Musgrove Park Hospital


Musgrove Park Hospital is part of Taunton and Somerset NHS Foundation Trust

Annual Report and Accounts

2009/2010

Taunton and Somerset NHS Foundation Trust

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

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Annual Report and Accounts 2009/10

Musgrove Park Hospital

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TAUNTON AND SOMERSET NHS FOUNDATION TRUST

ANNUAL REPORT AND ACCOUNTS 2009/10

1. Chairman's Report

Taunton and Somerset NHS Foundation Trust ("the Trust") was authorised by Monitor on 1 December 2007. This report therefore covers the third year of the Trust operating as an NHS Foundation Trust.

There is a wide range of measures and indicators that the Trust uses to provide assurance about performance. We have robust internal performance reviews and a comprehensive internal audit programme; the Board receives regular reports on patient complaints and concerns; the monthly patient survey work carried out by independent volunteers provides feedback from 150 in-patients each month; our exit cards give us additional anonymous feedback from hundreds of patients a year; we also fully co-operate with the national inpatient and outpatient surveys and take action based on the conclusions drawn; and we have good links with the local authority, scrutiny committee and the Local Involvement Networks (LINks).

In addition to this, external assessment of the Trust's performance remains a key indicator of success. In the last 12 months the Trust has been registered, without qualification, by the Care Quality Commission and received a rating from the now disbanded Healthcare Commission of providing a "good" quality of services and having "excellent" management of resources.

Other key targets have been set, internally and in partnership with stakeholders, to measure the quality of service and experience that the Trust provides.

There has been evidence of continued improvement in infection prevention and control. Both MRSA blood stream infections and incidents of Clostridium Difficile have been lower than the threshold set. At the same time, however, the Trust has experienced an extended and challenging norovirus outbreak which has, at its worst, affected 14 wards. While not alone in this among hospitals and care homes across the region, the implications have been difficult to manage with capacity stretched and some non-urgent operations postponed.

The national out-patient survey carried out by PICKER showed that the Trust had improved in areas such as offering choice to patients, ensuring privacy and copying correspondence to patients. However, there had been a deterioration in patients' views on the information they were given and the number of times that an appointment was changed.

The PICKER national inpatient survey was particularly positive, with 97% of patients asked saying that they would recommend the hospital to a friend or family member who needed treatment and improvements recorded on key areas highlighted in 2008.

The independent national staff survey concluded that the Trust compared well with the national average on issues such as staff suffering work related stress, staff feeling valued by colleagues and staff using flexible working options. The Trust compared less well on

staff feeling there are good opportunities to develop their potential and staff witnessing potentially harmful errors or near misses. The Trust also commissioned a comprehensive bespoke staff survey to understand staff engagement levels and how these could be increased. Over 2,800 staff responded to the survey (63%). Work is now on-going to address the issues raised.

Staff at the Trust also received regional and national recognition for the work they are doing. The team in anaesthetics who developed the interactive trauma board won local, regional and national best awards for their innovative project. The communications team won the national award for communications improving the quality of patient care for an innovative communication project emphasising the importance of effective listening. The clinical glaucoma team were honoured with a national award in the Glaucoma Achievements Award and an independent national group praised the excellent clinical results in the Intensive Therapy Unit for the second year running.

The bariatric team were also awarded level one status by the regional specialist commissioners, ensuring that Musgrove was one of the key regional centres for this surgery, and the national clinical lead for Pathology praised the work of the Somerset Pathology Service based at Musgrove. The radiotherapy services manager, Karen Anstey, was announced as South West Radiographer of the Year, and the Radiotherapy team were announced as the Team of the Year in the South West. The Beacon Centre also received the Macmillan Quality Environment Mark, the first of its kind in the UK, which recognises the leading-edge work being done in cancer care at the Beacon Centre.

The specialist Colorectal Nurse Lead won the prestigious Carol Baillie Nursing Award and the Cytology Screening Team were praised by the National Improvement Programme for revolutionising their service and dramatically reducing waiting times.

The Trust continues to develop new services where there is a clear clinical need and support from commissioners. In 2009 the Trust started offering a 24 hours a day, seven days a week primary angioplasty service for those who arrive at Musgrove with chest pain.

Waiting times have continued to reduce across the NHS and at Musgrove Park and if you compare the average time people waited for a first appointment 2 or 3 years ago, the difference is dramatic. However, demand for services has significantly increased and in some specialties, capacity is not sufficient to cope and meet the 18 week referral to treatment target. In orthopaedics the challenge is significant. The Trust is working closely with our commissioners to find alternative capacity and options for patients where that is necessary.

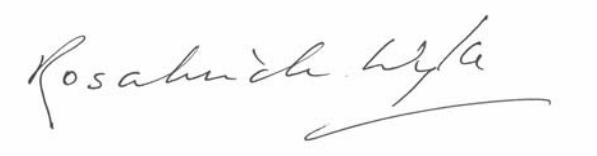
The Trust's strategic developments have continued to progress well. The Trust started work on the helipad outside the Accident and Emergency Department, and this will be open for flights by early summer. This will not only improve access to the department from more rural areas, but ensure that we can make the best use of tertiary centres such as Bristol by making transfers easier and safer. A helipad adjacent to A&E will also help protect the status of the department.

A second MRI scanner opened in 2009 providing additional capacity for an increasingly in-demand department.

Partnership working is important for the Trust as in a modern health economy organisations need to work together to benefit patients. The Trust has good working relationships with other foundation trusts in Somerset and with the main commissioners

at NHS Somerset. In addition, the Trust has good relationships with Somerset County Council and the local district Councils both via our partnership governors on the Members Council and with formal meetings of officers. The Trust prioritises patient and public involvement work and has active volunteer and Musgrove Partner groups. There are also good links with the new Local Involvement Networks (LINks) that have replaced the PPI Forums. Officers from the Trust meet with LINks officers on a regular basis and seek to give as much information as possible to allow the LINks to inform and engage with their members.

Our guiding principles for the future remain clear: ensure patient safety is absolutely prioritised, improve the patient experience in every way we can and cut out waste to make more of what we do.



Rosalinde Wyke
Chairman

2. Directors' Report and Management Commentary

The Directors present their annual report together with the audited financial statements for the year ended 31 March 2010. The Directors' report is a requirement of the Companies Act 2006 and incorporates the management commentary, which gives an analysis of the development and performance of the Trust over the year, together with an operating and financial review.

2.1 About the Directors (year ended 31 March 2010)

Rosalinde Wyke, Chair

Rosalinde has had a career in operations and senior management within the international finance and business information industry. A former full time carer, Rosalinde is active in the management of a number of community organisations, including Chairman of a Parish Council, Somerset IOD branch committee member, and chairing a multi-authority transport forum.

She is a PPE graduate with post-graduate training in accounting, information science, change management and more recently the IOD Diploma in Company Direction.

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She was a non-executive director of the Board for three years, including two years as Vice-Chairman before her Chair appointment.

Rosalinde is Chair of the Charitable Funds Committee and Nomination Committee.

Appointed as Chairman August 2006 – Appointment end date 31 July 2010.

Peter Merson - Vice-Chairman from 1 January 2009

Peter qualified as a veterinary surgeon. After three years in veterinary practice he spent the majority of his professional life with the Milk Marketing Board, where he was responsible for health and fertility in its national cattle breeding service. In 1995 he was appointed as the first Chief Executive of the Milk Development Council, and has also worked at the Royal Veterinary College. He is an accredited mediator with the Centre for Effective Dispute Resolution, and is also currently working with Somerset Family Mediation. He is chairman of the World Mission Group and the world development representative for the Diocese of Bath and Wells, and is a trustee of the Jubilee Debt Campaign. Peter's NHS experience includes four years as a non-executive director of Cotswold and Vale Primary Care Trust. Peter lives in North Petherton.

Besides acting as vice-chairman, Peter is the non-executive Security Champion and Infection Control Champion for the Trust and sits on the Governance, Treasury and Investment, Charitable Funds, Remuneration and Nomination Committees.

Appointed 1 January 2007 – Appointment end date 31 December 2010

Adele Barker – Non-Executive Director – Senior Independent Director

Adele is Customer Services Director for British Gas, a role she has held for the past five years. She has significant customer service, operational management and cultural change experience having worked for a number of top FTSE 100 companies, including Barclays, Orange and Marks & Spencer. Adele has a joint honours degree in English and History. Born at Musgrove Park Hospital, and educated in the county, Adele has strong associations with the area and lives on the outskirts of Taunton.

Adele is chair of the Governance and Remuneration Committees and a member of the Nomination Committee. She was appointed to the role of Senior Independent Director in January 2010.

Appointed 1 January 2007 – Appointment end date 31 December 2010.

Andrew Willis – Non-Executive Director

A qualified solicitor, Andrew has worked in London, Bristol and Southampton specialising in company and commercial law. Self-employed, he mostly focuses on legal training with post-graduate lawyers working for large City of London firms. He is an associate of the King's Fund specialising in corporate governance issues as part of the fund's leadership development team. Andrew's academic background is in economics and he is conducting PhD research at the London School of Economics into NHS productivity and incentives. He also teaches undergraduates at the LSE on a part-time basis.

Andrew's board experience includes three years as a director of Network Housing Group Limited (Network) (2002-2005) and Southampton University Hospitals NHS Trust (2000-2003). From 2006 to March 2010 he served as an independent member of Network's audit committee and is chairman of governors of a local school.

From 2005 to Nov 2009 he chaired the Trust's Audit Committee and served as the vice-chairman of the Board for two years. Andrew is a member of the Audit, Treasury and Investment, Remuneration and Nomination Committees and is the Board Champion for Mental Health.

Andrew lives on Exmoor and is co-founder of a horse rehabilitation business which operates on the Somerset-Devon border.

Re-appointed for 2nd term on 1 January 2009 – Appointment end date 31 December 2012.

Chris Harvey – Non-Executive Director

Chris lives near Tiverton and with his wife runs a small herd of pedigree cattle.

He worked in the printing and packaging industries as a board level finance director for many years and is now a non-executive director of a large housing association based at Weston-Super-Mare, and of a company which employs and trains disabled people in Devon and Somerset. He is also a governor at Bicton Agricultural College.

Chris has a law degree from Oxford University and is a chartered accountant, and has played rugby for Bath and Somerset.

Chris is chair of the Treasury and Investment Committee and a member of the Audit Committee, Remuneration and Nomination Committees.

Appointed 17 September 2007 – Appointment end date 16 September 2011.

Gill McComas – Non-Executive Director

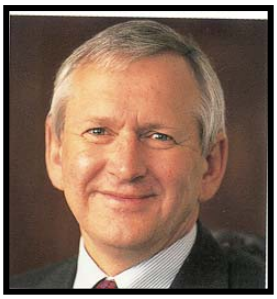
Gill has 25 years experience in the food manufacturing and retail industry. She has worked in marketing, communications and general management for companies such as United Biscuits, Premier Foods and Somerfield. She has a particular interest and expertise in acquisitions and change management. Married with two teenage children, Gill is also the chairperson of the Frome and Warminster Friends Group of Children's Hospice South West.

Gill lives in Witham Friary, near Frome, and enjoys skiing, swimming, eating out and watching her children's sporting activities.

Gill is a member of the Governance, Remuneration and Nomination Committees and sits on the Somerset Pathology Services Board.

Appointed 1 January 2009 – Appointment end date 31 December 2012.

David Clements – Non-Executive Director



David has over 40 years experience in the engineering and construction industries, principally with WS Atkins, Balfour Beatty and the Biwater Group and has been involved in a wide variety of Private Finance Initiative and Public Private Partnership capital schemes, including two acute hospital projects. He is also a non-executive Director of Partnerships UK plc, a public private partnership which is 49% owned by the Government and has recently been appointed as a non-executive Director of the Infrastructure Planning Commission.

David chairs the Trust's Audit Committee and is a member of the Remuneration and Nomination Committees and sits on the Surgical Project Board.

David is married with two grown up children and lives in Hinton St George in South Somerset. He lists gardening, music, hill walking and sailing an ocean going yacht from Dartmouth as his hobbies. He is also the Treasurer of the highly successful Hinton St George Music Festival, as well as being fully involved in other community activities in the village.

Appointed 1 January 2009 – Appointment end date 31 December 2012

Jo Cubbon – Chief Executive

Jo joined the Trust as Chief Executive on 1 April 2008. She is a Registered General Nurse, and a Registered Health Visitor and has an MBA from Liverpool University. Clinical specialties include sexual health and child care services. After a number of years in both clinical and senior management roles her first job as an NHS Chief Executive was at the Robert Jones and Agnes Hunt District NHS Trust in 2000. She took up the CEO role at Burton Hospitals before joining East Lancashire NHS Trust as CEO in 2005, a four site, 7,000 staff hospital with an annual budget of £293m. Jo has worked in Russia developing community services.

Jo is currently a nationally elected member of the Policy Board of NHS Employers.

Peter Lewis – Deputy Chief Executive

Peter is an Associate Member of the Chartered Institute of Management Accountants and joined the Trust as Director of Finance and Performance in April 2005. Prior to this he had been Director of Performance at Dorset and Somerset Strategic Health Authority and Director of Finance for Somerset Health Authority, as well as holding a number of more junior finance roles in the NHS.

David Allwright – Director of Corporate Planning and Performance

David has been an NHS manager since 1987 with over 11 years experience at board level. He joined the Trust in 2001 as Director of Planning and Facilities. David took on responsibility for performance in 2010. Before moving to Taunton in 2001 he was Assistant Chief Executive at North Devon Healthcare Trust. Prior to this he held a number of positions in the NHS in Hampshire, including general management posts at Winchester and Eastleigh Healthcare Trust and senior planning and commissioning posts in Southampton and Portsmouth Health Authorities.

Cecil Blumgart – Medical Director

Cecil studied medicine at the University of the Witwatersrand in South Africa. He started training in Anaesthetics in Johannesburg and completed his time in the Newcastle-Upon-Tyne rotation.

He was appointed as a Consultant Anaesthetist with responsibility for leading obstetric anaesthesia at Musgrove Park Hospital in 1992. He went on to become Clinical Director for Anaesthetics and Intensive Care, then Associate Medical Director of the Surgical Division.

Cecil developed an interest in Human Resources and was appointed as Associate Director - Medical Workforce in 2005 and as Acting Medical Director in April 2007. He has held the substantive role of Medical Director since July 2008. He also continues to provide a limited clinical service within the anaesthetics directorate.

Martine Price – Director of Governance and Nursing

Martine joined the Trust in July 2007. Previously she was the Deputy Nurse Director at Cardiff and Vale NHS Trust, one of the largest integrated teaching Trusts in the UK.

Qualifying as a Registered General Nurse, Martine has over 27 years professional and management experience in the Health Service. She has worked in a variety of roles in both acute and primary care, and in education. Martine gained an MSc in Nursing in 2000. She is a former council member and trustee of the Nursing and Midwifery Council.

Tim Jobson – Director of Clinical Service Development

Tim studied medicine at Oxford University, graduating in 1992. After junior medical posts he undertook research at the University of Nottingham, leading to a PhD in the cellular mechanisms which drive scarring. He then completed higher medical training in gastroenterology and was appointed as a Consultant Physician at Musgrove Park in April 2004.

Tim then joined the Information Technology team here as clinical lead, contributing to major projects throughout the organisation. He was appointed to the post of Director of Clinical Service Development in October 2008, and still continues to practice gastroenterology.

Changes in the Board of Directors

There was one additional director appointed during 2009/10. The Trust recruited Jo Ridgway as Director of Organisational Development and Workforce, commencing 1 September 2009.

There were two changes to directors' titles to reflect portfolio changes from 1 March 2010. Peter Lewis became Deputy Chief Executive and David Allwright, Director of Corporate Planning and Performance.

Jo Ridgway - Director of Organisational Development

Jo Ridgway joined the Trust as Executive Director of Organisational Development (OD) on 1 September 2009.

Jo has a track record in leading change as well as progressing and developing Human Resource (HR) services to deliver excellence and was most recently OD Programme Director for Cornwall County Council. She has also worked in senior HR and OD positions for Bedford County Council and Wiltshire County Council. Jo spent five years as Deputy Director and Director of HR and OD at the Royal United Hospital Bath in addition to time spent in hospitals in Oxford and Eastbourne. Jo has a Masters Degree in Strategic Human Resource Management from the Bristol Business School, is a Fellow of the Chartered Institute of Personnel and Development and has additional qualifications from Harvard University.

2.2 Management Commentary

Principal Activities of the Trust during 2009/10

Taunton and Somerset NHS Foundation Trust continued to provide a full range of services expected of a District General Hospital primarily from Musgrove Park Hospital in Taunton. Although its major catchment area is western Somerset it also received significant levels of referrals from South and North Somerset and parts of East Devon. West Somerset is very much a rural area and Trust consultants and supporting staff hold clinics in community hospitals run by NHS Somerset. In addition some specialities hold clinics in Yeovil District Hospital which serves the East Somerset population.

The Trust had a turnover of £231,937k in 2009/10 and employed over 3,500 (WTE) staff.

One of the main strategic projects developed during 2009/10 was the helipad outside the Accident and Emergency Department, as described in the Chairman's statement.

After detailed analysis of options and cost effectiveness, the Trust Board agreed a plan to prioritise the new surgical ward block build to replace the 1940s old building and not to proceed with the plans for an acute assessment unit. This was made in recognition of the need to prioritise resources and ensure the ward block is completed as early as possible.

A second MRI scanner opened in the year, providing additional capacity to reduce diagnostic waiting times.

The Beacon Centre, the new haematology and oncology centre for Somerset, opened in May 2009. The centre, developed as a Private Finance Initiative project, provides three linear accelerators for radiotherapy, an expanded day unit for chemotherapy and outpatient facilities. It also includes a small inpatient unit for oncology patients. The huge value of the centre has been demonstrated in the number of awards that the centre and cancer service staff have won.

Further examples of developments in 2009/10 are continued in Section 2.5

During 2009/10 the Trust worked closely with Yeovil District Hospital NHS Foundation Trust in reviewing services where there are opportunities for greater integration or co-ordination to improve acute healthcare across Somerset. This has included projects in cardiology and breast care, as well as developing Somerset Pathology Services in line with the Carter recommendations.

During the second full year as a foundation trust, membership grew to over 11,000 and the 27 Governors have been actively engaged in communication, patient experience, strategy and membership recruitments as well as fulfilling their statutory responsibilities.

The Trust's financial plans are set in the context of the longer term strategy as a foundation trust and support the short and long term objectives of:

- Improving quality and patient safety
- Improving the patient experience
- Making the most of resources, thereby creating the financial framework to enable the development of the surgical facilities at Musgrove Park Hospital.

Surpluses from previous and those planned for future years will be used to re-develop the surgical facilities on the site including the necessary enabling schemes

Clinical activity during 2009/10 was as follows:

NHS Clinical Activity	**2009/10**	**2008/09**	**2007/08**
Elective (Spells):	36,837	38,143	36,683
Non-Elective + Emergency Care (Spells)	37,355	37,668	35,154
Outpatients (Attends):	317,041	287,732	244,809
A&E (Attends):	49,988	48,281	47,314
Deliveries	3,389	3,214	3,099

Performance against key targets was as follows:

Monitor Compliance Framework			
	Target or Threshold	**Weight-ing**	**Actual**
Clostridium Difficile Target – Maximum 64 (post) for the year	64	1.0	48
MRSA Bacteraemias - Maximum 9 for the year	9	1.0	8
18 Weeks Referral to Treatment:-			
Admitted Patients - % within 18 weeks	90%	1.0	87.8%
- % data completeness	90% - 110%		95.8%
Non-Admitted Patients - % within 18 weeks	95%	1.0	97.6%
- % data completeness	90% - 110%		91.3%
	Target or Threshold	**Weight-ing**	**YTD**
Maximum two month wait from referral to treatment for all cancers	85%	1.0	91.5%
Maximum two month wait referral from an NHS Screening service to treatment for all cancers	90%		93.4%
Maximum waiting time of 31 days for subsequent treatments where subsequent treatment is surgery	94%	1.0	95.2%
Maximum waiting time of 31 days for subsequent treatments where subsequent treatment is drugs	98%		99.0%
Maximum waiting time of 31 days from diagnosis to 1st treatment for all cancers	96%	0.5	97.0%
Maximum waiting time of two weeks from Urgent GP referral date first seen for all urgent suspect cancer referrals	93%	0.5	96.5%
Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge	98%	0.5	98.4%
Thrombolysis: - within 60 minutes of Call to Needle	68%	0.5	67%*
Screening all elective inpatients for MRSA – Ratio of swabs to patients	>1.0	0.5	2.5

*From December 2009 24/7 angioplasty in place. No patients received thrombolysis

Principal Risks and Uncertainties

Financial

The Chief Executive of the NHS has talked about needing to save £20bn across the services in the next four years. Musgrove is not immune from these pressures and the Trust is developing plans to take £37m out of the hospital's cost base by 2013. Work has started on a variety of projects to cut out waste and do everything we can to ensure high quality and low cost. One of these developments will be to transform the way we manage patient administration in the hospital to dramatically improve patient experience whilst also reducing costs by taking out duplication, bringing together staff to maximise efficiency and adopting streamlined processes.

It is imperative to maintain a financial risk rating of at least 4, in order to provide flexibility in the access to capital to support the strategic plans of the Trust. There are, therefore, two financial risks to the plans of the Trust that have been identified. These are as follows:

Income assumptions: The income assumptions under-pinning the plans of the Trust are built on an assessment of demand under-pinned by contracts with commissioners. Whilst contracts are based on HRG version 4, NHS Tariffs, there is a risk of greater

disagreement with commissioners due to the added complexity of the tariff structure. As the Trust has one dominant commissioner, the Trust must work to mitigate some of this risk in agreeing a contract for 2010/11 and further develop in-year contract monitoring arrangements. There is currently no agreement on activity levels and income for 2010/11.

The achievement of cost improvement plans: The Trust plans to deliver a cost improvement plan of £11.7m in 2010/11. The development of each phase of the surgical re-build programme will be dependent on the success of the savings programme. The scale of change required and its impact on the workforce are risks which are being managed through the programme as part of a wider organisational development. The Trust, recognising the importance of organisational development, has appointed a director of organisational development and workforce, who has led a strategy entitled, 'Passionate about People', which aims to develop a flexible workforce, support staff through change and increase management capability.

Strategic

The PCT has had an outline business case approved for development at Bridgwater Community Hospital to provide a range of clinical services, including options for extending elective surgery. The Trust already provides most of the outpatient service there and has strong links with other departments, and has expressed its desire to build on the services already provided and design an imaginative and flexible solution for this growing population. At this stage, however, it is not known how the services will be commissioned by the PCT. Therefore, there remains a risk that an alternative provider is selected to provide new services. The primary risk is the loss of day-case surgery and associated income. To avoid additional risk in building fixed capacity and day surgery on the hospital site, the Trust will look at mobile and modular options to increase capacity in 2010/11 which can be removed from the site if activity is transferred by the PCT.

Operational

The key operational challenges facing the Trust over the coming year include the achievement of the 18 weeks waiting times targets, particularly in light of the large waiting list size in orthopaedics and general surgery due to historic demand issues during 2009/10. The Trust is working closely with the PCT to ensure its capacity and activity plans are consistent with the demand management responsibilities held by the PCT. The achievement of all NHS targets in the face of increased demand for services whilst delivering efficiency requirements will be challenging together with continuing the push to eliminate healthcare acquired infections such as MRSA (three hospital acquired cases in 2009/10).

The Trust has faced pressures in delivering some clinical services due to the difficulty in recruiting to key consultant posts in stroke medicine, elderly care and acute medicine. Contingency plans were introduced in these areas to ensure services were maintained. The Trust will be interviewing candidates for the two stroke posts in May/June.

Directors' Statement

Having considered the risks, the directors of the Trust reasonably expect that there are adequate resources to continue to operate for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

As far as the directors are aware there is no relevant audit information of which the auditors are unaware, and the directors have taken all the steps that they ought to take as directors in order to make themselves aware of any relevant audit information and to ensure that the auditors are aware of that information. PricewaterhouseCoopers are the external auditors for 2009/10.

The Trust has made no political or charitable donations.

The accounts have been prepared under a direction issued by Monitor.

Accounting policies for pensions and other retirement benefits are set out in note 1.3 of the accounts and details of senior employees remuneration can be found on page 46 of the Remuneration Report.

Personal data related incidents 2009/10

The Trust has raised awareness in information governance with its staff and encouraged the reporting of personal data related incidents. The Trust has started a data encryption project in accordance with the Department of Health requirements to secure all vulnerable information. The Trust has reported one serious untoward incident in 2009/10 involving personal data. This related to inaccurate programming of an NHS number into a fax machine in a community clinic.

Operating and Financial Review

Introduction

Taunton and Somerset NHS Trust came into existence on 1 December 1990 under the Taunton and Somerset NHS Trust (Establishment) order 1990 number 2449. The Trust was authorised as a Foundation Trust on 1 December 2007.

The six strategic aims of the Trust during 2009/10 were:

1. To provide the highest quality patient-centred service, ensuring patient safety drives every aspect of care

2. To work in partnership to develop and sustain first-class emergency and urgent care

3. To provide and enhance a full range of elective and planned services that are of such a high quality that patients have no wish to be treated elsewhere

4. To create a culture which empowers and supports staff to lead

5. To develop hospital buildings and facilities that are fit for 21st century care

6. To make the most efficient and productive use of resources and achieve our long-term investment plans

Financial Review

The directors have a responsibility to present a balanced and understandable assessment of the Trust's position. In meeting this responsibility, the accounts are provided in full within this Annual Report. The financial summary provides an overview of the key themes within this period.

The accounts for the year ended 31st March 2010 have been prepared, for the first time using International Financial Reporting Standards (IFRS). This methodology replaces United Kingdom Generally Accepted Accounting Practice (UKGAAP) as the basis for the preparation of year-end financial accounts in the NHS. There has been a carefully managed transition process that has been audited at each stage by the Trust's external auditors. The transition to IFRS has necessitated a number of changes of which the most important are as follows:

- *The requirement to account for the majority of Private Finance Initiative (PFI) projects on the face of the financial statements*. Prior to the implementation of IFRS, these were accounted for outside of the financial statements (or "off Balance Sheet"). As a result of this change in standards, the Trust has been required to account for both the Beacon Centre (Cancer Centre) and the multi storey car park as assets that appear in the Statement of Financial Position (previously the Balance Sheet). Consequently, capital assets of £16,500k have been added to the accounts in 2009/10 in respect of the Beacon Centre. The comparative year accounts have also been amended to show the introduction of the multi-storey car park at its modern equivalent value of £6,153k onto the Statement of Financial Position.

- *The requirement to account for un-taken holiday as at the end of the financial period.* The Trust has undertaken an exercise to identify the un-taken time in all of the staff groups and to calculate and accrue for the financial impact. This has resulted in additional accruals in both 2008/09 and 2009/10 of £1,580k and £752k respectively.

- The rules relating to leased assets that are required to be noted on the Statement of Financial Position have also changed and this has resulted in a number of new leased assets appearing in the accounts.

In addition to the changes required by IFRS, there has also been an HM Treasury requirement for NHS organisations to change the way in which their estate is valued. Under the IFRS rules, Trusts are required to value their estate on the basis of Modern Equivalent Asset Valuations (i.e. the cost of building a comparable property under existing market conditions). The exercise was carried out by the District Valuer as at 1st April 2009 and this resulted in a increase/(reduction) of £59k and £13,034k on the respective values of land and buildings. This has been treated as a prior period adjustment.

A further adjustment that has impacted on the Trust's accounts relates to the falling values of specialist buildings such as those in use at the hospital site. The Trust's accounting policies require all fixed assets to be valued at fair value at the end of the financial period. Consequently, an impairment review was carried out in March 2010 and this identified a further diminution in the value of land and buildings of £3,777k. The majority of this decrease was absorbed by the revaluation reserve, however £798k impacted on the Statement of Comprehensive Income and is included in the overall figure for impairments recognised in operating expenses of £2,212k.

Statement of Comprehensive Income

The Trust's Statement of Comprehensive Income (formerly the Income and Expenditure Account) shows a surplus of £918k. Although this represents a deterioration against 2008/09 (surplus £7,050k), this is partly due to a technical adjustment which came about on the completion of the Beacon Centre build. On completion of this project the building was immediately re-valued by the District Valuer and this resulted in an impairment of £774k.

Income

The Trust received income from activities totalling £206,261k for the period (£182,876k in 2008/09). The bulk of this relates to patient care activities and derives from its main service level agreements with local Primary Care Trusts (PCTs), the largest of which is Somerset PCT. The Trust continues to maintain a strong working relationship with the local health economy as it deals with strategic changes such as the shift towards primary care and greater patient choice. The Trust also received £25,676k for non-healthcare related income (£30,726k for 2008/09). This includes other income of £2,082k detailed in note 4.2 of the accounts.

Within the overall figures for income, the Trust generated £1,660k relating to private patients (£1,816k for 2008/09). Under the rules relating to foundation trusts, a cap is set that limits the permissible income that the Trust can generate from private patients. This derives from a base year (2002/03) and represents 1.6% of total income. This base year figure has recently been verified following a recent exercise overseen by Monitor. For the financial year 2009/10, the Trust's private patient income amounted to 0.80% of total income (1.04% for 2008/09) and was therefore within the cap.

Expenditure

Note 5.1 of the accounts details the key categories of operating expenditure, totalling £225,630k for the year (£201,966k for 2008/09). After accounting for this expenditure and for interest and dividends payable, the surplus for the period amounted to £918k (surplus £7,050k for 2008/09). As stated above, this deficit is after accounting for impairments to land and buildings amounting to £2,212k (see note 9.2 to the Accounts).

Statement of Financial Position - SOFP (formerly Balance Sheet)

The largest element on the SOFP is non-current assets amounting to £141,730k as at 31 March 2010 (£129,758k as at 31 March 2009). These comprise land, buildings, equipment, fixtures, intangibles and long term debtors and are set out in notes 10, 11 and 13 of the financial statements. The capital programme for the year was financed through a combination of the re-investment of the Trust's retained depreciation and cash available from retained income and expenditure surpluses from previous years. As a foundation trust, the Trust is able to fund capital expenditure through loans up to an approved level known as the Prudential Borrowing Limit (PBL). The Trust has a PBL of £65,600k in its 2009/10 accounts (£56,100k in 2008/09), and its borrowings amounted to £16,498k (2008/09 nil) (see note 14.4 to the accounts).

As set out above the 2009/10 financial year has seen a continuing fall in land and property prices, and this is reflected in the Trust's accounts (see note 11.6 to the Accounts)

Significant Capital projects completed in the period included:

- The new cancer facility, the Beacon Centre, which opened in May 2009 and accommodates the previous hospital chemotherapy and outpatient services, together with a new radiotherapy unit complete with three Elektra linear accelerators, a CT simulator and an 18 bed inpatient ward.
- Patient environment developments including re-decoration and re-flooring, improvements to stairwells in the Old Building and Duchess Building, including outpatient areas and general theatres
- Continued renewal and enhancement of major medical equipment as well as backlog maintenance to Trust properties including ongoing roof repairs and replacement of general theatre chiller plant.
- Improvements to the infrastructure including ongoing energy improvement measures and replacement of DHW and heating calorifiers,
- The replacement of Catheter lab 1 X-ray equipment and associated alterations.
- The installation of a second MRI scanner with associated accommodation alterations in the Duchess Building
- Commencement of works to provide a helipad on the hospital site to strengthen the Trust's role as a trauma 2 site and to improve transfer times for patients in inaccessible areas or who require urgent care
- The continued investment towards the development of a new Surgical Centre. The first phase involves the construction of a new purpose-designed Surgical Centre planned to open in October 2012. This will provide replacement ward accommodation, presently located in the Old Building, and a new Central Concourse with new retail outlets and entrance to Musgrove Park Academy.

The investment in 2009/10 amounted to £24.7m (including the PFI Beacon Centre) and includes:

- Refurbishment of part of the main kitchen and de-commissioned Satellite X-Ray accommodation as part of the decant requirements for the Surgical Centre Phase 1 works.
- New 1.2MVa standby generator as part of site wide rationalisation of standby power generation.

Future capital developments include:

- Completion of the helipad – completed in May 2010.
- Construction of new mould room to extend the clinical services in the Beacon Centre
- Centralised patient reception and administration services
- Continued investment in the infrastructure and maintenance of the asset base will continue to be a key priority for the Trust and will include information technology, health and safety, fire precautions and security.

