NHS
Gloucestershire Hospitals
NHS Foundation Trust

Annual report and accounts

2017 – 2018

Gloucestershire Hospitals NHS Foundation Trust

Annual Report and Accounts
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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

A copying charge will be made for copies or extracts of the Annual Report (with the exception of Foundation Trust Members).

1. MESSAGE FROM THE CHAIR

It is my pleasure to present the Annual Report of Gloucestershire Hospitals NHS Foundation Trust 2017/18.

While the circumstances in which we operate, and in particular our finances, remain challenging – of which more later – there can be no doubt that 2017/18 has been a year when we celebrated many successes.

As Deborah Lee, our Chief Executive, writes in her introduction to this report, Gloucestershire Hospitals appears on the national radar more and more and for all the right reasons - the acclaim from the Secretary of State for Health in respect of our Accident and Emergency performance, as the most improved Trust in England; improvements in mortality rates and sepsis care, cutting-edge research, or many awards for our staff, are just a few examples.

I have now been Chair of the Trust for 18 months and it would be fair to say that despite the steep personal learning curve it continues to be a hugely rewarding experience. In the past year, I continued my visits to wards and departments and meeting many staff to learn more about who we are and what we do. I continue to be inspired by the commitment and passion of the staff I meet, which even extends to the time outside working hours: a number of staff took part in the Walk for the Wards, in their free time at the weekend, to raise funds for their patients; others undertook fundraising activities for their wards, which were then match-funded by the Charitable Fund.

Shadowing porters at Gloucestershire Royal Hospital; helping serve tea and cakes on the wards with the Health Care Assistants; presenting awards to graduates of the Gloucestershire Quality and Safety Academy; visiting the mortuary; and observing an oncology chemo clinic gave me further opportunities to learn about our hospitals and experience first-hand the services which might not always be visible, but are vital to delivering *Best Care for Everyone*.

I am also very pleased with the progress we made in strengthening our governance arrangements, in part in response to the Financial Governance Review. The Non-Executive Team has played its role here, with the Quality and Performance, and Finance Committees going from strength to strength; Audit and Assurance Committee embracing its role and forensically examining the organisation's system of internal control; and the development of the relatively new Workforce Committee. Our Non-Executive Directors challenge, and support, their executive colleagues, always with the best interest of patients at the forefront of their minds.

As Chair of the Council Governors, I am also very proud of the further progress we made in enabling the Trust to better harness the great commitment and interest that Governors show in supporting the work of the Trust. The Quality and Performance, and Strategy and Engagement Governor Groups provided regular opportunities for updating the Governors on the work of the Trust, both building Governors' understanding of the hospitals and providing them with further opportunities to hold Non-Executive Directors to account. Having Governor Observers on Board Committees, and having Chairs of the Committees presenting to the Council of Governors, further improved the links between the Council and the Board and enabled stronger accountability. In 2017/18, we welcomed several new Governors, including a Governor representing Carers Gloucestershire – all bringing their passion and interests to the role. I would like to thank Governors for all they do, not least in their appointing of new Non-Executive Directors, and extend my commitment to supporting them even better to discharge their role in 2018/19.

Referring to new appointments, as Chair of the Board, I am equally proud of the progress we have made in recruiting some outstanding new Board members and developing the Board. In 2017/18 we made several Executive Director appointments; half of our Non-Executive Directors are also new, bringing in nursing, property and communication skills – all essential perspectives to add to our Board. New people bring new ideas; they also bring new energy and fresh approaches to tackling our challenges we face and help us turn our vision of *Best Care for Everyone* into reality. In 2017/18 we continued to further develop our approach to openness and transparency, and in the way we communicate more openly both internally and externally, and for example having stronger debate in the public section of Board meetings. One such area where we have been transparent about the challenges we faced, and have reported throughout the year, was our financial position. As Deborah writes in her message, the Trust's finances are an area where the Board and I are disappointed with aspects of last year's financial performance and notably the impact of TrakCare on our income, which resulted in the Trust finishing the year with £31.6m operational deficit against a planned deficit of £14.6m.

That said, we worked with our regulator, NHS Improvement, on a case to support the Trust to exit the Financial Special Measures (FSM) regime. The FSM team accept that the financial governance failings which contributed to the Trust being placed in FSM in 2016 have been addressed and whilst the Trust has not delivered the financial recovery plan for 2017/18, the reasons for this (income under-performance) are understood. Importantly the Trust has delivered its 5.7% Cost Improvement Plan, significantly exceeding the NHS national average. A credible financial plan for 2018/19 is supporting our efforts to improve the Trust's financial position.

It is very important to me, and from my broader discussions, I know it is important to the people of Gloucestershire that the services they receive operate seamlessly across organisational boundaries. That means that we need to further improve the way we work collaboratively with our partners, to make the best use of resources and ensure that we build a model of healthcare provision that meets our needs now and in the future. Gloucestershire's Sustainability and Transformation Partnership (STP) will be developing its *One System Business Case* (OSBC) and working on its proposal to become an Integrated Care System.

Looking further to the year ahead, we have many things to focus on including the capital award of £39.5m which will allow us to invest in both the Cheltenham General and Gloucestershire Royal sites, developing both hospitals having first produced detailed plans and getting them approved. Gloucestershire Managed Services (GMS), a wholly-owned estates and facilities subsidiary of the Trust, is in its first year of operation and will be developing its plans to deliver better services for the Trust, while remaining a part of the NHS family. With the new Board in place, another priority for me personally during the coming year will be to support the continued cultural change so welcomed by colleagues throughout the Trust. Such change is creating the conditions for further success, while seizing the opportunities the GMS, STP and the renewed focus on the NHS in its 70th anniversary year provide.

Deborah and I have already hosted visits to the Trust for many local and national partners as Gloucestershire Hospitals' *Journey To Outstanding* continues to attract national interest. I look forward to meeting with more groups and leaders in the months to come.

I would like to extend a huge thank you to all staff colleagues that regularly go that extra mile. It is simply impossible to exaggerate their caring commitment. I look forward to working with the Board and supporting Deborah and her team in the year ahead, to continue to help our Trust deliver the *Best Care for Everyone*.

Peter Lachecki
Chair

24th May 2018

2. MESSAGE FROM THE CHIEF EXECUTIVE

In this 70th anniversary year of the NHS, I am delighted to introduce the 2017/18 Annual Report for Gloucestershire Hospitals NHS Foundation Trust, my second since I joined the Trust in June 2016.

Throughout my time with the Trust I have been repeatedly struck by the number of tremendous examples of where our staff are leading the way in delivering innovative, high quality care and receiving acclaim, both locally and nationally, for the things that we are doing here in Gloucestershire.

Increasingly, Gloucestershire Hospitals are being talked about nationally and thankfully, for all the right reasons! 2017/18 saw numerous successes and to name just a few: the Trust has moved from being an outlier in respect of mortality (measured by the number of patients who die compared to the expected number) to being better than the England average – this is a huge achievement by our staff, for our patients and their families and will remain a focus for the coming year. In July 2017, the Care Quality Commission (CQC) published its inspection report into the Trust's services and rated 70% of our services either good or outstanding; we received acclaim from the Secretary of State for Health in respect of our A&E performance when he took the time to write to the Chair and myself to acknowledge our standing as the most improved Trust in England having achieved the 4-hour waiting time standard in November 2017, the first time in more than four years and as result of this we were the only Trust to be 'promoted' in the regulatory league tables, as a result of our winter performance, moving from Segment 4 to Segment 2.

Staff on Ward 7a, alongside our Patient Experience Improvement team, won a national award for their project *Small Steps, Big Changes*. Staff working in endoscopy services are still celebrating their achievements having received national accreditation for the service for the first time in more than a decade; three of our front line nursing staff were invited to join Prince Charles and others at Buckingham Palace in recognition of their contribution to the profession, and finally, the pilot to reconfigure trauma and orthopaedic services is literally the talk of the NHS. You can read more about these and other improvements in our Quality Account, a 'sister publication' to the Annual Report.

Cancer care performance is an area of huge importance to the Board and to our staff and patients – there is barely a person in the county who is not touched by the experience of cancer, either personally or by association with friends and family. I am delighted therefore, with the progress we have made this year on cancer waiting times; not just because we have improved them significantly but moreover because we have done this 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. Stand out specialties include skin, gynaecology, lung and colorectal services; all of whom have embraced service redesign to improve care for patients. I'm sure it's only a matter of time before national recognition will follow here too.

Speaking of recognition, it would be remiss not to mention the Going the Extra Mile (GEM) Staff Awards launched in 2017/18. These individual and team awards, whereby anyone can nominate and be nominated by their peers, recognise those staff acting in line with our vision and values and going 'above and beyond' what is normally expected of an individual in their role. As I read the citations and sign personal letters for the winners and nominees, I am constantly moved by the stories of staff who do what is best for the patients, often at personal cost, exercising leadership and supporting colleagues both in clinical and non-clinical roles.

Throughout 2017/18 we worked hard to address the recommendations of the Financial Governance Review and worked with our regulator, NHS Improvement, to prepare a proposal for the national panel that would see the Trust discharged from the regulatory enforcement action which was in place in respect of both A&E performance (since August 2016) and financial governance (October 2016). The Board recently reviewed the progress against action plans and satisfied itself that the Trust delivered the agreed actions supporting the Enforcement Undertakings, with regard to both the A&E and the Financial Governance Review. I am therefore delighted that 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.

Trust's finances are one area where I am disappointed with some aspects of last year's performance. The Trust finished the year with a £31.6m operational deficit against an initial planned deficit of £14.6m. The key driver for this under performance was a reduction in income and whilst this was the result of a number of factors, it was largely attributable to the impact of our new computer system; thankfully, we are now well on the road to recovery and our plan for the coming year reflects this progress. However, when it comes to our staff, again they have excelled. The Trust delivered one of the strongest performances in the sector in respect of cost improvement, achieving a huge 5.7% reduction in costs (£28.5m) compared to the acute sector average of 3.5%; most importantly they did this whilst improving the quality and performance of many of our services as described earlier.

While extremely proud of what we have achieved together, I am under no illusion that there is much more to do. Our overall rating by the CQC remains *Requires Improvement* which is not where we want to be – our patients and staff deserve to be receiving and delivering the very best care in line with our vision of *Best Care For Everyone*. To this end, this year we embarked upon our '*Journey To Outstanding'* or #J2O as it is becoming known on Twitter! The recent capital award of £39.5m will allow us to invest in both the Cheltenham General and Royal Gloucestershire sites, developing 'Centres of Excellence' at both hospitals. Gloucestershire Managed Services, a wholly-owned estates and facilities subsidiary of the Trust, is part of this journey, as is our work in the areas of falls and pressure ulcer prevention, infection control and nutrition and hydration; our outpatient improvement programme; and the continued recovery from the challenging introduction of our new patient information system, to realise the many benefits for staff and patients that a fully functioning electronic patient record will bring.

Outstanding staff deliver outstanding care and so I am particularly excited about the Trust's first ever formal talent management programme which will ensure we support all staff to be the very best they can be, again reflecting our vision of *Best Care For Everyone*, which doesn't just cover the care for patients; caring for our staff is equally central to our approach. In the coming months, we will be encouraging our staff, through their annual appraisal, to define their own *Journey to Outstanding* and in doing so taking account of what matters to their patients. Our initiatives to look after our staff and help them develop their careers, will not only benefit the current staff but also help us attract new ones, as prospective employees increasingly choose Gloucestershire Hospitals as the place where they want to learn and advance their careers.

Looking at the wider health and care system in Gloucestershire, it is worth noting that our Sustainability and Transformation Partnership (STP), *One Gloucestershire*, is affording us many new opportunities to work together to improve the quality of services across the whole of the patient journey. Work continues to develop the One System Business Case (OSBC) and pace is now gathering; the OSBC phasing now indicates the commencement of public consultation in January 2019, assuming all prior approvals are successful (which is not a given). Following an unsuccessful first wave bid, the STP has been invited to resubmit its proposal to become an Integrated Care System (formerly Accountable Care System). If successful the system would join wave two systems (known as fast followers) and in doing so gain access to support, development opportunities and potentially additional resources to expedite our work on developing integrated commissioning and service provision.

Finally, my personal focus during 2017/18 remained on creating an environment and a culture where staff can flourish and deliver our vision of *Best Care For Everyone*. To this end, I appointed my new Executive Management Team to support me in developing an organisational culture where we are willing to listen to staff about the things that constrain them from delivering high quality care, a culture where staff feel safe and supported to innovate and improve their own services and a culture where we are willing to embrace, as golden opportunities, the things that (on occasions) go wrong so that we can learn and improve care for the future. The culture where all staff feel like leaders who are empowered to do what is best for our patients. This will remain one of my greatest priorities for the coming year.

I do hope you enjoy reading more about our rise to the challenges that face us, our achievements during this past year, as well as some of our priorities for the year ahead, both in this Annual Report and the Quality Account. May I also encourage you to keep up to date with the Trust's news via our newly-redesigned website www.gloshospitals.nhs.uk and social media including Facebook https://www.facebook.com/gloshospitals/ and Twitter @gloshospitals. And if you are considering your next career move, why not check out @GHNHSFTCareers and LinkedIn https://www.linkedin.com/company/gloucestershire-hospitals-nhs-foundation-Trust and join our fantastic team on our Journey to Outstanding.

With best wishes

Deborah Lee
Chief Executive Officer

25th May 2018

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 clinical strategy, quality priorities, the emergency care pathway and complaints process. 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***	***ESTATES & FACILITIES****	***CORPORATE SERVICES***
Acute Paediatrics	Anaesthetics	Acute Medicine	Clinical Haematology	Catering and Domestic Services	Business Development Marketing & Communications
Clinical Genetics	Breast	Cardiology	Dietetics	Energy Management	Business Intelligence
Community Paediatrics	Chronic & Acute Pain Services	Dermatology	Health Psychology	Glos Hospitals Parking (GHP) Contract	Clinical Audit
Gynaecology	Colorectal	Diabetes	Health Records	Property Services & Medical Engineering	Contracting
Midwifery	Critical Care	Emergency Department	Infection Control	Support Services	Corporate Governance (Trust Secretary)
Obstetrics	Ear/Nose & Throat (ENT)	Endoscopy	Medical Photography	Sustainability	Finance including Payroll
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
			Private Patients/Overseas Patients		Research and Development
			Radiology	**Estates and Facilities Division became Gloucestershire Managed Services (GMS) on 1st April 2018*	Safety (incl Emergency Planning)
					Strategy and Planning

3.4 Vision, Mission and Strategic Objectives

2018/19 will be the final year of our current 5-year Strategic Plan. During the year we will redesign our strategy to define the pace, direction, goals and objectives, to reflect our ambition to become an outstanding hospital to work in and receive care. We have refreshed our strategic objectives for 2018/19:

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	Our Strategic Objectives
Our Patients will	**By April 2019 we will**
→ Be safe in our care	→ Be rated good overall by the CQC
→ Be treated with care and compassion	→ Be rated outstanding in the domain of Caring by the CQC
→ Be treated promptly with no delays	→ Meet all national access standards
→ Want to recommend us to others	→ Have a hospital standardized mortality ratio of below 100
	→ Have more than 35% of our patients sending us a family friendly test response, and of those 93% would recommend us to their family and friends
Our Staff will	**By April 2019 we will**
→ Put patients first	→ Have an Engagement Score in the Staff Survey of at least 3.9
→ Feel valued and involved	→ Have a staff turnover rate of less than 11%
→ Want to improve	→ Have a minimum of 65% of our staff recommending us as a place to work through the staff survey
→ Recommend us as a place to work	→ Have trained a further 900 bronze, 70 silver and 45 gold quality improvement coaches
→ Feel confident and secure in raising concerns	→ Be recognized as taking positive action on health and wellbeing, by 95% of our staff (responding definitely or to some extent in staff survey)
Our Services will	**By April 2019 we will**
→ Make best use of our two sites	→ Have implemented a model for urgent care that ensures people are treated in centres with the very best expertise and facilities to maximize their chances of survival and recovery
→ Be organized to deliver centres of excellence for our population	→ Have systems in place to allow clinicians to request and review tests and prescribe electronically
→ Promote health alongside treating illness	→ Rolled out Getting it Right First Time Standards across the target specialties and be fully complaint in at least two clinical services
→ Use technology to improve	→ Have staff in all clinical areas trained to support patients to make healthy choices

Our Goals	Our Strategic Objectives
Our Organisation	
→ Use our resources efficiently	→ Show an improved financial position
→ Use our resources effectively	→ Be among the top 25% of Trusts for efficiency
→ Be one of the best performing Trusts	→ Have worked with partners in the Sustainability and Transformation Partnership to create integrated teams for respiratory, musculoskeletal conditions and leg ulcers
→ Be considered to be a good partner in the health and wider community	→ Be no longer subject to regulatory actions
	→ Be in segment 2 (targeted support) of NHS Improvement Single Oversight Framework

3.5 PATIENT CARE AND STAKEHOLDER RELATIONS

The Policy Context

The Comprehensive Spending Review in November 2015 included an £8.4 billion real terms increase in NHS funding by 2020/21. With this funding the NHS in England was expected to implement the Five Year Forward View, restore and maintain financial balance and deliver core access and quality standards. These expectations are reflected in the Government's Mandate to NHS England, setting out overall goals for 2020 and deliverable objectives for 2016/17. https://www.england.nhs.uk/wp-content/uploads/2015/12/05.PB .17.12.15-Annex-A-Mandate-to-NHS-England.pdf

All elements of the NHS were required to demonstrate how they would play their part in achieving these goals through two separate but connected plans:

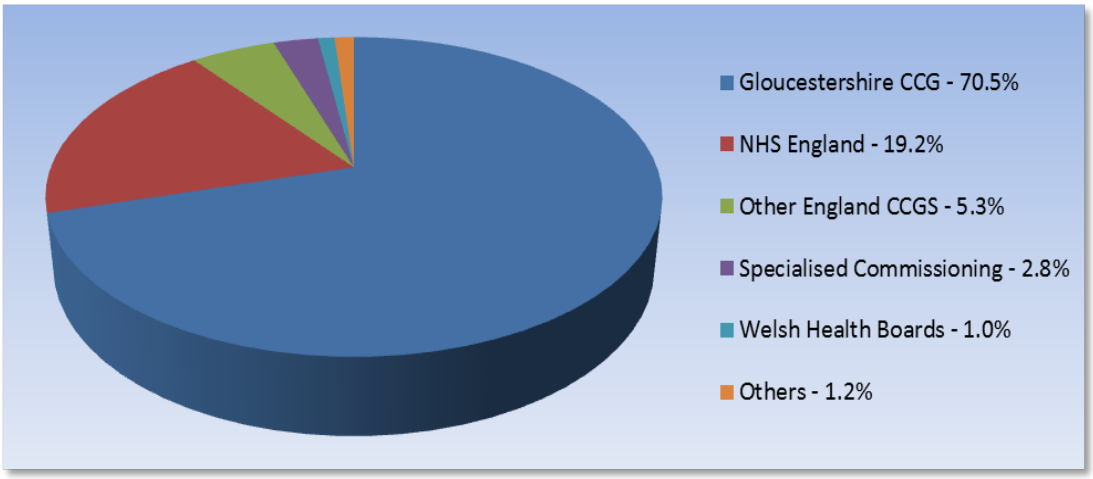
- A place based five year Sustainability and Transformation Plan (STP)
- A one year organization based Operational Plan (Operational Plan)

Operating Context

National - The November 2017 Budget committed an extra £1.6bn of NHS revenue funds and £354m of public capital for 2018/19. Real terms NHS revenue growth for 2018/19 will be 1.9% (versus growth of 2.0% in 2017/18, and 3.1% in 2016/17). This is less than originally requested in the NHS *Five Year Forward View* (5YFV)[1]. Across the country, factoring in England's growing and ageing patient population, age-weighted NHS revenue growth per person becomes 0.9% in 2018/19 and -0.4% in 2019/20[2]. NHS productivity has been growing at 1.7% each year, and administrative costs are less than 2%, some of the lowest in the world; however more efficiency gains have been mandated by government, and NHS England believes further reductions can be made in national, regional and local systems. Attention will continue to be focused on *Integrated Care Systems* (ICS; previously known as Accountable Care Systems and devolved health and care systems) and Sustainability and Transformation Partnerships (STPs)[3] to deliver system-wide quality and efficiency improvements.

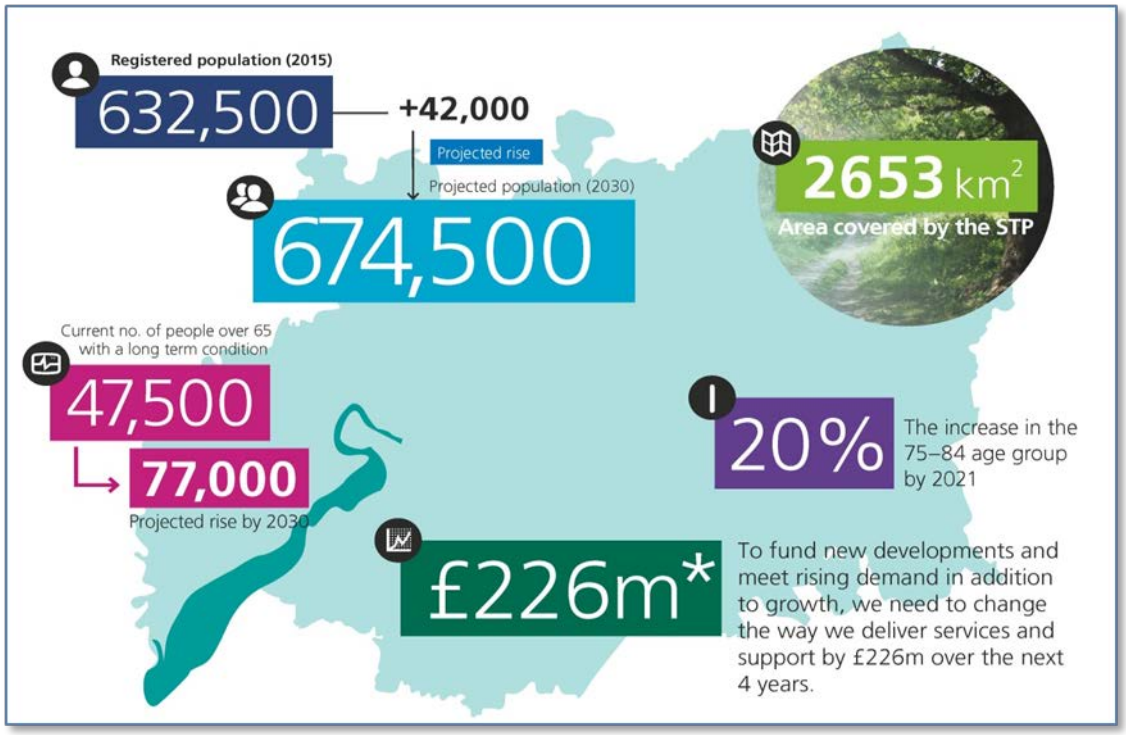
[1] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
[2] https://www.england.nhs.uk/wp-content/uploads/2017/11/04-pb-30-11-2017-nhs-planning-for-2018-19.pdf
[3] https://www.england.nhs.uk/systemchange/

Local - The Trust operates within the Gloucestershire health and social care system alongside partner organisations including Gloucestershire Clinical Commissioning Group (GCCG), Gloucestershire Care Services NHS Trust (community services), 2Gether NHS Foundation Trust (mental health services), South West Ambulance Trust (SWAST) over 80 GP surgeries, and Gloucestershire County Council. Collectively these partner organisations form the *One Gloucestershire* STP. This operating plan is consistent with the *One Gloucestershire* STP and the anticipated impact and benefits of the STP plan have been incorporated into our planning assumptions and contracts with commissioners. Our lead commissioner is GCCG and we also provide services to a wide range of other customers:



Gloucestershire Sustainability and Transformation Plan

Gloucestershire STP covers some 635,000 people (of which 29% are in rural areas), with the over 65 expected to rise from 47.5k to over 77k by 2030
There are 7 (1 Tier and 6 Tier 2) Local Authorities, 3 Trusts and 1 CCG within the geographical boundaries of the Gloucestershire STP.



The STP identifies the following pressures:

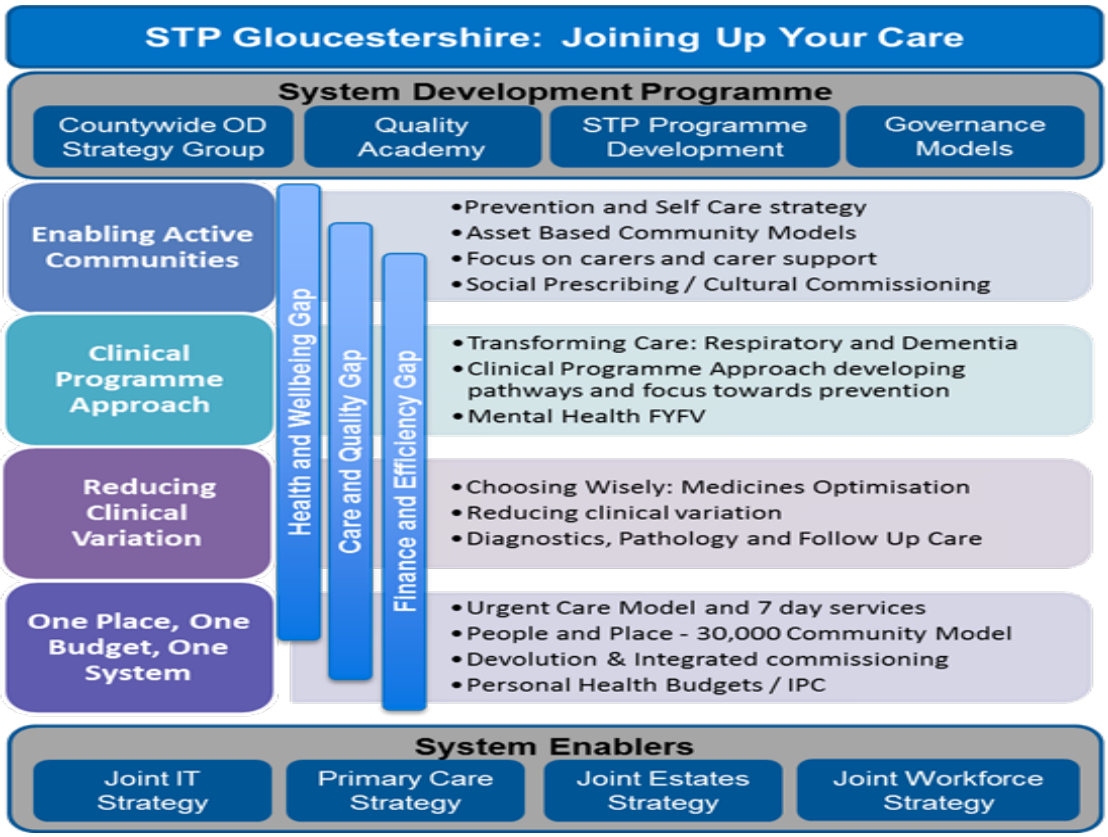
- A growing population with more complex needs
- Increasing demand for services

- Expectations of 7 day standards being met consistently irrespective of the day or the hour
- Innovations in technology and medicines
- Pressures on the workforce
- Limited finances
- All leading to a projected £226m gap in funding across Gloucestershire unless we make radical changes to the way we deliver services

During the year we have worked closely with other NHS providers within the STP footprint, Gloucestershire Care Services NHS Trust and 2gether NHS Foundation Trust, to design and implement new models of care which put the patients' needs at the centre and seek to overcome the organisational barriers that have previously prevented integrated care.

While around 90% of Gloucestershire patient flows occur within the STP geography, system and organisations, we recognise that most patients are unaware of organizational boundaries and distinctions; they simply want to be listened to, diagnosed, and treated with a minimum of delay. We also recognise that quality goes hand-in-hand with consistency, and the more we make our care consistent by reducing variation in practice, the more efficient it will be and we can identify financial benefits too.

Key work streams are shown in the diagram below



We are fully engaged in the delivery of the plan with representation across all groups. Our CEO is a member of the STP Delivery Board which oversees the progress of the STP, and we will continue to support its development and implementation through our leadership and participation across the four main delivery programmes (see right), which are monitored against four key indicators: *Care and Quality*; *Health and Wellbeing*; *Progress Against Plan*; *Finance and Efficiency*.

The challenges faced by the One Gloucestershire system lead to a projected £226m gap in funding across the county unless we make radical changes to the way we deliver services, which the STP will address. The One Place programme within the STP, if approved following consultation and engagement with all our stakeholders, would result in some important service improvements and changes in our hospitals to ensure we deliver the two centres of excellence we describe in our strategic goals.

Enabling Active Communities: We will continue to be an active partner in this community-led programme, ensuring pathways interface as necessary to streamline patient care.

One Place: We will continue to be actively involved in the Clinical Projects of this programme, notably in the 'Urgent Access, Support and Guidance', 'Urgent Treatment' and 'Care in Hospital' work streams, which link many of our operational standards and work into streamlined patient pathways that minimise organisational boundaries, and ensure resources are not wasted.

Clinical Programmes: Our approach involves working together to redesign pathways of care, with all partner organisations constructively challenging each other and themselves to remove barriers to those pathways working as smoothly and efficiently as possible. The priority for the Clinical Programme Groups (CPG), which are based around clinical specialties, is to improve the outcomes for patients both in terms of prevention of and consistent treatment of illness and injury, and ensuring delays are minimised. Our Director of Strategy and Transformation is the chair of the Respiratory CPG and we are represented clinically and operationally across Cancer, Dementia and Diabetes CPGs to ensure the patient benefits of integrated care pathways are defined and realised.

Reducing Clinical Variation: in 2018/19 our plans evolve further to focus on optimising outpatients, diagnostics and medicines variation, reducing variable practise to improve consistent quality and reduce wasted resources.

Local commissioning intentions

The 2016/17 through to 2017/18 Commissioning Intentions for Gloucestershire Clinical Commissioning Group (GCCG), our main commissioners, reaffirm the core principles set out in Joining Up Your Care and reinforced in the Five Year View with an ambitious programme of Transformation. The intentions highlight:

- A shared vision for Gloucestershire underpinned by risk shares to support joint delivery
- Clinical Programme Approach delivering tangible change in key Clinical Pathways (Eye Health, MSK, Urgent and Emergency Care)
- Comprehensive approach to quality: quality summits, service 'walk throughs', Integrated Community Teams roll out across Gloucestershire, supported by NHS Improving Quality

- Planning for the implementation of the Sustainability and Transformation plan to 2020 and delivery of a sustainable and financially balanced healthcare economy.
- System Resilience programme will continue to focus on admissions prevention and improving hospital flow

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 was around £305 million and planned income for specialised services was in the region of £91 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 2016/17 and the proportion by commissioner. The shifts in commissioning responsibility should be taken into account when making year on year comparisons.

Commissioner	Contract 2016/17 £'000	% Income	Contract 2015/16 £'000	% Income	Contract 2014/15 £'000	% Income	Contract 2013/14 £'000	% Income
Gloucestershire	305,115	71.5%	292,592	73.9%	287,875	74.0%	281,029	84.2%
Worcestershire	10,436	2.4%	10,828	2.7%	11,378	2.9%	12,731	4.4%
Herefordshire	4,265	1.0%	3,748	0.9%	3,238	0.8%	3,575	2.4%
Wales	4,046	0.9%	3,435	0.9%	2,906	0.7%	3,181	0.8%
Other CCG's including non-contracted activity	8446.7	2.0%	7,632	1.9%	6,634	1.7%	19,360	2.5%
Specialised Services	90,803	21.3%	74,180	18.7%	73,466	18.9%	72,432	4.9%
Private Patients	2,933	0.8%	3,500	0.9%	3,409	0.9%	3,299	0.9%
TOTAL	**426,638**	100%	**395,915**	100%	**388,906**	100%	**395,607**	100%

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.

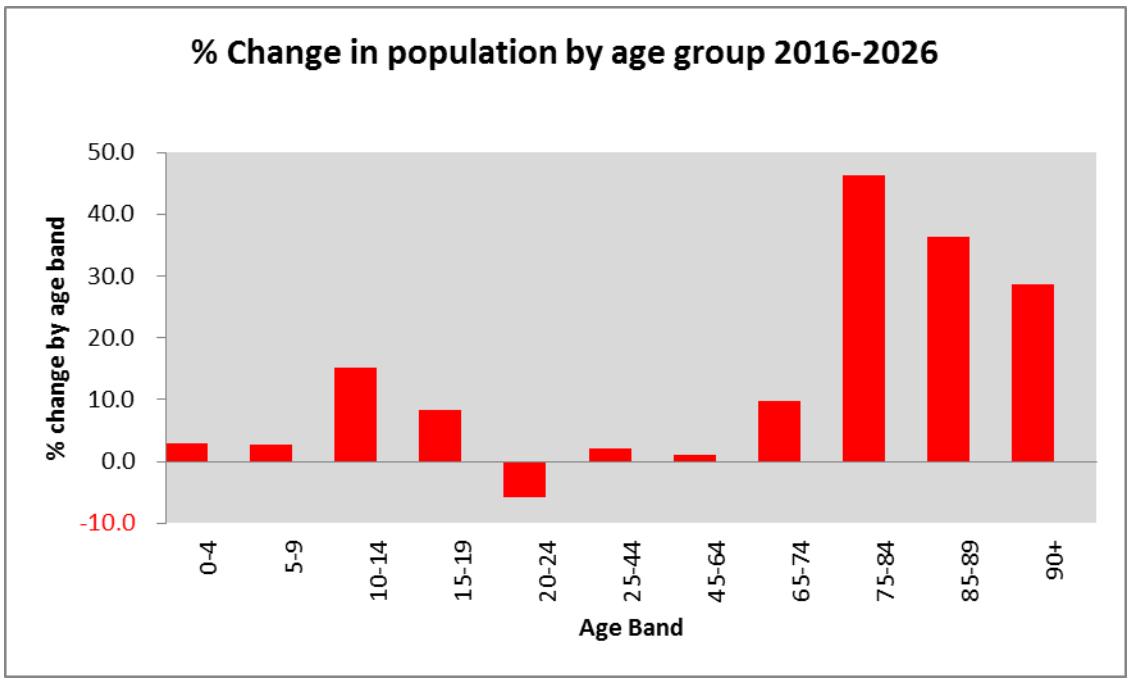
Main trends and factors underlying current position and likely to affect future development and performance

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 size of the population we serve is continuing to grow and is ageing. The population aged 65 and over is projected to grow at the fastest rate compared with other age groups in every region of England; the number of people aged 65 and over is projected to increase in all regions by an average of 20% between mid-2014 and mid-2024 as a result of the general ageing of the population as projected in the national population projections. The risk of all major causes of early death and serious illness increases with age. This means that the number of

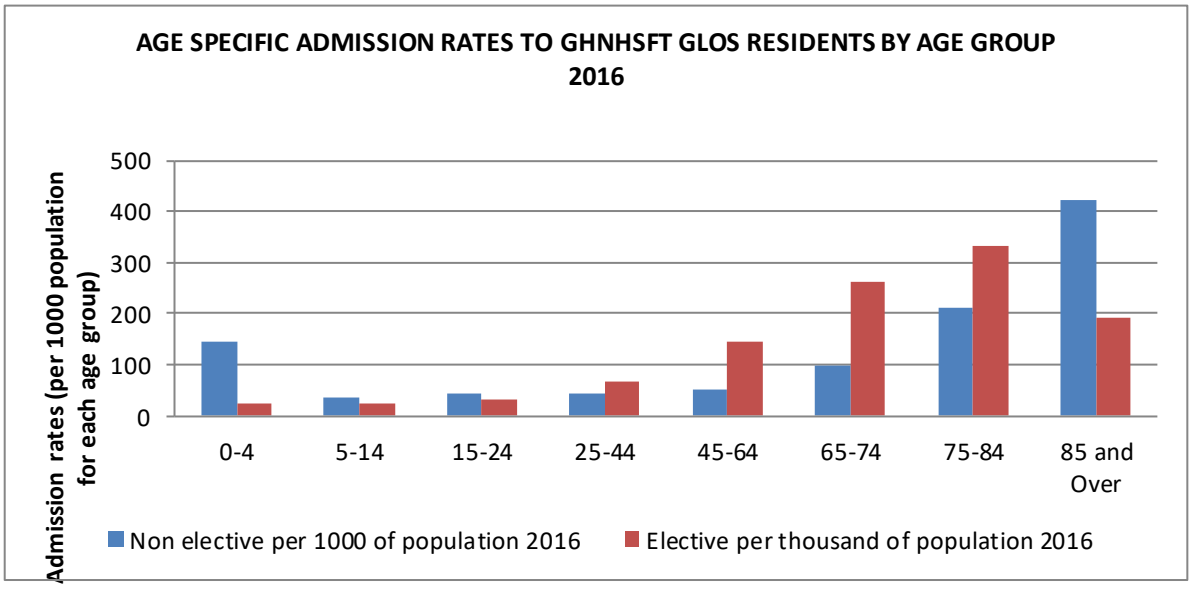
people living longer with a long-term illness will rise much more quickly than the growth in the population. Care for people with multiple long term conditions is often very complex. During 2016/17, we have continued to see an increase in the number of frail elderly people admitted, who need to stay with us for longer periods of time.

The graph below shows the projected percentage change in resident population by age group from 2016 to 2026. Over these ten years the overall population is expected to have a net increase of an additional 45,000 residents. The biggest challenge facing the county is the increase in the elderly population with the number of people aged 75-84 expected to rise by 46%

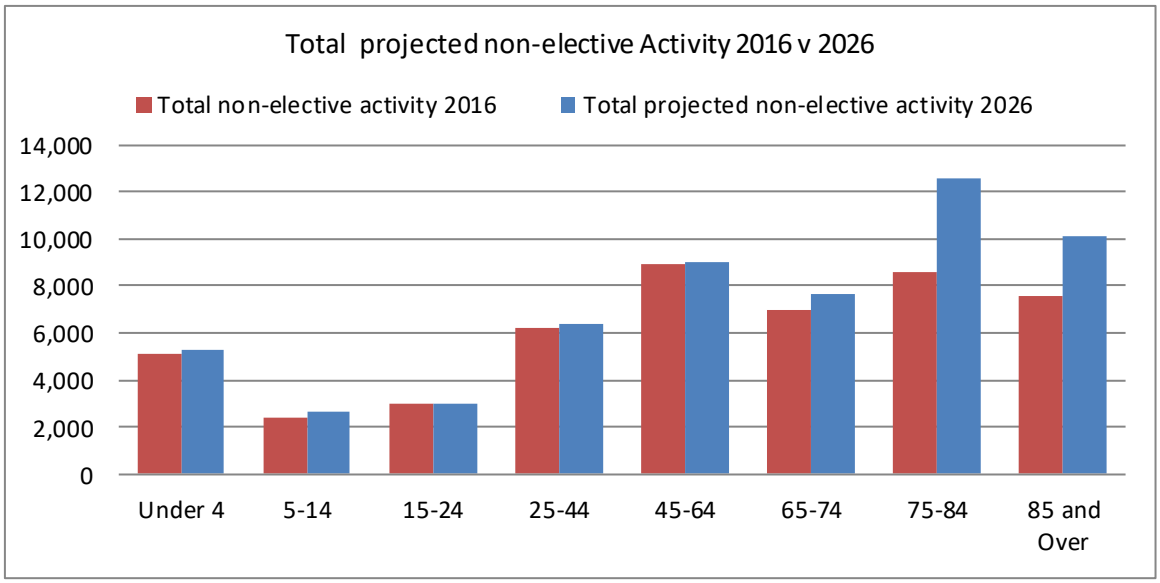


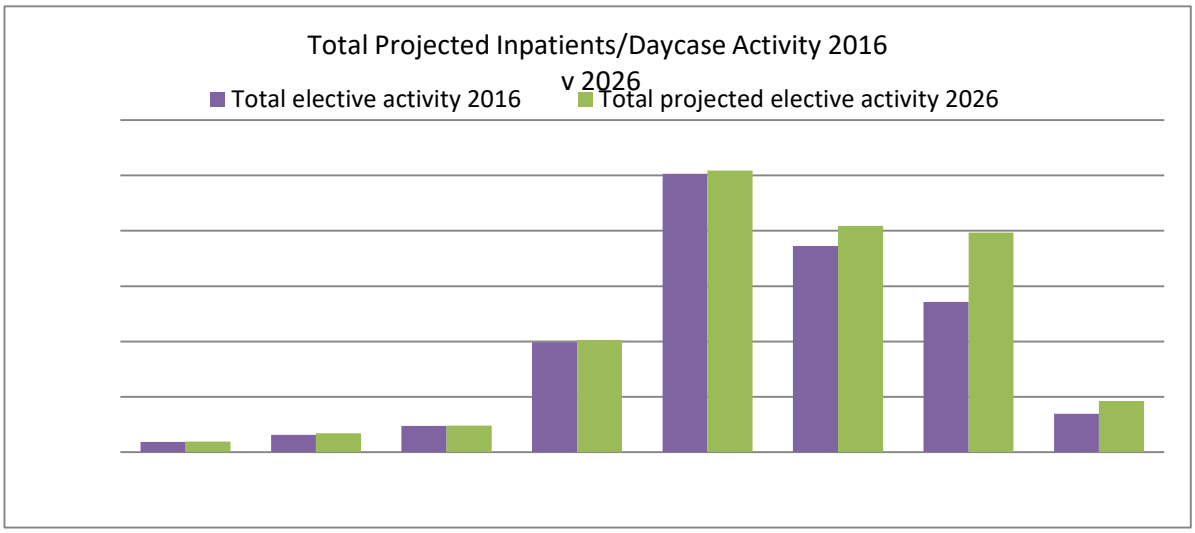
Changes in Demand

The increase in the elderly population as shown in the table above combined with the age specific admission rates shown in the table below demonstrates the significant increase in demand anticipated over the period to 2026.



This information shows that for the over 75-age group only, over the next ten years there will be an increase in admissions to our Trust of around 14,000 per annum more than in 2016 (7400 planned and 6500 emergency). This is shown in the tables below.





However, there is a wide range of factors that should in the same period reduce the demand for hospital beds. New technologies and innovations constantly offer opportunities for less invasive or more local interventions. The countywide strategy for healthcare in Gloucestershire has at its heart the commitment to reduce the reliance on hospital based care by altering pathways of care and providing alternatives to admission that enable people to access care as close to home as is safe and feasible. Schemes to deliver this service redesign are included in the Gloucestershire Quality Innovation, Productivity and Prevention (QIPP) plans. In addition the introduction of new providers into the healthcare landscape for Gloucestershire should also have the impact of reducing the proportionate demand on GHNHSFT. Significant work has also been carried out on the urgent care pathway, with the Trust implementing new ways of assessing and treating emergency patients.

This analysis demonstrates the scale of the challenge for healthcare in Gloucestershire and the importance of the QIPP programme delivering transformational change in service delivery if the impacts of demography and demand on GHNHSFT are to be reduced.

Evidence from 2016/17 is that the healthcare community in Gloucestershire is struggling to balance demand against capacity and this has been reflected in the deteriorating position of some access targets.

Development of our Services

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

Service Development	Contribution to Our Strategic Objectives
Improving Cancer Survivorship	This development is part of a new overall model of care for improving cancer survivorship in Gloucestershire. This innovative programme promotes joined up service improvement across primary, community, hospital, hospice care and public health. The development of acute cancer pathways is a core work stream of the overall planned programme of work. A partnership application to Macmillan has secured funding for a Programme Manager.
Ophthalmology Expansion	The Fairview Ophthalmology Centre at Cheltenham General Hospital was opened in May. It offers state of the art facilities and cutting edge imaging equipment. The development was funded through a two year joint working agreement between Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) and Novartis Pharmaceuticals UK Ltd.
Home Enteral Feeding	The Home Enteral Feeding Team was expanded to meet increased community demand including from the National Star College which helps people with disabilities realise their potential by providing tailored packages of support and care.
Palliative care	The Specialist Palliative Care Service in Gloucestershire is a multi-disciplinary team providing input across the community and hospital Trusts. We have invested in the service to improve both the availability and quality of end of life care for patients.

