	(132,036)	(133,118)
Provisions	23	**(4,686)**	(4,495)	(4,132)
Other Liabilities	21	**(1,816)**	(1,930)	(2,044)
Total non-current liabilities		**(135,047)**	(138,461)	(139,886)
Total assets employed		**46,854**	46,340	46,586
Financed by Taxpayers' Equity				
Public dividend capital		**27,111**	27,111	27,111
Revaluation reserve		**18,529**	18,551	18,551
Income and expenditure reserve		**1,214**	678	925
Total taxpayers' equity		**46,854**	46,340	46,586



Note:

The Balance Sheet has been restated from 1st April 2010 following a change in accounting treatment for Donated Asset Reserve and Government Grant Reserve.

These Reserves were previously held separately in Taxpayers Equity and were released over the life of the assets to which they related.

The revised accounting treatment is to charge the costs to the Statement of Comprehensive Income in the year in which the asset/liability arises. The impact on the Statement of Financial Position is that any balances held in these reserves now form part of the Income and Expenditure Reserve.

Great Western Hospitals NHS Foundation Trust
Accounts for the year ended 31 March 2012

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	Public Dividend Capital	Revaluation Reserve - Tangible assets	Donated Asset Reserve	Other Reserves	Income and Expenditure Reserve	**Total**
	£000	£000	£000	£000	£000	**£000**
Taxpayers' Equity at 1 April 2010 as previously stated	27,111	18,551	895	264	(235)	46,586
Prior period adjustment	**0**	**0**	**(895)**	**(264)**	**1,160**	**0**
Taxpayers' Equity at 1 April 2010 - restated	**27,111**	**18,551**	**(0)**	(0)	**925**	**46,586**
Surplus/(deficit) for the year	0	0	0	0	(247)	(247)
Transfers in respect of assets disposed of	0	0	0	0	0	0
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of on donated assets	0	0	0	0	0	0
Receipt of donated assets	0	0	0	0	0	0
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of on donated assets	0	0	0	0	0	0
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve	0	0	0	0	0	0
Public Dividend Capital received/paid	0	0	0	0	0	0
Additions/(reduction) in Other reserves	0	0	0	0	0	0
Taxpayers' Equity at 31 March 2011	**27,111**	**18,551**	**(0)**	**(0)**	**678**	**46,340**
TCS and merger adjustments	0	0	0	0	0	0
Surplus/(deficit) for the year	0	0	0	0	536	536
Transfers in respect of assets disposed of	0	(22)	0	0	0	(22)
Revaluation gains/(losses) and impairment losses property, plant and equipment	0	0	0	0	0	0
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of on donated assets	0	0	0	0	0	0
Receipt of donated assets	0	0	0	0	0	0
Transfers in respect of depreciation, impairment and disposal of donated assets	0	0	0	0	0	0
Public Dividend Capital received	0	0	0	0	0	0
Additions/(reduction) in Other reserves	0	0	0	0	0	0
Taxpayers' Equity at 31 March 2012	**27,111**	**18,529**	**(0)**	**(0)**	**1,214**	**46,854**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2012

	Notes	Year Ended 31 March 2012 £000	Restated Year Ended 31 March 2011 £000
Cash flows from operating activities			
Operating surplus from continuing operations		**15,201**	14,877
Depreciation and amortisation		**7,872**	7,536
Amortisation of PFI credit		**114**	0
Increase in inventories		**(1,019)**	(664)
(Increase) / decrease in trade and other receivables		**(5,242)**	4,491
Increase in trade and other payables		**5,195**	281
Increase / (decrease) in other liabilities		**180**	(633)
Increase / (decrease) in provisions		**406**	(721)
NET CASH GENERATED FROM OPERATIONS		**22,706**	25,167
Cash flows from investing activities			
Interest received		**333**	87
Purchase of Property, Plant and Equipment		**(3,337)**	(8,452)
Net cash used in investing activities		**(3,004)**	(8,365)
Cash flows from financing activities			
Capital element of Private Finance Initiative Obligations		**(1,425)**	(2,595)
Interest paid		**(57)**	(100)
Interest element of Finance Leases		**(39)**	0
Interest element of Private Finance Initiative Obligations		**(13,738)**	(14,002)
PDC dividends paid		**(1,185)**	(1,063)
Net cash generated (used in) financing activities		**(16,443)**	**(17,760)**
Increase/(decrease) in cash and cash equivalents		**3,259**	**(958)**
Cash and cash equivalents at 1 April 2011		**11,223**	12,181
Cash and cash equivalents at 31 March 2012	19	**14,482**	11,223

ACCOUNTING POLICIES

1 Basis of Preparation

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the FT ARM 2011/12 issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered in relation to the accounts.

1.1 Accounting Convention

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

1.1.1 **Subsidiaries**

Subsidiary entities are those over which the Trust has the power to exercise control or a dominant influence so as to gain economic or other benefits. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

Until 31st March 2013, NHS Charitable Funds considered to be subsidiaries are excluded from consolidation in accordance with the accounting direction issued by Monitor.

1.1.2 TCS Merger Note

The Trust acquired the contract to run Wiltshire Community Health Services (WCHS) from NHS Wiltshire with effect from 1st June 2011. This is operated under two commissioning contracts - one for Adult and Community Services and one for Maternity Services.

The Foundation Trust Annual Reporting Manual requires that all transfers of functions between public sector bodies will be accounted for using full merger accounting. As a result a full 12 months of WCHS has been included within the SOCI. The Department of Health has considerd it impracticable to restate the comparative information.

The Department of Health does not require Trusts to include prior year comparators for transfers under TCS (Transferring Community Services) and the amendments to the 2011/12 Opening Balances are shown by an adjustment to 1 April 2011 opening balances in the line 'Adjustment for transfer of functions' The following current and non-current assets were transferred to the Trust at book value, which also reflects their fair value, are included in the opening balances.

	At 1 April 2011	At 1 June 2011
	£'000	£'000
Non-Curent Assets	0	0
Current Assets	1,492	0
Non-current liabilities	0	0
Current liabilities	(1,492)	94

It should be noted that the information in the annual accounts includes 12 months results for WCHS, even though it was only unde the Operational management of the Trust for 10 months of the year. The actual value of the contract from the date of transfer (1st June 2011) for 2011/12 is £66.2m.

The current year reported results of the Trust can be analysed as follows:

	1 April 2011- 31 May 2011		1 June - 31 March 2012	
	Great Western Hospitals NHS FoundationTrust	Wiltshire Community Health Services	Total Combined Organisation	Total for the Year
	£'000	£'000	£'000	£'000
Operating Income	33,854	12,964	243,657	290,475
Operating Expenses	(31,397)	(12,954)	(230,923)	(275,274)
Finance Costs	(2,442)	0	(12,223)	(14,665)
Surplus/Deficit for the period	**15**	**10**	**511**	**536**
Other Comprehensive Income		-		
Total comprehensive income for the period	**15**	**10**	**511**	**536**

1.2 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services.