Other Financial Issues

In view of the relatively healthy position on the Statement of Comprehensive Income, the Trust has achieved a financial risk rating of 4 for the financial year (4 for the financial year 2008/09), this score reflects the Trust's strong financial position and is reflected in the key metrics shown in the table below.

Financial Criteria	**Ratio**	**Actual**	**Rating**
Underlying Performance	EBITDA Margin	7.00%	3
Achievement of Plan	EBITDA % Achieved	90.54%	4
Financial Efficiency	ROA	5.03%	4
	I & E Surplus Margin	1.20%	3
Liquidity	Liquid Ratio	53 Days	4
Total Weighted Score			**4**

The Trust is also obliged to comply with the public sector's better payment practice code which 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. Details of compliance with this code are:

Better Payment Practice Code	**2009/10**		**2008/09**	
	No	**£000**	**No**	**£000**
Total trade invoices paid	74,181	91,581	71,892	75,349
Total trade invoices paid within target	58,293	66,990	69,741	71,770
Percentage of trade invoices paid within target	79%	73%	97%	95%

The fall in the figures between 2008/09 is due to two factors:

a) A stricter methodology is now in place for recording the point at which invoices are received which is linked to the date on the invoice. However, where invoices are dated earlier than despatch this will impact adversely on the figure.

The changeover of the Trust's financial ledger system during 2009/10 created some delays in the early months of the year. This was further complicated by the fact that the Trust was required to run two Accounts Payable ledgers for the year.

As set out in note 5.4 to the Accounts, during the financial year, the Trust was not required to pay any interest under the Late Payment of Commercial Debt (interest) Act 1998 (2008/09 zero).

The Statement of Financial Position details that the Trust is financed by taxpayers' equity, principally in the form of Public Dividend Capital, effectively a government loan on which the Trust pays an annual dividend. A further source of funding comes from the reserves that have built up since the establishment of the Trust in 1991. These principally comprise the income and expenditure and revaluation reserves but also include a donated assets reserve that records charitable donations to the Trust's equity.

There were no material post balance sheet events that need to be commented on or any statements in previous years' operating and financial reviews which were not borne out by events.

Note 7 to the Accounts details the disclosure relating to early retirements due to ill health arising during the year.

Note 23 of the accounts deals with related party transactions and shows that none of the Board members or key management staff or parties related to them has undertaken any material transaction with the Trust.

In line with the requirements for foundation trusts to prepare accounts in compliance with International Financial Reporting Standards, the Trust has reviewed all of its accounting policies for the year ended 31 March 2010. This has resulted in the inclusion of some amended policies including those relating to asset valuation and employee benefits discussed above.

The Trust Board acts as the Corporate Trustee for the Taunton and Somerset NHS Foundation Trust General Charitable Funds registered with the Charities Commission. This charity also administers funds on behalf of Somerset Primary Care Trust. The charity continues to gratefully receive donations from benefactors and continues to use these funds for the benefit of both patients and staff. The Charitable Fund Annual Report and accounts for 2009/10 are published separately and are available from the NHS Foundation Trust on request.

The Trust's external auditors for the financial year 2009/10 were Pricewaterhouse-Coopers' who replaced the previous auditors, the Audit Commission from 1 April 2009. PricewaterhouseCooper's fees amounted to £55k comprising £40k for statutory audit work and £15k for other work undertaken in the year, involving the review of the initial two stages of the IFRS implementation (total of £97k for 2008/09).

Future Developments

The financial plan for 2010/11 is set in the context of the longer term strategy of the Trust and supports both the delivery of the short term and longer term objectives. In particular, the 2010/11 plan is focused on supporting the following:

- Improving quality and patient safety
- Moving towards eliminating delays for patients
- Creating the financial framework to enable the development of the surgical facilities

The Trust's plans in 2010/11 and for future years consider the need to maintain surpluses in order to ensure the redevelopment of surgical facilities on the Musgrove site. In this context, for 2010/11, the Board has agreed, at its March 2010 meeting, a financial plan that includes the following key items:

- capital investment made up of:
  - routine programme investment of £7.2 million
  - investment as part of surgical scheme programme of £6.9 million.
- potential developments costing £9.5 million, being:
  - £1.9 million of previously approved schemes which have not started during 2009/10.
  - a development fund of £7.6 million to support service developments that are required to deliver objectives including additional capacity to deal with increased demand in specific specialties.
- efficiency requirements totalling £11.7m including £1.7m due to non-recurrent savings in 2009/10.

2.3 Improvements for Patients

Listening to patients and stakeholders

The Trust values and welcomes all feed-back from stakeholders, particularly its patients and carers, as it is crucial to developing and improving services that they meet the needs and expectations of its patients and their families.

Patient and Public Involvement

Musgrove Park Hospital undertakes a broad range of activities to understand and involve patients, carers and the public, both formally and informally, to influence and impact upon the hospital's operational delivery. Patient and public feedback is used to inform the Trust's understanding of the patients' experience of Musgrove so that improvements can be made as necessary.

In the period 2009/10 the Trust worked with the following organisations:

Health Overview and Scrutiny Committee

Somerset County Council stood down the specific Overview and Scrutiny Committee for Health in May 2009. A working relationship remains between the Scrutiny Officer at the council and the communications department at the Trust, so that any questions or concerns re health raised by the general Overview and Scrutiny Committee can be answered promptly and appropriately.

Local Information Networks (LINks)

Regular meetings have taken place between senior members of Trust staff and LINks officers since the Somerset LINks became established properly in the county during the year. The Stewardship Group, the steering group for LINks, has struggled to become established in Somerset but groundwork has been put in place to enable a positive working relationship with the Group once they are ready to move forward.

Primary Care Trust PPI Group

This is a steering group run by NHS Somerset that includes lay user membership; a senior member of staff from Musgrove Park Hospital sits on the group in order to inform its commissioners of involvement and feedback activities at the hospital.

In the period 2009/10 the Trust continued to involve members of the public in the work of the hospital as follows:

Musgrove Partners

These are a group of volunteers (44 in March 2010) who are involved with the hospital as lay users, working on a range of projects and committees and sitting on interview panels for key posts. They are not staff but they are not completely independent due to their close involvement with the hospital. They bring a community view to the Trust's activities and are trained to remind staff on steering groups and committees of the importance of focusing on patient experience. During 2009/10 they underwent an in-house training programme to ensure that they were equipped to carry out this work, and specific specialised training was given to those wishing to sit on interview panels or to facilitate public focus groups. The latter was a

new Musgrove Partner role that began in June 2009. In 2009/10 there were Musgrove Partners working on more than 60 different placements at the hospital and Musgrove Partners helped the Trust appoint to 40 different posts at band 7 or above.

Public Consultation

There were no formal consultations carried out by the Trust during the period 2009/10, but a specific public awareness exercise was undertaken in November 2009 in order to inform the local community of the plans to build a new surgical block on the site. A stand was set up in the local shopping centre for two days to inform the public of the plans and to ascertain the level of support. This was overwhelmingly positive.

In addition early in 2010 the strategic projects team at the hospital worked with local disability groups to inform them of the need to move the designated disabled car park on the site to make way for a new helipad, and to seek advice from them on ways of making this move easier for disabled patients.

Patient Feedback

National Surveys

Two national patient surveys took place during the period 2009/10, as follows:

National Inpatient Survey 2009 – Sample of 467 patients (completed postal questionnaires). The hospital's results showed significant improvement on the 2008 results, with results of four questions significantly better than in 2008 and only one question significantly worse (there was no significant difference on the other 74 questions). Comparing the hospital with the other 72 Trusts that the PICKER Institute surveyed, Musgrove Park Hospital was significantly better than average on 38 questions and significantly worse on average on just five.

National Outpatient Survey 2009 – Sample of 478 patients (completed postal questionnaires) The hospital's results showed improvement generally on the 2007 results (the last national outpatient survey), with results of four questions significantly better than in 2008 and three questions significantly worse (there was no significant difference on the other 42 questions). Comparing the hospital with the other 72 Trusts that the PICKER Institute surveyed, Musgrove Park Hospital was significantly better than average on 22 questions and significantly worse on average on just two.

The Trust has a broad range of methods for obtaining patient feedback as follows, all of which are overseen by the Patient Feedback Implementation Group that reports to the Patient Experience Committee. The Patient Experience Working Group (Governors' Group) also has a responsibility to monitor patient feedback.

Feedback Cards

The Trust used its feedback card system to obtain feedback from patients prior to discharge. Comments made on feedback cards are monitored by ward/department Sisters and acted on locally wherever possible.

Electronic Surveys

In April 2009 the Trust began to work with the PICKER Institute to deliver internal patient surveys that are carried out electronically. A team of 20 volunteers has been recruited and trained who interview patients at the bedside or in waiting areas to ask them a range of patient

experience questions, with the responses recorded on hand-held computers and then analysed by the PICKER Institute. Results are monitored and disseminated to the hospital by the Patient Feedback Implementation Group to ensure that areas of weakness are identified and improvements instigated as necessary.

Considerable improvement was seen through the year in general patient satisfaction levels for inpatients (1,602 patients from 21 wards interviewed) according to the monthly survey results. The Trust attributes this mainly to ward Sisters being able to regularly monitor satisfaction levels for their areas and to remind staff of the importance of e.g. considering patient's privacy, providing clear information, welcoming patients on arrival etc. In addition, some specific measures were taken as a direct result of feedback from this source:

- Work was undertaken to enable staff to negotiate admission dates with patients wherever possible, including re-introducing a Surgical Admissions Card for some specialities, which patients take home after their consultation and then ring in to arrange their date when they've had a chance to consult their diaries/families.

- Noise at night – quieter closing bins and apron dispensers were ordered and nursing staff were reminded of the importance of wearing soft footwear and offering patients ear plugs with the nightly medicines round.

- From the outpatients survey (397 patients interviewed) there was dissatisfaction expressed by some patients about having to wait more than 30 minutes for their consultation, and not being informed of the delay or the reason for it. The outpatient team acted on this by ensuring that there was a notice board placed in each general outpatient area that was used only for notices about delays.

- Concerns about lack of confidentiality when booking-in also led to a decision to look into installing self-registration kiosks, a project that is currently still being developed.

Focus Groups

Various patient focus groups have taken place during 2009/10 which have raised a variety of qualitative issues that have been addressed, including improving privacy, wheelchair availability, access to support groups, improvement to patient appointment letters and better identification of staff from uniforms.

In-house department-led patient satisfaction surveys

Nine patient surveys were undertaken locally by various departments in the Trust, using both qualitative and quantitative techniques of capturing patient experience.

Additional work based on general patient feedback

Patients with Learning Disabilities

Feedback from several sources (notably focus groups, PALS/Complaints and governors) indicated that work needed to be done to improve care for patients with learning disabilities. A task and finish group, chaired by the Concerns and Complaints Manager, was commissioned by the Patient Experience Committee. Work is ongoing but includes:

- development of a policy to support practice and provide clear standards;
- identification of training needs and the development of a staff training plan;

- development of literature in an appropriate format for patients with learning disabilities to provide information and support them with all aspects of their care;
- review of physical facilities to identify side rooms in the Trust which could be suitable for accommodating patients with learning disabilities and their carer/carers.

Non-English Speaking Patients

Somerset Racial Equality Council raised the issue on behalf of non-English speaking patients that the Trust was not consistently meeting the needs of these patients by providing interpreters. This led to a large-scale review of the service provided, negotiation of a contract with a new provider and training/awareness for Trust staff on how/when to use the service. A new policy is also under development to ensure that the needs of these patients are met consistently and appropriately.

Handling Complaints

The Trust takes all complaints seriously and has a system in place to ensure that each one is thoroughly reviewed and where appropriate changes in practice are introduced.

Complaints

There have been 453 formal complaints this year, slightly down from last year when 507 were received. With the new NHS Complaints Regulations in place from April 2009, the emphasis has been on greater flexibility in complaint resolution, with greater involvement and choice for complainants. Some less serious complaints may be resolved easily by a phone call from the appropriate matron or manager, followed up by a letter. In the case of more complex complaints, following investigation, a meeting is offered as the main option for resolution, where this is appropriate. Many such meetings have taken place with a tape recording made of the discussions. In most cases these have been successful in achieving a resolution for the complainant but also in demonstrating clearly to staff the need for change and improvement. A surprising number of people still wish to have a written response in the first instance.

Concerns

Throughout the year there have been 1,375 contacts with PALS raising a variety of concerns, problems or enquiries simply for information or signposting. This is a slight decrease on the previous year when 1,505 contacts were received. Many of these can be readily resolved but a proportion can be very complex and time-consuming. However the service continues to be popular with users who appreciate being readily able to talk to a person who is willing to listen and to help sort out their concern there and then where possible.

Learning from complaints and concerns

Changes and improvements which have occurred in the past year where concerns and complaints have helped to inform the need include:

- changes to the criteria for reduced price car parking to make this more equitable;
- following re-siting of some disabled parking spaces to facilitate the building of a helipad, additional support provided to disabled users in managing the increased journey from the new car park site to the hospital buildings;
- revision of the A&E head injury chart to include facial weakness as a warning sign;

- a protocol in A&E whereby patients who return for a follow up visit for the same condition are then seen by a middle grade doctor or consultant;
- a change in practice in Outpatients to ensure that no interruptions occur during a consultation unless there is an emergency;
- a complete review of all Trust administrative processes;
- improvements to patient information prior to x-ray procedures;
- improvements to the layout of the waiting and reception area of MAU for patients waiting for assessment or a bed. This includes the provision of new comfortable chairs.

Developments in 2009/10 that are improving patient care

Some examples of major service developments from the year include:

Improvements in patient safety

The first strategic aim of the Trust is to ensure that the highest quality patient-centred care is provided. In 2009/10 the Trust aimed to consolidate the significant achievements of its previous involvement in two phases of the Safer Patient Initiative. It is now focusing on patient safety at the front line in order to further embed the culture of safety throughout the organisation. The Trust is now part of a third wave of the Safer Patient Initiative process, the South West Quality and Patient Safety Improvement Programme.

Central to quality improvement is nursing care. A three year nursing and midwifery strategy was developed focusing on creating a calm, safe, clean environment of personalised care for every patient. Nurse leaders aim to enhance the efficiency and cost effectiveness of the nursing workforce, as well as to develop nursing leadership skills and team working to strengthen confidence in caring. In 2009/10 the ward sisters provided additional leadership time to take this forward.

The clinical pathway transformation programme of work has provided opportunities across the Trust to redesign whole care pathways, largely managed by clinical teams in collaboration with NHS Somerset.

Healthcare associated infections have reduced significantly. The number of MRSA bloodstream infections for the year was eight, of which two were post-48 hr hospital acquired infections. This compared to 55 post-48 hr in 2008/09. Similar reductions have been seen for C.Difficile. In 2009/10 there were 48 post-48 hr C.Difficile cases in the hospital, a reduction of 11.4% against the 55 cases in 2008/09.

New treatment that is saving lives

The Trust has started offering 24 hours/day, 7 days/week primary angioplasty services for those who arrive at Musgrove Park Hospital with chest pain. This is an excellent development for health services in Somerset, and it is not an exaggeration to say that it is saving lives. Since the service started in December 2009, 43 patients have been referred. Waiting times for treatment, measured in minutes from call to needle and for hospital (door to needle) are

better than the national average and the mortality rate is lower than benchmark. One interesting development of this service is that while 20 referrals have come from the Taunton area, 17 were from Yeovil and 6 from further afield.

Extension of the bowel screening programme for patients between the ages of 60 and 70 years has led to a detection and removal of potentially cancerous polyps.

Taking services closer to patients

The development of the Beacon Centre has meant that patients who previously had to travel to Bristol for cancer treatment can now be treated closer to home.

The new centre for oncology and haematology care (The Beacon Centre) opened to patients in May 2009, and was formally opened by His Royal Highness, the Duke of Gloucester in February 2010. The Centre, developed as a private finance initiative project, provides three linear accelerators for radiotherapy and an expanded day unit for chemotherapy in outpatient facilities. It also includes a small inpatient unit for oncology patients. The huge value of the centre has been demonstrated in a number of awards that the centre and the cancer service staff have won. These include; South West Radiographer of the Year, South West Radiotherapy Team of the Year, Macmillan Quality Environment to Work, Carol Bailey Nursing Award for the Specialist Colorectal Nurse Lead. In addition the cytology screening team were praised by the National Improvement Programme for revolutionising their service and dramatically reducing waiting times.

Improving Patient Care

A second MRI scanner opened in the year, providing additional capacity for reducing waiting times for diagnostic services.

Many services at the Trust receive specialist external recognition. The team in anaesthetics which developed the interactive trauma board won local, regional and national awards for its innovative projects.

The clinical glaucoma team was honoured with a national award in the Glaucoma Achievements Award and an independent national group praised the excellent clinical results in the intensive therapy unit for the second year running.

The bariatric team was awarded Level 1 status by the regional specialist commissioners, ensuring that Musgrove Park Hospital was one of the key regional centres for this surgery. The national clinical lead for pathology praised the work of the Somerset Pathology Service based at Musgrove.

“An Hour to Listen" was an hour long presentation seen by over 600 staff. It emphasised the importance of truly effective listening, both to patients and to their relatives, and looked at the experience of being in hospital from a patient perspective. The project beat over 200 entries to gain a national award in November 2009.

The programme used the very best but rarely used learning techniques to help staff make a real difference for patients. The project used stories, video, involvement, sound, discussion and challenge to engage with staff.

Improving Patient Experience

Mixed Sex Wards

Significant improvements were made during 2009 in eliminating mixed-sex wards and treatment areas. This is reflected in the PICKER results, which showed that in 2009/10 98% of patients reported now having access to single sex facilities. This compared to 72% of patients reporting they were sharing facilities with a member of the opposite sex in 2008/09.

The scope for further improvement is limited by the configuration of the existing old wards.

The Trust is continuing to use its foundation trust status to develop services in improved patient care through investment of surpluses to fund the surgical scheme which will provide single room ward accommodation as part of its first phase due to commence in 2010.

Research and Development

During the year the hospital has continued to work hard to develop high quality clinical research across the organisation. Dr Rob Andrews, Consultant Diabetician, received a research grant of £130,000 from the National Institute of Health Research School of Primary Care for an extension of his Early Actid study looking at the effects of diet and exercise in diabetes.

2.4 Valuing Staff

The Trust's performance depends on its staff who are committed to delivering a high quality service to patients. Their efforts help the Trust achieve excellent results for patients, despite record levels of activity.

Passionate about People

The Trust has developed an organisational development (OD) strategy, *Passionate about People*. The Trust is clear that a focus upon its culture, its leadership and the engagement of its staff will lead to better patient outcomes and happier staff. The strategy has at its core the need to develop its staff and leaders, so that they can make the best decisions regarding patient care within the current challenging national and local climate.

Passionate about People focuses upon the key themes of:

- attracting, developing, focusing and inspiring the finest talent
- building a strong cohort of inspirational leaders
- giving staff and their representatives a strong voice
- living the values of the Trust and challenging those who do not

The refreshed OD team, led by a new executive director of OD who joined the Trust in September 2009, has already made inroads into delivering against this strategy. As a first stage the OD team worked with others across the organisation to listen to what staff have to say about working within the hospital. The section below entitled "Staff Survey" gives more detail.

In order to ensure that key messages land appropriately with all staff groups, much effort has been put into communications, especially internal communications. This has been the focus in the latter part of 2009/10. A range of more innovative communication solutions have been trialled, including video blogs with the chief executive and members of the executive leadership team. The use of on-line feedback through the hospital's "rumour buster" site has allayed staff fears on changes being proposed. The regular staff news bulletin and team briefs continue to gain large audiences with positive feedback. The hospital will continue to use innovative and traditional forms of communication in order to get its messages across and most importantly to listen to the views of staff.

So that staff are prepared for the inevitable changes that will be made across the public sector which will affect health, the Trust is rolling out skills for change workshops which will include how to lead change and how to communicate change effectively so that maximum benefit can be achieved.

A coaching programme is core to our desire to become a *great* hospital. To enable all of our managers to have the right skill set, behavioural set and knowledge to do their jobs with excellence, a bespoke management training programme is being developed to include a development centre in which senior staff will be able to have their competencies and skills assessed by experts in order to determine any training needs, plus access to a coaching programme.

Staff Surveys

In addition to the Annual NHS Staff Survey, a bespoke staff engagement survey was undertaken in March 2010 as part of the Trust's organisational strategy, Passionate about People, in order to fully understand what our staff feel about the culture, values and priorities of the hospital. As the Trust embarks upon significant change we need to understand what the social fabric of the hospital looks and feels like from all perspectives and what we can do as a consequence to engage with our staff on this journey.

The Annual NHS Staff Survey

The Annual NHS Staff Survey covers subjects such as work/life balance, teamwork appraisals and perceived support from managers, allowing trusts to benchmark their employees attitudes and experiences with other NHS trusts. The 2009 staff survey was structured around the four staff pledges contained in the NHS Constitution. Of the 40 key issues covered Taunton and Somerset NHS Foundation Trust scored in the top 20% of all trusts in four areas and above average in a further 10 areas. Within these areas there was a deterioration on 2008/09 performance, which reflects the uncertainty felt by staff in a period of change. The Trust is formulating an action plan to address issues raised in the survey, focusing on the areas in which it performed less well, in addition to work on issues highlighted by the bespoke staff engagement survey.

Summary of performance - NHS staff survey

Staff Survey

	2008/09		**2009/10**		**Trust Improvement/ Deterioration**
Response rate	*Trust*	*National Average*	*Trust*	*National Average*	
	62%	*55%*	*59%*	*55%*	3% deterioration

	2008/09		2009/10		Trust Improvement/ Deterioration
Top 4 ranking scores	*Trust*	*National Average*	*Trust*	*National Average*	
	12%	*17%*	*16%*	*17%*	4 % deterioration
Question: Percentage of staff suffering work-related injury in last 12 months					
	81%	*77%*	*76%*	*75%*	5% deterioration
Question: Percentage of staff feeling valued by their work colleagues					
	76%	*70%*	*73%*	*71%*	3% deterioration
Question: Percentage of staff using flexible working options					
	2.41%	*2.51%*	*2.55%*	*2.59%*	. 10% deterioration
Question: Staff intention to leave jobs					

	2008/09		2009/10		Trust Improvement/ Deterioration
Bottom 4 ranking scores	*Trust*	*National Average*	*Trust*	*National Average*	
Question	*18%*	*35%*	*17%*	*27%*	1% deterioration
Question: Percentage of staff having equality and diversity training in the last 12 months					

Question	*91%*	*95%*	*97%*	*95%*	6% deterioration
Question: Percentage of staff reporting errors, near misses or incidents witnessed in the last month					

Question	*41%*	*37%*	*45%*	*38%*	4% deterioration
Question: Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month					

Question	*38%*	*42%*	*41%*	*42%*	3% Improvement
Question: Percentage of staff feeling there are good opportunities to develop their potential at work					

Members of staff reporting witnessing errors increased in 2009/10. However, this is against a drive in the Trust to encourage incident reporting.

Staff Engagement Survey 2010 Results

In February 2010, the Trust invested in its staff by asking every member of the workforce what it is like to work for Musgrove Park Hospital. This is the first time that all staff have had an opportunity to comment on a bespoke questionnaire designed specially for our hospital.

63% of our staff filled in the questionnaire, which represents over 2,800 staff, a great achievement. Key themes emerged:

- staff want to continue to work for the hospital
- staff are happy with their remuneration packages
- our staff understand the need for change.

However, the responses also highlighted some concerns which include:

- staff are unsure what changes are needed and how they will fit in
- some staff feel unsure about speaking up and contributing ideas and giving their opinion.

The Trust Board takes very seriously the results from this important survey and has identified a number of key areas of focus:

Improving visibility of senior managers – which, done in an effective and sustainable way, should also have a positive impact on wider perceptions of how the organisation is managed and management of change.

Clear, compelling, open and honest communications around change – ensuring that employees have a clear understanding of the vision for the future, the reasons for change

and the progress Musgrove is making towards becoming a 'great' hospital. It is important not to lose sight of the overarching aims of the hospital during times of change, and to communicate how change will ultimately benefit the patient

Building a culture of 'employee voice' – providing employees with an opportunity to speak up and get involved in decision making will make them feel empowered and that they are part of the future of the organisation.

A fair, respectful culture with a zero tolerance to unreasonable behaviour – employees feeling that they are treated fairly and with respect is a key driver of engagement, and there is room for improvement with regard to this aspect.

We are running two facilitated action planning sessions with senior managers to ensure that we focus our improvement plans on the four agreed priority areas. In addition to this each division/department will be asked to identify a further one/two areas for improvement which are specific to their area. The outputs from these various plans will be collated and fed back into the Trust Board to ensure that the process continues to evolve and that this does not become a one off initiative but part of 'How we do things around here' moving forward.

Workforce Information

The Trust continues to report a healthy staff base with turnover in 2009/10 at 10% (This figure excludes junior doctors who turnover annually as part of their training requirements). This represents a relatively stable workforce and we know that staff enjoy working at the Trust and plan to stay. This has been evidenced through the recent staff engagement survey results.

The workforce data below is based upon all staff in post (excluding trainee clinical psychologists and bank staff), and it includes junior doctors in training. The data is correct as at 31st March 2010.

Staff Group	Head count As at 31/03/2010[1]	Full Time Equivalent (FTE)	FTE%	Turnover April 09 to March 10
Professional, Scientific and Technical	118	100.38	2.86%	5.04%
Additional Clinical Services	809	661.53	18.83%	13.18%
Administrative and Clerical	969	829.00	23.60%	12.09%
Allied Health Professionals	229	194.73	5.54%	25.21%
Estates and Ancillary	244	208.50	5.93%	9.12%
Healthcare Scientists	149	135.49	3.86%	10.49%
Medical and Dental	459	433.08	12.33%	45.91%
Nursing and Midwifery (Registered)	1,156	950.46	27.05%	8.75%
Grand Total	**4,014**	**3,389.2**	**100%**	**15.11%**

[1] Please note these figures relate to a different time period to note 6.2 in the accounts. The figures in the table above reflect the head count as at year end, whilst the accounts state the average monthly persons employed.

The proportion of working days lost in the NHS due to sickness absence averages 4.5% (Reform Survey 09). This can be a substantial burden on finances in organisations with such large workforces. The Trust proportion of working days lost through sickness last year was relatively low at 3.24 %, one of the lowest in the NHS.

As the Trust moves through into 2010 and beyond the organisational shape will change. There will be exciting opportunities for our staff to take on different roles and to retrain for posts that become available. The Trust must manage its pay budgets carefully so every time someone leaves the Trust will look to see how it can fill that post differently, always with an eye on reducing costs, although never at the expense of compromising patient (or staff) safety or care.

The OD team continues to push forward innovative solutions to workforce scarcity issues, such as in some medical specialties, with junior doctors and in some technical areas. A comprehensive workforce strategy is being considered presently that will see the emergence, over 2010/11 of new roles across the organisation at junior, middle and senior levels. Training is crucial and *Passionate about People* sets out the need for all staff to have regular appraisal discussions with their managers so that both parties are able to look back on performance and plan for the future as well as identify development needs. Those development needs will in future, seamlessly feed the corporate training and development offering.

A flagship development academy, building upon the excellent work of the post-graduate medical and education unit has been launched. Many staff will learn together in this purpose built on-site facility. A comprehensive programme of targeted learning and development sessions are starting to be rolled out.

Equality

The Trust is committed to raising awareness and making further improvements relating to equality and diversity for patients and staff.

The Trust has in place a Corporate Equality Scheme which sets out its commitment to promoting equality and equal access to all. The Trust has undertaken staff consultation on organisational values and respecting differences is now represented within its core values ("everyone is different and we will treat them with dignity and respect").

All policies adopted in the Trust are required to have an Equality Impact Assessment carried out. Equality and diversity issues are covered in mandatory training for all staff and guidance is available on the Trust's intranet.

The executive director of organisational development and workforce leads on equality and diversity at the Trust, and performance is monitored through the Assurance and Governance Committee on a monthly basis and also through monthly PICKER (patient survey responses) and the bespoke staff engagement survey results.

Corporate priorities currently are focused on the outcomes of the recent staff engagement survey with particular attention relating to the treatment of our staff. This work will be performance managed through the divisional boards' quarterly reviews and will be tested against the next staff engagement survey planned to run within the next 12/18 months.

A Trust Equality and Diversity Strategy will be developed by June 2010, which will explain how the Trust intends to demonstrate its commitment as an organisation which champions diversity and challenges discrimination. The Trust recognises that treating service users and their carers as individuals with dignity, courtesy and respect is an integral part of the equality and diversity agenda.

The Strategy will aim to:

- Demonstrate the Trust's commitment to equality and diversity through equity of access to its services, information and buildings.
- Demonstrate its commitment to a human rights based approach to its work, ensuring human rights principles and standards are at the heart of policy and service delivery.
- Demonstrate the Trust's commitment through equity of access to employment, promotion and training.
- Reinforce the Trust's Equality Impact Assessment of each Trust function, service, strategy and policy in order to identify any adverse affects upon any minority group.
- Identify how service users and carers can be engaged in ensuring discrimination is eliminated, diversity is promoted and individuals have equality of access to Trust services and employment.

An Equality and Diversity committee that will meet every three months will be convened and it will have responsibility to draw up a robust Single Equality Action Plan to support the strategy aims.

Training has been further developed and is progressing as part of a Mandatory Training review.

The Trust publishes its equality scheme, the results of monitoring staff and service users, information in relation to race, disability and gender equality via its public website and annual report. Other statistics cover:

- age
- ethnicity
- gender (including transgender)
- disability (staff recorded disability).

The Trust publishes the results of equality impact assessments.

Future priorities and targets

- The Trust will review the Single Equality Strategy and action plan on an annual basis.

- The Trust plans to work with a wide range of organisations and partnerships such as Somerset County Council, Somerset Racial Equality Council, Age Concern Somerset, Somerset Gay Health, Compass Disability, South Somerset Disability Forum, South Somerset Equalities Group, Multi-faith Forum, Somerset Older Citizens Alliance and Community Cohesion Forum, to ensure everyone has an opportunity to contribute to changes and reviews of services.

- The Trust will ensure all staff have specific training to assist their understanding of equality, diversity and human rights to develop a culturally capable workforce and one which treats service users and carers with dignity and respect. The Trust will also ensure equality and diversity and human rights issues runs through all of its learning and development provisions.

- Monitored arrangements will be strengthened through the Equality and Diversity Committee that will report to the Assurance and Governance Committee and Trust Board on a six-monthly basis.

- The Trust will be looking at the Communications Strategy around the benefits of valuing a diverse workforce which will increase engagement of staff. Work is just about to start on a zero tolerance approach to inappropriate behaviours.

Summary of performance – workforce statistics

The following table provides workforce and staff membership percentages by age and ethnicity. Since 1 April 2007 all staff employed by the Trust automatically become members of the Trust unless they choose to opt out. Prior to that date staff had to apply to become a member.

Age	Staff 2008/09	%	Staff 2009/10	%	Membership 2008/09	%	Membership 2009/10	%
16-20	175	3.9	138	2.9	111	4.7	76	2.8
21-25	404	9.0	454	9.7	287	12.3	372	13.8
26-30	481	10.7	497	10.6	249	10.7	352	13.1
31-35	471	10.5	526	11.2	224	9.6	320	11.9
36-40	568	12.6	592	12.7	293	12.6	328	12.2
41-45	632	14.0	632	13.5	310	13.3	331	12.3
46-50	616	13.7	641	13.7	320	13.7	337	12.5
51-55	543	12.1	578	12.4	275	11.8	287	10.6
56-60	365	8.1	368	7.9	177	7.6	179	6.6
61-65	177	3.9	176	3.8	66	2.8	87	3.2
66+	68	1.5	77	1.6	19	0.9	26	1.0

Age	Staff 2008/09	%	Staff 2009/10	%	Member-ship 2008/09	%	Member-ship 2009/10	%
Ethnicity								
White British	3,921	87.1	4,045	86.5	1,140	48.9	1,762	65.4
White Other	141	3.1	144	3.1	123	5.3	157	5.8
Mixed	17	0.4	20	0.4	10	0.4	34	1.2
Asian or Asian British	103	2.3	129	2.8	35	1.5	83	3.1
Black or Black British	33	0.7	39	0.8	9	0.4	19	0.7
Chinese	13	0.3	13	0.3	3	0.1	24	0.9
Any Other Ethnic Group	78	1.7	80	1.7	13	0.6	23	0.9
Not Stated	194	4.3	205	4.4	998	42.8	593	22.0
Gender								
Male	1014	22.5	1062	22.7	543	23.3	671	24.9
Female	3486	77.5	3613	77.3	1,788	76.7	2,024	75.1
Trans- gender			0		0		0	
Disabled (Self declared)	15	0.3	20	0.4	N/A		N/A	

Fair consideration for disabled applicants and employees

The Trust has in place a disability equality scheme which sets out the Trust's strong commitment to promote disability equality beyond the requirements of the Disability Discrimination Act of 1995. Progress against plans are monitored through the Assurance

and Governance Committee. This group also monitors information relating to workforce issues to ensure that any imbalance with respect to racism or disability is addressed.