Our Goals and Strategic Objectives	Progress 2017/18 and priorities for 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	➢ Review of Ward to Board business-as-usual quality standards delivery ('Journey To Outstanding'). ➢ Assurance mapping using CQC update. ➢ Review of the Quality and Performance dashboard initiated to ensure oversight of all key CQC and NHS Improvement indicators. ➢ Review of Quality Model delivery within Divisions, including patient experience indicators and resulting improvement programmes (currently 20 projects, including 2 national award nominations). ➢ A&E 4-hour wait standard ahead of trajectory during winter; Trust moved up from Segment 4 to 2 (February 2018) – to be sustained to continue meeting locally and nationally agreed trajectories (2018/19 priority). ➢ RTT recovery plan not delivered; link to TrakCare recovery (2018/19 priority). ➢ Diagnostics 6 week standard met – to be sustained to

Our Goals and Strategic Objectives	Progress 2017/18 and priorities for 2018/19
➢ Have improved the experience in our outpatients departments, reducing complaints to less than 30 per month	continue meeting national trajectories (2018/19 priority). ➢ Mortality rates falling; on target for achievement. ➢ Focused work in progress to identify themes and trends in outpatient complaints.
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	➢ Staff recognition awards launched (January 2018). ➢ Junior doctor engagement/listening events launched in acute medical areas (December 2017). ➢ Diversity Network launched (November 2017). ➢ Monthly Listening Events in Q4 focusing on Travel to Work (priority from 2016 staff survey). ➢ Talent management system in development (2018/19 priority). ➢ Finance and HR establishment records being reconciled (2018/19 priority). ➢ Began development of Nurse Associate, advanced clinical practice and apprentice roles (2018/19 priority). ➢ Doctors in Training Streamlining Programme, to ensure starters & joiners have the best experience. ➢ GSQIA programme - Q1 will see bronze cohorts 20 and 21; silver cohorts 17-20; gold cohorts 1-2. ➢ 'One stop shop' for staff health and wellbeing in development.
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	➢ Moved physical locations of cardiology and acute care to ensure correct resources to meet demand. ➢ Temporary bed closures in low activity periods. ➢ New Clinical Model Outline Strategic Case developed (2018/19 priority). ➢ New cancer centre of excellence build programme established and scoping begun (2018/19 priority). ➢ Bids submitted to fund GRH site development. ➢ TrakCare governance strengthened; CEO now senior responsible officer. Resource identified, Digital Recovery team appointed, and recovery plan developed (2018/19 priority). ➢ GIRFT reconfiguration of Trauma & Orthopaedics successful; full implementation to continue and lessons learned to inform further specialties' implementations (2018/19 priority). ➢ Over 125 staff trained to support patients making healthy choices; training programme to continue, and initiative to link to wider system opportunities. ➢ Continue to identify opportunities for 7-day services as part

Our Goals and Strategic Objectives	Progress 2017/18 and priorities for 2018/19
	of our transformation and continuous improvement work, notably in unscheduled care and streamlining emergency patients. ➢ Participation in the *100,000 Genomes* project.[4]
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 NHS Improvement Single Oversight Framework	➢ Theatres Managed Service implemented. ➢ Reduction in discretionary spend. ➢ Orthopaedics virtual fracture clinic. ➢ Delivery of financial recovery against trajectory not favourable despite significant cost improvement measures. 'Realistic stretch' position exceeds original forecasted deficit reported to NHS Improvement (includes unplanned cost pressures; challenged by executives) (2018/19 priority). ➢ Efficiency-focused CIP schemes being delivered; monitored through weekly Division 'deep dives' with executives and PMO to increase and sustain pace (2018/19 priority). ➢ 2018/19 CIP schemes and associated quantified benefits in development; started developing increased focus in Q4 on transformational change programmes (2018/19 priority). ➢ Integration of respiratory teams delayed from April 2018 to October 2018 due to slippage of HR legal framework, financial model and development of the clinical model. Model for integrated leg ulcer service agreed. New MSK model progressing (2018/19 priority). ➢ Subsidiary company for estates and facilities services approved (2018/19 priority).

[4] https://www.genomicsengland.co.uk/the-100000-genomes-project/

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 has faced additional challenges associated with the implementation of the new Electronic Patient Record system, TrakCare. This has significantly impacted on our ability to deliver the planned income position for the year. The Trust is reporting a £33m control total deficit against an initial deficit plan of £14.6m – the variance largely driven by income recovery. The Trust remains in Financial Special Measures (FSM) for this reason despite delivering expenditure position within forecast alongside a CIP of 5.7%.

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 in the latter part of the year. Progress has been made for our key cancer standards and delivery for these continues to be a high priority for the year ahead.

Our Board Assurance Framework (BAF) is a tool for our Board of Directors to assure itself about the successful delivery of the organisation's principal objectives. The risks identified in the Board Assurance Framework are based on a collective assessment of the Executive Directors across each portfolio within which the Trust operates. These are informed through the risks identified through our risk management process of any activities within the daily operations of the Trust that impact on the achievement of its principal objectives and the Constitutional Standards of the NHS.

The Trust operates with a Board Assurance Framework to ensure the monitoring of strategic and operational programmes of work. Effective reporting and assurance flows to the Trust Board, including a monthly Quality and Performance report, supported by review at the Quality and Performance committee. This report spans all aspects of the Strategic Oversight Framework and the CQC domains, covering key quality, performance and financial metrics.

The Care Quality Commission

Gloucestershire Hospitals NHS Foundation Trust has had a number of inspections since first registering with Care Quality Commission (CQC). The most recent announced comprehensive inspection took place in March 2015. . Our current registration status is "Requires Improvement". CQC carried out an announced inspection throughout 24-27 January 2017 and an unannounced inspection at Gloucestershire Royal on 6 February 2017. This was a focused inspection to follow-up on concerns from a previous inspection. As such, not all domains were inspected in all core services.

The inspection team inspected the following seven core services at the Gloucestershire Royal Hospital:

- Urgent and emergency services
- Medical care (including older people's care)
- Surgery
- Maternity and gynaecology
- Services for children's and young people
- End of life care
- Outpatients and diagnostic imaging

They did not inspect the critical care services (previously rated outstanding).

As the CQC did not inspect all services they did not rate Gloucestershire Royal Hospital at this inspection.

The Care Quality Commission has not taken enforcement action against Gloucestershire Hospitals NHS Foundation Trust during 2017/18.

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 and Performance Committee and can be seen in the Quality Account.

CQC ratings chart

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	N/A	Requires improvement	N/A	N/A
Maternity and gynaecology	Requires improvement	N/A	N/A	N/A	N/A	N/A
Services for children and young people	Good	N/A	N/A	N/A	N/A	N/A
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	N/A	N/A	Requires improvement	N/A	N/A
Overall	Requires improvement	N/A	N/A	N/A	N/A	N/A

In December of 2016 we launched our new patient administration system, TrakCare. The implementation did not go as planned and the impact of this change was underestimated on all services across the Trust. During the year this has led to our being unable to report against key national targets. The work to address these challenges is well underway and will ensure full recovery in 2018-19. In the meantime teams from across the Trust have worked extremely hard to ensure that we have limited the impact on patient experience and the provision of care.

3.7 Developing our services and improving patient care

Gloucestershire Hospitals actively asks for feedback from patients and their friends and families and 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.

We do this by:

- Using questionnaires, text messaging and comment cards.
- Listening to what our patients tell us in person.
- Responding to Twitter, letters and emails you send us, and feedback posted on NHS Choices.
- Listening to what you tell the Patient Advice and Liaison Service (PALS).
- Holding meetings with patient groups.
- Seeking 'patient stories' (asking patients to gives us an in-depth account of their experience to help us understand the issues better).
- Holding focus groups with our local services users.
- Shadowing our patients to then co-design the improvement work.
- Writing the story of the ideal care experience.
- Carrying out quality improvement project work supported by the Patient Experience Improvement Team.
- Forming project teams to take large change projects forward.

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 robust programme of engagement in place with a wide range of stakeholders as their contributions help shape our quality improvement work.

Service improvements

Utilising the principles of experience based co-design and patient and family centred care methodologies, which are quality improvement science tools, we have listed below some of the quality improvement work and projects that our Trust has carried out in 2017/18: -

- NHS England Maternity Challenge fund (£49k) has supported our Maternity Insight 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.
- Engagement of Foundation Trust Members in how our services are provided and then further involvement in research projects including i4i RAPIDE project.
- Learning disability hospital user group (HUG) which produces easy read information, develops our signage and consults on training packages in response to staff feedback.
- Cancer services user group who review and contribute to the action plan following the national cancer survey.
- 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.
- Focus group with bereaved families to understand their experiences and work with them to further improve our end of life and bereavement services.
- Gloucestershire Emergency Elderly Care (GEEC) project, which is a quality improvement project, addressing the experiences of elderly patients within our

emergency department. Involving observations and shadowing of our elderly patients.

- We have carried out local surveys in colposcopy, breast screening (further patient and staff engagement planned in April 2018), maternity triage (which has helped inform the changes to the maternity triage service), scalp cooling to understand the experiences of patients and staff of this new service, use of sedation in orthodontics.
- Alzheimer's Society Memory Cafés – attendance at the memory cafés to provide reassurance and information to patients and carers.
- Here is a link to the quality improvement projects that have been completed through our Gloucestershire Safety & Quality Improvement Academy.
- Codesign with the Voluntary Sector – Gloucestershire Deaf Association (GDA). There is clear evidence which shows that deaf patients are often unable to access clinical services and take part in health consultations in a way hearing people often take for granted. Studies have shown this 'inadvertent negligence' leads to poorer health outcomes (*source: SignHealth 'Sick of It' 2014 report*). A deaf patient told her compelling story to the Trust Board in May 2017 and we are now able to report back on the many improvements that we have made since that story was heard.
- We have created **Deaf Communication Cards** in partnership with the GDA and corresponding reception counter-top notices for deaf patients. GDA's Chief Executive said "*We are enormously grateful to Gloucestershire Hospitals NHS Foundation Trust for putting their Trust in deaf patients to know what works for them. Initial objections to the cards centred around the idea that an ID card somehow stigmatises the deaf patient, but this is a hearing person's false perception. Deaf people feel no stigma about being deaf. However, because it is so easy to mistake deafness for other conditions, including dementia or learning difficulties, it is critical that in a medical situation particularly, it is recognised immediately and communication support is put in place promptly.*"

Picture: The Deaf Communication Card

In the first three months since the change ideas have been implemented (Aug-Oct 2017), out of 109 BSL interpreter assignments, there have been just 9 (8%) occasions when GDA has learnt of the appointment from the Deaf BSL user rather than the hospital, which shows an immediate and significant **22%** improvement compared to the preceding months. In September, GDA received 100% of the 19 BSL interpreter bookings from the hospital.

Patient Experience Network National Awards (PENNA)

The non-profit Patient Experience Network (PEN) announced winners for its national healthcare awards to recognise outstanding initiatives and national good practice across the NHS. From these, an overall category winner was chosen by the judges. This year, the winning project was from our Trust for 'Small Steps – big Changes', an initiative to engage their staff more in using patient feedback data from a range of sources – such as surveys, the Friends and Family Test and routine comments to

staff – to turn into action to improve patient experience. The project began on one ward and is currently being rolled out across more areas. Judges felt it was innovative in the way it empowered staff to take ownership of issues identified by patients and to drive changes that could make a difference – even if only to a few people at a time. The Trust was also runner up in the category Communicating Effectively with Patients and their families for the Deaf Communication cards.

Patient Advice and Liaison Service (PALS)

Patient Advice and Liaison Service is a first stop service for patients, their families and carers who have a query or concern about our hospitals or services. The team provides an impartial and confidential service and aims to help resolve issues by addressing them as quickly as possible. Where PALS is unable to help, the enquirer is directed to a more appropriate person or organisation.

The majority of PALS contacts relate to requests for information about hospital processes or putting people in touch with the correct department or individual who can help them. The service also collates comments, suggestions and concerns made either directly to the service or through the patient experience feedback mechanisms available throughout the hospitals. PALS is an integral part of the Patient Experience Improvement Team and works closely with the Complaints Team to provide a comprehensive service to patients and their families. PALS can be contacted by telephone, email, letter to the hospital or via the leaflet 'We're here to help' which is available in public areas on all hospital sites. The PALS team also meets with patients on the wards or in departments should this be required.

During 2017/18 the PALS team dealt with approximately 2,500 requests, compliments and concerns. The main categories related to communication, appointments / admission and discharge, information requests and cancellations or delays in appointments. There were also many compliments to various staff and departments.

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 2017/18 (compared with 2016/17)

Indicator	2016/17	2017/18	Notes/ Other information
Number of written complaints	913	1031	This is an increase of 118 complaints.
Rate of written complaints per 1000 inpatient spells	5.4	6.26*	This figure is the Year to date figure to the end of Q3, as activity for Q4 has not yet been confirmed.
Complaints acknowledged within 3 working days	98%	97%	The Trust consistently achieves a high standard for the acknowledging complaints.
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.	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

Gloucestershire Hospitals welcomes feedback of any type and views 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.

Improvements in patient information

The Trust library of clinical patient information leaflets continues to grow, year on year, with many new titles added during 2017. These leaflets support our patients with well-written and clear information to help improve their overall hospital experience. They help patients to make a choice about their treatment and include information to ensure their safety during their pathway. Where possible, leaflets are tested with patients as part of quality improvement programmes.

Supporting people with a learning disability

One of our commitments is to ensure that all our patients get excellent care and treatment. Adults and children with learning disabilities, especially those with moderate to severe disability, often have more health problems than other people. Patients with learning disabilities may need special consideration to ensure they receive the care and treatment which meets their specific needs and maintains their safety. Preparation is crucial in supporting people with learning disabilities; whether carrying out examinations, investigations, treatment or supporting an admission onto a ward. We may be able to make adjustments to ensure that the journey into hospital goes more smoothly, for example through pre-visits or by arranging appointments that will minimise waiting. Our Learning Disability Liaison nurses can be contacted for help and advice.

Carers

We have a Carers Gloucestershire Hospital Liaison Officer, based on our wards full time, who can provide support and advice for carers of patients on our wards. The Liaison Officer has made contact with many carers in 2017/18. We understand that families, friends and neighbours have an important role in meeting the care needs of many patients, both before admission to hospital and following discharge. We want to promote the health and independence of carers, by involving them during the patient's stay in hospital, and planning his or her discharge home. We are developing a Carer's Quality Improvement Strategy which demonstrates our commitment to supporting the needs of carers. Also, one of our appointed Governors represents Carers of Gloucestershire.

Service improvements following patient surveys

National Inpatient Survey (published May 2017)
The National Inpatient Survey is conducted every year. The Picker Institute conducts the survey on behalf of Gloucestershire Hospitals, and other NHS organisations and the results allow us to identify where we are performing better or worse than the average and, most importantly, where we can improve (of the Picker Trusts we are currently ranked 69/83). A total of 1250 patients were sent the questionnaire and of the 1203 eligible 530 returned a completed questionnaire, giving us a response rate of 44%.

Key facts about the 520 inpatients who responded to the survey:

- 27% of patients were on a waiting list/planned in advance
- 69% came as an emergency or urgent case
- 59% had an operation or procedure during the stay
- 50% were male; 50% were female
- 7% were aged 16-39
- 19% were aged 40-59
- 19% were aged 60-69
- 56% were aged 70+.

How the Trust has improved since the 2015 survey?
A total of 63 questions were used in both the 2015 and 2016 surveys. Compared to the 2015 survey, the Trust was:

- Significantly BETTER on 0 questions
- Significantly WORSE on 4 questions
- The scores show no significant difference on 59 questions

How the Trust compared to other Trusts
The survey showed that our Trust was:

- Significantly BETTER than average on 0 questions
- Significantly WORSE than average on 25 questions
- The scores were average on 42 questions

The survey highlighted many positive aspects of the patient experience:

- Overall: 83% rated care 7+ out of 10.
- Overall: treated with respect and dignity 80%
- Doctors: always had confidence and Trust 80%
- Hospital: room and ward was very/fairly clean 96%
- Hospital: toilets and bathrooms were very/fairly clean 93%
- Care: always enough privacy when being examined or treated 88%

Most patients are highly appreciative of the care they receive. However, it is evident that there is also room for improving the patient experience

Improvements in response to the inpatient survey

The patient experience improvement team are supporting a “bottom up” frontline approach to patient experience improvement with the team supporting 21 patient experience quality improvement projects across the organisation. The team are also completing their Gold Coach Award QI training so that they support frontline clinicians to deliver their projects. In an effort to assist the identification of the nurse in charge we have ordered and handed out brightly coloured badges.

The Trust is building upon the work undertaken last year to implement and embed the *SAFER* Programme (detailed in the Quality Account). This programme with its focus 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. Significant progress has been made against each one of the core SAFER elements as detailed below:

The five elements of the SAFER patient flow bundle are:

S – Senior review. All patients will have a senior review before midday by a clinician able to make management and discharge decisions.
A – All patients will have an expected discharge date and clinical criteria for discharge. This is set assuming ideal recovery and assuming no unnecessary waiting. Medication and transport is then arranged and booked ready for that discharge date.
F – Flow of patients will commence at the earliest opportunity from assessment units to inpatient wards. Wards that routinely receive patients from assessment units will ensure the first patient arrives on the ward by 10 am.
E – Early discharge. 33% of patients will be discharged from base inpatient wards before midday.
R – Review. A systematic multi-disciplinary team review of patients with extended lengths of stay (>7 days – ‘stranded patients’) with a clear ‘home first’ mind set. This ‘stranded’ patient review takes place on a daily basis and covers all patients across the hospital with a length of stay greater than seven days.

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.

3.8 Financial Performance

The financial performance for 2017/18 is characterised by a significant variance from initial plan driven by income under-recovery. The Trust has delivered a control total deficit of £33m (once adjusting for technical factors required by our regulators) which represents an unfavourable variance of £18.4m against the initial planned deficit of £14.6m. The Trust remains in FSM and continues to work hard to deliver sustainable financial performance. The table below shows the financial position against plan for the financial year.

Month 12 Financial Position	M12 Cumulative Budget £000s	M12 Cumulative Actuals £000s	M12 Cumulative Variance £000s
SLA & Commissioning Income	439,649	434,517	(5,132)
PP, Overseas and RTA Income	4,734	4,642	(92)
Operating Income	62,659	59,262	(3,397)
Total Income	**507,042**	**498,421**	**(8,621)**
Pay	335,864	334,685	1,179
Non-Pay	160,924	186,685	(25,761)
Total Expenditure	**496,788**	**521,370**	**(24,582)**
EBITDA	**10,254**	**(22,949)**	**(33,203)**
EBITDA %age	**2.0%**	**(4.6%)**	**(6.5%)**
Non-Operating Costs	24,885	28,615	(3,730)
Surplus/(Deficit)	**(14,631)**	**(51,564)**	**(36,933)**
STF Funding			
Surplus/(Deficit)	**(14,631)**	**(51,564)**	**(36,933)**
Fixed Asset Impairments	0	(19,971)	19,971
Surplus/(Deficit) after Impairments	**(14,631)**	**(31,593)**	**(16,962)**
Capital Donations I&E Impact	0	(90)	90
CQUIN Risk Reserve	0	1,536	(1,536)
Surplus/(Deficit) After Tech Adjustments	**(14,631)**	**(33,039)**	**(18,408)**

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 2017/18 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 £28.5m in the 2017/18 financial year which represents 5.7% of annual turnover. This reflects under-performance against a planned value of £34.7m but still exceeds both the sector average and the average for the group of Trusts in Financial Special Measures. Of the £28.5m 75% 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, 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

2018/19 Financial outlook

The Trust incurred an operating deficit in the year of £31.6m and is forecasting a further significant operating deficit in 2018/19. 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 recovery 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 2018/19.

Conclusion

The Trust has applied going concern in the preparation of its 2017/18 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 2017/18 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 2017/18 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 2017/18 the Better Payment Practice Code (BPPC) performance was 82% by value and 85% 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 period	125,081	255,232
Total Bill paid within Target	106,079	209,719
Percentage of Bills paid within target	85%	82%

The Trust has not paid any interest under the late payment of commercial debt in 2017-18.

The Trust income from the provision of goods and services for the purposes of the health service in England was 86.7% 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 Financial Governance Review

In November 2016 the Trust was found to be in breach of its license following a material decline in its reported financial position. The Trust entered into Enforcement Undertakings with its regulator NHS Improvement and was subsequently, in December 2016, placed in Financial Special Measures (FSM). The Trust has remained in the FSM regime throughout the 2017/18 financial year. The Trust was subject to increased monitoring and oversight as part of the regime. The impact of being in FSM included increased costs of borrowing and no access to Sustainability and Transformation funding or national capital funds g. The Trust developed a financial plan for 2018/19 that showed an improved financial position over the 2017/18 final outturn. In May 2018 the Financial Governance Regulatory Enforcement Undertakings were lifted.

3.13 Gloucestershire Hospitals Subsidiary Company: Gloucestershire Managed Services (GMS)

Following months of detailed work to determine the desirability and feasibility of establishing a subsidiary company (known as SubCo), the Board of Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) met on Wednesday 28 February and approved the plans to establish a wholly owned subsidiary company (SubCo) effective from 1st April 2018. The company will employ around 675 support staff from estates and facilities, sterile services and materials management functions.

The Board was clear that it could only approve the proposal if the evidence pointed to long term benefits for staff and patients, which it resolved was the case. The Board concluded that the new organisation will deliver a wide range of benefits and will address many of the challenges it is facing, through the focus that will come from establishing a subsidiary company whose primary purpose is to deliver truly excellent support services to NHS patients and staff. The proposal also demonstrated how the model will deliver better value for money to the Trust thereby supporting its aim to deliver higher quality services at lower cost.

A key characteristic of this subsidiary company is that it will continue to serve the NHS and patients at the Trust's hospitals. This new way of working will allow the new organisation to concentrate on delivering valuable support services to our hospitals that are more innovative and responsive to the staff and patients who they support, resulting in a workforce that is even more engaged and satisfied.

In reaching its decision the Trust Board took into account the views of staff who were consulted with extensively as part of the process; the questions and concerns raised by staff during this period have significantly shaped the final proposal. The staff told us that they place huge value on being part of the NHS and we have been able to reassure them that this new organisation will be wholly owned by Gloucestershire Hospitals NHS Trust and staff will continue to support and work alongside all of their current NHS colleagues, delivering or supporting care to NHS patients. Very importantly, the staff will retain their current terms and conditions, including their NHS pension and access to other benefits NHS staff enjoy.

3.14 Important events since the end of the financial year affecting the Trust

The Trust has established Gloucestershire Managed Services Ltd. which is described in Note 38 to the consolidated and Trust financial statements. 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

3.15 Details of any oversees operations

Not applicable.

Signed: _____

Deborah Lee
Chief Executive Officer

25th May 2018

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. Thirteen meetings of the Board of Directors were held in 2017/18. 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. 2017/18 saw further strengthening and maturing of the corporate governance arrangements, including the form and function of Board sub-committee arrangements to ensure they are well placed to provide Board with the required levels of assurance. The Trust's corporate governance function was also strengthened, including the Board-level Director appointment with responsibility for corporate governance and the appointment of a Non-Executive Director with a clinical background – both completed during 2017/18..

Following the Financial Governance Review, the Trust Board was strengthened with several substantive executive director appointments made in 2017/18.

The Trust also undertook a review of the Board skills and experience and the Council of Governors commenced the Non-Executive Directors recruitment process in the latter part of 2017/18.

The Operational Plan 2017/19 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 & 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: 6th November 2019. Attended: 13/13 Board meetings.

4.2.2 Non-Executive Directors

Non-Executive directors are appointed for three-year terms of office as agreed by the Council of Governors. They may serve two 3 year 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:31st January 2020. Attended: 13/13 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 Vice Chairman of the Roses Theatre, 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: 30th April 2019. Attended: 11/13 Board meetings.

Tony Foster

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: 31st May 2018. Attended: 11/12 Board meetings.

Tracey Barber

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.

Appointed until: 31st August 2019. Attended: 11/13 Board meetings.

Dr 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: 31st January 2020. Attended: 12/13 Board meetings.

Alison Moon (From 4th September 2017)

A nurse since 1980, Alison's focus is to ensure the highest possible quality healthcare services for all. After training at Bristol's Frenchay Hospital, Alison has held a variety of clinical and leadership roles across the NHS and charitable sector. She has an MA in Management from Bristol Business School.

Alison is an experienced executive director with nursing, quality, governance and service improvement portfolios including previous roles as deputy chief executive in both an NHS Foundation Trust and commissioning. Alison has been on the Board of Trustees at St Peter's Hospice, Bristol since 2012. Previous roles include being the regional clinical champion for improving the care of people with dementia in all acute hospitals in the South West and as Transition Director leading on the merger of three CCGs.

Alison has been the Independent Registered Nurse on the Governing Body of Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group since April 2018

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: 3rd September 2020. Attended: 7/7 Board Meetings.

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 13/13 Board meetings.

Director of People and Organisational Development and Deputy Chief Executive: Emma Wood (From 1st November 2017)

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 5/5 Board meetings.

Director of Human Resources and Organisational Development: Dave Smith (To 2nd November 2017)

Dave Smith had overall responsibility for human resources and organisational development including training and development and occupational health. He joined the NHS and the Trust in April 2009 having previously worked as a Human Resources Director in the banking and finance industry. He has an MA in Strategic Human Resources Management.

Attended 7/7 Board meetings.

Director of Strategy and Transformation: Simon Lanceley (From 8th January 2018)

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: 3/3 Board Meetings.

Director of Clinical Strategy: Dr Sally Pearson (To 30th January 2018)

Sally Pearson was appointed as Director of Clinical Strategy in April 2002, following a period of 10 years as Director of Public Health for Gloucestershire Health Authority. She had overall responsibility for strategic direction and planning, partnership with other organisations, research and innovation, marketing and programme management.

Attended 9/10 Board meetings.

Director of Quality and Chief Nurse: Steve Hams (From 25th September 2017)

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 6/6 Board meetings.

Nursing Director: Maggie Arnold (To 29th September 2017)

Maggie Arnold was responsible for the leadership of nursing and midwifery. She also had responsibility for the management of all operational nursing issues including nursing and midwifery policies and development. She led on Safeguarding Adults and Children, Infection Control, Mental Health and patient experience. An experienced trauma nurse she has an MSc in health and social care and worked for the NHS for approximately 37 years.

Attended 6/6 Board meetings.

Medical Director: Dr Sean Elyan

Dr Sean Elyan was appointed as Medical Director at the end of 2005 and now undertakes 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 has overall responsibility for medical leadership and jointly for clinical governance, quality and clinical leadership. He has an interest in service change and brings 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: 11/12 Board meetings.

Finance Director: Steve Webster (From 19th June 2017 to 31st March 2018)

Steve Webster was responsible for finance, procurement, and information management and technology. He joined the Trust in June 2017 after a variety of finance director roles across the South of England and in Wales. He has extensive experience of financial recovery and of major PFI and information technology schemes from these NHS roles, and prior to that worked in local government. He was awarded HFMA Finance Director of the Year for 2010.

Attended 9/9 Board meetings.

Acting Director of Finance: Sarah Stansfield (From 1st April 2017 to 19th June 2017)

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 4/4 Board meetings.

Chief Operating Officer: Caroline Landon (From 9th October 2017)

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 6/6 Board meetings.

Interim Chief Operating Officer: Arshiya Khan (From 22nd May 2017 to 31st October 2017)

As Chief Operating Officer, Arshiya was 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 had shared responsibility for the overall strategic direction, performance and success of the Trust.

Arshiya joined us in November 2016 as Deputy Chief Operating Officer and stepped into the Chief Operating Officer role in May 2017. With a medical background and experience as a regulator, she has previous experience as an executive director in primary care and had worked as senior operational director in acute Trusts.

Attended 2/2 Board meetings.

Interim Chief Operating Officer: Natasha Swinscoe (To 19th May 2017)

Natasha Swinscoe is a graduate of the NHS Management Training Scheme and has over 20 years' experience in the NHS as a senior manager and leader.

As Chief Operating Officer Natasha had responsibility for the operational day to day running of our hospitals.

Formerly serving as a Director of Development at the West of England Academic Health Science Network, as Programme Director for the Community Children's Health Partnership and as Acting Director of Operations at the North Bristol NHS Trust; Natasha has worked in both commissioning and provider organisations gaining experience of adult and child mental health, children's community and acute services, adult surgical and specialist renal and transplantation services as well as leading complex transformational change programme.

Attended 2/2 Board meetings.

Director of Corporate Governance: Lukasz Bohdan (From 13th November 2017)

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 4/4 Board meetings.

4.3 Board's balance, completeness and appropriateness

The Board undertook a self-assessment of its skills in early 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, 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.

Name	**Title**	**Interest**
Mrs Maggie Arnold	Director of Nursing	Nil returns
Ms Tracey Barber	Non-Executive Director	Non-Executive Director - Affinity Trust ACCEA Clinical Excellent Awards Committee
Mr Lukasz Bohdan	Director of Corporate Governance	Director of Gloucestershire Hospitals Subsidiary Company (trading as Gloucestershire Managed Services)
Dr Sean Elyan	Medical Director	Clinical Advisor Kambia Appeal Hope for Tomorrow Acting Chair Advisor Medicine Unboxed
Dr Claire Feehily	Non-Executive Director	Trustee – Stroud Cotswold Citizens Advice Director – Guinness Care Director – Alliance Homes Group Chair – Alliance Living Care
Mr Tony Foster	Non-Executive Director	The Determinations Panel of the Pensions Regulator
Mr Rob Graves	Non-Executive Director	Nil returns
Mr Steve Hams	Director of Quality and Chief Nurse	Director of Curhams Ltd Partner is an employee of Oxford Radcliffe Hospitals NHSFT
Ms Arshiya Khan	Interim Chief Operating Officer	Partnership in Cambridge Global Advisors, LLP
Mr Peter Lachecki	Trust Chair	Managing Director, Lachecki Consulting Ltd Daughter and son-in-law are directors of a different company bidding for contracts with the Trust
Mr Simon Lanceley	Director of Strategy and Transformation	Nil returns
Ms Caroline Landon	Chief Operating Officer	Nil returns
Ms Deborah Lee	Chief Executive	My husband is an independent healthcare practitioner, though does not work within the Gloucestershire health system
Ms Alison Moon	Non-Executive Director	Independent Registered Nurse, Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group Trustee, St Peters Hospice, Bristol Director of A J Moon & Associates Ltd
Mike Napier	Non-Executive Director	Nil returns

Name	Title	Interest
Mr 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)
Dr Sally Pearson	Director of Clinical Strategy	Faculty of Public Health – Local Board Member South-west Clinical Senate Council Member Educational Advisor to National Clinical Assessment Service Governor Rednock School
Dave Smith	Director of Human Resources and Organisational Development	Nil returns
Sarah Stansfield	Interim Finance Director	Director – Gloucestershire Managed Services
Natashia Swinscoe	Interim Chief Operating Officer	Nil returns
Steve Webster	Director of Finance	Nil returns
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 attends 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) Tony Foster Alison Moon (from September 2017)
Quality and Performance Committee	Dr Claire Feehily (Chair) Tracey Barber Peter Lachecki (until September 2017) Alison Moon (From September 2017)
Finance Committee	Keith Norton (Chair) Tony Foster Dr Claire Feehily
Workforce Committee	Tracey Barber (Chair) Keith Norton Rob Graves
Gloucestershire Managed Services Committee	Rob Graves (Chair) Keith Norton Alison Moon
Charitable Funds Committee	Tony Foster (Chair) Peter Lachecki (until September 2017) Alison Moon (from September 2017)
Remuneration Committee	Peter Lachecki (Chair) Tony Foster Keith Norton Tracey Barber Dr Claire Feehily Rob Graves Alison Moon (from September 2017)

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 2018 the Trust had 10,928 Patient and Public members and 8,800 Staff members giving a total of 19,728 Foundation Trust Members.

The Council of Governors is an active and a valued part of the Trust decision making processes. The Trust has established a series of events to engage Members and build their understanding of the Trust and this has had very positive feedback. 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 23 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 2017/18 where appropriate and have been involved in many other activities during the year over which they continue to have an influence. They:

- are represented 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:

- actively recruited FT members
- participated in the development and delivery of the Membership Strategy
- participated in the Quality Report
- attended the Annual Meeting
- attended Trust seminars
- 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, on 21 February 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). On 3 April 2018 the shortlisting panel met and drew up a shortlist; the Recruitment Team then invited shortlisted candidates for the interview. Interviews were held on 19 April 2018 and, following the appointment by the Council of Governors, a successful candidate was offered the non-executive director role.

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.

The **Patient constituency** 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 2017/18 elections were held to fill vacancies caused by the term of office of some Governors coming to an end. The Trust commissioned Electoral Reform Services (ERS) to conduct the elections on its behalf using the single transferrable vote system. The Board of Directors confirms that all elections to the Council of Governors have been held in accordance with the election rules as set out in the Trust's constitution.

Summary of Results for September 2017:

Constituency	**Governor**	**New Governors**
Cheltenham	Julius Marstrand	Re- elected
Cotswold	Anne Davies	Re- elected
Forest of Dean	Alison Jones	Elected
	Valerie Wood	Elected
Gloucester City	Liz Berragan	Elected
Stroud	Jeremy Marchant	Elected
Out of County	Marguerite Harris	Elected
Medical/Dental Staff	Dr Tom Llewellyn	Re-elected
Nursing/Midwifery Staff	Sarah Mather	Elected
Other Non-Clinical Staff	Richard Baker	Elected
	Nigel Johnson	Elected
Allied Health Professionals	Charlotte Glasspool	Elected

Appointed Governors		
Gloucestershire County Council	Andrew Gravells	Appointed
Healthwatch	Maggie Powell	Appointed (December 2017)
Carers Gloucestershire	Jacky Martell	Appointed (March 2018)

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

CONSTITUENCY	NAME	LAST RESULT	TERM OF OFFICE	ELECTION DUE
PUBLIC				
Cheltenham Borough Council Area	Alan Thomas	Elected 2016	3 years	2019
	Vacancy			
Cotswold District Council Area	Jenny Hincks	Re-elected 2016	3 years	2019
	Anne Davies	Elected 2016	3 years	2019
Forest of Dean District Council Area	Alison Jones	Elected 2017	3 years	2020
	Valerie Wood	Elected 2017	3 years	2020
Gloucester City Council Area	Liz Berragan	Elected 2017	3 years	2020
	Graham Coughlin	Elected 2016	3 years	2019
Out of County	Marguerite Harris	Elected 2017	3 years	2020
Stroud District Council Area	Jeremy Marchant	Elected 2017	3 years	2020
	Pat Eagle	Elected 2016	3 years	2019
Tewkesbury Borough Council Area	Geoff Cave	Elected 2016	3 years	2019
	Ann Lewis	Re-elected 2016	3 years	2019
STAFF				
Allied Healthcare Professionals (AHPs)	Charlotte Glasspool	Elected 2017	3 years	2020
Medical/Dental Staff	Tom Llewellyn	Re- Elected 2017	3 years	2020
Nursing/Midwifery Staff	Sarah Mather	Elected 2017	3 years	2020
	Sandra Attwood	Re-elected 2016	3 years	2019
Other/Non-Clinical Staff	Richard Baker	Elected 2017	3 years	2020
	Nigel Johnson	Elected 2017	3 years	2020
APPOINTED				
Gloucestershire County Council	Andrew Gravells	Appointed July 2017	3 years	2020*
Gloucestershire Clinical Commissioning	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	2020

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

This register of Governors' interests is held by the Trust Secretary, at Trust Headquarters, Alexandra House, Cheltenham General Hospital, Sandford Road, Cheltenham GL53 7AN where it can be viewed by the public.

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	Royal College of Nursing
Richard Baker	Nil returns
Liz Berragan	Partnership working with GHNHSFT – I work at the University of Gloucestershire delivering foundation and undergraduate curricula for nursing NMC register RCN HEE SW Simulation network (Executive Committee)
Geoff Cave	Current service user
Graham Coughlin	Nil returns
Anne Davies	Helping to set up a small charity - Ciren Self-help
Christopher Dunn	Governor: Peak Academy W.E. Academic Health Science Network Registered Pharmacist – Independent, not active GPUC – 2033418 HEA – 4152 Service user
Pat Eagle	Periodically review Research Papers for NIHR and am active member of Healthwatch Gloucestershire, at times working with CCG Honorary Welfare Officer and Caseworker for the RAFA Urology Department carer for user of Rheumatology and Orthopaedics
Charlotte Glasspool	Nil returns
Andrew Gravells	Gloucestershire County Councillor and Council vice-chair Member of the Conservative Party Service user
Colin Greaves	Nil returns
Marguerite Harris	Nil returns
Jenny Hincks	Governors GHNHSFT Healthwatch GICC – Service User forum Carers Gloucestershire – charity carer of Adults Glos Carers Gloucestershire – Healthwatch GHNHSFT service user
Peter Jackson	Nil returns
Nigel Johnson	Membership of the Conservative Party
Alison Jones	Service user
Ann Lewis	Healthwatch
Tom Llewellyn	BMA and RCEM professional body memberships
Jacky Martel	Employee – Carers Gloucestershire Trustee – Allsorts Gloucestershire Son and myself are service users
Jeremy Marchant	Nil returns

Governor	Interests
Julius Marstrand	FTN Healthwatch Gloucestershire The Patient Association
Sarah Mather	Nil returns
Denise Powell	Patient member of CCG Cancer Patient reference group
Maggie Powell	Director of Chelsea Square Management Ltd Trustee of Glos Young Carers (1997-2012) Member of Healthwatch Member of Labour Party
Rob Randles	Nil returns
Alan Thomas	Teilo Training Consultancy – self Governor – 2gether NHSFT Board member – Healthwatch Gloucestershire Patient leader – NHSE SL – CCG Assurance (Paid attendance fee) Wife is a Trust employee Service user
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.

	5th April 2017	19th June 2017	5th September 2017	18th October 2017	6th December	21 February 2018	Total
Julius Marstrand Cheltenham Borough Council Area	✓	✓	✓	✓	✓	**X**	5/6
Alan Thomas Cheltenham Borough Council Area	✓	✓	✓	✓	✓	✓	6/6
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**	✓	2/3
Valerie Wood Forest of Dean District Council Area	-	-	-	✓	**X**	✓	2/3
Peter Jackson Forest of Dean District Council Area	✓	✓	✓	**-**	**-**	**-**	3/3
Liz Berragan Gloucester City Council Area	-	-	-	✓	✓	**X**	2/3
Graham Coughlin Gloucester City Council Area	✓	✓	✓	✓	**X**	✓	5/6
Denise Powell Gloucester City Council Area	✓	✓	✓	**-**	**-**	**-**	3/6
Jeremy Marchant Stroud District Council Area	**-**	**-**	**-**	✓	**X**	✓	2/3
Pat Eagle Stroud District Council Area	✓	✓	✓	✓	**X**	✓	5/6
Chris Dunn Stroud District Council Area	✓	✓	**-**	**-**	**-**	**-**	2/2
Geoff Cave Tewkesbury Borough Council Area	✓	✓	**X**	**X**	✓	**X**	3/6
Ann Lewis Tewkesbury Borough Council Area	✓	✓	✓	**X**	✓	✓	5/6
Marguerite Harris Out of County	**-**	**-**	**-**	✓	✓	✓	3/3
Dr Tom Llewellyn Staff (Medical/Dental)	✓	✓	✓	✓	✓	✓	6/6
Sarah Mather Staff (Nursing/Midwifery)	**-**	**-**	**-**	✓	**X**	✓	2/3
Sandra Attwood Staff (Nursing/Midwifery)	**X**	**X**	✓	✓	✓	✓	4/6
Rob Randles Staff (Nursing/Midwifery)	✓	✓	✓	**-**	**-**	**-**	3/3
Charlotte Glasspool Staff (Allied Healthcare Professionals)	**-**	**-**	**-**	**X**	✓	✓	2/3
Richard Baker Staff (Non-clinical/Other)	**-**	✓	✓	✓	✓	✓	5/5
Nigel Johnson Staff (Non-clinical/Other)	**-**	✓	**X**	✓	✓	**X**	3/5
Cllr Andrew Gravells Appointed (Gloucestershire County Council)	**-**	**-**	✓	**X**	**X**	✓	2/4

	5th April 2017	19th June 2017	5th September 2017	18th October 2017	6th December	21 February 2018	Total
Colin Greaves Appointed (Gloucestershire Clinical Commissioning Group)	✓	✓	✓	✓	**X**	✓	5/6
Maggie Powell Appointed (Healthwatch)	-	-	-	-	✓	✓	3/5
Chris Graves Appointed (Healthwatch)	-	✓	✓	-	-	-	2/2

Key: ✓ attended
X apologies
- not in post

4.15 Governance & Nominations Committee – 2017/18

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 workplan 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

	26 April 2017	14 August 2017	12 October 2017	14 November	30 January 2018	15 February 2018
Peter Lachecki Chair	✓	✓	✓	✓	✓	✓
Rob Graves Senior Independent Director	-	-	-	✓	✓	✓
Alan Thomas Lead Governor	✓	✓	✓	✓	✓	**X**
Jenny Hincks Governor	✓	✓	✓	**X**	-	-
Peter Jackson Governor	✓	-	-	-	-	-
Nigel Johnson Governor	-	-	-	-	✓	✓
Tom Llewellyn Governor	-	-	-	-	✓	✓
Julius Marstrand 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 (Governors are required to have audit experience)	Colin Greaves (until January 2018) Marguerite Harris (from January 2018)
Charitable Funds Committee	Vacancy
Gloucestershire Managed Services Committee	Nigel Johnson
Quality and Performance	Pat Eagle (until January 2018) Graham Coughlin (from January 2018)
Finance	Alan Thomas
Workforce	Tom Llewellyn (until January 2018) Richard Baker (from January 2018) Geoff Cave

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 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 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

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. Further, during 2017/18 the Board initiated a self-assessment against the 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.

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.

Patient and Public Constituency	**Numbers**
Cheltenham	2,194
Cotswolds	1,299
Forest of Dean	1,141
Gloucester	2,254
Stroud	1,579
Tewkesbury	1,646
Unknown	7
Patient (out of county)	808
TOTAL	**10,928**

Staff constituency	
AHP/scientific/technical staff	977
Medical/Dental	985
Nursing/Midwifery	2,560
Other	4,358
TOTAL	**8,880**

Table 1 Membership size and movement

Public constituency	**2016 - 2017**	**2017 - 2018**	**2018 - 2019 (estimated)**
At year start (April 1)	10,935	10,434	10,120
New members	185	75	140
Members leaving	686	389	700
At year end (March 31)	10,434	10,120	9,560
Staff constituency	**2016 - 2017**	**2017 - 2018**	**2018 - 2019 (estimated)**
At year start (April 1)	8,373	8,849	8,600
New members	1,722	1,650	1,600
Members leaving	1,459	1,619	1,500
At year end (March 31)	8,739	8,880	8,700
	Staff data supplied from ESR by GHNHSFT Workforce Information Department		
Patient (out of county) constituency	**2016 - 2017**	**2017 - 2018**	**2018 - 2019 (estimated)**
At year start (April 1)	699	697	808
New members	33	126	60
Members leaving	35	15	50
At year end (March 31)	697	808	818

All estimated figures for 2018-2019 are based upon a rounded up three year average. Overall public and patient constituency target for 2018-2019 is 10,378 .

Table 2 Analysis of current membership

PUBLIC constituency	**Number of members 2016 - 2017**	**Number of members 2017 - 2018**	**Eligible membership (2017 - 2018)** *Any resident over the age of 15 in the Gloucestershire County can become a member of the Public Constituency.*
Age (years)			
0-16	2 (0.1%)	2 (0.1%)	14,881 (2.8%)
17 – 21	59 (1.8%)	39 (1.2%)	34,937 (6.7%)
22+	3,179 (98.1%)	3,182 (98.7%)	472,404 (90.5%)
Unknown	7,194*	6,897*	-
Gender			
Male	4,265 (41.0%)	4,124 (41%)	307,202 (49.0%)
Female	6,135 (59.0%)	5,958 (59%)	319,232 (51.0%)
Unknown	34	38	-
Ethnicity			
Asian/Asian British	391 (4.4%)	402 (4.3%)	12,433 (2.1%)
Black/Black British	88 (1.0%)	90 (1.0%)	5,150 (1.0%)
Mixed	42 (0.5%)	43 (0.5%)	8,661 (1.5%)
Other	0 ** (0%)	0 **	729 (0.1%)
White	8,325 (94.1%)	8,778 (94.3%)	569,647 (95.5%)
Unknown	1,588	1,508	-
Eligible population data based on the Office for National Statistics and supplied by Membership Engagement Services (MES). **The Trust now only reports age categories based on the dates of birth recorded. This is a change to how the Trust has previously reported and as a consequence we do not have dates of birth recorded for the majority of our members.* ***Due to a reclassification of ethnic groups the 'Chinese' category is now part of Asian/Asian British category hence the zero figure in the 'Other' category.*			
Socio-economic groupings (Public Constituency)	**Number of members 2016 – 2017**	**Number of members 2017 – 2018**	**Population**
ABC1	6,157 (60.2%)	5983	102,300 (56.4%)
C2	2,082 (20.4%)	2030	40,063 (22.1%)
DE	1,990 (19.5%)	1936	39,181 (22.0%)
Unclassified	205	171	0
All socio-economic data for members and population provided by MES and is based on postcode, for some members (171) we do not have a postcode registered.			
PATIENT constituency (out of county patients)	**Number of members 2015 - 2016**	**Number of members 2016 - 2017**	**Eligible membership (2016 - 2017)** *Any out of county patient aged over 15 that has been treated by the Trust in the last 3 years is eligible to become a member of the Patient Constituency.*
Age (years)			
0-16	0 (0%)	0 (0%)	3367 (2.0%)
17-21	7 (4.52%)	3 (1.8%)	7715 (4.7%)
22+	148 (95.48%)	167 (98.2%)	153,598 (93.3%)
Unknown	544*	527*	
Eligible data supplied by the GHNHSFT Information Department **The Trust now reports age categories based on the dates of birth recorded. This is a change to how the Trust has previously captured and reported this data; consequentially the majority of our members do not have dates of birth recorded.*			

NB. All 'unknown/not provided' Trust figures have been excluded when generating percentages as this data cannot be used to identify under/over represented areas, which is the intention of the percentage comparisons.

Membership Commentary

i) Movement of Members

The public and patient constituencies have seen a loss of 389 members **(714 in 2016-2017)** with the majority ceasing to be members as they are deceased.

This year **75** patient and public members were recruited **(218 in 2016-2017)**. This is a decrease on 2016-2017. The Trust has not actively recruited new members during 2017-2018. Members have been recruited through our volunteering scheme, staff leavers being invited to join the public constituency and through the Trust webpages. The Trust will be investing further in the corporate governance/membership function in 2017/18.

ii) Representation of membership

Public Constituency

Any resident over the age of 15 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 a small over representation of the 'Asian/Asian British' and small under-representation of members identifying themselves in the 'Mixed' category.

Patient constituency

'Out of county' patients who are over the age of 15 and have been treated in the Trust in the last 3 years are eligible to become a member in this constituency. We have seen a rise in this constituency in the last year, for reasons unknown to us.

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. This is being reviewed as a result of the introduction of the General Data Protection Regulation from May 2018.

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 are:

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. A review of our more established membership will be taking place into 2018-2019 to enable this further. 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. Recruitment of new members took place at 'The Big Health Check Day' which is an event for people with learning disabilities.

