NHS
Great Western Hospitals
NHS Foundation Trust

# Great Western Hospitals NHS Foundation Trust
# Annual Report and Accounts
# 2017/18

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# 2017/18

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# CHAIR AND CHIEF EXECUTIVE'S STATEMENT

Welcome to our Annual Report and Accounts for 2017/18.

This has been a year of continued transformation and hard work by our staff to meet the pressure of increasing demand alongside improvements in the quality of care we provide to patients and working to build a more integrated approach to health and care in Swindon and Wiltshire.

Over the last year the response to improvement work following our Care Quality Commission inspection in 2015 was evident in the positive feedback received during our follow-up inspection in 2017. There remain a number of areas to improve on but we continue to move in the right direction, with nearly two thirds of our services now rated as good or outstanding, as we rightly place patient safety at the centre of everything we do. As you read through this report you will see that there is much to celebrate and many examples of exemplary and innovative care.

These achievements are testament to the efforts and commitment of our 4,500 dedicated staff working at the Great Western Hospital and across the community in Swindon.

We have continued good work helping us to identify deteriorating patients sooner, implementing and embedding the national Early Warning Score across the Trust, including community areas.

We have improved patient flow, patient length of stay and the number of patients experiencing delayed transfers of care through a number of service improvements, notably through the enhancement of Ambulatory Care, a GP referral programme and joint working with our partners.

We ended last year (2016/17) with a small surplus due to funding received as part of the Sustainability and Transformation Fund (STF). Funding made available to Trusts if they hit certain specific finance and performance goals. The Trust ended this year with a £7.8m deficit including STF and additional funding for winter, with an underlying deficit position of £11.3m, principally caused by increasing levels of demand, bed capacity and agency staffing costs. The underlying financial position was a deficit of £11.3m. In addition the Trust received £0.9m of Core Sustainability & Transformation Funding (STF) , £2m of STF Incentive funding and £0.7m funding for winter pressures. Including this funding the Trust reported a deficit of £7.8m

During the course of the year we were lifted out of financial enforcement action, a situation we have been in since 2015 as the Trust was able to demonstrate improved financial governance. This was a significant milestone in that whilst finances are still challenging, the hard work our staff have done over the past three years to save almost £40m is recognised. GWH has and will be actively involved in developing the priority services together with our partners in the Sustainability Transformation Partnership (STP).

Looking forward, as the population of Swindon, as well as surrounding areas, continues to grow at pace and above the national average we are constrained by the size, capacity and flexibility of our estate. We have a significant structural deficit as a result of our Private Finance Initiative (PFI) and therefore addressing our capacity gaps from both a physical space and a workforce perspective are top priorities to continue to deliver high quality care for local people.

Continuing as we are is not the appropriate option so we are prioritising opportunities to further develop the Integrated Care System model in Swindon, following local development of an operating model during 2017. As is the case across the UK, health, social care and community services in Swindon are currently being delivered within a fragmented and complex system. While good progress has been made in terms of understanding the gaps in service, the challenge to redesign services to ensure a more integrated and efficient approach to the delivery of care across the health and social care system will feature as a key aim for 2018/19.

Following stabilisation of the Swindon Community Health Service during 2017/18, greater collaboration is now required with the acute trust with particular regard to integrating urgent and ambulatory care, older people and stroke pathways.

Demand in our Emergency Department continues to be high, particularly over the winter months, but despite this our performance against the 4 hour standard was better in the first three months of 2018 compared to

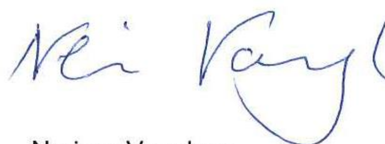
same period in 2017, which was largely due to the hard work and commitment from our staff. Our 2017/18 year end performance was 87.2%, which reflected our improved Q4 performance (the Q4 target was 85% and performance achieved was 86.2%).

Our Brighter Futures Team has worked incredibly hard over the last few years and has now raised £2.2 million of the £2.9 million needed to help bring radiotherapy to Swindon. This service, to be run by Oxford University Hospitals on the GWH site, will massively improve patient care and we aim to reach our target by the end of the summer which we hope will coincide with the start of the building work for the centre.

You will find many more success stories in this report, alongside an honest account of the difficulties we face and the challenges ahead.

It is an honour to lead this Trust, and to be supported by a Board which shows resolute dedication to the NHS. It is only with the full support of our staff, volunteers and partners in health and social care, who we rely on to help us keep people well and out of hospital, that we can meet the changing needs of Swindon and Wiltshire.

Roger Hill
Chairman
24 May 2018



Nerissa Vaughan
Chief Executive
24 May 2018

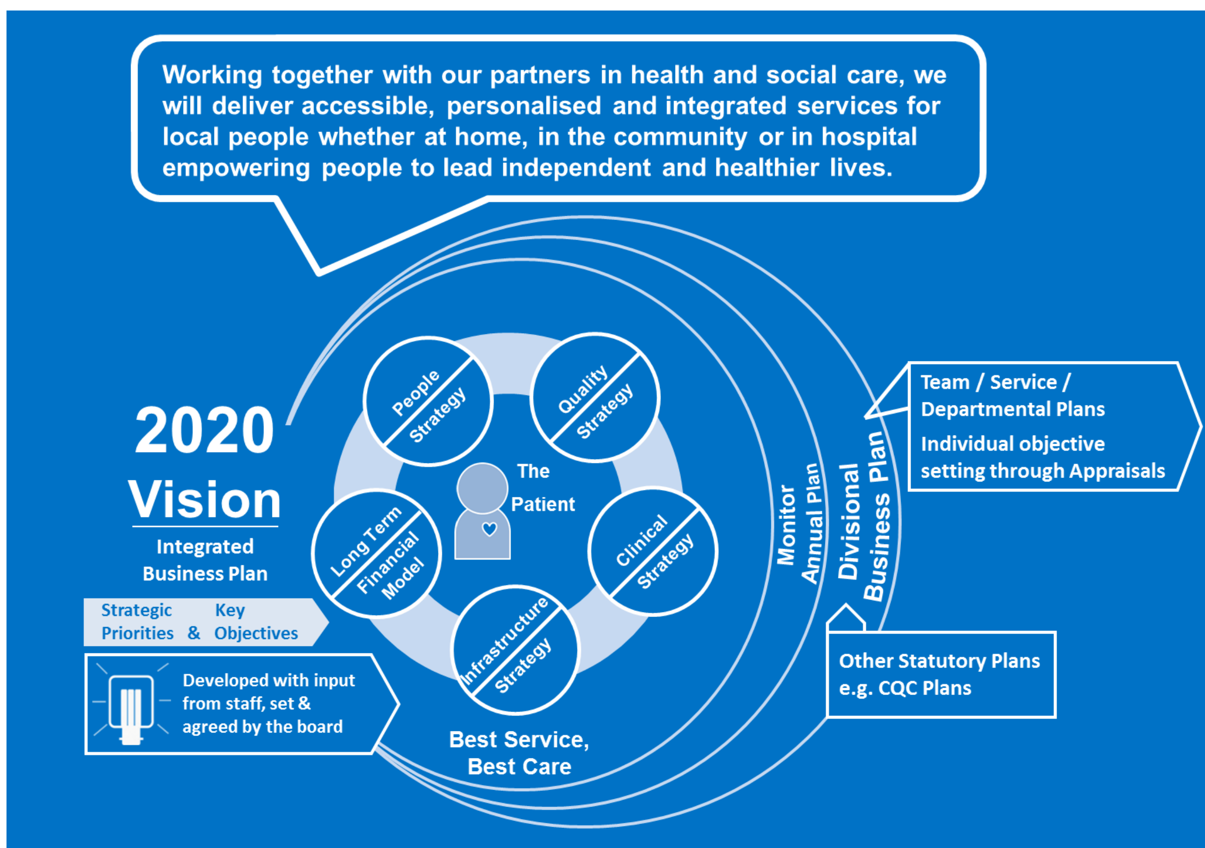
# PERFORMANCE REPORT

# 1. Overview of Performance

This section provides information about the Trust's main objectives and strategies and principal risks. A brief overview and analysis of performance is included.

### 1.1 Trust Strategy

## Our five year vision




Our vision is deliberately ambitious and to deliver it we will need to move further and faster to adopt new and innovative ways of delivering care. Providing **Best Service, Best Care** will be at the forefront of our approach but we will do so in a safe and sustainable way to ensure the long term viability of the Trust.

Our overall approach is centred on patient care, which provides an overarching direction and context for all Trust strategies. It is part of a dynamic process and has been informed by our organisation and operational plans as well as discussions with key partners including staff, patients, their carers, commissioners, members and our local community.

## 1.2 Our priorities

We will continue to provide high quality care for patients and service users in the right place and at the right time by delivering the most efficient use of resources. Our strategy is designed with the patient as the absolute focus, with quality and safety as the foundation of how we develop and deliver services in a sustainable way.

We have set ourselves four strategic priorities that drive the broad outcomes we aim to achieve in the next five years.

- We will make our patients the centre of everything we do
- We will ensure that everything we do supports the long term viability of the Trust, working smarter not harder making the best use of limited resources
- We will innovate and identify new ways of working
- We will build capacity and capability by investing in our staff, infrastructure and partnerships.

Over the next few years improvements will be delivered through progressive pieces of work with benefits being achieved at different times.

## 1.3 Our objectives

The Trust Board has agreed six key objectives which guide everything we do as a Trust, which are:

- To deliver consistently high quality, safe services which deliver desired patient outcomes and we will perform in the top 25% (upper quartile) of comparable Trusts in delivering Hospital Standardised Mortality Rate (HSMR), patient satisfaction and staff satisfaction.
- To improve the patient and carer experience of every aspect of the service and care that we deliver.
- To ensure that staff are proud to work for the Trust and would recommend the Trust as a place to work, and to receive treatment.
- To secure the long-term financial health of the Trust.
- To adopt new approaches and innovation to improve services as healthcare changes whilst continuing to become even more efficient.
- To work in partnership with others so that we provide seamless care for patients.

These priorities are underpinned by our five key internal strategies which describe how we will achieve our vision:

- **People Strategy** – addresses the culture we aim to foster to ensure staff can deliver best care, how we will meet the workforce challenges facing the Trust and the commitments we are making to our staff.

- **Quality Strategy** – setting out clear ambitions for the standard of service and care we aspire to deliver and how we will provide services that are effective, safe and provide the best patient experience.

- **Clinical Strategy** – setting out the acute and community transformation agenda for the Trust and how this will support integration of our services in a sustainable and viable way.

- **Infrastructure Strategy** – setting out our approach to making the best use of our IT, estate and business intelligence infrastructure to empower our staff, reduce barriers to work by giving them the tools and information to support them in their roles and to support the delivery of better patient care.

- **Long Term Financial Model (LTFM)** – addressing key financial challenges and opportunities over the next five years.

We know that there will always be significant change in the NHS and this makes a coherent set of priorities and a clear sense of direction all the more important.

Actions to deliver the objectives are considered through the Finance Report, Operational Report, Quality Report and Workforce Report considered through the Board Committees.

## 1.4 Business Model

Great Western Hospitals NHS Foundation Trust is a not-for-profit, public benefit corporation forming part of the wider NHS providing health care and services. We provide and develop healthcare according to core NHS principles - free care, based on need and not ability to pay.

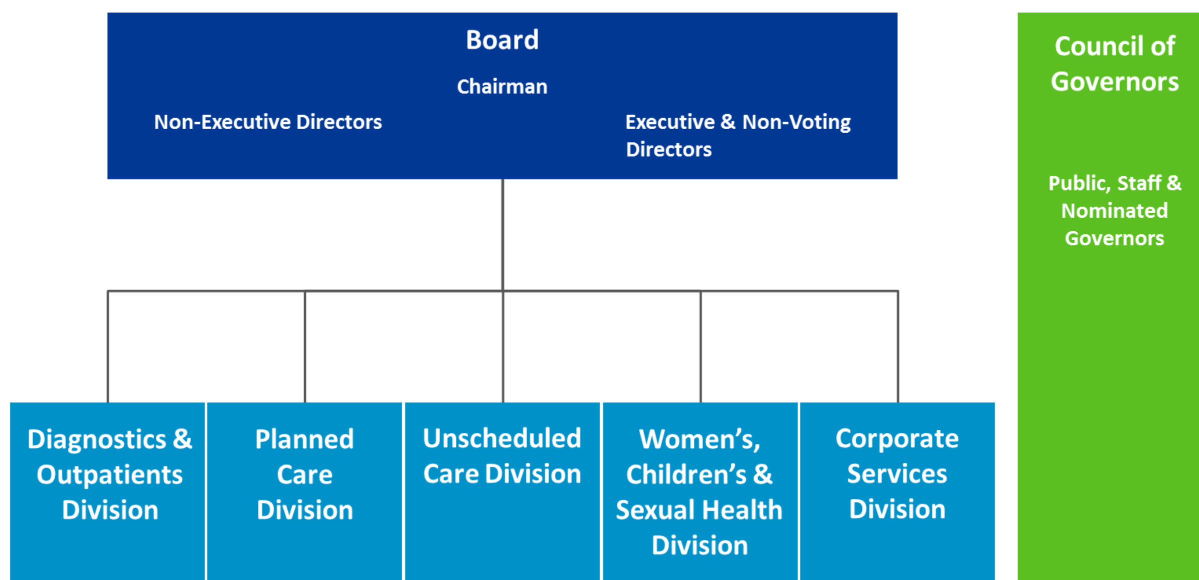
We are not directed by Government and so have greater freedom to decide, with our Governors and members, our own strategy and the way services are run. We can retain surpluses and borrow to invest in new and improved services for patients and service users.