All job applications are considered for short-listing with the removal of applicants personal details, including disability. This ensures that selection criteria are based on skills and abilities. Applicants have an option to request consideration under the Guaranteed Interview Scheme.

A case conference is held each month for individuals who are on long-term sickness absence. An active Occupational Health Service provides advice to managers regarding staff returning to work following absence. Consideration is given to returning a member of staff to their substantive post with adaptations as appropriate or redeployment if necessary.

In the year to 31 March 2010, the Trust received 226 applications for jobs from people who declared themselves to have a disability, (2.27% of total applicants). Of these 49 were short-listed (1.93 % of total applicants), and 7 of these applicants were appointed (1 % of the total appointed).

Learning and Development

The Trust is committed to providing learning and development for all staff. Recent emphasis has been on:

- Mandatory Training
  From July 2009, a Trust-wide review by a multi-professional group has been taking place to establish the mandatory training requirements for each topic area. This group established which topics were needed for all staff groups. All work undertaken by the group has been in full consultation with the Operational Leads.

  As a result a proposal was put forward and approved by the Trust for a half-day (four hour) corporate essential learning session as part of the Corporate Induction and three-yearly thereafter. This programme would incorporate all topics requiring discussion and staff awareness and all staff groups would be entitled to attend any of the dates. The format of the session follows video clips of a family who visit the hospital for various reasons. Each clip is intended to be an introduction to the topic it relates to. The launch date for this is 20th April 2010.

  Further work regarding mandatory training is still ongoing. This includes looking at alternative options for delivery/capturing knowledge for example, designing an online questionnaire that if successful could replace the need for classroom attendance.

- Appraisal
  There has been a concerted effort to improve the quality and quantity of appraisals undertaken over the last 12 months, through provision of appraisal training across the Trust.

  In the year to the end of March 2010, 125 appraisers (managers who will be appraising their staff) attended appraisal training workshops. This group represented Planned Care, Clinical Support, Finance, Planning and Facilities, Emergency and Urgent Care, IM&T divisions/departments,

The Learning and Development intranet site was up-dated to include appraisals on the home page, including Key Skills Framework information, downloads for the new appraisal and Personal Development Plan documentation, Appraisal User Guide, The Principles of a Good Appraisal and associated policies.

The planned launch of e-learning appraisal training on Mollie (the new e-learning course management system) will go live at the end of June. The programme is called Appraising your Staff, takes approx 30-40 minutes to complete and covers:

- supporting your Staff
- ensuring appraisals are ongoing
- providing feedback.

All activities and initiatives linked to the care, support and development of our workforce are important to us. Having the right staff in the right jobs, with the right skills, knowledge and behaviour will give our hospital the best chance of sustainability and success over the next 3 – 5 years.

Employee Involvement

As an employer of an average of approximately 4,000 staff, the Trust is committed to the principles of partnership working and staff involvement. The Trust has a strategic partnership forum which meets regularly. It provides an effective method of regular consultation between managers and staff representatives, and is intended to form the basis of a constructive and co-operative approach towards achieving corporate goals.

The Trust also has other consultative bodies to discuss specific areas of joint interest with staff representatives, such as the MNF (Medical Negotiating Forum), and the HR Policy/Operational partnership Group.

In addition to these, two-way engagement is encouraged through regular briefing sessions led by the chief executive, quarterly meetings, with the staff governors, plus the internal communication methods described on page 26.

Health and Safety and Occupational Health

The management of health and safety is an integral part of the Trust's risk management strategy and managed through the divisional structures. A central advisory resource is available to support divisions, undertake training and provide a strategic overview. Any health and safety issues are reported and managed through divisional risk registers, at a local level with upward reporting and on to the corporate risk register in accordance with the risk management procedure. There were no significant health and safety issues during 2009/10.

The Trust is supported by an occupational health department which undertakes pre-employment health assessment, immunisations to protect employees and patients and has a supporting and advisory role to assist the return to work of employees who have been absent through health problems. A counselling service is provided to staff.

2.5 Working in Partnership

Social and Community Issues

The Trust provides care to a population of around 340,000. However, it provides many services countywide to over 500,000. The Trust has very strong links with other health organisations within Somerset. It provides a number of clinical services into Yeovil NHS Foundation Trust and also to the provider arm of NHS Somerset. Good working relations continue with health partners in NHS Somerset, Somerset Partnership Mental Health Trust and neighbouring hospitals in Yeovil, Weston, Barnstaple and beyond.

The Trust has contributed to the Local Area Agreement and is identified as a leading or key partner in a number of key strategic areas to be taken forward over the next three years, including Project Taunton, which will impact upon the Trust in respect of increased housing and in terms of being a major employer within the area.

2009/10 has seen a number of service developments on the hospital site to benefit the Somerset community:

- A county-wide 24 hours a day/7 days a week primary angioplasty service for patients with chest pain.

- The midwife-led maternity unit which opened in 2008/09 continues to attract an increasing number of births from across Somerset, providing choice to mothers.

- The Beacon Centre, which opened in May 2009, has had a significant impact on patients who previously had to travel to Bristol for radiotherapy treatment.

- Bowel cancer screening offered to everyone between 60 and 69 through a simple home test to detect any signs of bowel cancer, continues to refer significant numbers of patients having potentially cancerous polyps removed.

- The helipad situated outside the Accident and Emergency Department will from early summer improve access to the department from rural areas across Somerset and make transfers easier and safer.

The Trust has good working relationships with local colleges. Projects in 2009/10 have included the launch of a dedicated NVQ course in partnership with Somerset College for hospital staff and placements for college students. In addition a membership campaign was developed and run by a class of students at Bridgwater College, which led to an increase of 300 members in the 17-21 year age range.

The governors have ensured that the Trust maintains good links to the community in key partner organisations, such as the County Council, District Council and Universities. Elections to the Members' Council were strongly supported with all seats contested and a high turnout.

Membership recruitment has taken place throughout the community at publicly attended events, such as country fairs and shows, as well as regular recruitment on the hospital site. For the larger events recruitment has been partnered with health promotion and a number of Medicine for Members meetings have been held throughout the region with clinicians speaking on subjects such as raising healthy children, children, managing diabetes and healthy heart.

The Trust has continued to develop its link with the health service in Zanzibar, sending two teams to the country to pass on their expertise and training and learn from the communities there. This project will continue into 2010/11.

The Trust continues to have an active "Art for Life" committee to ensure that art work is used throughout the hospitals creating an attractive and welcoming environment for patients, staff and visitors. The involvement of Art for Live in the interior design for the Beacon Centre led to the Beacon receiving the Macmillan Quality Environment Work – the first of its kind in the UK.

A recycling scheme throughout the hospital reduces unnecessary waste of paper, glass, plastic bottles and cans. The Trust is looking into working with a partner to further reduce energy consumption going forward. Staff allotments have been developed on site to further promote and encourage sustainability.

3. Corporate Governance and Directors' Information

The Trust is a public benefit corporation established under the Health and Social Care (Community Health Standards Act 2003) - which has been replaced by the National Health Service Act 2006.

The Board of Directors of Taunton and Somerset NHS Foundation Trust attach great importance to ensuring that the Trust operates at high standards and seeks to observe the principles set out in the Monitor NHS Foundation Trust Code of Governance.

The Board is responsible for the strategic planning, culture and performance management of the Trust and for ensuring proper standards of corporate governance are maintained. The Trust's Scheme of Delegation sets out the decisions reserved to the Board and its sub-committees and directors, and decisions delegated to management. The Board accounts for the performance of the hospital and consults on its future strategy with its members through the Members' Council.

The Members' Council role is to influence the strategic direction of the Trust to take account of the needs and views of the members, to hold the Board to account on its performance, to develop a representative diverse engaged membership and to make an improvement to the patient experience. In addition it carries out its statutory duties, including the appointment of the chairman and non-executive directors of the Trust and appointment of the external auditors.

Governance Structure

The Trust's Constitution and terms of reference for the Board's committees were reviewed in 2009/10 to ensure they continue to comply with best practice. The Trust Constitution, which has remained unchanged since authorisation, will be revised in 2010/11 to reflect proposed changes in respect of the re-appointment of non-executive directors.

Chairman

The chairman of the Trust is Rosalinde Wyke, a non-executive director who has no conflicting relationships. Her appointment is on the basis that she works 3.5 days per week for the Trust. Details of the chairman's other commitments are listed on page 4. The Board remains confident that she does have sufficient time to devote to the Trust.

Vice-Chair

The Vice-Chair is Peter Merson, who has been elected to this position by the Members' Council, on the recommendation of the Board, for a year ending in December 2010. Peter Merson deputises for the Chairman at Board and other meetings (internally and externally) if she is unable to attend.

Senior Independent Director

The Senior Independent Director is Adele Barker, who has been elected to this position by the Board, in consultation with the Members' Council. Part of the role of the Senior Independent Director is to provide another route for communication with governors if they feel unable to raise a particular concern through the Chairman for any reason.

Board of Directors ("the Trust Board")

The Trust Board consists of seven non-executive directors, all of whom are considered by the Board to be independent and seven executive directors. Executive directors hold permanent NHS contracts, subject to NHS Terms and Conditions.

The Board, having considered its composition to fulfil its functions and remain within Monitor's Terms of Authorisation, confirms that it is appropriately composed. In order to strengthen the Board, an additional executive director was appointed in September 2009 to advise the Board on organisational development and workforce.

The Board holds a Register of Interests declared by directors. These interests include directorships of companies with whom the Trust could do business, together with other interests which the directors believe might be relevant to their Board membership. The Trust has not entered into any material transaction with a company for which a declaration has been made. The Register of Interests is available from the Trust Secretary on 01823 342511.

Appointment re-election and the Nomination Committee

The directors are responsible for assessing the size, structure and skill requirements of the Board and for considering any changes necessary or new appointments. If a need is identified the Nomination Committee, which comprises the chairman, chief executive and the non-executive directors, supported by the director of organisational development and workforce, will produce a job description, instruct recruitment consultants as necessary, short-list and interview candidates. If the vacancy is for a non-executive director, the Members' Council convenes a Nomination Working Group. The Nomination Working Group then instructs recruitment consultants if required, short-lists and interviews candidates, then recommends the selected candidates to the Members' Council for appointment.

Non-executive directors are appointed for four year terms in office, subject to an open recruitment process at the end of each term. The Members' Council has requested a change to the Constitution to allow for initial appointment of a four year term in office, followed by a re-election for a second three year term in office on an uncontested basis, subject to satisfactory appraisal. The Constitution is currently under review to make this change.

The chairman's term of office expires on 31 July 2010 and the governors' Nomination Working Group is currently leading on an appointment process in accordance with the Trust Constitution providing for open competition.

The chairman, other non-executive directors and chief executive (except in the case of the appointment of a new chief executive), are responsible for deciding the appointment of executive directors. The chairman and the other non-executive directors are responsible for the appointment and removal of the chief executive, whose appointment requires the approval of the Members' Council.

Membership of Board and Sub-Committees at 31 March 2010

	Position	Trust Board	Governance Committee	Audit Committee	Treasury & Investment Committee	Charitable Funds Committee	Remuneration Committee	Nomination Committee
NEDs								
Rosalinde Wyke	Chairman	C	✓	**	✓	C	✓	C
Peter Merson	Vice-Chair, NED	✓	✓		✓	✓	✓	✓
Adele Barker	Senior Independent Director, NED	✓	C				C	✓
Andy Willis	NED	✓		✓	✓		✓	✓
Chris Harvey	NED	✓		✓	C		✓	✓
David Clements	NED	✓		C			✓	✓
Gill McComas	NED	✓	✓			✓	✓	✓
EXECUTIVES								
Jo Cubbon	Chief Executive	✓	✓	**	✓		*	*
Peter Lewis	Deputy Chief Executive	✓		*	✓	✓		
David Allwright	Director of Corporate Planning & performance	✓	✓		✓	✓		
Martine Price,	Director of Governance & Nursing	✓	✓	*				
Cecil Blumgart	Medical Director	✓	✓					
Tim Jobson	Director of Clinical Service Development	✓						
Jo Ridgway	Director of Organisational Development & Workforce	✓				✓	*	*

C = Chair of the committee *By invitation ** Annually

Attendance record for the year as at 31 March 2010

The table on page 42 sets out the Trust Board and Board sub-committee meetings held during 2009/10, showing the attendance of executive and non-executive directors throughout the year.

Trust Auditors

PricewaterhouseCoopers LLP (PwC), was appointed as the Trust's external auditors for an initial term of three years commencing 1 April 2009.

The internal audit services are provided by RSM Tenon on a shared service arrangement with NHS Somerset, Somerset Partnership and Yeovil NHS Foundation Trust. This contract has been extended into 2010/11 for a fourth year and will be reviewed next year.

Audit Committee

The Audit Committee is responsible to the Board for reviewing the adequacy of the governance, risk management and internal control processes within the Trust. In carrying out this work the committee primarily utilises the work of internal audit and external audit. The Audit Committee also takes assurance from the views of other external agencies about the Trust's procedures and from the Governance Committee.

From 1 December 2009, David Clements took over from Andrew Willis as chair of Audit. Andrew Willis had been chair of Audit for five years and it was felt that to maintain independence, a change in the chairing arrangements was appropriate. Andrew Willis has stayed on as a member of the Audit Committee in the medium-term to provide continuity. Chris Harvey, the third member of the Audit Committee, has significant financial experience and is a qualified accountant.

The audit review of the financial year-end annual report and accounts is discussed by the Audit Committee with the external auditors before the Board approves and signs the financial statements.

The Audit Committee ensures that there is an effective internal audit function established by management that meets mandatory NHS internal audit standards, and it reviews the work and findings of the external auditor.

The Audit Committee agrees the schedule of internal audit reviews, receives the reports and follows-up on the issues raised. Where issues are identified management of the areas reviewed are asked to attend the meeting and report on the steps taken to avoid similar issues arising again. The Audit Committee receives and monitors the policies and procedures associated with countering fraud and corruption. An independent local counter-fraud service produces a quarterly counter-fraud progress report giving up-dates on both reactive and pro-active work undertaken in the Trust.

The Audit Committee reviews and monitors the external auditors' independence and objectivity at least once a year. In addition to the work on auditing the Trust's financial statements the external auditors carried out detailed reviews relating to the first two stages of the IFRS implementation, this work was approved by the Audit Committee. The external auditors did not undertake any other work for the Trust during 2009/10.

Trust Board and Sub-Committee attendance 2009/10

Note: The membership of the Board Sub-Committees was reviewed in November 2009, which is reflected in the number of meetings that were attended.

	Position	Trust Board	Governance Committee	Audit Committee	Treasury & Investment Committee	Charitable Funds Committee	Remuneration Committee	Nomination Committee
		Number of eligible meetings attended in 2009/10						
NEDs								
Rosalinde Wyke	Chairman	12 out of 12	7 out of 7	1 out of 1	7 out of 7	2 out of 2	2 out of 2	1 out of 1
Peter Merson	Vice-Chair, NED	10 out of 12	7 out of 7	------	7 out of 7	2 out of 2	1 out of 2	0 out of 1
Adele Barker	Senior Independent Director, NED	11 out of 12	7 out of 7	------	-----	0 out of 1	2 out of 2	1 out of 1
Andy Willis	NED	12 out of 12	-----	5 out of 5	-----	-----	2 out of 2	1 out of 1
Chris Harvey	NED	12 out of 12	-----	------	7 out of 7	-----	2 out of 2	1 out of 1
David Clements	NED	11 out of 12	-----	4 out of 5	5 out of 5	-----	1 out of 2	1 out of 1
Gill McComas	NED	10 out of 12	5 out of 7	-----	4 out of 4	1 out of 2	1 out of 2	1 out of 1
EXECUTIVES								
Jo Cubbon	Chief Executive	12 out of 12	4 out of 7	1 out of 1	6 out of 7		-----	-----
Peter Lewis	Deputy Chief Executive	12 out of 12	4 out of 7	5 out of 5	6 out of 7	1 out of 2	-----	-----
David Allwright	Director of Corporate Planning & performance	10 out of 12	6 out of 7	-----	6 out of 7	2 out of 2	-----	-----
Martine Price,	Director of Governance & Nursing	11 out of 12	7 out of 7	3 out of 5	-----	-----	-----	-----
Cecil Blumgart	Medical Director	11 out of 12	5 out of 7	------	-----	1 of 1	-----	-----
Tim Jobson	Director of Clinical Service Development	12 out of 12	1 out of 4	------	-----	1 of 1	-----	-----
Jo Ridgway	Director of Organisational Development & Workforce	6 out of 7	2 out of 4	------	-----	-----	-----	-----

Board Committee and Directors' performance appraisal

The directors recognise the importance of evaluating the performance and effectiveness of the Board as a whole, of the committees and of the individual directors. This is assessed during the year in terms of:

- Attendance at Board and committee meetings;
- The independence of individual directors;
- The ability of directors to make an effective contribution to the Board and committees through the range and diversity of skills and experience each director brings to the role;
- The Board's ability to make strategic decisions and to manage the Trust effectively.

The Board has undertaken performance evaluation in respect of Board meetings through ~~discussion~~ attendance and review by an external assessor. In terms of individual appraisals, the Chairman undertakes the appraisal of the chief executive and the non-executive directors, having sought feedback from the other directors; the chief executive undertakes the appraisal of the other executive directors; and a senior independent director undertakes the appraisal of the chairman, having sought feedback from the rest of the Board and from the governors. The process for the review of the Chairman and the non- executive directors has been approved by the Members' Council Remuneration Working Group, which then confirms completion of the process to the Members' Council.

The chief executive discusses the executive directors' appraisals with the chairman and reports their outcome to the Remuneration Committee.

Opportunities are provided for directors to attend conferences and training, as appropriate, to strengthen their skills to enable them to discharge their duties. Training for executive directors is arranged in accordance with individual needs and responsibilities, as well as being part of whole Board development and training.

The Board underwent a performance review with an external consultancy, imd Ltd, in 2009/10 to provide an independent evaluation of the Board's performance and identify ongoing issues for the Board as a whole. During 2009/10 a board development programme was executed externally facilitated by independent consultants where appropriate.

The results of the performance evaluation process in respect of the year to 31 March 2010 was that the Board collectively and the Directors individually were deemed to have performed well.

Trust Secretary

The Board has direct access to the advice and services of the Trust Secretary, who is responsible for ensuring that the Board and Committee procedures are followed. The Secretary is also responsible for ensuring the timely delivery of information and reports and advising the Board through the chairman on all corporate governance matters.

Statement of Compliance with the NHS Foundation Trust Code of Governance

The Trust Board considers that it was compliant with the provisions of the NHS Foundation Trust Code of Governance with the exception of the following code provisions:

C2.1 Executive directors are not subject to reappointment at intervals of five years, save for the Medical Director and Director of Clinical Service Development, who are on three year fixed-term contracts to ensure independent medical advice is provided to the Board.

C2.2 Non-executive directors are appointed for four year terms not three. The governors proposed a longer term on the basis that the Constitution provided for open competition and the four year term provided better value. The Constitution will be undergoing a review in 2010/11 to enable reappointment for a second term without the need for open competition; in this case a second term would be for three years.

A.3.2 One half of the Board, including rather than excluding, the Chairman, comprises non-executive directors determined by the Board to be independent.

F.3.7 The Auditor does provide non-audit services. When this occurs auditor objectivity and independence is safeguarded by the limitation and prior approval by the Audit Committee being required before any non-audit service can be undertaken.

4. Remuneration Report 2009/2010

The Trust's Remuneration Committee consists of the non-executive directors and determines the level of remuneration, terms of service for the chief executive and other executive directors. In setting pay for executive directors the Remuneration Committee seeks to strike a balance between setting pay at a level sufficient to recruit, retain and reward individuals of a high calibre whilst ensuring best value in the use of public finances.

In 2009/10, the Remuneration Committee developed a policy for the remuneration of senior managers with HayGroup, independent recruitment specialists. The pay policy for Executive Directors is based on a formal job evaluation with market identification for each post, either broader markets or public sector markets. For posts that fall within the broader market, pay is set within the median pay range (base salary comparison) and for public sector market pay is set within the upper quartile pay range. In determining pay within a given salary range, the following factors are taken into account:

- ongoing level of performance
- capability
- experience in role
- the availability of appropriate talent
- challenging complexity of the job and its particular context
- individual track record
- importance to business
- marketability
- salary history.

The policy is reviewed on an annual basis to provide an up to date pay range within the markets and external advice is to be sought every two years on market positioning of current posts and current and anticipated trends. Performance related pay has not been included as part of the pay policy.

Following the adoption of this policy in June 2009, raises in pay were effected for four of the executives plus a cost of living increase applied to all executives of 1.5% in accordance with national pay guidance.

The Remuneration Committee agreed there was to be no pay increase for executive directors or for senior managers for 2010/11 and the chairman was asked to write to the governors on the Remuneration Working Group to state that it was the wish of the non-executive directors not to receive a cost of living increase. This request was subsequently approved by the Remuneration Working Group in February 2010.

The Remuneration Committee also approved the salary of the director of organisational development and workforce as a new post to the Trust replacing the former director of HR post.

Executive members of the Board are employed on contracts with no fixed or specified term save for the medical director and director of clinical service development, who are subject to a three year fixed term in respect of their executive roles. Notice periods for executive members of the Board are set at six months. No provision is made for additional termination payments, and the Trust can confirm that no significant awards were made to past senior managers during 2009/2010.

The Remuneration Committee met twice during 2009/2010. These meetings were supported by a director from Hay Group on one occasion to develop and agree the executive pay policy and provide guidance. On both occasions, the Trust Secretary was in attendance to take minutes and both meetings were attended by the chief executive (save for when her salary was being discussed) for the purpose of providing further detail on executive posts being discussed.

Attendance at meetings was as follows:

Rosalinde Wyke	2 out of 2
Andy Willis	2 out of 2
Peter Merson	1 out of 2
Adele-Lee Barker	1 out of 2
Chris Harvey	2 out of 2
Gill McComas	2 out of 2
David Clements	1 out of 2

See pages 47 and 48 for salary and pension entitlements for senior managers.

The Remuneration Committee is chaired by the senior independent director as recommended in Monitor's Code of Governance.

Remuneration Working Group

The Members' Council has appointed a Remuneration Working Group which is responsible for the remuneration and terms of employment for the non-executive directors of the Trust Board.

In 2009/10, two meetings of the Members' Council and the Remuneration Working Group were held. Membership and attendance as follows:

Paul Roberton, Chair	2 out of 2
Cliff Mann	1 out of 2
Leonard Daniels	2 out of 2
Jonathan Secker-Walker	2 out of 2
Diane Kotelnikoff	2 out of 2

The Remuneration Working Group reviewed pay against an independent review of the market by HayGroup and determined that HayGroup was consistent with national and local comparators. Following the request from the Trust Board Remuneration Committee not to apply a salary increase for 2010/2011, a nil pay increase was agreed.

The Remuneration Working Group reviewed the fees paid to the chair of the Audit Committee and senior independent director which remained unchanged, and approved a fee for the vice-chair role when the senior independent director and vice-chair roles were separated. The Remuneration Working Group also approved the salary to be advertised in respect of the chairman, in respect of the appointment process taking place in 2010/2011.

Non-executive directors serve a maximum tenure of nine years, subject to two four year terms, plus one additional year. Non-executive directors are not required to serve a period of notice on leaving office.

Salary and Pension entitlements of senior managers (audited)

A) Salaries and Allowances

Name and Title	2009-10			2008-09		
	Salary (Bands of £5000)	Other Remuneration (Bands of £5000)	Benefits in Kind	Salary (Bands of £5000)	Other Remuneration (Bands of £5000)	Benefits in Kind
Executive Directors	**£000**	**£000**	**Rounded to the nearest £100**	**£000**	**£000**	**Rounded to the nearest £100**
Ms J Cubbon Chief Executive	165-170		5,700	150-155	0	5,400
Dr C Blumgart Medical Director *1	25-30	155-160	100	20-25	150-155	200
Mr P Lewis Deputy Chief Executive and Finance Director	120-125		0	110-115	0	200
Mr D Allwright Director of Planning and Performance	110-115		100	100-105	0	100
Mr T Jobson, Director of Clinical Service Development *1	20-25	130-135	100	10-15	65-70	0
Ms M Price Director of Governance and Nursing	95-100		0	85-90	0	0
Ms J Ridgway Director for Organisational Development and Workforce (from 1.9.09)	60-65		100	0	0	0
Non Executive Directors *2						
Ms A R Wyke Chair	40-45		5,200	45-50	0	5,800
Mr A Willis	10-15		1,000	15-20	0	3,300
Miss A Barker	10-15		0	10-15	0	0
Mr P Merson Vice Chair	10-15		400	15-20	0	300
Mr C Harvey	10-15		1,600	10-15	0	2,300
Mr D Clements	10-15		1,400	0-5	0	300
Ms G McComas	10-15		2,000	0-5	0	0

***1** Other Remuneration is for clinical employment with the Trust.

***2 2008-9 remuneration for Non Executive directors included back pay for period November 2007 - 31 March 2008.**
The benefits in kind received by the Non Executives are for Taxable mileage (home to base) where the Trust meets this obligation and the Executive Directors are for lease car and taxable mileage.

B) Pension Benefits (audited)

Name and title	Real increase in pension at age 60 (bands of £2500)	Real increase in lump sum at age 60 (bands of £2500)	Total accrued pension at age 60 at 31 March 2010 (bands of £5000)	Lump sum at age 60 related to accrued pension at 31 March 2010 (bands of £5000)	Cash Equivalent Transfer Value at 31 March 2010 To nearest £1000	Cash Equivalent Transfer Value at 31 March 2009 To nearest £1000	Real Increase in Cash Equivalent Transfer Value - funded by employer To nearest £1000	Employers Contribution to Stakeholder Pension To nearest £100
Executive Directors								
Ms J Cubbon, Chief Executive	2,501-5,000	7,501-10,000	40,001-45,000	125,001-130,000	824	689	70	0
Dr C Blumgart, Medical Director	0-2,500	2,501-5,000	45,001-50,000	135,001-140,000	943	844	40	0
Mr P Lewis, Deputy Chief Executive and Finance Director	0-2,500	5,001-7,500	30,001-35,000	95,001-100,000	424	359	34	0
Mr D Allwright, Director of Planning and Performance	2,501-5,000	10,001-12,500	30,001-35,000	95,001-100,000	568	459	60	0
Ms M Price, Director of Governance and Nursing	2,501-5,000	10,001-12,500	30,001-35,000	90,001-95,000	505	428	39	0
Mr T Jobson, Director of Clinical Service Development	0-2,500	0-2,500	20,001-25,000	60,001-65,000	324	286	16	0
Ms J Ridgway Director of Organsiation Development and Workforce (from 1.9.09)	0-2,500	0-2,500	0-5,000	0-5,000	13	0	5	0

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

Signed  Date: 4 June 2010

Jo Cubbon, Chief Executive

5. Members' Council and Membership

The Trust has a Members' Council. The Board reports to the Members' Council on the performance of the Trust and its progress against agreed objectives and consults on its future direction. The Members' Council meets quarterly, each meeting is held in public. Governors report matters of concern raised by members individually or at their constituency meetings to the Chairman in the first instance for a timely response and also to the Members' Council. Members of the public have an opportunity to ask questions of the Governors and any Directors in attendance at the Members' Council meeting.

Membership comprises individuals in the following categories:

- Public membership, anyone aged 16 or over who lives in one of the state constituencies (Taunton Deane, West Somerset, East Somerset and Rest of England) and wishes to become a member of the Foundation Trust
- Staff – any member of staff on permanent employment contracts or those who have worked at the Trust for at least 12 months, including contractual staff

Members are represented on the Members' Council by representatives from the public, staff and other stakeholder groups. More than half of the Council is elected from the Trust memberships, which means the 11,790 public and staff members have a significant influence on the hospital's future strategy. In this way, Taunton & Somerset NHS Foundation Trust is directly accountable to its local community. The Trust's membership strategy sets out a vision of a representative and engaged membership. The Trust has a membership manager who drives this area of work.

Role of Governors

The Members' Council is representative of the membership of the Trust and responsible for holding the Board of Directors to account for the performance of the Trust and ensuring the Board acts so that the Trust does not breach its Terms of Authorisation. Governors are responsible for regularly feeding back information about the Trust, its visions and its performance to the constituencies and stakeholder organisations that elected or nominated them. Governors have a collective statutory responsibility for the appointment of the Chairman and the non- executive directors, agreeing their terms and conditions as well as the appointment of the external auditors and receive the annual accounts, audited report and the annual report. The Members' Council is consulted by the Trust Board on its plans each financial year and responds as appropriate when consulted by the directors on specific issues.

Composition

The Members' Council comprises three main groups:

<u>Public Governors</u>

There are 15 publicly elected governors from four constituencies:

- Taunton: The area represented by Taunton Deane Borough Council - five governors;
- West Somerset: The area represented by West Somerset District Council and Sedgemoor District Council – five governors;

- East Somerset: The area represented by Mendip District Council and South Somerset District Council – four governors;
- Rest of England: Anywhere in England not included in the above areas – one governor.

Staff Governors

There are five staff governors elected by self nomination and constituency voting representing a minimum of 3 out of 5 staff groups.

- Medical and Dental
- Nursing and Midwives
- Hotel and Estates Services
- Clerical, Administrative & Managerial
- Allied Professionals, Scientific and Technical

Stakeholder Governors

The Trust has a further seven partnership governors who are appointed by partnership or stakeholder organisations as follows:

- NHS Somerset
- Universities of Plymouth and Bournemouth
- West Somerset and Sedgemoor District Councils
- South Somerset and Mendip District Councils
- Somerset Partnership NHS Foundation Trust
- Taunton Deane Borough Council
- Somerset County Council.

Governor resignations and elections April 2009 to March 2010

In accordance with its Constitution, the Trust uses a method of single transferable voting for all elections. The single transferable voting system is designed to minimise wasted votes. It allocates the elector's vote to his or her most preferred candidate and then, after candidates have either been elected or eliminated, transfers unused votes according to the voter's next stated preference. An external electoral agent is appointed by the Trust to oversee the election process.

In the event that a governor resigns mid-term, the remaining governors can either invite the candidate who polled the next highest number of votes in the original election to fill the vacant seat for the remaining period of office, or call an election. The Constitution states that if the unexpired period of the term of office is less than six months the seat may be left vacant until the next elections are held.

Elections were held during November 2009 within staff constituency (three seats) and three of the public constituencies, (two seats each) for terms beginning 1 December 2009.

Electoral Reform Services was appointed to oversee the election. The chairman held informal briefing sessions in order for prospective candidates to find out more about Taunton and Somerset NHS Foundation Trust and the governor role. All seats were contested and the voter turnout ranged between 31% and 39% in the public constituencies and 19% for the staff constituency.

Alan Lovell resigned in May 2009 and his seat remained vacant until the November elections. Two governors, John Attree (Staff) and June Churchill (Public) resigned in February 2010 and the Members' Council approved the filling of these vacancies by inviting the highest polling candidate from the elections held in November to fill the seats for the remaining terms of office, Linda Owen-Thomas (Staff) and Sabina Ahmed (Public).

Rosemarie Parsons, Partnership Governor for Somerset County Council was not re-elected in the June council elections and was replaced by Stephen Martin-Scott in July 2009.

A full list of governors in post on 31 March 2010 and changes during the year is set out on pages 52 to 54 with details of the number of Members' Council meetings attended by each governor.

Register of Governors' interests

A register of governors' interests is maintained. A copy of the latest version submitted to the Members' Council is available via the Governors Support Manager who can be contacted on 01823 342051.

Understanding the view of Governors and Members

A proportion of the Trust's directors attend each Members' Council meeting to listen to the discussions on the topics being considered and questions raised by governors and members. The Trust Board meets with the Members' Council mid-way through the year to provide progress on the annual objectives and to facilitate discussions designed to hold the Board to account.