A Trust-wide website development project has taken into account the availability and accessibility of the membership pages. This is due to be completed in 2018-2019.

Members continue to receive the membership newsletter, Involve with positive feedback being received from members as to the content and presentation of this publication. 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
- 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 attending a Prospective Governor evening
- 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

Work around the recruitment materials including an e-welcome package will be taken forward into 2018-2019, however an easy read version of the application form has been developed and tested successfully.

The objectives of the strategy will be further developed and initiated during 2018/2019 to reflect the 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

25th May 2018

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 and the Monitor 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 six 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.

Five meetings were held during the financial year, on 12th April 2017, 26th May 2017, 22nd August 2017, 20th September 2017 and 28th March 2018 and attendance is recorded below:

Members Present 12th April 2017		**In Attendance**
Peter Lachecki	Tony Foster	Deborah Lee[1]
Tracey Barber	Rob Graves	Martin Wood[5]
Claire Feehily	Keith Norton	

Members Present 26th May 2017		**In Attendance**
Peter Lachecki	Tony Foster	Deborah Lee[2]
Tracey Barber	Rob Graves	Natashia Judge[5]
Claire Feehily	Keith Norton	

Members Present 22nd August 2017		**In Attendance**
Peter Lachecki		Deborah Lee[3]
Tracey Barber		Natashia Judge[5]
Tony Foster		

Members Present 20th September 2017		**In Attendance**
Peter Lachecki	Keith Norton	Natashia Judge[5]
Tony Foster	Rob Graves	
Claire Feehily		

Members Present 28th March 2018		**In Attendance**
Peter Lachecki	Rob Graves	Deborah Lee[4]
Claire Feehily	Alison Moon	Lukasz Bohdan[5]
Tony Foster	Keith Norton	

1. *The Chief Executive was in attendance to present a report on Proposed Remuneration for the Chief Operating Officer and Executive Director Remuneration*
2. *The Chief Executive was in attendance to present a report on Pay Awards for Executive Directors*
3. *The Chief Executive was in attendance to present a report on New Appointee Executive Director Remuneration*
4. *The Chief Executive was in attendance to present a report on the proposed remuneration for the Interim Director of Finance and a report on the proposed appointment and remuneration of the Interim Chair of the Estates and Facilities Subsidiary Company.*
5. *Martin Wood, Natashia Judge and Lukasz Bohdan attended, 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.

During 2017/18 the Remuneration Committee agreed remuneration of the appointee Executive Directors, using the NHS Improvement's benchmarking data. These decisions were made in the context of recruiting of several substantive Executive Directors.

Non-Executive remuneration and terms and conditions of service are reviewed and decided periodically by the Governance and Nominations 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 1st April to 31st March. In terms of measuring performance:

- Executive Directors are reviewed by the Chief Executive
- The Chairman undertakes the performance review of the Chief Executive and Non-Executive Directors
- The Chairman is appraised by the Senior Independent Director/Vice Chair

Following the establishment of the Estates and Facilities Subsidiary Company, the Remuneration Committee also deals with the terms and conditions of the Subsidiary's Directors.

Peter Lachecki
Chair

25th May 2018

6.2 Senior managers' remuneration policy

Executive Directors are employed on permanent contracts with six months' notice periods and termination and sickness arrangements in accordance with the standard national terms. These terms are too voluminous to repeat in the report but are available on the Department of Health website. The start date for Executive Directors is:

Deborah Lee	13 June 2016
Emma Wood	1 November 2017
Dave Smith	1 April 2009 - 2 November 2017
Simon Lanceley	8 January 2018
Sally Pearson -	2 August 1993 - 30 January 2018
Caroline Landon	19 October 2017
Arshiya Khan	22 May 2017 - 31 October 2017
Natashia Swinscoe	21 November 2016 - 21 May 2017
Sean Elyan	1 November 2005
Steve Hams	25 September 2017
Maggie Arnold	16 October 1995 - 9 October 2017
Steve Webster	19 June 2017 - 31 March 2018
Lukasz Bohdan	13 November 2017

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

Salary and Pension entitlements of executive and non-executive directors							
Name and title		Salary and fees	Taxable Benefits	Annual Performance related bonuses	Long Term Performance Related bonuses	Pension related benefits	Total Remuneration
Year ended 31 March 2017		(Bands of £5,000)	(£00)	(Bands of £5,000)	(Bands of £5,000)	(Bands of £2,500)	(Bands of £5,000)
Clair Chilvers	Chair, with effect until 7th November 2016	25-30	0	N/A	N/A	0	25-30
Peter Lachecki	Chair, with effect from 7th November 2016	20-25	0	N/A	N/A	0	20-25
Tony Foster	Non Executive Director	10-15	0	N/A	N/A	0	10-15
Maria Bond	Non Executive Director, with effect until 30th April 2016	0-5	0	N/A	N/A	0	0-5
Gordon Mitchell	Non Executive Director, with effect until 27th September 2016	5-10	0	N/A	N/A	0	5-10
Clive Lewis	Non Executive Director, with effect until 31st August 2016	5-10	0	N/A	N/A	0	5-10
Helen Munro	Non Executive Director, with effect until 21st December 2017	10-15	0	N/A	N/A	0	10-15
Ann Marie Millar	Non Executive Director, with effect until 27th October 2016	5-10	0	N/A	N/A	0	5-10
Keith Norton	Non Executive Director, with effect from 1st May 2016	10-15	0	N/A	N/A	0	10-15
Tracey Barber	Non Executive Director, with effect from 1st September 2016	5-10	0	N/A	N/A	0	5-10
Rhona MacDonald	Non Executive Director, with effect from 4th October 2016 to 31st March 2017	5-10	0	N/A	N/A	0	5-10
Dr Claire Feehily	Non Executive Director, with effect from 1st February 2017	0-5	0	N/A	N/A	0	0-5
Robert Graves	Non Executive Director, with effect from 1st February 2017	0-5	0	N/A	N/A	0	0-5
Dr Frank Harsent	Chief Executive, with effect until 15th May 2016	20-25	0	N/A	N/A	0	20-25
Deborah Lee	Chief Executive, with effect from 13th June 2016	150-155	0	N/A	N/A	150-152.5	300-305
Eric Gatling	Director of Service Delivery, with effect until 8th January 2017	120-125	0	N/A	N/A	25-27.5	145-150
Natasha Swinscoe	Director of Service Delivery, with effect from 21st November 2016	50-55	0	N/A	N/A	90-92.5	145-150
Dr Sean Elyan[1]	Medical Director	175-180	0	N/A	N/A	50-52.5	225-230
Dr Sally Pearson	Director of Clinical Strategy	145-150	0	N/A	N/A	70-72.5	215-220
Maggie Arnold	Nursing Director	110-115	0	N/A	N/A	87.5-90	200-205
David Smith[2]	Director of Human Resources	105-110	22	N/A	N/A	35-37.5	140-145
Helen Simpson[3]	Director of Finance, with effect until 30th September 2016	165-170	0	N/A	N/A	20-22.5	185-190
Stuart Diggles[4]	Director of Finance, with effect from 1st October 2016	160-165	0	N/A	N/A	0	160-165

Note:

1 Dr Sean Elyan receives salary of £84,178 for clinical duties that is included in salary and fees

2 David Smith taxable benefit relates to lease car

3 Helen Simpson had a lease car but no taxable benefit due to private use contribution

4 Mr S Diggles was appointed as Interim Director of Finance and Information from 1st October 2016 and was remunerated to 31 March 2017 via consultancy fees of £161,250 (exclusive of VAT) payable to Task Finance Limited, a company which he is a director and 50% shareholder. Additional expenses of £18,607 (exclusive of VAT) were also paid that were directly related to the provision of services to the Trust.

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

Director Pensions 2016/17									
Pension benefits of Senior Managers		**Real increase/(decrease)in pension at age 60**	**Real increase/(decrease)in related lump sum at age 60**	**Total accrued pension at age 60 at 31 March 2017**	**Lump sum at age 60 related to accrued pension at 31 March 2017**	**Cash Equivalent Transfer Value as at 1 April 2016**	**Real increase/(decrease) in Cash Equivalent Transfer Value**	**Cash Equivalent Transfer Value as at 31 March 2017**
		(Bands of £2,500)	**(Bands of £2,500)**	**(Bands of £5,000)**	**(Bands of £5,000)**	**£'000**	**£'000**	**£'000**
Dr Frank Harsent	Chief Executive, with effect until 15th May 2016			0	0	0	0	0
Deborah Lee	Chief Executive, with effect from 13th June 2016	5-7.5	17.5-20	35 to 40	110 to 115	553	144	733
Eric Gatling	Director of Service Delivery, with effect until 8th January 2017	0-2.5	2.5-5	50 to 55	150 to 155	920	68	1,008
Natasha Swinscoe	Director of Service Delivery, with effect from 21st November 2016	0-2.5	2.5-5	25 to 30	70 to 75	403	26	476
Dr Sean Elyan	Medical Director	2.5-5	0-2.5	85 to 90	165 to 170	1,337	130	1,467
Dr Sally Pearson	Director of Clinical Strategy	2.5-5	10-12.5	60 to 65	180 to 185	1,176	123	1,299
Maggie Arnold	Nursing Director	2.5-5	12.5-15	35 to 40	110 to 115	745	126	870
David Smith	Director of Human Resources	0-2.5	0-2.5	10 to 15	0	176	43	219
Stuart Diggles	Director of Finance, with effect from 9th September 2016			0	0	0	0	0
Helen Simpson	Director of Finance, with effect until 30th September 2016	0-2.5	0-2.5	55 to 60	170 to 175	1,048	29	1,106

Note:

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 2016/17 in respect of Dr F Harsent and Stuart Diggles

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 2017/18 was £190k to £195k (2016/17 £175k to £180k). This was 6.9 times (2016/17 6.4) the median workforce, which was £27,635 (2016/17 £27,635)

In 2017/18,2 employees (2016/17 2 employees) received remuneration in excess of the highest-paid director. Remuneration ranged from £199k to £207k (2016/17 £210k to £212k).

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 2017-18 against 2016-17, this increased by £15K (8.57%).

It should be noted that during 2017-18 we observed considerable turnover across the Trust Board; this led to the appointment of a number of new members of the Trust Board:

- Chief Operating Officer (replacing former Chief Operating Officer)
- Deputy Chief Executive and Director of People and OD (replacing former Director of Human Resources)
- Director of Strategy and Transformation (replacing former Director of Clinical Strategy)
- Chief Nurse and Director of Quality (replacing former Director of Nursing)
- Director of Finance (replacing Interim support)
- Director of Corporate Governance (New post)

As noted in the Annual statement on remuneration, during 2017/18 the Remuneration Committee agreed remuneration of the appointee Executive Directors, using the NHS Improvement's benchmarking data.

Deborah Lee
Chief Executive Officer

25th May 2018

7. STAFF REPORT

7.1 OVERVIEW

With circa 7,700 employees, our 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.

In November 2017 the Trust welcomed a new Director of People and Organisational Development, who reviewed the workforce strategy and confirmed the immediate 6-12 month priorities to ensure the Trust makes progress against the aspiration to 'Deliver an Excellent Employee Experience'. Progress against these priorities is monitored by the Workforce Committee, a sub-committee of the Trust Board.

In summary the key strategic priorities for late 2017 and 2018 were identified as:

Establishment Realignment

Our current establishment data is held in both the Electronic Staff Record system (ESR) and on the purchase ledger. These data sets vary, which can result in inaccurate establishment reporting, poor quality workforce information and restricted vacancy profile reporting. Through reviewing the establishment need versus budget and through the proactive agreement of a baseline funded position we are seeking to improve financial control, the quality of workforce planning and design. Significant steps have been taken to progress this work, starting with the realignment of Doctors in Training, to support the national Doctors in Training Streamlining Pilot.

CIP Delivery

There are a number of ways in which we continue to contribute to the delivery of CIP and the Trusts financial recovery programme from reviewing policies, supporting the reduction in agency expenditure, to supporting and facilitating organisational change.

Reducing Bureaucracy and Creating Efficiencies

A key focus for our workforce during 2017/18 was the consultation exercise and development of proposals to develop a Wholly Owned Subsidiary Company (SubCo). As a result of this project, the Trust Board oversaw the launch of a Subsidiary Company; NHS Gloucestershire Managed Service (NHSGMS), on April 1st 2018. Work will continue with the Board of GMS to realise the benefits and efficiencies proposed by the model whilst ensuring the employment package and staff experience offered to staff remains competitive and in line with Trust values.

Talent Development

A system of talent management and succession planning is currently being refined, after a series of workshops with leaders and the wider workforce, to develop a model that is both meritocratic whilst providing staff with an opportunity to 'self-identify' as talent.

Health and Wellbeing Agenda

During the latter part of 2017, the Health and Safety agenda was realigned to fall under the portfolio of the new Director of People and Organisational Development, The Health and Wellbeing agenda was previously split between *public* and *staff*

Health and Wellbeing priorities (divided between the then Director of HR& OD and the Director of Clinical Strategy), under the new model this was merged as part of the complete Health and Safety portfolio. A new emphasis on diversity commenced with the launch of our diversity network and we have commenced a review of our Health and Wellbeing offer to staff, reviewing the feasibility of a 'one stop shop' to signpost staff to services efficiently, maximising benefits for staff whilst simultaneously reducing the impact of health and wellbeing issues on the productivity and attendance of the workforce.

Staff Engagement

The Trust prides itself in open and transparent communication, two way feedback and listening. Staff are actively encouraged to contribute to the Trust decision making and have a number of channels to ensure their voice is heard. The Trust has focused on improving the methods of engagement and two way feedback which has included the launch of local 'GEM' (Going the Extra Mile) Awards and the launch of a new Diversity Network. Work to develop a 'Staff Experience Improvement Group' will commence with the intention to build on this momentum and ensure that staff experience data is captured and feeds into the decisions we make as an organisation.

Analysis of Staff Numbers

01 Apr 2017 to 31 Mar 2018

Average number of employees (WTE basis)	**Group**			
	Permanent Number	**Other Number**	**2017/18 Total Number**	**2016/17 Total Number**
Medical and dental	1,339	41	**1,380**	1,256
Ambulance staff	-	-	**-**	-
Administration and estates	1,343	5	**1,349**	1,413
Healthcare assistants and other support staff	379	2	**380**	388
Nursing, midwifery and health visiting staff	1,977	82	**2,059**	2,019
Nursing, midwifery and health visiting learners	851	-	**851**	892
Scientific, therapeutic and technical staff	1,245	13	**1,259**	1,237
Healthcare science staff	-	-	**-**	-
Social care staff	-	-	**-**	-
Other	21	4	**25**	3
Total average numbers	**7,155**	**148**	**7,303**	**7,208**

7.2 Gender Split of Workforce

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

Head	Male	Female	Total	Male %	Female %
Chair & Directors	8	6	**14**	57%	43%
Band 8a+ staff	67	173	**240**	28%	72%
All Employees	1592	6197	**7789**	20%	80%

The numbers of females outweigh the number of males across all staff groups, albeit the ratio of female to male staff reduces with seniority. There is no obvious reason for this trend, however work is currently underway to formalise our approach to the management of talent and succession planning, to further ensure that

promotion and development opportunities are awarded through a structured meritocratic process.

7.3 Talent Development

A system of talent management and succession planning will be launched by June 2018. The design will enable 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 meritocracy will pervade, as will the ability for staff to be both recommended as 'talent' and 'self-identify'.

An improved link to appraisal and a shift from appraisals as a means to performance management alone to one where it is also about a career conversation will be implemented.

7.4 Developing a Sustainable Workforce

Workforce supply continues to be challenging across a number of areas; notably Nursing and Midwifery and Junior and Middle Grade Doctors. There have been a number of reasons for this, most significantly the reduced numbers of staff entering/completing commissioned training programmes. Staff Turnover sits at 12.24%, however targeted work within Nursing and Midwifery staff groups has reduced turnover to 10.89% across this professional group.

Our approach to workforce planning is clinically driven and linked to the business planning cycle, assessing the shape of the workforce profile in relation to capacity and demand across the Trust. As part of the business planning process, clinicians and managers work together to identify risks and issues in terms of their current and future workforce, and to develop associated plans to address these concerns. These plans are aggregated into the Trust-wide plan; furthermore our workforce assumptions are now fed into the Health Education England workforce plans, through engagement across Gloucestershire Sustainability and Transformation Partnership.

Recruiting and retaining the required workforce for the Trust remains a significant challenge. To ensure a safe nursing workforce, we continue to implement our comprehensive Nurse Recruitment and Workforce Development strategies, both in terms of executing a broad range of recruitment options and in developing new roles and ambitious career pathways.

For several years we have recruited and supported nurses from non-European countries to pass the challenging assessment processes that enable them to register with the NMC as Band 5 nurses. In November 2017, a new "Occupational Language Test" (OLT) was introduced to allow overseas nurses to be tested against their ability to write and speak English relating to nursing and healthcare. This replaced the more general 'International English Language Test (IELT) and evidence of candidates having passed the OLT is now a requirement by GHT prior to them being recruited. The subsequent development pathway for these recruits involves support to pass the computer-based test (CBT) of nursing competence and intense training in the clinical and decision-making skills required to pass the Objective Structured Clinical Examination (OSCE). A pass in this is required prior to the Nursing and Midwifery Council accepting staff as registered nurses in the UK. As such these nurses are employed as HCAs on our wards until they have passed this international assessment. Since April 2017, 69 overseas nurses have completed all the assessments and are now working in our Trust as registered nurses with a further 23 at various points in the pathway.

A significant change to the healthcare education funding system came into effect in September 2017 moving Allied Health Professional, healthcare science and nursing degree programmes from nationally funded bursaries and commissions to student loans. Nationally, the evidence suggests this led to a 33% drop in applications for adult nursing degrees, although the local position has been different and enrolment is slightly higher than previous years. With the introduction of a new adult nursing degree programme at the University of Gloucestershire and intakes of students from UWE and Worcester University, Gloucestershire will offer placements to c160 first year nursing students, approximately 65 more than previous years. In 2017, including second and third year students, we provided a total of 348 placements for adult nurse degree students. Clearly, after so much investment, we hope to recruit the newly qualified graduates to start their career with us and to that end, we hold regular recruitment events for third year nursing and midwifery students from all universities and 'on-boarding' workshops and events to stay in touch with our local students. The aim is to help socialize and welcome these undergraduates making them more likely to join us in their first role. Feedback from these has been exceptionally positive with an average of 80 students commencing work with us.

In April 2017, as part of a countywide partnership, our Trust commenced the pilot Trainee Nursing Associates (TNA) programme, recruiting 13 of our best HCAs to become pioneers for this brand new national role. The programme lasts two years with a day per week of academic study at the University of Gloucestershire and a combination of four "hub" placements for three days a week in Gloucestershire Hospital and another four placements with our partnering Trusts. Work is to plan the scope of practice for this Band 4 Nursing Associate role and how the role complements the Band 5 Nurse role. The county has applied to offer a further 41 TNAs (18 in GHFT) for a second cohort to start in the summer of 2018, this time through the apprenticeship route.

The wider apprenticeship agenda continues to grow with our Trust achieving an impressive 100 apprentices in March 2017 across a wide range of roles and services. A tendering process was held by the Gloucestershire STP partnership to offer and pilot a leadership and management qualification at level 3 for more experienced staff. A local provider Gloucestershire Enterprise Limited (GEL) were successful in this bid and started a new programme earlier this year with the aim of expanding this offer to higher numbers if it proves successful. As the range of approved apprenticeship courses and registered providers increases, it is hoped more staff will be able to take on apprenticeships either as vehicles for their continuing development or as part of the developing career pathways to offer new routes into healthcare professions.

As a way to attract a talent pool of newly qualified AHPs and Nurses who have successfully achieved a high grade degree and completed the first preceptorship year post graduation, our Trust is introducing a new and innovative development opportunity to recruit. The Chief Nurse Junior Fellow programme for between 12 - 15 people will commence in a Division where it is currently hard to recruit too. The programme will be accompanied by a dedicated day per week of targeted personal development, mentored by a nursing director and supported in a service improvement project (trained to Silver academy level). This programme will start in June 2018 (September 2018 for external candidates) and allow the Chief Nurse Junior Fellows the chance to be added to the Talent Pool at the end of the year for a fast-tacked career in our Trust.

In terms of other roles, work continues to develop Assistant Practitioner band 4 roles in AHPs, theatres and Healthcare Science roles (utilizing apprenticeships as they become available). To respond to the ongoing challenges in medical workforce supply, combined with shortages at Junior and Middle Grade Doctor Level and the national imperative to deliver 7 day services, other new and enhanced roles are being considered:

- A full scoping of our current staff in advanced, specialist or Nurse Practitioners including what experience and qualifications they have as relevant to developing a senior (Bands 7 and 8) Advanced Clinical Practitioner (ACP) role. Work continues to identify where this ACP role could be most beneficial in complementing, and in some cases replacing, Medical staff. The strategic vision and associated business cases will be agreed in 2018.

- Further development of the Physician Associate role in certain specialties continues with 2 having employed in 2017 and a further 8 in training with local universities.

- A full programme of Non-medical prescribing education continues with a particular focus on the Pharmacy Prescriber role, exploring ways in which prescribers could work in teams with non-prescribing clinical colleagues so as to release clinical time.

With the identification of new roles and recruitment/retention priorities, the Strategic Education and Sustainable Workforce Group revised its Terms of Reference to strengthen the governance for the above programmes of work and ensure a strong link between the strategic aims and implementation of workstreams. The group reports to the Workforce Committee.

7.5 Cross County Collaboration

The One Gloucestershire Sustainable Transformation Plan for workforce is overseen by the Local Workforce Advisory Board and supported by a structure of sub-working groups which address the workforce challenges and aim to ensure a successful, efficient and safe supply of staff in Gloucestershire. Successes include the securing of £900,000 of education funding from HEE to enable ten workforce development projects. This agenda remains essential given the current challenges around workforce supply, to ensure we compete less for a finite resource and ensure our focus is on developing suitable roles which will attract and retain high quality healthcare workers in Gloucestershire

7.6 Temporary Workforce

Whilst it is our aim to have a fully employed substantive workforce, it is also recognized that a contingent workforce (i.e. a temporary and flexible workforce employed directly by our Trust that can be called upon to deal with peaks and troughs of demand) is vital. We have an internal Bank which manages flexible requests for temporary cover for nurses and medical staff. Bank workers are typically engaged without fixed or guaranteed hours, and are able to cover both planned and unplanned shortages. There is also the need to source temporary workers from external agencies, frequently at increased cost. The workforce supply issue in a number of professions, notably in the medical and nursing workforces has resulted in a significantly increased reliance on agency workers over the last 2 years. This is neither desirable nor sustainable, not just from the perspective of increased costs, but more importantly from the perspective of continuity and quality of patient care. We have undertaken significant work to reduce this reliance, not only by adopting internal strategies, but also by working in partnership with NHS Improvement. The result was a reduction in agency use in 17/18 by 26%. Whilst the most important focus is on increasing recruitment numbers and improving retention, other strategies to be adopted this year include:

- Business Case and implementation of a new E-Rostering solution for all staff groups including Bank Management module;
- Approval levels for “Off – Framework” agency escalated to executive directors;
- Continued incentivising bank shift payments for existing substantive staff;
- Review of the Bank Offer including rates and service relaunch to include regular recruitment campaigns for increasing the Bank resource targeting new, external workers including current agency staff;

- A collaborative approach to bank recruitment and agency management countywide linked to STP;
- A review of the existing arrangements for agency use including a programme of reducing rates in line with the NHS Improvement agency rate caps;
- Commencement of Temporary Staffing service review to include integration of AHP / HSS and Corporate staff groups to form fully centralised Bank and Agency Management service.

While having made progress over the last six months, this will remain an area of considerable focus as we seek to both maintain and increase traction at increasing our internal fill rates through an invigorated and relaunched internal Bank service all the while reducing our utilisation of external agency workers. Success also provides the Trust with considerable cost savings.

7.7 Sickness Absence and Health and Wellbeing

Our Trust's sickness rate for the period 2017 to 2018 reduced to 3.94% compared to a national average for large acute Trusts of 4.57% (to November 17) and a Department of Health target of 3%. This is a slight decrease in absence compared to the previous year.

Sickness Absence Long Term	1.94%
Sickness Absence Short Term	2.00%
Annual Sickness Absence	3.94%

Divisional HR Business Partners, supported by the Employee Relations Manager and HR Advisory Team have remained crucial to robust sickness absence management alongside the continued partnership working between trade union and professional representative colleagues. Amendments to the Trust Sickness Absence Management Process during 2017 provides Managers with improved guidance and a framework to support intervention at an earlier stage in order to support staff who are absent from work to improve attendance and address health concerns where possible.

We are delighted to have completed the Workplace Wellbeing Charter assessment during 2017. We achieved accreditation and were awarded "Excellence" in the categories of: leadership, absence management, health and safety and smoking; we were awarded "Achievement" in the alcohol and substance misuse category; and awarded "Commitment" to making progress in the categories of mental health, healthy eating and physical activity. We are now formulating and implementing action plans to drive these forward as priorities across the organisation, with a particular focus on musculo-skeletal injuries and stress. The Health and Wellbeing Group will oversee the development and delivery of specific action plans.

A significant amount of focus was given to improving the health and wellbeing of our staff in 2017, which included the following key actions:

- Distributing regular reminders to leaders about the importance of supporting the health and wellbeing of their team members through: 100 Leaders sessions; monthly Leaders' Learning Digests
- The launch of a monthly staff recognition scheme – the 'gem' awards – to recognise and celebrate great colleagues
- The launch of the Trust Diversity Network in November 2017 to support and promote the diversity of our workforce, particularly the nine legally protected characteristics. A programme of activity is being devised to both offer support, signposting and celebration of vulnerable protected characteristics including disability and mental health
- The promotion of the Freedom to Speak Up Guardian role
- Listening events within Divisions and departments and team meetings to discuss ways of improving staff engagement and health-wellbeing.

In addition to our work within the Trust, One Gloucestershire STP has established a STP Health and Wellbeing Group. It has had particular focus on MSK and stress, along with supporting improvement in flu jab uptake across our STP. The Trust achieved 74% flu jab uptake across the workforce in 2017/18, exceeding the 70% CQUIN target

There are some key steps planned in the next year to build on this momentum and continue to improve staff health and wellbeing through 2018/19 and beyond. In order to drive forward and manage the delivery of these actions a simple Health and Wellbeing Group will be created with a priority to include the development of a 'One Stop Shop' for Staff Health and Wellbeing. The Trust has many channels of support available for staff however current accessibility of these and our response to immediate need can be challenging. A review of services will commence in Spring 2018 and will determine if more can be achieved within our financial envelope. This review will identify the current return on investment for employee Health and Wellbeing services and will include: Occupational Health, Staff Support, and Physiotherapy services. Furthermore the review will benchmark with other organisations with a 'one stop shop' / signposting provision and make recommendations for the development of enhanced, more accessible staff wellbeing service.

A key focus for a new Staff Experience Improvement Group will be to improve the triangulation of data relating to staff experience, to enable in depth analysis and targeted intervention. This will include the launch of an online engagement / communications tool, which will enable staff to provide feedback and improve two way communication with our workforce. This will also provide an opportunity for us to promote health and wellbeing resources, such as the 'one stop shop' in an easily accessible way.

7.8 Staff policies and actions applied during the financial year

Policies applied during the financial year for giving full and fair consideration to applications for employment made by disabled persons, having regard to their particular aptitudes and abilities.

Our Trust is proud to be recognised as a 'Disability Confident Leader'. Our recruitment team proactively engage with candidates to ensure that individual needs are met throughout the recruitment and appointment process whilst advising managers on their duty to make reasonable adjustments for disabled candidates/ employees.

Between April 2017 and March 2018, our Trust received 15,993 applications for employment (an increase of 623 from 2016/17). 5% (794) of these candidates declared a disability during the application process (a slight reduction from 5.2% representing 796 candidates in 2016/17). 43% of the candidates who declared a disability met the basic criteria for the position (increase from 39.6% in 2016/17) and were shortlisted for interview. From the 342 disabled candidates shortlisted for interview, 41 were appointed into roles within our Trust. This represents a slight decrease when compared to 2016/17 data. It can also be noted that the number of candidates choosing not to disclose their disability status increased significantly; from 149 in 2016/17 to 266 in 2017/18. Raw data is shown in the table below:

Job applications: disabled applicants

		Applications	% of total applications	Short-listed	Appointed	Appointed as % of shortlist	% of overall appointees
Disability	Yes	794	5.0%	342	41	5.40%	4.2%
	No	14,933	93.4%	5843	929	93%	94.7%
	Undisclosed	266	1.70%	95	11	1.50%	1.1%

Policies applied during the financial year for continuing the employment of, and arranging for appropriate training for ***employees*** who have become disabled persons during the period.

For any member of staff declaring disablement (in accordance with the definition set out in the Equality Act 2011) during the course of their employment with our Trust appropriate support is provided to ensure they are able to remain in and fulfil their employment through a process of 'reasonable adjustments'.

This is managed in accordance with the Trust Sickness Management Policy supported by HR, the Line Manager, Occupational Health Practitioners and any other treating Clinicians.

Options that are considered include, but are not limited to the following: amendments to roles and responsibilities in existing role, provision of technology or other equipment in order for them to be able to continue in their role, amendment to hours/shifts, and redeployment to other suitable alternative roles in the organisation.

Training can be provided internally through in-house training programmes or externally where appropriate via various agencies such as the Job Centre Plus. Our Trust does not currently retain accurate information on the number of employees classified as 'disabled', as this is dependent on whether or not the employee chooses to classify themselves in this way, therefore each case regarding a 'disabled' employee is managed individually in accordance with their individual needs and Trust Policy. The launch of our Trusts 2017 'Diversity Network' aims to encourage staff to share their experience and seek support where appropriate as part of their employment experience.

Actions have been taken in the financial year to consult employees or their representatives on a regular basis so that the views of employees can be taken into account in making decisions which are likely to affect their interests.

A number of initiatives exist to allow meaningful consultation and recognition of the employee voice.

The NHS Staff Survey results provide us with an opportunity to make a genuine difference to the way we work. Local action plans within Divisions have provided an opportunity to engage with our staff on issues that matter to them such as travel to work and openness and transparency.

Our staff partnership and accompanying consultative mechanisms are well embedded. There are positive and productive working relationships between our Trust and our staff side representatives. This has proved to be very effective in supporting the many workforce issues that have been delivered. As an example in 2017/18 we consulted on the proposed development of a wholly owned subsidiary company with staff in our Estates and Facilities Division. Despite national trade union pressure against the development of these proposals, our collaborative

working relationship with local trade union colleagues resulted in a meaningful and engaging consultation process with our workforce and the development of proposals which were strongly influenced by the voice of our workforce; such as long term protection of Agenda for Change terms and conditions for transferring staff.

Formal consultation with staff and their elected representatives takes place within the Staff Committee and Local Negotiating Committee environments. In addition to our staff side colleagues, we also have a number of elected Staff Governors who work hard to represent the voice of their constituents.

Regular listening events continue to provide our staff with the opportunity to meet with the Chief Executive and other executive colleagues. These events have provided a good opportunity for staff to discuss issues. Executive colleagues regularly participate in 'back to the floor' events, meeting and working alongside staff in their working environments to hear about the issues that matter the most to them.

In 2017 we successfully completed the Workplace Wellbeing Charter assessment and were awarded "Excellence" in the categories of: leadership, absence management, health and safety and smoking; we were awarded "Achievement" in the alcohol and substance misuse category; and awarded "Commitment" to making progress in the categories of mental health, healthy eating and physical activity. We are now formulating and implementing action plans to drive these forward as priorities across the organisation, with a particular focus on MSK and stress.

Despite the wide range of methods of engaging with our workforce, we recognise that there is limited triangulation of the data gathered in order ensure this intelligence. The development of a new 'Staff Experience Improvement Group' will be created to implement a range of staff engagement actions. A key objective of the group will be to improve the triangulation of data relating to staff experience, to enable in depth analysis and targeted intervention. The group will also deliver the launch of an online engagement / communications tool, which will enable staff to provide feedback and improve two way communications with our workforce.
Information on policies and procedures with respect to countering fraud and corruption.

Our Trust has a designated Local Counter Fraud Team and apposite 'countering fraud and corruption' policy framework. Our Raising Concerns Policy and the appointment of a Freedom to Speak Up Guardian and Non-Executive Director with Freedom to Speak Up guardian role, provide a framework for staff to raise concerns anonymously or otherwise to selected senior managers. The Trust currently uses an externally hosted bespoke system (Speak in Confidence) for anonymous reporting of concerns, including those relevant to fraud and corruption.

7.9 Exit packages

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 wrapped up 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. One non-contractual payment was agreed

during the period 2017 to 2018, with approval from HM Treasury (HMT), to the value of £14,000.

The Directors confirm that there were no exit packages in 2017/18.

7.10 Equality reporting

The Trust has devoted increased focus and attention on equality, diversity and inclusion issues in the last 12 months.

As part of the Trust's Workforce Strategy (published December 2016) there are three key strategic priorities around equality and diversity:

1. Embed equality and diversity as part of our Trust 'DNA' extending the opportunity to hear from staff about their real experience of working in our Trust;
2. Introduce and track performance against the Workforce Race Equality Standard (WRES), taking appropriate actions to improve performance;
3. Improve the experience and contribution of staff with a disability or long-term condition;

These underpin our two Equality Objectives, which were formulated in 2015/16 as part of the national Equality Delivery System (EDS2) and our Public Sector Equality Duty:

Equality Objective 1 – BAME Staff

Engaging with this group of staff will support further development that is being built upon through the Workforce Race Equality Standard. We will look to set up a BAME network within the Trust to provide a voice for this group of staff.

Equality Objective 2 – Working with staff who have a disability

We will support staff into employment who have learning disabilities, where we have committed to support this through the national campaign.
Following the appointment of a new Chair and Vice-Chair of the Equality Steering Group, a comprehensive review of the membership and terms of reference was carried out in December 2016.

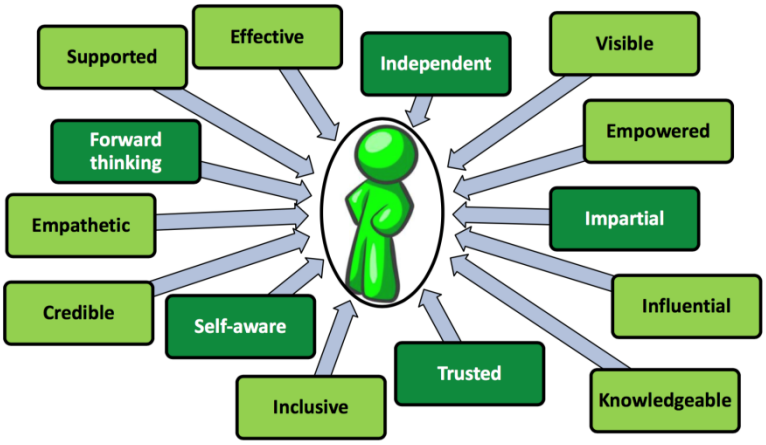
Since then, in 2017/18 we have completed the following to help deliver our strategic priorities and equality objectives:

- We completed a detailed analysis of the 2016 annual staff survey results against the protected characteristics of race and disability (as these are our priority areas of focus). We subsequently identified trends, and presented these to staff during a listening campaign which coincided with the NHS Diversity & Inclusion Week in May 2017
- In November 2016 we established a staff diversity network. This is staff-led, with senior leadership support championing it
- We used the listening campaign to better understand the specific actions we can take to improve the experience of staff who have a disability and formulated a number of recommendations
- We have focused on developing the capability and confidence of leaders and managers by embedding equality, diversity and inclusion considerations into all leadership development learning opportunities offered by the Trust
- We published the Workforce Race Equality Standard in August 2017 and identified a number of actions from these results
- We began to make preparations/groundwork for the Workforce Disability Equality Standard which is scheduled to launch in 2018.

7.11 Freedom to Speak Up

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.

Freedom to Speak Up Guardian Role



Suzie Cro, Deputy Director of Quality was appointed as Freedom to Speak Up Guardian on 1st April 2017 and since then progress has been made in a number of areas. The Freedom to Speak Up Guardian reports to a nominated Non-Executive Director. The guardian works together with the senior leadership team to promote a culture where staff feel enabled to speak up about their concerns which are acted upon in a timely way.

This year the guardian has:-

- Set up the role and established a strategy and action plan to be monitored through the Freedom to Speak Up Group attended by the Non-Executive Director, Director of Safety and Deputy Chief Executive and Director of People and OD
- Attended training with the National Guardian's Office
- Reviewed the current Trust 'Raising Concerns Policy' and worked towards implementing national policy Freedom to Speak Up (whistleblowing) policy produced by NHS Improvement
- Promoted the role with materials produced by the National Guardian's Office to ensure consistent communication across the Trust so that staff are familiar with the role even when they move to a new organisation
- Implemented a communications plan for the message and the Guardian role. One of the actions being to meet as many staff as possible by attending ward/departmental meetings and taking opportunities to speak to staff
- Increased the number of people contacting the office for advice and support
- Networked with the South West Freedom to Speak Up regional network and within the Gloucestershire area (Gloucestershire Care Services and 2gether Trusts).

Speaking up data

Concerns	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Number of issues raised directly with the Freedom To Speak Up Guardian	3	1	4	23
Number of issues raised anonymously	2	1	1	0
Nature of issue				
• Patient quality issues	1	2	1	13
• Staff safety				
• Behavioural / relationship	1			
• Unacceptable behaviour (bullying / harassment)		1	2	16
• System issues	1			
Action	Yes	Yes	Yes	Yes
Outside referral	No	No	No	No
Detriment	1	0	0	0
Feedback "would they speak up again"	1 Yes	N/A as cases not closed	Yes	Yes

Learning from the data

- The Freedom to Speak Up Guardian is available for advice and support. Although the number of cases has risen this may be due to the accessibility and visibility of the Guardian;
- Staff are able to contact the Freedom to Speak Up Guardian through the anonymous Speak In Confidence dialogue system, an online web based tool;
- Our staff behaviours matter and poor staff behaviours impact on our patients, on our colleagues and our reputation as an organisation. The number of concerns about behaviours has risen and this trend escalated to the Director of Quality and Chief Nurse.
- One concern has led to a quality summit process being convened by the Director of Quality and Chief Nurse so that the issues could be reviewed and shared.

Future priorities

Over the next 18 months the aims are to:-

- Improve our speaking up culture by looking at implementing other Trust's successful initiatives as well as our own
- Improve our accountability (fair, honest, open, behaviours and practices when concerns are raised)
- Improve our transparency by reporting Freedom to Speak up Concerns being reported internally and externally with our lessons learned
- Provide training for staff: how to raise a concern, how to receive a concern, and how to act to establish the facts
- Promote the learning and improvement by talking about case studies or staff experience stories
- Develop particular strategies for recognised vulnerable groups (locums, agency staff, students and trainees)
- Develop connections and partnerships so that we are speaking up together

- Spread the word creatively and innovatively across the Trust and further into the wider One Gloucestershire arena
- Help lead the change so that Speaking Up becomes business as usual
- Keep the Board fully sighted on, and engaged in, all Freedom to Speak Up matters
- Develop a local network of Ambassadors within the Trust with staff experience champions
- Measure the cultural change via monitoring aspects of the annual staff survey.

7.12 Developing Our Response to the Staff Survey

In response to the 2016 staff survey results and feedback from face-to-face engagement events, four **Trust-wide priorities** were agreed which we have been working on for the last 12 months:

1. Travel to work
2. Developing and promoting a culture of openness and transparency
3. Acting on and demonstrating use of patient/service user feedback
4. Improving visibility of, and support from, leaders and managers.

In addition to the four Trust-wide priorities, a key feature of our approach to improving the employee experience has the establishment of divisional, departmental and staff group action plans which also have their own key priorities to work on.

A brief overview of the progress and achievements made to date is set out below:

Priority 1 – Travel to work

- **A new 99 shuttle bus service** was launched in August 2017 – bigger buses; whilst losing the racecourse stop there are now additional stops at Arle Court park and ride, Cheltenham town centre, Gloucester bus station. The service operates over longer operating hours, and free WiFi is available. There are proposed new bus stops to launch at Longlevens and TGI Friday's Cheltenham in 2018/19
- **Public transport and Bikes** – 50% discount available on the 801 service. A Stagecoach West single journey offers a reduced fare to NHS of £1.80. A NHS-discounted season ticket is available with Stagecoach West. There are increased cycle storage facilities – new cycle shed for 40 bikes at CGH; new cycle shed for 20 bikes at GRH
- **Parking –** proposed additional permits e.g. occasional user, weekend. New permit system has a delayed rollout – now scheduled for summer 2018
- Listening events have taken place in January-February 2018 to get feedback on the new bus service, and to get views on parking permit proposals.

Priority 2 – Developing and promoting a culture of openness and transparency

- **Values -** we engaged with 100 Leaders to get their views on the Trust's values. This was followed by a Board seminar in summer 2017 which considered our values against organisational priorities. Our plan for 2018/19 is to focus on three of the existing values (Caring – Excelling – Listening) and drive this focus through a number of strategic and operational initiatives
- **Openness and transparency** – these principles have been regularly demonstrated through the weekly Trust-wide communications. These

have also been incorporated into leadership training e.g. sessions on 100 leaders, existing development programmes

- **FGR/CQC -** The Financial Governance Review report was published in August 2017. A presentation of the findings was delivered by the CEO and Chair – this was filmed and subsequently promoted through the weekly newsletter and intranet
- **CQC report** - Findings from the report, following the inspection in early 2017, were shared and discussed widely at divisional/departmental and Trust levels. CEO organised special listening events with junior A&C staff in response to feedback from CQC about their experiences

Priority 3 – Acting on and demonstrating use of patient/service user feedback

- Engaged staff with patient experience data as a Silver QI project, moving from 2-3 patient experience projects going to nearly 30
- The patient experience improvement team have been using Gold QI coaching skills to enable staff to engage with their data and more improvements in the year
- The Trust has commenced a programme to drive patient service called ***Journey to Outstanding*** (#J20)
- Consultation has commenced on a draft of our Patient Experience (PE) Strategy which is now entitled "Deliver What Matters Most".

Priority 4 – Improving visibility of, and support from, leaders and managers

- **Freedom to Speak Up** – the freedom to speak up guardian role was officially launched and a steering group has been established. The Guardian has attended many staff meetings to talk to staff about the role and promote it
- **Good practice for leaders** – there have been regular reminders to leaders about the importance of the support they demonstrate to teams and individuals. Evidenced through – content on 100 Leaders sessions; content of monthly Leaders' Learning Digest
- **Diversity Network** – we hosted five launch events between November-December 2017 to promote and launch the network. We currently have over 50 members. First meeting was held January 2018. An organising committee representing a diverse range of protected characteristics has been established. Network meetings are scheduled to take place every 2 months. We have delivered regular reminders to senior leaders about the importance of this initiative
- **Recognising staff** – In January 2018 we launched a monthly staff recognition scheme called the "Gem Award" to recognise and celebrate great colleagues.

7.13 The 2017 Staff Survey Results

The national NHS staff survey was held between October and December 2017, and was a full survey of all employees (as is standard practice for our Trust). The Trust's response rate was 47% which is above the average NHS return of 44%. For the first time we offered some staff the opportunity to complete their survey online. We had a higher response rate from staff that completed the survey online vs. those who received the survey by post.

Responses are compressed into 32 Key Findings. Ten out of the 32 key findings show statistically significant changes; of these 8 key findings have deteriorated and 2 key findings have improved. The remaining 22 are not statistically significant.

The areas where scores are statistically significant and deteriorated since 2016 are:

- Key Finding 1 – staff recommending the organisation as a place to work or receive treatment
- Key Finding 2 – staff satisfaction with the quality of work and care they are able to deliver
- Key Finding 5 – recognition and value of staff by managers and the organisation
- Key Finding 8 – staff satisfaction with level of responsibility and involvement
- Key Finding 14 – staff satisfaction with resourcing and support
- Key Finding 17 – percentage feeling unwell due to work-related stress in the last 12 months
- Key Finding 18 – percentage attending work in last 3 months despite feeling unwell because they felt pressure
- Key Finding 19 – organisation and management interested in and taking action on health and wellbeing

The areas where scores are statistically significant and improved since 2016 are:

- Key Finding 23 – percentage experiencing physical violence from staff in the last 12 months
- Key Finding 24 – percentage reporting most recent experience of violence.

Employee engagement is a composite score made up of three Key Findings:

KF1 – Staff recommending the Trust as a place to work or receive treatment
KF4 – Staff motivation at work
KF7 – Staff ability to contribute towards improvement at work

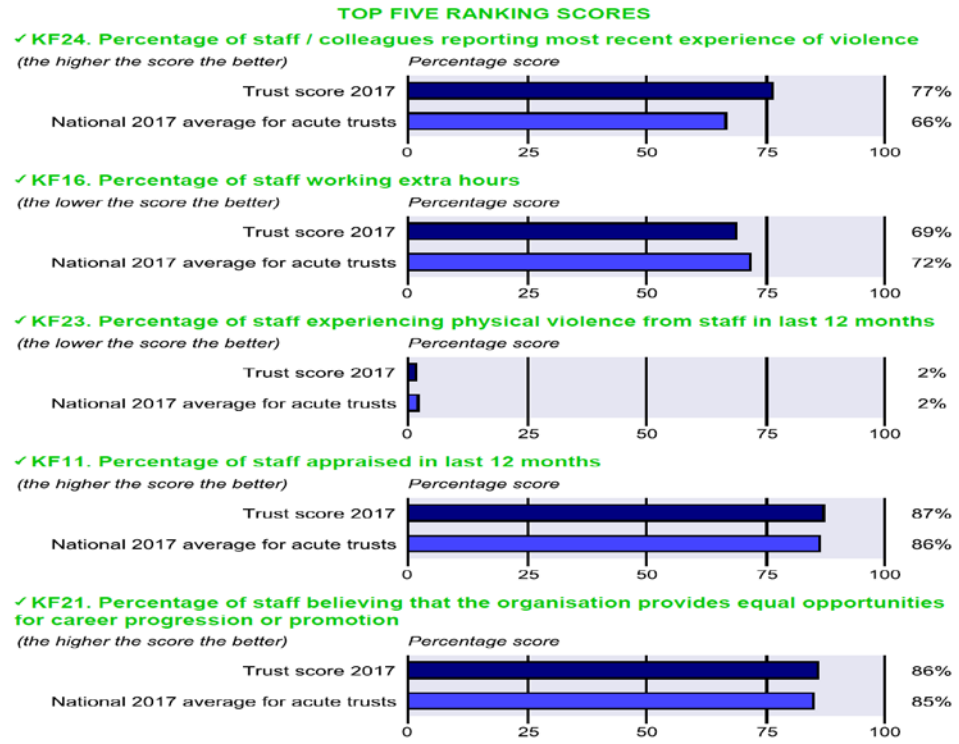
The table below shows the progress made by our Trust in terms of employee engagement over the last 6 years. This year our overall staff engagement score has unfortunately fallen for the first time since the data has been captured in this way. Equally, the average engagement score for acute Trusts also dropped from 3.81 in 2016 to **3.79** in 2017 indicating a likely national trend.