We are accountable to our local communities through members and Governors; our commissioners through contracts; Parliament (in that we lay our annual report and accounts before Parliament); the Care Quality Commission (through the legal requirement to register and meet the associated standards for the quality of care provided); and NHS Improvement through the NHS provider licence.

NHS Improvement's role as the sector regulator of health services in England is to protect and promote the interests of patients by promoting the provision of services which are effective, efficient and economical and which maintains or improves their quality.

As a Foundation Trust, we are responsive to the needs and wishes of our local communities. Anyone who lives in the Trust-wide geographical area or works for our Foundation Trust can become a member. Members elect our Council of Governors, who in turn approve the appointment of our Chief Executive and appoints the Chairman and Non-Executive Directors. The Non-Executive Directors appoint the Executive Directors and together they form the Board of Directors. The Board as a whole is responsible for decision making, whilst the Council of Governors, amongst other things, is responsible for holding the Non-Executive Directors to account for the performance of the Board and for representing the views of members to inform decision making.

## 1.5 Organisational structure 2017/18




## 1.6 Principal activities of the Trust

The regulated activities that the Trust is currently registered to provide include: -

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

Information on all registered sites/locations and activities can be obtained by contacting the Trust or visiting the CQC website.

## 1.7 Location of services

Great Western Hospitals NHS Foundation Trust has its main headquarters at the Great Western Hospital (GWH) in Swindon. The Trust's geographical area covers Wiltshire, parts of Bath and North East Somerset, parts of Hampshire, Dorset, Oxfordshire, West Berkshire and Gloucestershire, covering a population of approximately 1,300,000 people.

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

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

**Within the Community**
From April 2016 the Trust is a provider of Community health services across Swindon, these Services are provided by Community Nurses and Therapist, located at various GP practices, Health Centres and Patients homes.

## 1.8 History of the Trust

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

On 1 June 2011, the Trust won the contract to provide a range of community health services and community maternity services across Wiltshire and the surrounding areas, which were previously provided by Wiltshire Community Health Services. However during 2014/15 the Trust ceased to provide community maternity services which transferred to the Royal United Hospital, Bath NHS Foundation Trust following competitive tender.

During 2015/16, the Trust established a Joint Venture, Wiltshire Health & Care LLP (a limited liability partnership), with Royal United Hospitals Bath NHS Foundation Trust and Salisbury NHS Foundation Trust to competitively bid in partnership for Wiltshire Adult Community Services. In January 2016 the Joint Venture was notified that it had been successful in its bid and was awarded the contract from 1 July 2016.

In the final quarter of 2015/16 the Trust placed an expression of interest to Swindon Clinical Commissioning Group for the provision of Swindon Integrated Adult Community Services. The Trust was agreed as the preferred provider, but prior to formal contract, the Trust was asked to "caretake" the services due to the existing provider "SEQOL" ceasing to operate. Therefore, from 1 October 2016, the Trust provided adult community health services in Swindon under a caretaker agreement. A formal contract for these services began in August 2017.

## 1.9 Principal risks and uncertainties facing the Trust

The Trust has in place a Risk Management Strategy which provides a framework for the identification and management of risk. Risks to the Trust's strategic objectives are identified each year when the Trust formulates its annual plan and risks are identified locally through directorates and teams.

The principal risks and uncertainties facing the Trust during 2017/18 against our strategic objectives are set out below: -

| Strategic objective | Principal risk |
|---|---|
| **Strategic Objective 1** To deliver consistently high quality, safe services which deliver desired patient outcomes | Failure to maintain high quality patient care including failure to meet key quality indicators |
| **Strategic objective 2** To improve the patient and carer experience of every aspect of the service and care that we deliver | Lack of co-ordination between providers and commissioners in Swindon to address issues of demand and capacity |
| | Risk of inability to manage demand across the health economy due to activity shift both to the community and in terms of demand management schemes |
| **Strategic Objective 3** To ensure that staff are proud to work for the Trust and would recommend the Trust as a place to work, and to receive treatment | Failure to recruit the right people to deliver high quality patient care and drive down agency spend |
| | Lack of the requisite transformation and service improvement skills required to materially transform the business |
| **Strategic Objective 4** To secure the long-term financial health of the Trust | Failure to deliver recurrent CIPs impacting on financial sustainability |
| | Non-achievement of community efficiency and integration resulting in missed opportunity to improve financial sustainability and reduce the risk of activity shifts |
| | Increasing burden of PFI impacting on financial sustainability |
| | Inability to manage demand creating significant pressure and cost |
| **Strategic objective 5** To adopt new approaches and innovation to improve services as healthcare changes whilst continuing to become even more efficient | Lack of alignment of Trust plans and commissioner intentions |
| | Future role of District General Hospitals and policy changes which may potentially reduce the scope of services not provided in acute hospitals of similar size |
| **Strategic objective 6** To work in partnership with others so that we provide seamless care for patients | Failure to retain Wiltshire adult services following a competitive exercise |
| | Sustainability of SEQOL and the impact the organisation has on our own ability to deliver services |

## 1.10 Going concern

The accounts have been prepared on a going concern basis. The Trust's Annual Plan forecasts a deficit of £5.0m for the year ending 31 March 2019. This includes the receipt of £7.1m from the Provider Sustainability Fund (PSF formerly Sustainability and Transformation Fund). In addition the Trust has identified a borrowing requirement to maintain a minimum monthly cash balance of at least £1m and this is also set out in the Trust's 2018/19 Annual Plan. The Trust has £6.1m of DHSC borrowing due to be repaid in 2018/19, however DHSC have indicated that the repayment of £4.9m can be deferred to 2019/20 leaving borrowing to be repaid in 2018/19 of £1.2m.

The NHS Improvement NHS Foundation Trust Annual Reporting Manual 2017/18 states that financial statements should be prepared on a going concern basis unless management either intends to apply to the Secretary of State for the dissolution of the NHS FT without the transfer of the services to another entity, or has no realistic alternative but to do so.

There is a material uncertainty related to events or conditions that may cast significant doubt on the entity's ability to continue as a going concern and that it may therefore be unable to realise its assets and discharge its liabilities in the normal course of business.

After making enquiries and considering the material uncertainties described above, there are no plans to transfer the service elsewhere and the Directors have a reasonable expectation that the Trust will secure adequate resources to continue in operational existence for the foreseeable future and continue to adopt the going concern basis in preparing the Annual Report and Accounts.

# 2. Performance Analysis

## 2.1 Review of the Trust's business, development and performance during the financial year

The Trust's Annual Plan submitted to NHS Improvement (the regulator of Foundation Trusts) sets out the organisation's priorities for delivery during the year. Set out below is an overview of the Trust's business during 2017/18 which includes key developments, mapped against our strategic priorities which guide the direction of the Trust.

| We will make our patients the centre of everything we do |
|---|
| The Trust was most recently inspected by the Care Quality Commission (CQC) in March 2017, this was a follow up visit to a full inspected carried out in October 2015. The initial inspection showed areas of strength and areas for improvement. Our kind and compassionate care was clear to the inspectors, who saw first-hand how we treat patients with dignity and respect. Inspectors observed many examples of high quality care and an organisation with solid foundations, a clear vision and established leadership. We knew many of the challenges highlighted and many improvements were already underway, but this inspection gave us a fresh perspective into where further progress could be made. Our culture of kindness and compassion, which is fundamental to safe and high quality care, gave us a strong foundation to build upon. The follow up visit focussed on identified areas that required improvement at the original visit, the CQC acknowledged that good progress had been made in most areas, the Trust has plans to ensure that remaining actions are undertaken and that additional feedback and recommendations are incorporated. |

| We will ensure that everything we do supports the long term viability of the Trust, working smarter not harder making the best use of limited resources |
|---|
| The Trust has made good strides to achieve significant savings and stabilise the overall financial position. However, as pressure to the system continues this becomes difficult to maintain. The underlying issue contributing to the deterioration is the structural deficit linked to the Trust's PFI contract (currently accounting for 4% of Trust income each year and will continue to grow). The Trust has endeavored to drive value out of this contract via all of the routes available to it and continues to discuss potential options with NHS England and NHS Improvement.<br><br>The Trust's ability to improve the financial position with the current level of structural deficit, and the associated pressure this creates as regards being able to flex the estate, creates a situation in which the maintenance of financial balance is becoming increasingly challenging. The Trust is therefore prioritising opportunities to further develop the Integrated Care System model in Swindon, exploiting opportunities that Model Hospital and GIRFT afford the Trust and continuing to work collaboratively with the STP.<br><br>7 Transformation programmes (having saved £40m in the last three years) continue and ensure that the Trust does not look at costs savings in isolation but also actively investigates pathway redesign and improved ways of working.<br><br>The Business Improvement Group has been established and embedded as a governance mechanism for the delivery of any investment decision as part of the business planning process. All investment proposals must align with Trust priorities and must be within the investment envelope available. Appropriate proposals will go before the Executive Committee for formal approval. |

| We will innovate and identify new ways of working |
|---|
| We plan to remodel our secondary care services so that they are integrated with community and social care, putting in place processes to support patients to live healthily at home for as long as possible, and when care is needed for it to be provided in the most suitable setting. Good progress has been made on this. The Trust is a joint venture partner in Wiltshire Health & Care LLP, which provides community services to Wiltshire patients, and we have been providing a caretaking role for Swindon Community Health Services since October 2016 and under formal contract since August 2017. Securing both services allows us to develop our integrated, planned and preventative pathways with local partners, including the voluntary sector, |

commissioners and clinical networks, which are vital in delivering quality services to NHS Constitutional standards.

Maintaining patient flow where patients are admitted to hospital is key to quality, performance and financial sustainability. This relies on a whole system approach to support people outside of hospital in the community. As a Trust, therefore, we need to focus on the things we are in control of whilst working with the system to address systemic constraints through the development of an Integrated Care Model. Where patients are admitted to hospital, processes are being re-designed to improve flow through the Right Patient, Right Place programme. We will develop integrated, planned, and prevention based pathways working with local partners, including the voluntary sector, commissioners and clinical networks to share best practice, learning, and resource to deliver more robust demand management as part of the integration of a new model for Swindon community services.

## We will build capacity and capability by investing in our staff, infrastructure and partnerships

During 2017 the Trust has worked collaboratively with our Sustainability & Transformation Partnership (STP) partner organisations, including commissioners, public health and other providers, on the development of our STP.

The Leadership Group of the Bath & North East Somerset, Swindon and Wiltshire Sustainability & Transformation Partnership (BSW STP) met in September 2017 to review progress against planned activities to date, and to review the governance arrangements. The Leadership Group used this meeting as an opportunity to re-commit to the aims and purpose of the STP, which were agreed as follows:

- Leadership development to build system success
- Horizon scanning and learning from others so that we understand what 'good' looks like
- Establishment of a prioritised and deliverable programme of Transformation and improvement in health and social care for BSW through:
- A shared understanding of the existing 'state of play', variations in outcomes and opportunities for improvement linked to populations
- Identification of a small number of transformational programmes that target the greatest opportunities for improvements that are best delivered on an STP-wide basis
- Building system capabilities to work differently and deliver change
- Oversight of development of Place Based Commissioning and delivery (Integrated Care Systems) and broader commissioning opportunities
- System-wide approaches to risk share and gain share

**Progress against STP Plan**

Planned Care
Priorities include:

- Reduce referral variation
- Continue to refresh and align clinical access policies
- Reduce variation in clinical quality and efficiency indicators for procedures
- Maximising delivery of RightCare and "Getting it Right First Time" (GIRFT)
- Deliver Cancer Five Year Forward View
- Maternity Transformation

Proactive and Preventative
Priorities include:

- Progress and support delivery of National Diabetes Prevention Programme
- Focus on Older People and Mental Health with workshops to determine strategic direction

Urgent and Emergency Care
Priorities include:

- Extended GP access plans across the footprint
- Designation of Urgent Treatment Centres to meet the national requirements
- Development of the frailty model
- DTOC reduction – linked to implementing 8 high impact changes
- Roll out of Care Home model commencing with red bag schemes

- Development of the Mental Health Urgent Care Assessment Model
- Development of the technology to support new models (111 interoperability)

Acute Sustainability
Priorities include:
Back Office
- Plans being developed for Occupational Health provision – outsourcing or lead provider
- Proposal being developed for RUH and AWP Payroll & Pensions to be transferred to Sustainability & Transformation Partnership
- GWH has presented proposal to Swindon Clinical Commissioning Group (CCG) regarding taking on some of the Commissioning Support Unit (CSU) portfolio, to include HR functions
- Procurement testing lead buyer model across 3 trusts, potential for further significant savings, and working together on achieving NHS Procurement standards level 2 (level 1 achieved)
- Royal United Hospitals, Bath (RUH) and Salisbury Foundation Trust (SFT) collaborating on procurement of web platform

Fragile Services
- Radiology – clinical teams agreeing priorities for 6 months, including stop tests of limited clinical value, shared access to MRI protocol, opportunities for joint procurement
- Pathology – NHSI hub and spoke models being progressed

Key priorities for the Enabling workstreams include:
- Estates: supporting existing capital plans e.g. Wiltshire's Strategic Outline Case for Chippenham, Melksham and Trowbridge; survey of utilisation of existing back office accommodation.
- Workforce: training and development consolidation; agency and bank harmonisation; apprenticeships (this was seen as an area of positive progress); all Trusts delivering on the NHSI Retention Toolkit; Retain Programme to address attrition rates on nursing courses
- Digital: Health & Social Care Network procurement requirements defined; roadmap for BSW Network Infrastructure created with funding routes; MH requirements captured; Population Health pilot identified with Unipart; review of Shared Care technologies in BSW; bids produced – Direct Booking focused UEC Transformation Bid, Estates and Technology Transformation Fund (ETTF) Technology funding bid – for network infrastructure in BaNES and Swindon to match bid already approved for Wiltshire.