Each Governor Working Group has an executive lead who works with the governors to plan agendas and implement actions agreed at these meetings.

Engagement with Governors and Members

The Trust held constituency meetings across its four public constituency areas. Meetings were held to coincide with Medicine for Members presentations to afford members the opportunity to speak to their representative governors as well as attracting members of the public who are not members and had questions for the governors.

Attendances at the Medicine for Members meetings have increased to such an extent that many of the presentations have had to be repeated twice on the same day to meet demand with the constituency meeting held in between to interface with both groups.

The annual Members Meeting held in September 2009 was attended by 175 members. The event included a presentation on membership growth, development that had occurred at the hospital and priorities going forward plus presentations on patient and clinical matters. Feedback from attendees was positive.

Members are able to contact the Governors via the Trust by email, telephone or in writing. Details are provided from the Trust website. During 2009/2010 a members' only area has been developed on the Trust website with access to additional information about the Trust. Governors also communicate with members at recruitment and membership events, the annual members' meeting, constituency meetings and through the members' newsletter published three times a year.

Membership as at 31 March 2010

Public Membership

Constituency	Number of members 01.04.09	Number of members 31.03.10	% increase over year (absolute figures in brackets)	% population that are members
Taunton	3,431	4,293	20.0% (862)	5.9%
West Somerset	1,610	2,415	33.3% (805)	2.4%
East Somerset	1,211	1,624	25.4% (413)	0.9%
Rest of England	470	763	38.4% (293)	n/a

Staff Membership

Constituency	Number of members 01.04.09	Number of members 31.03.10	% increase over year (absolute figures in brackets)	% population that are members
Medical & Dental	333	371	10.2% (38)	82.4%
Nursing & Midwives	832	1,017	18.2% (185)	58.1%
Hotel & Estates Services	221	263	15.9% (42)	55.2%
Admin, Clerical & Managerial	633	711	10.9% (78)	62.8%
Allied Professionals, Scientific & Technical	312	333	6.3% (21)	58.7%

The Trust remains on target to achieve over 10,000 public members by 30 November 2010.

Major actions in 2009/2010 to increase and develop membership

The strategy for the year was to increase membership numbers by 2,500 in the public constituencies and 360 in the staff constituencies. This was exceeded for staff and within 5% for the public.

A focus for the recruitment during the year was the under 44 age group who were targeted through recruitment events with a ballot by college students as an assignment for their academic courses.

The Membership Manager also worked closely with the Governors in attending public events in the outpatient department.

Taunton and Somerset NHS Foundation Trust – Members' Council

Elected Governors to 31 March 2010

Constituency name	Full name	Date of appointment	End of tenure	Total attendance Members Council meetings
Taunton Deane	June Churchill	01-Dec-07	01-Feb-10	4 of 5
	Leonard Daniels	01-Dec-07	30-Nov-12	6 of 6
	Hazel Hancock	01-Dec-07	30-Nov-10	5 of 6
	Jeanette Keech	01-Dec-09	30-Nov-12	1 of 2
	Vivienne Knighton	01-Dec-07	30-Nov-09	4 of 4
	Ron Powell	01-Dec-07	30-Nov-10	5 of 6
West Somerset	Steve Barham	01-Dec-09	30-Nov-12	2 of 2
	Mike Bickersteth	01-Dec-07	30-Nov-12	5 of 6
	Alex Brown	01-Dec-07	30-Nov-10	6 of 6
	Alan Lovell	01-Dec-07	01-Apr-09	1 of 1
	Jonathan Secker-Walker	01-Dec-07	30-Nov-10	4 of 6
	Pamela Upfold	01-Dec-07	30-Nov-10	6 of 6
East Somerset	Bob Champion	01-Dec-07	30-Nov-09	0 of 6
	Kate Forsyth	01-Dec-07	30-Nov-10	4 of 6
	Diane Kotelnikoff	01-Dec-07	30-Nov-10	5 of 6
	Jim Mochnacz	01-Dec-09	31-Nov-12	2 of 2
	Tony Wood	01-Dec-07	30-Nov-12	6 of 6
Rest of England	Basil Brunning	01-Jul-08	30-Nov-10	6 of 6
Staff	John Attree	01-Dec-07	01-Feb-10	2 of 5
	Ian Gauntlett	01-Dec-07	30-Nov-11	6 of 6
	Cliff Mann	01-Dec-07	30-Nov-12	3 of 6
	Sally Moran	01-Dec-07	30-Nov-09	4 of 4
	Linda Owen-Thomas	01-Feb-10	30-Nov-11	1 of 1
	Gillian Stapleton	01-Dec-09	30-Nov-12	2 of 2
	Andrew Tandy	01-Dec-09	30-Nov-12	2 of 2

Appointed Governors to 31 March 2010

Stakeholder Organisation	Full name	Date of appointment	Attendance
NHS Somerset	Jan Hull	01-Dec-09	4 of 6
Universities of Plymouth and Bournemouth	Susan Twose	01-Dec-09	4 of 6
West Somerset and Sedgemoor District Council	Duncan McGinty	01-Dec-09	2 of 6
South Somerset and Mendip District Council	Paull Robathan	01-Dec-09	5 of 6
Somerset Partnership NHS Foundation Trust	Diana Rowe	01-Dec-09	5 of 6
Taunton Deane Borough Council	Nigel Stuart-Thorn	01-Dec-09	6 of 6
Somerset County Council	Stephen Martin-Scott	01-Dec-09	2 of 4

Changes to the membership of the Members' Council – 2009/10

John Attree (Staff) and June Churchill (Taunton) resigned Feb 2010.
Linda Owen-Thomas replaces John and Sabina Ahmed is replacing June.

Sabina Ahmed: In accordance with the Trust's Constitution the Members' Council at their meeting on the 4th March 2010 approved filling the Public Governor vacancy in the Taunton Deane Constituency by inviting the highest polling unsuccessful candidate from the elections held in November 2009 to take office to fill the vacancy for the remainder of the term to 30 November 2010.

Linda Owen-Thomas: As above, inviting the highest polling unsuccessful candidate from a third staff group to fill the vacancy until the next Staff annual elections. Term of office ends 30th November 2011.

Rosemarie Parsons: Partnership Governor – Somerset County Council was not re-elected in the June Council elections - vacancy filled by Stephen Martin-Scott Partnership Governor Somerset County Council – July 2009

Alan Lovell: Public Governor – West Somerset resigned May 2009 – His resignation was formally reported to the late May Members' Council and fell within the six months prior to completion of his term of office and in accordance with the Constitution there was no additional requirement for an interim election.

David Wrede: Staff Governor resigned February 2009 – vacancy filled by Linda Owen-Thomas highest polling unsuccessful candidate from the elections held in November 2008.

Bob Champion: Unfortunately due to domestic challenges Bob Champion has not been able to make any of the Members' Council meetings in 2009. The Members' Council were content that due to the circumstances Bob Champion would continue to the end of his term of office in November 2009.

6. Quality Account Report

Musgrove Park Hospital

TAUNTON & SOMERSET NHS FOUNDATION TRUST

Quality Report 2009- 2010
Incorporating the Quality Account

Part One – Introduction

Statement of Quality from the Chief Executive of Taunton & Somerset NHS Foundation Trust, Jo Cubbon

Welcome to our 2009/2010 Quality Account which sets out our commitment to the continuing improvement of the quality of services that we deliver. A Quality Account publishes information on the quality of our services at the same level of importance as we publish our financial accounts. The Chairman, Board Directors and I are very proud of our organisation and all the staff who work within it and we welcome the opportunity to share our priorities, achievements and challenges with you.

This report highlights areas where we have done well but also identifies where we need to make improvements. We strive to provide high quality care and in doing so have set ourselves ambitious targets. Details of our priorities for the coming year 2010/2011 are included and have been developed with the help of our Foundation Trust Members, Governors, members of the public and commissioners. We very much hope that this document will provide our patients and public with assurance of our continuing development and commitment to the provision of high quality care.

The economy is going through a tough time, so the years ahead are going to be extremely challenging for all public sector organisations. We will all have to make savings and increase our productivity at the same time as maintaining and increasing quality of care for our patients.

So, how do we get through this challenging time and maintain our high standards?

I think we need to emphasise three things:

1. Quality is absolutely key. I do not believe those who argue that quality and costs are direct opposites. It is simply not true to say we must sacrifice quality to save money. We have projects at Musgrove which prove the very opposite – by making savings and streamlining services you can also improve quality and provide the best clinical outcome.

2. Safety is also central to this. We can have the greatest staff, the most modern equipment, the finest buildings – but if we do not provide the safest possible care, then we are wasting our time. Patients expect no less.

3. The third principle for me is engagement. If we can engage with people who need our services, we can ensure we constantly improve. We work closely with our staff, the

Friends of Musgrove Park Hospital, the Primary Care Trust, and the newly formed Local Involvement Networks (LINks) and, of course, our Foundation Trust Members.

In last year's report I described the series of "staff conversations" that we held to discuss and share views, highlighting what our staff felt was important to both patients and them. We have continued this work into 2009/10 including seeking the views of Foundation Trust members and some members of the public and staff groups who had been patients themselves. The result of this consultation was that in June 2009 the Board adopted a new statement of its vision and values to help motivate and guide staff, and to inform and assure patients and the public:

Vision
"The very best patient centred care at the heart of everything we do"

Values

- **Put Patients First**
  In everything we do, we will view our actions from the perspective of a patient.

  Patient care is at the centre of all we do as individuals and as a hospital. We will do all we can to make each patient's experience better.

- **Lead and Listen**
  The best patient care happens where there is clear leadership and a willingness to learn.

  We will ensure that there is clinical involvement in our decision making. We will encourage openness, honesty and feedback. We will look to learn and improve, not blame.

- **One Team**
  The best patient care depends on great teamwork with all team members fully playing their part.

  We know teamwork makes for better care for our patients and a better working environment. We will work closely with our colleagues, our patients, our healthcare partners and the community to deliver the best patient care.

- **Strive for the Best**
  The best patient care comes from excellence becoming the standard.

  We want to continuously improve. We will create flexibility for innovation. We will add value and make the best use of our resources. We want the care we offer to be the very best.

It is the Board's intention that this expression of its vision and values describes what we aspire for and should become embedded throughout the hospital in the way all our staff behave.

Divisions and departments are being encouraged to use this statement to inform their decision-making processes and also to refer to it in their communication plans and in the recruitment and induction of new staff. We want to be sure that all our behaviours as individuals, teams and as an organisation are consistent with our values.

Thank you for taking the time to read this Quality Account. I look forward to developing this report each year, building on previous editions and would welcome any feedback on this

report or suggestions of what you would like to see in future editions. Please send your comments to me at: qualityreport@tst.nhs.uk

I certify as Chief Executive of Taunton & Somerset NHS Foundation Trust that to the best of my knowledge the information within this document is accurate.

Signed Date: 4 June 2010
Jo Cubbon
Chief Executive

Part Two: Priorities for improvement and statements of assurance from the board

Quality - The Patient at the Heart of Everything We Do

The first strategic aim of the Trust is to ensure that the highest quality patient-centred care is provided. Improving our organisation through better quality measures and outcomes has been a focus for 2009/10.

Strong leadership is essential within a successful organisation and, as reflected in our strategic objectives, our Board is committed to ensuring the hospital provides safe quality care to our patients. At each Board meeting, in addition to finance and performance reports our Board receives a quality report which is produced by the Medical Director and the Director of Governance and Nursing. This is supplemented each quarter by a more detailed report covering a wider range of topics including patient complaints and concerns. These quality reports provide the Board with information on performance with respect to a variety of quality indicators. They also highlight issues that are important to the Trust, our patients and our visitors. Included within the report are the key quality priorities we identified last year.

In addition, executive and non executive Board Members take part in regular "walkabouts"; visiting different areas of the hospital, speaking to staff, seeing the care given first hand and bringing back issues that require action.

Stakeholder Involvement

We are fortunate in the Trust to have a strong history of working with our patients and members of the public. This helps us to understand their experience of our care and what aspects they feel we can improve on. We are continuing to develop these relationships, recognising that they provide us with rich information to assist us in the development of our clinical priorities. Our Governors work stream on "Patient Experience" has been valuable in highlighting the views of the membership and suggestions on the format of this report. In addition the Trust's quality priorities have been informed by patients, carers, staff and members of the public through their involvement in patient feedback interviews, feed back from exit cards, inpatient surveys and focus groups. We also use information from complaints and calls to our Patient Advice Liaison Service. 2009/10 saw the introduction of quarterly quality monitoring meetings with our Commissioners which ensures clear agreement on our priorities that are reflected in this report. We have a continued and valued relationship with our LINk and look forward to strengthening this over the coming year.

Quality Improvement Priorities 2009/10

In last year's Quality Report we identified the following four priorities for 2009/10:

- **Continue year on year reduction of hospital acquired infections**
- **Maintain Hospital Standard Mortality Ratio (HSMR) at 90 or less**
- **Increase the percentage of patients who would definitely recommend the hospital to their friends**
- **Focus on privacy and dignity – single sex accommodation**

PRIORITY: Continue year on year reduction of hospital acquired infections

Reducing harm to our patients by avoiding hospital acquired infection is fundamental to the care we provide. We have a clear strategy with a dedicated Infection Prevention and Control Team who work with our clinical staff ensuring that standards are maintained and that

appropriate monitoring arrangements are in place. Over the last two years we have delivered and sustained significant improvements.

Our targets for 2009/10 were:

- ***Less than 9 cases of Methycillin Resistant Staphylococcus Aureus (MRSA)***

MRSA is a bacteria which in most cases causes no problems. It is however important that good hygiene practice takes place in the hospital to prevent MRSA from being spread to patients. This is because it can cause a serious infection if it enters the bloodstream or urinary tract which can be difficult to treat. A key action we take to prevent this is to take a swab from patients who are scheduled to come into hospital. Where MRSA is identified we ensure they receive treatment so that they are free of MRSA before they are admitted. We have now extended this to over 80% of our emergency admissions and aim to increase this to 100%.

We look at each case of MRSA bloodstream infection to understand how this occurred and to identify any learning in order to prevent a similar infection in other patients. This information is reported to the Trust Board at its monthly meeting.

We are proud of the way our staff have worked hard to reduce healthcare acquired infections and the table below shows how we have continued to meet our target to reduce this through such vigilance. As shown the total for this year was 8 cases; however only two of these cases were found in patients who had been in hospital for more that two days (an indication that the infection was acquired whilst the patient was in the hospital).

MRSA Infection	
2006/2007	36 cases
2007/2008	16 cases
2008/2009	8 cases (target 12 or below)
2009/2010	8 cases (target 9 or below)

- ***Less than 64 cases of Clostridium Difficile***

Clostridium Difficile is a type of bacteria sometimes found in the gut of healthy adults and causes no problems. However, it can cause illness when normal bacteria are reduced through use of antibiotics. Our target for this year was to have no more than 64 cases. As shown in the table below we were considerably below this at 48 cases, and can demonstrate a year on year reduction.

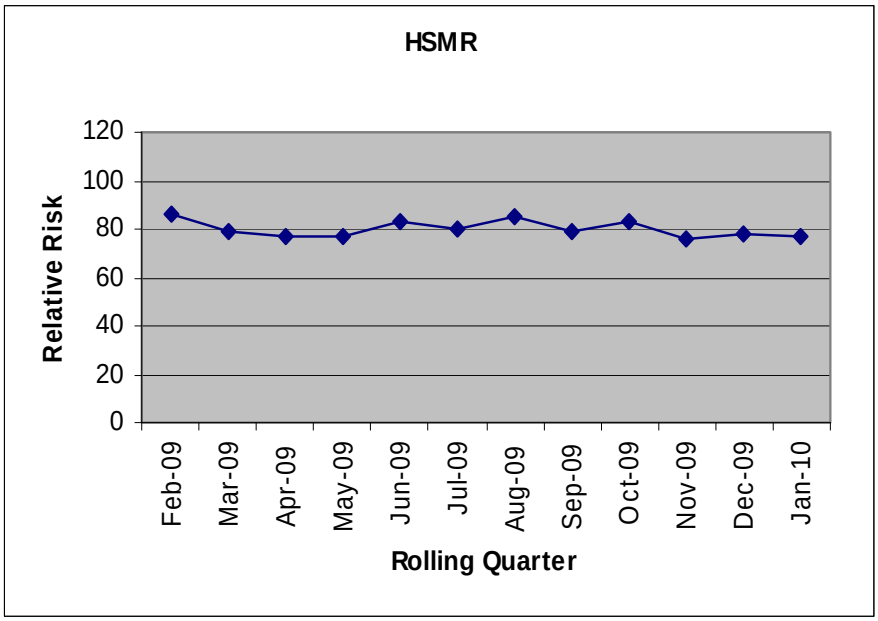
Clostridium Difficile	
2007/2008	66 cases
2008/2009	55 cases (target 73)
2009/2010	48 cases (target 64)

PRIORITY: Maintain Hospital Standard Mortality Ratio (HSMR) at 90 or less

HSMR is a national measure which sets 100 as representing expected deaths occurring in a hospital and comparing this against hospitals with similar patient admissions.

Although 100 represents a match of actual deaths compared to what would be considered as normal given the type of hospital services provided, the range is understandably wide depending on the number of cases included in the analysis. For each month anything between 80 and 100 can be considered within the expected range.

During 2008/09 we achieved 85.4 and for 2009/10 we set a local target to maintain this at 90 or less. As the graph shows we achieved this ambition.



In addition to looking at our results month by month we also compare ourselves with other similar providers using Dr Foster information. This shows us that for quarter 3 2009/10 we compared well within the NHS South West region and nationally as follows:

National best	57.9
NHS South West best	72.1
Musgrove Park	**78.1**
National worst	108.9

PRIORITY: Increase the percentage of patients who would definitely recommend the hospital to their friends

Our target for 2009/10 was to improve the percentage of patients who would definitely recommend the hospital to their friends.

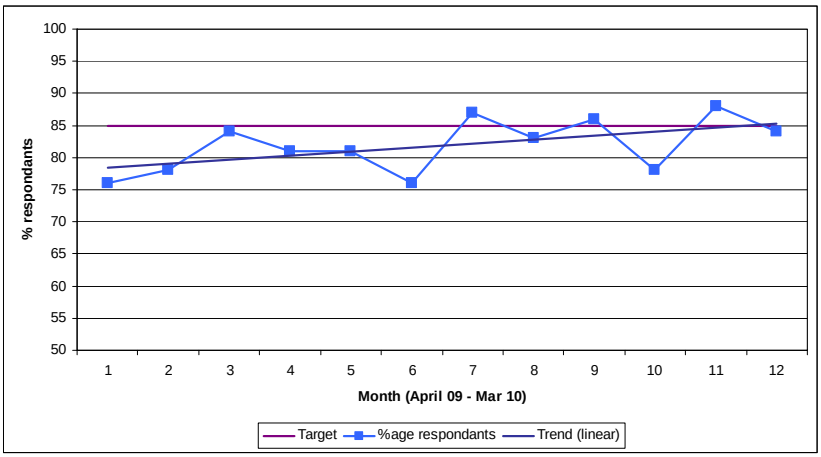
Each year a national survey is carried out which asks patients how they rated the care they received. This survey is carried out externally and all Trusts receive a report which details the response and also compares the result with other hospitals.

National Inpatient Survey score	
2007	79%
2008	83%
2009	81%

Although the Trust has received good scores we felt that we could do better and took the decision to undertake a monthly survey of our patients to help understand their experiences. The benefit of this is that we can make any improvements without delay.

One of the questions that we ask our patients is if they would recommend the hospital to their friends. 2009/10 was the first year we carried out our own monthly inpatient survey and the graph below shows a clear improvement trend towards our ambitious target of 85%. The value of a monthly survey is that we can immediately respond to any dips and review factors that may have influenced this.

Patients who would definitely recommend hospital to their friends



PRIORITY: Focus on privacy and dignity – single sex accommodation

Our target for 2009/10 was to deliver a significant reduction in the number of patients who reported that they shared sleeping accommodation or toilet/wash facilities with members of the opposite sex.

We know that being in hospital can be a difficult and worrying time, and it is natural for people to feel vulnerable.

At Musgrove we are doing all we can to ensure that patients are treated well. This obviously means the very best medical treatment, but is also about every patient's right to privacy and dignity. We recognise that a very important part of this is not sharing sleeping areas or bathroom and washing facilities.

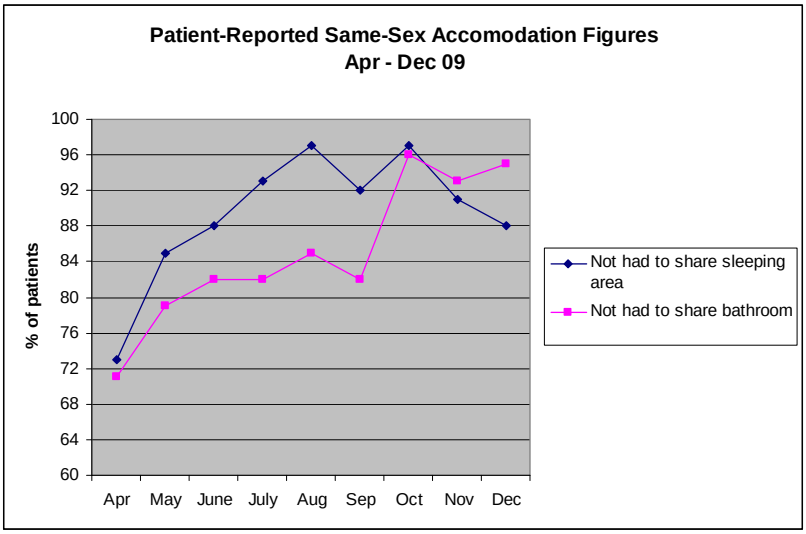
We are proud that mixed sex accommodation has been virtually eliminated at Musgrove. Work was undertaken in 2009 to provide more toilets and screening in our emergency admission and day case areas. In addition, we carried out work to upgrade inpatient wards so that all wards now have separate sleeping areas for men and women, with same sex toilets and bathrooms nearby.

As we continue to upgrade buildings we will continue to prioritise same sex accommodation. Work is planned to start this year on the new 112 bed surgical ward block, where every bed will be in a single room with en suite toilet and washing facilities.

The annual national inpatient survey which is carried out on all Trusts also asks patients about their experience of single sex accommodation. The question asked "Did you ever share a sleeping area with patients of the opposite sex?" Although our position has improved we have not yet reached the threshold for inclusion in the top 20% of Trusts.

	Score for top 20% of Trusts	Musgrove Score
2007	88% or above (did **not** have to share)	73%
2008	87% or above	73%
2009	91% or above	86%

In order to obtain information during the year we have also included this in our monthly inpatient survey. The new arrangements which took place during 2009 place are reflected in the graph below which shows a increase in the number of patients who reported they did not have to share bathroom or sleeping areas with patients of the opposite sex. From January 2010 and onwards we have introduced new amended questions to reflect new Department of Health requirements. We will continue to carefully monitor this during 2010/11.



Quality Improvement Priorities: 2010 -2011

In 2010/11, continuing to be guided by its 'Strategy for Continuous Quality Improvement' approved by the Board in January 2009, the Trust will aim to consolidate the significant achievements of its previous involvement in two phases of the Safer Patient Initiative. We will focus on patient safety at 'the front line' in order to further embed the culture of safety throughout the organisation so that it becomes 'business as usual'. In particular, this will involve participation in three external safety improvement programmes. These will concentrate on specific risk areas and the more effective capture and use of clinical data to help improve outcomes of treatment and to support assurance and performance management.

Central to quality improvement will be the implementation of the first year's plans identified in the Trust's 'Nursing and Midwifery Strategy 2010-13'. As well as focusing on creating a 'calm, safe, clean environment of care' , and 'personalised care for every patient', nurse leaders aim to enhance the efficiency and cost effectiveness of the nursing workforce, as well as developing nursing leadership skills and team working to strengthen confidence in caring.

Another key component of the Trust's drive to improve the quality of care and patient experience in 2010/11 will be the 'Clinical Pathway Transformation' programme of work. This opportunity to redesign whole care pathways will be aimed at, led and managed by clinical teams, in collaboration with NHS Somerset. It is also expected that these will deliver financial benefits to the Trust.

The chosen priorities align with the Trust's Quality Strategy and are in line with national and local health community priorities. The indicators have been developed from internal and external discussion.

Our ambition is to have the following Key Quality Improvement Indicators for 2010/11:

1) **Sustaining the reduction of hospital acquired infections**
2) **Right Patient Right Place**
3) **All inpatients to be given a predicted date of discharge from hospital**
4) **All patients to have a Venous Thromboembolism assessment**

1 Sustaining the reduction of hospital acquired infections

As we have described above, reducing hospital acquired infections is an important issue, a national priority and one that our Governors have identified as an ongoing priority. Over the last few years we have made significant improvements and, as illustrated earlier, in 2009/10 only two cases of MRSA arose after 48 hours of admission. We are committed to continuing our vigilance in this and plan to extend our screening program. Each case will continue to be treated as a serious incident requiring full investigation. Our targets for 2010/11 are:

- Three or less cases of MRSA acquired after 48 hours of admission (we had two cases in 2009/10)
- Sixty or less cases of C Difficile acquired after 48 hours of admission (we had 48 cases in 2009/10)

This information is collected directly from our laboratories and inputted to an infection control database. The results will continue to be reported to the Trust Board at each Board meeting. They are also available to the public through the Board papers.

2 Right Patient Right Place

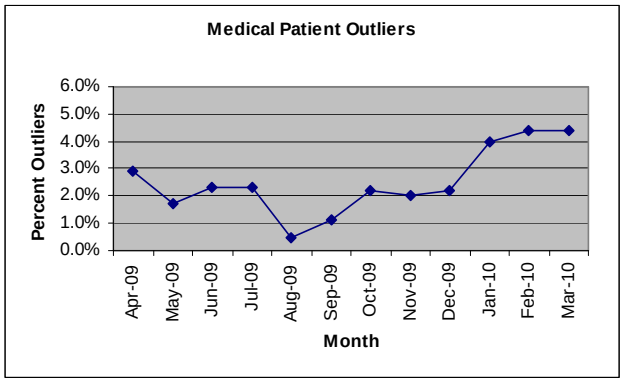
We know from our patient experience work, which includes complaints and PALS concerns, that it is unsettling for patients and inefficient for the Trust for patients to move wards during their stay. This may of course be necessary for clinical reasons which are entirely appropriate. However we know that there are sometimes other reasons, such as unavailability of beds on the appropriate ward, which leads to patients being cared for in other areas. Our aim for 2010/11 is that patients will be admitted to the right ward and only moved if clinically necessary. This area of work is monitored through our Acute Care Strategy which brings together a number of elements to ensure sound bed management.

We will report on the following indicators:

- Number of medical outliers
- Reduction in the length of stay

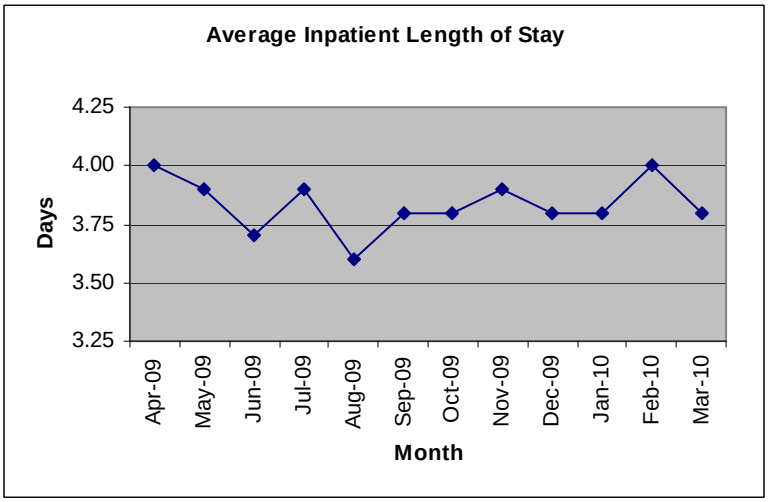
Number of medical outliers

The graph below illustrates the number of medical patients during 2009/10 who were not in the most appropriate ward for their clinical condition. These patients are described as outliers. As the graph shows, the winter months of 2009/10 saw the number of outliers increase. This was a deterioration from the previous year. We know that this was largely due to norovirus being present throughout the community for some considerable time, which led to ward closures and restricted visiting in the hospital. This is a source of concern to patients and can be seen reflected in their complaints and comments to Governors. This is valuable information to help with our bed management plans for next winter.



Reduction in the length of stay

We know that patients do not like to be in hospital longer than necessary and it is unacceptable for patients to spend unnecessary time with us, for example whilst waiting for tests or other investigations. One measure we do to assess this is to monitor the average length of stay. The graph below shows that our monthly average ranged from 3.6 to 4 days during the year.



Using the most recent complete data for quarter 3 2009/10 we have benchmarked against other hospitals in the NHS South West area using data from Dr Foster:

For elective (planned) cases (including day cases):

NHS South West Health Authority - best	3.7 days
Musgrove Park Hospital	**3.8 days**
NHS South West Health Authority - worst	6.3 days

For non-elective (emergency) cases:

NHS South West Health Authority - best	3.9 days
Musgrove Park Hospital	**3.9 days**
NHS South West Health Authority - worst	6.0 days

Our target for 2010/11 in respect of this priority is:

- to achieve 1% or less medical patient outliers at all times
- to achieve 3.8 days or less length of stay averaged for the whole year.

This information is collected through our data collection systems. Patients who are not on the correct ward are monitored at daily bed meetings. The Matrons who attend the meetings then ensure that the outliers receive appropriate care and are transferred to an appropriate ward as soon as possible. Performance against these targets are reported to the Trust Board at each meeting.

3 All inpatients to be given a predicted date of discharge from hospital

In last year's Quality Report we described the work of our Discharge Action Group in helping to provide patients with information on what they should do when they leave hospital. This group is part of the Acute Care Strategy and the work of the group has continued with progress including:

- Development of a discharge policy
- Development of protocol led discharge
- Working with the Primary Care Trust to streamline District Nurse referrals using an electronic system
- Working with the Primary Care Trust to fast track continuing health care patients
- Development of a one stop pharmacy process
- Development of specific patient discharge ward rounds

The Patient Experience Group of our Member's Council specifically asked us to look at discharge planning and for 2010/11 we are focusing on ensuring patients know their predicted date of discharge. It helps patients and us to plan ahead if it is understood as early as possible when we anticipate that a patient will be able to leave the hospital. We know from our surveys and complaints that we are not always clear when we expect patients to be discharged and frequently there can be non clinical reasons why discharges are delayed. This makes it extremely difficult for patients and their relatives to put appropriate plans in place and also for other patients waiting to be admitted.

Whilst our ambition is for all patients, our target for 2010/11 is that by the end of March 2011 80% of adult inpatients surveyed will have been informed of their predicted discharge date.

This information will be collected through our monthly inpatient survey reported to the Trust Board at each meeting.

4 All patients to have a Venous Thromboembolism assessment

The development of a Venous Thromboembolism (VTE) requires immediate action and it is therefore important that patients are assessed for the risk of developing a VTE whilst in our

care. This indicator is a priority within the NHS operating framework and has been issued as a requirement by the National Institute for Clinical Effectiveness (NICE). There will also be direct reporting on this to the Department of Health. We have a developed action plan to deliver the requirements, and to inform this we carried out an audit examining the records of a sample of patients from each ward. This showed that our assessment completion rate in March 2010 was 55%, which we need to improve on.

From June 2010 we will be required to undertake an assessment on every inpatient. We are currently:

- Developing a policy and process to support this
- Developing an electronic system to record the data
- Piloting forms to collect the information
- Educating the ward staff who will be involved

Whilst our ambition is for all patients, our target is for 90% of adult patients admitted to the hospital to receive a VTE risk assessment.
The Trust Board will receive a report on this at each meeting.

Statements of Assurance from the Board

Review of Services
During 2009/10 the Taunton & Somerset NHS Foundation Trust provided or sub contracted five NHS services in the following areas:

- Acute Adult and Paediatric Care
- Maternity Services
- Accident and Emergency treatment
- Diagnostic Services
- Community Based Services (various)

The Taunton & Somerset NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these NHS Services.

The income generated by the NHS services reviewed in 2009/10 represents 100% of the total income generated from the provision of NHS services by the Taunton & Somerset NHS Foundation Trust for 2009/10.

