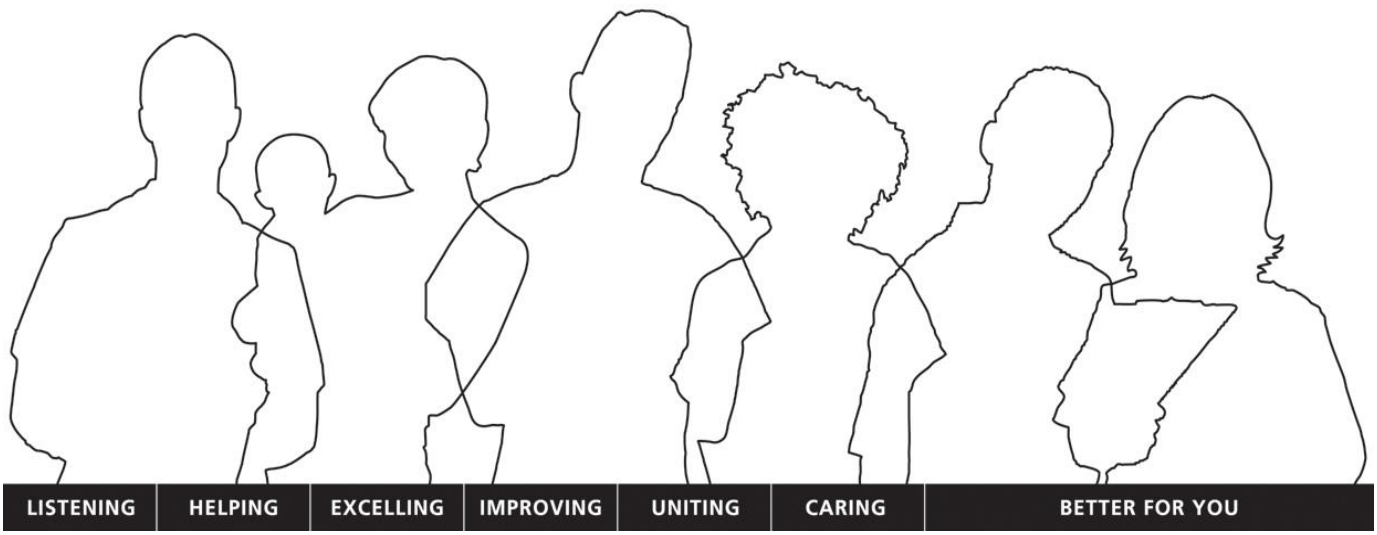
Gloucestershire Hospitals
NHS Foundation Trust

Annual Report and Accounts
2018 – 2019



Gloucestershire Hospitals NHS Foundation Trust

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GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST: ANNUAL REPORT AND ACCOUNTS 2017/18

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Copies of the Annual Report and Summary Financial Statements are available for inspection at:

Trust Headquarters, Cheltenham General Hospital, Alexandra House, Sandford Road, Cheltenham, GL53 7AN
Or visit the Trust website: www.gloshospitals.nhs.uk

Copies of the full Financial Accounts are available for inspection at Trust Headquarters, Cheltenham General Hospital, Alexandra House, Sandford Road, Cheltenham, GL53 7AN

1. MESSAGE FROM THE CHAIR

I am delighted to present the Annual Report of Gloucestershire Hospitals NHS Foundation Trust 2018/19. This is an opportunity to highlight some of the main developments to our services and the improvements that we have made to care over the last year, while also reporting on our performance against key national and locally determined clinical standards, waiting times and quality improvement priorities.

2018/19 has been a landmark year for our Trust. Change within large organisations like ours can seem to take an age but it does feel like we are pointing firmly in the right direction now, and in a much more timely way than most of us would have thought possible.

Being rated as 'Good' overall by the Care Quality Commission's (CQC) inspection team really is a tremendous achievement. A big challenge that I set myself in coming into this role nearly three years ago now was to get out and about and see what our colleagues do. As I did that I very quickly formed the opinion that having seen colleagues in action, and the passion and care with which they work, that it really warrants the word 'outstanding'. That is why the current rating must act only as a stepping stone in our journey to outstanding. The best organisations are continuously striving to improve and our focus will remain in achieving this outcome for our patients.

As Chair I carry additional responsibility for the effective governance of the organisation and in particular the administration of Board and its Committees. Therefore, from my perspective, coming out of Financial Special Measures (FSM) last autumn was incredibly significant. When we announced the sudden and unexpected change in our financial position in the autumn of 2016, I observed first-hand the reputational impact this had on the organisation. We remain one of the quickest turnaround organisations in the country to exit the FSM regime, which is a clear signal to me of the calibre and ability of the workforce at this Trust. Equally impressive was the 'Good' rating that we received as part of the 'Well-Led' element of the CQC inspection. This element of the inspection process was a lens on how the Trust's leadership, governance and financial and strategic planning is practised. Getting these elements right is absolutely essential in delivering our vision of Best Care for Everyone.

We continue to enjoy great energy from our Governors in supporting us to make more informed decisions about the future delivery of health care at our hospitals. We now have a settled team. Through the Council of Governors and its underpinning Governor Groups, regular engagement with the Trust's work has been afforded which has the benefit of helping our Governors better understand the work programmes, and in turn enables the provision of valuable critical insight. In particular I would like to thank our Governors for their commitment and resolve in refreshing the Trust's Constitution, which will guide and support the organisation well into the future. Additionally we are indebted to our Governors for the recruitment of two new Associate Non-Executive Directors as well as a Non-Executive Director.

We continue to have Governor Observers on Board Committees as well as having Committee Chairs presenting to the Council of Governors. This has strengthened the links between the Council and the Board while providing appropriate accountability.

Our financial position remains challenging, having ended the year with an operational deficit of £29.6m against a control total deficit of £18.8m. It is impressive how colleagues have responded to cost reduction having achieved around a 5% reduction in costs (£27m) whilst maintaining, and in many cases enhancing, patient care and services.

Looking ahead I am excited at the prospect of publishing our five year strategy, which will inform and guide us in our journey to outstanding. The strategy, informed by a wide

body of work, including the NHS Long Term Plan, will set out how we address our key challenges through eight underpinning or enabling strategies. I am hopeful that this work will resonate with every single member of the team – all 7,500! It will demonstrate how we are moving confidently into the future, developing services that excel and nurturing a workforce that's caring, inspired and innovative.

In the many interactions I have with people in Gloucestershire I know that it is important to them to have care that is more seamless and joined up and which transcends organisational boundaries. To achieve this we need to work more collaboratively with our partners so that resources can be better targeted and engaged to meet the health and care needs of patients now and into the future. As part of a shadow Integrated Care System, we are continuing to develop our One System Business Case (OSBC) and working on proposals, which we plan to engage and consult on over the coming year.

It would be remiss of me not to extend a huge thank you to all those who each and every day go the extra mile. It is this commitment and goodwill that is the bedrock of the system that keeps it all together and allows us to provide the quality of care we want for our patients. I am excited at the prospect of what we can achieve in the year ahead and I look forward to working with you.

Peter Lachecki
Chair

24 June 2019

2. MESSAGE FROM THE CHIEF EXECUTIVE

In what has been a milestone year for Gloucestershire Hospitals NHS Foundation Trust it gives me enormous pleasure to present the 2018/19 Annual Report. In a year in which we have achieved so much for our patients there is a great deal that we can be hugely proud of. There is a palpable feeling across the organisation that the last year has been a turning point and some of the shortcomings, which have consumed our energy, resource and time since I came into post three years ago are now well and truly behind us. That space has been filled with a new found confidence and belief that we can now get on with the job of designing new services for the future that will ensure our patients benefit from the very best care possible.

A real marker in that journey was our Care Quality Commission (CQC) inspection last autumn following which our independent regulator rated us as 'Good' overall. Gloucestershire is now one of the few systems, if not the only in the country, that has all of its main NHS provider bodies rated as 'good'. This stands us in good stead as we look to the future with optimism and excitement at what joined up, integrated care could mean to our patients and service users. What was particularly satisfying about our inspection was the way in which the inspection team was struck by the sea change in culture witnessed this time around – less than two years after their last inspection. This was illustrated through the visibility of leadership, at all levels of the organisation, and embodied in our quality improvement movement, which stood us apart and was even described as the wholly grail in terms of CQC language as 'outstanding'. The CQC weren't the only visitors to heap praise on the Academy this year. International guru and safety expert, Dr Don Berwick visited Gloucestershire in October last year and spent time immersed in some of the things we are doing throughout Gloucestershire to drive quality improvement. His comments about the Trust soon became the talk of the County and beyond, as social media platforms tweeted and posted his now infamous comments: "What's in the water here? I've not had an experience in these visits as exciting as what is happening in Gloucestershire. I don't think I've seen anything like this; it's really special." Transformational change of this kind is incredibly hard to achieve and is much, much more than a list of ticks against an action plan from a previous inspection. More humbling though is the official acknowledgement and recognition that our staff richly deserve in being rated 'Good'.

In November 2018 the Trust was taken out of Financial Special Measures (FSM) by its regulator, NHS Improvement, having significantly strengthened the way finances are managed. The Trust was placed in special measures following an unexpected and significant deterioration in its financial position in 2016. Coming out of FSM, particularly in such a short period of time, is a significant achievement and a real vote of confidence in the Trust. Again, it says a huge amount for our staff who embedded a culture of robust financial management, whilst continuing to deliver increasingly high quality and sustainable patient services. Another positive milestone in the year which positions us well in delivering our exciting vision for Gloucestershire Hospitals and the patients that we serve.

The most high profile standard which acute Trusts are judged against is the four-hour A&E waiting standard. To that end the Trust achieved 92.8% for the year against a target of 95%, which makes it one of the best performing in the country. This really is an incredible achievement particularly in the context of rising demand. When I arrived in the Trust in 2016, 370 attendances in our A&E departments would have been a busy day so to peak at 500 plus on some days is simply unprecedented. In responding to the challenge staff across our site teams, emergency department and assessment units and wards have been simply superb and, as ever, our partners across the patch have done their very utmost to support us during these unprecedentedly busy periods.

The CQC did rate us as 'requires improvement' for the responsiveness of our services – a reflection of the long waiting times experienced by some patients. Improving waiting times for our patients is a key priority for the Trust in the coming year. Re-establishing national reporting against the Referral to Treatment (RTT) standard in March (79.7%) is a significant milestone in that improvement journey. In recognition of the impact on our patients, this issue is receiving a huge amount of focus within the Trust and we fully acknowledge that we are not currently achieving the national standard. However, we are absolutely determined to remedy this and have robust plans in place to ensure we do this as quickly as possible. Diagnostic tests or procedures are a critical element in the care of most patients. Shorter waiting times are beneficial, as they help people get quicker access to the treatments they need, which is why I'm so proud that we've embedded delivery against the six week diagnostic standard. There are signs too that we have started to embed improvements across cancer standards, having achieved the two week waiting standard (93%) in quarter four (January, February and March 2019). Cancer care remains of huge importance to the Board and to our staff and patients not least because there is barely a person in the county who is not touched by the experience either personally or by association with friends and family. What's particularly pleasing is that we've continued to make these improvements through the efforts of our staff who have embraced innovation and service improvement to redesign the way we deliver cancer care, improving both patient experience and waiting times.

In the last year we've made huge progress in advancing our vision in becoming a digital exemplar. We moved on from the challenge that was the deployment of our new Patient Administration System (PAS) and we are now looking ahead confidently at the next 12 months or so at what the development of an Electronic Patient Record will mean for patient care. There is no doubt that this will completely transform the way we deliver care and the potential gains are simply huge.

I am overawed by the scale and breadth of accolades and awards that individual staff members and teams receive. My weekly staff blog is peppered with congratulatory messages, which gives me great encouragement in knowing the tremendous work that's going on to improve the quality of care for our patients and their families. Susie Durrell, for example, one of our Consultant Physiotherapists, received an MBE in the New Year's Honours lists for her lifelong work in physiotherapy. Meanwhile the work Andrew Seaton, Director of Safety, and Suzie Cro, Deputy Director of Quality, have been doing to bring together the teams who are responsible for investigating all matter of things from complaints, to serious incidents, to Duty of Candour through to inquests and clinical negligence claims, received high praise at a national awards ceremony. The impetus for the change to ways of working was a recognition that many of the patients and families who are touched by these different types of investigation are one and the same and the contact with multiple teams and processes, at a time of often heightened anxiety, distress and grief, is often a further stress which should be avoided in as much as is possible. This new way of working not only ensures that scarce investigatory skills are targeted in the right way but it provides families with a single point of contact and a more streamlined, simpler and quicker way to get their vitally important questions answered. An example of the work that we are delivering GSQIA is the national Point of Care Foundation's Sweeney Programme which again with support from the Patient Experience Improvement Team, has been embraced by the Trust.
Founder, and GP, Dr Kieran Sweeney lighted upon the fact that despite being a caring and compassionate healthcare professional, it was only when he became a patient himself did he truly understand the value of stepping into the patients shoes and seeing care through their eyes. Using tried and tested tools and experiential techniques, the programme helps staff get as close to experiencing the patient's journey as possible. The programme's driving principle is that staff can only truly consider what matters most to the patient, and then change their actions accordingly, if they are given the space, time, and resources to understand the patient's perspective. The programme affords staff this opportunity whilst equipping them with tools to bring about quality improvement.

The Trust's financial position remains challenging having ended the year with an operational deficit of £29.6m against a control total deficit of £18.8m. There were three main drivers which contributed to this variance, all of which were flagged early in the financial year; a shortfall in the national funding for the agenda for change pay award, a shortfall in identified CIP when a stretch target was agreed to deliver the initial control total and the resulting loss of Provider Sustainability Funding (PSF) due to non-delivery of the position in Quarter 4. The yearend saw two further adjustments; adversely, increased depreciation as a result of changes to asset lives and positively additional PSF from the general NHS Improvement incentive fund. However, our staff excelled in delivering cost improvement, achieving about 5% reduction in costs (£27m) compared to the acute sector average of between 3% and
5%. Perhaps most importantly of all staff did this whilst improving the quality and performance of many of our services as outlined earlier.

Finally, a personal goal for me and my newly appointed Executive Management Team throughout 2018/19 was to create the strategic direction and culture in which our staff can excel in delivering our vision of Best Care for Everyone. I am greatly encouraged by the huge strides that we have made over the last year and I look forward to working with you in the year ahead as we continue to ensure we provide the kind of care and service to our patients that we would expect for our family and loved ones.
Annual Report and Accounts 2018/19

This Annual Report is an opportunity to discover more about our journey, the challenges that we've faced and priorities for the year ahead. You may want to read it in tandem with our sister publication, the Quality Account 2018/19. If you want to learn more about the latest developments at the Trust do follow us on Facebook (https://www.facebook.com/gloshospitals/) and Twitter (@gloshospitals) or our website (www.gloshospitals.nhs.uk). Did you know there are more than 350 different careers in the NHS? If you want to join us on our Journey to Outstanding check out @GHNHSFTCareers and LinkedIn https://www.linkedin.com/company/gloucestershire-hospitals-nhsfoundation-Trust

With best wishes

Deborah Lee
Chief Executive Officer

24 June 2019

3. PERFORMANCE REPORT

3.1 OVERVIEW

The purpose of this section of the report is to give the reader a short summary that provides them with sufficient information to understand the Trust, its purpose, the key risks to the achievement of its objectives and how it has performed during the year.

3.2 BACKGROUND TO THE TRUST

Gloucestershire Hospitals NHS Foundation Trust received authorisation on 1 July 2004. It was formed from Gloucestershire Hospitals NHS Trust, which was established following a reconfiguration of health services in Gloucestershire in 2002. The Trust provides acute hospital services from two large district general hospitals, Cheltenham General Hospital and Gloucestershire Royal Hospital. Maternity Services are also provided at Stroud Maternity Hospital. Trust staff also provide outpatient clinics and some surgery from community hospitals throughout Gloucestershire.

The Trust remains the major provider of secondary care services in the area. Analysis shows that for Gloucestershire we are the leading acute healthcare provider by a significant margin.

3.3 STRUCTURE OF THE TRUST

Council of Governors

The Council of Governors has an important role to play in the governance of a Foundation Trust. When Parliament created NHS Foundation Trusts, it provided them with independence from central government and a governance structure that ensured participation from within the local communities they serve. NHS Foundation Trust governors are the direct representatives of local interests within Foundation Trusts. Governors do not undertake operational management of Trusts; rather they challenge Non-Executive Directors individually and collectively to hold them to account for the Trust's performance. It is also the governors' responsibility to represent the interests of the public and members in their constituencies, particularly in relation to the strategic direction of the Trust.

The Council has made a positive impact on the way that the Trust interacts with its local community. Governors participate in the development of strategy and have taken a particular interest in such issues as the development of the Trust's strategy, quality and equality and diversity priorities. The Board has agreed that one Governor be an observer on Board Committees to add a governor perspective to their business. Additionally, the Governors' Governance and Nominations Committee is responsible, *inter alia*, for advising the Council on the appointment of Non-Executive Directors and appraisal of the Chair.

Board of Directors

The strategic direction of the Trust is set, and its business governed, by the Board of Directors, who (subject to the Constitution) exercise all the powers of the Trust. The Board of Directors may delegate any of its powers to a committee of Directors or to an Executive Director. Exceptionally the Board has reserved issues set out in Standing Financial Instructions and Standing Orders for Board level decision.

The Directors have collective responsibility for:

- Setting the strategic direction for the Trust
- Providing leadership and governance within a framework of effective controls

- Providing accountability to governors and being responsible to members and stakeholders
- Understanding and managing the operational, business and financial risks to which the Trust is exposed
- Monitoring the work undertaken and the effectiveness of the formal Board Committees
- Reviewing the performance of the senior management team.

Management Structure

The Trust's management structure is based around Divisions. These are designed to support and facilitate delegation of decision making to clinical teams and to enable more involvement by clinical leaders in strategic issues. This was further developed in 2010 by the appointment of Divisional Chiefs of Service thus strengthening the leadership and accountability within each Division. The composition of each Division is summarised overleaf:

DIVISIONAL COMPOSITION – SERVICE LINES

WOMEN & CHILDREN	***SURGERY***	***MEDICINE***	***DIAGNOSTIC & SPECIALIST***	***CORPORATE SERVICES***		***GLOUCESTERSHIRE MANAGED SERVICES***
Acute Paediatrics	Anaesthetics	Acute Medicine	Clinical Haematology	Business Development Marketing & Communications		Catering and Domestic Services
Clinical Genetics	Breast	Cardiology	Dietetics	Business Intelligence		Energy Management
Community Paediatrics	Chronic & Acute Pain Services	Dermatology	Health Psychology	Clinical Audit		Glos Hospitals Parking (GHP) Contract
Gynaecology	Colorectal	Diabetes	Health Records	Contracting		Property Services & Medical Engineering
Midwifery	Critical Care	Emergency Department	Infection Control	Corporate Governance (Trust Secretary)		Support Services
Obstetrics	Ear/Nose & Throat (ENT)	Endoscopy	Medical Photography	Finance including Payroll		Sustainability
Special Care Baby Unit (SCBU) / Neonatal Intensive Care Unit (NICU)	Ophthalmology	Gastroenterology	Medical Physics	Human Resources		
	Oral & Maxillo Facial	General Old Age Medicine	Oncology	IT Services		
	Theatre & Day Surgery	Neurology	Outpatients and Booking Services	Legal Services		
	Trauma & Orthopaedics	Rehabilitation	Palliative Care	Nursing Management		
	Upper Gastrointestinal (GI)	Renal Services	Pathology	Patient Experience (incl Complaints & PALS)		
	Urology	Respiratory	Pharmacy	Procurement		
	Vascular	Rheumatology	Physiotherapy Services	Programme Management		**Estates and Facilities Division became*
			Private Patients/Overseas Patients	Research and Development		*Gloucestershire Managed Services (GMS) on 1st April 2018*
			Radiology	Safety (incl Emergency Planning)		*– a wholly owned subsidiary company*
				Strategy and Planning		

3.4 VISION, MISSION AND STRATEGIC OBJECTIVES

2018/19 was the final year of our current 5-year Strategic Plan:

Our Vision:

Best Care for Everyone

Our Mission:

“Improving health by putting patients at the centre of excellent specialist health care”

Our Goals:

Our goals are described in 4 core areas:

Our Patients: to improve year on year the experience of our patients

Our Staff: to develop further a highly skilled and motivated and engaged workforce which continually strives to improve patient care and Trust performance

Our Services: to improve year on year the safety of our organisation for patients, visitors and staff and the outcomes for our patients

Our Organisation: to ensure our organisation is stable and viable with the resources to deliver its vision

Our Values:

Our Values underpin everything we do and describe, in single words, the way we expect our staff to behave towards our patients and their families and carers, and colleagues. After listening to patients and staff the Trust has identified six core values, described here in the words of patients. These are:

Listening Patients said: "Please acknowledge me, even if you can't help me right now. Show me that you know that I'm here."

Helping Patients said: "Please ask me if everything is alright and if it isn't, be willing to help me."

Excelling Patients said: "Don't just do what you have to, take the next step and go the extra mile”.

Improving Patients said: "I expect you to know what you're doing and be good at it."

Uniting Patients said: "Be proud of each other and the care you all provide."

Caring Patients said: "Show me that you care about me as an individual. Talk to me, not about me. Look at me when you talk to me."

Our Strategic Objectives set out our approach to meet our vision by identifying the following strategic initiatives aligned to our goals

Our Goals and Strategic Objectives	Progress 2018/19
Our Patients will… ➢ **Be safe in our care** ➢ **Be treated with care and compassion** ➢ **Be treated promptly with no delays** ➢ **Want to recommend us to others** **By April 2019 we will…** ➢ **Be rated good overall by the CQC** ➢ **Be rated outstanding in the domain of Caring by the CQC** ➢ **Meet all national access standards** ➢ **Have a hospital standardised mortality ratio of below 100** ➢ **Have more than 35% of our patients sending us a family friendly test response, and of these 93% would recommend us to their family and friends** ➢ **Have improved the experience in our outpatients departments, reducing complaints to less than 30 per month**	➢ CQC overall rating 'Good' announced February 2019 ➢ CQC 'Caring' domain all rated as 'Good' with 'Outstanding' Critical Care ➢ A&E 4-hour wait standard – sustained position in Segment 2. Performance trajectory sustained Q1-3, Q4 data not available until after submission of plan ➢ RTT reporting recovery plan delivered January 2019 ➢ Hospital standardised mortality ratio below 100 achieved 2018 and maintained ➢ Diagnostics 6 week standard met – to be sustained to continue meeting national standards ➢ Focused work continues to identify themes and trends in outpatient complaints, for action in the Outpatients programme plan and operational management
Our Staff will… ➢ **Put patients first** ➢ **Feel valued and involved** ➢ **Want to improve** ➢ **Recommend us as a place to work** ➢ **Feel confident and secure in raising concerns** **By April 2019 we will…** ➢ **Have an Engagement Score in the Staff Survey of at least 3.9** ➢ **Have a staff turnover rate of less than 11%** ➢ **Have a minimum of 65% of our staff recommending us as a place to work through the staff survey** ➢ **Have trained a further 900 bronze, 70 silver and 45 gold quality improvement coaches** ➢ **Be recognised as taking positive action on health and wellbeing, by 95% of our staff responding *Definitely* or *To some extent* in the staff survey**	➢ New talent management system launched ➢ Nurse Associate, advanced clinical practice and apprentice roles implemented/further rolled out ➢ Finance and HR establishment records being reconciled ➢ GSQIA programme – further regular cohorts of Bronze training and Silver programmes, exceeding stated objective. 2 new Gold Coaching cohorts launched ➢ 'One stop shop' for staff health and wellbeing scoped and in development

Our Goals and Strategic Objectives	Progress 2018/19
Our Services will… ➢ **Make best use of our two sites** ➢ **Be organised to deliver centres of excellence for our population** ➢ **Promote health alongside treating illness** ➢ **Use technology to improve** **By April 2019 we will…** ➢ **Have implemented a model for urgent care that ensures people are treated in centres with the very best expertise and facilities to maximise their chances of survival and recovery** ➢ **Have systems in place to allow clinicians to request and review tests and prescribe electronically** ➢ **Rolled our *Getting It Right First Time (GIRFT)* standards across target specialties and be fully compliant in at least two clinical services** ➢ **Have staff in all clinical areas trained to support patients make healthy choices**	➢ New Clinical Model Outline Strategic Case developed ➢ New cancer centre of excellence health planning completed ➢ Allocated £39.5m strategic site development funding; planning in progress ➢ TrakCare governance further strengthened; CDIO appointed to Board, TrakCare Recovery progressing as planned; RTT reporting reinstated ➢ Reconfiguration of Gastroenterology services as part of winter planning ➢ Several hundred staff trained to support patients making healthy choices; training programme to continue, and initiative to link to wider system opportunities
Our Organisation will… ➢ **Use our resources efficiently** ➢ **Use our resources effectively** ➢ **Be one of the best performing trusts** ➢ **Be considered to be a good partner in the health and wider community** **By April 2019 we will…** ➢ **Show an improved financial position** ➢ **Be among the top 25% of trusts for efficiency** ➢ **Have worked with partners in the Sustainability and Transformation Partnership to create integrated teams for respiratory, musculoskeletal conditions and leg ulcers** ➢ **Be no longer subject to regulatory action** ➢ **Be in segment 2 (targeted support) of the NHSI Single Oversight Framework**	➢ Exited Financial Special Measures regulatory action in late 2018 ➢ Cost Improvement Programme (CIP) schemes being delivered; monitored through regular Division 'deep dives' with executives and PMO to increase and sustain pace ➢ Delivery of financial recovery against trajectory not favourable despite significant CIP ➢ Range of investment projects approved through new process to drive further quality and financial improvements ➢ Integration of respiratory teams commenced September 2018 and will continue through 2019/20. New MSK model progressing

Throughout the current strategic period, the Trust Board received a quarterly Board Assurance Framework report commenting on progress made in the delivery of the strategic objectives and providing assurance on how effectively the principal risks to the objectives were controlled.

As the Trust has now come to the end of the current strategic period, analysis of the progress of each Strategic Objective has been completed. This describes whether each strategic objective has been achieved, providing narrative to support this. This demonstrates that:

- 10 Strategic Objectives have been achieved
- 5 Strategic Objectives have been partially achieved
- 6 Strategic Objectives have not been achieved however signification progress has been made for a number of these

The table below provides commentary on the year end position and highlights those which will be rolled over to the new strategic plan and those that have either become business as usual or will continue to be monitored as part of other objectives.

While risks to some of the objectives have been controlled effectively, other risks have materialised. Consequently, some strategic objectives were not achieved or achieved only in part. The detailed scrutiny and challenge have been undertaken in the board Committees and the learning has been taken into account while developing the new strategy.

BAF code	Status	Objective to be achieved by 31 March 2019	Comments	Incorporation in new Strategic Plan
1.1	Achieved	Be rated good overall by the CQC	On 8th February 2019, the CQC published a report that rated the Trust as "Good" overall. CQC inspected 4 out of the 8 core services (Urgent and Emergency Care, Medicine, Surgery and Outpatients) in October/November 2018.	The Trust will now aim to be rated as "Outstanding" overall.
1.2	Not achieved	Be rated outstanding in the domain of 'Caring' by the CQC	On 8th February 2019, the CQC published a report that rated the Trust as "Good" in the caring domain overall. Only the 4 services that were "requires improvement" were inspected. Intensive Care Services have maintained their "Outstanding" rating from the 2015 inspection. At the self-assessment stage of the CQC inspection the Trust rated Maternity, Children and Young People, End of Life Care as well as Intensive Care Services as "Outstanding" in this domain which would have given an overall rating of "Outstanding" if they had been inspected.	This SO will continue as part of the Trust objective to be rated "Outstanding" overall.
1.3	Partially achieved	Meet all national access standards	See the Trust Board Quality and Performance report for comprehensive update on performance. Performance against the 4 hour standard for GHFT was 85.9%, with STP position in Q4 FY18/19 of 90.1% – strongest performance continuing in many years and ahead of NHSE (NHS England) trajectory. Trajectory has been set for the year at 90% for the 4 hour standard. Referral to Treatment (RTT) reporting has been suspended for 18 months and returned to reporting in Q1 April 2019 at 79.7% in line with the Trak Recovery Plan. Significant validation work continues and variation of circa 2% to be expected until a more stabilised position at the end of Q1. Cancer Delivery plan presented and endorsed by Q&P Committee with 2WW standard met for Q4 18/19 (93.6%) and hit 90% as a whole (best performance since 2015/16). Q4 62 day performance was 76.7% (unvalidated), prompting a revised 62 day recovery plan to deliver September 2019. Considerable progress to date is noted in the Q&P exception report in Lower GI and Lung with significant clearance of the Urology backlog. Cancer continues to be monitored closely for delivery. Specific actions by tumour site e.g. prostate are detailed in the Cancer Delivery Plan.	Work will continue in the new Strategic Plan.

BAF code	Status	Objective to be achieved by 31 March 2019	Comments	Incorporation in new Strategic Plan
1.4	Achieved	Have a hospital standardised mortality ratio of below 100	Dr Foster data shows a HSMR for the 12 month period is 99.1 (94.5 – 103.8), this is within the expected range. A mortality dashboard is now in use for the learning from deaths report to the Board. There has been enhanced input of the Bereavement Team into the death review process and recognition of Medical Examiner in national guidance. Continued consistent delivery	Work is now 'business as usual'.
1.5	Partially achieved	Have more than 35% of our patients sending us a family friendly test (FFT) response, and of those 93% would recommend us to their family and friends	The objective of 35% of patients responding to the FFT was not met in any area and the target set for the Trust is 10% above the national average. The Trust has no control over whether a patient chooses to respond or not. However, the Trust performs positively against the national average for response rate in all four FFT domains (Outpatients, Maternity, Inpatients and Emergency Department). The FFT score of 93% of recommending us (positive score) to their friends and family was met in Outpatients and Maternity. The Emergency Department and Inpatient scores were below the 93% set within the objective.	The FFT requirements are changing; they will not be known until May 2019 and will have to be implemented by October 2019. The positive scores will continue to be monitored as part of the objective to be rated "Outstanding" but will not be a stand-alone objective.
1.6	Achieved	Have improved the experience in our outpatient departments, reducing complaints to less than 30 per month	The Trust has set an internal target of 35 working days for response times and so only Q3 data is complete. The Trust received 65 outpatient related complaints in October, November and December Q3 data. This objective has been achieved as there was an average of 22 complaints per month that have an issue assigned as 'Service Area – Outpatients'.	Complaints will continue to be monitored as part of the objective to be rated "Outstanding" but will not be a stand-alone objective. Outpatient experience improvement is one of our Quality Account improvement areas for 2019/20.

BAF code	Status	Objective to be achieved by 31 March 2019	Comments	Incorporation in new Strategic Plan
2.1	Not achieved – however significant progress made	Have an Engagement Score in the Staff Survey of at least 3.9	Staff survey scores are now calculated differently compared to previous years therefore a direct comparison with previous year's engagement score (3.71, and the strategic objective of 3.9) is not possible. 2018 score for staff engagement is 6.8 (out of 10) compared to 2017 score of 6.7. The average for acute trusts is 7.0. Significant progress has been made with staff engagement resulting in a noticeable cultural shift, as reflected in our recent CQC rating. Multiple staff engagement forums and networks now exist and staff and patient experience data is considered collectively through our patient and staff experience group leading to active work streams delivering continuous improvement	The Trust has a caring workforce which meets the needs of its patients, colleagues and partners; is future proofed and focuses on attraction, development and retention of talent. Colleagues will recognise the Trust as an outstanding employer, driven by its values and ambition to deliver best care for everyone. Colleagues will be equipped and inspired to do things differently to deliver best care for everyone.
2.2	Not achieved – however significant progress made	Have a 'Staff Turnover Rate' of Less Than 11%	The staff turnover rate was recorded as 11.83% (10.95% via NHSI view) in March 2019. This compares favourably to a number of other large acute Trusts, including those with an outstanding rating.	The Trust has a caring workforce which meets the needs of its patients, colleagues and partners; is future proofed and focuses on attraction, development and retention of talent.
2.3	Not achieved – however significant progress made	Have a Minimum of 65% of 'Our Staff Recommending Us as a Place to Work' through the Staff Survey	Our score has increased to 55.9%. Through our Staff and Patient Experience Improvement Group (SPEIG) we continue to develop our capacity and ability to triangulate data, supporting interventions and action plans in priority areas.	Colleagues will recognise the Trust as an outstanding employer, driven by its values and ambition to deliver best care for everyone. Colleagues will be equipped and inspired to do things differently to deliver best care for everyone.

BAF code	Status	Objective to be achieved by 31 March 2019	Comments	Incorporation in new Strategic Plan
2.4	Partially achieved	Have trained a further 900 bronze, 70 silver and 45 gold quality improvement coaches	The GSQIA has delivered the expected Bronze and Silver programmes but has not achieved the delivery of the Gold programme. The Bronze and Silver programmes have delivered double the expected targets, reaching 2006 and 143 staff completing courses respectively. This increase is due to staff demand, the programmes continue to be booked in advance and extra programmes have been added. In addition GSQIA have been supporting several Quality Collaborative including Better Births in maternity, the request for this support is increasing with two further requests currently being considered. The Gold programme was delayed as a consequence of the delay in agreeing the new Quality Framework, the Framework requires a Gold coach in each specialty to manage the local Improvement programme. With the Quality Framework agreed we have recruited a further 18 Gold coaches to the programme and will be running further programmes later in the year as part of the roll out.	Further work to improve the Trust learning capabilities has begun with the development of the GSQIA Human factors faculty, 16 staff will receive intensive training and then deployed to provide detailed analysis of serious incidents, design and testing of new systems and team crew resource training, this approach will be supported by GSQIA.
2.5	Not achieved – however significant progress made	Be recognised as taking positive action on health and wellbeing, by 95% of our staff (responding definitely or to some extent in staff survey)	Our score has decreased to 22.3%. This reflects a continuing drop in this score for this question over the last 4 years. Whilst Trust employees have been able to access a number of sources of support, we identified considerable gaps relating to ease of access and co-ordination of the various pathways. In response to this a new Health and Wellbeing Hub, launches in May 2019. This new service will co-ordinate pathways of support for staff relating to their Financial, Physical and Mental wellbeing.	The Trust has a caring workforce which meets the needs of its patients, colleagues and partners; is future proofed and focuses on attraction, development and retention of talent. Colleagues will be equipped and inspired to do things differently to deliver best care for everyone.
3.1	Partially achieved	Have implemented a model for urgent care that ensures people are treated in centres with the very best expertise and facilities to maximise their chances of survival and recovery	New assessment units have been implemented at GRH. From June 2019 Ambulatory Care will be co-located with our Emergency Department at CGH to reduce unnecessary admissions.	New strategic objective drafted that relate to this area: 'We have established centres of excellence for urgent and emergency care, obstetrics and paediatrics, planned care and oncology.'

BAF code	Status	Objective to be achieved by 31 March 2019	Comments	Incorporation in new Strategic Plan
3.2	Achieved	To complete TrakCare recovery work to enable the Trust to resume national RTT reporting by February 2019 (amended)	The Objective was achieved, although one month later than indicated due to Trust decision to undertake an additional testing cycle.	The Objective will not continue in the new plan as delivered and no longer relevant
3.3	Achieved	Rolled out Getting it Right First Time Standards across the target specialities and be fully compliant in at least two clinical services	The Trust is dedicated to implementing and embedding the 'Getting it Right First Time' standards within the Trust and has now recruited a Clinical Lead and a Service Improvement Lead to undertake this work. There are now regular meetings with the clinical and service improvement leads to review progress and facilitate progress and an annual review will take place with the executive team. Reconfiguration of Trauma & Orthopaedics service to support compliance was implemented from October 2017 as a pilot for winter pressures. Gastroenterology services were reconfigured as part of winter planning. GIRFT is also championing the veterans aware process; this is to ensure that ex forces personnel are able to access expert care within the NHS and are not disadvantaged by moves to different areas.	GIRFT programme will continue into 2019/20 as more specialties are included and best practice is shared nationally.

BAF code	Status	Objective to be achieved by 31 March 2019	Comments	Incorporation in new Strategic Plan
3.4	Achieved	Have staff in all clinical areas trained to support patients to make healthy choices	Making Every Contact Count (MECC) is a national approach which encourages NHS staff and others to have a brief discussion with patients about lifestyle factors as a natural part of their conversation and to refer or signpost patients to support - for example, from the Gloucestershire Healthy Lifestyle Service (HLS). During the second part of 2018/19, HLS ran a further programme of face to face MECC training sessions for staff. In total, over the two year period of the strategy, in excess of 220 staff across all areas of the Trust received this training. More in depth or targeted training has also been provided for a number of groups. For example, Gloucestershire Public Health team and the HLS team have been working especially closely with the Women and Children's Division, to develop a more focussed healthy lifestyle approach for pregnant women – to reduce the number of women who smoke in pregnancy and to promote maintaining a healthy weight in pregnancy and beyond. The Trust's Learning and Development Team has also provided access to a range of e-learning modules through the learning platform – MECC, smoking cessation, obesity, alcohol awareness. There has been good uptake from staff from all areas of the Trust.	Prevention is a key theme in the NHS Long Term Plan, and it is recognised that acute hospitals can also make a contribution in this area. Further MECC training will be provided in the year ahead and health and wellbeing and prevention will continue to be reflected in the future activities of the Trust, as the detailed work programmes are developed to underpin the new, emerging Trust Strategy. Incorporated into draft People & OD strategic objective: 'Colleagues will recognise the Trust as an outstanding employer, driven by its values and ambition to deliver best care for everyone.' Operational objectives and metrics will support this, including the implementation of a new Health & Wellbeing hub for staff.

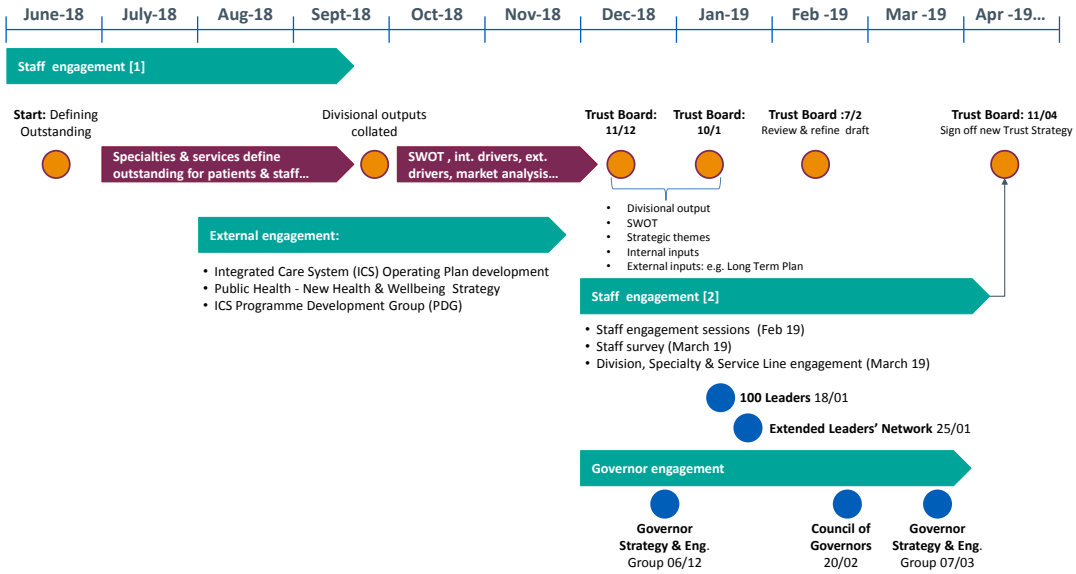
BAF code	Status	Objective to be achieved by 31 March 2019	Comments	Incorporation in new Strategic Plan
4.1	Achieved	Show an improved financial position	The Trust delivered a control total deficit of £33.0m in the 2017/18 financial year. The financial position for 2018/19 (subject to final audit) is a control total deficit of £29.6m, showing an improvement of £3.4m between years. It should be highlighted that the 2018/19 financial performance was materially adverse to the planned deficit of £18.8m due to cost pressures from the national pay award, under-delivery of CIP and the associated loss of PSF in Q4. The CIP position was £27.0m vs a plan of £30.3m so although performance is adverse to plan it represents a second year of delivery of c.6% and performance well in excess of sector average.	
4.2	Achieved	Be among the top 25% of trusts for efficiency	The RAG rating For Q3 has been left blank due to the lack of an agreed method for measuring efficiency however the Trust benchmarks favourably for efficiency on Model Hospitals, hence objective has been rated as achieved. By the end of the 18/19 financial year the Trust had delivered £26.95m (89%) of CIP against the annual NHS Improvement target of £30.3 million. The delivery splits into £21.0 million recurrent and £6.0 million of non-recurrent schemes. Weekly deep dives with divisions, COO (Chief Operating Officer), Chief Nurse, Medical Director and Director of Programme Management were established to increase pace to year end. Detailed project plans and associated quantified benefits for implementation in 2018/19 are developed, stretching to Q1 2019/20.	Work will continue in the new Strategic Plan.

BAF code	Status	Objective to be achieved by 31 March 2019	Comments	Incorporation in new Strategic Plan
4.3	Achieved for Respiratory & MSK Partially achieved for Diabetes Not achieved for leg ulcers	Have worked with partners in the Sustainability and Transformation Partnership to create integrated teams for respiratory, musculoskeletal conditions and leg ulcers.	Respiratory • Staff consultation (GCS) & engagement (GHFT) on 7-day working and service specification completed in September 2018 • Phased implementation of the integrated team started on 27th September • GHFT respiratory consultants have begun pilot for respiratory advice and guidance service within the Gloucester locality • Respiratory defined as a priority ICS programme for 2019/20 Diabetes • Model for integrated leg ulcer service agreed. • Awaiting funding for implementation of community clinics from CCG. Musculo Skeletal (MSK) conditions • The significant progress made to reduce the fractured neck of femur mortality rate by 37% (20 lives saved this year) with GHFT being been shortlisted for a HSJ award • MSK Foot and ankle triage now live • Full Business Case for MSK specialised triage being approved by the CCG Priorities committee. • eRS and booking processes have been configured, with joint training being organised. The referral form has been tested within Primary Care, in conjunction with Cancer 2WW form..	New strategic objective drafted that relate to this area: 'We work within a successful Integrated Care System to design and implement integrated models of care.'
4.4	Achieved	Be no longer subject to regulatory action	The Trust was released from Financial Special Measures in Q3 2018/19 and a number of the associated Enforcement Undertakings. The small number of residual Undertakings, expired on 31st March 2019.	The Objective will not continue in the new plan as delivered and no longer relevant.
4.5	Not achieved	Be in segment 2 (targeted support) of the NHSI Single Oversight Framework	The Trust moved from Segment 4 to Segment 3 but did not achieve Segment 2. This is reflective of the Trust's ongoing financial deficit and failure to deliver the 2018/19 Control Total.	This issue (but not specific objective) will be a feature of the 2019/20 strategic objectives.

BAF code	Status	Objective to be achieved by 31 March 2019	Comments	Incorporation in new Strategic Plan
4.6	Achieved	The Trust will have a high quality research portfolio, which is visible to staff and patients, embedded alongside routine care, and achieves the annual High Level Objectives (HLO) defined by the National Institute Health Research (NIHR).	GHFT recruited 1678 patients in 2018/19 against an initial CRN target of 1000 and a stretch target of 2300. The research portfolio is of high quality with over 100 NIHR studies currently open to recruitment across an increasing range of specialities. Key strength areas are anaesthesia, oncology, cardiovascular, hepatology, MSK, ophthalmology, renal, stroke and surgery. The Trust now hosts a CRN West of England wide senior vaccines research nurse who successfully oversaw the delivery of a logistically complex vaccines study in the region, demonstrating the start of what is hoped will be a big growth area for the Trust. The Trust objective for research and work towards identifying the potential benefits of becoming a University Hospital Trust has increased its profile. Development of the new research strategy has identified further ways to increase that profile. In terms of the NIHR High Level Objectives the trust achieved 50% and 80% against targets of 60% for commercial and non-commercial Recruitment to Time and Target (RTT). The 50% in commercial studies reflects the far lower number of studies which have closed (6) leading to a higher impact on overall measure. One of those studies not achieving RTT recruited one out of a target of two patients where there was particularly complex inclusion criteria. The Trust was congratulated for recruiting at all as many UK sites did not manage to. The Trust exceeded the national target for set up within 40 days with 89% and recruitment of first patient within 30 days of opening did not meet target, work to investigate the reasons for this (outside of low target studies) will be carried out to put in place an improvement plan.	Work in the area will continue in the new Strategic Plan / under the new Strategic Objectives the basis of which is the new research strategy. Particular growth areas are expected to be in reproductive health and childbirth, vaccines and palliative care. There is a planned move towards opening an increasing number of larger observational studies to enable a wider number of our patients to have the opportunity to take part in research. Coupled with a communications strategy to raise the profile (both internally and externally) and increase the number of GCP (Good Clinical Practice) trained staff to further embed the portfolio alongside routine care.

2019/20 will see the launch of our new five-year Trust Strategy. The strategy has been co-designed with staff and partners using a range of internal and external drivers including strength, weakness, opportunity and threat (SWOT) analysis, risk registers, benchmarking data, market analysis, Gloucestershire Integrated Care System (ICS) objectives and national direction such as the NHS Long Term Plan.

Fig 1. Approach taken to develop our new Trust strategy



Our strategic intent is to provide **outstanding care through two thriving but distinct hospital sites** and, as a lead provider within an Integrated Care System (ICS), through a range of community facilities and integrated models of care.
We want to be a Hospital Trust **patients, families and carers recommend and staff are proud to be part of**.

We will be **a collaborative ICS partner** to ensure patients, families, carers , staff and other stakeholders benefit from the value a high performing, high energy acute Trust can bring to this partnership.

We have **no plans to merge with other organisations** but we recognise that as the ICS develops, partners may need to adapt their organisational form to ensure opportunities to improve patient experience and outcomes, staff experience and value for money do not get delayed. For example by ensuring the timescale and flexibility of our decision making processes align.
We will continue to provide acute and specialist care for residents of Gloucestershire and adjacent regions; Herefordshire, South Worcestershire, Wiltshire, and where it is the right thing to do for patients, and this can be supported by a strong clinical and financial business case, **we will work with commissioners, providers and clinical networks in these regions to secure and extend our clinical service offer**.

We want the quality of care we provide to be rated ***Outstanding*** **by the Care Quality Commission (CQC)** and our use of resources to be rated ***Outstanding*** **by NHS Improvement**.

We believe becoming an accredited **University Hospital Trust** will increase our capacity and capability to deliver Best Care for Everyone and are committed to exploring the best way to achieve this.

Our new strategy will be delivered through a combination of eight enabling strategies, as shown below.

Fig 2. Trust strategy structure

The strategy includes a new purpose statement but retains our vision statement – staff told us it strikes the right balance of being aspirational, memorable and meaningful.

Our Purpose:

To improve the health, wellbeing and experience of the people we serve by delivering outstanding care every day.

Our Vision:

Best Care for Everyone.

Our Values:

Our Values underpin everything we do and describe the way we expect staff to behave towards patients, their families and carers, and colleagues. We have three values, described below in the words of patients:

Caring Patients said: "Show me that you care about me as an individual. Talk to me, not about me. Look at me when you talk to me."

Listening Patients said: "Please acknowledge me, even if you can't help me right now. Show me that you know that I'm here."

Excelling Patients said: "I expect you to know what you're doing and be good at it."

Our focus in 2019/20 is to refresh the behaviours we expect staff to demonstrate when delivering care and working with colleagues in line with these values.

Our Strategic Objectives:

The Board agreed the following Strategic Objectives for 2019-24 at its Board meeting on 9 May 2019:

#	Theme	Description	Lead Strategy
1	Outstanding Care	We are recognised for the excellence of the care and treatment we deliver to all of our patients and their families, evidenced by our CQC Outstanding rating and delivery of all of the NHS constitutional waiting time standards	**Quality**
2	Compassionate Workforce	We have a compassionate, skilful and sustainable workforce, organised around the patient, who describe us as an outstanding employer that attracts, develops and retains the very best people	**People & OD**
3	Quality improvement	Quality improvement is at the heart of what we do; our staff feel empowered and equipped to do the very best for their patients and each other	**Quality**
4	Care Without Boundaries	Health and social care across Gloucestershire is experienced 'without boundaries'. Patients, carers and staff design, receive and deliver integrated care across organisations, with the patient and their family and carers at the heart of all we do	**Clinical**
5	Patient Involvement	Patients and the public tell us that they feel involved in the planning, design and evaluation of services that are increasingly provided in ways that reflect the needs and wishes of our local communities	**Comms & Engagement**
6	Centres of Excellence	We will have established *Centres of Excellence,* on our two hospital sites, to enable our services to provide urgent, planned and specialist care to the standards of the best, and ensure as many Gloucestershire residents as possible receive care within the County	**Clinical**
7	Financial Balance	We are a Trust in financial balance, with a sustainable financial footing reflected through our NHSI *Outstanding* rating for *Use of Resources*	**Financial**
8	Fit For Purpose Estate	We will make best use of our estate to deliver our vision of *Best Care For Everyone,* and increasingly utilise the estate of our integrated care system partners to provide care that is accessible and joined up	**Estate**
9	Digital Future	We are using technology to drive safe, reliable and responsive care. Our electronic patient record is embedded and has released staff time to care and treat our patients; it 'talks' to our partners in the health and care system to ensure care for the patient is joined up	**Digital**
10	Driving Research	We are a research active Trust providing access for our patients to innovative and ground breaking treatments; through their endeavours, staff from all disciplines will be contributing to tomorrow's evidence base and be amongst the best University Hospitals in the UK	**Research**

3.5 PATIENT CARE AND STAKEHOLDER RELATIONS

The Policy Context

The settlement announced in June 2018 promised NHS England's revenue funding would grow by an average of 3.4% per year average over five years, delivering a real terms increase of £20.5 billion by 2023/24, moving closer to the NHS long-term average funding trend of 3.7% per year since 1948. The extra spending will need to deal with current pressures and unavoidable demographic change and other costs, as well as new priorities. The NHS Long Term plan, published in January 2019, sets out five key 'tests' against this funding increase:

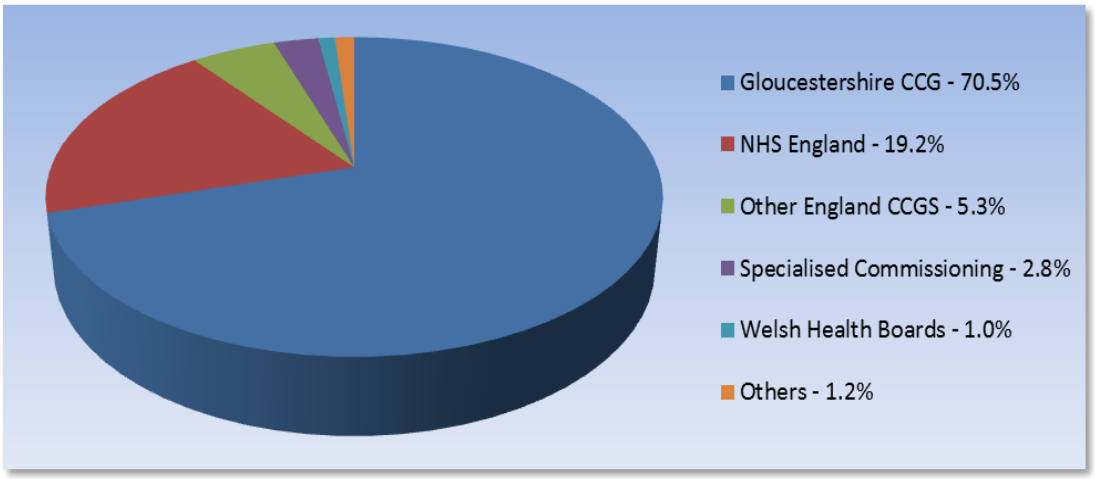
- The NHS (including providers) will return to financial balance;
- The NHS will achieve cash-releasing productivity growth of at least 1.1% a year, with all savings reinvested in frontline care;
- The NHS will reduce the growth in demand for care through better integration and prevention;
- The NHS will reduce variation across the health system, improving providers' financial and operational performance;
- The NHS will make better use of capital investment and its existing assets to drive transformation

Operating Context

We work within the Gloucestershire health and social care system alongside partner organisations including:

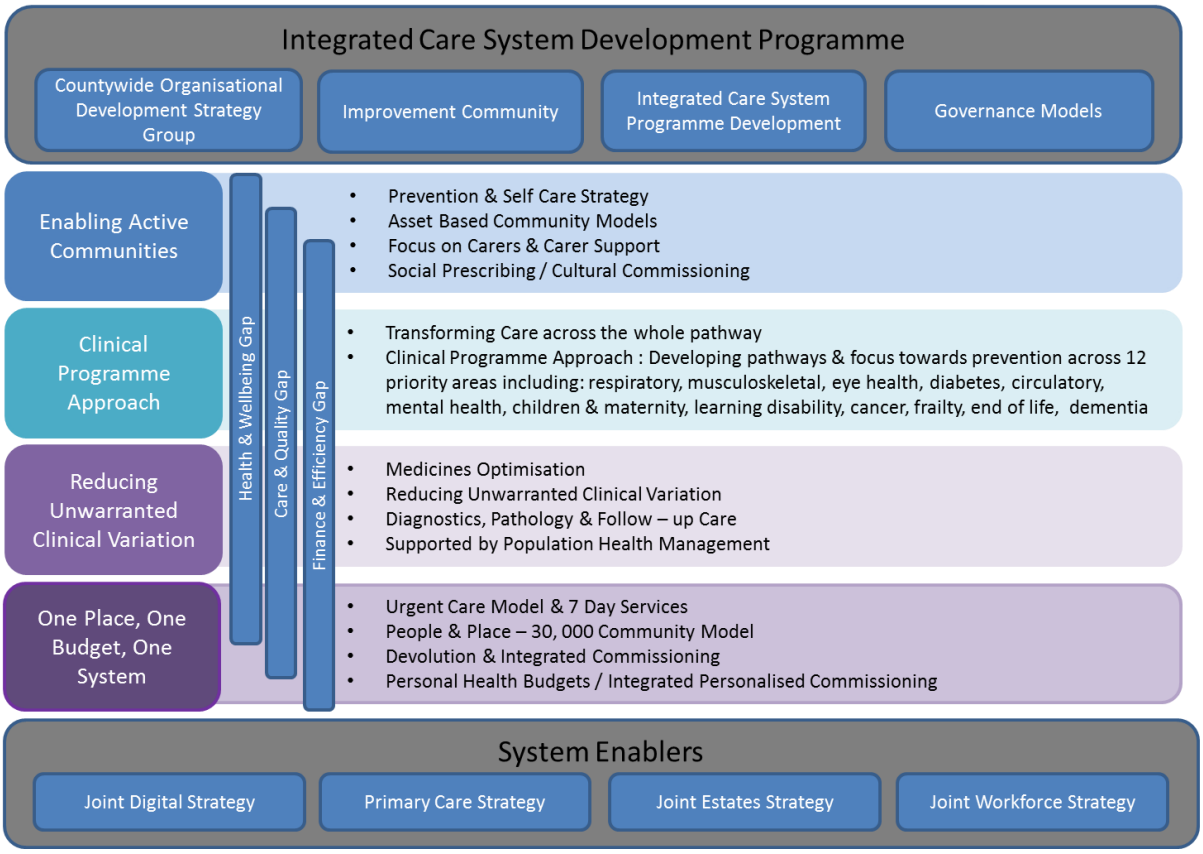
- Gloucestershire Clinical Commissioning Group (GCCG), our lead commissioner.
- Gloucestershire Care Services NHS Trust (community services) } *merging 2019-20*
- 2Gether NHS Foundation Trust (mental health services) } *merging 2019-20*
- South West Ambulance Trust (SWAST)
- 80 GP surgeries
- Gloucestershire County Council (Tier 1) and six Tier 2 Local authorities

Our lead commissioner is GCCG and we also provide services to a wide range of other customers:



The *One Gloucestershire* Integrated Care System (ICS)
Collectively these partner organisations form the *One Gloucestershire* ICS; our vision is to improve health and wellbeing, we believe that by all working better together, in a more joined up way, and using the strengths of individuals, carers and local communities, we will transform the quality of care and support we provide to local people.

The ICS's four priority transformational programmes and four enabling programmes remain our focus and we believe they will set a good foundation for our delivery against the first five years of the NHS Long-Term Plan:



The Gloucestershire Strategic Forum has reviewed ICS priorities for 2019/20, and emphasised:

- **Improving mental health:** including improving dementia care and a renewed focus on mental health and wellbeing, and support for regular users of health and care services.
- **Urgent & Emergency Care:** the One Place programme remains central to delivering our new model of care within Gloucestershire
- **Focus on proactive care in partnership with local communities:** including building capacity in primary, community and VCSE care, reducing demand for acute services and improving end of life care
- **Improve population health:** rapid delivery of place-based integrated working through Integrated Locality Partnerships and a focus on wellbeing, prevention and self-care. Increasingly we will influence the wider determinants of health including loneliness and isolation whilst also improving or use and application of population health management.
- Focus on **enabling conditions** including: a culture that fosters engagement and co-creation; existing enabling programmes of workforce, estates and digital; maturing the system approach to allocation of resources to ensure investments are used to create greatest improvement; effective governance that facilitates shared decision making

Our system operational plan gives full details on the governance structure and priorities at programme level. The most critical milestones for 2019/20 are detailed below.

Clinical Programme Approach: the clinical programmes have expanded to encompass 13 pathways and the transformation approach is being to bear fruit within the system. Some of the top level milestones in 2019/20 will be.

- **Pathway integration** across a number of pathways including musculoskeletal, diabetes and respiratory - implementation throughout 2019/20
- **Peri-natal mental health** services will continue to develop, including the introduction of a new specialist mental health team and expansion of the community support offer.
- **Children's and Young People Mental Health Trailblazer** - four Mental Health Support Teams (MHSTs) to develop models of early intervention on mild to moderate mental health issues; beginning May 2019 and will be fully embedded from November 2019. We have been selected to trial a four-week waiting time for referral to treatment for specialist children and young people's mental health services by Spring 2020.
- Increased focus on cross-cutting requirements of vulnerable groups, **including Learning Disabilities**, and how we increase support in these areas, the scoping of this work will take place in Quarter 1 of 2019/20.

Reducing Unwarranted Clinical Variation: whilst continuing to deliver on our successful medicines optimisation work the progress around diagnostic and outpatient optimisation will be accelerated supported by improved benchmarking and analytics.

Urgent & Emergency Care: The One Place and Centres of Excellence Programmes are working on our central priority of increasing out of hospital and same day emergency care. They will also ensuring our system can be organised to deliver better health outcomes and more efficient care pathways for our population, through a fully integrated urgent care system and the delivery of 'centres of excellence' for elective care. It is anticipated that

- Public engagement will take place between now and Summer 2019
- A citizen's jury approach will be used to facilitate the decision making process
- Public consultation anticipated in Autumn 2019 moving towards implementation in 2020/21.
- Continuing focus on delivery of Clinical Assessment Services and Urgent Treatment Centre test and learn sites for impact as early as possible and for winter 2019/20.
- Risk stratification and support of regular users of services will begin to deliver with a pilot in two localities in the first six months of the year followed by evaluation and potential roll-out.

Place based primary care & community partnerships: our system has 100% coverage of primary care networks. This year we will build on this to ensure that the Integrated Locality Partnership (ILP) model is in place for our whole population by summer 2019. Place based prioritisation supported by population health analytics will be a priority for the end of 2019/20. The ILPs will be supported by specialists in managing complex frail patients, and those with complex long term conditions creating a "channel shift" from hospital based to community based care. The merger of two of the main community-based partners, Gloucestershire Care Services NHS Trust and 2gether NHS Foundation Trust in autumn 2019 is a critical milestone for our system as we more closely align our objectives particularly around our integrated locality teams.

Enablers: good progress is being made by these programmes and they will have increased priority in 2019/20. Our digital programme went live with the joint care record in 2018/19 and this will be further expanded during 2019/20 with primary care and

acute trust information becoming available. Our first full population health management cycle will be complete by April 2019 and embedding this further into our business as usual will take place through the year to maximise opportunities for prevention, supported self-management and enhanced community activation.

Efficiency: Overall the ICS transformation schemes are aimed at ensuring sustainability for our system with an emphasis on sustainable, high quality models of care and shifting care out of hospitals wherever possible. We are committed to an open book approach to financial and activity planning and have moved to a model of full involvement from all partners in prioritising investments and agreeing areas of efficiency. As we move our partnership forwards we will increase the responsibility on the system to deliver against the first year of our 5 year plan towards achieving the NHS Long-Term plan. Gloucestershire Hospitals NHS Foundation Trust is committed to fully contributing to further development and delivery of system-wide transformational programmes to ensure that we can deliver on our commitments to our population and contribute towards improving health and well-being across our county.

The Trust's Market Position

The Trust continues to be the market leader for the provision of acute health services in Gloucestershire; the value of planned GCCG income is around £349 million and planned income for specialised services is in the region of £92.7 million.

The trend over the next year is that the Trust's level of market share is likely to continue, with only a marginal transfer of some activity and income to other providers.

The table below shows the total Trust contract values in 2018/19 and the proportion by commissioner. The shifts in commissioning responsibility should be taken into account when making year on year comparisons:

Commissioner	Contract 2018/19 £'000	% Income	Contract 2017/18 £'000	% Income	Contract 2016/17 £'000	% Income	Contract 2015/16 £'000	% Income	Contract 2014/15 £'000	% Income	Contract 2013/14 £'000	% Income
Gloucestershire	317,388	70.3	306,918	70.8	305,115	71.2	284,392	70.4	276,208	68.6	266,436	69.8
Worcestershire	9,550	2.1	9,929	2.3	10,902	2.5	10,828	2.7	11,378	2.8	11,747	3.1
Herefordshire	3,419	0.8	3,944	0.9	4,265	1.0	3,748	0.9	3,238	0.8	3,311	0.9
Wales	4,923	1.1	3,987	0.9	4,046	0.9	3,435	0.9	3,035	0.8	3,188	0.8
Other CCGs including non-contracted activity	26,977	6.0	24,326	5.6	24,426	5.7	27,917	6.9	34,424	8.5	19,854	5.2
Specialised Services	87,836	19.5	83,024	19.2	78,867	18.4	72,713	18.0	73,446	18.2	76,612	20.1
Private Patients	1,213	0.3	1,254	0.3	1,039	0.2	1,018	0.3	957	0.2	721	0.2
TOTAL	451,305	100.0	433,382	100.0	428,660	100.0	404,051	100.0	402,687	100.0	381,869	100.0

Note: Figures for 2018/19 are from month 12 all others are from month 13 so some adjustments which will be relatively minor could be expected.

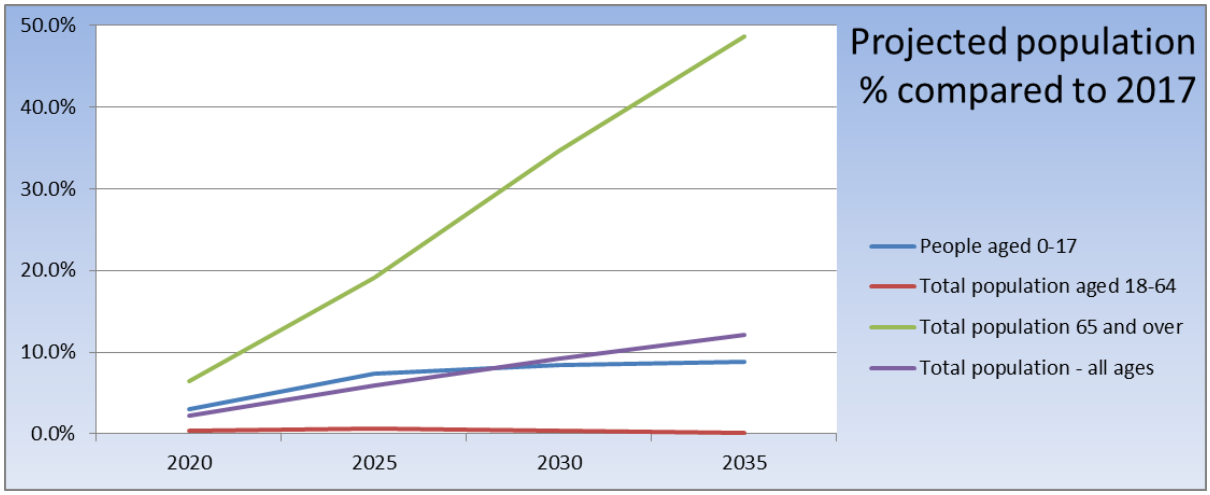
Trust income by commissioner

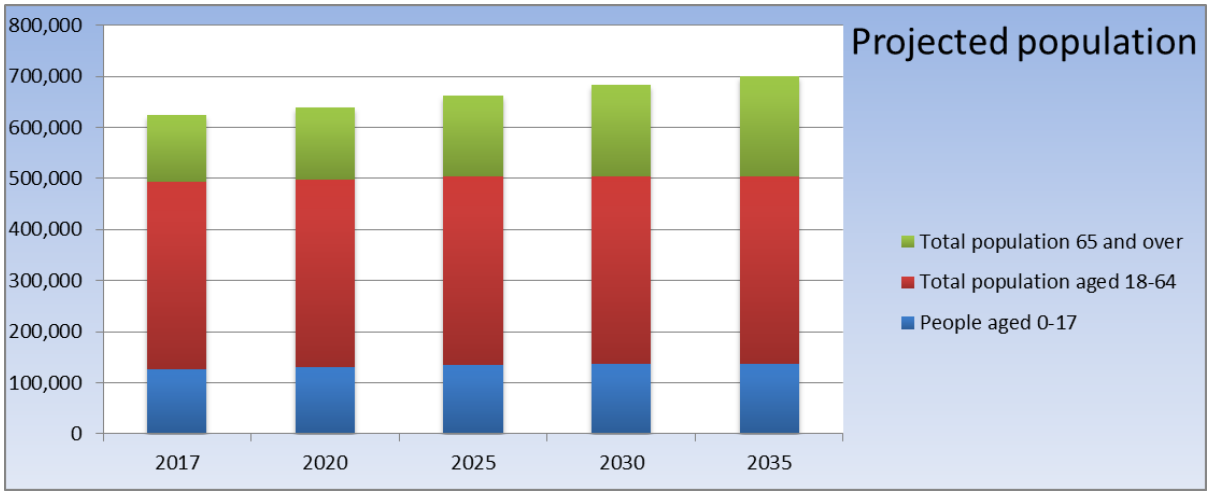
Our market share within the health economy is therefore stable. As the only major provider of NHS acute care in Gloucestershire we have little competition for our non-elective services. Whilst the independent and third sector provision in Gloucestershire is growing it remains a small proportion of commissioning spend. Strategic initiatives in neighbouring Trusts have not had significant impact on the flow of patients. Our main challenge is the increasing demand for acute healthcare and how it is managed through increased efficiency and new approaches. Further to this, we remain focused on repatriating as much activity carried out by alternative providers as we develop capacity through our efficiency and improvement work.

Main trends and factors underlying current position and likely to affect future development and performance

Demographic Changes

Some local planning needs are related to specific age groups and therefore it is important to understand the possible changes to the age structure of an area when planning for the future. The Trust serves a local population of approximately 630,000, of which around 29% live in rural areas. By 2035 this population is projected to grow to just over 700,000, largely in the over-65 demographic.





The risk of all major causes of early death and serious illness increases with age. This means that the number of people living longer with a long-term illness will rise much more quickly than the growth in the population. Care for people with multiple long term conditions is often very complex. In recent years we have continued to see an increase in the number of frail elderly people admitted, who need to stay with us for longer periods of time.

However, there is a wide range of factors that should in the same period rationalise the demand for hospital beds. New technologies and innovations constantly offer opportunities for less invasive or more local interventions. The ICS strategy for healthcare in Gloucestershire reflects the NHS Long Term Plan commitment to reduce the reliance on hospital-based care by changing pathways in partnership with community providers and commissioners, and providing alternatives to admission that enable people to access care as close to home as is safe and feasible.

In our hospitals we continue to implement the Getting It Right First Time (GIRFT) programme, and have been cited in the NHS Long Term Plan for the positive impact this has had for our Trauma and Orthopaedic surgery patients. Significant work has also been carried out on the urgent care pathway, with the Trust implementing new ways of assessing and treating emergency patients, seeing our performance against the 4 hour wait standard sustainably improve through 2018-19. Our hospital standardised mortality ratio dropped and was maintained below 100, and we met and sustained the 6 week wait standard for Diagnostics.

Evidence from 2018/19 is that the healthcare community in Gloucestershire is struggling to balance demand against capacity; whilst this has been reflected in some deterioration of access targets, recent initiatives are starting to address this, and this is reflected in our Operational Plan trajectories for 2019/20

Development of our Services

The Trust has an excellent record of service development to meet changing demands and the requirements of commissioners. The Trust reviews proposals and development schemes for their potential to contribute to the delivery of our strategic objectives. Examples of developments progressing over the past year can be seen in the following table:

Service	Contribution to Our Strategic Objectives
New clinical model – 'Centres of Excellence'	This ICS-wide development seeks to ensure all urgent care and elective care health services in the county can be organised to deliver better health outcomes and more efficient care pathways for our population. For our hospitals this means reviewing our services to ensure they are located and staffed in the most safe, efficient and effective ways possible.
Gastroenterology reconfiguration	As part of our action plan for winter 2018-19 we moved some of our gastroenterology services.
Integration of respiratory teams	In September 2018 we further integrated our respiratory teams with ICS partners in the community as an early adopter of our new ICS ways of working.
Strategic Site Development	We have been allocated £39.5m from Wave 3 capital bids to develop our sites; we have appointed health planners and subsequently a primary construction partner to progress this.

3.6 STATEMENT FROM THE CHIEF EXECUTIVE ON THE PERFORMANCE OF THE TRUST

Overview

We have been an NHS Foundation Trust since July 2004 and we are pleased that the freedoms and responsibilities that this brings enables us to work with our members through our Council of Governors to shape our direction of travel, and that working with commissioners we can develop the services and facilities that are needed by our local communities.

This has been a challenging financial year for the Trust. A number of the issues facing us are common across the wider NHS as the system continues to balance delivering high quality care against increasing demand and reducing financial resources. The Trust is reporting a £29.6m control total deficit against a control total deficit plan of £18.8m – the variances are explained later in this chapter

Performance challenges for the Trust in respect of the constitutional standards continued in the earlier part of the year, with the Trust making significant positive progress in many of the national performance measures across the four national access standards for accident and emergency services, elective waiting times, cancer services and diagnostic tests. For accident and emergency waiting times the Trust has made significant progress, delivering against the locally agreed trajectories, and diagnostics has consistently delivered all year. Progress has been made for our key cancer standards and delivery for these continues to be a high priority for the year ahead building on the best performance in the 2 week wait referral standard for many years. The Trust has now re-commenced reporting of Referral to Treatment standard and this is represents the first step on the Trusts journey to delivery of this standard

The Board Assurance Framework acts as the Trust's primary mechanism for ensuring that the Trust Board receives adequate assurance and that the Trust is actively pursuing its corporate objectives and that the risks to these objectives are being appropriately treated. The BAF enables the Board to understand the risks which have the potential to impact on the organisation's strategic objectives. The BAF provides the Trust with a single but comprehensive method for the effective and focused management of the principal risks to meeting the Trust's overall strategic objectives. The risks identified from the BAF cover the full range of strategic objectives and include consideration of present risks, future risks, risks arising from within the organisation and risks occurring as a result of external pressures and changes.

The BAF is a well-established tool with the content refreshed by the Executive Leads for each of the strategic objectives. The BAF report describes the principal risks to the strategic objectives identified by the Executive Team; the controls in place to mitigate these risks; the sources of assurance on these controls; any gaps in the controls and assurances; any actions associated with these gaps; and a narrative describing progress against the strategic objectives in the reporting cycle. Each strategic objective has a RAG rating of 'achievability' of the objective within the strategic period.

The Care Quality Commission

During 2018/19 Gloucestershire Hospitals NHS Foundation Trust has undergone an (unannounced) inspection of cores services and an (announced) Well-led inspection of the Trust's governance and leadership. This resulted in the Trust being rated as GOOD by the Care Quality Commission. Consequently, the Trust has joined a group of around one third of acute hospital trusts who are rated good or better and this achievement completes the 'hat-trick' of all three NHS providers in the county being rated good by the CQC – we believe we are the only STP that can claim this accolade!

The inspection team inspected the following four core services at the Gloucestershire Royal and Cheltenham General Hospitals:

- Urgent and emergency services
- Medical care (including older people's care)
- Surgery
- Outpatients

The Care Quality Commission has not taken enforcement action against Gloucestershire Hospitals NHS Foundation Trust during 2018/19.

Gloucestershire Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period. There is a responsive Action plan which responds to all the CQC "must do" and "should do" actions. Progress against this plan is being monitored through the Quality Delivery Group and assurance is received through the Quality and Performance Committee and can be seen in our Quality Account.

The Well-led inspection looked at how well the Trust manage the governance of its services or how well leaders continually improved the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish. The inspection report accompanying the 'good' rating noted, amongst other findings, that:

- The trust's leadership team had the experience, capacity, capability and integrity to manage a well-led organisation.
- The executive team had an appropriate range of skills, knowledge and experience.
- It was apparent to us that all appointments had been made in close alignment with the trust's priorities and were values-based appointments
- The non-executive director (NED) appointments had been drawn from a wide and relevant range of expertise and experience and again had been carefully selected in alignment with the trust's priorities and values.
- In Spring 2018, NHS Improvement carried out a review of actions taken and were satisfied the trust had taken appropriate steps to improve financial governance.
- The trust board had a sound understanding of and approach to the trust's financial position and areas of opportunity.
- The trust had created an associate NED role and was actively promoting this to Black Minority Ethnic (BME) underrepresented groups.
- The Council of Governors was an established group, and had a positive impact on the way the trust communicated with the local community, although further work was required around member engagement, which was acknowledged by the trust and actions to address this were underway.
- There were opportunities and programmes running for development in senior leadership, including opportunities for staff below team manager level.
- Succession planning was in place throughout the trust.
- Leaders at all levels were visible and approachable for their patients and staff. Most staff we spoke to in focus groups knew who the executive team were and could mostly name them.
- The leadership team understood the challenges to quality and sustainability and they could identify the actions needed to address them.
- The trust had a clear vision and set of values with quality and sustainability as the top priorities. After listening to patients and staff the trust had identified six core values, which were described in the words of patients.
- There was a realistic strategy for achieving the priorities and delivering good quality sustainable care.

- There was cooperative working with external partners to develop an integrated care system in the county of Gloucestershire.
- Staff knew and understood the trust's vision, values and strategy and how achievement of these applied to the work of their team

However:

- Some of the executive team recognised that the pace of change could at times be difficult for staff.
- Not all staff had the opportunity to discuss their learning and career development needs at appraisal.
- The turnover of staff had been stable between September 2017 and September 2018 and was improving but had consistently been worse than the trust target of less than 11%.
- Staff in some focus groups felt that risks were not always escalated properly and that when they raised concerns no or limited action was taken.
- IT systems were not effective to monitor and improve the quality of care, although plans to resolve this were progressing well.
- Some staff working operationally on wards felt ill-informed of the winter plan and did not feel engaged in its development.

CQC ratings chart

Ratings tables

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓

Month Year = Date last rating published

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Gloucestershire Royal Hospital	Good ↑ Jan 2019	Good ↑ Jan 2019	Good →← Jan 2019	Requires improvement →← Jan 2019	Good ↑ Jan 2019	Good ↑ Jan 2019
Cheltenham General Hospital	Good ↑ Jan 2019	Good ↑ Jan 2019	Good →← Jan 2019	Requires improvement →← Jan 2019	Good ↑ Jan 2019	Good ↑ Jan 2019
Stroud Maternity Hospital	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015
Overall trust	Good ↑ Jan 2019	Good ↑ Jan 2019	Good →← Jan 2019	Requires improvement →← Jan 2019	Good →← Jan 2019	Good ↑ Jan 2019

As a result of this most recent inspection, 90.5 % of the Trust's services are now rated Good or Outstanding compared to 72.5% two years ago. Whilst the improvements since our last inspection have been plain for all to see, this is a very welcome endorsement by the CQC. The response from staff has been phenomenal and this

rating marks an important milestone in our *Journey To Outstanding.* In their press release, the CQC commented “Since their first comprehensive inspection in March 2015, Gloucestershire Hospitals NHS Foundation Trust has implemented and thoroughly embedded improvements and I am pleased to congratulate the trust in reaching an overall rating of good. Patients we met on inspection were entirely positive about their care. We found staff to be dedicated, kind, caring and patient focused. We found clear evidence of leaders who were visible and committed to continual improvement and instilling a shared vision of high quality care.

3.7 DEVELOPING OUR SERVICES AND IMPROVING PATIENT CARE

Patient experience performance data - making better use of patient experience data for service improvement

Patient experience is one of the three main pillars of quality of care alongside safety and effectiveness. The "Golden Thread" within all our service and quality improvement work is to improve patient experience across the organisation whilst focusing on providing best personalised care for all.

Gloucestershire Hospitals NHS Foundation Trust actively seeks feedback from patients, their friends and families and then acts on it. This is because we want every patient to have the best experience possible. Insight and feedback helps our staff to know what we are doing well (and the things we should keep on doing) as well as what we need to change. Good experience of care, treatment and support are essential parts of our service alongside clinical effectiveness and safety.

We use quantitative and qualitative patient experience data to support our change processes:

- We assess what experience is currently like, and measure whether improvement activities have made a difference.
- We use insight data to help us understand why reported experience is sometimes not as good as we might hope and then generate ideas for change.