**Impact of STP on Local Operational Planning**
Our Trust is represented in each of the key workstream programmes and participates in regular planning with partners to support outcome delivery. We are leading the Acute Sustainability workstream, a sub-group of the Planned Care workstream, which has as its objectives:

- Improved resilience for challenged specialities i.e. hard to recruit/high demand specialities
- Clinically led/opportunity to define outputs / new models of care in conjunction with a variety of health and care stakeholders
- Reduced transactional cost and improved cost efficiency
- Flexible workforce opportunities

Where planned service developments across the STP have an impact on local services, these have been factored into Divisional business plans so that resource and capacity requirements are understood and aligned, and to ensure that the Trust and STP objectives remain harmonised. We have contributed to and continue to engage in the development of the STP's Financial Recovery Plan, and following first review by NHSE/I are now working with our STP partners to develop a detailed and credible plan to close our financial gap.

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

A detailed performance report is provided elsewhere in the Trust's Quality Report (Section 11 refers).

## 2.3 Research and innovation 2017/18

The number of patients receiving relevant health services provided or sub-contracted by Great Western Hospitals NHS Foundation Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 1207 to end March 2018. Another year in which we successfully met and even exceeded our set target.

We currently have 67 actively recruiting Department of Health endorsed (portfolio) research projects. We also participate in a number of studies which are more difficult to recruit to given the complex nature of the inclusion and exclusion criteria. We believe it is important to have these studies open in order to give our patients the opportunity of participating in such studies should they be eligible. We run observational studies together with interventional studies.

We continue to attract commercial companies and our reputation, particularly within cardiology and rheumatology remains strong.

Every effort is made to ensure we achieve recruitment to time and target.

Research continues to gives our patients more opportunities to participate in and access to new and innovative treatment pathways.

With funding received from the Department of Health through our Local Clinical Research Network (LCRN), R&I have and will continue to provide strong research support throughout the Trust.

## 2.4 Impact of the Trust's business on the environment

Details of the impact of the Trust's business on the environment, social and community issues and on employees, including information about policies in relation to those matters and the effectiveness of those policies, are referred to below.

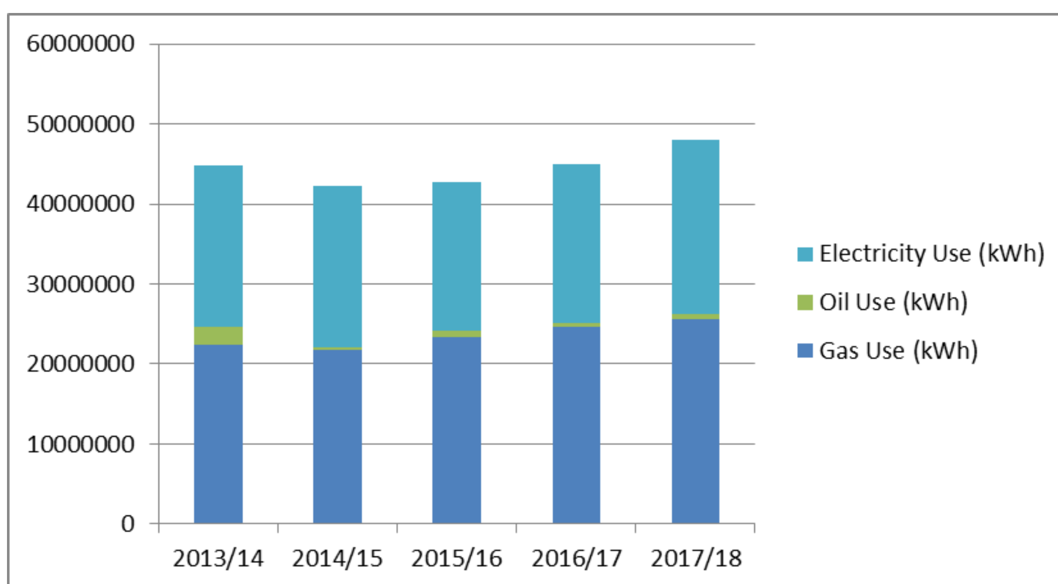
### Environmental matters

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

### Energy

Graph 1 shows energy consumption in kwH for the Great Western Hospital NHS Foundation Trust since 2013/14. The Great Western Hospital remains the largest user of utilities, and the colder winter and increase in activity has led to an increase us. The Trust is currently working towards the installation of a Combined Heat and Power unit at the Great Western Hospital as well as changing all the light fittings to more energy efficient LEDs.

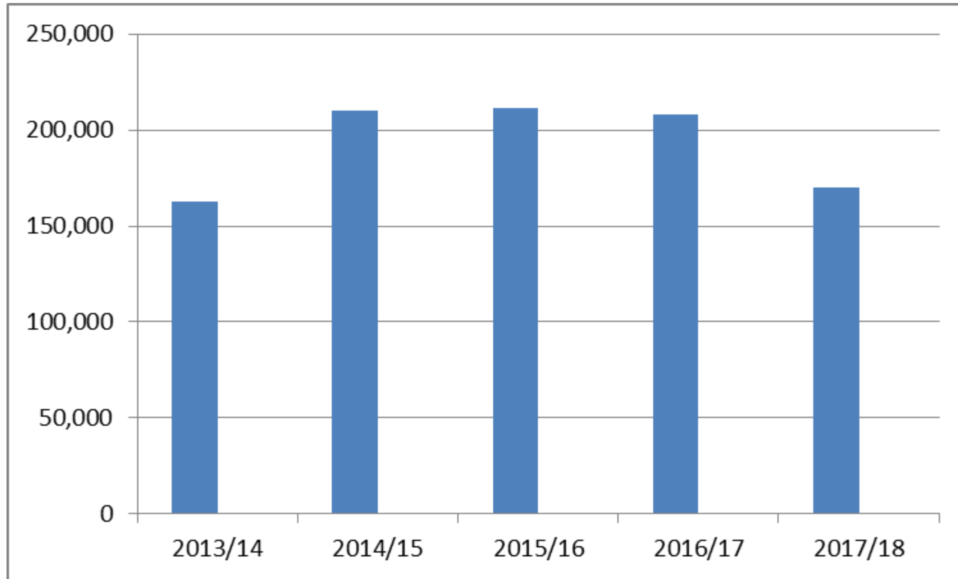
**Graph 1 – Utility consumption (KwH)**



### Water

The data below reflects the data that is available at the time of going to print. It is anticipated that water usage will remain similar to last year.

## Graph 2– Water consumption ($m^3$)

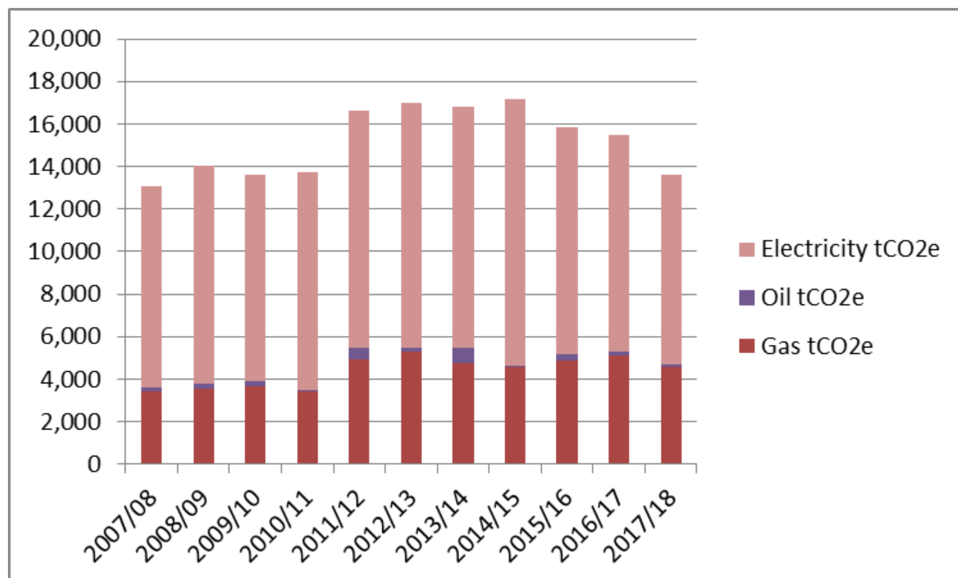



### Carbon reduction

Carbon reduction is one area where the Trust has legal targets to be achieved. There is a NHS Carbon Reduction Strategy which is underpinned by the Climate Change Act[2]. We are working towards achieving a percentage reduction in $CO_2$e emissions each year which will assist the NHS as a whole with reaching the overall target of reducing 80% $CO_2$e emissions by 2050. Graph 3 shows carbon emissions in tonnes from utility consumption for the Trust since the baseline year of 2007.

The Trust has a statutory duty to assess the risks posed by climate change, and these are on the risk register. The Trust is also aware of the potential need to adapt the buildings and services to reflect changes in climate and illnesses in our locality.

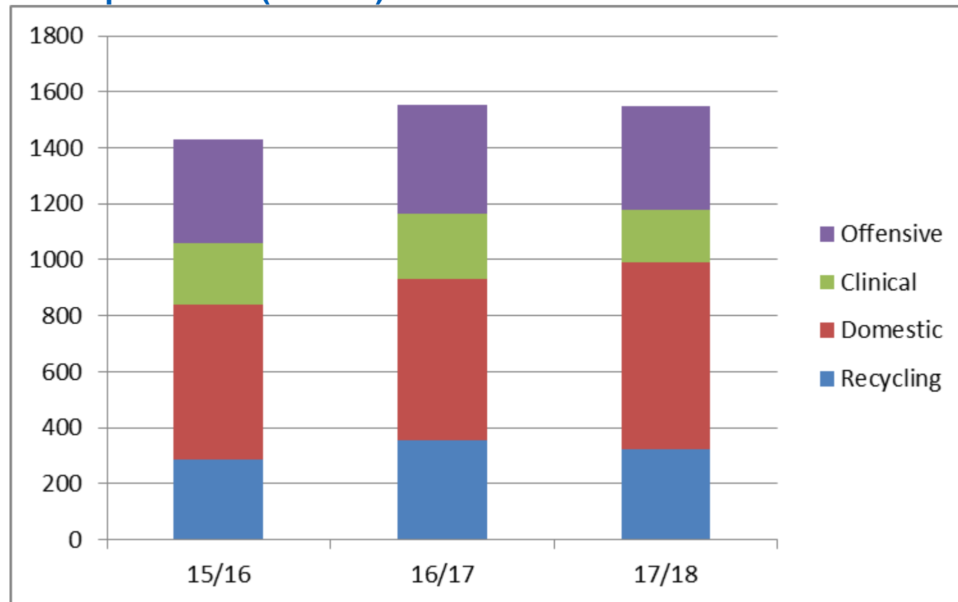
## Graph 3– $CO_2$e emissions for utility consumption (tonnes)



### Waste

At the time of going to print information was not available for the waste that is produced by Swindon Community Services as part of their clinical activity. Waste has remained about the same as last year.

## Graph 4 – Waste produced (tonnes)




### 2.5 Events since year end

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

### 2.6 Details of overseas operations

None during 2017/18.

### 2.7 Consultations

There were no formal public or stakeholder consultations during 2017/18.

## 2.8 Main trends, developments or matters likely to impact on the Trust business in 2018/19

In the spring of 2016, as part of the 5 Year Integrated Business Plan (IBP), the Trust undertook a comprehensive bottom up demand and capacity exercise to review all elective and non-elective demand and capacity across the divisions. This was aligned with clinician job plans, outpatient templates and contractual activity (demand) against each speciality. The work was completed by triangulating a range of data sources (job plans, finance, previous modelling activities), and sense checking against operational performance, resulting in a comprehensive analysis which identified the capacity gaps within services. This work highlighted stepped increases in demand in some specialities e.g. chemotherapy; areas that could benefit from an STP focus through joint working e.g. pathology; and areas where demand outstripped capacity e.g. dermatology. Variances in the demand and capacity modelling are being proactively managed internally through comprehensive job planning, the development of business cases to support an agreed service model, and externally with our Commissioners and partners through system wide joint working; we are also jointly undertaking deep dives into services where there are specific performance challenges.

Looking at the future demographic profile of Swindon, which includes the impact of major new housing developments leading to an expected population growth of in excess of 2% per year, (faster than the national average), the Trust is working with our Commissioners on demand management schemes and pathway developments to ensure the appropriateness of patients seen and admitted.