Income relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

1.3 Expenditure on Employee Benefits

1.3.1 Short term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from the employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that the employees are permitted to carry forward leave into the following period.

ACCOUNTING POLICIES (continued)

1.3.2 Pension Costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under direction of the Secretary of State, in England and Wales. 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.

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

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement regardless of the method of payment.

The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised in the income and expenditure reserve and reported in the
. Statement of Comprehensive Income as an item of 'other comprehensive income'

Local Government Superannuation Scheme

Some employees are members of the Local Government Superannuation Scheme which is a defined benefit pension scheme. The scheme assets and liabilities attributable to these employees can be identified and are recognised in the Trust accounts. The assets are measured at fair value, and the liabilities at the present value of future obligations.

1.4 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.5 Property, plant and equipment

1.5.1 Recognition

Property, plant and equipment is capitalised where:

- they are held for use in delivering services or for administrative purposes.
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust.
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- individually have a cost of at least £5,000; or
- form a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial equipping and setting-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

ACCOUNTING POLICIES (continued)

1.5.2 Measurement

Valuation

All property, plant and equipment are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Land and Property assets are valued every 5 years with a 3 yearly interim valuation also carried out. Annual impairment reviews are carried out in other years. The 3 and 5 yearly interim revaluations are carried out by a professionally qualified valuer in accordance with the Royal Chartered Institute of Surveyors (RICS) Appraisal and Valuation Manual. The valuations are carried out on the basis of a Modern Equivalent Asset as required by HM Treasury. The annual reviews are carried out using the most appropriate information available at the date of the review. A revaluation was carried out on 31 March 2010.

Equipment assets values are reviewed annually internally to determine the remaining life based on past and forecasted consumption of the economic useful life of the asset.

Property used for the Trust's services or for administrative purposes are stated in the Statement of Financial Position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the Trust and the cost of the item can be determined reliably.

Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been classified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Leasehold properties are depreciated over the primary lease term.

Equipment is capitalised at current cost and depreciated evenly over the estimated lives of the asset.

	Years
Medical equipment and engineering plant and equipment	5 to 15
Furniture	10
Information technology equipment	5
Transport	6

ACCOUNTING POLICIES (continued)

Revaluation Gains and Losses
Revaluation gains are recognised in the revaluation reserve , except where, and to the extent that, they reverse a revaluation decrease that has been previously recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
In accordance with the FT ARM, impairments that are due to a loss of economic benefit or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charges to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'Held for Sale' once all the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales
- the sale must be highly probable i.e.

  management are committed to a plan to sell the asset

  an active programme has begun to find a buyer and complete the sale.
  the asset is being actively marketed at a reasonable price.
  the sale is expected to be completed in within 12 months of the date of classification as 'Held for Sale' and
  the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the assets economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

ACCOUNTING POLICIES (continued)

1.6 Donated, government grant and other grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor imposes a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

This change in accounting treatment was effective from a April 2010 and has resulted in the restatement of the 2010/11 balances.

The donated and grant funded assets are subsequently accounted for in the same manner as other property, plant and equipment.

1.7 Private Finance Initiative (PFI) Transactions

PFI Transactions that meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. The underlying assets are recognised as property, plant and equipment at their fair value. An equivalent financial liability is recognised in accordance with IAS 17.

The annual contractual payments are apportioned between the repayment of the liability, a finance cost and the charges for services.

The service charge is recognised in operating expenses and the finance cost is charged to the Statement of Comprehensive Income.

1.7.1 Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

1.8 Intangible assets

1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

ACCOUNTING POLICIES (continued)

1.8.2 Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.
Expenditure on research is not capitalised.
Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development

1.8.3 Software

Software which is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of the hardware e.g. application software is capitalised as an intangible asset.

1.8.4 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at fair value. Revaluation gains and losses and impairments are treated in the same manner as for Property, Plant and Equipment.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.8.5 Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.8.6 Revenue Grants and other Grants

Government grants are grants from Government Bodies other than income from Primary Care Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. Pharmacy stocks are valued at average cost, other inventories are valued on a first-in first-out basis. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks. Work-in-progress comprises goods and services in intermediate stages of production.

ACCOUNTING POLICIES (continued)

1.10 Financial instruments and financial liabilities

1.10.1 Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

1.10.2 Classification

Financial assets are classified as fair value through income and expenditure, loans and receivables. Financial liabilities are classified as fair value through income and expenditure, or as other financial liabilities.

Financial assets and financial liabilities at 'fair value through the income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short term. Derivatives are also categorised as held for trading unless they are designated as hedges. Assets and liabilities in this category are classified as current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains and losses in the Statement of Comprehensive Income.

1.10.3 Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets. The Trust's loans and receivables comprise current investments, cash and cash equivalents, NHS debtors, accrued income and other debtors.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial assets or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

1.10.4 Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or to intangible assets is not capitalised as part of the cost of those assets.

1.10.5 Determination of Fair Value

For Financial assets and financial liabilities carried at fair value, the carrying amounts are determined from current market prices.

ACCOUNTING POLICIES (continued)

1.10.6 Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

1.10.7 Accounting for derivative financial instruments

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through income and expenditure. They are held at fair value, with any subsequent movement recognised as gains or losses in the Statement of Comprehensive Income.

1.11 Trade receivables

Trade receivables are recognised and carried at original invoice amount less provision for impairment. A provision for impairment of trade receivables is established when there is objective evidence that the Trust will not be able to collect all amounts due according to the original terms of receivables. The amount of the provision is recognised in the Statement of Comprehensive Income.

1.12 Deferred income

Deferred income represents grant monies and other income received where the expenditure has not occurred in the current financial year. The deferred income is included in current liabilities unless the expenditure, in the opinion of management, will take place more than 12 months after the reporting date, which are classified in non-current liabilities.

1.13 Borrowings

The Trust can borrow within the limits set by Monitor's Prudential Borrowing Code. The Trust's position against its prudential borrowing limit is disclosed in note 22.1 on Page 28. The PFI non-current lease liability counts as part of the Trust's Prudential Borrowing Limit.

1.14 Leases

1.14.1 Finance Leases

Where substantially all of the risks and rewards of ownership of a lease asset are borne by the Trust the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present minimum value of the lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property, plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

1.14.2 Operating Leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

1.14.3 Lease of Land and Buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

ACCOUNTING POLICIES (continued)

1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2% in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 2.8% in real terms.

1.15.1 Clinical Negligence Costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed in note 23 on page 29 but is not recognised in the Trust's accounts.

1.15.2 Non-Clinical Risk Pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 25 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 25, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.17 Public Dividend Capital

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not an equity financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), and (ii) net cash balances with the Government Banking Services (GBS), excluding any cash balances held in GBS accounts that relates to a short term working capital facility and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the accounts.