We collect and use feedback/insight data by:

  - Using questionnaires, text messaging and comment cards.
  - Listening to what our patients tell us in person
  - Reviewing social media feedback through our Patient Tracking Voice System (NHS Choices, Google, Twitter, Facebook etc.)
  - Responding to letters and emails patients send us
  - Listening and improving in response to our feedback given to the Patient Advice and Liaison (PALS) and Complaints Services.
  - Holding meetings with patient groups (focus groups)
  - Seeking 'patient stories' (asking patients to gives us an in-depth account of their experience to help us understand the issues better).
  - Shadowing our patients to then assist us with co-designing services.
  - Using insight experience data, not just to respond to when things have gone wrong, but to shape what 'outstanding' looks like and things we could do better: our patients often suggest better ways of doing things, simple ideas to make it a better experience for them.
  - Carrying out quality improvement project work supported by Gloucestershire Safety and Quality Improvement Academy (GSQIA) with the Patient Experience Improvement Team leading.
  - Forming project teams with patient involvement to take large change projects forward.

- It helps us challenge our assumptions about what the problem areas are as far as our patients are concerned; sometimes we assume something is more of an issue than our patients think it is.
- It motivates us to take action and remind us of what we are trying to achieve – Best care for all.

Friends and Family Test

Summary of Friends and Family Test (FFT) performance during quarter 4 2018/19
In Quarter 4 the Trust positive score of 91% did not meet the strategic target of a 93% positive recommendation score overall. The team continue to support wards and service areas to review their data and to respond to the comments. Wards have the ability to produce "You said" "We did" posters for their areas and this is audited via the Nursing Assessment and Accreditation System (NAAS) – a performance assessment framework to measure the quality of nursing care delivered by individuals and teams. After NAAS inspections wards have been contacting the patient experience improvement team and we have enabled them to re-engage with the FFT data system.

Table 1: Breakdown by quarter of each area against the Trust target

	Target 2018/19	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4
Trust positive score	93%	91%	91%	91%	91%
Inpatient FFT positive score *(includes day case)*	93%	91%	87%	87%	90%
Emergency Department FFT positive score	93%	84%	84%	82%	83%
Outpatient FFT positive score	93%	92%	93%	93%	93%
Maternity (Birth) FFT positive score	93%	96%	94%	99%	96%

Engaging with our patients and stakeholders

We appreciate that our success would not be possible without the support and collaboration of our key stakeholders. Stakeholder engagement is a priority for us to further build strong partnerships and trusted relationships - the foundation of our vision and strategy. We have a programme of engagement in place with a wide range of stakeholders as their contributions help shape our quality improvement work.

Service and quality improvements

Utilising the principles of experience based co-design and patient and family centred care methodologies, which are quality improvement (QI) science tools, we have listed below examples of our quality improvement work and projects that our Trust has carried out in 2018/19: -

- We have completed many "silver level" quality improvement projects that have a patient experience focus through our **Gloucestershire Safety Quality Improvement Academy**

Three examples of or projects:-

Increasing support for our carers in a hospital setting
It is important that we support our Carers who play a key role in our patients care and recovery. It has been shown that when Carers feel supported they are more able and likely to continue in their caring role which improves discharge and re-admission rates. The concern is that access to Carer support is not available on all ward areas and has resulted in an unequable service across the Trust.

Implementation of Day Case Management of Hyperemesis Gravidarum in Gynaecology

Previously women were referred via their GP or directly attend A&E from where they are admitted to a ward bed for a period of hydration. Once discharged, patients had to go via the same referral routes for further admission if further hydration required. There was duplication of work associated with poor patient experience.

Development of an online patient information enquiry service for digitally literate patients

Our National Adult Inpatient survey score showed that our provision of patient information had exceeded the "Picker average" of 19% and we needed to improve. Patients need to agree to consent, are encouraged to self-manage their care and we need to ensure person centred care, to achieve this patients need the most appropriate information.

- Through improvement work as part of **Better Births** we have co-designed a support group for dads called Support and Help for Every Dad (SHED). The group was established this year to run alongside the broader support group peer support group is for Dads who are coping with the wide range of issues associated with having a baby on the special care baby unit. We also have another 16 maternity QI projects in progress.

- We completed an **NHS England Maternity Challenge** funded project which utilised the Friends and Family Test to improve maternity services and asked women to identify members of staff who went the extra mile for them. This project has been shortlisted for a Patient Experience National Award.

- Our **Learning Disability Hospital User Group** (HUG) leads improvement work for people with Learning Disabilities. The group has service users who help us to co-design our services with their needs in mind. The Group has produced easy read information, developed our signage to be more accessible and enables us to review our services through their experiences.

- We are re-developing our cancer services patient experience improvement pathway to make improvements following the findings of the **National Cancer Survey** are taken forward in a collaborative and cohesive way.

- After the publication of our **National Children and Young People Survey**. We are completing our Experience Based Co-design project with young people aged 8-15 years old looking at how we can better involve this patient group in decisions about their care and treatment (no decision about me without me).

- In response to our work **Learning from Deaths** we held a focus group with bereaved families to understand their experiences of our services so that we can improve our end of life and bereavement services.

- We are working with the **Voluntary Sector** with a group called Insight to improve our services for people who support people living with sight loss or blindness. We have run focus group and aim to have another in 2019.

- In response to our **National Adult Inpatient Survey** we asked the Point of Care Foundation come and deliver a specialised patient experience improvement training called the "Sweeney programme" and 6 teams of staff have led projects within their ward areas that have made a difference to our patients. They shadowed patients across our services and in response to what they have seen they have re-designed appointment letters, redecorated ward areas, set up "feedback trees", made films to support women in early labour and helped to improve discharge processes.

Information on complaints handling

The Trust aims to adhere to the *Principles of Remedy* produced by the Parliamentary and Health Service Ombudsman in 2007 and the *Local Authority Social Services and National Health Service Complaints (England) Regulations 2009*, in order to produce reasonable, fair and proportionate resolutions as part of our complaints handling procedures.

These include:

- Getting it right
- Being patient (customer) focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement

We are committed to responding to issues of concern raised by a patient, relative or carer and learning from these. We provide an accessible and impartial service, with all issues raised being handled not only with the seriousness they deserve, but also in a way that provides answers that are full, frank and honest.

Complaints performance 2018/19

Indicator	2016/17	2017/18	2018/19	Notes/ Other information
No. of written complaints	913	1031	898	
Rate of written complaints per 1000 inpatient spells	5.4	6.26*	-	
Complaints acknowledged within 3 working days	98%	97%	97%	
PHSO cases	**19 cases** 9 were partially upheld, 0 upheld and 10 not upheld	**15 cases** 5 partially upheld 1 not upheld 1 they decided not to investigate 2 in draft 6 still being investigated.	16 cases We are in the process of completing the complaints annual report and more info will be provided when this is submitted to July QPC as agreed by SH in May QDG.	All action plans that are developed in response to cases that are upheld are reviewed at the Safety and Experience Review Group, which reports to Q&P committee.

What were our patients' main concerns

The main theme of the complaints are related to clinical treatment, appointments, communications, admissions and discharge, patient care, and in relation to Trust values and behaviours amongst staff.

Learning from complaints and concerns

We welcome feedback of any type and view complaints as an opportunity to review the care and treatment we provide our patients. We investigate all complaints and concerns in order to identify any learning and make any necessary changes.

Action plans are always developed when corrective actions are identified during complaint investigations. These are regularly reviewed and monitored within the divisions. This process ensures that information provided by the users of our service influences future service improvements.

3.8 FINANCIAL PERFORMANCE

The financial performance for 2018/19 is characterised by a variance from control total driven by three material factors; a shortfall in the national funding for the agenda for change pay award, a shortfall in identified CIP when a stretch target was agreed to deliver the initial control total and the loss of Provider Sustainability Funding (PSF) due to non-delivery of the position in Quarter 4. The year end saw two further adjustments; increased depreciation as a result of changes to asset lives and additional PSF from the general NHS Improvement incentive fund. The Trust has delivered a control total deficit of £29.6m (once adjusting for technical factors required by our regulators) which represents an unfavourable variance of £10.7m against the initial planned deficit of £18.8m. The table below shows the financial position against plan for the financial year.

Month 12 Financial Position	Annual Budget £000s	2018/19 Actual £000s	Variance £000s
SLA & Commissioning Income	444,587	448,024	3,437
PP, Overseas and RTA Income	5,710	4,809	(901)
Other Income from Patient Activities	5,418	6,153	734
Operating Income	74,301	74,611	311
Total Income	**530,016**	**533,596**	**3,581**
Pay	346,475	354,115	(7,641)
Non-Pay	178,709	187,594	(8,885)
Total Expenditure	**525,184**	**541,709**	**(16,525)**
EBITDA	**4,832**	**(8,113)**	**(12,945)**
EBITDA %age	**0.9%**	**(1.5%)**	**(2.4%)**
Non-Operating Costs	22,751	26,361	(3,610)
Surplus/(Deficit) with Impairments	**(17,919)**	**(34,474)**	**(16,555)**
Less Fixed Asset Impairments	0	4,774	4,774
Surplus/(Deficit) excluding Impairments	**(17,919)**	**(29,700)**	**(11,781)**
Excluding Donated Assets	(902)	144	1,046
Control Total Surplus/(Deficit)	**(18,821)**	**(29,557)**	**(10,736)**

Income disclosures required by section 43(2a) of the NHS Act 2006.
Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. The Trust can confirm compliance with this requirement for the 2018/19 financial year.

Information on the impact that other income it has received has had on its provision of goods and services for the purposes of health services in England
Other income received has had no impact on the provision of goods and services for the purposes of the health service in England.

Cost Improvement Programme (CIP)

The Trust has delivered CIP to the value of £27.0m in the 2018/19 financial year which represents 5.1% of annual turnover. This reflects under-performance against a planned value of £30.3m but still exceeds the sector average. Of the £27.0m 78% has been delivered through recurrent schemes targeting cost reductions.

3.9 KEY ISSUES AND RISKS

The Trust has significantly strengthened its approach to the identification and control of risks. Risks to the Trust's strategic objectives are captured in the Board Assurance Framework and risks of an operational nature are captured through divisional and departmental risk registers.

The major risks facing the organisation are those from operational pressures driven by demand exceeding capacity, risks to patient experience and potentially outcomes associated with significant backlogs of patients awaiting routine outpatient or inpatient care, risks to do with recruitment and retention of clinical staff, and risks associated with delivery of the Trust's financial plan.

3.10 GOING CONCERN

The accounting concept of going concern refers to the basis of measurement of an organisation's assets and liabilities in its accounts. The going concern assumption is a fundamental principle in the preparation of financial statements, under which an entity is ordinarily viewed as continuing in business for the foreseeable future. If the entity could not continue as a going concern, assets and liabilities would need to be recorded in the accounts on a different basis, reflecting their value on the winding up of the entity.

The Board should formally consider and confirm whether the Trust has the ability to continue as a going concern. Such a review is considered as part of the annual accounts audit and is a requirement of International Accounting Standard (IAS1).

The principles of going concern are:

Assessing Going Concern

Directors should make and document a rigorous assessment of whether the Trust is a going concern when preparing annual financial statements. The process carried out by the directors should be proportionate in nature and depth depending upon the size, level of financial risk and complexity of the Trust and its operations.

The Review Period

Directors should consider all available information about the future when concluding whether the Trust is a going concern at the date they approve the financial statements. Their review should usually cover a period of at least twelve months from the date of approval of the annual financial statements.

IAS1 under IFRS also states that the operating cycle of an entity is the time between the acquisition of assets for processing and their realisation in cash or cash equivalents and that when an entity's normal operating cycle is not clearly identifiable, it is assumed to be twelve months. A failure to consider a period of at least twelve months from the balance sheet date would be contrary to the requirements within accounting standards for companies applying IFRS.

Disclosures

Directors should make balanced, proportionate and clear disclosures about going concern for the financial statements to give a true and fair view. Directors should disclose if the period that they have reviewed is less than twelve months from the date of approval of annual financial statements and explain their justification for limiting their review period.

Findings

2019/20 Financial outlook

The Trust incurred an operating deficit in the year of £29.6m and is forecasting a material improvement in the deficit position for 2019/20, supported by non-recurrent funding made available by NHS Improvement. The Trust's operating and cash flow forecasts have identified the need for continued additional financial support to enable it to meet debts as they fall due over the foreseeable future, which is defined as a period of 12 months from the date these accounts are signed.

Financial plans are in place to enable the continuity of services and distress funding is being received in the short term to ensure that liabilities are met and services provided. At the point of finalising these financial statements we note the following:

- The Trust still requires significant external cash funding. Applications for funding will continue to support the planned deficit for 2019/20.

Conclusion

The Trust has applied going concern in the preparation of its 2018/19 financial statements and will disclose in its accounts risks and other uncertainties and key assumptions, but none of these impact a risk on the going concern principle.

The Trust activities together with the factors likely to affect its future development, performance and position are set out in its 2018/19 Annual Report. The financial position of the Trust, its cash flows, liquidity position and borrowings will be described in the annual accounts and report for the 2018/19 year. In addition, the notes to the financial statements will include the Trust's objectives, policies and processes for managing its capital, its financial risk and gives details of any financial instruments and exposure to any credit risk.

Actions Arising from the Report

Having considered the material uncertainties and the Trust's financial recovery plans and the likelihood of securing additional financial funding to support the financial operations, the directors have determined that it remains appropriate to prepare the accounts on a going concern basis. The accounts do not include any adjustments that would result if Gloucestershire Hospitals NHS Foundation Trust was unable to continue as a going concern.

3.11 BETTER PAYMENT PRACTICE CODE PERFORMANCE (BPPC)

For the financial year 2018/19 the Better Payment Practice Code (BPPC) performance was 77.6% by value and 76.5% by number as detailed below. 95% is the best practice benchmark and work to improve the Trust position against this benchmark is ongoing.

	Cumulative for Financial Year	
	Number	£'000
Total Bills Paid Within Year	111,075	233,174
Total Bills Paid Within Target	85,002	181,056
Percentage of Bills Paid Within Target	76.5%	77.6%

The Trust has not paid any interest under the Late Payment of Commercial Debts (Interest) Act in 2018-19. The notional interest under the terms of the Act for 2018-19 would be £208k.

The Trust income from the provision of goods and services for the purposes of the health service in England was 85.7% of our total income. The Trust has therefore met the requirement that our income from the provision of goods and services for the purpose of health services in England must be greater than its income from the provision of goods and services for any other purposes.

3.12 IMPORTANT EVENTS SINCE THE END OF THE FINANCIAL YEAR AFFECTING THE TRUST

There have been no events subsequent to period end which require adjustment of or disclosure in the consolidated and Trust financial statements or notes thereto

3.13 DETAILS OF ANY OVERSEES OPERATIONS

Not applicable.

3.14 GLOUCESTERSHIRE MANAGED SERVICES

Performance Review

Overview

Gloucestershire Managed Services ("GMS") is the trading name for Gloucestershire Hospitals Subsidiary Company Limited. GMS is a company limited by shares and a wholly owned subsidiary of Gloucestershire Hospitals NHS Foundation Trust ("the Trust"). The company was incorporated on 22 December 2017 and remained dormant until 1 April 2018. On that date GMS took over the running of the Facilities and Estates functions for the Trust under the auspices of an Operated Healthcare Facilities Agreement ("OHFA"). Under this arm's length agreement GMS runs support services for the Trust and to enable this 660 staff formerly directly employed by the Trust transferred to GMS under TUPE arrangements. Subsequent to this a further 126 staff TUPE transferred from Interserve Ltd to GMS on the termination date (Sept 2018) of the cleaning subcontract for Cheltenham General Hospital.

The business case supporting the establishment of the subsidiary company was approved by the Trust Board in February 2018. The business case identified a range of potential benefits particularly with respect to improving the efficiency and effectiveness in the provision of non-clinical support services and asset management.

GMS remains an integral part of the Trust providing and managing all of the buildings and associated infrastructure and providing a range of non-clinical services that contribute to the overall success of the group. Whilst a number of other NHS Trusts have contracted out large parts of their non-clinical services to private sector providers, the Trust has retained strategic control of its assets and supporting services directing improved efficiency and raised quality standards.

Governance

The Trust exercises its governance over GMS at three levels. As the shareholder the Trust has agreed the Articles of Association for GMS and has set out an agreed Schedule of Reserved and Delegated matters. The Trust also monitors the contractual performance of GMS against the terms of the OHFA. In addition GMS reports regularly on its business performance to the Trust. The primary focus for this control is the GMS Committee a formal subcommittee of the Trust Board with the responsibility for oversight of the governance and performance of GMS.

GMS Board

The Board of GMS is made up of a non-executive Chair and one other non-executive Director, two representatives of the Trust, the Managing Director of GMS and the Finance and Commercial Director for GMS. The directors of GMS who served during the year are:

Lukasz Bohdan (appointed 22 December 2017)

Kathryn Headdon (Non-Executive Chair - appointed 10 April 2018)

Neil Jackson (Managing Director GMS - appointed 8 March 2018)

Kaye Law Fox (Non-Executive Vice Chair - appointed 8 November 2018)

Jonathan Shuter (appointed 13 September 2018)

Sarah Stansfield (appointed 8 March 2018, resigned 13 September 2018)

Simon Wadley (Finance and Commercial Director GMS - appointed 18 March 2019)

Stephen Webster- appointed 22 December 2017, resigned 31 March 2018

Lukasz Bohdan and Jonathan Shuter are employees of Gloucestershire Hospitals NHS Foundation Trust.

The GMS Remuneration Committee was created during the year to 31 March 2019 comprising of the Non-Executive Chair, the Non-Executive Vice Chair and the Directors appointed by the Trust as GMS (Non-Executive) Directors

The GMS Board audit responsibilities are exercised as a function of the GMS Board. Assurance is provided to the Trust (Group) Audit Committee.

Vision, Mission and Strategic objectives

GMS has been established as a subsidiary of the Trust with the clear ambition:

"To become the regional provider of choice for efficient and effective services, integrated healthcare infrastructure, delivered sustainably and in a socially responsible way to enable our customers to deliver excellence in patient care."

Through this approach GMS will develop a range of appropriate specialties and service offers built around the provision of the Operated Healthcare Facilities for the Trust and its partners. GMS will:

- Develop a well-motivated and highly competent workforce ready to meet the challenges of the future;
- Specialise in provision of fully managed health infrastructure and related services;
- Grow as a consequence of the market within the NHS and beyond over time;
- Grow and nurture a workforce drawn from our community at all levels of qualification and background;
- Expand scope of services provision to the Trust for areas of core competencies where GMS can add value;
- Generate income and profit as a result of providing services and expertise to other NHS/non NHS bodies
- In general, create an alternative business model to public or private provision for healthcare associated infrastructure and services in the future market.

- Deliver this in customer focused a socially responsible way, establishing a reputation for excellent customer service and effective corporate social responsibility (CSR).

GMS are committed to developing a new culture, employer brand and promise, which defines the relationship between employee and employer and reflects the unique nature of GMS, its staff and the services it delivers. This will differentiate its people and provide the core building blocks to deliver the vision and expectations of GMS going forward.

The Trust is looking to GMS to support its strategic plan to maintain and grow its clinical service offering by finding new and innovative ways to generate efficiencies and revenues.

Services Transferred

The following summarises the services taken on by GMS:

Asset Management

- Strategic asset planning and advice
- Health planning and the planning, designing and project management of minor, medium and major capital projects including stakeholder engagement;
- Ensuring Estate/technical compliance;
- Energy and utilities cost control and management;
- Lifecycle planning and maintenance services;
- Public Finance Initiative (PFI) and Public Private Partnership (PPP) service monitoring and partnership management.

Prime Contracting

- Prime contacting and alternative capital development approaches will be explored further to ensure GMS develops the knowledge and expertise to provide a range of asset provision models to supports its clients' needs;
- As appropriate GMS will provide a greater range of services with its own workforce. This may be to build a core offer or to prepare the service for a more commercially viable partnership or contracting arrangement.

Operational services

- Catering services, including making use of the spare capacity and to capitalise on our experience delivering health specific menus
- Customer services (including helpdesk, switchboard and call centres)
- Sterile services
- Provision of soft FM operational services and ensuring compliance;
- Responsive repairs and maintenance
- Gardens and grounds maintenance
- Managed print and postal services
- Security and incident response (including violence and aggression response);
- Minor works and moves management
  Logistics and Supplies
- The provision of supplies ensuring best value, effective stock control and effective supplies management
- Transport and logistics services to region
- Portering and distribution

Community Direct Services to GP and other customers

- Currently medical engineering and sterilisation services are provided to all NHS service providers across Gloucestershire. The opportunity exists to develop a more complete service offer to GPs and other partners.

Operational Challenges

GMS core contract is the Operated Healthcare Facility Agreement (OHFA) with the Trust. The bulk transferred services and assets that are the subject of the OHFA are significantly challenged and as such initial focus is being placed on turning the services around and identifying viable approaches to recovering the asset position from a "run to fail" model to a "flexible predictive lifecycle" approach to asset management. Additionally, the following observations and challenges are worth noting:

- Poor Estate and Backlog – The Trust is a significant outlier in terms of its backlog position not only for the estate but for equipment and infrastructure. This has a significant impact on increasing maintenance costs and future asset liabilities.
- Service Quality and Performance – the condition of the estate and Cost Improvement Programmes (CIP) applied over a number of years has limited important service scope and service transformation resulting in issues with quality and service delivery in several GMS service areas. A level of investment will be required to support transformational improvement and recovery of the service offer.
- Utilisation – the trust has a relatively high rate of space occupancy utilisation, however the costs per Weighted Activity Unit (WAU) suggest that the level of completed clinical episodes are lower than the benchmark. This may be as a result of repeated visits during a clinical episode or less than optimum utilisation of space in available hours.
- Procurement and supply chain-a significant review of Estates and Facilities suppliers has been undertaken, with a further review of options to be undertaken to in-source activity if more cost effective. Further review and procurement of supplies and product selection will be ongoing.
- Energy, utilities and sustainability – the benchmark year energy costs are based on the energy mix prior to operation of the Combined Heat and Power (CHP) plant at Gloucester Royal Hospital. We expect that once the effect of the CHP operation on the energy mix cost is applied the Trust will move to a mid to lower quartile costs. Also a re-procurement of water and sewerage (taking advantage of deregulation of the market) is expected to bring these costs into line with the benchmark.

GMS Aim

GMS aim is to establish new ways to:

1. Motivate and Reward staff appropriately, e.g. for improved productivity and efficiency, providing employment packages more aligned to the sector in which GMS competes for that staff group. Thereby allowing the GMS Leadership team and staff to be incentivised to create high quality core services and commercially valuable services that improve core services and grow revenues for the group;
2. Take advantage of opportunities to transform services, through significantly improved business and market intelligence and take advantage of improved service and infrastructure management approaches and technologies within GMS;
3. Operate with greater autonomy and flexibility to meet the needs of the Trust and other clients and enable more commercially focused services and investment decisions.

The above will enable GMS to become the competitive provider of choice, delivering efficient, integrated healthcare infrastructure in Gloucestershire, and to deal with the operational challenges above faced by GMS and the Trust.

Key Objectives Financial Year 2018/19

Key Objectives for Financial Year 2018/19 were established with the original business case and plan and are as follows:

- To complete the transitional activities relating to the establishment of GMS and the transfer of its operations from the trust.

- To achieve an agreed financial target demonstrating a Profit Before Tax (PBT) of £2.1m, including delivery of a £1m CIP

- To meet the services level requirements as set out in the OHFA.

- To establish programmes of work that would, following a period of stabilisation, focus on improving the core services of soft services, hard services, supplies and logistics, asset management and project management, including identifying potential areas for income generation and establishing market offers for broadening the service provision. This includes, but is not limited to, establishing revised terms and conditions for GMS staff appointed after 1 April 2018.

Summary of performance against objectives

Transitional Activities

Completing the transitional activities, following both the approval of the Business Plan in February 2018 and the accelerated implementation of the establishment of GMS, have been the key challenges facing GMS and the Trust during the year. Particular areas of activity, which represent the highlights, include:

1. Completing the legal documentation and agreements between the Trust and GMS
2. Completing the novation of supplier contracts from the Trust to GMS
3. Completing the transfer of customer contracts and arrangements
4. Establishing the banking and cash flow management processes
5. Reviewing and revising the governance arrangements between the Trust and GMS
6. Establishing the arrangements for audit and assurance processes, including putting in place a comprehensive risk management strategy and policy
7. Clarifying the assumptions behind the financial model, including the baseline cost position particularly in relation to Energy and Utilities costs
8. Undertaking a small number of re-procurement exercises for sub contracted services

Work continues in all of these areas.

Financial Performance

Against Financial Targets, GMS achieved:

- £45.9m Income against £44.5m Target
- £1.1m Nett Income against the £2.1m Target
- Achieved £1,029k of CIP savings,
- GMS delivered £270k or 0.6% efficiency savings.
- Absorbed £353k activity related cost pressure and

- Absorbed £711k of Agenda For Change pay award, that was initially planned to be funded centrally but was subsequently the subject of a national decision related to Trust Subsidiary Companies and was not funded.

Other pressures relate to variations being sanctioned by the Trust, but potentially booked against Lifecycle funding, reducing available budget for essential maintenance. There will be greater focus on this in Financial Year 2019/20

Operational delivery

The following summarises GMS performance during Financial Year 2018/19 against the Key Performance Indicators within the OHFA:

During the year the Trust agreed to a number of amendments to the KPIs to improve the quality of measures and focus on aspects that are most valued by the Trust; these were in the areas of estates repairs, parking, sterile services & switchboard.

GMS supported the Trust to deliver its capital programme for Financial Year 2018/19 delivering £7.2M of Capital expenditure and providing professional services to support the wider Trust capital programme. The key highlights are:

- Lifecycle investment in repairing the aging estates including infrastructure replacement and repair of buildings and environmental improvements
- Medical Equipment Fund (MEF) provides for the replacement and modernisation of mobile medical devices used in patient care.
- Major Projects including modernisation and refurbishment of operation theatres, professional support to the major capital scheme, supporting the Integrated Care System (ICS) programme.

Strategic and Service Development

A number of strategic projects have been initiated during the year. These will commence delivery during 2019/20 with planned benefits accruing to the Trust and GMS:

Colleague to Customer Improvement Program -

- The Board and management of GMS are passionate about driving continual improvements to the levels of service it provides for its customer and for GMS to improve, it must understand more about customer expectation and satisfaction with the services received.
- Through gaining a better understanding of the needs and satisfaction levels the Trust has, GMS will mitigate against business risks and develop itself to become more customer focused and productive.
- This understanding of the customer and what the Trust need to deliver a high level of patient care will also connect GMS staff with the core vision and purpose of the organisation so providing a better working environment.
- Measuring customer satisfaction and linking these results back to daily working plans and schedules will allow GMS staff to provide the best possible estates and facilities services thereby supporting and contributing to excellent patient care

Modernisation of logistics and portering-

- Portering and logistics services are very responsive to the Trust's needs, and this initiative will introduce new, leading practice systems to help further enhance the service and improve inpatient's experiences.

- The new award-winning systems will make it possible to know the location of the workforce within the hospital, improving communication and allowing staff to more efficiently respond to customer demands, through:
  - Reduced repeat journeys and delays
  - Improved patient flow within the hospitals
  - Reduced instances of clinical staff carrying out portering tasks
- This initiative uses mobile devices which can also be used to record data for planning, for example, identifying the busiest areas and times requiring support.
- GMS is working in partnership with the Trust to agree the initiative scope, and test it in a proof of concept before deploying more widely.

The fully supported ward-

- The fully supported ward builds on the lessons learnt from the previously completed service improvement of domestic services, and aims to enhance the inpatient experience. The introduction of ward coordinators, responsible for controlling and supplying services to the ward enables a more joined-up approach with a focus on service timeliness and quality.

- Other key benefits include:

  - Releasing more nursing time to care.
  - Improving catering with hot, nutritious and appetising food
  - Increasing the availability of cleaners to clean the ward
  - Providing a total bed cleaning service to reduce turnaround times

- GMS is working in partnership with the Trust to agree the concepts, test them in a proof of concept pilot before making improvements and deploying more widely.

Asset management and reduction of backlog

- Part of the GMS professional service is the estates strategic advisory services around the provision and utilisation of built assets. Improving asset management is a strategic aim in GMS and aligns to the need to move the trust estate from a 'run to fail' position to a planned preventative approach that will significantly reduce the Trust's operational risk of service disruption from failed equipment and assets.

- GMS and Trust asset priorities for Year 2: -
  - Focus on high priority areas for compliance and health and safety.
  - 2nd order priorities are those impacting on space or infrastructure availability
  - 3rd order priority are investments to reduce backlog/extend asset life.

Workforce development plan-

- During Year 2 GMS will extend the implementation of the values and competency-based recruitment and development approach to ensure staff are appointed with the right skills and values for the role. This process has commenced in year one focusing on hard to recruit to areas and implementing common leadership and management skill framework and competencies. This will be developed for the wider workforce to ensure the required guidance is in place to support the appraisal and review process. It will involve developing values with workforce engagement that align with the GMS vision, and identifying industry relevant standards of which, GMS services should operate within, followed by a gap analysis of competencies and skills.

- The key areas for improvement are:
    - Talent management – to recruit and develop the best staff to achieve the best outcomes for them, the company and its customers
    - Monitor and gather data through the Customer Relationship Management (CRM) system to inform the development of the culture through a feedback loop to enhance productivity and improve quality of service delivery
    - Introduce performance management mechanisms which will measure the individual and team performance so that GMS can ensure that teams are working towards their agreed objectives

New staffing terms and conditions-

Staff who transferred to GMS from the Trust retain their Agenda for Change term and conditions. GMS have introduced revised Terms and Conditions for new staff to the organisation who were not part of the original Trust to GMS TUPE transfer. These terms are more aligned to local and industry norms, and so will support the key aim to reward and motivate staff in a manner more appropriate for this sector.

Additional Highlights
Contractual arrangements between GMS and the Trust

A feature of the operating model is that GMS will be drawing on Shared Services and the Trust's capabilities, particularly during the first few years. Services provided by the Trust fall into four categories:

- Shared Services – transactional finance, procurement, payroll and other related services;
- People Services – operational and tactical support for workforce, and organisational development;
- IT Services – Countywide IT Services (CITS) will provide Information Management Technology (IMT) support including networking, telephony and desktop services;
- Finance Services – The Trust provide transactional and operational finance services to GMS;
- Other corporate services including risk and safety, learning, communications and governance;

Separate SLA's to reflect current service have been prepared, however as GMS business plan develops its requirements from its supports service these will also need be redefined and amended.

Key Risks and Issues

GMS operates a Board Assurance Framework (BAF), the risks below are linked to the Strategic Objectives and managed via the BAF:

Financial Risks

- GMS Fails to deliver its financial targets for the year resulting in a reduced (or Zero) dividend to GHFT.
- GMS Fails to deliver a long term financial plan that demonstrates sustainability and a contribution to the Trust financial position.
- GMS fails to achieve HMRC clearance on the activities of GMS under tax law leading to lower financial performance.

Regulatory Risks

- GMS fails to comply with statutory & technical standards resulting in enforcement actions against the company.
- GMS fails to comply with statutory Health and Safety standards, resulting in harm to patients and/or staff or Public.

Operational Delivery and Performance Risks

- GMS fails to recruit and retain sufficient staff of suitable qualifications and experience, which undermines the Company's ability to deliver contractual service standards
- GMS fails to maintain appropriate monitoring and management information systems results in the company not being able to properly monitor both compliance and performance improvement
- GMS fails to modernise internal systems and processes, so failing to increase capacity and risking achievement of service standards and financial targets.

Customer Risks

- GMS fails to meet contractually defined service standards resulting in a claim for breach of contract leading to financial loss and damaged reputation
- There is a breakdown in the strategic relationship between GMS and the Trust leading to risk to long term sustainability

Growth & Organisational Development Risks

- GMS fails to deliver service standards and increase productivity which limits the company's ability to win additional work and new contracts.

3.15 GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST CHARITABLE FUND

Charity vision and purpose

The Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) General Charitable Fund is an independent registered charity (registered number 1051606). Cheltenham and Gloucester Hospitals Charity is the registered working name for the charity. The Charity exist to raise funds and receive donations and grants for the benefit of our patients. By securing donations, legacies, grants and sponsorship, Cheltenham and Gloucester Hospitals Charity can provide additional funds that make a real difference for our patients, their families, friends and the staff who treat them.

Cheltenham and Gloucester Hospitals Charity has a shared vision with the Trust, namely to deliver “Best care for everyone”, with the aim of raising funds to create the best possible experience for patients, their families and staff by funding extra care and equipment over and above that provided by the NHS.

Charity Mission

Our Charity’s mission is as follows:

The charity raises funds, for the public benefit, ‘for any charitable purpose or purposes relating to the National Health Service wholly or mainly for the service provided by the Gloucestershire Hospitals NHS foundation Trust.'

Governance

The Trust is the Corporate Trustee of the charity, and the charity is regulated by the Charity Commission as well as the Charity Commission.

The Trustee delegates responsibility for some of the day to day running of the charity to the Charitable Funds Committee, chaired by a Non-Executive Director. In 2018/19 the Trustee established the Investment Committee to establish and oversee the investment strategy and policy.

The charity consists of over 120 charitable funds, each dedicated to an individual ward or service. Whilst the charitable funds share the same financial systems as GHNHSFT, a separate bank account is maintained for the charity. Each fund is managed by a nominated fund advisor who, along with the Director of Fundraising, is responsible for ensuring that expenditure is in accordance with the funds governing documents. Expenditure in excess of £1,000 but below £5,000 on single items requires the authority of the Chief Nurse and Director of Quality and the Director of Fundraising, while proposed expenditure in excess of £5,000 requires the approval of the Charitable Funds Committee and either the Medical Equipment Fund or Capital Control Group. The Committee is responsible for considering the Annual Accounts, fund balances and investment performance together with approving requests for expenditure above the current delegated limit of £5,000.

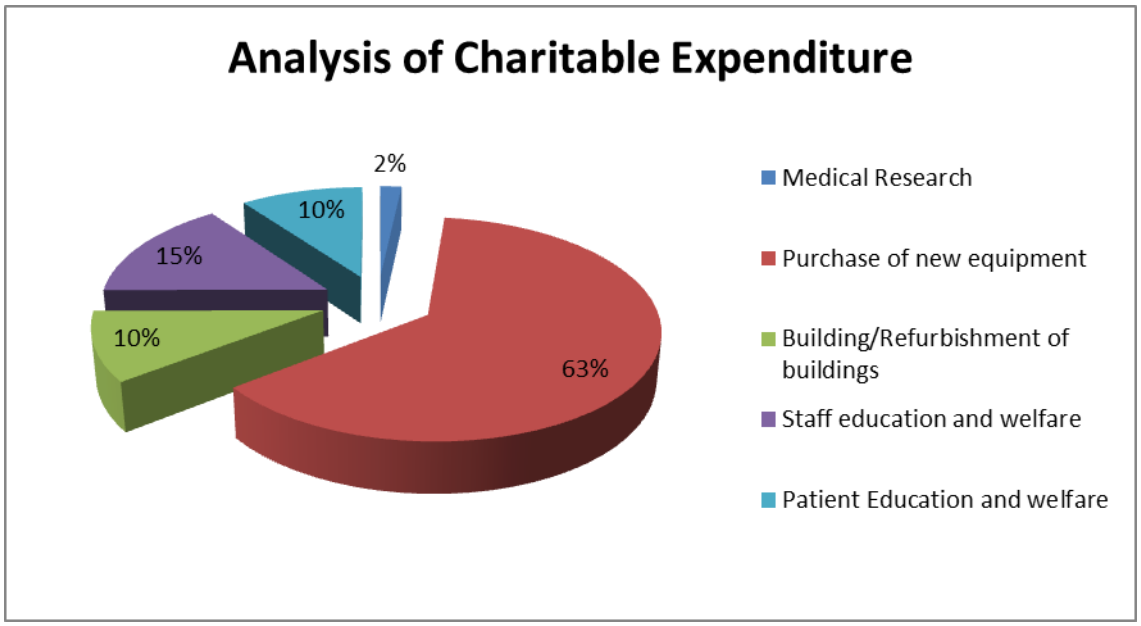
In terms of risk management, the charity’s systems and protocols are to some degree homogenous with that of the Trust itself. Accordingly, the Trust’s system has been utilised to track and mitigate for the charity. The Charity Risk Register is reviewed by the Charitable Funds Committee twice a year.

The Charity operates within the overall governance arrangements of the Trust. Since the 1 April 2013 the Charitable Funds are required to be consolidated as part of the Trust’s Annual Accounts.

Financial Review

In 2018/19 the charity was in receipt of £1.9 million in donated income, and spent £746k on projects, equipment, research and training across both the hospitals and on services provided by the Trust in the wider community across the counties of Gloucestershire, Herefordshire and Worcestershire. The overall fund balance is £4.4 million, up from £3.5 million in 2017/18. This increase is due to the CT scanner appeal, with funds totalling £1.9 million being held as restricted income for the appeal. The Trustee firmly holds the view that donated monies should be spent within a reasonable period from the receipt. The first two CT scanners are due to be purchased in early 2019/20.

The charity's reserves as at 31 March 2019 were £318,876, with investments carrying an unrealised loss of £17,960. The charity receives generous donations from grateful patients, their families, friends, people within the local community and staff. The charity's fundraising team also oversee major fundraising appeals.



2018/19 Highlights

In November 2018 the charity launched a Scanner Appeal for £1.2million, to match fund a single donation of £1.2million that had been received in 2017/18. Altogether the appeal will fund three new CT scanners, two in Gloucestershire Royal Hospital and one in Cheltenham General Hospital, and two mobile digital x-ray machines. By the end of March 2019, after just five months, the appeal had secured £817,604 towards the total.

The largest of the charitable funds is FOCUS, supporting the Gloucestershire Oncology Centre.

In 2018/19 the charity purchased state of the art technology for the treatment of skin cancers, thanks to the generosity of a supporter who remembered FOCUS in their will. There are Sky Ceilings in place in each of the radiotherapy treatment rooms and in the waiting areas of the oncology centre. These have helped create a calm and soothing environment for our patients, particularly in the spaces where there is no natural light. We have also purchased more rise and recline chemotherapy chairs, providing additional comfort and security for patients receiving their chemotherapy treatment.

The Jaundice Monitor Appeal in 2018/19 enabled the charity to purchase 28 jaundice monitors for community midwives to use on a daily basis when out visiting new babies and their families in Gloucestershire. The meters improve the process of testing

jaundiced babies, reducing cases of severe jaundice and beginning treatment of babies at high risk at the earliest opportunity.

The 2018/19 Dementia Appeal has funded six new reminiscence therapy devices known as RITAs. These are new touch screen technology which enables staff or volunteers to engage patients with activities including listening to music or poetry, watching films or historic cultural moments and group exercises. This helps staff to 'unlock' memories, trigger conversation and make patients feel more at ease, which in turn helps to improve both the patient experience and health.

The charity has also supported innovative studies including one with the potential to make a real impact for the many people who are undergoing diagnosis for thyroid cancer, both in the local area and across the UK. Using specially developed fibre-optic probes which can target tissue below the skin, the research team have previously demonstrated that it is possible to tell the difference between healthy and cancerous tissue by measuring the light emitted when a low power laser is shone upon the tissue; a technique called Raman spectroscopy. The study will develop the diagnostic technique further and demonstrate the potential to benefit people with thyroid cancer, who are often aged in their 30s or 40s.

There have been some great examples of staff fundraising across the year, including staff taking part in the annual Walk for Wards, and the stroke teams raising over £6,000 from cake sales and raffles. In the local community, the Gloucestershire Fire and Rescue Service pushed a hospital bed round all the fire stations in Gloucestershire, raising over £23,000 as they went to support local cancer patients.

The hospitals are also supported by grants from a number of local and national charities. The Gloucester and Cheltenham Leagues of Friends organisations have been providing that support for over 70 years. In December 2018, the Friends of Gloucestershire Royal took the decision to close. Both organisations have funded a many valuable projects in both hospitals, large and small, making a huge difference for our staff and patients. Other funders include LINC, Pied Piper, Cobalt Health, Gloucestershire Eye Therapy Trust, Gloucestershire Arthritis Trust and Daisychain Benevolent Fund to name a few.

Signed:

Deborah Lee
Chief Executive Officer

24 June 2019

4. DIRECTORS REPORT

OUR ORGANISATIONAL STRUCTURE

4.1 BOARD OF DIRECTORS

The Chair of the Board of Directors is Peter Lachecki, who was appointed Chair of Gloucestershire Hospitals NHS Foundation Trust in November 2016. The Chair is also the Chair of the Council of Governors and is appointed or removed by the Council of Governors. Eleven meetings of the Board of Directors were held in 2018/19. The dates of the meetings of the Board are advertised on the Trust's web site and displayed publicly at the entrance to Trust Headquarters, Alexandra House, Cheltenham General Hospital, Sandford Road, Cheltenham GL53 7AN. Agendas, papers and minutes are published on the website and are also available in hard copy at meetings and on request.

The Board is required to comply with its Standing Orders, Standing Financial Instructions and the Licence as issued by NHS Improvement, the independent regulator for Foundation Trusts. The Board is required to submit an annual plan to NHS Improvement and regular reports to confirm compliance with both the Trust's Financial and Governance targets.

4.2 GOVERNANCE

The Trust continues to refine its governance arrangements in line with The NHS Foundation Trust Code of Governance. 2018/19 saw further strengthening and maturing of the corporate governance arrangements, including the form and function of Board committee arrangements to ensure they are well placed to provide Board with the required levels of assurance. The Board's Standing Orders, Standing Financial Instructions and Scheme of Delegation were also revised to ensure fit for purpose governance arrangements which support compliance with the NHS Foundation Trust Code of Governance and best practice as well as delivery of the Trust's Strategic objectives.

The Trust also completed a review of the Board skills and experience and the Council of Governors undertook the Non-Executive Directors recruitment in the latter part of 2018/19.

The Operational Plan 2019/20 set out the Trust's financial, quality and operating objectives for the year and was an accurate reflection of the current shared vision of the Trust Board having had regard to the views of the Council of Governors and is underpinned by the strategic plan. The Operational Plan was consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans.

The Operational Plan will be available on the Trust's website by using the following link https://www.gloshospitals.nhs.uk/about-us/reports-and-publications/

The Directors are responsible for preparing the Annual Report and Accounts and they consider that, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and stakeholders to assess the Trust's performance, business model and strategy.

Details of the individuals who at any time during the financial year were directors of the Trust are set out below.

4.2.1 CHAIR

Peter Lachecki

Peter Lachecki is a former Non-Executive Director of Worcestershire Health and Care NHS Trust (2011 – 2016). He Chaired the Quality & Safety Committee, was a member of the Audit Committee and was deputy Chairman. His most senior appointment in a corporate role was as Global Category Director at Kraft Foods, where he led a complex group of internal functions including finance, sales and research and development.

Peter is a qualified executive coach and continues to run a coaching and team development business. He has been Chair at Gloucestershire Hospitals NHS Foundation Trust since November 2016.

Appointed until: 6 November 2019. Attended: 11/11 Board meetings.

4.2.2 NON-EXECUTIVE DIRECTORS

Non-Executive directors are appointed for three-year terms of office. They may serve two terms. Appointments may be terminated by the Council of Governors. All the Non-Executive Directors meet the independence criteria detailed in NHS Improvement's Code of Governance. Details of current terms of office are provided below.

Vice Chair: Rob Graves

Rob Graves has had an extensive career in the finance function of 3M Company (a component of the Dow Jones Industrial Average) including director level positions in the U.S.A, Belgium and the United Kingdom.

A qualified accountant, he has significant experience of leading large finance teams, serving complex business units, spanning operational accounting and business planning functions and has been instrumental in establishing a European shared service operation.

In 2011 he transferred to the Board of Gloucestershire Care Services NHS Trust where he served initially as Audit Chair and subsequently as Vice Chair and Chair of the Finance Committee prior to joining the Board of Gloucestershire Hospitals NHS Foundation Trust in February 2017.

Appointed until: 31 January 2020. Attended: 11/11 Board meetings.

Tracey Barber (to 31 August 2018)

Tracey Barber has spent much of her career in marketing in the private sector. As well as having extensive business skills, she is an experienced Non-Executive Director, having held roles at the 2gether Trust and the Ministry of Defence.

Despite working across nine businesses in the UK, Tracey finds time to commit to the area she lives in as well as spending valued time with her family.

Resigned with effect from: 31 August 2018. Attended: 2/6 Board meetings.

Claire Feehily

Claire Feehily has more than 30 years' experience in social care, health and housing sectors.

Formerly the Chair of Healthwatch Gloucestershire and an NHS non-executive director since 2010, Claire is also a qualified accountant. Currently Claire holds board positions with The Guinness Partnership, Alliance Homes and is the Audit Chair at The National Archive.

Claire has particular expertise in financial and risk governance, and in helping organisations to engage properly with those who use services and to learn from what they say. Claire provides Board oversight on Raising Concerns with the Freedom to Speak Up Guardian reporting to her on these issues.

Appointed until: 31 January 2020. Attended: 9/11 Board meetings.

Tony Foster (to 31 May 2018)

Tony Foster was formerly a Director of ICI Chemicals & Polymers Ltd and Chief Executive of ICI Chlorchemicals Business. He became a full-time member of the Criminal Cases Review Commission from 1997 to 2006 and was a member of the Council of the Competition Commission from 2003 to 2009.

He has been Chairman of the Animal Health and Veterinary Laboratories Agency, and a non-executive director of the Legal Ombudsman. He is currently a member of the Determinations Panel of the Pensions Regulator.

Appointed until: 31 May 2018. Attended: 3/3 Board meetings.

Alison Moon

A nurse since 1980 and with an MA in Management, Alison's focus is to ensure the highest possible quality healthcare services for all. Having trained at Bristol's Frenchay Hospital, Alison has held a variety of clinical and leadership roles across the NHS. Alison is an experienced Board level director having worked in a variety of NHS organisations in the South West and she has been on the Board of Trustees at St Peter's Hospice, Bristol since 2012.

Alison is the Independent Registered Nurse on the Governing Body of Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group and also provides Executive Coaching.

Alison has previously worked for Gloucestershire Hospitals NHS Foundation Trust and is delighted to be able to contribute again to developing and delivering high quality, patient-centred healthcare services for the people of Gloucestershire.

Appointed until: 3 September 2020. Attended: 10/11 Board Meetings.

Mike Napier (From 10 May 2018)

Mike Napier is an experienced senior executive with a background covering a range of corporate services. He spent 31 years with Royal Dutch Shell plc, during which time he headed their global Procurement, Real Estate and Corporate Communications divisions. He has lived and worked in a number of countries across five continents. He also has more than ten years' experience as a non-executive director in the UK.

Mike is a keen sportsman; he runs, plays golf and club cricket and also follows Gloucester County Cricket Club and Gloucester Rugby Club.

Appointed until: 31 May 2021 Attended: 8/10 Board meetings.

Keith Norton

Keith Norton is a retired Management Consultant, and spent the last part of his full-time career working on major projects in Cheltenham for eight years. He has extensive business skills, and is an experienced Non-Executive Director and Pension Trustee.

Keith lives near Tewkesbury and is a Life Patron (with his son) of the Cheltenham Music, Science, Jazz and Literature Festivals, a Volunteer at the Foodbank in Tewkesbury, and a member of Ronnie Scott's in London.

Appointed until: 30 April 2019. Attended: 8/11 Board meetings.

Associate Non-Executive Directors

In 2018/19 the Council of Governors agreed to create Associate Non-Executive Director role and subsequently recruited two individuals to that role. This is part of Board succession planning.

4.2.3 EXECUTIVE DIRECTORS

Chief Executive: Deborah Lee

Deborah Lee joined the Trust as Chief Executive Officer (CEO) in June 2016 from the University Hospitals Bristol NHS Foundation Trust (UHBNHSFT) where she was the Chief Operating Officer and Deputy CEO. As CEO, Deborah is ultimately responsible for the day-to-day management of the organisation and for implementing the long and short-term strategy.

Deborah has been nationally recognised by the Health Service Journal as one of the Top 50 Inspirational Women in Healthcare. She qualified originally as a registered nurse, before returning to university to read economics and subsequently gained an MBA from Bristol Business School.

Deborah started her NHS management career in 1990 and has worked in acute, primary and community sectors, holding board appointments in three different commissioning organisations before joining UHBNHSFT.

Attended 11/11 Board meetings.

Director of People and Organisational Development and Deputy Chief Executive: Emma Wood

Emma is an experienced executive whose specialisms include employee relations and engagement, organisational design and development, resourcing and talent development.

With a strong track record across both private and public sector, Emma previously worked at South Western Ambulance Service NHS Foundation Trust as well as Avon and Somerset Constabulary. Emma holds a BA in Psychology and Education and an MSC in Integrated Professional Practice from UWE. She is a Chartered Fellow of the Chartered Institute of Personnel and Development. Emma is currently studying for a PHD at the University of the West of England (UWE).

Attended 10/11 Board meetings.

Director of Corporate Governance: Lukasz Bohdan

Lukasz has responsibility for corporate governance across the Trust and acts as the principal advisor to the Chair, Chief Executive, Board, Council of Governors, clinical Divisions and the organisation as a whole on all aspects of governance ensuring the Trust benefits from high quality, progressive governance practices.

Prior to joining Gloucestershire Hospitals Lukasz led Oxfordshire Health and Care Transformation Programme and the Oxfordshire Clinical Commissioning Group's Programme Office, contributing to financial recovery of the CCG, system risk mitigations and new models of care across the health and care system.

His previous roles included leading corporate strategy, performance and change functions at Avon and Somerset Police, leading strategy development and implementation at the Audit Commission, business transformation work in local government and consultancy projects for government and private sector clients in Poland and the US.

Lukasz holds a Master of Law degree from the Jagiellonian University in Krakow, Poland, an MA from the University of Exeter, an MBA from the Open University Business School and the NHS Leadership Academy Award in Executive Healthcare Leadership

Attended 10/11 Board meetings.

Medical Director: Sean Elyan (to 28 February 2019)

Dr Sean Elyan was appointed as Medical Director at the end of 2005 and undertook this post 4 days per week whilst continuing with his clinical post as a Consultant Clinical Oncologist (Appointed to the Trust in 1993) for the rest of the time.

He had overall responsibility for medical leadership and jointly for clinical governance, quality and clinical leadership. He has an interest in service change and brought knowledge to the Trust from his national work on Schwartz rounds and with the Point of Care Foundation. He is also the Caldicott Guardian and the General Medical Council Responsible Officer.

Attended 9/10 Board meetings.

Director of Quality and Chief Nurse: Steve Hams

Steve Hams joined us as Executive Director of Quality and Chief Nurse in October 2017 and is responsible for nursing, midwifery, allied health professions and quality. He is also the Director of Infection Prevention and Control.

Steve has been a registered nurse for more than 20 years, having initially specialised in coronary care. Steve has held a number of senior nursing and commissioning posts in the NHS, voluntary sector and higher education and he and his family are residents of Gloucestershire.

Attended 8/11 Board meetings.

Digital and Chief Information Officer: Mark Hutchinson (from 1 October 2018)

Mark Hutchinson began as the Chief Digital and Information Officer at the Trust in October 2018. During 22 years working in Acute NHS Hospitals Mark has been involved in a number of ground-breaking projects. While CIO at Airedale NHS Trust he set up the first Telemedicine service in the NHS in England. Salford Royal NHS Trust were recognised as the most digitally mature hospital in the NHS after Mark implemented an Electronic Patient Record in 2013.

Attended 3/4 Board meetings

Director of Strategy and Transformation: Simon Lanceley

Simon joined the Trust in January 2018, from GE Healthcare Finnamore, a health and social care consultancy, where he worked with providers and commissioners across the country to design, plan and implement strategic and operational service change to improve clinical, operational and financial performance.

Simon has come back to the Trust, having previously worked in the role of Associate Director for Programme Management and Service Improvement and has over 12 years' experience of working in the NHS.

Simon is responsible for working with our partners, staff and patients to define the Trust's Strategy and for leading the Transformation Programme to get us there. Simon also has responsibility for Innovation, Research & Development, Business Planning and Communications.

Attended 10/11 Board meetings.

Chief Operating Officer: Caroline Landon

Caroline joined the Trust in October 2017 from Epsom and St Helier University Hospitals NHS Trust where she was Chief Operating Officer.

Caroline has worked in the NHS for more than 25 years and has come back to Gloucestershire Hospitals NHS Foundation Trust having previously worked in the role as Divisional Director of Operations. Before joining Epsom and St Helier, Caroline was Executive Director of Operations at West Hertfordshire Hospitals NHS Trust. Caroline has also worked in general surgery, women's services, theatre and anaesthetics, sexual health and also has experience in 18 week and emergency department performance roles.

Caroline is responsible for the day to day operational delivery of the services across the Trust and ensuring that we provide high quality services in an efficient and productive manner. She has shared responsibility for the overall strategic direction, performance and success of the Trust.

Attended 9/11 Board meetings.

Medical Director: Mark Pietroni (from 1 March 2019)

Dr Mark Pietroni was appointed on the 1 of March 2019, with an initial 6 month tenure.

Mark's career path has been varied, having spent 15 years in Bangladesh and, more recently, as Director of Public Health for South Gloucestershire; alongside this latter role Mark has worked as an Acute Physician and most recently also as Specialty Director for Unscheduled care at Gloucestershire Hospitals NHS Foundation Trust.

Mark will continue to practice as an acute physician one day a week while dedicating the rest of his week to his executive role.

Attended 1/1 Board meetings.

Director of Finance: Sarah Stansfield

Sarah Stansfield joined the Trust as Director of Operational Finance in May 2016 from Ernst & Young LLP where she was a consultant in the healthcare management team.

She started her NHS finance career in 2004 on the NHS Graduate Financial Management Training Scheme in Northamptonshire and has worked in Acute and Mental Health Trusts for over 10 years.

She has a BA in Economics and Econometrics from the University of Sheffield and is an Associate Member of the Chartered Institute of Management Accountants.

Attended 10/11 Board meetings.

4.3 BOARD'S BALANCE, COMPLETENESS AND APPROPRIATENESS

The Board undertook a self-assessment of its skills in summer 2018. This informed the subsequent recommendations to the Council of Governors regarding the skills and experience to be sought through non-executive director recruitment.

Overall, the Board considers it possess the appropriate balance, completeness and appropriateness of skills. Addressing the Board's diversity and ensuring the Board members represent the communities the Trust serves is an ongoing effort.

4.4 PERFORMANCE EVALUATION OF THE BOARD ITS COMMITTEES, AND ITS DIRECTORS

The Board and its committees undertake their performance evaluation both on an ongoing basis, through 'Board/Committee reflections at the end of each meeting and, periodically, through formal self-assessments and using best practice checklists.

The Chair undertakes the appraisal of the Chief Executive and Non-Executive Directors. The Senior Independent Director/Vice Chair undertakes the Chair's appraisal. The Chief Executive undertakes performance evaluation of Executive Directors.

4.5 REGISTER OF INTERESTS

A summary of the Register of Interests is given below. The full Register of Interests of the Board of Directors is available for public inspection at Trust Headquarters, Alexandra House, Cheltenham General Hospital, Sandford Road, Cheltenham. GL53 7AN and is published annually on the Trust website.

Name	Title	Interest
Lukasz Bohdan	Director of Corporate Governance	Director of Gloucestershire Hospitals Subsidiary Company (trading as Gloucestershire Managed Services)
Tracey Barber	Non-Executive Director	Non-Executive Director - Affinity Trust ACCEA Clinical Excellent Awards Committee
Sean Elyan	Medical Director	Clinical Advisor Kambia Appeal Hope for Tomorrow Acting Chair Advisor Medicine Unboxed
Claire Feehily	Non-Executive Director	Friend of Sue Ryder Trustee of the Heritage Lottery Fund / National Heritage Memorial Fund Director – Guinness Care (01/02/09 – 30/09/18) Trustee – Stroud Cotswold Citizens Advice Chair – Alliance Living Care & Independent Board Member Non-Executive Board Member of the National Archives
Tony Foster	Non-Executive Director	The Determinations Panel of the Pensions Regulator
Rob Graves	Non-Executive Director	Nil returns
Steve Hams	Director of Quality and Chief Nurse	Director of Curhams Ltd Partner is an employee of Oxford Radcliffe Hospitals NHSFT
Mark Hutchinson	Chief Digital and Information Officer	Formerly employed by Allscripts UK Formerly purchased an EPR from allscripts whilst working for Salford Royal NHS Trust Formerly purchased an EPR from Allscripts whilst working for University Hospital South Manchester NHS Foundation Trust
Peter Lachecki	Trust Chair	Managing Director, Lachecki Consulting Ltd
Simon Lanceley	Director of Strategy and Transformation	Nil returns
Caroline Landon	Chief Operating Officer	Nil returns
Deborah Lee	Chief Executive	My husband is an independent healthcare practitioner, though does not work within the Gloucestershire health system
Alison Moon	Non-Executive Director	Director A J Moon & Associates Ltd Independent Registered Nurse, Governing Body Bristol, North Somerset and South Glos Clinical Commissioning Group
Mike Napier	Non-Executive Director	Nil returns
Keith Norton	Non-Executive Director	Trustee Director, PA Pension Trustees Creditor of PA Consulting group Chair, Roses Theatre, Tewkesbury Managing Director – the Dower House

		Cider Company LTD (dormant)
Mark Pietroni	Medical Director	Nil returns
Sarah Stansfield	Interim Finance Director	Director – Gloucestershire Managed Services (to 13 September 2018)
Emma Wood	Director of People and Organisational Development	Nil returns

4.6 DECISIONS DELEGATED TO MANAGEMENT BY THE BOARD OF DIRECTORS

The scheme of delegation is included in the Trust's Standing Orders and the documents outlining Reservation of Powers to the Board and Delegation of Powers. This sets out the decisions which are the responsibility of the Board of Directors. These are actioned either by the Trust Board or a Committee of the Board.

4.7 STEPS THAT THE BOARD OF DIRECTORS HAVE TAKEN TO UNDERSTAND THE VIEWS OF GOVERNORS AND MEMBERS

The Chair of the Trust Board is also the Chair of the Council of Governors and is the conduit between the two bodies. The full Council of Governors meets at least six times a year and also holds an annual meeting. The Chief Executive and the Trust Secretary attend Council meetings and Executive Directors attend when necessary.

Non-Executive Directors are strongly encouraged to attend each Council of Governors meetings where they can be held to account for the performance of the Board.

The Chair reports to Board any issues raised by the Council of Governors and the Board receives the minutes of Council of Governors meetings for information. Further, as Board members are encouraged to regularly attend Council of Governors and participate in Governor working groups, they have first-hand knowledge of the issues raised by Governors. Nominated Governors attend Board Committees as observers and feed in views of Governors as part of each meeting's agenda.

4.8 INFORMATION TO AUDITORS

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

4.9 BOARD COMMITTEES

The Trust has a number of Board Committees involving Non-Executive Directors:

Committee	Non-Executive Director Representative
Audit and Assurance Committee	Rob Graves (Chair) Alison Moon Tony Foster (until 31 May 2018) Mike Napier (from 31 May 2018)
Finance and Digital Committee	Keith Norton (Chair) Tony Foster (until 31 May 2018) Mike Napier (from 31 May 2018) Claire Feehily
Gloucestershire Managed Services Committee	Rob Graves (Chair – until June 2018) Mike Napier (Chair – from June 2018) Keith Norton (until June 2018)

	Alison Moon (until June 2018) Claire Feehily (from June 2018)
People and Organisational Development Committee	Tracey Barber (Chair – until June 2018) Alison Moon (Chair – from June 2018) Keith Norton Rob Graves
Quality and Performance Committee	Claire Feehily (Chair) Tracey Barber (until 31 August 2018) Alison Moon Peter Lachecki (interim)
Remuneration Committee	Peter Lachecki (Chair) Tracey Barber (until 31 August 2018) Claire Feehily Tony Foster (until 31 May 2018) Rob Graves Mike Napier Keith Norton Alison Moon

4.10 COUNCIL OF GOVERNORS

As an NHS Foundation Trust we have established a Council of Governors, elected by our Membership base. At the end of March 2019 the Trust had 10,233 Public members and 9124 Staff members giving a total of 19,357 Foundation Trust Members.

The Council of The Council of Governors has an agreed Code of Conduct, a programme of meetings and a programme of involvement in Trust affairs. The Council of Governors is composed of 22 Governors. They represent Trust staff, public and patient constituencies and stakeholders: Governors act in the best interests of the Trust and adhere to its values and code of conduct. Alan Thomas is the Lead Governor who works closely with the Chair and Chief Executive and the relationship is based on mutual trust, integrity and openness.

Governor's statutory duties are to:

- Hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors.
- Appoint or remove the Chairman and Non-Executive Directors of the Trust
- Approve the appointment of future Chief Executives
- Appoint or remove the Trust's external auditors
- At the General Meeting receive the Trust's accounts and annual report
- Decide the remuneration, allowances and terms and conditions of office of the Non- Executive Directors.
- Represent the interests of Members of the Trust as a whole and the interests of the public
- Approve "significant transactions"
- Approve an application by the Trust to enter into a merger, acquisition, separation or dissolution
- Decide whether the Trust's non-NHS work would significantly interfere with its principal purpose, which is to provide goods and services for the health service in England, or performing its other functions
- With the Board of Directors approve amendments to the Trust's Constitution"

Governors have been involved in these activities during 2018/19 where appropriate and have been involved in many other activities during the year over which they continue to have an influence. They:

- have governor representatives on Board Committees
- receive presentations on issues of concern to their constituents
- feed back to the Trust views of the Trust's members, the public and, in case of the appointed governors, their organisations', on the Trusts forward plan, including its objectives, priorities strategy and delivery
- attend Members' seminars and tours on areas of interest
- shape strategies and goals

They have:

- undertaken review of the Trust's constitution
- engaged members within their constituencies and contributed to the development of the Governors' engagement plan
- participated in the development of new Trust strategy and values
- attended the Annual Meeting
- attended Governor development sessions
- been engaged in service reconfiguration discussions/planning

Acting on the recommendation of the Governors' Governance and Nominations Committee, and taking account of the Board skills stock take, during 2018 the Trust's Council of Governors agreed to proceed with the recruitment of non-executive directors and approved the job description, the process and the composition of the shortlisting panel (Chair of the Trust; Lead Governor; another Governor; and an independent assessor, in advisory capacity). The Council also approved the creation of Associate Non-Executive Director (Associate NED) role and led the recruitment process leading to appointment of two Associate NEDs.

The responsibilities of the Board of Directors in relation to governors are:

- To present to the Council of Governors at a general meeting the Annual Accounts, any report of the auditor on them and the Annual Report
- To have regard to the views of the Council of Governors in preparing its forward plan.

Non-Executive Directors of the Board regularly attend Council of Governor meetings and membership events to understand the views of Governors and Members. Executive Directors attend when necessary.

4.11 CONSTITUENCIES EXPLAINED

The **Public Constituencies** are geographical areas which share the same boundaries as Gloucestershire's six city, borough and district council areas. There is also a public constituency, Out of County, which is open to all patients who live outside Gloucestershire but who have been treated in the Trust's hospitals in the last three years.

The **Staff Constituency** is open to all those who are employed under a permanent contract of employment by the Trust, are employed for a minimum of twelve months on a short term contract, or are employed by shared or hosted services or working for external contractors in the Trust for at least 12 months.

There are also appointed **Stakeholder Governors** representing the local Clinical Commissioning Group, local authorities, Carers Gloucestershire and the Gloucestershire Healthwatch.

4.12 ELECTIONS

In 2018/19 no elections were needed as no governors came to the end of their Terms of Office. A member of the Council was co-opted following a vacancy arising in Cheltenham Constituency.

The Governors who currently serve on the Council are as follows:

CONSTITUENCY	NAME	LAST RESULT	FIRST ELECTED	TERM OF OFFICE	ELECTION DUE
PUBLIC					
Cheltenham Borough Council Area	Alan Thomas	Re-elected 2016	Jul 2013	3 years	2019
	Tim Callaghan	Elected 2018	May 2018	2 years	2020
Cotswold District Council Area	Jenny Hincks	Re-elected 2016	Sep 2010	3 Years	2019
	Anne Davies	Re-elected 2017	October 2016	3 years	2020
Forest of Dean District Council Area	Alison Jones	Elected 2017	October 2017	3 years	2020
	Valerie Wood	Elected 2017	October 2017	3 years	2020
Gloucester City Council Area	Liz Berragan	Elected 2017	October 2017	3 years	2020
	Graham Coughlin	Elected 2016	October 2016	3 years	2019
Out of County	Marguerite Harris	Elected 2017	October 2017	3 years	2020
Stroud District Council Area	Jeremy Marchant	Elected 2017	October 2017	3 years	2020
	Pat Eagle	Elected 2016	October 2016	3 years	2019
Tewkesbury Borough Council Area	Geoff Cave	Elected 2016	October 2016	3 years	2019
	Ann Lewis	Re-elected 2016	Jul 2013	3 years	2019
STAFF					
Allied Healthcare Professionals	Charlotte Glasspool	Elected 2017	October 2017	3 years	2020
Medical/Dental Staff	Dr Tom Llewellyn	Re-elected 2017	July 2015	3 years	2020
Nursing/Midwifery Staff	Sarah Mather	Elected 2017	October 2017	3 years	2020
	Sandra Attwood	Re-elected 2016	Sep 2010	3 years	2019
Other/Non-Clinical Staff	Nigel Johnson	Elected 2017	June 2017	3 years	2019
APPOINTED					
Gloucestershire County Council	Cllr Andrew Gravells	Appointed July 2017		3 years	2020
Gloucestershire CCG	Colin Greaves	Appointed April 2016		3 years	2019
Healthwatch	Maggie Powell	Appointed December 2017		3 years	2020
Carers Gloucestershire	Jacky Martel	Appointed March 2018		3 years	2021

** or to date of next County Council election, whichever is soonest.*

4.13 GOVERNORS' REGISTER OF INTERESTS

Under Section 30 of Schedule 7 of the National Health Service Act 2006, a Register of Governors' interests must be kept by each NHS Foundation Trust.

The full Register of Governors' interests is available for public inspection at Trust Headquarters, Alexandra House, Cheltenham General Hospital, Sandford Road, Cheltenham. GL53 7AN and is published annually on the Trust website.

The main purpose of this Register is to provide information of any pecuniary interest or other material benefit which a Governor receives, which might reasonably be thought by others to influence his/her actions, speeches or votes at Council meetings or actions taken in his/her capacity as a member of the Council of Governors.

Governor	Interests
Sandra Attwood	Nil returns
Richard Baker	Nil returns
Liz Berragan	Nil returns

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

Governor	Interests
Tim Callaghan	Wife is a Gloucestershire GP, Cancer Clinical Lead for Gloucestershire CCG and Chair of the Gloucestershire GP Education Trust (GGPET) - various from 2010
Geoff Cave	Nil returns
Graham Coughlin	Nil returns
Anne Davies	Nil returns
Pat Eagle	Nil returns
Charlotte Glasspool	Nil returns
Andrew Gravells	Nil returns
Colin Greaves	Nil returns
Marguerite Harris	Nil returns
Jenny Hincks	CTC -Councillor-none pecuniary 2007- 2019 CDC - councillor- none pecuniary 2011-2019 DART - Trustee -1997-current Watermoor school Board member - 2016-current Sarah Bowley Almshouses - 2016 - current Carers Glos Chair Alliance and CoAG 2015- 2019 Healthwatch member 2017-current WRVS (RVS) 1971-current GHNHSFT Governor Current Scope member 1995- current Temperance Trust - 2016-current
Nigel Johnson	Nil return
Alison Jones	Nil return
Ann Lewis	Nil return
Tom Llewellyn	Nil return
Jacky Martel	Employed by Carers Gloucestershire - we work in partnership with GHFT especially around our Hospital Liaison Officer but have no financial relationship (from 01/07/2018) Service User, as a relative
Jeremy Marchant	Nil returns
Sarah Mather	Nil returns
Maggie Powell	Nil returns
Alan Thomas	Chair HWG [Non Financial Personal] from 01/04/2017 to 31/03/2019 Membership of NICE COPD Guidelines Committee NICE Lay Member of the Technical Appraisal and Highly Specialised Technologies Appeal Panel (involvement payments) Member of NHSE's Stakeholder Forum for Digital Healthcare in Primary Care (involvement payments)
Valerie Wood	Nil returns

4.14 GOVERNOR ATTENDANCE AT COUNCIL MEETINGS

Governor attendance at Council meetings is recorded and reported to demonstrate to constituents that their elected and appointed governors are attending to discharge their duties and to fulfil a statutory requirement.

	18th April 2018	20th June 2018	15th August 2018	17th October 2018	19th December	20th February 2019	Total
Tim Callaghan Cheltenham Borough Council Area	-	✓	✓	✓	x	✓	4/6
Alan Thomas Cheltenham Borough Council Area	✓	x	✓	✓	✓	✓	5/6
Jenny Hincks Cotswold District Council Area	x	✓	x	✓	✓	✓	4/6
Anne Davies Cotswold District Council Area	✓	✓	✓	✓	✓	✓	6/6
Alison Jones Forest of Dean District Council Area	✓	x	x	✓	x	✓	3/6
Valerie Wood Forest of Dean District Council Area	✓	x	✓	x	✓	✓	4/6
Liz Berragan Gloucester City Council Area	x	✓	x	✓	✓	✓	4/6
Graham Coughlin Gloucester City Council Area	x	✓	x	✓	✓	x	3/6
Jeremy Marchant Stroud District Council Area	✓	✓	✓	✓	✓	✓	6/6
Pat Eagle Stroud District Council Area	✓	✓	✓	x	✓	x	4/6
Geoff Cave Tewkesbury Borough Council Area	✓	✓	x	✓	✓	x	4/6
Ann Lewis Tewkesbury Borough Council Area	x	✓	✓	✓	x	✓	4/6
Marguerite Harris Out of County	✓	✓	x	x	✓	x	3/6
Tom Llewellyn Staff (Medical/Dental)	✓	✓	✓	✓	✓	✓	6/6
Sarah Mather Staff (Nursing/Midwifery)	✓	✓	x	x	✓	✓	4/6
Sandra Attwood Staff (Nursing/Midwifery)	✓	✓	✓	✓	✓	✓	6/6
Charlotte Glasspool Staff (Allied Healthcare Professionals)	✓	✓	✓	✓	✓	✓	6/6
Richard Baker Staff (Non-clinical/Other)	✓	x	✓	-	-	-	2/3
Nigel Johnson Staff (Non-clinical/Other)	✓	x	✓	✓	✓	✓	5/6
Andrew Gravells Appointed (Gloucestershire County Council)	✓	x	✓	x	x	✓	3/6
Colin Greaves Appointed (Gloucestershire Clinical Commissioning Group)	✓	✓	✓	✓	✓	✓	6/6

	18th April 2018	20th June 2018	15th August 2018	17th October 2018	19th December	20th February 2019	Total
Maggie Powell Appointed (Healthwatch)	✓	✓	✓	✓	✓	✓	6/6
Jacky Martel Appointed (Carers Gloucestershire)	✓	✓	✓	✓	✓	✓	6/6

Key: ✓ attended
X apologies
- not in post

4.15 GOVERNANCE & NOMINATIONS COMMITTEE – 2018/19

The Council of Governors has a Governance and Nominations Committee. This is chaired by the Chair of the Trust/Council of Governors and its membership and attendance is shown in Table 1 below. The Committee conducts the general business on behalf of the full Council, such as the development and revision of processes and protocols for Chair and Non-Executive Director recruitment and their appraisals, the review of governor expenses and the work plan for the Council of Governors.

Additionally, the Council of Governors has delegated to the Governance & Nominations Committee work to undertake some of its statutory roles in particular the process for the re-appointment of Non-Executive Directors.

Six meetings were held during the year and members' attendance is recorded below:

Governor Attendance at Governance & Nomination Committee meeting

	9 April 2018	9 July 2018	8 October 2018	11 December 2018	14 January 2019	14 February 2019
Peter Lachecki Chair	✓	✓	✓	✓	✓	✓
Rob Graves Senior Independent Director	✓	✓	✓	✓	✓	✓
Alan Thomas Lead Governor	✓	✓	✓	✓	**X**	✓
Nigel Johnson Governor	✓	✓	✓	✓	✓	✓
Tom Llewellyn Governor	✓	✓	✓	**X**	✓	✓
Geoff Cave Governor	**-**	**-**	**-**	✓	✓	**X**

Key: ✓ present
X apologies
- not in post

4.16 GOVERNORS ATTENDANCE AT BOARD COMMITTEES

Elected Governors sit on the Governance & Nominations Committee

Nominated Governors attend Trust Board Committees as Observers as follows:

Committee	Governor Representative (s)
Audit and Assurance Committee	Lead: Marguerite Harris Deputy: Colin Greaves
Finance and Digital Committee	Lead: Alan Thomas
Gloucestershire Managed Services Committee	Lead: Nigel Johnson Deputy: Graham Coughlin (from October 2018)
Quality and Performance Committee	Lead: Graham Coughlin (until October 2018) Lead: Geoff Cave (from October 2018) Deputy: Anne Davies
People and Organisational Development Committee	Staff Lead: Richard Baker (until September 2018) Staff Lead: Charlotte Glasspool (from October 2018) Staff Deputy: Sarah Mather Public Lead: Geoff Cave (until October 2018) Public Lead: Liz Berragan (from October 2018) Public Deputy: Pat Eagle

4.17 OTHER MANDATORY DISCLOSURES

Anti-Bribery

Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) is committed to applying the highest standards of ethical conduct and integrity in its business activities. Every employee and individual acting on behalf of GHNHSFT is responsible for maintaining the organisation's reputation and for conducting GHNHSFT's business lawfully and professionally.

The Trust defines bribery as a financial advantage or other reward that is offered to, given to, or received by an individual or company (whether directly or indirectly) to induce or influence that individual or company to perform public or corporate functions or duties improperly. Bribery does not have to involve cash or an actual payment exchanging hands and can take many forms such as a gift, lavish treatment during a business trip or tickets to an event. Employees and others acting for or on behalf of the organisation are strictly prohibited from making, soliciting or receiving any bribes or unauthorised payments. Employees and other individuals acting for the organisation should note that bribery is a criminal offence that may result in up to 10 years' imprisonment and/or an unlimited fine for the individual and an unlimited fine for the organisation.

Bribery and corruption has a detrimental impact on the GHNHSFT business by undermining good governance and organisational integrity. We benefit from carrying out our functions in a transparent and ethical way and thereby helping to ensure that there is honest, open and fair competition in the NHS. Where there is a level playing field, GHNHSFT can lead by example and deliver excellent services to our patients.

The Board and senior management team are committed to implementing and enforcing effective systems throughout GHNHSFT to prevent, monitor and eliminate bribery, in accordance with the Bribery Act 2010.

The GHNHSFT has developed, and regularly reviews, key policies outlining our position on preventing and prohibiting fraud and bribery, promoting the highest standards of business conduct and managing conflicts of interest. These policies include the Counter Fraud, Bribery and Corruption policy Policy, Bribery and Corruption

policy, Standards of Business Conduct and the Speaking Out Policy. These policies, which are available on the GHNHSFT intranet, apply to all employees as well as temporary and agency workers, management consultants and contractors acting for or on behalf of the GHNHSFT. All employees and other individuals acting for the GHNHSFT are required to familiarise themselves with the GHNHSFT policies and comply with any amendments with immediate effect.

As part of its anti-bribery measures, the organisation is committed to transparent, proportionate, reasonable and bona fide hospitality and promotional expenditure. Such expenditure must only be offered or accepted in accordance with the procedures set out in the organisation's policies. A breach of the organisation's Standards of Business Conduct policy by an employee will be treated as grounds for disciplinary action, which may result in a finding of gross misconduct, and immediate dismissal.

GHNHSFT will not conduct business with service providers, agents or representatives that do not support the organisation's anti-bribery objectives. We reserve the right to terminate its contractual arrangements with any third parties acting for, or on behalf of, the organisation with immediate effect where there is evidence that they have committed acts of bribery.
The success of the organisation's anti-bribery measures depends on all employees, and those acting for the organisation, playing their part in helping to detect and eradicate bribery. Therefore, all employees and others acting for, or on behalf of, the organisation are encouraged to report any suspected bribery. Employees are encouraged to use internal reporting procedures as set out in the Speaking Out Policy and the Counter Fraud, Bribery and Corruption policy. GHNHSFT will support any individuals who make such a report, provided that it is made in good faith.

However, employees can also report their concerns externally as an alternative to internal reporting procedures if they wish to remain anonymous to the Local Counter Fraud Service on ghn-tr.fraudaccountmailbox@nhs.net or call 0300 422 2726/2753 01452 318 842/826; http://www.gloshospitals.nhs.uk/en/Wards-and-Departments/Other-Departments/Counter-Fraud-Service/Contact-Us/ or via

The NHS Fraud and Corruption Reporting Line on Freephone 0800 028 40 60 or by filling in an online form at www.reportnhsfraud.nhs.uk. This provides an easily accessible route for the reporting of genuine suspicions of fraud / bribery within or affecting the NHS. All calls are dealt with by experienced caller handlers.

A statement that the Trust has complied with the cost allocation and charging guidance issued by HM Treasury

The Directors confirm that the Trust has complied with the cost allocation and charging guidance issued by HM Treasury

Details of political donations (if any)

Not applicable.

Consultancy spend

£2.8m was spent on consultancy fess during 2017-18, to support a number of the Trusts key objectives.

Disclosures relating to NHS Improvement's well-led framework

Material inconsistencies between the Annual Governance Statement (AGS) , the corporate governance statement, the quality report, and annual report and reports arising from Care Quality Commission planned and responsive reviews of the NHS foundation trust and any consequent action plans developed by the NHS foundation trust.