The Trust is a joint venture partner in Wiltshire Health & Care LLP, which provides adult community services to Wiltshire patients, and is now (since August 2017) providing Swindon Adult Community Health Services. Securing both services allows us to develop our integrated, planned and preventative pathways with local partners, including the voluntary sector, commissioners and clinical networks, which are vital in delivering quality services to NHS Constitutional standards. Although this was a joint venture the staff were employed by this Trust. However on 31 March 2018, the staff concerned TUPE transferred to the Wiltshire Health and Care Partnership

Unhealthy living with people smoking, drinking too heavily, eating too much of the wrong types of food and not doing enough exercise is creating increased demand for healthcare. Nationally we are seeing an increase in obesity - the King's Fund predicts that in the UK by 2020, 37% of men and 34% of women will be obese, resulting in more than 550,000 cases of diabetes, around 400,000 additional cases of heart disease and stroke, and up to 130,000 additional cancer cases.

Locally projections indicate a continued growth of 3% year on year in the numbers of patients being diagnosed with cancer and we have seen chemotherapy episodes increase by 10.1% year on year for the last five financial years.

We know that over the next five years our local population is expected to increase by 3.6% (Ordnance National Survey results) in Wiltshire and faster than the national average, annual 2% increase in Swindon (based on Local Authority projections). People over 65 (retirement age population) currently make up 20% of the Wiltshire population and 15% of Swindon's, and this group will see the largest growth of the next 20 years with the number of people over 75 and 85 years old growing fastest.

Older people are more likely to need health and care services and we know that a large proportion of healthcare resources are consumed by people aged over 65. Much of this resource is needed for frail and vulnerable older people. Our local population reflects trends in national population changes and in 2013 the King's Fund predicted that the number of people over 85 years old is expected to increase nationally by 106% over the next 20 years, and this will be reflected in increasing numbers of long term conditions.

Older people are more likely to suffer from complex and long term conditions (for example Chronic Obstructive Pulmonary Disease (COPD) and dementia) and this will put increased demand on the Trust to provide services. Nationally, people with long term conditions account for 70% of all hospital bed days, with the number of people with long term conditions expected to double over the next 10 years.

Our ageing population and the increased prevalence of chronic diseases such as hypertension, diabetes, coronary heart disease, COPD and respiratory conditions requires a reorientation away from an emphasis on

acute care towards prevention, self-care and care that is integrated and provided in the community. We continue to see an increase in people needing one-to-one nursing due to mental health issues or dementia which reflects the increasing acuity and frailty of patients. Nationally, the number of people expected to be living with dementia is expected to double over the next 40 years and this is reflected locally with the number of people over 65 years old with dementia projected to increase by 22% in Wiltshire and 24.8% in Swindon by 2020 (figures from Projecting Older People Population Information (POPPI) data).

To support people with long term conditions, we will need to provide better coordination of care to prevent avoidable ill health and hospital admissions. With improved community integration there is the opportunity to manage the demand reaching the acute sector, and by managing more care in the community, there is opportunity to provide timely, quality care, with better value for money.

As new technologies are introduced, patients expect care and treatment to be available seven days a week, and provided in the most convenient manner to suit their busy lifestyles. As we all become used to seven day services like online shopping and call centres, so too patients expect us to offer similar access and service. In addition patients increasingly expect care and services to be 'linked' no matter where they enter into the system. This becomes more challenging at a time when money is getting much tighter and with the large complex nature of health and social care.

The health indicators for people in Swindon are generally better than the England average but there are significant inequalities between the health of people living in the most affluent and most deprived areas. People living in deprived areas of Swindon have a life expectancy that is 8.9 years lower for men and 6.5 years lower for women than the least deprived areas.

Over the past ten years, all-cause mortality rates have fallen and the early death rate from heart disease and stroke is now similar to the England average. Swindon has higher than average obesity in adults and average obesity in children, and this presents greater challenges for us as obese patients have a greater number of associated health issues such as diabetes, cardiac and vascular problems as well as more complex needs when accessing maternity services and surgery. Swindon has higher than average numbers of people with diabetes and ranks poorly against peers for effective management of these patients.

The health of people in Wiltshire is generally better than the England average and deprivation is lower than average. However, the rural nature of Wiltshire and poor public transport provision has implications for us in providing health services and moving services currently based in the acute hospital into the community. Compared to Swindon, Wiltshire has an older population with significantly fewer people in the 20-40 year old bracket. Wiltshire's large retirement age population, which we expect to increase by 15.8% by 2020 (ONS), has implications for the provision of healthcare both at Great Western Hospital (where we receive approximately 22% of Wiltshire's non-elective and elective activity) but more significantly within the community. This will result in an increased demand for services to support older people with long term conditions and complex needs. This group of people may have issues accessing care and will need services to be provided close to their homes.

There will still be growth amongst the younger sections of the population and this will be supported and encouraged by planned housing developments in areas such as Trowbridge. Military personnel account for 3.3% of Wiltshire's population and every year 60% of people leaving the armed forces who are based in the South West settle here. Between 2014 and 2019, an estimated additional 4,300 military personnel (and 13,000 dependents) will relocate from Germany to the Salisbury plain area. Analysis shows that between 50-75% of the service population will seek healthcare outside the 'wire'. Military personnel and ex-service people often have specific health needs and we will work with our partners in mental health trusts and social care to ensure we support the health needs of these individuals.

We also provide healthcare to people in the borders of the counties around Great Western Hospital - Gloucestershire, Oxfordshire and West Berkshire. In general, the health of these areas is better than the England average, and over the last ten years early death rates from heart disease and stroke have fallen. In line with the national trend, the retirement age population is increasing in these areas with associated implications for the Trust as a provider of health care services. Priorities for commissioners in these counties include reducing early deaths from heart disease and stroke, supporting people with long term conditions and reducing childhood obesity. We have seen an increase in the number of GP referrals from neighbouring counties as changes in other trusts drive patient flow, and patient choice and traditional geographical boundaries become blurred.

The challenges we are facing at national and trust level are unprecedented, and we are taking a proactive approach to planning for the future to deliver transformational change across our services, which will enable us to deliver high standards of healthcare and positive patient experience. We do this with a 'whole system' approach to ensure that we consider the entire patient pathway and act on opportunities regardless of operational boundaries.

## 2.9 Opportunities for the year ahead

Our Operational Plan 2017 - 2019 details the overall plan for the next year. However, listed below are our current key priorities:

- Continue our quality improvement journey, delivering CQC recommendations and supporting our 500 extra lives initiative.
- Integrating acute and community pathways to help improve patient care, manage demand and improve flow.
- Develop the Team Swindon Integrated Care Model, learning from best practice and delivering a joined up health system for Swindon.
- Deliver improved performance, focussing on the ED four hour indicator, 18 weeks RTT and Cancer waiting times.
- Ensure safe staffing levels through improved recruitment and retention and reducing our reliance on agency staff.
- Living within our means, delivering on Cost improvement Plans, leading on transformation schemes to build a more sustainable future and working positively with our STP partners in Bath & North East Somerset, Wiltshire and Swindon.

## 2.10 Key challenges / main risks and uncertainties facing the Trust in the future

The Trust recognises that there will be significant challenges ahead in 2018/19, and specifically with controlling the level of budget deficit forecast, while delivering our key performance targets. This is in line with the national context of increasingly constrained resources against a backdrop of growth in activity, but also reflects some key local challenges including the impact of managing winter pressures, high numbers of medically-fit patients awaiting discharge, difficulty in recruitment and retention for a range of clinical posts and the sustainability of certain services.

### An ageing population

Many of the diseases that would have killed people years ago - when the NHS was created - are now able to be treated or cured, which is fantastic news for everyone. As our ageing population increases, more people are living with one or more long term complex conditions such as diabetes or heart and kidney disease, which means they need on-going treatment and specialist care. By 2020, we expect our retirement age Population to increase to 18.5% in Swindon and 15.8% in Wiltshire with the largest growth in people over 85 years old. This means that as a Trust, we are caring for increasing numbers of frail and acutely unwell people who have complex health and social needs.

### Lifestyle factors

The way we live is seriously affecting our health with people smoking, drinking too heavily, eating too much of the wrong types of food, and not doing enough exercise. This all impacts on our health, and nationally we are seeing an increase in obesity – the King's Fund predicts that in the UK by 2020 37% of men and 34% of women will be obese, resulting in more than 550,000 cases of diabetes, around 400,000 additional cases of heart disease and stroke, and up to 130,000 additional cancer cases.

**Increase in long term conditions**

NHS England estimates that 15.4 million people (over a quarter of the population) have a long term condition and an increasing number have multiple long term conditions and this is expected to increase. People with long term conditions use a significant proportion of healthcare services (up to 50% of GP appointments and 70% of hospital bed days) This is reflected locally as we are seeing increasing numbers of patients with long term conditions who require regular and on-going care.

**Changing patient expectations and rising costs**

Originally tackling disease was the main job of the NHS, but we now all expect so much more. From advice on health management through to mental and social care and fast, efficient customer service whether at home, in the community or a hospital environment. This means that limited resources are more stretched to provide the responsiveness and quality of service that patients expect. As new technologies are introduced, patients expect care and treatment to be available seven days a week and provided in the most convenient manner to suit their busy lifestyles. As we all become used to seven day services like online shopping and call centres, so too patients expect us to offer similar access and service. This becomes more challenging at a time when money is getting much tighter.

**Increasing demand**

In general, we are experiencing an increase in demand for all our services but in particular more and more people are visiting our Emergency Department and Minor Injury Units as their first port of call. The Emergency Department at Great Western Hospital was designed to support 48,000 attendances per annum and is currently seeing in excess of 84,000 per annum. This is stretching the ability of these departments to respond, as well as creating pressure on other services within the Trust. Many people attend these departments because they are open 24/7 and they may be unclear about the most suitable place to access appropriate advice. Every winter sees an increase in the numbers visiting these departments and we need to support people to choose the most appropriate setting of care and understand where to access information and advice. Increased pressure in other sectors such as social services also has a negative impact on the Trust and affects our ability to support patients to return home as soon as possible. We cannot continue as we are with the massive increases in demand we have seen in recent years. Moving into 2018/19 the Trust will be developing plans to look at potential options available to meet this.

**Workforce**

As a trust, our challenge is to keep recruiting the right people as demand grows and models of care change. Nationally and locally, there are shortages of key groups of health professionals and as a trust we are competing with other healthcare providers to fill vacancies and avoid using expensive agency staff.

The main risks and uncertainties facing the Trust are included in the Trust's Operational Plan 2017 - 2019, together with proposed actions to mitigate those risks. Examples are included in the Annual Governance Statement (Section 10 refers).

**Brexit**

The impact on public services, particularly the NHS, during and post Brexit negotiations could be significant.

Some of the future risks could include:

- The blocking of skilled workers from the EU, potential loss of skilled EU workers currently residing in the UK
- Potential loss of British skilled workers to overseas should vacancy levels rise and system pressures increase
- A reduction on research and development, as access to EU funded in this area is removed
- Regulations, standards and training needs may need to be looked at, impacts could be seen to the Working Time Directive, health and safety safeguards and even patient behavioural changes if food labelling, tobacco controls and lifestyle choices are affected
- The NHS is already under significant financial pressure with demand rising, further tightening on public sector budgets generally could have further impacts

The output of Brexit negotiations and the extent to which they impact directly on the Trust will take considerable time before they are known, given the Brexit timetable. Some workforce experts are warning that healthcare staff from the European Union who were considering coming to work in the NHS are choosing not to do so because of uncertainty over Brexit. This is impacting on our ability to attract good levels of interest in difficult to fill roles and this may impact further as the Brexit debate continues.

However, the Trust will proactively plan, as far as it is able, for likely scenarios and will review regularly as more is known.

## 2.11 Position of the business at the year end

The financial figures reported in the accounts represent the consolidated accounts of the Trust and the NHS Charity in accordance with DH Group Accounting Manual

The financial year 2017/18 has been a challenging year financially. The Trust did not achieve its financial control total due to continued activity pressures, especially around winter, and CIP delivery of 79% of plan. The Trust was allocated £6.7m Sustainability & Transformation Funding (STF) in 2017/18 and was set a control total of £1.8m surplus along with activity trajectories for ED. The Trust achieved 50% of the ED target in Quarter 1 along with a share of STF Incentive funding and so received £2.9m of STF in 2017/18.

The Trust ended the year with a £7.8m deficit including STF and additional funding for winter, with an underlying deficit position of £11.3m. This is a deterioration from the position in 2016/17 due to increase in non-elective activity pressures and continued reliance on agency staff to cover substantive vacancies.

Over the last three years the Trust has delivered just under £40m of savings/efficiencies against a background of continues service pressures. The challenge for the Trust is to deliver transformational change over the coming years whilst maintaining and improving quality.

The Trust has experienced another year of growth with unprecedented demands around the winter period which led to additional costs around staffing and supplies and loss of income due to the cancellation of elective activity. The Trust has seen an increase in non-elective activity of 8% whilst elective reduced by 15% compared to 2016/17. Agency spend was £15.3m which is a slight reduction from 2016/17 but has exceeded the agency cap by £6.7m and remains an area of focus for 2018/19. In addition high cost drugs continue to increase significantly year on year which is another area of focus for 2018/19.
The following financial summary relates to the Trust only: -

- Income was £0.7m below plan. The main driver is Sustainability and Transformation Funding (£3.9m below plan) and Non-Elective Activity (£3.5m above plan).

- Expenditure was £8.6m above plan. The main drivers for this were costs associated with covering staff vacancies and additional activity, especially over the winter period. Drugs were overspent by

£3.4m and clinical supplies by £1.6m, offset by an underspend on other costs of £6m. Pay expenditure was £9.5m above plan and the Trust continued to incur agency and locum costs to fill vacancies and to ensure safe staffing levels.