ACCOUNTING POLICIES (continued)

1.18 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.19 Corporation Tax

The Trust does not have a corporation tax liability for the year 2011/12. Tax may be payable on activities as described below:

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

1.20 Foreign exchange

The functional and presentational currencies of the Trust is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the date of the transaction. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Statement of Comprehensive Income in the period in which they arise.

1.21 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

1.22 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However, the note on losses and special payments is compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

ACCOUNTING POLICIES (continued)

1.23 Critical Accounting Estimates and Judgements

International accounting standard IAS1 requires estimates, assumptions and judgements to be continually evaluated and to be based on historical experience and other factors including expectation of future events that are believed to be reasonable under the circumstances. Actual results may differ from these estimates. The purpose of the evaluation is to consider whether there may be a significant risk of causing a material adjustment to the carrying value of assets and liabilities within the next financial year, compared to the carrying value in these accounts. The following significant assumptions and areas of estimation and judgement have been considered in preparing these financial statements. Value of land, buildings and dwellings £159m: This is the most significant estimate in the accounts and is based on the professional judgement of the Trust's independent valuer with extensive knowledge of the physical estate and market factors. The value does not take into account potential future changes in market value which cannot be predicted with any certainty.

Income for an inpatient stay can start to be recognised from the day of admission, but cannot be precisely calculated until after the patient is discharged. For patients occupying a bed at the 2011/12 financial year end, the estimated value of partially completed spells is shown in the table below.

Untaken annual leave: salary costs include an estimate for the annual leave earned but not taken by employees at 31 March 2012, to the extent that staff are permitted to carry up to 5 days leave forward to the next financial year. This shown below:

	As at 31 March 2012	As at 31 March 2011
	£'000	£'000
Partially Completed Spells	1,284	720
Untaken Annual Leave	645	521

Provisions: Assumptions around the timing of the cash flows relating to provisions are based upon information from the NHS Pensions Agency and expert opinion within the Trust and from external advisers regarding when legal issues may be settled.

1.24 New Accounting Standards

Accounting standards that have been issued but have not yet been adopted

The following accounting standards, amendments and interpretations have been issued by the IASB and IFRIC but are not yet required to be adopted:

Effective for the next financial year ending 31 March 2013:	**Effective Date**
IFRS 7 Financial Instruments Disclosure Amendments Transfer of Financial Assets	1 January 2013
IAS 12 Income Taxes Amendment	1 January 2013
Effective for future financial years:	
IFRS 10 Consolidated Financial Statements	1 January 2013
IFRS 11 Joint Arrangements	1 January 2013
IFRS 12 Disclosure of Interests in Other Entities	1 January 2013
IFRS 13 Fair Value Measurement	1 January 2013
IAS 1 Presentation of Financial Statements on other Comprehensive Income	1 July 2012
IAS 27 Separate Financial Statements	1 January 2013
IAS 28 Associates and Joint Ventures	1 January 2013
IFRS 9 Financial Instruments Financial Assets, Financial Liabilities	1 January 2013
Financial Assets	
Financial Liabilities	

The Trust has considered the above new standards, interpretations and amendments to published standards that are not yet effective and concluded that they are either not relevant to the Trust or that they would not have a significant impact on the Trust's financial statements, apart from some additional disclosures.

The Trust has not early adopted any new accounting standards, amendments or interpretations.

2. Segmental Analysis

The Trust's Board has determined that the Trust operates in two material segments which is Great Western Hospitals and Wiltshire Community Health Services. This is reflected in the Trusts' Contracts.

	GWH	WCHS	Total
Operating Income	**£'000**	**£'000**	**£'000**
NHS Clinical Income	185,747	75,860	261,607
Private Patients	3,797		3,797
Other Non Mandatory/Non Protected Revenue	3,079	512	3,591
Research & Development Income	700	(44)	656
Education and Training Income	6,839	16	6,855
Misc Other Operating Income	9,615	4,354	13,969
Total Income	**209,777**	**80,699**	**290,475**

3. Income from Activities (by Type)

	Year Ended 31 March 2012	Restated Year Ended 31 March 2011
	£000	£000
NHS Foundation Trusts	**324**	0
NHS Trusts	**448**	13
Primary Care Trusts	**259,332**	179,172
Local Authorities	**1,503**	1,347
Private Patients	**3,797**	3,040
Non-NHS: Overseas patients (non-reciprocal)	**320**	74
NHS Injury Cost Recovery scheme	**1,565**	1,515
	267,289	185,161

NHS Injury Cost Recovery scheme income is shown gross and is subject to a provision for doubtful debts of 10.5% (2010/11 9.6%) to reflect expected rates of collection.

The increase in income from NHS Foundation Trusts and NHS Trusts relates to income for services provided by Wiltshire Community Services.

3.1 Income from Activities (by Class)

	Year Ended 31 March 2012	Restated Year Ended 31 March 2011
	£000	£000
Elective income	**39,919**	41,367
Non elective income	**73,366**	64,218
Outpatient income	**38,643**	36,824
A & E income	**7,783**	7,433
Other NHS clinical income	**38,189**	32,279
Community contract income	**65,593**	0
Private patient income	**3,797**	3,040
	267,289	185,161

3.2 Private Patient Income

	Year Ended 31 March 2012	Base Year 2002/3
	£000	£000
Private patient income	**3,797**	1,587
Total patient related income	**267,289**	99,359
Proportion (as percentage)	**1.4%**	1.6%

Please note: The proportion of Private Patient Income to the total patient related income of the Trusts should not exceed its proportion whilst the body was an NHS Trust in 2002/03 (the base year).

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

4. Other Operating Income	**Year ended 31 March 2012 £000**	Year ended 31 March 2011 £000
Research and Development	**656**	573
Education and Training	**6,855**	6,512
Charitable and other contributions to expenditure	**805**	644
Non-patient care services to other bodies	**2,448**	2,215
Staff recharges	**2,065**	1,532
Other Income	**10,356**	6,075
	23,185	17,551

Analysis of Other Operating Income

Charitable and Other Contributions to Expenditure		
Macmillan Nurses	108	108
Prospect Hospice	98	77
Contributions from suppliers to support staff posts	584	449
Charitable Funds Recharge	15	10
Total	805	644

Non-patient care services to other bodies		
Mortuary	31	27
Renal	381	289
Sterile Services	377	663
Drugs provided to other NHS bodies	587	675
Bowel Screening Programme	223	68
Other Misc amounts	849	493
Total	2,448	2,215

Other Income includes		
Car Parking (Staff & Patients)	1,090	993
Estates recharges	1,548	329
IT recharges	47	47
Pharmacy sales	6	7
Clinical Excellence Awards	177	176
Catering	232	25
Property Rentals	2,655	1,101
Payroll & Procurement Services	214	78
Occupational Health Service	168	163
Dietetics	77	72
Ultrasound Photo Sales	51	32
Heart Improvement Programme	942	1,426
Transport services	282	
Other	2,867	1,626
Total	10,356	6,075

The increase in Estates recharges relates to management services relating to community sites rented to other bodies £900K

The increase in Property rentals relates to £1.5m income from sites within the Wiltshire Health Community Servcies contract which transferred in 2011/12

The increase in Payroll & Procurement services relates to the provision of these services to NHS Swindon , NHS Wiltshire and Royal National Hospital for Rheumatic Diseases.
The increase in Catering relates to services provided through the Wiltshire Community Health Services contract.