There are no material inconsistencies between the AGS, the Quality Report, and Annual Report and reports arising from Care Quality Commission planned and responsive reviews of the NHS foundation trust and any consequent action plans developed by the NHS foundation trust.

How the foundation trust has had regard to NHS Improvement's well-led framework in arriving at its overall evaluation of the organisation's performance, internal control and board assurance framework and a summary of action plans to improve the governance of quality.

Gloucestershire Hospitals NHS Foundation Trust has had regard to NHS Improvement's well-led framework in in arriving at its overall evaluation of the organisation's performance, internal control and board assurance framework. Detailed discussion of the Trust's performance is included in Section 3: Performance report; Section 6 Quality report and Section 10 Annual Governance Statement. During 2018/19 the Trust underwent the CQC Well-Led inspection, which led to an overall 'Good' rating. Due to the overlap between the NHSI and CQC framework, and in consultation with NHSI, the Trust did not undertake externally facilitated review against the NHSI well-led framework.

Signed

Deborah Lee
Chief Executive Officer

24 June 2019

5 MEMBERSHIP REPORT

This section describes the current state of the Trust membership including the number of members per constituency, the movement of members, and their representation in relation to each constituency population. It also outlines the steps for future recruitment.

Public Constituency	**Numbers**
Cheltenham	2,217
Cotswolds	1,309
Forest of Dean	1,152
Gloucester	2,275
Stroud	1,597
Tewkesbury	1,664
Unknown	19
Out of County	808
TOTAL	**10,233**

Staff constituency	
AHP/scientific/technical staff	1,002
Medical/Dental	1,053
Nursing/Midwifery	2,591
Other	4,478
TOTAL	**9,124**

Table 1 Membership size and movement

Public constituency	**2016 - 2017**	**2017 - 2018**	**2018 - 2019**
At year start (April 1)	10,935	10,434	10,120
New members	185	75	126
Members leaving	686	389	14
At year end (March 31)	10,434	10,120	10,233
Staff constituency	**2016 - 2017**	**2017 - 2018**	**2018 - 2019**
At year start (April 1)	8,373	8,849	8967
New members	1,722	1,650	1803
Members leaving	1,459	1,619	1646
At year end (March 31)	8,739	8,880	9124
	Staff data supplied from ESR by GHNHSFT Workforce Information Department		
Out of County constituency	**2016 - 2017**	**2017 - 2018**	**2018 - 2019**
At year start (April 1)	699	697	808
New members	33	126	0
Members leaving	35	15	0
At year end (March 31)	697	808	818

Table 2 Analysis of current membership

Analysis of current membership		
Public constituency	**Number of members**	**Eligible membership**
Age (years):		
0-16	5	121,737
17-21	28	34,516
22+	3,312	475,857
Ethnicity:		
White	568	569,647
Mixed	4	8,661
Asian or Asian British	7	12,433
Black or Black British	5	5,150
Other	0	1,093
Socio-economic groupings*:		
AB	3,112	46,082
C1	2,941	56,218
C2	2,048	40,063
DE	1,955	39,181
Gender analysis		
Male	4,162	309,156
Female	6,014	321,795
Out of County constituency	**Number of members**	**Eligible membership**
Age (years):		
0-16	0	
17-21	0	
22+	808	

The analysis section of this report excludes:
- 6888 public members with no dates of birth, 1538 members with no stated ethnicity and 57 members with no gender
- 620 patient members with no dates of birth

Membership Commentary

Movement of Members

The public constituencies have seen an increase of 113 members. The Trust has not actively recruited new members during 2018-2019. Members have been recruited through our volunteering scheme, staff leavers being invited to join the public constituency and through the Trust webpages. The Trust has invested further in the corporate governance/membership function and an 18 month engagement action plan is underway to support engagement with members and eventually further recruitment.

Representation of membership

Public Constituency

Any resident over the age of 16 in the Gloucestershire County can become a member of the Public Constituency.

Age

The 22+ age group remains over represented with the 0-16 and 17-21 age groups under represented.

Gender

Gender analysis identifies that our membership is unbalanced against the eligible population, with an under-representation continuing in the Male Gender category.

Ethnicity

There is reasonably balanced ethnic representation in membership with over representation of the 'Asian/Asian British' and under-representation of members identifying themselves in the 'Mixed' category.

Staff constituency

Staff members are part of an 'opt out' scheme and so the membership will for the most part be reflective of our workforce. Staff members rarely opt-out of membership.

Membership Eligibility

The Trust has two types of membership constituencies: public constituencies and staff constituencies.

Members of the Public Constituency are individuals who are:

- Live in the area of the Trust
- Are not eligible to become members of the Staff Constituency
- Are not disqualified from Membership
- Are at least 16 years of age at the time of their application to become a Member

The Public Constituency is divided in the following classes:

- Cheltenham Borough Council Area
- Tewkesbury Borough Council Area
- Stroud District Council Area
- Cotswolds District Council Area
- Gloucester City Council Area
- Forest of Dean District Council Area
- Out of County

Out of County membership applies to those who live in areas outside of Gloucestershire where the Trust provides services, including:

- Bristol
- Herefordshire
- Oxfordshire
- Somerset
- South Gloucestershire
- Swindon
- Warwickshire
- Wiltshire
- Worcestershire
- Aneurin Bevan University Health Board area
- Powys Teaching Health Board area

Members of the Staff Constituency are individuals who are:

- Employed under a contract of employment with the Trust which has no fixed term or a fixed term of at least 12 months, or
- Have been continuously employed under a contract of employment with the Trust for at least 12 months; or
- Not so employed but who nevertheless exercise functions for the purposes of the Trust and who have exercised the functions for the purposes of the Trust continuously for at least 12 months. For the avoidance of doubt, this does not include those who assist or provide services to the Trust on a voluntary basis.
- who have not been disqualified from Membership

The Staff Constituency is divided into the following classes:

- The Medical and Dental Staff class
- The Nursing and Midwifery Staff class
- The Allied Health Professionals Staff class
- The Other/ Non-Clinical Staff class

Membership Strategy

A new membership strategy was developed during 2017 and agreed by Governors at their Strategy and Engagement meeting on 15th June 2017.

The agreed objectives for 2017-2020 were:

Objective 1 – To build and maintain our membership numbers by actively recruiting and retaining members

Objective 1: Key objectives for 2017-2018

- To maintain an accurate membership database
- Targeted recruitment drives
- Review recruitment material to reflect new stratification of membership

Objective 2 – To effectively engage and communicate with members

Objective 2: Key objectives for 2017-2018

- To make the membership webpage more accessible
- Use social media to communicate with members
- To promote the work of the Trust and its Governors through Members' newsletter
- Make opportunities for members to meet Governors
- Re-develop the welcome letter for members to include an e-welcome pack
- Provide members with more opportunities to engage with Trust work including opportunities to become involved in quality improvement

The implementation of an effective database management system at the beginning of the 2015/16 year has allowed us to continue maintaining accurate data from that point. This database management system has allowed us to increase the number of members that we communicate with using email and therefore, engage with our members more effectively too.

Members continue to receive the membership newsletter, Involve with positive feedback being received from members as to the content and presentation of this publication. This now also includes articles from governors explaining their role and recent events and activities they have taken part in. Relationships continue to build between the hospital charity and our members with communication about our charity being sent to members.

Members have also had the opportunity to:

- Review patient information through the regular patient experience report shared with the Council of Governors
- Deliver patient stories to Board
- Attend three seminars
- Become more involved in staff training
- Become patient advisors on Research and Development
- Become a Governor including
- Attend the Annual Members Meeting
- Become Patient Assessors for Patient Led Assessments of the Care Environment (PLACE)
- Continue to be involved in the Leading Together project
- Participate in a survey on NHS funded patient transport
- Workshops and training provided by the National Institute for Health Research

A refreshed Membership Strategy will be developed throughout 2019 for 2020 with membership priorities for the Trust as directed by the Governors.

5.1 Contacting Trust Governors and Directors

Members who wish to contact Governors or Directors may do so by writing to the Trust Secretary, at Trust Headquarters, Alexandra House, Cheltenham General Hospital, Sandford Road, Cheltenham GL53 7AN

Signed

Deborah Lee
Chief Executive Officer

24 June 2019

6 REMUNERATION REPORT

6.1 ANNUAL STATEMENT ON REMUNERATION

The Remuneration Committee of the Trust is established in accordance with Schedule 7 of NHS Act 2006, applicable sections of the Companies Act 2006 (420-422), Regulation 11 and parts 3 and 5 of schedule 8 of the Large and medium sized companies and groups (accounts and reports). Regulations 2008 (SI 2008/410), parts 2 and 4 of schedule 8 of the Regulations as adopted by NHSI and the NHS Foundation Trusts Code of Governance.

The Committee determines the remuneration, allowances and other terms of office of the Executive Directors. The Trust's Remuneration Committee comprises the Trust Chair and all Non-Executive Directors. The Committee is attended by the Chief Executive and others at the request of the Chair in an advisory capacity where appropriate.

Four meetings were held during the financial year, on 12 June 2018, 12 July 2018, 10 January 2019 and 14 March 2019 and attendance is recorded below:

Members Present 12 June 2018		**In Attendance**
Peter Lachecki		Deborah Lee[1]
Rob Graves		Lukasz Bohdan[2]
Keith Norton		

Members Present 12 July 2018		**In Attendance**
Peter Lachecki	Rob Graves	Deborah Lee[3]
Alison Moon	Mike Napier	
Keith Norton		

Members Present 10 January 2019		**In Attendance**
Peter Lachecki	Rob Graves	Deborah Lee[4]
Alison Moon	Mike Napier	Lukasz Bohdan[5]
Keith Norton		Natashia Judge[6]

Members Present 14 March 2019		**In Attendance**
Peter Lachecki	Alison Moon	Deborah Lee[7]
Claire Feehily	Mike Napier	Natashia Judge[8]
Rob Graves	Keith Norton	

1. *The Chief Executive was in attendance to present a report on Gloucestershire Managed Services (GMS) Interim Chair's Extension.*
2. *The Director of Corporate Governance was in attendance to present reports on GMS Interim Finance and Commercial Director Appointment and Permanent GMS Recruitment.*
3. *The Chief Executive was in attendance to present a report on Executive Chief Digital and Information Officer Remuneration.*
4. *The Chief Executive was in attendance to present a report on Pensions Lifetime Allowance, Very Senior Manager Pay Guidance and New Executive Director Terms and Conditions.*
5. *The Director of Corporate Governance was in attendance to present the revised Terms of Reference for the Committee.*
6. *Either the Corporate Governance Manager or Director of Corporate Governance attends, at the request of the Chair, in their capacity as the Officer to the Committee to minute the proceedings.*
7. *The Chief Executive was in attendance to present reports on new Terms and Conditions for the Medical Director and a paper on the appointment of a substantive Chair to Gloucestershire Managed Services.*

8. *Either the Corporate Governance Manager or Director of Corporate Governance attends, at the request of the Chair, in their capacity as the Officer to the Committee to minute the proceedings.*

The Committee considers and acts with delegated authority from the Board on all matters concerning Executive Director remuneration and terms of service. It considers internal and external comparisons on Executive Director remuneration using available market intelligence, a review of regional trends, NHS provider data and the NHSI VSM benchmarks.

In 2018/19 the remuneration committee agreed to implement the NHSI recommended VSM uplift across the Executive Team where the eligibility criteria had been met.

In addition the Remuneration committee increased the CEO's remuneration to ensure it was aligned to the national benchmarks, having been below the lower quartile benchmark for *Very Large Acute Trusts*. Due process was followed in terms of seeking NHSI and ministerial opinion.

Non-Executive Directors' remuneration and terms and conditions of service are developed and reviewed periodically by the Council of Governors' Governance and Nominations Committee (G&N Committee) and ratified by the Council of Governors.

All Directors of the Trust are subject to individual performance review. This involves the setting and agreeing of objectives for a 12 month period running from 1 April to 31 March. In terms of measuring performance:

- Executive Director performance is reviewed by the Chief Executive throughout the year at regular one to ones and annually in an appraisal; this is informed by 360 feedback from Board members and direct reports.
- The Chairman undertakes the performance review of the Chief Executive and Non-Executive Directors; these are also informed by 360 feedback from Board members and in the case of the Chief Executive other external stakeholders. The appraisal of Non-Executive Directors is overseen by the G&N Committee.
- The Chairman is appraised by the Senior Independent Director who seeks views widely from members of the Board, governors and other stakeholders.

Following the establishment of the Estates and Facilities Subsidiary Company, Gloucestershire Managed Services (GMS), the Remuneration Committee also oversees the terms and conditions of the Subsidiary's Directors as a reserved matter linked to the Company's articles of association. Remuneration for Directors of GMS is established given due regard to internal benchmarks and the market place as applied to private estates and facilities companies in the region.

Peter Lachecki
Chair

24 June 2019

6.2 SENIOR MANAGERS' REMUNERATION POLICY

Executive Directors are employed on permanent contracts. Their remuneration is set with consideration of the NHSI benchmarks for very large acute trusts, and final salary influenced by other market factors to ensure the Trust attracts and retains the very best talent. Additional allowances relating to car and relocation are offered to those who qualify and are paid in line with HMRC guidance.

Executives are contracted to six months' notice and termination/loss of office period and benefit from standard NHS terms and conditions relating to sickness benefits, pension, redundancy, maternity, paternity and others. Loss of office could be unremunerated if there was a finding of gross misconduct. Further details of these standard offers can be found on the Department of Health website. Following these terms ensures consistency with other employee benefits and terms of conditions and parity against all groups of employees. The Trust does not consult employees on senior manager remuneration as the standard terms and conditions are offered and national benchmarks for remuneration met and not exceeded.

Remuneration Components
The table below describes the elements of remuneration that support attraction and retention of Senior Management talent into our Trust, supporting the delivery of our short and long term strategic objectives.

In line with NHSI requirements, all Executive Directors are subject to a potential claw back of 10% annual salary for Executives who fail to meet adequate standards of performance; no Executive in 2018/19 had monies clawed back.

Where Executives have met or exceeded the £150,000 threshold, opinion has been sought and obtained in accordance with the Treasury rules.

Remuneration Component	**Description**	**Maximum amount available**
Annual Salary	Determined through NHSI Benchmarks for very large Acute Trusts Consideration given to market forces and breadth of role.	In line with NHSI requirements, all Executive Directors are subject to a potential claw back of 10% annual salary, for Executives who fail to meet adequate standards of performance
Relocation Allowance	Relocation expenses offered where appropriate, subject to local policy and HMRC rules	Payment in line with HMRC guidance.
Car Lease Allowance or Salary Uplift	Car lease or salary uplift (Executive Directors)	Up to 3% salary uplift, or car lease allowance
Other Agenda for Change Terms	Standard NHS terms and conditions relating to sickness benefits, pension, redundancy, maternity, paternity and others	Maximum available in accordance with Agenda for Change

The start dates for Executive Directors are:

Lukasz Bohdan	13 November 2017
Sean Elyan	1 November 2005 – 28 February 2019
Steve Hams	25 September 2017
Mark Hutchinson	1 October 2018
Simon Lanceley	8 January 2018
Caroline Landon	19 October 2017 – 31 March 2019
Deborah Lee	13 June 2016
Mark Petroni (secondment)	1 March 2019
Sarah Stansfield (acting up)	18 April 2018 – 10 June 2018
Sarah Stansfield (substantive)	11 June 2018
Emma Wood	1 November 2017
Steve Webster	19 June 2017 – 12 April 2018

The start and end dates for Non-Executive Directors are:

Claire Feehily	1 February 2017 – 31 January 2020
Rob Graves	1 February 2017 – 30 January 2020
Peter Lachecki	7 November 2016 – 6 November 2019
Alison Moon	4 September 2017 – 3 September 2020
Mike Napier	10 May 2018 – 9 May 2021
Keith Norton	1 May 2016 – 30 April 2019

The start dates for Gloucestershire Managed Services (GMS) Non-Executive Directors are:

Role	**Post Holder**	**Appointed***	**Resigned***
Chair	Kathy Headdon	10 April 2018	N/A
Independent Non-Executive Director	Kaye Law-Fox	8 November 2018	N/A
Trust-appointed Non-Executive Director	Lukasz Bohdan	22 December 2017	N/A
Trust-appointed Non-Executive Director**	Sarah Stansfield	8 March 2018	13 September 2018
Trust-appointed Non-Executive	Jonathan Shuter	13 September 2018	
Managing Director	Neil Jackson	8 March 2018	N/A
Finance and Commercial Director***	Simon Wadley	18 March 2019	

* 'Appointed' and 'Resigned' dates reflect Companies House records.
** Steve Webster held post of Director between 22 December 2017 – 31 March 2018
*** Rod Anthony was of interim Finance and Commercial Director. He was not a Director registered with the Companies House.

Governor Expenses

In 2018/19: 23 governors have been in office and eligible to claim travel and parking expenses.

The total number of governors claiming expenses was 7 and total amount of expenses claimed was £1,802.00.

This compares to a total number of 10 governors claiming expenses in 2017/18 at a total value of £1763.93.

Non-Executive Director Expenses

In 2018/19: 7 non-executive directors have been in office and eligible to claim travel and parking expenses.

The total number of non-executive directors claiming expenses was 5 and total amount of expenses claimed was £1408.15

Salary and Pension entitlements of executive and non-executive directors							
Name and title		Salary	Expense payments (taxable) to nearest £100	Performance pay and bonuses	Long term performance pay and bonuses	All pension related benefits	Total Remuneration
Year ended 31 March 2019		(Bands of £5,000)	(£)	(Bands of £5,000)	(Bands of £5,000)	(Bands of £2,500)	(Bands of £5,000)
Peter Lachecki	Chair	50-55	0	N/A	N/A	0	50-55
Tony Foster	Non Executive Director	0-5	0	N/A	N/A	0	0-5
Keith Norton	Non Executive Director	10-15	0	N/A	N/A	0	10-15
Tracey Barber	Non Executive Director	5-10	0	N/A	N/A	0	5-10
Dr Claire Feehily	Non Executive Director	10-15	0	N/A	N/A	0	10-15
Robert Graves	Non Executive Director	15-20	0	N/A	N/A	0	15-20
Alison Moon	Non Executive Director	10-15	0	N/A	N/A	0	10-15
Mike Napier	Non Executive Director	10-15	0	N/A	N/A	0	10-15
Deborah Lee	Chief Executive	225-230	0	N/A	N/A	137.5-140	360-365
Caroline Landon	Chief Operating Officer	140-145	0	N/A	N/A	47.5-50	190-195
Dr Sean Elyan[1]	Medical Director (1 November 2005 - 1 March 2019)	175-180	0	N/A	N/A	0-2.5	175-180
Simon Lanceley	Director of Strategy and Transformation	135-140	0	N/A	N/A	135-137.5	270-275
Steve Hams	Nursing Director	135-140	0	N/A	N/A	87.5-90	225-230
Emma Wood	Director of Human Resources	145-150	0	N/A	N/A	42.5-45	185-190
Sarah Stansfield	Director of Finance (acting 18 April - 11 June 2018, substantive 11 June 2018)	145-150	0	N/A	N/A	80-82.5	230-235
Lukasz Bohdan	Director of Corporate Governance	95-100	0	N/A	N/A	30-32.5	130-135
Mark Pietroni	Medical Director (secondment 1 March 2019)	5-10	0	N/A	N/A	42.5-45	50-55
Steve Webster	Director of Finance (19 June 2017 -12 April 2018)	5-10	0	N/A	N/A	0-2.5	5-10
Mark Hutchinson	Digital & Chief Information Officer (from 1 October 2018)	55-60	0	N/A	N/A	12.5-15	70-75

Note:

1 Dr Sean Elyan received salary of £87,854 for clinical duties that is included in salary and fees

*relevant figures subject to audit

Salary and Pension entitlements of executive and non-executive directors							
Name and title		Salary	Expense payments (taxable) to nearest £100	Performance pay and bonuses	Long term performance pay and bonuses	All pension related benefits	Total Remuneration
Year ended 31 March 2018		(Bands of £5,000)	(£)	(Bands of £5,000)	(Bands of £5,000)	(Bands of £2,500)	(Bands of £5,000)
Peter Lachecki	Chair	50-55	0	N/A	N/A	0	50-55
Tony Foster	Non Executive Director	10-15	0	N/A	N/A	0	10-15
Keith Norton	Non Executive Director	10-15	0	N/A	N/A	0	10-15
Tracey Barber	Non Executive Director	10-15	0	N/A	N/A	0	10-15
Dr Claire Feehily	Non Executive Director	10-15	0	N/A	N/A	0	10-15
Robert Graves	Non Executive Director	15-20	0	N/A	N/A	0	15-20
Alison Moon	Non Executive Director with effect from 4th September 2017	5-10	0	N/A	N/A	0	5-10
Rhona MacDonald	Non Executive Director with effect until 2nd April 2017	0-5	0	N/A	N/A	0	0-5
Deborah Lee	Chief Executive	190-195	0	N/A	N/A	30-32.5	220-225
Natasha Swinscoe	Director of Service Delivery with effect until 21st May 2017	20-25	0	N/A	N/A	55-57.5	70-75
Arshiya Khan	Director of Service Delivery with effect from 22nd May 2017 to 31st October 2017	50-55	0	N/A	N/A	97.5-100	150-155
Caroline Landon	Chief Operating Officer with effect from 19th October 2017	65-70	0	N/A	N/A	50-52.5	120-125
Dr Sean Elyan[1]	Medical Director	175-180	0	N/A	N/A	47.5-50	225-230
Dr Sally Pearson	Director of Clinical Strategy with effect untl 30th January 2018	125-130	0	N/A	N/A	0-2.5	125-130
Simon Lanceley	Director of Strategy and Transformation with effect from 8th January 2018	30-35	0	N/A	N/A	5-7.5	35-40
Maggie Arnold	Nursing Director with effect until 9th October 2017	60-65	0	N/A	N/A	0-2.5	60-65
Steve Hams	Nursing Director with effect from 25th September 2017	65-70	0	N/A	N/A	77.5-80	145-150
David Smith[2]	Director of Human Resources with effect until 2nd November 2017	60-65	16	N/A	N/A	0-2.5	60-65
Emma Wood	Director of Human Resources with effect from 1st November 2017	60-65	0	N/A	N/A	42.5-45	100-105
Sarah Stansfield	Director of Finance with effect from 1st April 2017 to 18th June 2017	30-35	0	N/A	N/A	52.5-55	80-85
Steve Webster	Director of Finance with effect from 19th June 2017	125-130	0	N/A	N/A	0-2.5	125-130
Lukasz Bohdan	Director of Corporate Governance with effect from 13th November 2017	35-40	0	N/A	N/A	25-27.5	60-65

Note:

1 Dr Sean Elyan received salary of £85,020 for clinical duties that is included in salary and fees

2 David Smith taxable benefit relates to a lease car

*relevant figures subject to audit

Director Pensions 2018/19								
Pension benefits of Senior Managers		**Real increase/(decrease)in pension at pension age**	**Real increase/(decrease)in pension lump sum at pension age**	**Total accrued pension at pension age at 31 March 2019**	**Lump sum at age pension age related to accrued pension at 31 March 2019**	**Cash Equivalent Transfer Value as at 1 April 2018**	**Real increase/(decrease) in Cash Equivalent Transfer Value**	**Cash Equivalent Transfer Value as at 31 March 2019**
		(Bands of £2,500)	**(Bands of £2,500)**	**(Bands of £5,000)**	**(Bands of £5,000)**	**£'000**	**£'000**	**£'000**
Deborah Lee	Chief Executive	7.5 to 10	15 to 17.5	45 to 50	130 to 135	806	236	1,042
Mark Pietroni	Medical Director (secondment 1 March 2019)	0 to 2.5	0 to 2.5	10 to 15	5 to 10	142	5	199
Caroline Landon	Chief Operating Officer	2.5 to 5	0 to 2.5	15 to 20	0 to 5	137	65	202
Dr Sean Elyan1	Medical Director (1 November 2005 - 1 March 2019)	0 to 2.5	0 to 2.5	0 to 5	0 to 5	1,560	0	0
Mark Hutchinson	Digital & Chief Information Officer (from 1 October 2018)	0 to 2.5	0 to 2.5	35 to 40	95 to 100	512	48	609
Simon Lanceley	Director of Strategy and Transformation	7.5 to 10	0 to 2.5	10 to 15	0 to 5	58	101	159
Steve Hams	Nursing Director	5 to 7.5	7.5 to 10	30 to 35	85 to 90	418	135	553
Emma Wood	Director of Human Resources	2.5 to 5	0 to 2.5	10 to 15	0 to 5	78	52	130
Sarah Stansfield	Director of Finance (acting 18 April - 11 June 2018, substantive 11 June 2018)	5 to 7.5	0 to 2.5	15 to 20	0 to 5	109	68	181
Steve Webster	Director of Finance (19 June 2017 -12 April 2018)	0 to 2.5	0 to 2.5	0 to 5	0 to 5	1,398	0	0
Lukasz Bohdan	Director of Corporate Governance	0 to 2.5	0 to 2.5	5 to 10	0 to 5	48	35	82

No pension contributions were made in 2018/19 in respect of Steve Webster

Dr Sean Elyan opted out of contributions from 01-01-2018

*relevant figures subject to audit

Director Pensions 2017/18								
Pension benefits of Senior Managers		**Real increase/(decrease)in pension at pension age**	**Real increase/(decrease)in pension lump sum at pension age**	**Total accrued pension at pension age at 31 March 2018**	**Lump sum at age pension age related to accrued pension at 31 March 2018**	**Cash Equivalent Transfer Value as at 1 April 2017**	**Real increase/(decrease) in Cash Equivalent Transfer Value**	**Cash Equivalent Transfer Value as at 31 March 2018**
		(Bands of £2,500)	**(Bands of £2,500)**	**(Bands of £5,000)**	**(Bands of £5,000)**	**£'000**	**£'000**	**£'000**
Deborah Lee	Chief Executive	2.5 to 5	7.5 to 10	35 to 40	115 to 120	733	72	806
Natasha Swinscoe	Director of Service Delivery with effect until 21st May 2017	0 to 2.5	0 to 2.5	30 to 35	75 to 80	476	9	543
Arshiya Khan	Director of Service Delivery with effect from 22nd May 2017 to 31st October 2017	0 to 2.5	2.5 to 5	15 to 20	40 to 45	204	34	280
Caroline Landon	Chief Operating Officer with effect from 19th October 2017	0 to 2.5	0 to 2.5	10 to 15	0 to 5	99	17	137
Dr Sean Elyan	Medical Director	2.5 to 5	0 to 2.5	90 to 95	165 to 170	1,467	93	1,560
Simon Lanceley	Director of Strategy and Transformation with effect from 8th January 2018	0 to 2.5	0 to 2.5	5 to 10	0 to 5	51	1	58
Steve Hams	Nursing Director with effect from 25th September 2017	0 to 2.5	2.5 to 5	25 to 30	80 to 85	355	33	418
David Smith	Director of Human Resources with effect until 2nd November 2017	0 to 2.5	0 to 2.5	10 to 15	0 to 5	219	9	234
Emma Wood	Director of Human Resources with effect from 1st November 2017	0 to 2.5	0 to 2.5	5 to 10	0 to 5	52	11	78
Sarah Stansfield	Director of Finance with effect from 1st April 2017 to 18th June 2017	0 to 2.5	0 to 2.5	10 to 15	0 to 5	86	5	109
Steve Webster	Director of Finance with effect from 19th June 2017	0 to 2.5	0 to 2.5	65 to 70	200 to 205	1,398	0	1,398
Lukasz Bohdan	Director of Corporate Governance with effect from 13th November 2017	0 to 2.5	0 to 2.5	0 to 5	0 to 5	33	6	48

All of the above are Executive Directors; Non-Executive Directors do not receive pensionable remuneration
No contribution was made by the Trust to a stakeholder pension
No pension contributions were made in 2017/18 in respect of Steve Webster

*relevant figures subject to audit

6.3 Pay Multiple and Year-On-Year Variance

All NHS Foundation Trusts are required to disclose the relationship between the remuneration of the highest paid director in its organisation and the median remuneration of the Trust's workforce.

The banded remuneration of the highest paid director in Gloucestershire Hospitals NHS Foundation Trust in the financial year 2018/2019 was £225k to £230k (2017/2018 £190k to £195k). This was 8.1996 times (2017/18 6.4) the median workforce, which was £28,050 (2017/18 £27,635)

In 2018/19, no employees received remuneration in excess of the highest-paid director (2017/18 2 employees).

Total remuneration includes salary, non-consolidated performance-related pay and benefits in kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

For future years the remuneration committee will continue to follow national pay guidance where appropriate.

The salary and pension entitlements of executive and non-executive directors table, the directors' pension table and the pay multiple calculations are subject to audit.

When we compare the banded remuneration of the highest paid Director in Gloucestershire Hospitals for the financial year 2018/19 against 2017/18, this increased by £35k (18%).

It should be noted that during 2018/19 the Trust appointed a number of new members of the Trust Board:

- Director of Finance
- Executive Digital and Chief Information Officer (New post)
- Medical Director (interim)
- Trust Non-Executive Directors: Mike Napier
- Gloucestershire Managed Services Non-Executive Director: Kay Law-Fox (new Post)

As noted in the Annual statement on remuneration, during 2018/19 the Remuneration Committee agreed remuneration of the appointee Executive Directors, using the NHS Improvement's benchmarking data.

Signed

Deborah Lee
Chief Executive Officer

24 June 2019

7. STAFF REPORT

7.1 OVERVIEW – STAFF DATA

With circa 9,124 employees, the Trust is the largest employer in the county. The majority of our staff live in the local communities and so they and their families are also users of our services. On both a national and local basis, workforce supply and in particular, clinical workforce supply, has become one of the most challenging issues that NHS organisations are currently facing. The attraction, recruitment, retention and engagement of our workforce remain a significant current and future priority for our Trust.

Staff analysis
01 Apr 2018 to 31 Mar 2019

Average number of employees (WTE basis)	**Group**			
	Permanent Number	**Other Number**	**2018/19 Total Number**	**2017/18 Total Number**
Medical and dental	1,316	31	**1,347**	**1,380**
Ambulance staff	-	-	**-**	**-**
Administration and estates	1,550	15	**1,565**	**1,349**
Healthcare assistants and other support staff	402	-	**402**	**380**
Nursing, midwifery and health visiting staff	2,008	80	**2,088**	**2,059**
Nursing, midwifery and health visiting learners	834	2	**836**	**851**
Scientific, therapeutic and technical staff	1,160	14	**1,174**	**1,259**
Healthcare science staff	-	-	**-**	**-**
Social care staff	-	-	**-**	**-**
Other	23	3	**26**	**25**
Total average numbers	**7,293**	**145**	**7,438**	**7,303**

Staff Costs	
	£000
Salaries and wages	278,116
Social security costs	25,192
Apprenticeship levy	1,336
Employer's contributions to NHS pensions	33,155
Temporary staff (including agency)	16,316
Total gross staff costs	**354,115**

Gender Split of Workforce

The table below shows the breakdown of staff in terms of gender;

Head	Men	Women	Total	Men%	Women%
Chair & Directors	9	6	**15**	60%	40%
Band 8a+ staff	77	199	**276**	28%	72%
All Employees	1659	6315	**7974**	21%	79%

The number of women outweighs the number of men across all staff groups, albeit the ratio of women to men reduces with seniority. There is a very slight increase in the ratio of men employed (2017-18 was 20%) and the Board has an additional (male) member.

Sickness Absence

The Trust's sickness rate for the period 2018 to 2019 was 3.81% as compared to 2017 to 2018 (3.94%). This compares to a national average for large acute Trusts of 4.35 % (to Nov 2018) this is a slight reduction in absence compared to the previous year.

Sickness Absence Long Term	1.89%
Sickness Absence Short Term	1.92%
Annual Sickness Absence	3.81%

7.2 STAFF POLICIES AND ACTIONS APPLIED DURING THE FINANCIAL YEAR

7.2.1 RECRUITMENT POLICY FOR DISABLED PERSONS/ APPLICANTS

Recruitment and Selection Policy

As stated within our Recruitment and Selection Policy; the Trust positively supports and encourages applications from disabled candidates. As a member of the 'two ticks' scheme, we are committed to interview all disabled applicants who meet the minimum criteria for the role. Shortlisting managers are proactively notified of candidates who meet the requirement to be interviewed under the guaranteed interview scheme and will signpost managers for further support where reasonable adjustments / special arrangements are required.

As part of our standard interview assessment, all candidates are asked whether they are able to meet the physical demands of the job as outlined in the job description, including the Manual Handling tasks of the post.

Between April 2018 and March 2019, the Trust received 16,547 applications for employment (an increase of 544 from 17/18). 3.6% (599) of these candidates declared a disability during the application process (a reduction from 5% representing 794 candidates in 2017/18). However, 51% of the candidates who declared a disability met the basic criteria for the position (increase from 43% in 2017/18) and were shortlisted for interview. From the 307 disabled candidates shortlisted for interview, 43 were appointed into roles within the Trust. This represents a slight increase when compared to 2017/18 data (41 candidates were appointed in 2017/18 from a pool of 342). It should be noted that the number of candidates opting not to disclose their disability status continues to rise year on year, this has increased from 149 in 2016/17, to 266 in 2017/18 to a high of 386 in the past year.

Disabled?	Applications	% of Total Applications	Shortlisted	Shortlisted as % of <u>all</u> shortlisted	Appointed	Appointed as % of <u>all</u> appointed
Yes	599	3.60%	307	4.60%	43	3.00%
No	15,562	94.00%	6308	93.60%	1360	95.50%
Undisclosed	386	2.30%	123	1.80%	21	1.50%

Recruitment Training

We offer training for recruiting mangers through a number of mechanisms. All recruiting mangers have (or have booked to attend) unconscious bias training throughout 2018, as an important part of delivering our Equality Action Plan. In addition to this training, we offer a recruitment workshop to support the development of knowledgeable, skilled and confident interviewers to ensure the most suitable candidates are selected for employment. Safer recruitment training is also offered through e-learning packages, in addition to ongoing advice and support to recruiting managers – provided through dedicated recruitment advisor support.

7.2.2 REASONABLE ADJUSTMENTS FOR PEOPLE WHO HAVE BECOME DISABLED DURING THE YEAR

From time to time, the health of individual employees can deteriorate and individuals may identify themselves as newly disabled or as suffering from a long term health condition. This could be identified through sickness management, or through regular employee and line management interaction (such as 1:1 meetings or appraisal) or as a consequence of the employee seeking additional support. Managers are encouraged to seek further advice via the Human Resources team and through Occupational Health advice where appropriate.

The Trust has worked with the local Access to Work scheme to support both new and existing employees with disabilities. More recently this has included interventions such as the procurement of specialist equipment, or an assessment for the need for increased braille signage on our site. Support offered to our employees includes, but is not limited to: amendments to roles and responsibilities, provision of technology or specialist equipment, amendment to working patterns/ hours and redeployment to other suitable alternative roles within the organisation.

All staff members are encouraged to join/ engage with our Diversity Network. Our executive lead for the protected characteristic of Disability is The Finance Director, Sarah Stansfield for physical disabilities, alongside one of our Non-Executive Directors Alison Moon and the Medical Director, Mark Pietroni for mental health illnesses. The CEO during mental health awareness week recorded a video for staff on her previous mental health experiences when feeling stressed at work. We have active membership within the Diversity network from a variety of staff who identify themselves as disabled and the Deputy CEO and Director of People and OD regularly shares her experience of being a disabled member of the Board at Trust events.

We recognise the importance for our employees of being able to access swift support for a variety of individual health and wellbeing needs. During 2018 we worked with a variety of staff and staff side representatives to design a Health and Wellbeing provision for our employees, ready for Launch in spring 2019. Our ‘one stop shop’ provision will signpost staff to the most appropriate support/resource to meet their needs. This will include specialist advice for employees with new or existing disabilities via Occupational Health, Human Resources and Access to Work support where appropriate. The launch of this service is underpinned by a new Reasonable Adjustments Policy, which aims to provide a clear process for employees and their line mangers to follow in order to meet the needs of disabled employees.

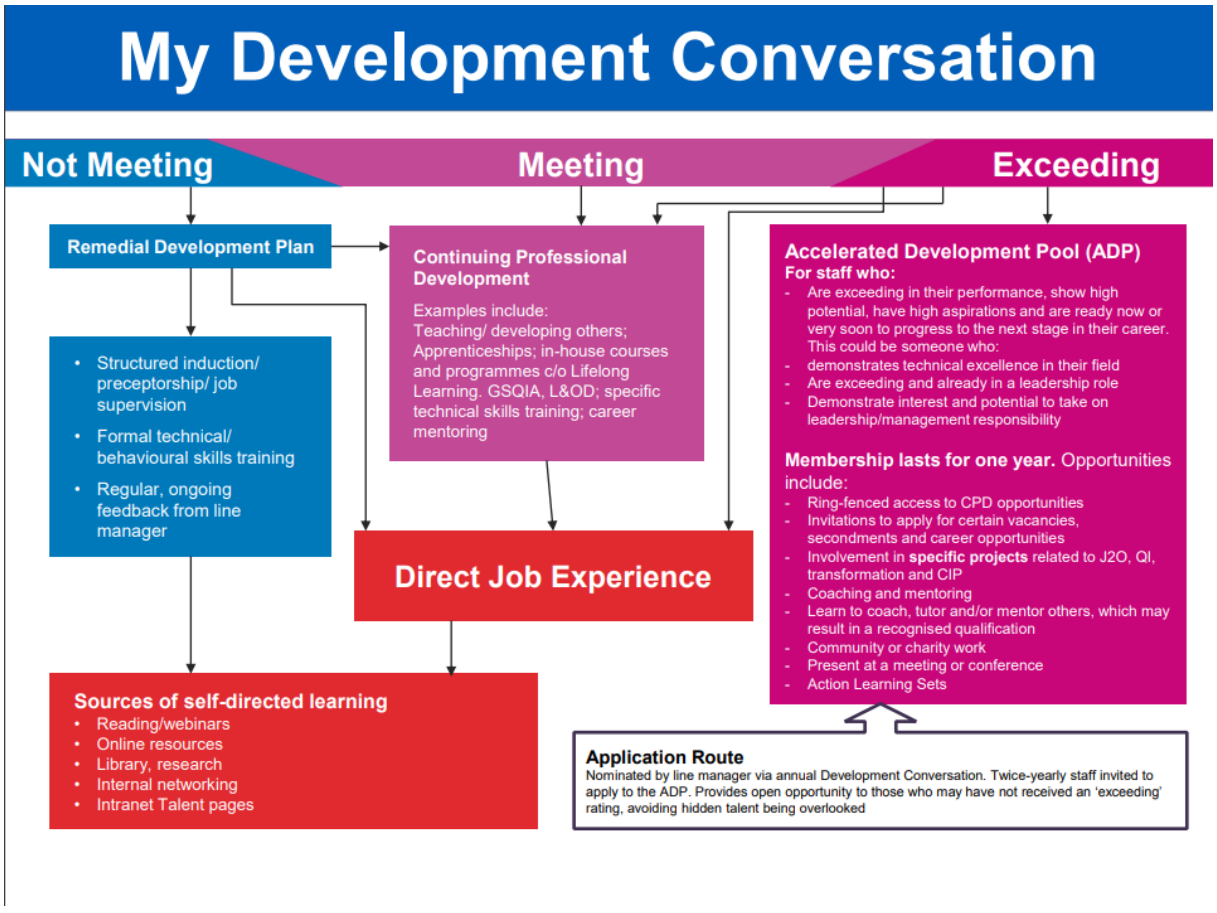
7.2.3 TRAINING, CAREER DEVELOPMENT AND PROMOTION OF DISABLED EMPLOYEES

The Trust Lifelong Learning team work with Managers to support apprentices and other members of staff with disability onto programmes and into the workplace. Within the past year this has included making reasonable adjustments for a staff member with learning difficulties to support their access to the Trainee Nurse Associates

programme. The Education Team's Lecturer Practitioners have supported and signposted nursing staff with dyslexia and provide flexible support to any delegate who requires additional help, regardless of whether or not they have been formally identify as disabled.

For apprentices undertaking a level 2 apprenticeship with special educational needs, learning difficulties or disabilities who have struggled to achieve the regular English and/or maths minimum requirement we will accept achievement of functional skills in English and/or maths. Where required, every effort is made to enable apprentices with special educational needs, learning difficulties or disabilities achieve the minimum English and maths requirements of the specific apprenticeship. This includes the appropriate use of access arrangements, reasonable adjustments and other approved qualifications that are detailed in the 2018 to 2019 list of qualifications in the English and maths legal entitlement offer.

A system of talent management and succession planning was launched in June 2018 linked to a new appraisal process which aims to encourage 'career conversations' to be held with staff. The design has enabled the creation of talent pools and an easy means to fill vacancies, succession plan, address secondment opportunities and focus initiatives such as learning and development opportunities.



The principle of equality of opportunity and meritocracy pervades, and as such staff have the ability to be recognised as talent or self-identify as such. Where staff are successful in their application to be regarded as talent they enter the 'Accelerated Development Pool' for one year and their career and learning opportunities are bespoke to their career path and aspirations. The first entrants to the pool commenced in December 2018 and disability is one of the protective characteristic represented.

7.2.4 ACTION TAKEN TO UPDATE EMPLOYEES ON MATTERS OF CONCERN TO THEM

During 2018, we increased our presence across social media channels such as facebook and twitter; recognising this as a popular platform from which to communicate with our workforce.

2018 saw the launch of our #J20 Journey to Outstanding campaign and '#AandE Live'; supporting engagement with both staff and patients alike, as we embrace some of the key challenges facing our organisation. The #J2O initiative has seen divisions, departments; wards and teams look to define what outstanding looks like for them as staff members and for their patients and customers. The outputs of this have been used to assist in the design of our new Trust Strategy. As our strategy ends on 1 April 2019 we have engaged with staff on our vision, mission, values, equality objectives and overarching strategic objectives to ensure the Board is advised from the bottom up. We have achieved this by using forums already planned, organising workshops, face to face sessions and on line surveys. As each iteration is drafted further engagement is cascaded through divisional Tri's and via Executive leads for corporate divisions.

Similarly we have used podcasts over the year, with supporting infographics, to communicate updates to staff on more complex matters such as the Trusts Financial health and the implementation of Trak and the Electronic Patient Record.

Whilst we have embraced these new methods of communication, we recognise that in order to update an entire workforce, we need to rely on a variety of communication tools. To this end, we continue to use weekly CEO blogs, Monthly 'Involve' sessions which are videoed and uploaded onto the intranet, the 'Outline' newsletter, face to face staff briefings and workshops to enable us to connect with the workforce on the issues that matter to them.

We regularly meet with our 100 leaders and this last years extended this further to ensure middle management were briefed and involved by establishing an Extended Leaders Network.

We regularly manage and oversee complex consultation processes where we reconfigure services or transfer services, such as the creation of our subsidiary company, Gloucestershire Managed Services. Operational changes such as moves between wards are now guided by a process of change which whilst not formal in nature sets out best practice for communicating change to affected staff.
Notable examples of engagement include:

- We held a number of Winter Learning Debriefs to understand and reflect on the experiences of staff during Winter 2017/18 and some of the learning from these debrief sessions informed some of the changes we made to approaching Winter 2018/19;
- We hosted a number Diversity Network events throughout the year covering topics including Mental Health, Black History Month and Pride. We used these as an opportunity to seek feedback and engagement on equality priorities and initiatives;
- We conducted a range of staff focus groups aimed at HCAs to better understand the staff experience and reasons why turnover has been higher with this staff group. Feedback from the HCAs informed an Action Plan which has been monitored and delivered by our newly-formed Staff & Patient Experience Improvement Group;
- We ran regular focus groups with multidisciplinary staff over a 3 month period to seek feedback on the design and content of new appraisal/talent development paperwork. Staff input resulted in 14 iterations before the finalised version was published and launched in July 2018;

- In July 2018 we launched a new "Extended Leadership Network" which is open to over 400 mid-level managers to come together on a quarterly basis to connect, learn and give feedback on Trust-wide initiatives;
- Through our divisions we undertook extensive engagement with colleagues across the organisation to talk about "Our Journey to Outstanding" (J2O) and what it means to them. Feedback informed our early thinking around a new set of strategic objectives
- We facilitated a range of staff engagement activities in Quarter 4 to enable staff to help select and give feedback on our new strategic priorities, new equality objectives and the future direction of our organisational values. This comprised of weekly half-day engagement sessions and an online survey which was open for all staff in the Trust to complete.

7.2.5 ACTIONS TAKEN TO CONSULT WITH STAFF, OR REPRESENTATIVES, TAKING VIEWS INTO ACCOUNT ON MATTERS LIKELY TO AFFECT THEIR INTERESTS

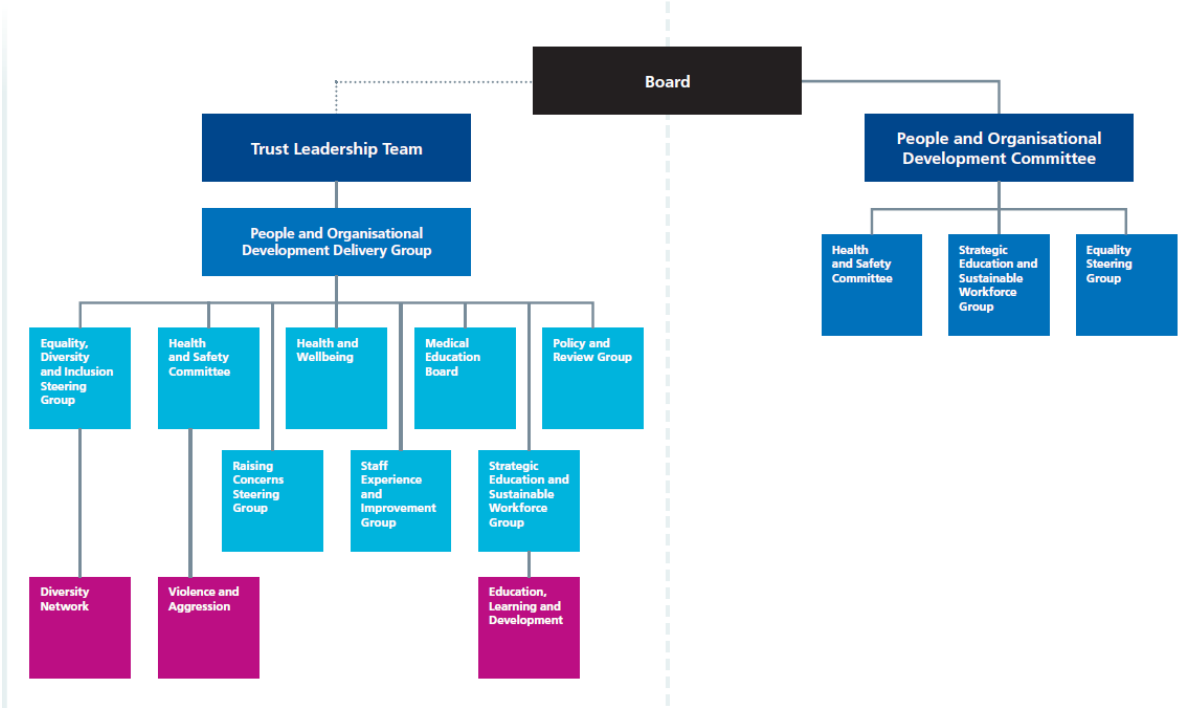
There are a number of ways in which our Leadership team seeks to listen to the voice of our workforce, whilst consulting with teams and individuals in a meaningful way. At a local level, this is demonstrated through encouraging an open and transparent culture, sharing news and ideas with teams and listening to employee views. The Trust leadership team is visible, utilising opportunities through planned and unplanned 'back to the floor' events to seek feedback and listen to staff views on current issues. The NHS 70 celebrations offered a great opportunity to not only celebrate with staff but also to connect with employees, listen to their experiences and opinions on what matters to them.

Formally, our Executive Team proactively engages with a well embedded committee of elected staff side representatives and a Local Negotiating Committee representing Medical staff. Whilst the independent committee structures and constitution agreements provide a formal mechanism for consultation, these forums are commonly utilised to share less formal updates on our day to day business and to discuss issues that really matter to staff. Issues can range from updates on the Trusts financial position and local consultation exercises; to everyday concerns such as car parking and estate issues. In addition to our staff side colleagues, the Trust has a number of elected Staff Governors who are committed to representing the voice of their constituents and whom regularly provide feedback via the Council of Governors and Board and its sub-committees.

The Director of People and OD/Deputy CEO, and Deputy Director regularly meet staff side representatives on a one to one basis and their regional counterparts. The Director of People and OD sits on a regional ICS Staff Partnership Forum and a newly established People and OD governance structure enables a member of staff side to be represented at each working group.

The Staff Survey results provide us with a regular opportunity to consider feedback on a number of key issues, whilst our Staff Experience and Improvement Group seeks to triangulate this data with a wide range of other metrics and feedback, such as freedom to speak up data and staff turnover, to identify areas of concern. The link between engaged staff and patient care has resulted in the extension of this group to triangulate patient experience data and in 2019 it will become the Staff, Patient experience and improvement group.

People and Organisational Development Governance Structure



7.2.6 ACTIONS TAKEN TO ENCOURAGE THE INVOLVEMENT OF EMPLOYEES IN OUR PERFORMANCE

Through the range of aforementioned communication methods, the Trust Leadership Team seeks to involve employees by providing regular updates regarding the trusts performance. Regular presentations to the staff side joint committee and the Local Negotiating Committee via both the Chief Executive and Financial Update (quarterly via a Pod Cast), provide an opportunity for us to share key messages and capture staff feedback.

In addition the Trust is renowned for its improvement culture and our approach to quality improvement and staff involvement in leading projects which improve patient care, experience and ultimately Trust performance.

As noted in the CQC 2019 report: "*Across the trust there was a fully embedded and systematic approach to improvement called the Gloucestershire Safety and Quality Improvement Academy (GSQIA). This framework empowered front line staff with the tools to support a change and implement a quality improvement project. Staff said that this had created a recognisable brand, and some described it as a "social movement". Throughout all the focus groups there was a narrative on quality improvement and innovation. Staff at all levels were engaged in the process and could give examples where quality of care for patients had improved because of quality improvement projects."*

7.2.7 INFORMATION ON H&S PERFORMANCE AND OCCUPATIONAL HEALTH

The Trust has a contract in place with Working Well, operated by 2gether Foundation Trust, for the provision of Occupational Health Services. The contract is reaching the end of its tenure and the Trust is currently redesigning the scope of this service provision in response to increasing demand, limited Occupational Health resources and the implementation of our new Health and Wellbeing Hub which will see staff move through pathways at a faster pace and in new ways.

The Trust also offers psychological support through an on-site staff support provision and this will be strengthened in 2019 with the introduction of an Employee Assistance Provider. The staff support service also run learning events such as resilience training and debriefs following critical or major incidents.

The Health and Safety committee is chaired by the Director of People and OD/Deputy CEO and assurance on compliance is managed through the Board committee structure. The Trust has an expert Health and Safety/Corporate risk manager and devolved risk managers at a local level. Annual objectives and measures are approved at the Trust Leadership Team and ratified by the Board through the committee structure. The Board are regularly updated on RIDDOR matters, HSE visits and any improvement notices and serious incidents relating to Health and Safety matters.

In terms of the HSE the Trust was visited on the 29th November 2018 to review procedures following a series of RIDDOR needle-stick injuries. (Reportable injuries are those where there is a confirmed injury involving a patient with identified blood borne virus). The overall rate of all SHARP injuries over a period of 12 months had been constant but a peak in reports has been noticed.

The inspection by the HSE identified two main concerns; firstly the regulations require the Trust to remove as far as reasonably practicable any unsafe SHARP devices that have safer alternatives. (Improvement Notice JL211218A described below) They found unsafe SHARPS that had previously been replaced and unsafe SHARPS that should have been replaced in clinical areas.

Improvement Notice (no reference)

The Health & Safety (Sharp instruments in Healthcare) Regulation 2013, Regulation 5(1)(b)

To comply with this notice the Trust was required to substitute traditional unprotected medical Sharps with a safer sharp where is reasonably practicable to do so.

Date for Compliance 31st March 2019. The HSE revisited the Trust to ensure compliance in April and this improvement notice was deemed to have been met and has been closed.

Improvement Notice JL211218A

The second notice describes the lack of an effective SHARPS management system. The HSE found that the Trust had insufficient controls around ordering and control of stock, the monitoring of unsafe SHARPS and the reporting of RIDDOR injuries.

Improvement Notice JL211218B

Management of Health & Safety at Work Regulations 1999

To comply with this notice the Trust needs to create a detailed action plan covering the following elements of a management system - Plan, Organisation, Control, Monitoring and Review and report RIDDOR within the expected timescales.

Date for Compliance 31st May 2019

To facilitate improvements the Director of People and OD/Deputy CEO established the following groups to deliver upon the changes required.

Executive group –	**Chair** - Director of People & OD **Members –** Director of Quality & Chief Nurse, QI&S Director, Chief Nurse, Lead for Infection Control, Head of Procurement, Corporate Training Lead
Required Working Groups	
Task & Finish Group	**Lead**- QI&S Director – Members - Divisional Risk Managers
Training Group - Lead	**Lead** – Members - QI&S Director, Corporate Training lead
Equipment Group	**Lead** - Head of Procurement – Procurement & Med Management
Comms Group	**Lead -** QI&S Director with Comms

7.2.8 COUNTER FRAUD POLICIES AND CORRUPTION

The Trust has a designated Local Counter Fraud Team and works within the 'countering fraud and corruption' policy framework. Our Raising Concerns Policy and the promotion of our Freedom to Speak Up Guardian, provide a framework for staff to raise concerns anonymously or otherwise to selected senior managers. We also support an on line system which enables anonymous reporting of issues of concern.
In 2019 a new national counter fraud e-learning package will be released to staff.
The Gloucestershire Local Counter Fraud Service provides our hospitals with prevention advice, detection and investigation of fraud, theft, embezzlement, corruption and any other irregularities against our hospitals. Every employee and individual acting on behalf of our organisation is responsible for maintaining our reputation and for conducting our business lawfully and professionally.
Our Board and senior management team are committed to implementing and enforcing effective systems throughout our Trust to prevent, monitor and eliminate bribery, in accordance with the Bribery Act 2010.

7.3 STAFF SURVEY

7.3.1 COMMENTARY

The NHS staff survey is conducted annually. From 2018 onwards, the results from questions are grouped to give scores in ten indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.

The response rate to the 2018 survey among trust staff was 46% (2017: 47%). Scores for each indicator together with that of the survey benchmarking group (Acute Trusts) are presented below.

7.3.8 SUMMARY OF PERFORMANCE

	2018/19		2017/18		2016/17	
	Trust	Benchmarking Group	Trust	Benchmarking Group	Trust	Benchmarking Group
Equality, diversity and inclusion	**9.2**	9.1	9.1	9.1	9.2	9.2
Health and wellbeing	5.8	5.9	5.9	6.0	6.1	6.1
Immediate managers	6.7	6.7	6.5	6.7	6.6	6.7
Morale	6.0	6.1	NA	NA	NA	NA
Quality of appraisals	5.1	5.4	4.9	5.3	5.0	5.3
Quality of care	7.2	7.4	7.1	7.5	7.3	7.6
Safe environment – bullying and harassment	**8.0**	7.9	7.9	8.0	8.0	8.0
Safe environment – violence	**9.5**	9.4	9.4	9.4	9.3	9.4
Safety culture	6.5	6.6	6.3	6.6	6.3	6.6
Staff engagement	6.8	7.0	6.7	7.0	6.8	7.0

Colour-highlighted scores show a RAG status of our performance compared to the 2017/18 scores. Scores in **bold-underlined** highlight where we perform above the average score for the benchmarking group.

Since the 2017 survey, **the overall trend is up**:

- Improvement in scores in eight of the ten themes by between 0.1 and 0.2.
- Five of these improvement areas are statistically significant (see below)

- Health and Wellbeing has fallen slightly by 0.1. There has been a persistent, gradual decline in this score since 2016
- Morale is a new category so no data is available to compare with last year.

Theme	2017 score	2017 respondents	2018 score	2018 respondents	Statistically significant change?
Equality, diversity & inclusion	**9.1**	3566	**9.2**	3089	↑
Health & wellbeing	**5.9**	3588	**5.8**	3098	Not significant
Immediate managers	**6.5**	3591	**6.7**	3113	↑
Morale		0	**6.0**	3068	N/A
Quality of appraisals	**4.9**	3032	**5.1**	2629	Not significant
Quality of care	**7.1**	3115	**7.2**	2755	Not significant
Safe environment - Bullying & harassment	**7.9**	3564	**8.0**	3087	Not significant
Safe environment - Violence	**9.4**	3563	**9.5**	3084	↑
Safety culture	**6.3**	3565	**6.5**	3086	↑
Staff engagement	**6.7**	3607	**6.8**	3142	↑

We exceed the average benchmarking score in three themes:

- Equality, Diversity & Inclusion (+0.1)
- Safe environment - Bullying and harassment (+0.1)
- Safe environment - Violence (+0.1)

Based on the results the following themes will be addressed as a priority at a Trust-wide level over the next 12 months:

Quality of Appraisals

a. We will expand our approach to Talent Development through increased membership of our Accelerated Development Pool (ADP);
b. We will target refresher training at line managers in departments where the experience is poor;
c. On a quarterly basis we will survey staff members who have had a recent appraisal, and take action where we find experience has been worse.

Bullying, Harassment and Violence

d. We will launch an education and awareness campaign aimed at managers and staff about bullying and harassment;
e. We will refresh our organisational values and identify a universal behaviour framework to develop clear expectations around appropriate and inappropriate behaviours at work;
f. We will continue to strengthen and embed support mechanisms for staff who report bullying and harassment, including the Freedom to Speak Up Guardian and the Diversity Network;
g. We will review our policy and practice and review trends.

Health & Wellbeing

h. We will launch a new Staff Advice and Support Hub which will act as a one-stop shop for managers and colleagues regarding any aspect of their physical, mental and financial health and wellbeing;
i. We will work closely with partners in One Gloucestershire ICS to develop a range of education and awareness campaigns which promote good health and wellbeing at work;

In addition, each division will identify actions and priorities and review these by professional staff group.

The Staff and Patient Experience Improvement Group will monitor progress and delivery of specific actions against these priorities on a monthly basis. This will be overseen by the People and OD Delivery Group and the Board subcommittee, People and OD.

The Trust intend to involve staff in the prioritisation of local action plans and also conduct pulse surveys to establish real time information on improvements or areas of concern. A new communication and engagement strategy will be devised in 2019 which will review how we communicate and engage with staff and how we can ensure improvements in our systems.

7.4 TU FACILITY TIME DISCLOSURE

The following information was published on the 31st July 2018, in accordance with the Trade Union (Facility Time Publication Requirements) Regulations 2017.

Relevant union officials	
Number of employees who were relevant union officials during the relevant period	*Full-time equivalent employee number*
32	28.06

Percentage of time spent on facility time for each relevant union official	
Percentage of time	*Number of employees*
0%	0
1-50%	32
51%-99%	0
100%	0

Percentage of pay bill spent on facility time	
Total cost of facility time	£60,323
Total pay bill	£334,822,000
Percentage of the total pay bill spent on facility time (total cost of facility time ÷ total pay bill) x 100	0.02%

Percentage of pay bill spent on facility time
Percentage of total paid facility time hours spent by employees who were relevant union officials, on paid trade union activities
100%

7.5 **Expenditure on consultancy and off payroll engagements**

Table 1: For all off-payroll engagements as of 31 March 2019, for more than £245 per day and that last for longer than six months

Number of existing engagements as of 31 March 2019	8
Of which...	
No. that have existed for less than one year at time of reporting.	3
No. that have existed for between one and two years at time of reporting.	3
No. that have existed for between two and three years at time of reporting.	0
No. that have existed for between three and four years at time of reporting.	0
No. that have existed for four or more years at time of reporting.	2

Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019, for more than £245 per day and that last for longer than six months

Number of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2018	7
Of which:	
Number assessed as within the scope of IR35	0
Number assessed as not within the scope of IR35	7
Number engaged directly (via PSC contracted to trust) and are on the trust's payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	7
Number of engagements that saw a change to IR35 status following the consistency review	0

Table 3: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	17

7.6 Exit packages (Annex 1 to Ch 2) – subject to audit

The regulatory framework applicable to public sector organisations, including the National Health Service, imposes strict parameters and restrictions with regard to expenditure of public monies.

Regulatory bodies, including NHS Improvement [formerly Monitor], Her Majesty's Revenue and Customs [HMRC] and the national standing financial instructions framework prevent misuse of public monies, including any payment of non-contractual monies to which employees or former employees are disentitled according to the individual's employment contract.

Non-contractual payments, sometimes enclosed within the legally binding 'Settlement Agreement' [formerly Compromise Agreement] may include, for example, a one-off non-contractual payment [such as a lump sum payment] as part of an individual's agreement to depart the organisation for a variety of reasons, including performance related matters. There were **no** non-contractual payments agreed with HM Treasury during the period 2018 to 2019.

The Trust agreed two **contractual** exit packages, via settlement agreements, to the value of £12,161 and £5,078 respectively.

(All figures subject to audit)

Signed

Deborah Lee
Chief Executive Officer

24 June 2019

8. NHS FOUNDATION TRUST CODE OF GOVERNANCE

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

Gloucestershire Hospitals NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

The Board considers that for 2018/19 the Trust has complied with the Code.

Relating to	Summary of requirement	Response
Board and Council of Governors	The schedule of matters reserved for the board of directors should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors.	Page 11-12
Board, Nomination Committee(s), Audit Committee, Remuneration Committee	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors.	See Directors' Report Page 60
Council of Governors	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	See Directors' Report Page 71
Council of Governors	The annual report should include a statement about the number of meetings of the council of governors and individual attendance by governors and directors.	See Directors' Report Page 73
Board	The board of directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary.	See Directors' Report Page 61

Relating to	Summary of requirement	Response
Board	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS Foundation Trust.	See Directors' Report Page 61 - 66
Board	The annual report should include a brief description of the length of appointments of the non-executive directors, and how they may be terminated	See Directors' Report Page 61 - 66
Nominations Committee(s)	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.	See Remuneration Report Page 84
Nominations Committee(s)	The disclosure in the annual report on the work of the nominations committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director.	The appointment of Non-Executive Directors followed the process proposed by the Committee and agreed by the Council of Governors
Chair / Council of Governors	A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report.	See Directors' Report page 67
Council of Governors	Governors should canvass the opinion of the Trust's members and the public, and for appointed governors the body they represent, on the NHS Foundation Trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	Page 68-70 Page 82-83

Relating to	Summary of requirement	Response
Council of Governors	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the Foundation Trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the Foundation Trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)	Not applicable
Board	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.	Page 66
Board	Where there has been external evaluation of the board and/or governance of the Trust, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the Trust.	Not applicable (comply)
Board	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS Foundation Trust's performance, business model and strategy. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report).	Page 60
Board	The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls.	See Annual Governance Statement
Audit Committee / control environment	A Trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	The internal audit function in 2018/19 was performed by BDO

Relating to	Summary of requirement	Response
Audit Committee / Council of Governors	If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.	Not applicable (comply)
Audit Committee	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	See Annual Report of the Audit and Assurance Committee
Board / Remuneration Committee	Where an NHS Foundation Trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	Not applicable
Board	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	See Directors' Report
Board / Membership	The board of directors should monitor how representative the NHS Foundation Trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	See Membership Report

Relating to	Summary of requirement	Response
Membership	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS Foundation Trust's website and in the annual report.	See Membership Report page 83
Membership	The annual report should include: • brief description of the eligibility requirements a for joining different membership constituencies, including the boundaries for public membership; • information on the number of members and the number of members in each constituency; and • a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership including progress towards any recruitment targets for members.	See Membership Report
Board / Council of Governors	The annual report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS Foundation Trust. As each NHS Foundation Trust must have registers of governors' and directors' interests which are available to the public, an alternative disclosure is for the annual report to simply state how members of the public can gain access to the registers instead of listing all the interests in the annual report.	See Directors' Report Page 67-68
Board	The board should ensure that adequate systems and processes are maintained to measure and monitor the NHS Foundation Trust's effectiveness, efficiency and economy as well as the quality of its health care delivery	Comply
Board	The board should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance	Comply
Board	The board should report on its approach to clinical governance.	Comply
Board	The chief executive as the accounting officer should follow the procedure set out by NHS Improvement for advising the board and the council and for recording and submitting objections to decisions.	Comply
Board	The board should establish the constitution and standards of conduct for the NHS Foundation Trust and its staff in accordance with NHS values and accepted standards of behaviour in public life	Comply

Relating to	Summary of requirement	Response
Board	The board should operate a code of conduct that builds on the values of the NHS Foundation Trust and reflect high standards of probity and responsibility.	Comply
Board	The NHS Foundation Trust should arrange appropriate insurance to cover the risk of legal action against its directors.	Comply
Chair	The chairperson should, on appointment by the council, meet the independence criteria. A chief executive should not go on to be the chairperson of the same NHS Foundation Trust.	Comply
Board	In consultation with the council, the board should appoint one of the independent non-executive directors to be the senior independent director.	Comply
Board	The chairperson should hold meetings with the non-executive directors without the executives present.	Comply
Board	Where directors have concerns that cannot be resolved about the running of the NHS Foundation Trust or a proposed action, they should ensure that their concerns are recorded in the board minutes.	Comply
Council of Governors	The council of governors should meet sufficiently regularly to discharge its duties.	Comply
Council of Governors	The council of governors should not be so large as to be unwieldy.	Comply
Council of Governors	The roles and responsibilities of the council of governors should be set out in a written document.	Comply
Council of Governors	The chairperson is responsible for leadership of both the board and the council but the governors also have a responsibility to make the arrangements work and should take the lead in inviting the chief executive to their meetings and inviting attendance by other executives and non-executives, as appropriate.	Comply
Council of Governors	The council should establish a policy for engagement with the board of directors for those circumstances when they have concerns.	Comply
Council of Governors	The council should ensure its interaction and relationship with the board of directors is appropriate and effective.	Comply
Council of Governors	The council should only exercise its power to remove the chairperson or any non-executive directors after exhausting all means of engagement with the board.	Not applicable during the year
Council of Governors	The council should receive and consider other appropriate information required to enable it to discharge its duties.	Comply

Relating to	Summary of requirement	Response
Board	At least half the board, excluding the chairperson, should comprise non-executive directors determined by the board to be independent.	Comply
Board / Council of Governors	No individual should hold, at the same time, positions of director and governor of any NHS Foundation Trust.	Comply
Nomination Committee(s)	The nominations committee or committees, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors.	Comply
Board / Council of Governors	Directors on the board of directors and governors on the council should meet the "fit and proper" persons test described in the provider licence.	Comply
Nomination Committee(s)	The nominations committee should regularly review the structure, size and composition of the board and make recommendations for changes where appropriate.	Comply
Nomination Committee(s)	The chairperson or an independent non-executive director should chair the nominations committee.	Comply
Nomination Committee(s) / Council of Governors	The governors should agree with the nominations committee a clear process for the nomination of a new chairperson and non-executive directors.	Comply
Nomination Committee(s)	Where an NHS Foundation Trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should consist of a majority of governors.	Comply
Council of Governors	When considering the appointment of non-executive directors, the council should take into account the views of the board and the nominations committee on the qualifications, skills and experience required for each position.	Comply
Council of Governors	The annual report should describe the process followed by the council in relation to appointments of the chairperson and non-executive directors.	Comply
Nomination Committee(s)	An independent external adviser should not be a member of or have a vote on the nominations committee(s).	Comply
Board	The board should not agree to a full-time executive director taking on more than one non-executive directorship of an NHS Foundation Trust or another organisation of comparable size and complexity.	Comply
Board / Council of Governors	The board and the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make.	Comply

Relating to	Summary of requirement	Response
Board	The board and in particular non-executive directors, may reasonably wish to challenge assurances received from the executive management. They need not seek to appoint a relevant adviser for each and every subject area that comes before the board, although they should, wherever possible, ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis.	Comply
Board	The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the NHS Foundation Trust's expense, where they judge it necessary to discharge their responsibilities as directors.	Comply
Board / Committees	Committees should be provided with sufficient resources to undertake their duties.	Comply
Chair	The senior independent director should lead the performance evaluation of the chairperson.	Comply
Chair	The chairperson, with assistance of the board secretary, if applicable, should use the performance evaluations as the basis for determining individual and collective professional development programmes for non-executive directors relevant to their duties as board members.	Comply
Chair / Council of Governors	Led by the chairperson, the council should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities.	Comply
Council of Governors	There should be a clear policy and a fair process, agreed and adopted by the council, for the removal from the council of any governor who consistently and unjustifiability fails to attend the meetings of the council or has an actual or potential conflict of interest which prevents the proper exercise of their duties.	Comply
Board / Remuneration Committee	The remuneration committee should not agree to an executive member of the board leaving the employment of an NHS Foundation Trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the board first having completed and approved a full risk assessment.	Comply
Board	The directors should report that the NHS Foundation Trust is a going concern with supporting assumptions or qualifications as necessary.	Comply

Relating to	Summary of requirement	Response
Board	At least annually and in a timely manner, the board should set out clearly its financial, quality and operating objectives for the NHS Foundation Trust and disclose sufficient information, both quantitative and qualitative, of the NHS Foundation Trust's business and operation, including clinical outcome data, to allow members and governors to evaluate its performance.	Comply
Board	The board of directors must notify NHS Improvement and the council of governors without delay and should consider whether it is in the public's interest to bring to the public attention, any major new developments in the NHS Foundation Trust's sphere of activity which are not public knowledge which it is able to disclose and which may lead by virtue of their effect on its assets and liabilities, or financial position or on the general course of its business, to a substantial change to the financial wellbeing, health care delivery performance or reputation and standing of the NHS Foundation Trust. The board of directors must notify NHS Improvement and the council of governors without delay and should consider whether it is in the public interest to bring to public attention all relevant information which is not public knowledge concerning a material change in: • The NHS Foundation Trust's financial condition; • The performance of its business; and/or • The NHS Foundation Trust's expectations as to its performance which, if made public, would be likely to lead to a substantial change to the financial wellbeing, health care delivery performance or reputation and standing of the NHS Foundation Trust.	Comply
Board / Audit Committee	The board should establish an audit committee composed of at least three members who are all independent non-executive directors.	Comply
Council of Governors / Audit Committee	The council should take the lead in agreeing with the audit committee the criteria for appointing, re-appointing and removing external auditors.	Comply
Council of Governors / Audit Committee	The NHS Foundation Trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the NHS Foundation Trust.	Comply

Relating to	Summary of requirement	Response
Council of Governors	When the council ends an external auditor's appointment in disputed circumstances, the chairperson should write to NHS Improvement informing it of the reasons behind the decision.	Comply (not applicable)
Audit Committee	The audit committee should review arrangements that allow staff of the NHS Foundation Trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters.	Comply
Remuneration Committee	Any performance-related elements of the remuneration of executive directors should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels.	Comply (not applicable)
Governance and Nominations Committee	Levels of remuneration for the chairperson and other non-executive directors should reflect the time commitment and responsibilities of their roles.	Comply
Remuneration Committee	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination.	Comply
Remuneration Committee	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments.	Comply
Council of Governors / Remuneration Committee	The council should consult external professional advisers to market-test the remuneration levels of the chairperson and other non-executives at least once every three years and when they intend to make a material change to the remuneration of a non-executive.	Comply
Board	The board should clarify in writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between governors and any local consultative forums.	Comply
Board	The chairperson should ensure that the views of governors and members are communicated to the board as a whole.	Comply
Board	The board should be clear as to the specific third party bodies in relation to which the NHS Foundation Trust has a duty to co-operate.	Comply

Relating to	Summary of requirement	Response
Board	The board should ensure that effective mechanisms are in place to co-operate with relevant third party bodies and that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority in each.	Comply

Signed

Deborah Lee
Chief Executive Officer

24 June 2019

9. NHS IMPROVEMENT'S SINGLE OVERSIGHT FRAMEWORK

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A Foundation Trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

The Single Oversight Framework applied from Quarter 3 of 2016/17. Prior to this, Monitor's Risk Assessment Framework (RAF) was in place. Information for the first two quarters of 2016/17 relating to the RAF has not been presented as the basis of accountability was different. This is in line with NHS Improvement's guidance for annual reports.

Segmentation
Gloucestershire Hospitals NHS Foundation is currently placed in Segment 3 "Mandated support".

This segmentation information is the Trust's position as at 31st March 2019 Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS Improvement website.

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the Trust disclosed above might not be the same as the overall finance score here.

Area	Metric	2018/19 scores				2017/18 scores			
		Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
Financial sustainability	Capital service capacity	4	4	4	4	4	4	4	4
	Liquidity	4	4	4	4	4	4	4	4
Financial efficiency	I&E margin	4	4	4	4	4	4	4	4
Financial controls	Distance from financial plan	3	2	1	1	4	3	1	2
	Agency spend	3	3	3	2	3	3	4	3
Overall scoring		**4**	**3**	**3**	**3**	**4**	**4**	**3**	**3**

In April 2018 the Trust's A&E Regulatory Enforcement Undertakings were lifted and in May 2018 the Financial Governance Regulatory Enforcement Undertakings were also lifted. In June 2018, the Trust received a Compliance Certificate against items 2.1-2.5, 2.10-2.12 and 3.1 – 3.2.

The Trust's Financial Special Measures (FSM) status was lifted in November 2018. As a result of the lifting of FSM, the NHSI regulatory team has reviewed the Trust's compliance with the Enforcement Undertakings issued in parallel to the Trust being placed in FSM and decided to issue the Trust with a Compliance Certificate against items 1.1 – 1.8 and 2.15 relating to Financial Special Measures. Further, NHSI concluded that undertakings 2.13 – 2.14, relating to commissioning an external Well-Led board governance review, need not be retained. As a result, only enforcement undertakings 2.6-2.9, relating to medium-term financial recovery plan, remain in place. NHSI supported the Trust to agree a recovery plan for 2019/20.

Signed

Deborah Lee
Chief Executive Officer

24 June 2019

10. STATEMENT OF ACCOUNTING OFFICERS RESPONSIBILITIES

The National Health Services Act 2006 states that the Chief Executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the National Health Service Act 2006, has given Accounts Directions which require Gloucestershire Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair state of affairs of Gloucestershire Hospitals NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting officer is required to comply with the requirements of the *Department of Health Group Accounting Manual* and in particular to:

- Observe the Accounts Direction issued by NHS Improvement, 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 (and the Department of Health Group Accounting Manual)* have been followed, and disclose and explain any material departures in the financial statements.
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance and
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy 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 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 the *NHS Foundation Trust Accounting Officer Memorandum.*

Signed

Deborah Lee
Chief Executive Officer
24 June 2019

11. ANNUAL GOVERNANCE STATEMENT 2018/19

11.1 SCOPE OF RESPONSIBILITY

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

11.2 THE PURPOSE OF THE SYSTEM OF INTERNAL CONTROL

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Gloucestershire Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Gloucestershire Hospitals NHS Foundation Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

11.3 CAPACITY TO HANDLE RISK

The Trust's Risk Management Strategy outlines the leadership arrangements and accountabilities for risk management within the Trust. The Strategy, which was introduced in November 2017, replaced the Risk Management Framework and in doing so strengthened assurance and monitoring systems. During 2018/19 I continued to take personal interest in this agenda strengthening many approaches to risk management including further development of the Risk Management Group and ongoing improvements to risk management arrangements and compliance.

Risk register procedures identify responsible managers and assuring committees in relation to action plans to eliminate identified risks and/or reduce their impact.

In order to ensure that all staff have sufficient awareness of risk management and are competent to identify, assess and manage risk within their working environment, the Trust has identified the risk management training needs of all staff from front line staff to Directors. This training is delivered as part of the Trust's Risk Management Training Programme. An e-learning module is also in place. Managers with responsibility for the management of staff are responsible for ensuring that their staff are able to access and attend the relevant training. In respect of new staff, information on risk management including information on incident reporting is included in the general induction arrangements for all staff. The Trust also developed a Simple Guide to Risk Management and continued to raise awareness and develop capacity and capability to identify, assess and manage risk throughout the organisation.

11.4 THE RISK AND CONTROL FRAMEWORK

I can confirm that a risk and control framework has operated throughout 2018/19, which is designed to provide assurance that there is an effective system of internal control to manage the principal risks identified by the organisation.

The Quality Framework is the key document describing the quality governance arrangements within the Trust. The framework describes quality under the Key Lines of Enquiry (KLOEs), namely, Well Led, Safe, Effective, Responsive and Caring. A reporting framework and committee structure reaching into the organisation provides assurance against the Care Quality Commission (CQC) regulations on a continuous basis and identifies good practice and areas of concern.

Key quality risks are monitored through the risk management process on the Trust Risk Register and the Board Assurance Framework (BAF). The BAF and Trust Risk Register reflect the organisation's risk profile and support the Board in making a declaration on the effectiveness of the Trust's system of internal control in the Annual Governance Statement.

Board committees scrutinise risks scoring 12 or above using the risk domains in the risk matrix on a quarterly basis as follows:

- Quality and Performance Committee – Oversight of patient safety, quality, reputation and statutory risks
- People and Organisational Development Committee – Oversight of workforce, health & safety and environmental
- Finance and Digital Committee – Oversight of finance and business
- GMS Committee – Oversight of risks relating to Gloucestershire Managed Services (GMS)
- Audit and Assurance Committee – responsible for scrutinising the overall systems of internal control and for ensuring the provision of effective independent assurance via internal audit, external audit and local counter fraud services

The role of the Committees in this respect is to review the current controls and mitigation plans and to refer or re-evaluate risks for further consideration by the Trust Leadership Team.