Staff Engagement	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
Overall Staff Engagement	3.50	3.59	3.66	3.71	3.71	**3.67**
KF7: Staff ability to contribute towards improvements at work	64%	65%	66%	67%	67%	65%
KF1: Staff recommendation of the Trust as a place to work or receive treatment	3.27	3.43	3.58	3.62	3.64	3.57
KF4: Staff motivation at work	3.70	3.77	3.77	3.86	3.85	3.82

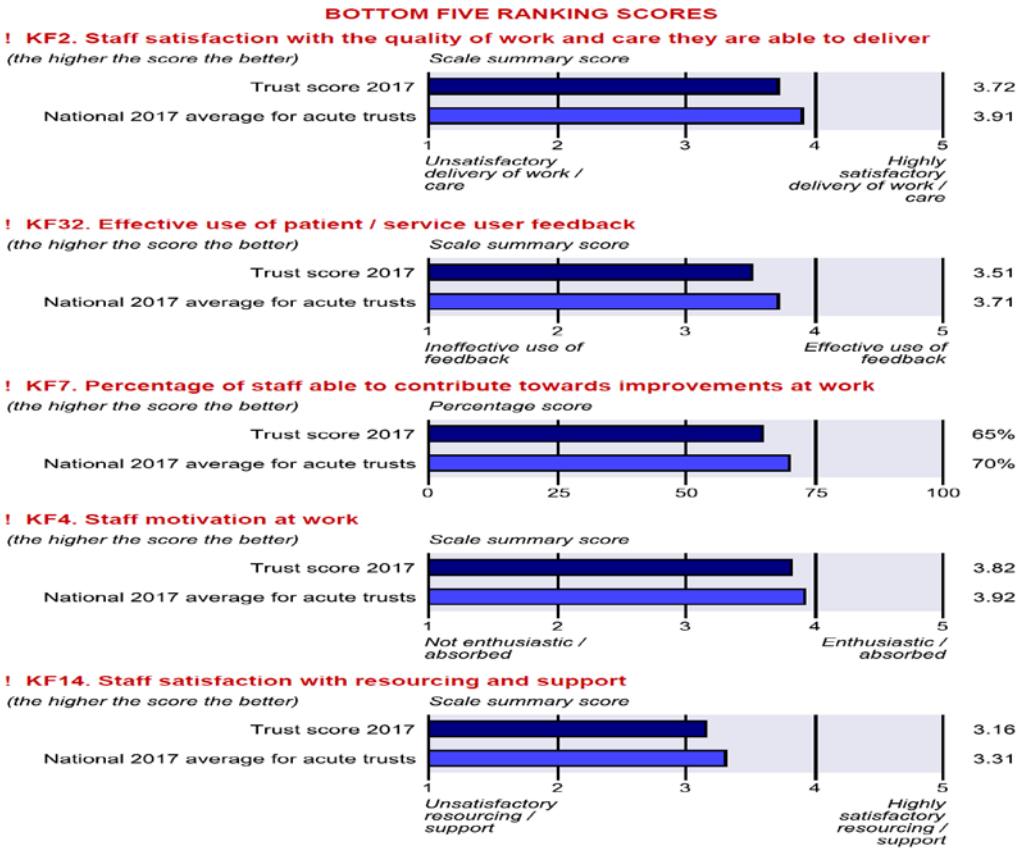
Whilst it is disappointing that our engagement score has dropped, it is also recognised that there has been a period of significant change within the Trust and staff are challenged with increasing demands and financial restraint.

Other significant scores include:

- The five key areas in which the Trust compares most favourably with other acute Trusts in England



- The five Key Findings for which the Trust compares least favourably with other acute Trusts in England:



The richness of the data provided enables us to consider variation across divisions and staff groups; it is clear that a one-size-fits-all approach will not glean the sufficient traction and growth of improvement we are aiming for.

Therefore for 2018/19 we will triangulate staff survey results against other data sources available e.g. patient surveys, staff friends and family test, sickness absence/turnover etc. to gain an holistic understanding of what is going, and take appropriate remedial actions to address this.

7.14 Off Payroll:

Off-payroll engagements are listed in the table below.

For all off-payroll engagements as of 31 March 2018, for more than £245 per day and that last for longer than six months	
	2017/18
	Number of engagements
Number of existing engagements as of 31 March 2018	4
Of which:	
Number that have existed for less than one year at the time of reporting	3
Number that have existed for between one and two years at the time of reporting	-
Number that have existed for between two and three years at the time of reporting	-
Number that have existed for between three and four years at the time of reporting	-
Number that have existed for four or more years at the time of reporting	1

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last for longer than six months	
	2017/18
	Number of engagements
Number of new engagements, or those that reached six months in duration between 1 April 2017 and 31 March 2018	8
Of which:	
Number assessed as caught by IR35	3
Number assessed as not caught by IR35	5
Number engaged directly (via PSC contracted to department) and are on the departmental payroll	-
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	-

For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018	
	2017/18
	Number of engagements
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	-
Number of individuals that have been deemed "board members and/or senior officials with significant financial responsibility". This figure should include both off-payroll and on-payroll engagements.	14

7.15 Exit packages

The Directors confirm that there were no exit packages in 2017/18.

7.16 Staff costs

A breakdown of staff costs is shown in the table overleaf:

Staff costs 2017/18

	Group			
			2017/18	2016/17
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	261,284	-	**261,284**	253,513
Social security costs	23,774	-	**23,774**	23,270
Apprenticeship levy	1,281	-	**1,281**	
Employer's contributions to NHS pensions	31,650	-	**31,650**	31,099
Pension cost - other	-	-	**-**	-
Other post employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	-	-	**-**	-
Temporary staff		16,696	**16,696**	21,792
NHS charitable funds staff	198	-	**198**	204
Total gross staff costs	**318,187**	**16,696**	**334,883**	**329,878**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**318,187**	**16,696**	**334,883**	**329,878**
Of which				
Costs capitalised as part of assets	-	-	**-**	-

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 2017/18 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 9-10
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 39
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 46 - 50
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.	Page 53
Board	The board of directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary.	Page 37

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 38 - 43
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 37 - 45
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 63 - 64
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 three 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.	Page 38
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 46-47 Page 61-62

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 43
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 37
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 2017/18 was performed by Price Waterhouse Coopers (PwC)

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.	Page 129
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 / 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 section 5
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.	Page 62

Relating to	Summary of requirement	Response
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.	Page 60
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.	Pages 45 - 56
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
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

Relating to	Summary of requirement	Response
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
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

Relating to	Summary of requirement	Response
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
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

Relating to	Summary of requirement	Response
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.	This formed part of the Board Governance review recommendations relating to Governor Effectiveness
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
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

Relating to	Summary of requirement	Response
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
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, with quality aspects addressed by the Quality and Performance Committee

Relating to	Summary of requirement	Response
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)
Remuneration 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
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

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 4: "Providers in special measures - there is actual or suspected breach of licence with very serious and/or complex issues".

This segmentation information is the Trust's position as at 31st March 2018 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**	**2017/18 scores**				**2016/17 scores**	
		Q4	**Q3**	**Q2**	**Q1**	**Q4**	**Q3**
Financial sustainability	Capital service capacity	4	4	4	4	4	4
	Liquidity	4	4	4	4	4	4
Financial efficiency	I&E margin	4	4	4	4	4	4
Financial controls	Distance from financial plan	4	3	1	2	4	4
	Agency spend	3	3	4	3	4	4
Overall scoring		**4**	**4**	**3**	**3**	**4**	**4**

The Trust worked throughout 2017/18 with its regulator NHS Improvement to prepare a proposal for consideration by the national panel that would see the Trust discharged from the regulatory enforcement action which was remained in place during 2017/18 in respect of both A&E performance (since August 2016) and financial governance (October 2016).

A number of ‘evidence gathering’ activities by NHS Improvement took place towards the end of 2017/18 including reviewing Board and committee reports and spending time with staff in urgent and emergency care services. The Board reviewed the progress against action plans and, meeting the Trust’s executive and non-executive directors, satisfied itself that the Trust delivered the agreed actions supporting the Enforcement Undertakings, with regard to both the A&E and the Financial Governance Review.

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

Further, The Trust worked with the NHS Improvement throughout 2017/18 on a case to support the Trust to exit the Financial Special Measures (FSM) regime. The FSM team accept that the financial governance failings which contributed to the Trust being placed in FSM have been addressed and whilst the Trust has not delivered the financial recovery plan for 2017/18, the reasons for this (income under performance) are understood and importantly the Trust has delivered its 5.7% Cost Improvement Plan. Recently submitted credible plan for 2018/19 is supporting these efforts.

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
- 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

25th May 2018

11. ANNUAL GOVERNANCE STATEMENT 2017/18

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 2018 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 replaced the Risk Management Framework and in doing so strengthened assurance and monitoring systems. During 2017/18 I continued to take personal interest in this agenda strengthening many approaches to risk management including further development of an executive risk management group and assigning executive lead for risk management to the newly appointed Director of Corporate Governance to support me in my execution of this duty.

Risk register procedures identify responsible managers and assuring committees in relation to action plans to eliminate/reduce identified risks. An Internal Audit review of risk management during the year recognised that the Trust had worked hard to develop a strong culture of risk management over the last few years. The review recognised the value of the Risk Management Group in leading work in this area; it further noted on the and attention given to risk management by leadership across the organisation.

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 was also developed. 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.

11.4 The risk and control framework

I can confirm that a risk and control framework has operated throughout 2017/18, 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.

The Board Assurance Framework (BAF) is the key document enabling 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 live document updated by the Executive leads for each of the strategic objectives and provides the basis for both the assurances and gaps in control reported in the Annual Governance Statement. 2017/18 saw further development of the BAF with the Board Committees starting to undertake a detailed scrutiny of risk, controls, assurances and gaps – to be undertaken on a quarterly basis, with assurance provided to the Board following the completion of each quarterly cycle.

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

The Board has also approved a Risk Register Procedure document which outlines the processes involved to update and disseminate the Trust's Risk Register and to agree and monitor the action plans to eliminate or reduce risk. The systems, processes and assurance mechanisms have been strengthened in the new Risk Management Strategy and associated policies and procedures.

The Trust Risk Register comprises the most significant risks facing the Trust, is representative of the challenges facing the Trust and includes clinical, financial, operational, reputational, environmental and other risk areas.

The management of the Trust Risk Register is through the Trust Leadership Team (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.

Risk Management Group scrutinises the risk management processes and reporting mechanism to provide system assurance and holds Divisions and Directors to account for the devolved management function.

Board committees also scrutinise risks scoring 12 or above using the risk domains in the risk matrix as follows:

- Quality and Performance Committee – Oversight of patient safety, quality, reputation and statutory risks
- Workforce Committee – Oversight of human resources, health & safety and environmental
- Finance Committee – Oversight of finance and business
- GMS Committee (in place for 2017/18) – Oversight Gloucestershire Managed Services (GMS)

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 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 or above or 12 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 sets 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 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 newly established Risk Management Group.

Serious Untoward Incidents (SUIs) 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 summary of the current Serious Untoward Incidents (SUIs) is reported to the Trust Board (bi-monthly). In most cases a SUI 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 SUI investigations are carried out in a timely way and investigations and their action plans are closed. The operational committee responsible for SUIs is the Safety and Experience Review Group which is chaired by the Director of Safety and has the Executive Directors of Nursing and Medicine 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 Trust Board. 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 Trust has been subjected to review of its emergency preparedness during 2016/17 and no serious concerns were highlighted.

The Gloucestershire Hospitals NHS Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission.

The Trust, however, 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.

In November 2016 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, where it remains pending regulatory review. The Trust has developed a detailed financial plan for 2018/19 which has been scrutinised by NHS Improvement.

The report of the Independent Review of Financial Governance was presented to the Trust Board in May 2017.The Board accepted number of recommendations arising from the review at its July 2017 meeting. Three recommendations were not accepted in full though actions arise from them, in part, and are underway. The Board reviewed the report at its March 2018 meeting and accepted the report as a source of assurance that good progress was being made against the recommendations. The report presented to the Board in March 2018 confirmed that 2017/18 actions were completed; the nature of many actions meant they would remain ongoing e.g. Board development. The final action was completed by the end of April 2018, when the Executive Quarterly Reviews were established.

The Trust worked throughout 2017/18 with its regulator NHS Improvement to prepare a proposal for consideration by the national panel that would see the Trust discharged from the regulatory enforcement action which was currently in place in respect of both A&E performance (since August 2016) and financial governance (October 2016).

A number of 'evidence gathering' activities by NHS Improvement took place towards the end of 2017/18 including reviewing Board and committee reports and spending time with staff in urgent and emergency care services. The Board reviewed the progress against action plans and satisfied itself that the Trust delivered the agreed actions supporting the Enforcement Undertakings, with regard to both the A&E and the Financial Governance Review.

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.

Further, The Trust worked with NHS Improvement throughout 2017/18 on a case to support the Trust exiting the Financial Special Measures (FSM) regime. The FSM team accept that the financial governance failings which contributed to the Trust being placed in FSM have been addressed and whilst the Trust has not delivered the financial recovery plan for 2017/18, the reasons for this (income under performance) are understood and importantly the Trust has delivered its 5.7% Cost Improvement Plan. The Trust recently submitted a credible financial plan for 2018/19, which is supporting these efforts.

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.

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.

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

We operate 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 bi-monthly meetings..

The Trust has made excellent progress in delivering its Cost Improvement Programmes (CIPs) during 2017/18, delivering £28.5m against a Financial Recovery Plan target of £34.7m. This performance represents delivery of efficiency to the proportion of 5.7% of turnover which is ahead of both the sector average and, specifically, those Trusts in FSM. 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

The Trust's Information Governance Toolkit score for 2017/18 has been published as 76%, and is graded green.

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 Serious Incident Requiring Investigations involving personal data as reported to the Information Commissioner's office in 2017–18 (Level 2)

Date of incident (month)	Nature of incident	Nature of data involved	Number of data subjects potentially affected	Notification steps
12-Apr-17	Lost or stolen paperwork	A doctor's ward handover sheet found in a public place by a member of Trust staff	25	Patients not contacted, as information had been contained within the Trust

Date of incident (month)	Nature of incident	Nature of data involved	Number of data subjects potentially affected	Notification steps
15-Apr-17	Lost or stolen paperwork	Ward Nursing handover sheet found in a public place by a member of Trust staff	27	Patients not contacted, as information had been contained within the Trust
14-Sep-17	Non-secure Disposal – paperwork	MDT meeting notes including an identifiable list of patients received by another care provider in a box delivered from stores	17	Patients not contacted, as information secured and destroyed by NHS care provider
20-Sep-17	Lost or stolen paperwork	Ward handover sheet found in a public place by a member of Trust staff	20	Patients not contacted, as information had been contained within the Trust
29-Sep-17	Disclosed in Error	Copy of discharge summary data transferred to a server located in the USA in error. Against previously agreed data handling processes	18	Patients not contacted, as information had been secure at all times.
12-Oct-17	Lost or stolen paperwork	Ward handover sheet found in a public place by a member of Trust staff	35	Patients not contacted, as information had been contained within the Trust
01-Nov-17	Lost or stolen paperwork	A doctor's ward handover sheet found in a public place by a member of Trust staff	30	Patients not contacted, as information had been contained within the Trust
10-Nov-17	Disclosed in Error	Emergency Department discharge summaries sent in error to another health and social care provider.	8	Patients not contacted, as information secured and destroyed by health and social care provider
24-Nov-17	Lost or stolen paperwork	Ward handover sheet found in a public place by a member of Trust staff	30	Patients not contacted, as information had been contained within the Trust

Date of incident (month)	Nature of incident	Nature of data involved	Number of data subjects potentially affected	Notification steps
Further action on information risk	GHNHSFT will continue to monitor and assess its information risks, in light of the incidents above. The processes and controls within the teams involved have been reviewed in order to identify and address any weakness and ensure the improvement of systems where required. Extensive communication to Trust staff specifically highlighting the need to ensure safe keeping of handover sheets has been introduced as a regular reminder. Additional controls have been implemented including tighter controls on each ward in terms of who can print them and how they are distributed. Further plans in progress to improve ease of confidential disposal of handover sheets. A review of data processing procedures that resulted in information being copied to server in USA has been carried out by system supplier and assurance received that these have been corrected.			

Summary of other personal data related incidents internally reported 2017–18 (Level 1) As per HSCIC guidance

Category	Breach Type	Total
B	Disclosed in Error	22

Risks to data security 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, PCs etc.). Further technical controls planned for implementation include vulnerability scanning and asset discovery and posture.

Process controls include subscription to CareCERT alerts and a process for tracking the implementation of these alerts. A tested major-cyber cyber incident response plan (countywide as network is across STP partners), a regular programme of user communications around existing policies and good user hygiene followed up with randomised phishing attack simulations.

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.

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 there are appropriate controls in place to ensure the accuracy of the data.

The production of the Quality Report is overseen by the Quality and Performance Committee. This is a committee 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). 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. In January 2018, 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 24th May 2018.

The quality of the data used in the Quality Report is scrutinised as part of the External Audit of the Quality Report. 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. In December of 2016 we launched our 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 Quality and Performance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The failings in governance, associated with the unexpected decline in the Trust's reported financial position, were subject to external review (Financial Governance Review) and its findings were presented to the Board in May 2017. As reported in section 4, above, the Trust delivered the agreed actions supporting the Financial Governance Review.

2017/18 saw further strengthening and maturing of the controls environment, including the form and function of Board sub-committee arrangements to ensure they are well placed to provide Board with the required levels of assurance. The Trust's corporate governance function was also strengthened, including the Board-level Director appointment with responsibility for corporate governance.

The Audit 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 governance, risk management and control is 'Generally satisfactory with some improvements required'. Internal Audit are satisfied that sufficient internal audit work has been undertaken to allow an opinion to be given as to the adequacy and effectiveness of governance, risk management and control.

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 areas where we noted such weaknesses included cyber awareness and staff education, UK visas and immigration procedures, elements of the business continuity plans and contract governance mechanisms.

The Trust has made progress in improving and strengthening its internal control environment during 2017/18. The issues noted in the course of 2017/18 internal audit reviews were fewer in number and of lesser severity than in the previous year.

Internal Audit completed all 16 of the internal audit reviews in the 2017/18 internal audit plan for the year ended 31st March 2018. Two reviews were high risk, eight reviews have an overall rating of medium, three were low risk rated, none were advisory and two were not risk rated.

Internal Audit's work has identified no critical, eight high, 26 medium and 12 low and one advisory risk rated findings to improve weaknesses in the design of controls and/or operating effectiveness. Internal Audit classified three internal audit reports as high risk and we identified eight individual high risk findings in our internal audit reviews. The Trust has implemented a number of the recommendations raised during 2017/18 and has action plans in place to implement those that have not been implemented.

The number and priority of critical risk recommendations is slightly lower compared to last year (none compared to one in the prior year). There are fewer high risk rated recommendations (eight compared to 15), fewer medium risk recommendations (20 compared to 26) and a also fewer low risk recommendations as the prior year (12 compared to 20).

The 46 risk rated findings issued this year were split between 20 relating to control design and 26 relating to operating effectiveness.

During the course of their work Internal Audit identified a number of weaknesses that they consider should be reported in the Annual Report. They are:

High risk rated produced reports during the year:

Business Continuity Management This included the identification of two high risk findings regarding:

- Business Impact Analysis (BIA) had been conducted but did not include identification of critical activities at a sufficient level to enable prioritisation; we recommended that these are updated to include identification of critical resource requirements and interdependencies, amongst other factors.
- Business Continuity plans do not reflect the critical services identified in the BIAs; accordingly we recommended that additional guidance, templates and training is provided to support this activity.

All actions remain open at year end.

Cost Improvement Programme, this included the identification of three high risk findings regarding:

- The requirement to act upon and respond to the Trust's unidentified CIP gap of £9.7m including the undertaking of a lessons learned exercise to ensure limit repeat issues for the 18/19 plan.
- The Trust are yet to move to their desired Programme Management Office (PMO) structure of separate PMO function and delivery support, we endorsed internal plans to adjust current structures to support PMO delivery.
- Enhanced engagement so far as monitoring and performance review activities of CIP schemes, including KPIs.

All actions have been closed at year end.

HR (Operational) Prevention of Illegal Working; this review identified 2 high risk findings:

- Further work is required to ensure all Right to Work checks are completed accurately, thoroughly and in advance of an individual joining the Trust; further support is required to provide HR team sufficient empowerment in this space.
- Further work is required with regard to document retention, recording and tracking of individuals, including the undertaking of follow on checks for staff with visa or employment expiry dates.

All actions have been closed at year end.

Medium risk rated reports produced during the year:

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).

Internal Audit identified issued eight medium risk rated reports during the year:

The **Clinical Audit – Mortality review** gave rise to 3 medium risk rated findings:

- The requirement for enhanced and more consistent reporting processes for Trust mortality reviews.
- The new mortality policy has been disseminated across the Trust but further work is required to ensure sufficient awareness and confidence in its interpretation and application.
- The need for additional training and lack of training compliance was the root cause for a number of issues identified, particularly with regard to application of the new policy.

HR Strategic (Recruitment & On-boarding) identified three medium risk rated findings

- Policies and procedural documentation were out of date and contained a number of errors; accordingly they require an overhaul to enable them to be used as a reliable and accurate form of guidance by the HR department.
- The Trust did not have a single view of the number of new joiners at any specified point in time; the tracking of joiners is complicated by the use of a number of systems and methods which do not interface. We recommended that a methodology which provided a single, reliable point of view and tracking system should be implemented. Further, due to lack of capacity the consistency with which compliance checks were being undertaken also required significant improvement.
- Ongoing improvement is required to track the use of honorary contracts in place across the Trust.

The **Governance Contract Management,** with Financial Shared Services (FSS), was one of the 5 medium risk rated reports issued. We raised recommendations for improvements in respect of the following:

- We recommended that the KPIs in the Service Level Agreement (SLA) were reviewed and updated for current processes and delivery. We also recommended more comprehensive and consistent reporting of performance by FSS against the KPIs
- There is a history of the SLA being signed much later than the start of the financial year. Our recommendations included the need for the SLA to be signed in advance of the financial year going forward.
- We recommended that Partnership Board meetings should be held quarterly as per the SLA, not on the current 6 monthly basis. Further, we made recommendations for improvement in the quality of meeting minutes and actions agreed.
- Finally we recommended that the FSS should consult with the Partnership when making decisions which may have financial implications for the partnership such as entering into contracts.

The **Prescribing review (non-medical prescribing)** identified 2 medium risk rated findings:

- The need for the Trust to implement an overarching non-medical prescribing strategy, supported by the generation of a high level operational document.
- Further work is required with regarding the communication, review and oversight of prescribing errors, both for non-medical and medical prescribers.

The undertaking of the **Information Security, Phishing Exercise** was Medium risk rated and gave risk to 1 high risk finding. This was due to the following:

- The phishing exercise allowed us to capture a number of user credentials, which amounted to almost half of those who followed the link within our phishing email and visited our fake login page.
- In total 300 employees were included within our phishing exercise of which 80 **(26.6%)** followed the link embedded within the email and 38 **(12.6%)** entered their credentials into the fake login form.
- PwC also observed a number of weak passwords used by employees who submitted their credentials to our fake login page. In most instances these words included additional numbers and capitalisation, for example “123Orange”, which means that they will meet minimum password complexity and length requirements. However, modern passwords crackers will typically apply appended numbers, special characters and capitalisations to their wordlists meaning that it would be trivial for an attacker to guess these passwords if they were in a position to conduct a password brute force guessing attack.

The **Core Financial Systems Phase 1** report identified one medium risk rated finding:

- As raised in prior years, there remained work to be conducted to improve and update the authorised signatory listing to ensure transactions are being approved by appropriate individuals.

The **Core Financial Systems Phase 3** report identified two medium risk rated findings:

- There is a need for enhanced robust governance and controls to be put in place regarding the VAT returns; we recommended the need for defined roles and responsibilities between the shared services and the Trusts, defined policies and procedures, enhanced visibility over the timeliness of feedback and submission. We identified further recommendations for the enhanced need for the incorporation of externally flagged VAT issues to be reflected within future VAT returns

- As raised in prior years, there remained work to be conducted to improve and update the authorised signatory listing to ensure transaction are being approved by appropriate individuals.

The **Quality Monitoring (CQC)** report identified three medium risk rated findings:

- At the time of the audit only 4 of the 30 actions were complete, we therefore recommended that the Trust review and prioritise the completion of the remainder
- We identified that further evidence was required for one action to enable full validation of its completion
- We recommended that 5/30 actions needed target completion dates adding to ensure accountability and completion of the actions ahead of the deadline.

During the year Internal Audit undertook follow up work on previously agreed actions. The internal audit reviewed progress on the 62 recommendations raised last year: 58 had been fully implemented or were now closed; and there were four recommendations from the prior year (2016/17) still ongoing; two high (Cancer Waiting Times & Controls Over Use of Agency Doctors), one medium and one low risk. Internal Audit recognised that significant progress made regarding these however further work is required for their completion. Additionally there remains one open action (low risk – Agency Nursing) from 2015/16.

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.

The following areas, which were audited during 2017/18, were assessed as low risk:

- Risk management
- Core Finance Phase 2
- Finance (P2P)

It is good practice to review periodically the effectiveness of governance arrangements. During 2017/18, the Trust launched a review of its Constitution and supporting documents, including the Standing Orders and Standing Financial Instructions. A review of management and reporting lines was undertaken as well as a review of quality governance and reporting. Revised quality reporting to the Quality and Performance Committee began in March 2018 with further improvements planned for the first quarter of 2018.

Executive managers 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 2017/18 and the positive direction of travel, as recognised in the Head of Internal Audit's Opinion of 'generally satisfactory with some improvements required'. I can confirm that action plans are in place to embed and ensure continuous improvement of the arrangements and to address outstanding issues.

I am confident that the improvements delivered with regard to corporate governance in 2017/18 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

25th May 2018

12. QUALITY REPORT

The Foundation Trust has had regard to NHS Improvement's quality governance framework in arriving at its overall performance. The quality framework is designed to provide Quality Assurance for the Trust and support the principles of continuous improvement. Quality is assured using the five key questions set by Care Quality Commission (CQC) regulatory framework and aims to demonstrate continuous compliance with the regulations. It will ensure that all Gloucestershire Hospitals' activities are included within both a governance and performance management system that can then provide assurances to all parts of the organisation. The structures should integrate with, rather than be separate from, the day to day activities of the divisions and provide assurances to the Chief Executive and the Trust Board on the robustness of governance arrangements, and the provision of Best Care for Everyone.

The Quality Framework recognises governance as the systems and processes, by which the Board will lead, direct and control its functions in order to achieve organisational objectives, and relate to and work with its stakeholders who include patients, their carers and the public. In addition, the Board recognises that risks to achievement of objectives exist and need to be identified and managed. There are a number of specific areas of governance including corporate governance, financial governance, clinical governance, research governance and information governance. This framework is designed to meet the requirements to monitor the CQC regulations and fulfil NHS Improvement's current Quality Governance Framework.

The Health and Social Care Act 2012 identifies several quality-related duties. The quality framework sets down how these are to be achieved and how aspects of clinical governance are to be integrated into the Trust arrangements and how quality will be continuously monitored, improved and assurance as follows:

The Trust has contracts for the provision of services with commissioners such as NHS Gloucestershire. These contracts include conditions in relation to clinical governance arrangements and improving quality that the Trust needs to meet.

All NHS organisations have to account for the care they provide with the same level of scrutiny as used for financial management by publishing quality accounts. The quality accounts will report against the five CQC key questions.

There are several key principles that have been established for a successful and sustainable framework:

Within the Divisions the Chief of Service is accountable for quality, and demonstrate how this responsibility is discharged through scrutiny of their services and reporting to the Quality & Performance Committee and Executive Divisional reviews.

- The importance of embedding continuous improvement for safety, effectiveness and good patient experience into everyday practice.

- The need to be transparent with quality information in line with publishing quality accounts and accountability.

This framework has been established to provide evidence to support compliance with CQC regulation and outcomes and connects to the other governance arrangements to include:

- The legal and governance arrangements in place for the conduct of research on NHS patients, staff and in NHS premises

- The Risk Management Framework and associated Divisional risk management arrangements.
- Information Governance arrangements.

Organisation

Wards and departments will have regular team meetings and as a minimum discuss, improve and monitor any specified performance indicators including Nursing metrics, Safety Thermometer, patient survey, complaints, compliments and concerns, investigate and feedback learning from incidents, maintain the H&S manual and discuss any H&S concerns and share any new policies.

Specialties will monitor quality performance by establishing a representative multidisciplinary committee and using the Trust Quality Model to structure quality activity. The specialty quality lead will receive exception based reports from the relevant wards and departments as indicated above at the meeting.

Divisions will review formally the quality arrangements and performance of each specialty. Exceptions and concerns will be escalated to the Divisional review systems. They will produce a quality report each quarter bringing together the five key questions of quality, relevant Trust objectives including good practice which will be ratified by the Chief of Service through a formal route. These reports will be scrutinised periodically by the Quality Delivery Group.

The Quality & Performance Committee will receive exception reports from key committees from the executives directors and the performance dashboard.

Leadership and accountability

The Chief Executive is the Accountable Officer for the Gloucestershire Hospitals. She is accountable for ensuring that the Trust can discharge its legal duty for all aspects of governance and quality each year, and for the health and safety of staff, visitors and contractors in the Trust.

The Director of Quality and Chief Nurse has overall responsibility for Quality in partnership with Executive Directors and Chief of Services and collectively they are accountable for the quality, safety and patient experience in their areas of responsibility; their organisational processes must be able to discharge the requirements of the strategic objectives, the Care Quality Commission Regulations, legislative requirements and other specific NHS standards.

The Director of Safety and Deputy Director of Quality and Freedom to Speak Up Guardian, in partnership with the Director of Quality and Chief Nurse, and the Medical Director, ensures organisational arrangements are in place which satisfies the legal requirements of the Trust for quality, patient safety, and continuing improvements for patients and staff.

The Director of Safety is the lead for quality improvement through the Quality and Safety Improvement Academy (including clinical audit), patient safety and the delegated lead for health and safety.

The Deputy Director of Quality leads the work of improving patient experience, by ensuring the Trust uses every opportunity to inform practice through service user involvement and feedback, and by ensuring the Trust meets related legal and national standards and for coordination of the Quality Account.

The Director of Strategy and Transformation is responsible for Research and Development in the Trust.

The Director of Corporate Governance has Trustwide lead over governance.

The Director of People has responsibility to ensure the Trust meets Health and Safety requirements.

The Director of Safety is responsible for ensuring that exception reports on Serious Incidents are included in reports to both the Trust Leadership Team meeting and the Quality and Performance Committee and for maintenance of the Trust Risk Register and Assurance Framework.

Managers are responsible for the safety of patients and\or staff and\or hospital buildings. They have a duty to implement systems that monitor safety and take reasonable action to maintain and improve safety.

All staff are responsible for their own and others' health and safety within their immediate environment and for participating in wider governance, quality and risk management issues within their department. This includes ensuring that they:

- have access to, understand and follow all Trust policies and procedures;
- work in a safe manner at all times having due regard to any person who might be affected by their actions and raise any concerns regarding quality and safety;
- in addition, all staff should have clear objectives set and documented as part of their annual performance reviews.

The Trust Board has specific duties placed on it in relation to all aspects of governance including financial, information, research, clinical and corporate governance. In addition, it needs to integrate these aspects so that it can be assured across all of these areas. A number of Trust Board Committees with Non-Executive Director chairs and members have been established to make sure that the necessary assurances can be provided to the full Board in support of its responsibilities to assure that robust systems are in place to manage governance, quality and safety.

A key role for the Non-Executive Director (NED) is to seek assurances and provide a challenge to the Executive team; therefore the NEDs need to have a level of understanding of basic processes and information presented to them in the key Committees.

Assurance of quality systems is provided by the Expert Advisory Groups (H&S, Transfusion, Infection Control and Radiation etc.). These groups are responsible for monitoring standards and systems, developing policy, training and alerting the Trust to any concerns:

Assurance of quality activity is provided by the Divisions on a quarterly basis and is established through their governance, quality and safety arrangements. The Divisional arrangements will be an integral element of the Trust's framework and form a major part of the initial performance management focus.

The day-to-day management of quality, safety and patient experience is the duty of the Trust Leadership Team with support from the corporate clinical governance, research, information and safety team.

Monitoring assurance of these processes and activity has been delegated to the Quality and Performance Committee, supported by information from the Directors and Divisions and a network of specialty and expert committees.

In addition and crucially, the Trust Board then assures itself through its regular review of reports received from these arrangements, for example, the Trust Risk Register, Board Assurance Framework, Complaints Report, Infection Control Report.

The Trust Leadership Team is responsible for validation and managing significant risks to the operation of the Trust, and the governance and quality issues arising from the management of the Trust's activities. It will do this through the regular review of the Trust Risk Register. The Trust Risk Register is made up of the most significant risks from the Divisions and specific risks identified by the Executive Team and other Directors.

This Risk Management Group also monitors the Divisional and Domain Risk Registers on a rolling annual programme, whereby the Division or Director presents their current risks. This Group provides assurance to Trust Board on the risk management system through this process

The Quality and Performance Committee receives assurance on quality systems. This process provides assurance to the Trust Board that it is discharging its legislative requirements across all these areas. It discharges its duty by ensuring that there is an appropriate committee structure monitoring standards and reporting progress and concerns, and by receiving reports from Directors and Division on quality, safety activity and patient experience. In particular, the Committee monitors and assure themselves that the Divisions:

1.1 have appropriate structures in place to discharge their responsibilities;
1.2 that they are consistently discharging their responsibility by monitoring and reporting their quality and safety activity;
1.3 are reporting their concerns formally and transparently;
1.4 that they are continuously improving.

The Divisions set up and maintain systems to enable the following activity to occur:

1.5 Escalation of concerns\risks\serious incidents from Specialties in real time with monthly follow up and monitoring of actions within the Division.
1.6 Escalation of concerns\risks\serious incidents to the Trust Management team in real time and as part of the Divisional risk register and Quality Report.
1.7 To performance manage quality activity in the Division over the three domains through an annual individual specialty review and collation of the Divisional Quality Report.
1.8 Maintain compliance with the Care Quality Commission Regulation and report any concerns with compliance.
1.9 To manage and review the Divisional Risk register by following the Gloucestershire risk management and assessment procedure. To validate the Departmental\Specialist Risk Register and receive quarterly update reports. To report any significant risks to the Trust Management Team.
1.10 To provide assurance via formal and standardised quarterly reports to the Quality Committee across the three domains following the Trust template (Appendix 2).
1.11 To monitor red and orange incidents, significant complaints, patient feedback, claims and inquests, trends and their action plans. To monitor response times to complaints and to ensure that actions on raised issues are taken.
1.12 To monitor essential improvement & audit plans. To co-ordinate responses for national reports relevant to the clinical area, and to monitor and report progress on quality related guidance such as NICE.
1.13 Demonstrate public and patient involvement and ensure actions are taken as necessary in response to patient feedback mechanisms.
1.14 To monitor quality indicators and outcomes across all activities and take appropriate actions.
1.15 To monitor appraisal, training and development activities.

External Assurance

External assurance from visits, inspections and accreditations are an essential part of quality assurance and management, recommendations need to be implemented where possible.

This report will have identified - see section 3 - any recommendations made by the external organisation at the visit and each recommendation will have an action point, which includes responsibility for completing the actions and timescales.

13. SUSTAINABILITY REPORT

13.1 INTRODUCTION

As Gloucestershire Hospitals Foundation Trust 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 by 2020 from a 2013 baseline.

13.2 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.

The Trust uses the Good Corporate Citizenship (GCC) tool as a way to measure our contribution and progress towards a range of activities associated with Sustainable Development and Corporate Social Responsibility. The tool covers eight thematic areas - travel; procurement; facilities management; workforce; community engagement, buildings; models of care and adaptation.

In 2017 our overall score was 62%, a 2% improvement on 2016. For 2015 the target was 50% in each area rising to 75% by 2020. In 2017 the Trust exceeds 50% in seven areas, scoring over 75% in Workforce and Facilities Management. The Trust scores less well in Buildings and Procurement. The Buildings score will improve once the county Sustainable Transformation Plan is finalised and the Trust's Estates Strategy can be developed.

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 2018.

13.3 CARBON REDUCTION COMMITMENT ENERGY EFFICIENCY SCHEME (CRC)

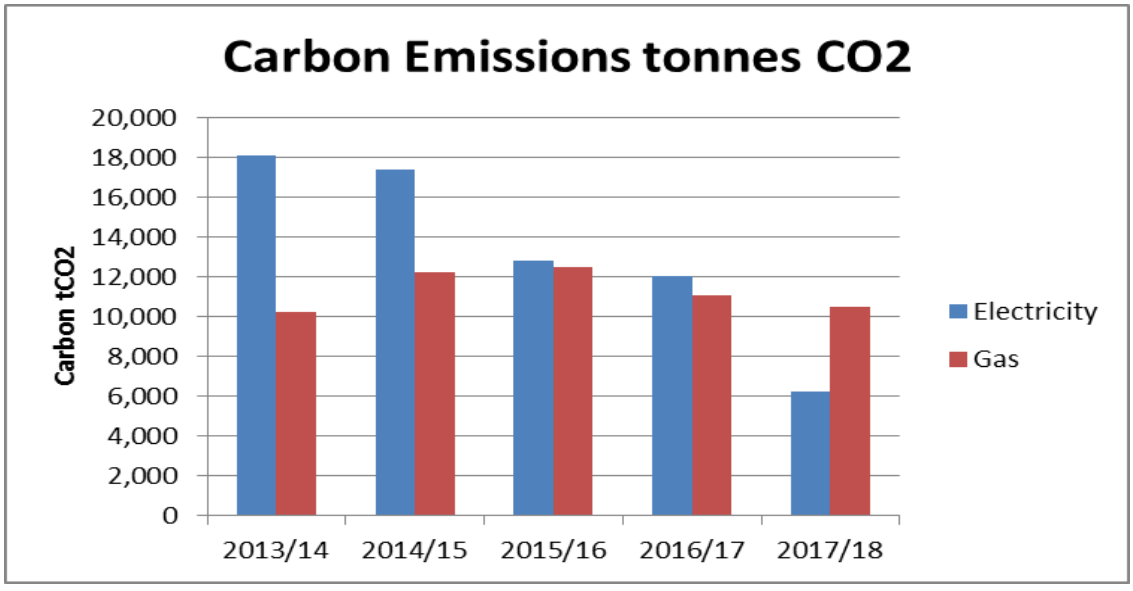
The Trust is a participant in the CRC. For the reporting year 2017/18 it is **estimated** that the Trust will declare 16,704 tonnes of CO2 and will purchase and surrender carbon allowances to cover these emissions at a cost of over £295,661.

This is a 16% decrease on the declared CRC carbon emissions from 2016/17 when the Trust overall emissions were recorded at 19,959 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 unit.

13.4 ENERGY AND WATER

GHNHSFT is estimated to have spent £5.7m on gas, electricity and water in 2017/18, including operational management charges. NB: the figures for 2017/18 are estimates.

Resource		2013/14	2014/15	2015/16	2016/17	2017/18
Gas	Use (kWh)	48,136,497	58,423,482	59,520,043	60,062,487	56,854,097
	tCO_2e	10,212	12,257	12,487	11,085	10,471
Oil	Use (kWh)	54,546	79,435	64,443	58,190	24,279
	tCO_2e	17	25	21	18.3	6
Electricity	Use (kWh)	32,323,886	31,724,857	22,273,744	22,633,386	17,791,983
	tCO_2e	18,098	17,381	12,806	12,066	6,255
Total Energy CO_2e		28,328	29,664	25,314	23,151	16,731



The combined heat and power unit (CHP) at Cheltenham continued to perform well throughout year 3 of operation although an engine breakdown in July reduced the overall availability and planned run hours. The annual saving in year 3 of the contract is reported at £536,910 a slight shortfall of around -£9,502. Improvements to the LTHW distribution have shown improvements in the first quarter of year 4 contract (November 2017 - February 2018).

The Energy Performance contract with Veolia naturally matured in July 2017 so enabling Vital Energi to begin the installation of a 2.5MW CHP at Gloucestershire Royal Hospital. Final commissioning and setup was undertaken during April 2018 and the unit will produce a saving for 2018–2019.

The roll out and use of LED lighting is now standard practice for all new works with around 1,000 fittings being replaced across the Trust in 2017-2018. Additional upgrades to lighting in Pathology and Pharmacy at GRH are about to commence with a number of additional areas identified for the coming year.

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.

Changes under the water deregulation legislation which saw a move to Water Plus for its invoicing created untold problems with the Trust still waiting for invoices dating back to December 2016 and estimated to total over £200,000. These problems prevented the accurate reporting of water data to 2017 ERIC returns which is likely to be the same for 2018.

As from 1st January 2018 the Trust was amongst one of the first NHS Trusts to move all its water supplies contracts across to Castle Water under the CCS framework where the charges are now at only 1.95% rather than those offered by Water Plus. We will need to wait and see if the invoicing and reporting improves although the early signs for Castle Water are positive.

13.5 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 will be added when the staff parking permit system is revised in September 2018.

In 2017 the Trust began 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 existing 1.5 mile exclusion zone for standard parking permits is to be replaced. Staff who work standard office hours and who live within 40 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. Staff will continue to benefit from reduced fares with the major bus provider within the county and it is hoped to introduce a pre-payment card which will give even more discount on bus journeys. 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. Improvements have been made to lighting in one of the sheds at Cheltenham General.

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 58 members of staff have received cars or have them on order. The carbon offset is 310 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 a portfolio of projects including investigating better ways to promote bus use amongst patients, visitors and staff. We are exploring options for the joint procurement of pool cars and fleet vehicles together with ways in which we can 'green' the fleet. The council has numerous vehicles that are used for school transport and which lie unused for much of the day. Another working group is looking to see if any of these could be utilised for non-emergency patient transport as sharing the cost of these vehicles could save money for both the council and NHS organisations.

Fleet and grey fleet reviews

The Energy Saving Trust is conducting two reviews for the Trust – these are funded by the Department of Transport. The first report is a green fleet review which looks at the carbon intensity of our fleet and will advise on the opportunities for us to introduce electric or hybrid fleet vehicles. It looks at our fleet operation, vehicle mileage, the wider electric vehicle charging infrastructure and whether there are any government grants available to us to purchase Ultra Low Emission Vehicles. It will also include a section on air quality.

The second report is an analysis of the grey fleet (staff use of own car for work purposes) and will make suggestions regarding use of car clubs, pool cars and conferencing facilities which may help us to reduce our carbon and expenditure. The reports should be completed in April.

13.6 WASTE

The Waste Management Team is currently looking at options for replacing the cardboard baler in the waste yard at Gloucestershire Royal for a compactor. Gloucestershire Royal is regularly recycling over six tonnes of cardboard per month, and a compactor would be able to manage the volume more efficiently and reduce

the amount of man hours required to operate the baler. Cheltenham General recycles over four tonnes of cardboard per month.

The team are also 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. Once collected, the filled re-usable sharps containers are taken to a treatment facility where they are opened, emptied and disinfected using an automated wash-line featuring state-of-the-art robotics. Following this three-stage process, the disinfected containers are meticulously inspected and then re-assembled before they are returned to the Trust for re-use. 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. Please note that this has yet to be agreed by the Trust's Risk Manager (Health and Safety). This system has been seen in operation at the Good Hope Hospital in Birmingham.

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.

13.7 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, cookies and fruit pies which are 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 shop at Cheltenham General.

The in-house Catering team are compliant in the CQUIN improvement programme (2017-18) 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.

The Catering department 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 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.

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. 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 next big step will be to reduce or even eliminate cardboard takeaway coffee cups.

13.8 PRIVATE FINANCE INITIATIVE

Part of the Gloucestershire Royal site is a 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 14 years old replacement equipment tends to be more efficient than the original.

In 2014 the Trust reduced the incoming voltage from 245V to 235V through tap changing. This has reduced energy consumption by about 5% and extended the life of all electrical equipment which is rated at 220/230V. Original light fittings are being replaced by LEDs as part of an on-going programme with about 60% 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. Once the program is completed in December 2018 we anticipate total annual savings of £65,000 per annum.

In early 2018 one of the chillers was repaired, with the planned replacement deferred for around three years largely due to legislative changes around refrigerant media.

In 2018 the belt driven fans will be upgraded with direct driven fans in accordance with the EU Ecodesign of Energy Related Products Directive (widely known as the ErP Directive), with anticipated annual energy savings of £32,000.

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.