The increase in Transport services relates to the take on of this service with the transfer of Wiltshire Community Health Services in 2011/12

5. Operating Expenses	**Year Ended 31 March 2012 £000**	Restated Year ended 31 March 2011 £000
Services from Foundation Trusts	**1,575**	441
Services from other NHS Trusts	**10,001**	135
Services from PCTs	**4,650**	1,189
Services from other NHS bodies	**13**	0
Purchase of healthcare from non NHS bodies	**133**	72
Employee Expenses - Executive Directors	**855**	711
Employee Expenses - Non-Executive Directors	**126**	127
Employee Expenses - Staff	**171,129**	118,719
Drug Costs	**17,811**	13,011
Supplies and services - clinical	**22,377**	18,416
Supplies and services - general	**2,604**	1,689
Consultancy services	**259**	44
Establishment	**4,442**	2,173
Research and development	**656**	564
Transport	**337**	205
Premises	**7,942**	5,154
Increase / (decrease) in bad debt provision	**541**	(387)
Depreciation on property, plant and equipment	**7,620**	7,385
Amortisation on intangible assets	**252**	152
Loss on disposal of property, plant and equipment	**73**	0
Audit services (Statutory audit)	**63**	59
Audit services (Other Assurance Services)	**13**	17
Clinical negligence	**5,723**	3,842
Patient travel	**1,509**	909
Car parking and security	**177**	26
Insurance	**187**	97
Hospitality	**68**	67
Legal Fees	**854**	439
Training courses and conferences	**596**	551
Other Services	**11,519**	11,473
Losses, ex gratia & special payments	**7**	35
Other	**1,163**	521
	275,274	187,835

Staff Exit Packages
The Trust has not agreed any staff exit packages in 2011/12 (31 March 2011: £nil).

Limitation on auditor's liability
The limitation on the auditor's liability is £1,000,000

Other Services

Other Services - includes cleaning, catering, portering, housekeeping and estates services.
The increase in Clinical Negligence relates to the additional contributions for Wiltshire Community Health Services.

Services Provided by Foundation Trusts

The increase in Services provided by Foundation Trust's relates to payments to Salisbury NHSFT (£1,017k) for accommodation for Wiltshire Community Health Services.

Services Provided by Other NHS Trusts

The increase in Services from other NHS Trust's relates to payments to the Royal United Hospital for accommodation and medical cover (£7,017k) and Clinical Negligence (£1,935k) for Wiltshire Maternity Services which are operated from that site.

Services Provided by PCTs

The increase in Services provided by PCTs relates to payments to Bath & North East Somerset PCT (£134k), Somerset PCT (£226k) and Wiltshire PCT (£2,945k) relating to accommodation for Wiltshire Community Health Services.

The increase in Employee Expenses, Drugs Costs, Clinical and Non Clinical Supplies, Establishment Expenses, Costs and Patient Travel relate to the increase in expenditure in providing Wilthire Community and Maternity Services.

Bad Debt Provision

The increase in Bad Debt Provision is due to the Injury Recovery Scheme (£114k) and Overseas Visitors (£67k).

6. Operating leases - as Lessee

	Year Ended 31 March 2012	Year ended 31 March 2011
	£000	£000
Minimum lease payments	**5,599**	251
Contingent rents	**0**	0
Less sublease payments received	**0**	0
	5,599	251

Total future minimum lease payments	**Year Ended 31 March 2012**	Year Ended 31 March 2011
Payable:	**£000**	£000
Not later than one year	**4,203**	231
Between one and five years	**4,371**	193
After 5 years	**52**	0
Total	**8,626**	424

The increase in minimum lease payments is due to the merger with Wiltshire Community Services and relate to building and equipment utilised in the delivering of these services at a total cost of £5,011k.

7. Employee costs and numbers

7.1 Employee Expenses

	Year Ended 31 March 2012			Year Ended 31 March 2011		
	Total	**Permanently Employed**	**Other incl agency**	Total	Permanently Employed	Other incl agency
	£000	**£000**	**£000**	£000	£000	£000
Salaries and wages	**144,146**	**140,338**	**3,808**	100,119	96,515	3,604
Social security costs	**10,810**	**10,810**	**0**	7,711	7,711	0
Pension costs - defined contribution plans Employers contributions to NHS pensions	**17,028**	**17,028**	**0**	11,600	11,600	0
	171,984	**168,176**	**3,808**	119,430	115,826	3,604

7.2 Average number of employees

	Year Ended 31 March 2012			Year ended 31 March 2011		
	Total	**Permanently Employed**	**Other incl agency**	Total	Permanently Employed	Other incl agency
	Number	**Number**	**Number**	Number	Number	Number
Medical and dental	**473**	**464**	**9**	465	437	28
Administration and estates	**1,216**	**1,181**	**35**	764	739	25
Healthcare assistants and other support staff	**901**	**900**	**1**	607	573	34
Nursing, midwifery and health visiting staff	**1,892**	**1,797**	**95**	1,208	1,166	42
Nursing, midwifery and health visiting learners	**5**	**5**	**0**	2	2	0
Scientific, therapeutic and technical staff	**680**	**667**	**13**	395	391	4
	5,168	**5,014**	**154**	3,441	3,308	133

As part of Transforming Community Services Agreement 2,100 staff transferred form NHS Wiltshire on 1 June 2011.

7.3 Key Management Compensation

	Year Ended 31 March 2012	Year Ended 31 March 2011
	£000	£000
Salaries and short term benefits	**785**	687
Social Security Costs	**81**	72
Employer contributions to NHSPA	**82**	79
	948	838

Key management compensation consists entirely of the emoluments of the Board of Directors of the NHS Foundation Trust. Full details of Directors' remuneration and interests are set out in the Directors' Remuneration Report which is a part of the annual report and accounts.

There are currently six Directors to whom pension benefits are accruing under defined benefit schemes.

7.4 Highest Paid Director

Executive Name & Title Salary	**Total remuneration**	
	2011/12	**2010/11**
Dr A F Troughton, Medical Director	£194,218	£184,726

The above remuneration is on an annualised basis and is that of the highest paid director. This includes salary, performance related pay, severance payments and benefits in kind where applicable but excludes employer pension contributions. The Medical Director was Acting Chief Executive for the period May to September 2011.