The Trust has a Risk Management Group which is Executive led, its role is to scrutinise the risk management processes and reporting mechanism to provide system assurance and holds Divisions and Directors to account for the devolved management function.

11.4.1 THE BOARD ASSURANCE FRAMEWORK

The BAF acts as the Trust's primary mechanism for ensuring that the Trust Board receives adequate assurance and that the Trust is actively pursuing its corporate objectives and that the risks to these objectives are being appropriately treated. The BAF enables the Board to understand the risks which have the potential to impact on the organisation's strategic objectives. The BAF provides the Trust with a single but comprehensive method for the effective and focused management of the principal risks to meeting the Trust's overall strategic objectives. The risks identified from the BAF cover the full range of strategic objectives and include consideration of present risks, future risks, risks arising from within the organisation and risks occurring as a result of external pressures and changes.

The BAF is a well-established tool with the content refreshed by the Executive Leads for each of the strategic objectives. The BAF report describes the principal risks to the strategic objectives identified by the Executive Team; the controls in place to mitigate these risks; the sources of assurance on these controls; any gaps in the controls and assurances; any actions associated with these gaps; and a narrative describing progress against the strategic objectives in the reporting cycle. Each strategic objective has a RAG rating of 'achievability' of the objective within the strategic period.

The BAF provides the basis for both the assurances and gaps in control reported in the Annual Governance Statement. Board Committees undertake a detailed scrutiny of risk, controls, assurances and gaps of their assigned strategic objectives on a quarterly basis, following which the BAF report for all strategic objectives is reviewed by the Audit and Assurance Committee and then presented to the Board quarterly for assurance.

2018/19 saw further development of the BAF with the improvement of the Board's and Committees' reports, which now contain a summary table with current and previous period RAG ratings for all of the strategic objectives, a commentary on the changes and analysis of issues. As a result, the report focuses on the progress and changes between reporting periods and draws the Committees' and the Board's attention to issues requiring their focus, such as gaps in controls or assurances without plans to address them.

11.4.2 TRUST'S RISK MONITORING, ESCALATION AND ASSURANCE PROCESS

The Board-approved Risk Management Strategy sets out the Trust's framework within which the Trust leads, directs and controls the risks to its key functions. The strategy is supported by associated policies and procedures, systems, processes and assurance mechanisms. Risk Register Procedure outlines the processes for updating and disseminating the Trust's Risk Register, agreeing and monitoring the action plans to eliminate or reduce risk.

The Trust Risk Register comprises the most significant operational risks facing the Trust and the controls and mitigation showing how well the risks are being managed. The Trust Risk Register is representative of the challenges facing the Trust and includes clinical, financial, operational, reputational, environmental and other risk areas.

The Trust has adopted a risk appetite framework which identifies clinical safety as the least tolerable risk and, for this reason, safety risks scoring 12> are included within the Trust risk register. All other risks scoring 15 and above, or 12 and above for safety, will be reviewed and assessed against the impact on the strategic objectives by the Executive team as part of the BAF oversight.

A risk that scores 15 and above or 12 and above for safety domain, using the Trust risk matrix (see below), will be defined as significant. The management of the risk may still reside with the presenting Director, but adding it to the Trust Risk Register results in extra scrutiny at an appropriate nominated senior committee and increased awareness of its implication across the entire Trust Leadership Team. This allows oversight and scrutiny of significant risks by the Board who receive and review the Trust Risk Register at every Board meeting.

Risk scoring = consequence x likelihood (C x L)

Impact / Consequence	Likelihood				
	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

	1 - 3	Low risk
	4 - 6	Moderate risk
	8 – 12	High risk
	15 - 25	Extreme risk

To support decision-making, the Trust's Board set out its relative willingness to accept risk across domains as follows:

	Relative willingness to accept risk				
	Low		Medium		High
	1	2	3	4	5
Safety					
Quality					
Workforce					
Statutory					
Reputation					
Business					
Finance					
Environmental					

The Board uses risk appetite to inform strategic decision-making.

Principal risks to compliance with the NHS foundation trust licence condition 4 (FT governance) and actions identified to mitigate these risks

As set out in Section 3.9, The Trust has significantly strengthened its approach to the identification and control of risks. Risks to the Trust's strategic objectives are captured in the Board Assurance Framework and risks of an operational nature are captured through divisional and departmental risk registers.

The major risks facing the organisation are those from operational pressures driven by demand exceeding capacity, risks to patient experience and potentially outcomes associated with significant backlogs of patients awaiting routine outpatient or inpatient care, risks to do with recruitment and retention of clinical staff, and risks associated with delivery of the Trust's financial plan.

Throughout 2018/19 the Trust has continued to refine its governance arrangements in line with The NHS Foundation Trust Code of Governance. 2018/19 saw further strengthening and maturing of the corporate governance arrangements, including the form and function of Board committee arrangements to ensure they are well placed to provide Board with the required levels of assurance. The Board's Standing Orders, Standing Financial Instructions and Scheme of Delegation were also revised to ensure fit for purpose governance arrangements which support compliance with the NHS Foundation Trust Code of Governance and best practice as well as delivery of the Trust's Strategic objectives.

Also, during 2018/19 the Trust has further strengthened its governance, management and assurance structures, including changes to structures and reporting lines (See Figure 1, below); Committees' remit and Terms of Reference; individual roles and responsibilities; and development of the Board Assurance Framework and reporting.

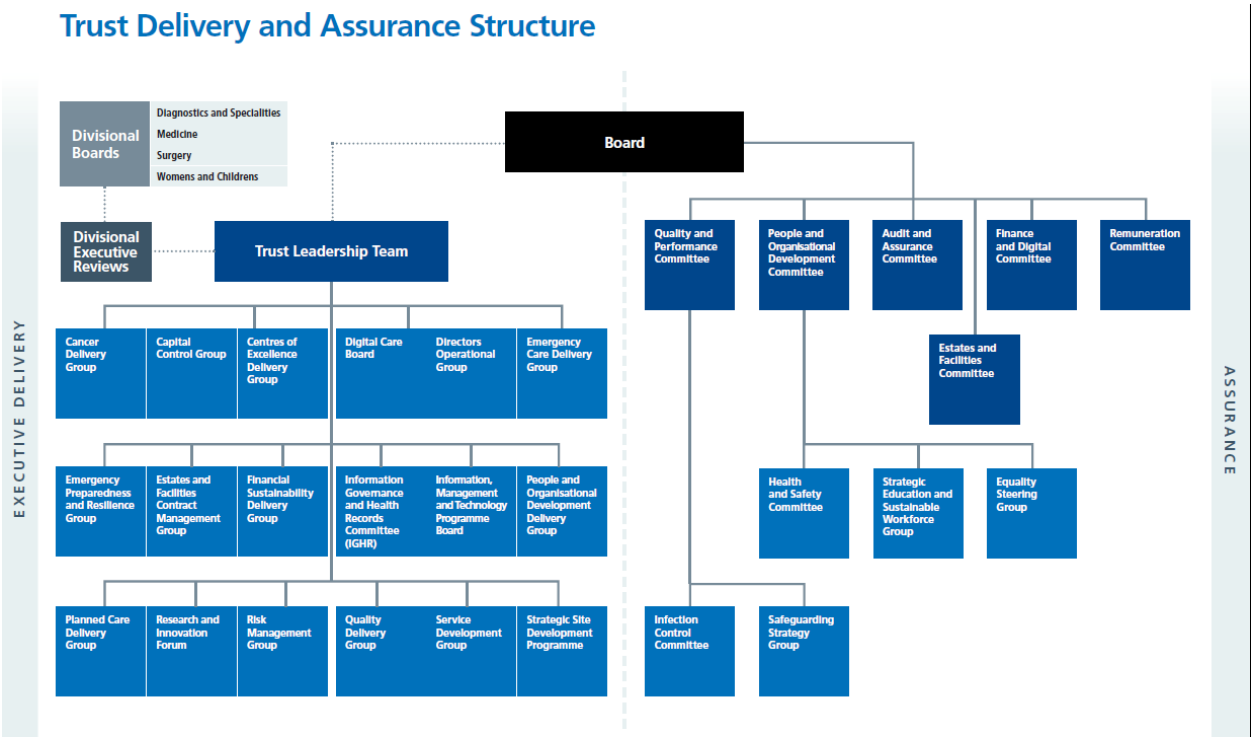
Resulting changes provided further clarity on the responsibilities of directors and committees and reporting lines and accountabilities between the Board, its committees and the executive team, ensuring there were no gaps. Consequently, this resulted in improvements to the effectiveness of governance structures at the top of the organisation. Divisional Governance Review undertaken in Quarter 4 provided moderate level of assurance and led to the identification of areas of improvement in divisional governance, which the Trust is working to address.

As the governance arrangements matured, so has the culture of support, challenge, openness and transparency. This in turn lead to dynamic identification, assessment and mitigation of risks, as set out in the Trust Risk Register (TRR) and Board Assurance Framework (BAF) - detail in 2018/19 public Board meeting papers available at https://www.gloshospitals.nhs.uk/about-us/our-board/board-papers/

The Board has sight of timely and accurate information to assess risks to compliance with the trust's licence. Further, the Board and its Committees maintain oversight over the Trust's performance, both via the BAF and dedicated reports (e.g. Quality and Performance, Workforce, Finance).

As discussed later in the Statement, the management directed internal audit resource at areas of known concern/risks (e.g. cyber security, divisional governance, aspects of subsidiary company's governance) and has taken/is taking steps to address the findings, thereby mitigating relevant risks. As demonstrated by the CQC inspection report and Head of Internal Audit's opinion and (draft) External Auditor's Opinion, and as stated in the conclusion to this Statement, there are no significant internal control issues (or risks)

Figure 1.



Key ways that the trust is able to assure itself of the validity of its Corporate Governance Statement, required under NHS foundation trust condition 4(8)(b)

The Board Assurance Framework acts as the Trust's primary mechanism for ensuring that the Trust Board receives adequate assurance and that the Trust is actively pursuing its corporate objectives and that the risks to these objectives are being appropriately treated.

The BAF enables the Board to understand the risks which have the potential to impact on the organisation's strategic objectives. The BAF provides the Trust with a single but comprehensive method for the effective and focused management of the principal risks to meeting the Trust's overall strategic objectives. The risks identified from the BAF cover the full range of strategic objectives and include consideration of present risks, future risks, risks arising from within the organisation and risks occurring as a result of external pressures and changes.

Additionally, in assuring itself of the validity of its Corporate Governance Statement, the Board takes into account:

- Its own work programme and assurance received throughout the year;
- Board Committees' work programmes, with issues escalated to the Board, via the Audit and Assurance Committee's Chair's report;
- the work of the internal audit, as reviewed at the Audit and Assurance Committee (with issues escalated to the Board, via the Audit and Assurance Committee's Chair's report)
- self-assessment against the Well-led framework and the CQC Well-Led inspection report
- challenge and scrutiny undertaken as part of the dedicated Board meeting to sign-off the Annual Report and Accounts and self-certifications.

Integration of risk management with other organisational processes
Risk management is embedded in the activity of the organisation and integrated with business, financial and workforce planning. For example, the intolerable risks process, undertaken as part of 2019/20 business planning, used information on Trust risk registers to inform priority funding decisions.

11.4.3 LOCAL AND DIVISIONAL RISK REGISTERS

Each Division has its own risk register, which captures how divisional risks are being managed and each Specialty has its own sub-set of the Divisional risk register to ensure local ownership and management of the risks. The Trust Risk Register is reviewed at each Trust Leadership Team (TLT) and Trust Board meeting. The management of the Trust Risk Register is through the TLT, which meets monthly. The function of this group is to validate new significant risks, and remove mitigated risks from the register. This process is replicated at governance meetings throughout the Trust at the appropriate levels, to ensure that current risks and their controls / actions are on risk registers and managed dynamically as the risk environment changes.

Incident reporting
The Trust has a strong culture of reporting incidents. To reinforce the importance of this, the Trust incident reporting process enables staff to submit reports and encourages them to seek feedback on these reports from local managers. Incident reporting informs the identification and assessment of risk both proactively and reactively and corporate oversight of incident reporting including emerging themes resides with the Risk Management Group.

Serious Incidents (SIs) are identified in a report and a verbal briefing is provided to the Quality and Performance Committee on a monthly basis, together with evidence of our meeting reporting standards. A quarterly report on learning from SIs is also presented to the Quality and Performance Committee. A summary of the current SIs is reported to the Trust Board on a monthly basis. In most cases a SI investigation is triggered when the impact of the incident reaches level four or five "Impact" on the Trust matrix, this usually in the category for harm, publicity or service continuity. The purpose of the report is to provide assurance that SI investigations are carried out in a timely way and investigations and their action plans are closed.

The operational committee responsible for SIs is the Safety and Experience Review Group which is chaired by the Director of Safety and has the Executive Medical Director and Executive Director of Quality and Chief Nurse as well as a Clinical Commissioning Group representative in its membership. This committee monitors progress of the investigations and any high level trends recommending any further investigation.

Information on the complaints and concerns reported to the Trust during each quarter is presented to the Quality and Performance Committee and reported annually to the Quality and Performance Committee. An update of lessons learned is included in the report.

Business continuity plans, dealing with emergency preparedness and civil contingency requirements, are in place across the Trust and the Chief Operating Officer is responsible for oversight of these plans and this function. The Audit and Assurance Committee received internal audit report covering this area and continued to receive assurance reports on progress with implementing agreed management actions.

Public stakeholders are involved in managing risks which impact on them through appropriate partnership fora, including the STP governance mechanisms.

Regulatory Compliance
The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission.

The Trust was subject to regulatory enforcement action in two areas during 2017/18, having been found to be in breach, or at risk of breaching, its provider license. The first was issued in August 2016 and pertained to the persistent failure to meet the national 4 hour A&E standard. The second was issued in November 2016 when the Trust was found to be in breach of its license following a material decline in its reported financial position and an apparent failure of Board governance in this respect. The Trust entered into Enforcement Undertakings with its regulator NHS Improvement and was subsequently (December 2016) placed in Financial Special Measures.

In April 2018 the Trust's A&E Regulatory Enforcement Undertakings were lifted and in May 2018 the Financial Governance Regulatory Enforcement Undertakings were also lifted. In June 2018, the Trust received a Compliance Certificate against items 2.1-2.5, 2.10-2.12 and 3.1 – 3.2.

The Trust's Financial Special Measures (FSM) status was lifted in November 2018. As a result of the lifting of FSM, the NHSI regulatory team has reviewed the Trust's compliance with the Enforcement Undertakings issued in parallel to the Trust being placed in FSM and decided to issue the Trust with a Compliance Certificate against items 1.1 – 1.8 and 2.15 relating to Financial Special Measures. Further, NHSI concluded that undertakings 2.13 – 2.14, relating to commissioning an external Well-Led board governance review, need not be retained. As a result, only enforcement undertakings 2.6-2.9, relating to medium-term financial recovery plan, remain in place. NHSI supported the Trust to agree a recovery plan for 2019/20.

The Trust has now moved from Segment 4 to Segment 3 under the Single Oversight Framework.

The Annual Governance Statement provides assurance that risks to compliance with the terms of its licence are being appropriately addressed. Reports are presented to the Board throughout the year in assessing our Trust's performance, compliance with relevant legislation and ensuring the effective, efficient and economic operation of our Trust. The Council of Governors provides a further layer of governance by holding Non-

Executive Directors individually and collectively to account for the performance of the Board.

The Board and its Committees (Quality and Performance and People and Organisational Development) ensure that short, medium and long-term workforce strategies and staffing systems are in place, which assure the Board that staffing processes are safe, sustainable and effective. Relevant reports are presented to the Committees and the Board and the Quality and Performance Committee and the People and Organisational Development Committee held a joint session to explore relevant issues. A new People strategy, supporting the new Strategic Plan, is in development and subject to the Committee's and Board's scrutiny.

Our Deputy Director of People is a nominated lead for workforce safeguarding concerns, acting as a nominated point of contact for the Local Authority Safeguarding Team. The 'Developing Workforce Safeguards' build on the National Quality Board's (NQB) expectations as outlined in 'Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time – Safe sustainable and productive staffing' (2016). The Trust can confirm that the NQB guidance is embedded in our safe staffing governance and that the three components of evidence-based tools (where they exist), professional judgement and outcomes are used in our safe staffing processes.

The Director of Quality and Chief Nurse has undertaken two safe nurse staffing reviews for adult inpatient wards using the nationally agreed Safer Nursing Care Tool deployed through the three times daily acuity and dependency census in SafeCare Live. Overall assessment has indicated a shortfall of registered nurses to meet the acuity and dependency needs of patients, and as such the Trust has identified additional funds to support an improvement in establishments, alongside further transformation of the un-registered nursing workforce to support an improved skill mix of registered nurses. The Trust has undertaken detailed reviews in theatres, outpatients and has commissioned Birth Rate + to undertake a review of maternity staffing to support the Better Births Programme and Continuity of Carer.

During 2018/19 the Trust has undertaken detailed workforce reviews of healthcare assistants and radiographers to better understand workforce challenges. Model Hospital has been used to benchmark workforce indicators to ensure the Trust is maintaining its peer average position. Workforce indicators are included within the Quality and Performance report which is presented to the Quality and Performance Committee and Board of Directors each month.

The Trust has a twice daily process for assessing nursing workforce deployment to ensure patient need matches effective deployment. Where operational demands require a temporary increase in workforce supply this is fulfilled through the internal bank service or through a master vendor agency supplier; overall fill rates are within tolerable limits at circa. 90% and reviewed monthly by the Quality and Performance Committee. During 2018/19, small changes to bed reconfiguration have taken place in order to match workforce deployment with patient acuity and our respiratory ward at Gloucestershire Royal Hospital has reduced its bed base to support the effective deployment of registered nurses and allied health professionals.

During 2018/19, the Trust has undertaken a small number of service reconfigurations within the surgical and medical divisions. Whilst nursing and allied health professional numbers have not been reduced, service delivery has been optimised. In these instances a quality impact assessment has been completed.

With respect to the medical workforce, junior doctor training posts are regulated by the Deanery and feedback on training posts is received through the Junior Doctor Forum, the General Medical Council and training surveys, and the Board receives a quarterly

Guardian Report on Safe Working Hours from the Guardian for Safe Working. Within Unscheduled Care, a demand and capacity review was conducted in 2018/19 which reviewed the junior doctor and consultant staffing levels. Through the Trust's work regarding establishing Centres of Excellence, a review of junior and senior medical staffing has been conducted within: Unscheduled Care, Trauma and Orthopaedics, Gastroenterology and Upper and Lower Gastrointestinal surgery. The Ear Nose and Throat (ENT) specialty has also conducted a review of their junior and senior medical staffing. The medical division has conducted a gap analysis of weekend consultant staffing and is currently reviewing the results.

The Foundation Trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

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 updated in accordance with the timescales detailed in the Regulations.

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

The Foundation Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with (see Sustainability Report for detail).

11.5 REVIEW OF ECONOMY, EFFICIENCY AND EFFECTIVENESS OF THE USE OF RESOURCES

The Trust operates a comprehensive and inclusive annual business planning process, which helps strengthen the organisation's clinical, financial and operational sustainability and supports delivery of our strategic objectives. The plan is approved by the Board each year and submitted to NHS Improvement. Overall performance is monitored at meetings of the Trust Board and its Committees which cover the areas of audit, quality, performance, workforce, finance and subsidiary company activities. Any areas of concern are highlighted and mitigating actions taken where required. The Committees meet monthly and provide assurance to the Trust Board of all areas within their scope to its monthly meetings.

The Trust has made excellent progress in delivering its Cost Improvement Programmes (CIPs) during 2018/19, delivering £27.0m against a plan of £30.3m. This performance represents delivery of efficiency to the proportion of over 5% of turnover which is ahead of the sector average. CIPs are subject to a comprehensive quality impact assessment, which considers any potential impacts on service delivery and quality, before being approved for implementation. Performance management of CIPs delivery is exercised via Finance Committee and the Turnaround Implementation Board, which provides the environment for a robust "confirm and challenge" process of delivery against plan.

Delivery of economic, efficient and effective services is an underpinning focus of the Trust's governance arrangements which are supported by internal and external audit reviews. Findings and recommendations from audits are monitored and reported through the Audit Committee. The Trust's external auditors are required as part of their annual audit to satisfy themselves that the Trust has made proper arrangements for

securing economy, efficiency and effectiveness in its use of resources and report by exception if, in their opinion, the Trust has not. The Trust also has a Counter Fraud service for the proactive prevention, detection and reactive investigation of fraud.

11.6 INFORMATION GOVERNANCE

NHS Digital released a new Data Security and Protection Toolkit (which replaced the Information Governance Toolkit) during 2018/19. All organisations that have access to NHS patient data and systems must use the toolkit to provide assurance that they are practising good data security and that personal information is handled correctly.

The standards assessed within the Data Security and Protection Toolkit are based on the National Data Guardian's ten published Data Security Standards and provide an overall test of the quality of data systems, standards and processes within an organisation.

The Trust's 2018/19 self-assessment published 31 March 2019 has a status of "Standards not Met". There were two areas of non-compliance:

- The Trust achieved 87% against a mandatory target of 95% for staff completing annual Information Governance refresher training.
- A specific requirement that a Penetration test be conducted in the previous 12 months to confirm that all networking components have had their default passwords changed was accidentally omitted from the test specification.

An Improvement Plan to deal with these issues before 30 September 2019 has been developed and submitted to NHS Digital and will form the basis for the Trust's Information Governance immediate work plan during 2019/20. Approval of the improvement plan by NHS Digital is awaited.

In addition to monitoring against the DSP toolkit self-assessment tool, risks to data security within our Trust are managed through multiple technical, process and governance controls. We use the National Security Centres "10 steps to Cyber-Security" as a framework for our data risk management.

Technical controls include software applications for anti-virus (server and desktop), anti-spamming, firewall protection, internet filtering and software patching for IT infrastructure (servers, networks, and PCs). New technical controls for 2018/19 have included implementation of vulnerability scanning and asset discovery.

Process controls include subscription to national CareCERT alerts and a process for tracking the implementation of these alerts. A major cyber incident response plan is in place (countywide as network is across STP partners), and is part of ongoing review.

Governance controls include monthly countywide cyber security forums, risks review through monthly Information Management and technology (IM&T) Board, and quarterly Information Governance forums. Risk escalation is as per the Trusts risks management policy.

The Trust's continuing improvement plans for 2019/20 include achieving Cyber Essentials Plus accreditation. This is a government-supported, industry-led scheme to assess and manage levels of protection against on-line threats

During 2018/19 key Information Governance policies have been reviewed for compliance with the General Data Protection Regulation including the introduction of a specific Data Protection and Confidentiality Policy.

The effectiveness and capacity of these systems is routinely monitored by our Trust's Information Governance and Health Records Committee. A performance summary is presented to our Finance and Digital Committee and/or Trust Board annually.

Information governance incidents are reviewed and investigated throughout the year and reported internally through the Trust's Information Governance and Health Records Committee.

Any incidents which meet the criteria set out in NHS Digital Guidance on notification, based on the legal requirements of the General Data Protection Regulation (GDPR) and guidance from the Information Commissioner's Office (ICO), are reported to the ICO through the DSP Toolkit where they may also be monitored by NHS England.

The Information Governance Toolkit is available on the Health and Social Care information Centre (HSCIC) website (igt.hscic.gov.uk). The information quality and records management attainment levels assessed within the Information Governance Toolkit provide an overall measure of the quality of data systems, standards and processes within an organisation.

The effectiveness and capacity of these systems is routinely monitored by our Trust's Information Governance and Health Records Committee. A performance summary is presented to our Trust Board annually.

Information governance incidents including any data breaches classified using HSCIC guidance at level 1 or level 2 in severity are reviewed and investigated throughout the year and reported internally through the Trust's Information Governance and Health Records Committee. In addition any level 2 severity incidents are reported to the Information Commissioner's Office in accordance with HSCIC reporting guidelines.

Summary of Incidents Reported to the ICO in 2018/19 under Article 33 GDPR

Summary of breach	Category
3rd party sensitive information disclosed in error, as part of request for copy of patient record.	Confidentiality
Unavailability of record resulting in distress and repeated test.	Unavailability
Adopted child's new name disclosed in error.	Confidentiality

Summary of confidentiality incidents internally reported 2018/19

Reportable breaches (detailed above)	3
Number of confirmed Non-reportable breaches	123
Number of no breach / Near miss incidents.	225
Total number of confidentiality incidents internally reported	351

A large number of the near miss reported incidents relate to lost SmartCards which are disabled when reported as missing.

Examples of non-reportable breaches were documents left insecure in a public place, incorrect information documented and information sent to the wrong destination. Process reviews of trends of incidents are planned for 2019/20 to identify areas and opportunity for improvement.

11.7 ANNUAL QUALITY REPORT

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on 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 Trust took the following actions to assure the Board that the Quality Report represents a balanced view and that there are appropriate controls in place to ensure the accuracy of the data.

The Director of Quality and Chief Nurse jointly with the Medical Director leads the production of the Quality Report. The governance and production of the Quality Report is overseen by the Quality and Performance Committee. The committee is a subcommittee of the Board and has clinical and managerial representation from across the Trust and includes Non-Executive Directors, Directors, a Governor and representation from Gloucestershire Clinical Commissioning Group (GCCG). Much of the data contained within the report is reviewed by the Committee throughout the year.

Quality priorities are identified with regard to local and national priorities, performance against quality metrics within the organisation, and the views of our stakeholders, leading to the selection of those that have the highest possible impact across the overall Trust. Board members, Governors, GCCG, Gloucestershire Healthwatch and the Gloucestershire Health and Care Overview and Scrutiny Committee were invited to input into the Quality Report. GCCG, Gloucestershire Healthwatch and Gloucestershire Health and Care Overview and Scrutiny Committee were also invited to provide statements for inclusion in the Report. The final Quality Report for inclusion in the Annual Report as the Quality Report was endorsed by the Board on 28th May 2019.

Our quality improvement plans play a key role in our report as the plans are monitored quarterly across the year at the Quality Delivery Group which is chaired by the Director of Quality and Chief Nurse so that if support can be given to the project this is done in a timely way. Contributions to the Quality Account are made by staff across the whole organisation. Support is given to those contributing who have not written reports before.

As part of the External Audit of the Quality Report, external audit scrutinise data relating to two mandated indicators and the governor indicator only. Most local quality data is collected through the Business Intelligence Unit and where relevant our Clinical Audit department. The Trust adopts the national definitions when available or agrees data definitions with the relevant lead. The results are then reported in the Quality and Performance Report and Trust Quality reports and Quality Accounts. The accuracy of elective waiting time data and the risks to the quality and accuracy of this data were impacted in December of 2016 we launched a new patient administration system, TrakCare, designed to modernise the way we manage clinical information supporting improvements in care delivery. It is clear that we underestimated the impact it would have, and continues to have, on our services. We are working hard to address the operational and reporting issues that have arisen since we went live and to ensure that, until such time as the issues are resolved and benefits realised, we limit the impact on our patients' experience, particularly in outpatient care where the impact is being felt most acutely.

The Trust produces a series of data quality reports which enable operational and validation team staff to review a wide range of data including waiting times data for accuracy and if necessary, to amend or update it. Operational staff work to detailed

protocols to allow them to record the various component that contribute to the waiting times datasets in line with national definitions.

11.8 REVIEW OF EFFECTIVENESS

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit and Assurance Committee and the Quality and Performance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

2018/19 saw further strengthening and maturing of the controls environment, including the form, function and modus operandi of Board committee arrangements to ensure they are well placed to provide Board with the required levels of assurance. The CQC Well-Led inspection, rating the Trust as 'Good', provided independent assurance of the effectiveness of the Trust's governance arrangements.

The Audit and Assurance Committee has encompassed an assurance function and sought assurances in respect of the major systems of internal control.

The overall opinion of the Head of Internal Audit on the adequacy and effectiveness of the organisation's risk management, control and governance processes is that they "are able to provide moderate assurance that there is a sound system of internal control, designed to meet the Trust's objectives and that controls are being applied consistently".

Governance, risk management and control in relation to business critical areas is generally satisfactory. However, Internal Audit noted some areas of weakness or non-compliance in the framework of governance, risk management and control which potentially put the achievement of objectives at risk. The weaknesses in the design and/or effectiveness of controls are described below.

The Trust has made progress in improving and strengthening its internal control environment during 2018/19.

Internal Audit completed 12 internal audit reviews for the year ended 31 March 2019. Areas for internal audit were specifically chosen by the Trust as areas which needed to be reviewed. The systems reviewed were rated according to the level of assurance as to the design and the operational effectiveness of controls within the system. The assurance levels are: 'substantial', 'moderate', 'limited' or 'no'. The systems were rated as follows:

Audit	Level of Assurance		Number of Recommendations		
	Design	Effectiveness	High	Medium	Low
Serious Incidents			0	1	2
Shared Service: Procurement			0	6	1
Budgetary Control			2	2	0
Freedom to Speak Up	N/A – Advisory Review	N/A – Advisory Review	2	4	0

Operational Business Planning			1	5	1
Medication Income Streams			1	4	0
Patient Experience			0	3	0
Key Financial Systems			0	2	2
Infection Control Reporting			0	2	0
Cyber Security			2	5	1
GMS – BAF & Risk Registers	N/A – Advisory Review	N/A – Advisory Review	2	1	0
GMS – Performance Reporting			0	5	0
Divisional Governance			0	6	0

Internal Audit's work has identified no critical, 10 high, 46 medium and 7 low risk rated findings to improve weaknesses in the design of controls and/or operating effectiveness. The Trust has implemented a number of the recommendations raised during 2018/19 and has action plans in place to implement those that have not been implemented.

The number and priority of critical risk recommendations (reports rated as having 'no' level of assurance) is the same as last year (none). There are more high risk rated recommendations (10 compared to 8), more medium risk recommendations (40 compared to 26) and fewer low risk recommendations compared to the prior year (10 compared to 12). This reflects the Executive Team's approach of directing the internal audit resources to known areas of concern.

Internal audits with high and medium risk rated findings are as follows:

Serious Incidents
Serious Incidents (SI) in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified.

A Monday morning Serious Incident Panel has been set up to scope and agree the incidents that are to be taken forward as an SI. The Safety and Experience Review Group (SERG) meetings and SI Panel meetings are attended by relevant staff to ensure input into specific cases. Action plans and learning points from Serious Incidents are monitored and taken to at least three SERG meetings.

The Trust Policy for managing, reporting and reviewing of incidents was out of date. There was evidence to suggest that the actual processes in operation were more appropriate than the processes recorded within the policy.
There was no quality control of serious incident data and files recorded within Datix once they had been completed and the final report submitted.

Shared Service: Procurement
The NHS Procurement & Commercial Standards (the "Standards") were launched in May 2012 to support the recommendations from the Public Accounts Committee by providing a clear vision of good procurement.

The Shared Procurement Service Strategy requires accreditation at level 2 of the NHS Procurement & Commercial Standards during 2019-20. It was noted that a Procurement 5 Year Forward Plan had been created for 2017-2022. All tenders/quotes reviewed followed the correct procurement route.

The Shared Procurement Service did not have a Head of Procurement in post and this had proven difficult to fill. It was observed during interviews with key Trust staff, that there is a lack of confidence in Procurement, which has led to lack of engagement between them and each member Trust.

Tender recommendation reports that covered more than one Trust did not separate the contribution per Trust, and just recorded the total value of the contract. It is therefore difficult for each Trust to establish the value of the contract requiring approval in accordance with its scheme of delegation.

Budgetary Control
Good budget management is achieved where budgets are monitored at both a strategic and operational level, and budget holders are held to account for managing their budgets.

A Service Development Group (SDG) had been set up in the Trust, responsible for reviewing business proposals raised by departments, determining information requirements in relation to the business development process, and ensuring the business proposals are linked to the Trust's long term improvement and service development strategies.

There was guidance provided by Finance to the Divisional leads that set out budget setting, sign off, monitoring and changing processes that staff could follow. However, it has not been disseminated to all budget holders. At the time of the audit (Month 5), a number of budget holders were still unaware of their budget for 2018/19. 90% of budget holders who responded to our survey said they did not receive relevant training in the past 12 months and 81% would like more training in understanding, monitoring and managing their budget.

There was no long term integrated operational plan in the Trust that links the finance plan to workforce and operational plans, in order to achieve the Trust's long term strategic objectives. There had been a lack of engagement/consultation between Divisional operational leads and the budget holders during the budget setting process, which resulted in the budget not being wholly aligned with service demand. Comprehensive meetings are not always taking place between Finance and budget holders and variances between budget and actual spend is not monitored and investigated adequately by all budget holders.

Changes to the budget are not monitored by Finance and at Divisional level, although the Head of Corporate Finance is in the process of designing a template showing movements in budget by cost centres for future monitoring purposes.

Freedom to Speak Up (FTSU)
We understood that the Trust was in the process of promoting FTSU arrangements in order to raise staff awareness; initiating a Strategy to facilitate a structured approach for staff to follow; and introducing training programmes for staff to improve FTSU practice and culture across the Trust. However, we noted the following weaknesses from the survey undertaken:

- 15% of staff did not know or did not think they understood the concept of FTSU, whilst 62% of staff did not know what the FTSU Guardian's role was. Although the majority of managers (over 70%) understood their roles and responsibilities in identifying and resolving staff's concerns, less than half managers had a structured approach in managing issues raised and only 30% managers are confident that concerns can be properly managed.
- 41 (21%) people reported they had not obtained any information relating to FTSU and would like to receive some. 50% of people had previously raised concerns, most of which related to 'harassment and bullying'.40% - 50% of staff agreed that they could raise concerns freely. Only 10%-20% of people felt their voices were heard and there were changes after they raised concerns.

Operational Business Planning

Operational Business Plans build on the strategic plans put in place by Trusts. They set out how the Trust is going to respond to national and local challenges and that they will respond to them 'by continuing our improvement journey and working with our partners across the Gloucestershire Health and Social Care System.'

The triangulation of capacity and demand, workforce planning and financial planning was not working in practice. There was a more top down process in place where finance is informing the workforce planning process, rather than capacity and demand. The 17/18 operational planning process was driven by NHSI requirements and deadlines, rather than the internal governance of the Trust requiring a plan by an agreed time in the year.

Clinical pressures on staff during the 17/18 process meant that divisional plans were in draft and at various stages of completion, and not fully aligned to strategic objectives as late as February 2018. Progress against the operational plan does not form part of business as usual activities. The plan is completed and then is not referred to again until the following year's plan is required to be completed (Finding 4).

Lessons learnt as a result of the operational business planning process are not identified and embedded into the next planning process.

Medication Income Streams

High cost drugs approved by NICE and commissioned by NHS England are recorded and approved on the BlueTeq system. Drugs that require this approval are flagged on the pharmacy system and a dispenser checks that the appropriate approvals have been made.

The Trust had a significantly higher percentage of PbR excluded drug expenditure; in 2017/18 this was 81.9%, against an average of 74%. PbR excluded high cost drugs are by definition more expensive than PbR included drugs, so having a higher proportion of PbR excluded drugs means higher costs when compared to other similar organisations.

The highest spends within the medical division are reviewed in relation to savings opportunities available for the following years. There were very few queries from the commissioners regarding BlueTeq approvals, and the Trust has to date been able to successfully respond to these queries. Details behind the formulary and drug procurement savings are now given to the Finance Team to verify the figures included within the pharmacy CIP tracker, before the savings are included on the finance savings plan and before they are transacted.

There was no review to ascertain whether all high cost drugs recorded within the pharmacy system are recharged monthly. There is no review to ensure that all high cost drugs are captured fully by the SQL recharging report. It was uncertain whether all

high cost drug recharges are covering the costs. The processes undertaken monthly to ascertain the high cost drug recharges are complex and only undertaken in full by one member of staff.

CIP targets are only estimated for the forthcoming year; forward planning pharmacy CIPs would be beneficial to financial planning, and ensuring resources are in place for realising the saving.

Patient Experience
This review focused on the national Adult Inpatient Survey 2017 and the National Maternity Survey 2017. For the first time the Inpatient Survey and the Staff Survey results were triangulated at a joint Quality and Performance and (Q&P) People and Organisational Development (OD) Committee. An Inpatient Survey Improvement Plan has been developed by the Deputy Director of Quality which detailed the areas of improvement identified from the Survey, mapping to the current QI projects and new corporate actions. The action plan is monitored and updated quarterly at the Quality Delivery Group and the Quality and Performance Meeting.

Although a number of QI projects and action plans have been introduced at a corporate level and divisional level to improve patient experience there was a lack of Divisions' engagement in reviewing the corporate plan and identifying if more could be done to improve patient experience.

It was not clear, due to a number of changes to posts at the time of the publication of the results; if the Adult Inpatient Survey results had been fed back to Surgical and Medical Divisional Boards or were discussed at their Divisional Quality Meetings as these Divisions do not currently have specific remedial action plans.

There was a lack of staff engagement in Divisions (except W&C) in respect of developing actions to improve patient experience in response to the Adult Inpatient Survey.

Key Financial Systems
The financial position of the Trust at 30 November 2018 was an operational deficit of £16.2m. This was a favourable variance to budget and NHSI Plan of £0.3m. Sample testing covered transactions for both Gloucestershire Hospitals NHS FT and 2Gether NHS FT.

Access to the payments and creditors system is restricted to approved users. Evidence is maintained of the request to set up the new user, and the team will only set up users who have been requested by approved members of staff.

Invoices received are not paid until a goods received note is placed against the original purchase order, whilst disputed invoices are not paid until the dispute has been satisfactorily resolved.

Procurement card transaction logs are appropriately maintained recording expenditure, and passed to finance monthly if the cards have been used.

The authorised signatory lists needed review and updating in line with staff changes to ensure appropriate authorisations can be ensured when a request for payment is made to the Accounts Payable Team. There were three procurement cards in place across the two Trusts, it was recommended that terms and conditions of their use are agreed and the cards are signed out by the agreed officers.

Infection Control Reporting
Reducing Healthcare-associated infections (HCAIs) remains high on the Government's safety and quality agenda and in the general public's expectations for quality of care. Additionally, regulation changes now mean commissioning organisations will hold providers to account for their performance, and assess their contribution to sustained improvement in infection prevention and control practices that reduce HCAIs and antimicrobial resistance. An improvement plan was published in March 2018; this was a wide ranging plan to deliver improvements and reduce the harm of a hospital acquired infection. The improvement plan is operationally delivered by the Infection Control Committee and assurance provided by the Quality and Performance Committee.

As required by Public Health England, all cases with specimen dates during a specific month have been entered onto the website by the 15th of the following month, with the data having been signed-off by the Trust's Chief Executive Officer (CEO). The Nursing staff, IC Team, and the Lab are following the national guidance published by PHE – 'Mandatory enhanced MRSA, MSSA and Escherichia coli bacteraemia, and Clostridium difficile infection surveillance Protocol 2013' - to identify, test, diagnosis and report on the HCAI cases.

The Lock Down Process needs to be updated to take account of new NHSI guidance that takes effect from April 2019. The way the information is presented was also potentially misleading in terms of the way cases are apportioned
Errors were identified in the 2018/19 internal and external reporting. The Trust over-reported one case of E.coli and under-reported one Trust apportioned case of C. diff. A more robust validation framework should be put in place.

Cyber Security
Vulnerabilities in the IT systems, IT infrastructure and hardware that are used to collect, process and retain ever increasing amounts of the Trust's confidential information, combined with a perceived lack of awareness regarding security issues can be exploited by an attacker, compromising the Trust's information assets and causing significant financial and reputational damage.

The Trust has established a Cyber Security group that meets on a monthly basis to provide the Local Digital Roadmap (LDR) Board with an overview of the progress made by the Cyber Security team.

The Trust's IT risk register indicated that cyber security is a Trust-wide issue. The Trust receives the bulletins from NHS Digital CareCERT to assess the cyber threats and technical details of recently identified vulnerabilities and exploitations within different IT platforms including the recommended actions, in order to resolve any associated risks. The Trust's external penetration test was performed by a third party vendor in June 2018 and remediation plans were developed and all the high rated weaknesses resolved.

Testing identified that there are 67 domain administrators present on the active directory. There are 59 Windows 2003 servers and 12 Windows XP machines that were running on unsupported operating systems.

The Trust did not perform vulnerability assessments on a routine basis or have an appropriate mechanism to manage unknown devices that have physically connected to the IT network.

There was no appropriate record of firewall configurations nor are the rules reviewed on a regular basis and a number of end point devices contained out of date anti-virus protection. Members of staff are not provided with appropriate cyber security training.

GMS – BAF and Risk Registers
It is essential that there is an effective and efficient assurance framework in place to give sufficient, continuous and reliable assurance on organisational stewardship and the management of the major risks to organisational success and delivery of improved, cost effective, public services.

The work we undertook showed engagement with the BAF process by the GMS Board at an early stage. Internal controls and key sources of assurance had been mapped to the 4 aspects of the GMS operating environment (environment, market, organisation and governance). Risks were categorised in the same manner. The BAF document as presented to the GMS Board was, in effect, a comprehensive Risk Management Strategy (subject to a few additions). The 'lines of defence' model in use is good practice and can be used to highlight gaps or duplication in the control and assurance environment, in effect from ward to board.

However, the BAF needed enhancing with the inclusion of some key elements of best practice, in particular strategic objectives, principal risks, gaps in control and assurance and resultant action plans. The BAF and the Risk Log needed to be cross-referenced to demonstrate how they are interlinked.

It was identified that improvements could be made to the layout and content of the Risk Log and that the BAF document could be reshaped as the GMS Risk Strategy.

GMS – Performance Reporting
The importance of data for NHS bodies and the patients they serve has never been higher, and data quality has been identified as crucial by NHSI. Good quality information underpins the delivery of effective patient care. GMS has a formal contract with Gloucestershire Hospitals NHS FT to provide a range of estates and facilities management services. The contract contains performance standards that GMS have to achieve; non-compliance can result in the application of financial service penalty deductions.

Electronic data recording systems are in use in Cleaning, Estate, and Portering Departments. On a monthly basis, data is extracted directly from the relevant system and sent to the Information Team for validation and reporting. Our testing confirmed that the performance reports presented to the GMS Board and GMS Committee agree with the raw data recorded in the systems (except for Portering due to the system weakness and delay in data entry).

There is no Data Quality Strategy in place and no local Data Assurance Framework established to ensure high level of data quality and data security. Testing identified that the Portering system produced incorrect calculations which had led to performance under-reporting. We noted that completion of Fire Risk Assessments is calculated taking into account all areas where assessment is required but only when the Fire Safety Team deem there has been a significant change. This overstated performance.

The method used to calculate the Trust wide cleaning score was not in compliance with the national guidance, as it was not weighted according to the size of the area assessed.

Divisional Governance
The Trust received a CQC inspection in October 2018 and the report was published on 07 February 2019. Within this inspection the Trust was rated as 'Good' within the well led domain and also 'Good' across both Surgery and Medicine Divisions. The surgical division was rated good because there was a new leadership team in many areas of the surgical division, and Trust wide, to strengthen the surgical leadership and it had a vision for what it wanted to achieve and workable plans to turn it into action . The medical division was rated good because managers at all levels in the service had the

right skills and abilities to run a service and strived to provide a good service and the service used a systematic approach to continually improve the quality of its services and the service collected, analysed, managed and used most information well.

Good practice was noted in a number of areas, including the Trust Delivery and Assurance Structure covering the top 3 tiers of the organisation; the Divisional Boards meeting on a monthly basis and subject to a monthly Executive Review; monthly tri-to-tri meetings held between divisional tri and service line tri; and evidence of the escalation of information upwards from specialties through to divisional boards.

However, there are no clear divisional governance guidance detailing Trust expectations on terms of reference, frequency of meetings attendance, reports produced and how information is escalated. There is no clear process for escalating information downwards and sideways where necessary. There was evidence that meetings were not consistently quorate within Executive Divisional Reviews and the Surgical Quality Assurance Group and that this was not noted in the minutes. The Surgery Division have Clinical Lead Guidance detailing the role and responsibilities of the Specialty Leads in relation to the divisional governance structure. Whilst the Medicine Division has Clinical Leads there is no specific guidance on what is expected of them in relation to the divisional governance structure. Medicines Quality Board does not have agreed terms of reference. The groups/committees within the Trust's delivery and assurance structure do not all have approved terms of reference in place.

In conclusion, there are clear governance processes in place across the Trust's delivery and assurance structure, but there is no guidance on how the divisional structures link in to this or how they should interact between divisions. There are many similarities across the two divisions, however it should be reviewed how the divisions can better share best practice and escalate information when required. We have issued a moderate design and moderate operational effectiveness audit opinion.

Other weaknesses were identified within the organisation's clinical audit - mortality review, HR (strategic), Governance Contract Management, Prescribing, County Wide IT Phishing, Core Financial Systems Phases 1 and 3, Quality Monitoring (CQC).

During the year Internal Audit undertook follow up work on previously agreed actions and noted significant progress made in delivering the agreed management actions. There are no open actions resulting from audits undertaken prior to 2018/19.

The internal audit also identified a number of areas where few weaknesses were identified and/or areas of good practice. Areas of good practice were noted in all reports issued.

It is good practice to review periodically the effectiveness of governance arrangements. During 2018/19, the Trust completed a review of its Constitution and supporting documents, including the Standing Orders, Board Committee Terms of Reference and Standing Financial Instructions. In support of these documents, the Trust created a 'Schedule of Decisions Reserved to the Board and the Scheme of Delegation'. A review of management and reporting lines was undertaken as well as a review of quality governance and reporting following which a revised delivery and assurance structure map was created.

Executive Directors within the organisation, who have responsibility for the development and maintenance of the system of internal control, also provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. I have also been advised on the effectiveness of the system of internal control by relevant internal mechanisms such as the Trust

Board, Quality and Performance, Audit and Assurance and Risk Management Committees.

11.9 Conclusion

I am very pleased with progress made in improving and strengthening the Trust's internal control environment during 2018/19 and the positive direction of travel, as recognised in the overall opinion of the Head of Internal Audit on the adequacy and effectiveness of the organisation's risk management, control and governance processes, who "are able to provide moderate assurance that there is a sound system of internal control, designed to meet the Trust's objectives and that controls are being applied consistently". I can confirm that action plans are in place to embed and ensure continuous improvement of the arrangements and to address outstanding issues. I can confirm that no significant internal control issues have been identified.

I am confident that the improvements delivered with regard to corporate governance in 2018/19 will continue into the next financial year, as both the Trust's arrangements and ways of working further mature and develop.

Signed

Deborah Lee
Chief Executive Officer

24 June 2019

NHS
Gloucestershire
Managed Services

12. SUSTAINABILITY SECTION

12.1 INTRODUCTION

As an NHS organisation we have an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of rising cost of natural resources.

The Trust acknowledges the impact we have on the local economy, society and environment and are therefore committed to continually work to actively integrate sustainable development into our core business.

As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020.

Gloucester Managed Services (GMS) provides a complete Estates and Facilities services provision to Gloucestershire Hospitals NHS Foundation Trust (GHFT) through a Operated Healthcare Facilities Agreement (OFHA), the arrangements include the provision of professional services such as sustainably advice in addition to improving the sustainability of the services GMS provides to the Trust.

12.2 POLICIES

In order to embed sustainability within our business it is important to explain where in our process and procedures sustainability features.

Area	Is sustainability considered?
Travel	Yes
Procurement (environmental)	Yes
Procurement (social impact)	Yes
Suppliers' impact	Yes

One of the ways in which an organisation can embed sustainability is through the use of a Sustainable Development Management Plan. Our SDMP is for the period 2015-2020 and so our plans for a sustainable future are well known within the organisation and clearly laid out.

Climate change brings new challenges to our business both in direct effects to the healthcare estates, but also to patient health. Examples of recent years include the effects of heat waves, extreme temperatures and prolonged periods of cold, floods, droughts etc. The organisation has identified the need for the development of a board approved plan for future climate change risks affecting our area. An adaptation plan and associated action plan will be developed in 2019.

12.3 CARBON REDUCTION COMMITMENT ENERGY EFFICIENCY SCHEME (CRC)

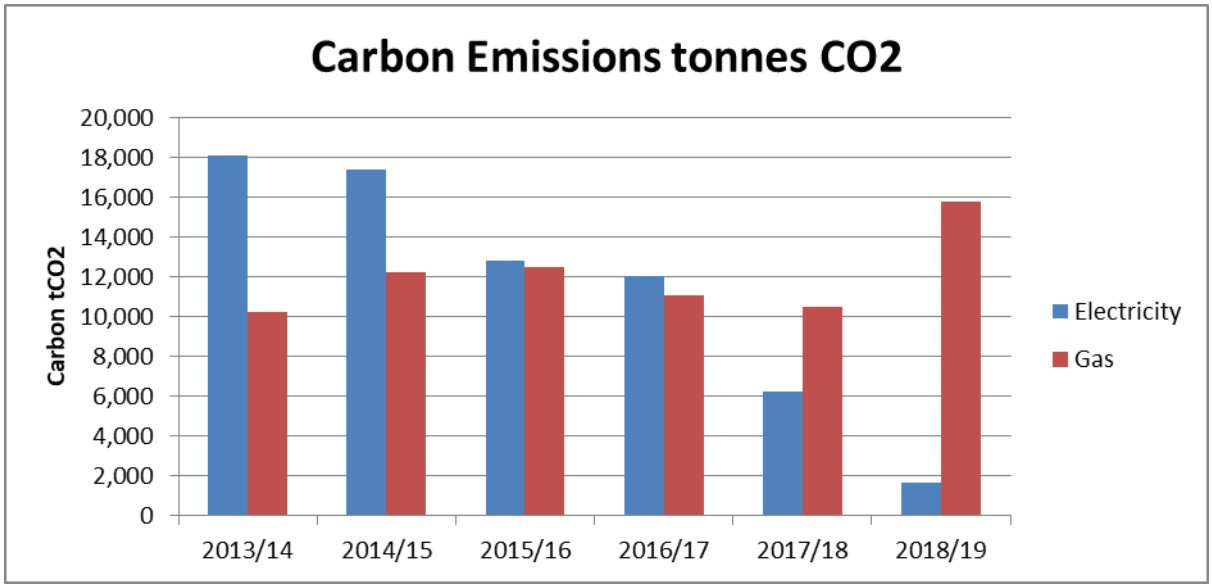
The Trust is a participant in the Carbon Reduction Commitment. For the reporting year 2018/19 it is **estimated** that the Trust will declare 17,600 tonnes of CO2 and will purchase and surrender carbon allowances to cover these emissions at a cost of over £322,000.

This is an increase on the declared CRC carbon emissions from 2017/18 when the Trust CRC emissions were recorded at 17,434 tCO2. The CRC figure is different to the Trust overall emissions figures as the CRC scheme excludes some gas emissions and includes the electricity produced by the combined heat and power units.

12.4 ENERGY AND WATER

GHNHSFT is estimated to have spent £3.8m on gas, electricity and water in 2018/19. Electricity cost and consumption and CO2 tonnages are all estimated.

Resource		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Gas	Use (kWh)	48,136,497	58,423,482	59,520,043	60,062,487	56,854,097	85,965,330
	tCO_2e	10,212	12,257	12,487	11,085	10,471	15,814
Oil	Use (kWh)	54,546	79,435	64,443	58,190	24,279	No data
	tCO_2e	17	25	21	18.3	6	No data
Electricity	Use (kWh)	32,323,886	31,724,857	22,273,744	22,633,386	17,791,983	7,027,940
	tCO_2e	18,098	17,381	12,806	12,066	6,255	1,989
Total Energy CO_2e		28,328	29,664	25,314	23,151	16,731	17,803



The combined heat and power plant at Gloucestershire Royal came online in May 2018. This has generated a considerable saving in electrical consumption from the national grid although there is a corresponding increase in the gas consumption. There is currently an export restriction on this CHP which prevents it operating at full output to match site demand, but this restriction is due to be lifted in October 2019 when national network upgrade works will be completed.

It should be noted that the carbon emissions declared under CRC do not include the oil used for the back-up generators but do include the electricity used by the tenants who have aerials on the Tower Block roof at Gloucestershire Royal. The CRC also counts the carbon from the CHP plant differently in that it excludes the input gas but counts the generated electricity. The Trust's annual comparative figures include the gas used by the CHP but ignore the electricity generated by the plant.

The average weather temperatures measured in Degree Days was much lower than the previous year, with 1897 Degree Day equivalent between April 2018–March 2019 compared to 2187 in 2017/18. This has had a direct influence on the gas and electrical consumption throughout the Trust.

Systemlink software is now being used for energy reporting, analysis and validation. It is being used to provide departmental analysis with profile reports for individual areas and departments (subject to sub meters). User web pages showing targets, cost and consumption per site/department are being developed.

The introduction of Gloucestershire Managed Services in April 2018 created untold delays in producing data and processing invoices from our energy suppliers whilst the energy contracts were novated and reset, and unfortunately there are still a small number of outstanding issues with invoices.

The Trust has been granted over £600,000 by NHS Improvement for lighting upgrades and this will assist the Trust to fulfil its strategy of replacing old light fittings with energy efficient ones. The Trust is also working with Sauter on an investment appraisal for improvements to the Building Management Systems.

12.5 TRAVEL

We can improve local air quality and improve the health of our community by promoting active travel – to our staff and to the patients and public that use our services. We support a culture for active travel to improve staff wellbeing and reduce sickness.

Travel to Work

In August 2017 a new shuttle bus contract started. Buses are operating longer hours and are a larger size in order to help more staff use the service. Staff can park at the Arle Court park and ride in Cheltenham and travel directly to either Cheltenham General or Gloucestershire Royal. An additional stop in Gloucester bus station has proved popular and provides two additional buses each hour to the hospital. Two more stops were added in September 2018, giving two residential areas and Cheltenham railway station users easy access to the hospital sites. Over 17,200 journeys are now made each month with about 75% of those made by staff. Fee paying public are only about 2% with about 23% of users being members of the public who hold a concessionary bus pass. A survey of shuttle bus users was conducted in January-February 2019 and the findings will be used to improve the service.

A reduced fare is available to Trust staff with two local bus companies, one of which also offers a monthly travel pass paid through a salary sacrifice arrangement proving further savings to the staff member. Information about buses and the fare discounts are advertised on the Trust internet, intranet, through staff communications and at occasional bus promotion events.

In 2017 the Trust began work on a 'Travel to Work' programme. The issue of parking has been raised in recent staff surveys and the parking permit classifications and criteria for the issue of permits have not changed since 1990s. Staff views were gathered in January and February 2017 and in January 2018 feedback sessions were held to explain how the staff survey results had influenced the shuttle bus contract and

also the planned changes to staff parking provision. The proposed scheme is planned to be introduced in autumn 2019.

The existing 1.5 mile exclusion zone for standard parking permits is to be replaced. Staff who work standard office hours and who live within 50 minutes travel by public transport will no longer be eligible for a car parking permit. Instead they will be encouraged to walk, cycle and use public transport etc. The tightening of permit criteria, the introduction of an on-line parking permit application system and a re-designation of car parks, should ensure that staff who use their own vehicle on Trust business and those who work shifts are able to park on site. The changes should promote staff health and wellbeing and reduce the congestion on the hospital sites.

Cycling

The Trust continues to offer a salary sacrifice scheme for the purchase of bicycles and there are discounts with local bike shops.

The Bicycle Users Group manages access to on-site facilities such as the secure bike sheds across both the acute sites. Over the last 12 months a change of the security codes and a clear out of the sheds was completed and included removal of abandoned locks. Membership of the group continues to increase and is currently in excess of 400 members.

Car scheme

The Trust offers staff the ability to lease a new car through a salary sacrifice scheme. In the first year of the scheme car could have maximum carbon emissions of 120g/km CO2 but this has now been reduced to 110g/km and will reduce to a maximum of 100g/km in 2019.

In addition, Tusker (the lease car scheme company) has included a Carbon Offsetting Initiative at no cost to the Trust. This allows staff to offset the carbon emissions of their new car and therefore to have a carbon neutral car for the duration of their lease agreement. Staff choose from one of four schemes (based in India, Chile, Brazil or Indonesia) and receive a regular newsletter to keep them informed on the schemes progress.

Since the scheme began in June 2016 75 members of staff have received cars or have them on order. The carbon offset is 370 tonnes CO2.

Joint transport groups

The Trust is working with the Gloucestershire County Council transport team and the other NHS organisations within the county on a variety of transport projects. A number of short-life working groups are looking at an assortment of projects including electric vehicles and clean fleet.

12.6 WASTE

The cardboard baler at Gloucestershire Royal Hospital was replaced by a cardboard compactor in November 2018. The volume of cardboard recycled has increased by 8.18 tonnes in the last 3 months compared to the 3 months prior to the installation of the compactor, with a rise from 21.64 tonnes to 29.82 tonnes. Cheltenham General recycles over four tonnes of cardboard per month.

GMS are investigating options regarding the introduction of re-usable sharps bins into the Trust. For each re-usable container used, up to 600 single-use containers are prevented from being incinerated, i.e. disposed as a whole unit along with the sharps

waste. A typical 1200 bed Trust would saves 11.5 tonnes of CO2 per annum - equivalent to running two small cars for a year! It has been estimated that using the re-usable sharps containers would save the Trust approximately £11,000 per annum. The Trust has a preferred supplier and is now waiting for confirmation from them as to the potential savings in cost and carbon emissions, before taking the project any further.

There are now two waste auditors in place with one at each site. Their sole role is to audit all wards and departments through an ongoing programme. The internal audits will identify areas that need to improve on segregation and increase recycling volumes. The waste auditors also encourage staff to have Waste Watchers in their department/ward.

The waste team are working on three new waste minimisation projects.

1. Recycling of blue sterilisation wrap and patient transfer sheets

GMS is exploring further options to improve recycling for the Trust including a solution developed by Thermal Compaction Group Ltd, who are the only providers of this service. They currently hold all necessary worldwide patents on this recycling process called Sterimelt and are leading research on whether the process could also be used to recycle single use plastic items.

The recycling of Polypropylene has been identified as a possible income generator and in addition, offers possible cost avoidance in relation to waste disposal. Current items for consideration under this scheme are Sterile Services Wraps used in theatres and any aseptic procedure undertaken within the Trust and non-soiled disposable patient slide sheets.

2. Warp It - Furniture and resource re-use programme

GMS is assessing the potential benefits of joining the Warp It online peer to peer redistribution network for organisations. Warp It makes it very easy for individuals in an organisation to share or give surplus items to individuals inside the same organisation, in the first instance. If items are not required within the primary organisation they can be passed onto partners. Items can be furniture, electrical equipment, office consumables (such as stationery and ink jet cartridges), lab equipment, supplies and medical equipment etc.

Warp It brings the unused into use, saving money, avoiding carbon emissions and landfill. The eco tool improves sustainability, reduces waste, reduces spend and improves internal/external collaboration and resilience. Warp It is part of the circular and collaborative economy- the tool is also considered to be part of the collaborative consumption movement.

Warp It is used in many Healthcare Trusts and including North Bristol NHS Trust where it has been in use for a two years. The North Bristol example will be used to base process and procedures required to ensure risk and responsibilities are effectively managed.

3. Food waste recycling

GMS are in the early stages of researching three different food recycling systems which turn food waste into fertiliser or biomass fuel and are assessing the suitability of each of the Trust food recycling systems.

12.7 CATERING

In June 2016 the Catering team opened Fosters Farm Shop within the restaurant at Gloucestershire Royal. The shop sells seasonal fruit and vegetables, produce from local suppliers and cakes, tray bakes and scones with the majority produced in-house. The shop has proved popular, giving access to locally produced items, supporting local companies and helping to improve the health and wellbeing of patients, staff and visitors. In 2017 the scheme was extended with the opening of a small concession in the Glass House coffee shop at Cheltenham General.

The GMS Catering team have ensured that the Trust achieved the Commissioning for Quality and Innovation (CQUIN) improvement programme (2017-18, 2018-19) requirement to reduce sugar levels and make healthier food and drink more widely available on NHS premises. The reduction of food waste is an ongoing programme on both sites.

GMS and the Trust follow the Government Buying Standards, fresh meat is from the Red Tractor assurance scheme and all fish and palm oil products are from sustainable sources. Dairy and bakery products, fruit and vegetables and fresh meat are all from suppliers within the county or the South-West.

In 2017 new patient menus were introduced to enable the Trust to comply with Patient Led Assessment of Care Environments PLACE criteria. The menus change twice a year so there are spring-summer and autumn-winter patient menus which allow greater use of seasonal local fruit and vegetables reducing food miles.

The in-house production of cakes, sandwiches and salads has enabled a move to paper and cardboard packaging for these items and hot food take-out containers are now bio-degradable. Plastic disposable cutlery is now only available to customers who purchase takeaway food, helping to reduce its usage. Cardboard and cans are recycled and provide a small income for the Trust. All plastic products are recycled and the department continue to reduce disposables. The Catering department no longer use black plastic for ready meal containers or disposable coffee lids as they were not recyclable and have moved to a white plastic instead.

As part of their commitment to sustainability, our retail outlets are encouraging the use of re-usable cups by offering a bamboo travel mug at a promotional price. They also offer a discount to customers who bring their own mugs for hot beverages and have signage by their hot drinks machines encouraging customers to use the china mugs rather than disposable.

12.8 PFI

Part of the Gloucestershire Royal site is a Private Finance Initiative (PFI) scheme and Apleona PPP Limited are responsible for the maintenance and upkeep of that part of the building. The contract requires them to replace items on a like-for-like basis but as the building is now 15 years old replacement equipment tends to be more efficient than the original.

Original light fittings are being replaced by LEDs as part of an on-going programme with about 70% complete and the rest due in the next two years. Current annual savings are 372,037 kWh and this equates to £37,000 of savings annually assuming a unit cost of 10p/unit.

A more efficient emergency lighting is being installed which provides instant feedback on performance and function via information gateways and the Cloud.

These replacement schemes allow the building to perform better and make it more resilient. The energy savings are passed on to the Trust in the form of reduced energy bills and a corresponding decrease in carbon emissions.

12.9 PROCUREMENT

GMS and Trust procurement services are committed to meeting industry best practice of incorporating both environmental and the wider Social Economic Responsibilities (SER) principles into all contracting activity undertaken. They support GMS and the Trust in meeting the procurement elements of the NHS Sustainable Development Assessment Tool (SDAT) which is aligned to the UN Sustainable Development Goals (SDGs).

Building on the foundation of previous work undertaken, which has focused on environmental sustainability, for example: requesting our suppliers to support moves towards less packaging, use of higher percentages of recycled materials in their products/packaging, to use more fuel efficient and/or alternative fuel vehicles, to share innovations in carbon offsetting and supporting the reduction of the Trusts carbon footprint.

This has most recently underpinned by the zero tolerance of modern slavery within our immediate and extended supply chain(s). This includes moving to evaluating suppliers on how they monitor their supply chains, how they ensure no materials used to deliver contract(s) are created through the use of bonded labour or infringement of human rights. This area has been recently expanded to incorporate the wider SER principles, for example; ensuring there is no unnecessary use of zero hour's contracts, that supplier's staff have an active voice in their workplace and that they are already moving to, or signed up to the national living wage.

All procurement exercises undertaken are reviewed and relevant sustainability and SER factors incorporated into the specifications and the evaluation methodologies, to ensure the Trust gets a sustainable solution that demonstrates the best value for public money being spent.

12.10 MATERIALS MANAGEMENT / RECEIPT & DISTRIBUTION

Materials Management have been working on improving the bulk storage of Personal Protective Equipment (PPE) items and a small amount of ward consumables. This gives the department the ability to react to ward demands quickly ensuring agreed sustainable products are available rather than sourcing alternatives. This also gives a financial saving due to buying in bulk. This has secured in the region of £40,000 saving for the Trust.

The joint GMS/GHFT Clinical Product Evaluation Group (CPEG) has been running since August 2018. This Group meets once a month to look at possible savings opportunities and more sustainable alternatives. All identified opportunities are presented to a wide group of clinical staff and divisional experts to look at the new product and decide if the product should be accepted, trialled or refused. Trials are organised by GMS with data gathered and a final report presented to the CPEG for final decision. This has provided a saving of £50,000.

12.11 HEALTH AND WELLBEING

The health and wellbeing of staff is important to the Trust and support such as occupational therapy and self-referral physiotherapy is detailed elsewhere within the Trust annual report. In May 2019 we will launch the 2020 Staff Advice and Support Hub, which is a brand new venture that will signpost colleagues to services which support their physical, mental and financial health and wellbeing.

The Trust has been focussing on sharps injuries since these are a well-known risk in the health and social care sector. Sharps contaminated with an infected patient's blood can transmit more than 20 diseases, including hepatitis B, C and human immunodeficiency virus (HIV). The transmission of infection depends on a number of factors, including the person's natural immune system. There were 126 sharps injuries in the Trust in 2018. Whilst these rarely lead to serious illness, the worry and stress about the potential consequences can have a significant personal impact on an injured employee. We are required by law to reduce the risk of a sharps injury and to provide safer sharps wherever this is reasonably practicable. We are in the process of replacing unsafe sharps wherever practicable as well as reviewing our training, policy and risk assessments. Health and wellbeing is important to us and we hope staff will appreciate the benefits of safer devices across the hospital.

12.12 FUTURE DEVELOPMENTS

Last year, we were successful in a Sustainability & Transformation (STP) bid to NHSE in April 2018 for £39.5m to develop both of our sites (GRH & CGH) to resolve a number of issues within planned and urgent care across Gloucestershire. There will be both new build and redevelopment and both will aim for the highest level in BREEAM Healthcare, with buildings incorporating high energy efficiency and flexible designs. This will also provide an opportunity to redesign the bus stop area at Gloucestershire Royal Hospital, with a view to improving the area and maximising the number of available bus stops.

12.13 SCOPE 1, 2 AND 3 EMISSIONS

Area	Type	Unit	Cost £
Greenhouse Gas Emissions	Scope 1 (gas consumption, fleet vehicles and anaesthetic gases)	17,545 tCO_2e	Total Scope 1, 2 and 3 emissions (not including anaesthetic gas) £3,800,000 estimated
	Scope 2 (electricity consumption)	1,989 tCO_2 (estimated)	
	Scope 3 (business travel)	180 tCO_2	
Waste minimisation and management	(a) total waste arising = 2,385 tonnes (b) waste to energy = 857 tonnes (c) waste recycled/reused = 534 tonnes (d) waste incinerated = 232 tonnes (e) waste sent to landfill = 33 tonnes (f) waste sent to an AT plant = 729 tonnes		£549,622

The Trust has reported on the carbon emissions from anaesthetic gases. These are nitrous oxide, Entonox, Desflurane, Isoflurane and Sevoflurane and are all used in theatres or the maternity units. In 2017/18 these produced 2,144 tCO2e but in 2018/19 this has dropped to 1,582 tCO2e due to the reduction in use of desflurane.

Scope 1 emissions have risen by 24% from last year mostly due to the increase in gas usage associated with the new CHP at Gloucestershire Royal Hospital which came online in May 2018. As expected this has produced a significant drop in Scope 2 emissions (by 68%) although this figure is approximate due to estimated electricity use at Gloucestershire Royal.

From April 2018 to March 2019 the shuttle bus (service 99) covered 178,816 miles, carried 212,224 passengers and produced 303 tCO_2. The costs and carbon associated with this contract are not included in the Scope 1, 2 and 3 emissions above.

12.14 GOVERNANCE AND MONITORING PROCESSES

Implementation of the SDMP has continued during the period of organisation change within the Trust. The committee structure is being re-established to enable the development of the cross organisational sustainability strategy for 2020 and beyond. Monitoring of carbon emissions and consumption, together with sustainable developments e.g. new shuttle bus stops has continued.

The Trust routinely reports through the Department of Health's "Estates Return Information Collection" mechanism (ERIC).

The GMS and the Trust were pleased to receive a certificate in recognition of “Excellence in Sustainability Reporting” for the 2017-18 annual sustainability report from the Sustainable Development Unit for NHS England and Public Health England – with the Healthcare Financial Management Association and NHS Improvement.

15. OVERVIEW OF FORWARD PLANS FOR 2018/19

- To work with Vital Energi Limited (the Trust's energy performance contractor) to validate new technologies at Cheltenham General and Gloucestershire Royal and to develop further projects.

- To ensure that the Trust will meet the UK national targets on carbon reduction by reducing consumption of gas and electricity and developing more on-site generation. Continue to monitor and report on progress, engaging with staff and visitors to reduce carbon emissions and promote success.

- To ensure that the legislative requirements associated with carbon reduction and sustainability are met e.g. Display Energy Certificates and Carbon Reduction Commitment Energy Efficiency Scheme.

- To develop further projects on waste prevention, elimination and segregation, reducing the volume of waste sent to landfill and increasing the amount sent for recycling.

- To investigate options for expanding behavioural change programme focusing on energy, water and waste with the aim of educating staff, making them more sustainable in their activities and reducing carbon.

- Reduce the number of staff parking permits as staff living within a 50 minute travel time by public transport will not be eligible for a permit. The Trust will promote active travel and help them to use the bus, cycle or walk to work.

- To investigate the use of pool cars to see if greater access to these would reduce the number of staff using their own vehicles for Trust business.

- To continue to develop links with the wider community in areas relating to carbon reduction and sustainable development.

- To work with the county council and other public sector organisations on travel initiatives such as bus promotion, electric vehicles and fleet specifications.

- To use the new telephony system to enable more flexible working better use of telephone and video conferencing to reduce meeting related travel. To identify opportunities for further use of telecare.

- Re-establish the sustainability committee structure within the Trust
- Use the Health Outcomes Travel Tool and the SDAT to assess Trust performance and inform action plan.

- To progress waste minimisation projects on food waste, re-use of items, re-usable sharps bins and recycling of theatre instrument set-wrap.

- To commence Trust wide move to LED lighting once funding is released.

13 ANNUAL REPORT OF THE AUDIT AND ASSURANCE COMMITTEE

13.1 INTRODUCTION

In accordance with best practice, the Audit and Assurance Committee produces an Annual Report setting out how the Committee has met its Terms of Reference during the past year.

13.2 REMIT AND TERMS OF REFERENCE

In addition to the normal range of financially based responsibilities the Committee has responsibility for scrutinising all risks and controls which may affect the Trust's business. This particularly relates to areas of risk management and clinical governance where the Committee is responsible for advising the Main Board as to whether a robust assurance framework is in place and operating effectively. The Committee is also acting as the Group Audit Committee ensuring that the subsidiary company has effective audit arrangements in place.

13.3 MEMBERSHIP

The Committee consists of three Non-Executive Directors, one of whom is required to have recent relevant financial experience. In addition, the meetings are attended on a regular basis by the Director of Corporate Governance, Director of Finance, the Chief Executive, the Director of Safety, the Local Counter Fraud Specialist and the Internal and External Auditors. Representatives of GMS, the Trust's estates and facilities subsidiary company, attend for relevant agenda items. A representative from the Council of Governors observes each meeting. Time is also allocated, prior to each meeting, for private discussion to take place between Committee Members and the internal and external auditors.

The Committee has undertaken an annual self-assessment which, overall, showed compliance with good practice. The self-assessment also identified areas of further development (e.g. identifying costs incurred by the Committee and further clarifying the role of the Committee in regard to clinical audit).

13.4 2018/19 – REVIEW OF THE YEAR

In accordance with its terms of reference the Committee has met on six occasions over the last year. The cycle of meetings revolves around the reporting cycle of Internal and External Auditors and the Annual Report and Accounts of the Foundation Trust. An additional meeting is held with Members of the Committee in April where the Finance Team provide a comprehensive briefing on year end accounts; this meeting also provided an opportunity for the Committee to review a draft Annual Report.

Governance, Risk Management and Internal Control

The Committee has reviewed relevant disclosure statements, in particular the Annual Governance Statement (AGS) together with the Head of Internal Audit Opinion, external audit opinion and other appropriate independent assurances and considers that the AGS is consistent with the Committee's view on the Trust's system of internal control. Accordingly, the Committee supports Board Approval of the AGS.

The Committee has reviewed the completeness of the risk management system and the extent to which it is embedded in the organisation. The Committee believes that adequate systems for risk management are in place; ongoing work is required to ensure these are complied with throughout the whole organisation and continue to evolve to meet the needs of the Trust.

Internal Audit

Throughout the year the Committee has worked effectively with internal audit to strengthen the Trust's internal control processes. The Committee has noted that significant progress has been made in responding to internal audit findings, with no outstanding actions resulting from previous years' audits and good executive management engagement and ownership of the internal audit plan and individual audits within it.

The Committee has also in year:

- Reviewed and approved the internal audit programme, operational plan and more detailed programme of work
- Considered the major findings of internal audit and are assured that management have responded in an appropriate manner and that the Head of Internal Audit Opinion and that the Annual Governance Statement reflects any major control weaknesses

External Audit

EY were the Trust's External Auditors throughout the financial year.

The Committee has in year:

- Reviewed and agreed external audit's annual plan
- Reviewed and commented on the reports prepared by external audit
- Reviewed and commented on regular updates on matters impacting on the wider sector prepared by external audit
- Considered the interim audit findings and received assurance that these have been addressed prior to final annual accounts audit
- Reviewed and commented on the reports and opinion delivered as part of the final accounts audit

Management

The Committee has challenged the assurance process when appropriate and has requested and received assurance reports from Trust management and various other sources both internally and externally throughout the year. This process has also included calling managers and directors to account when considered necessary to obtain relevant additional assurance.

Financial Reporting

The Committee has reviewed the annual financial statements before submission to the Board and are entirely satisfied with the submission.

Other Matters

Further examples of the Audit and Assurance Committee's work during 2018/19 include:

- Review of cyber security at the Trust including the identification and escalation of relevant risks to the Trust Board
- Review of clinical audit arrangements
- Review of GDPR compliance

- Obtaining assurance on the Trust's Emergency Prevention, Preparedness and Response (EPPR) arrangements, including a review of NHE England's EPPR external assurance report
- Obtaining assurance on the design and effectiveness of the Trust risk management arrangements
- Scrutiny of counter fraud reports
- Development of an appropriate process to review the accounting and audit arrangements of GMS, the Trust's estates and facilities subsidiary company*
- Regular review and refinement of the Board Assurance Framework

**Following the establishment of the Estates and Facilities Subsidiary Company (SubCo), trading as Gloucestershire Managed Services (GMS) in April 2018, the remit of the Committee was extended to cover the Subsidiary. Accordingly, the Committee acted as the Group Audit Committee obtaining assurance that the subsidiary company had effective audit arrangements in place.*

The Committee's terms of reference were revised accordingly.

Conclusion

The Committee is of the opinion that this annual report is consistent with the Annual Governance Statement and Head of Internal Audit Opinion and there are no matters that the Committee is aware of at this time that have not been disclosed appropriately.

Gloucestershire Hospitals NHS Foundation Trust

Annual accounts for the year ended 31 March 2019

Foreword to the accounts

Gloucestershire Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2019, have been prepared by Gloucestershire Hospitals NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed .....

Name **Deborah Lee**
Job title **Chief Executive Officer**
Date **24 June 2019**

Statement of Comprehensive Income

	Note	2018/19 Trust £000	2018/19 Group £000	2017/18 Trust £000	2017/18 Group £000
Operating income from patient care activities	3	458,985	458,985	439,159	439,159
Other operating income	4	70,358	76,443	59,262	61,240
Operating expenses	7, 9	(556,796)	(560,922)	(541,341)	(542,196)
Operating surplus/(deficit) from continuing operations		**(27,452)**	**(25,494)**	**(42,920)**	**(41,797)**
Finance income	12	1,029	196	51	109
Finance expenses	13	(6,214)	(6,214)	(5,508)	(5,508)
PDC dividends payable		(1,845)	(1,845)	(3,721)	(3,721)
Net finance costs		**(7,030)**	**(7,863)**	**(9,178)**	**(9,120)**
Other gains / (losses)	14	-	77	534	542
Share of profit / (losses) of associates / joint arrangements	21	-	-	-	-
Gains / (losses) arising from transfers by absorption	46	-	-	-	-
Corporation tax expense		-	(212)	-	-
Surplus / (deficit) for the year from continuing operations		**(34,482)**	**(33,492)**	**(51,564)**	**(50,375)**
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations	15	-	-	-	-
Surplus / (deficit) for the year		**(34,482)**	**(33,492)**	**(51,564)**	**(50,375)**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Impairments	8	(19,615)	(19,615)	(26,971)	(26,971)
Revaluations	19	-	-	-	-
Share of comprehensive income from associates and joint ventures	21	-	-	-	-
Fair value gains/(losses) on equity instruments designated at fair value through OCI	22	-	-		-
Other recognised gains and losses		-	-	-	-
Remeasurements of the net defined benefit pension scheme liability / asset	39	-	-	-	-
Other reserve movements		-	-	-	-
May be reclassified to income and expenditure when certain conditions are met:				-	
Fair value gains/(losses) on financial assets mandated at fair value through OCI	22	-	-	-	-
Recycling gains/(losses) on disposal of financial assets mandated at fair value through OCI	14	-	-	-	-
Foreign exchange gains / (losses) recognised directly in OCI		-	-	-	-
Total comprehensive income / (expense) for the period		**(54,097)**	**(53,107)**	**(78,535)**	**(77,346)**
Surplus/ (deficit) for the period attributable to:					
Non-controlling interest, and		-	-	-	-
Gloucestershire Hospitals NHS Foundation Trust		(34,482)	(33,492)	(51,564)	(50,375)
TOTAL		**(34,482)**	**(33,492)**	**(51,564)**	**(50,375)**
Total comprehensive income/ (expense) for the period attributable to:					
Non-controlling interest, and		-	-	-	-
Gloucestershire Hospitals NHS Foundation Trust		(54,097)	(53,107)	(78,535)	(77,346)
TOTAL		**(54,097)**	**(53,107)**	**(78,535)**	**(77,346)**

The Trust's control total deficit for 2018/19, excluding the impact of impairments was £29.6m, as detailed in Note 2 on page 15

Statement of Financial Position

	Note	31 March 2019 Trust £000	31 March 2019 Group £000	31 March 2018 Trust £000	31 March 2018 Group £000
Non-current assets					
Intangible assets	17	10,412	10,412	9,130	9,130
Property, plant and equipment	18	231,338	231,216	251,010	251,010
Other investments / financial assets	22		1,954	-	1,877
Receivables	26	5,185	5,185	4,463	4,463
Other assets	27	600	-	-	-
Total non-current assets		**247,535**	**248,767**	**264,603**	**266,480**
Current assets					
Inventories	25	7,434	7,571	7,131	7,131
Receivables	26	23,784	25,431	19,276	19,310
Other investments / financial assets	22	-	-	-	-
Other assets	27	-	-	-	-
Non-current assets for sale and assets in disposal	28	-	-	-	-
Cash and cash equivalents	29	4,836	9,846	5,447	6,947
Total current assets		**36,054**	**42,849**	**31,854**	**33,388**
Current liabilities					
Trade and other payables	30	(50,420)	(54,432)	(47,510)	(47,524)
Borrowings	32	(12,527)	(12,527)	(4,703)	(4,703)
Other financial liabilities	33	-	-	-	-
Provisions	35	(160)	(160)	(160)	(160)
Other liabilities	31	(5,837)	(5,837)	(3,284)	(3,284)
Liabilities in disposal groups	28	-	-	-	-
Total current liabilities		**(68,945)**	**(72,956)**	**(55,657)**	**(55,671)**
Total assets less current liabilities		**214,644**	**218,660**	**240,800**	**244,197**
Non-current liabilities					
Trade and other payables	30	-	-	-	-
Borrowings	32	(135,295)	(135,294)	(111,219)	(111,219)
Other financial liabilities	33	-	-	-	-
Provisions	35	(1,434)	(1,434)	(1,472)	(1,472)
Other liabilities	31	(6,860)	(6,860)	(7,235)	(7,235)
Total non-current liabilities		**(143,589)**	**(143,588)**	**(119,926)**	**(119,926)**
Total assets employed		**71,055**	**75,072**	**120,874**	**124,271**
Financed by					
Public dividend capital		172,676	172,676	168,768	168,768
Revaluation reserve		23,706	23,706	43,321	43,321
Other reserves		209	209	209	209
Income and expenditure reserve		(125,536)	(125,898)	(91,424)	(91,424)
Charitable fund reserves	24	-	4,379	-	3,397
Total taxpayers' equity		**71,055**	**75,072**	**120,874**	**124,271**

The notes on pages 8 to 49 form part of these accounts.