- Savings delivered totalled £11.0m against a target of £14.0m, an achievement of 79% and shortfall of £3.0m. Of the savings delivered £8.4m were achieved recurrently and £2.7m were delivered non-recurrently. In addition non-recurrent savings of £4.2m relating to recruitment lag were achieved.
- The cash balance at year end was £1.4m for the Trust and was £3.3m below plan. The year-end cash balance was after receipt of £9.6m borrowing from the Department of Health. This borrowing is to support the Trust's daily cash position.

**High level summary**

The table below provides an overview of the Trust's financial position for 2017/18. As well as Sustainability & Transformation Funding which was based on performance, the Trust received a one-off cash payment of £0.7m in recognition of extreme winter pressures. The Trust also benefited from a share of Sustainability & Transformation Fund Incentive cash of £2m which was distributed to all Trust's that had signed up top their control total for 2017/18 even if the control total was not achieved.

Following the transfer of Wiltshire Community Services to Wiltshire Health & Care LLP, the Trust commenced the process to transfer all of the Wiltshire Community Assets to NHS Property Services. The non PFI assets transferred on 1 July 2017 leaving Savernake owned by GWH. It is expected that Savernake will transfer in 2018/19.

**What this means**

Overall the Trust received an additional £2.7m one off external funding in 2017/18. This money cannot be used to support an in year cost or future costs; it is purely a cash injection to support the overall financial position.

**Summary of the year End Position for Great Western Hospital**

| | Plan | Actual | Variance |
|---|---|---|---|
| **Surplus/(Deficit) Reported in Statement of Comprehensive Income** | **£1,796** | **(£36,262)** | **(£38,058)** |
| Impairment | £0 | £2,000 | £2,000 |
| Revaluation | £0 | (£2,086) | (£2,086) |
| Transfer of Wiltshire Assets | £0 | £28,612 | £28,612 |
| NHS Charity | £0 | (£121) | (£121) |
| Depreciation not charged to I & E | £0 | £86 | £86 |
| **Normalised Position including national support** | **£1,796** | **(£7,771)** | **(£9,567)** |
| | | | |
| Sustainability & Transformation Fund | £6,756 | £861 | (£5,895) |
| Sustainability & Transformation Fund Incentive | £0 | £1,997 | £1,997 |
| Winter Funding | £0 | £695 | £695 |
| | | | |
| **Total Income & Expenditure Position** | **(£4,960)** | **(£11,324)** | **(£6,364)** |
| | | | |
| Negative is Deficit/Positive is Surplus | | | |

## 2.12 Analysis using financial and key performance indicators

The earnings before interest, taxes, depreciation, and amortization (EBITDA) at year end were £15.1m which was £9.4m worse than plan. The EBITDA income percentage was 4.5% against a plan of 7.2%. Creditors at year end amounted to £40.4m and were £15.1m lower than plan. Creditor days averaged 41.4. The Trust's Use of Resources Rating (UoR) at year end was 4 against a planned rating of 3. This is explained further in the Regulatory Ratings Report (Section 7 refers). Information about the Trust's performance is included in the Quality Report (Section 11 refers).

## 2.13 Additional activity creating pressure on finances

The following tables highlight activity levels by point of delivery for the GWH Acute and Community and Maternity contracts.

**TABLE – GWH Acute Activity**

| Point of Delivery | 2011/12 | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 | Variance from last year % |
|---|---|---|---|---|---|---|---|---|
| New Outpatients | 137,504 | 148,766 | 160,295 | 149,247 | 158,170 | ***164,426*** | ***160,529*** | ***-2.4%*** |
| Follow Up Outpatients | 263,066 | 274,326 | 291,214 | 299,806 | 308,468 | ***306,409*** | ***300,051*** | ***-2.1%*** |
| Day Cases | 27,320 | 27,838 | 30,969 | 33,059 | 33,934 | ***33,648*** | ***33,552*** | ***-0.3%*** |
| Emergency Inpatients | 35,804 | 38,192 | 39,178 | 43,055 | 45,341 | ***47,633*** | ***50,359*** | ***5.7%*** |
| Elective Inpatients | 6,723 | 6,343 | 6,247 | 5,936 | 5,863 | ***5,607*** | ***5,203*** | ***-7.2%*** |
| Emergency Department Attendances | 70,731 | 77,642 | 75,440 | 78,522 | 82,425 | ***84,232*** | ***74,456*** | ***-11.6%*** |
| ***Total*** | ***541,148*** | ***573,107*** | ***603,343*** | ***609,655*** | ***634,201*** | ***641,955*** | ***624,150*** | ***-2.8 %*** |

Note - There are some immaterial changes to patient numbers reported for 2014/15.

Note – The increase in activity in 2017/18 was around Non Elective care which meant the Trust was unable to deliver elective care or to meet Private Patient Income targets. These pressures mean the Trust was in escalation for most of the year and in the winter period extreme escalation. The costs of this were not planned and were incurred at a premium and contributed to the financial deficit.

**TABLE – Community Activity**

| Point of Delivery | 2011/12 | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 | Variance from last year % |
|---|---|---|---|---|---|---|---|---|
| Minor Injuries Unit | 46,507 | 41,755 | 42,884 | 44,315 | 47,277 | **41,067** | **34,934** | **-14.9%** |
| Admitted Patients | 7,445 | 8,498 | 7,998 | 2,311 | 1,181 | **972** | **969** | **-0.3%** |
| Community contacts including outpatients | 803,545 | 789,473 | 804,341 | 716,513 | 633,423 | **477,359** | **527,976** | **10.6%** |
| ***Total*** | ***857,497*** | ***839,726*** | ***855,223*** | ***763,139*** | ***681,881*** | **519,398** | **563,879** | **8.6%** |

Note – The inpatient admissions (Wiltshire community activity only) between 2014/15 and 2015/16 have decreased due to the reduction in beds.

Note – Contacts are show as decreased across the same period due to the implementation of SystemOne. During 2016/17 nearly all community services moved from using ePEX to our new electronic patient record SystmOne. Whilst the clinicians were being trained on the new system for each service there was a gap during which little activity was recorded. Also in the same year the adult Learning Disabilities Service moved to the local Council system and we are no longer able to report this as our activity. Child Community services moved to Virgin Care from April 2016.

## 2.14 Contractual arrangements

The Trust does not have any contractual arrangements with persons which are essential to the business of the Trust.

## 2.15 Continued investment in improved services for patients

The Trust has continued to invest in improved services as follows: -

- £808k investment in provision of an Ambulatory Care service alongside ED to ensure more appropriate treatment of patients attending ED
- £489k in Outsourcing to support delivery of elective activity
- £250k Investment to implement of new E-Roster system
- £198k Investment in ED nurse staffing model
- £150k Clinical Excellence Awards
- £133k to support Overseas Recruitment
- £134k Investment in Theatres to support nursing staff and additional Trauma lists
- £118k to Investment in Outpatient Administration
- £95k Haematology Service Review
- £65k to support temporary additional CT capacity
- £60k to support Pharmacy Antimicrobial Stewardship Team to support delivery of Commissioning for Quality and Innovation (CQUIN)

## 2.16 Financial implications of any significant changes in Trust objectives and activities, including investment strategy or long term liabilities

As at 31 March 2018 the Trust has three PFI schemes, Great Western Hospital, System C Medway Integrated Clinical Information System and Savernake Hospital. Savernake Hospital transferred to the Trust on 1 April 2013 as part of the transfer of community assets from Wiltshire Primary Care Trust (PCT). The Trust has a Working Capital Facility of £8.5m and utilised £6.6m of it as at 31 March 2018.

## 2.17 Charitable Donations

Total income through the Charitable Funds for 2017/18 was £0.8m of which £0.7m related to donations and legacies.

## 2.18 Future developments

The Trust continues to roll out a 5 Year Integrated Business Plan which sets out our strategy and areas of key focus for the future, known as our 2020 vision. Future developments are also detailed within the Trust's annual Operational Plan. These include:

### A Whole System Approach

We plan to continue working towards a remodel of our secondary care services so that they are integrated with community and social care, putting in place processes to support patients to live healthily at home for as long as possible, and when care is needed, for it to be provided in the most suitable setting. Good progress has been made on this.

During 2015 the Trust successfully bid and was successful for Adult Community Services in Wiltshire through a Joint Venture with Royal United Hospitals Bath NHS Foundation Trust and Salisbury NHS Foundation Trust. In 2016 the Trust bid and was successful in being identified as the preferred provider for Swindon Adult Community Health Services, this was initially delivered in a 'caretaker' capacity as the CCG requested the Trust step in due to operational and financial difficulties experienced by the previous provider and has been formalised since August 2017.

Maintaining patient flow where patients are admitted to hospital is key to quality, performance and financial sustainability. This relies on a whole system approach to support people outside of hospital in the community. As a Trust, therefore, we need to focus on the things we are in control of whilst working across the wider system to address systemic constraints. Where patients are admitted to hospital, processes are being re-designed to improve flow through the Right Patient, Right Place programme. We will develop integrated, planned, and prevention based pathways working with local partners, including the voluntary sector, commissioners and clinical networks to share best practice, learning, and resource to deliver more robust demand management as part of the mobilisation and integration of a new model for Swindon Integrated Care.

### Emergency Department (ED) & Non-Elective Demand

Management of ED and Non-Elective activity remains the most significant operational challenge as demand for these services continues to exceed plan. The ED trajectory has been calculated on the basis of demographic and morbidity factors, previous years' seasonal performance, the resilience of the local health and social care systems, and the trend of increasing inpatient admission.

Swindon is a very challenged health system that has experienced significant and ongoing year on year increases in acute admissions. The context to this rise is as follows:-

- The population of Swindon is expected to increase by 2% per year, which is higher than the national average;
- Within that population, the elderly (i.e. over 65) element is set to increase more significantly i.e. by 18.5% by 2020, with the over 75s within that group growing the fastest.
- The elderly population is most likely to present with severe medical conditions such as COPD and Diabetes crises, stroke and heart conditions, and will tend to generate longer lengths of stay and experience delayed discharges, thus reducing the hospital's operative bed stock;
- Delayed Transfers of Care have been a consistent feature of the Swindon health and social care economy for several years.
- Swindon's Primary Care services are severely compromised with a high percentage of GP posts in the borough vacant, which leads to patients defaulting to ED attendance, and compromises out of hospital alternatives to admission;
- Swindon Community Health services have been historically highly contractualised and poorly resourced, leading to small numbers of hospital discharges, particularly at weekends. Although the Trust has now formally managed these services since August 2017, addressing the service deficits will not be accomplished quickly.

- The above factors have led to the Trust consistently incurring a bed occupancy of over 100% (including regular commissioning of escalation facilities). Additional commissioned beds can reach up to 60 in the winter months, and between 30 and 40 for the rest of the year.

Within this context the Trust continues to work towards improved performance, but this is challenging. The Trust continues to introduce a wide range of improvements to processes within the hospital but this only serves to mitigate the continuing challenge of rising acute admissions, and the impact of a rising and increasingly elderly and sick population, rather than resolving it. Therefore consideration needs to be given to a more sustainable solution to include a large ED footprint.

In the longer term, we plan to exploit the integration of Swindon Community Health Services with that of acute hospital services to establish a full frailty pathway, including comprehensive geriatric assessment within the AMU, the elderly care wards and SWICC and the establishment of an Older Peoples' Short Stay Unit; pursuing integrated long term condition pathways in Diabetes, Respiratory Medicine and Heart Disease, and physically integrating the location and pathways of Acute Stroke and Stroke Rehabilitation Services, facilitated by commissioners. It has also been agreed to fully refresh the system's Urgent Care Strategy, with a particular emphasis on out of hospital and admission avoidance initiatives and services, with commissioners, and to redesign and strengthen the pathways for End of Life care, both in the acute and community settings.

The service is working at pace both internally and with its partners to secure robust patient pathways and ensure timely flow from the hospital. These programmes of work which include Right Patient Right Place, Integrated Front Door and Discharge to Assess are being monitored and reviewed through the local ED Delivery Groups.

### Cancer

During 2017/18 the Trust has seen a deterioration in all areas of cancer performance mainly due to capacity to meet the additional demand.

The cancer team has focused on the clinical pathways that contribute to this deteriorated performance and improvements to all cancer targets including the 2 week wait performance are now being seen but there remain challenges around capacity and as yet the improvement is not sustained.

### Referral to Treatment (RTT)

There are considerable challenges in meeting referral to treatment times in most specialities due in part to resource constraints, but also to an NHS Improvement instruction for Trusts to cease non-urgent elective activity during winter pressures. The Trust is now rolling out a RTT recovery plan, but recovery to the national performance standard of 92% was not achievable (86.7% achieved at year end).

### Future Activity Planning

As part of the current business planning process the Trust now undertakes a bottom up activity planning methodology to inform divisional business plans. This task is owned by the clinical delivery leads to ensure that there is full understanding of the data that is being used to develop the overall model and informs the basis of our activity planning.

## Quality & Care Quality Commission (CQC) Improvement

The Trust was most recently inspected by the Care Quality Commission (CQC) in March 2017. Prior to that there was an inspection in 2015. The initial inspection showed areas of strength and areas for improvement. Our kind and compassionate care was clear to the inspectors, who saw first-hand how we treat patients with dignity and respect. Inspectors observed many examples of high quality care and an organisation with solid foundations, a clear vision and established leadership. We knew many of the challenges highlighted and many improvements were already underway, but this inspection gave us a fresh perspective into where further progress could be made. Our culture of kindness and compassion, which is fundamental to safe and high quality care, gave us a strong foundation to build upon. The follow up visit focussed on identified areas that required improved at the original visit, the CQC acknowledged that good progress had been made in most areas, particularly in the Emergency Department and around internal governance generally. The Trust has plans to ensure that the actions suggested are undertaken and that additional feedback and recommendations are incorporated.