7.5 Multiple Statement

	2011/12	**2010/11**	**% change**
Highest paid director's total remuneration	£194,218	£184,726	5.1%
Median total remuneration	£28,702	£26,146	9.8%
Ratio	6.77	7.07	-4.2%

All NHS Foundation Trusts are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisations workforce. The median total remuneration above is the total remuneration of the staff member lying in the middle of the linear distribution of staff employed in the Trust, excluding the highest paid director. This is based on an annualised full time total staff equivalent remuneration as at the reporting period date.The movement in the above ratio of -4.2% is due to the increased staff numbers through the merger with Wiltshire Community Services.

8. Retirements due to ill-health

During the year to 31 March 2012 there were 5 early retirements from the Trust agreed on the grounds of ill-health (31 March 2010 - 4 early retirements). The estimated additional pension liabilities of these ill-health retirements will be £368,490 (31 March 2011 - £113,566). The cost of these ill-health retirements will be borne by the NHS Pensions Agency.

9. Better Payment Practice Code

9.1 Better Payment Practice Code - measure of compliance

	Year Ended 31 March 2012		Year ended 31 March 2011	
	Number	**£000**	Number	£000
Total trade bills paid in the year	**41,617**	**77,899**	36,766	106,952
Total trade bills paid within target	**35,101**	**67,917**	34,578	103,129
Percentage of trade bills paid within target	**84.34%**	**87.19%**	94.05%	96.43%
Total NHS bills paid in the year	**2,078**	**25,585**	2,045	22,927
Total NHS bills paid within target	**1,038**	**12,426**	1,518	19,952
Percentage of NHS bills paid within target	**49.95%**	**48.57%**	74.23%	87.02%

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

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

The Trust was charged £558.51 in the year for late payment of commercial debts (31 March 2011 £2,833.79).

10. Finance Income

	Year Ended 31 March 2012	Year Ended 31 March 2011
	£000	£000
Interest on loans and receivables	**333**	217
	333	217

11. Finance Expense

	Year Ended 31 March 2012	Year Ended 31 March 2011
	£000	£000
Working Capital Facility Fee	**56**	97
Interest on late payment of commercial debt	**1**	3
Interest on obligations under Finance leases	**39**	0
Interest on obligations under PFI	**13,738**	14,002
	13,834	14,102

12. Taxation

The activities of the Trust have not given rise to any corporation tax liability in the year (31st March 2011- £nil).

13. Intangible Assets

13.1 2011/12:	Computer software - purchased	Licences and trademarks	Total
	£000	£000	£000
Gross cost at 1 April 2011	895	1,329	2,224
Additions purchased	244	0	244
Additions donated		0	0
Reclassifications	0	0	0
Gross cost at 31 March 2012	**1,139**	**1,329**	**2,468**
Amortisation at 1 April 2011	72	982	1,054
Provided during the year	141	111	252
Amortisation at 31 March 2012	**213**	**1,093**	**1,306**
Net book value			
Purchased	927	235	1,162
Donated	0	0	1
Total at 31 March 2012	**927**	**235**	**1,162**

13.2 2010/11:	Computer software - purchased	Licences and trademarks	Total
	£000	£000	£000
Gross cost at 1 April 2010	186	1,329	1,515
Additions purchased	283	0	283
Additions donated	0	0	0
Reclassifications	426	0	426
Gross cost at 31 March 2011	**896**	**1,329**	**2,225**
Amortisation at 1 April 2010	31	872	903
Provided during the year	41	110	151
Amortisation at 31 March 2011	**72**	**982**	**1,054**
Net book value			
Purchased	824	347	1,171
Donated	0	0	1
Total at 31 March 2011	**824**	**347**	**1,171**

Reclassification relates to transfer of assets from tangible assets.

13.3 Valuation and economic useful lives

The valuation basis is described in note 1.5 to the accounts. There is no active market for the Trust's intangible assets and there is no revaluation reserve.

The economic useful lives of intangible assets are finite and are described in note 1.8 to the accounts.

PFI Intangible Assets are depreciated over the life of the PFI Contract.
Economic useful lives of intangible assets are finite and amortisation is charged on a straight line basis:

	Minimum useful life Years	Maximum useful life Years
Software	5	5
Licences and trademarks	5	12

14. Property, plant and equipment

14.1 2011/12:	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Gross cost at 1 April 2011	21,049	153,375	5,206	5,299	30,999	58	11,180	2,952	230,118
Additions Purchased	0	629	0	1,405	956	0	759	48	3,797
Additions donated	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluation gains	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	(73)	0	0	0	(73)
Gross cost at 31 March 2012	**21,049**	**154,004**	**5,206**	**6,704**	**31,882**	**58**	**11,939**	**3,000**	**233,842**
Depreciation at 1 April 2011	0	16,561	308	0	21,011	58	7,475	1,687	47,100
Provided during the year	0	4,516	135	0	1,557	0	1,126	286	7,620
Impairments	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Depreciation at 31 March 2012	**0**	**21,077**	**443**	**0**	**22,568**	**58**	**8,601**	**1,973**	**54,720**
Net book value									
- Purchased at 31 March 2012	21,049	132,927	4,763	6,704	8,915	0	3,338	1,017	178,713
- Donated at 31 March 2012	0	0	0	0	399	0	(0)	10	409
Total at 31 March 2012	**21,049**	**132,927**	**4,763**	**6,704**	**9,314**	**0**	**3,338**	**1,027**	**179,122**
Analysis of property, plant and equipment									
Net book value									
- Protected assets at 31 March 2012	21,049	132,927	4,763	0	0	0	0	0	158,739
- Unprotected assets at 31 March 2012	0	0	0	6,704	9,314	0	3,338	1,027	20,383
Total at 31 March 2012	**21,049**	**132,927**	**4,763**	**6,704**	**9,314**	**0**	**3,338**	**1,027**	**179,122**
Asset Financing									
Net book value									
- Owned	21,049	132,927	4,763	6,704	9,314	0	3,338	1,027	179,122
- Finance Leased	0	0	0	0	0	0	0	0	0
Total at 31 March 2012	**21,049**	**132,927**	**4,763**	**6,704**	**9,314**	**0**	**3,338**	**1,027**	**179,122**