Name **Deborah Lee**

Job title **Chief Executive Officer**

Date **24 June 2019**

Statement of Changes in Equity for the year ended 31 March 2019

Group	Public dividend capital £000	Revaluation reserve £000	Financial assets reserve* £000	Other reserves £000	Merger reserve £000	Income and expenditure reserve £000	Charitable fund reserves £000	Non-controlling interest £000	Total £000
Taxpayers' and others' equity at 1 April 2018 - brought forward	**168,768**	**43,321**	**-**	**209**	**-**	**(91,424)**	**3,397**	**-**	**124,271**
Impact of implementing IFRS 15 on 1 April 2018	-	-	-	-	-	-	-	-	-
Impact of implementing IFRS 9 on 1 April 2018	-	-	-	-	-	-	-	-	-
Surplus/(deficit) for the year	-	-	-	-	-	(34,474)	982	-	**(33,492)**
Transfers by absorption: transfers between reserves	-	-	-	-	-	-	-	-	-
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	-	-	-	-	-	-	-	-
Other transfers between reserves	-	-	-	-	-	-	-	-	-
Impairments	-	(19,615)	-	-	-	-	-	-	**(19,615)**
Revaluations	-	-	-	-	-	-	-	-	-
Revaluations and impairments - charitable fund assets	-	-	-	-	-	-	-	-	-
Transfer to retained earnings on disposal of assets	-	-	-	-	-	-	-	-	-
Share of comprehensive income from associates and joint ventures	-	-	-	-	-	-	-	-	-
Fair value gains/(losses) on financial assets mandated at fair value through OCI	-	-	-	-	-	-	-	-	-
Fair value gains/(losses) on equity instruments designated at fair value through OCI	-	-	-	-	-	-	-	-	-
Recycling gains/(losses) on disposal of financial assets mandated at fair value through OCI	-	-	-	-	-	-	-	-	-
Foreign exchange gains/(losses) recognised directly through OCI	-	-	-	-	-	-	-	-	-
Other recognised gains and losses	-	-	-	-	-	-	-	-	-
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	-	-	-	-	-	-	-
Public dividend capital received	3,908	-	-	-	-	-	-	-	**3,908**
Public dividend capital repaid	-	-	-	-	-	-	-	-	-
Public dividend capital written off	-	-	-	-	-	-	-	-	-
Other movements in public dividend capital in year	-	-	-	-	-	-	-	-	-
Other reserve movements	-	-	-	-	-	-	-	-	-
Taxpayers' and others' equity at 31 March 2019	**172,676**	**23,706**	**-**	**209**	**-**	**(125,898)**	**4,379**	**-**	**75,072**

* Following the implementation of IFRS 9 from 1 April 2018, the 'Available for sale investment reserve' is now renamed as the 'Financial assets reserve'

Statement of Changes in Equity for the year ended 31 March 2018

Group	Public dividend capital £000	Revaluation reserve £000	Available for sale investment reserve £000	Other reserves £000	Merger reserve £000	Income and expenditure reserve £000	Charitable fund reserves £000	Non-controlling interest £000	Total £000
Taxpayers' and others' equity at 1 April 2017 - brought forward	**166,519**	**70,292**	**-**	**209**	**-**	**(39,860)**	**2,208**	**-**	**199,368**
Prior period adjustment	-	-	-	-	-	-	-	-	-
Taxpayers' and others' equity at 1 April 2017 - restated	**166,519**	**70,292**	**-**	**209**	**-**	**(39,860)**	**2,208**	**-**	**199,368**
Surplus/(deficit) for the year	-	-	-	-	-	(51,564)	1,189	-	**(50,375)**
Transfers by absorption: transfers between reserves	-	-	-	-	-	-	-	-	-
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	-	-	-	-	-	-	-	-
Other transfers between reserves	-	-	-	-	-	-	-	-	-
Impairments	-	(26,971)	-	-	-	-	-	-	**(26,971)**
Revaluations	-	-	-	-	-	-	-	-	-
Revaluations and impairments - charitable fund assets	-	-	-	-	-	-	-	-	-
Transfer to retained earnings on disposal of assets	-	-	-	-	-	-	-	-	-
Share of comprehensive income from associates and joint ventures	-	-	-	-	-	-	-	-	-
Fair value gains/(losses) on available-for-sale financial investments	-	-	-	-	-	-	-	-	-
Recycling gains/(losses) on available-for-sale financial investments	-	-	-	-	-	-	-	-	-
Foreign exchange gains/(losses) recognised directly through OCI	-	-	-	-	-	-	-	-	-
Other recognised gains and losses	-	-	-	-	-	-	-	-	-
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	-	-	-	-	-	-	-
Public dividend capital received	2,249	-	-	-	-	-	-	-	**2,249**
Public dividend capital repaid	-	-	-	-	-	-	-	-	-
Public dividend capital written off	-	-	-	-	-	-	-	-	-
Other movements in public dividend capital in year	-	-	-	-	-	-	-	-	-
Other reserve movements	-	-	-	-	-	-	-	-	-
Taxpayers' and others' equity at 31 March 2018	**168,768**	**43,321**	**-**	**209**	**-**	**(91,424)**	**3,397**	**-**	**124,271**

Information on reserves

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 organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health and Social Care as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Other reserves
On the original setting up of the Trust in 2003 there was an error made on the initial PDC to cover the total value of the net assets of the new organisation. The adjustment was credited to other reserves. This reserve will remain with the Trust until the Trust is dissolved.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the trust.

Charitable funds reserve
This reserve comprises the ring-fenced funds held by the NHS charitable funds consolidated within these financial statements. These reserves are classified as restricted or unrestricted; a breakdown is provided in note 27.

Statement of Cash Flows

	Note	31 March 2019 Trust £000	31 March 2019 Group £000	31 March 2018 Trust £000	31 March 2018 Group £000
Cash flows from operating activities					
Operating surplus / (deficit)		(27,452)	(25,494)	(42,920)	(41,797)
Non-cash income and expense:					
Depreciation and amortisation	7.1	13,803	13,803	9,660	9,660
Net impairments	8	4,774	4,774	19,971	19,971
Income recognised in respect of capital donations	4	(320)	(320)	(352)	(352)
(Increase) / decrease in receivables and other assets		(5,593)	(7,240)	(720)	(720)
(Increase) / decrease in inventories		(303)	(441)	269	269
Increase / (decrease) in payables and other liabilities		7,778	11,131	280	280
Increase / (decrease) in provisions		(54)	(54)	(94)	(94)
Movements in charitable fund working capital		-	125	-	131
Tax (paid) / received		-	(212)	-	-
Net cash flows from / (used in) operating activities		**(7,367)**	**(3,928)**	**(13,906)**	**(12,652)**
Cash flows from investing activities					
Interest received		124	124	51	51
Purchase and sale of financial assets / investments		-	-	-	-
Purchase of intangible assets		(1,282)	(1,282)	(1,737)	(1,737)
Sales of intangible assets		-	-	-	-
Purchase of PPE and investment property		(15,902)	(15,902)	(9,553)	(9,553)
Sales of PPE and investment property		-	-	2,587	2,587
Net cash flows from charitable fund investing activities		-	71	-	-
Net cash flows from / (used in) investing activities		**(17,060)**	**(16,989)**	**(8,652)**	**(8,652)**
Cash flows from financing activities					
Public dividend capital received		3,908	3,908	2,249	2,249
Movement on loans from DHSC		29,501	29,501	30,164	30,164
Capital element of finance lease rental payments		(2,055)	(2,055)	(2,041)	(2,041)
Capital element of PFI, LIFT and other service concession payments		(103)	(103)	(676)	(676)
Interest on loans		(3,868)	(3,868)	(2,907)	(2,907)
Interest paid on finance lease liabilities		(170)	(170)	(214)	(214)
Interest paid on PFI, LIFT and other service concession obligations		(1,927)	(1,927)	(2,169)	(2,169)
PDC dividend (paid) / refunded		(1,470)	(1,470)	(4,375)	(4,375)
Net cash flows from / (used in) financing activities		**23,817**	**23,817**	**20,031**	**20,031**
Increase / (decrease) in cash and cash equivalents		**(611)**	**2,899**	**(2,527)**	**(1,273)**
Cash and cash equivalents at 1 April - brought forward		**5,447**	**6,947**	**7,974**	**8,220**
Prior period adjustments		-	-		-
Cash and cash equivalents at 1 April - restated		**5,447**	**6,947**	**7,974**	**8,220**
Cash and cash equivalents at 31 March	29	**4,836**	**9,846**	**5,447**	**6,947**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts

Note 1.1.1 Accounting convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.1.2 Going concern
The accounting rules (IAS 1) require management to assess, as part of the accounts preparation process, the NHS Foundation Trust's ability to continue as a going concern. The financial statements have been prepared on a going concern basis as we do not either intend to apply to the Secretary of State for the dissolution of the NHS Foundation Trust without the transfer of the services to another entity, or consider that this course of action will be necessary.

We are also required to disclose material uncertainties in respect of events or conditions that cast significant doubt upon the going concern ability of the NHS Foundation Trust and these are disclosed below.

The Trust incurred a deficit in the year of £34.1m (see Note 2) and is planning for a deficit of £1.5m in 2019/20. The Trust's operating and cash flow forecasts have identified the need for continued additional financial support to enable it to meet debts as they fall due over the foreseeable future, which is defined as a period of 12 months from the date these accounts are signed.
A financial plan was put in place for 2018/19 which enabled the continuity of services and distress funding was both planned and received over the course of the year to ensure that liabilities could be met and services provided. The Trust plan was submitted to NHS Improvement at the start of the year which indicated a material deficit for 2018/19 and consequent significant cash funding requirements to enable the Trust to meet its liabilities and to continue the provision of services. At the point of finalising these financial statements we note the following:

To date the Trust has received distress funding of £93.7m from the Department of Health and Social Care. Additional cash funding will be required in 2019/20 to the value of £14.4m. The source of this funding will be NHS Improvement distress financing loans. On a monthly basis cash forecasts are submitted to NHS Improvement with a loan requirement. Funding has been drawn down in this way since September 2016 and we do not anticipate any risk in accessing the necessary cash support for 2019/20.

Having considered the material uncertainties and the Trust's financial plan for 2019/20 and the likelihood of securing additional financial funding to support the financial operations, the directors have determined that it remains appropriate to prepare these accounts on a going concern basis. The accounts do not include any adjustments that would result if Gloucestershire Hospitals NHS Foundation Trust was unable to continue as a going concern.

Note 1.2 Critical judgements in applying accounting policies
The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

a) Plant and equipment is valued at depreciated replacement cost, the valuation being assessed by the Trust's Independent Valuer who values those assets with a written down value of greater than £100k. This process also includes those equipment items currently leased.

b) The Trust leases a number of equipment assets and the Trust has assessed the risks and rewards of ownership in categorising these leases as either operating or finance leases.

c) The Trust is required to review property, plant and equipment for impairment in between formal valuations by a suitably qualified valuer. Management make judgements about the condition of assets and review their estimated lives taking account of the professional advice of the Trust's Independent Valuer.

d) The Trust employed an independent consultancy to develop an optimised alternative site Modern Equivalent Asset model as the basis of the valuation. The assumption for this is that the number of buildings and size of site would reduce if building now to provide the same services. The valuation of buildings is net of VAT for the first time in the 2018/19 financial year. This reflects the set-up and operation of the Trust wholly owned subsidiary on the 1st April 2018, Gloucestershire Managed Services, and the assumption that the subsidiary company will be used to replace any such assets.

Note 1.2.1 Sources of estimation uncertainty
The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

a) the cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements as an accrual. As the calculation involves a large number of staff, sampling techniques are used to collate the results for the entire Trust. The amount accrued in 2018-19 was £464k.

b) The useful economic life of each category of fixed asset is assessed when acquired by the Trust. A degree of estimation is used in assessing the useful economic lives of assets asset lives are detailed in note 1.7.6.

Note 1.3 Consolidation
The NHS Foundation Trust is the corporate trustee to Gloucestershire Hospitals charitable fund. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the Trust's accounting policies and
- eliminate intra-group transactions, balances, gains and losses.

The Trust wholly owns Gloucestershire Hospitals Subsidiary Company Ltd (known as Gloucestershire Managed Services, GMS) which form part of the consolidated accounts. GMS provides the estates, facilities, sterile services and materials management services for the Trust. Its turnover for the period ended 31st March 2019 was £46m and its gross assets at 31 March 2019 totalled £6.6m.

Entities over which the Trust has the power to exercise control are classified as subsidiaries and are consolidated. The Trust has control when it has the ability to affect the variable returns from the other entity through its power to direct relevant activities. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to non-controlling interests are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where subsidiaries' accounting policies are not aligned with the Trust or where the subsidiaries' accounting dates are not coterminous. The amounts consolidated are drawn from the financial statements of Gloucestershire Hospitals charitable fund and GMS. Intra-entity balances, transactions and gains/losses are eliminated in full on consolidation.

Note 1.4.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of health care services. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Where income is received for a specific activity which is to be delivered in a subsequent 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.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.4.2 Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.4.3 Other income

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.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social securily costs and the apprenticeship levy 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

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme.

Employer's 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.

Note 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition
Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Note 1.7.2 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 valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis net of VAT.

A formal revaluation is required every 5 years with an interim formal valuation in the third year of each cycle. A Modern Equivalent Asset Optimised Alternative Site valuation was undertaken as at 1st April 2017 by the Trust's Independent Valuer. A desk top valuation, measured on a MEA basis and excluding VAT, was undertaken by the Trust's Independent Valuer as at 31.03.2019.

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. The Market Value valuation is on the assumption that the property is sold following the cessation of the existing operations consistent with the Department of Health and Social Care guidelines.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

PFI assets are valued net of VAT.

Operational equipment is valued at current value except where these are considered to be of short useful life or low value. If this is the case a depreciated replacement cost basis is used as a proxy. Equipment surplus to requirements is valued at net recoverable amount.

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.7.3 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 ie:
- management are committed to a plan to sell the asset
- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed 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 abandoned or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.7.4 Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.7.5 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions
PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM*, are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual unitary payment is separated into the following component parts using a model:
- payment for the fair value of the services received
- repayment of the finance lease liability, including finance costs, and
- payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

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

Note 1.7.6 Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Land is assumed to have an infinite life	-	-
Buildings, excluding dwellings	15	79
Plant & machinery	5	15
Transport equipment	7	7
Information technology	3	5
Furniture & fittings	10	10

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.8 Intangible assets

Note 1.8.1 Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the Trust intends to complete the asset and sell or use it
- the Trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset and
- the Trust can measure reliably the expenses attributable to the asset during development.

Software
Software which is integral to the operation of hardware, eg 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, eg application software, is capitalised as an intangible asset.

Note 1.8.2 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 current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

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

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

Note 1.8.3 Useful economic life of intangible assets
Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Development expenditure	1	8

TrakCare Asset implementation
During 2014/15 the Trust procured a clinical information system "TrakCare". The Trust began the implementation process in 2014-15, which is expected to be completed during 2019-20. The system will be run through a managed service agreement and accounted for through the Statement of Comprehensive Income.

During the implementation phase a significant number of staff will be utilised to ensure there is appropriate knowledge within the organisation to effectively operate the system. These will be defined roles with defined benefits arising from them. The Trust is capitalising the costs arising from the implementation due to the future economic benefits that will be derived from the system. The basis for this treatment is under IAS 38 Intangible Assets (Research and Development).

The Trust proposes to commence amortising the asset following the completion of the recovery and revalidation work.

Note 1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. The Trust's inventories comprise mainly of drugs held in the Pharmacy and medical and surgical equipment (MSE) principally held in operating theatres and surgical departments. The pharmacy stock is subject to an integrated stock system which accounts for the stock held at average cost basis. MSE is held in a variety of locations and is accounted for on a first in first out basis.

Note 1.10 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of Gloucestershire Hospitals NHS FT's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.11 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The Trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

Allowances acquired under the scheme are recognised as intangible assets.

Note 1.12 Financial assets and financial liabilities

Note 1.12.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by the Office for National Statistics (ONS).

This includes 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 and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Note 1.12.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

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

Financial assets are classified as subsequently measured at a fair value through other comprehensive income.

Financial liabilities classified as subsequently measured at fair value through income and expenditure.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Financial assets measured at fair value through other comprehensive income

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition.

Financial assets and financial liabilities at fair value trough income and expenditure

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.12.3 Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.13 Leases
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.13.1 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 asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

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

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

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.14 Provisions
The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 38.3 but is not recognised in the Trust's accounts.

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 NHS Resolution 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.

Note 1.15 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 39 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 39, 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.

Note 1.16 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 organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.17 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.18 Corporation tax
Section 148 of the Finance Act 2004 amended S519A of the Income and Corporation Taxes Act 1988 to provide power to the Treasury to make certain non-core activities of Foundation Trusts potentially subject to corporation tax. This legislation became effective in the 2005/06 financial year. In determining whether or not an activity is likely to be taxable a three-stage test may be employed:
• The provision of goods and services for purposes related to the provision of healthcare authorised under Section 14(1) of the Health and Social Care Act 2003 (HSCA) is not treated as a commercial activity and is therefore tax exempt;
• Trading activities undertaken in house which are ancillary to core healthcare activities are not entrepreneurial in nature and not subject to tax. A trading activity that is capable of being in competition with the wider private sector will be subject to tax;
• Only significant trading activity is subject to tax. Significant is defined as annual taxable profits of £50,000 per trading activity.

The majority of the Trust's activities are related to core healthcare and are not subject to tax. However, the Trust's commercial subsidiary is subject to corporation tax.

Note 1.20 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.21 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 that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.22 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.23 Transfers of functions
The Trust had no transfer of functions in or out during 2018-19

Note 1.24 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

Note 1.25 Standards, amendments and interpretations in issue but not yet effective or adopted
• IFRS 14 Regulatory Deferral Accounts - Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DHSC group bodies.
• IFRS 16 Leases - Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted. The Trust has assessd that this will not have a material impact on the Trust accounts.
• IFRS 17 Insurance Contracts - Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
• IFRIC 23 Uncertainty over Income Tax Treatments - Application required for accounting periods beginning on or after 1 January 2019.

Note 1.27 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2018/19

Note 2 Operating Segments

The financial information presented to the Trust Board by the Director of Finance regarding the performance of the Trust is based on the whole Trust as one entity (i.e. it is not split over operating segments). The Trust's internal management structure is based on operating divisions i.e. Surgery, Medicine, Diagnostics and Specialties, Women and Children, Estates and Facilities and Corporate Services. The Divisional boards are provided with financial information specific to their operational areas.

Accordingly, for segmental reporting the Trust considers the presentation to inform the Board representative of the business of healthcare as its sole segment.

Operating Division	**2018/19**			**2017/18**		
	Trust	**Hosted Services**	**Total**	**Trust**	**Hosted Services**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
Diagnostics & Specialities	115,028	-	115,028	107,505	-	107,505
Medicine	121,606	-	121,606	115,327	-	115,327
Surgery	131,790	-	131,790	125,800	-	125,800
Women & Children	49,334	-	49,334	39,110	-	39,110
Estates & Facilities	37,957	-	37,957	34,589	-	34,589
Corporate Services	47,350	29,345	76,695	42,408	28,221	70,630
Trustwide	4,911	-	4,911	18,657	-	18,657
Capital financing	27,230	-	27,230	18,910	-	18,910
Total Expenditure	535,205	29,345	564,550	502,306	28,221	530,528
Total Income	500,723	29,345	530,068	470,713	28,221	498,935
Deficit	(34,482)	-	(34,482)	(31,593)	-	(31,593)

2018/19 & 2017/18 Hosted Services relate to GP and Public Health Trainee Schemes.

Reconciliation of Statement of Comprehensive Income (SOCI)

	2018/19	**2017/18**
	£000	**£000**
Statement of Comprehensive Income	(54,097)	(51,564)
Net impairments	19,615	19,971
Charitable fund contra		
Operational Deficit	(34,482)	(31,593)

The Trust performance on a control total basis equates to £29.6m deficit (Operational deficit less impairments in expenditure of £4.4m and donated asset expenditure of £0.1m)

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.1

Note 3.1 Income from patient care activities (by nature)	31 March 2019		31 March 2018	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Elective income	78,495	78,495	73,598	73,598
Non elective income	111,404	111,404	100,212	100,212
First outpatient income	32,742	32,742	31,350	31,350
Follow up outpatient income	39,045	39,045	37,384	37,384
A & E income	19,021	19,021	17,999	17,999
High cost drugs income from commissioners (excluding pass-through costs)	48,630	48,630	49,521	49,521
Other NHS clinical income	117,658	117,658	123,499	123,499
Private patient income	2,981	2,981	2,965	2,965
Agenda for Change pay award central funding	3,572	3,572	-	-
Other clinical income	5,437	5,437	2,631	2,631
Total income from activities	**458,985**	**458,985**	**439,159**	**439,159**

Note 3.2 Income from patient care activities (by source)	31 March 2019		31 March 2018	
	Trust	Group	Trust	Group
Income from patient care activities received from:	£000	£000	£000	£000
NHS England	105,565	105,565	97,058	97,058
Clinical commissioning groups	339,183	339,183	332,252	332,252
Department of Health and Social Care	3,572	3,572	-	-
Other NHS providers	291	291	302	302
NHS other	5,566	5,566	3,951	3,951
Local authorities	-	-	-	-
Non-NHS: private patients	2,981	2,981	2,965	2,965
Non-NHS: overseas patients (chargeable to patient)	381	381	408	408
Injury cost recover scheme	546	546	1,269	1,269
Non NHS: other	900	900	954	954
Total income from activities	**458,985**	**458,985**	**439,159**	**439,159**
Of which:				
Related to continuing operations	458,985	458,985	439,159	439,159
Related to discontinued operations	-	-	-	-

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)	31 March 2019		31 March 2018	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Income recognised this year	381	381	408	408
Cash payments received in-year	252	252	225	225
Amounts added to provision for impairment of receivables	100	100	0	0
Amounts written off in-year	113	113	35	35

Note 4 Other operating income	31 March 2019		31 March 2018	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Other operating income from contracts with customers:				
Research and development (contract)	2,035	2,035	2,137	2,137
Education and training (excluding notional apprenticeship levy income)	13,791	13,791	13,225	13,225
Non-patient care services to other bodies	8,382	11,138	6,396	6,396
Provider sustainability / sustainability and transformation fund income (PSF / STF)	8,575	8,575	-	-
Income in respect of employee benefits accounted on a gross basis	31,944	31,944	30,163	30,163
Other contract income	5,007	6,483	6,919	6,919
Other non-contract operating income:				
Education and training - notional income from apprenticeship fund	305	325	70	70
Receipt of capital grants and donations	320	320	352	352
Charitable fund incoming resources	-	1,832	-	1,978
Total other operating income	**70,358**	**76,443**	**59,262**	**61,240**
Of which:				
Related to continuing operations	70,358	76,443	59,262	61,240
Related to discontinued operations	-	-	-	-

****** Analysis of Other Operating Income: Other**	2018/19	2017/18
	Total	Total
	£000	£000
Car parking **	832	965
Crèche services	843	852
Catering	1,118	969
Other	3,690	4,133
Total	**6,483**	**6,919**

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2018/19 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	-
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-

Note 5.2 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	31 March 2019 £000
within one year	-
after one year, not later than five years	-
after five years	-
Total revenue allocated to remaining performance obligations	-

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 5.3 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2018/19 £000	2017/18 £000
Income from services designated as commissioner requested services	454,723	434,832
Income from services not designated as commissioner requested services	4,262	4,327
Total	**458,985**	**439,159**

Note 5.4 Profits and losses on disposal of property, plant and equipment

There were no disposals during the reporting period

Note 6.1 Fees and charges

HM Treasury requires disclosure of fees and charges income. The following disclosure is of income from charges to service users where income from that service exceeds £1 million and is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed.

	2018/19 £000	2017/18 £000
Income	-	-
Full cost	-	-
Surplus / (deficit)	-	-

Note 7.1 Operating expenses	31 March 2019		31 March 2018	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Purchase of healthcare from NHS and DHSC bodies	-	-	-	
Purchase of healthcare from non-NHS and non-DHSC bodies	5,228	5,228	4,783	4,783
Purchase of social care	-	-	-	-
Staff and executive directors costs	336,824	354,334	334,685	334,883
Remuneration of non-executive directors	136	173	138	138
Supplies and services - clinical (excluding drugs costs)	35,835	40,058	44,113	44,113
Supplies and services - general	11,307	16,756	18,499	18,499
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	68,841	68,841	61,318	61,318
Inventories written down	-	-	-	-
Consultancy costs	2,812	2,861	2,838	2,838
Establishment	4,040	4,624	2,379	2,379
Premises	49,054	23,515	18,257	18,257
Transport (including patient travel)	625	1,082	1,209	1,209
Depreciation on property, plant and equipment	13,803	13,803	9,660	9,660
Amortisation on intangible assets	-	-	-	-
Net impairments	4,774	4,774	19,971	19,971
Movement in credit loss allowance: contract receivables / contract assets	231	231	-	-
Movement in credit loss allowance: all other receivables and investments	-	-	405	405
Audit fees payable to the external auditor				
audit services- statutory audit	61	65	67	70
other auditor remuneration (external auditor only)	9	9	5	5
Internal audit costs	93	93	96	96
Clinical negligence	16,938	16,938	17,118	17,118
Legal fees	165	165	333	333
Insurance	391	391	406	406
Research and development	27	27	24	24
Education and training	1,808	1,828	1,383	1,383
Rentals under operating leases	473	473	930	930
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	1,915	1,915	1,435	1,435
Charges to operating expenditure for off-SoFP PFI / LIFT schemes	-	-	-	-
Car parking & security	0	259	225	225
Hospitality	13	13	11	11
Losses, ex gratia & special payments	21	22	18	18
Other NHS charitable fund resources expended	-	776	-	654
Other	1,372	1,668	1,035	1,035
Total	**556,796**	**560,922**	**541,341**	**542,196**
Of which:				
Related to continuing operations	556,796	560,922	541,341	542,196
Related to discontinued operations	-	-	-	-

Note 7.2 Other auditor remuneration	31 March 2019		31 March 2018	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Other auditor remuneration paid to the external auditor:				
1. Audit of accounts of any associate of the trust	-	-	-	-
2. Audit-related assurance services	9	9	5	5
3. Taxation compliance services	-	-	-	-
4. All taxation advisory services not falling within item 3 above	-	-	-	-
5. Internal audit services	-	-	-	-
6. All assurance services not falling within items 1 to 5	-	-	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	-	-	-
Total	**9**	**9**	**5**	**5**

Note 7.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (2017/18: £2m).

Note 8 Impairment of assets	31 March 2019		31 March 2018	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Net impairments charged to operating surplus / deficit resulting from:				
Other	4,774	4,774	19,971	19,971
Total net impairments charged to operating surplus / deficit	**4,774**	**4,774**	**19,971**	**19,971**
Impairments charged to the revaluation reserve	19,615	19,615	26,971	26,971
Total net impairments	**24,389**	**24,389**	**46,942**	**46,942**

Note 9 Employee benefits

	31 March 2019		31 March 2018	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Salaries and wages	264,585	278,116	261,284	261,284
Social security costs	24,105	25,192	23,774	23,774
Apprenticeship levy	1,283	1,336	1,281	1,281
Employer's contributions to NHS pensions	31,488	33,155	31,650	31,650
Temporary staff (including agency)	15,363	16,316	16,696	16,696
NHS charitable funds staff	-	219	-	198
Total gross staff costs	**336,824**	**354,334**	**334,685**	**334,883**
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	**336,824**	**354,334**	**334,685**	**334,883**
Of which				
Costs capitalised as part of assets	-	-	-	-

Note 9.1 Retirements due to ill-health

During 2018/19 there were 5 early retirements from the trust agreed on the grounds of ill-health (6 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £312k (£550k in 2017/18).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 10 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

Note 11 Operating leases

Note 11.1 Gloucestershire Hospitals NHS Foundation Trust as a lessor

The Trust does not receive any operating lease income.

The Trust has a number of short term (tenable with 1 years notice by either side) "leases" whereby other NHS organisations within Gloucestershire use rooms or facilities. The charge incorporates facilities management together with other recharges to facilitate the use of the accommodation. Accordingly there is no rent as such to be able to split out of the total cost. The income is therefore recorded above within other operational income.

Note 11.2 Gloucestershire Hospitals NHS Foundation Trust as a lessee

The Trust provides staff (subject to meeting certain criteria) with a lease vehicle, which is available for both personal and business duties. This is based on the NHS lease scheme. Vehicles are initially leased on a fully maintained basis for 3 years with an option to extend to a fourth year.

The Trust occupies a former Victorian Warehouse converted to office accommodation which houses the County's Finance and Procurement Shared Services. The lease was due to expire in 2017/18 but has now been extended to September 2028. The Trust also occupies an industrial unit in Cinderford where it provides a dialysis service. The lease is due to expire in 2033.

	2018/19		2017/18	
	Trust	Group	Trust	Group
Operating lease expense	£000	£000	£000	£000
Minimum lease payments	473	473	930	930
Contingent rents	-	-	-	-
Less sublease payments received	-	-	-	-
Total	**473**	**473**	**930**	**930**

	31 March 2019		31 March 2018	
	Trust	Group	Trust	Group
Future minimum lease payments due:	£000	£000	£000	£000
- not later than one year;	437	437	421	421
- later than one year and not later than five years;	1,130	1,130	1,195	1,195
- later than five years.	1,179	1,179	1,380	1,380
Total	**2,746**	**2,746**	**2,996**	**2,996**
Future minimum sublease payments to be received	-	-	-	-

Note 12 Finance income

Finance income represents interest received on assets and investments in the period.

	2018/19		2017/18	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Interest on bank accounts	124	124	51	51
Interest income on finance leases	-	-	-	-
Interest on other investments / financial assets	-	-	-	-
NHS charitable fund investment income	-	72	-	58
Other finance income	905	-	-	-
Total finance income	**1,029**	**196**	**51**	**109**

Note 13.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2018/19		2017/18	
	Trust	Group	Trust	Group
Interest expense:	£000	£000	£000	£000
Loans from the Department of Health and Social Care	4,100	4,100	3,104	3,104
Other loans	-	-	-	-
Overdrafts	-	-	-	-
Finance leases	171	171	215	215
Interest on late payment of commercial debt	-	-	-	-
Main finance costs on PFI and LIFT schemes obligations	1,288	1,288	1,323	1,323
Contingent finance costs on PFI and LIFT scheme obligations	639	639	846	846
Total interest expense	**6,198**	**6,198**	**5,488**	**5,488**
Unwinding of discount on provisions	16	16	20	20
Other finance costs	-	-	-	-
Total finance costs	**6,214**	**6,214**	**5,508**	**5,508**

Note 13.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2018/19		2017/18	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Total liability accruing in year under this legislation as a result of late payments	-	-	-	-
Amounts included within interest payable arising from claims made under this legislation	-	-	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-	-	-

Note 14 Other gains / (losses)

	2018/19		2017/18	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Gains on disposal of assets	-	-	534	534
Losses on disposal of assets	-	-	-	-
Gains / losses on disposal of charitable fund assets	-	-	-	100
Total gains / (losses) on disposal of assets	**-**	**-**	**534**	**634**
Gains / (losses) on foreign exchange	-	-	-	-
Fair value gains / (losses) on investment properties	-	-	-	-
Fair value gains / (losses) on financial assets / investments	-	77	-	(92)
Fair value gains / (losses) on charitable fund investments & investment properties	-	-	-	-
Fair value gains / (losses) on financial liabilities	-	-	-	-
Recycling gains / (losses) on disposal of financial assets mandated as fair value through OCI	-	-	-	-
Total other gains / (losses)	**-**	**77**	**534**	**542**

Note 15 Discontinued operations

The Group has no discontinued operations during the accounting period

Note 16.1 Intangible assets - 2018/19

Trust & Group	Software licences £000	Internally generated information technology £000	Development expenditure £000	Total £000
Valuation / gross cost at 1 April 2018 - brought forward	-	-	9,130	9,130
Transfers by absorption	-	-	-	-
Additions	-	-	1,282	**1,282**
Impairments	-	-	-	-
Reversals of impairments	-	-	-	-
Revaluations	-	-	-	-
Reclassifications	-	-	-	-
Transfers to / from assets held for sale	-	-	-	-
Disposals / derecognition	-	-	-	-
Valuation / gross cost at 31 March 2019	-	-	10,412	10,412
Amortisation at 1 April 2018 - brought forward	-	-	-	-
Amortisation at 31 March 2019	-	-	-	-
Net book value at 31 March 2019	-	-	10,412	10,412
Net book value at 1 April 2018	-	-	9,130	9,130

Note 16.2 Intangible assets - 2017/18

Trust & Group	Software licences £000	Internally generated information technology £000	Development expenditure £000	Total £000
Valuation / gross cost at 1 April 2017 - as previously stated	-	-	7,393	7,393
Prior period adjustments	-	-	-	-
Valuation / gross cost at 1 April 2017 - restated	-	-	7,393	7,393
Transfers by absorption	-	-	-	-
Additions	-	-	1,737	**1,737**
Impairments	-	-	-	-
Reversals of impairments	-	-	-	-
Revaluations	-	-	-	-
Reclassifications	-	-	-	-
Transfers to / from assets held for sale	-	-	-	-
Disposals / derecognition	-	-	-	-
Valuation / gross cost at 31 March 2018	-	-	9,130	9,130
Amortisation at 1 April 2017 - as previously stated	-	-	-	-
Prior period adjustments	-	-	-	-
Amortisation at 1 April 2017 - restated	-	-	-	-
Amortisation at 31 March 2018	-	-	-	-
Net book value at 31 March 2018	-	-	9,130	9,130
Net book value at 1 April 2017	-	-	7,393	7,393

Note 17.1 Property, plant and equipment - 2018/19

Trust & Group	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2018 - brought forward	**11,450**	**223,754**	**4,069**	**1,159**	**65,547**	**763**	**35,556**	**343**	**342,640**
Transfers by absorption	-	-	-	-	-	-	-	-	-
Additions	-	8,897	-	1,577	5,090	-	2,834	-	**18,398**
Impairments	-	(22,868)	-	-	-	-	-	-	**(22,868)**
Reversals of impairments	-	3,242	11	-	-	-	-	-	**3,253**
Revaluations	-	-	-	-	-	-	-	-	-
Reclassifications	-	576	-	(576)	-	-	-	-	-
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	-	-	-	-	-
Valuation/gross cost at 31 March 2019	**11,450**	**213,601**	**4,080**	**2,160**	**70,637**	**763**	**38,390**	**343**	**341,423**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**11,826**	**3,893**	**-**	**48,131**	**627**	**26,810**	**343**	**91,630**
Transfers by absorption	-	-	-	-	-	-	-	-	-
Provided during the year	-	7,352	-	-	3,885	-	2,566	-	**13,803**
Impairments	-	5,853	-	-	-	-	-	-	**5,853**
Reversals of impairments	-	(1,079)	-	-	-	-	-	-	**(1,079)**
Revaluations	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	-	-	-	-	-
Accumulated depreciation at 31 March 2019	**-**	**23,952**	**3,893**	**-**	**52,016**	**627**	**29,376**	**343**	**110,207**
Net book value at 31 March 2019	**11,450**	**189,649**	**187**	**2,160**	**18,621**	**136**	**9,014**	**-**	**231,216**
Net book value at 1 April 2018	**11,450**	**211,928**	**176**	**1,159**	**17,416**	**136**	**8,746**	**-**	**251,010**

Note 17.2 Property, plant and equipment - 2017/18

Trust & Group	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation / gross cost at 1 April 2017 - as previously stated	**34,266**	**229,262**	**7,740**	**2,253**	**74,086**	**763**	**31,504**	**343**	**380,216**
Prior period adjustments	-	-	-	-	-	-	-	-	-
Valuation / gross cost at 1 April 2017 - restated	**34,266**	**229,262**	**7,740**	**2,253**	**74,086**	**763**	**31,504**	**343**	**380,216**
Transfers by absorption	-	-	-	-	-	-	-	-	-
Additions	-	5,357	-	668	3,325	-	4,052	-	**13,402**
Impairments	(22,821)	(13,720)	(3,693)	-	-	-	-	-	**(40,234)**
Reversals of impairments	-	1,310	-	-	-	-	-	-	**1,310**
Revaluations	-	-	-	-	-	-	-	-	-
Reclassifications	5	1,545	22	(1,762)	190	-	-	-	-
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	(12,054)	-	-	-	**(12,054)**
Valuation/gross cost at 31 March 2018	**11,450**	**223,754**	**4,069**	**1,159**	**65,547**	**763**	**35,556**	**343**	**342,640**
Accumulated depreciation at 1 April 2017 - as previously stated	**-**	**3,874**	**153**	**-**	**54,124**	**599**	**24,851**	**343**	**83,944**
Prior period adjustments	-	-	-	-	-	-	-	-	-
Accumulated depreciation at 1 April 2017 - restated	**-**	**3,874**	**153**	**-**	**54,124**	**599**	**24,851**	**343**	**83,944**
Transfers by absorption	-	-	-	-	-	-	-	-	-
Provided during the year	-	3,674	-	-	3,999	28	1,959	-	**9,660**
Impairments	-	4,810	3,740	-	-	-	-	-	**8,550**
Reversals of impairments	-	(532)	-	-	-	-	-	-	**(532)**
Revaluations	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	(9,992)	-	-	-	**(9,992)**
Accumulated depreciation at 31 March 2018	**-**	**11,826**	**3,893**	**-**	**48,131**	**627**	**26,810**	**343**	**91,630**
Net book value at 31 March 2018	**11,450**	**211,928**	**176**	**1,159**	**17,416**	**136**	**8,746**	**-**	**251,010**
Net book value at 1 April 2017	**34,266**	**225,388**	**7,587**	**2,253**	**19,962**	**164**	**6,653**	**-**	**296,272**

Note 17.3 Property, plant and equipment financing - 2018/19

Trust & Group	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Charitable fund PPE assets £000	Total £000
Net book value at 31 March 2019										
Owned - purchased	11,450	138,398	-	2,160	10,327	136	9,014	-	-	**171,485**
Finance leased	-	8,181	187	-	5,913	-	-	-	-	**14,281**
On-SoFP PFI contracts and other service concession arrangements	-	40,847	-	-	-	-	-	-	-	**40,847**
Off-SoFP PFI residual interests	-	-	-	-	-	-	-	-	-	-
Owned - government granted	-	-	-	-	-	-	-	-	-	-
Owned - donated	-	2,223	-	-	2,381	-	-	-	-	**4,604**
NBV total at 31 March 2019	**11,450**	**189,649**	**187**	**2,160**	**18,621**	**136**	**9,014**	**-**	**-**	**231,216**

Note 17.4 Property, plant and equipment financing - 2017/18

Trust & Group	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Charitable fund PPE assets £000	Total £000
Net book value at 31 March 2018										
Owned - purchased	11,450	162,271	-	1,159	11,059	136	8,746	-	-	**194,821**
Finance leased	-	7,788	176	-	3,867	-	-	-	-	**11,831**
On-SoFP PFI contracts and other service concession arrangements	-	39,592	-	-	-	-	-	-	-	**39,592**
Off-SoFP PFI residual interests	-	-	-	-	-	-	-	-	-	-
Owned - government granted	-	-	-	-	-	-	-	-	-	-
Owned - donated	-	2,277	-	-	2,490	-	-	-	-	**4,767**
NBV total at 31 March 2018	**11,450**	**211,928**	**176**	**1,159**	**17,416**	**136**	**8,746**	**-**	**-**	**251,010**

Disclosure

Included within the dwelling figures above at 31 March 2019 are a number of properties formerly in the ownership of Gloucestershire Royal NHS Trust and the East Gloucestershire NHS Trust (which now form the Gloucestershire Hospitals NHS Foundation Trust) sold to a registered Housing Association in April 2000 and June 2004 respectively. These units were for residential accommodation mainly to NHS staff and families. The registered Housing Association is now responsible for this provision with the Trust having nomination rights. Both separate agreements contain a 99 year lease with a Trust only option to break at 30 years and every 5 years, which if exercised will enable the Trust to take back the freehold of the land and buildings with vacant possession at no cost. They have been valued by the independent professional advisor on a residual value basis.

Plant and machinery includes a number of "finance leases" included as part of the IFRS requirements which relate to high cost medical equipment which the Trust will use for the whole primary lease period which is consistent with its perceived asset life. At the balance sheet date the value of these leases equates to £5,913k. This equipment is for Radiology equipment, linear accelerators and ultrasound machines. Also included within the plant machinery isequipment relating to GMS at the balance sheet date the value of tjhese assets was £240k.

Included within building is the PFI scheme consisting of a Diagnostic & Treatment centre, therapy services, a new accident and emergency department and 75 inpatient bed spaces. The scheme was handed over in April 2002 and runs for 31 years and 10 months from that date. The initial scheme cost including all fees was £39.6m. The value at the Statement of Financial Position date is £40.8m.

With the exception of plant and machinery, the above values have been determined by the Trust's Independent Valuer, their revaluation of the Trust estate to DRC values is consistent with Department of Health and Social Care guidance.

The residential accommodation properties above have been valued at residual value.

In April 2011 a new Multi Storey Car Park became operational. This facility has been constructed by a third party on land owned by the Trust and leased to the Third party for a period of 30 years.

During that period the car park will be used for car parking by staff and visitors at Gloucestershire Royal Hospital. The third party operator will receive all income and be responsible for all out goings with the Trust receiving income when a certain level of receipts are achieved. The value of its construction was £8.7m, which was brought onto the balance sheet at 31 March 2012 as a leased asset offset by deferred income.

Note 18 Donations of property, plant and equipment

Additions - donated relate to assets either purchased wholly or items partially funded by the Trust's own charitable funds. The Charitable Funds are administered by the Trust's Main Board as Corporate Trustee. Funds are registered with the Charity Commissioners registration charity number 1051606. Additionally from time to time an external charity working closely with the Trust may provide funding directly for a capital project.

Note 19 Revaluations of property, plant and equipment

The value and remaining useful asset lives of land and building assets are estimated by the Trust's Independent Valuer. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. Valuations are carried out primarily on the basis of depreciated replacement cost for specialised operational property and existing use value for non-specialised operational property.

A Modern Equivalent Asset Optimised Alternative Site valuation was undertaken as at 1st April 2017 by the Trust's Independent Valuer. The underlying principle is that the valuation of land and buildings should reflect a modern configuration of the estate required for the provision of the same services as already provided by the existing estate. With service delivery requirements evolving, this requires the Trust to consider whether the existing buildings and sites are optimal in terms of number and size. If the Trust were starting with a "clean sheet", the Modern Equivalent Asset aligned to service delivery would be very different to the current layout in terms of buildings configuration and the number of sites.

A desk top valuation, measured on a MEA basis, was undertaken by the Trust's Independent Valuer as at 31.03.2019.

Note 20.1 Investment Property

The Group has no investment property

Note 21 Investments in associates and joint ventures

The Group has no investments in associates and joint ventures.

Note 22 Other investments / financial assets (non-current)

	Group	
	2018/19	2017/18
	£000	£000
Carrying value at 1 April - brought forward	**1,877**	**1,969**
Prior period adjustments		-
Carrying value at 1 April - restated	**1,877**	**1,969**
Impact of implementing IFRS 9 on 1 April 2018	-	
Transfers by absorption	-	-
Acquisitions in year	-	-
Movement in fair value through income and expenditure	77	(92)
Movement in fair value through OCI	-	-
Net impairments	-	-
Transfers to / from assets held for sale	-	-
Amortisation at the effective interest rate	-	-
Current portion of loans receivable transferred to current financial assets	-	-
Disposals	-	-
Carrying value at 31 March	**1,954**	**1,877**

Investments relate to charitable fund investment portfolio.

Note 22.1 Other investments / financial assets (current)

The Group has no current investments/ financial assets.

Note 23 Disclosure of interests in other entities

The Trust has no interests in other unconsolidated subsidiaries, joint ventures, associates or unconsolidated structured entities.

Note 24 Analysis of charitable fund reserves

The Gloucestershire Hospitals Charitable Fund has been consolidated within this set of accounts

	31 March 2019 £000	31 March 2018 £000
Unrestricted funds:		
Unrestricted income funds	4,379	3,397
Revaluation reserve	-	-
Other reserves	-	-
Restricted funds:		
Endowment funds	-	-
Other restricted income funds	-	-
	4,379	**3,397**

Unrestricted income funds are accumulated income funds that are expendable at the discretion of the trustees in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds may be accumulated income funds which are expendable at the trustee's discretion only in furtherance of the specified conditions of the donor and the objects of the charity. They may also be capital funds (e.g. endowments) where the assets are required to be invested, or retained for use rather than expended.

Note 25 Inventories

	31 March 2019		31 March 2018	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Drugs	3,148	3,148	2,818	2,818
Work In progress	-	-	-	-
Consumables	3,912	4,049	3,736	3,736
Energy	374	374	576	576
Other	-	-	-	-
Charitable fund inventory	-	-	-	-
Total inventories	**7,434**	**7,571**	**7,131**	**7,131**
of which:				
Held at fair value less costs to sell	-	-	-	-

Inventories recognised in expenses for the year were £110,652k (2017/18: £110,033k). Write-down of inventories recognised as expenses for the year were £0k (2017/18: £0k).

Note 26.1 Receivables

	31 March 2019		31 March 2018	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Current				
Contract receivables*	21,457	22,074		
Contract assets*	-	-		
Trade receivables*			11,619	11,619
Capital receivables	-	-	-	-
Accrued income*			3,543	3,543
Allowance for impaired contract receivables / assets*	(1,373)	(1,373)		
Allowance for other impaired receivables	-	-	(1,416)	(1,416)
Deposits and advances	-	-	-	-
Prepayments (non-PFI)	1,501	1,855	2,493	2,493
PFI prepayments - capital contributions	-	-	-	-
PFI lifecycle prepayments	-	-	-	-
Interest receivable	-	-	-	-
Finance lease receivables	-	-	-	-
PDC dividend receivable	486	486	861	861
VAT receivable	2,258	2,377	30	30
Corporation and other taxes receivable	-	-	-	-
Other receivables	-	-	2,146	2,146
NHS charitable funds: trade and other receivables	-	12	-	34
Total current receivables	**24,329**	**25,431**	**19,276**	**19,310**
Non-current				
Contract receivables*	5,185	5,185		
Contract assets*	-	-		
Trade receivables*			-	-
Capital receivables	-	-	-	-
Accrued income*			-	-
Allowance for impaired contract receivables / assets*	-	-		
Allowance for other impaired receivables	-	-	-	-
Deposits and advances	-	-	-	-
Prepayments (non-PFI)	-	-	-	-
PFI prepayments - capital contributions	-	-	-	-
PFI lifecycle prepayments	-	-	-	-
Interest receivable	-	-	-	-
Finance lease receivables	-	-	-	-
VAT receivable	-	-	-	-
Corporation and other taxes receivable	-	-	-	-
Other receivables	-	-	4,463	4,463
NHS charitable funds: trade and other receivables	-	-	-	-
Total non-current receivables	**5,185**	**5,185**	**4,463**	**4,463**
Of which receivable from NHS and DHSC group bodies:				
Current	16,551	16,551	15,638	15,638
Non-current	-	-	-	-

*Following the application of IFRS 15 from 1 April 2018, the trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Other contract receivables non current 2018/19 £4,640k consists of Residential accommodation (£614k), Hereford Radiotherapy Centre £3,339k and Road Traffic Accident income £1,914k. These were reclassified in 2018-19 from other receivables.

Other receivables non current 2017/18 £4,463k consists of Residential accommodation (£658k), Hereford Radiotherapy Centre £3,207k and Road Traffic Accident income £1,914k

Note 26.2 Allowances for credit losses - 2018/19

	Trust & Group
	Contract receivables and contract assets £000
Allowances as at 1 Apr 2018 - brought forward	**1,416**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	-
Transfers by absorption	-
New allowances arising	320
Changes in existing allowances	-
Reversals of allowances	(89)
Utilisation of allowances (write offs)	(274)
Changes arising following modification of contractual cash flows	-
Foreign exchange and other changes	-
Allowances as at 31 Mar 2019	**1,373**

Note 26.3 Allowances for credit losses - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	Trust & Group
	All receivables £000
Allowances as at 1 Apr 2017 - as previously stated	**1,617**
Prior period adjustments	
Allowances as at 1 Apr 2017 - restated	**1,617**
Transfers by absorption	
Increase in provision	412
Amounts utilised	(606)
Unused amounts reversed	(7)
Allowances as at 31 Mar 2018	**1,416**

Note 26.4 Exposure to credit risk

There is currently no exposure to credit risk.

Note 27 Other assets

The group had no other assets.

Note 28 Non-current assets held for sale and assets in disposal groups

There are no non-current assets held for sale or assets in disposal groups

Note 28.1 Liabilities in disposal groups

The Trust has no liabilities in disposal groups

Note 29.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2018/19		2017/18	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
At 1 April	**5,447**	**6,947**	**7,974**	**8,220**
Prior period adjustments			-	-
At 1 April (restated)	**5,447**	**6,947**	**7,974**	**8,220**
Transfers by absorption	-	-	-	-
Net change in year	(611)	2,899	(2,527)	(1,273)
At 31 March	**4,836**	**9,846**	**5,447**	**6,947**
Broken down into:				
Cash at commercial banks and in hand		2,481	-	-
Cash with the Government Banking Service	4,836	7,365	5,447	6,947
Deposits with the National Loan Fund	-	-	-	-
Other current investments	-	-	-	-
Total cash and cash equivalents as in SoFP	**4,836**	**9,846**	**5,447**	**6,947**
Bank overdrafts (GBS and commercial banks)	-	-	-	-
Drawdown in committed facility	-	-	-	-
Total cash and cash equivalents as in SoCF	**4,836**	**9,846**	**5,447**	**6,947**

Note 29.2 Third party assets held by the trust

Gloucestershire Hospitals NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	Group and Trust	
	31 March 2019	31 March 2018
	£000	£000
Bank balances	-	-
Monies on deposit	-	-
Total third party assets	-	-

Note 30.1 Trade and other payables

	31 March 2019		31 March 2018	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Current				
Trade payables	7,435	8,286	10,072	10,072
Capital payables	3,415	3,415	5,220	5,220
Accruals	32,750	35,233	25,212	25,212
Receipts in advance and payments on account	-	-	-	-
Social security costs	6,820	7,382	6,664	6,664
VAT payables	-	-	-	-
Other taxes payable	-	-	-	-
PDC dividend payable	-	-	-	-
Accrued interest on loans*	-	-	342	342
Other payables	-	-	-	-
NHS charitable funds: trade and other payables	-	116	-	14
Total current trade and other payables	**50,420**	**54,432**	**47,510**	**47,524**
Non-current				
Trade payables	-	-	-	-
Capital payables	-	-	-	-
Accruals	-	-	-	-
Receipts in advance and payments on account	-	-	-	-
VAT payables	-	-	-	-
Other taxes payable	-	-	-	-
Other payables	-	-	-	-
NHS charitable funds: trade and other payables	-	-	-	-
Total non-current trade and other payables	-	-	-	-
Of which payables from NHS and DHSC group bodies:				
Current	5,586	5,586	3526	3526
Non-current	-	-	-	-

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note 32. IFRS 9 is applied without restatement therefore comparatives have not been restated.

Note 30.2 Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

Group and Trust	31 March 2019 £000	31 March 2019 Number	31 March 2018 £000	31 March 2018 Number
- to buy out the liability for early retirements over 5 years	-		-	
- number of cases involved		-		-

Note 31 Other liabilities

	31 March 2019		31 March 2018	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Current				
Deferred income: contract liabilities	-	-	-	-
Deferred grants	5,837	5,837	3,284	3,284
Deferred PFI credits / income	-	-	-	-
Lease incentives	-	-	-	-
Other deferred income	-	-	-	-
NHS charitable funds: other liabilities	-	-	-	-
Total other current liabilities	**5,837**	**5,837**	**3,284**	**3,284**
Non-current				
Deferred income: contract liabilities	6,860	6,860	7,235	7,235
Deferred grants	-	-	-	-
Deferred PFI credits / income	-	-	-	-
Lease incentives	-	-	-	-
Other deferred income	-	-	-	-
NHS charitable funds: other liabilities	-	-	-	-
Net pension scheme liability	-	-	-	-
Total other non-current liabilities	**6,860**	**6,860**	**7,235**	**7,235**

Note 32 Borrowings

	31 March 2019		31 March 2018	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Current				
Bank overdrafts	-	-	-	-
Drawdown in committed facility	-	-	-	-
Loans from DHSC	10,361	10,361	2,968	2,968
Other loans	-	-	-	-
Obligations under finance leases	1,598	1,598	1,632	1,632
PFI lifecycle replacement received in advance	-	-	-	-
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	568	568	103	103
NHS charitable funds: other current borrowings	-	-	-	-
Total current borrowings	**12,527**	**12,527**	**4,703**	**4,703**
Non-current				
Loans from DHSC	112,480	112,480	89,796	89,796
Other loans	-	-	-	-
Obligations under finance leases	4,852	4,852	2,892	2,892
PFI lifecycle replacement received in advance	-	-	-	-
Obligations under PFI, LIFT or other service concession contracts	17,962	17,962	18,531	18,531
NHS charitable funds: other current borrowings	-	-	-	-
Total non-current borrowings	**135,294**	**135,294**	**111,219**	**111,219**

Note 32.1 Reconciliation of liabilities arising from financing activities

Group	Loans from DHSC	Other loans	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2018	**92,764**	**-**	**4,524**	**18,634**	**115,922**
Cash movements:					**-**
Financing cash flows - payments and receipts of principal	29,501	-	(2,055)	(103)	**27,344**
Financing cash flows - payments of interest	(3,868)	-	(170)	(1,289)	**(5,327)**
Non-cash movements:					**-**
Impact of implementing IFRS 9 on 1 April 2018	342	-	-	-	**342**
Transfers by absorption	-	-	-	-	**-**
Additions	-	-	3,981	-	**3,981**
Application of effective interest rate	4,102	-	170	1,288	**5,560**
Change in effective interest rate	-	-	-	-	**-**
Changes in fair value	-	-	-	-	**-**
Other changes	-	-	-	-	**-**
Carrying value at 31 March 2019	**122,841**	**-**	**6,450**	**18,530**	**147,821**

Note 33 Other financial liabilities

The Trust has no other financial liabilities

Note 34 Finance leases

Note 34.1 Gloucestershire Hospitals NHS Foundation Trust as a lessor

The Trust does not receive any finance lease income.

Note 34.2 Gloucestershire Hospitals NHS Foundation Trust as a lessee

Obligations under finance leases where the trust is the lessee.

	31 March 2019		31 March 2018	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Gross lease liabilities	**6,700**	**6,700**	**4,955**	**4,955**
of which liabilities are due:				
- not later than one year;	1,683	1,683	1,781	1,781
- later than one year and not later than five years;	3,545	3,545	2,763	2,763
- later than five years.	1,472	1,472	411	411
Finance charges allocated to future periods	(250)	(250)	(431)	(431)
Net lease liabilities	**6,450**	**6,450**	**4,524**	**4,524**
of which payable:				
- not later than one year;	1,598	1,598	1,632	1,632
- later than one year and not later than five years;	3,437	3,437	2,559	2,559
- later than five years.	1,415	1,415	333	333
Total of future minimum sublease payments to be received at the reporting date	-	-	-	-
Contingent rent recognised as expense in the period	-	-	-	-

Note 35.1 Provisions for liabilities and charges analysis (Group)

Trust & Group	Pensions: early departure costs £000	Pensions: injury benefits* £000	Legal claims £000	Re-structuring £000	Equal Pay (including Agenda for Change) £000	Redundancy £000	Other £000	Charitable fund provisions £000	Total £000
At 1 April 2018	**1,559**	**-**	**73**	**-**	**-**	**-**	**-**	**-**	**1,632**
Transfers by absorption	-	-	-	-	-	-	-	-	-
Change in the discount rate	-	-	-	-	-	-	-	-	-
Arising during the year	17	-	49	-	-	-	-	-	**66**
Utilised during the year	(87)	-	-	-	-	-	-	-	**(87)**
Reclassified to liabilities held in disposal groups	-	-	-	-	-	-	-	-	**-**
Reversed unused	-	-	(33)	-	-	-	-	-	**(33)**
Unwinding of discount	16	-	-	-	-	-	-	-	**16**
Movement in charitable fund provisions	-	-	-	-	-	-	-	-	-
At 31 March 2019	**1,505**	**-**	**89**	**-**	**-**	**-**	**-**	**-**	**1,594**
Expected timing of cash flows:									
- not later than one year;	160	-	-	-	-	-	-	-	**160**
- later than one year and not later than five years;	1,345	-	89	-	-	-	-	-	**1,434**
- later than five years.	0	-	-	-	-	-	-	-	**0**
Total	**1,505**	**-**	**89**	**-**	**-**	**-**	**-**	**-**	**1,594**

Note 35.2 Clinical negligence liabilities

At 31 March 2019, £240,288k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Gloucestershire Hospitals NHS Foundation Trust (31 March 2018: £224,265k).

Note 36 Contingent assets and liabilities

	31 March 2019		31 March 2018	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Value of contingent liabilities				
NHS Resolution legal claims	-	-	-	-
Employment tribunal and other employee related litigation	-	-	-	-
Redundancy	-	-	-	-
Other	(46)	(46)	(542)	(542)
Gross value of contingent liabilities	**(46)**	**(46)**	**(542)**	**(542)**
Amounts recoverable against liabilities	-	-	-	-
Net value of contingent liabilities	**(46)**	**(46)**	**(542)**	**(542)**
Net value of contingent assets	-	-		

The contingent liability of £46k (17/18 £42k) relates to early retirement injury benefit.

At 31/03/2018, the contingent liability of £500k related to an assessment of the impact of the Bear Scotland ruling relating to whether overtime needs to be included in holiday pay calculations. The likelihood of this liability being paid has increased and is now accrued.

Note 37 Contractual capital commitments

	31 March 2019		31 March 2018	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Property, plant and equipment	3,367	3,367	1,229	1,229
Intangible assets	1,500	1,500	1,700	1,700
Total	**4,867**	**4,867**	**2,929**	**2,929**

Note 38 Other financial commitments

The group / trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	31 March 2019		31 March 2018	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
not later than 1 year	-	-	-	-
after 1 year and not later than 5 years	-	-	-	-
paid thereafter	-	-	-	-
Total	-	-	-	-

Note 39 Defined benefit pension schemes

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

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Note 39.1 Changes in the defined benefit obligation and fair value of plan assets during the year

	2018/19		2017/18	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Present value of the defined benefit obligation at 1 April	-	-	-	-
Prior period adjustment			-	-
Present value of the defined benefit obligation at 1 April - restated	-	-	-	-
Transfers by absorption	-	-	-	-
Current service cost	-	-	-	-
Interest cost	-	-	-	-
Contribution by plan participants	-	-	-	-
Remeasurement of the net defined benefit (liability) / asset:				
- Actuarial (gains) / losses	-	-	-	-
Benefits paid	-	-	-	-
Past service costs	-	-	-	-
Business combinations	-	-	-	-
Curtailments and settlements	-	-	-	-
Present value of the defined benefit obligation at 31 March	-	-	-	-
Plan assets at fair value at 1 April	-	-	-	-
Prior period adjustment			-	-
Plan assets at fair value at 1 April -restated	-	-	-	-
Transfers by normal absorption	-	-	-	-
Interest income	-	-	-	-
Remeasurement of the net defined benefit (liability) / asset:				
- Return on plan assets	-	-	-	-
- Actuarial gain / (losses)	-	-	-	-
- Changes in the effect of limiting a net defined benefit asset to the asset ceiling	-	-	-	-
Contributions by the employer	-	-	-	-
Contributions by the plan participants	-	-	-	-
Benefits paid	-	-	-	-
Business combinations	-	-	-	-
Settlements	-	-	-	-
Plan assets at fair value at 31 March	-	-	-	-
Plan surplus/(deficit) at 31 March	-	-	-	-

Note 39.2 Reconciliation of the present value of the defined benefit obligation and the present value of the plan assets to the assets and liabilities recognised in the balance sheet

	31 March 2019		31 March 2018	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Present value of the defined benefit obligation	-	-	-	-
Plan assets at fair value	-	-	-	-
Net defined benefit (obligation) / asset recognised in the SoFP	-	-	-	-
Fair value of any reimbursement right	-	-	-	-
Net (liability) / asset after the impact of reimbursement rights	-	-	-	-

Note 39.3 Amounts recognised in the SoCI

	Group	
	2018/19	2017/18
	£000	£000
Current service cost	-	-
Interest expense / income	-	-
Past service cost	-	-
Losses on curtailment and settlement	-	-
Total net (charge) / gain recognised in SOCI	-	-

Note 40 On-SoFP PFI, LIFT or other service concession arrangements

Note 40.1 Imputed finance lease obligations

The following are obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

	31 March 2019		31 March 2018	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Gross PFI, LIFT or other service concession liabilities	**30,488**	**30,488**	**31,878**	**31,878**
Of which liabilities are due				
- not later than one year;	1,840	1,840	1,391	1,391
- later than one year and not later than five years;	7,066	7,066	7,337	7,337
- later than five years.	21,582	21,582	23,150	23,150
Finance charges allocated to future periods	(11,958)	(11,958)	(13,244)	(13,244)
Net PFI, LIFT or other service concession arrangement obligation	**18,530**	**18,530**	**18,634**	**18,634**
- not later than one year;	568	568	103	103
- later than one year and not later than five years;	2,392	2,392	2,492	2,492
- later than five years.	15,570	15,570	16,039	16,039

Note 40.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future obligations under these on-SoFP schemes are as follows:

	31 March 2019		31 March 2018	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**92,948**	**92,948**	**98,027**	**98,027**
Of which liabilities are due:				
- not later than one year;	5,206	5,206	5,079	5,079
- later than one year and not later than five years;	22,156	22,156	21,616	21,616
- later than five years.	65,586	65,586	71,332	71,332

Note 40.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2018/19		2017/18	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Unitary payment payable to service concession operator	**5,079**	**5,079**	**4,955**	**4,955**
Consisting of:				
- Interest charge	1,288	1,288	1,323	1,323
- Repayment of finance lease liability	103	103	675	675
- Service element and other charges to operating expenditure	1,915	1,915	1,435	1,435
- Capital lifecycle maintenance	1,134	1,134	676	676
- Revenue lifecycle maintenance	-	-	-	-
- Contingent rent	639	639	846	846
- Addition to lifecycle prepayment	-	-	-	-
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	-	-	-	-
Total amount paid to service concession operator	**5,079**	**5,079**	**4,955**	**4,955**

Note 41 Off-SoFP PFI, LIFT and other service concession arrangements

Gloucestershire Hospitals NHS Foundation Trust incurred the following charges in respect of off-Statement of Financial Position PFI and LIFT obligations:

	31 March 2019		31 March 2018	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Charge in respect of the off SoFP PFI, LIFT or other service concession arrangement for the period	-	-	-	-
Commitments in respect of off-SoFP PFI, LIFT or other service concession arrangements:				
- not later than one year;	-	-	-	-
- later than one year and not later than five years;	-	-	-	-
- later than five years.	-	-	-	-
Total	-	-	-	-

Note 42 Financial instruments

Note 42.1 Financial risk management

A financial instrument is a contract that gives rise to a financial asset of one entity and a financial liability or equity instrument of another entity.

IFRS 7, Financial Instruments Disclosure and Presentation, 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.

Credit Risk

Because of the continuing service provider relationship that the NHS Foundation Trust has with local Clinical Commissioning Groups and NHS England and the way those bodies are financed, the NHS Foundation Trust is not exposed to the degree of credit risk faced by many other business entities. The Trust has invoices for services and facilities provided to NHS organisations which are currently being queried by the other parties, notably NHS bodies, within Gloucestershire and Welsh NHS bodies .These are subject to a provision for impaired receivables as set out in note 21.1. Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which IFRS 7 mainly applies.

Market Risk

This is the risk that the fair value or cash flows of a financial instrument will fluctuate because of changes in market prices. This includes currency risk (foreign exchange rates) and interest rate risk.

The NHS Foundation Trust has limited powers to borrow or invest surplus funds. Cash is held on deposit with a number of safe harbour institutions which are deemed to have significantly low risk and high liquidity.

100% of the Foundation Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. Gloucestershire Hospitals NHS Foundation Trust is not, therefore, exposed to significant interest-rate risk. The Trusts PFI scheme unitary payments are linked to RPI.

Liquidity risk

This is the risk that the NHS Foundation Trust will encounter difficulties meeting obligations associated with financial liabilities.

The NHS Foundation Trust's net operating costs are incurred under annual service agreements with local Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Foundation Trust also largely finances its capital expenditure from funds made available from Government under an agreed limit. Gloucestershire Hospitals NHS Foundation Trust is not, therefore, exposed to significant liquidity risks.

Note 42.2 Carrying values of financial assets

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

Group	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Carrying values of financial assets as at 31 March 2019 under IFRS 9				
Trade and other receivables excluding non financial assets	25,885	-	-	**25,885**
Other investments / financial assets	-	-	-	**-**
Cash and cash equivalents	7,317	-	-	**7,317**
Consolidated NHS Charitable fund financial assets	2,541	1,953	-	**4,494**
Total at 31 March 2019	**35,743**	**1,953**	**-**	**37,696**

Group	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Carrying values of financial assets as at 31 March 2018 under IAS 39					
Trade and other receivables excluding non financial assets	21,018	-	-	-	**21,018**
Other investments / financial assets	-	-	-	-	**-**
Cash and cash equivalents	5,447	-	-	-	**5,447**
Consolidated NHS Charitable fund financial assets	16	3,377	-	-	**3,393**
Total at 31 March 2018	**26,481**	**3,377**	**-**	**-**	**29,858**

Note 42.3 Carrying values of financial liabilities

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

Group	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9			
Loans from the Department of Health and Social Care	122,841	-	**122,841**
Obligations under finance leases	6,450	-	**6,450**
Obligations under PFI, LIFT and other service concession contracts	18,530	-	**18,530**
Other borrowings	-	-	**-**
Trade and other payables excluding non financial liabilities	45,316	-	**45,316**
Other financial liabilities	-	-	**-**
Provisions under contract	-	-	**-**
Consolidated NHS charitable fund financial liabilities	116	-	**116**
Total at 31 March 2019	**193,253**	**-**	**193,253**

Group	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39			
Loans from the Department of Health and Social Care	92,764	-	**92,764**
Obligations under finance leases	4,524	-	**4,524**
Obligations under PFI, LIFT and other service concession contracts	18,634	-	**18,634**
Other borrowings	-	-	**-**
Trade and other payables excluding non financial liabilities	40,968	-	**40,968**
Other financial liabilities	-	-	**-**
Provisions under contract	-	-	**-**
Consolidated NHS charitable fund financial liabilities	14	-	**14**
Total at 31 March 2018	**156,904**	**-**	**156,904**

Note 42.4 Maturity of financial liabilities

	31 March 2019		31 March 2018	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
In one year or less	57,843	57,959	45,670	45,684
In more than one year but not more than two years	31,978	31,978	4,657	4,657
In more than two years but not more than five years	69,425	69,425	12,066	12,066
In more than five years	33,891	33,891	94,497	94,497
Total	**193,137**	**193,253**	**156,890**	**156,904**

Note 43 Losses and special payments

Group	2018/19 Total number of cases Number	2018/19 Total value of cases £000	2017/18 Total number of cases Number	2017/18 Total value of cases £000
Losses				
Cash losses	-	-	-	-
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	1,254	266	1,597	606
Stores losses and damage to property	-	-	-	-
Total losses	**1,254**	**266**	**1,597**	**606**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	-	-
Extra-contractual payments	-	-	-	-
Ex-gratia payments	50	21	36	14
Special severance payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**50**	**21**	**36**	**14**
Total losses and special payments	**1,304**	**287**	**1,633**	**620**
Compensation payments received		-		-

Note 44 Gifts

There are no gifts that require disclosure

Note 45.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £342k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £0k decrease in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classifiction of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £0k.

Note 45.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

Note 45 Related parties

Gloucestershire Hospitals NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

During the period, none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Gloucestershire Hospitals NHS Foundation Trust.

The Department of Health and Social Care is regarded as a related party. During the period, Gloucestershire Hospitals NHS Foundation Trust, including in carrying out its role of host to the Gloucestershire Finance, Procurement and Estates Shared Services, has had a significant number of material transactions with the Department and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

NHS Gloucestershire CCG
NHS Wyre Forest CCG
NHS Redditch & Bromsgrove CCG
NHS South Worcestershire CCG
NHS Herefordshire CCG
NHS Wiltshire CCG
NHS Swindon CCG
NHS South Warwickshire CCG
NHS Oxfordshire CCG
NHS England
Wye Valley NHS Trust
The Welsh Assembly (as part of NHS Wales which includes a number of commissioners)
2gether NHS Foundation Trust
Gloucester City Council
Cheltenham Borough Council
NHS Litigation Authority
NHS Logistics Authority
NHS Blood and Transplant Service
NHS Pensions Agency

The Foundation Trust has also received revenue and capital payments from its charitable fund. The Trustees of this fund are also members of the NHS Foundation Trust Board.

Note 48 Transfers by absorption

The Trust had no transfers by absorption

Note 49 Prior period adjustments

There were no prior period adjustments

Note 50 Events after the reporting date

There are no significant post reporting date events to report

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Our Quality Account

2018-2019

Best Care for Everyone

Gloucestershire Hospitals NHS Foundation Trust

Quality account 2018/19

Our Quality Account is our annual report about the quality of our services provided by us, Gloucestershire Hospitals NHS Foundation Trust. Our Quality Accounts aims to increase our public accountability and drive our quality improvements. Our Quality Account looks back on how well we have done in the past year at achieving our quality goals. It also looks forward to the year ahead and defines what our priorities for quality improvements will be and how we expect to achieve and monitor them.

Contents

Quality Account 2018/19

Our Trust

Gloucestershire Hospitals NHS Foundation Trust provides acute hospital services from two large district general hospitals, Cheltenham General Hospital and Gloucestershire Royal Hospital. Maternity Services are also provided at Stroud Maternity Hospital. Trust staff also provide outpatient clinics and some surgery from community hospitals throughout Gloucestershire. The Trust is the major provider of secondary care services in the area; the Trust has a £500m annual operating income, 960 beds, over 125,000 emergency attendances and nearly 800,000 outpatient appointments each year. The trust has 8,000 members of staff who are committed to providing high quality acute elective and specialist services under its vision of 'Best Care For Everyone' to a diverse population of over 620,000.

Gloucestershire Royal Hospital provides general hospital services. Gloucestershire Royal Hospital has a 24-hour Emergency department, a state of the art Children's Centre and a women's centre. The hospital also has a range of operating theatres, inpatient wards and provides outpatient services from a dedicated outpatient department.

Gloucestershire Royal Hospital

Cheltenham General Hospital

Cheltenham General Hospital provides general hospital services. Cheltenham has state-of-the-art critical care facilities and is home to the specialist Oncology Centre as well as breast screening facilities at the Thirlestaine Breast Care Centre. This hospital also has an Interventional Radiology operating theatre; surgical robot used in treating prostate cancer and provides a wide range of outpatient services. Cheltenham Birth Centre is also located on the site.

The trust also provides services from community hospitals in Stroud, Berkeley Vale, Forest of Dean, Tewkesbury and North Cotswolds, Cirencester, Evesham and Ross on Wye and there is a midwife led birth centre in Stroud.

Our priorities and statements of assurance

Part 1: Statement on quality from the Chief Executive of Gloucestershire Hospitals NHS Foundation Trust

Chief Executive's welcome to the Quality Account

I am delighted to introduce you this year's Quality Account. Every NHS Trust is required to publish a Quality Account which sets out how the Trust is performing against the quality standards and priorities set both nationally by Government and locally by the Trust Board and its commissioners. However, in Gloucestershire Hospitals, we have aimed to make it so much more. Our aim has been to develop an Account that connects our community and our staff with the huge achievements of the last year alongside our ambitions for the future. And, whilst the Quality Account is our opportunity to reflect on and celebrate the many, many things that we have achieved in the last year, equally importantly, it is our chance to look back on the challenges that we didn't conquer and to ensure that we learn from these and remain focussed on improvement, wherever it is called for.

The Year That's Gone

The year was characterised by numerous highlights which are described throughout this report however, for many staff and myself included, it will be the year in which we secured a 'good' rating following the Care Quality Commission's (CQC) inspection of our services in the autumn of last year. The 'good' rating of itself was a huge achievement with more than 90% of our services now rated 'good' or 'outstanding' However, ratings aside, what was most pleasing was the accompanying narrative which described the huge progress we have made since the CQC's last inspection two years ago, in respect of culture, leadership and quality improvement. These things take time to develop, they are not easily achieved (or always maintained) but they stand us in such good stead as we continue our *Journey to Outstanding.*

One particular approach that was highlighted as outstanding practice is something we have chosen to focus on in our Quality Account; namely the work of our Improvement Academy. The CQC acknowledged and recognised that we now have a "*fully embedded and systematic approach to quality improvement throughout our organisation*" and that this is due to the work of all our staff and, importantly, through the leadership and enabling culture of our Gloucestershire Safety and Quality Improvement Academy (GSQIA).

The CQC weren't the only visitors to heap praise on the Academy this year. International guru and safety expert, Dr Don Berwick visited Gloucestershire in October last year and spent time immersed in some of the things we are doing throughout Gloucestershire to drive quality improvement. His comments about the Trust soon became the talk of the County and beyond, as social media platforms tweeted and posted his now infamous comments.

What's in the water here? I've not had an experience in these visits as exciting as what is happening in Gloucestershire. I don't think I've seen anything like this; it's really special.

Under the leadership of our Director of Quality Improvement & Safety, Andrew Seaton, quality improvement has now become a frontline activity with more than 25% of our workforce – clinical and non-clinical - trained to listen to patients and implement small and larger scale changes that make a real difference to patient care. As a result of this, each Monday, my weekly staff messages typically contain mention of a member of staff or team who has received acclaim for the things they are doing here in Gloucestershire, or the words of a patient or family member who has written to me thanking the Trust for the excellent care they, or their loved one, has received.

It is no coincidence that the NHS Constitutional standards are all about patients' experience of waiting; waiting for NHS care, whether it be waiting more than four hours to be seen in our Emergency Department or 18 weeks for an outpatient appointment or operation, is one of the things that patients and the wider public tell us matters the most when they are judging the quality of NHS healthcare. In 2018/19 we made considerable progress in this area; more than 90% of our patients in ED were seen in line with the national 4 hour standard positioning us in the top 25% of Trust's nationally, the previously elusive two week cancer waiting time standard was achieved in December 2018 - for the first time in more than two years – and was delivered for the rest of the year whilst more than 99% of patients received their diagnostic test within 6 weeks of referral leaving the Trust the best performing hospital in the South West Region for this standard. However, there is much more to be done in this area; cancer patients continue to wait too long to be treated following diagnosis and patients waiting for elective operations such as a cataract surgery or hip replacement are not routinely treated within the national standard of 18 weeks from referral. Improving the waiting experience of our patients will therefore remain a huge priority for 2019/20 and we have set ourselves the ambitious goal of achieving the 62 day cancer waiting time standard from September this year.