13.9 PROCUREMENT

Procurement have embedded within their processes, the need for sustainability to be considered when undertaking procurement projects by utilising the Government Buying Standards. Sustainability questions are included in tender documentations, when applicable, that cover environmental, social and economic impacts of the product or service over its lifetime and these responses will be taken into account when awarding a contract.

During 2018 Procurement are required to renew the corporate Office Furniture Supplies contract. For this we will be using the "Government Buying Standard for Office Furniture" as a guide to asking the necessary questions and securing a supplier who views sustainability with the same importance as the Trust. In this instance, Trust will avoid purchasing new furniture where items can be reused or recycled.

13.10 SCOPE 1, 2 AND 3 EMISSIONS

Area	Type	Unit	Cost £
Greenhouse Gas Emissions	Scope 1 (gas and oil consumption, fleet vehicles and anaesthetic gases)	14,159 tCO_2e	Total Scope 1, 2 and 3 emissions (not including anaesthetic gas) £4,390,550
	Scope 2 (electricity consumption)	6,255 tCO_2	
	Scope 3 (business travel)	173 tCO_2	
Waste minimisation and management	(a) total waste arising = 2,371 tonnes (b) waste to energy = 903 tonnes (c) waste recycled/reused = 1,218 tonnes (d) waste incinerated = 220 tonnes (e) waste sent to landfill = 30 tonnes		£549,187

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 2007/08 there was 2,971 tCO2e from these gases, however in 2017/18 this has dropped to 2,144 tCO2e.

From mid-August 2017 to March 2018 the shuttle bus (service 99) covered 110,862 miles, carried 120,507 passengers and also produced 188 tCO_2. The costs and carbon associated with this contract are not included in the Scope 1, 2 and 3 emissions above. NB: data for April to mid-August is not available as the period was covered by a different contractor.

13.11 GOVERNANCE AND MONITORING PROCESSES

The Sustainability Group is charged with responsibility for developing, promoting and overseeing the Trust's activities in this area of work. Quarterly reports on progress within the Sustainable Development Action Plan are presented to the Sustainability Group, together with quarterly trend monitoring of carbon emissions, energy, water and waste. The data for these reports comes from supplier invoices.

The Sustainability Group used video-conferencing for all of their quarterly meetings. This reduces the carbon associated with travel of the committee members and will encourage other Trust committees to consider using this technology for their meetings.

The Trust routinely reports through the Department of Health's "Estates Return Information Collection" mechanism (ERIC).

13.12 SUSTAINABILITY TEAM

In 2015 the Sustainability Team was launched and there are over 50 staff volunteers from all areas of the organisation. The Sustainability Team are advocates for good sustainability practice, helping to raise awareness in sustainability issues, encouraging others and leading by example to create a positive behavioural change amongst all staff. A member of the team produced a guide to sustainable printing, aimed at helping staff reduce the volume of printing by best use of margins, font size etc. and this has been shared with all Trust staff. Several meetings have been held with team members sharing ideas and providing updates on sustainability initiatives within their areas.

13.13 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 introduce a behavioural change programme which will look at 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 40 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 working from home and better use of telephone and video conferencing to reduce meeting related travel. To identify opportunities for further use of telecare.

14. ANNUAL REPORT OF THE AUDIT AND ASSURANCE COMMITTEE

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.

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.

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, a representative from the Council of Governors and the Internal and External Auditors. 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, some related to the expanding remit of the Committee which, in 2018/19 will also be covering the estates and facilities subsidiary – the Gloucestershire Managed Services GMS).

2017/18 – 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.

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.

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 changes have already been made to the internal control environment and specifically those controls that relate to finance.

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
- Oversaw the appointment of new internal auditors, BDO, and the handover between the outgoing (PwC) and incoming auditors.

External Audit

KPMG were engaged to provide External Audit services for the Trust for the 2016/17 financial year. At the beginning of 2017/18, they were replaced by Ernst and Young LLP.

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 considers them to be accurate.

Other Matters

Further examples of the Audit and Assurance Committee's work during 2017/18 include:

- Review of cyber security at the Trust including the identification and escalation of relevant risks to the Trust Board;
- Scrutiny of counter fraud reports
- Key contribution to the development and quarterly reviews of the revised Audit and Assurance Framework

The Committee recognises the hard work in response to the Financial Governance Review and the strengthening of the Trust's corporate governance function, including the appointment of a Board-level Director with responsibility for corporate governance and the appointment of a Non-Executive Director with a clinical background – both completed during 2017/18.

Following the establishment of the Estates and Facilities Subsidiary Company, the remit of the Committee will be extended in 2018/19 to cover the Subsidiary. The Committee's terms of reference will be revised in early 2018/19 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.

Rob Graves
Audit and Assurance Committee Chair

25th May 2018

15. ACCOUNTS

Gloucestershire Hospitals NHS Foundation Trust

Annual accounts for the year ended 31 March 2018

Foreword to the accounts

Gloucestershire Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2018, 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**
Date **25 May 2018**

Statement of Comprehensive Income

		2017/18		2016/17	
		Trust	Group	Trust	Group
	Note	£000	£000	£000	£000
Operating income from patient care activities	3	439,159	439,159	439,869	439,869
Other operating income	3	59,262	61,240	66,315	67,551
Operating expenses	5, 7	(541,341)	(542,196)	(528,679)	(529,885)
Operating surplus/(deficit) from continuing operations		**(42,920)**	**(41,797)**	**(22,495)**	**(22,465)**
Finance income	10	51	109	36	98
Finance expenses	11	(5,508)	(5,508)	(4,430)	(4,430)
PDC dividends payable		(3,721)	(3,721)	(6,457)	(6,457)
Net finance costs		**(9,178)**	**(9,120)**	**(10,851)**	**(10,789)**
Other gains / (losses)	12	534	542	1,077	1,172
Surplus / (deficit) for the year from continuing operations		**(51,564)**	**(50,375)**	**(32,269)**	**(32,082)**
Surplus / (deficit) for the year		**(51,564)**	**(50,375)**	**(32,269)**	**(32,082)**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Impairments	6	(26,971)	(26,971)	3,867	3,867
Revaluations	17	-	-	-	-
Total comprehensive income / (expense) for the period		**(78,535)**	**(77,346)**	**(28,402)**	**(28,215)**
Surplus/ (deficit) for the period attributable to:					
Gloucestershire Hospitals NHS Foundation Trust		(51,564)	(50,375)	(32,269)	(32,082)
TOTAL		**(51,564)**	**(50,375)**	**(32,269)**	**(32,082)**
Total comprehensive income/ (expense) for the period attributable to:					
Gloucestershire Hospitals NHS Foundation Trust		(78,535)	(77,346)	(28,402)	(28,215)
TOTAL		**(78,535)**	**(77,346)**	**(28,402)**	**(28,215)**

The Trust operational deficit for 2017/18, excluding the impact of impairments was £31,593k, as detailed in Note 2 on page 14

Statement of Financial Position

	Note	31 March 2018 Trust £000	31 March 2018 Group £000	31 March 2017 Trust £000	31 March 2017 Group £000
Non-current assets					
Intangible assets	14	9,130	9,130	7,393	7,393
Property, plant and equipment	15	251,010	251,010	296,272	296,272
Other investments / financial assets	18	-	1,877	-	1,969
Trade and other receivables	21	4,463	4,463	4,668	4,668
Total non-current assets		**264,603**	**266,480**	**308,333**	**310,302**
Current assets					
Inventories	20	7,131	7,131	7,400	7,400
Trade and other receivables	21	19,276	19,310	17,697	17,760
Cash and cash equivalents	23	5,447	6,947	7,974	8,220
Total current assets		**31,854**	**33,388**	**33,071**	**33,380**
Current liabilities					
Trade and other payables	24	(47,510)	(47,524)	(44,355)	(44,425)
Borrowings	26	(4,703)	(4,703)	(5,356)	(5,356)
Provisions	28	(160)	(160)	(182)	(182)
Other liabilities	25	(3,284)	(3,284)	(2,089)	(2,089)
Total current liabilities		**(55,657)**	**(55,671)**	**(51,982)**	**(52,052)**
Total assets less current liabilities		**240,800**	**244,197**	**289,422**	**291,630**
Non-current liabilities					
Borrowings	26	(111,219)	(111,219)	(83,126)	(83,126)
Provisions	28	(1,472)	(1,472)	(1,524)	(1,524)
Other liabilities	25	(7,235)	(7,235)	(7,612)	(7,612)
Total non-current liabilities		**(119,926)**	**(119,926)**	**(92,262)**	**(92,262)**
Total assets employed		**120,874**	**124,271**	**197,160**	**199,368**
Financed by					
Public dividend capital		168,768	168,768	166,519	166,519
Revaluation reserve		43,321	43,321	70,292	70,292
Other reserves		209	209	209	209
Income and expenditure reserve		(91,424)	(91,424)	(39,860)	(39,860)
Charitable fund reserves	19	-	3,397	-	2,208
Total taxpayers' equity		**120,874**	**124,271**	**197,160**	**199,368**

The notes on pages 8 to 41 form part of these accounts.

The annual accounts were approved by the Board of Directors on 24th May 2018 and signed on behalf of the Trust by:

Name Deborah Lee
Position CEO
Date 25.5.18

Deborah Lee
Chief Executive
25 May 2018

Statement of Changes in Equity for the year ended 31 March 2018

Group	Public dividend capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Charitable fund reserves £000	Total £000
Taxpayers' and others' equity at 1 April 2017 - brought forward	**166,519**	**70,292**	**209**	**(39,860)**	**2,208**	**199,368**
Surplus/(deficit) for the year	-	-	-	(51,564)	1,189	**(50,375)**
Impairments	-	(26,971)	-	-	-	**(26,971)**
Public dividend capital received	2,249	-	-	-	-	**2,249**
Taxpayers' and others' equity at 31 March 2018	**168,768**	**43,321**	**209**	**(91,424)**	**3,397**	**124,271**

Statement of Changes in Equity for the year ended 31 March 2017

Group	Public dividend capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Charitable fund reserves £000	Total £000
Taxpayers' and others' equity at 1 April 2016 - brought forward	**166,519**	**67,334**	**209**	**(8,500)**	**2,021**	**227,583**
Prior period adjustment	-	-	-	-	-	-
Taxpayers' and others' equity at 1 April 2016 - restated	**166,519**	**67,334**	**209**	**(8,500)**	**2,021**	**227,583**
Surplus/(deficit) for the year	-	-	-	(32,269)	187	**(32,082)**
Impairments	-	3,867	-	-	-	**3,867**
Transfer to retained earnings on disposal of assets	-	(909)	-	909	-	-
Taxpayers' and others' equity at 31 March 2017	**166,519**	**70,292**	**209**	**(39,860)**	**2,208**	**199,368**

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 adjustement was credited to other reserves. This reserve will remain with the Trust until the Trust is disolved.

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 19.

Statement of Cash Flows

	Note	31 March 2018 Trust £000	31 March 2018 Group £000	31 March 2017 Trust £000	31 March 2017 Group £000
Cash flows from operating activities					
Operating surplus / (deficit)		(42,902)	(41,797)	(22,495)	(22,465)
Non-cash income and expense:					
Depreciation and amortisation	5.1	9,660	9,660	9,946	9,946
Net impairments	6	19,971	19,971	14,301	14,301
Income recognised in respect of capital donations	3	(352)	(352)	(658)	(658)
(Increase)/decrease in receivables and other assets		(720)	(720)	8,819	8,889
(Increase)/decrease in inventories		269	269	636	636
Increase/(decrease) in payables and other liabilities		280	280	(11,975)	(12,045)
Increase/(decrease) in provisions		(94)	(94)	124	124
Movements in charitable fund working capital		-	131	-	(144)
Other movements in operating cash flows		-	-	-	162
Net cash flows from / (used in) operating activities		**(13,888)**	**(12,652)**	**(1,302)**	**(1,254)**
Cash flows from investing activities					
Interest received		51	51	36	36
Purchase of intangible assets		(1,737)	(1,737)	(3,809)	(3,809)
Purchase of PPE and investment property		(9,553)	(9,553)	(10,515)	(10,515)
Sales of PPE and investment property		2,587	2,587	2,790	2,790
Net cash flows from / (used in) investing activities		**(8,652)**	**(8,652)**	**(11,498)**	**(11,498)**
Cash flows from financing activities					
Public dividend capital received		2,249	2,249	-	-
Movement on loans from DHSC		30,164	30,164	30,786	30,786
Capital element of finance lease rental payments		(2,041)	(2,041)	(2,222)	(2,222)
Capital element of PFI, LIFT and other service concession payments		(676)	(676)	(742)	(742)
Interest paid on finance lease liabilities		(214)	(214)	(277)	(277)
Interest paid on PFI, LIFT and other service concession obligations		(2,169)	(2,169)	(2,093)	(2,093)
Other interest paid		(2,907)	(2,907)	(1,902)	(1,902)
PDC dividend (paid) / refunded		(4,375)	(4,375)	(6,726)	(6,726)
Net cash flows from / (used in) financing activities		**20,031**	**20,031**	**16,824**	**16,824**
Increase / (decrease) in cash and cash equivalents		**(2,509)**	**(1,273)**	**4,024**	**4,072**
Cash and cash equivalents at 1 April - b/f		**7,974**	**8,220**	**3,950**	**4,148**
Cash and cash equivalents at 1 April - restated		**7,974**	**8,220**	**3,950**	**4,148**
Cash and cash equivalents at 31 March	23	**5,465**	**6,947**	**7,974**	**8,220**

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 2017/18 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 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 doubt upon the going concern ability of the NHS Foundation Trust and these are disclosed below.

The Trust incurred an operating deficit in the year of £31.6m (see Note 2) and is forecasting a further significant operating deficit in 2018/19. 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.

Recovery plans were put in place in the year to enable the continuity of services and distress funding was received in the short term to ensure that liabilities could be met and services provided. The Trust presented its plan to NHS Improvement in the year which indicated a deficit for 2017/18 and 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 £61.2m to 31 March 18 from the Department of Health and Social Care. Additional cash funding will be required in 2018/19 to the value of the planned deficit, £29.7m. The source of this funding will be NHSI dristress financing loans. On a monthly basis cash forecasts are submitted to NHSI with a loan requirement. Funding has been drawn down in this way since September 2016 and we do not anticipate any risk in assessing the necessary cash support for 2018/19

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 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. The judgement of residual life is based on the assumption that the buildings and services would be subject of a future robust maintenance regime.

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.

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 accrued in 2017-18 was £405k.

b) for partially completed spells an estimate is made of the income accruing to the Trust from patients in hospital on 31 March 18 awaiting discharge or part way through their treatment (partially completed spells or PCS). This technique uses an average figure based on accrued monthly income received over the first three quarters of the year the amount accrued in 17-18 was £2,089k.

c) The useful economic life of each category of fixed asset is assessed when acquired by the Trust. A degree of estimation is occasionally used in assessing the useful economic lives of assets.

Note 1.3 Consolidation

The NHS Foundation Trust is the corporate Trustee to Gloucestershire Hospitals Charitable Fund. The Foundation Trust has assessed its relationship to the Charitable Fund and determined it to be a subsidiary because the Foundation 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 FRS102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the Foundation Trust's accounting policies; and
- eliminate intra-group transactions, balances, gains and losses.

Note 1.4 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of 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.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security 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.

Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

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
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; and
- the cost of the item can be measured reliably.
- individually have a cost of at least £5,000: or form a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependendent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or form part of the initial setting-up costs of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic 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 to the location and condition necessary for it to be capable of operating in the manner intended by management.

Non Current assets are stated at the lower of replacement cost and recoverable amount. On initial recognition they are measured at cost (for leased assets, fair value) including any costs, such as installation, directly attributable to bringing them into working condition. The carrying values of non current assets are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable. The costs arising from financing the construction of the fixed asset are not capitalised but are charged to the income and expenditure account in the year to which they relate.

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. This resulted in a reduction in asset values of £46,942k and an impairment to the Statement of Comprehnsive Income of £19,971k. A further desk top valuation, measured on a MEA basis, was undertaken by the Trust's Independent Valuer as at 31.03.2018.

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.

Assets in the course of construction are valued at cost and are valued by professional valuers as part of the Trust's valuation exercise when they are brought into 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 economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, 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 dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic 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 and LIFT 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 seperated 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 Economic lives of property, plant and equipment

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Land is assumed to have an infinite life		
Buildings, excluding dwellings	37	90
Dwellings	37	90
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 economic 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 economic 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 economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic 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 2018-19. 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 go-live of phase 2.

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.

Note 1.12 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

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.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement

Financial assets are categorised as "fair value through income and expenditure", as loans and receivables, and financial liabilities are classified as other financial liabilities.

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

Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not "closely-related" to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

Loans and receivables

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

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

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Financial liabilities

All financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as non current liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from quoted market prices.

Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

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

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 as an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

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 28.2 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, possible assets arising from past events whose existence will only be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 29 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 29, unless the possibility 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 or non-occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events that are not recognised because 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.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

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
Gloucestershire Hospitals NHS Foundation Trust is a Health Service Body under the definition of section 519A Income and Corporation Taxes Act (ICTA) 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this Act. There is a power for HM Treasury to dis-apply the exemption in relation to specified activities of a Foundation Trust (section 519A (93) to (8) ICTA 1988). The Trust is not within the scope of corporation tax in respect of activities which are not related to, or ancillary to, the provision of healthcare, as the profits derived from these activities do not exceed £50,000 per annum.

Note 1.19 Foreign exchange
The functional and presentational currencies of the Trust are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:
• monetary items (other than financial instruments measured at "fair value through income and expenditure") are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

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 Transfers of functions [to / from] [other NHS bodies / local government bodies]
The Trust had no transfer of functions in or out during 2017-18.

Note 1.23 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2017-18.

Note 1.24 Standards, amendments and interpretations in issue but not yet effective or adopted
• IFRS 9 Financial Instruments - Application required for accounting periods beginning on or after 1 January 2018
• IFRS 15 Revenue from Contracts with Customers - Application required for accounting periods beginning on or after 1 January 2018
• IFRS 16 Leases - Application required for accounting periods beginning on or after 1 January 20189
• IFRS 17 Insurance Contracts - Application required for accounting periods beginning on or after 1 January 2021
• IFRIC 22 Foreign Currency Transactions and Advance Consideration Application required for accounting periods beginning on or after 1 January 2018
• IFRIC 23 Uncertainty over Income Tax Treatments Application required for accounting periods beginning on or after 1 January 2019

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		**2017/18**			**2016/17**	
	Trust	**Hosted Services**	**Total**	**Trust**	**Hosted Services**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
Diagnostics & Specialities	107,505	-	107,505	105,013	-	105,013
Medicine	115,327	-	115,327	116,613	-	116,613
Surgery	125,800	-	125,800	121,855	-	121,855
Women & Children	39,110	-	39,110	39,028	-	39,028
Estates & Facilities	34,589	-	34,589	34,504	-	34,504
Corporate Services	42,408	28,221	70,630	40,251	28,177	68,428
Trustwide	18,657	-	18,657	19,311	-	19,311
Capital financing	18,910	-	18,910	21,135	-	21,135
Total Expenditure	502,306	28,221	530,528	497,709	28,177	525,887
Total Income	470,713	28,221	498,935	479,741	28,177	507,918
Deficit	**(31,593)**	**-**	**(31,593)**	**(17,968)**	**-**	**(17,968)**

2017/18 & 2016/17 Hosted Services relate to GP and Public Health Trainee Schemes.

Reconciliation of Statement of Comprehensive Income (SOCI)

	2017/18	**2016/17**
	£000	**£000**
Statement of Comprehensive Income	(51,564)	(32,269)
Net impairments	19,971	14,301
Operational Deficit	**(31,593)**	**(17,968)**

Note 3 Operating income from patient care activities (Group)

Note 3.1 Income from patient care activities (by nature)	2017/18 Trust £000	2017/18 Group £000	2016/17 Trust £000	2016/17 Group £000
Elective income	73,598	73,598	76,438	76,438
Non elective income	100,212	100,212	97,025	97,025
First outpatient income	31,350	31,350	68,511	68,511
Follow up outpatient income	37,384	37,384	-	-
A & E income	17,999	17,999	16,332	16,332
High cost drugs income from commissioners (excluding pass-through costs)	49,521	49,521	-	-
Other NHS clinical income	123,499	123,499	175,916	175,916
Private patient income	2,965	2,965	2,933	2,933
Other clinical income	2,631	2,631	2,714	2,714
Total income from activities	**439,159**	**439,159**	**439,869**	**439,869**
Other Operating Income				
Research and development	2,137	2,137	2,189	2,189
Education and training	13,295	13,295	12,897	12,897
Receipt of capital grants and donations	352	352	658	658
Non-patient care services to other bodies	6,396	6,396	10,536	10,536
Sustainability and Transformation Fund income	-	-	3,225	3,225
Income in respect of staff costs where accounted on gross basis	30,163	30,163	30,125	30,125
Incoming resources received by NHS charitable funds	-	1,978	-	1,236
Other income*****	6,919	6,919	6,685	6,685
Total other operating income	**59,262**	**61,240**	**66,315**	**67,551**
Of which:				
Related to continuing operations	59,262	61,240	66,315	67,551
	498,421	**500,399**	**506,184**	**507,420**

****** Analysis of Other Operating Income: Other**	2017/18 Total £000	2016/17 Total £000
Car parking **	965	933
Crèche services	852	852
Catering	969	1,196
Other	4,133	3,704
Total	**6,919**	**6,685**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2017/18 Trust £000	2017/18 Group £000	2016/17 Trust £000	2016/17 Group £000
NHS England	97,058	97,058	101,174	101,174
Clinical commissioning groups	332,252	332,252	328,192	328,192
Other NHS providers	302	302	310	310
NHS other	3,951	3,951	4,546	4,546
Non-NHS: private patients	2,965	2,965	2,933	2,933
Non-NHS: overseas patients (chargeable to patient)	408	408	359	359
NHS injury scheme	1,269	1,269	1,309	1,309
Non NHS: other	954	954	1,046	1,046
Total income from activities	**439,159**	**439,159**	**439,869**	**439,869**
Of which:				
Related to continuing operations	439,159	439,159	439,869	439,869

** with effect from 1 April 2010 the operation of the Trusts car parks was taken over by an external car parking provider. All revenues and expenses (see note 3.1) formerly derived by the Trust are now accounted for by the external operator. The income for car parks relates to commission paid by the provider to the Trust when certain income levels are met.

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2017/18		2016/17	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Income recognised this year	408	408	359	359
Cash payments received in-year	225	225	207	207
Amounts written off in-year	35	35	245	245

Note 4 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:

	2017/18		2016/17	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Income from services designated as commissioner requested services	434,832	434,832	435,531	435,531
Income from services not designated as commissioner requested services	4,327	4,327	4,338	4,338
Total	**439,159**	**439,159**	**439,869**	**439,869**

Note 4.1 Profits and losses on disposal of property, plant and equipment

The Trust sold theatre equipment to GenMed during the year. The profit on sale was £534k

Note 5.1 Operating expenses (Group)

	2017/18		2016/17	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Purchase of healthcare from non-NHS and non-DHSC bodies	181	181	285	285
Staff and executive directors costs	334,685	334,883	329,674	329,878
Remuneration of non-executive directors	138	138	136	136
Supplies and services - clinical (excluding drugs costs)	48,715	48,715	48,174	48,174
Supplies and services - general	18,499	18,499	19,190	19,190
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	61,318	61,318	58,272	58,272
Consultancy costs	2,838	2,838	1,998	1,998
Establishment	2,379	2,379	4,396	4,396
Premises	18,257	18,257	19,284	19,284
Transport (including patient travel)	1,209	1,209	1,091	1,091
Depreciation on property, plant and equipment	9,660	9,660	9,946	9,946
Net impairments	19,971	19,971	14,301	14,301
Increase/(decrease) in provision for impairment of receivables	405	405	8	8
Change in provisions discount rate(s)	-	-	(2)	(2)
Audit fees payable to the external auditor				
audit services- statutory audit	72	75	58	61
other auditor remuneration (external auditor only)	-	-	1,465	1,465
Internal audit costs	96	96	77	77
Clinical negligence	17,118	17,118	15,559	15,559
Legal fees	333	333	123	123
Insurance	406	406	418	418
Education and training	1,383	1,383	1,346	1,346
Rentals under operating leases	930	930	592	592
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis	1,435	1,435	1,847	1,847
Car parking & security	225	225	255	255
Hospitality	11	11	15	15
Losses, ex gratia & special payments	18	18	21	21
Other NHS charitable fund resources expended	-	654	-	999
Other	1,035	1,035	150	150
Total	**541,341**	**542,196**	**528,679**	**529,885**
Of which:				
Related to continuing operations	541,341	542,196	528,679	529,885
Related to discontinued operations	-	-	-	-

Trust Expenditure in 2017/18, excluding the impact of impairments, was £521,370k. for 2016/17, the comparable expenditure figure was £514,378k.

Note 5.2 Other auditor remuneration (Group)

	2017/18		2016/17	
	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
3. Taxation compliance services	-	-	-	-
4. All taxation advisory services not falling within item 3 above	-	-	122	122
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	-	-	1,334	1,334
Total	**-**	**-**	**1,465**	**1,465**

Note 5.3 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £2m (2016/17: £2m).

Note 6 Impairment of assets (Group)

	2017/18		2016/17	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Net impairments charged to operating surplus / deficit resulting from:				
Changes in market price	-	-	14,301	14,301
Other	19,971	19,971	-	-
Total net impairments charged to operating surplus / deficit	**19,971**	**19,971**	**14,301**	**14,301**
Impairments charged to the revaluation reserve	26,971	26,971	(3,867)	(3,867)
Total net impairments	**46,942**	**46,942**	**10,434**	**10,434**

Note 7 Employee benefits (Group)

	2017/18		2016/17	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Salaries and wages	261,284	261,284	253,513	253,513
Social security costs	23,774	23,774	23,270	23,270
Apprenticeship levy	1,281	1,281	-	-
Employer's contributions to NHS pensions	31,650	31,650	31,099	31,099
Temporary staff (including agency)	16,696	16,696	21,792	21,792
NHS charitable funds staff	-	198	-	204
Total gross staff costs	**334,685**	**334,883**	**329,674**	**329,878**
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	**334,685**	**334,883**	**329,674**	**329,878**

Note 7.1 Retirements due to ill-health (Group)

During 2017/18 there were 6 early retirements from the trust agreed on the grounds of ill-health (7 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £550k (£344k in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 8 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 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 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 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 last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

Note 9 Operating leases

Note 9.1 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 9.2 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.

	2017/18		2016/17	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Operating lease expense				
Minimum lease payments	930	930	592	592
Total	**930**	**930**	**592**	**592**

	31 March 2018		31 March 2017	
	Trust	Group	Trust	Group
Future minimum lease payments due:	£000	£000	£000	£000
- not later than one year;	421	421	397	397
- later than one year and not later than five years;	1,195	1,195	195	195
- later than five years.	1,380	1,380	-	-
Total	**2,996**	**2,996**	**592**	**592**

Note 10 Finance income

Finance income represents interest received on assets and investments in the period.

	2017/18		2016/17	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Interest on bank accounts	51	51	36	36
NHS charitable fund investment income	-	58	-	62
Total	**51**	**109**	**36**	**98**

Note 11.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2017/18		2016/17	
	Trust	Group	Trust	Group
Interest expense:	£000	£000	£000	£000
Loans from the Department of Health and Social Care	3,104	3,104	2,048	2,048
Other loans	-	-	12	12
Finance leases	215	215	277	277
Main finance costs on PFI and LIFT schemes obligations	1,323	1,323	1,362	1,362
Contingent finance costs on PFI and LIFT scheme obligations	846	846	731	731
Total interest expense	**5,488**	**5,488**	**4,430**	**4,430**
Unwinding of discount on provisions	20	20	-	-
Total finance costs	**5,508**	**5,508**	**4,430**	**4,430**

Note 12 Other gains / (losses) (Group)

	2017/18		2016/17	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Gains on disposal of assets	534	534	1,077	1,077
Gains / losses on disposal of charitable fund assets	-	100	-	-
Total gains / (losses) on disposal of assets	534	634	1,077	1,077
Fair value gains/(losses) on charitable fund investments & investment properties	-	(92)	-	95
Total other gains / (losses)	**534**	**542**	**1,077**	**1,172**

Note 13 Trust income statement and statement of comprehensive income

In accordance with Section 408 of the Companies Act 2006, the trust is exempt from the requirement to present its own income statement and statement of comprehensive income. The Group's deficit for the period was -£50,393k (2016/17: -£32,082k). The Group's total comprehensive income/(expense) for the period was -£77,364k (2016/17: -£28,215k).

Note 14.1 Intangible assets - 2017/18

Trust & Group	Development expenditure	Total
	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	**7,393**	**7,393**
Additions	1,737	1,737
Valuation / gross cost at 31 March 2018	**9,130**	**9,130**
Net book value at 31 March 2018	**9,130**	**9,130**
Net book value at 1 April 2017	**7,393**	**7,393**

Note 14.2 Intangible assets - 2016/17

Trust & Group	Development expenditure	Total
	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**3,584**	**3,584**
Prior period adjustments	-	-
Valuation / gross cost at 1 April 2016 - restated	**3,584**	**3,584**
Transfers by absorption	-	-
Additions	3,809	3,809
Valuation / gross cost at 31 March 2017	**7,393**	**7,393**
Net book value at 31 March 2017	**7,393**	**7,393**
Net book value at 1 April 2016	**3,584**	**3,584**

Note 15.1 Property, plant and equipment - 2017/18

Trust & Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	**34,266**	**229,262**	**7,740**	**2,253**	**74,086**	**763**	**31,504**	**343**	**380,216**
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**
Reclassifications	5	1,545	22	(1,762)	190	-	-	-	**-**
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 - brought forward	**-**	**3,874**	**153**	**-**	**54,124**	**599**	**24,851**	**343**	**83,944**
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)**
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 15.2 Property, plant and equipment - 2016/17

Trust & Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**34,776**	**236,394**	**7,972**	**1,949**	**71,058**	**576**	**29,539**	**336**	**382,599**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Valuation / gross cost at 1 April 2016 - restated	**34,776**	**236,394**	**7,972**	**1,949**	**71,058**	**576**	**29,539**	**336**	**382,599**
Additions	-	3,944	-	633	3,222	-	1,965	-	**9,764**
Impairments	-	(36,480)	(232)	-	-	-	-	-	**(36,712)**
Reversals of impairments	-	26,278	-	-	-	-	-	-	**26,278**
Reclassifications	-	329	-	(329)	(194)	187	-	7	**(0)**
Disposals / derecognition	(510)	(1,203)	-	-	-	-	-	-	**(1,713)**
Valuation/gross cost at 31 March 2017	**34,266**	**229,262**	**7,740**	**2,253**	**74,086**	**763**	**31,504**	**343**	**380,216**
Accumulated depreciation at 1 April 2016 - as previously stated	**-**	**(0)**	**0**	**-**	**49,969**	**571**	**23,125**	**333**	**73,998**
Accumulated depreciation at 1 April 2016 - restated	**-**	**(0)**	**0**	**-**	**49,969**	**571**	**23,125**	**333**	**73,998**
Provided during the year	-	3,874	153	-	4,155	28	1,726	10	**9,946**
Impairments	-	2,600	-	-	-	-	-	-	**2,600**
Reversals of impairments	-	(2,600)	-	-	-	-	-	-	**(2,600)**
Accumulated depreciation at 31 March 2017	**-**	**3,874**	**153**	**-**	**54,124**	**599**	**24,851**	**343**	**83,944**
Net book value at 31 March 2017	**34,266**	**225,388**	**7,587**	**2,253**	**19,962**	**164**	**6,653**	**-**	**296,272**
Net book value at 1 April 2016	**34,776**	**236,394**	**7,972**	**1,949**	**21,089**	**5**	**6,414**	**3**	**308,601**

Note 15.3 Property, plant and equipment financing - 2017/18

Trust & Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Total
	£000	£000	£000	£000	£000	£000	£000	£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**
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**

Note 15.4 Property, plant and equipment financing - 2016/17

Trust & Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017								
Owned - purchased	31,651	171,677	-	2,253	11,572	164	6,653	**223,970**
Finance leased	2,615	8,006	7,587	-	5,810	-	-	**24,018**
On-SoFP PFI contracts and other service concession arrangements	-	43,259	-	-	-	-	-	**43,259**
Owned - donated	-	2,446	-	-	2,580	-	-	**5,026**
NBV total at 31 March 2017	**34,266**	**225,388**	**7,587**	**2,253**	**19,962**	**164**	**6,653**	**296,272**

Disclosure

Included within the dwelling figures above at 31 March 2018 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 £3,867k. This equipment is for Radiology equipment, linear accelerators and ultrasound machines.

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 £36.9m.

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.

In August 2014 the new Hereford Radiotherapy Centre became operational. This facility has been constructed on land owned by a third party and in 2014-15 was reclassified as a long term debtor to be amortised over a period of 25 years.

Note 16 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 Trustees. 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 17 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. This resulted in a reduction in asset values of £46,942k and an impairment to the SOCI of £19,971k. A further desk top valuation, measured on a MEA basis, was undertaken by the Trust's Independent Valuer as at 31.03.2018.

The appropriate assets have been written down to their recoverable amount within the Statement of Financial Position, with the loss charged to the revaluation reserve to the extent there was a balance remaining and thereafter to expenditure as an impairment of property, plant and equipment.

Note 18 Other investments / financial assets (non-current)

	Group	
	2017/18	2016/17
	£000	£000
Carrying value at 1 April - brought forward	**1,969**	**1,974**
Movement in fair value	(92)	95
Disposals	-	(100)
Carrying value at 31 March	**1,877**	**1,969**

Note 19 Analysis of charitable fund reserves

	2018	2017
	£000	£000
Unrestricted funds:		
Unrestricted income funds	3,397	1,780
Other reserves	-	426
Restricted funds:		
Other restricted income funds	-	2
	3,397	**2,208**

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 20 Inventories

	2017/18		2016/17	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Drugs	2,818	2,818	2,672	2,672
Work In progress	-	-	-	-
Consumables	3,736	3,736	4,277	4,277
Energy	576	576	450	450
Other	-	-	-	-
Charitable fund inventory	-	-	-	-
Total inventories	**7,131**	**7,131**	**7,400**	**7,400**
of which:				
Held at fair value less costs to sell	-	-	-	-

Inventories recognised in expenses for the year were £110,033k (2016/17: £106,467k). Write-down of inventories recognised as expenses for the year were £0k (2016/17: £0k).

Note 21.1 Trade receivables and other receivables

	2017/18		2016/17	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Current				
Trade receivables	11,619	11,619	7,895	7,895
Accrued income	3,543	3,543	6,209	6,209
Provision for impaired receivables	(1,416)	(1,416)	(1,617)	(1,617)
Deposits and advances	-	-	-	-
Prepayments (non-PFI)	2,493	2,493	1,952	1,952
PDC dividend receivable	861	861	207	207
VAT receivable	30	30	592	592
Other receivables	2,146	2,146	2,459	2,459
NHS charitable funds: trade and other receivables	-	34	-	63
Total current trade and other receivables	**19,276**	**19,310**	**17,697**	**17,760**
Non-current				
Other receivables	4,463	4,463	4,668	4,668
NHS charitable funds: trade and other receivables	-	-	-	-
Total non-current trade and other receivables	**4,463**	**4,463**	**4,668**	**4,668**
Of which receivables from NHS and DHSC group bodies:				
Current	15,638	15,638	10,921	10,921

Other receivables 2017/18 £4,463k consists of Residential accommodation (£658k), Hereford Radiotherapy Centre £3,207k and Road Traffic Accident income £1,914k

Other receivables 2016/17, £4,668k consists of Residential accommodation (£700k), Hereford Radiotherapy Centre £3,635k and Road Traffic Accident income £1,733k

Note 21.2 Provision for impairment of receivables

	2017/18		2016/17	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
At 1 April as previously stated	**1,617**	**1,617**	**2,205**	**2,205**
Increase in provision	412	412	125	125
Amounts utilised	(606)	(606)	(596)	(596)
Unused amounts reversed	(7)	(7)	(117)	(117)
At 31 March	**1,416**	**1,416**	**1,617**	**1,617**

Note 21.3 Credit quality of financial assets

Trust & Group	**31 March 2018 Trade and other receivables**	**31 March 2017 Trade and other receivables**
Ageing of impaired financial assets	**£000**	**£000**
0 - 30 days	-	-
30-60 Days	-	-
60-90 days	-	-
90- 180 days	-	-
Over 180 days	1,416	1,617
Total	**1,416**	**1,617**
Ageing of non-impaired financial assets past their due date		
0 - 30 days	956	975
30-60 Days	484	310
60-90 days	183	79
90- 180 days	71	120
Over 180 days	913	163
Total	**2,607**	**1,647**

The above analysis of financial assets excludes NHS debt.

Note 21.4 Credit quality of financial assets (continued)

The Trust has a policy of reviewing the aged debt and providing for the impaiment on the basis of the type of debt and age.

Note 22 Other assets

The Trust has no other assets.

Note 23 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.

	2017/18		2016/17	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
At 1 April	**7,974**	**8,220**	**3,950**	**4,148**
Net change in year	(2,527)	(1,273)	4,024	4,072
At 31 March	**5,447**	**6,947**	**7,974**	**8,220**
Broken down into:				
Cash at commercial banks and in hand	-	-	9	9
Cash with the Government Banking Service	5,447	6,947	7,965	8,211
Total cash and cash equivalents as in SoFP	**5,447**	**6,947**	**7,974**	**8,220**
Total cash and cash equivalents as in SoCF	**5,447**	**6,947**	**7,974**	**8,220**

Note 23.1 Third party assets held by the trust

Gloucestershire Hospitals NHS Foundation Trust held cash and cash equivalents which relate to monies held by the the foundation trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

Note 24 Trade and other payables

	2017/18		2016/17	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Current				
Trade payables	902	902	5,077	5,077
Capital payables	5,220	5,220	1,723	1,723
Accruals	25,212	25,212	21,114	21,114
Social security costs	6,664	6,664	6,594	6,594
Accrued interest on loans	342	342	146	146
Other payables	9,170	9,170	9,701	9,701
NHS charitable funds: trade and other payables	-	14	-	70
Total current trade and other payables	**47,510**	**47,524**	**44,355**	**44,425**
Of which payables from NHS and DHSC group bodies:				
Current	3,526	3,526	5,183	5,183

Note 25 Other liabilities

	2017/18		2016/17	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Current				
Deferred grants	3,284	3,284	2,089	2,089
Total other current liabilities	**3,284**	**3,284**	**2,089**	**2,089**
Non-current				
Deferred income	7,235	7,235	7,612	7,612
Total other non-current liabilities	**7,235**	**7,235**	**7,612**	**7,612**

Note 26 Borrowings

	2017/18		2016/17	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Current				
Loans from DHSC	2,968	2,968	2,635	2,635
Obligations under finance leases	1,632	1,632	2,046	2,046
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	103	103	675	675
Total current borrowings	**4,703**	**4,703**	**5,356**	**5,356**
Non-current				
Loans from DHSC	89,796	89,796	59,966	59,966
Obligations under finance leases	2,892	2,892	4,525	4,525
Obligations under PFI, LIFT or other service concession contracts	18,531	18,531	18,635	18,635
Total non-current borrowings	**111,219**	**111,219**	**83,126**	**83,126**

Note 27 Finance leases

Foundation Trust as a lessor

Future lease receipts due under finance lease agreements where the trust is the lessor:

The Trust did not have any finance lease agreement as a lessor.

Foundation Trust as a lessee

Obligations under finance leases where the trust is the lessee.

	2017/18		2016/17	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Gross lease liabilities	**4,955**	**4,955**	**7,217**	**7,217**
of which liabilities are due:				
- not later than one year;	1,781	1,781	2,260	2,260
- later than one year and not later than five years;	2,763	2,763	4,121	4,121
- later than five years.	411	411	836	836
Finance charges allocated to future periods	(431)	(431)	(646)	(646)
Net lease liabilities	**4,524**	**4,524**	**6,571**	**6,571**
of which payable:				
- not later than one year;	1,632	1,632	2,046	2,046
- later than one year and not later than five years;	2,559	2,559	3,789	3,789
- later than five years.	333	333	736	736

Note 28.1 Provisions for liabilities and charges analysis (Group)

Trust & Group	Pensions - early departure costs	Legal claims	Total
	£000	£000	£000
At 1 April 2017	**1,611**	**95**	**1,706**
Arising during the year	44	19	**63**
Utilised during the year	(87)	8	**(79)**
Reversed unused	(29)	(49)	**(78)**
Unwinding of discount	20	-	**20**
Movement in charitable fund provisions	-	-	**-**
At 31 March 2018	**1,559**	**73**	**1,632**
Expected timing of cash flows:			
- not later than one year;	87	73	**160**
- later than one year and not later than five years;	1,472	-	**1,472**
- later than five years.	0	-	**0**
Total	**1,559**	**73**	**1,632**

Note 28.2 Clinical negligence liabilities

At 31 March 2018, £224,265k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Gloucestershire Hospitals NHS Foundation Trust (31 March 2017: £185,143k).

Note 29 Contingent assets and liabilities

	2017/18		2016/17	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Value of contingent liabilities				
Other	(542)	(542)	(587)	(587)
Gross value of contingent liabilities	**(542)**	**(542)**	**(587)**	**(587)**
Amounts recoverable against liabilities	-	-	-	-
Net value of contingent liabilities	**(542)**	**(542)**	**(587)**	**(587)**
Net value of contingent assets	-	-		-

The contingent liability arises from an assessment of the impact of the Bear Scotland ruling relating to whether overtime needs to be included in holiday pay calculations.

The Trust has assessed the impact as a contingent liability given that payment is not considered probable. The base contingent liability has been valued at £500k, with an additional £42k relating to Early Retirement Injury Benefit. The reduction from the prior year is all attributable to a reassessment of the Early Retirement Injury Benefit.

Note 30 Contractual capital commitments

	2017/18		2016/17	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Property, plant and equipment	1,229	1,229	1,983	1,983
Intangible assets	1,700	1,700	1,400	1,400
Total	**2,929**	**2,929**	**3,383**	**3,383**

Note 31 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 32 On-SoFP PFI, LIFT or other service concession arrangements

Note 32.1 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:

	2017/18		2016/17	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Gross PFI, LIFT or other service concession liabilities	**31,878**	**31,878**	**33,877**	**33,877**
Of which liabilities are due				
- not later than one year;	1,391	1,391	1,998	1,998
- later than one year and not later than five years;	7,337	7,337	6,808	6,808
- later than five years.	23,150	23,150	25,071	25,071
Finance charges allocated to future periods	(13,244)	(13,244)	(14,567)	(14,567)
Net PFI, LIFT or other service concession arrangement obligation	**18,634**	**18,634**	**19,310**	**19,310**
- not later than one year;	103	103	675	675
- later than one year and not later than five years;	2,492	2,492	1,822	1,822
- later than five years.	16,039	16,039	16,813	16,813

Note 32.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future obligations under these on-SoFP schemes are as follows:

	2017/18		2016/17	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	98,027	98,027	102,982	102,982
Of which liabilities are due:				
- not later than one year;	5,079	5,079	4,955	4,955
- later than one year and not later than five years;	21,616	21,616	21,089	21,089
- later than five years.	71,332	71,332	76,938	76,938

Note 32.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2017/18		2016/17	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Unitary payment payable to service concession operator	4,955	4,955	5,201	5,201
Consisting of:				
- Interest charge	1,323	1,323	1,362	1,362
- Repayment of finance lease liability	675	675	519	519
- Service element and other charges to operating expenditure	1,435	1,435	1,847	1,847
- Capital lifecycle maintenance	676	676	742	742
- Revenue lifecycle maintenance	-	-	-	-
- Contingent rent	846	846	731	731
Total amount paid to service concession operator	**4,955**	**4,955**	**5,201**	**5,201**

Note 33 Financial instruments

Note 33.1 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 33.2 Carrying values of financial assets

Trust & Group	Loans and receivables	Assets at fair value through the I&E	Total book value
	£000	£000	£000
Assets as per SoFP as at 31 March 2018			
Embedded derivatives	-	-	-
Trade and other receivables excluding non financial assets	17,821	-	**17,821**
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	**23,284**	**3,377**	**26,661**

Trust & Group	Loans and receivables	Assets at fair value through the I&E	Total book value
	£000	£000	£000
Assets as per SoFP as at 31 March 2017			
Embedded derivatives	-	-	-
Trade and other receivables excluding non financial assets	14,946	-	**14,946**
Other investments / financial assets	-	-	-
Cash and cash equivalents	7,974	-	**7,974**
Consolidated NHS Charitable fund financial assets	246	1,969	**2,215**
Total at 31 March 2017	**23,166**	**1,969**	**25,135**

Note 33.3 Carrying values of financial liabilities

Trust & Group	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2018			
Embedded derivatives	-	-	-
Borrowings excluding finance lease and PFI liabilities	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**
Trade and other payables excluding non financial liabilities	40,968	-	**40,968**
Total at 31 March 2018	**156,904**	**-**	**156,904**

Trust & Group	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2017			
Embedded derivatives	-	-	-
Borrowings excluding finance lease and PFI liabilities	62,601	-	**62,601**
Obligations under finance leases	6,571	-	**6,571**
Obligations under PFI, LIFT and other service concession contracts	19,310	-	**19,310**
Trade and other payables excluding non financial liabilities	44,425	-	**44,425**
Total at 31 March 2017	**132,907**	**-**	**132,907**

Note 33.4 Maturity of financial liabilities

	2017/18		2016/17	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
In one year or less	45,670	45,684	49,781	49,781
In more than one year but not more than two years	4,657	4,657	4,369	4,369
In more than two years but not more than five years	12,066	12,066	43,844	43,844
In more than five years	94,497	94,497	34,913	34,913
Total	**156,890**	**156,904**	**132,907**	**132,907**

Note 34 Losses and special payments

Trust & Group	2017/18 Total number of cases Number	2017/18 Total value of cases £000	2016/17 Total number of cases Number	2016/17 Total value of cases £000
Losses				
Bad debts and claims abandoned	1,597	606	2,190	596
Total losses	**1,597**	**606**	**2,190**	**596**
Special payments				
Extra-contractual payments	-	-	-	-
Ex-gratia payments	36	14	47	16
Total special payments	**36**	**14**	**47**	**16**
Total losses and special payments	**1,633**	**620**	**2,237**	**612**
Compensation payments received		-		-

Note 35 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)
2 gether 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 36 Transfers by absorption

The Trust had no transfers by absorption

Note 37 Prior period adjustments
There were no prior period adjustments

Note 38 Events after the reporting date
The Trust Board has approved the plans to establish a wholly owned subsidiary company (Gloucestershire Managed Services) effective from 1st April 2018. The company began trading on the 1st April 2018 and employs 675 support staff from estates and facilities, sterile services and materials management functions. The Board was clear that it could only approve the proposal if the evidence pointed to long term benefits for staff and patients, which it resolved was the case. The Board concluded that the new organisation will deliver a wide range of benefits and will address many of the challenges it is facing, through the focus that will come from establishing a subsidiary company whose primary purpose is to deliver truly excellent support services to NHS patients and staff.