14. Property, plant and equipment

14.2 Prior year 2010/11:	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Gross cost at 1 Dec 2010	21,049	149,803	5,206	1,837	42,994	58	11,111	2,851	234,909
Additions Purchased	0	3,572	0	3,462	803	0	227	40	8,104
Additions donated	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	(329)	0	(158)	61	(426)
Revaluation gains	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	(12,469)	0	0	0	(12,469)
Gross cost at 31 March 2011	**21,049**	**153,375**	**5,206**	**5,299**	**30,999**	**58**	**11,181**	**2,952**	**230,119**
Depreciation at 1 Dec 2010	0	12,530	173	0	31,623	58	6,393	1,407	52,184
Provided during the year	0	4,031	135	0	1,857	0	1,082	280	7,385
Impairments	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	(12,469)	0	0	0	(12,469)
Depreciation at 31 March 2011	**0**	**16,561**	**308**	**0**	**21,011**	**58**	**7,475**	**1,687**	**47,100**
Net book value									
- Purchased at 31 March 2011	21,049	136,814	4,898	5,299	9,365	0	3,705	1,239	182,369
- Donated at 31 March 2011	0	0	0	0	623	0	(0)	26	649
Total at 31 March 2011	**21,049**	**136,814**	**4,898**	**5,299**	**9,988**	**0**	**3,705**	**1,265**	**183,018**
Analysis of property, plant and equipment									
Net book value									
- Protected assets at 31 March 2011	21,049	136,814	4,898	0	0	0	0	0	162,761
- Unprotected assets at 31 March 2011	0	0	0	5,299	9,988	0	3,705	1,265	20,257
Total at 31 March 2011	**21,049**	**136,814**	**4,898**	**5,299**	**9,988**	**0**	**3,705**	**1,265**	**183,018**
Asset Financing									
Net book value									
- Owned	21,049	136,814	4,898	5,299	9,988	0	3,705	1,265	183,018
- Finance Leased	0	0	0	0		0	0	0	0
Total at 31 March 2011	**21,049**	**136,814**	**4,898**	**5,299**	**9,988**	**0**	**3,705**	**1,265**	**183,018**

Reclassification relates to transfer of assets from intangible assets.

14. Property, plant and equipment (cont.)

14.3 Revaluation

The Trust has not revalued land, buildings and dwellings in 2011-12 as there has not been a significant change in asset values. All other assets are valued at depreciated replacement cost with no indexation in year due to the current economic climate.

14.4. Non-current assets held for sale

The Trust has no non-current assets held for sale (31 March 2011: £nil).

15. Capital commitments

There are no commitments under capital expenditure contracts at the end of the period (31st March 2011: £300K), not otherwise included in these financial statements.

16. Inventories

16.1 Inventories	**31 March 2012**	31 March 2011
	£000	£000
Materials	**4,839**	3,820
	4,839	3,820

Inventories carried at fair value less costs to sell where such value is lower than cost are nil (31 March 2011 - £nil).

16.2 Inventories recognised in expenses	**31 March 2012**	31 March 2011
	£000	£000
Inventories recognised as an expense	**42,500**	33,109
Write-down of inventories recognised as an expense	**0**	37
	42,500	33,146

17. Trade and other receivables

	Current	
	31 March 2012	31 March 2011
	£000	£000
NHS receivables	**2,455**	2,926
Other receivables with related parties	**1,018**	0
Provision for impaired receivables	**(940)**	(399)
Prepayments	**1,023**	1,009
Lifecycle prepayment	**3,426**	0
Accrued Income	**3,170**	2,734
Other receivables	**3,310**	2,016
PDC receivable	**114**	49
	13,577	8,336

18.1 Provision for impairment of receivables

	31 March 2012	31 March 2011
	£000	£000
Balance at 1 April	**399**	786
Increase in provision	**541**	0
Amounts utilised	**0**	0
Unused amounts reversed	**0**	(387)
Balance at 31 March	**940**	399

18.2 Analysis of Impaired Receivables

	31 March 2012	31 March 2011
	£'000	£'000
Ageing of impaired receivables		
0-30 days	**40**	15
30-60 days	**12**	7
60-90 days	**75**	8
90-180 days	**386**	157
over 180 days	**427**	212
	940	399
Ageing of non-impaired receivables past their due date		
0-30 days	**1,752**	1,460
30-60 days	**625**	217
60-90 days	**458**	343
90-180 days	**237**	413
over 180 days	**2,417**	1,536
	5,489	3,969

19. Cash and cash equivalents	**31 March 2012 £000**	31 March 2011 £000
Balance at 1 April	**11,223**	12,181
Net change in year	**3,259**	(958)
Balance at 31 March	**14,482**	11,223
Made up of		
Cash with Government Banking Service	**14,473**	11,216
Commercial banks and cash in hand	**9**	7
Cash and cash equivalents as in statement of financial position	**14,482**	11,223
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**14,482**	11,223

20. Trade and other payables	**Current**		**Non-Current**	
	31 March 2012 £000	31 March 2011 £000	**31 March 2012 £000**	31 March 2011 £000
NHS payables	**2,947**	2,496	**0**	0
Trade payables - capital	**1,350**	1,857	**0**	0
Other trade payables	**3,631**	1,523	**288**	0
Other payables	**8,798**	4,172	**0**	0
Accruals	**5,030**	4,413	**0**	0
Receipts in advance	**3,002**	5,516	**124**	0
	24,758	19,976	**412**	0

Other payables include outstanding pension contributions of £2,053,755. (31 March 2011: £1,453,927).

Receipts in advance include the PFI advance payment from NHS Wiltshire.
The increase in accruals as at 31 March 2012 is due to an increase in the accrual for annual leave and salary enhancements £526k still outstanding at 31/3/12 and the aquisition of Wiltshire Community Health Services £1,241k

The increase in NHS Payables as at 31 March 2012 is due to an increase in services purchased from other NHS organisations as a result of the acquisition of Wiltshire Community Health Services.

21. Other liabilities	**Current**		**Non-current**	
	31 March 2012 £000	31 March 2011 £000	**31 March 2012 £000**	31 March 2011 £000
Deferred income	**1,425**	1,016	**1,816**	1,930
	1,425	1,016	**1,816**	1,930

21.1 Tax Payable
Tax payable of £1,788,001.64 (31 March 2011: £1,324,016.28) consists of employment taxation only (Pay As You Earn), owed to Her Majesty's Revenue and Customs at the period end.

22. Borrowings

22.1 Prudential borrowing limit	**31 March 2012 £000**	31 March 2011 £000
Prudential borrowing limit set by Monitor	**133,100**	135,700
Working capital facility	**14,000**	14,000
Actual borrowing in year - long term	**132,666**	133,461
Actual borrowing in year - working capital	**0**	0

The Trust is required to comply and remain within a prudential borrowing limit. This is made up of two elements:

- the maximum cumulative amount of long term borrowing. This is set by reference to the four ratios test set out in Monitor's Prudential Borrowing Code. The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact on the long term borrowing limit.

- the amount of any working capital facility approved by Monitor.

Further information on the NHS Foundation Trust Prudential Borrowing Code and Compliance Framework can be found on the website of Monitor, the Independent Regulator of NHS Foundation Trusts.

There has been no necessity to use its overdraft facility. The actual long term borrowing relates to the Trust's PFI Lease Liability and Finance Leases. These are both within this limit.