In the year that has gone, we have made some important decisions about our 'digital future' and under the leadership of our Chief Digital and Information Officer, Mark Hutchinson, this year is the year that we can say that we have finally recovered from the challenging introduction of our replacement Patient Administration System some two years ago. This milestone, enabled us to look out and ahead and we have now embarked upon realising the original vision for our patients and our staff of a fully electronic patient record driving increasingly safe and reliable care whilst releasing our doctors, nurses and other staff from administrative tasks which will free them up to spend more time with our patients and families.

One of the things that characterises the very best organisations is their willingness to look out and learn from others as well as to look inwards and examine themselves. In our attempt to embrace this philosophy, our regular *100 Leaders' Forum* has become characterised by a 'key note speaker' whose brief is to expose us to the world outside Gloucestershire Hospitals and challenge our thinking. This year we have been fortunate in having a wide variety of speakers and three in particular stand out for me; Chris Hopson, Chief Executive of NHS Providers who gave us the most thrilling insights into the 'politics' of life at the top of the NHS, Duncan Selbie, Chief Executive of Public Health England challenged us to truly examine whether our

actions as a healthcare organisation (or individuals) are enough given the limited evidence that we are closing the longstanding health inequalities gap between the best and worst off and Aidan Fowler, National Director of Safety who reminded us that organisations cannot "blame their way to safety" but must embrace every near miss and incident as a gift through which we can learn and in so doing, become safer.

The Year Ahead

Our community's health and care needs are changing. People are living longer; new medicines and technologies are being discovered and more of us are living with long-term conditions such as diabetes, asthma or enduring mental illness. We need our services to be designed around the patient and their increasingly complex needs, so that care is not only patient centred but personalised. Our quality priorities for the next year have been developed knowing that they will be important and meaningful for our whole community and reflect the priorities of our developing Integrated Care System (ICS). This ambition is perhaps best reflected in one of our recently developed Strategic Objectives for the coming years ahead, which states that

Health and social care across Gloucestershire is experienced to be 'without boundaries'. Patients, carers and staff designing, receiving and delivering integrated care across organisations, with the patient, their carers and their family at the heart of all we do

2019/20 will be a year when we achieve a 'step change' in our approach to co-designing services through involving and engaging the public, our patients and their advocates and our staff by making sure that we all 'walk in their shoes'. The Sweeney Projects we have embarked upon capture this essence through the words of their founder and GP, Dr Kieran Sweeney who said *"despite being a caring and compassionate healthcare professional, it was only when I became a patient himself did I truly understand the value of stepping into the patients shoes and seeing care through their eyes".*

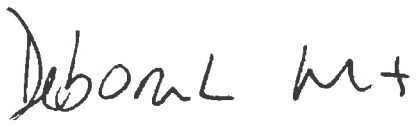
Thank you

The NHS is nothing without its dedicated and skilled staff and my colleagues throughout Gloucestershire Hospitals exemplify this sentiment. The backdrop to this contribution from staff is an NHS which is busier than ever, with patients who (rightly) expect more and more from us all and stakeholders who are (rightly) impatient for us to address the residual challenges we face. However, challenges there may be, but there isn't a day goes by when the endeavours of a staff member aren't brought to my attention for the outstanding expertise, care and compassion they have shown a patient, a family member or colleague; or a week when I am not asked to shine a spotlight on a team or individual who has 'gone the extra mile' for a patient or colleague or a month when I am not proud to announce another 'first' in respect of our improving performance.

Finally, quality improvement doesn't just happen; it needs passion, direction, scrutiny, challenge and most importantly unrelenting support from the very top of the organisation and therefore, I'd like to take this opportunity to formally thank Dr Claire Feehily, non-executive board director and chair of the Trust's Quality and Performance (Q&P) Committee, who as Chair of the Q&P Committee has steered the organisation through the last two years of unprecedented improvement and has been a champion for every patient, every carer and every staff member that needed their voice to be heard at the 'top of the shop'. In keeping with our philosophy, Claire is handing over the baton for Q&P to Board colleague Alison Moon (and in turn picking up the baton for Audit Committee) and therefore I'd like to formally thank Claire for her huge contribution to quality improvement in our Trust.

Formal bit

And finally, the formal bit – I can confirm that to the best of my knowledge, the information included in this report has been subject to all appropriate scrutiny and validation checks and as such represents a true picture of the Trust's activities and achievements in respect of quality.



Deborah Lee,
Chief Executive Officer

Part 2 and 3: Priorities for improvement and statements of assurance

Helping us to continuously improve the quality of care

The following 2 sections are divided into four parts:

Part 2

- Part 2.1
    - What our priorities for 2019/20 are : explains why these priorities have been identified and how we intend to meet our targets in the year ahead.

    - How well we have done in 2018/19: looks at what our priorities were during 2017/18 and whether we achieved the goals we set ourselves. Where performance was below what was expected, we explain what went wrong and what we are doing to improve

- Part 2.2
    - Statements of assurance from the Board

- Part 2.3
    - Reporting against core indicators

Part 3

- The later sections of the report provide an overview of the range of services we offer and give some context to the data we share in section three.

Part 2.1: Our priorities

Our priorities for improving quality 2019/20

Our Quality Account is an important way for us to report on the quality of the services we provide and show our improvements to our services that we deliver to our local communities. The quality of our services is measured by looking at patient safety, the effectiveness of treatments our patients receive, and patient feedback about experiences of the care we provided. The quality priorities detailed in this report form a key element of the delivery of the Trust's objective to provide the "*Best Care for Everyone*"

Our consultation process
Our quality priorities have been developed following consultation with staff and stakeholders and are based on both national and local priority areas.

We have utilised a range of data and information, such as: -

- Analysis of themes arising from internal and external quality reports and indicators
    - **Patient experience insights** – National Survey Programme data, Complaints, PALs concerns, Compliments, feedback from the Friends and Family Test (FFT), and local survey data, focus groups, experience stories to Board.
    - **Patient safety data** – safer staffing data, national reviews, incidents, claims, duty of candour, mortality reviews and Freedom to Speak up data.
    - **Effectiveness and outcomes** - Getting It Right First Time reports, clinical audits, outcomes data.
- Staff, key stakeholders and public engagement – seeking the views of people at engagement events.
- Engaging directly with our Governors on our quality priorities as they are required by law to represent the interests of both members of our Trust and of the public in Gloucestershire. Many of our Governors sit on steering groups and committees and so are able to influence and challenge quality of care.
- Review of progress against last year's priorities, carrying forward any work streams which have scope for on-going improvement.
- Ensuring alignment with national priorities and those defined by the Academic Health Science Network patient safety collaborative.
- Reviewing key reports such as
    - The NHS Long Term Plan so that we consider how we will deliver the national aspirations locally.
    - "**Learning from Gosport**" which was the Government's response to the report of the independent panel.

As a result, we are confident that the priorities we have selected are those which are meaningful and important to our community. Progress against these priorities will be monitored through the Quality Delivery Group, chaired by the Executive Director of Quality and Chief Nurse, and by exception to the Quality and Performance Committee (a Governor sits on our Quality and Performance Committee).

The Quality Delivery Group is responsible for monitoring the progress of the organisation against our quality improvement priorities. The Group meets every month and reviews a series of measures which give us a picture of how well we are doing. This will allow appropriate scrutiny against the progress being made with these quality improvement initiatives, and also provides an opportunity for escalation of issues. This will ensure that improvement against each priority remains a focus for the year and will give us the best chance of achievement.

Table: Our priorities for improving quality

Priority quality indicator goals 2019/2020	Why we have chosen this indicator
WELL LED - continuous improvement	
Continuous quality improvement with the GSQIA To further enhance our quality improvement systems with support from the Quality Improvement by our Gloucestershire Safety and Quality Improvement Academy (GSQIA)	• To further embed our QI approach to enable us to be rated as an outstanding organisation by CQC. • CQC were impressed with our overall QI approach.
To continue to develop our speaking up systems and processes through **Freedom to Speak Up**	• This is an area that staff have indicated that they would like us to improve • National driver to improve after the Gosport Independent Enquiry. • Staff Survey results
EXPERIENCE - enhancing the way staff and patient feedback is used to influence care and service development	
To improve patient experience of our **discharge processes**	• Continuation of the safe and proactive discharge programme which was a Commissioning for Quality Improvement (CQUIN 19/20). • Our Adult Inpatient Survey data indicates this as an area of improvement. • Endorsed by our Governors.
To improve **cancer patient experience**	• In order to achieve an Outstanding rating for Cancer Services we want to co-ordinate our improvement work to where it is most needed. • Local data from our Cancer Survey.
To improve **outpatient experience**	• Our local data supports that this is an area for improvement. • Endorsed by our Governors
To improve **mental health care** for our patients coming to our acute hospital	• Our CQC feedback from our most recent inspection advises us that we can make improvements in this area. Our local data and The Long Term Plan supports that this is an area for improvement.
To develop a **real time patient experience survey programme**	• Our staff would like access to more real time patient experience data (Staff Survey) • Our patients would like to provide us with feedback on how we could improve.
SAFETY - lessons are learnt and improvements are made	
To enhance and improve our **safety culture**	• National driver with the consultation for the national patient safety strategy and also the CQC Never Events report. • Our Staff Survey results
To improve our patients beginning their **first treatment for cancer within 62 days** following an urgent GP referral for suspected cancer.	• National NHS Constitution target

Priority quality indicator goals 2019/2020	Why we have chosen this indicator
To improve the issue of patients being **lost to follow up**	• Local data supports this as an area of focus • Endorsed by our Governors
To improve our **prevention of pressure ulcers**	• The national Stop the Pressure programme led by NHS Improvement.
To prevent **hospital falls**	• Implementing the three high impact actions • CQUIN 2019/20 • Endorsed by our Governors
To improve the **learning from our investigations into our serious medication errors**	• Our local data supports this as an area of focus.
To improve our **care of patients whose condition deteriorates** and to deliver time critical care – (to include Stroke care, VTE and sepsis).	• National drivers – The Long Term Plan. • Local data supports that we need to fully embed our NEWS2 system and that we appropriately respond to our patients.
CLINICAL EFFECTIVENESS / RESPONSIVENESS	
To improve our **learning into action systems** – including learning from national investigation reports as well as learning from our own local investigations (learning from deaths, complaints, Duty of Candour, serious incidents and legal claims).	• National driver after Gosport Independent Panel findings. • Our staff tells us that this is an area where they would like to see an improvement. • Endorsed by our Governors
To improve our care for **patients with diabetes**	• National Driver – Long Term Plan. • Our local data supports that this is an area that we should focus on improvements.
To improve our care of patients with **dementia** (including diagnosis and post diagnostic support)	• National drivers – Long Term Plan. • Our local data supports that this is an area that we should focus on.
To improve our **nursing care standards** the continuation of Nursing Assessment and Accreditation Scheme (NAAS	• Local data supports this as an area for improvement.
To improve our **infection prevention and control standards** (reducing our Gram-negative blood stream infections by 50% by 2021)	• National driver • Endorsed by our Governors
Rolling out of **Getting it Right First Time** standards in targeted standards	• National driver • Endorsed by our Governors
Delivering the 10 standards for **seven day services** (especially 2, 8, 5, 6)	• National driver
To deliver the programme of **Better Births** (maternity care)	• National driver
To improve our care of children **transition**ing to adult care	• National driver • Local data supports this as an improvement area • Endorsed by our Governors

How well have we done in 2018/19?

2.1 Well led
2.1.1 Learning to improve

- To build the capacity and capability of our staff to improve services through our Quality Academy
- To participate in and learn from
  - the results of national audits, and
  - reviews of our services Getting It Right First Time (GIRFT)
- To respond to patient feedback and surveys around discharge (CQUIN)

2.1.2 Harnessing the benefits of technology

- To develop the use of our clinical information system to support the ordering of tests and the communication of results, and preparing to use the system for prescribing.
- To establish Advice and Guidance services for non-urgent GP referrals, allowing GPs to access consultant advice prior to referring patients in to secondary care (CQUIN)

2.2 Patient safety
2.2.1 Investigations and learning from deaths

- To provide an annual summary on reviewing and learning from deaths.

2.2.2 Reducing the impact of serious infections (CQUIN)

- Timely identification of patients with sepsis in emergency departments and acute inpatient settings
- Timely treatment for sepsis in emergency department and acute inpatient settings
- Antibiotic review
- Reduction in antibiotic consumption per 1,000 admissions
- To learn from serious incidents

2.3 Effective
2.3.1 Delivering high quality urgent and emergency care

- To ensure our local response to the National Urgent and Emergency Care Review, includes the development of models of care that ensure patients are treated with the very best expertise and facilities in order to maximise their chances of survival and a good recovery
- Progress to delivering specialist input within 14 hours, daily Consultant review every day, timely diagnostics and interventions (4 key standards in national programme by 2018).
- Improving services for people with mental health needs who present to the Emergency Department (CQUIN)

2.3.2 Improving the use of medicines (CQUIN)

- To optimize the use of medicines commissioned by specialised services
- To introduce standardized doses of anti-cancer therapies

2.4 Responsive
2.4.1 Preventing ill health by risky behaviours - alcohol and tobacco (CQUIN)

- To support healthier behaviours

2.4.2 Preventing ill health (CQUINs)

- Improvement of health & wellbeing of NHS staff – 5% improvement in two of the three annual staff survey questions on health & wellbeing, MSK and stress
- Healthy food for staff, visitors and patients – changes to food and drink provision – focus on reducing sugars on sale in drinks etc.
- Improving the uptake of flu vaccinations for frontline clinical staff

2.5 Patient experience / caring
2.5.1 Best care for everyone

- To ensure safe staffing levels and implement the new approach to measuring Care Hours per Patient Day (CHPPD) on wards.
- To prevent falls and pressure ulcers
- To improve end of life care

2.1 Well led

2.1.1 Learning to Improve – our quality improvement academy

Quality priority

To continue to build the capacity and capability of our staff to improve services through the Gloucestershire Safety and Quality Improvement Academy (GSQIA)

Background

The GSQIA was built in June 2015 with the aim of developing a centralised source of safety and quality improvement education programmes to provide staff with the skills, tools and the support to contribute to the Trust vision of embedding continuous quality improvement into normal everyday working. Quality Improvement is about making a real difference, directly or indirectly to patient care. It's not about finding new clinical approaches (research) but about improving our own systems and processes to make them more patient focused, safe, efficient, timely or relevant to the latest clinical guidelines. We offer 3 levels of QI training "Bronze", "Silver" and "Gold".

Table: Overview of training

Gloucestershire Quality Improvement Academy Training
Bronze Level – Introduction to Quality Improvement
The Bronze level course provides an overview of quality improvement tools and methods. It is a 4 hour classroom based session and is suitable for anyone sponsoring or taking part in a Quality Improvement initiative or who has an interest in learning about Quality Improvement.
Silver level – Quality Improvement in Action
On the Silver Level course, Improvers come with an area for improvement identified and the QI team works with them to create and support their Quality Improvement project. The programme is a combination of taught theory and supported application of QI tools, to create improvement aims, diagnose problems, identify and test change ideas and measure the impact. The 6 month programme includes monthly follow on sessions with continued support and culminates in the participants creating a poster and presenting the results of their improvement work to qualify as an Improvement Practitioner at their Graduation and Awards Ceremony.
Gold level – Coaching Quality Improvement
The Gold programme covers a combination of leadership, coaching & QI skills, designed to develop an improvement 'habit' within individuals. Gold QI coaches will support Improvers to undertake QI projects at a local level and work within their department to identify and coordinate a programme of improvements.

How we performed 2017/18

Progress continued to be made in terms of embedding the Trust approach to Quality Improvement and increasing the capability and capacity of staff to undertake QI projects. The QSQIA was also recognised externally for its approach and was shortlisted for 2 Health Service Journal (HSJ) awards, under the following titles:

- A communication strategy to create an Improvement Movement in an Acute Hospital Trust
- Learning to Improve - An Academy Approach

How we have performed 2018/19

The GSQIA has exceeded its targets for numbers trained in the Bronze and Silver levels of the QI programme. Only 8 Gold QI coaches completed the next level of the programme, partially due to delays in the roll out of the revised Quality Model, to which it is linked.

A visit by Don Berwick, former President and Chief Executive Officer of the Institute for Healthcare Improvement, provided positive feedback on the work of the GSQIA and the consistency of the scientific approach to Quality Improvement. Similarly the CQC visit highlighted the work of the Academy as an area of outstanding practice.

"You're clearly building on a sense of community. It's really special"

- Don Berwick

Care Quality Commission

Outstanding practice

Across the trust there was a fully embedded and systematic approach to improvement called the Gloucestershire Safety and Quality Improvement Academy (GSQIA). This framework empowered front line staff with the tools to support a change and implement a quality improvement project. Staff said that this had created a recognisable brand, and some described it as a "social movement". Throughout all the focus groups there was a narrative on quality improvement and innovation. Staff at all levels were engaged in the process and could give examples where quality of care for patients had improved because of quality improvement projects.

Data

Following an initial target to train approximately 10% of staff (800) in Quality Improvement methods by the end of 2018, revised targets were proposed and included in the Trust objectives for 2017-2019.

Table: Target and actual figures

	March 2019 Target Increase (Totals)	**Q3 2018/19 Increase (Totals)**	**Q4 Final numbers (at 18th March 2019)**
Bronze	+900 (1537)	+1131 (1768)	+1318 (1955)
Silver	+70 (97)	+86 (113)	+99 (126)
Gold	+45 (45)	+8 (8)	+8 (8)

Numbers of staff completing courses (excluding Non GHT staff):

- **Bronze = 1804 staff**

  Including NHS Gloucestershire Managed Services (GMS) Staff (GMS is a wholly owned subsidiary company set up by Trust on 1st April 2018).

- **Silver = 126 staff**

  With a further 129 projects in progress

- **Gold = 8 staff**

  With an additional 16 starting in the new cohorts 3 and 4, taking the total to 32 Gold QI coaches currently in training.

Figure: Bronze Quality Improvement training

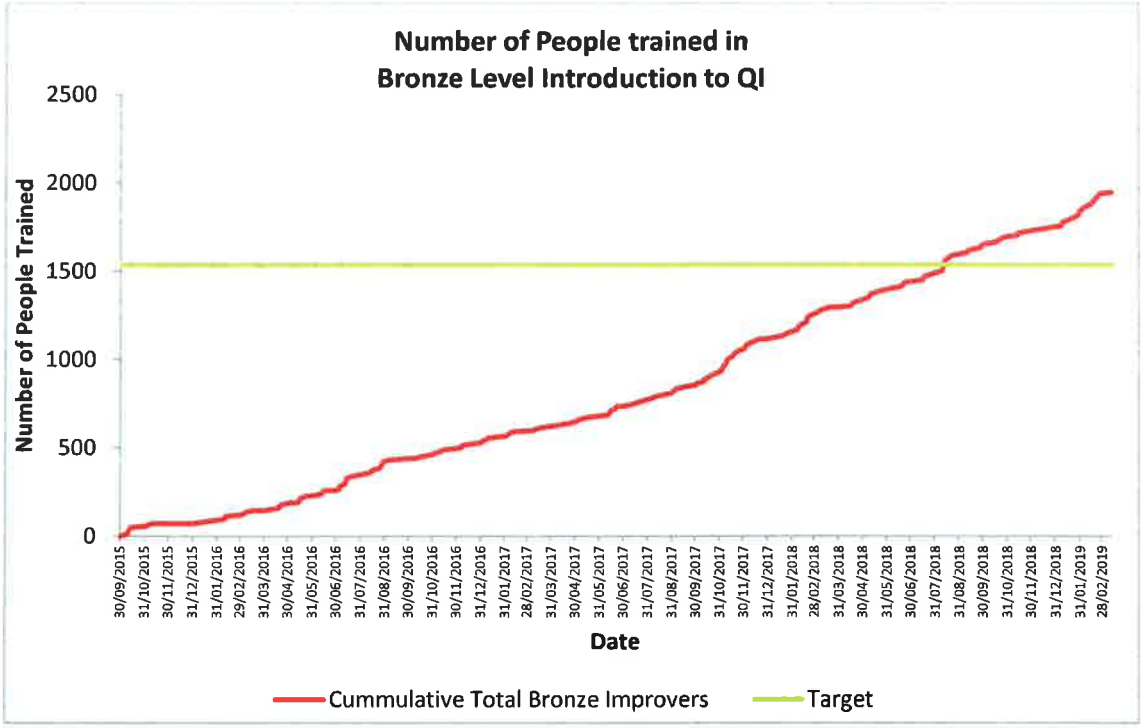
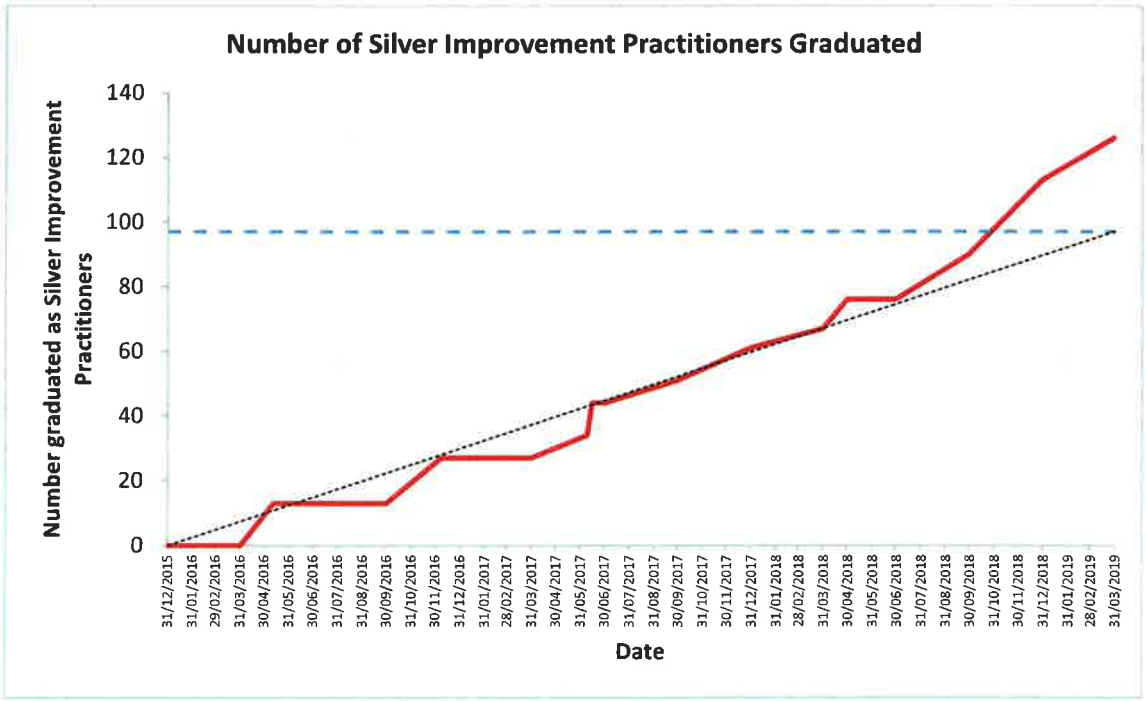


Figure: Silver Quality Improvement training



Plans for improvement 2019/20

The work of the GSQIA will continue and information can be reviewed on our Trust website, with regular communications about our work on Facebook, Instagram, LinkedIn and Twitter.

Two new cohorts of Gold Quality Improvement coaches began their training programmes in March 2019, as we continue to work towards the ambition of having 90 Gold QI coaches across the Trust.

This year will also see the introduction of the first Human Factors programme to the GSQIA portfolio of training. This will mark the beginning of the expansion of the GSQIA into the field of Safety. Also training on experience based co-design will mark further expansion into patient experience.

2.1.2 Learning to improve – national audits

Quality priority

To participate in and learn from the results of national audits

Background

Clinical audit is a way to find out if healthcare is being provided in line with standards and enables care providers and patients know where their service is doing well, and where there could be improvements. The aim is to allow quality improvement to take place where it will be most helpful and will improve outcomes for patients. Clinical audits can look at care nationwide (national clinical audits).

An example of improvement work that has taken place in response to a specific clinical audit would be our response to The National Paediatric Diabetes Audit 2016-17 Report (published in 2018).

The National Paediatric Diabetes Audit

The Gloucestershire Paediatric Diabetes Team has recently implemented a number of changes to develop their service in response to the audit findings. The improvements include:

- Starting carbohydrate counting from diagnosis,
- Holding high HbA1c meetings (**HbA1c**, is a form of hemoglobin (a blood pigment that carries oxygen that is bound to glucose). The blood test for **HbA1c** level is routinely performed in people with type 1 and type 2 diabetes mellitus),
- Starting annual review clinics,
- Holding more regular team meetings,
- Producing a quarterly patient newsletter,
- Holding parents' evenings,
- Organising a PGL adventure holiday camp, and
- Family events.

These service improvements/interventions have helped to improve patient experience and outcomes and are reflective of the recommendations from the report.

The 2018 report highlighted that one of the outcomes that teams should be working towards is to "Ensure that all children and young people with diabetes are provided

with an ongoing programme of structured education from diagnosis, tailored to their individual needs".

As part of the RCPCH Quality Improvement programme, the Gloucestershire Paediatric Diabetes Team wanted to focus on making their service more patient-centred and improve patient engagement. Their aim was to improve the clinic experience for patients and their families, as well as staff, based on their own input, thereby encouraging greater engagement and patient attendance.

Identifying areas for improvement
After the audit the improvement team surveyed patients, families and staff to identify areas for improvements. They formed working groups for four main interventions and trialled a series of changes, adapting as they went through.

Improvements implemented included:

- Amending clinic letters and allowing extra time to prepare for clinics and reduce waiting times.
- Introducing a "Getting Ready for Clinic Sheet" in order to provide clear written action plans that could be taken away from the clinic.
- Rearranging the clinic furniture so the sessions felt less "interview-like".
- Supporting patients to have greater ownership of their diabetes management by providing information and guidance on downloading during clinics, enabling them to download HbA1c records from home.

How we have performed 2018/19
The improvement team surveyed patients'/families' opinions of their interventions using a smiley face scale. The improvements have been very well received. Responses to the changes in clinic furniture layout were 88% positive and 12% neutral. Similarly, their 'Getting Ready for Clinic' sheet yielded 94% positive responses and 6% neutral, with comments such as, "It let us have a voice in the clinic". Verbal and written feedback indicates that patients and their families feel "highly motivated" by the HbA1c log charts in clinic.

Requesting that patients arrive 15 minutes early for appointments has yielded no improvement on clinic duration. The greatest impact on this is the length of time spent in with the consultant, reflecting the complexity of our patients' needs. Their next step is to consider effective use of waiting time, perhaps with micro-teaching.

Results show offering downloading instructions to the portal Diasend in clinic was valuable and 72% of those surveyed indicated that they would now be happy to download at home, with some indicating that knowing they would need to download in clinic would encourage them to do it at home prior to clinic. The number of patients now using the portal Diasend to download at home has increased since their intervention, from 55% of the caseload, to 63%. They have also begun recording

monthly clinic HbA1c averages, with a view to monitoring the impact of future interventions on this key aspect of diabetes management.

Plans for improvement 2019/20

The Gloucestershire Paediatric Diabetes Team want to continue to improve their services and have a number of further quality improvement projects in development, such as tracking HbA1c levels, using new technology and improving diabetes education.

Quality priority

To participate in and learn from reviews of our services: Getting it Right First Time (GIRFT)

Background

Getting It Right First Time is a national programme designed to improve the quality of care within the NHS by reducing unwarranted variations. By tackling variations in the way services are delivered across the NHS, and by sharing best practice between trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and sometimes resultant cost savings.

Importantly, GIRFT is led by frontline clinicians who are expert in the areas they are reviewing. This means the data that underpins the GIRFT methodology is being reviewed by people who understand those disciplines and manage those services on a daily basis. The GIRFT team visit every trust carrying out the specialties they are reviewing, investigating the data with their peers and discussing the individual challenges they face.

How we have performed 2018/19

We are dedicated to implementing and embedding the 'Getting it Right First Time' standards within the Trust and have now recruited a Clinical Lead and a Service Improvement Lead to undertake this work. There are now regular meetings with the clinical and service improvement leads to review progress and facilitate progress and an annual review will take place with the executive team. Many of the actions required are not only within the gift of each service but have implications to service redesign and sometimes countywide input.

Reconfiguration of Trauma & Orthopaedics (T&O) service to support compliance was implemented from October 2017. The rationale was to split the Trauma (non-planned patients) and Elective (planned) patients. All trauma and paediatric surgery is now carried out in Gloucestershire Royal, although fracture clinics remain at Cheltenham General Hospital, Gloucestershire Royal Hospital and Stroud Hospital. All arthroplasty (joint replacement surgery) is carried out at Cheltenham where the wards are ring-fenced however it was not possible to take all elective surgery to

Cheltenham due to theatre availability and kit requirements; spinal surgery and some foot and ankle surgery currently remain at Gloucester.

Elective outpatient clinics remain at both main sites and all community hospitals. Benefits for Trauma patients include a review 7 days a week, the availability of a senior decision maker in the Emergency Department and dedicated Trauma theatres with timely specialist surgery available. Benefits for Elective patients have been an increased number of patients and fewer cancellations. There has been a slight drop in the number of elective cases in January and February 2018; this is partly due to the refurbishment of one of the Orthopaedic Theatres at CGH and partly due to the winter pressures which have affected the elective work on the GRH site.

Data

The following services have had GIRFT reviews and have started working on the recommendations:

Service	GIRFT Visit	Number of GIRFT Recommendations	Number of Actions:			
			Completed	Green	Amber	Red
Dermatology	19.12.2018	20	0	20	0	0
Diabetes	22.01.2019	14	0	14	0	0
Endocrinology	02.11.2018	6	0	6	0	0
Ear, Nose and Throat (ENT)	21.04.2017	10	2	8	0	0
General Surgery	13.03.2018	7	2	5	0	0
Obstetrics & Gynaecology	29.11.2017	14	3	6	5	0
Oral, Maxilla Facial (OMF)	21.04.2017	6	3	3	0	0
Ophthalmology	30.08.2017	7	2	4	1	0
Paediatric Surgery	11.08.2017	8	5	1	1	1
Spinal	23.11.2016	8	3	1	2	2
T&O	04.07.2014 & 10.01.2017	24	20	1	3	0
Vascular	10.02.2017	16	2	12	2	0
Urology	21.06.2017	26	12	10	3	1

The following services have had a GIRFT review but await the recommendations:

Specialty	Date of Meeting
Anaesthetics & Perioperative Medicine	23.11.2018
Emergency Medicine	11.10.2018
Renal	11.01.2019

The following services have completed the initial questionnaire and expect a visit during 2019/20:

Specialty
Acute and General Medicine
Breast Surgery
Cardiology
Radiology
Respiratory
Rheumatology

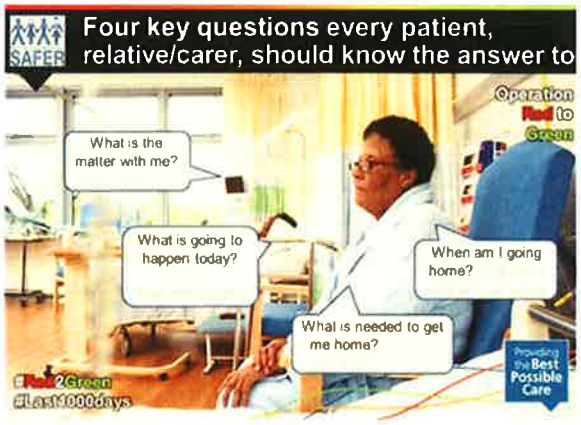
Plans for improvement 2019/20

Further work will be undertaken to raise the profile of this work in the coming year and to link with the excellent New Quality Framework.

There are a number of challenges that are very challenging and will require multiple agency working. Reconfiguration of General Surgery is in progress with proposed start date September 2019. Reconfiguration of estate for the Urology service is almost complete enabling completion of a number of actions including timely assessment for patients with suspected cancer.

GIRFT is also championing the veteran's aware process; this is to ensure that ex-forces personnel are able to access expert care within the NHS and are not disadvantaged by moves to different areas. Gloucestershire Hospitals is working towards the Veteran's Covenant Hospital Alliance accreditation which we hope will be achieved in the coming year.

2.1.4 Learning to improve - proactive and safe discharge



Quality priority

To improve care for a proactive and safe discharge from hospital (CQUIN)

Background

Our goal is that we enable patients to get back to their usual place of residence in a timely and safe way. For older people in particular, we know that longer stays in hospital can lead to worse health outcomes and can increase their long-term care needs. Hospital stays for older adults are longer and more disruptive than for younger people and their care does not always fit within usual ambulatory care pathways (NHS England, 2013). In addition, older people are more likely to stay a long time in hospital, to be moved while there, to experience delayed discharge, and to be readmitted within a month as an emergency (McMurdo and Witham 2013; British Geriatrics Society 2012a; Cornwell 2012).

In 2018/19, the local CQUIN for proactive and safe discharge focused on the quality of discharges. The local CQUIN element was based on the safer discharge bundle as a measure of the quality of discharges.

Monitoring was focused on five areas:

- Number of discharges before 12pm
- Number of TTOs arranged the day before discharge
- Number of patients with TTOs on discharge
- Number and quality of discharge summaries
- Number of patient transports aborted on the day because the patient was not ready for discharge
- Number of discharge related complaints

How we have performed

The Trust continued to build upon the work undertaken last year to implement and embed the *SAFER* Programme. The SAFER programme focused on improved patient flow is enabling us to improve our discharge rates to return patients to their

place of safety within seven days of admission. The introduction of this initiative reduced length of stay and now this has been further improved by the introduction of the *Red2Green* toolkit as part of SAFER which identifies a set of tasks for the day which need to be completed for each patient in order to progress their discharge and improve the quality of their inpatient stay. We have mapped existing discharge pathways and collected baseline information on effectiveness of discharge processes from every ward creating a real time dashboard.

Improvements that we made

- Workstations on Wheels (WoWs) were resurrected and then linked to printers.
- Staff education sessions were held to enable speedier processes for Tablets to Take Home and Discharge Summaries.
- A change of process for discharging overnight patients in Bibury Ward. Now to be discharged from Endoscopy thereby being discharged from Bibury from Midday.
- Twilight Ward clerk team now operating on the Gloucester site between 17:00-21:00.
- Silver QI project with the implementation of the 'Golden' patient identified the day before as the patient that staff must proactively support to get home by midday.
- Introduced 'Breakfast Club' in Discharge Waiting Area so that suitable patients could arrive early for their breakfast
- Transport to be booked following Board round
- One-Stop dispensing training for all staff
- Discharge Dashboard
- Involve Volunteers in collection from pharmacy

Data

Table: Number of discharges before 12 midday

Ward	Baseline data	Quarter 3	End of February 2019
Avening Ward	6.5%	8.7%	11.1%
Bibury Ward	9.4%	10.8%	8.7%
Ward 3A	14.2%	27.4%	33.3%
Ward 8B	10.2%	8.2%	6.7%

Table: Number of Tablets to Take Out (TTOs) arranged the day before discharge

Ward	Baseline <=24hr	Quarter 3	Baseline >24hr	Quarter 3
Avening Ward	63.6%	66.2%	29.1%	23.5%
Bibury Ward	53.2%	48.9%	36.5%	31.8%
Ward 3A	45.9%	39.0%	46.6%	58.5%
Ward 8B	65.4%	68.7%	24.9%	20.1%

Table: Number of discharge summaries ready on day of discharge

Ward	*Baseline data*	*Quarter 3*
Avening Ward	94.3%	98.7%
Bibury Ward	91.4%	83.9%
Ward 3A	82.4%	97.6%
Ward 8B	90.4%	96.4%

Plans for improvement 2019/20

There is a considerable evidence for the harm caused by poor patient flow through our hospitals. Delays can lead to poor outcomes for patients, create financial pressures and impact on key NHS performance measures. Delayed discharge has serious impact across health and care systems, reducing the ability of emergency departments to respond to people's needs, and increasing costs to local health economies and so we will continue our improvement work in 2019/20. The desired outcomes will be improvement in patient outcomes, improvement in patient flow, and reduction in delayed discharges (and thus reduction in associated costs).

2.1.5 Harnessing the benefits of technology – ordering of test results

Quality priority

To develop the use of our clinical information system to support the ordering of tests and the communication of results, and preparing to use the system for prescribing.

Background

Currently we operate a paper based process for the ordering of tests. This reliance on paper has a number of risks and inefficiencies as well as a limited ability to provide an audit trail or assurance of requests.

How we have performed 2018/19

Following a NHS Digital Deep Dive exercise in September 2017 it was recommended to the Trust that the development of TrakCare (the procured patient administration system) be stopped until a time that the Trust had returned to reporting national required Referral to Treatment Times (RTT) and regained stability with its ability to function as a trusted Patient Administration System. This prevented the Trust from planning/ designing or allocating any resource in to the roll out of the functionality that has been clearly identified as a necessary development. The Trust then entered a period of recovery which had an unknown timescale at that stage. This recovery period is now nearing completion with the trust planning to go back to RTT reporting March 2019s data.

Plans for improvement 2019/20

The development of our clinical systems to enable clinicians to order and communicate results remains a priority and now that the Patient Administration System has achieved a level of stability and optimisation the Information Management Technology team remain committed to delivering an ambitious agenda that will see the improvement of the Trusts digital maturity and the role out of advanced clinical functionality including order communications over the next two years. The 2019/20 work plan sees the initiation of a project that includes the design, configuration and roll out of advanced clinical functionality including clinical documentation, order communications and electronic prescribing. It is worth noting that this will not all be rolled out within the 2019/20 year the necessary and significant design and build work will take place.

2.1.6 Harnessing the benefits of technology – offering advice and guidance

Quality priority: Offering Advice and Guidance

To set up and operate Advice & Guidance (A&G) services through the Electronic Record System platform for non-urgent General Practitioners (GP) referrals, allowing GPs to access consultant advice prior to referring patients into secondary care.

Background

The GP Forward View set out the need to improve GP access to consultant advice on potential referrals into secondary care. In 2016 Winpenny et al reviewed a large number of studies on interventions in primary care aimed at improving the effectiveness and efficiency of outpatient services, including studies on email and phone requests for specialist advice and concluded that, "there *is substantial opportunity to reduce the number of patients who are seen in outpatients clinics*"; reducing inappropriate referrals with a proportion not requiring referrals after advice was given. The design of this CQUIIN draws on learning from local areas around the country where A&G services have already been set up. Early outcomes do not yet constitute a robust evidence base on referrals and activity avoided, so have not been generalised as expectations for the wider system, but they do show encouraging early signs

How we have performed 2017/18 and now in 2018/19

2017/18: The requirement for A&G services to be in place for specialties covering 35% of referrals was met for 4 required services.

Quality standards - A&G within 2 days met throughout Q4 but A&G within 5 days not achieved throughout Q4, (related to 4 specialities). Achieved 50% of total value for achievement of Q1 and Q2; Q3 and Q4 Quality standards were not achieved.

2018/19: The requirement for A&G services to be in place for specialities covering 75% of referrals were met for 17 services by start Q4 – appears achieved but not confirmed as yet.

Quality Standard of A&G within 2 days and 5 days – both standards met in Q1 and Q3; not achieved in Q2; Q4 data not yet available

Data

Final indicator requires A&G services in place for 17 specialities responsible for receiving 75% coverage of total GP referrals by start Q4 and quarterly delivering A&G on 2 local quality standards – i) 80% A&G given within 2 days and ii) 95% A&G given within 5 days as an aggregate of the 17 services.

Plans for improvement 2019/20

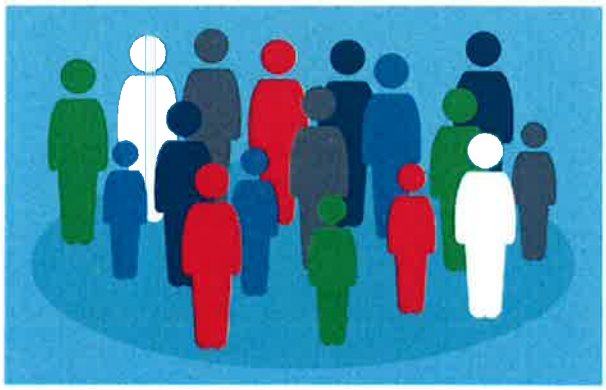
This CQUIN ends as of 31st March 2019. It is anticipated that the standards may appear in the quality schedule of the main contract, but this is as yet unconfirmed.

On a divisional level it has been reported that the specialties will struggle to maintain this service without further resource. It is not certain how effective this service has been in reducing the referrals into secondary care.

2.2 Patient safety

2.2.1 Investigations and learning from deaths

Our annual summary on reviewing and learning from deaths



Quality priority

Our aim is to prevent missed opportunities to have learnt from patient deaths and for us to improve our ability to include and listen to families when an investigation happens.

Background

In March 2017, the National Quality Board published the first National Learning from Deaths Guidance 'A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care'. In response to this guidance, our Hospital Mortality Review Group has developed a 'Learning from Deaths' policy which is published on our Trust website.

We aim, in this section of our report, to help you understand what we do when people within our community experience loss of a loved one whilst in the care of our Trust. We are very sorry for anyone who experiences a loss, and we know that this can be a very difficult and distressing time. As a family member, partner, friend or carer of someone who has died, we know that they may have had comments, questions or concerns about the care and treatment that their loved one received and they may also want to find out more information about the reasons for their death.

We know that the death of a loved one is traumatic for families and so we provide people with information about bereavement support services and practical advice about the things you may need to do following bereavement. This includes:

- collecting any personal items belonging to the person who has died,
- making arrangements to see the person who has died,
- collecting the death certificate,

- how to register the death.

We know that this can be even more concerning when concerns have been raised, or when a family is involved in an investigation process. Case note reviews (or case record reviews) are carried out in certain circumstances.

Firstly, case note reviews are routinely carried out in our Trust on a proportion deaths to learn, develop and improve healthcare, as well as when a problem in care may be suspected. A clinician (usually a doctor), who was not directly involved in the care, will look carefully at their case notes. They will look at each aspect of their care and how well it was provided. When a routine review finds any issues with a patient's care, we contact their family to discuss this further.

Secondly, we also carry out case note reviews when a significant concern is raised with us about the care we provided to a patient. We consider a 'significant concern' to mean:

- any concerns raised by the family that cannot be answered at the time; or
- anything that is not answered to the family's satisfaction or which does not reassure them.

This may happen when a death is sudden, unexpected, untoward or accidental. When a significant concern has been raised, we will undertake a case note review for your loved one and share our findings with you.

Aside from case note reviews, there are specific processes and procedures that we need to follow where the deceased had a learning disability, a child died, or a mother died in a maternity setting, or as a result of a mental health related homicide. If this is the case, we will provide you with the relevant details on these processes.

Update for 2018/19 on how we have performed

- All deaths (100%) in the Trust have a high level review by the Trust Bereavement Team and the Trust Medical Examiners.
- All families meet with the Bereavement Team and have the opportunity to gives us any comments on care.
- Patients are logged on a dedicated section of the Trust Datix System designed to also accommodate the recording of Structured Judgement Reviews (SJRs) and has been structured to include the comments from families to the Bereavement Team when they meet the family to pass on the Death Certificate.
- The feedback is overwhelmingly positive and is routinely shared with the relevant ward area. Areas for improvement reflect the general pressure on staff.
- Themes are now emerging of areas for improvement including our response to the deteriorating patient, communication between teams, the importance of early

senior review and the importance of ensuring the completion of robust documentation.

- Areas of excellent care are also being identified although the approach to using this information to drive change requires further work.
- Further work is ongoing to draw out learning themes from death reviews across all Divisions, with the Divisional Representatives on the Hospital Mortality Group now bringing to the group the top three themes to emerge from deaths reviews to each monthly meeting.
- It is intended to separate the Hospital Mortality group into two sections in preparation for the attendance of two family representatives at the meeting. It is also under discussion to set up a separate family represented reference group.
- Family attendance at a surgical multidisciplinary group is being planned with the intention of rolling this approach out to other Divisions.

Our data 2018/19

Hospital Standardised Mortality Ratios (HMSR) (include super spells)

The HSMR is a method of comparing mortality levels in different years or for different sub-populations in the same year, while taking account of differences in case mix. The ratio is of observed to expected deaths (multiplied conventionally by 100). Thus, if mortality levels are higher in the population being studied than would be expected, the HSMR will be greater than 100. The HSMR is a calculation used to monitor death rates in a trust. The HSMR is based on a subset of diagnoses which give rise to around 80% of in-hospital deaths. HSMRs are based on the routinely collected administrative data often known as Hospital Episode Statistics (HES), Secondary Uses Service Data (SUS) or Commissioning Datasets (CDS).

For all of the 56 diagnosis groups, the observed deaths are the numbers that have occurred following admission in each NHS Trust during the specified time period.

The expected number of deaths in each analysis is the sum of the estimated risks of death for every patient.

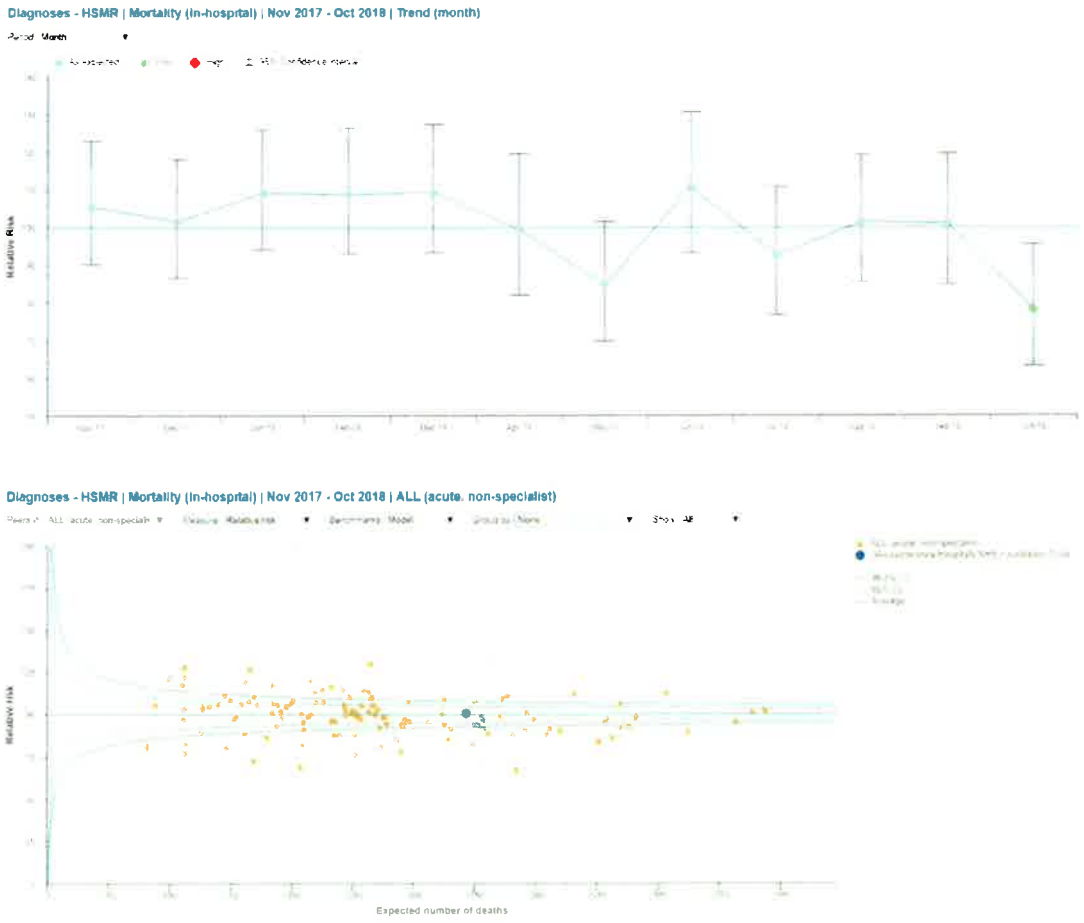
HSMR DETAILS

	Deaths	Bereavement	Medical Examiner Review
Quarter 4 17/18	651	651	651
Quarter 1 18/19	460	460	460

	Deaths	Bereavement	Medical Examiner Review
Quarter 2 18/19	463	463	463
Quarter 3 18/19	475	475	475

HSMR Graph

The graph below shows the rolling 3 month average HSMR in hospital indicator showing a downward trend within the expected range on the funnel plot.



Plans for improvement 2019/20

The requirement for us is clear. It is not simply enough to have a robust process for reviewing deaths in care, important though this is. We need to continue to engage with and support bereaved families, to provide mechanisms for staff support and debriefing and to ensure active and robust oversight. Most importantly we need to continue to translate learning into sustainable action to improve the way we look after the people in our care.

2.2.2 Reducing the impact of serious infections

Quality priority

There should be timely (90%) identification of patients with sepsis in emergency departments and acute inpatient settings. There should be timely (90%) treatment for sepsis in the emergency departments and acute inpatient settings. Assessment of clinical antibiotic review should happen between 24 and 72 hours of patients with sepsis. There should be a reduction in total antibiotic consumption per 1000 admissions, carbapenem (restricted antibiotics not used as first line) antibiotic consumption per 1,000 admissions and an increase in the proportion of antibiotics used in the Access group of the AWaRe category (as defined by the World health Organisation). Antibiotics within the Access group are defined by NHS Improvement as "key antibiotics which are narrow spectrum and used as first-line treatment options".

Background

Every year in the UK there are 150,000 cases of sepsis, resulting in 44,000 deaths, more than bowel, breast and colon cancer combined. Sepsis is a life-threatening condition that arises when the body's own response to an infection injures its own tissues and organs. Sepsis can lead to shock, multiple organ failure and death, especially if not recognised early and treated quickly.

Update for 2018/19 on how we have performed

In 2018/19, as in the previous year, reducing the impact of serious infections CQUIN has four main objectives:

Part A: patients who meet the clinical criteria for sepsis should be screened for sepsis using locally agreed protocol

Part B: those who present with red flag sepsis, severe sepsis or septic shock, must receive antibiotics within an hour. These patients should also receive a review after three days of antibiotics.

Part C: patients presenting with sepsis and initiated on antibiotics must have the antibiotics reviewed within 24-72 hours by a competent clinician. The plan following the review must be documented within the medical records and must include a documented rationale if intravenous antibiotics are continued beyond the review.

Part D: reduction in total antibiotic consumption per 1000 admissions, reduction in carbapenem consumption per 1000 admissions and an increase in the proportion of antibiotics used in the Access group of the AWaRe category. Note: This part applies to all patients, not only patients presenting with sepsis.

For the past four years, the screening of sepsis patients in the emergency department has been, on average, above 90%. The delivery of antibiotics within an hour of diagnosis has improved and continues to be delivered to high levels. This improved performance supported by the Gloucestershire Safety and Quality Improvement Academy (GSQIA) and the Trust has been recognised as one of the most improved hospitals in England.

In 2017/18 part 2c was only achieved in 84% of patients against a target of 90% at the end of quarter 4. For part 2d the total antibiotic target was not met. However the English Surveillance Programme for Antimicrobial Utilisation and Resistance (ESPAUR) Report 2018 by Public Health England noted that, "*In 2017, the increased level of antibiotic prescribing in hospital inpatients also reflects a shortage in the supply of a key broad-spectrum antibiotic, piperacillin/tazobactam. The need to use 2 or more alternative antibiotics to give the same degree of antibacterial coverage resulted in an additional 2.2 million DDDs being dispensed.*" Note: DDD = Defined Daily Dose.

Data for 2018/19 compared with 2017/18

Figure: Emergency Department - Proportion of patients who required screening for Sepsis who received screening

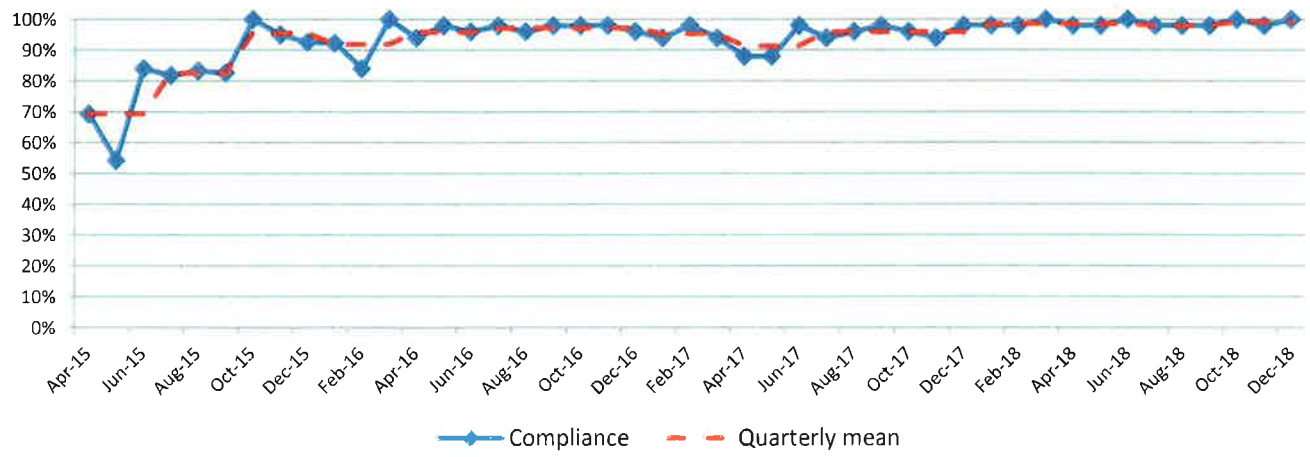
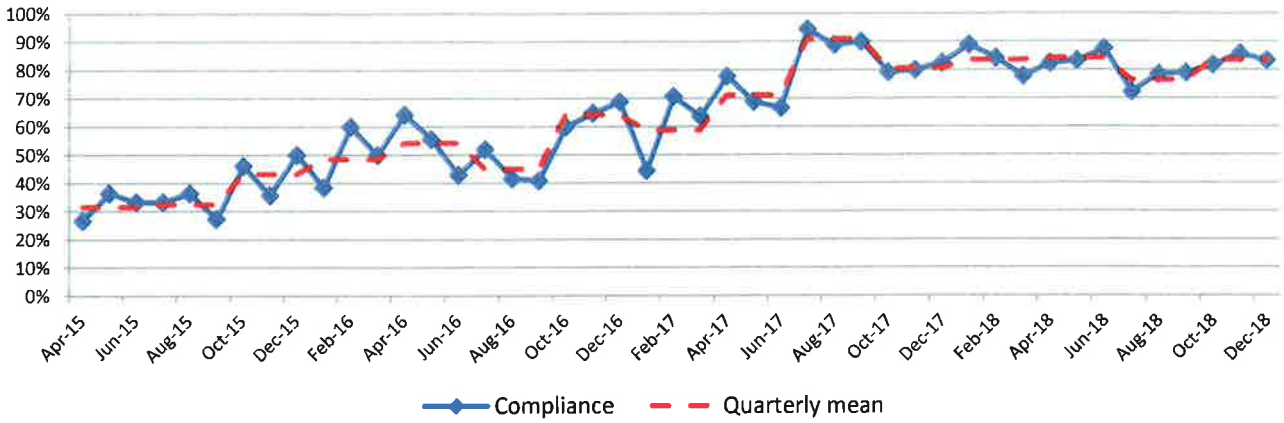


Figure: Emergency Department - Proportion of patients who received Antibiotics within 1 hour of diagnosis of Sepsis



*April 2017 – Change of CQuIN definition to time form diagnosis to antibiotic being given

Part 2c.

2017/2018

Quarter **GHFT Result**	**Q1:** **Apr -Jun-17**	**Q2:** **Jul- Sep17**	**Q3:** **Oct-Dec17**	**Q4:** **Jan -Mar18**
Percentage of antibiotic prescriptions reviewed within 72 hours	**79%**	**83%**	**74%**	***84%**
Target	**>25%**	**>50%**	**>75%**	**>90%**

2018/2019

Quarter **GHFT Result**	**Q1:** **Apr -Jun-18**	**Q2:** **Jul- Sep18**	**Q3:** **Oct-Dec18**	**Q4:** **Jan -Mar19**
Percentage of antibiotic prescriptions reviewed between 24-72 hours as per criteria	**72%**	**60%**	**51%**	**Results pending**

Target	**≥25%**	**≥50%**	**≥75%**	**≥90%**

The target has not been achieved in Quarter 3 2018/2019.

Part D

Total antibiotic and carbapenems

	2017-18 antibiotic consumption (DDD/1000adm) (figures below from fingertips)	18/19 target antibiotic consumption (DDD/1000adm) (Total 3% ↓on 17/18 consumption: CPM 3% ↓ on 17/18 consumption)	2018-19			
			Q1 DDD/ 1000 adm (rolling 12 month ave)	Q2 DDD/ 1000 adm (rolling 12 month ave)	Q3 DDD/ 1000 Adm (rolling 12 month ave)	Q4 DDD/ 1000 Adm (rolling 12 month ave)
Total	4058	3936	4151	3990	4459 provisional	**Results pending**
CPM	88	85	77.5	71.3	59 provisional	**Results pending**

We are on target for achieving the carbapenem target but less likely to achieve the total antibiotic target, but await confirmed figures for Q3 and Q4.

Proportion of antibiotics used in the Access group of the AWaRe category

Proportion of total antibiotic prescribing from the 'Access' category of the WHO essential Medicines List AWaRe index	Target for 18/19 (increase by 3% from baseline 2016 calendar year				
		Q1	Q2	Q3	Q4
	49.09%	44.4%	51.5%	49%	**Results pending**

On target to achieve this but await confirmed figures for Q3 and Q4. This was a new target for 2018/19 and was not monitored in 2017/18.

Plans for improvement 2019/20

For 2019-20 sepsis management will undergo a review alongside a review of the management of the deteriorating patient, from this review an improvement programme will be established which will be monitored by the Resuscitation & Deteriorating patient Committee. Any national or local reporting requirements will be maintained.

2c

Further work is being undertaken to improve documentation in the medical records with regards to the course length following the antibiotic review, this is the main reason for not achieving the target for 2c to date in 2018/19.

2d

Further Antimicrobial Stewardship work will continue to be undertaken to ensure that antibiotics are prescribed and reviewed appropriately and that antibiotics are not continued unnecessarily.

Relevant CQUINS for 2019/2020 include:

Prevention of ill health:

Antimicrobial Resistance

- Lower Urinary Tract Infections in Older People
- Antibiotic Prophylaxis in Colorectal Surgery

Medicines optimisation and stewardship:

- Improved Antifungal Stewardship across the NHS in England

2.2.3 Serious incidents

Quality priority
To learn from serious incidents

Background

Quality management is the act of overseeing all activities and tasks needed to maintain a desired level of excellence. Establishing a quality approach involves quality control and assurance mechanisms (checking), and quality improvement. Quality improvement is the technique that moves learning into practice. The management of incidents is one of the components of a safety system. It requires and open fair blame culture, the ability to carry out high quality investigations, the technical ability to assess the incident (root cause analysis) through a human factors lens and to take recommendations through to quality improvement to test changes and behaviours embedding them into every day practice.

Following the introduction of the Statutory Duty of Candour, the Trust reviewed it's incident investigation model to ensure that all incidents considered to have caused moderate (or above) harm to patients were investigated through detailed Root Cause Analysis (RCAs) and investigation reports shared with patients, next of kin and/or families and centralised investigation in the Safety Department, thereby providing an evident increase in both quality, efficiency and learning. By way of further improvement, as of 2019, the Complaints team joined to form the Patient Investigation and Learning Team.

How we have performed 2018/19

Incident reporting rates in the Trust are very healthy, on average the Trust reports 16,000 incidents a year which places the Trust positively in the top half of reporting rates in the NHS and reflects a good open culture.

There have been two Never Events in the past year, the first involving the wrong route of medication and the second involving the wrong site operation. Overall there have been 31 serious incidents (including Never Events), the main theme being delays to care.

All investigations were completed on time or had formal extensions granted and generated an improvement plan which is monitored until completion. The serious incident process follows Duty of Candour principles involving the patient and\or the next of kin, this includes an extra step to ask the patient of family if they require any questions answered as part of the investigation response.

Plans for improvement 2019/20

To improve the learning and therefore improvement we aim to develop a human factors faculty as part of the GSQIA. Our aim is to improve our analysis of the root cause analysis and future design or solutions to the problem through this approach.

Human Factors, often referred to as ergonomics, is an established scientific discipline used in many other safety critical industries. Human Factors approaches underpin current patient safety and quality improvement science, offering an integrated, evidenced and coherent approach to patient safety, quality improvement and clinical excellence.

Human Factors principles can be applied in the identification, assessment and management of patient safety risks, and in the analysis of incidents to identify learning and corrective actions. More broadly, Human Factors understanding and techniques can be used to inform quality improvement in teams and services, support change management, and help to emphasise the importance of the design of equipment, processes and procedures.

In the coming year we will train 16 members of staff who will develop the approach and mechanisms to support our goal, this will be in parallel to the introduction of the Quality Framework which enables the infrastructure to enhance this improved approach.

2.3 Effective

2.3.1 Delivering high quality urgent and emergency care

Quality priority

To ensure our local response to the National Urgent and Emergency Care Review includes the development of models of care that ensure patients are treated with the very best expertise and facilities in order to maximise their chances of survival and a good recovery

Background

Urgent and Emergency Care is provided by a number of different practitioners. The vast majority is provided in primary care by General Practitioners, nurses, pharmacists and in other community settings such as Minor Injury Units. The Emergency Departments at Gloucestershire Royal and Cheltenham General Hospitals see the sickest and most urgent patients and those referred from primary care. Ensuring that the patient is seen by the most appropriate practitioner first time is one of the ways to improve the quality of care and the speed with which it can be delivered.

The national benchmark for Emergency Departments is the 95% 4-hour standard: 95% of patients should be seen, treated and either discharged or admitted within 4 hours of arriving at the department. In the last few years we have failed to meet this target. In 2017, we have worked hard to improve our systems, to reduce unnecessary steps in the patient pathway and to improve the quality of care we give.

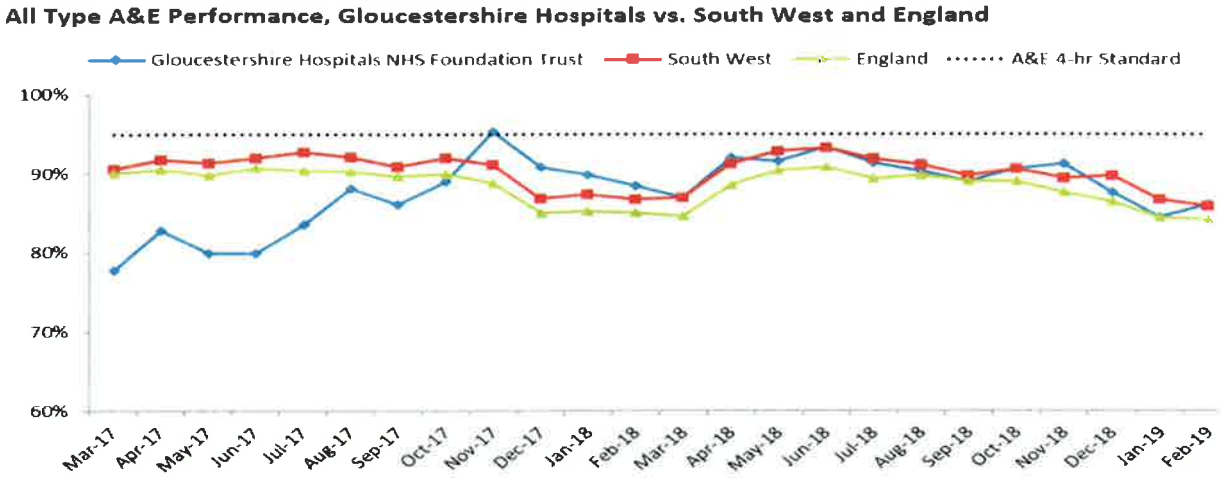
How we performed 2018/19

Our Urgent and Emergency Care Performance (as per validated monthly return) has improved over the last two years, although has shown periods of considerable variation from one month to the next.

We have not delivered the 95% standard since November 2017 (and prior to this the trust had not delivered the standard since August 2014). Since November 2017, however, the Trust has consistently performed slightly higher than the national average, and generally above the regional average (only dipping slightly below the regional average in August 18, December 18 and January 19 in the last year and reporting in excess of 85% in every month of 2018.

See Graphs 1 & 2 and Tables 1-3 below for monthly published 4 hour performance, 17/18 and 18/19 in relation to STP and Regional performance, as well as Trust performance over the last three years.

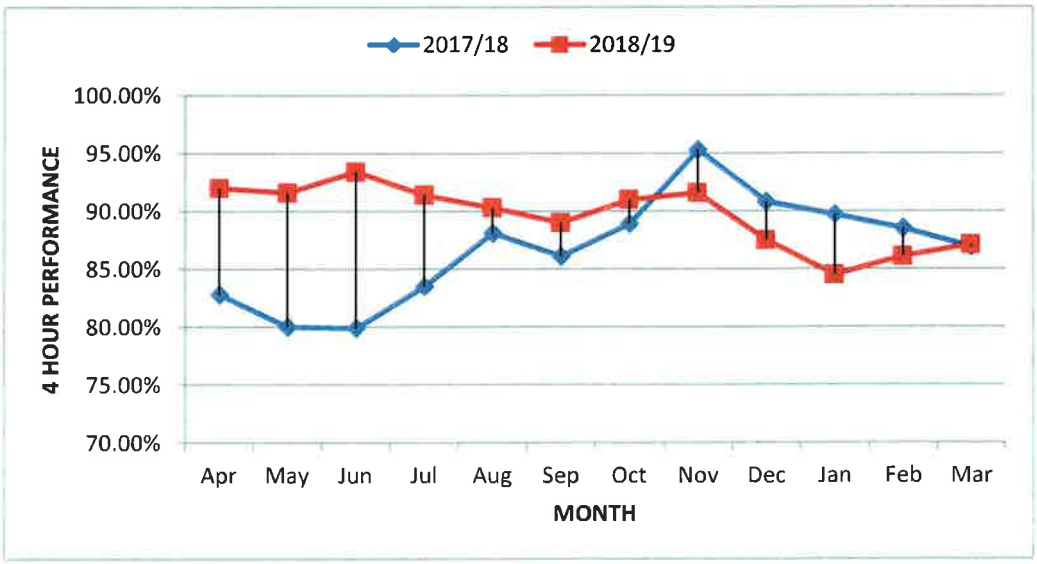
Table 1: All Type A&E Performance, Gloucestershire Hospitals NHS Foundation Trust vs. South West and England



Data Source: Monthly MSitAE Data Return (SDCS), Validated and Published Data

As illustrated in table 1, over the course of the year performance over Financial Year (FY) 2018/19 has exceeded that in FY 2017/18.

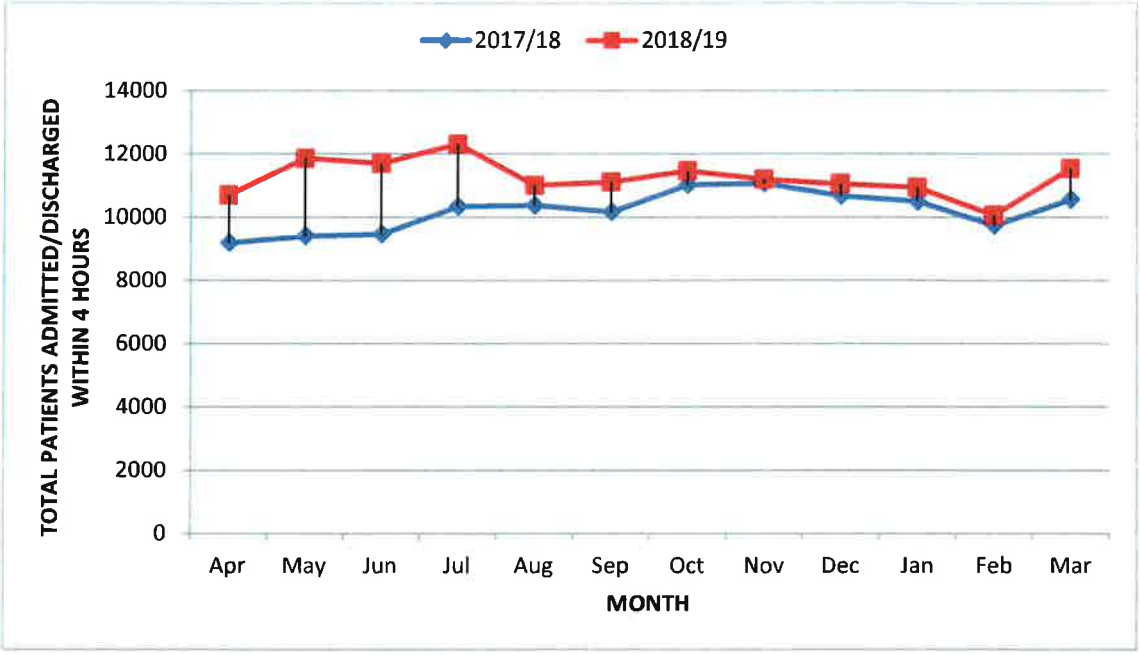
Table 1: Emergency department 4 hour standard 2017/18 & 2018/19



After achieving the 95% 4 hour standard across both hospitals in the November of 2017/18, the new financial year (2018/19) saw continued delivery of >90%. This has been above of the agreed NHSI performance trajectory.

However, the Trust and wider health economy has experienced a challenging winter period, with unprecedented levels of patients attending GHNHSFT's Emergency Departments. Despite this the number of patients seen, treated or discharged within 4 hours is greater month on month when compared to 2017/18 (Table 2).

Table 2: Total Emergency department attendances seen, treated and admitted or discharged within 4 hours of arrival 2017/18 vs 2018/19



Same Day Emergency Care (SDEC) has seen a significant improvement in the number of patients attending Acute Medical Initial Assessment and the Surgical Assessment Unit. Approximately 35% of the medical take is now processed through an ambulatory pathway with 85% discharged on the same day.

This is what we said we would do

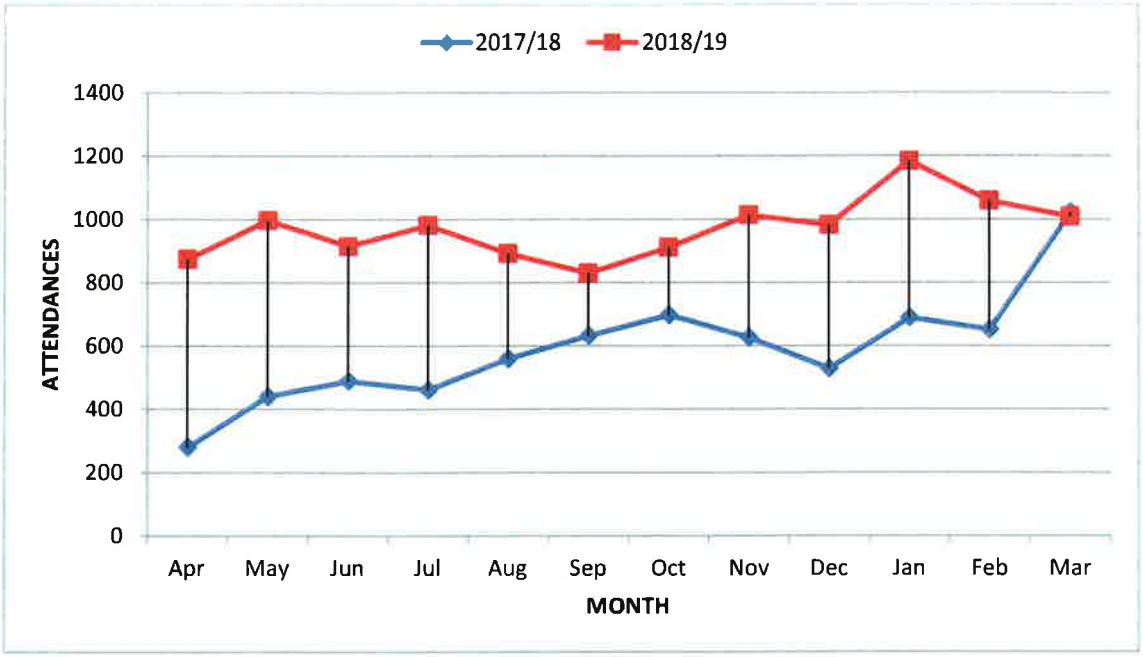
i) We will increase the number of hours that the Ambulatory Emergency Care unit is open extending it until late in to the evening.

As demonstrated in figure 1 there has been a significant increase in ambulatory care presentations due to 4 main factors:

- Extended opening hours
- Weekend working

- Process over pathway
- Relocation to of AMIA to dedicated outpatient facility

Table 3: TOTAL ATTENDANCES TO AEC/AMIA 2017/18 vs 2018/19



ii) We will open a dedicated Surgical Admissions Unit for emergency admissions.

In October 2018, the Surgical Assessment Unit opened at GRH. This was achieved by ring fencing 8 beds on surgical ward and changing the staffing model to enable rapid assessment and treatment of ambulatory patients. This is a 24/7 model.
It is anticipated that throughput will increase from September 2019 when there will be a dedicated Consultant (not based in theatre) who will support the on call admission of patients. Surgery is also involved in the roll out plan for Cinapsis which will enable them to manage their referrals in a semi-bookable environment and accept patients directly from GP practices.

Month	No. of attendances	No. admitted to a bed	No. discharged	No. sent home to return (admissions saved)
November 2018	413	186 (45%)	161 (39%)	66 (16%)
December 2018	413	173 (42%)	185 (45%)	55 (13%)
January 2019	468	190 (40.5%)	219 (47%)	59 (12.5%)
February 2019	461	184 (40%)	201 (44%)	74 (16%)
March 2019	511	173 (34%)	235 (46%)	103 (20%)

Plans for improvement 2019/20

- Ambulatory Medical Initial Assessment to run 24 hours a day 7days a week
- Surgical Assessment Unit to have dedicated Consultant
- Explore further ambulatory care facilities including gynaecology and trauma
- Roll out of Cinapsis programme across the whole hospital
- Pilot Urgent Treatment Centre model at both GRH and CGH (including bookable appointments for 111)
- Improved performance against the 60 minute time to assessment ED quality metric

2.3.2 Delivering high quality urgent and emergency care – specialist input into care planning

Quality priority

Progress to delivering specialist input within 14 hours, daily consultant review every day, timely diagnostics and interventions (4 key standards in national programme)

Background

Early consultant review with rapid diagnostics speeds up decision making ensures appropriate care plans are in place and delivers high quality care to patients. Medical patients are admitted to medical assessment units for review by consultants before they are transferred to the general wards. Patients admitted overnight are reviewed the next morning.

A consultant is present on the admission unit in Cheltenham General Hospital from 8am to 8pm Monday to Friday and from 8am to 5pm Saturday and Sunday. A consultant is present on the admission unit at Gloucester Royal Hospital from 8am-9pm Monday to Friday and from 8am to 5pm Saturday and Sunday. Consultants across a number of medical specialties are on-call 24 hours a day.

How we have performed

We participate in the national Society of Acute Medicine Benchmarking Audit (SAMBA) each year. The last audit was in 2018.

Results from the SAMBA audit show a Tier 1 medical review being completed within 4 hours at 81% in Gloucester and 94% in Cheltenham.

This has improved on the previous year where 58% of patients received a tier 1 medical review within 4 hours at Gloucester and 88% in Cheltenham.

In addition to this 64% of patients had a consultant review within 12 hours at Gloucester with 79% receiving at 12 hours consultant review at Cheltenham. Again both of these results showed improvement on the previous year.

Data

Figure: Gloucestershire Royal Hospital patients were seen by a doctor within 4 hours

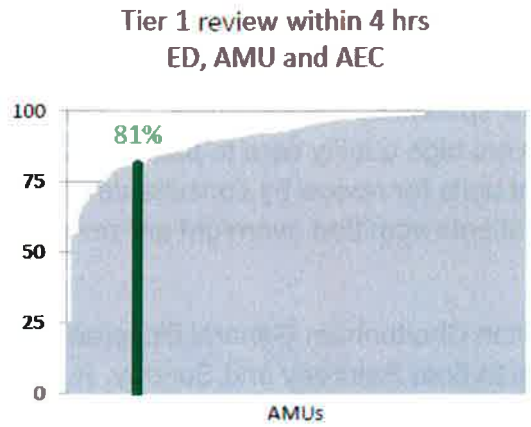
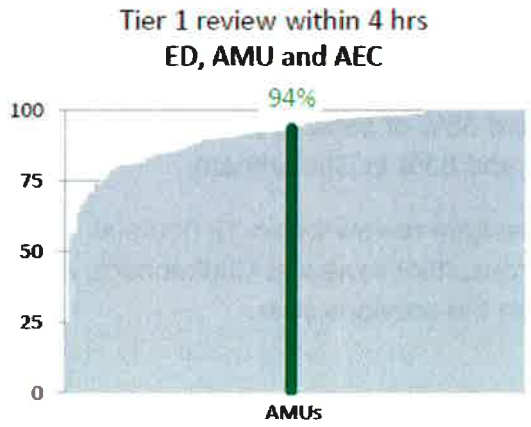


Figure: Cheltenham General Hospital patients were seen by a doctor within 4 hours



A 1-hour diagnostic target was introduced for the admission unit in Gloucestershire Royal Hospital in 2017. This will be extended to Cheltenham General.

The Ambulatory Emergency Care (AEC) centre was extended to weekend 8am to 6pm (4pm for last referral) in Gloucestershire Royal Hospital in 2017. Hours will be extended to 8am to 10pm (8pm for last referral). The use of the AEC allows rapid early assessment, investigation and treatment frequently avoiding the need for a

patient to stay overnight. Patients get a more rapid service and hospital beds are kept for the sickest patients.