Gloucestershire Hospitals
NHS Foundation Trust

Quality Account 2017/2018

What is a quality account?

A Quality Account is an annual report about the quality of services provided by an NHS healthcare organisation. Quality Accounts aim to increase public accountability and drive quality improvements in the NHS. Our Quality Account looks back on how well we have done in the past year at achieving our 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

Part 1: Statement on quality from the Chief Executive

In this the 70th anniversary year of the NHS, I am delighted to introduce the Quality Account for Gloucestershire Hospitals NHS Foundation Trust. 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. It serves many purposes but our intention in Gloucestershire has been to develop an Account that connects local people and our staff with the huge achievements of the last year alongside the ongoing challenges, which have shaped our priorities for the coming year.

Since joining the Trust more than 18 months ago, I have been repeatedly struck by the number of examples where our staff are leading the way in delivering innovative, high quality care. As a result, barely a Monday goes by when my weekly staff message doesn't contain a mention of a member of staff or team who have received acclaim for the things they are doing here in Gloucestershire or a patient hasn't written to me thanking the Trust for the care they have received.

The highlights from the last year are almost too many to mention so please do take the time to dive into the full report but before you do, below are a few of the things that really have transformed outcomes and experience for our patients, of which I am especially proud.

In July, the Care Quality Commission (CQC) published its inspection report into the Trusts services and rated 70% of our services either *good* or *outstanding;* we received acclaim from the Secretary of State for Health in respect of our A&E performance when he took the time to write to the Chair and me to acknowledge our standing as the most improved Trust in England having achieved the 4 hour waiting time standard in November 2017, the first time in more than four years; staff on ward 7a, alongside our patient experience team, won a national award for their project *Small Steps, Big Changes;* staff working in endoscopy services are still celebrating their achievements having received national accreditation for the service for the first time in more than a decade; three of our front line nursing staff were invited to join Prince Charles and others at Buckingham Palace in recognition of their contribution to the profession and finally, the work led by Mr Vinay Takwale and his colleagues in trauma and orthopaedic services is literally the talk of the NHS – there is barely a platform or conference when Professor Tim Briggs, National Lead for the Getting It Right First Time Programme isn't sharing the news about what staff in Gloucestershire Hospitals achieved last year.

One of the things that concerned me most when I arrived in the Trust was the higher than expected mortality rate affecting our patients, or put simply, more patients were dying than was expected given the nature of the population we serve. A year on, under the leadership of Medical Director, Dr Sean Elyan, I couldn't be more pleased with the improvements that staff have achieved for our patients and their families – a 14% reduction in mortality over the year resulting in the Trust now reporting a lower than expected number of deaths. Read about some of the things that have contributed to this huge achievement including the inspiring work to transform care and outcomes for patients who experience hip fracture which has resulted in a huge 37% reduction in the mortality of patients affected by this life changing event and the work done to improve the detection and treatment of sepsis - an infection which if left untreated, even for a short time, can result in the death of previously fit and healthy people - resulting in 96% of our patients receiving best care compared or the 'Sepsis Six Bundle' (as it's often known) compared to 52% last year.

The NHS is often described as a 'cradle to grave' service and in the pages that follow you can hear about the things our staff in maternity services are doing to respond to the national *Better Births* transformation programme to ensure that every woman in Gloucestershire has the best possible experience and outcome at what is such a very special time for most. You can also read about the approach that staff right throughout the Trust are embracing to ensure that those who have reached the end of their life receive the very best possible care, by signing up to our End of Life Charter which means that whatever the underlying cause of a patient's illness, and wherever they are cared for in the Trust, they get the same compassionate and expert care.

The Quality Account is not only our opportunity to reflect on and celebrate the things that we have achieved in the last year but equally importantly it is our chance to look to our quality priorities for the year ahead and, despite the huge number of achievements set out in this report, we still have much to do.

Our overall rating by the CQC remains *Requires Improvement* which is not where we want to be – our patients and staff deserve to be receiving and delivering the very best care in line with our vision of *Best Care for Everyone*. To this end, this year we have embarked upon our 'Journey to Outstanding' or #J2O as it is becoming known on Twitter! Under the leadership of our new Chief Nurse, Steve Hams we are redoubling our efforts in the areas of falls and pressure ulcer prevention, infection control and nutrition and hydration which signals our commitment to delivering the 'fundamentals of care' to the very highest standards . We know that our patients' experience of outpatients is not what it should be and Caroline Landon; Chief Operating Officer will be working closely with fellow Director of Strategy and Transformation, Simon Lanceley to implement our outpatient improvement programme. Under the leadership of our digital lead, Mark Hutchinson, this year will be the year that we can say that we have recovered from the challenging introduction of our new patient information system TrakCare and begin embarking

upon realising the many benefits for staff and patients that a fully functioning electronic patient record will bring and finally, Emma Wood our Director of People and Organisational Development will be launching the Trust's first talent management programme to ensure we support all staff to be the very best they can be, again reflecting our vision of *Best Care For Everyone* which doesn't just talk to care for patients but is equally central to our approach to caring for our staff.

Finally, the NHS is nothing without its patients and staff. One of the ways that I keep in touch with what it feels like to be a patient or member of staff in one of our hospitals, is to ensure that I prioritise my time so that I am able to spend time out and about in our services listening to staff and patients, hearing first-hand about their personal experiences of delivering and receiving care. With this backdrop, I have never felt more aware of just how challenging it is for staff throughout the NHS and our hospitals are no exception. It has been a long winter, vacancies in key areas persist and staff tell us that they are not always able to give the care they would like to give. 2018 will be a year when we really do 'walk in your shoes' - improving our patients' and staff's experience of work will be at the heart of everything we do. The correlation between staff who feel valued and fulfilled and excellent patient care is well established; both groups deserve the very best the NHS has to offer and I am therefore immensely proud to be a member of a Board which places this ambition centre stage.

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

25th May 2018

Part 2: Priorities for improvement and statements of assurance

Helping us improve the quality of care

Quality Accounts are an important way for us to report on quality and show improvements in our services we deliver to our local communities and stakeholders. The quality of our services is measured by looking at patient safety, the effectiveness of treatments patients receive, and patient feedback about care provided. Each year our Quality and Performance Committee agrees a set of priorities which help us improve the quality of care we provide for our patients. These priorities are identified because they are important to us, our regulators and/or commissioners and are decided following discussions with our Council of Governors, the Gloucestershire Health and Care Overview and Scrutiny Committee (HCOSC) and Healthwatch Gloucestershire.

The following section is divided into four parts:

- Part 2.1 - What are our priorities for 2018/19: explains why these priorities have been identified and how we intend to meet our targets in the year ahead.
- How well have we done in 2017/18: 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.

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.

The Quality and Performance Committee is responsible for monitoring the progress of the organisation against our quality improvement priorities. The Committee meets every month and reviews a series of measures which give us a picture of how well we are doing. The Quality and Performance Committee is a subcommittee of the Board and has clinical and managerial representation from across our Trust. It includes non-executive directors, executive directors, an observer governor, representation from Gloucestershire Clinical Commissioning Group and is currently chaired by Dr Claire Feehily, Non-Executive Director.

Part 2.1: Our priorities

Our priorities for improving quality

What are our priorities 2018/19

The table below provides an overview of our priorities for 2018/19. This table gives you an at- a-glance view of the work we will continue to undertake. During the year we have reviewed all the information available to us relating to the quality of our services and as NHS England published a two-year scheme on the CQUIN goals the view was that our CQUIN priorities should also be our focus for 2 years so that we could deliver focused clinical quality improvements. CQUIN stands for **C**ommissioning for **QU**ality and **IN**novation. The system was introduced in 2009 to make a proportion of our income conditional on demonstrating improvements in quality and innovation in specified areas of patient care.

Progress against the priorities identified will be measured by agreed metrics and monitored by the Quality and Performance Committee throughout the year. We have aligned our priorities with the dimensions of quality we are measured against by the Care Quality Commission: Safe, Caring, Effective, Responsive and Well Led.

Table: Our priorities for improving quality

Priority Area		Objectives 2018/19	Supports Strategic Goal
SAFE	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*	***Our patients will...****be safe in our care, be treated promptly with no delays* ***Our staff will...****put patients first* ***Our organisation will...****use its resources effectively, be one of the best performing trusts*
	Investigations and learning from deaths	• *To provide an annual summary on reviewing and learning from deaths.*	***Our patients will...****be safe in our care* ***Our staff will...****want to improve* ***Our organisation will...****be considered a good partner in the health and wider community*

Priority Area		Objectives 2018/19	Supports Strategic Goal
EFFECTIVE	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)*	***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* ***Our staff will…**put patients first, want to improve* ***Our services will…**make best use of our two sites, be organised to deliver centres of excellence for our population* ***Our organisation will…**use our resources efficiently, use our resources effectively, be one of the best performing trusts, be considered a good partner in the health and wider community*
	Improving the use of medicines (CQUIN)	• *To optimise the use of medicines commissioned by specialised services* • *To introduce standardised doses of anti-cancer therapies*	***Our patients will**…be safe in our care* ***Our staff will**…put patients first* ***Our organisation will**…use our resources efficiently, use our resources effectively*
RESPONSIVE	Preventing ill health by risky behaviours - alcohol and tobacco	• *To support healthier behaviours.*	***Our services will**…promote health alongside treating illness*
	Preventing ill health (CQUIN)	• *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*	***Our patients will**…want to recommend us to others* ***Our staff will**…feel valued and involved, want to improve, recommend us as a place to work* ***Our services will**…promote health alongside treating illness* ***Our organisation will**…be one of the best performing trusts, be considered a good partner in the health and wider community*
CARING	Time to care	• *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*	***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* ***Our staff will**…put patients first, want to improve, recommend us as a place to work, feel confident and secure in raising concerns* ***Our services will**… promote health alongside treating illness* ***Our organisation will**…use our resources efficiently, use our resources effectively, be one of the best performing trusts, be considered a good partner in the health and wider community*

Priority Area		Objectives 2018/19	Supports Strategic Goal
WELL LED	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 increase the use of the national e-referral system to allow patients to choose appointment times that suit them by publishing all of our first outpatient appointment slots available on NHS e-Referral Service (eRS) (CQUIN)* • *To establish Advice & Guidance services for non-urgent GP referrals, allowing GPs to access consultant advice prior to referring patients in to secondary care (CQUIN)*	***Our patients will**...be safe in our care, be treated promptly with no delays* ***Our staff will**...put patients first, feel valued and involved, want to improve, recommend us as a place to work* ***Our services will**...make best use of our two sites, be organised to deliver centres of excellence for our population, use technology to improve* ***Our organisation will**...use our resources efficiently, use our resources effectively, be one of the best performing trusts, be considered a good partner in the health and wider community*
	Learning to improve	• *To participate in and learn from the results of national audits, and reviews of our services* • *To respond to patient feedback and surveys around discharge* • *To build the capacity and capability of our staff to improve services through our Quality Academy* • *To learn from serious incidents*	***Our patients will**...be safe in our care, be treated promptly with no delays* ***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* ***Our services will**...make best use of our two sites, be organised to deliver centres of excellence for our population, use technology to improve* ***Our organisation will**...use our resources efficiently, use our resources effectively, be one of the best performing trusts, be one of the best performing trusts*

How well have we done in 2017/18

SAFE

Reducing the impact of serious infections

Quality priority

There should be timely identification of patients with sepsis in emergency departments and acute inpatient settings. There should be timely 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 antibiotic consumption per 1,000 admissions.

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. Each month our hospitals' Emergency Department (A&E) treats between 40 and 50 patients with sepsis.

How have we performed

In 2017/18, as in the previous year, reducing the impact of serious infections CQUIN has two main objectives:

Part A: patients who meet the clinical criteria for sepsis should be screened for sepsis using the local tool

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.

For the past three 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.

Data

Figure: Emergency Department - Proportion of patients who required screening for Sepsis who received screening

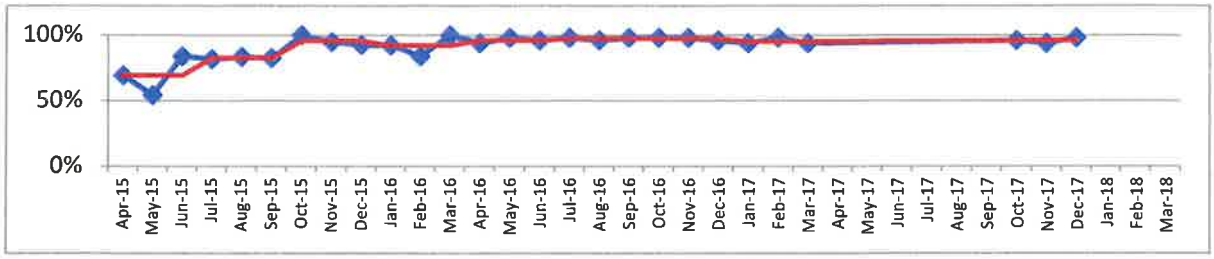
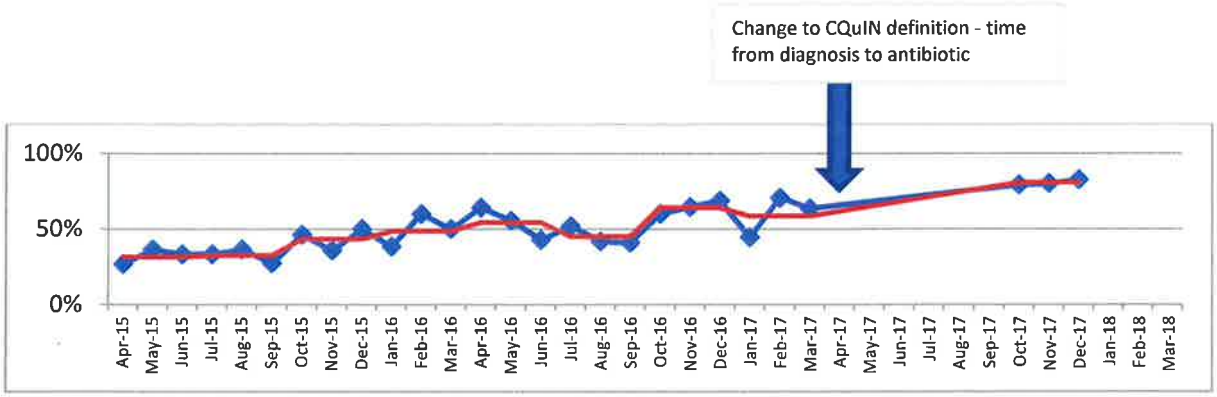


Figure: Emergency Department - Proportion of patients who received Antibiotics within 1 hour of diagnosis of Sepsis



Plans for improvement 2018/19

The quality improvement work will be continuing and we will work to meet and exceed the CQuIN targets set for 2018/19.

EFFECTIVE

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 have performed

We have seen a steady and sustained improvement in performance and quality across a number of metrics. For example, in November 2017 we achieved the 95% 4-hr standard across both hospitals for the first time in 7 years; patient reported outcomes from the Friends and Family Test improved by 10%, the number of patients and the number of hours that patients were looked after in the corridors in the Emergency Department decreased, and the number of operations cancelled in the 2017/18 winter was significantly reduced.

Data

Figure: Emergency department 4 hour standard 2016/16 & 2017/18

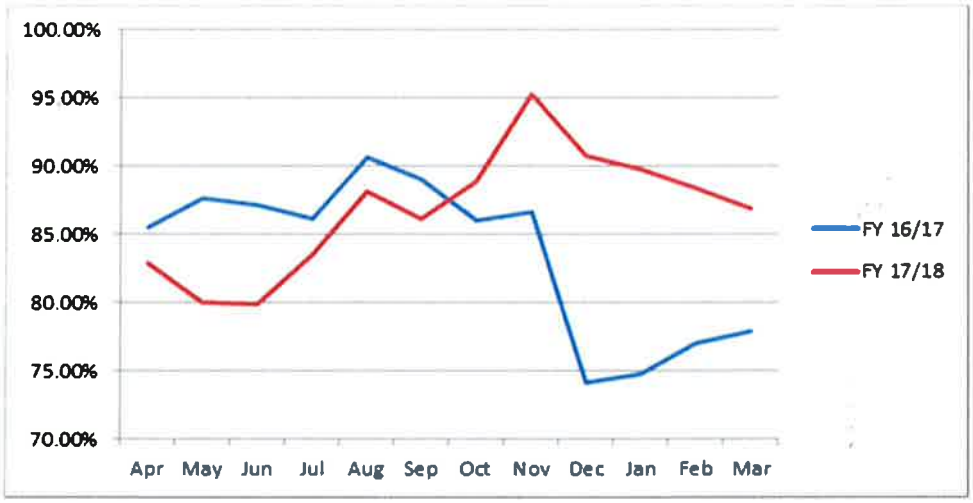
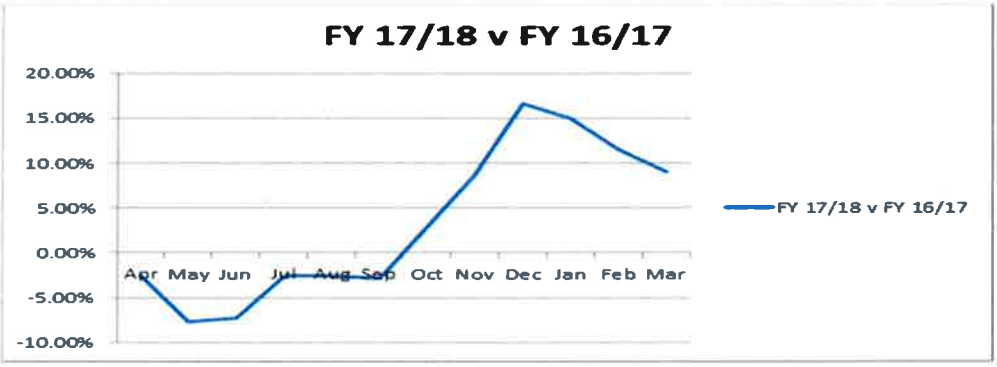


Figure: Emergency department 4 hour standard difference between 2017/18 vs 2016/17



Plans for improvement 2018/19

We will increase the number of hours that the Ambulatory Emergency Care unit is open extending it until late in to the evening.

We will open a dedicated Surgical Admissions Unit for emergency admissions.

The recently awarded capital funding will include a number of developments in both Cheltenham General Hospital and Gloucestershire Royal Hospital that will improve and extend the facilities in the Emergency Departments in 2018/19.

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 by 2018)

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 2017. At Gloucestershire Royal Hospital 65% of patients were seen by a doctor within 4 hours and 67% of patients were reviewed by a consultant within 8 hours of admission; the figures for Cheltenham General Hospital were 88% reviewed by a doctor within 4 hours and 58% by a consultant within 8 hours of admission.

Data

Figure: Gloucestershire Royal Hospital patients were seen by a doctor within 4 hours

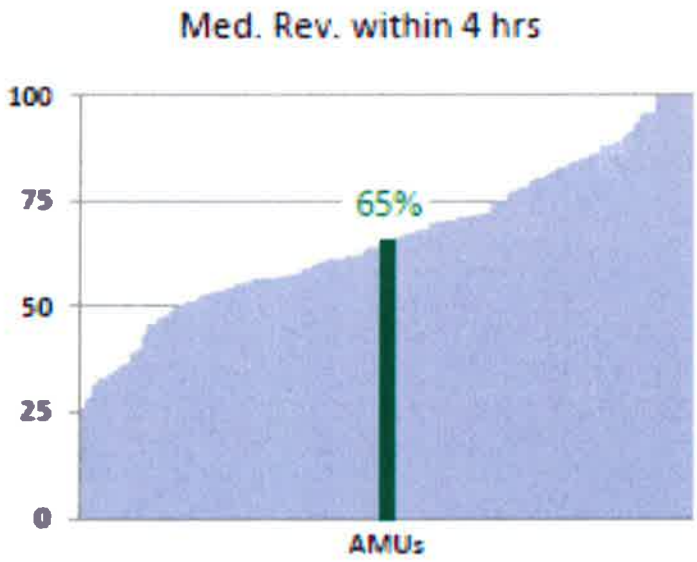
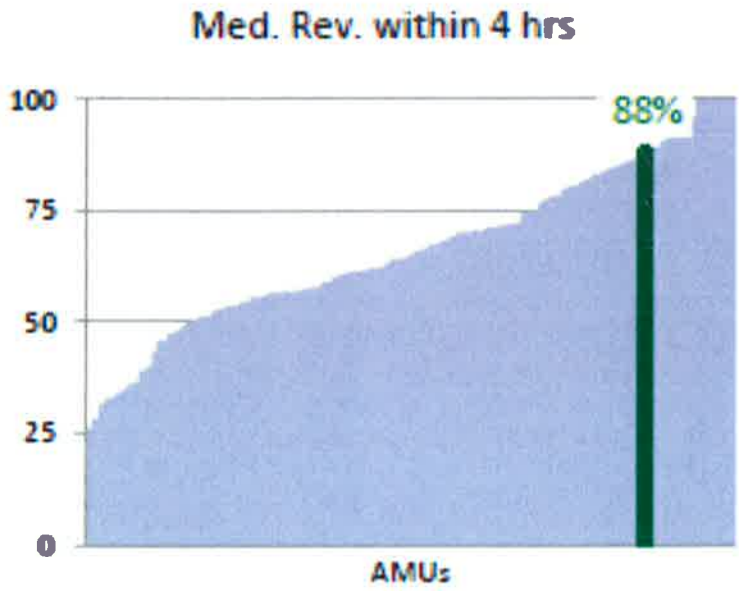


Figure: Cheltenham General Hospital patients were seen by a doctor within 4 hours



Plans for improvement 2018/19

A 1-hour diagnostic target was introduced for the admission unit in Gloucestershire Royal Hospital in 2017. This will be extended to Cheltenham General in 2018.

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) in 2018. 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.

A 1-hour troponin pathway (test to rule out a heart attack) will be introduced in 2018 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).

An Acute Medical Initial Assessment unit (AMIA) will be opened at Gloucestershire Royal Hospital in 2018. 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.

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 meets 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.

Data

The National picture is that Emergency Department attendances by patients in mental health crisis continue to rise by around 10% per year.

The efforts and joint working of primary and secondary care in Gloucestershire ensure that despite significant monthly variation, referral rates have not matched the National trend.

Figure: Cheltenham General Hospital (CGH) Emergency Department April 17-March 18

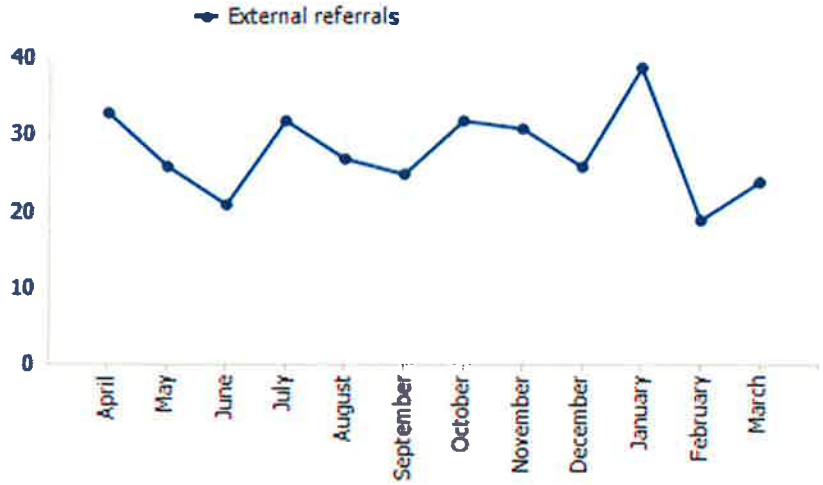


Figure: Gloucestershire Royal Hospital (GRH) Emergency Department April 17-March 18

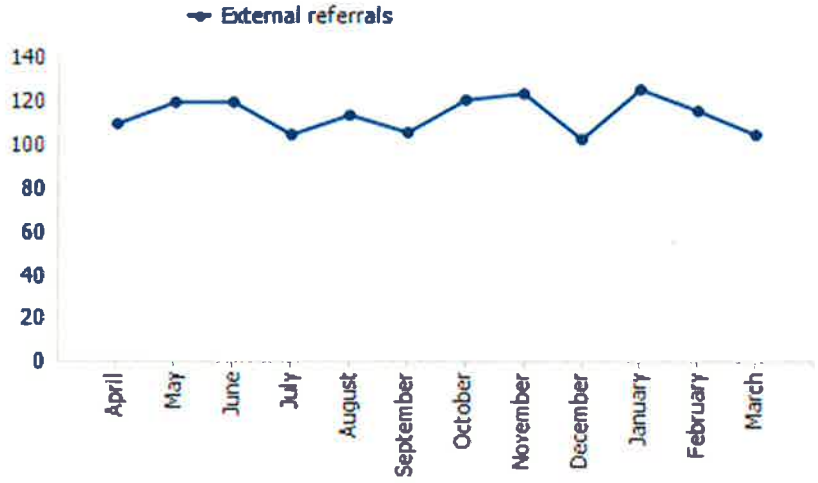


Figure: Alcohol Inpatient GRH/CGH Apr 2017-Mar 2018:

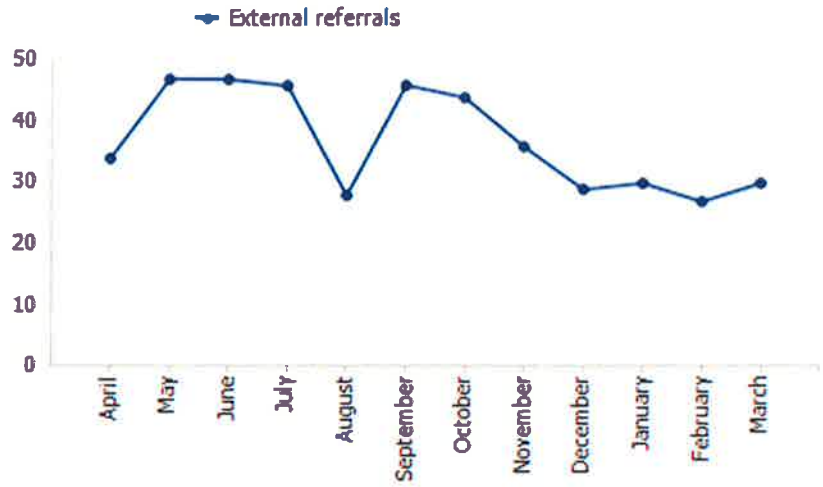


Figure: Older Age GRH Apr 2017-Mar 2018:

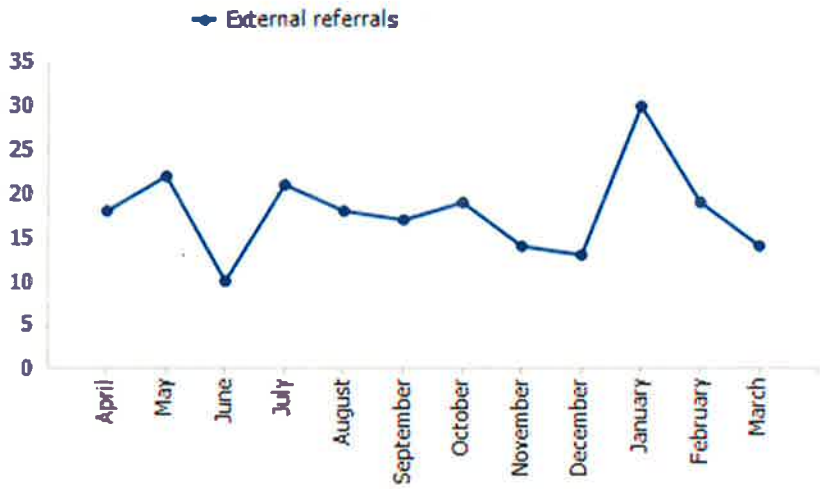
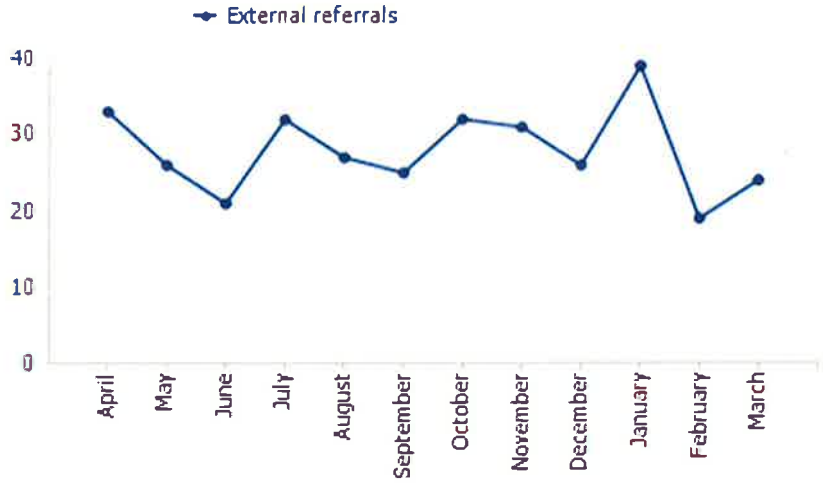


Figure: Older Age CGH April 17-March 18:



Plans for improvement 2018/19

Funding and plans are in place to improve the interview facilities at Cheltenham General Hospital Emergency Department to provide a safe space, which meets national standards and provides equity of facilities in both Cheltenham and Gloucester.

Time to assessment by an Emergency Department practitioner and then by the Mental Health Liaison Team remains longer than we would aim for with too many patients in crisis spending longer than 4 hours in the Emergency Department. Further work to improve this will be undertaken.

The development of our team of Emergency Nurse Practitioners and Physician Associates aims to increase the number of staff able to undertake risk assessments and mental state examinations in the Emergency Department. The aim will be to reduce time to assessment and improve quality of care.

Work with Gloucestershire Police will continue to ensure that new legislation about care of patients in crisis, held under section 136 of the Mental Health Act results in timely and high quality care.

The Royal College of Emergency Medicine document "*Mental Health in Emergency Departments - A toolkit for improving care*" was revised in October 2017. Many of the described initiatives to ensure care are in place and work will continue to ensure further improvement for all age groups of patients.

The effective use of complex devices

Quality priority

To ensure that the selection of internal cardiac devices remains consistent with the commissioning policy, service specification and relevant NICE guidance.

Background

Complex implantable cardiac devices are Implantable Cardioverter Defibrillators (ICD) and Cardiac Resynchronisation Therapy (CRT) devices. In the right patient, complex devices can reduce the risk of sudden death, improve quality of life and improve the prognosis in patients with heart disease.

Clinical decision making around device selection varies between units and this variance may impact on clinical outcomes as well as the overall cost of the complex devices.

The staffing of cardiology departments involved in implanting complex cardiac devices also varies cross England which impacts on the effectiveness of decision making, results in variation of device programming and outpatient follow-up arrangements as well as on-call cover for related emergencies.

This CQUIN scheme promoted:

- Enhancement and maintenance of local governance systems to ensure compliance with national policies and specifications.
- Development of sub-regional network policies to encourage best practice when determining device choice including minimum standards for patient consent to ensure the best device is selected for that patient.
- To improve timely access for all patients who need referral for consideration of complex device implantation.
- To ensure that referral pathways and robust decision making processes are developed for complex and clinically unusual cases.

How we have performed

We achieved quarter 1 and quarter 3 of the CQuIN and we are on track to deliver quarter 4. Results for quarter 2 were not robust due to capacity and data issues.

As of last year we went to a zero cost model for procurement of complex devices, the devices we procure are part of a regional south west procurement exercise

undertaken yearly to ensure the best quality cost effective product (zero cost - refers to a business decision that does not entail any expense upon execution).

The speciality has also engaged with two complex cardiology stakeholder forums in the last year with NHS South and South West with the purpose of benchmarking data for specialised commissioning across the region this included complex device insertion (excluding pacemaker).

Plans for improvement 2018/19

This CQUIN has been retired and so therefore will not be reported on in 2018/19.

Improving the use of medicines

Quality priority

To optimise the use of medicines commissioned by specialised services

Background

The prescribing and administration of a medicine is the most common therapeutic intervention that occurs to a patient within Gloucestershire Hospitals NHS Foundation Trust. Optimising their use provides a further opportunity for the NHS to improve patient outcomes, pathways and experience, whilst reducing expenditure, unwarranted variation and wastage.

How we have performed

This CQUIN has been designed to support Trusts and commissioners to realise this benefit through a series of modules that improve productivity and performance related to medicines. This includes the faster adoption of best value medicines with a particular focus on the uptake of best value generics, and biosimilar biologics as they become available, thus allowing us to treat more patients for the same amount of money. Targets based upon income for quarters 1 and 2 were met in full, and delivery on quarter 3 was 99%.

Working with our clinicians, one project involved pharmacy further developing homecare services which utilise a dispensing and home delivery service for high cost specialist drugs. This utilises a zero rated VAT option that previously has only been available to community pharmacy. This not only saves money but reduces the number of times a patient has to attend the hospital. Over 2000 patients now have specialist medicines supplied in this manner. One in every four pound spent on all medicines utilises this service, representing 85% of all outpatient prescribing.

Similarly delivery of our biosimilar biologics programme involving infliximab and etanercept is progressing well. Against a national target of 80%, January saw us deliver 97% of infliximab and 82% etanercept as the biosimilar product.

Gloucestershire Hospitals NHS

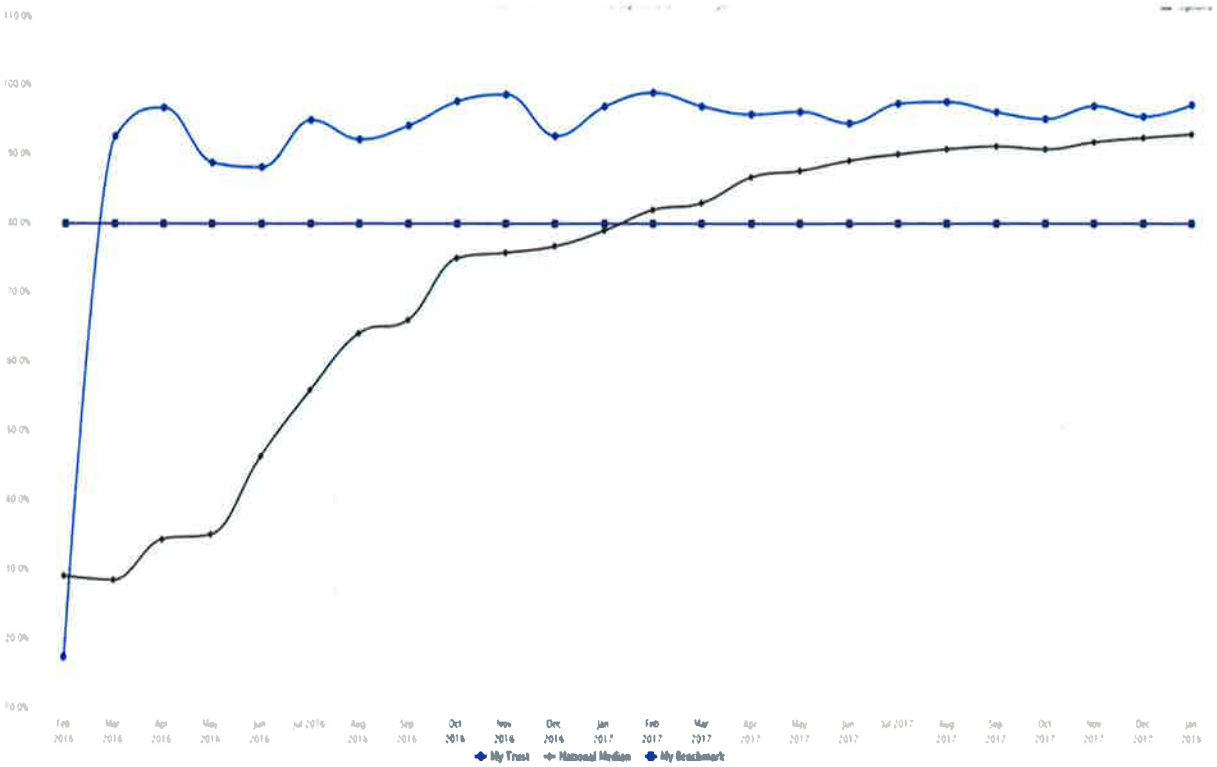
Going into Hospital?

Please ensure you bring all of your medicines into hospital with you. If not, your relatives/ carers will be asked to bring them in within 24 hours of your admission.

This information regarding your medicines is an essential part of your care

BETTER FOR YOU

Data



Plans for improvement 2018/19

The quality improvement work for this CQUIN will be continuing.

Quality priority

To introduce standardised doses of anticancer therapies

Background

The treatment of cancer via chemotherapy is the single biggest service within NHS England's specialised commissioning spends. 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 the elderly population increasing as well as advancement in chemotherapy treatments, this cost is increasing by approximately 8% per year. Traditionally, chemotherapy doses have been unique to individual patients based on a dose per kg of body weight. Such specific dosing has been demonstrated not to provide additional clinical or patient benefit and significantly increases time and costs of preparation and costs of 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 it 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. The target was 80% and we have achieved this for all three quarters.

Plans for improvement 2018/19

The quality improvement work for this CQUIN will be continuing.

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-inforced 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 2017

Question 9a – Does your organisation take positive action on health and well-being? *Answering "Yes, definitely"*

2017: **25%** (drop of 4% on previous year)

Question 9b – In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities? Answering *"No"*

2017: **76%** (drop of 1% on previous year)

Question 9c – During the last 12 months have you felt unwell as a result of work related stress? Answering *"No"*

2017: **62%** (drop of 4% on previous year)

It is disappointing that scores in the 2017 staff have deteriorated. In the last 12 months we have undertaken the following to try and improve the overall health and wellbeing of staff, including:

- Completed the Workplace Wellbeing Charter assessment. We achieved accreditation and were awarded "Excellence" in the categories of: leadership, absence management, health and safety and smoking; we were awarded "Achievement" in the alcohol and substance misuse category; and awarded "Commitment" to making progress in the categories of mental health, healthy eating and physical activity. We are now formulating and implementing action plans to drive these forward as priorities across the organisation, with a particular focus on MSK and stress.

- Distributed regular reminders to leaders about the importance of supporting the health and wellbeing of their team members through: 100 Leaders sessions; monthly Leaders' Learning Digests. This is ongoing.
- Launched a monthly staff recognition scheme – the Going the Extra Mile (GEM) awards – to recognise and celebrate great colleagues
- Launched a Diversity Network to support and promote the diversity of our workforce, particularly the nine legally protected characteristics. A programme of activity is being devised to offer support, signposting and celebration of vulnerable protected characteristics including disability and mental health.
- Established and promoted the new Freedom to Speak Up Guardian role
- Divisions and departments have been undertaking their own listening events and team meetings to discuss ways of improving staff engagement and health-wellbeing
- One Gloucestershire Sustainability and Transformation Plan (STP) has established a STP Health & Wellbeing Group. It has had particular focus on MSK and stress, along with supporting improvement in flu jab uptake

Plans for improvement 2018/19

There are some key actions we plan to take, in order to improve staff health and wellbeing in 2018/19. In order to drive forward and manage the delivery of these actions a 'Staff Experience Improvement Group' will be created to implement a range of staff engagement, health and wellbeing actions. The newly formed group will replace/ merge the former Staff Health and Wellbeing Group and Staff Engagement Steering Group.

Key priorities for this new working group will include:

- The Development of a 'One Stop Shop' for Staff Health and Wellbeing. The two greatest causes of staff absence are MSK and psychological issues. The Trust has many channels of support however current accessibility of these and our response to immediate need is challenging. A review of services will commence in Spring 2018 and will determine if more can be achieved within our financial envelope, the review will:
    - Identify the current return on investment for employee Health and Wellbeing services. To include: Occupational Health, Staff Support, Physiotherapy services.
    - Benchmark with other organisations 'one stop shop' / signposting provision
    - Make recommendations for the development of enhanced, more accessible staff wellbeing service provision.

- Improve the triangulation of data relating to staff experience, to enable in depth analysis and targeted intervention.

- Launch an online engagement / communications tool, which will enable staff to provide feedback and improve two way communications with our workforce. This will also provide an opportunity for us to promote health and wellbeing resources, such as the 'one stop shop' in an easily accessible way.

- Further develop and deliver the action plans relating to the Workplace Wellbeing Charter. Specifically these relate to three categories, where we have made a 'commitment' to improve as part of the workplace wellbeing charter assessment process: Mental Health, Healthy Eating and Physical activity.

Quality priority

Healthy food for staff, visitors and patients – changes to food and drink provision – focus on reducing sugars on sale in drinks

Background

Our Trust 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.

How we have performed

We have been building on work completed by the catering teams 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 In-house restaurants areas produce homemade options. The Deli bar has salads, fresh soup, sandwiches, Paninis, cakes, hot menu options, fresh fruit and takeaway fresh fruit pots. At breakfast we now have available porridge, low sugar high fibre breakfast cereal. The hot breakfast option includes traditional fare as well as poached and scrambled egg, with potatoes items being baked rather than fried.

Traditional theme days promote different food types, throughout the year including BBQ in the summer, traditional Christmas fare, specialised dishes have been created with low calorific values these dishes are very popular with staff and visitor. Supporting the main meals we offer couscous, seasonal vegetables, potatoes and rice. 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 and there are no price promotions on unhealthy food items including buy one get one free deals and a change to the impulse buys at till points have included healthy options. All homemade sandwiches are 400kc or below and do not exceed the recommended fat

levels. We have reduced the number of sweetened hot and cold beverages in line with the CQUIN and government targets, reporting 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.

Plans for improvement 2018/19

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
- Reviewing further what is provided out of hours for staff and visitors
- Looking at the patients' menu again in spring/summer

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419245/balanced-scorecard-annotated-march2015.pdf

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 2017/18.

Communication

- We mixed up our communication channels and used screensavers, social media, the intranet and emails
- Kept staff updated throughout the campaign by providing regular updates

Our flu team

- Included staff from all parts of the organisation

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

Data

76% of our patient facing staff received the flu vaccination this year; this is an 18% improvement on the previous year.

Plans for improvement 2018/19

Next year we are setting our sights high and want to ensure that at least 85% 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.

RESPONSIVE

Proactive and safe discharge

Quality priority

Supporting proactive and safe discharge using the Emergency Care Data Set and increasing the proportion of patients admitted via non-elective routes being discharged from acute hospitals to their usual place of residence within seven days

Background

Our goal is that we enable patients to get back to their usual place of residence in a timely and safe way.

How we have performed

The Trust is building upon the work undertaken last year to implement and embed the *SAFER* Programme. This programme with its focus 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.

Significant progress has been made against each one of the core SAFER elements as detailed below:

The five elements of the SAFER patient flow bundle are:

S – Senior review. All patients will have a senior review before midday by a clinician able to make management and discharge decisions.

A – All patients will have an expected discharge date and clinical criteria for discharge. This is set assuming ideal recovery and assuming no unnecessary waiting. Medication and transport is then arranged and booked ready for that discharge date.

F – Flow of patients will commence at the earliest opportunity from assessment units to inpatient wards. Wards that routinely receive patients from assessment units will ensure the first patient arrives on the ward by 10 am.

E – Early discharge. 33% of patients will be discharged from base inpatient wards before midday.

R – Review. A systematic multi-disciplinary team review of patients with extended lengths of stay (>7 days – 'stranded patients') with a clear 'home first' mind set. This 'stranded' patient review takes place on a daily basis and covers all patients across the hospital with a length of stay greater than seven days.

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.

Alongside this each ward is supporting their patients, where possible, to become part of the *End PJ Paralysis* scheme. This approach encourages patients to sit out and dress in their own clothes each morning thereby installing a sense of wellbeing, dignity and independence that is recognised by both staff and patients. Patients are also being encouraged to proactively ask staff about their discharge plans; asking staff each day what action is being taken that day to progress their discharge.