22.2 PFI lease obligations

Amounts payable under PFI on SoFP obligations:	**31 March 2012 £000**	31 March 2011 £000
Gross PFI liabilities	262,969	275,673
Of which liabilities are due		
Within one year	15,489	12,579
Between one and five years	52,263	52,152
After five years	195,217	210,942
Less future finance charges	(130,934)	(142,212)
	132,035	133,461
Net PFI liabilities		
Of which liabilities are due		
Within one year	4,430	1,425
Between one and five years	10,762	9,729
After five years	116,843	122,307
	132,035	133,461
Included in:		
Current borrowings	4,430	1,425
Non-current borrowings	127,605	132,036
	132,035	133,461

22.3 Finance lease obligations

Amounts payable under Finance lease obligations:	**31 March 2012 £000**	31 March 2011 £000
Gross Finance lease liabilities	768	0
Of which liabilities are due		
Within one year	139	0
Between one and five years	506	0
After five years	122	0
Less future finance charges	(137)	0
	631	0
Net Finance lease liabilities		
Of which liabilities are due		
Within one year	103	0
Between one and five years	447	0
After five years	81	0
	631	0
Included in:		
Current borrowings	103	0
Non-current borrowings	528	0
	631	0

No finance leases were held in 2010-11.

22.4 Charges to expenditure

The total charged in the year to expenditure in respect of the service element of On-Statement of Financial Position PFI contracts was £11,352k (£11,162k 2010/11)

The Trust is committed to the following annual charges

	31 March 2012	31 March 2011
PFI commitments in respect of service element:	**£000**	£000
Not later than one year	**12,327**	11,979
Later than one year, not later than five years	**50,428**	48,247
Later than five years	**195,212**	203,531
Total	**257,967**	263,757
PFI commitments present value in respect of service element:		
Not later than one year	**11,910**	11,387
Later than one year, not later than five years	**43,938**	42,798
Later than five years	**128,723**	131,983
Sub total	**184,571**	186,168

The estimated annual payments in future years are expected to be materially different from those which the Trust is committed to make during the next year as the service payment is increased annually in accordance with the increase in the Retail Price Index (RPI).

23. Provisions

	Current		**Non current**	
	31 March 2012	31 March 2011	**31 March 2012**	31 March 2011
	£000	£000	**£000**	£000
Pensions relating to other staff	**119**	117	**1,292**	1,082
Legal claims	**100**	0	**0**	0
Other	**346**	233	**3,394**	3,413
	565	350	**4,686**	4,495

	Pensions relating to other staff	**Legal claims**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**
At 1 April 2011	1,199	0	3,646	**4,845**
Arising during the year	298	100	161	**559**
Used during the year	(116)	0	(57)	**(173)**
Reversed unused	0	0	(24)	**(24)**
Unwinding of discount	30	0	14	**44**
At 31 March 2012	**1,411**	**100**	**3,740**	**5,251**
Expected timing of cash flows:				
Within one year	119	100	346	**565**
Between one and five years	424	0	3,017	**3,441**
After five years	868	0	377	**1,245**
	1,411	100	3,740	**5,251**

The provision under 'legal claims' relates to an outstanding Employment Tribunal Claim (31 March 2011: £nil). The provisions under 'other' includes s106 Agreement of £2,900k (31st March 2011 £2,900k) and AGW Cardiac Network Redundancy provision £161,000 (31st March 2011: £137,000)

Provisions within the annual accounts of the NHS Litigation Authority at 31 March 2012 include £31,653,683 in respect of clinical negligence liabilities of the Trust (31 March 2011 - £26,974,277).

The Trust has not made a provision under the Carbon Emissions Scheme as the Trust is not required to be registered in 2011/12 as the properties managed by the Trust are below the threshold. This is not anticipated to change in 2012/13.

24. Events after the reporting period

There are no events after the reporting period

25. Contingencies

There are no contingent assets and liabilities for the period ended 31 March 2012

26. Related party transactions

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

The Trust is under the common control of the Board of Directors. During the year none of the Board Members or members of the key management staff or parties related to them, has undertaken any material transactions with the Great Western Hospitals NHS Foundation Trust.

It should be noted that the Trust has a Non- Executive Director, Cllr Kevin Small, who is also a Councillor for Swindon Borough Council with whom the Trust has had material transactions relating mainly to the Section 106 agreement (£2.9m) and our Pooled Budget (£936k)

The Department of Health is regarded as a related party. During 2011/12 the Trust has had a significant number of material transactions with other entities for which the Department is regarded as the Parent Department. These entities are listed below.

.	Receivables	Payables	Revenue	Expenditure
	£000	**£000**	**£000**	**£000**
NHS South West	30	0	6,188	5
NHS Swindon	992	216	112,486	687
NHS Wiltshire	715	5,583	118,563	3,805
NHS Bath & North East Somerset	16	59	7,424	134
NHS Berkshire	45	0	6,049	0
NHS Bristol	49	0	5,130	9
NHS Gloucester	83	83	6,658	83
Royal United Hospital NHS Trust	520	1,479	1,055	8,774
NHS Litigation Authority	0	385	0	5,676
NHS Pension Scheme	0	2,055	0	17,028
Total	2,450	9,860	263,553	36,201

The Trust has also received revenue payments from a number of charitable funds, certain of the Trustees for which are also members of the Trust Board. The audited accounts of these Funds held on Trust are not included in this annual report and accounts and will be audited and published at a later date. A copy of these will be available on the Trusts' internet site.

27. Private Finance Initiative contracts

27.1 PFI schemes on-Statement of Financial Position

The Trust has 3 PFI schemes which are deemed to be on-Statement of Financial Position at the period end. These are the Main Hospital and Brunel Treatment Centre (treated as one agreement), Downsview Residences and the agreement in place with Systems C.

Great Western Hospital

The contract commenced on 5 October 1999 for a period of 30 years until 4 October 2029. In terms of the contract the operator company was obliged to build the Great Western Hospital, which was completed in November 2002, for subsequent occupation and use by the Trust. The Trust pays the operator company a quarterly availability fee for the occupation of the hospital and a quarterly service fee for the services provided by the operator such as portering and catering. In October 2003 the Trust entered into a variation of the original agreement for the construction of the Brunel Treatment Centre which is an extension to the original hospital. The construction of the Treatment Centre has resulted in increased availability and service charges, however, the main terms of the contract including the termination date remain unchanged. Subsequently, in September 2006, the Trust entered into a refinancing agreement which resulted in a reduction in the annual availability payment again with no change to the contract term. The amount of the availability payment is determined annually and increased based on a combination of the annual increase in the Retail Price Index (RPI) and a fixed percentage increase of 2.5%. The operator is obliged to maintain the buildings and replace lifecycle elements of the buildings where necessary. At the end of the contract term the hospital buildings revert back to the Trust for Nil consideration. The nature of the contract meets the criteria for treatment as a service concession under IFRIC 12. Accordingly the hospital buildings are treated as an asset under property, plant and equipment with the resultant liability being treated as a finance lease under IAS 17.