Part Three gives an overview of our achievements and progress within quality indicators that have been selected by us and our stakeholders. The data reviewed covers the three dimensions of quality – patient safety, clinical effectiveness and patient experience. We indicate where the amount of data available for review has impeded this objective.

Information on participation in clinical audits and national confidential enquiries
During 2009/10 twenty six clinical audits and seven national confidential enquiries covered NHS services that Taunton & Somerset NHS Foundation Trust provides.

During 2009/10 the Trust participated in 92.3% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries that it was eligible to participate in.

The national clinical audits and national confidential enquires that the Trust was eligible to participate in during 2009/10 are as follows:

Name of Audit	Coverage	Notes
NNAP Neonatal care	100%	
NDA National Diabetes Audit	98.4%	78 records rejected due to data errors
ICNARC CMPD Adult Critical Care Units	100%	
National Elective Surgery PROMs	c.60%	Coverage figures available for April – December 2009
CEMACH Perinatal Mortality	100%	
NJR Hip and Knee Replacements	100%	
Renal Registry: Renal Replacement Therapy	100%	Part of regional report via Bristol
NLCA Lung Cancer	100%	
NBOCAP: Bowel Cancer	100%	
DAHNO: Head and Neck Cancer	100%	
MINAP:AMI and other ACS	100%	
Heart Failure Audit	25%	Data submitted for 3 months
NHFD: Hip Fracture	100%	
NHS Blood and Transplant: Potential Donor Audit	100%	
Adult Cardiac Interventions	100%	
National Kidney Care Audit	100%	Part of network via RD&E
National Sentinel Stroke Audit	100%	
National Audit of Dementia: Dementia Care	Ongoing	Data collection on track
National Falls and Bone Health Audit	Ongoing	Data collection on track
National Comparative Audit of Blood Transfusion	100%	
College of Emergency Medicine: Pain in Children; Asthma; Fractured NOF	82.7%	
National Mastectomy and Breast Reconstruction Audit	100%	
National Oesophageal-Gastric Cancer Audit	100%	
RCP Continence Care Audit	100%	
TARN: Severe Trauma	0%	Participating in 2010/11
British Thoracic Society: Respiratory Diseases	0%	
Name of National Confidential Enquiry		
NCEPOD Deaths in Acute Hospital (Medical/Surgical)	100%	
NCEPOD Deaths in Acute Hospital (Anaesthetics)	100%	
NCEPOD Deaths in Acute Hospital (Acute Kidney Injury)	100%	
NCEPOD Parenteral Nutrition	100%	
NCEPOD Emergency and Elective Surgery in the Elderly	100%	
NCEPOD Deaths Following Surgery in Children	100%	
NCEPOD Perioperative Care Study	100%	

Taunton & Somerset NHS Foundation Trust participated in all national clinical audits that it was eligible to participate in during 2009/10 except for the TARN severe trauma audit (the

Trust has established appropriate systems and is participating in this audit in 2010/11) and the British Thoracic Society respiratory diseases audit.

The national clinical audits and national confidential enquiries that Taunton & Somerset NHS Foundation Trust participated in, and for which data collection was completed during 2009/10, are included in the table above, along with 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.

The reports of 12 national clinical audits were reviewed by the Trust in 2009/10 and we intend to take the following actions to improve the quality of healthcare provided:

Name of Audit	Key Actions
NNAP Neonatal care	• Re-launch of local policy for administration of antenatal steroids • Increase in consultant time for the unit and review of job planning • Focusing on assessment of babies' temperature on admission
ICNARC CMPD Adult Critical Care Units	• No significant issues identified from report
NJR Hip and Knee Replacements	• No significant issues identified from report
NLCA Lung Cancer	• No significant issues identified. Peer review work plan to include action to address minor concern related to presence of CNS at diagnosis.
NBOCAP: Bowel Cancer	• No significant issues identified from report
DAHNO: Head and Neck Cancer	• Actions underway to improve completeness of data submitted
NHFD: Hip Fracture	• Establishment of quarterly fractured neck of femur meeting with a range of care staff represented (Orthopaedic Consultant, Orthogeriatrician, Physiotherapists, Occupational Therapists, Anaesthetist, Ward Nursing Staff, Pharmacist)
NHS Blood and Transplant: Potential Donor Audit	• No significant issues identified from report
Adult Cardiac Interventions	• No significant issues identified from report
National Sentinel Stroke Audit	• Stroke investment plan to include interdisciplinary service • Development of user group to improve communication with patients and carers
National Falls and Bone Health Audit	• Introduction of new multi-factorial risk assessment documentation, with monitoring systems to ensure it is used appropriately
National Comparative Audit of Blood Transfusion	• New blood transfusion observation chart introduced to improve recording of observations • Competency assessments being undertaken for all staff (due for completion November 2010)

The reports of 69 local clinical audits were reviewed by the Trust in 2009/10. Action plans are developed for all audits where issues are identified and, as an example of key actions from local audits, the Trust intends to take the following actions to improve the quality of the healthcare provided:

- Introduction of a bed rails risk assessment tool and associated guidance to reduce the risk of falls from bed
- Development of improved guidance for sleep disorder studies
- Review of referral systems for, and Clinical Nurse Specialist input to, diagnoses of melanoma to improve the patient experience
- Increased use of conservative measures (e.g. physiotherapy and bladder training) for the management of incontinence
- Improvements in the anaesthetic management of morbidly obese women receiving caesarian sections
- Review of systems for the management of community acquired pneumonia to speed up the provision of antibiotics

The Trust publishes an annual report of all clinical audit activity, including national and local audits. The report for 2009/10 is due in July 2010 and will be published on the Trust's internet site.

Information on participation in clinical research

Taunton & Somerset NHS Foundation Trust's main contribution to the national R&D strategy lies in the recruitment of patients into externally-funded and externally-led multi centre trials and other well designed studies such as those found on the National Institute of Health Research (NIHR) Portfolio.

The number of patients receiving NHS services provided or sub-contracted by Taunton & Somerset NHS Foundation Trust in 2008/09 that were recruited during that period to participate in research approved by a research ethics committee was 1888.

The number of patients receiving NHS services provided or sub-contracted by the Trust that were recruited during that period to participate in research approved by a research ethics committee was 1416 from 62% of studies where data has been collected, with data collection for the remaining 38% ongoing.

Date	Research projects approved	Total Research projects open	Total recruitment into all research projects	National Institute of Health Research Projects open	Recruitment into National Institute of Health Research Portfolio projects
2008/09	49	182	1888	112	283
2009/10	48	207	1416*	138	1045

*Represents approximately 62% of studies as data collection for 09/10, for non-NIHR portfolio studies, is ongoing.

The increasing participation and recruitment into NIHR portfolio clinical research demonstrates Taunton & Somerset NHS Foundation Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. This is facilitated through our dedicated clinical trials unit, which comprises eighteen staff devoted to supporting NIHR research portfolio projects and which is set to grow by a further five research staff during 2010/11.

Taunton & Somerset NHS Foundation Trust used national systems to manage the NIHR portfolio studies in proportion to risk. The median time to complete the risk checks using these systems was 13 days.

Locally the Trust provided joint funding with the Peninsula Stroke Network for a research team to attend a one week research school run by the NIHR Research Design Service South West in order to develop stroke research ideas into potential grant applications, and funding to the obesity/diabetes, respiratory and anaesthetic departments to enable staff to work on protocol development with academic colleagues from Bristol University. A consultant in the diabetes department was successful in securing a grant of £130,000 from NIHR to continue his research into the effects of diet and exercise on diabetes.

We host the Taunton and Somerset Research & Development Consortium which provides a research management and governance service to both the Trust and to Somerset Primary Care Trust. This facilitates a link between primary and secondary care research, particularly in the area of stroke rehabilitation research.

Information on the use of the Commissioning for Quality and Innovation (CQUIN) Framework

Taunton & Somerset NHS Foundation Trust income in 2009/10 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework due to the contractual agreement with our commissioners.

Information relating to registration with the Care Quality Commission (CQC)

The Care Quality Commission is the independent regulator of health and adult social care services in England. They also protect the interests of people whose rights are restricted under the Mental Health Act.

The CQC carries out their responsibilities by:

- Driving improvement across health and adult social care
- Putting people first and championing their rights
- Acting swiftly to remedy bad practice
- Gathering and using knowledge and expertise, and working with others.

Full information on the CQC can be found on their website www.cqc.org.uk

Taunton & Somerset NHS Foundation Trust is required to register with the Care Quality Commission and our current registration status is registration with no conditions.

The Care Quality Commission has not taken any enforcement against this Trust during 2009/10.

The Trust is subject to periodic review by the Care Quality Commission and the last review was in October 2009. The CQC performed an unannounced inspection on 7th October 2009 to assess whether Taunton and Somerset NHS Foundation Trust was adequately protecting patients, workers and others from healthcare-associated infection. The CQC's assessment of the Trust following that review "found no evidence that the Ttrust has breached the regulation to protect patients, workers and others from the risks of acquiring a healthcare-associated infection."

The review identified some areas for improvement and the Trust has provided assurance that we have addressed the areas for improvement. The Trust completed the following:

- Ensuring that the environment for providing healthcare is suitable, clean and well maintained
- Having an adequate provision of suitable handwashing facilities and antibacterial hand rub

- Using effective arrangements for the appropriate decontamination of instruments and other equipment, which are detailed in the appropriate policies

In carrying out the Annual Health Check, the Care Quality Commission assessed the Trust as providing good quality services and having excellent management of resources. This was the same result as the previous year. They also reviewed inpatient services, surveying patients' views, which reflected that 93% of patients rated the care at Musgrove as excellent, very good or good.

Taunton & Somerset NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Information on quality of data

The Trust is committed to ensuring that the data we use to measure our performance is accurate for we can only improve what we measure. We have a Data Quality Policy in place, and to enable us to ensure that information and data quality issues are dealt with in a coordinated way we have formed a Data Quality Group. This group has the remit to coordinate all data quality activity into a Trust wide frame work that aims to:

- Ensure core training is carried out to improve the quality of the data collected
- Provide a foundation for a programme of monitoring and improvement
- Establish consistency with NHS data definitions and use of information
- Support the information governance agenda

Taunton & Somerset NHS Foundation Trust submitted records during 2009/10 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:

- 97.5% for admitted patient care
- 98.7% for outpatient care
- 90.7% for accident and emergency care

The percentage of records in the published data which included the patient's valid General Practitioner Code was:

- 100% for admitted patient care
- 99.9% for outpatient care
- 100% for accident and emergency care

The Taunton & Somerset NHS Foundation Trust score for 2009/10 for Information Quality and Records Management, assessed using the Information Governance Toolkit, was 79.37%.

Clinical coding error rate

Clinical coding translates the medical terminology written by clinicians to describe a patient's diagnosis and treatment into standard, recognised codes.

Taunton & Somerset NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission. The error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

- Primary Diagnoses incorrect 11.7%
- Secondary Diagnoses incorrect 5.0%
- Primary Procedures incorrect 5.8%
- Secondary Procedures incorrect 9.0%

The sample audited was data from 1 July to 30 September 2009 (Quarter 2 2009). The total sample size was 300 finished consultant episodes (FCE) and the following services were reviewed:

- 100 Paediatrics FCE
- 100 General Surgery FCE
- 70 Orthopaedic non-trauma procedures
- 30 Normal delivery 19 yrs and over no complications

These results should not be extrapolated further than the actual sample audited.

Part 3 Other information

This section identifies some of the quality improvement work the Trust undertakes. It sets out quality indicators for each of the quality domains – safety, effectiveness and patient experience. The rationale for choosing these are identified and where available we have given previous years' data and any national benchmark information. A number of these were included in last year's report.

The indicators set out below are only a small section of our quality improvement work; some of the other areas of progress during the year include:

- Improved governance structure and processes
- Attainment of level two Risk Management Standards (CNST) in Maternity to match our level two in general acute care
- Increased patient participation in Patient Reported Outcome Measures (PROMS)
- Assessment of safeguarding processes leading to a compliant declaration being made
- Colorectal Nurse given national award for work with bowel cancer
- Opening of our Beacon Centre, a specialist cancer centre
- Our obesity service was awarded level one status by the south west specialist commissioning group
- New safer streamlined surgical technique for suprapubic catheterisation introduced
- Hosting the Quality First conference
- Participation in six work streams within the South West Patient Safety Network. These are: Medicine Management
  Perioperative Care
  General Ward (transforming care)
  Critical Care
  Acute Acre
  Neonatal Care

Set out below are some of the indicators we use to measure patient safety, clinical effectiveness and patient experience.

Patient Safety
Right medicine at the right time Ensuring that patients continue to receive the medicine they normally take at home whilst in hospital is extremely important when patients have pre existing medical conditions. This indicator is part of our Safer Patient Programme, working with the Institute for Health Improvement. Our aim is that such medication is logged and understood as early as possible when they are admitted to hospital. Our pharmacy has introduced systems to achieve this for all patients. **Local Target: 95% compliance** **Actual 2008/09 90% compliance** **Actual 2009/10 94% compliance**
Improving communication for safe care:- safety briefings on the ward and operating theatres Another work stream within our Safer Patient Programme to improve patient safety is to improve communication and to reduce the risk of adverse events. We have introduced safety briefings; these bring together all the staff at the start of a shift or operating session to identify and plan the care of patients with specific medical problems or other special needs. **Local Target: 95% compliance** **Actual 2008/09: 91% compliance** **Actual 2009/10 92% compliance**
Control of infection: Handwashing

A key component in the reduction of infection is thorough handwashing by our clinical staff. In 2008/09 our audits concentrated on the technique that was used when staff wash their hands. The result for the year was 96% handwashing compliance against a target of 90%.

For the 2009/10 audit we changed the audit tool to focus on assessing whether staff wash their hands when they should do so. We therefore cannot compare this year's results against last year. The target for this remains 90%, with Matrons providing an exception report and action plan when the score is below this for their areas. Despite a period of adjustment when the new audit tool was introduced the result for the year was 88%.

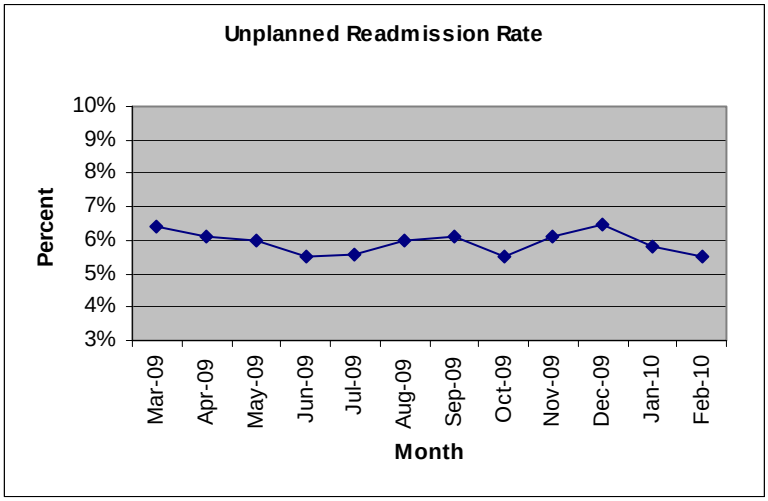
Local Target: 90% compliance
Actual 2009/10 88% compliance

Clinical Effectiveness

Reducing the number of patients who are readmitted to the hospital

We aim to reduce to a minimum the number of patients who are readmitted back to hospital unexpectedly. This is a measure that is collected through Dr Foster data (obtained through our patient information systems) which enables us to compare our results with other similar hospitals. The measure we use is a return to hospital with 28 days of discharge.

Our results for 2009/10 are set out below.



Our results have been benchmarked against Dr Foster data using the most recent complete data for quarter 3 2009/10. Musgrove benchmarks well within the South West Health Authority.

NHS South West Health Authority - best	4.8 %
Musgrove Park Hospital	**5.5 % (2008/09 = 6.2%)**
NHS South West Health Authority - worst	8.1 %

Performance against this indicator will be reported to the Trust Board on a quarterly basis.

Target:
In 2008/09 and 2009/10 we set a target to reduce this to below 10% and achieved this throughout these two years. For 2010 we aim to achieve 5.5% by year end.

Caring for Stroke Patients on a Stroke Ward

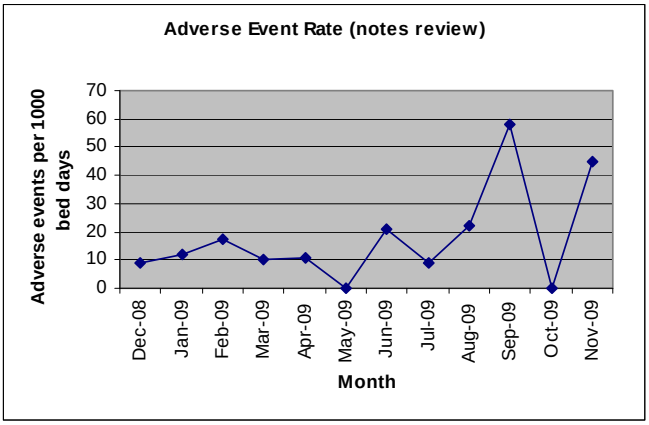
Caring for stroke patients on a specialist stroke ward is a priority highlighted in the NHS 2010/11 Operating Framework. We are aware of our commissioners wish to see an improvement in this and we have set ourselves an ambitious target for 70% of stroke patients to spend 90% of their time on a specialist stroke ward. Through our monitoring process we know that for Quarter 3 2009/0 (quarter 4 data not available at time of report) we achieved this for 43% of stroke patients.

Target 2010/11:

70% of stroke patients to spend 90% of their time in the stroke ward

Adverse Event Rates

It is important that we understand and learn from occasions when patient care is not at the standard we and our patients expect. Using a Global Trigger Tool developed by the Institute of Healthcare Improvement and working with the NHS Southwest patient safety programme, we have introduced a process in which trained clinical staff review samples of patient records. They identify any adverse events (such as complications, unplanned return to theatre) which may have occurred during that patient's stay. As well as learning from these episodes we monitor the number of adverse events found. The graph below shows the results to date and in taking the process forward we will be training more staff to undertake the reviews and improving the process to reduce bias.



The Trust has set a target for 2010/11 for 15 or less adverse events per 1000 bed days.

Performance against this indicator will be reported to the Trust Board on a quarterly basis.

Patient Experience

Patient Surveys

A national survey of inpatients is conducted by the NHS each year. This information is valuable but a problem is that it only occurs once a year and there is a delay before results are available. In addition the Trust has no control over the questions that are asked to ensure that they reflect local needs. Since our report last year we have introduced an inpatient survey which is carried out each month by a team of volunteers. They interview approximately 135 patients each month and record their responses directly onto a hand held computer. The information is uploaded to the Picker Institute who analyse the data and report back to the Trust. This provides us with real time information on patient experience which is shared with the wards who can immediately respond to issues as they arise. The information is also presented to the Trust Board each quarter.

A group involving volunteers and members of staff developed the questions to be included in our survey. These questions were informed by the results of the national inpatient survey in respect of areas we needed to improve. The Picker Institute was chosen as they would provide comparison data with other similar hospitals and against the national survey. As we have progressed, the volunteers who carry out the survey have helped us to identify additional questions from their experience of talking to patients.

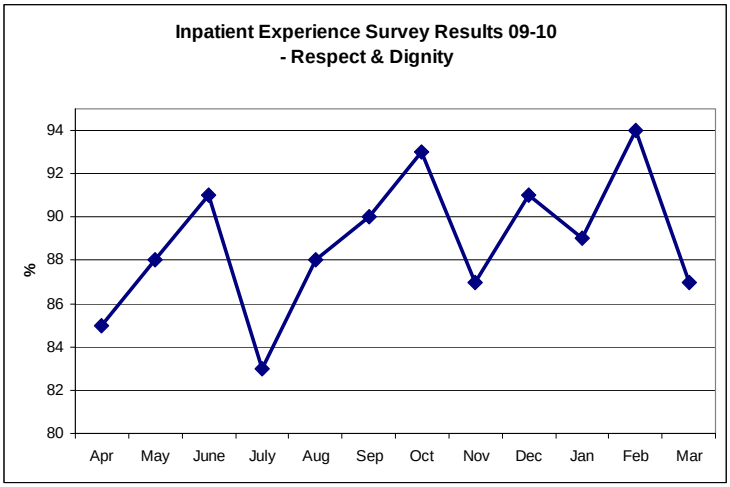
Questions we have asked patients include:

- if they feel they are treated with dignity and respect
- if they are happy with the level of involvement in their care

Patient Experience

Through our monthly inpatient survey ask patients if they feel they are treated with dignity and respect

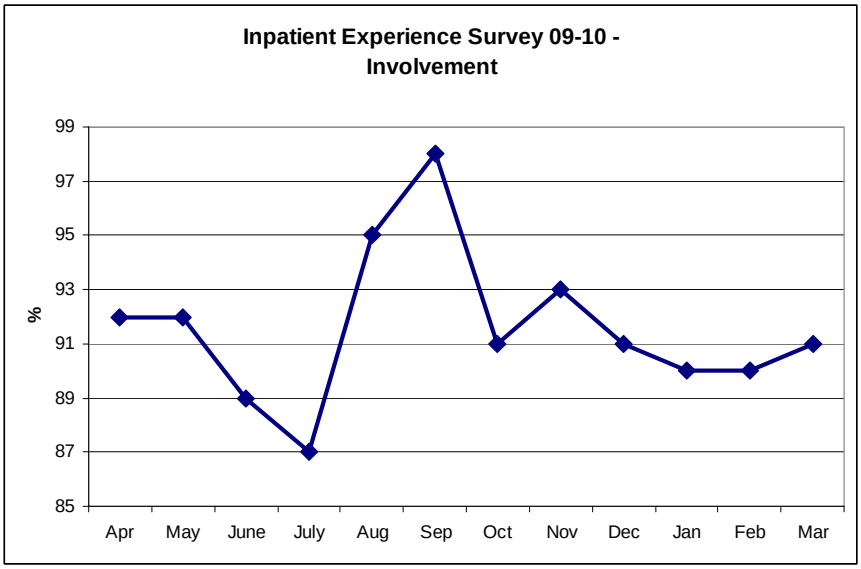
Baseline from 2009/10 the first year of survey = 89%



Target for 2010/11: 90% or more of patients surveyed feel they are treated with dignity and respect

Through our monthly inpatient survey ask patients if they are happy with the level of involvement in their care

Baseline from 2009/10 the first year of survey = 91%



Target for 2010/11: 90% or more of patients surveyed feel happy with the level of involvement in their care

All patients to have a fall assessment carried out whilst they are in the hospital

Reducing patient falls in elderly people is a national priority outlined in standard six of the National Service Framework for Older People. This document aims to reduce the number of falls that results in serious injury and to ensure that effective treatment and rehabilitation is provided for those who fall. We know that the majority of people who come into our hospital are elderly and through our own internal incident reporting system we know that a number of patients will experience a fall whilst in hospital. Prevention of falls is a key area identified in our Quality Improvement Strategy.

We have established a committee specifically to take forward our work on the prevention of falls and they have been instrumental in implementing a number of actions including the following:

- Falls Risk Prevention and Care Plan completed and ratified
- Falls Champion on each Ward, and increased falls monitoring
- Analysis of data regarding patient falls
- Musgrove Partner (lay volunteers) walk the wards identifying obstacles etc
- Pharmacists checking for medication issues with known fallers
- Trial of “Wander Mats”

A regular monthly audit takes place using Audit Tool and Safer Patient Initiative methodology. The information is reported to the Trust Board through our Governance processes.

Target 2010/11
A specific focus for 2010/11 is that every adult patient admitted to the hospital has a falls risk assessment carried out.

Help with meals for patients

The national inpatient survey showed that not all our patients who needed help to eat meals were getting the help they needed on a regular basis. In last year's quality report we described how we had introduced a "red tray" system which alerts staff to patients who need help eating so that they can be assisted. We have also introduced 'protected mealtimes' across the hospital which means that during mealtimes all other activity on wards stops so that patients can concentrate on their food.

The results from the national survey which asked patients "Did you get enough help from staff to eat your meals?" are set out below. We continue to have a good result although disappointedly we just missed remaining in the top 20% of Trusts in the 2009 survey. Our Nutrition Steering group will look in more detail at these results and will use these to inform practice.

	Score for top 20% of Trusts	**Musgrove Score**
2007	76 or above	74
2008	78 or above	85
2009	77 or above	76

NATIONAL TARGETS AND REGULATORY REQUIRMENTS

The Trust Board declared compliance against all 24 core standards in the Care Quality Commission annual health check declaration for 2009/10.

In addition the Trust met all but one (18 weeks RTT Admitted) of the national targets as per Monitor's Compliance Framework, as illustrated in the table below.

Key Targets	Target	2008/09	2009/10
*Cancer: Diagnosis to Treatment in 31 Days	96%	-	96.9%
*Maximum waiting time of 31 days for subsequent treatments where subsequent treatment is surgery	94%	-	95.3%
*Maximum waiting time of 31 days for subsequent treatments where subsequent treatment is Drugs	98%	-	99.0%
*Cancer: Referral to Treatment in 62 Days	85%	-	91.7%
*Maximum two month wait referral from an NHS Screening service to treatment for all cancers	90%	-	93.4%
*Maximum two month wait from consultant's upgrade to treatment for all cancers	TBC	-	89.8%
Maximum Waiting Times: Number of patients waiting more than 26 weeks to be admitted to hospital	0	0	0
Maximum Waiting Times: Number of patients waiting more than 13 weeks for an outpatients appointment	0	0	0
MRSA year on year reduction: (2006/07 = 38)	12	8	8
18 Week Referral to Treatment: Admitted Patients	90%	92%	84.3% (Mar) 87.8% (whole year)
18 Week Referral to Treatment: Non-Admitted Patients	95%	99%	96.9% (Mar) 97.6% (whole year)
Sexual Health: Access to GU Clinic (48 hours)	100%	100%	100%
A&E Waiting Times: 4 hours to admission, transfer or discharge	98%	98.3%	98.4%
Cancelled Operation: Offered another binding date within 28 days	95%	99%	96%
Thrombolysis for Heart Attacks: within 60 minutes of call	68%	94.7%	67%
Maximum Waiting Times: Revascularisation (No. >3 months)	0%	0%	0%
*Cancer: Referral to first appointment (14 days)	93%	-	96.5%
Cancer: Referral to first appointment (14 days) – Symptomatic Breast Referrals – From January 2010	93%	-	95.8% Q4 Only
Maximum Waiting Times: Rapid Access Chest Pain Clinics (14 days)	100%	100%	100%
Delayed Transfers of Care – maximum level	3.5%	1.4%	3.2%

*Cancer Targets for amended/introduced to reflect Cancer Reform Strategy in place for 2009/10. Previous performance measured against Cancer Plan.

Annex:

A draft copy of our quality account was sent:

- NHS Somerset (Primary Care Trust)
- NHS South West
- Local Involvement Network (LINKs)
- Overview and Scrutiny Committee (OSC)

Both Links and OSC welcomed the opportunity to see the draft Quality Account but were not in a position to consider this and comment this year.

NHS Somerset provided the Trust with the following comment:

Thank you for giving us the opportunity to comment on the Quality Account 2009/10 for Taunton and Somerset NHS Foundation Trust.

During 2009 -10 NHS Somerset has strengthened the arrangements for monitoring the quality and patient experience for health services that we commission from Taunton and Somerset NHS Foundation Trust. We have welcomed the Trust engagement in this process as part of quality contract monitoring. This has placed NHS Somerset in a strong position from which to comment on the Taunton and Somerset NHS Foundation Trust for 2009 -10.

We have reviewed the report submitted for the four Quality Improvement priorities for inclusion in the Quality Accounts for 2009 / 10. These are:

- *continue year on year reduction of hospital acquired infections*
- *maintain Hospital Standardised Mortality Ratio (HSMR) at 90 or less*
- *increase the percentage of patients who would definitely recommend the hospital to their friends*
- *focus on privacy and dignity – single sex accommodation*

We can confirm that the key performance indicators included for hospital acquired infections and for hospital standardised mortality ratio are congruent with the data submitted to us as part of the contract monitoring process.

We commend the Trust for the achievements in each of these areas and in particular for the strong performance on reducing healthcare acquired infection. Healthcare acquired infection is a matter of great concern to patients and their families and it is a significant achievement to have achieved the targets set.

We also commend the Trust on the progress made in achieving the Department of Health standards for Delivering Single Sex Accommodation. Compliance with these standards makes an important contribution to the experience of patients using your services, in protecting their privacy, and maintaining their dignity when they are most vulnerable.

The improvement trend set by the Trust to achieve 85 % for patients who would recommend the hospital to their friends for 2009 -10 is a key indicator of the quality of the services that the Trust provides. The development of the Trust's own patient surveys using volunteers to obtain real time feedback on the experience of patient's using your services is an excellent local approach.

Quality Improvement Priorities for 2010 -11

NHS Somerset welcomes the continued focus on sustaining the reduction of hospital acquired infection, and all patients to have a venous thromboembolism assessment as national and local priorities for 2010 -11. The Right Patient, Right Place, approach and all patients to have a predicted date of discharge from hospital will focus improvement on the experience of patients using your services and impact on the outcome of their care. The focus on reducing medical outliers and ensuring robust bed management to achieve the targets that you have set will be both challenging at times of pressure on services but will also assist.

The level of participation of the Trust in Clinical Audits both national and local provides evidence of the quality and clinical effectiveness of the services provided.

NHS Somerset notes the improvements made in clinical coding during the year and the data is congruent with our performance data.

Part 3 Other Information

It is positive to see the additional areas of quality improvement identified by the Trust, and particularly the continued focus on patient safety initiatives. It would be helpful to also see, included the work within the Trust to improve the timeliness of the provision of discharge information for patients to achieve the contractual obligation and support continuity of care and improvements in patient safety.

The data recorded for the number of patients readmitted to hospital is congruent with the data submitted to us as part of the contract monitoring process.

We are pleased to see the focus on stroke care, as achieving this quality standard for stroke patients cared for on a stroke ward has been found to improve the health outcomes for people following a stroke. We would also encourage the Trust to continue to focus on contingency arrangements for future Norovirus outbreaks to reduce the impact of this on stroke care.

We note the reference to the compliance of the Trust with Safeguarding processes and the statement of compliance made with the Care Quality Commission recommendations for safeguarding children published during 2009 -10. It would be helpful to include details of the Trusts achievement in relation to attendance by staff at safeguarding children training and the significant progress that the Trust has made during 2009 -10 and the audits completed for checking for safeguarding concerns for children attending accident and emergency units. The Trust has also made significant improvements in meeting the standards for the provision of hospital services for children following the former Healthcare Commission Review of Children's Services in Hospital.

We would also encourage the Trust to include an outline of the arrangements in place for management of serious untoward incidents and to highlight three or four key actions taken to improve quality of services provided during 2009 -10 as a result of the lessons learned from these.

We look forward to continuing to work with Taunton and Somerset NHS Foundation Trust to improve the safety, clinical effectiveness and patient experience of the services provided by the Trust, and in development of the Quality Account for 2010/11. Our work with the Trust in monitoring reviewing the quality, patient safety and patient experience of services throughout the year will support this. We will also consider the Chief Nursing Officer nurse sensitive metrics that have recently been published so that these can be reported within the Trust Quality Account for 2010 -11.

I hope you find these comments useful.

NHS South West received the Quality Account for errors or omissions and invited to comment.

As at 4 June 2010 no comments have been received.

Minor amendments and clarification were made to the Quality Account after it was sent to the above organisations following consideration by our Governance Committee. These were:

- Setting an 80% Target for 2010/11 of adult patients surveyed to be informed of their predicted discharge date. Replaced 100% for 2010/11
- Setting a 2010/11 target for 90% of adult patients admitted to the hospital to receive a VTE risk assessment. Changed from 100% to reflect the national target.
- Clarification that the stroke target is locally set by the Trust
- Setting a target for 2010/11 for 15 or less adverse events per 1000 bed days. Changed from 10 per 1000 bed days to reflect the improved process of assessment

In addition minor amendments were made as recommended by the Trust's external auditors, PricewaterhouseCoopers, for consistency and ease of comprehension, none of which were material or altered the substance of the report.