Ambulatory Medical Initial Assessment (AMIA) has replaced the AEC in GRH and is open from 8am-10pm with last referral at 8pm. The AMIA sees an average of 35 (new) patients per day turning 85% of those around (home) on the same day.

A 1-hour troponin pathway (test to rule out a heart attack) will be introduced speeding up the treatment of patients who require it and facilitating the earlier discharge of patients who do not (who may be required to stay for 6-12 hours for repeat blood tests at the moment)

We are now using a 1h troponin pathway. A fallout from this has been an increase in the number of positive troponins with an increase in referral to the cardiology team and Rapid Access Chest Pain Clinic. It does speed up discharge for non-cardiac chest pain but we have not proven this.

An Acute Medical Initial Assessment unit (AMIA) will be opened at Gloucestershire Royal Hospital. This will enable the early rapid assessment of patients referred by their General Practitioner for a medical opinion by a consultant or other senior doctor.

As above but in addition cinapsis (a referral management tool) went live in 2018 which allows the acute physicians to manage the G.P referred medical take via AMIA and the Acute Medical Unit (AMU).

Plans for improvement 2019/20

We now have 9-5pm Respiratory Hot Clinic Service which runs across the acute floor.

We have a virtual chronic pain clinic which has 2 slots a fortnight for frequent attenders to use an alternate pathway. We would like to expand and formalise this process.

We have a new Frailty Assessment Unit attached to AMU at GRH. This is currently in development; with the proposal to ring fence beds for frail patients, introduce the Rockwood score the Medical Clerking Proforma. We may wish to develop this service in CGH.

In order to improve flow and quality of care within the acute floor I would like to consider an in-house liaison psychiatrist to be embedded within the acute medical unit. This would provide timely reviews both within the ED and Acute Floor.

2.3.3 Delivering high quality urgent and emergency care – patients with mental health needs

Quality priority

Improving services for people with mental health needs who present to the Emergency Department

Background

Ensuring that people presenting at the emergency department with mental health needs have these met more effectively through an improved, integrated service, reducing their future attendances at the Emergency Department. Patients with mental health problems coming to the Emergency Department in crisis will be aware that timely and quality treatment often remains difficult to deliver.

A Royal College of Emergency Medicine survey in 2016 showed that 31% of respondents felt that crisis care overall had improved whilst 26% felt it had got worse. 49% of respondents felt care had deteriorated for children and young people.

How we have performed

Through a person centred approach and collaborative working, there has been a 45% reduction in the attendance rate for specified frequent attendance patients.

The Mental Health Liaison team now provides a 24/7 support and care for 16 year olds and above at both hospitals. They work closely with the Emergency Departments and 2gether NHS Foundation Trust and act as our psychiatric liaison service. They receive referrals from Emergency Departments and within the hospitals to provide specialist expertise and assessment. The service for under 16 year olds is provided by the Children and Young Peoples Service (CYPS) and for a 2 year pilot, it has expanded its scope and hours of availability, receiving referrals direct from the Emergency Department.

Standards for care delivered within the Emergency Department are described by National Institute for Health and Care Excellence (NICE), Royal College of Emergency Medicine (RCEM), the Royal College of Psychiatrists and the Care Quality Commission (CQC) and relate to mental state examination, assessment of risk, documentation, appropriate facilities, referral or follow up and time to assessments.

- Audit against Nice Guideline standards for care (NCG16) in September 2017 demonstrated 100% compliance.

- The interview facility at Gloucestershire Royal Hospital has been improved and now meet national safety standards and those set by Royal College of Emergency Medicine and the Care Quality Commission.
- Data submitted to the Care Quality Commission early in 2018 showed that in the preceding 12 months there were no patients admitted outside of Gloucestershire due to a lack of beds.
- The Mental Health Liaison Team facilitates discharge to community management for 95% of referrals.

Progress on 2018/2019 plans

The interview facilities at Cheltenham General Hospital Emergency Department have been upgraded to provide a safe space, which meets national standards and increases equity of facilities in both Cheltenham and Gloucester.

Work has been undertaken to examine the causes of time delays between arrival, having an Emergency Mental Health risk Assessment completed and being seen by a mental health practitioner (if indicated). These are now well understood and additional training has been provided for our qualified Emergency Nurse Practitioners and Physician Associates to enable them to complete these risk assessments. Additional improvements have been identified in the triage process and will be implemented in the forthcoming year.

A High Intensity Network has now been established in Gloucestershire to focus on those patients who are repeatedly interacting with more than one public service. This predominantly requires close collaboration between the police and the mental health Trust, but the acute trust has been closely involved in the setting up of this initiative and is well acquainted with the initial cohort of patients.

The Mental Health CQuIN has, to date, exceeded required performance and attracted the full available tariff in year 1 and year 2 to date. However, it is unlikely to attract the full tariff for Q4 as Emergency Care Data Set (ECDS) has not yet been implemented within the Trust and therefore our coding returns will not meet the required quality. However, a point to note is that Gloucestershire has a much smaller percentage of repeat attenders with primary mental health problems than surrounding providers. This is partially due to demographic differences and partially due to the longevity of the cooperation between GHT and 2gether and our joint monitoring of frequent attenders.

Plans for improvement 2019/20

2gether have just employed a Frequent Attender Manager for alcohol dependent patients and we fully expect that this will make a significant impact on our alcohol dependant patients with mental health problems over the forthcoming year.

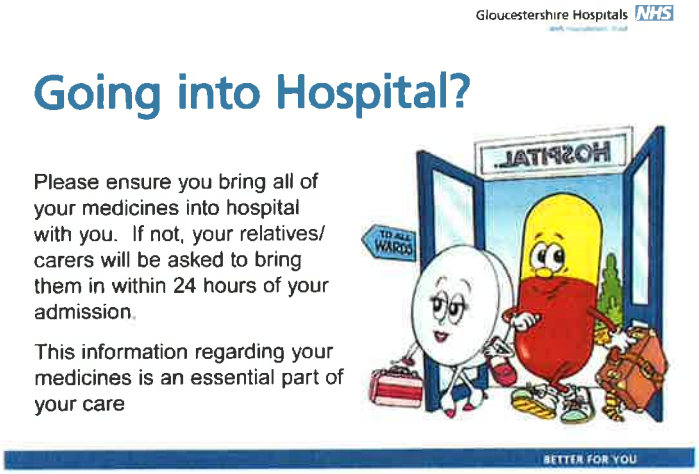
Unfortunately, the business case submitted by the Mental Health Liaison Team to increase the size and remit of the team has been turned down and therefore the planned improvements in service offer will not now be deliverable.

We are expecting the re-modelling of the Emergency Department at Cheltenham General Hospital as part of the work towards becoming an Urgent Treatment Centre and this will increase and improve the space utilisation and provision for patients with primarily mental health presentations. We will also be rolling out the improvements to the triage process which we have identified and anticipate that this will be embedded within the year.

2.3.4 Improving the use of medicines commissioned by specialised services

Quality priority

To optimise the use of medicines commissioned by specialised services



Background

Within Gloucestershire Hospitals NHS Foundation Trust, the prescribing and administration of a medicine is the most common therapeutic intervention that occurs to a patient. Optimising the use of medicines provides an opportunity within the NHS to improve patient experience, pathways and outcomes, whilst reducing expenditure, wastage and unwarranted variation.

How we have performed 2018/19

To improve productivity and performance in relation to medicine use, this Commissioning for Quality and Innovation (CQUIN) framework proposes the faster adoption of best value medicines with a particular focus on the uptake biosimilar biologics as they become available, thus allowing us to treat more patients for the same amount of money. Working closely with clinicians within dermatology, gastroenterology, paediatrics and rheumatology, pharmacy has led on the successful delivery of 100% of targets for quarters 1, 2 and 3.

Data

Pharmacy has led on the successful delivery of 100% of targets for quarters 1-3. Delivery of our biosimilar biologics programme has progressed well, particularly for adalimumab where savings generated will exceed £800,000 for the full year. The target of switching to the biosimilar biologic in 80% of cases was achieved early, within 5 months rather than the required 12 month period.

Plans for improvement 2019/20

During 2019-20, to further improve efficiency in the IV chemotherapy pathway from pharmacy to patient we will looking to reduce chemotherapy waste which can occur when a patient specific dose is prepared in advance but the then the patient's clinical condition changes which means this particular dose or drug is no longer required. The NHS has focused on improving antibiotic stewardship which has proved successful in improving the use of antibiotics and limiting antimicrobial resistance. Building on these achievements, we will be focusing on anti-fungal stewardship, to reduce inappropriate use of anti-fungal agents and prevent the development of resistance to antifungals through the development of anti-fungal stewardship.

2.3.5 Improving the use of medicines – standardised doses of anticancer therapies

Quality priority

To introduce standardised doses of anticancer therapies

Background

The single biggest service within NHS England's specialised commissioning services is the treatment of cancer via chemotherapy. It is estimated that NHS England spends approximately £1.5 billion on the routine commissioning of chemotherapy, with medicine costing 80% of this.

How we have performed

With an increasing aging population as well as advancement in chemotherapy treatments, the cost of chemotherapy is increasing by approximately 8% per year. Traditionally, chemotherapy doses have been calculated on an individual patient basis with a dose per kg of body weight. However such specific dosing has been demonstrated not to provide additional clinical or patient benefit, but it has significantly increased the time and costs in preparing the chemotherapy and leds to drug wastage.

Standardising chemotherapy doses across certain weight bands provides many advantages. It allows chemotherapy to be prepared in advance; it simplifies the process reducing risk and reduces waiting times for patients. Batch production within the Pharmacy Aseptic Manufacturing Unit (PAMU) can now occur, which minimises waste. Similarly, if a patient is unwell on the day and can't receive chemotherapy, that product can be kept for the next available patient. Working nationally, we are now aligning our doses bands to have a standardised approach which means that some batches can be prepared externally and bought in ready to use. To date, the targets have achieved for all three quarters of 2018-19.

Data

To date, the targets have achieved for all three quarters of 2018-19.

Plans for improvement 2019/20

During 2019-20, to further improve efficiency in the IV chemotherapy pathway from pharmacy to patient we will looking to reduce chemotherapy waste which can occur when a patient specific dose is prepared in advance but the then the patient's clinical condition changes which means this particular dose or drug is no longer required. The NHS has focused on improving antibiotic stewardship which has proved successful in improving the use of antibiotics and limiting antimicrobial resistance. Building on these achievements, we will be focusing on anti-fungal stewardship, to

reduce inappropriate use of anti-fungal agents and prevent the development of resistance to antifungals through the development of anti-fungal stewardship.

2.4 Responsive

2.4.1 Preventing ill health by risky behaviours - alcohol and tobacco

Quality priority

To support healthier behaviours (CQUIN)

Background

We need to take action to address risky behaviours, with a focus on alcohol consumption and smoking. Smoking and harmful use of alcohol are amongst the most significant risk factors in the global burden of disease in England. Smoking and harmful alcohol consumption costs the NHS an estimated £2bn and £3.5bn a year respectively. Smoking causes almost 80,000 premature deaths a year, and contributes to 1.7m hospital admissions. Alcohol consumption is responsible for an estimated 23,000 premature deaths a year and contributes to about 1m hospital admissions. The costs to society are significantly higher. Evidence suggests that smoking and harmful alcohol consumption could cost c£13.8bn and c£21bn each year respectively.

Preventing ill health through smoking cessation and reductions in alcohol consumption can significantly reduce the burden on the NHS; premature mortality and morbidity; and will help to reduce health inequalities. This action can also contribute to the ambition set out in the Five Year Forward View (5YFV) around the need for a "*...radical upgrade in prevention...*" and to incentivise and support healthier behaviour.

Tackling these behaviours has a positive impact on the NHS

- Inpatient smoking cessation interventions are effective, regardless of admitting diagnosis; they lead to a reduction in wound infections, improved wound and bone healing, and longer term reduced risk of heart disease, stroke, cancer and premature death.
- Inpatient alcohol identification and brief advice (IBA) is effective in hospital settings and likely to have an impact on future hospital admissions, and chronic disease management such as hypertension.

This CQUIN incentivises non-specialist interventions for which there is sound evidence of effectiveness in reducing ill health and thereby the burden on health services, when delivered at scale.

The interventions are brief, and include components such as: short screening questions, brief or very brief advice on the benefits of drinking less or stopping smoking, and where appropriate referral to specialist services. For example, a single

intervention (including screening) should be between 30 seconds and 5 minutes depending on the complexity or interest of the patient.

How we have performed

Alcohol identification and brief advice

Alcohol identification and brief advice (IBA) aims to identify and influence patients who are increasing or higher risk drinkers (i.e. those who drink above low-risk levels).

The intervention is most impactful when it helps identify and advise patients who are not dependent but whose drinking is increasing their risk of a wide range of ill health linked to drinking alcohol (i.e. c28% of population). In addition, the intervention will identify dependent drinkers who need further support.

Healthcare professionals can deliver the intervention as a short informal conversation, for example, while undertaking routine care or as part of assessment or discharge.

Very brief advice for smoking cessation: ASK, ADVISE, ACT

Very brief advice for smoking cessation (VBA) aims to identify and influence patients who smoke to make a quit attempt.

Healthcare professionals can deliver VBA, in as little as 30 seconds. The intervention is made up of 3 core components: ASK, ADVISE and ACT; although public health benefits are maximised when healthcare professionals refer patients directly for an evidence-based smoking intervention (in the community or on site) with behavioural support and stop smoking medicines.

Healthcare professionals do not require a comprehensive knowledge about tobacco dependency to deliver VBA effectively, though some basic information may enhance the quality of delivery. In its simplest form, healthcare staff would:

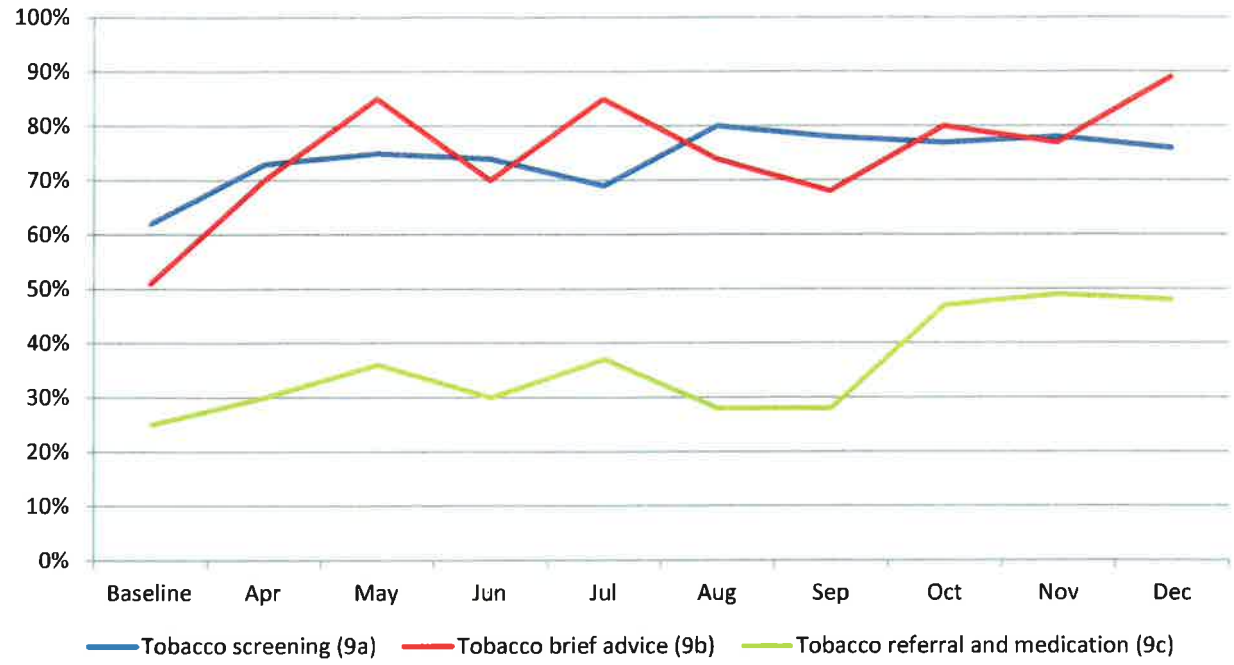
1. ASK – and record smoking status - Is the patient a smoker, ex-smoker or a non-smoker?

2. ADVISE – on the best way of quitting - The best way of stopping smoking is with a combination of medication and specialist support.

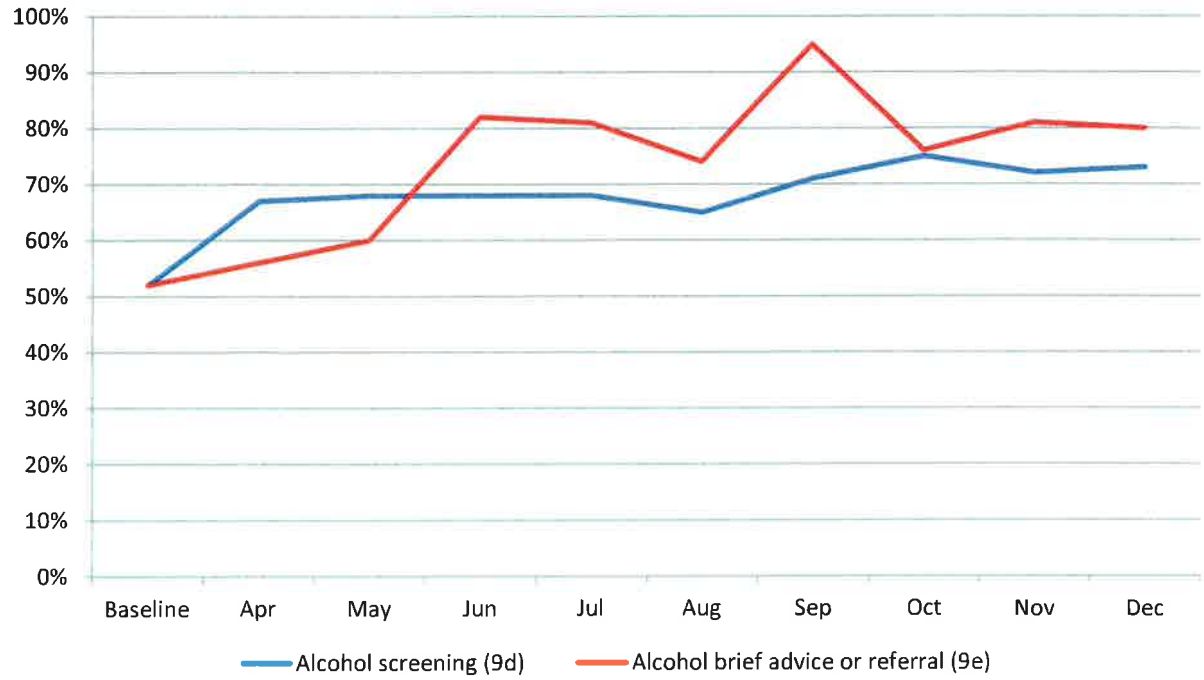
3. ACT – by offering referral to specialist support and prescribing medication if appropriate. They are up to four times more likely to quit successfully with support.

Data

Graph: Tobacco – Screening, brief advice and referral/medication



Graph: Alcohol – Screening and brief advice or referral



Plans for improvement 2019/20

We will continue to identify champions for the continued implementation of this CQUIN at all levels of the organisation, including our champion at Board level the Director of Quality and Chief Nurse.

We will continue to identify a team of clinicians and managers who will be responsible for the continued success of the CQUIN; including, clinical specialists, data managers, those with responsibility for training, and smoking cessation/ alcohol care teams.

2.4.2 Preventing ill health (CQUIN) – health and wellbeing of our staff

Quality priority

Improvement of health and wellbeing of NHS staff – the goal was a 5% improvement in two of the three annual staff survey questions on health and wellbeing, musculoskeletal (MSK) problems and stress

Background

Our goal is to improve the support available to our staff to help promote their health and wellbeing in order for them to remain healthy and well. In 2015, Public Health England estimated the cost of sickness absence to the NHS at £2.4bn. Some reports have estimated this to be 27% higher than the UK public sector average, and 46% higher than the average for all sectors. However, there are many reasons that sickness absence rates in the health sector may be higher than average. Work can often be physically, emotionally and psychologically demanding and the NHS is one of few organisations that work 24 hours a day, 365 days per year. Despite these challenges, there is much we can do as an employer to improve staff health and wellbeing.

The benefits to us of a healthier workforce are clear:

- **Improved patient safety and experience**: The NHS health and well-being review led by Dr Steven Boorman outlined the link between staff health and wellbeing and patient care. This includes improvements in safety, efficiency and patient experience from introducing employer led health and wellbeing schemes.

- **Improved staff retention and experience:** NHS staff retention rates are shown to improve when staff feel their employer cares about their health and wellbeing. Not only does better staff retention mean lower recruitment costs but it also often leads to improved team cohesion and better working environments.

- **Reduced costs:** Although the overall cost of sickness absence is estimated at £2.4bn, even small reductions in sickness absence can have a large impact across the NHS. If sickness absence was reduced by 1 day per person per year then the NHS would save around £150m, equivalent to around 6,000 full time staff. These financial savings do not even take into account the reduced use of agency staff or the costs of recruitment to tackle staff retention issues, and therefore are most likely to understate the overall impact on NHS finances.

- **Setting an example for other industries to follow:** The NHS should be leading the way in implementing a health and wellbeing strategy and providing an example that others can follow.

- **Re-enforced public health promotion and prevention initiatives:** NHS England's Five Year Forward View emphasises the importance of closing the health and wellbeing gap: if the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be compromised. If we want to reinforce the message on health promotion and prevention then it is important that we are leading by example.

How we have performed

Staff survey 2018

Question 11a

Does your organisation take positive action on health and well-being? Answering "Yes, definitely"

Our scores declined to 22.3%, whilst this is a trend across all organisations surveyed, we unfortunately score below average on this indicator.

	2015	2016	2017	2018
Best	52.1%	52.2%	51.5%	46.7%
Your org	29.7%	29.1%	24.9%	22.3%
Average	30.7%	32.0%	31.7%	27.8%
Worst	14.8%	18.2%	19.1%	15.3%

Question 11b

In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities? Answering *"No"*

Our scores for 2018 show a small increase in the number of staff reporting as experiencing MSK problems as a result of work activities. Staff answering "No" decreased from c76% to c74%.

	2015	2016	2017	2018
Worst	33.5%	34.4%	34.6%	37.8%
Your org	22.3%	22.1%	24.2%	25.8%
Average	25.1%	25.6%	25.8%	28.7%
Best	19.2%	18.6%	19.7%	20.2%

Question 11c

During the last 12 months have you felt unwell as a result of work related stress? Answering *"No"*

2018 survey scores show a drop of 2% on the previous year, with more staff reporting that they have felt unwell as a result of work related stress and 60% stating that they **haven't** felt unwell as a result.

	2014	2015	2016	2017	2018
Worst	50.8%	44.9%	44.2%	45.9%	46.7%
Your org	36.0%	34.0%	32.7%	37.6%	40.5%
Average	37.5%	36.0%	35.3%	36.7%	38.9%
Best	27.5%	24.7%	25.3%	27.9%	28.9%

Unfortunately the scores in the 2018 staff survey associated with the preventing ill health CQUIN have all deteriorated. This reflects the national average trend from the 2018 survey.

Despite the deterioration in scores, there were a number of actions we set out to complete in 2018, which we have taken or are working towards completion of:

- Launched new approach to Talent Development/appraisals, including the launch of a new Advanced Development Pool.
- Launched range of J2O initiatives and engaged with staff as part of our CQC inspection preparation and improvement to staff and patient experience.
- Increased our use of social media engagement to promote great work using #J2O
- Established Staff and Patient Experience Improvement Steering Group (SEIG) to monitor and identify specific staff experience and retention initiatives; through improved triangulation of data relating to staff experience, to enable in depth analysis and targeted intervention.
- Junior Doctor Mental Health programme launched August 18
- Launched combined staff and patient health-wellbeing group
- Launched and published Equality of Opportunity Action Plan for 18/19, delivered by Equality Diversity Inclusion Steering Group
- Launched Flu vaccine programme
- Relaunched Schwarz Rounds
- Launched monthly individual and quarterly team Gem Awards for colleagues to recognise one another who 'Go the Extra Mile'
- Launch of local staff recognition schemes in some areas
- Used 'Speak Up' month in October to continue promoting Freedom to Speak Up Guardian role and function
- Kitchen table events launched from November 2018

Plans for improvement 2019/20

In addition to this, there are a number of tasks we will continue to work on during 2019/20, including:

- Planned launch of our new 'one-stop shop' health and wellbeing hub (planned for May launch), making it easier for staff to access clear support pathways for a range of health and wellbeing issues.
- Rollout of new e-rostering system and new bank working options
- Build on the promotion, visibility and membership of the Trust Diversity Network
- Working with ICS partners to design and promote ICS-wide education/awareness campaigns around staff health-wellbeing
- A large range of health campaigns already delivered in 18/19, with more to follow in 2019.
- Continued work to triangulate key staff and patient experience indicators, to support the prioritisation of interventions and focus of the Staff and Patient Experience Group.

2.4.3 Preventing ill health (CQUIN) – healthy food options

Quality priority

Healthy food for staff, visitors and patients – changes to food and drink provision – focus on reducing sugars in drinks on sale

Background

Gloucestershire Managed Service (GMS) is taking action on junk food and obesity by ensuring that healthy food options are available for our patients, visitors and staff including those working night shifts. GMS have been building on work completed by our Catering Department developing a set of patient and staff /visitor menus with reduced salt and sugar in the recipes, hydrogenated Trans fatty acids have been eliminated from the cooking process. The Deli bar has salads, fresh soup, sandwiches, Paninis, jacket potatoes, fresh fruit and takeaway fresh fruit pots. The farm shops in Fosters, Blue Spa and the Glass House promote local produce and the homemade cakes are popular. At breakfast, we now have available porridge, low sugar high fibre breakfast cereals. The hot breakfast option includes traditional fare as well as poached and scrambled eggs, except for fried eggs all breakfast items are baked or grilled.

Traditional theme days promote different food types, throughout the year including BBQ in the summer, traditional Christmas fare; promoting national Nutrition and Hydration week. Menus now have calorie information for those customers who are watching their weight. The introduction of freshly made to order fruit smoothies has been popular with our customers especially in the summer. Unhealthier accompaniments like chips are available at a higher price than plain carbohydrates such as rice and new potatoes to encourage healthy choices.

To meet the CQUIN all chocolate bars are 250 kc or less we have sourced a high quality sugar free chocolate which is popular and there are no price promotions on unhealthy food items. Increased healthier options at till points, and there are no unhealthy promotions. Increased the range of sandwiches to include Paninis.

All homemade sandwiches are 400kc or below and do not exceed the recommended fat levels. We have eliminated all sweetened hot and cold beverages in Fosters, Blue Spa and the Glass House.

CQUIN and government targets are reported regularly to the Trust Health and Wellbeing Committee and the Healthy Workforce (NHS England).

The main focus is further compliance with the CQUIN primarily looking at the **% and** going beyond this where we can.

GMS demonstrates a strong commitment to health and wellbeing, and have sustained the CQUIN over the past two years.

How we have performed

In Year Two (2018/19):

The same three areas will be kept but a further shift in percentages will be required

- **80%** of drinks lines stocked must have less than 5 grams of added sugar per 100ml. In addition to the usual definition of SSBs it also includes energy drinks, fruit juices (with added sugar content of over 5g) and milk based drinks (with sugar content of over 10grams per 100ml).
- **80%** of confectionery and sweets do not exceed 250 kcal.
- At least **75%** of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and do not exceed 5.0g saturated fat per 100g[1].

We will be:-

- **Working with our suppliers to improve offers in the vending services**
  We have worked with our vending contractor to reduce the amount of cold beverages with less than 5 grams of added sugar per 100ml. Sweet snacks have also been reduced to just one run of chocolate in the vending machines which do not exceed 250kcal. 75% of made in house sandwiches Paninis and prepacked meal (wraps, salads, pasta salads) available in vending contain 400kcal (1680 kJ) or less per serving and not exceed 5.0g saturated fat per 100g. All of the above exceeds 80% compliance

- **Reviewing further what is provided out of hours for staff and visitors**
  GMS have a chilled food vendor on each site, filled and maintained by our staff, which offer a range of home cooked chilled ready meals, fruit, yoghurts, sandwiches, savoury snacks and salads

- **Looking at the patients' menu again in spring/summer**
  Continuing with seasonal menus for patients, taking advantage of seasonal produce to reduce menu fatigue

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419245/balanced-scorecard-annotated-march2015.pdf

Plans for improvement 2019/20

- Development of fruit and vegetable stalls
- Expansion of deli bar and chilled produce
- Recipes cards along with the ingredients to purchase

2.4.4 Preventing ill health (CQUIN) – staff flu vaccinations

Quality priority

Improving uptake of flu vaccinations for frontline clinical staff

Background

Influenza is a highly contagious upper respiratory tract disease causing significant morbidity and mortality among high-risk groups. Immunization of frontline healthcare workers in the NHS is considered to be beneficial in reducing subclinical infection, staff sickness absences and protects patients. Each year Public Health England launches the Seasonal Flu Campaign to help reduce influenza transmission by reinforcing the message that it is vital that frontline staff to get vaccinated.

How we have performed

We have used many of elements recommended by NHS Employers to run our Flu campaign during 2018/19.

Communication

- We refreshed our communication campaign with a "takeover" of the National FluFighter Twitter account for a day during the weeklong national jabathon.

- Staff made pledges on placards and said why they got the vaccine to encourage others
- We ran a new email campaign targeting individuals that had not been vaccinated.

Our flu team

- Included staff from all parts of the organisation
- Matrons in all areas led as the peer-vaccinator for their area
- Our outstanding peer vaccinators were treated to Afternoon Tea and received awards for their hard work, kindly sponsored by one of our suppliers.

Supported – all hands on deck

- Champions at all levels of the organisation

Ran a peer vaccination scheme

- Peer vaccinators were our stars going the extra mile to make sure that the vaccination was available to as many staff as they could get to.

Myth busting

- Included myth busting in our communications
- Used clinical evidence to support our communications
- Challenged misconceptions

Accessibility

- Set up mobile flu vaccinations clinics on all wards including at night

Data

79.2% of our patient facing staff received the flu vaccination this year; this is a slight improvement on the previous year. We aimed to reach 85% of frontline staff as an internal target but did meet the external target of 75%.

Next year we are setting our sights high and want to ensure that at least 80% of our patient facing staff have received the flu vaccination. We are developing our plans to ensure ease of access for our staff alongside a vibrant campaign to help staff understand the benefits of protecting themselves and their patients.

Plans for improvement 2019/20

We plan to commence our peer vaccination training in the summer to ensure we are ready to deliver vaccinations as soon as they arrive in early October. We will again use our matrons as the star peer-vaccinators and make this a leader-led initiative.

We will target the high performing peer vaccinators and ensure they are supported to go even further this year.

2.5 Patient experience

2.5.1 Best care for everyone – time to care - Care Hours per Day

Quality priority

To ensure safe staffing levels and implement the new approach to measuring Care Hours per Patient Day (CHPPD) on wards

Background

From May 2016, all acute trusts with inpatient wards/units began reporting monthly CHPPD data to NHS Improvement. Since January 2019 we have collected daily CHPPD from all wards across both main sites. This will allow us to review the deployment of staff on a shift-by-shift basis. When looking at this information locally alongside other patient outcome measures, we will be able to identify how we can change and flex their staffing establishment to improve outcomes for patients and improve productivity.

Nationally, work has begun to consider appropriate application of this metric in other care settings and to include other healthcare professionals such as Allied Health Professionals (AHPs). As with other indicators, CHPPD should never be viewed in isolation but as part of a local quality dashboard that includes patient outcome measures alongside workforce and finance indicators. The aim is to help ward sisters/charge nurses; clinical matrons and hospital managers make safe staffing decisions.

How we have performed

The CHPPD measure is validated daily by matrons and reviewed monthly by the senior nursing and midwifery team to ensure there is effective deployment of staff to meet the needs of patients and in our care. The CHPPD are, by their very nature, variable depending on the clinical area and the types of patients being cared for. The CHPPD measure is also scrutinised monthly by the Quality and Performance Committee where the Director of Quality and Chief Nurse is held to account for the effective deployment of nursing and care staff.

Data

This table details the current funded CHPPD by division and provides the Safer Nursing Care Tool (SNCT) requirement based on the daily January acuity census

Division	Funded CHPPD	SNCT CHPPD
Surgery	7.40	6.2
Medicine	7.57	8.0
Women's & Children (9A)	9.11	8.8

Plans for improvement 2019/20

Measurement of CHPPD 3 times per day by all wards is now underway. Further embedding that and ensuring matrons are routinely validating the census is an area of specific focus for the senior nursing teams. Quarterly staffing summits are held by the Deputy Chief Nurse to review establishments against reported CHPPD to ensure the nursing workforce is deployed and utilised safely and ensures that we remain responsive to varying patient acuity. During the year we aim to ensure daily staffing meetings are based on reported CHPPD and that matrons, site team and the Temporary Staffing Service work together to respond efficiently and effectively to changing needs.

Recommendations from the staffing reviews are to be implemented across divisions and include an uplift to establishments using the new band 4 Nursing Associates, reduction in variation of nurse to patient ratio across the 24 hour period, re-introduction of ward leaders in to staffing numbers twice per week, introduction of matrons in to staffing numbers once per month and a review of other support roles available to ward teams.

2.5.2 Best care for everyone - prevention of pressure ulcers

Quality priority

To prevent pressure ulcers

Background

Avoidable pressure ulcers are a key indicator of the quality and experience of patient care. Despite progress since 2012 in the management of pressure ulcers they remain a significant healthcare problem and 700,000 people in the UK are affected by pressure ulcers each year. Treating pressure ulcers costs the NHS more than £3.8 million every day.

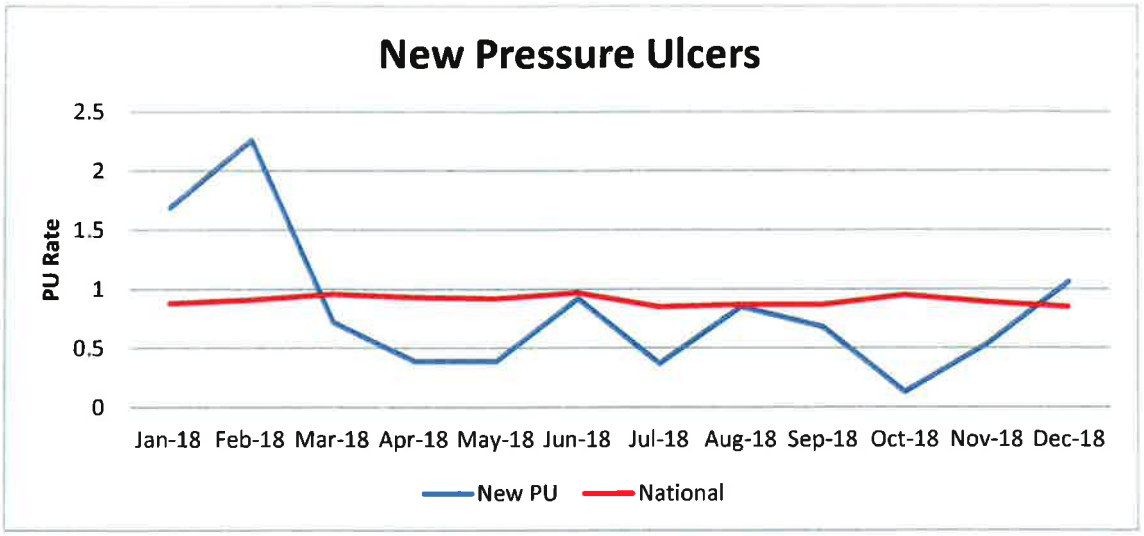
We know that many pressure ulcers are preventable, so when they do occur they can have a profound impact on the overall wellbeing of patients and can be both painful and debilitating (Moore et al 2009). Preventing them will improve care for all our vulnerable patients.

Pressure ulcers are skin and deep tissue damage due to the lack of blood flow due to pressure on the tissue, and underlying vascular structures, developing usually over bony prominences. Pressure Ulcers are classified by the European Pressure Ulcer Advisory Panel (EPUAP, 2009), as four 'grades' from one to four. One is the most superficial, and four is the deepest (including loss of muscle, and often extending to and exposing bone).

How we have performed

The Trust is committed to reduce the number of pressure ulcers developing in patients in our care. To achieve this, the Tissue Viability Team are developing a new programme of work comprising education, audit, equipment provision and learning from investigation.

Data



This figure details the rate of newly reported pressure ulcers in hospital in-patients per month compared to the national average. The trust is consistently below the national average for most of the 2018 calendar year.

The React to Red innovation will continue into 2019/20, following a very successful stop the pressure focus day in 2018.

Plans for improvement 2019/20

The trust will appoint a new Lead Nurse for Tissue Viability giving this important area a renewed focus at a senior level. The team are developing a programme of work to include improvements to the investigation and dissemination of learning from new pressure ulcers. Continued work with our strong cohort of link practitioners. We are exploring ways in which a Registered Dietitian could input in to the team, further enriching our offer for patients.

2.5.3 Best care for everyone - prevention of falls

Quality priority

To prevent falls

Background

Falls are the most commonly reported type of patient safety incident in healthcare. Around 250,000 patients fall in acute and community hospitals each year (NHS England, National Reporting and Learning System, 2016). Over 800 hip fractures and about 600 other fractures are reported. There are 130 deaths associated with falls. Although most falls do not result in injury, patients can have psychological and mobility problems as a result of falling.

Nationally there are more than 200 patient falls reported per month on the incident reporting system from which patients' experience moderate harm injuries (Duty of Candour) or become the subject of Coroners' Inquests. There is an inevitable rate of falls due to the challenges of rehabilitation and patient choice alongside an evidence base of actions that might prevent some falls occurring; the Trust approach so far has been to implement the evidence based practice through the nursing care plan process.

How we have performed

The current falls action plan has largely been completed with a new programme of work being developed by the Trust Falls Group. The programme plan is based on best evidence for the prevention of falls (NICE – Falls in Older People) and learning from incident investigation.

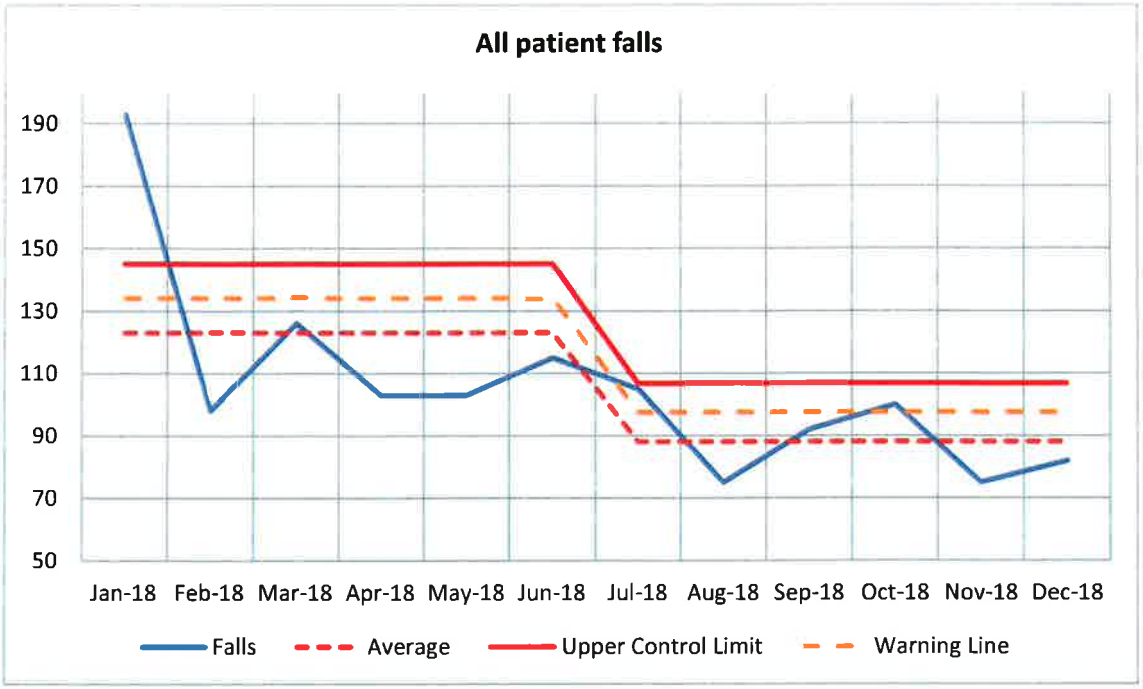
Data

Falls rates based on Datix reports

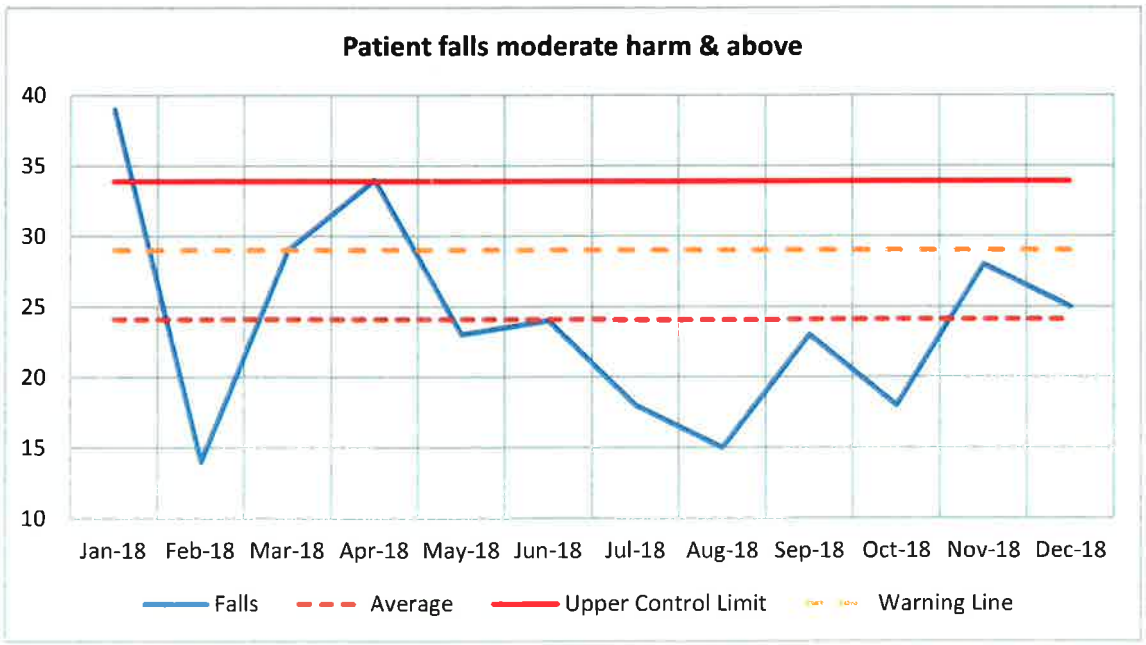
The Royal College of Physicians (RCP) report a fall rate of 6.6 per 1000 bed day rate taken from their college audit of acute hospitals. The National Patients Safety Agency (NPSA) historically report a 4.8 per 1000 bed day rate but include a wider group of Acute Trusts which would include hospitals with naturally low falls rates.

During 2018/19, we have further supplemented our specialist team with a Falls Prevention Specialist Nurse, who will work alongside members of the multidisciplinary team.

Table: All falls (2018)



The data above shows all falls over the 2018 calendar year. There was a statistically significant decrease in average falls from July onwards.



The data above details harm from falls categorised as moderate or above during the 2018 calendar year.

The Trust Falls Group have completed thematic reviews of the root causes of falls looking at the trends and also for any learning. We are participating in the Royal College of Physicians National Audit of Inpatient Falls and this will be reviewed to support the development of our annual programme, which will be presented, to our Quality and Performance Committee in quarter 1 of 2019/20.

Plans for improvement 2019/20

All falls that are categorised as moderate harm or above will have a rapid review completed within 3 days with immediate feedback of any urgent learning points to the clinical areas. The most serious cases will be reviewed weekly by the Trust's established Executive Serious Incidents Panel.

We will commence a programme of teaching of staff groups involved in care giving such as porters, domestics and volunteers. We will also review the clinical staff training. To support the new CQUIN to reduce in-patient falls we will focus on improvement of recording lying and standing blood pressure as part of the falls assessment.

2.5.4 Best care for everyone - to improve experience at the end of life

Quality priority
To improve end of life care

Background
In 2017, we launched Gloucestershire's End of Life Care Strategy. Our Trust Board were the first to sign up to the End of Life Care Charter, confirming a true organisational commitment to end of life care.

How we have performed
Since the launch, a number of departments have embraced the charter ranging from our Emergency Department, to Oncology and Clinical Physiology to the Library.

We successfully appointed a Clinical Lead Nurse for End of Life and a Specialist in Palliative Care, a brand new role to help co-ordinate, deliver and drive forward end of life care. Our Trust based webpages are up and running and our first staff email bulletin went out. This helps to share news on what is happening across the Trust, as well as feedback received from relatives and learning from incidents/complaints.

The End of Life Care Champions have a formal job description, agreed by their line managers and ensuring they are enabled to have time to enhance end of life care within their areas.

Our Clinical Commissioning Group has established a Clinical Programme Group for end of life care and we are one of only 11 CCG's across the country to have done this. One of our medical consultants is deputy chair ensuring that we are at the heart of countywide developments. We will be working to break down cross-organisational boundaries and explore societal changes. Projects have already included a pilot of

Just in Case Boxes to improve access to medications and exploration of "Respect". Respect is a process that creates personalised recommendations for a person's clinical care in a future emergency when or if they are unable to make or express choices.

Gloucestershire held its most successful Dying Matters week with the highest number of contacts with the public the information bus has ever had.

In 2018, we were committed to all clinical areas being signed up to the End of Life Care Charter. Nursing Accreditation and Assessment System (NAAS) data is supporting this achievement.

A key goal of this year is to look at education provision for our staff ensuring that we are able to provide consistent training, which fulfils new national standards for all healthcare professionals. The Trust has committed to supporting mandatory training around EOLC recognising it's cross-cutting importance for all. GHNHSFT was shortlisted as part of the EOLC Clinical Programme Group for a Health Service Journal award and this was highlighted as out-standing practice by the Health Service Journal Awards panel when feedback was given. We are continuing to work with the professional education team to ensure this is appropriate for all of the different professional groups – clinical and non-clinical across the Trust.

Through our End of Life Care Quality Group, we will be sending out quarterly emails to share learning around incident/concerns/complaints, as well as hearing about examples of best practice. We are also working with our Information & Technology colleagues to ensure key aspects of care are including within the new electronic patient record (EPR). There have been further delays to the EPR but we remain in discussion with the relevant teams. Recent introduction of Joining Up Your Information (JUYI) is enabling some access to documented care priorities and key clinical information across the One Gloucestershire system.

Our End of Life Care champions will be running their own event later in the year, showcasing their roles, how they can support colleagues and highlighting the growing resources available to all. Regular champions days have been held throughout this year with a range of out-puts including ward information boards, updated information regarding overnight rooms and comfort measures to ensure relatives are given refreshments when visiting.

We will be continuing to work with the countywide Clinical Programme Group to forward established work programmes. Key projects which will be completed this year include a full review of shared care paperwork for the expected last days of life and a switch of standard medications prescribed at end of life which will result in more consistent supplies through more reliable drug company provision, as well as potentially producing a substantial cost saving without detriment to symptom relief. We will be holding events during Dying Matters week and looking at 'improving the conversation', through initiatives like the 'Knead to Know' project. This initiative

encourages conversations to happen whilst an activity, bread making, is taking place.

Shared care plan was updated and launched countywide in June 2018 with a switch from diamorphine to morphine as standard opioid prescribed. The latter has ensured both a cost saving and more ease of access to the medications. This has also tied in with the use of a 'Just in Case Box/Bag' across the county which provides a consistent 'format' for the medications dispensed and ease of checks.

Data

- We have received over 200 compliments from bereaved families over the care provided to their relatives.
- Our volunteers have made over 500 syringe pump bags for our patients.
- We have named End of Life champions for all clinical areas alongside many from non-clinical departments.
- We were shortlisted for the Health Service Journal Compassionate Patient Care Award.
- We made a change in our pain relief medication practices (opioid) and this has enabled us to save £40k per annum across the county One Gloucestershire area.
- We have received excellent feedback from staff regarding the our newsletters which have enabled dissemination of learning from incidents and complaints as well as learning from excellence in care.
- We have assessed all ward/clinical areas and they have scored green in the NAAS which demonstrates that we are providing high standards of care for our patients.
- Contributed to National Audit for Care at End of Life (NACEL) and our results showed that there were no significant concerns/variation highlighted with our results when compared to other organisations.

Plans for improvement 2019/20

Within our continuous improvement plan we aim to:-

- Further develop our programmes for the education programme for the Trust.
- Embed the Supportive and Palliative Care Indicators Tool (SPICT) prognostication tool into standard practice to improve identification of the likely last year of life.

- Work with One Gloucestershire to adopt ReSPECT plans (Recommended Summary Plan for Emergency Care and Treatment). We recognise that although not an End of Life document, this is vital in supporting patient's to have a voice and a choice.
- A key priority for the coming year is supporting our multi-disciplinary teams to have conversation with people about their plans which will be promoted on Twitter using the hashtag #HaveTheConversation.
- Building on the EOLC Champions work to date with further public and staff events to support.
- Repeat the NACEL audit.
- Alongside countywide partners, develop robust guidance for application of fast track discharge and education around this process.

Part 2.2: Statements of assurance from the board

The following section includes response to a nationally defined set of statements which will be common across all Quality Reports. These statements serve to offer assurance that our organisation is:

- performing to essential standards, such as
- securing Care Quality Commission registration
- measuring our clinical processes and performance, for example through participation in national audits involved in national projects and initiatives aimed at improving quality such as recruitment to clinical trials.

Information on the review of services

The purpose of this statement is to ensure we have considered quality of care across all our services. The information reviewed by our Quality and Performance Committee is from all clinical areas. Information at individual service level is considered within our divisional structure and any issues escalated to the Quality and Performance Committee.

Health Services

During 2018/19 Gloucestershire Hospitals NHS Foundation Trust provided and/ or subcontracted **107** NHS services.

Gloucestershire Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these relevant health services.

The income generated by the NHS services reviewed in 2018/19 represents 86.7% of the total income generated from the provision of the NHS services by Gloucestershire Hospitals NHS Foundation Trust for 2018/19.

Information on participation in clinical audit

From 1 April 2018 to 31 March 2019, 35 national clinical audits and 5 national confidential enquiries covered relevant health services that Gloucestershire Hospitals NHS Foundation Trust provides.

During that period, Gloucestershire Hospitals NHS Foundation Trust participated in 97% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in. Where national audits could not be undertaken then local data was collected and reviewed.

The national clinical audits and national confidential enquiries that Gloucestershire Hospitals NHS Foundation Trust was eligible to participate in during 2018/19 are as follows:

Adult Community Acquired Pneumonia
BAUS Urology Audits: Cystectomy
BAUS Urology Audits: Nephrectomy
BAUS Urology Audits: Percutaneous nephrolithotomy
BAUS Urology Audits: Radical prostatectomy
Bowel Cancer (NBOCAP)
Cardiac Rhythm Management (CRM)
Case Mix Programme (CMP)
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)
Diabetes (Paediatric) (NPDA)
Elective Surgery (National PROMs Programme)
Falls and Fragility Fractures Audit programme (FFFAP)
Inflammatory Bowel Disease (IBD) programme
Learning Disability Mortality Review Programme (LeDeR)
Major Trauma Audit The Trauma Audit and Research Network (TARN)
Mandatory Surveillance of Bloodstream Infections & clostridium difficile infection
Maternal, Newborn and Infant Review Programme Clinical Outcome
Myocardial Ischaemia National Audit Project (MINAP)
National Asthma & COPD Audit programme
National Audit of Breast Cancer in Older Patients (NABCOP)
National Audit of Dementia
National Bariatric Surgery Registry (NBSR)
National Cardiac Arrest Audit (NCAA)
National Emergency Laparotomy Audit (NELA)
National Heart Failure Audit
National Joint Registry (NJR)
National Lung Cancer Audit (NLCA)
National Maternity and Perinatal Audit (NMPA)
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)
National Oesophago-gastric Cancer (NAOGC)
National Ophthalmology Audit
National Prostate Cancer Audit

National Vascular Registry
Sentinel Stroke National Audit programme (SSNAP)
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme

The national clinical audits and national confidential enquiries that Gloucestershire Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2018/19, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:

Audit Title	**Submission Information**
Adult Community Acquired Pneumonia	New for 2018 data collection ongoing
BAUS Urology Audits: Cystectomy	122 87% according to HES for 2015 2016 and 2017 combined
BAUS Urology Audits: Nephrectomy	237 93.24% according to HES for 2015 2016 and 2017 combined
BAUS Urology Audits: Percutaneous nephrolithotomy	65 HES % not provided for 2015 2016 and 2017 combined
BAUS Urology Audits: Radical prostatectomy	399 89.4% according to HES for 2015 2016 and 2017 combined
Bowel Cancer (NBOCAP)	Patients diagnosed between 1 April 2017 and 31 March 2018.
Cardiac Rhythm Management (CRM)	Full submission 100%
Case Mix Programme (CMP)	100% of patients admitted to critical care areas
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	Full Submission of Nationally mandated dataset.
Diabetes (Paediatric) (NPDA)	Data collection is ongoing it is anticipated that we will submit a whole clinic cohort
Elective Surgery (National PROMs Programme)	2017/18 (latest report) 809 were submitted for Hip Replacement and 907 for Knee Replacement
Falls and Fragility Fractures Audit programme (FFFAP)	The Trust is participating and data collection is still ongoing.
Learning Disability Mortality Review Programme (LeDeR)	There have been 16 learning disabilities deaths reported to LeDeR in the last financial year.
Major Trauma Audit The Trauma Audit and Research Network (TARN)	Current case ascertainment rate is 100% +
Mandatory Surveillance of Bloodstream Infections & clostridium difficile infection	100% of identified cases reported.
Maternal, Newborn and Infant Review Programme Clinical Outcome	21 cases between April 18 and Feb 19
Myocardial Ischaemia National Audit Project (MINAP)	75% entered (476 cases submitted for Quarter1-3) 70% required for minimum data standard
National Asthma & COPD Audit programme	COPD 351 for GRH and 210 for CGH Asthma data collection ongoing from November 2018

Audit Title	Submission Information
National Audit of Breast Cancer in Older Patients (NABCOP)	All data from COSD
National Audit of Dementia	CGH 33 GRH 48
National Bariatric Surgery Registry (NBSR)	All cases performed in Gloucester are submitted to NBSR.
National Cardiac Arrest Audit (NCAA)	137 to March 2019
National Emergency Laparotomy Audit (NELA)	Continued submission of emergency laparotomy patients to the audit with over 150 cases in 2018/19
National Heart Failure Audit	Approx. 35% of cases entered to date. 70% required for minimum data standard
National Joint Registry (NJR)	A total of 1964 cases for 2017/18 (540 hips, 658 knees, 45 shoulders , other revision work)
National Lung Cancer Audit (NLCA)	340 Cases for the 2017 audit period
National Maternity and Perinatal Audit (NMPA)	100%
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	100%
National Oesophago-gastric Cancer (NAOGC)	100%
National Ophthalmology Audit	3754 100% of which 3453 were eligible
National Prostate Cancer Audit	699 for a rolling year to Feb 2019
National Vascular Registry	AAA 7 Carotid 62 100% extraction from NVR database
Sentinel Stroke National Audit programme (SSNAP)	875 100%
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	April 2018– March 2019 33 incidents reported to SHOT

National Confidential Enquiries

Child Health Clinical Outcome Review Programme and; Medical and Surgical Clinical Review Programme	Cancer in Children, Teens and Young Adults	Information returned for all national confidential enquiries
	Perioperative Diabetes	
	Pulmonary Embolism	
	Acute Bowel Obstruction	
	Long Term Ventilation	

The reports of 35 of national clinical audits were reviewed (or will be reviewed once available) by the provider in 2018/19 and Gloucestershire Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Audit Title	Was the report reviewed?	Actions taken as a result of audit/use of the database
BAUS Urology Audits: Cystectomy	Individual clinician data is reviewed at a consultant level. The overall results are reviewed at audit meetings and used to highlight specific issues for more detailed review.	Cystectomy wound complication rate and results were reviewed. An improvement has led to the use PICO dressings and a push for enhanced recovery for these patients.
BAUS Urology Audits: Nephrectomy	Individual clinician data is reviewed at a consultant level. The overall results are reviewed at audit meetings and used to highlight specific issues for more detailed review.	Nephrectomy complications and transfusion rates are being reviewed in more detail. The first 20 robot renal cases have been reviewed, the data from which have been submitted as part of the 2018 BAUS.
BAUS Urology Audits: Percutaneous nephrolithotomy	Individual clinician data is reviewed at a consultant level. The overall results are reviewed at audit meetings and used to highlight specific issues for more detailed review.	Length of stay longer than national average, therefore move towards more mini PCNL to reduce length of stay.
BAUS Urology Audits: Radical prostatectomy	Individual clinician data is reviewed at a consultant level. The overall results are reviewed at audit meetings and used to highlight specific issues for more detailed review.	---

Audit Title	Was the report reviewed?	Actions taken as a result of audit/use of the database
Bowel Cancer (NBOCAP)	Annual Report 2018 – Published in December 2018, the majority of the results in this report are for patients diagnosed 1 April 2016 to 31 March 2017. Reviewed at Clinical Governance Meeting on 10 Jan 2019.	Discussed that data ascertainment for CRM involvement was low and encouraged data for the next upload to be reviewed and amended whilst it is still possible to do so. This is felt to be a problem with the data from the GRH site rather than CGH. Rate of a negative CRM looks low compared to other Trusts but this is because this data field was not completed in a large percentage of patients (not a previously reported metric).
Cardiac Rhythm Management (CRM)	National Audit Report, Yearly from NICOR, Report February 2017	Data collected for national database of pacing/ICD/CRT. Report shows rates for pacing per million and also percentage of physiological pacing – a quality standard. We achieved national targets in terms of physiological pacing and number per million for pacing. Our CRT numbers for the last year were lower than expected due to the unexpected retirement of a colleague but are now back within range.
Case Mix Programme (CMP)	Yes at individual unit M&M. Lessons are shared between units at cross county quarterly meetings. The reports provide information on mortality rates, length of stay, etc and provide the Trust with an indication of our performance in relation to other ICUs.	Where trends are identified then these allow us to make recommendations about changes to practice. Standards are reviewed against those proposed as quality indicators by the Intensive Care Society. On the GRH site, DCC is a substantial outlier compared with the rest of the country in terms of: 1. Delayed discharges due to lack of ward beds – outside our control. 2. Out of hours discharges with well documented increase in mortality of those patients –due to lack of ward beds – outside our control.

Audit Title	Was the report reviewed?	Actions taken as a result of audit/use of the database
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	Data is included in the annually produced National Audit Report from NICOR	Data collected both for national audit (see above) and to generate operator specific outcome reports. These are publically available via BCIS or NICOR. Data for last complete calendar year show departmental performance is above expected for case mix using current risk model.
Diabetes (Paediatric) (NPDA)	The latest report is due to be published in May 2019 and will be reviewed within the governance meeting.	This year has seen many improvements within the Paediatric Diabetes team and these are outlined within this report.
Elective Surgery (National PROMs Programme)	Surgical review	---
Falls and Fragility Fractures Audit programme (FFFAP)	Data collection is still ongoing. Once published the report will be reviewed, monitored and discussed at the Trust Falls Steering group meetings that occur quarterly.	The report has not yet been published but actions are taken in real time, these consist of ward learning from the events around the fall and how it was managed.
Learning Disability Mortality Review Programme (LeDeR)	A focus has been placed on trying to work through a backlog dating back to 2017 (including community deaths). 2 Deaths have been reviewed and 2 deaths are about to be reviewed from this financial year.	Since 2017 there have been 13 hospital deaths reviewed. Feedback for improvement has included documentation standards, health records filing, completion of food charts, completion of fluid charts, documentation of capacity assessment, documentation of resuscitation status with patient and family/carers and timely referral to Dietitian. The learning is discussed at the Learning Disabilities steering group meeting. Documentation especially food and fluid charts is included in the learning disabilities face to face training with the newly qualified staff nurses and Acute Care ward staff.

Audit Title	Was the report reviewed?	Actions taken as a result of audit/use of the database
Major Trauma Audit The Trauma Audit and Research Network (TARN)	Report is reviewed quarterly in the trauma network meetings.	Data completion has increased from 56% and is now 92.1% The new TARN co-ordinator streamlined data transfer between the trauma unit and MTC and in conjunction with Business Intelligence Unit has modified the data collection system to improve data collection. The Trusts mortality rate continues to be in line with nation averages.
Mandatory Surveillance of Bloodstream Infections & clostridium difficile infection	Cases reported at board level on a monthly basis and discussed at the Trust Infection Control Committee The various improvements highlighted are reviewed at monthly Infection Control Committee meeting and bimonthly AMS committee.	A comprehensive trust wide C. difficile reduction plan is in place with a focus on reducing potential contamination and improving management of patients with C. difficile infection including the development of Nurse led C. difficile ward rounds. Completion of comprehensive MDT post infection reviews of trust apportioned cases of *C. difficile.* Monthly assurance audits of CDI patient management and practice with CCG and Lead Nurse for IPC and AMS. Improved staff awareness and education programme; with a particular focus of hand hygiene and prompt stool testing and isolation and treatment patients for CDI. Comprehensive Antimicrobial Stewardship strategy which focuses on reducing inappropriate antibiotic usage, review of patients at 24-72hrs of antibiotic therapy, up to date and accessible trust antibiotic prescribing guidelines, staff education and public awareness of AMS.
Maternal, Newborn and Infant Review Programme Clinical Outcome	Yes, all losses over 22 weeks are reviewed at risk meeting then PMRT with results.	There has been no specific actions but learning points are disseminated throughout the service.

Audit Title	Was the report reviewed?	Actions taken as a result of audit/use of the database
Myocardial Ischaemia National Audit Project (MINAP)	Data included in the Annual National Audit Report from NICOR Formal report due out later in 2019	Achieved the minimum standard for data input. To look further at achieving the Best Practice tariff.
National Asthma & COPD Audit programme	The report has not yet been published.	---
National Audit of Breast Cancer in Older Patients (NABCOP)	Reviewed locally. There have been no concerns and the Trust is not an outlier.	No actions required
National Audit of Dementia	The report has not yet been published.	The report will be reviewed by the Dementia Committee when it's published.
National Bariatric Surgery Registry (NBSR)	Local review	---
National Cardiac Arrest Audit (NCAA)	The report is reviewed within the Resuscitation Department and then shared at the Deteriorating Patient and Resuscitation Committee meetings every quarter. The data is also reviewed at year end. The report itself is split into the two different sites for comparison.	We highlight areas where Simulation training would be beneficial, particularly looking at escalation of the deteriorating patient and effective communication of DNACPR decisions in place. We incorporate all data collected within mandatory training to raise awareness of expected survival to discharge from an in hospital cardiac arrest. Benchmarking our status nationally for different outcomes such as; number of CPR attempts, survival to discharge, demographics of patients, locations of arrests, time of arrests etc. We investigate potential non-arrests and unexpected non-survivors highlighted by NCAA. A project is just being commenced looking at why we are consistently above the national average regarding successful resuscitation attempts.

Audit Title	Was the report reviewed?	Actions taken as a result of audit/use of the database
National Emergency Laparotomy Audit (NELA)	Yes – Quarterly joint surgical and anaesthetic NELA meetings to review results and discuss deaths	ELC collaboration continues and we continue to perform well with a mortality rate at CGH of <7%. We continue to strive for greater rates of HDU admission post-op across the trust and for even higher rates of consultant surgeon and anaesthetic led care which is already high. We are soon to introduce new boarding cards to standardise pre op work up. A new elderly care review system was introduced in November 2018 for > 80 year olds post emergency laparotomy as like many centres we had very low rates of elderly care review post operatively.
National Heart Failure Audit	National Heart Failure Audit Annual Report from NICOR later in 2019	There is a plan to increase data input and achieve the minimum standard. To look at achieving the Best Practice Tariff
National Joint Registry (NJR)	Data published in annual report (15th NJR report) Data has been discussed and used for individual surgeons' appraisal.	The Trust received a national award for data quality again this year. Outlier identification and management was undertaken and a review process agreed with Jon Mutimer (Regional Clinical Coordinator for NJR).
National Lung Cancer Audit (NLCA)	The outcomes are reviewed at the lung AGM.	Changes are being planned to amalgamate GRH and CGH MDT. Moving MDT to Wednesday afternoon will facilitate >95% surgical attendance.
National Maternity and Perinatal Audit (NMPA)	The NMPA have delayed the production of the report, it is anticipated that it will be produced in the coming months.	---

Audit Title	Was the report reviewed?	Actions taken as a result of audit/use of the database
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	The information is reviewed at Paediatric governance and neonatal consultants meetings.	Following last year's improvement work on temperature on admission and first consultation data is now above target. A working group is being put together to further explore improvements for chronic lung disease.
National Oesophago-gastric Cancer (NAOGC)	Local review	---
National Ophthalmology Audit	This year's report is due to be published in August 2019 and will be reviewed at a national level by the Royal College of Ophthalmologists'.	The case complexity adjusted PCR rate was 0.8% and the case adjusted visual acuity loss rate was 0.6%, both of these are better than the national average.
National Prostate Cancer Audit		The Trust has not had the manpower to complete this audit annually except for the components that have been part of COSD. Since January 2019 we now have a new role in the CNS Admin team and have started to use the post to enter data so the quality and quantity of the data input will increase
National Vascular Registry	The data is regularly reviewed at governance meetings.	---
Sentinel Stroke National Audit programme (SSNAP)	Ongoing regular reviews at Stroke/TIA business meetings- most recently on 19/3/19	1)Regular reviews of front door targets arranged- these happen on a weekly basis with direct feedback to ED and radiology 2)The audit forms the basis of a therapy business plan for increasing therapists 3) The audit has indirectly helped with plans to open a new Stroke Therapy Unit at the Vale Community Hospital 4) The audit results are regularly used by the stroke team for service improvement planning e.g. thrombolysis and thrombectomy pathways

Audit Title	Was the report reviewed?	Actions taken as a result of audit/use of the database
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	When the SHOT report is issued it is reviewed by GHNHSFT Hospital Transfusion Committee (HTC) who look at the recommendations before any actions are taken by the Trust.	The SHOT 2017 report was published in July 2018 1. The HTC is looking at the SHOT key recommendation for a pre transfusion TACO checklist and is gathering information about how best to proceed. This work is included in the QI Plan for 2019/20 for blood transfusion (the plan was sent to the QI manager in February.) 2. The SHOT key recommendation for implementing all available IT systems to support blood transfusion practice is being considered in the TrakCare development for the pathology modules. This is supported by the HTC. The SHOT report for 2018 will be published in July 2019

The reports of 193 local clinical audits were reviewed by the provider in 2018/19 and these are reviewed and actioned locally. This includes 40 'Silver' quality improvement projects graduated through the Gloucestershire Safety and Quality Improvement Academy (GSQIA) during 2018/19, some examples of actions associated with graduated QI projects are as follows:

General admissions	Improvement in paperwork and processes for storing and recording patients property to reduce loses and improve patient experience and cost of claims
Medications	Facilitating the safe administration of insulin for patients with diabetes to maintain independence and improve patient experience
Learning from excellence	Development of a formal process for capturing excellence to allow learning from positive outcomes as well as from incidents that occur
Staff	Development of a positive staff culture in midwifery by using 'Restorative Clinical Supervision'
Carers	Increasing carers awareness of the support and services that can be accessed

Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by Gloucestershire Hospitals NHS Foundation Trust in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee 1678.

Information on the use of Commissioning for Quality & Innovation (CQUIN) framework

A proportion of Gloucestershire Hospitals NHS Foundation Trust income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between Gloucestershire Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2018/19 and for the following 12- month period are available electronically at *https://www.england.nhs.uk/wp-content/uploads/2019/03/CQUIN-Guidance-1920-080319.pdf.*

For 18/19 the focus of the CQUIN scheme remained the same as 17/18 in that it is intended to deliver clinical quality improvements and drive transformational change. In 18/19 the scheme was updated to reflect the ambitions of the Five Year Forward View Next Steps, the NHS Mandate and the Planning Guidance. For 2018/19 the scheme shifted focus to prioritising STP engagement and delivery of financial balance across local health economies:

There were two parts to the scheme:

1.Clinical quality and transformational indicators – 12 indicators (10 National, 1 local and 1 Armed Forces) have been defined which aim to improve quality and outcomes for patients including reducing health inequalities, encourage collaboration across different providers and improve the working lives of NHS staff.

2.Supporting local areas – 1% of the CQUIN funding has been earmarked to support the development of Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) – reinforcing the critical role local partners have to deliver system wide objectives. This looked like:

- 1.5% eligible contract value for National CCG commissioned CQUINS
- 1.0% eligible contract value for CCG STP
- 2.0% eligible contract value for Specialised Commissioned CQUINS

- 2.0% eligible contract value for Armed Forces

In 2018/19 the Trust agreed a year end contract settlement with NHS Gloucestershire Clinical Commissioning Group (GCCG) and their CQUINS were included as a block agreement with no further financial risk for their commissioned CQUINs, the blocked figure was £7,161.200 (2017/18: £7.3m) however GHT committed to continue to deliver and report CQUINS as they contribute to quality outcomes in line with Trust objectives.

Prescribed Specialised Services (PSS) CQUIN is forecast at £1,076.373 (Although the overall contract is blocked this is achieved by a balancing adjustment but with a variable CQUIN element). We have therefore not agreed with the commissioner the CQUIN payment yet and if they reduced our CQUIN allocation it would be balanced with a payment elsewhere.
South Worcestershire is the same as PSS with a forecast of £203.426 and an Armed Forces contribution of £7,746.

We will not know the full CQUIN position until early June when CQUIN eligibility has been agreed based on a review of our target compliance. It is also dependent on agreement of the year end income positions that the CQUIN is associated with.

18/19 CQUINS:

CQUIN	Description	18/19 Value (£)	Achieved
Medicine Optimisation (PSS)	To support the procedural and cultural changes required fully to optimise use of medicines commissioned by specialised services.	499,802	499,802
Dose Banding (PSS)	Implementation of nationally standardised doses of SACT using the dose-banding principles and dosage	499,802	4996,802
Spinal Hub (PSS)	To establish and operate regional spinal surgery networks, data flow and MDT for surgery patients. To promote the better management of spinal surgery by creating and supporting a regional network of a hub centre and providers	166,601	124,950
Enhanced Supportive Care (PSS)	Implementation of the Enhance Supportive care approach for cancer and non-cancer services-early referral to a Supportive Care Team to secure improved outcomes and avoidance of	166,601	166,601

	inappropriate aggressive treatment		
Armed Forces Covenant	Embedding AF covenant	7,746	7,746
Health & Wellbeing (CCG)	Improving the support available to NHS staff to help promote their health and wellbeing in order for them to remain healthy and well: a)HR/staff survey questions b) Food c) Flu vaccinations	861,450	Tbc-no Q4 outcome report from CCG
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) (CCG)	Timely identification, treatment and review of patients with sepsis in ED and acute inpatient settings, Reduction in antibiotic consumption per 1,000 admissions	861,450	tbc
Improving services for people presenting to A&E with MH issues (CCG)	Ensuring that people presenting at A & E with MH needs have these needs met more effectively through an improved, integrated service, reducing their future attendance at A&E	861,450	tbc
Advice and Guidance (CCG)	To improve GP access to consultant advice prior to referring patients in secondary care.	861,450	tbc
Supporting Proactive & safe discharge (CCG)	Supporting proactive and safe discharge. Emergency Care Data Set (ECDS). Increasing proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within 7 days of admission by 2.5% points from baseline.	861,450	tbc
Preventing ill health by risky behaviours – alcohol and tobacco	To help deliver on FYFV objectives particularly around the need for a '…radical upgrade in prevention…' and to '…incentivising and supporting healthier behaviour' (alcohol and tobacco) Also supports delivery against	861,450	tbc

(CCG)	the FYFV efficiency target by generating a projected national net cost-saving.		

2018/19 Performance to Q3:

CCG commissioned: Q1 – Q3 performances across the board were generally good with no financial impact due to the year-end contract agreement with GCCG – however the position is still unclear for SWCCG. Final Q3 position awaiting confirmation and no Q4 report from commissioners yet. With no block agreement we have incurred financial penalties but this is difficult to quantify. The WCCG CQUIN value overall is £203k of eligible contract value

CQUINs that missed their milestones Q1-Q3:

1. **Reducing the impact of Serious Infections (Antimicrobial Resistance and Sepsis) –**
    - 1a) Timely identification in ED and IP to include NEWS2 (target -90% within 1 hour
      by Q4) – achieved for Q1, Q2 and Q3 in all areas
    - 1b) Timely Treatment within 1 hour in ED and IP (90% target –NEWS2 in Q3-Q4 must
      also be 90%):
      Q1 – partial achievement (ED -86%; IP 76%)
      Q2 – partial achievement (ED 76% ; IP 83%)
      Q3 – partial achievement (ED 84%; IP 82%)
    - 1c) Review within 72hours (meet review criteria and IV oral switch assessment for antibiotic prescriptions)
      Q1 and Q2 – achieved
      Q3 – failed to achieve IV assessment target of 75% (51%)
    - 1d) reduction in consumption – Q4 final assessment on consumption but indicative results show we are unlikely to achieve the overall reduction target of 3%
2. **Improving services for people presenting to A&E with MH issues:** Good work between providers and requirements to maintain 20% reduction in attendances for this cohort of patients has been successful up to Q3, however ECDS data submission is part of reporting requirements and are currently not possible with Trak so Q3 was not achieved purely because of lack of ECDS reporting and not the good work with patients.
3. **Advice & Guidance:**
   2 day (80%) and 5 day (95%) standards and rollout criteria for A&G were achieved in Q1; Not achieved Q2 as both targets were not met; Q3 both

standards were met but rollout target was not met due to delay in Ophthalmology going live, therefore not achieved for Q3

4. **Supporting Proactive and Safe Discharge** – Q1 not achieved; Q2 achieved because a plan was submitted; Q3 was not achieved, despite work beginning, because there was no consistent improvement in core metrics
5. **Preventing ill health by risky behaviours** – Tobacco and alcohol: audits for each with targets against a baseline:
    - Tobacco Screening
    - Tobacco Brief Advice
    - Tobacco referral & med offer
    - Alcohol Screening
    - Alcohol Brief advice & referral

    Q1 and Q2 – targets achieved
    Q3 – partial achievement because 3 elements –*Tobacco Screening*, B*rief Advice* and *Alcohol Brief advice & referral* – did not meet the minimum requirements of 10% improvement on previous quarter.
6. Health and Wellbeing:
    a) HR/staff survey questions – has not achieved the improvement required
    b) Food – waiting Q4 report
    c) Flu vaccinations – achieved the target of 75%

Specialised commissioned: generally performing well

7. Medicines Optimisation – significant effort has resulted in full achievement Q1-Q4
8. Dose Banding SACT – significant effort has resulted in full achievement Q1-Q4
9. Spinal Hub – No Q1 report required; Q2 achieved; Q3 partial payment – Q4 achieved
10. Enhanced Supportive Care – Q1-Q4 achieved
11. Armed Forces – full achievement likely

2019/20 CQUINS:
From 1 April 2019, both the CCG and PSS schemes are being reduced in value to 1.25% and 0.85% respectively with a corresponding increase in core prices, allowing more certainty around funding to invest in agreed local priorities. A maximum of 5 indicators have been prescribed nationally for each contract, however, for GHT we have agreed one PSS CQUIN and for GCCG – and WCCG and associates – we have agreed five schemes. (See table below)

Medicines Optimisation (NHSE PSS)	4 Areas to improve the management of medicines: • Minimise chemotherapy waste • Reducing unwarranted clinical variation between centres by auditing prior approvals	£581,869

	(Blueteq) of NHSE commissioned drugs • Faster adoption of prioritised best value medicines and treatment at local level • Anti-fungal stewardship – reduce inappropriate use and prevent development of resistance to antifungals	
CCG1 – Antimicrobial resistance – 1a) lower UTI in older people; 1b) antibiotic prophylaxis in elective colorectal surgery	Prioritise AMR and stewardship: 1a) Reducing inappropriate antibiotic prescribing, improve diagnosis, treatment and management of p[patients with UTI 1b) Implement NICE guidance for Surgical Prophylaxis to reduce number antibiotic doses used for colorectal surgery and improve compliance with antibiotic guidelines	£840,663
CCG2- Staff flu vaccinations	Achieving 80% uptake of flu vaccinations by frontline clinical staff as a crucial lever for reducing spread of flu during winter months, where it can have significant impact on the health of patients, staff, their families and the overall safe running of NHS services	£840,663
CCG3- Screening and Brief advice for tobacco and alcohol use in inpatient settings	Part of the ongoing programme to deliver the Long Term Plan and a key component of alcohol and tobacco users path to cessation: 3a) Alcohol & Tobacco screening 3b) Tobacco – Brief Advice 3c) Alcohol – Brief Advice	£840,663
CCG7- Three high impact actions to prevent hospital falls	Taking 3 actions as part of a comprehensive multi-disciplinary falls intervention – resulting in fewer falls, reducing length of stay and treatment costs	£840,663

CCG11 Same Day Emergency Care (SDEC):	These conditions are from the top 10 conditions with which patients present in a SDEC setting. Each has set of clear actions to be taken by providers to improve same day treatment and pressure for hospital beds, improving length of stay and patient experience: **11a) PE** **11b) Tachycardia with AF** **11c) Community acquired pneumonia**	£840,663
Armed Forces	Armed Forces CQUIN	£4,451

Care Quality Commission (CQC)

Gloucestershire Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is "Good". Gloucestershire Hospitals NHS Foundation Trust has no conditions on registration. The Care Quality Commission has not taken enforcement action against Gloucestershire Hospitals NHS Foundation Trust during 2018/19.