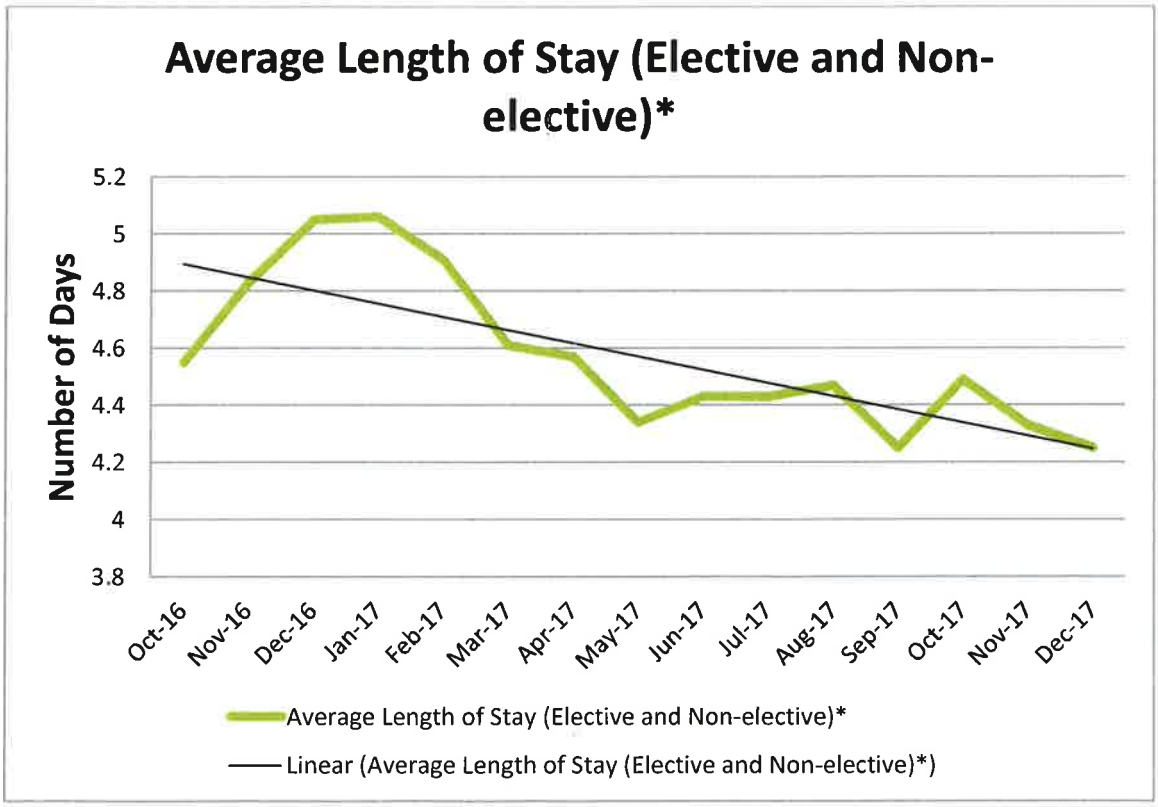
To support these proactive approaches we have looked to redesign our own internal *Onward Care Team* (OCT) which works with patients who have more complex discharge needs. This team has now aligned staff to each ward ensuring that each complex discharge is conducted in a safe and timely manner.

In order to share learning and provide challenge a daily Trust wide meeting is held attended by a multi professional team which seeks to unblock delays and identify trends that effect patient flow. These trends are then shared with the wider health

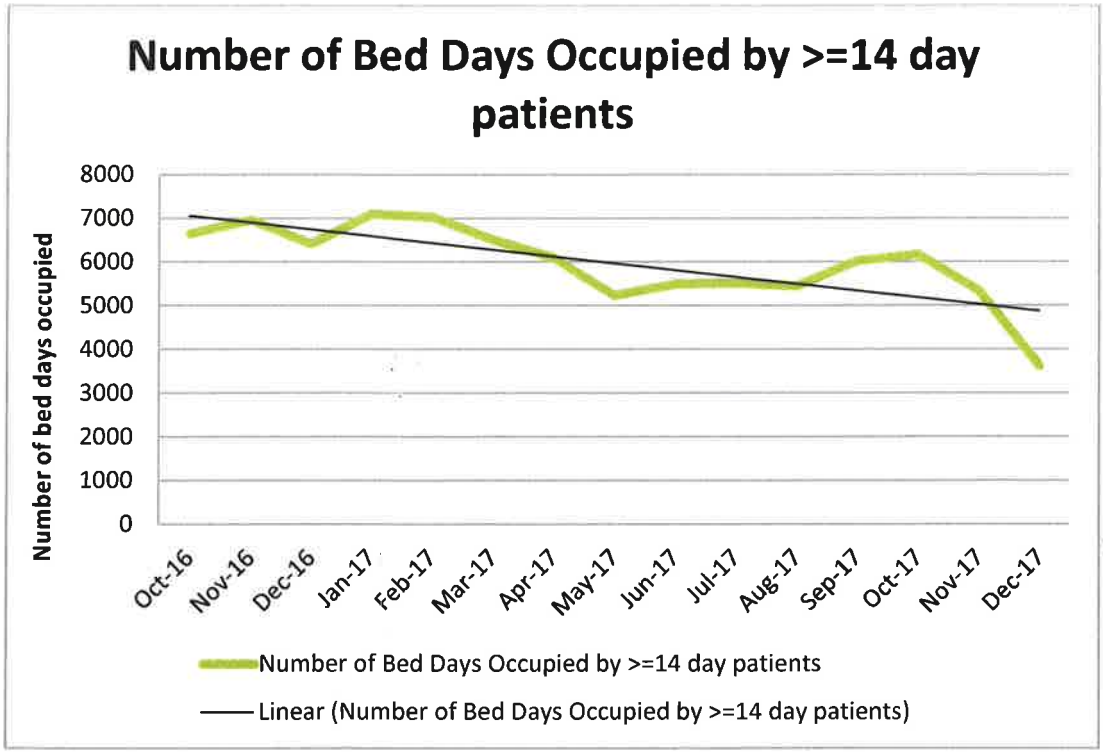
and social care system including commissioners in order to improve and redesign patient pathways.

As part of the 7 day service programme we have introduced the Weekend Assessment and Discharge team aiming to increase flow and discharges at the weekends. This team consists of medics, nurses and senior therapists; this has resulted in a significant increase in discharges during the weekend period.

Data



One of the Trust priorities this year has been to reduce the number of patients with a 14-day or more length of stay within our hospitals. A particular success has been the introduction of Gallery Ward – our medically stable for discharge ward. Launched in April 2017 the ward follows a therapy led model of discharge focussing on enabling patients to gain their independence as far as possible.



Plans for improvement 2018/19

Going forward the Trust will be seeking to embed more robust admission avoidance pathways seeking to maintain patients within their own homes. This includes the formation of the new Acute Medical Initial Assessment unit, which will support the Emergency Department by taking direct GP referrals and providing senior assessment and review from a whole system perspective.

In addition to the above, designated Frailty Beds will be introduced supporting these particularly vulnerable patients ensuring that their hospital stay is as timely and effective as possible thereby reducing the risk of deconditioning (having lost fitness or muscle tone, especially through lack of exercise).

Time to care

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. Over time, this will allow us to review the deployment of staff within a specialty and by comparable ward. 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.

The introduction of CHPPD for nurse and healthcare support staffing in the inpatient/acute setting is the first step in developing the methodology as a tool that can contribute to a review of staff deployment. 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 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.

Plans for improvement 2018/19

The CHPPD will become an increasingly important measure during 2018/19, with the introduction of a more agile e-rostering system. It will be possible to undertake near real time assessment of patient acuity, which in turn will enable us to deploy our staff more effectively to meet increasing care needs of patients. We will also use CHPPD as part of our twice-yearly review of safe staffing levels and will conclude our work as part of the NHS Improvement workforce efficiency collaborative.

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.

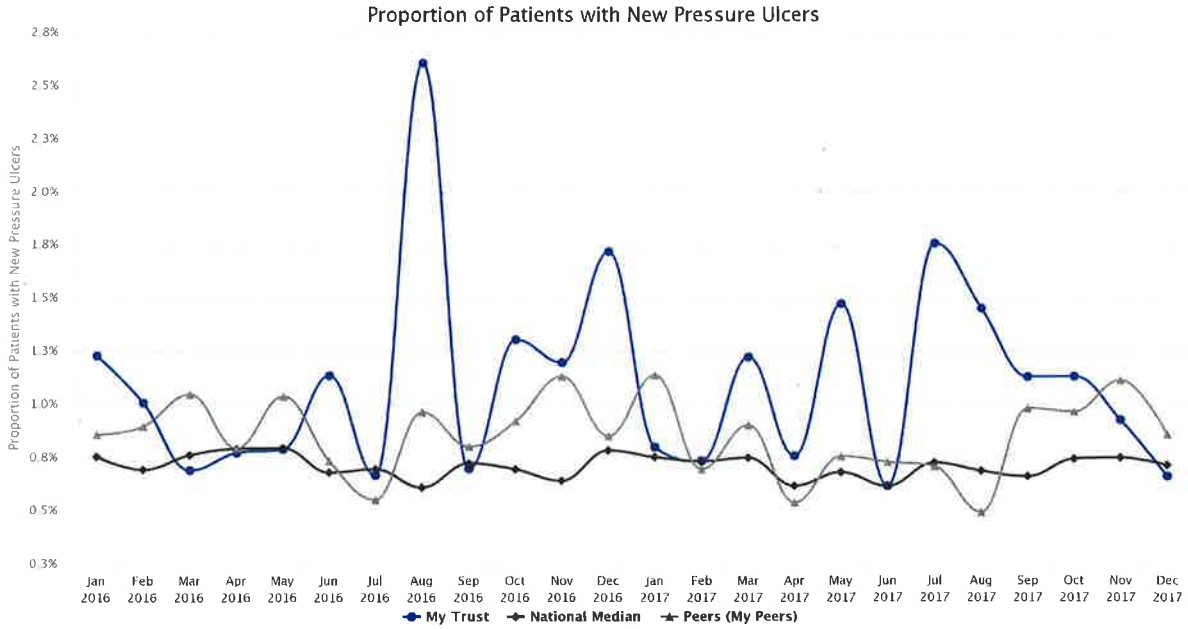
We know that many pressure ulcers are preventable, so when they do occur they can have a profound impact on the overall wellbeing of patients and can be both painful and debilitating (Moore et al 2009). Preventing them will improve care for all our vulnerable patients.

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, 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 has developed an action plan for 2017-18 comprising education, audit, equipment provision and innovation. Additionally, the Trust was invited to join the first NHS Improvement Collaborative on reducing pressure ulcers, and undertook two projects on reductions in heel ulcers, and those associated with medical equipment such as face oxygen masks.

Data



Plans for improvement 2018/19

This innovation will continue into 2018, with further developments around 'React to RED' as a mnemonic to remind staff to increase prevention techniques where skin redness is noted.

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.

There are more than 200 patient falls reported per month on the incident reporting system, with patients' experiencing moderate harm injuries (Duty of Candour) or becoming 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 is under review, the action plan is based on best evidence for the prevention of falls (NICE – Falls in Older People) and learning from incident investigation. The Trust has a Falls Group made up of clinical experts and safety and improvement staff. It is chaired by a Divisional Director of Nursing.

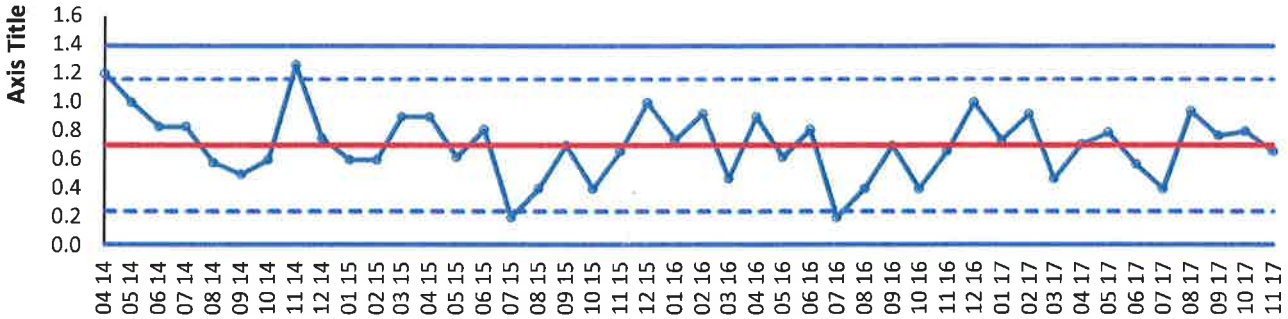
Data

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 NSPA historically report a 4.8 per 100 bed day rate but include a wider group of Acute Trusts which would include hospitals with naturally low falls rates.

During 2018/19 we will further supplement our specialist team with a Falls Prevention Specialist Nurse, who will work alongside members of the multidisciplinary team.

Harm from falls per 1000 bed days (April 2014 – Nov 2017)



The data above shows normal variation of harm from falls over an extended period of time with a mean fall rate of 0.7. The NPSA historically report a rate of 0.6 in an all hospital setting.

Plans for improvement 2018/19

There will be a thematic review of the root causes of falls looking at the trends and also for any learning. The data within the Royal College of Physicians National Audit of Inpatient Falls (Nov 2017) will be reviewed and this will lead to a revision of the falls action plan, which will be presented, to our Quality and Performance Committee in late summer 2018.

Quality priority

To improve end of life care

Background

In 2017, we launched our Trust'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 Specialist 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 bus has ever had!

Plans for improvement 2018/19

In 2018, we are committed to all clinical areas being signed up to the End of Life Care Charter.

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.

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.

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.

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.

WELL LED

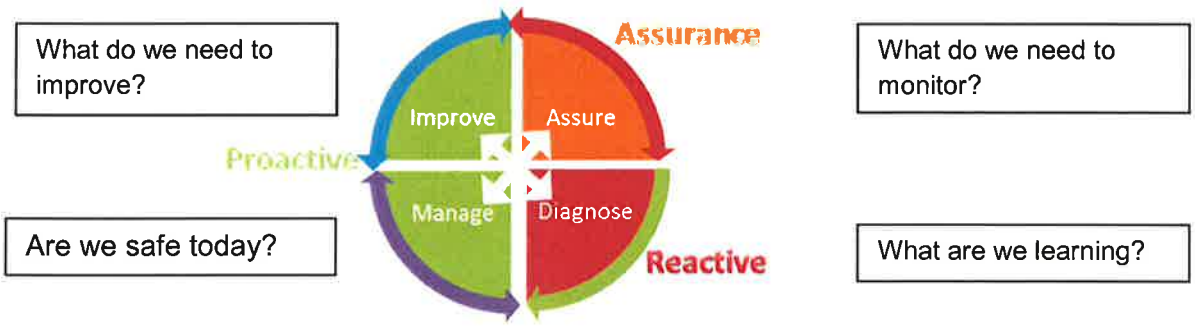
Learning to improve

Quality priority

To participate in and learn from the results of national audits and reviews of our services

Background

Quality assurance data is used for judgement; wherever possible it should be benchmarked against comparable external data such as national audits and should be displayed over longitudinal periods. Following testing in the past year a new model to manage quality at a local level has been established and is based simply on the concept of what is important for the patient.



Plans for improvement 2018/19

Each department\specialty will identify a range of relevant evidence based indicators such as relevant national audits that can be regularly measured that would provide continuous assurance that the service provided is at its highest standard. The indicators will be monitored using a suitable approach depending on the data. This will include using Statistical process control charts for monitoring processes over time. Positive and negative exceptions will be reported to the Divisional Quality Board with any necessary action, action arising from this report would be monitored at the Specialty quality meeting and an improvement plan established were performance is below the expected standard.

Quality priority

To respond to patient feedback and surveys on discharge

Background

We receive feedback from patients about their discharge experience in a number of formats. These include;

- Friends and Family Test (FFT)
- National Survey Programme including In-patients
- Concerns, Complaints and Compliments
- Social Media links.

How we have performed

We use the learning from this feedback to assist us in improving the care and services we provide to our patients. This has resulted in a number of programmes, work streams and quality improvement projects focusing on improving discharge.

Programmes and work streams include;

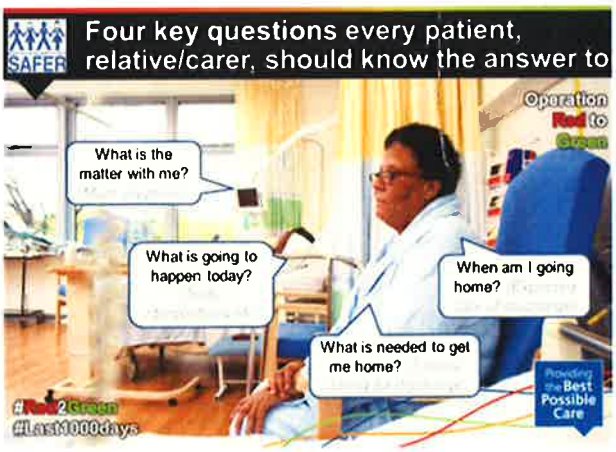
- **SAFER** programme focusing on "patients being in our hospital no longer than necessary".
- **The Emergency Department-** Good diagnosis in ED not only helps direct patients to the most appropriate care. It also helps avoid unnecessary admissions to hospital.
- **The Acute Care Unit-** A key priority in the Acute Care Units is ensuring patients are placed in the best possible location and that might well not be in hospital. There are numerous options for patients in ACU other than hospital admission.
- **Wards-** We are improving the way we discharge patients from our care.
- **Discharge Waiting Area-**The Discharge Waiting Area or Discharge Lounge plays a vital role in speeding the patient's journey. It has a highly qualified team who can look after all patients once they have been declared medically fit for discharge.

A number of new initiatives and processes have been introduced as part of these work programmes which, include;

- **Ward Rounds** – Ward rounds are now structured using the SORT mnemonic, **S** Sick - Sick Patients, **O** Out - Out today or tomorrow?, **R** Rest of the patients , **T** To come in?
- **Board Rounds -** Every day patients are coming into our Emergency Department and need beds on our Wards. Good board rounds ensure the greatest numbers of beds are available for them.
- **Managing complex discharges-** We flag up, as early as possible, patients who have complex conditions that will prevent them going home in a straightforward way.

- **Information for families and patients -** We will provide better information for families and patients by making sure our patients know the answer to 4 key questions
- What is the matter with me? (main diagnosis)
    - What is going to happen today? (Tests, interventions etc.)
    - What is needed to get me home? (Clinical criteria for discharge)
    - When am I going home? (Expected date of discharge)

The project team offered this SAFER poster to each ward sister to display in every ward area.



- **Single point of access (SPA) -** The SPA is responsible for a range of patient services. The most important role of its staff is allocating beds in community hospitals as close to the patient's home as possible. They also have access to enablement facilities, community rapid response teams and Intra Venous therapy teams.
- **Tablets to take out (TTOs) ready the day before discharge-**Pharmacy has reduced the average time it takes to turn round a prescription from three hours to ninety minutes and we are aiming to get TTOs ordered the day before.

A number of quality improvement projects have been taken through the Gloucestershire Safety and Quality Improvement Academy with a focus on reducing length of stay, improving the discharge experience and making care safer for our patients. These include;

- Improving the quality of information General Practitioners receive about newly started medication on their patients discharge paperwork
- Improving the quality of discharge summaries in the Paediatric setting
- Reduce the number of TTOs (tablets to take out prescriptions) that are sent to pharmacy from the wards in the afternoons.

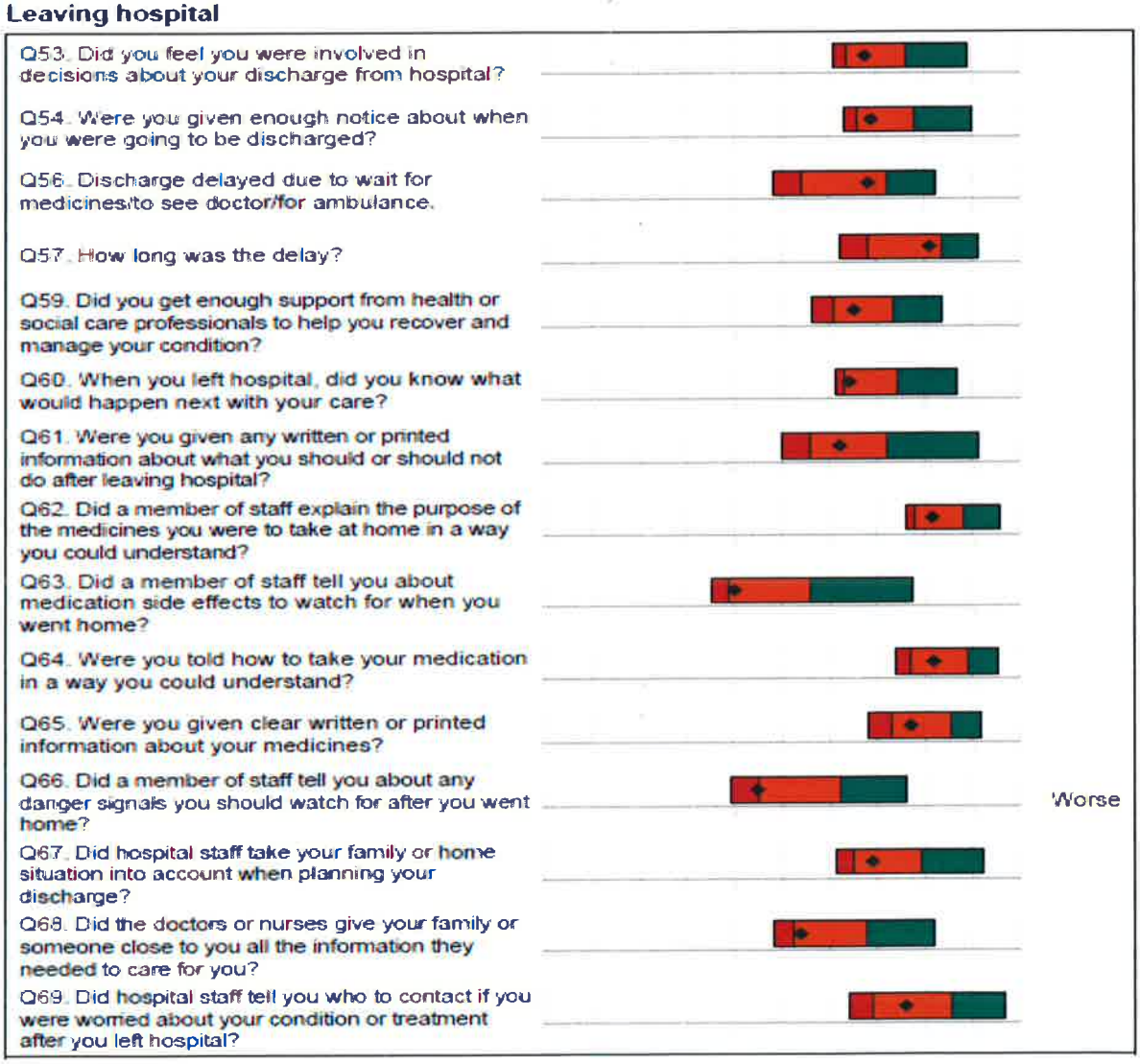
- Improving the care of older patients undergoing vascular surgery through the implementation of a comprehensive geriatric assessment
- Improving communication between secondary and primary care for patients who have an acute Kidney injury.
- Reducing length of stay for infants with neonatal chronic lung disease who require home oxygen
- Improving the quality of medical handover at the weekend

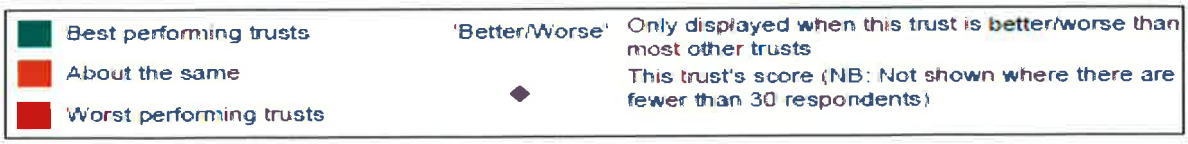
Data

Figure: Inpatient Survey data published by CQC June 2016

Gloucestershire Hospitals NHS Foundation Trust

Leaving hospital





Plans for improvement 2018/19

The Patient Experience Improvement Team during 2018/19 will continue to work with Gloucestershire Safety and Quality Improvement Academy to facilitate discharge improvement work across the Trust. This work links to our corporate strategic objective of improving the patient experience of care. We are working with the Point of Care Foundation to run a programme called the "Sweeney Programme" which will assist senior leaders in the Trust to focus on improvement work relating to our patient experience indicators and insights.

In 2018/19 we will continue to use the feedback we receive from patients and carers about their discharge experience. This feedback will steer improvement work ensuring that we learn from when things have not gone well and preventing reoccurrence in the future.

Quality priority

To build capacity and capability of our staff to improve services through the Quality Academy

Background

The Academy was created in June 2015 with the aim of developing a centralised source of Safety & Quality improvement education programmes to provide staff with the skills, tools and the support to contribute to the Trust vision to embed Continuous Quality Improvement into normal everyday working.

How we have performed

The initial aim of the Academy was to deliver a programme of Quality Improvement education and support internal to the Trust, with the longer-term aim of developing and delivering accredited education programmes external to the Trust whilst establishing an external reputation within the field of Safety & Quality Improvement. The GSQIA has been shortlisted for a HSJ award of for building an improvement movement. The work of the academy can be reviewed on the Trust website for GSQIA with regular communication on Twitter and Facebook.

Data

Following an initial target to train approximately 10% of staff (800) in Quality Improvement methodologies by the end of 2018, revised targets were proposed and included in the Trust objectives for 2017-2019. Progress so far is as follows.

	March 2019 Target Increase (Totals)	Current Status Increase (Totals)	To be trained to meet target
Bronze	+900 (1537)	+555 (1192)	345
Silver	+70 (97)	+34 (61)	36
Gold	+45 (45)	0	45

There are currently another 70 projects in progress. There are also 30 Gold QI coaches currently in training. 2 more cohorts due to start in June 2018 to achieve the 45 target.

Figure: Bronze improvement training

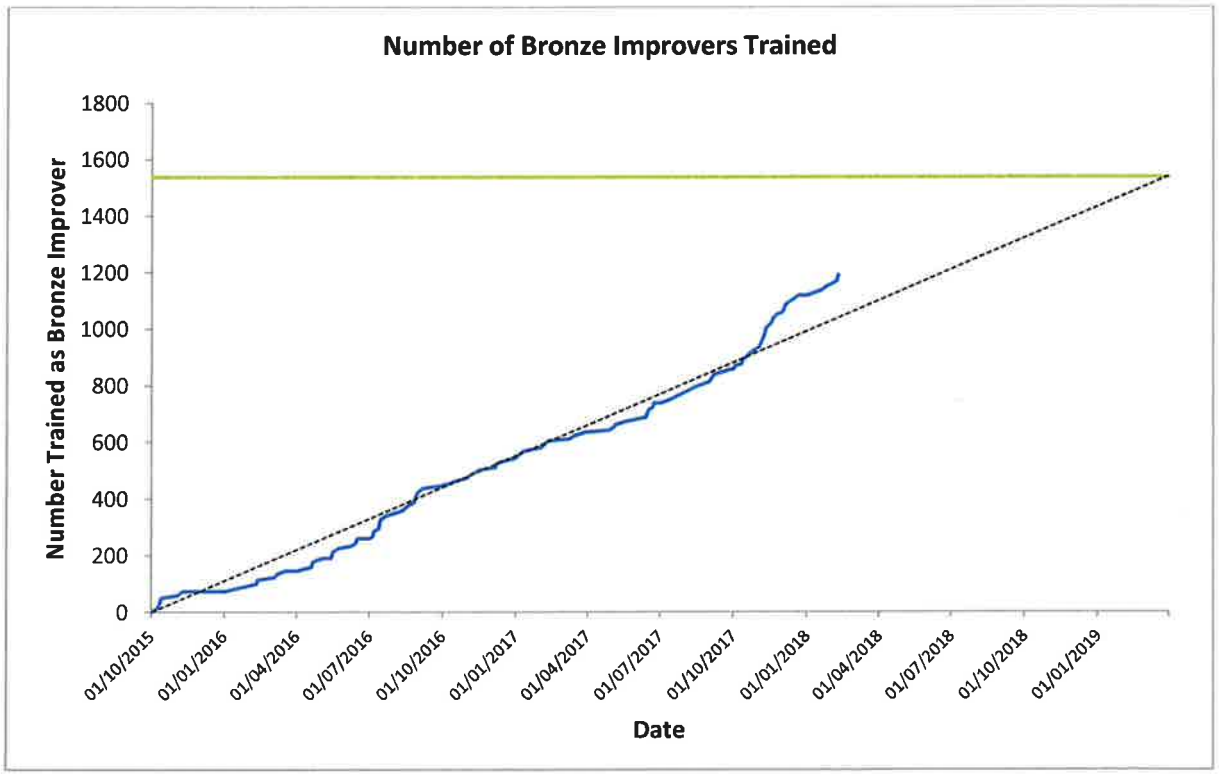
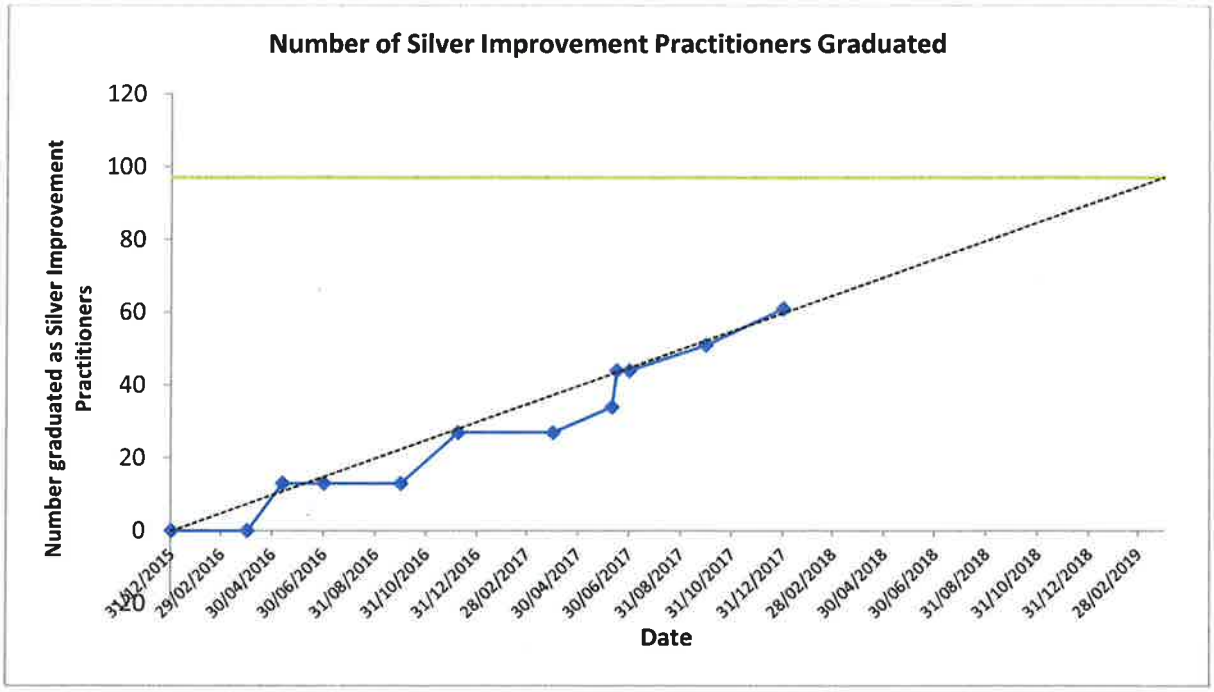


Figure: Silver improvement training



Plans for improvement 2018/19

We will continue to train our staff in quality improvement and will have trained a further 900 Bronze, 70 Silver and 45 Gold Quality Improvement Coaches by April 2019.

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. During 2017/18 Gloucestershire Hospitals NHS Foundation Trust provided and/ or subcontracted 117 NHS services.

The Trust has reviewed the data available to us on the quality of care in all of these NHS services. The income generated by the NHS services reviewed in 2017/18 represents 100% of the total income generated from the provision of the NHS services by Gloucestershire Hospitals NHS Foundation Trust for 2017/18.

Information on participation in clinical audit

From 1 April 2017 to 31 March 2018, 37 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 95% 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 2017/18 are as follows:

Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)
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)
Endocrine and Thyroid National Audit
Falls and Fragility Fractures Audit programme (FFFAP)
Fractured Neck of Femur
Inflammatory Bowel Disease (IBD) programme
Major Trauma Audit
Maternal, Newborn and Infant Review Programme Clinical Outcome
National Audit of Breast Cancer in Older Patients (NABCOP)
National Audit of Dementia
National Bariatric Surgery Registry (NBSR)
National Cardiac Arrest Audit (NCAA)
National Chronic Obstructive Pulmonary Disease Audit programme (COPD)
National Emergency Laparotomy Audit (NELA)
National Heart Failure Audit
National Joint Registry (NJR)
National Lung Cancer Audit (NLCA)
National Maternity and Perinatal Audit
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)
National Ophthalmology Audit
National Vascular Registry
Oesophago-gastric Cancer (NAOGC)
Pain in Children
Procedural Sedation in Adults (care in emergency departments)

Prostate Cancer
Sentinel Stroke National Audit programme (SSNAP)
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme
UK Parkinson's Audit

The national clinical audits and national confidential enquiries that Gloucestershire Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2017/18, 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:

	Number	Percentage
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	--	57% to date (70% required for minimum data standard)
BAUS Urology Audits: Cystectomy	42	100%+ based on HES for 2014/15/16 combined
BAUS Urology Audits: Nephrectomy	67	92% based on HES for 2014/15/16 combined
BAUS Urology Audits: Percutaneous nephrolithotomy	44	95% based on HES for 2014/15/16 combined
BAUS Urology Audits: Radical prostatectomy	133	HES % not provided
Bowel Cancer (NBOCAP)	438	100% case ascertainment (data completeness: pre-treatment 70%, performance status 88%)
Cardiac Rhythm Management (CRM)	Full submission	100%
Case Mix Programme (CMP)	All patients admitted to critical care areas	100%
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	Full Submission of Nationally mandated dataset.	100%
Diabetes (Paediatric) (NPDA)	270 patients	100% of appropriate cases
Elective Surgery (National PROMs Programme)	Based on patient returns (patient reported outcome measures)	August to November 2017 Hip : 85.1% Knee : 98.6%
Endocrine and Thyroid National Audit	100 Thyroid and 20 Parathyroid - 2016 caseload	100%
Falls and Fragility Fractures Audit programme (FFFAP)	20 cases at GRH and 20 at CGH	67% (aim was 30)

Fractured Neck of Femur	Eligible cases: 74 GRH, 34 CGH	100% (Based on 100 cases if expected number of cases >250)
Major Trauma Audit (TARN)	Ongoing case entry	Data accreditation 93.3% GRH, 91.2% CGH but data completeness 56%
Maternal, Newborn and Infant Review Programme Clinical Outcome	Data entered for all maternal deaths and still births	100%
Medical and Surgical Clinical Outcome Review Programme	Current data collection:	50% of Acute Heart Failure 43% Chronic Neurodisability
National Audit of Breast Cancer in Older Patients (NABCOP)	All data from COSD	100%
National Bariatric Surgery Registry (NBSR)	100% (to March 2016) Primary Procedures 133 and Revisional Surgery 10	Submission in arrears, working towards 100%
National Cardiac Arrest Audit (NCAA)	121 (any resuscitation event)	100%
National Chronic Obstructive Pulmonary Disease Audit programme (COPD)	208 admissions captured in 2017 across county	Online audit tool to capture all cases
National Emergency Laparotomy Audit (NELA)	232	100% Continual submission of emergency laparotomy patients
National Heart Failure Audit	--	50% of cases entered Data is entered via NICOR web portal (70% required for minimum data standard)
National Joint Registry (NJR)	1739 cases	100% of eligible and consented cases
National Lung Cancer Audit (NLCA)	372	100% of cohort
National Maternity and Perinatal Audit	Full submission	100%
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	559 eligible episodes of care included in 2017 report (2016 data)	100% The NNAP uses the mandatory database, 'Badger' to access all records needed per question.
National Ophthalmology Audit	4086 cases	100% Medisoft extraction
National Vascular Registry	AAA 77 Carotid 56	100% extraction from NVR database
Oesophago-gastric Cancer (NAOGC)	Full clinical cohort	100%
Pain in Children	100 GRH, 107 CGH	100% (Based on 100 cases if expected number of cases >250)
Procedural Sedation in Adults (care in emergency departments)	61 GRH, 50 CGH	100% (Based on 100 cases if expected number of cases >250)

Prostate Cancer	520 2016/17 (Current report) 507 This year	Varying levels of data completeness
Sentinel Stroke National Audit programme (SSNAP)	All patients admitted with stroke entered – Approximately 800-900 every year	100%
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	21 cases (incidents) reported to SHOT	100% of eligible cases
UK Parkinson's Audit	40 patients	100% of minimum sample

National Confidential Enquiries

Child Health Clinical Outcome Review Programme and Medical and Surgical Clinical Review Programme	Chronic Neuro disability	Information returned for all national confidential enquiries
	Young People's Mental Health	
	Cancer in Children, Teens and Young Adults	
	Acute Heart Failure	
	Perioperative Diabetes (ongoing)	

The reports of 100% of national clinical audits were reviewed (or will be reviewed once available) by the provider in 2017/18. Where results or case ascertainment have been found to be below required standards, the following actions have been noted, with the intention of improving the quality of data submitted or the quality of care provided:

Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Additional resource allocated to achieve the minimum standard. Look to achieve the Best Practice Tariff.
Cardiac Rhythm Management (CRM)	CRT numbers for the last year were lower than expected due to the unexpected retirement of a colleague. Local data analysis has found we are now back within range.
Diabetes (Paediatric) (NPDA)	Quality Improvements continue with foot examination, urine screening for albuminuria, blood pressure measurement and encouraging patients to attend structured education sessions. Moving forward, an issue relating to data capture has been reported to IT regarding the new dataset, some of this information is not available electronically, which may make it appear that the team has not been completing care processes required for the national audit.
Elective Surgery (National PROMs Programme)	Q1 is now handed out at Pre-admission clinic as per national guidelines. This has shown an increase in the returns rate. When looking at the monthly breakdown, it has shown an interesting pattern. Patients may be seen up to 6 weeks prior to surgery (and longer if cancelled or delayed) and their return will show in a different month to the actual surgery. Due to seasonal variability, this means that it looks like we have (in some months) more returns than surgeries performed. It was decided nationally, that from Oct 2017, PROMs data would no longer be collected for Varicose Veins and Groin Hernias, and distribution of Q1 was subsequently discontinued in these groups. Patients undergoing surgery between August and October 2017 will continue to be sent Q2 at the appropriate time. Work is ongoing to obtain permission to receive SEFT data which will allow for more time-sensitive and consultant level data to be obtained (at the point of Q2 return).

Falls and Fragility Fractures Audit programme (FFFAP)	The action plan has been updated and additional resource has been allocated (extra hours) to give support to ward staff to try and properly implement the falls care bundle on the wards. A focus has been given to taking patients lying /standing BP and getting medication reviews completed (which remains an issue nationally).
Inflammatory Bowel Disease (IBD) programme	Current assessment of resource/ funding for subscription to audit tool.
Major Trauma Audit	Data completeness is 56% due to the Trauma co-ordinator post being vacant for 4 months. We are working on improving data collection and we are going to change the trauma notes to highlight the use of TXA and the discussion with TTL. M&M cases discussed. Now the mortality is in line with the other trusts. We noticed that the Consultants don't record their attendance at Trauma and this issue was discussed at the ED staff meeting and it will be disseminated to the other colleagues. More trauma calls to be put out and the cases to be discussed with TTL.
Maternal, Newborn and Infant Review Programme Clinical Outcome	No specific actions but learning points disseminated throughout the service
National Bariatric Surgery Registry (NBSR)	To get local access to the database, in order to maintain an up-to-date dashboard so that information/ outcomes can be reviewed more quickly.
National Cardiac Arrest Audit (NCAA)	Actions taken are split into: • Areas where simulation training would be beneficial for identifying deteriorating patients and need for increased awareness of DNACPR • Training needs surrounding outcomes of futile attempts and DNACPR identification • Analysing our benchmarking status nationally for various outcomes including numbers of CPR attempts, survival to discharge, demographics of patients, locations of arrests etc. • Investigate submission of potential non-arrests and unexpected non-survivors and highlighted by the NCAA.
National Chronic Obstructive Pulmonary Disease Audit programme (COPD)	Increase use of discharge bundle (ensuring that respiratory staff are increasing their utilisation of the bundle, and looking at ways to have more time for staff to complete these tasks.) Use of coding department to better understand how many cases are being missed. Examine ways the existing patient tracking software can help us to identify eligible patients. Look at eligibility for best-practice tariff and how this might help bolster staff numbers. Consider education for staff to help the respiratory team find eligible patients.
National Heart Failure Audit	Plan to increase data input and achieve the minimum standard and to look at achieving the Best Practice Tariff.
National Joint Registry (NJR)	Discussion of data at surgeon level. Accurate number of cases undertaken recorded aiding tendering decision making. Identification of outliers. Contribution to national picture for arthroplasty. We are a positive outlier for data linkability and data quality and have received a national award for this, due to the work undertaken by the nurse practitioner.
National Lung Cancer Audit (NLCA)	Improvements noted in chemo rates for NSCLC stage 3B/4, good PS – likely due to improved data collection and rolling data reviews. Similar improvements in small cell chemo rates. Both figures now in line with national averages. Surgical rate and 1 year survival within expected range.
National Maternity and Perinatal Audit	Awaiting results of further analysis by NMPA. As they stand, results not recognised by GHNHSFT.

National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	A review of Thermoregulation has resulted in a Quality Improvement Project looking at an education package and bobble hat care bundle to further improve temperature on admission. Continued efforts to ensure badger reporting accuracy for 'first consultation' documentation, as not all consultations appear to be recorded on that system.
National Ophthalmology Audit	The Trust has been shown to be working within the national standards. Further clarification about how the data is used in the report is to be sought, as the local data used for submission reflects better outcomes.
Prostate Cancer	A review is being undertaken to fully understand additional support required in order to complete a full submission. All new cases are reviewed at MDT in real time.
Sentinel Stroke National Audit programme (SSNAP)	1) Weekly SSNAP breach report meetings undertaken to review data and look at pathway issues, and action plan ongoing 2) Increased Stroke specialist nurses to 3 WTE May 2017. Aim for 24/7 – business case to be written 3) Increased ward nursing numbers due April 2018 4) Need more SALT – review of Best Practice Tariff income to work out funding 5) Visit by National Stroke Lead due June 2018

257 local clinical audit and quality improvement projects were registered with the Quality Improvement team during 2017/18; these are reviewed and actioned locally. This includes 76 'Silver' quality improvement projects trained through the Gloucestershire Safety and Quality Improvement Academy (GSQIA). Some examples of actions associated with QI projects that have recently graduated from the academy are as follows:

ENT	Testing and introduction of biopsy and dental extraction lists to improve ENT cancer wait times
Maternity triage	Development of triage assessment forms, development and implementation of a data capture tool to reduce waiting times for women attending maternity triage
Neonatal unit	Introduction of 'Family Integrated Care' to the Neonatal unit to improve infants care, integration with families and staff satisfaction
Communication with deaf BSL users	Introduction of 'communication needs alert' on TrakCare, including presence of Gloucestershire Deaf Association telephone contact details. Design, implementation and promotion of countertop notices and 'Deaf Communication Card'
Renal services - Children to adult transition clinics	Engagement with patients transitioning from child to adult services to ensure they have a positive experience.
Pharmacy	Improving communication between pharmacists and nursing staff in order reduce TTOs sent in the afternoon. Development of ward communication sheet.

Elderly care	Use of UP forms to facilitate timely patient engagement and decision-making around ceilings of treatment, multi-disciplinary team approach.
Oncology	Implementation of a scalp cooling service for patients at risk of chemotherapy induced hair loss

Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by Gloucestershire Hospitals NHS Foundation Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee 1, 771.

Duty of Candour

For many years our Trust has delivered the 'being open' standards recommended for patients who have suffered avoidable serious harm or death. These standards require us to inform the patient or family of the event and provide an explanation and apology for what went wrong. Depending on the family's wishes, this can take the form of meetings, letters and/or sharing the serious incident report. The Duty of Candour is new legislation that came into force at the end of October 2014. It extends the definition from 'serious harm and death' to include 'moderate harm.' Arrangements within our divisions for investigating incidents which have, or have the potential to have caused moderate harm, varied.

The Safety Department works to ensure that all reported patient safety incidents that trigger the Duty of Candour are managed in accordance with statutory and contractual requirements. In October 2016 a new Duty of Candour Co-ordinator post and two Patient Safety Investigation posts were created. These new posts report to the Head of Patient Safety Investigations who reports directly to the Trust's Director of Safety. The Duty of Candour co-ordinator screens all moderate and harm incidents through our Datix reporting system with the Divisional Risk Managers, daily.

Trust staff report around 20-30 moderate harm incidents per week. It is necessary for each incident to be reviewed and consideration given to a) whether this has been correctly reported and b) whether on initial review it is considered that the patient has or may (in the future) suffer moderate harm or above. Of those 20-30 incidents, it is estimated that 2-3 cases per week fulfil the criteria for Duty of Candour. For those cases where the criteria is met a detailed root cause analysis is undertaken and a comprehensive investigation report and action plan, prepared. Involvement with the investigation and a final copy of the investigation report is routinely offered to all patients/carers that are involved with or affected by the incident. Where an Inquest is scheduled HM Coroner also receives a copy of our investigation report and action plan. During April 2017 – March 2018;

- **129** incidents following preliminary investigation were considered to have caused moderate harm or above (or had the potential to) and have received a detailed investigation by a Patient Safety Investigator.
- On the basis that around 20-30 potential moderate harm or above cases are reported per week and 2-3 cases accepted, there are approximately 900 cases in the period April 2017 to March 2018, that on further investigation have not met the threshold for a detailed harm investigation. However a significant proportion of those 900 will be followed through Divisional Governance arrangements for a moderate risk investigation and appropriate learning.