7. Sustainability / Climate Change Report

Background

Sustainability can be defined as '*Meeting the needs of current generations' without compromising the ability of future generations to meet their own needs.'*[1]

In January 2009 the DoH issued the document 'Saving Carbon Improving Health' (SCIH), a carbon strategy for the NHS. The aim of the strategy is to significantly reduce the impact the NHS has on the environment. In conjunction with this document runs the Good Corporate Citizenship (GCC) self assessment model, developed by the Government's Sustainability Unit to assist organisations in assessing their impact on the environment.

From April 2010 the Trust will be part of the Government's Carbon Reduction Commitment, a scheme affecting all businesses and organisations in the UK with high energy consumption to reduce carbon emissions. This requires the Trust to submit on a quarterly basis from 1 April 2010 MWh consumptions which calculate the Trust's carbon tonnage. In April 2011 the Trust will be required to submit payment for the amount of carbon produced during the year April 10 – March 2011 at the cost of £12 per tonne.

For subsequent years the Trust will be required to bid for the number of tonnes it is estimated it will need, with the number of tonnes allocated reducing by 5% each year. By implementing energy reducing schemes, organisations can work towards achieving lower permit quotas. Those organisations that find themselves in the position of having excess units will be able to trade them to those requiring additional tonnage. Initially the trade will come in the form of a rebate at a fixed fee per tonne, after three years, carbon will be sold on the free market and is likely to cost significantly more.

Sustainability Strategy

The Taunton and Somerset NHS Trust Sustainability Strategy uses both the Saving Carbon Improving Health and Good Corporate Citizenship (GCC) self assessment model to develop positive actions to reduce our impact on our local environment and forms part of a world wide commitment to reduction in green house gas emissions

An action plan has been created for each section of the following six sections of the GCC with an identified lead:

- Transport
- Procurement and food
- Facilities management
- Employment and skills
- Community engagement
- New Buildings

Success in the action plan will mean the Trust is moving towards being an environmentally responsible organisation, contributing to the protection of climate change and natural resources.

[1] Dictionary of Environmental Science and Technology – Andrew Porteous.

Governance

Sustainable practices are corporate responsibilities and thus require sound governance arrangements. This strategy is to be implemented via a Sustainability Committee led by an executive lead and will report periodically to the Hospital Management Team. To ensure sustainable options are considered when developing our service all business cases need to contain an indication of how any changes will take into consideration sustainable practices. Sustainable performance indicators need to form part of the annual Trust report. The Governance arrangements for this strategy are considered within the action plans.

Summary performance 2009/10

Area		**Non financial data**	**Non-financial data**		**Financial data (£)**	**Financial data (£)**
	Waste Type (tonnes)	**2008/09**	**2009/10**	**Waste Type**	**2008/09**	**2009/10**
Waste minimisation and management	Black bag waste	548	565	Black bag waste	47.5k	53.5k
	Healthcare waste	380	406	Healthcare waste	137.5k 4.2k	145k 5k
	WEEE / Haz	17	21	WEEE / Haz	1.4k	1.4k
	Recyclates	40	40	Recyclates (bin rental)		
	Utility	**2008/09**	**2009/10**	**Utility**	**2008/09**	**2009/10**
Finite Resources (real terms)	Water m^3	126529	127417	Water	310k	352k
	Electricity kWh	9639795	9502664	Electricity	1.09m	814k
	Gas kWh	25805528	25441637	Gas	836k	624.5k

As a result of managing the Trust's sustainable performance several measurable achievements have been made:

- Gas consumption has reduced by 749652 kWh saving £18k (*as below)
- Electricity consumption has reduced by 150214 kWh saving £12.7k (*normalised data) NB: real term data provided in table above
- Recycled approx. 40 tonnes of waste
- Saved 139 tonnes of carbon
- Created approx £5k in small projects

These savings have been made in two ways; the investment in new plant for the management of energy use and the education of staff in reducing energy use and waste segregation.

There have also been other advances made within each action plan which improve Trust performance environmentally. The following section aims to highlight progress that affects environmental performance.

Transport

- Implementation of an employee cycle scheme. Staff are able to purchase a bike through a salary sacrifice scheme. This means staff can save up to 48% on the cost of a new cycle. The Trust reduces the amount it spends on employee contributions and so also makes savings. To-date 106 staff have taken up the scheme.

- The Trust has worked with County Hall to reduce a specifically designed transport leaflet showing how to get to the Musgrove site by bus and other means. The leaflet is available around the site and is also distributed to many GP surgeries and community sites.

- A project to review travel expenses and travel payments is now underway, this will review payments made for car mileage and for rewarding cycle mileage. It will also examine promotion of greener lease cars and use of hire cars.

Facilities Management

- Each month a graph and article is placed in Team Brief to highlight to staff energy, water or waste performance.

- Inception of the Green Team has led to staff being trained to reduce the use of utilities and segregate waste better.

- Cessation of the use of bottled water for meetings and functions.

- Identification of large water leaks to reduce wasted water.

- Creation of staff allotments to encourage relaxation, green spaces and bio-diversity.

Procurement and Food

- Sustainable Procurement Risks and Opportunities User Tool (SPROUT) has now been included in all business cases. This allows both the purchaser and using departments to see the financial and sustainable impact of the project (inc. energy and consumable costs).

- Packaging and recycling waste is a focus of the general waste contract now out to tender; to be completed by November 2010.

Employment and Skills

- Each month an article is presented in the Trust Team Brief to highlight and inform staff of current performance and targets. This is backed up by quarterly articles in the Trust Acute Angle, giving staff more information on environmental performance and problems the Trust faces.

- The Trust has also encouraged staff to become voluntary ‘Green Advocates’ within the Green Team. These staff take forward the ‘Green Actions, not Grey Words’

campaign to other staff, encouraging everyone to use resources wisely and economically.

- Appraisal training and documentation now also describes members of staff roles and responsibilities regarding sustainability and Trust direction.

- All job descriptions will now include a 'sustainability' clause requiring staff to be aware of their usage of products and resources.

Community Engagement

- Two rounds of focus groups held so far where public perception of the Trust can be Gleaned. A third set of meetings is scheduled for November.

- There is regular attendance at the 'SmokeFree South West' meeting. On site meetings are also held with SFSW staff and it is intended to put a bid to them for additional assistance.

- Publicity generated for the new Musgrove Gallery and individual Art for Life projects. Good publicity generated for the allotment launch and sustainability programme.

New Buildings

- The Trust will be fully BREEAM (BRE Environmental Assessment Method) accredited following construction of the 1st Phase of the Surgical Centre. Currently we are still targeting very good as agreed by the Trust Board.

- The appointed contractor for the Surgical Centre has set its own target for recycling construction waste at 70%. Future projects will require contractor commitments to meet similar industry standards.

- For the Surgical Centre the Trust has participated in a programme of active community engagement with local residents, local patients, members. There has also been a number of events providing an open invitation to the public including a staffed display in Taunton town centre.

Future Priorities and targets

- 15% reduction in clinical waste weights

- 25% more waste being recycled

- 25% reduction in paper being used

- 5% energy reduction

These will be monitored monthly. In addition the six areas of focus identified above in line with the GCC will continue to be progressed with progress and actions monitored quarterly and reported annually.

8. Regulatory Ratings

Taunton and Somerset NHS Foundation Trust is regulated by Monitor, an independent regulator. Monitor requires all foundation trusts to report quarterly on finance, governance and mandatory services and describes a risk rating against each under the red, amber, green traffic light system. Where trusts are rated green, there are no further reporting requirements, trusts rated amber are required to report monthly against the areas where they are non-compliant and where trusts are rated red, they will be required to meet with Monitor to identify whether further intervention is necessary.

During 2009/10 the Trust went onto monthly monitoring having been rated amber in respect of one of the national targets, 18 weeks referral to treatment (RTT) for admitted patients. Whilst still rated amber, the performance dropped against this standard to an escalation level, which required the Trust Board to meet with Monitor in January 2010 to determine whether the Board was in significant breach of its authorisation and required further intervention. The conclusion of that meeting was that the Board is not in significant breach and had robust plans for meeting the national targets within a reasonable timescale. The Trust is currently reporting on a monthly basis against an agreed trajectory in respect of this target.

In Quarter 4 2009/10, the Trust rating turned red due to the rating rule that required a target missed for three consecutive quarters to move a Trust from amber to red rating. Due to the escalation process, the change to red status has not led to further intervention by Monitor.

The ratings process changes for 2010/11 to include a red/amber rating signifying de-escalation. It is anticipated that the Trust will be rated red/amber for Quarter 1 2010/11, given that the agreed trajectory brings the Trust back into compliance with the RTT target from Quarter 2 2010/11.

Table of analysis

**For 1st year of operating as a foundation trust status, the financial risk is capped at 4.*

	Annual Plan 2008/09	Q1 2008/09	Q2 2008/09	Q3 2008/09	Q4 2008/09
Financial risk rating	4	4(5)*	4(5)*	5	5
Governance risk rating	Green	Green	Green	Amber	Green
Mandatory services	Green	Green	Green	Green	Green

	Annual Plan 2009/10	Q1 2009/10	Q2 2009/10	Q3 2009/10	Q4 2009/10
Financial risk rating	4	5	5	4	4
Governance risk rating	Green	Green	Amber	Amber	Red
Mandatory services	Green	Green	Green	Green	Green

During 2009/10 the maternity services at the Trust was assessed by the NHS Litigation Authority in respect of their risk management standards. The Trust attained level 2, and is now rated at that level for both maternity and acute services.

During the year a number of cancer peer reviews were conducted in the Trust looking at urology, skin and upper GI cancer care. The outcome of these reviews was positive and any recommendations made have been taken forward internally.

9. Statement of Accounting Officer

Statement of the Chief Executive's responsibilities as the accounting officer of Taunton and Somerset NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the accounting officers' Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the NHS Act 2006, Monitor has directed the Taunton and Somerset 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 Taunton and Somerset NHS foundation trust and of its' income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the *NHS Foundation Trust Annual Reporting Manual* and in particular to:

- Observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the NHS foundation trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements; and
- Prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The accounting officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's *NHS Foundation Trust Accounting Officer Memorandum*.

Signed ……

Jo Cubbon
Chief Executive Date: 4 June 2010

10. Statement on Internal Control

Scope of responsibility

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

The Trust's Standing Orders and Scheme of Delegated Authority outline the accountability arrangements and scope of responsibility of the Board, executive directors and the organisation's officers. The Board has been fully involved in agreeing the strategic priorities of the Trust, with the most critical priorities being those set out in the Trust's Annual Plan 2009/2010 and Board objectives, against which the Board reports bi-annually to the Members' Council.

The Board receives regular reports from each of the nominated committees that report to it. The terms of reference of the sub committees of the Board have been reviewed to ensure that governance arrangements continue to be fit for purpose.

All executive directors report to me and the performance of the executive team is held to account through team and individual objectives.

The Trust's Board Assurance Framework has been in place for a year and has been reviewed and revised in line with national guidance. The Assurance Framework is used to inform the Board agenda.

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 on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Taunton & Somerset 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 Taunton and Somerset NHS Foundation Trust for the year ended 31 March 2010 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Trust has identified an executive director with responsibility for progressing risk management in the organisation. Divisional Leads for Risk are in place, and their responsibilities for risk management are clearly defined within their job descriptions.

The Governance Support Unit is responsible for providing appropriate training, support and guidance to enable all managers to carry out their risk management responsibilities.

Specific training courses on risk management for managers, risk assessment, incident management and investigation are supported by a corporate induction and mandatory update programme

Divisional Leads for Risk are members of the Trust's management groups for governance and risk, including the Incident Review Group and the Assurance and Governance Committee. These groups meet on a regular basis to share issues raised proactively from risk assessment and those raised reactively following incidents and complaints. This enables sharing of good practice and lessons learned via divisional governance structures.

The risk and control framework

The Trust's governance policy details how risk will be identified, evaluated and managed. It gives details of the monitoring arrangements and the authority for decision-making through identified posts or committees. The main methods for the identification of risk are:

- Review of compliance with key standards, for example the SfBH, CQC Registration Requirements and the NHS Litigation Authority Risk Management Standards, and legislation such as the Health and Safety at Work Act (1974).
- Executive review of annual and strategic objectives to identify potential risks to meeting those objectives.
- Local risk assessment at departmental level, feeding up to divisional risk registers.
- Facilitated risk identification sessions at various levels in the organisation.
- Incident reporting and complaints information.

Information from external sources such as audits and patient and staff surveys are also used to identify risks. All risks are assessed and evaluated using a standard form and scoring system, allowing direct comparison of all risks. From this evaluation, risks are categorised into one of three accountability levels, and responsibility for the control and monitoring of the risk is allocated to either the department, the division or the Trust executive team depending on the level identified. Responsibility for completing actions is allocated to an individual manager, with monitoring carried out by the relevant divisional committee or Trust executive director. The three accountability levels are set based on the Trust's risk appetite, which is regularly reviewed by the Board.

Risk identification is linked to the setting of organisational objectives, as detailed in the Assurance Framework, and divisional objectives. Capital planning includes an assessment of risk issues, and spending is prioritised on a risk basis. All papers considered by the Board are referenced to the risks they are aimed at addressing.

The Assurance Framework includes details of the significant risks that may affect the Trust achieving its objectives, how they are currently controlled and what sources of assurance the Board have that the risks are being managed appropriately. It also details action that is necessary to reduce the risks or improve sources of Board assurance, with prioritisation based on the standard Trust risk evaluation process. The Assurance Framework is reviewed on a bi-monthly basis by the Trust's Governance Committee and the Board every six months.

The Trust's objectives for 2009/10 were linked to the Standards for Better Health (SfBH) and Care Quality Commission outcomes with individual objectives aimed at ensuring ongoing compliance with the core standards or improving performance against the requirements of the developmental standards. The Trust has developed a system of

performance indicators for ongoing management of performance against the Standards. The Governance Support Unit has carried out mapping to the new CQC registration requirements, and future objectives will be linked to this framework.

Information and data security risks are identified and managed through the Trust's risk assessment and incident reporting processes. The Trust has established an Information Governance Steering Group to monitor this process and provide assurance on the systems in place for managing information risks.

As part of its ongoing commitment to risk management, the Governance Committee develops and monitors an annual plan that includes key risk management objectives.

The Audit Committee workplan is linked to risk and ensures the committee who receives reports from senior managers and internal or external audit as appropriate, test the controls in place for managing the key risks.

The Trust's key risks for 2010/11 are:

- The financial challenges of delivering services and the Trust's surgical scheme capital programme, without funding growth, which will be managed through ongoing monitoring of the Trust's cost improvement programme and budgetary control. This will be an ongoing risk and relates to the economic position of the UK, and related reductions in public sector funding.

- Meeting the national target for referral to treatment times in orthopaedics, this risk is being controlled through capacity planning and monitoring of demand, working with the commissioners to address variances.

- The Trust faces a degree of financial and operational risk in the future through the development of Bridgwater Community Hospital and the potential increase in capacity at Shepton Mallet Independent Treatment Centre, as this could reduce/ fragment patient pathways and lead to a reduction in efficiency through reduced use of hospital resources; the extent of the risk is not yet fully known, the risk is being mitigated through stakeholder discussions and sharing of planning assumptions with NHS Somerset to ensure the full impact of decisions on services at Musgrove Park Hospital is understood.

The Trust has a strategy and action plan for patient and public involvement which is monitored by the Patient Experience Committee. Lay users sit on a wide variety of Trust committees and groups that address risk issues, including the Quality Improvement and Patient Safety Committee.

The Foundation Trust is fully compliant with the core Standards for Better Health. In addition, the Trust has carried out a self assessment of compliance with the CQC registration requirements and has now been granted full registration for all of its activities with no conditions.

As an employer with staff entitled to membership of the NHS Pension Scheme control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately up-dated 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 and the Trust carries out equality impact assessments for all of its policies.

The Trust has undertaken risk assessments and carbon reduction delivery plans are in place in accordance with emergency preparedness and civil contingency requirements. These are 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.

Compliance with Monitor's Regulatory Framework

The Trust was not fully compliant against the national targets for 2009/10 and has declared non-compliance for three consecutive quarters in respect of its 18 week referral to treatment (admitted patients) targets.

This was due to a lapse in the control environment relating to the process of identifying variations in respect of demand in three specialty areas, and the speed at which action was taken to respond to the variations. This has contributed to the severity of the performance issues in respect of referral to treatment waiting times.

Actions have been taken to address these issues and to resolve performance problems which have been monitored by the Trust Board and reported monthly to Monitor against an agreed trajectory to bring the Trust back on target. The Board has met with Monitor through the escalation process and was not considered to be in significant breach of its terms of authorisation.

Review of economy, efficiency and effectiveness of the use of resources

The Trust ensures economy, efficiency and effectiveness through a variety of means, including:

- a robust pay and non-pay budgetary control system
- a suite of effective and consistently applied financial controls
- effective tendering procedures
- continuous service and cost improvement.

The Trust benchmarks efficiency in a variety of ways, including the National Reference Costs Index and by comparison with the annual surpluses generated by all foundation trusts.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the

Audit Committee and Governance Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board Assurance Framework provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principle objectives have been reviewed. My review is also informed by:

- Statements from each of the executive directors stating any significant control issues within their area of responsibility;
- The Trust's assurance process for monitoring levels of compliance against Care Quality Commission core standards;
- NHSLA Risk Management standards – achieved Level 2 compliance for acute services in December 2008, and for maternity services in January 2010;
- Clinical Pathology accreditation;
- Programme of work undertaken by Internal Audit;
- Care Quality Commission confirmation of the Trust's compliance with the Hygiene Code - October 2009;
- Deanery and college inspections;
- NPSA National reporting and Learning System Incident Report.

In assessing and managing risk the Board and its sub-committees have a substantial role to play in reviewing the effectiveness of the system of internal control as follows:

Trust Board: Through the review and approval of the Trust risk register, Board Assurance Framework and key performance indicators, and approval of the Trust's Governance/ Risk Management Strategy and commitment to the action plan for implementing the strategy.

Audit Committee: Through the review of the internal audit programme of work, receipt of reports from external audit, and assurances gained through management reviews requested by the Audit Committee.

Governance Committee: Through the review of Healthcare Commission core standards and the Care Quality Commission registration process, confirming the process by which the standards have been assessed, through the review and management of the Trust's risk register and the development of the Trust's Integrated Governance Policy.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual.*

The Governance Committee has established a working group to develop the annual Quality Report, involving executive and non-executive directors, with leadership from the Director of Governance and Nursing. Key stakeholders have been involved in the development of the report, including the Foundation Trust Members' Council Patient Care Group.

The quality metrics included in the report have been regularly reported to the Trust Board throughout the year as part of the quality and performance reports. Data quality issues

are addressed through the Trust's information governance systems in line with its Information and Data Quality Policy.

The metrics include key measures developed with our commissioners, NHS Somerset, to provide them with assurance that we are providing high quality care. Additional measures relating to patient experience are provided by the monthly assessments that the Trust has established in liaison with the Picker Institute, overseen by the Trust's Patient Experience Committee.

Review of effectiveness

A review of systems in place for maintaining and reviewing data quality is carried out on an annual basis as part of the Trust's information toolkit self-assessment. This self-assessment is subject to further scrutiny by internal audit.

Conclusion

Other than the non-compliance with the Referral to Treatment Target as detailed above, no significant internal control issues in 2009/10 have been identified.

Signed……..

Jo Cubbon
Chief Executive **Date:** 4 June 2010

11. Annual Accounts

TAUNTON AND SOMERSET NHS FOUNDATION TRUST

ACCOUNTS FOR THE YEAR ENDED

31 MARCH 2010

Taunton & Somerset NHS Foundation Trust

Annual Accounts for the Financial Year ended 31 March 2010

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FOREWORD TO THE ACCOUNTS

These accounts for the financial year ended 31 March 2010 have been prepared by Taunton and Somerset NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006 in the form in which Monitor, the Independent Regulator of NHS Foundation Trusts, with the approval of the Treasury, as directed.

Signed.....JoCubbon.....

Jo Cubbon
Chief Executive

Date: 4 June 2010

Accounting Officer Responsibility Statement is in at page 89 in the Annual Report

Independent Auditors' Report to the Council of Governors of Taunton and Somerset NHS Foundation Trust

We have audited the financial statements of Taunton and Somerset NHS Foundation Trust for the year ended 31 March 2010 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Cash Flows, the Statement of Changes in Taxpayers' Equity and the related notes. The financial reporting framework that has been applied in their preparation is the NHS Foundation Trust Annual Reporting Manual issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Respective responsibilities of directors and auditors
As explained more fully in the Statement of Accounting Officer Responsibilities Statement set out on page 89 of the Annual Report the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit the financial statements in accordance with relevant statute, the Audit Code for NHS Foundation Trusts issued by Monitor and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

This report, including the opinions, has been prepared for and only for the Board of Governors of Taunton and Somerset NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

The maintenance and integrity of the NHS Foundation Trust's website is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the website.

Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

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 NHS Foundation Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the NHS Foundation Trust; and the overall presentation of the financial statements.

Opinion on financial statements
In our opinion the financial statements:

- give a true and fair view, in accordance with the NHS Foundation Trust Annual Reporting Manual, of the state of the NHS Foundation Trust's affairs as at 31 March 2010 and of its income and expenditure and cash flows for the year then ended; and

- have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual.

Opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts

In our opinion

- the part of the Remuneration Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual; and

- the information given in the Directors' Report and all of the other information listed on the contents page of the Annual 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 in respect of the following matters where the Audit Code for NHS Foundation Trusts requires us to report to you if, in our opinion:

- adequate accounting records have not been kept, or returns adequate for our audit have not been received from locations not visited by us; or
- the financial statements are not in agreement with the accounting records and returns; or
- we have not received all the information and explanations we require for our audit; or
- the Statement on Internal Control does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual or is misleading or inconsistent with information of which we are aware from our audit; or
- we have not been able to satisfy ourselves that the NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 to the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Simon Cookson (Senior Statutory Auditor)
For and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Bristol
7 June 2010

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2010

	Note	2009/10 £000	2008/09 £000
Income from activities	3	**206,261**	182,876
Other operating income	4	**25,676**	30,726
Operating Expenses	5	**(225,630)**	(201,966)
Operating Surplus		**6,307**	11,636
Finance costs			
Finance income	8	**103**	707
Finance expense - financial liabilities	9.1	**(1,330)**	0
Finance expense - unwinding of discount on provisions	17	**(18)**	(23)
PDC Dividends payable		**(4,144)**	(5,270)
Net finance costs		**(5,389)**	(4,586)
SURPLUS FOR THE YEAR		**918**	7,050
Other comprehensive income:			
Revaluation losses and impairment losses on property, plant and equipment	22	**(2,989)**	(3,805)
Increase in the donated asset reserve due to receipt of donated assets	22	**592**	155
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of donated assets	22	**(451)**	(378)
Total Other Comprehensive Income		**(2,848)**	(4,028)
TOTAL COMPREHENSIVE INCOME/ (EXPENSE) FOR THE YEAR		**(1,930)**	3,022

All operations are continuing.

The notes on pages 10 to 36 form part of these accounts.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2010

	Note	31 MARCH 2010 £000	31 MARCH 2009 £000	1 APRIL 2008 £000
NON-CURRENT ASSETS:				
Intangible assets	10	**170**	211	105
Property, Plant and Equipment	11	**141,266**	129,255	137,082
Trade and other receivables	13	**294**	292	792
Total non-current assets		**141,730**	129,758	137,979
CURRENT ASSETS:				
Inventories	12	**2,623**	2,162	1,812
Trade and other receivables	13	**14,044**	12,963	10,880
Other financial assets	19	**0**	0	13,000
Cash and cash equivalents	18	**19,893**	21,237	577
Total current assets		**36,560**	36,362	26,269
CURRENT LIABILITIES:				
Trade and other payables	14.1	**(17,003)**	(18,999)	(18,928)
Borrowings	14.3	**(506)**	(26)	(68)
Provisions	17	**(541)**	(115)	(832)
Other liabilities	14.2	**(1,886)**	(2,000)	(2,204)
Total current liabilities		**(19,936)**	(21,140)	(22,032)
NON-CURRENT LIABILITIES:				
Borrowings	14.3	**(15,608)**	(23)	(49)
Provisions	17	**(804)**	(1,006)	(979)
Other liabilities	14.2	**(5,305)**	(5,565)	(5,824)
Total non-current liabilities		**(21,717)**	(6,594)	(6,852)
TOTAL ASSETS EMPLOYED		**136,637**	138,386	135,364
TAXPAYERS' EQUITY:				
Public dividend capital		**76,310**	76,129	76,129
Revaluation reserve	22	**29,033**	33,692	39,281
Donated asset reserve	22	**2,296**	2,155	2,219
Income and expenditure reserve	22	**28,998**	26,410	17,735
TOTAL TAXPAYERS' EQUITY		**136,637**	138,386	135,364

Prior year comparatives have been restated to take account of the transition to reporting under International Financial Reporting Standards. Where required, reconciliations have been prepared that explain material differences to amounts previously reported UKGAAP (note 31)

The financial statements on pages 6 to 36 were approved by the Board on 3 June 2010 and signed on its behalf by

Signed:……Jo Cubbon (Chief Executive)

Date: 4 June 2010

STATEMENT OF CHANGES IN TAXPAYER'S EQUITY YEAR ENDED 31ST MARCH 2010

	Public dividend capital (PDC)	Revaluation reserve	Donated assets reserve	Income and expenditure reserve	**Total**
	£000	£000	£000	£000	**£000**
Taxpayer's Equity at 1 April 2009	76,129	33,692	2,155	26,410	**138,386**
Surplus for the year	0	0	0	918	918
Revaluation gains/(losses) and impairment losses property, plant and equipment	0	(2,989)	0	0	(2,989)
Increase in the donated asset reserve due to receipt of donated assets	0	0	592	0	592
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of on donated assets	0	0	(451)	0	(451)
Total comprehensive (expense)/income for the period	**0**	**(2,989)**	**141**	**918**	**(1,930)**
Transfers to the income and expenditure account in respect of assets disposed of	0	(649)	0	649	0
Transfer of the excess of current cost depreciation over historical cost depreciation to the income and expenditure reserve	0	(1,021)	0	1,021	0
Public Dividend Capital received	181	0	0	0	181
Taxpayer's Equity at 31 March 2010	**76,310**	**29,033**	**2,296**	**28,998**	**136,637**

STATEMENT OF CHANGES IN TAXPAYER'S EQUITY YEAR ENDED 31ST MARCH 2009

	Public dividend capital (PDC)	Revaluation reserve	Donated assets reserve	Income and expenditure reserve	**Total**
	£000	£000	£000	£000	**£000**
Taxpayer's Equity at 1 April 2008	**76,129**	**39,281**	**2,219**	**17,735**	**135,364**
Surplus for the year	0	0	0	7,050	7,050
Revaluation gains/(losses) and impairment losses property, plant and equipment	0	(3,964)	159	0	(3,805)
Increase in the donated asset reserve due to receipt of donated assets	0	0	155	0	155
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of on donated assets	0	0	(378)	0	(378)
Total comprehensive income for the period	**0**	**(3,964)**	**(64)**	**7,050**	**3,022**
Transfers to the income and expenditure account in respect of assets disposed of	0	(122)	0	122	0
Transfer of the excess of current cost depreciation over historical cost depreciation to the income and expenditure reserve	0	(1,503)	0	1,503	0
Taxpayer's Equity at 31 March 2009	**76,129**	**33,692**	**2,155**	**26,410**	**138,386**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2010

	Note	2009/10 £000	2008/09 £000
Cash flows from operating activities			
Operating surplus from continuing operations		**6,307**	11,636
Non-cash income and expense:			
Depreciation and amortisation	5.1	**8,084**	7,953
Impairments	5.1	**2,212**	660
Transfer from the donated asset reserve	4.1	**(417)**	(379)
Amortisation of PFI credit	4.1	**(259)**	(259)
Increase in Trade and Other Receivables	13	**(897)**	(1,583)
Increase in Inventories	12	**(461)**	(350)
(Decrease)/Increase in Trade and Other Payables	14.1	**(1,294)**	383
Decrease in Other Liabilities	14.2	**(115)**	(204)
Increase/(Decrease) in Provisions		**224**	(690)
Tax (paid) / received		**336**	67
Other movements in operating cash flows		**(2)**	27
Net cash generated from operations		**13,718**	17,261
Cash flows from investing activities			
Interest received	8	**103**	707
Sales of financial assets	19	**0**	13,000
Purchase of intangible assets	10.1	**(12)**	(131)
Purchase of Property, Plant and Equipment	11.1	**(9,241)**	(4,839)
Net cash (used in)/generated from investing activities		**(9,150)**	8,737
Cash flows from financing activities			
Public dividend capital received		**181**	0
Capital element of finance lease rental payments		**(26)**	(62)
Capital element of Private Finance Initiative obligations	16.1	**(407)**	0
Interest element of finance leases	9.1	**(4)**	(6)
Interest element of Private Finance Initiative obligations		**(1,326)**	0
PDC Dividends paid		**(4,330)**	(5,270)
Net cash generated from/(used in) financing activities		**(5,912)**	(5,338)
(Decrease)/increase in cash and cash equivalents	18	**(1,344)**	20,660
Cash and cash equivalents at 1 April	18	**21,237**	577
Cash and cash equivalents at 31 March	18	**19,893**	21,237

NOTES TO THE ACCOUNTS

1.1 Accounting Policies

Monitor has directed that the financial statements of the Trust shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the financial statements have been prepared in accordance with the 2009/10 NHS Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts. The accounts have been prepared under the historical cost convention as modified by the revaluation of fixed assets in accordance with EU endorsed International Financial Reporting Standards and IFRIC interpretations. The preparation of financial statements in conformity with IFRS requires the use of certain critical accounting estimates and requires management to exercise its judgement to apply to the Trust's accounting policies (see note 1.19).

The charitable funds of the Trust are considered to be a subsidiary under IAS 27. However following HM Treasury dispensation from this requirement the charitable funds have not been consolidated into these accounts for 2009/10.

1.2 Income Recognition

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 NHS Foundation Trust is contracts with commissioners in respect of healthcare services.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

The Trust changed the form of its contracts with NHS commissioners to follow the Department of Health's payment by results methodology in 2006 except that the income from Somerset PCT is effectively fixed (only marginal variation with changes in activity) and paid at tariff rates. Amounts due to the Trust from Somerset PCT are paid and recognised by the Trust on a monthly basis.

The Trust has included income relating to partially completed inpatient spells at the period end which amounts to £902,000 (£718,000 for the period ended 31 March 2009). The sum included in the accounts is an indicative estimate based on an exercise carried out to identify partially completed spells as at 31st March 2010 (and at 31st March 2009 and 31st March 2008 for prior periods). The valuation was calculated by apportioning the tariff to the spells.

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

1.3 Expenditure

Expenditure on employees

Salaries, wages and employment-related payments are recognised in the period in which the service is received from 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 employees are permitted to carry-forward leave into the following period.

Pension costs

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 the direction of Secretary of State, in England and Wales. The NHS pension scheme is subject to a full valuation every four years by the Government Actuary. The latest valuation, published in December 2007, relates to the period 1 April 1999 to 31 March 2004.The notional deficit of the scheme was £3.3 billion as per that valuation.

It is not possible for the Trust to identify its share of the underlying scheme liabilities as the scheme is an NHS multi-employer scheme

Employers pension cost contributions are charged to 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.

Employer contributions are reviewed every four years following the scheme valuation. At the last valuation it was recommended that employer contributions continue at 14% of pensionable pay.

Other expenditure on 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

1.4 Intangible assets

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. Where internally generated assets are held for service potential, this involves a direct contribution to the delivery of services to the public.

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. Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairment previously recognised in operating expenses, in which case they are recognised in operating income. Decreases in asset values and impairments 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'.

Intangible assets held for sale are measured at the lower of their carrying amount of fair value less costs to sell.

Amortisation and impairment

Intangible assets are amortised on a straight line basis over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

The carrying value of intangible assets is reviewed for impairment at the end of the first full year following acquisition and in other periods if events or changes in circumstances indicate the carrying value may not

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 hardware e.g. application software, is capitalised as an intangible asset.

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

Asset category	Useful life (years)
Software licences	5-7

1.5 Property, Plant and Equipment

Recognition

Property, Plant and Equipment is capitalised where:

(a) it is held for use in delivering services or for administrative purposes;

(b) it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;

financial year;

(d) the cost of the item can be measured reliably and;

(e) has an individual cost of at least £5,000; or

(f) the items 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

(g) 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.

Measurement

Valuation

All property, plant and equipment assets 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. The frequency of the revaluations is dependant on the changes in the fair value of the items of property, plant and equipment being revalued.