## Transformation

The transformation programme at the Trust has successfully delivered a £40m saving over the past three years.

The Trust established 7 cross-cutting workstreams, each led by an Accountable lead:

1. Productive People
2. Better Buying
3. New Products, New Income
4. Right Response First Time
5. Streamlining Support
6. Elective Efficiency
7. Better Control

However, given continued pressure to the system further significant savings need to be achieved moving forward if traditional models of care continue. This underlines the importance of the Trust working closely with all system partners to work towards Integrated Care so that future savings requirements can be realistic and achievable targets.

## Long Term Financial Viability

The Trust has made considerable efforts to achieve significant savings and stabilise the overall financial position of the organisation. However, as pressure to the system continues this is becoming increasingly difficult to maintain. The underlying issue contributing to the deterioration is the structural deficit linked to the Trust's PFI contract (currently accounting for 4% of Trust income each year and will continue to grow). The Trust has endeavoured to drive value out of this contract via all of the routes available to it and continues to discuss potential options with NHS England and NHS Improvement for a longer term solution to the Trust's structural deficit which is circa £11m per annum.

The Trust's ability to improve the financial position with the current level of structural deficit, and the associated pressure this creates as regards being able to flex the estate, creates a situation in which the maintenance of financial balance is becoming increasingly challenging. The Trust is therefore prioritising opportunities to further develop the Integrated Care System model in Swindon, exploiting opportunities that the Model Hospital and GIRFT (Getting It Right First Time) afford and continuing to work collaboratively with the Sustainability & Transformation Partnership (STP).

## 2.19 No Trust branches outside UK

The Trust does not have branches outside the UK.

## 2.20 Notes to the Accounts

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

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

## 2.21 Explanation of amounts included in the annual accounts

Explanations of amounts included in the annual accounts are provided in the supporting notes to the accounts.

## 2.22 Preparation of the Accounts

The Accounts for the period ended 31st March 2017 have been prepared in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006 in the form that Monitor (the Independent Regulator of NHS Foundation Trusts) with the approval of the Treasury, has directed.

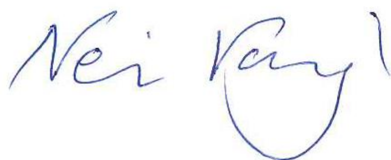
## 2.23 Preparation of the Annual Report and Accounts

The Directors consider the Annual Report and Accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy.

**Please note that the Trust has disclosed information on the above as required under the Companies Act 2006 that is relevant to its operations.**

Approved by the Board of Directors

Signed



Nerissa Vaughan, Chief Executive
Accounting Officer
24 May 2018

# ACCOUNTABILITY REPORT

# 3. Directors' Report

## General Companies Act Disclosures

### 3.1 Directors of Great Western Hospitals NHS Foundation Trust

Directors of Great Western Hospital NHS Foundation Trust during 2016/17: -

| | |
|---|---|
| Roger Hill | Chairman |
| Nerissa Vaughan | Chief Executive |
| Dr Nicholas Bishop | Non-Executive Director |
| Andy Copestake | Non-Executive Director |
| Oonagh Fitzgerald | Director of Human Resources |
| Peter Hill | Non-Executive Director *(from 1 April 2017)* |
| Karen Johnson | Director of Finance |
| Kevin McNamara | Director of Strategy & Community Services *(non-voting Director until 30 April 2017 and thereafter a voting Director)* |
| Jemima Milton | Non-Executive Director |
| Carole Nicholl | Director of Governance & Assurance (& Company Secretary) *(non-voting Board Director)* |
| Steve Nowell | Non-Executive Director<br>Senior Independent Director |
| Jim O'Connell | Chief Operating Officer *(from 12 October 2017)* |
| Dr Guy Rooney | Medical Director |
| Julie Soutter | Non-Executive Director<br>Deputy Chairman |
| Hilary Walker | Chief Nurse |

## 3.2 Board of Directors

The Board of Directors or Trust Board consisting of Executive, Non-Executive Directors and Non-Voting Members has overall responsibility for the performance of the Trust. The Board determines strategy and agrees the overall allocation of resources and ensures that adequate systems and processes are maintained to measure and monitor the Trust's effectiveness, efficiency and economy as well as the quality of its healthcare delivery. The Board takes decisions consistent with the approved strategy. The Executive Directors are responsible for operational management of the Trust. Non-voting Board Members do not have executive powers. Brief biographies for Board Members in 2017/18 are set out below.

## 3.3 Biography of individual Directors

**Roger Hill, Chairman**

Roger was appointed to the Board in April 2008. Until 1999 he had been both the Chairman and Managing Director of the UK subsidiary of Intergraph Corporation, a large American computer company. Subsequently he was a Board Director of a number of IT services companies, both in the UK and Ireland. Until 2008 he was a Governor of Newbury College. Roger was re-appointed as a Non-Executive Director in January 2012 for a further term of three years ending 30 April 2015. Roger was appointed the Senior Independent Director of the Trust from 1 October 2012. In 2013/14 Roger was appointed Chairman of the Trust from 1 February 2014 for a three year term ending 31 January 2017 and therefore he ceased to be the Senior Independent Director. In 2016/17 Roger was re-appointed as the Chairman for a further two year term ending 31 January 2019.

In 2017/18 Roger was an invitee of the Finance and Investment Committee. He was also a member of the Remuneration Committee and the Joint Nominations Committee.

**Nerissa Vaughan, Chief Executive**

Nerissa Vaughan joined the NHS in 1991 as a Graduate National Management trainee. She trained in Birmingham and after completing the Training Scheme took up her first post in Birmingham Family Health Services authorising developing GP commissioning. After a few years in commissioning at Birmingham Health Authority, she took up her first hospital management job in Dudley Road Hospital in Birmingham as Divisional Manager for Clinical Support Services, which included A&E, Pharmacy, Theatres, ICU, Therapies and a range of other support services. Nerissa became Project Director for the Wolverhampton Heart Centre, setting up a new Cardiac Tertiary Centre from scratch. Following this, she became interested in capital development and moved to Hull as Director of Planning. She oversaw a £200m capital programme which included a cardiac development and oncology PFI scheme. Keen to return to the Midlands, she took up post as Deputy Chief Executive at Kettering General Hospital and thereafter moved to her first Chief Executive role at King's Lynn where she led the Trust to Foundation Trust status. Nerissa became Chief Executive of this Trust in October 2011. Nerissa originates from Llanelli and holds a BA Degree in Theology and a Master of Science Degree in Health Service Management from Birmingham University.

**Dr Nicholas Bishop, Non-Executive Director**

Nick was a general and interventional radiologist, and board medical director in two acute hospitals. After being Assistant Medical Director for Commission for Health Improvement (CHI), he became senior medical advisor to the Healthcare Commission and the Care Quality Commission (CQC).

Nick is an Education Associate with the General Medical Council (GMC) and was appointed to the National Advisory Group on Clinical Audits and Enquiries in 2014. Now retired, he continues to chair CQC inspections of acute and specialist hospitals as a Specialist Advisor.

Nick became a Non-Executive Director on 1 August 2016. During 2017/18 his membership of Board Committee was as follows: -

- Chair of the Mental Health Governance Committee
- Chair of the Quality & Governance Committee
- Member of the Performance, People and Place Committee and the Audit, Risk & Assurance Committee
- Member of the Remuneration Committee
- Invitee to the Finance & Investment Committee.

**Andy Copestake, Non-Executive Director**

Andy joined the Board as a Non-Executive Director on 1 July 2016 having previously held a number of senior finance positions in the private, public and charity sectors.
From the late 1990s until May 2016, Andy was the Director of Finance at the National Trust in Swindon. Prior to that, he was the Finance Director at St Mary's NHS Trust in Paddington. Andy is a certified accountant.

During 2017/18 Andy's membership on Board Committee was as follows: -

- Member of the Audit, Risk & Assurance Committee, the Performance, People & Place Committee and the Finance & Investment Committee
- Member of the Charitable Funds Committee
- Member of the Remuneration Committee.

**Oonagh Fitzgerald, Director of Human Resources**

Oonagh joined the Trust in February 2008. Oonagh had previously worked as Director of Human Resources and Organisation Development at Kingston Hospital, South West London and prior to that she was Deputy Director of Human Resources at Mayday Healthcare NHS Trust in Croydon, South London. She is a Fellow of the Chartered Institute of Personnel and Development. She originally studied law at university and gained a Masters in HR Leadership in 2005.
Oonagh is responsible for the on-going recruitment drive and is committed to recruiting, motivating and developing high-quality staff and maintaining safe staffing levels.

**Peter Hill, Non-Executive Director**

Peter became a Non-Executive Director on 1 April 2017 following a 38-year career in the NHS. Peter brings a wealth of NHS experience to the Board, having fulfilled numerous clinical and non-clinical roles over the years. Peter began his NHS career as a nurse, with a variety of posts in London, Essex, Newcastle and Wiltshire. Peter's management and leadership roles have extended from Charge Nurse to Chief Executive, with his most recent position being Chief Executive for Salisbury NHS Foundation Trust.

During 2017/18 Peter's membership on Board Committee was as follows: -

- Member of the Performance, People & Place Committee becoming Chair of that Committee from 1 January 2018.
- Member of the Finance & Investment Committee and the Quality & Governance Committee.
- Member of the Remuneration Committee.
- Invitee to the Finance & Investment Committee.

**Karen Johnson, Director of Finance**

Karen Johnson was appointed as the Director of Finance in August 2015 after a period of Acting Director of Finance from February 2015. Prior to joining the Trust in June 2013 Karen was Acting Chief Finance Officer for Wiltshire Primary Care Trust.

Karen became a member of the Chartered Institute of Management Accountants (ACMA) in 2001 and has over 25 years' experience in the public sector including; Ministry of Defence, Local Authority and the NHS.

Karen joined the NHS in January 2010 and is committed to ensuring the public sector provides good value for money whilst maintaining good quality services. Karen was appointed Acting Director of Finance on 28 February 2015 and was later appointed as the substantive Director of Finance on 3 August 2015. Karen's focus is on ensuring that the Trust has a sustainable financial position.

**Kevin McNamara, Director of Strategy & Community Services**

Kevin first joined the Trust is November 2009 as Head of Marketing and Communications and has worked in the NHS for over 10 years. Kevin previously worked at South Central Strategic Health Authority (SHA) leading on public campaigns, market research, stakeholder engagement and parliamentary business. Before that Kevin worked for Thames Valley SHA on media relations. In his previous role in the Trust, Kevin lead on all aspects of communications and reputation management including the Patient Advice and Liaison Service and the way the Trust investigates and responds to complaints and other customer feedback. In December 2013 Kevin was appointed as the interim Director of Strategy. He is the Board lead for developing and implementing a five-year plan for the Trust and for identifying new business opportunities through bids, tenders and fundraising.

Kevin was appointed to the substantive position of Director of Strategy on 10 April 2014. In May 2017, Kevin became a voting Director known at the Director of Strategy and Community Services.

**Jemima Milton, Non-Executive Director**

Jemima was involved in Local Government for many years, first as a Councillor in Swindon holding a number of cabinet positions and then as a Councillor in Wiltshire where she took a key interest in Health and Social Care. Jemima was an active partner in the family farm with her late husband and during this time ran a catering company and then a Bed and Breakfast business. Jemima joined the Board on 1 January 2014, having previously been a governor of the Trust. In 2016/17 Jemima was re-appointed to the Board for a three year term ending 31 December 2019.

In 2017/18 Jemima's membership of Committees was as follows: -

- Chair of the Charitable Funds Committee
- Member of the Performance, People & place Committee, the Quality & Governance Committee and the Mental Health Governance Committee
- Member of the Remuneration Committee
- Invitee to the Finance & Investment Committee.

**Carole Nicholl, Director of Governance & Assurance (& Company Secretary) – Non-Voting Board Director**

Carole first joined the Trust in 2011 as Head of Corporate Governance & Company Secretary. Carole previously worked in local government managing a wide range of governance portfolios including elections, democratic services and corporate functions. Carole was appointed as Director of Governance & Assurance (and Company Secretary) in November 2016 and is responsible for the Trust's assurance framework, corporate risk, corporate governance, including the company secretarial function, compliance and regulation and legal services.

Carole's focus is to ensure that the Board receives assurance on all matters relating to Trust business and that there is an effective Council of Governors to represent the views of members and local people.

Carole originates from Worcestershire where she qualified as a Chartered Company Secretary. Thereafter Carole study in Oxford where she gained further qualifications including a Diploma in Management Studies.

**Steve Nowell, Non-Executive Director & Senior Independent Director**

Steve started his career as a lawyer working in private practice and in a number of industries before moving into management.

He spent the last 10 years of his career in financial services as a divisional director of Nationwide Building Society leading a wide range of risk and control functions, and was part of the organisation's senior leadership team looking at the organisation's wider strategy and performance.