Information on the use of Commissioning for Quality & Innovation (CQUIN) framework

Gloucestershire Hospitals NHS Foundation Trust's total CQUIN plan for 2017/18 was £8,849,227. As NHS Gloucestershire Clinical Commissioning Group had a block contract in place in 2017/18 the CQUIN payment is in effect fixed at £6,944,873. However we will not know the CQUIN position for the other commissioners 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. As a guide however the current Trust Total CQUIN income position for 2017/18 is estimated at £8,703,254 if we were to achieve 100% target eligibility.

The level of the Trust's income in 2017/18 conditional upon the quality and innovation goals is £7.3m (2016/17: £8.5m). In line with national rules this represents 2.0% of income for National CCG commissioned CQUINS (£5, 893,674 - includes the 0.5% STP) and 2.0% Specialised Commissioned CQUINS (£1,387,918)

As in previous years goals are linked to the improvements required through the NHS Outcomes Framework, NHS Operating Framework 2016/17 and delivering the Forward View 2016/17-2020/21.

For 2017/19 the scheme shifted focus to prioritising STP engagement and delivery of financial balance across local health economies:

- 1.5% was assigned to deliver against mandated National CQUINS
- 0.5% of National CQUIN will be subject to provider engagement and commitment to STP process (principals specified in contract) – CQUIN values include this financial element
- 0.5% National CQUIN will be subject to a risk reserve, which is subject to the system delivering its control total in line with national guidance (£1,673,551)
- Specialised CQUIN is offered at 2.0% eligible contract value

In 2017/18 the Trust agreed a year end contract settlement with Specialised Commissioning and GCCG; GCCG CQUINS were included as a block agreement with no further financial risk for GCCG commissioned CQUINs. This was fixed at 100% achievement.

Of the 2.5% of eligible contract value, 2% was fixed as part of the settlement and 0.5% relating to delivery of the system risk reserve, remained variable. GHT committed to continue to deliver and report CQUINS as most will be continuing in 18/19 and they contribute to quality outcomes in line with Trust objectives.

To date there is no contract settlement with Worcestershire CCG and Associates (2% equates to £267k) and there will be financial implications to non-achievement of the WCCG commissioned CQUINS.

Specialised Commissioning CQUINS remained variable in the 17/18 contract settlement with NHSE therefore there remain financial implications to non-achievement.

The agreed National and Specialised commissioned CQUINS for 17/18 – 18/19 are described in the table below:

Table 1: Specialised Commissioned CQUINS:

CQUIN	Description	17/18 Value (2% of eligible CV)	17/18 Lost income to end Q4	18/19 Potential Value
Medicine Optimisation	To support the procedural and cultural changes required fully to optimise use of medicines commissioned by specialised services.	517,260	2,586 (0.8%)-Q4 not achieved - awaiting appeal – further £187,507 at risk	500,151
Dose Banding	Implementation of nationally standardised doses of SACT using the dose-banding principles and dosage	517,260	0	500,151
Complex Devices **(being retired 18/19)**	This scheme seeks to ensure that device selection for patients remains consistent with the commissioning policy, service specification, and relevant NICE guidance and that contractual requirement are in place for providers			

	while new national procurement and supply chain arrangements are embedded.	172,420	43,105 (25%)	N/A
Spinal Hub	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	172,420	86,210 (50%)-Q4 not achieved – awaiting appeal – further £43,105 at risk	166,717
Enhanced Supportive Care (New 18/19)	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 inappropriate aggressive treatment	N/A	N/A	166,717
Armed Forces Covenant	Embedding AF covenant	8,558	6,418 (75%)	£7,746
CCG Commissioned CQUINS:				
Health & Wellbeing	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	327,428 327,428 327,428	Staff survey did not achieve - £327,428	£861,450
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	Timely identification, treatment and review of patients with sepsis in ED and acute inpatient settings, Reduction in antibiotic consumption per 1,000 admissions	982,279	* £454,306 (46%) -Q4 3 out 4 elements not fully achieved	£861,450

Improving services for people presenting to A&E with MH issues	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	982.279	Q4 report not available yet	£861,450
Advice and Guidance	To improve GP access to consultant advice prior to referring patients in secondary care.	982,279	*122,785 (16%) – Q4 report not available yet	£861,450
E-referrals – 1 year CQUIN only	Providers to publish ALL GP referrals to consultant-led 1st outpatient services on the NHS e-Referral Service. ALL First Outpatient Appointment slots available on NHS e-Referral Service by 31 March 2018.	982,279	*368,355 (50%) - Q4 report not available yet	No 18/19
Supporting Proactive & safe discharge – suspended 18/19	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.	982,279	*589,367 (100%)	Suspended 2018/19
Local CQUIN- Supporting Proactive and Safe Discharge	This new for 18/19 local CQUIN replaces the retired National Proactive and Safe Discharge (above) – based on the SAFER discharge bundle as a measure of the quality of discharges.	N/A	N/A	£861,450
Preventing ill health by risky behaviours - alcohol and tobacco (2018-19 only)	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 the FYFV efficiency target by generating a projected national net cost-saving.	N/A	N/A	£861,450
STP Engagement 'CQUIN'	Expanded STP engagement for which the provider is required to meet the conditions and requirements to achieve this 'CQUIN'			£3.3m

	TOTAL:	**7,281,592**	**tbc**	9,822,595

* Block contract agreement in place 17/18; not fully variable 18/19

2017/18 Performance to date:

CCG commissioned: Q1 – Q3 performances across the board were generally good with no financial impact due to the year-end contract agreement with GCCG. Still waiting full Q4 outcome report from commissioners. There is an ongoing issue with WCCG as local variations were agreed with GCCG but not WCCG. This has led to a higher level of WCCG non-achievement that has not been easy to capture retrospectively. With no block agreement we have incurred financial penalties but this is difficult to quantify. The WCCG CQUIN value overall is £266k - 2% of eligible contract value

CQUINs that missed their milestones Q1-Q3:

1. **Reducing the impact of Serious Infections (Antimicrobial Resistance and Sepsis)** – In Q1 fell short of the upper payment for treatment time target (90% within 1 hour) for both ED (71%) and Inpatient Department (51%) but in Q2 there was improvement to ED (91%) and IP (71%). All other elements within this CQUIN (Timely Identification and Antibiotic Review) were fully achieved for this period. Q3 – the % of antibiotic prescriptions documented and reviewed within 72 hours was not achieved by 1% - 74% against a target of 75%. The reduction of antibiotics by 1% usage target is not required to be met until Q4 Sepsis screening and identified patients receiving IV antibiotics within 1 hour – targets of above 90% achieved. Q4 targets – Timely outcome IP/ED achieved; Timely treatment IP/ED – not achieved; Antibiotic review – not achieved; reduction in antibiotics – 2 of the 3 elements not achieved.
2. **Improving services for people presenting to A&E with MH issues:** Partial achievement; good work between providers, however, required meetings have not taken place and data submission is part of ECDS (currently not possible). No Q4 outcome yet
3. **Advice & Guidance** – partial services rolled out ahead of milestone. Quality standards for response times not consistently met. No Q4 outcome yet
4. **E-referrals:** working on the polling range issue and some targets were extended to Q3 rather than Q2. Partial gap analysis is late but expected to achieve 90% roll out target. No Q4 outcome yet
5. **Supporting Proactive and Safe Discharge** – Not achieved; no reports submitted; This CQUIN is being suspended 18/19 in line with National guidance.

Specialised commissioned: generally performing well, securing £909,500 from a possible £1,040,954 in Q1-Q3:

1. Medicines Optimisation – full achievement to Q3 (£364,237) – Appealing not achieved Q4 milestones (£187,509)
2. Dose Banding SACT – full achievement Q1- Q4 achieved (£517,260)
3. Spinal Hub failed to achieve Q1 and Q2 (-£86,210); Q3 achieved (£43,105); failed Q4 – appealing (£43,105)
4. Cardiac Devices failed to achieve Q2 (-£42,105); achieved Q3 and Q4 (£86,210)
5. Armed Forces failed to achieve Q2-Q4 (£6,418)

2018/19 CQUINS:

Following on from the 17/19 agreed two year contracts with commissioners we will be continuing the CQUINS started in 17/18 for 18/19 (as detailed in Table 1), with the addition of the National CQUIN *Preventing ill health by risky behaviours - alcohol and tobacco* and a locally derived CQUIN based on the SAFER discharge bundle as a measure of the quality of discharges-replacing the retired Supporting Proactive Discharge CQUIN

Specialised Commissioning 2018/19 proposal in line with National Guidance has now been agreed:

- Medicines Optimisation and Dose banding – continuing with some revision of milestones –achievable.
- Spinal Hub – continuing, with some revision expected
- Cardiac Devices – retired
- CA1 *Enhanced Supportive Care* for cancer pathways – new scheme for 18/19 now that the *Complex Cardiac Devices* scheme has been retired.
- Armed Forces covenant –to be continued from 18/19

In line with National Guidance 18/19 schemes for acute provider's will total 1.50% CV, (a local scheme will attract the weighting created by the suspension of the proactive and safe discharge indicator (0.25%). The remaining 1% of ECV (£3.3m) will be attached to the expanded STP engagement for which the provider is required to meet the conditions and requirements to achieve this 'CQUIN'

Information Governance

The Trust's Information Governance Toolkit score for 2017/18 has been published as 76%, and is graded green.

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 Serious Incident Requiring Investigations involving personal data as reported to the Information Commissioner's office in 2017–18 (Level 2)

Date of incident (month)	Nature of incident	Nature of data involved	Number of data subjects potentially affected	Notification steps
12-Apr-17	Lost or stolen paperwork	A doctors ward handover sheet found in a public place by a member of Trust Staff	25	Patients not contacted, as information had been contained within the trust
15-Apr-17	Lost or stolen paperwork	Ward Nursing handover sheet found in a public place by a member of Trust Staff	27	Patients not contacted, as information had been contained within the trust
14-Sep-17	Non-secure Disposal – paperwork	MDT meeting notes including an identifiable list of patients received by another care provider in a box delivered from stores	17	Patients not contacted, as information secured and destroyed by NHS care provider
20-Sep-17	Lost or stolen paperwork	Ward handover sheet found in a public place by a member of Trust Staff	20	Patients not contacted, as information had been contained within the trust
29-Sep-17	Disclosed in Error	Copy of discharge summary data transferred to a server located in the USA in error. Against previously agreed data handling processes	18	Patients not contacted, as information had been secure at all times.
12-Oct-17	Lost or stolen paperwork	Ward handover sheet found in a public place by a	35	Patients not contacted, as information had

Date of incident (month)	Nature of incident	Nature of data involved	Number of data subjects potentially affected	Notification steps
		member of Trust Staff		been contained within the trust
01-Nov-17	Lost or stolen paperwork	A doctors ward handover sheet found in a public place by a member of Trust Staff	30	Patients not contacted, as information had been contained within the trust
10-Nov-17	Disclosed in Error	Emergency department discharge summaries sent in error to another health and social care provider.	8	Patients not contacted, as information secured and destroyed by health and social care provider
24-Nov-17	Lost or stolen paperwork	Ward handover sheet found in a public place by a member of Trust Staff	30	Patients not contacted, as information had been contained within the trust
Further action on information risk	GHNHSFT will continue to monitor and assess its information risks, in light of the incidents above. The processes and controls within the teams involved have been reviewed in order to identify and address any weakness and ensure the improvement of systems where required. Extensive communication to trust staff specifically highlighting the need to ensure safe keeping of handover sheets has been introduced as a regular reminder. Additional controls have been implemented including tighter controls on each ward in terms of who can print them and how they are distributed. Further plans in progress to improve ease of confidential disposal of handover sheets. A review of data processing procedures that resulted in information being copied to server in USA has been carried out by system supplier and assurance received that these have been corrected.			

Summary of other personal data related incidents internally reported 2017–18 (Level 1) As per HSCIC guidance

Category	Breach Type	Total
B	Disclosed in Error	22

Quality of data

Gloucestershire Hospitals NHS Foundation Trust submitted records during 2017/18 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data (please note this is for the period April 2017 to February 2018).

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
- 99% for accident and emergency care

The percentage of published data which included the patient's valid General Medical Practice Code was:

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

Gloucestershire Hospitals NHS Foundation Trust will, as always, be taking actions to improve data quality. We have a data quality action plan which is aligned to Schedule 6 of the contract with our lead commissioners. This action plan covers our requirements to submit our statutory reporting requirements.

Clinical coding

Gloucestershire Hospitals NHS Foundation Trust was not subject to the "Payment by Results clinical coding audit" during 2017/18.

The Care Quality Commission (CQC)

Gloucestershire Hospitals NHS Foundation Trust has had a number of inspections since first registering with CQC. The last full inspection occurred in March 2015 and was an announced comprehensive inspection. Our current registration status is "Requires Improvement". CQC carried out a focused announced inspection 24-27 January 2017 and a focused unannounced inspection at Gloucestershire Royal on 6 February 2017. This focused inspection was to follow-up on concerns from the previous full inspection. As such, not all domains were inspected in all core services.

The inspection team inspected the following seven core services at Gloucestershire Royal Hospital:

- Urgent and emergency services
- Medical care (including older people's care)
- Surgery
- Maternity and gynaecology
- Services for children's and young people
- End of life care
- Outpatients and diagnostic imaging

They did not inspect the critical care services (previously rated outstanding).The Care Quality Commission has not taken enforcement action against Gloucestershire Hospitals NHS Foundation Trust during 2017/18.

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 and Performance Committee.

CQC ratings chart

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	N/A	Requires improvement	N/A	N/A
Maternity and gynaecology	Requires improvement	N/A	N/A	N/A	N/A	N/A
Services for children and young people	Good	N/A	N/A	N/A	N/A	N/A
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	N/A	N/A	Requires improvement	N/A	N/A
Overall	Requires improvement	N/A	N/A	N/A	N/A	N/A

CQC list of "Must do" actions

Figure: Areas for improvement from CQC inspection in 2017

"Must do" area for improvement	Status 31st March 2018
Review processes to monitor the acuity of patients to ensure safe staffing levels.	In progress
Ensure wards are compliant with legislation regarding the Control of Substances Hazardous to Health	In progress
Review processes for ensuring effective cleaning of ward areas and equipment and patient waiting areas.	In progress
Review the governance and effectiveness of care and treatment through national audits.	In progress
Ensure patient records are kept securely always.	In progress
Ensure equipment is replaced to ensure safe diagnosis and treatment. (in report this relates to cardiac equipment)	In progress
Ensure the medical day unit is suitable for the delivery of care and protects patient's dignity and confidentiality.	In progress
Ensure all staff are trained and understand their responsibilities in a resuscitation situation.	Complete
Ensure resuscitation equipment is readily available and accessible to staff.	In progress
Ensure steps are taken to reduce the current typing backlog in some specialities.	In progress
Ensure specialities have oversight of their waiting lists.	In progress
Ensure that all information related to patient's mental capacity and consent for 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNA CPR) is available in the patient records.	In progress
Ensure trust staff comply with the requirements of the Mental Capacity Act (2005)	In progress
Ensure the Emergency Department is consistently staffed to planned levels to deliver safe, effective and responsive care.	In progress
Review support staff functions to ensure the emergency department is adequately supported.	In progress
Ensure that all staff are up to date with mandatory training and receive yearly appraisals in line with trust policy.	In progress
Ensure patients arriving in the emergency department receive a prompt face to face assessment by a suitably qualified clinician.	In progress

"Must do" area for improvement	Status 31st March 2018
Improve record keeping so that patients' records provide a contemporaneous account of assessment care and treatment.	In progress
Ensure patients in the emergency department receive prompt and regular observations and that early warning scores are calculated, recorded and acted upon.	In progress
Ensure the mental health assessment room in the emergency department meets safety standards recommended by the Royal College of Psychiatrists.	In progress
Ensure that a suitable space is identified for the assessment and observation of patients presenting at the emergency department with mental health problems.	In progress
When using Kemerton and Chedworth Suite for inpatients, provision must be made for the cleaning of the units at weekends and to provide patients with clean water jugs and drinks.	Complete
Ensure emergency resuscitation trolleys are checked and have guidelines attached according to best practice guidance and in line with trust policy.	In progress
Ensure the safe management of medicines at all times including storage, use and disposal and the checking and signed for controlled drugs.	In progress
Ensure all drug storage refrigerator temperatures are checked and the results are recorded daily. Additionally, if temperatures fall outside of the accepted range action is taken and that action is recorded.	In progress
Ensure patient group directions are up to date and consistent in their information.	Complete
Ensure women attending the triage unit within maternity service are seen within 15 minutes of arrival.	In progress
Ensure machines for near patient testing of patients' blood sugar, are calibrated daily and this is recorded or ensure all staff are trained in how to use the new machines, so the old machines can be removed.	Complete

During 2017/18 2,147 of Gloucestershire Hospitals NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 547 in the first quarter
- 428 in the second quarter
- 527 in the third quarter
- 645 in the fourth quarter

All cases are reviewed by medical examiner as per Trust policy. So record reviews by quarter

- 547 in the first quarter
- 428 in the second quarter
- 527 in the third quarter
- 557 in the fourth quarter (not all case reviews completed)

Total investigations in the first 3 quarters of 2017/18 are 1025 undertaken by specialties of which 377 were subjected to detailed investigation. We do not currently have the investigations by quarter available so this figure is a combined figure.

In summary 100% of cases are reviewed by the medical examiner.

In the period 1st April 2017 – 31st December 2017 (the first three quarters of 2017/18:-

- 1025 of 1502 (68.2%) of cases were investigated by the relevant speciality
- 377 of 1502 (25.1%) had a detailed review undertaken.

In the period 1st April 2017 – 31st December 2017 (the first three quarters of 2017/18:-

22 death investigations are judged to be more likely than not to have been due to problems in the care provided to the patient.

This represents 22 of 1502 (1.46%) deaths in the period

Summary of learning from case record reviews and investigations conducted in relation to the deaths identified above:-

- Important to optimise the handover between medical/nursing teams for sick patients (particularly on transfer) resulting in lack of follow-up of investigation results
- Care when discharging sick patients from ED to avoid missed opportunities for continuing care
- Reviewing blood results on patients discharged form ED
- Prioritising urgent CT head scans in at risk patients
- Patient falls – identifying patients at risk and minimising these risks
- Ensuring initiation of non-invasive ventilation where appropriate
- Identifying the deteriorating patient
- Prompt treatment of sepsis.

Description of the actions and learning:-

- Review of handover documentation and handover processes with junior doctors
- Optimising the use of ED documentation in transfer to ward care
- Change and development of new paperwork in the emergency department being assessed as pilot project
- New policy on indications for CT head scans and monitoring against these standards
- Trust wide falls group established by Chief Nurse and reporting to Quality and Performance Committee
- Increased input of respiratory senior team to acute medical unit and at ward level
- Continued work though the Trust deteriorating patient group to ensure appropriate timely management of patients
- Continued embedding of sepsis six pathway across the Trust with clear evidence of improved outcome for patients with sepsis.

An assessment of impact is that this work has been significant as service change has resulted from death reviews within this reporting period.

The number of case record reviews taking place before this period is not available as this was not recorded.

Seven day services

The Trust is working towards delivery on the National 7 day service standards and have undertaken a self-assessment during February 2018, against the 4 key standards for 7 Day Services for actions 18/19. Namely

- Consultant review
- Consultant on-going review
- Access to diagnostics
- Access to Consultant Directed interventions

The Trust have undertaken self-assessment against 6 key areas.

There are 6 sections of the tool to complete:

1. Leadership and governance
2. Data capture and information quality
3. Performance and change management
4. Policy and Procedures
5. Workforce readiness
6. Risks and mitigating actions

The Trust is developing an action plan for the 4 key standards into 18/19, with feedback from NHS England and from our audit findings.

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	Explanation of why GNHSFT considers that the data from the HSCIC are as described	Actions GHNHSFT intends to take to improve indicator and quality of services
a) SHMI for trust for the reporting period	2015/16	1.13	1.00	1.178	0.68	1.0872, within the expected range using NHS Digital's published banding (↓)	The Trust's figures are within expected range. We run a Trust Mortality Review Group, chaired by the Medical Director, which reviews this indicator and other more granular parameters in relation to mortality. We also use the Dr Foster Intelligence System to monitor mortality indicators.
	2016/17	1.12	1.00	1.23	0.73		
	2017/18	1.09	1.00	1.11	0.89		
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	20.9%	28.5%	54.6%	0.6%	*last data published June '17 for data period July'16-Jun'17	As above.
	2016/17	21.0%	31.1%	58.6%	11.2%		
	2017/18 *	26.1%	No data	No data	No data		
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	*2015/16 Published Sep-16. no new data release	
	2016/17	6,932/22	4955/19	23,990/60	3,510/26		
	2017/18 *	14,762/1	No data	No data	No data		
Rate per 100 admissions of patient safety incidents resulting / rate per 100 admissions resulting in	2015/16	30.04 / 0.2	35.77 / 0.18	73.46 / 0.82	18.6 / 0.35	*2015/16 Published Sep-16. no new data release	Our comparative reporting rate for incidents in all acute Trusts shows us as being in the middle 50% reporters.
	2016/17	41.82/0.13	39.89/0.15	71.81/0,6	21.15/0.06		

Indicator	Year	GHNHSFT	National average	Highest trust fig	Lowest trust fig	Explanation of why GNHSFT considers that the data from the HSCIC are as described	Actions GHNHSFT intends to take to improve indicator and quality of services
severe harm or death	2017/18	n/a	n/a	n/a	n/a		
Rate of C diff (per 100,000 bed days) among patients aged over two	2015/16	11.4	15.0	62.6	0.0	*Last Publication in July 2017 with data up to end March 17	The Trust will continue to monitor C diff rates on a monthly basis and an improvement plan has been developed which has been implemented. The plan will be monitored via the Quality Delivery Group.
	2016/17	12.5	13.2	82.7	0.0		
	2017/18 *	No data	No data	No data	No data		
Percentage of patients risk assessed for VTE	2015/16	93.3%	96.1%	100.0%	88.6%		An audit of VTE assessments has been commissioned and an improvement plan will be put in place once the issues have been diagnosed.
	2016/17*	93.5%	95.6%	100.0%	78.7%	*Data period: Apr16 - Dec16. Published Mar-17	
	2017/18	90.0%	95.3%	100.0%	77.0%	Data only includes Q1-3 (GHNHSFT did not submit data for Q1 17/18)	
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%	The data on the HSCIC has not been updated beyond 2011/12. This indicator is no longer reported locally. The preferred national and local indicator is now readmissions within 30 days which is broadly consistent with this indicator. *Published Mar-14. No further data as at 01/03/2018	
	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		
Readmissions within 28 days: age 16 or over	2011/12*	10.52%	11.45%	13.80%	9.34%	No national data has been published since 2011/12. This indicator is	
	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		

Indicator	Year	GHNHSFT	National average	Highest trust fig	Lowest trust fig	Explanation of why GNHSFT considers that the data from the HSCIC are as described	Actions GHNHSFT intends to take to improve indicator and quality of services
	2015/16	n/a	n/a	n/a	n/a	no longer reported locally. The preferred national and local indicator is now readmissions within 30 days which is broadly consistent with this indicator. *Published Mar-14. No further data as at 01/03/2018	
	2016/17	n/a	n/a	n/a	n/a		
	2017/18	n/a	n/a	n/a	n/a		
Responsiveness to inpatients' personal needs	2015/16	66.5	68.9	86.1	59.1	Last Data Published August 2017 for 2017/18 FY	Patient experience insight data is used to drive improvements. There will be a focused Trust project on improving discharge experience.
	2016/17	67.7	69.6	86.2	58.9		
	2017/18	63.6	68.1	85.2	60.0		
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	69.0%	65.0%	85.4%	46.0%		Staff Experience insight data is used by the organisation to improve staff experience.
	2016/17	64.0%	70.0%	84.8%	48.9%		
	2017/18	61.0%	70.0%	93.0%	42.0%		

Patient Reported Outcome Measures (PROMs)

Patient Reported Outcome Measures (PROMs) collect information on the effectiveness as perceived by the patients themselves of the NHS care they have received. Since April 2009, patients undergoing four different types of elective surgery – hip replacement, knee replacement, and groin hernia repair.

– have been invited to complete lifestyle questionnaires before and after their operations. Their responses are converted into scores and when taken with other clinical information, they allow the effectiveness of treatments to be assessed and hospital providers to be compared.

Two well-established general health and lifestyle surveys are used – EQ-5D & EQ-VAS (EuroQol five-dimensional descriptive health questionnaire and visual analogue scale) – alongside condition-specific questionnaires – Aberdeen Varicose Vein Questionnaire, Oxford Hip Scores and Oxford Knee Scores – each of which pose questions relating to the individual experience of the patient with the condition. Patients complete these surveys and questionnaires before and after their operations and the difference in their scores are used as a measure of the improvement resulting from their operation being carried out.

The figures we have reported in the figure below are the percentage of patients reporting an improvement in their health and well-being after their procedure as measured by each of the questionnaires. The figure for the Trust is shown against the England average improvement rate for comparison.

Figure: Patient Reported Outcomes Measures

April - March 2016							
	EQ-5D		**EQ VAS**		**Condition-specific Measure**		
Procedure	*Trust%*	*England %*	*Trust %*	*England %*	*Trust %*	*England %*	
Groin	50.8%	50.9%	37.9%	37.6%			
Hip	89.2%	89.6%	63.8%	66.5%	97.0%	97.5%	
Knee	80.9%	81.6%	54.8%	56.4%	97.2%	94.1%	
Varicose veins	50.0%	52.7%	31.4%	40.3%	87.5%	82.7%	
Latest available date 2016/17							
	EQ-5D		**EQ VAS**		**Condition-specific Measure**		
Procedure	*Trust%*	*England %*	*Trust %*	*England %*	*Trust %*	*England %*	
Groin	53.4%	51.3%	52.6%	39.2%			
Hip	81.3%	89.1%	59.1%	67.2%	91.6%	96.8%	
Knee	85.2%	81.1%	54.1%	57.4%	96.6%	93.8%	
Varicose veins	47.6%	51.9%	33.3%	40.3%	85.7%	81.5%	

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.

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	2016/17	2017/18	National target (if applicable)	Notes/ Other information
Clostridium difficile year on year reduction	42	56*	37 Cases Per year	*Unvalidated Position - April17 to March 18
MRSA bacteraemia at less than half the 2003/4 level: post 48hrs	3	4*	-	*Unvalidated Position - April17 to January 18
MSSA	39	100*		* Unvalidated 2017/18 figure up to March 2018
Never events	2	6*		* Unvalidated 2017/18 figure up to March 2018
Risk assessment for patients with VTE	93.5%	83.98%*		2016/16 reporting period April16-December 16 We were unable to report from Dec-16. Reporting for 2017/18 recommenced Sep-17. *2017/18 figure for September 17- March 18(Inclusive)
Crude mortality rate	1.3%	1.2%		2017/18 complete year
Dementia 1a: Case finding	88.5%	0.8%		2017/18 figure only from September 17 - March 18
Dementia 1b: Clinical assessment	100%	65.0%		
Dementia 1c: Referral for management	100%	11.00%		
% patients spending 4 hours or less in ED	83.7%	86.7%	95.0%	2017/18 complete year
Number of ambulance handovers delayed over 30 minutes *(<=1hr)	1884	506	0	2017/18 complete year

Indicator	2016/17	2017/18	National target (if applicable)	Notes/ Other information
Number of ambulance handovers delayed over 60 minutes	26	16	0	2017/18 complete year
Emergency readmissions within 30 days - elective & emergency	6.4%	6.9%		2017/18 complete year
% stroke patients spending 90% of time on stroke ward	85.6%	89.3%*	80.0%	2017/18 figure up to February 2018
% of women seen by midwife by 12 weeks	87.3%	89.5%	90.0%	2017/18 complete year
Number of written complaints	913	1031		
Rate of written complaints per 1000 inpatient spells	5.4	6.26*		*This figure is the Year to date figure to the end of Q3, as activity for Q4 has not yet been confirmed.
Max 2 week wait for patients urgently referred by GP	89.2%	82.3%	93.0%	2017/18 complete year
Max 2 week wait for patients referred with non cancer breast symptoms	93.2%	90.4%	93.0%	2017/18 complete year
Max 31 days decision to treat to first definitive treatment	96.8%	96.3%	96.0%	2017/18 complete year
Max 31 days decision to treat to subsequent treatment: surgery	94.7%	94.8%	94.0%	2017/18 complete year
Max 31 days decision to treat to subsequent treatment: drugs	100.0%	99.8%	98.0%	2017/18 complete year
Max 31 days decision to treat to subsequent treatment: radiotherapy	99.3%	99.1%	94.0%	2017/18 complete year
Max wait 62 days from urgent GP referral to 1st treatment (excl. rare cancers)	74.9%	75 %	85.0%	2017/18 complete year
Max wait 62 days from national screening programme to 1st treatment	92.5%	92.2%	90.0%	2017/18 complete year
18 week max wait from the point of referral to treatment (admitted patients adjusted)	77.6%			2016/17 data period: Apr16-Nov16
18 week max wait from point of referral to treatment (non-admitted patients adjusted)	87.1%			2016/17 data period: Apr16-Nov16
Percentage of incomplete pathways within 18 weeks for patients on incomplete	78.9%		92.0%	2016/17 data period: Apr16-Nov16

Indicator	2016/17	2017/18	National target (if applicable)	Notes/ Other information
pathways				
Average occupied bed days	5469	10507		
Average bed delays	285	332		
Delayed Transfer of Care rate	5.21%	3.16%		
Number of delayed discharges at month end	N/A	30*		Unvalidated

Signed

Peter Lachecki
Chair

25th May 2018

Signed

Deborah Lee
Chief Executive Officer

25th May 2018

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

NHS Gloucestershire CCG Comments in Response to Gloucestershire Hospitals NHS Foundation Trust Quality Report 2017/18

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 2017/18.

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 2017/18 to deliver a system wide approach to maintain, further develop and improve the quality of commissioned services and outcomes for service users and carers. We wish to acknowledge the Trust's continued contribution and ongoing commitment to the development of the Sustainability and Transformation Plan for Gloucestershire (STP).

Following the CQC inspection in January 2017, GHNHSFT were awarded an overall rating of 'requires improvement' which was the same as the previous rating awarded in 2015. However, it is pleasing to see that there were some areas that had improved, in particular 'End of Life care' was rated as 'good'. The CCG recognise the comprehensive action plan that has been developed in response to the inspection and welcome the Trusts commitment to ensuring the 'fundamentals of care' are of the highest standard at all times. The CCG have good visibility of the action plan and the progress that is being made against the deliverables.

The 2017/18 Quality Report is clear, easy to read and identifies how the Trust performed against the agreed quality priorities for improvement for 2017/18 and also outlines their priorities for improvement in 2018/19. 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 2018/19, whilst

acknowledging the very difficult financial challenges GHNHSFT have to address in the coming year. The CCG are particularly pleased to see that 'Pressure Ulcers' and 'Falls reduction' have been prioritised for improvement.

The CCG recognises the significant pressures that GHNHSFT experienced during the winter months but are pleased to note that the 4 hour A&E performance has significantly improved and congratulate the Trust on their achievement. The 10% improvement in patient reported outcomes of the emergency department is particularly pleasing to see. The focussed work that enables those with mental health needs who attend an emergency department is welcomed and the collaborative approach between the Trust and Gloucestershire's main Mental Health provider is demonstrating significantly improved outcomes for those in need of this level of support.

The CCG would like to congratulate the Trust for their outstanding work regarding the Safety and Quality Improvement Academy and the quality improvement initiatives delivered to date. This approach is endorsed by the CCG and welcomes the strengthening of a culture of continuous quality improvement. This approach is particularly evident within addressing expected mortality rates and it is encouraging to see that there has been a 14% reduction in mortality over the last year. The CCG are pleased to see that two areas in particular have contributed to this improvement, those being significantly improved outcomes for those with a hip fracture and the detection and timely treatment of sepsis, specifically within the Emergency department.

The CCG understands the issues that have arisen in relation to the implementation of Trakcare. The CCG note that the Trust now fully understands the operational and safety issues encountered and are sighted on the recovery plan. The CCG recognise the work now being undertaken to address the issues although the flow of information from the Trust has been severely disrupted and this has potentially led to a reduction in the quality of care for patients and the effectiveness of communication with the wider health community in Gloucestershire.

The CCG are aware of the number of Serious Incidents and Never Events that GHNHSFT have reported in the last year. The CCG will 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.

The CCG notes the work that GHNHSFT have undertaken in relation to proactive and safe discharge planning. Whilst it recognises that not all elements of the work programme were achieved in year, the ongoing commitment and energy is welcomed.

We are pleased to see the proposed improvement plans that aim to reduce infection rates at GHNHSFT, in particular C-diff. The CCG aim to work closely with the Trust

to provide support where required and monitor anticipated improvement within this area.

The CCG acknowledges the content provided on staff wellbeing and in particular the staff survey results. The CCG found the staff survey results disappointing but recognise the wider work planned to address this. The CCG were extremely pleased to see such a large increase in the uptake of flu vaccinations amongst staff and acknowledge the significant efforts that went into this year's campaign. The CCG is aware of the improved focus of patient experience with the Trust and is looking forward to seeing some closer working with the new Healthwatch provider in 2018/19.

GHNHSFT need to be in a strong position to manage both present and future challenges. The CCG will continue 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 2017/18 Quality Report contains accurate information in relation to the quality of services provided by GHNHSFT. During 2018/19 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.

Dr Marion Andrews-Evans

Executive Nurse & Quality Lead

NHS Gloucestershire CCG

Statement from Healthwatch Gloucestershire (HWG)

healthwatch Gloucestershire

Healthwatch Gloucestershire's Response to Gloucestershire Hospitals NHS Foundation Trust's Quality Statement 2017/2018

Healthwatch Gloucestershire welcomes the opportunity to comment on Gloucestershire Hospitals Trust's quality account for 2017/18. Healthwatch Gloucestershire exists to promote the voice of patients and the wider public with respect to health and social care services. Over the past year Healthwatch Gloucestershire came under a new provider but have continued to work with Gloucestershire Hospitals NHS Foundation Trust during this period. It is clear that the Trust has made significant progress in the Quality of care provided by its' patients and staff. General feedback to Healthwatch Gloucestershire supports that view. What follows should not imply that significant progress has been made.

We are pleased to note that there is a clearer focus on mental health in this year's quality account. However, it appears that this focus is centred in the Gloucestershire Royal site and therefore we would like to see further progress on the Cheltenham Hospital site. Healthwatch Gloucestershire has been heartened by evident progress through CQC inspections, however we would welcome clearer timelines of when the 'work in progress' actions will be completed. Patient Reported Outcome Measures (PROMS) are an important indicator of patient self-assessment when it comes to their NHS care. However, we note that in many cases, despite encouraging improvement in positive outcomes, these remain below average compared with England as a whole. We look forward to seeing improved outcomes over the coming year. Healthwatch Gloucestershire notes the excellent work done by Gloucestershire Hospitals NHS Foundation Trust by the Quality Academy in delivering its programme of delivery and support, and notes the number of bronze, silver and gold awards. We will be interested to see how the Gloucestershire Hospitals Trust evaluates the worth of these awards in the longer period and links to the long-term improvement of quality.

Healthwatch Gloucestershire looks forward to working with Gloucestershire Hospitals NHS Foundation Trust in the coming year to ensure that patients and the wider community are appropriately involved in providing feedback and that this feedback is taken seriously.

Alan Thomas

Chair of Healthwatch Gloucestershire 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 2017/18.

I consider that this is an open and honest Quality Account that does not shy away from the challenges faced by the Trust, it is clear where improvement is still needed, and has both patients and staff wellbeing at its centre.

These are challenging times for the NHS both at the national and local level. Whilst there is still much to do I feel that the new leadership team has reinvigorated the Trust and has a clear sense of direction.

The committee remains concerned that the Trust is still not meeting all of the cancer targets. The committee welcomes the introduction of standardised doses of anticancer therapies.

Given that the 4 hour A & E target is an indicator of how well the patient flow is through the hospital the committee welcomes the significant improvement in performance against this target. It was also good to see the positive partnership working across health and social care partners over the 'winter' period which delivered a robust response to significant demand.

The committee was pleased to note that the Trust has been awarded £39.5m capital funding to modernise hospital buildings, transform services and deliver even better patient care. Committee members particularly welcome that some of this funding will be spent on creating a safe space at Cheltenham General for staff to better manage people presenting with mental health issues.

The committee remains concerned that the Trust remains in financial special measures but acknowledges the work that the Trust is doing to redress this situation. Committee members are impressed that given this challenging financial situation the Trust has been able to improve and deliver better services to the patient, e.g. trauma and orthopaedic services and sepsis management. It is important not to overlook the turnaround in performance, through robust partnership working, with regard to delayed transfers of care.

The committee is aware of the issues arising from the implementation of the TrakCare system at the Trust in 2016, and the impact that this has had on the recovery from the financial deficit position. Committee members will continue to closely monitor this situation.

On behalf of the committee 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.

I would also like to thank Dr Sally Pearson for her many years work with the committee, and wish her well for the future.

Cllr Carole Allaway Martin
Chairman
Health and Care Scrutiny Overview and Committee

Independent Auditor's Limited Assurance Report to the Council of Governors of Gloucestershire Hospitals NHS Foundation Trust on the Quality Report

Annex 2: Statement of directors' responsibilities for the quality report

Statement of directors' responsibilities for the Quality Account

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.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality account.

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

- the content of the Quality Account meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16 and supporting guidance;
- the content of the Quality Account is not inconsistent with internal and external sources of information including:
- board minutes and papers for the period April 2017 to May 2018
- papers relating to quality reported to the board over the period April 2017 to May 2018
- feedback from commissioners dated 20/05/2018
- feedback from governors dated 04/05/2018
- feedback from local Healthwatch organisations dated 15/05/2018
- feedback from Overview and Scrutiny Committee dated 10/05/2018
- the trust's complaints report to be published, under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, in June 2017
- 2017 National patient Surveys
- 2017 National Staff Survey
- the Head of Internal Audit's annual opinion over the trust's control environment dated 18/05/2018
- the Quality Account presents a balanced picture of the NHS Foundation Trust's performance over the period covered;

- the performance information reported in the Quality Account is reliable and accurate;

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and

- these controls are subject to review to confirm that they are working effectively in practice;

- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and

- The Quality Account has been prepared in accordance with NHS Improvement's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Account.

The directors confirm to the best of their knowledge and belief they have complied with all of the above requirements in preparing the Quality Account, with the exception of the statement relating to data quality. The data underpinning the measure of performance reported in the Quality Account, up to the end of November 2016, is robust and reliable and conforms to specified data quality standards and prescribed definitions and has been subject to appropriate scrutiny and review. Following the implementation of a new Patient Administration System in December 2016, the Trust was unable to assure the data quality of information extracted from the system to support:

- Referral to Treatment times – Reporting still suspended
- Dementia assessment and referral – re-commenced reporting in October'17 (September Data)
- Monthly activity return – Re-Commenced reporting August 2017 (July Data)

A suspension of reporting was agreed with NHS Improvement as the regulator and a recovery plan is in place. Key elements of the action plan address:

- Changes to the system
- Addressing backlogs of data
- Improving data quality
- Re-establishing reporting.

By order of the Board,

Deborah Lee
Chief Executive

Peter Lachecki
Chair

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 2018 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Cash Flows, the Statement of Changes in Equity and the related notes1 to 38, 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 2018 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 Group Accounting Manual 2017/18 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 (C&AG) 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.

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.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or

- the Accountable Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Overview of our audit approach

Key audit matters	• Risk of fraud in revenue and expenditure recognition; • Misstatements due to fraud or error; and • Valuation of land and buildings.
Materiality	• Overall materiality of £5.421m which represents 1% of operating expenses

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.

Risk	Our response to the risk	Key observations communicated to the Audit Committee
Risk of fraud in revenue and expenditure recognition. 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.	To address the specific risks of fraud in revenue and expenditure recognition, we have: -Tested revenue and expenditure recognition policies; -Discussed with management any accounting estimates on revenue or expenditure recognition for evidence of bias; -Developed a testing strategy and tested material revenue and expenditure streams; -Tested revenue and expenditure cut-off at the period end date; and -Obtained the Department of Health agreement of balances data and investigated any significant differences (outside of DH tolerances).	There were no findings arising from our work to report to the Audit Committee.
Misstatements due to fraud or error. The financial statements as a whole are not free of material misstatements whether caused by fraud or error. As identified in ISA (UK and Ireland) 240, management is in a unique position to perpetrate	To address the risk of management override we have: -Identified fraud risks during the planning stages; -Inquired of management about risks of fraud and the controls put in place to address those risks; -Understood the oversight given by those charged with governance of management's processes over fraud; -Considered the effectiveness of management's controls designed to address the risk of fraud;	There were no findings arising from our work to report to the Audit Committee.

Risk	Our response to the risk	Key observations communicated to the Audit Committee
fraud because of its ability to manipulate accounting records directly or indirectly and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively. We identify and respond to this fraud risk on every audit engagement.	-Determined an appropriate strategy to address those identified risks of fraud; and -Performed mandatory procedures regardless of specifically identified fraud risks, including testing of journal entries and other adjustments in the preparation of the financial statements. In addition, to address the residual risk of management override we have performed the following specific procedures: -Tested the appropriateness of journal entries recorded in the general ledger and other adjustments made in the preparation of the financial statements, for example using our journal tool to focus our testing on specific journals such as those created at unusual times or by staff members not usually involved in journal processing; -Tested opening balances and ensured they had been correctly brought forward; -Assessed key accounting estimates for evidence of management bias, including valuation of property, plant and equipment, the pension liability and the PFI liability, and -Evaluated the business rationale for significant unusual transactions.	
Valuation of land and buildings. Property, plant and equipment is the most significant balance in the Trust's balance sheet, of which land and buildings is the most significant element. In 2017/18, the Trust adopted a Modern Equivalent Asset on an Alternative Site model as a basis of the valuation. This is the first year that the assets have been valued on this basis. This area therefore required additional focus as part of the external audit to ensure the methodology, assumptions and supporting data used to support the valuation are appropriate.	We used an EY valuations expert to assist the audit team to: -Test the reasonableness of the valuation model adopted; -Check the output of the Trust's valuer; and -Challenge the assumptions used by the Trust's valuer by reference to external evidence and our EY valuation specialists. We confirmed that the valuation has been accurately processed and reflected in the financial statements.	There were no findings arising from our work to report to the Audit Committee.

An overview of the scope of our audit

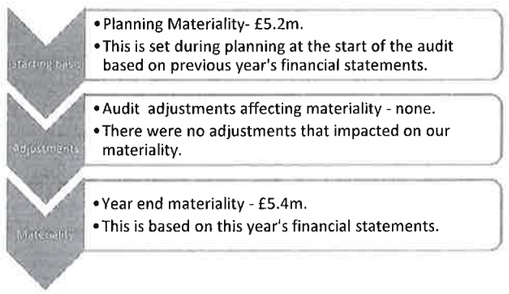
Tailoring the scope

Our assessment of audit risk, our evaluation of materiality and our allocation of performance materiality determine our audit scope for the Trust. This enables us to form an opinion on the financial statements. We take into account size, risk profile, the organisation of the Trust and effectiveness of controls, including controls and changes in the business environment when assessing the level of work to be performed.

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 Trust to be £5.4 million, which is 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 Trust's overall control environment, our judgement was that performance materiality was 50% of our planning materiality, namely £2.7million. We have set performance materiality at this percentage due to this being an initial audit and also having considered the number of changes to key staff and Board members.

Reporting threshold

An amount below which identified misstatements are considered as being clearly trivial.

We agreed with the Audit Committee that we would report to them all uncorrected audit differences in excess of £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 132 of the annual report, 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 prescribe by the Code of Audit Practice issued by the NAO

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 have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2017/18.

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 Trust, or a director or officer of the 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 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 2017/18 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 2017/18 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.

In respect of the following, we have matters to report by exception

- Proper arrangements to secure economy, efficiency and effectiveness

We report to you if we are not satisfied that the 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.

The table below presents the findings of our work in response to the risk areas identified:

Risk	***Our response to the risk***	***Key observations communicated to the Audit Committee***
Securing financial resilience - to consider whether the Trust has put in place 'proper arrangements' to secure economy, efficiency and effectiveness on its use of resources	Our approach has been as follows. We: - Monitored the financial position of the Trust through the year; -Considered the actions the Trust is taking to address the weak financial position; -Considered the outturn deficit position and savings achieved against plan; -Critically assessed the assumptions included in the Trust's financial plans; - Gained an understanding of the governance processes in place to support the future financial resilience of the Trust; and -Considered information from other regulators as appropriate.	The Trust was put in special measures by NHSI due to its financial position in September 2016. A financial recovery plan was produced and this included the 2017/18 plan with a planned £14.6m deficit, which was later revised to £27.8m and the Trust's final results in the Statement of Accounts showed a deficit of £51.564m. We have read supporting financial performance reports i.e. monthly finance reports to Board, CIP update reports, capital programme updates, NHSI submissions and minutes and papers from the Audit Committee meetings. Whilst there is evidence of improvements there is more to do and the Trust needs to continue with the progress made to achieve sustainable improvements to their financial position. Issues identified as part of the review of financial targets not being met included CIPs that, were not robust enough and then not followed through. The Trust undertook significant work in this area and arrangements have improved. They have re-worked how CIPs are identified and followed through to completion. As a result, for the 2017/18 year they have achieved CIPs of £28.5m, 5.7% of annual turnover, and of this 75% are recurring schemes. This evidences improved arrangements during 2017/18.

Qualified conclusion (Except for)

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in August 2017, with the exception of the matter(s) reported above, we are satisfied that, in all significant respects, Gloucestershire Hospitals NHS Foundation Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

Responsibilities of Accountable Officer

As explained more fully in the Accountable Officer's responsibilities statement set out on page 102 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 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.

Maria Grindley
for and on behalf of Ernst & Young LLP
Reading
29 May 2018

The following foot note should be added to the audit report when it is published or distributed electronically:

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

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