Downsview Residences

The contract commenced on 5 October 1999 for a period of 30 years until 4 October 2029. In terms of the contract the operator company was obliged to build the Downsview staff residences on the Hospital site for the provision of housing to hospital staff. At commencement of the contract the Trust made a capital contribution of £649k towards the construction cost of the building. The residences are managed by the operator company who rent the accommodation units to, primarily, Trust staff. The Trust does not pay the operator company an availability fee, however, a monthly service fee is paid for the servicing of the units which is based on usage. The operator is responsible for maintaining the buildings over the contract term. At the end of the contract term the accommodation buildings revert back to the Trust for Nil consideration. The nature of the contract meets the criteria for treatment as a service concession under IFRIC 12. Accordingly the residences are recognised as an asset under property, plant and equipment. The cost of the building less the capital contribution has been accounted for as deferred income and is released to income equally over the entire contract term.

Systems C

The Trust has a PFI contract in respect of the Integrated Clinical Information System which meets the criteria for recognition as a service concession agreement as envisaged under IFRIC 12 and has, accordingly, been treated as on statement of financial position. The contract is dated 27 May 2002 with an effective date of 13 November 2001. The contract is for 12 years and is due to expire on 12 November 2013. The contract is for the supply of computer hardware and software together with the provision of ongoing support and system management services.

28 Financial instruments and related disclosures

The key risks that the Trust has identified relating to its financial instruments are as follows:-

28.1 Financial risk

Because of the continuing service provider relationship that the Trust has with Primary Care Trusts (PCTs) and the way those PCTs are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Finance & Investment Committee.

28.2 Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

28.3 Credit risk

The majority of the Trust's income comes from contracts with other public sector bodies, resulting in a low exposure to credit risk. The maximum exposures as at 31 March 2012 are in receivables from customers, as disclosed in note 17 to the accounts. The Trust mitigates its exposure to credit risk through regular review of debtor balances and by calculating a bad debt provision at the period end.

The following shows the age of such financial assets that are past due and for which no provision for bad or doubtful debts has been raised:

	31 March 2012	31 March 2011
	£000	£000
By up to three months	**2,835**	2,020
By three to six months	**237**	413
By more than six months	**2,417**	1,536
	5,489	3,969

The Trust has not raised bad or doubtful debt provisions against these amounts as they are considered to be recoverable based on previous trading history.

The increase in the amounts is primarily due to an increase in income from the Injury Recovery Scheme for both GWH and Wiltshire Community Health Services (£1,321k) and Non-NHS Debtors (£272k)

28.4 Liquidity risk

The NHS Trust's net operating costs are incurred under annual service agreements with local PCTs, which are financed from resources voted annually by Parliament. The Trust also largely finances its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks. It should also be noted that the Trust has a Working Capital Facility of £14 million available within its terms of authorisation as an NHS Foundation Trust which reduces its liquidity risk still further.

28.5 Fair Values of Financial Instruments

All the financial assets and all the financial liabilities of the Trust are measured at fair value on recognition and subsequently at amortised cost.

The following table is a comparison by category of the carrying amounts and the fair values of the Trust's financial assets and financial liabilities at 31 March 2012 and 31 March 2011.

	Carrying Value 31 March 2012 £000	**Fair Value 31 March 2012 £000**	Carrying Value 31 March 2011 £000	Fair Value 31 March 2011 £000
Current financial assets				
Cash and cash equivalents	**14,482**	**14,482**	11,216	11,216
Loans and receivables:				
Trade and receivables	**7,540**	**7,540**	12,141	12,141
	22,022	**22,022**	23,357	23,357
Non-current financial assets				
Loans and receivables:				
Trade and receivables	**0**	**0**	0	0
Total financial assets	**22,022**	**22,022**	23,357	23,357
Current financial liabilities				
Financial liabilities measured at amortised cost:				
Obligations under PFI	**4,430**	**4,430**	1,425	1,425
Obligations under Finance Leases	**103**	**103**	0	0
Trade and other payables	**22,917**	**22,917**	12,704	12,704
Provisions under contract				
	27,450	**27,450**	14,129	14,129
Non-current financial liabilities				
Financial liabilities measured at amortised cost:				
Obligations under PFI	**127,605**	**127,605**	132,036	132,036
Obligations under Finance Leases	**528**	**528**	0	0
Provisions under contract	**2,900**	**2,900**	2,900	2,900
	131,033	**131,033**	134,936	134,936
Total financial liabilities	**158,483**	**158,380**	149,065	149,065
Net financial assets	**(136,461)**	**(136,358)**	(125,708)	(125,708)

The fair value on all these financial assets and financial liabilities approximate to their carrying value.

The following table reconciles the financial assets and financial liabilities that fall within the scope of IAS 39 to the relevant on-Statement of Financial Position amounts. Cash and cash equivalents and finance lease liabilities fall wholly within the scope of IAS 39.

	Current		**Non-current**	
	31 March 2012 £000	31 March 2011 £000	**31 March 2012 £000**	31 March 2011 £000
Trade and other receivables:	**1,474**	347	**0**	0
Non-financial assets	**114**	49	**0**	0
Prepayments	**4,450**	1,009	**0**	1,733
	6,038	1,406	**0**	1,733
Trade and other payables:				
Taxes payable	**3,430**	2,056	**0**	0
Non-financial liabilities	**0**	0	**0**	0
	3,430	2,056	**0**	0
Provisions:				
Financial liabilities	**0**	206	**0**	0
Provisions under legislation	**147**	144	**1,783**	1,732
	147	350	**1,783**	1,732

The provisions under legislation are for personal injury pensions £519,266 (31 March 2011: £538,845) and early retirement pensions £1,411,343 (31 March 2011: £1,199,428). These liabilities are not contracted, but are defined by legislation and are owed to the NHS Pensions Agency.

29. Third Party Assets

The Trust held £8,617 cash at bank and in hand at 31 March 2012 (31 March 2011: £10,161) which relates to monies held by the NHS Trust on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts.

30. Losses and Special Payments

There were 1,017 cases of losses and special payments totalling £47,744.40 approved in the year. (2010/11 - 1,712 cases totalling £71,621)

There were no clinical negligence, fraud, personal injury, compensation under legal obligation or fruitless payment cases where the net payment or loss for the individual case exceeded £100,000. (2010/11 - nil cases).

Losses and special payments are compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

31. Pooled Budget - Integrated Community Equipment Service

	31 March 2012	31 March 2011
Income:	**£000**	**£000**
Swindon Borough Council	517	537
Paediactrics	29	0
NHS Swindon	238	231
Great Western Hospitals NHS Foundation Trust	153	153
Total Income	**936**	920
Expenditure	936	1,078
Total Surplus/(Deficit)	**0**	(158)
Share of Surplus (Deficit):		
Swindon Borough Council	0	(84)
Swindon Borough Council De Minus level	0	(10)
NHS Swindon	0	(40)
Great Western Hospitals NHS Foundation Trust	0	(25)
Total Surplus/(Deficit)	**0**	(158)

The above disclosure is based on month 12 management accounts provided by Swindon Borough It should be noted that these figures are un-audited.

Great Western Hospitals NHS

NHS Foundation Trust