Steve became a Non-Executive Director on 1 June 2014. Steve was appointed Senior Independent Director from 1 January 2017. During 2017/18 Steve was re-appointed as a Non-Executive Director and as the Senior Independent Director for a further three year term ending 31 May 2019.
During 2017/18 Steve's membership of Board Committees was as follows: -

- Chair of the Finance & Investment Committee.
- Chair of the Performance, People & Place Committee until 31 December 2017
- Chair of the Remuneration Committee
- Member of the Joint Nominations Committee
- Member of the Audit, Risk & Assurance Committee and the Mental Health Governance Committee (from 1 January 2018)

**Jim O'Connell – Chief Operating Officer** *(from 12 October 2017)*

Jim joined the Board on 12 October 2017 following a brief career in the private sector. Jim has over 25 years' NHS experience with over 20 at executive level. Previous Chief Operating Officer posts have included University Hospitals Bristol NHS Foundation Trust, Salisbury Hospital NHS Foundation Trust and University Hospitals South Manchester NHS Foundation Trust.

Prior to working as Chief Operating Officer, Jim worked as a Workforce Director both at hospital and regional level and was National Programme Director for the implementation of the Electronic Staff Record (ESR) - the world's largest HR and payroll system. Jim's focus is on ensuring operational performance whilst maintaining high quality patient care and experience.

**Guy Rooney, Medical Director & Deputy Chief Executive**

Dr Guy Rooney first joined the Trust in 1999 as a new consultant in sexual health and HIV. Over the years he has been a key contributor to national guidelines; incorporating the management and testing of patients for HIV and extending to the recognition of sexual infections in children exposed to sexual abuse. His sexual health work has involved working for the UK Government in Russia, contributing to the National Sexual Health Strategy and a key author of STIF: a national training programme for primary care.
For the last few years he has been involved within the management structure of the Trust, initially as Clinical Lead for Non-acute Medicine, followed by Associate Medical Director for the Diagnostics & Outpatients Division.
Dr Guy Rooney joined the Board as Medical Director on 1 April 2014. He has driven the clinical engagement in all aspects of the work the Trust undertakes, in particular the transformation work outlined in Simon Stevens' (CEO NHS England) five-year vision for the NHS.
In 2016/17 Guy was re-appointment as the Medical Director and Deputy Chief Executive for a further two year term ending 31 March 2019.

**Julie Soutter, Non-Executive Director & Deputy Chairman**

Julie is a finance and management professional, with qualifications in finance (FCA) and change management, including managing programmes and projects and process improvement. She has worked across the professional, charitable, private and public sectors, with roles in large accountancy practices, senior positions in the NHS and not for profit organisations. Her experience covers finance, operations, performance management, strategy and business planning, project management, governance and service improvement.

Recent roles include Interim Chief Operating and Finance Officer for the Energy Systems Catapult, a government and commercially funded technology and innovation centre based in Birmingham, where Julie led the setting up and delivery of finance, HR, IT, facilities, procurement and governance functions and systems. Prior to that she was Director of Finance for the Chartered Institute of Housing, and Head of Operations at Innovate UK, which supports innovation in the commercial and academic sectors.

Julie has held a number of non-executive roles in the NHS, public and charitable sectors. She has been a Non-Executive Director since 1 January 2015. Julie became Deputy Chairman from 1 July 2016. During 2017/18 Julie was re-appointed for a further three year term ending 31 December 2020. Julie has given notice that she will cease to be Deputy Chairman on 31 May 2018.

During 2017/18 Julie's membership of Board Committees was as follows: -

- Chair of Audit, Risk and Assurance Committee
- Member of Finance & Investment Committee
- Member of the Quality & Governance Committee (until 28 February 2018)
- Member of the Performance, People & Place Committee (from 1 January 2018)
- Member of the Remuneration Committee
- Member of the Joint Nominations Committee

**Hilary Walker, Chief Nurse**

Hilary has been a Registered Nurse since 1985. She held a number of corporate nursing roles in the West Midlands before joining the Trust in May 2012 as interim Chief Nurse and thereafter was successful in securing the substantive Chief Nurse position from 1 January 2013. She is keen to strengthen the contribution of Nurses and Allied Health Professionals to modern healthcare and is focussed on improving the safety and quality of care and patient experience.

Hilary will retire from the Trust in May 2018.

In 2017/18 Julie Marshman, the Trust's Deputy Chief Nurse was appointed as the successor Chief Nurse to take up the post in May 2018 and Paul Lewis was appointed as a Non-Executive Director from 1 April 2018.

### 3.4 Length of appointments of Non-Executive Directors

Listed below are details of the length of appointments of those Non-Executive Directors who held office during 2017/18. Appointments are shown from 1 December 2008, being the date of Authorisation as a Foundation Trust.

| Name | First Term | Second Term | Third Term | Fourth Term |
|---|---|---|---|---|
| Roger Hill | 01.12.08 – 30.04.12 | 01.05.12 – 31.01.14 | 01.02.14 – 31.01.17 | 01.02.17 – 31.01.19 |
| Nick Bishop | 01.08.16 – 31.07.19 | | | |
| Andy Copestake | 01.07.16 – 30.06.19 | | | |
| Peter Hill | 01.04.18 – 31.03.21 | | | |
| Jemima Milton | 01.01.14 – 31.12.16 | 01.01.17 – 31.12.19 | | |
| Steve Nowell* | 01.06.14 – 31.05.17 | 01.06.17 – 31.05.20 | | |
| Julie Soutter* | 01.01.15 – 31.12.17 | 01.01.18 – 31.12.20 | | |

Non-Executive Directors are appointed by the Council of Governors. A Non-Executive Director or Chairman may be removed from office with approval of three-quarters of the members of the Council of Governors. The circumstances under which this might happen are included in the Trust's Constitution.

One new Non-Executive Director, Paul Lewis was appointed during 2017/18 to take up office from 1 April 2018 *Two Non-Executive Directors were re-appointed during 2017/18. The process involved assessment by the Joint Nominations Committee. The following considerations were taken into account and matched against a job description and person specification in respect of each re-appointment / appointment: -

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

The appointments were approved by the Council of Governors.

As recommended by the Local Counter Fraud Service (LCFS), the names of all Trust Directors (Executive and Non-Executive) are cross-referenced with the Disqualified Directors Register on the Companies House website on an annual basis. No Trust Directors appeared on the Disqualified Directors Register (as at 26 March 2018).

No Non-Executive Directors left the Trust during 2017/18.

### 3.5 Statement about the balance, completeness and appropriateness of the Board of Directors

The Non-Executive Directors are all considered to be independent of the Foundation Trust and the Trust Board believes it has the correct balance, completeness and appropriateness in its composition to meet the requirements of an NHS Foundation Trust. This is reviewed each time a non-executive director is appointed or re-appointed.

The Board is committed to reviewing its balance and composition in order to maintain its effectiveness. During 2017/18 the Trust again considered the requirements from Directors on the Board, looking in detail at the skills and qualities needed now and in the future. There was reflection on the existing composition of the Board against desired experience and knowledge on the Board and it was considered that customer services, staff engagement and cultural expertise was needed to ensure robust challenge. In 2017/18 recruitment commenced for new Non-Executive Directors which resulted in the Joint Nominations Committee recommending to the Council of Governors one candidate for appointment, namely Paul Lewis who has the relevant experience who will join the Trust on 1 April 2018. The Trust may appoint up to seven Non-Executive Directors in addition to the Chairman.

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

The Board considered its effectiveness in terms of decision making, refreshing its reserved powers, the Scheme of Delegation and the Terms of Reference of the Board Committees. The Board Committee structure has been designed to ensure lines of assurance on all areas of Trust business via Board Committee to the Board.

In April 2017 the Board held a workshop to consider its effectiveness, reviewing the added value of committees, reporting and information and considering assurance versus reassurance. The outcome was a self-assessment on whether further changes could be made to improve the effectiveness of the Board Committees and how they seek assurance for the Board.

For individual Non-Executive Directors, the Trust has in place a framework for their annual review. The evaluation of the Chair's performance is led by the Senior Independent Director with input from the Lead Governors and the Chief Executive on behalf of the Executive Directors and having regard to the views of the other Non-Executive Directors. The Chief Executive and Non-Executive Directors' performance is evaluated by the Chairman taking account of Governors' and other Directors' input. The Executive Directors' appraisals are led by the Chief Executive in April/May each year and are reported through the Remuneration Committee following a formal appraisal process.

In addition, the Board holds bi-monthly workshops to reflect on areas of Trust business and to consider more action planning and how individual matters link into the Trust's overall strategy.

### 3.7 Attendance at meetings of the Board of Directors during 2017/18

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

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

| | 6 April 2017 | 4 May 2017 | 1 June 2017 | 29 June 2017 Joint Council of Governors and Board | 6 July 2017 | 3 August 2017 | 7 September 2017 | 5 October 2017 | 2 November 2017 | 7 December 2017 | 4 January 2018 | 1 February 2018 | 1 March 2018 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Nick Bishop | ✓ | ✓ | ✓ | × | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Andy Copestake | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Oonagh Fitzgerald | ✓ | ✓ | ✓ | × | × | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Peter Hill | ✓ | ✓ | × | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Roger Hill (Chair) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | × |
| Karen Johnson | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Jemima Milton | ✓ | ✓ | ✓ | × | ✓ | × | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Kevin McNamara | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | × | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Carole Nicholl (non-voting member) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Steve Nowell | ✓ | ✓ | ✓ | × | × | ✓ | ✓ | ✓ | ✓ | ✓ | × | ✓ | ✓ |
| Jim O'Connell *(from 12-Oct-17)* | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | ✓ | ✓ | ✓ | ✓ | ✓ |
| Guy Rooney | ✓ | ✓ | ✓ | ✓ | ✓ | × | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Julie Soutter | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | × | ✓ | ✓ | ✓ | ✓ | × |
| Nerissa Vaughan | ✓ | × | ✓ | × | ✓ | ✓ | × | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Hilary Walker | ✓ | ✓ | ✓ | ✓ | × | ✓ | ✓ | × | ✓ | ✓ | ✓ | ✓ | ✓ |

### 3.8 Decisions reserved for the Board of Directors

There are certain matters which are reserved for the Board of Directors to decide relating to regulation and control; appointments; strategic and business planning and policy determinations; direct operational decisions; financial and performance reporting arrangements; audit arrangements and investment policy. The Reservation of Powers to the Board was refreshed in March 2018 and will be refreshed again during 2018/19. A full copy can be obtained from the Company Secretary.

### 3.9 Interests of Directors

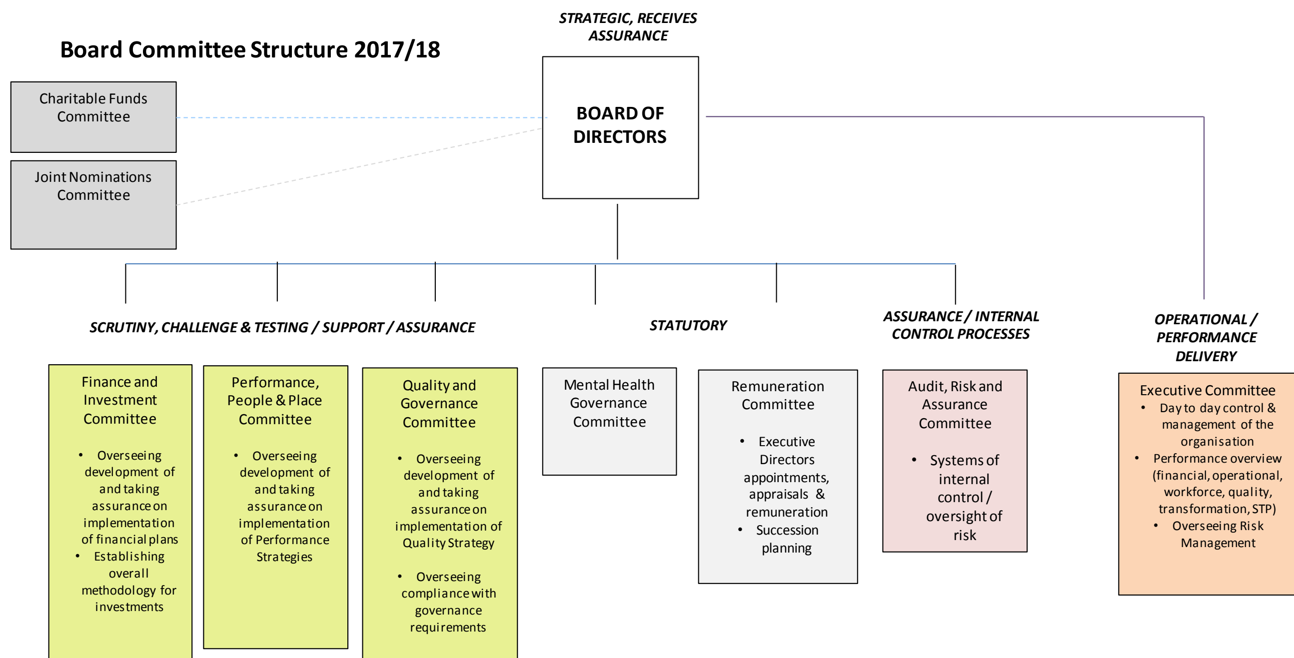
A Register of Interests of Directors is maintained, a copy of which can be obtained from the Company Secretary.

### 3.10 Significant commitments of the Chairman

There were no substantial changes to commitments during the year and the Chairman, Roger Hill was able to devote the appropriate time commitment to this role.