Property assets

The fair value of land and buildings is determined by valuations carried out by the District Valuers of the Revenue and Customs Government Department. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual and are carried out primarily on the basis of Depreciated Replacement Cost (DRC) which is measured on a Modern Equivalent Asset basis for specialised operational property. Non specialised operational property is measured on an Existing Use Value.

The component elements of each property asset are depreciated individually where the value of the component parts are judged to be material in relation to the overall value of that asset and where the useful economic lives of the components are significantly different to that of the overall property asset. The component parts that are individually depreciated by the Trust are building structures, engineering elements and external works.

The value of land for existing use purposes is assessed at existing use value. For non-operational properties including surplus land, the valuations are carried out at open market value.

Additional alternative open market value figures have been supplied for operational assets scheduled for imminent closure and subsequent disposal. In addition, open market values have been provided for land, residences and the Priorswood depot.

Assets under construction are valued at cost and are subsequently revalued by professional valuers if, when brought into use, factors indicate that the value of the asset differs materially from its carrying value. Otherwise, the asset should only be re-valued on the next occasion when all assets of that class are re-valued. Work in progress is assessed at the financial year end on the basis of identified work completed that has been certified as such by Trust staff or advisors. Payments on account for work not yet undertaken are accounted for as prepayments.

Non-property assets:

For non-property assets the depreciated historical cost basis has been adopted as a proxy fair value in respect of assets which have short lives or low values.

Depreciation

Items of Property, Plant and Equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits.

The Trust depreciates its non-current assets on a straight-line basis over the expected life of the asset after allowing for the residual value. Useful lives are determined on a case by case basis. The typical life for the following assets are:

Asset category	Useful life (years)
Freehold property - buildings	15 – 65
Freehold property - dwellings	40 – 60
Plant	5 – 15
Equipment - transport	5 - 10
Equipment - information technology	3 - 8
Equipment - furniture and fittings	4 - 15

Freehold land is considered to have an infinite life and is not depreciated.

Assets under 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.

Property, plant and equipment which has been reclassified 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, retrospectively.

Revaluation and impairment

The carrying values of property, plant and equipment assets are reviewed for impairment when events or changes in circumstances indicate their carrying value may not be recoverable.

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairment previously recognised in operating expenses, in which case they are recognised in operating income.

Decreases in asset values and impairments 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'.

De-recognition

Assets intended for disposal are reclassified as 'Held for Sale' once all of 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
- the sale is expected to be completed 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 and the assets are not re-valued, except where the 'fair value less costs to sell' falls below the carrying amount. 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 asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.6 Corporation Tax

The Trust does not have a corporation tax liability for the year 2009/10.

1.7 Donated assets

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

1.8 Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in Monitor's Accounting Reporting Manual, 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 two PFI initiatives that are currently held on Statement of Financial Position are the Beacon Centre (cancer facility) and the multi storey car park.

Beacon Centre

Details of the outstanding liability are provided in note 16. The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services and maintenance, the finance cost is calculated using the implicit interest rate for the scheme. Lifecycle replacement costs relating to plant and equipment have been included in the operators financial model and are reflected in the outstanding liabilities in note 16. The Trust did not give any assets to the operator.

The service charge is recognised in operating expenses and the finance cost is charged to Finance Costs in the Statement of Comprehensive Income.

Multi Storey Car Park

The liability relating to the multi storey car park is included in 'other liabilities' (note 14.2) and further information about the nature of the project is included at note 16. This is a public private partnership project (PPP). It relates to the building of a car park (completed in October 2006) and the provision of services for 25 years. The ownership of the building will pass to the Trust after the 25 year concession period. Throughout this period the operator collects income for car parking fees and pays an agreed proportion of this to the Trust, no other financial transactions take place. The Trust controls the service provided and the prices paid, consequently, the asset is included in the Trust's Statement of Fiancial Position. At the inception of the service provision (in October 2006), the cost to the operator was identified as £6,470,000, this was introduced onto the Statement of Financial Position as a deferred PFI credit under 'Other Liabilities'. The liability is amortised over the period of the service concession (25 years). The annual amortised sum is credited to other income in the Statement of Comprehensive Income. All lifecycle and replacement costs are borne by the operator and have been modelled into the contract between the Trust and the operator. The Trust did not give any assets to the operator. The capital value of the asset was introduced in October 2006 at the cost to the operator and was subsequently revalued by the District Auditor.

C) Staff Nursery

The operator is required to provide childcare facilities over the concession period, of 30 years. The services are provided to Trust employees in the first instance and to the public thereafter. The land was provided by the Trust on a 99 year lease. Other than this, there is no financial cost to the Trust and no payment is received from the operator in respect of the lease. The land and building will revert to Trust ownership at the end of the 99 year lease. The Trust does not control the prices charged by the operator, consequently this is accounted for off SoFP.

1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the weighted average cost method. A review of slow moving and obsolete stock is carried out quarterly and written off where considered appropriate.

1.10 Cash, bank and overdrafts

Cash, bank and overdraft balances are recorded at the current values of these balances in the Trust's cash book. These balances exclude monies held in the Trust's bank account belonging to patients (see" third party assets" below). Account balances are only set off where a formal agreement has been made with the bank to do so. In all other cases overdrafts are disclosed within current liabilities. Interest earned on bank accounts and interest charged on overdrafts is recorded as "interest receivable" and "interest payable" respectively in the periods to which they relate. Bank charges are recorded as expenditure in the periods to which they relate.

1.11 Provisions

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the statement of financial position date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2% in real terms.

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 17. No provision is included in the accounts of the Trust for these costs.

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.

Other provisions

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arsing from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.12 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 21 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 21, 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.

1.13 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.

1.14 Leases

The trust as lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased 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 value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance Costs in the Statement of Comprehensive Income.

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. Leased land is treated as an operating lease.

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.

The trust as lessor

The Trust also receives income in respect of buildings and facilities leased to third parties, these are detailed in note 4.2.

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

1.15 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 a financial instrument within the meaning of IAS 32.

A charge, reflecting the forecast cost of capital utilised by the Trust, is paid over 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 and the amount included in the accounts is based on the Trust's un-audited accounts.

Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for donated assets and cash held with the Office of the Paymaster General. Average relevant net assets are calculated as a simple mean of opening and closing relevant net assets.

1.16 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 the statement of comprehensive income on an accruals basis, including losses which would have been made good through insurance cover had trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.17 Financial instruments and financial liabilities 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.

Financial assets or liabilities in respect of assets acquired or disposed through finance leases are recognised and measured in accordance with the accounting policy for leases described above.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

1.17 De-recognition

Cont

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.

Classification and Measurement

Financial assets are categorised as "fair value through income and expenditure". Loans and receivable are categorised as "available for sale financial assets".

Financial liabilities are classified as "fair value through income or expenditure" or as "other financial liabilities".

Financial assets and financial liabilities at 'fair value through income and expenditure'

Financial assets and liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or 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. Derivatives which are embedded in other contracts but which are not 'closely related' to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and liabilities. The Trust had no such assets or liabilities at the statement of financial position date.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The Trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and 'other receivables'.

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 asset 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.

Available for Sale financial assets

Available for Sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the Trust intends to dispose of them within 12 months of the financial position date.

Available for Sale financial assets are recognised initially at fair value, with gains or losses recognised in reserves and reported in the statement of comprehensive income as an item of 'other comprehensive income'. When items classified as 'available for sale' are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in 'finance costs' in the statement of comprehensive income'.

Other financial liabilities

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 intangible assets is not capitalised as part of the cost of those assets.

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' is impaired. Financial assets are impaired and impairment losses are recognised if, and only 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.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of a bad debt provision that is determined specifically on individual assets.

1.18 Standards Issued but not yet adopted

Under International Financial Reporting, organisations are required to state those standards that have not yet been adopted in the preparation of the accounts. The following list provides details of the standards that have not been adopted by the NHS as well as those that are yet to be adopted by the European Union.

Standards not yet adopted by the NHS

- IAS 24 (amendment): Related party disclosures
- IAS 27 (revised): Consolidated and separate financial statements
- IAS 32 (amendment): Financial instruments, presentation or rights issues
- IAS 39 (amendment): Eligible hedged items
- IFRS 1 (revised, plus further amendments): First time adoption of IFRS
- IFRS 2: Share-based payment - group cash-settled share based payment transactions
- IFRS 3 (revised): Business combinations
- IFRS 9: Financial Instruments
- IFRIC14, IAS 19 (amendment): Prepayments of a minimum funding requirement
- IFRIC 17: Distributions of non-cash assets to owners
- IFRIC 18: Transfers of assets from customers
- IFRIC 19: Extinguishing financial liabilities with equity instruments
- Annual improvements 2009 and 2010

Standards and interpretations not yet adopted by the EU

- IFRIC 19: Extinguishing financial liabilities with equity instruments
- IFRIC 14: Prepayments of a minimum funding requirement
- IFRS 1: First time adoption of IFRS, additional exemptions
- IFRS 1: First time adoption of IFRS, exemption to not include new fair value hierarchy
- IAS 24: Related party disclosures
- IFRS 9: Financial instruments

The above standards, to the extent that they are applicable to the Trust, are expected to be implemented in the next 1 - 3 years.

1.19 Critical Estimates and Accounting Judgements

Note 11.1 details the revaluations to land, property, plant and equipment during the accounting period in order to ensure that fixed assets are included in the accounts at fair value. As part of this process, an impairment review was carried out in March 2010 in which the specialised buildings were revalued using construction industry indices. Other fixed assets including the dwellings, Priorswood depot and the non-property assets have not been revalued as the Trust has judged that the carrying value of these assets approximate to fair value. In making this judgement, the Trust has considered available market information as well as the absence of any key factors that would indicate an impairment.

2 Segmental Reporting

The Taunton and Somerset NHS Foundation Trust is managed by the Board of Directors, which is made up of both Executive and Non-Executive Directors. The Board is responsible for strategically and operationally leading the work of the hospital. The Non-Executive Directors bring external expertise to the organisation and provide advice and guidance to the Executive Directors. The Executive Directors take care of the day to day running of the hospital.
The Board is therefore considered to be the Chief Operating Decision Maker (CODM) of the hospital. The monthly financial information presented to the Board includes Trust level Statement of Comprehensive Income, a Statement of Financial Position, a Statement of Cash flow and other financial indicators such as the financial risk rating.

The Trust does not currently report financial income and expense analysed by Directorate i.e. by segments. Information reported to the Board is specifically analysed for its purpose, for example Trust pay spend against budget analysed by employee groups and income stream expectations by type (NHS Clinical, non NHS etc,) compared to actual achieved. Information such as delivery of the savings plan is a Trust wide position paper but detailed into the areas tasked with implementing savings. With the introduction of Service Line Reporting across the NHS and significant developments within the Trust, information will in future be available and reported by service segment. This has been developed during 2009/10 and will be operational from early in the 2010/11 financial year.

The Trust provides elective, non elective, outpatient and A&E services. The majority of these services are funded by Primary Care Trusts, which provide 86% of the Trust's income. Income is also generated from providing private patient treatment which represents less than 1% of total Trust income. Income from overseas based patients is negligible. Other income generated by the Trust includes educational and training grants. Note 3 provides a detailed breakdown of the funding streams.

The monthly information reported to the Board has moved towards full IFRS reporting basis during the year and therefore is comparable with the year end statutory accounts format. The financial information contained within the March Board paper also reflects all but two final adjustments; an accounting adjustment to net off pay recharges rather than to show them gross and an accounting entry to adjust the Beacon Centre impairment.

	Unaudited £000	Audited £000
Operating Income from continuing operations	233,155	231,937
Operating Expenses from continuing operations	(228,478)	(225,630)
(Deficit)/ Surplus from continuing operations	(712)	918
TOTAL COMPREHENSIVE INCOME/ (EXPENSE) FOR THE YEAR	(4,315)	(1,930)

The difference between the (deficit)/surplus from continuing operations relates to the write back of £1,630,000 being an overstatement of the the impairment of the Beacon Centre in the draft accounts. The difference in the total comprehensive (expense) comprises the £1,630,000 impairment referred to above plus an additional posting to the revaluation reserve relating to the revaluation of dwellings and Priorswood depot previously posted to prior years.

3 Operating Income

3.1 Income from activities by activity

	2009/10 £000	2008/09 £000
Elective income	**59,508**	58,685
Non-elective income	**91,538**	83,081
Outpatient income	**41,536**	32,869
A&E income	**4,377**	3,917
Other NHS clinical income	**3,540**	2,273
Private patient income	**1,660**	1,816
Other non-protected clinical income	**4,102**	235
	206,261	182,876

3.2 Income from activities by customer type

	£000	£000
NHS Foundation Trusts	**2,451**	0
Primary Care Trusts	**200,284**	173,836
Local Authorities	**94**	0
Department of Health - other	**441**	6,098
Non NHS: Private patients	**1,660**	1,816
Non-NHS: Overseas patients (non-reciprocal)	**7**	0
NHS Injury Scheme (was RTA)	**656**	865
Non NHS: Other	**668**	261
	206,261	182,876

The NHS Injury Scheme income is subject to a provision for doubtful debts of 7.8% to reflect expected rates of collection.

3.3 Private Patient Income

	2009/10 £000	Base Year £000
Private patient income	**1,660**	1,740
Total patient related income	**206,261**	108,423
Proportion (as percentage)	**0.80%**	1.60%

Section 44 of the 2006 Act requires that the proportion of private patient income to total patient related income of NHS Foundation Trusts should not exceed the proportion in the base year (2002/03).

4 Other Operating Income

4.1 Other operating income comprises

	2009/10 £000	2008/09 £000
Research and development	**736**	559
Education and training	**10,593**	7,347
Charitable and other contributions to expenditure	**105**	37
Transfers from donated asset reserve	**417**	379
Non-patient care services to other bodies	**11,484**	17,584
Other income	**2,082**	4,561
Amortisation of PFI deferred credits		
Main scheme	**259**	259
Total other operating income	**25,676**	**30,726**

Non patient care services to other bodies includes income for Pharmacy, Estates, HR and IT services provided to other NHS bodies.

4.2 Other income comprises

	2009/10 £000	2008/09 £000
Car parking	**225**	210
Staff recharges	**0**	29
Staff accommodation rentals	**464**	424
Clinical tests	**0**	0
Clinical excellence awards	**336**	1,197
Catering	**962**	823
Other	**95**	1,878
Total	**2,082**	4,561

5 Operating Expenses

5.1 Operating expenses comprise:

	2009/10 £000	2008/09 £000
Services from Foundation Trusts	**208**	131
Services from other NHS Trusts	**9**	61
Services from other NHS bodies	**453**	2,462
Purchase of healthcare from non NHS bodies	**1,768**	1,586
Executive Directors costs	**887**	788
Non-Executive Directors costs	**137**	123
Staff costs	**143,901**	130,610
Drug costs	**16,440**	15,493
Supplies and services - clinical	**24,469**	23,511
Supplies and services - general	**5,794**	2,448
Establishment	**2,962**	2,424
Research and development	**20**	20
Transport	**1,546**	1,333
Premises	**9,159**	7,825
Increase/(decrease) in bad debt provision	**604**	(336)
Depreciation on property, plant and equipment	**8,031**	7,928
Amortisation on intangible assets	**53**	25
Impairments of property, plant and equipment	**2,212**	660
Audit fees:		
audit services - statutory audit	**40**	97
other services (see note below)	**15**	10
Clinical negligence	**3,187**	1,767
Loss on disposal of other property, plant and equipment	**16**	39
Legal fees	**66**	48
Consultancy costs	**1,000**	626
Training, courses and conferences	**974**	883
Patient travel	**86**	45
Redundancy	**270**	178
Early retirements	**140**	0
Insurance	**153**	143
Other services, e.g. external payroll	**553**	917
Losses, ex gratia & special payments	**7**	4
Other	**470**	117
Total	**225,630**	201,966

Note: other audit services comprised the review of the IFRS opening balances and comparative accounts exercises by PricewaterhouseCoopers LLP.

5.2 Arrangements containing an operating lease

5.2.1 Minimum lease payments made

	31 MARCH 2010 £000	31 MARCH 2009 £000
Minimum lease payments	**542**	413
Total	**542**	413

These costs are included within operating expenses categories of transport (£103,000), Supplies and Services -Clinical (£262,000) and Premises (£177,000).

5.2.2 Future operating lease obligations

	31 MARCH 2010 £000	31 MARCH 2009 £000
Future minimum lease payments due:		
Not later than one year	**395**	250
Later than one year and not later than five years	**622**	655
Later than five years	**3,172**	2,665
Total	**4,189**	3,570

5.3 Limitation on auditors' liability

Disclosure is required by the Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations 2008, where the Trust's contract with it's external auditors provides for a limitation of the auditors' liability.

The Board of Governors appointed PricewaterhouseCoopers LLP (PWC) as external auditors from the financial year 31 March 2010. The engagement letter signed on 9 April 2009 states that the liability of PWC, its members, partners and staff (whether in contract, negligence or otherwise) shall in no circumstances exceed £1 million in the aggregate in respect of all services (2008/2009 nil).

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

	2009/10 £000	2008/09 £000
Amounts included within other interest payable arising from claims made under this legislation	**0**	0
Compensation paid to cover debt recovery costs under this legislation	**0**	0
	0	0

6 Staff costs

6.1 Staff costs

	2009/10 £000	2008/09 £000
Salaries and wages	**114,654**	104,445
Social security costs	**8,977**	7,972
Employers contributions to NHS Pensions	**14,446**	13,273
Termination benefits	**0**	99
Agency and contract staff	**7,121**	5,787
Total	**145,198**	131,576

6.2 Average monthly number of persons employed (WTE basis)

	2009/10 Number	2008/09 Number
Hospital medical and dental staff	**452**	396
Administration and estates staff	**956**	883
Healthcare assistants and other support staff	**882**	729
Nursing, midwifery and health visiting staff	**975**	919
Scientific, therapeutic and technical staff	**528**	555
Total	**3,793**	**3,482**

6.3 Employee benefits

	2009/10 £000	2008/09 £000
Subsidised Catering Facilities	95	97
Clinical Accommodation	4	397
Staff Health Promotion	290	202
Total	389	696

6.4 Directors remuneration and other benefits

The aggregate remuneration and other benefits receivable by Directors during the financial year totalled £1,100,200. Employer contributions to the NHS pension scheme in relation to Directors was £114,700.

Benefits are accruing under the NHS defined benefit pension scheme to eight of the Directors. No benefits are accruing under any money purchase schemes.

There were no other benefits, advances or guarantees existing with any of the Directors as at 31 March 2010.

7 Early retirements due to ill-health

During the year from 1st April 2009 to 31 March 2010 there were 5 early retirements from the Trust on the grounds of ill-health (4 in the year to 31 March 2009). The estimated additional pension liabilities of these ill-health retirements is £284,000 (£215,000 in the year to 31 March 2009). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

8 Finance income

	2009/10 £000	2008/09 £000
Bank interest	103	707
Total	**103**	707

9.1 Finance expense - financial liabilities

	2009/10 £000	2008/09 £000
Finance leases	**4**	0
Finance costs for PFI obligations		
Main finance costs	**1,326**	0
	1,330	0

9.2 Impairment of assets (PPE and intangibles) - recognised in operating expenses note 5.1

	2009/10 £000	2008/09 £000
Loss or damage from normal operations	**0**	201
Abandonment of assets in course of construction	**640**	0
Changes in market price	**1,572**	459
Total impairments	**2,212**	660

The changes in market price comprise £774,000 relating to a valuation conducted by the District Valuer on completion of the Beacon Centre (cancer facility). £798,000 relates to a fall in the value of specialist buildings in the period 1 April 2009 to 31 March 2010. Note 11.1 gives full details of these revaluations. Of the assets abandoned in the course of construction, £575,000 is for the write off of enabling work carried out in respect of development work on the site previously occupied by Alfred Morris House and £65,000 is for the write off of plant expenditure previously included in asset under construction and now written off. For 2008/09, £201,000 of the £258,000 relates to the demolition of Alfred Morris House, (the total value of the impairment was £955,000 of which £754,000 was offset against the revaluation reserve). The remaining £57,000 related to the write off of debit balances on the revaluation reserve.

10.1 Intangible Assets 2009/10

	Software licences £000	Total £000
Fair value at 1 April 2009	457	**457**
Additions purchased	12	**12**
Fair value at 31 March 2010	**469**	**469**
Amortisation at 1 April 2009	246	**246**
Provided during the year	53	**53**
Amortisation at 31 March 2010	**299**	**299**
Net book value		
- Purchased at 1 April 2009	191	**191**
- Donated at 1 April 2009	20	**20**
- Total at 1 April 2009	**211**	**211**
- Purchased at 31 March 2010	156	**156**
- Donated at 31 March 2010	14	**14**
- Total at 31 March 2010	**170**	**170**

10.2 Intangible Assets 2008/09

	Software licences £000	Total £000
Fair value at 1 April 2008	326	**326**
Additions purchased	131	**131**
Fair value at 31 March 2009	457	**457**
Amortisation at 1 April 2008	221	**221**
Provided during the year	25	**25**
Amortisation at 31 March 2009	246	**246**
Net book value		
- Purchased at 1 April 2008	80	**80**
- Donated at 1 April 2008	25	**25**
- Total at 1 April 2008	**105**	**105**
- Purchased at 31 March 2009	191	**191**
- Donated at 31 March 2009	20	**20**
- Total at 31 March 2009	**211**	**211**

All short life assets including intangibles are carried at depreciated historic cost as a proxy to fair value.

10.3 Economic Life of Intangible Assets

	Min Life Years	Max Life Years
Intangible assets purchased		
Software licenses	5	7

11.1 Property, Plant and Equipment 2009/10

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Fair value at 1 April 2009	18,430	88,130	3,007	1,728	31,331	51	9,374	2,172	**154,223**
Additions purchased	0	14,924	0	2,707	5,757	0	1,088	224	**24,700**
Additions donated	0	20	0	0	562	0	0	10	**592**
Impairments charged to revaluation reserve	(921)	(2,823)	0	0	0	0	0	0	**(3,744)**
Impairments charged to donated assets reserve	0	(33)	0	0	0	0	0	0	**(33)**
Reclassifications	0	390	25	(454)	(9)	41	7	0	**0**
Revaluation surpluses	0	601	154	0	0	0	0	0	**755**
Disposals	0	0	0	0	(2,072)	(6)	0	0	**(2,078)**
Fair value at 31 March 2010	17,509	101,209	3,186	3,981	35,569	86	10,469	2,406	**174,415**
Accumulated depreciation at 1 April 2009	0	0	0	0	18,978	51	4,548	1,391	24,968
Provided during the year	0	3,452	75	0	2,693	4	1,617	190	8,031
Impairments recognised in operating expenses	0	1,572	0	640	0	0	0	0	2,212
Reclassifications	0	0	0	0	(13)	13	0	0	0
Disposals	0	0	0	0	(2,056)	(6)	0	0	(2,062)
Accumulated depreciation at 31 March 2010	**0**	**5,024**	**75**	**640**	19,602	62	6,165	1,581	**33,149**
Net book value									
- Owned at 1 April 2009	18,430	81,228	3,007	1,728	11,114	0	4,826	766	121,099
- Finance lease at 1 April 2009	0	5,975	0	0	46	0	0	0	6,021
- Donated at 1 April 2009	0	927	0	0	1,193	0	0	15	2,135
NBV total at 1 April 2009	**18,430**	**88,130**	**3,007**	**1,728**	**12,353**	**0**	**4,826**	**781**	**129,255**
- Owned at 31 March 2010	17,509	82,842	3,111	3,341	12,296	1	4,304	805	124,209
- Finance leased as at 31 March 2010	0	12,465	0	0	2,287	23	0	0	14,775
- Donated at 31 March 2010	0	878	0	0	1,384	0	0	20	2,282
NBV total at 31 March 2010	**17,509**	**96,185**	**3,111**	**3,341**	**15,967**	**24**	**4,304**	**825**	**141,266**

11.2 Analysis of Property, Plant and Equipment 31 March 2010

Net book value									
Protected assets at 31 March 2010	16,467	94,157	1,361	0	0	0	0	0	111,985
Unprotected assets at 31 March 2010	1,042	2,028	1,750	3,341	15,967	24	4,304	825	29,281
Total at 31 March 2010	**17,509**	**96,185**	**3,111**	**3,341**	**15,967**	**24**	**4,304**	**825**	**141,266**

11.3 Property, Plant and Equipment 2008/09

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Fair value at 1 April 2008 as restated	**23,375**	**89,111**	**3,290**	**1,821**	**31,132**	**111**	**8,678**	**3,585**	**161,103**
Additions purchased	0	198	15	1,504	2,026	0	719	0	4,462
Additions donated	0	0	0	0	155	0	0	0	155
Impairments charged to the revaluation reserve	0	(754)	0	0	0	0	0	0	(754)
Reclassifications	0	1,568	0	(1,597)	10	0	0	19	0
Revaluation surpluses	(4,945)	(1,993)	(298)	0	521	0	0	45	(6,670)
Disposals	0	0	0	0	(2,513)	(60)	(23)	(1,477)	(4,073)
Fair value at 31 March 2009	**18,430**	**88,130**	**3,007**	**1,728**	**31,331**	**51**	**9,374**	**2,172**	**154,223**
Accumulated depreciation at 1 April 2008 as restated	**0**	**0**	**0**	**0**	**18,410**	**111**	**2,946**	**2,554**	**24,021**
Provided during the year	0	3,090	76	0	2,848	0	1,618	296	7,928
Impairments recognised in operating expenses	0	660	0	0	0	0	0	0	660
Revaluation surpluses	0	(3,750)	(76)	0	190	0	0	18	(3,618)
Disposals	0	0	0	0	(2,470)	(60)	(16)	(1,477)	(4,023)
Accumulated depreciation at 31 March 2009	**0**	**0**	**0**	**0**	**18,978**	**51**	**4,548**	**1,391**	**24,968**
Net book value									
- Owned at 1 April 2008	23,375	88,133	3,290	1,821	11,264	0	5,732	1,013	134,628
- Finance lease at 1 April 2008	0	0	0	0	119	0	0	0	119
- Donated at 1 April 2008	0	978	0	0	1,339	0	0	18	2,335
NBV total at 1 April 2008	**23,375**	**89,111**	**3,290**	**1,821**	**12,722**	**0**	**5,732**	**1,031**	**137,082**
- Owned at 31 March 2009	18,430	87,203	3,007	1,728	11,114	0	4,826	766	127,074
- Finance leased as at 31 March 2009	0	0	0	0	46	0	0	0	46
- Donated at 31 March 2009	0	927	0	0	1,193	0	0	15	2,135
NBV total at 31 March 2009	**18,430**	**88,130**	**3,007**	**1,728**	**12,353**	**0**	**4,826**	**781**	**129,255**

11.4 Analysis of Property, Plant and Equipment 31 March 2009

Net book value									
Protected assets at 31 March 2009	17,334	85,995	1,186	0	0	0	0	0	104,515
Unprotected assets at 31 March 2009	1,096	2,135	1,821	1,728	12,353	0	4,826	781	24,740
Total at 31 March 2009	**18,430**	**88,130**	**3,007**	**1,728**	**12,353**	**0**	**4,826**	**781**	**129,255**

11.5 Economic Life or Property, Plant and Equipment

	Min Life Years	Max Life Years
Land	Infinite	Infinite
Buildings excluding dwellings	15	65
Dwellings	40	60
Assets under Construction & Payments on Account	1	4
Plant and Machinery	5	15
Transport Equipment	5	10
Information Technology	3	8
Furniture and Fittings	4	15

Of the total value of land, buildings and dwellings of £116,805,000, £1,063,000 was held on long leasehold. Assets were held under Finance Leases are detailed in note 15.

11.6 Revaluation of assets

Beacon Centre

During the accounting period, the Beacon Centre (cancer facility) was revalued following completion. This valuation was carried out by an independent valuer, the District Valuer, and the valuation was effective from 9 May 2009, being the date the facility came into operation. The valuation was carried out in accordance with the terms of the Royal Institute of Chartered Surveyors valuation standard and valued the asset to fair value in accordance with the Revaluation model set out in IAS 16. Due to the specialist nature of the building, fair value is determined by using the depreciated replacement cost method of valuation as a proxy to market value. The revaluation resulted in an impairment of £774,000 which has been accounted for in the Statement of Comprehensive Income account and is detailed in note 9.2.

Modern Equivalent Asset Valuations

During the accounting period a valuation was undertaken to revalue the land, buildings and dwellings on the basis of modern equivalent asset valuations. The valuation was carried out by an independent valuer, the District Valuer and the effective date of the valuation was 1 April 2009. the valuation was carried out in accordance with the terms of the Royal Institute of Chartered Surveyors valuation standard and in accordance with the Revaluation model set out in IAS 16.

The Modern Equivalent Asset Valuation exercise resulted in a net de-valuation of the Trust's land, buildings and dwellings of £13,034,000. The valuation was accounted for as a prior period adjustment and a further exercise was undertaken by the Trust to calculate the respective adjustments for both 2007/08 and 2008/09.

Impairment Review March 2010

An impairment review of the land, property and dwellings was carried was carried out in March 2010, this resulted in a further estimated fall in value of £4,575,000. This estimation was made using construction industry indices and was applied to specialist buildings only. The impairments relating to the revaluations are dealt with in note 9.2. Of the total decrease in value of £4,575,000, £798,000,was accounted for in the Statement of Comprehensive Income (note 9.2) and £3,777,000 was set off against available balances in the revaluation and donated assets reserves.

11.7 Non Current assets held for sale

No non-current assets were held for sale at the financial year end.

12 Inventories	31 MARCH 2010 £000	31 MARCH 2009 £000	1 APRIL 2008 £000
Raw materials and consumables	**2,623**	2,162	1,812
Total	**2,623**	2,162	1,812

13 Trade receivables and other receivables

13.1 Trade receivables and other receivables

	31 MARCH 2010			31 MARCH 2009			1 APRIL 2008		
	Financial Assets £000	**Non Financial Assets £000**	**Total £000**	Financial Assets £000	Non Financial Assets £000	Total £000	Financial Assets £000	Non Financial Assets £000	Total £000
Current									
NHS receivables	**7,789**	**0**	**7,789**	8,019	0	8,019	8,378	0	8,378
Provision for impaired receivables (note 13.1)	**(1,358)**	**0**	**(1,358)**	(860)	0	(860)	(1,273)	0	(1,273)
Prepayments	**0**	**904**	**904**	0	718	718	0	760	760
Accrued income	**3,623**	**1,552**	**5,175**	235	0	235	6	0	6
PDC receivable	**0**	**186**	**186**						
Other receivables	**942**	**406**	**1,348**	2,520	2,331	4,851	1,318	1,691	3,009
Total current trade and other receivables	**10,996**	**3,048**	**14,044**	9,914	3,049	12,963	8,429	2,451	10,880
Non Current									
NHS receivables	**294**	**0**	**294**	292	0	292	272	0	272
Provision for impaired receivables	**0**	**0**	**0**	**0**	**0**	**0**	**(45)**	**0**	**(45)**
Other receivables (note 13.1)	**0**	**0**	**0**	0	0	0	565	0	565
Total non current trade and other receivables	**294**	**0**	**294**	292	0	292	792	0	792
TOTAL RECEIVABLES	**11,290**	**3,048**	**14,338**	**10,206**	**3,049**	**13,255**	**9,221**	**2,451**	**11,672**

13.2 Provision for impairment of receivables

	2009/10 £000	2008/09 £000	2007/08 £000
Opening balance	**860**	1,318	1,313
Increase in provision	**662**	391	472
Amounts utilised	**(106)**	(122)	0
Unused amounts reversed	**(58)**	(727)	(467)
Closing balance	**1,358**	860	1,318

The Trust's policy is to fully impair specific debts which it considers may not be fully recoverable. Those debts not imparied the Trust are considered to be collectable and of good credit quality.

13.3 Analysis of impaired receivables

	31 MARCH 2010 £000	31 MARCH 2009 £000	31 MARCH 2008 £000
Ageing of impaired receivables			
Up to three months	**0**	0	325
In three to six months	**0**	0	36
Over six months	**1,358**	860	957
Total	**1,358**	860	1,318
Ageing of non-impaired receivables past their due date			
Up to three months	**11,949**	12,043	10,910
In three to six months	**742**	561	255
Over six months	**1,647**	651	507
Total	**14,338**	13,255	11,672

Current debt is considered to be collectable in full.