Gloucestershire Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Secondary uses services data

Gloucestershire Hospitals NHS Foundation Trust submitted records during 2018/19 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data: which included the patient's valid NHS number was:

99.8% for admitted patient care

100% for outpatient care and

98.9% for accident and emergency care.

Which included the patient's valid General Medical Practice Code was:

100% for admitted patient care;

100% for outpatient care; and

99.3% for accident and emergency care.

Data quality: relevance of data quality and action to improve data quality

Good quality information underpins the effective delivery of safe and effective patient care. Reliable data of high quality informs service design and improvement efforts. High quality information enables safe, effective patient care delivered to a high standard.

High quality information is:-

1. Complete
2. Accurate
3. Relevant
4. Up to date (timely)
5. Free from duplication (for example, where two or more difference records exist for the same patient)

Gloucestershire Hospitals NHS Foundation Trust will be taking the following actions to improve data quality

- Identification, review and resolution of potential duplication of patient records
- Monitoring of day case activity and regular attenders
- Gathering of user feedback
- All existing reports have been reviewed and revised
- Routine DQ reports are automated and are routinely available to all staff on the Trust intranet via the Business Intelligence portal 'Insight'
- The Trust continues to work with an external partner to advise the Trust on optimising the recording of clinical information and the capture of clinical coding data.
- Gloucestershire Hospitals NHS Foundation Trust regularly send data submissions to SUS and via these submissions we receive DQ reports back from SUS. Based on SUS DQ reports we action all red and amber items highlighted in report to improve Data Quality.
- In data published for the period April 2018 to March 2019, the percentage of records which included a valid patient NHS number was:
    - 99.8% for admitted patient care (national average: 99.4%)
    - 100% for outpatient care (national average: 99.6%)
    - 98.9% for accident and emergency care (national average: 97.6%)
- The percentage of published data which included the patient's valid GP practice code was:
    - 100% for admitted patient care (national average: 99.9%)
    - 100% for outpatient care (national average: 99.8%)

    - 100% for accident and emergency care (national average: 99.3%)
- A comprehensive suite of data quality reports covering the Trust's main operational system (TRAK) is available and acted upon. These are run on a daily, weekly and monthly
- These reports and are now available through the Trust's Business Intelligence system, Insight. These include areas such as:-
    - Outpatients including attendances,
    - Outcomes, invalid procedures
    - Inpatients including missing data such as
    - NHS numbers, theatre episodes
    - Critical care including missing data, invalid
    - Healthcare Resource Groups
    - A&E including missing NHS numbers,
    - Invalid GP practice codes
    - Waiting list including duplicate entries, same day admission

On a daily basis any missing/incorrect figures are highlighted to staff and added or rectified. Our Trust Data Quality Policy is currently under review.

Most of the Trust systems have an identified system manager with data quality as a specified duty for this role. System managers are required under the Clinical and Non- Clinical Systems Management Policy to identify data quality issues, produce data quality reports, escalate data quality issues and monitor that data quality reports are acted upon.

Data Quality is now part of the yearly mandatory training package for staff – a signed statement is needed that tells staff that DQ is everyones responsible to ensure good quality and clinically safe data.

Information Governance Assessment Report

NHS Digital have released a new Data Security and Protection Toolkit (which replaced the Information Governance Toolkit) during 2018/19. All organisations that have access to NHS patient data and systems must use the toolkit to provide assurance that they are practising good data security and that personal information is handled correctly.

The standards assessed within the Data Security and Protection Toolkit are based on the National Data Guardian's ten published Data Security Standards and provide an overall test of the quality of data systems, standards and processes within an organisation.

The Trust's 2018/19 self-assessment published 31.03.2019 has a status of "Standards not Met". There were two areas of non-compliance:

- The Trust achieved 87% against a mandatory target of 95% for staff completing annual Information Governance refresher training
- A specific requirement that a Penetration test be conducted in the previous 12 months to confirm that all networking components have had their default passwords changed was accidentally omitted from the test specification

An Improvement Plan to deal with these issues before 30 September 2019 has been developed and submitted to NHS Digital and will form the basis for the Trust's Information Governance immediate work plan during 2019 /2020.

Approval of the improvement plan by NHS Digital is awaited – at this point the publication status will be changed to "Standards not fully met (Plan Agreed)'.

In addition to monitoring against the DSP toolkit self-assessment tool, risks to data security within our Trust are managed through multiple technical, process and governance controls. We use the National Security Centres "10 steps to Cyber-Security" as a framework for our data risk management.

Technical controls include software applications for anti-virus (server and desktop), anti-spamming, firewall protection, internet filtering and software patching for IT infrastructure (servers, networks, and PCs.). New technical controls for 2018/19 have included implementation of vulnerability scanning and asset discovery.

Process controls include subscription to national CareCERT alerts and a process for tracking the implementation of these alerts. A major cyber incident response plan is in place (countywide as network is across STP partners), and is part of ongoing review.

Governance controls include monthly countywide cyber security forums, risks review through monthly IM&T boards, and quarterly Information Governance forums. Risk escalation is as per the Trusts risks management policy.

The Trust's continuing improvement plans for 2019/20 include achieving Cyber Essentials Plus accreditation. This is a government supported, industry led scheme to assess and manage levels of protection against on-line threats.

During 2018-19 key Information Governance policies have been reviewed for compliance with the General Data Protection Regulation including the introduction of a specific Data Protection and Confidentiality Policy.

The effectiveness and capacity of these systems is routinely monitored by our Trust's Information Governance and Health Records Committee.

Information governance incidents are reviewed and investigated throughout the year and reported internally through the Trust's Information Governance and Health Records Committee.

Any incidents which meet the criteria set out in NHS Digital Guidance on notification, based on the legal requirements of the General Data Protection Regulation (GDPR) and guidance from the Information Commissioner's Office (ICO) are reported to the ICO through the DSP Toolkit where they may also be monitored by NHS England.

Summary of Incidents reported to the Information Commissioner's office in 2018–19 under Article 33 GDPR

Summary of breach	Category
3rd party sensitive information disclosed in error, as part of request for copy of patient record.	Confidentiality
Unavailability of record resulting in distress and repeated test	Unavailability
Adopted child's new name disclosed in error.	Confidentiality

Summary of confidentiality\ incidents internally reported 2018–19

Reportable breaches (detailed above)	3
Number of confirmed Non-reportable breaches	123
Number of no breach / Near miss incidents.	225
Total number of confidentiality incidents internally reported	351

A large number of the near miss reported incidents relate to lost SmartCards which are disabled on reported as missing.

Examples of non-reportable breaches were documents left insecure in a public place, incorrect information documented and information sent to the wrong destination. Process reviews of trends of incidents are planned for 2019/20 to identify areas and opportunity for improvement.

Clinical coding

Gloucestershire Hospitals NHS Foundation Trust was not subject to the "Payment by Results clinical coding audit" during 2018/19.

Learning from deaths

During 2018/19 1949 of Gloucestershire Hospitals NHS Foundation Trust patients died. This comprised of the following number of deaths which occurred in each quarter of that reporting period:

- 460 in the first quarter

- 463 in the second quarter
- 475 in the third quarter
- 551 in the fourth quarter

These quarterly results are broken down by Division as follows:

Division	Q1 Total	Q2 Total	Q3 Total	Q4 Total	Divisional Year Total
Surgery	82	88	76	112	358
Medicine	344	344	367	394	1449
D&S	26	23	31	38	118
W&C	8	8	1	7	24
TOTALS	**460**	**463**	**475**	**551**	**1949**

[Data Quarters 1 – 3 only, Quarter 4 not yet available]*

- The total number of deaths across all Divisions for the reporting year 2018/19 is 1949 of which 100% are reviewed by the Medical Examiner as per Trust policy.

- Of these 1949 deaths, 272* were subjected to a detailed investigation by way of satisfying the criteria to trigger a Structured Judgement Review (SJR).

- Of these 272* SJRs carried out, 20* identified that the cause of death is judged to be more likely than not to have been due to problems in the care provided to the patient.

- Therefore, across all four Divisions for Quarters 1 – 3:

  - The percentage of deaths which resulted in an SJR = 5.8%.

  - Out of all 272 SJRs conducted, the percentage of deaths identified as having sub-optimal care as a contributing factor = 8.1%.

  - Therefore, out of the total number of deaths reported across the Trust, the percentage of deaths for which sub-optimal care was a contributing factor = 0.2%.

Learning themes from all deaths reported, with particular focus on any sub-optimal care, are brought on a monthly basis to the Hospital Mortality Group by the Divisional Mortality representative from where recommended suggestions for improvements

are passed on to the relevant committee or group. A summary of recent learning themes can be seen in Table 2. It should be noted that excellence in care is also reported and that learning from this is valued and shared.

The above data is taken from the following sources:

1. Mortality stats report on the BI tool – Insight;
2. SJR stats taken from Datix;
3. Quarterly Learning from Deaths Reports authored by the Medical Director and taken through Quality & Performance Committee and then on to Main Board;
4. Outcomes from the monthly Hospital Mortality Group, chaired by the Medical Director.

Additional information is provided in the supporting tables:

- Table 1 – breakdown of above data
- Table 2 – Summary of Learning Themes to come out of the SJR process
- Table 3 – Learning from Deaths – Using the SJR methodology

Table 1: Quarterly Breakdown of deaths which triggered an SJR and any poor care attributable

Surgical Division	No. of deaths	No of ME reviews	No. of SJRs triggered	No. of deaths where poor care identified as a contributing factor
Q1	82	82	9	0
Q2	88	88	29	1
Q3	76	76	30	1
Q4	112	112	*	*
Year Totals	**358**	**358**	**68***	**2***

Medical Division	No. of deaths	No of ME reviews	No. of SJRs triggered	No. of deaths where poor care identified as a contributing factor
Q1	344	344	43	2
Q2	344	344	46	8
Q3	367	367	81	7
Q4	394	394	*	*
Year Totals	**1449**	**1449**	**170***	**17***

D&S Division	No. of deaths	No of ME reviews	No. of SJRs triggered	No. of deaths where poor care identified as a contributing factor
Q1	26	26	15	1
Q2	23	23	6	0
Q3	31	31	13	0
Q4	38	38	*	*
Year Totals	**118**	**118**	**34***	**1***

W&C Division *[N.B – Paediatrics follow their own review process)*	No. of deaths	No of ME reviews	No. of SJRs triggered	No. of deaths where poor care identified as a contributing factor
Q1	8	8	0	0
Q2	8	8	0	0
Q3	1	1	0	0
Q4	7	7	0	0
Year Totals	**24**	**24**	**0**	**0**

2018/19 Summary by Division

Division	No. of deaths	Total No of ME reviews	No. of SJRs triggered	No. of deaths where poor care identified as a contributing factor
Surgery	358	358	68*	2*
Medicine	1449	1449	**170***	**17***
D&S	118	118	**34***	**1***
W&C	24	24	**0**	**0**
TOTALS	**1949**	**1949**	**272****	**20****

In percentage terms, by Division:

Division	Total no. of deaths for Quarters 1 – 3	% of SJRs vs total number of deaths – Qs 1 to 3	% where sub-optimal care was identified vs no. of SJRs undertaken	% of sub-optimal care identified vs total number of deaths – Qs 1 – 3
Surgery	246	27.6	2.9	0.8
Medicine	1055	11.9	16.11	1.6
D&S	80	42.5	2.9	1.2
W&C	17	0	0	0
Totals	**1398**	**5.8**	**8.1**	**0.2**

An assessment of impact is that this work has been significant as many service changes and improvements have resulted from death reviews within this reporting period and our areas for improvement and the areas where we have achieved high standards of care are evidenced in Table 2 below.

Table 2: Learning Themes for Service Changes for Hospital Mortality Improvement Group to focus on

SUMMARY OF LEARNING AND IMPROVEMENT AREA THEMES / LEARNING POINTS FROM SJRS REPORTING SUB-OPTIMAL CARE	
1.	Recognising the possible negative effect on possible outcome of: ➢ Loss of notes ➢ Inadequate documentation ➢ Delayed referral to other Specialties ➢ Delayed reviews or inadequate reviews at weekends.
2.	Failure to review DS from previous admission which might have led to more aggressive treatment.
3.	Importance of holistic approach to complex elderly patients.
4.	NIV to only be delivered by adequately trained staff in respiratory high-acuity bay (if at GRH).
5.	Nursing staff should be advised on how to manage (and document care of) interventions such as femoral catheters.

Table 3: Learning Themes for Service Changes for Hospital Mortality Improvement Group to focus on that need to be replicated and spread

SUMMARY OF LEARNING THEMES / LEARNING POINTS FROM SJRS REPORTING EXCELLENT CARE	
1.	Early prescription of symptomatic medications and given in line with palliative care wishes.
2.	Early implementation of shared care plan in frail terminal patient
3.	UP forms filled out appropriately.
4.	Early recognition that the patient was in the terminal phase of life.
5.	No anticipatory medication used but always documented in notes that patient was comfortable.
6.	Good communication with family at all stages.
7.	Learning point – In situations where large doses of strong analgesics are being used consider further patient review, examination and investigation
8.	Prompt assessment and management.

The number of case record reviews in 2016/17 was not recorded.

The number of case record reviews 2017/18 was 998 (48%).

The number of case record case record reviews for 2018/19 was the total number of deaths across all Divisions for the reporting year 2018/19 is 1949 of which 100% are reviewed by the Medical Examiner as per Trust policy.

We did not collect this data for 2017/18 in this format but will be able to report this in the next Quality Account.

Gloucestershire Safety &
Quality Improvement Academy

Gloucestershire Hospitals NHS
NHS Foundation Trust

Learning from deaths:

Using the structured judgement review methodology

Nicky Holton, Divisional Risk Manager, Surgical Services

Thanks to Leta Beard, Datix Administrator, Hospital Mortality Group, Bereavement Team and Mortality leads

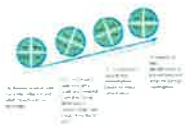
1.Background

The Royal College of Physicians commenced a programme in 2016 to introduce a standardised methodology for reviewing case records of adult patients who have died in acute general hospitals in England and Scotland. The primary goal was to improve healthcare quality through qualitative analysis of mortality data using a standardised, validated approach linked to quality improvement activity. GHNHSFT introduced a policy for reviewing deaths in 2017 based on the structured judgement review (SJR) tool. The policy identified a number of triggers for which deaths were to be reviewed. To support this implementation the Datix incident reporting system was modified to report in hospital deaths and reporting commenced by the bereavement team in January 2018. The new tool required a culture change in how mortality was reviewed in the organisation and raised concerns regarding responsibilities, workload and resource which needed to be overcome.

2. Aims (6 month project)

1. To increase the numbers of SJR undertaken Trust wide by 50%
2. To introduce and improve the numbers of key learning messages identified Trust wide by 50%
3. To design and complete reports for key divisions, specialties and expert groups

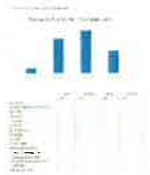
3. How it was achieved



4. What the project achieved?

Divisional/Specialty reports

Expert Group Report



Datix User Guides

Key Learning Messages

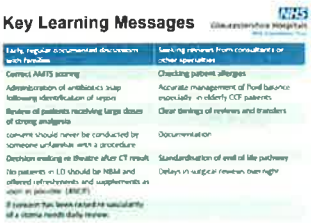
Performance Monitoring

SOP

Number of SJRs completed - **81% improvement**

Number of key messages completed **150% improvement**

Example of key learning Messages



5. Conclusion

The project achieved its aims in increasing the numbers of SJRs undertaken by 81% and the number of key learning messages identified by 150%. The success was influenced by the work of the Hospital Mortality Group members raising the profile of SJRs and the Registrar review project from September 2018. 4 specialty reports, 2 divisional presentations and one expert group report were completed with positive feedback received.

6. Next Steps

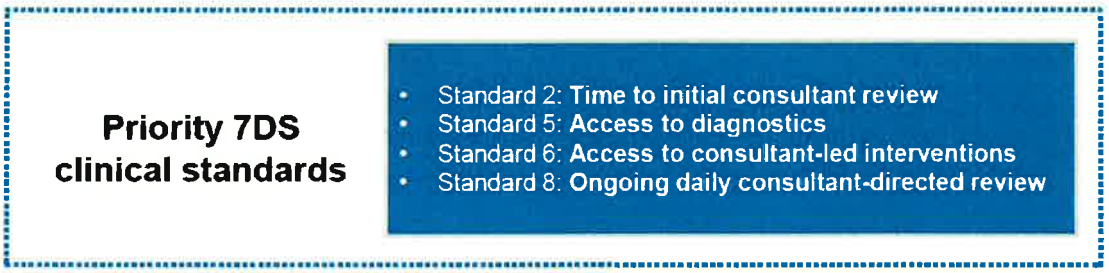
1. Continue to improve engagement by extending reports to other specialties and expert groups
2. Improve timeliness of SJR completion and quality assure process
3. Circulation of key learning via newsletters, posters etc
4. Improve multidisciplinary involvement in SJRs
5. Clarify links between SJRs and duty of candour/serious incidents
6. Further interrogate datix to investigate specific concerns

Seven day services

The seven day services (7DS) programme is designed to ensure our patients that are admitted as an emergency, receive high quality consistent care, whatever day they enter hospital.

What do seven day services mean for patients?

We are working to meet the four standards identified as being 'must do' by 2020.



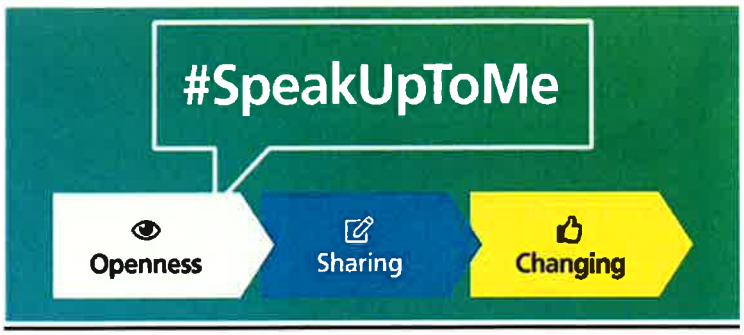
This will ensure our patients admitted to hospital in an emergency:

- don't wait longer than 14 hours to initial consultant review
- get access to diagnostic tests with a 24-hour turnaround time — for urgent requests, this drops to 12 hours and for critical patients, one hour
- get access to specialist, consultant-directed interventions
- with high-dependency care needs receive twice-daily specialist consultant review, and those patients admitted to hospital in an emergency will experience daily consultant-directed ward rounds

NHS England changed the process on 24 October 2018, whereby they are replacing the self-assessment survey for 7 day services with the Board Assurance Framework. The formal requirements were outlined to the Trust on the 28 November 2018. A compliance report was submitted for assurance to our Quality and Performance Committee in February 2019 as the requirement was to complete a trial run by February 2019, with full implementation planned of the new framework by June 2019.

Freedom to Speak Up (Gosport)

Gosport Inquiry recommendations



Effective speaking up arrangements protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is an indicator of a CQC well-led Trust. We have been rated in the Well Led Domain as "Good" and our improvement work in this area was acknowledged.

Our Freedom to Speak up Guardian is Suzie Cro. Freedom to Speak Up Guardians are appointed and employed by the Trust, though their remit requires them to act in an independent capacity. Guardians are trained, supported and advised by the National Guardian Office. All Guardians are expected to support their Trust to become a place where speaking up becomes business as usual. The role, supporting processes, policy and culture are there to meet the needs of workers in this respect, whilst also meeting the expectations of the National Guardian's Office.

Key issues to note

- The Freedom to Speak up Guardian (FTSUG) has 1 day a week allocated to lead this work but the workload has significantly increased.
- Each appointment is 1 hour long and people often need 1 or 2 follow up appointments.
- Engagement activities have continued across the sites promoting the role as much possible but this has been significantly reduced because of capacity issues.

Data reported to the National Guardian's Office (NGO)

Concerns	End of year 2017/18	April – June Q 1	July – Sept Q 2	Oct- Dec Q 3	Jan – March Q 4	Totals 2018/19
Number of people raised directly with the Freedom To Speak Up	31	9	20	25	11	**65**

Concerns	End of year 2017/18	April – June Q 1	July – Sept Q 2	Oct- Dec Q 3	Jan – March Q 4	Totals 2018/19
Guardian						
Number of issues raised anonymously	4	9	3	3	0	15
Nature of issue						
- Patient quality issues	17	1	10	8	2	20
- Staff experience – unacceptable behaviour (bullying / harassment)	19	3	12	23	9	47
Action	Support and advice	Yes	Yes	Yes	Yes	All staff provided with support and advice
Outside referral	0	0	0	0	0	0
Number of case where people indicate detriment	1 case	None	None	None	None	0
Of the people asked in this quarter who would speak up again	The majority of individuals would speak up again.	Yes 100%	Yes 100%	Yes 100%	Yes 100%	Yes 100%

Themes and trends

- <u>Staff groups Q4</u>
    - 0 Medical Staff
    - 6 Nurses
    - 0 midwives
    - 2 HCAs

- 1 AHP
- 1 Corporate staff
- 0 Admin staff
- 0 GMS staff
- 4 other

- Themes
  - Bullying and harassment is the most common reason to request to see the FTSUG.
  - The next common reason this quarter was the lack of consultation through organisation change (Winter Pressures).
  - There were no anonymous cases in Q4 and 3 cases in Q3 were
    - Infection control practices
    - Staff behaviours x 2

Case studies

Case study 1
A band 5 member of staff (non-nursing) came to see the FTSUG about alleged bullying in the workplace. The staff member had tried to raise concerns with the individual directly but this had made no impact. The staff member raised concerns with their line manager who expressed that this was way the individual always acted so advised that they should learn to cope. The line manager was thought to have taken no actions.

The staff member came to see me as FTSUG to talk about their concerns as they felt that they were not being listened to.

Support
The staff member was very distressed as the alleged bullying had continued for many months. The FTSUG listened.
The FTSUG advised about staff support services but advised there was currently a 3 month delay in obtaining an urgent appointment. Advice was given about seeking support from their own GP.

Advice
The Dignity at Work Policy was reviewed together and the next steps that the individual could take. They choose to go back and speak to their line manager. They were invited to come back and have a 2nd appointment after their meeting.
They were advised about leadership development opportunities and the coaching opportunities available to them.
They were offered HR support and advice for investigation of their concerns.

Follow up
The FTSUG contacted the individual to ask for an update after their meeting on several occasions and got no reply.

Investigation

There was no investigation into the alleged issues but this was at the request of the individual even though this was available through the Dignity at Work Policy.

Outcome and resolution
- They apologized for not getting back to me sooner.
- Unfortunately they felt that the issues that they discussed with me (with all the will) would not ever have changed.
- For these reasons, they chose to leave the trust and have taken employment elsewhere. They advised me that they were not alone with their thoughts. People have left before them for the same reasons and they know that a few more people are considering the same.

Feedback for the FTSUG
They took the opportunity to thank you the FTSUG for the "wonderful work" that they do. As much as in this instance their situation did not resolve, it was still nice to have someone to speak with and they will certainly take away with them all of my advice. They thanked the FTSUG once again.

Case study 2
The FTSUG had a call from a distressed member of staff and they asked to see me urgently about alleged bullying and harassment in the workplace. The staff member had not yet raised concerns with their line manager as they were the one who they were having issues with.

Support
The staff member was very distressed as felt that they had had the "wind knocked out their sails". They had lost all confidence in their abilities. They had not been sleeping for a month. They were very stressed and were considering going off sick due to stress. As FTSUG I listened and then offered advice.

Advice
The Dignity at Work Policy was reviewed together and the next steps that the individual could take. They choose to go back and speak to their line manager but before they did they agreed to go and have some coaching with the Leadership and OD team to enable them to have a "difficult" conversation with their line manager. The aim of the coaching was to give them the confidence to do this.

Follow up
The individual contacted me after their 1st coaching conversation and the first conversation with their line manager had gone really well. The contacted me after their second coaching conversation and they were very happy as again the conversation again had gone well.

Investigation
There was no investigation into the alleged incident but this was at the request of the individual even though this was available through the Dignity at Work Policy. They chose to manage this through local resolution and informal processes.

Outcome and resolution
The issues have been resolved for them with the outcome they wanted.

Feedback for the FTSUG
Overall, they now feel that they have closure and can move forward now. They wanted me to know helpful myself and their leadership coach have been. It has helped immensely to know that they have a voice in what sometimes can feel a very overwhelming 118rganization – one of many staff. To be listened to and supported has been enough to give them the ability and confidence to rectify the situation.

Learning and feedback

The FTSUG requests closure for each case and any learning from the case is shared with appropriate staff members.

Publication of National reports and Trust response

The Gosport War Memorial Independent Review was published in this year and there is a gap analysis paper written in response to this review which went to the Quality Delivery Group (QDG) in April 2019.

Expected national changes in 2019 in response to Gosport

1. CQC is reviewing how it assesses the statutory duty of candour.
2. The Government will place listening to and learning from feedback at the heart of care and improving care with a new strategy to be published this year.
3. NHSI – A new Patient Safety strategy this Autumn to make it easier for staff to report risks and for action to be taken.
4. NHSE – A review of the governance and leadership of the Controlled Drug Accountable Officer role in NHS England;
5. NHSE – A review of the operation of the lead Controlled Drug Accountable Officers in NHS England, including the effectiveness of Local Intelligence Networks.
6. NHSE - An assurance process to assess how 'Designated Bodies' (which include NHS Trusts and Foundation Trusts) are reflecting on the learning from the report and reviewing arrangements in their organisation in the light of it.
7. NHSE - An assurance process focused on the appropriateness of anticipatory prescribing guidelines and that they are being followed.

Overview of our speaking up system and processes

- We are developing our "Speaking Up" **strategy** which has been co-produced with staff after a month of conversations with staff in October 2018 and will be part of the enabling quality strategy due for publication in May/June 2019.
- We have set up clear governance **structures** with lines of accountability and reporting with an Executive Lead and also a Non Executive Director lead.
- We have a **steering group** that monitors the delivery of the strategy and guides the work plan and reports in to the People and Organisational Development Delivery Group.
- We appointed a **Freedom to Speak Up Guardian** (FTSUG) 2 years ago. The allocated resource is 1 day a week (can be 2 days if the need arises).
- We have developed an **intranet** site for staff so that they can found out information.
- We have produced a **policy** so that staff can follow clear systems.

- We have many ways that staff can speak up and include this in a short guide for staff.

Who can you speak up to for quality or staff experience concerns?

- Your line manager in the first instance (if appropriate)
- An Executive or Non-Executive Director (NED) – Claire Feehily is our named NED
- Freedom to Speak up Guardian 07789 864970
- Report the incident on Datix web
- If you don't have access to a computer or Datix, call the minor incident line on ext: 5757
- Raise your concern anonymously by signing up online to the Speak in Confidence System
- Report the incident to HR
- Approach your Trade Union representative
- If the concern relates to potential fraud or corruption, contact our Counter Fraud Team

Find out more
Our Speaking Up/Raising Concerns Policy and more information about how you can raise your concerns, is available on our staff intranet. Contact Suzie.Cro@nhs.net or call her on: 07789864970

- We also have developed an **anonymous reporting system**.
- Each person who speaks up is given feedback about how the issue was handled and any outcomes.
- We have a **video** for staff to watch if they want to understand what speaking up is about.
- Everyone is asked if they would speak up again and this is recorded.
- All staff are advised if they suffer detriment that they must come back and report this to the FTSUG or the NED Lead.
- We review the National Guardian Office **Case Reviews** of other organisations and complete a gap analysis exercise against any of the recommendations. We have an action plan for any gaps which is reviewed by the steering group.
- We work with staff with the premise that **all concerns are investigated** (but only if they give permission).
- An **Annual Speaking Up report** is taken to the board (last report November 2019) and quarterly reports to the People and Organisational Development Committee (sub board).
- We undertook a **survey of staff** views on Speaking in July 2018 and we are working on making improvements in response to the survey.
- Every member of staff who speaks up is **thanked** by the FTSUG and is asked whether they would speak up again.
- In 18 months of reporting only **1 staff member has reported suffering detriment** after speaking up (1/85 cases).

National Guardian Office

Our Speaking up data is shared with the National Guardian Office on a quarterly basis and all Trust data can be found on the National Guardian Office website for benchmarking purposes. The National Guardian Office (NGO) had October as "speaking up" month and there was a range of national activities.

CQC

In October 2018 CQC visited the Trust for their Well Led review of services. In the narrative produced for the Trust nurses and midwives were well aware of the FTSUG role but medical staff were less so. The FTSUG will ensure that there are more engagement activities with medical staff over the 2019-20 year.

FTSUG Regional Forum

In October the South West Regional Freedom to Speak up Guardians had their meeting in Gloucestershire and this was attended by the National Guardian Dr Henerietta Hughes.

Trust Steering Group

- The NHSI Speaking Up Board self-review tool has been completed and will be reviewed at each Steering Group meeting.
- October was #SpeakUpToMe month and there were many activities throughout the month to support this initiative.
    - Kitchen tables
    - Walkabout activities
    - FTSUG Tweetathon (31 tweets)
- The Speaking up Survey has an action plan which has been updated for this quarter. Not all actions will be completed by the deadlines due to capacity issues for the Guardian.

Future priorities

- Recruitment of additional Guardians to resolve the resource/capacity issues.
- Publication of the speaking up strategy within the Quality Improvement Strategy.
- Continue to monitor the action plan for the speaking up survey and implement the actions in as timely way as possible.
- Training package for Ambassadors to be developed working with Gloucestershire Care Services (March 20th 1st workshop).

Rota gaps

Statement NHS doctors in training rota gaps

Doctors in Training rota gaps

The quality of the services is measured by looking at patient safety, the effectiveness of treatments patients receive, and patient feedback about the care provided. As part of our Quality Account 2018/19 we are providing a statement on our Trust Doctors in Training Rota Gaps, which we are required to report on annually through the following legislation schedule 6, paragraph 11b of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016.

Monitoring, Delivery and Assurance

The Guardian of Safe Working presents a quarterly board report directly to Trust Board, providing an update and assurance on the monitoring of exception reports and medical rota gaps.

Improvements (2018/19)

Through analysis of our data and knowing what are issues are in 2018/19 we took the following steps to make improvements

1. Discussion with departments to ascertain supply and demand requirements ensuring our rotas are recruited to.
2. Prospective approach to filing gaps, where known, to reduce reliance on agency staff.
3. Guardian of Safe Working proactively involved with rota's to ensure these maintain safe working hours along with good training/education opportunities, encouraging future applicants.

Next Steps (2019/20)

In 2019/20 we intend to improve our approach to long term (5 year) workforce planning, to support forecast rota gaps. Rota gap information will underpin workforce plans, triangulating this information with other workforce, activity and quality indicators and with consideration of known labour market supply issues. In addition to this our Guardian of Safe Working will seek to improve the information dashboard relating to rota gaps, enabling a more proactive response and improving collaborative working with our clinical Divisions.

Part 2.3 Reporting against core indicators

Since 2012/13 NHS foundation trusts have been required to report performance against a core set of indicators using data made available to the Trust by the Health and Social Care Information Centre (HSCIC), now known as NHS Digital.

NHS Improvement has produced guidance for the Quality Account outlining which performance indicators should be published in the annual document. You can see our performance against these mandated indicators in the next Figure.

Figure: Reporting against core indicators

Indicator	Year	GHNHSFT	National average	Highest trust fig	Lowest trust fig	*GHT considers that this data is as described for the following reasons.*	*GHT intends to take or has taken the following actions to improve this percentage/proportion/score/ rate/number, and so the quality of its services, by these actions listed.*
a) The value and banding of the Summary Hospital level Indicator SHMI for trust for the reporting period	2015/16	1.13	1	1.178	0.68	2018/19 data period: Jan18-Dec18 (latest published data as at 20/05/2019)	The actions to be taken have already been described within this report and are monitored by the improvement group The Hospital Mortality Review Group (delivery) and Q&P Committee (assurance).
	2016/17	1.12	1	1.23	0.73		
	2017/18	1.09	1	1.11	0.89		
	2018/19	1.0453	1	1.2264	0.6993		
b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period	2015/16	20.90%	28.50%	54.60%	0.60%	2018/19 data period: Jan18-Dec18 (latest published data as at 20/05/2019)	The actions to be taken have already been described within this report and are monitored by the improvement group The Hospital Mortality Review Group & End of Life Steering Group (delivery) and Q&P Committee (assurance).
	2016/17	21.00%	31.10%	58.60%	11.20%		
	2017/18 *	26.10%	No data	No data	No data		
	2018/19	32.00%	34.70%	60.00%	15.00%		
Number of patient safety incidents / number which resulted in severe harm or death	2015/16	11,517 / 40	9,465 / 39	23,990 / 60	3,510 / 26	2018/19 data period: Apr18-Sept18 (latest published data as at 04/04/2019)	The actions to be taken have already been described within this report and are monitored by the improvement group Safety and Experience Review Group (delivery) and Q&P Committee (assurance).
	2016/17	6,932/22	4955/19	23,990/60	3,510/26		
	2017/18 *	14,762/1	No data	No data	No data		
	2018/19	7,045/28	5,583/19	23,692/87	566/3		
Rate per 1000 bed days of patient safety incidents resulting / rate per 1000 bed days resulting in severe harm	2015/16	30.04 / 0.2	35.77 / 0.18	73.46 / 0.82	18.6 / 0.35	From 2014/15 the rate is calculated per 1,000 bed days instead of per 100	
	2016/17	41.82/0.13	39.89/0.15	71.81/0.6	21.15/0.06		
	2017/18	n/a	n/a	n/a	n/a		
	2018/19	44.0/0.2	44.1/0.1	107.4/0.2	13.1/0.1		

Indicator	Year	GHNHSFT	National average	Highest trust fig	Lowest trust fig	*GHT considers that this data is as described for the following reasons.*	*GHT intends to take or has taken the following actions to improve this percentage/proportion/score/ rate/number, and so the quality of its services, by these actions listed.*
or death						admissions, and the figures are drawn from all non-specialist acute trusts. 2018/19 data period: Apr18-Sept18 (latest published data as at 04/04/2019)	
Rate of C diff (per 100,000 bed days) among patients aged over two	2015/16	11.4	15	62.6	0	2017/18 data period: Apr17-Mar18 (latest published data as at 04/04/2019)	The actions to be taken are within an improvement plan and are monitored by an improvement committee The Infection prevention and Control Committee (Delivery) and Q&P Committee (assurance).
	2016/17	12.5	13.2	82.7	0		
	2017/18	17.3	13.7	91.0	0.0		
	2018/19	No data	No data	No data	No data		
Percentage of patients risk assessed for VTE	2015/16	93.30%	96.10%	100.00%	88.60%	2018/19 data period: Apr18-Dec18 (latest published data as at 04/04/2019)	The actions to be taken are that we have a Task and Finish Group set up to improve this indicator been described within this report and are monitored by the improvement group The Hospital Mortality Review Group (delivery) and Q&P Committee (assurance).
	2016/17*	93.50%	95.60%	100.00%	78.70%		
	2017/18	90.00%	95.30%	100.00%	77.00%		
	2018/19	93.73%	95.55%	100.00%	70.94%		
Percentage of patients aged 0-15 readmitted to hospital within 28 days of being discharged	2011/12*	9.88%	10.26%	14.94%	6.40%		
	2012/13	n/a	n/a	n/a	n/a		
	2013/14	n/a	n/a	n/a	n/a		
	2014/15	n/a	n/a	n/a	n/a		
	2015/16	n/a	n/a	n/a	n/a		
	2016/17	n/a	n/a	n/a	n/a		
	2017/18	n/a	n/a	n/a	n/a		
	2018/19						
Readmissions within 28 days: age 16 or over	2011/12*	10.52%	11.45%	13.80%	9.34%		
	2012/13	n/a	n/a	n/a	n/a		
	2013/14	n/a	n/a	n/a	n/a		
	2014/15	n/a	n/a	n/a	n/a		
	2015/16	n/a	n/a	n/a	n/a		
	2016/17	n/a	n/a	n/a	n/a		
	2017/18	n/a	n/a	n/a	n/a		

Indicator	Year	GHNHSFT	National average	Highest trust fig	Lowest trust fig	*GHT considers that this data is as described for the following reasons.*	*GHT intends to take or has taken the following actions to improve this percentage/proportion/score/ rate/number, and so the quality of its services, by these actions listed.*
	2018/19	n/a	n/a	n/a	n/a		
Responsiveness to inpatients' personal needs	2015/16	66.5	68.9	86.1	59.1	2017/18 data period: Apr17-Mar18 (latest published data as at 04/04/2019)	
	2016/17	67.7	69.6	86.2	58.9		
	2017/18	65.8	68.6	85.0	60.5		
	2018/19	No data	No data	No data	No data		
Staff Friends & Family Test Q12d (if a friend or relative needed treatment I would be happy with the standard of care provided by this organisation)	2015/16	69.00%	65.00%	85.40%	46.00%	2018/19 data period: Survey in Sept18-Dec18 (latest published data as at 04/04/2019)	The actions to be taken are monitored by the improvement group Staff and Experience Improvement Group (delivery) and People and OD Committee (assurance).
	2016/17	64.00%	70.00%	84.80%	48.90%		
	2017/18	61.00%	70.00%	93.00%	42.00%		
	2018/19	65%	70%	87%	41%		

Patient Reported Outcome Measures (PROMs)

The trust's patient-reported outcome measures scores for:

(i) groin hernia surgery
(ii) varicose vein surgery
(iii) hip replacement surgery and
(iv) knee replacement surgery during the reporting period.

	EQ-5D		**EQ VAS**		**Condition-specific Measure**	
Procedure	*Trust%*	*England %*	*Trust %*	*England %*	*Trust %*	*England %*
Groin	Data no longer published					
Hip	88.0%	90.0%	67.8%	68.3%		
Knee	86.0%	83.0%	58.0%	60.0%		
Varicose veins	Data no longer published					

Part 3: Other information

The following section presents more information relating to the quality of the services we provide.

In the figure below there are a number of performance indicators which we have chosen to publish which are all reported to our Quality & Performance Committee and to the Trust Board. The majority of these have been reported in previous Quality Account documents. These measures have been chosen because we believe the data from which they are sourced is reliable and they represent the key indicators of safety, clinical effectiveness and patient experience within our organisation.

Indicator	2017/18	2018/19	National target (if applicable)	Notes/ Other information
Maximum 6-week wait for diagnostic procedures	0.56%	0.54%	<1%	Apr18-Mar19
Clostridium difficile year on year reduction	56*	56	<=3 per month	Apr18-Mar19
MRSA bacteraemia at less than half the 2003/4 level: post 48hrs	4*	6	0	Apr18-Mar19
MSSA	100*	164	TBC	Apr18-Mar19
Never events	6*	1	0	Apr18-Mar19
Risk assessment for patients with VTE	83.98%*	93.20%	>97%	Apr18-Mar19
Crude mortality rate	1.20%	1.09%	No target	April 18 to March 19 (usual caveats around Trak data)
Dementia 1a: Case finding	0.80%	1.90%	>=90%	Apr18-Mar19
Dementia 1b: Clinical assessment	65.00%	27.90%	>=90%	
Dementia 1c: Referral for management	11.00%	2.80%	>=90%	
% patients spending 4 hours or less in ED	86.70%	92.8%	>=95%	Apr18-Mar19
Number of ambulance handovers delayed over 30 minutes *(<=1hr)	506	664	< previous year	Apr18-Mar19
Number of ambulance handovers delayed over 60 minutes	16	14	< previous year	Apr18-Mar19
Emergency readmissions within 30 days - elective & emergency	6.90%	6.90%	<8.25%	Apr18-Feb19
% stroke patients spending 90% of time on stroke ward	89.3%*	90.80%	>=80%	Apr18-Mar19
% of women seen by midwife by 12 weeks	89.50%	89.80%	>90%	Apr18-Mar19
Number of written complaints	1031	898	No target	Apr18-Mar19
Rate of written complaints per 1000 inpatient spells	6.26*	5.65	No target	Apr18-Mar19
Max 2 week wait for patients urgently referred by GP	82.30%	90.00%	>=93%	Apr18-Mar19 (unvalidated)
Max 2 week wait for patients referred with non cancer breast symptoms	90.40%	95.80%	>=93%	Apr18-Mar19 (unvalidated)
Max 31 days decision to treat to first definitive treatment	96.30%	94.60%	>=96%	Apr18-Mar19 (unvalidated)
Max 31 days decision to treat to subsequent treatment: surgery	94.80%	95.30%	>=94%	Apr18-Mar19 (unvalidated)
Max 31 days decision to treat to subsequent treatment: drugs	99.80%	99.90%	>=98%	Apr18-Mar19 (unvalidated)
Max 31 days decision to treat to subsequent treatment: radiotherapy	99.10%	99.30%	>=94%	Apr18-Mar19 (unvalidated)
Max wait 62 days from urgent GP referral to 1st treatment (excl. rare cancers)	75%	74.80%	>=85%	Apr18-Mar19 (unvalidated)
Max wait 62 days from national screening programme to 1st treatment	92.20%	96.50%	>=90%	Apr18-Mar19 (unvalidated)

Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways	Not reported in 2017/18	79.75%	92%	Mar19
Delayed Transfer of Care rate	3.16%	3.15%	No target	Mar19
Number of delayed discharges at month end	30*	43	No target	Mar19

Annex 1: Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

Statement from NHS Gloucestershire Clinical Commissioning Group

NHS Gloucestershire Clinical Commissioning Group (CCG) welcomes the opportunity to provide comments on the Quality Report prepared by Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) for 2018-19. The past year has continued to present major challenges across both Health and Social care in Gloucestershire and we are pleased that GHNHSFT have worked jointly with partner organisations, including the CCG and colleagues within the local authority during 2018/19 to deliver a system wide approach to maintain, further develop and improve the quality of commissioned services and outcomes for service users and carers.

Following the CQC inspection in October 2018 GHNHSFT were awarded an overall rating of 'Good' demonstrating the Trusts commitment to making improvements and developments from the previous CQC inspection. The CCG wishes to add their congratulations to the Trust and commend all the hard work undertaken. The CCG recognise the comprehensive action plan that has been developed in response to the recent inspection and welcome the Trusts ongoing commitment to ensuring that the actions identified by the CQC inspection are being appropriately taken forward. The CCG have good visibility of the action plan and the progress that is being made against the deliverables.

The 2018/19 Quality Report is a comprehensive document which identifies how the Trust performed against the agreed quality priorities for improvement for 2018/19 and also outlines their priorities for improvement in 2019/20. The report is open and transparent and it is noted that the Trust have acknowledged the areas where the achievements have not been realised as quickly as they had aimed for. The CCG endorses the quality priorities that have been selected for 2019/20, whilst acknowledging the very difficult financial challenges and workforce pressures that GHNHSFT have to address in the coming year. The CCG are particularly pleased to see as part of the quality priorities for 2019/20 work to include improving patient experience on discharge processes and improving mental health care for patients.

Continuing the trend of last year the Trust have again faced another very challenging winter period with unprecedented numbers of patients attending the Emergency Department. The CCG recognises the significant pressures that GHNHSFT have experienced and commend them on the continued focus on the delivery of the 4 hour target during these testing times. The specific work around the Ambulatory Care Unit and the Surgical Assessment Unit is proving to have a significant impact on assisting timely patient assessment and overall experience for patients requiring urgent care.

The CCG understands the issues that have arisen in relation to the implementation of Trakcare and recognise the progress being made on the recovery plan, in particular the focused work on clinical validation. The CCG will continue to monitor how this work can improve the quality of care for patients and the effectiveness of communication with the wider health community in Gloucestershire.

The CCG are aware of a number of Serious Incidents that GHNHSFT have reported in the last year and the Never Event reports as they occur. The CCG continue to work with the Trust in relation to the management of these incidents/events in order to ensure that all learning and improvement actions are embedded within clinical environments and wider

system learning is shared. The Trust's Safety & Experience Review Group, with representation and challenge from the CCG, continues to retain detailed oversight of all serious incidents, complaints and never events. There is a clear and robust system in place for ongoing monitoring of all action plans and recommendations.

The CCG are pleased to see the improvement plans that aim to reduce infection rates at GHNHSFT, in particular C-diff which continue to take effect. The enhancement of the infection control team has shown a significant impact on patient care. The CCG continues to work closely with the Trust to provide support where required and monitor improvements. The CCG also work closely with the Trust to monitor the Influenza outbreaks and the promotion of staff flu vaccinations, acknowledging the significant efforts that went into last year's campaign. The CCG were extremely pleased to see such a large increase in the uptake of flu vaccinations amongst frontline staff.

The CCG acknowledges the content of the Trusts Quality Account and in particular the staff survey results. The CCG found the recent staff survey results again to be disappointing but recognise the wider work planned to address this. The CCG will continue to work with the Trust to deliver acute services that provide best value whilst having a clear focus on providing high quality, safe and effective care for the people of Gloucestershire. Gloucestershire CCG confirms that to the best of our knowledge we consider that the 2018/19 Quality Report contains accurate information in relation to the quality of services provided by GHNHSFT. During 2019/20 the CCG will work with GHNHSFT, all stakeholders including the people of Gloucestershire, to further develop ways of receiving the most comprehensive reassurance we can regarding the quality of the acute hospital services provided to the residents of Gloucestershire and beyond.

Julie Symonds
Deputy Director of Nursing

Statement from Healthwatch Gloucestershire (HWG)

Healthwatch Gloucestershire welcomes the opportunity to comment on Gloucestershire Hospitals NHS Foundation Trust's quality account for 2018/19. The role of Healthwatch is to promote the voice of patients and the wider public in respect to health and social care services and we welcome the opportunity to comment. Over the past year we have continued to work with Gloucestershire Hospitals NHS Foundation Trust to ensure that patients and the wider community are appropriately involved in providing feedback and that this feedback is taken seriously.

We are pleased to see that the Trust continue to focus on the experiences of patients with mental health issues who are inpatients in the hospitals and those patients who have mental illness and access services through the Emergency Department. Mental health is a priority for Healthwatch over 2019/20 and therefore, we would be happy to share with the Trust, any relevant, anonymous feedback that we gather during our engagement.

The continued work on the Gloucestershire Safety and Quality Improvement Academy (GSQIA) is welcomed. In particular, the commitment to further expanding this into patient experience. We look forward to hearing more about the outcomes of the work over the coming year.

The Trust has continued to actively engage with and build on its existing relationship with local Healthwatch in 2018/19.

We acknowledge the Trust's continued commitment to patient and public engagement and their efforts to build on relationships with local Healthwatch and look forward to working with the Trust over the coming year to ensure that the experiences of patients, their families and unpaid carers are heard and taken seriously.

Bob Lloyd-Smith
Chair of the HWG Steering Group

Statement from Gloucestershire Health and Care Overview and Scrutiny Committee

On behalf of the Health and Care Overview and Scrutiny Committee I welcome the opportunity to comment on the Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) Quality Account 2018/20.

I welcome the report's openness in identifying where improvement is needed and the planned changes in response to these challenges.

The committee notes the dedication to implementing and embedding the 'Getting it Right First Time' standards within the Trust which is reflected in the recruitment of a new Clinical Lead and a Service Improvement Lead to undertake this work.

The Committee recognises that this is a period of substantial change for the Trust with a number of service reconfiguration pilots and temporary changes in progress. For example reconfiguration of estate for the Urology service is almost complete enabling completion of a number of actions including timely assessment for patients with suspected cancer.

The committee will look to scrutinise these proposals and act as a critical friend in relation to these changes. Members have expressed concern about the way in which change has been communicated and how it fits with the 'Getting it Right First Time' model.

It is clear that good workforce planning is important in ensuring the success of these changes to ensure better outcomes for patients. The report outlines the steps taken in 2018/19 to identify the supply and demand requirements across departments and the next steps for 2019/20 identifying the intention to further improve long term workforce planning.

It is pleasing to see that progress has continued to be made in terms of embedding the Trust's approach to Quality Improvement with this being recognised externally by being shortlisted for 2 Health Service Journal awards.

I particularly wish to thank Deborah Lee and Peter Lachecki for their engagement with the committee, and their willingness to answer the many questions asked by committee members.

Cllr Carole Allaway Martin
Chair
Health Overview & Scrutiny Overview and Committee

Annex 2: Statement of directors' responsibilities for the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

In preparing the quality report, directors have taken steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the *NHS foundation trust annual reporting manual 2018/19* and supporting guidance *Detailed requirements for quality reports 2018/19*
- the content of the quality report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2018 to March 2019
  - papers relating to quality reported to the board over the period April 2018 to March 2019
  - feedback from commissioners dated 02/05/2019
  - feedback from governors dated 28/04/2019

    Our Governors have contributed to identifying the priorities for next year 2019/20 and have also provided us with feedback on this year's Quality Account.
  - feedback from local Healthwatch organisations dated 09/05/19
  - feedback from overview and scrutiny committee dated 01/05/2019
  - the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated July 2018

    https://www.gloshospitals.nhs.uk/contact-us/feedback-and-complaints-pals/
  - the 2017 national patient survey published by CQC 13/06/2018 (https://www.cqc.org.uk/provider/RTE/surveys
  - the 2017 national staff survey published November 2018

    https://www.nhsstaffsurveys.com/Page/1064/Latest-Results/2018-Results/
  - the Head of Internal Audit's annual opinion of the trust's control environment dated 01/04/2019
  - CQC inspection report dated 07/01/2019

    https://www.cqc.org.uk/provider/RTE

This quality report presents a balanced picture of the NHS foundation trust's performance over the period covered.

The performance information reported in the quality report is reliable and accurate

There are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice.

The trust is currently not reporting performance against the indicator Referral to Treatment times (RTT) due to the implementation of a new digital patient administration system TrakCare, the directors have a plan in place to remedy this and return to full reporting by May 2019.

The data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.

The quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

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

By order of the board

28/5/19 Date ..... Chairman

28/5/19 Date ..... Chief Executive

Annex 3: Independent Auditor's Limited Assurance Report to the Council of Governors of Gloucestershire Hospitals NHS Foundation Trust on the Quality Report

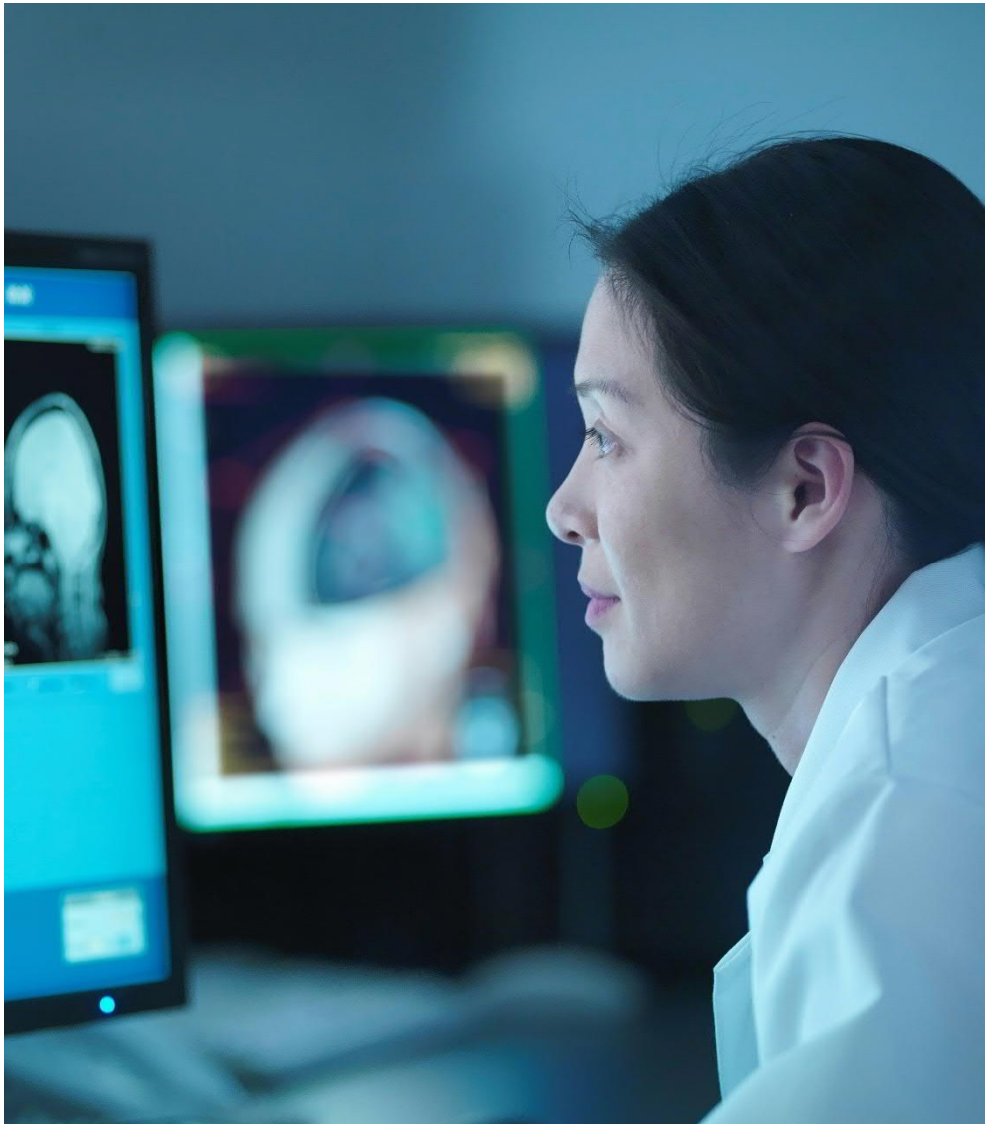
External Assurance on the Quality Report

Gloucestershire Hospitals NHS Foundation Trust

28 May 2019

Building a better working world

Contents



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Apex Plaza
Forbury Road
Reading
RG12 1YE

Council of Governors

Gloucestershire Hospitals NHS Foundation Trust

Alexandra House,

Cheltenham General Hospital,

Cheltenham GL53 7AN

28 May 2019

Dear Governors,

External Assurance on the Trust's Quality Report

We are pleased to present our findings following our review of the Gloucestershire Hospitals NHS Foundation Trust's ('the Trust's') Quality Report for the year ended 31 March 2019.

The purpose of this report to the Council of Governors is to set out the work that we have performed, our findings and conclusions and any recommendations for improvement concerning the content of the Trust's Quality Report and our testing on mandated and local indicators as required by NHS Improvement.

We would like to take this opportunity to thank the employees of the Trust for their assistance during the course of our work.

Yours faithfully

Maria Grindley

Associate Partner
For and on behalf of Ernst & Young LLP
Enc

Section 1

Executive Summary

Executive Summary

1.1 Responsibilities

We have been engaged by the Trust to perform an independent assurance engagement in respect of the Trust's Quality Report for the year ended 31 March 2019 and certain performance indicators contained within the report. Our review is undertaken in accordance with the 'Detailed Requirements for Quality Reports 2018/19' issued by NHS Improvement on 17 December 2018 ('the Detailed Guidance').

NHS Improvement's 'Detailed Requirements for External Assurance for Quality Reports for Foundation Trusts 2018/19' ('the Assurance Requirements') sets out the work that we are required to complete on the Trust's Quality Report for the year ended 31 March 2019, which is published as part of its Annual Report.

As auditors we are required to:

- Review the content of the Quality Report against the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018/19 ('FT ARM'), which is supported by the Quality Reports requirements in the Detailed Guidance;
- Review the content of the Quality Report for consistency against the other information sources detailed in Section 2.1 of the Detailed Guidance;
- Undertake substantive testing on two mandated performance indicators and at least one locally selected indicator (to include, but not necessarily be limited to, an evaluation of the key processes and controls for managing and reporting the indicators and sample testing of the data used to calculate the indicator back to supporting documentation);
- Provide a signed limited assurance report in the Quality Report on whether anything has come to our attention that leads us to believe that the Quality Report has not been prepared in line with the requirements set out in the FT ARM and Detailed Guidance and/or is not consistent with the other information sources detailed in Section 2.1 of the Assurance Requirements and whether there is evidence to suggest that the two mandated indicators have not been reasonably stated in all material respects in accordance with the FT ARM and Detailed Guidance; and
- Provide a report to Trust's Council of Governors ('the Governors' Report') of our findings and recommendations for improvements on the content of the Quality Report, the mandated indicators and the locally selected indicator.

1.2 Key findings

We have reviewed the Trust's Quality Report and found that:

- Its content is in line with NHS Improvement's requirements; and
- It is consistent with other information published by/about the Trust.

In our detailed findings section of this report (section 2) we have included comments about the content and consistency of the Quality Report and made recommendations for the Trust to consider.

Executive Summary (cont'd)

1.2 Key findings (cont'd)

We have also undertaken testing on two mandated indicators and one local indicator. The two mandated indicators tested are:

- % of patients with a total time in A & E of 4 hours or less from arrival to admission, transfer or discharge; and
- % of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer.

In both instances we found no evidence to suggest that the two mandated indicators have not been reasonably stated in all material respects. Further details of our findings are in Section 2.2.

The local indicator tested was:

- The value and banding of the Summary Hospital Level indicator SHMI

We note that this indicator is computed by NHS Digital using information provided by the Trust and other information. The assurance work performed has concentrated on the information provided by the Trust which is used in computing the indicator. We also note that should the indicator be mandated for assurance in future years we would be unlikely to issue an opinion. The main grounds for this are around completeness of data and the fact that we are unable to verify that the data presented to audit is the data submitted to NHS Digital for calculation of the indicator.

We found no evidence to suggest, within the scope of our work as set out above, that the local indicator has not been reasonably stated in all material respects. Further details of our findings are in Section 2.3.

As a result of our findings from the work we have performed, we will issue an unqualified limited assurance report to the Trust. This will conclude that nothing has come to our attention which leads us to believe that:

- The Quality Report is not prepared in all material respects in line with the criteria set out in the FT ARM and Detailed Guidance;
- The Quality Report is not consistent in all material respects with the sources specified in the Assurance Requirements; and
- The indicators identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the FT ARM and supporting guidance and the six dimensions of data quality set out in the Detailed Guidance.

A copy of this report is provided in Appendix A.

Section 2

Detailed Findings

Detailed findings

2.1 Content of the Quality Report

Compliance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2018/19

We have reviewed the content of the Quality Report against the requirements set out by NHS Improvement in the FT ARM.

We found that the Quality Report submitted for our review largely met the requirements, except for the following issues;

- more detail was required on the actions taken to improve data quality;
- there was limited narrative around the assessment of the learning from deaths;
- no detail on the patients who had died in the previous period;
- the 6 week wait for diagnostic procedure indicator was missing;
- narrative comparison of performance on the 4 hour wait target with other providers; and
- other minor clerical issues.

These have now been corrected in the final Quality Report.

Consistency with other specified documents

The Quality Report is also reviewed for consistency with the following documents:

- Council of Governors / Board minutes for the period April 2018 to 24rd May 2019
- Papers relating to quality, reported to the Council of Governors / Board for the period April 2018 to May 2019;
- Feedback from Commissioners;
- Feedback from Governors;
- Feedback from local Healthwatch organisations;
- Feedback from the Overview and Scrutiny Committee;
- The Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009;
- Care Quality Commission inspection;
- The latest national and local patient survey dated 13-6-18;
- The latest national and local staff survey dated Nov 2018;and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 1- 4-19;

Our review concluded that the contents of the Quality Report published by the Trust are consistent with these documents.

Detailed findings (cont'd)

2.2 Testing of mandated performance indicators

In 2018/19, we have performed testing on the following two mandated indicators:

- % of patients with a total time in A & E of 4 hours or less from arrival to admission, transfer or discharge, and
- % of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer.

In both instances we found no evidence to suggest that the two mandated indicators have not been reasonably stated in all material respects.

2.3 Locally selected indicator

In 2018/19, NHS Improvement's guidance also requires the testing of a locally selected indicator. The assurance work on this indicator does not contribute to our limited assurance report in Appendix A.

Governors selected

- The value and banding of the Summary Hospital Level indicator SHMI

We found no evidence to suggest, within the scope of our work, that the local indicator has not been reasonably stated in all material respects. Further details of our findings are in Section 2.3.

We note that this indicator is computed by NHS Digital using information provided by the Trust and other information. The assurance work performed has concentrated on the information provided by the Trust which is used in computing the indicator. We also note that should the indicator be mandated for assurance in future years we would be unlikely to issue an opinion. The main grounds for this are around completeness of data and the fact that we are unable to verify that the data presented to audit is the data submitted to NHS Digital for calculation of the indicator.

Appendix A

Limited assurance report – final

Limited assurance report – final

Limited assurance report on the content **of the Quality Reports** and mandated performance indicators

Independent auditor's report to the Council of Governors of Gloucestershire Hospitals NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Gloucestershire Hospitals NHS Foundation Trust ("the Trust") to perform an independent assurance engagement in respect of Gloucestershire Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2019 (the 'Quality Report') and certain performance indicators contained therein.

This report is made solely to the Trust's Council of Governors, as a body, in accordance with our engagement letter dated 14th May 2018. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019 to enable the Council of Governors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators.

To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors as a body, for our examination, for this report, or for the conclusions we have formed.

Our work has been undertaken so that we might report to the Council of Governors those matters that we have agreed to state to them in this report and for no other purpose. Our report must not be recited or referred to in whole or in part in any other document nor made available, copied or recited to any other party, in any circumstances, without our express prior written permission. This engagement is separate to, and distinct from, our appointment as the auditors to the Trust.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- % of patients with a total time in A & E of 4 hours or less from arrival to admission, transfer or discharge
- % of patients receiving firs definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer

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

Respective responsibilities of the directors and Ernst & Young LLP

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual 2018/19' issued by NHS Improvement.

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

- the Quality Report is not prepared in all material respects in line with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual 2018/19' (published on 6 November 2018), which is supported by NHS Improvement's 'Detailed requirements for quality reports 2018/19' (published on 17 December 2018) issued by NHS Improvement;
- the Quality Report is not consistent in all material respects with the sources specified in Section 2.1 of the 'Detailed guidance for external assurance on quality reports 2018/19' and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the 'NHS Foundation Trust Annual Reporting Manual 2018/19' and supporting guidance and the six dimensions of data quality set out in the 'Detailed Guidance for External Assurance on Quality Reports 2018/19'.

Limited assurance report – final

Limited assurance report on the content **of the Quality Reports** and mandated performance indicators

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS Foundation Trust Annual Reporting Manual 2018/19' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with the other information sources detailed in Section 2.1 of the 'Detailed guidance for external assurance on quality reports 2018/19'. These are:

- Board minutes for the period April 2018 to 24th May 2019;
- Papers relating to quality reported to the Board over the period April 2018 to 24th May 2019;
- feedback from commissioners;
- feedback from governors;
- feedback from local Healthwatch organisations;
- feedback from Overview and Scrutiny Committee**;**
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the national patient survey, dated 13/6/18;
- the national staff survey; dated November 2018;
- the Head of Internal Audit's annual opinion over the trust's control environment, dated 1/4/2019; and
- Care Quality Commission inspection report.

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of Gloucestershire Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting Gloucestershire Hospitals NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Gloucestershire Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included, but were not limited to:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the 'NHS Foundation Trust Annual Reporting Manual 2018/19' to the categories reported in the Quality Report; and
- reading the documents.

Limited assurance report – final

Limited assurance report on the content **of the Quality Reports** and mandated performance indicators

The objective of a limited assurance engagement is to perform such procedures as to obtain information and explanations in order to provide us with sufficient appropriate evidence to express a negative conclusion on the Quality Report**.** The procedures performed in a limited assurance engagement vary in nature and timing from, and are less in extent than for, a reasonable assurance engagement. Consequently, the level of assurance obtained in a limited assurance engagement is substantially lower than the assurance that would have been obtained had a reasonable assurance engagement been performed.

Inherent limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance. The scope of our assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Gloucestershire Hospitals NHS Foundation Trust.

The scope of our assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Gloucestershire Hospitals NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual 2018/19 (published on 6 November 2018) and the Detailed requirements for quality reports 2018/19 (published on 17 December 2018) issued by NHS Improvement;
- the Quality Report is not consistent in all material respects with the sources specified in Section 2.1 of the 'Detailed guidance for external assurance on quality reports 2018/19'; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with NHS Foundation Trust Annual Reporting Manual 2018/19 (published on 6 November 2018) and the Detailed requirements for quality reports 2018/19 (published on 17 December 2018) issued by NHS Improvement .

Maria Grindley
Ernst & Young LLP,
Apex Plaza, Forbury Road, Reading, RG1 1YE
28th May 2019

The maintenance and integrity of the Gloucestershire Hospitals NHS Foundation Trust web site is the responsibility of the directors; the work carried out by Ernst & Young LLP does not involve consideration of these matters and, accordingly, Ernst & Young LLP accept no responsibility for any changes that may have occurred to the Quality Report since it was initially presented on the web site. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

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Ernst & Young LLP

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ey.com

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

Opinion

We have audited the financial statements of Gloucestershire Hospitals NHS Foundation Trust for the year ended 31 March 2019 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, Statement of Cash Flows, the Statement of changes in equity and the related notes 1 to 50, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union and HM Treasury's Financial Reporting Manual (FReM) to the extent that they are meaningful and appropriate to NHS foundation trusts.

In our opinion, the financial statements:

• give a true and fair view of the state of Gloucestershire Hospitals NHS Foundation Trust and Group's affairs as at 31 March 2019 and of its income and expenditure and cash flows for the year then ended; and

• have been prepared in accordance with the Department of Health and Social Care's Group Accounting Manual 2018/19 and the directions under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report below. We are independent of the Foundation Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard and the Comptroller and Auditor General's AGN01, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Material uncertainty related to going concern

We draw attention to note 1.1.2 in the financial statements, which indicates that the Foundation Trust has been unable to meet its financial targets and has reported a significant deficit in year and is budgeting for a further deficit in the next financial year. The Foundation Trust is reliant on continued revenue support loans from the Department of Health and Social Care to continue operating. As stated in note 1.1.2, these events or conditions indicate that a material uncertainty exists that may cast significant doubt on the Foundation Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Overview of our audit approach

Key audit matters	• Fraud in Revenue and Expenditure Recognition – year-end accruals and unrecorded liabilities • First operational year of the Gloucester Managed Services subsidiary • Valuation of Land and Buildings
Materiality	• Overall materiality of £5.564m which represents 1% of operating expenditure.

Key audit matters

Key audit matters are those matters that, in our professional judgment, were of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those which had the greatest effect on: the overall audit strategy, the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in our opinion thereon, and we do not provide a separate opinion on these matters.

In addition to the matter described in the material uncertainty related to going concern section, we have determined the matters described below to be the key audit matters to be communicated in our report.

Risk	Our response to the risk	Key observations communicated to the Audit and Assurance Committee
Risk of fraud in revenue and expenditure recognition in year-end accruals and unrecorded liabilities. Refer to the Audit and Assurance Committee Report (pages 153 – 155 of annual report); Accounting policies (pages 8-14 of financial statements); and Note 30.1 of the Consolidated Financial Statements (page 36 of financial statements) Under ISA 240 there is a presumed risk that revenue may be misstated due to improper revenue recognition. In the public sector, this requirement is modified by Practice Note 10 issued by the Financial Reporting Council, which states that auditors should also consider the risk that material misstatements may occur by the manipulation of expenditure recognition. There is a risk that year-end accruals are misstated to influence or manipulate the recognition of revenue and expenditure. There is no change in the risk profile in the current year.	• We performed walkthroughs of each significant class of expenditure transactions and assessed the design effectiveness of key controls. • We have tested a sample of year-end accruals to ensure the accruals are valid and appropriately valued. • We have performed unrecorded liabilities testing by reviewing payments made and invoices recorded after year-end to ensure these were recorded in the correct period. • We have reviewed Department of Health (DH) agreement of balances data and investigated any significant differences (outside of DH tolerances).	Our work in this area has not identified any material misstatements arising from fraud in revenue and expenditure recognition in year-end accruals and unrecorded liabilities.

Risk	Our response to the risk	Key observations communicated to the Audit and Assurance Committee
Risks involved from the first year of operation of Gloucestershire Managed Services The transfer of opening balances from the Foundation Trust to Gloucestershire Managed Services was an area of risk in this first year of the subsidiary. The accounts of Gloucestershire Managed Services will be consolidated into the Group Accounts and as this is the first year of operation there is the risk that errors may occur.	We have: • Carried out an opening balances review for Gloucestershire Managed Services by testing transactions that were transferred from the Foundation Trust to the subsidiary. The balances transferred were not significant and were below our group materiality. • Reviewed the treatment of Gloucestershire Managed Services transactions within the Group accounts. This included substantive testing of revenue, expenditure and creditors, • Undertaken cut-off and unrecorded liabilities testing.	Our work in this area has not identified any material misstatements arising from the first year of operation of Gloucestershire Managed Services. Our work showed that opening balances were correctly transferred. Bank reconciliations and different ledgers allowed each entity's transactions to be clearly identified and consolidated. Our substantive testing of significant areas of Gloucestershire Managed Services impacting on the group accounts has not identified any material misstatements.
Valuation of Land and Buildings The fair value of Property, Plant and Equipment (PPE) represent significant balances in the Foundation Trust's accounts (£232m at 31 March 2019) and are subject to valuation charges. Management is required to make material judgemental inputs and apply estimation techniques to calculate the year-end balances recorded in the balance sheet.	We have: • Considered the work performed by the Foundation Trust's valuers, including the adequacy of the scope of the work performed, their professional capabilities and the results of their work. • Sample tested key asset information used by the valuers in performing their valuation. • We have tested the valuers assumptions against our expectations. • Considered the annual cycle of valuations and whether there were any specific changes to assets communicated to the valuer. • Reviewed assets not subject to valuation in 2018/19 to confirm that the remaining asset base is not materially misstated. • Considered changes to useful economic lives as a result of the most recent valuation and clarification of the guidance in this area. • Checked that accounting entries have been correctly processed in the financial statements.	Our work in this area has not identified any material misstatements on the valuation of land and buildings. Our review of the work performed by the valuer and the testing of assumptions did not identify any issues. The annual cycle of valuations was appropriate and the only assets that were not revalued were plant and equipment and IT assets, for which we tested additions, disposals and depreciation. The useful economic lives used are appropriate. The accounting entries have been correctly processed into the financial statements. We confirmed that the Foundation Trust's

	In addition to the above areas which we set out in our plan we have also: • considered the applicability of asset valuations being included in the Balance Sheet net of VAT. This is as a result of the Foundation Trust's subsidiary, Gloucestershire Managed Services, being responsible for future rebuilds. • Looked at the estimate for build cost per square meter and considered this against the upper and lower quartile range for the BCIS index. • considered the use of smoothing applied by the valuer against other recognised indices.	approach to asset valuations being included in the balance sheet net of VAT was in line with Department of Health and Social Care Code guidance which has been adopted for IAS16. Our review of the estimate for build cost per square meter was within our acceptable range, albeit at the lower end of this range. The smoothing period applied by the valuer was found to be reasonable.

An overview of the scope of our audit

Tailoring the scope
Our assessment of audit risk, our evaluation of materiality and our allocation of performance materiality determine our audit scope for the Foundation Trust. This enables us to form an opinion on the financial statements. We take into account size, risk profile, the organisation of the Foundation Trust and effectiveness of controls, including controls and changes in the business environment when assessing the level of work to be performed. All audit work was performed directly by the audit engagement team.

In assessing the risk of material misstatement to the Group financial statements, and to ensure we had adequate quantitative coverage of significant accounts in the financial statements, we designated the subsidiary, Gloucestershire Managed Services, as a specific scope component to the group and completed specific procedures in relation to Gloucestershire Managed Services covering opening balances and consolidation. The Charity was not a significant component to the group due to its size and risk profile. However, as there are balances within the Foundation Trust financial statements and related notes, we have undertaken an overall analytical review of the Charitable Fund Accounts along with an analysis of any amounts which are impacting directly on the group accounts.

Of the components selected, we performed an audit of the complete financial information of Gloucestershire Hospitals NHS Foundation Trust component ("full scope components") which was selected based on its size and risk characteristics. For Gloucestershire Managed Services ("specific scope components"), we performed audit procedures on specific accounts within those components that we considered had the potential for the greatest impact on the significant accounts in the financial statements either because of the size of these accounts or their risk profile. The significant accounts tested included revenue, expenditure and creditors as well as procedures undertaken to test for cut-off and unrecorded liabilities. The audit scope of these components may not have included testing of all significant accounts of the component but will have contributed to the coverage of significant balances tested for the Group.

Changes from the prior year
Gloucester Managed Services was incorporated as a subsidiary from 1 April 2018, and was brought into audit scope as a specific scope component, representing 7% of Group Expenditure.

Materiality
The magnitude of an omission or misstatement that, individually or in the aggregate, could reasonably be expected to influence the economic decisions of the users of the financial

statements. Materiality provides a basis for determining the nature and extent of our audit procedures.

We determined materiality for the Group to be £5.65 million (2018: £5.4 million), which is 1% (2018: 1%) of operating expenses. Materiality is set using expenditure as a basis, since the main function of the entity is to provide services to the local community and as such the income statement is considered the most appropriate basis for determining materiality.

Performance materiality
The application of materiality at the individual account or balance level. It is set at an amount to reduce to an appropriately low level the probability that the aggregate of uncorrected and undetected misstatements exceeds materiality.

On the basis of our risk assessments, together with our assessment of the Group's overall control environment, our judgement was that performance materiality was 75% (2018: 50%) of our planning materiality, namely £4.2million (2018: £2.7million). We have set performance materiality at this percentage due to this being our second year of audit and key finance staff have remained consistent with the prior year.

Reporting threshold
An amount below which identified misstatements are considered as being clearly trivial.
We agreed with the Audit and Assurance Committee that we would report to them all uncorrected audit differences in excess of £0.28m (2018: £0.27m), which is set at 5% of planning materiality, as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds.

We evaluate any uncorrected misstatements against both the quantitative measures of materiality discussed above and in light of other relevant qualitative considerations in forming our opinion.

Other information

The other information comprises the information included in the annual report set out on pages 1 to 155, other than the financial statements and our auditor's report thereon. The directors are responsible for the other information.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in this report, we do not express any form of assurance conclusion thereon.

We read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.
We have nothing to report in this regard.

Opinion on other matters prescribed by the Code of Audit Practice issued by the National Audit Office

In our opinion:
• the information given in the performance report and accountability report for the financial year for which the financial statements are prepared is consistent with the financial statements; and

• the parts of the Remuneration and Staff report identified as subject to audit has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2018/19.

Matters on which we report by exception

The Code of Audit Practice requires us to report to you if:

• we issue a report in the public interest under schedule 10(3) of the National Health Service Act 2006;

• we refer the matter to the regulator under schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the Foundation Trust, or a director or officer of the Foundation Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency;

• we are not satisfied that the Foundation Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources as required by schedule 10(1)(d) of the National Health Service Act 2006;

• we have been unable to satisfy ourselves that the Annual Governance Statement, and other information published with the financial statements meets the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018/19 and is not misleading or inconsistent with other information forthcoming from the audit; or

• we have been unable to satisfy ourselves that proper practices have been observed in the compilation of the financial statements.

We have nothing to report in respect of these matters.

The NHS Foundation Trust Annual Reporting Manual 2018/19 requires us to report to you if in our opinion, information in the Annual Report is:

• materially inconsistent with the information in the audited financial statements; or

• apparently materially incorrect based on, or materially inconsistent with, our knowledge of the NHS Foundation Trust acquired in the course of performing our audit; or

• otherwise misleading.

We have nothing to report in respect of these matters.

Responsibilities of Accountable Officer

As explained more fully in the Accountable Officer's responsibilities statement set out on page 121 of the Annual Report, the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the company's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Council of Governors intend to cease operations, or have no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Auditor's responsibilities with respect to value for money arrangements

We are required to consider whether the Foundation Trust has put in place 'proper arrangements' to secure economy, efficiency and effectiveness on its use of resources. This is based on the overall criterion that "in all significant respects, the audited body had proper arrangements to ensure it

took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people".

Proper arrangements are defined by statutory guidance issued by the National Audit Office and comprise the arrangements to:
• Take informed decisions;
• Deploy resources in a sustainable manner; and
• Work with partners and other third parties.

In considering your proper arrangements, we draw on the requirements of the guidance issued by NHS Improvement to ensure that our assessment is made against a framework that you are already required to have in place and to report on through documents such as your annual governance statement.

We are only required to determine whether there are any risk that we consider significant within the Code of Audit Practice which defines as:

"A matter is significant if, in the auditor's professional view, it is reasonable to conclude that the matter would be of interest to the audited body or the wider public. Significance has both qualitative and quantitative aspects".

Our risk assessment supports the planning of sufficient work to enable us to deliver a safe conclusion on arrangements to secure value for money and enables us to determine the nature and extent of further work that may be required. If we do not identify any significant risk there is no requirement to carry out further work. Our risk assessment considers both the potential financial impact of the issues we have identified, and also the likelihood that the issue will be of interest to local taxpayers, the Government and other stakeholders.

Certificate

We certify that we have completed the audit of the financial statements of Gloucestershire Hospitals NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office on behalf of the Comptroller and Auditor General (C&AG).

Use of our report

This report is made solely to the Council of Governors of Gloucestershire Hospitals NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006 and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors, for our audit work, for this report, or for the opinions we have formed.

Maria Grindley for and on behalf of Ernst & Young LLP
Reading
25 June 2019

The maintenance and integrity of the Gloucestershire Hospitals NHS Foundation Trust web site 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 web site. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.