14 Trade and other payables

14.1 Trade and other payables at the SoFP date are made up of:

	31 MARCH 2010			31 MARCH 2009			1 APRIL 2008		
	Financial Liabilities	**Non Financial Liabilities**		Financial Liabilities	Non Financial Liabilities		Financial Liabilities	Non Financial Liabilities	
	£000	**£000**	**Total £000**	£000	£000	Total £000	£000	£000	Total £000
Current									
Receipts in advance	**0**	**0**	**0**	0	43	43	0	64	64
NHS payables	**2,339**	**0**	**2,339**	1,904	0	1,904	1,665	0	1,665
Trade payables - capital	**330**	**0**	**330**	1,368	0	1,368	1,747	0	1,747
Other trade payables	**4,451**	**0**	**4,451**	6,042	0	6,042	0	0	0
Taxes payables	**0**	**3,005**	**3,005**	0	2,669	2,669	0	2,602	2,602
Other payables	**3,582**	**0**	**3,582**	3,311	0	3,311	5,046	0	5,046
Accruals	**3,296**	**0**	**3,296**	3,662	0	3,662	7,804	0	7,804
TOTAL TRADE AND OTHER PAYABLES	**13,998**	**3,005**	**17,003**	**16,287**	**2,712**	**18,999**	**16,262**	**2,666**	**18,928**

14.2 Other liabilities

	31 MARCH 2010 £000	31 MARCH 2009 £000	1 APRIL 2008 £000
Current			
Deferred income	**1,627**	1,741	1,945
Deferred PFI credits, multi storey car park	**259**	259	259
Total other current liabilities	**1,886**	2,000	2,204
Non-current			
Deferred PFI credits, multi storey car park	**5,305**	5,565	5,824
Total other non-current liabilities	**5,305**	5,565	5,824
TOTAL OTHER LIABILITIES	**7,191**	7,565	8,028

Multi Storey Car Park

The annual repayment of the finance lease obligation comprises the amortisation of the lease over the 25 year concession term. This amounted to £259,000 in each of the years above. There are no restrictions or contingent rents.

14.3 Borrowings

	31 MARCH 2010 £000	31 MARCH 2009 £000	1 APRIL 2008 £000
Current			
Obligations under finance leases	**9**	26	68
Obligations under Private Finance Initiative contracts	**497**	0	0
	506	26	68
Non-Current			
Obligations under finance leases	**14**	23	49
Obligations under Private Finance Initiative contracts	**15,594**	0	0
	15,608	23	49
TOTAL BORROWINGS	**16,114**	49	117

The above borrowings relate to finance leases for items of plant and equipment and liability (see note 15 below) and for the Beacon centre cancer facility (see note 16 below).

14.4 Prudential Borrowing Limit	31 MARCH 2010 £000	31 MARCH 2009 £000	1 APRIL 2008 £000
Total long term borrowing limit set by Monitor	**52,900**	43,400	43,100
Working capital facility agreed by Monitor	**12,700**	12,700	12,700
TOTAL PRUDENTIAL BORROWING LIMIT	**65,600**	56,100	55,800
Long term borrowing at 1 April	**0**	0	0
Net actual borrowing in year - long term	**16,498**	0	0
Long term borrowing at 31 March	**16,498**	0	0
Working capital borrowing at 1 April	**0**	0	0
Net actual borrowing in year - working capital	**0**	0	0
Working capital borrowing at 31 March	**0**	0	0

Financial Ratios	2009/10 Actual Ratios	2009/10 Approved Ratios	2008/09 Actual Ratios	2008/09 Approved Ratios
Minimum Dividend Cover	**4**	3	4	3
Minimum Interest Cover	**7**	8	0	0
Minimum Debt Service Cover	**7**	7	0	0
Maximum Debt Service to Revenue	**0.01**	0.01	0	0

The NHS Foundation Trust is required to comply and remain within a Prudential Borrowing Limit. This is made up of two elements :

a) the maximum cumulative amount of long-term borrowing. This is set by reference to the five ratio tests set out in Monitor's Prudential Borrowing Code. The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact on the long term borrowing limit.

b) The amount of any working capital facility approved by Monitor.

Further information on the NHS Foundation Trust Prudential Borrowing code and Compliance Framework can be found on the website of Monitor, the Independent Regulator of Foundation Trusts.

As there was no significant borrowing prior to 2009/10, comparative ratios are provided for minimum dividend cover only.

15 Finance lease obligations

	31 MARCH 2010 £000	31 MARCH 2009 £000	1 APRIL 2008 £000
Gross lease liabilities	**27**	57	132
of which liabilities are due:			
- not later than one year;	**11**	30	74
- later than one year and not later than five years;	**16**	27	58
Finance charges allocated to future periods	**(4)**	(8)	(15)
Net lease liabilities	**23**	49	117
- not later than one year;	**9**	26	68
- later than one year and not later than five years;	**14**	23	49
Net Book Value of non PFI assets held on finance leases	**26**	**45**	**119**

The above leasing commitments are finance leases in respect of portering vehicles, cardiac catheter imaging equipment (ceased 2007/08) and liquid based cytology. These are standard leases paid in periodic fixed payments and there are no restrictions or renewable options. The differences between the net book value of assets held under finance leases and finance lease obligations comprises capital repayments, interest charges and asset depreciation.

16.1 Private Finance Initiative obligations

Timing of liabilities:	31 MARCH 2010 Total £000	31 MARCH 2009 Total £000	1 APRIL 2008 Total £000
Gross PFI liabilities are due:			
- not later than one year;	**1,970**	0	0
- later than one year and not later than five years;	**7,107**	0	0
- later than five years.	**32,468**	0	0
Total Gross Liabilities	**41,545**	**0**	0
Net PFI liabilities are due:			
- not later than one year;	**497**	0	0
- later than one year and not later than five years;	**1,672**	0	0
- later than five years.	**13,922**	0	0
Total Net Liabilities	**16,091**	**0**	0
Finance charges allocated to future periods	**(25,454)**	0	0
Reconciliation between Net Book values of PFI assets held under finance leases and PFI Liabilities			
Net Liability (as above)	**16,091**	**0**	0
Revaluations and impairments	**(1,259)**	0	0
repayments / amortisation of capital sum	**407**	0	0
Depreciation	**(490)**	0	0
Net Book Value of PFI Assets held on finance leases	**14,749**	**0**	**0**

The PFI obligation above relates to the Beacon Centre (cancer facility) which opened in May 2009. Note, the accounting entries relating to the multi storey car par are dealt with in note 14.2, Other Liabilities.

Future commitments for PFI schemes
The Trust is committed to make the following payments for on-SoFP PFIs obligations (relating to the Beacon Centre) during the next year in which the commitment expires:

	31 Mar 2010 Total	31 Mar 2009 Total
	£000	£000
26th to 30th years (inclusive)	**2,919**	0
	2,919	**0**

16.2 Private Finance Transactions

A) The Beacon Centre
The project agreement is with the Taunton Linac Company Ltd (the operator) for the provision of a new Oncology and Haematology Centre on the Musgrove Park Hospital site (The Beacon Centre) including the supply and maintenance of the building and major medical equipment within the facility. The facility opened in May 2009 and provides state of the art non-surgical cancer services to the residential population of Somerset, in a suitable location and setting at Taunton and Somerset NHS Trust. The new Oncology and Haematology Centre provides:

- Two Linear Accelerators (a third has been purchased by the Trust)
- One simulation suite with processing and treatment planning facilities
- 18 bed Oncology Ward
- Chemotherapy suite for 22 day patients
- Outpatients suite with 4 consulting and 8 examination

Key Features of the Scheme:
In return for an agreed monthly payment, the following facilities are provided to the Trust by the Operator plus associated hard FM and asset renewal services:
- Inpatient and Outpatient facilities
- Radiotherapy treatment area
- Administrative offices
- Public spaces

Under the Project Agreement, the above facilities are be provided at a pre-determined level of quality for the 30 year term (excluding the construction period).

The operator has also procured, installed, and will maintain and replace major medical equipment for the full 30 years of the operating period. The major equipment requirements include two Linear Accelerators. However, soft FM services such as portering, catering and cleaning are provided by the Trust and are outside the scope of this PFI project.

Nature of Payment
The Operator provides the services in return for an annual service charge. In covering payment for facilities, other services and financing, the annual service charge is unitary in nature. The Trust has agreed a payment mechanism that incorporates the principles of the NHS Standard Form contract. This relates payment to the successful (or otherwise) achievement of the service and quality standards set out in the output specification. The unitary payment can be abated for instances of non-performance against the standards in the output specification up to a maximum of 100% of the unitary fee, which fall into three areas:

a) Failure events – where there is a failure to meet a specific service standard relating to a particular area of the hospital.

b) Failure events – relating to the Radiotherapy

c) Quality Failures – where there is a failure to supply a service across a wider range of parameters, which cannot be attributed to a specific area of the hospital.

The unitary payment relating to the Beacon Centre is set by the contract between the Trust and the operator and is subject to an inflationary uplift based on the Retail Price Index (RPI). The total unitary payment for 2009/10 amounted to £2,668,000 and will be £2,919,000 for 2010/11. The Beacon Centre asset and liability was initially recognised in the Statement of Financial Position at £16,498,000. On completion, the assets were revalued by the District Valuer and this resulted in the value falling by £774,000 to £15,724,000. There was an additional revaluation of £485,000 in March 2010 making up the total impairment of £1,259,000 in note 16.1 above. The net book value of the asset at 31 March 2010 was £14,749,000 (note 16.1)

Property ownership
The site on which the new Oncology facilities have been built is in the freehold ownership of the Trust.

Expiry of contract
On expiry of the contract (May 2039), the facility will revert to the ownership of the Trust for no payment.

B) Provision of Multi Storey Car Park

This is a public private partnership project (PPP). It relates to the building of a car park (completed in October 2006) and the provision of services for 25 years. The ownership of the building will pass to the Trust after the 25 year concession period. The residual value (assessed by professional valuation) is £4,468,000. Throughout this period the operator pays an agreed proportion of the car parking fees to the Trust, no other financial transactions take place. In 2008/09 the project was accounted for outside of the accounts under United Kingdom Generally Accepted Accounting Practice (UKGAAP), except that the residual value of the asset at the end of the concession period was accumulated over its life. In 2009/10 this has been accounted for under International Financial Reporting Standards and the asset together with the outstanding liability is required to be accounted for in the Statement of Financial Position. The Trust is also required to show this change of treatment in the comparative accounts of 2008/09 including the opening position at 1st April 2008. These adjustments are summarised below:

	31 MARCH 2010	31 MARCH 2009	1 APRIL 2008
	£000	£000	£000
Net Book Value of asset (included in property, plant and equipment, note 11.1)	**5,660**	5,975	6,153
Liability (see deferred PFI credits, note 16)	**5,564**	5,824	6,083

C) Staff Nursery

This is accounted for off Statement of Financial Position. The operator is required to provide childcare facilities over the concession period, of 30 years. The services are provided to Trust employees in the first instance and to the public thereafter. The land was provided by the Trust on a 99 year lease. Other than this, there is no financial cost to the Trust. The land and building will revert to Trust ownership at the end of the 99 year lease.

17 Provisions for liabilities and charges

	Pre 1995 Early Retirements £000	Personal Injury Claims £000	Injury Benefit £000	Other £000	Total £000
At 1 April 2009	257	54	810	0	**1,121**
Arising during the year	32	33	54	410	**529**
Utilised during the year	(25)	(11)	(41)	0	**(77)**
Reversed unused	0	0	(246)	0	**(246)**
Unwinding of discount	6	0	12	0	**18**
At 31 March 2010	**270**	**76**	**589**	**410**	**1,345**
Expected timing of cash flows:					
- not later than one year	20	76	35	410	**541**
- later than one year and not later than five years	75	0	133	0	**208**
- later than five years	175	0	421	0	**596**
Total	**270**	**76**	**589**	**410**	**1,345**

Provisions note

Pre 1995 early retirements are calculated on figures supplied by the NHS Pensions Agency and a significant amount of the payments are expected to be greater than one year. The Personal Injury provisions are based on the expected values and probabilities quantified by the NHSLA. The outcome of these cases are inherently uncertain and the timing of payments is dependant on the progression of each case. The figures included in the summary are based purely on the Trust's excess reflecting the fact that the NHSLA make the majority of payments direct. The Injury Benefit provisions are based on figures supplied by the NHS Pensions Agency a significant amount of the payments are expected to be greater than 1 year. Other provisions comprise potential redundancy and restructuring costs in which the outcome is uncertain and in which the financial impact has been estimated.

Clinical Negligence liabilities

£33,882,000 is included in the provisions of the NHS Litigation Authority at 31 March 2010 in respect of potential clinical negligence liabilities of the Trust (31 March 2009 - £22,658,000).

Contingent liabilities in respect of clinical negligence claims are discussed in note 21

18 Cash and cash equivalents

	31 MARCH 2010 £000	31 MARCH 2009 £000	31 MARCH 2008 £000
At 1 April	**21,237**	577	1,575
Net change in year	**(1,344)**	20,660	(998)
At 31 March	**19,893**	21,237	577
Current asset investments	**0**	0	
Cash at commercial banks and in hand	**66**	8,638	124
Cash with the Government Banking Service	**19,827**	12,599	453
SoCF	**19,893**	**21,237**	**577**

19 Other financial assets

Other financial assets held at 1 April 2008 of £13,000,000 represent funds deposited in the National Loans Fund. This was a fixed term investment held at that date.

20 Contractual Capital Commitments

Commitments under capital expenditure contracts at 31 March 2010 were £3,473,000 (Year to 31 March 2009 £5,350,000). These all relate to property, plant and equipment.

21 Contingent (Liabilities)/Assets

The contingent liabilities at 31 March 2010 were £32,250 (31 March 2009 £22,500). This relates to outstanding NHS Litigation claims.

The Trust's VAT advisers have submitted a back dated claim for a refund of VAT for catering, private patients and construction projects. This claim has been made possible following a series of court judgements that allows NHS Trusts a temporary window in which to make backdated claims. The total amount claimed amounts to £1,325,000. The success of this claim will depend on the extent to which this is accepted by HMRC and the outcome is likely to be known during the 2010/11 financial year.

22.1 Movements on Reserves

Movements on reserves in the year comprised the following:

	Revaluation Reserve	Donated Asset Reserve	Income and Expenditure Reserve	**Total**
	£000	£000	£000	**£000**
Taxpayers' equity at 1 April 2009	33,692	2,155	26,410	**62,257**
Surplus/(deficit) for the year	0	0	918	**918**
Revaluation gains/(losses) and impairment losses property, plant and equipment	(2,989)	0	0	**(2,989)**
				0
Increase in the donated asset reserve due to receipt of donated assets	0	592	0	**592**
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of on donated assets	0	(451)	0	**(451)**
Transfers to the income and expenditure account in respect of assets disposed of	(649)	0	649	**0**
historical cost depreciation to the Income and Expenditure Reserve	(1,021)	0	1,021	**0**
At 31 March 2010	29,033	2,296	28,998	60,327

22.2 Nature and Purposes of Reserves

Revaluation Reserve

The reserve comprises the sum of all past revaluations of the Trust's non-current assets that have resulted in increases in the value (not including donated assets). The reserve can be used to absorb future revaluations of non-current assets that result in a fall in value to the extent that a positive reserve exists for that class of asset.

Donated Assets Reserve

This reserve represents the element of theTrust's net assets that is derived from assets that have been donated to the Trust. As such the reserve is adjusted for annually to account for new donations as well as disposals, revaluations, impairments and depreciation of existing assest. The uses of the donated assets reserve are limited to issues relating to donated assets

Income and Expenditure Reserve

This reserve is an accumulation of all past surpluses and deficits. There are also periodic transfers to the reserve from the revaluation reserve relating to the disposal on non-current assets and the excess cost of current depreciation over historic cost depreciation. As all transactions, in the normal course of business, are accounted for in the Statement of Comprehensive Income, the uses of the income and expenditure reserve are limited to prior period adjustements.

23 Related Party Transactions

Taunton & Somerset NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health. 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 Taunton & Somerset NHS Foundation Trust.

The Trust Board is the Corporate Trustee of the charitable funds

The Department of Health is regarded as a related party. During the year Taunton & Somerset NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. A summary of these transactions are listed below.

These transactions represent income and expenditure from a range of services and supplies. Expenditure, for example, includes the purchase of an ambulance service. Income relates to the commissioning of patient care services, the provision of IT and estates services and the sale of drugs.

	Income from related party £000	Expenditure to related party £000	Receivables owed by related party £000	Payables owed to related party £000
Value of transactions with board members in 2009/10	0	0	0	0
Value of transactions with key staff members in 2009/10	0	0	0	0
Value of balances (other than salary) with related parties in relation to doubtful debts at 31 March 2010	872	0	872	0
Value of balances (other than salary) with related parties in respect of doubtful debts written off in year at 31 March 2010	0	0	0	0
Value of transactions with other related parties in 2009/10				
Department of Health	1,212	0	6	0
Somerset PCT	192,162	453	6,410	627
Yeovil District Hospital Foundation Trust	3,823	158	1,562	116
South West Strategic Health Authority	9,423	0	162	412
Other NHS Bodies	17,985	4,873	1,837	668
Charitable Funds	626	57	54	0

Value of transactions with board members in 2008/09	0	0	0	0
Value of transactions with key staff members in 2008/09	0	0	0	0
Value of balances (other than salary) with related parties in relation to doubtful debts at 31 March 2009	0	0	607	0
Value of balances (other than salary) with related parties in respect of doubtful debts written off in year at 31 March 2009	0	0	0	0
Value of transactions with other related parties in 2008/09				
Department of Health	6,303	0	36	0
Other NHS Bodies	198,722	14,160	7,983	1,904
Charitable Funds	514	0	52	0

24 Financial Instruments

IFRS 7, IAS 32 and 39, dealing with Financial Instruments, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. The Trust can borrow funds up to its Prudential Borrowing set by Monitor using the risk rating methodology. The Trust also has the ability to invest surplus cash, the risks resulting from transactions of this nature are mitigated by the Foundation Trusts treasury and investment policies and protocols and by the reporting of performance against financial targets to the Foundation Trust regulator, Monitor. The prudential borrowing limit is set using Monitor's risk rating methodology.

Liquidity risk

The NHS Trust's net operating costs are incurred under annual service agreements with local Primary Care Trusts, which are financed from resources voted annually by Parliament. The introduction of Payment by Results has created inherent risk of performing at below the planned activity levels thereby endangering its income. The Trust has mitigated this risk through the arrangement of a working capital facility of £12.7M with the National Westminster Bank. The Trust currently finances its capital expenditure from funds made available from cash surpluses generated by the Trust's activities. The PFI project relating to the Beacon Centre has created liabilities on the Statement of Financial Position that the Trust is committed to meeting for the duration of the service concession, this liability is subject to annual inflationary uplift. In addition, the future plans for the surgical re-development will require borrowing, the Trust plans to limit its risk by accessing borrowing via the Foundation Trust Financing Facility. The approval of major capital projects such as the Beacon Centre are subject to comprehensive project development processes involving the creation of separate project boards, continuous scrutiny by the Trust Board and also through the involvement of NHS partners including the host PCT and the South West Strategic Health Authority.

Credit Risk

The risk that the trust will fail to collect all due income is mitigated by the ongoing strong arrangements that exist with its host PCT, Somerset PCT, from which most income derives. Other credit risk is provided for by the continuous processes of reviewing debt management and ensuring that debts that are unlikely to be collected are appropriately impaired. The review of impaired debts for 2008/09 (per note 13) identified that it was appropriate to provide for all debts over nine months old. This represents a reduction from the previous policy of providing for debts over three months and is based on the experience of debt collection in year and a review of debts collected since the year end. In addition, the Trust reviews all debts to identify specific impaired debts. The total impaired debt (per note 13) is £1,358,000 of which £1,139,000 relates to NHS debt and £219,000 is for non NHS debt.

Interest-Rate Risk

Some of the financial instruments have a fixed interest rate which means the Trust is exposed to interest rate risk. If the interest rate moves interest paid could be higher than the market rates, and/or interest received could be lower than the market rates. Of the financial assets set out in note 26, all are denominated in sterling.

Investment Risk

The Trust's investments are held either in the National Loans Fund temporary deposits or short term deposits with the Royal Bank of Scotland or HBOS. These are short term investments that are normally invested for a term of one to four weeks. The relative liquidity of these deposits ensures that the Trust mitigates any risk of being unable to fulfil its contractual commitments arising, for example from a sudden reduction in income. The Trust uses the protocols set out in its Treasury Management Policy to ensure that credit risk is managed and that only banks with acceptable credit ratings are included in the panel of approved organisation for investment. The Treasury and Investment Committee (sub committee to the Board) oversees the management of working capital and the investment of surplus cash to ensure that the Trust optimises its returns whilst minimising risk.

25 Foreign Currency Risk

The Trust has negligible foreign currency income or expenditure.

26 Financial Assets and Liabilities by Category

Assets as per SoFP	At 31 March 2010 Total £000	At 31 March 2010 Loans and Receivables £000	At 31 March 2009 Total £000	At 31 March 2009 Loans and Receivables £000	At 1 April 2009 Total £000	At 1 April 2009 Loans and Receivables £000
Trade and other receivables excluding non financial assets	**11,290**	**11,290**	10,206	10,206	9,221	9,221
Other investments	**0**	**0**	0	0	13,000	13,000
Other financial assets	**0**	**0**	0	0	0	0
Non current assets held for sale and assets held in disposal group	**0**	**0**	0	0	0	0
Cash and cash equivalents (at bank and in hand)	**19,893**	**19,893**	21,237	21,237	577	577
Total	**31,183**	**31,183**	31,443	31,443	22,798	22,798

Liabilities as per SoFP	At 31 March 2010 Total £000	At 31 March 2010 Other Financial Liabilities £000	At 31 March 2009 Total £000	At 31 March 2009 Other Financial Liabilities £000	At 1 April 2009 Total £000	At 1 April 2009 Other Financial Liabilities £000
Borrowings excluding Finance lease and PFI liabilities	**0**	**0**	0	0	0	0
Obligations under finance leases	**23**	**23**	49	49	117	117
Obligations under Private Finance Initiative contracts	**16,091**	**16,091**	0	0	0	0
Trade and other payables excluding non financial liabilities	**13,998**	**13,998**	16,287	16,287	16,262	16,262
Other financial liabilities	**0**	**0**	0	0	0	0
Provisions under contract	**1,345**	**1,345**	1,121	1,121	1,811	1,811
Liabilities in disposal groups excluding non-financial liabilites	**0**	**0**	0	0	0	0
Total	**31,457**	**31,457**	17,457	17,457	18,190	18,190

27 Fair Values

27.1 Fair Values of financial assets as 31 March 2010

	Book Value £000	Fair Value £000
Non current trade and other receivables excluding non financial asse	294	294
Other Investments	0	0
Other	30,889	30,889
Total	31,183	31,183

27.2 31.2 Fair values of financial liabilities at 31 March 2010

	Book Value £000	Fair Value £000
Non current trade and other payables excluding non financial liabilitie	0	0
Provisions under contract	1,345	1,345
Loans	0	0
Other	30,112	30,112
Total	31,457	31,457

Financial assets consists of debtors, accrued income and prepayments. The carrying amounts are determined by their recoverable amount.
Financial liabilities consists of creditors, accruals and provisions. The carrying amounts are determined by their invoiced amount.

28 Third Party Assets

The Trust held £829.72 cash at bank and in hand at 31 March 2010 (£995.23 at 31 March 2009) which relates to monies held by the NHS Trust on behalf of patients. This has been excluded from cash at bank and in hand figure reported in the accounts.

29 Intra-Government and Other Balances

	Receivables: amounts falling due within one year £000	Receivables: amounts falling due after more than one year £000	Payables: amounts falling due within one year £000	Payables: amounts falling due after more than one year £000
English NHS Foundation Trusts	2,262	0	300	0
English NHS Trusts	40	0	178	0
Department of Health	6	0	0	0
English Strategic Health Authorities	516	0	412	0
English Primary Care Trusts	7,876	294	643	0
RAB Special Health Authorities	0	0	0	0
NHS Whole Government Accounts bodies	34	0	2	0
Other Whole Government Accounts bodies	0	0	0	0
At 31 March 2010	**10,734**	**294**	**1,535**	**0**

30 Losses and Special Payments

There were 84 cases of losses and special payments totalling £7,000 (199 cases totalling -£15,000 08/09). There were no cases exceeding £250,000 for the current period and prior period.

31 Reconciliation of accounts prepared under UK GAAP to IFRS

The financial year ended 31 March 2010 is the first year that the Trust has produced financial statements prepared under International Financial Reporting Standards. The Trust is required under IFRS1 to produce reconciliations that explain how the transition has been accounted for.

The Trust is required to prepare the following:

Reconciliation of surplus / deficit under UKGAAP to IFRS for the year ended 31 March 2009	Note 31.1
Reconciliation of equity under UKGAAP to IFRS as at 1 April 2009	Note 31.2
Reconciliation of equity under UKGAAP to IFRS as at 1 April 2008	Note 31.3
Effect on cash flows under UKGAAP to IFRS for the year ended 31 March 2009	Note 3.4

31.1 Reconciliation of surplus for the year ended 31 March 2009 under UKGAAP to IFRS

	£000	£000
Retained surplus for 2008-09 under UK GAAP		6,346
IFRS Adjustments for:		
UKGAAP Adjustment	119	
IAS 17	(8)	
IAS 19	146	
IAS 36	754	
IFRIC 12	(307)	
		704
Retained surplus for 2008-09 under IFRS		**7,050**

31.2 Reconciliation of Taxpayers' equity at 31 March 2009 under UKGAAP to IFRS

	Public Dividend Capital £000	Revaluation reserve £000	Donated Asset Reserve £000	Income and expenditure reserve £000	**Total Taxpayer's equity £000**
Taxpayers' equity at 31 March 2009 UK GAAP	76,129	45,820	2,295	28,783	**153,027**
Adjustments for:					
Prior period adjustments (under UKGAAP)	0	(12,994)	(140)	(387)	**(13,521)**
IAS 16		0	0	0	**0**
IAS 17	0	67	0	(70)	**(3)**
IAS 19	0	0	0	(1,580)	**(1,580)**
IFRIC 12	0	799	0	(336)	**463**
Taxpayers' equity at 31 March 2009 under IFRS	**76,129**	**33,692**	**2,155**	**26,410**	**138,386**

31.3 Reconciliation of Taxpayers' equity at 31 March 2008 under UKGAAP to IFRS

	Public Dividend Capital £000	Revaluation reserve £000	Donated Asset Reserve £000	Income and expenditure reserve £000	**Total Taxpayer's equity £000**
Taxpayers' equity at 31 March 2008 UK GAAP	76,129	58,177	2,359	15,077	**151,742**
Adjustments for:					
Prior period adjustments (under UKGAAP)	0	(19,827)	(140)	4,484	**(15,483)**
IAS 16	0	0	0	0	**0**
IAS 17	0	64	0	(62)	**2**
IAS 19	0	0	0	(1,726)	**(1,726)**
IFRIC 12	0	867	0	(38)	**829**
Taxpayers' equity at 31 March 2008 under IFRS	**76,129**	**39,281**	**2,219**	**17,735**	**135,364**

31.4 Reconciliation of cash flows under UK GAAP to IFRS for the year ended 31 March 2009

	2008-09 £000 UKGAAP	**2008-09 £000 IFRS**
Net cash generated from operations	**17,658**	**17,261**
Cash flows from investing activities		
Interest received	697	707
Sales of financial assets	5,000	13,000
Purchase of intangible assets	(138)	(131)
Purchase of Property, Plant and Equipment	(5,275)	(4,839)
Sales of Property, Plant and Equipment	11	0
Net cash generated from investing activities	**295**	**8,737**
Cash flows from financing activities		
Capital element of finance lease rental payments		(62)
Interest paid	(23)	0
Interest element of finance lease		(6)
PDC Dividend paid	(5,270)	(5,270)
Net cash generated used in financing activities	**(5,293)**	**(5,338)**
Increase/(decrease) in cash and cash equivalents	12,660	20,660
Cash and cash equivalents at 1 April	8,577	577
Cash and cash equivalents at 31 March	21,237	21,237

Note :The transition from UKGAAP to IFRS did not alter the cash position for the Trust.

Explanation of Key Movements

(a) UKGAAP Adjustments

Before making any adjustments for IFRS, the Trust is required to adjust for any further amendments relating to UKGAAP accounting that have become apparent after the submission of the accounts for that period. The main adjustment to taxpayers' equity in this category relates to the revaluation of the land and buildings using modern equivalent asset valuations. During the year, the District Valuer was commissioned to revalue the land and buildings using the modern equivalent methodology. Under IFRS, the Trust is required to apply such changes not only to the current year but also to previous years, consequently the tables include adjustments for both years (-£15,026,000 at 31 March 2008 and -£13,034,000 at 31 March 2009) to reflect these reductions in taxpayers equity. This has also resulted in a reduction to depreciation in 2008/09, consequently £521,000 has been added to the surplus for that year (see note 35.1 above), this has been offset by changes to impairments relating to the I&E account amounting to £402K. A further adjustment was made to the balances for both years to reflect an amendment relating to the residual value of the multi storey car park (PFI project), which were previously excluded from the Statement of Financial Position). The transfer of £4,991,000 from the revaluation reserve to the income and expenditure reserve reported in the 2008/09 accounts and relating to a correction of an earlier year movement, has also been treated as a UKGAAP adjustment.

(b) IAS 16 Property

The Trust has been required to revalue its estate on a valuation basis that is different to that used in the past. During the 2009/10 financial year the District Valuer was commissioned to revalue the land and buildings on a modern equivalent asset basis. Under IFRS the Trust is required to apply such changes not only to the current year but also to previous years, consequently the tables above show a £15,026,000 reduction in the asset values (and consequently taxpayers' equity) in 2007/08 and a £13,034,000 reduction in 2009/10. This has also resulted in a reduction to depreciation in 2008/09 and consequently a £521,000 increase in the surplus.

(c) IAS 17 Leases

Under IFRS, the Trust has been required to review its leasing arrangements including the designation of leases as either finance or operating leases. As a result of this work, three leases were identified that had previously been treated as operating leases and have since been re-classified as finance leases. Consequently the adjustments to the surplus (and to taxpayer's equity) for both years reflect the financial impact of this.

(d) IAS 19 Employee benefits

The Trust is required to account for the financial effect of any untaken holiday pay at the end of the financial period. An exercise was carried out to identify this value at 1 April 2008 and 31 March 2009, this resulted in balances being brought into the accounts (including taxpayer's equity) of £1,732,000 and £1,586,000 respectively.

(e) IAS36 Impairment of Assets

Under UKGAAP, any impairments that relate to a permanent diminution of economic benefit were taken to the Statement of Comprehensive Income (previously the Income and Expenditure Account) regardless of whether any balance existed on the revaluation reserve. Under IFRS, all impairments are required to be set off initially against the revaluation reserve and then taken to the Statement of Comprehensive Income. The UKGAAP accounts for 2008/09 reported an impairment of £955,000 in respect of the demolition of Alfred Morris House. All of this was taken to the Statement of Comprehensive income, however, under IFRS, £754,000 of this balance should be set off against the revaluation reserve thus increasing the reported surplus by this figure.

(f) IFRIC 12 Service Concession Arrangements

The adjustments relating to IFRIC 12 relate to the introduction into the accounts of the multi storey car park which was provided under a PPP arrangement. Under UKGAAP such arrangements were accounted for outside of the accounts. However, under IFRS, these arrangements are shown on the Statement of Financial Position. The adjustment to taxpayers' equity reflects the introduction of this asset into fixed assets (at £7,179,000) netted off against the liability of the service concession (to the provider, Q Park, of £6,470,000). The above entries also include adjustments relating to the initial revaluation of the property, the depreciation of the building and the amortisation of the service concession.

(g) Key Movements in Cash Flow Statement

The principal change relates to the requirement under IFRS to treat the opening value of cash investments held in one week deposits as financial assets. As a result £8,000,000 has been re-analysed from 'cash at 1st April' to 'sales of financial assets'. In addition, the cash flows relating the adjustments set out in (a) to (e) above have required re analysis in the cash flow statement in particular the write back of the residual value of PFI assets has cause the purchases of property, plant and equipment to drop by £447,000 and there has also been a small re-analysis of software licences from intangible fixed assets to tangible fixed assets. There are also some minor changes to interest as a result of the introduction of finances leases (as above).