## 3.11 Committee structure

The structure of the Board committees during 2017/18 was as follows: -




Sitting below this top level structure are a number of working groups and other meetings. The Terms of Reference for the Board Committees are refreshed each year with the latest refresh in March 2018.

## 3.12 Key Committees

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

The Board has established the following committees: -

- Charitable Funds Committee
- Audit, Risk and Assurance Committee*
- Quality and Governance Committee
- Finance and Investment Committee
- Mental Health Governance Committee*
- Remuneration Committee*
- People, Performance and Place Committee
- Executive Committee

* Statutory Committees

The Joint Nominations Committee is established by the Council of Governors.

## 3.13 Accounting policies for pensions and other retirement benefits

Accounting policies for pensions and other retirement benefits are set out in the notes to the accounts and details of senior employees' remuneration can be found in the remuneration report (Section 4 refers).

## 3.14 Well Led

Trust Boards are responsible for all aspects of leadership of their organisations with a duty to conduct their affairs effectively and demonstrate measurable outcomes that build patient, public and stakeholder confidence that high quality, sustainable care is being provided. Boards operate in challenging environments characterised by the increasingly complex needs of an ageing population, growing emphasis on working with local system partners to create innovative solutions to long-standing sustainability problems, workforce shortages and the slowing growth in the NHS budget.

These challenges require changes in how leaders equip and encourage people at all levels in the NHS to deliver continuous improvement in local health and care systems and gain pride and joy from their work. Robust governance processes should give the leaders of organisations, those who work in them, and those who regulate them, confidence about their capability to maintain and continuously improve services.

In-depth, regular and externally facilitated developmental reviews of leadership and governance are good practice. Rather than assessing current performance, these reviews should identify the areas of leadership and governance of organisations that would benefit from further targeted development work to secure and sustain future performance.

The Trust is required to have an external well led governance review every three years (licence condition) with the last one being in 2016. Notwithstanding this, the Trust seeks to assure itself that aspects of being well led are regularly considered and reviewed to ensure steps are taken to address any areas for improvement.

The Trust has sought to understand exactly what is required under the eight key lines of enquiry (KLOEs) in the well led guidance, mapping the requirements into a framework. The purpose of the Well Led Framework is to put in place a mechanism whereby we routinely ask ourselves the detailed questions under the KLOE in a systematic and methodical way to gain confidence that we are well led in the way that our regulators would expect and on the basis of how we will be assessed.

This will enable the Board to know how it complies with the well led requirements; enable the Board to instruct actions to address any areas of weakness and lead to continuous improvement on being well led.

The framework in its development has been reported to the Quality & Governance Committee and will be rolled out during 2018/19. This framework will bring together oversight of a number of actions already taking place around well led, such as Board development and workshop sessions; consideration and learning from a number of sources such as the staff survey and various training events.

In addition the Trust is focused on well led below Board level through the roll out of a compliance framework supported by robust governance.

## 3.15 Interests held by Directors and Governors

Details of company directorships and other significant interests held by Directors or Governors which may conflict with their management responsibilities are registered. The Trust maintains a register of interests which is open to the public, available from the Company Secretary.

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

### 3.16 Cost allocation and charging requirements

The Trust has complied with the cost allocation and charging requirement set out in HM Treasury and Office of Public Sector Information Guidance.

### 3.17 Political donations

There were no political donations during 2017/18.

### 3.18 Better Payment Practice Code

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or valid invoice, whichever is the latter. Information on measure of compliance is included in Note 9 to the accounts.

### 3.19 Working with suppliers

The Great Western Hospitals NHS Foundation Trust works with a large number of suppliers across a very diverse portfolio. Our aim is to work in partnership with our suppliers and to build strong relationships that enable us to obtain best value for money when purchasing the quality of goods and services the Trust needs to support patient care.

The Trust has an E-Procurement tool which enhances transparency of our contracting processes, gives visibility of the contracts the Trust is tendering for, makes it easier for suppliers to engage with us and reduces the paperwork suppliers have to complete during formal tendering processes.

### 3.20 Enhanced Quality Governance Reporting

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

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

Arrangements are in place to ensure quality governance and quality is discussed in more detail within the Annual Governance Statement (Section 10 refers).

### 3.21 Quality Governance Framework

The Trust has had regard to NHS Improvement's Quality Governance Framework in arriving at its overall evaluation of its performance, internal control and Board Assurance Framework. The Trust seeks to ensure that the Trust strategy; capabilities and culture; processes and structure and measurements are mapped against the Quality Governance Framework. Quality Governance is discussed in more detail elsewhere in this report namely in the Quality Report (Section 10 refers) and in the Annual Governance Statement (Section 9 refers).

During 2017/18 the Trust had in place a number of plans and processes which contribute to ensuring Quality Governance. Examples of this include: -

- On-going development of the Trust's business strategy with particular emphasis on quality. In addition, sitting under the Trust Strategy, is a Quality Strategy encompassing eight domains. Key Performance Indicators have been agreed to focus on patient care, positive patient experiences and good clinical outcomes.

- Following a previous governance review reporting structures were again refreshed and posts realigned / established with a focus on quality. In 2017/18 the Trust Quality Governance Framework was further developed to support Clinical Divisions to self-assess against the expected systems and processes of quality governance.

- Divisional quality dashboards continue to be enhanced, to support department and divisions in their monitoring and reporting of quality performance indicators.

- Regular reporting to the Board on risks and potential risks to quality, with action plans in place to address any gaps in assurance. A further refreshing of risk management in the organisation took place during 2017-18 with continued focus on the management of risks at local levels, with a particular emphasis on how risk is key to the Trusts' self-assessment on quality. Additional training and workshop sessions continue to be held to raise awareness of the need to identify and manage risk, including risks which may compromise the Trust's ability to consistently deliver high quality care. An internal audit review of risk management took place during 2017/18 following which a number of key performance indicators have been agreed to support monitoring the robustness of risk management in the organisation.

- Ongoing refreshment of the Board to ensure that the Board has the necessary skills and qualities to manage the Trust and deliver the quality agenda. During 2016-17 a clinical Non-Executive Director was appointed. He now Chairs the Quality and Governance Committee.

- Promotion of a quality focused culture throughout the Trust evidenced by the role of staff values and communication and feedback mechanisms. Quality is considered in developing policies and procedures for the Trust with consideration given to the impact on clinical effectiveness, patient experience and the quality of care.

- There are clear processes for escalating quality performance issues to the Board. These are documented, within policies and procedures determining which issues should be escalated. These amongst other issues include escalation of serious untoward incidents and complaints. Robust improvement plans are put in place to address quality performance issues.

- A robust and effective Board Assurance Framework and Risk Management process, which provides a valuable tool for identifying risks, managing them, ensuring controls are in place and addressing any gaps in those controls. The Board Assurance Framework focuses on oversight of metrics to indicate mitigation of strategic risks including quality. Reporting through the Board Committees is now embedded.

- Patient experience is important to the Trust. Each month the Board considers a quality report which includes patient feedback in terms of numbers of comments and complaints, and a quarterly more detailed report on themes and learning. Patient stories and patient comments are shared with the Board regularly.

- Quality information is analysed and challenged in a number of areas. The Board reviews a monthly Quality Report, which includes metrics and analysis of essential quality indicators, such as Infection Prevention and Control, Incident Reporting and Clinical Audit.

- During the course of the year, the internal auditor carried out audits of a number of areas associated with quality governance such as risk maturity, medicines management and equipment management.

- During 2017/18 the Trust was again inspected by the Care Quality Commission (CQC0. Their report provided assurance around the Trust's compliance with the key lines of enquiry (KLOE) under the CQC assessment framework. A number of must and should do actions were identified which are being progressed by core service teams. A KLOE Committee has been established to oversee delivery of actions with reporting into the Trusts Quality and Governance Committee up to Trust Board.

- The work of the core service leads to self-assess compliance against the CQC's key lines of enquiry is supported by an assurance framework which has been established by the Trust.

*Note - The Information Governance (IG) Toolkit is a Department of Health measuring tool that allows organisations to assess themselves against IG policies, IG law and central guidance. It demonstrates whether we can be trusted with public data.*

# Patient Care

### 3.22 Development of services to improve patient care

We treat thousands of patients every year as outlined in the Overview of Performance Report (Section 1 refers). Service improvements are also included in the Overview of Performance Report.

### 3.23 Performance against key healthcare targets

Details of performance against key healthcare indicators is set out elsewhere in the Quality Report (Section 11 refers).

### 3.24 Arrangements for monitoring improvements in the quality of healthcare

Continuous monitoring of the Quality Accounts and improvement plan and national targets is done monthly. The improvement indicators and national targets are reported through to our Commissioners and Trust Board via an Executive Committee. The Quality Account improvement indicators also inform a Patient Quality Committee each month.

Compliance Monitoring of the CQC regulations is undertaken through the Patient Quality Committee, Quality and Governance Committee and Executive Committee up to Trust Board. In addition the Trust has established a Key Lines of Enquiry Committee to oversee roll out of actions delivered by the core services and to gain assurance that continuous monitoring is in place to ensure improvements are sustained. Exceptions in compliance or risks to compliance are identified and included in the Trust's Risk Register.

In addition the Trust has in place an Improvement Committee which oversees the roll out of milestone actions to drive improvement and also tests and challenges embeddedness of improvement.

### 3.25 Progress towards targets

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

Progress towards targets as agreed with local Commissioners, together with details of other key quality improvements, are included in the Quality Report (Section 11 refers).

### 3.26 New or significantly revised services

Details of services throughout the year are included in the Overview of Performance Report (Section 1 refers). There were no new or significantly revised services during 2017/18 other than those detailed below.

In the final quarter of 2015/16 the Trust placed an expression of interest to Swindon Clinical Commissioning Group for the provision of Swindon Integrated Adult Community Services. The Trust was agreed as the preferred provider but, prior to formal contract, the Trust was asked to "care take" the services due to the existing provider "SEQOL" ceasing to operate. From 1 October 2016, the Trust provided adult community health services in Swindon under a caretaker agreement. A formal contract for these services began on 1 August 2017.

The Trust has been working with other health and social care providers in the Swindon system and has developed a target operating model for integrated care, this will focus on removing unnecessary and costly variation and duplication across the system and exploit opportunities to work collaboratively and benefit from best practice. This will be a key aim for 2018/19.

The Trust has previously entered into a joint venture with the Royal United Hospital, Bath Foundation Trust and Salisbury Foundation Trust for the provision of community services in Wiltshire. Although this was a joint venture commencing 1 June 2017, the staff were employed by this Trust. However on 31 March 2018, the staff concerned TUPE transferred to the Wiltshire Health and Care Partnership.

### 3.27 Improvement in patient / carer information

This is referred to in the Quality Report (Section 10 refers).

### 3.28 Focusing on the patient

How the Trust has focused on the patient, with examples, is included in the Performance Report referred to elsewhere in this document (Section 2 refers).

### 3.29 Complaints Handling

**Published under Regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009**

This is referred to in the Quality Report (Section 10 refers).

### 3.30 Using patient experience to drive service improvements

This is referred to in the Quality Report (Section 10 refers).

## Stakeholder Relations

### 3.31 Partnerships and alliances

The Trust has continued to place significant emphasis on building strong relationships with local providers and commissioners. Looking forward, the Trust is actively working to develop partnerships and closer working relationships with a network of organisations across Swindon, which will place us well in our ambition to become an Integrated Care Organisation. Work continues across our STP (Sustainability & Transformation Plan) footprint (covering BANES, Wiltshire & Swindon), here we are looking at how best to work together as a system to deliver real service improvements to patients, efficiencies and savings.

Work has continued with our partners at the Oxford University Hospitals NHS Foundation Trust (OUH) on plans to develop a local Radiotherapy Unit on the Great Western Hospital site in Swindon. The development was given the official go ahead in March 2016. A crucial element of the development of this service will be a multi-million fundraising appeal, which was launched in early 2015 by our Trust, and which as of January 2018 had already reached the £2,000,000 mark. Building work for the unit it scheduled to begin towards the end of 2018. Further work with OUH has begun to develop a Pathology Network along with Milton Keynes University Hospital NHS Foundation Trust and Buckinghamshire Healthcare NHS Trust. This new network approach will look to develop the service, identifying efficiencies from joint working and measures to enhance the service.

### 3.32 Development of services with others and working with our partners to strengthen the service we provide

Examples of how the Trust has developed services with others and worked with partners to strengthen the services we provide is included in the Overview of Performance Report (Section 1 refers).

### 3.33 Health and Overview Scrutiny Committees (HOSCs)

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

### 3.34 Local Healthwatch organisations

We continue to engage with the local Healthwatch organisations in the Trust's geographical area and in particular for Swindon and Wiltshire.

### 3.35 Public and patient involvement activities

Details of engagement events with the public and patients is included in the Disclosures set out in the NHS Foundation Trust Code of Governance Report (Section 6 refers).

# Additional disclosures

### 3.36 Statement as to disclosures to auditors

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

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

### 3.37 Income disclosures

The income the Trust receives from the provision of goods and services for the purposes other than health care does not exceed the income it receives from the provision of goods and services for the provision of health.

### 3.38 Other income

Other income totalling £27m does not have a negative impact on provision of goods and services for the purposes of the health service in England.

Nerissa Vaughan

Chief Executive

24 May 2018

# 4. Remuneration Report

## Information not subject to audit

**Including disclosures required by section 156 (1) of the Health and Social Care Act 2012, which amended paragraph 26 of Schedule 7 to the NHS Act 2006**

### 4.1 Remuneration Committee

The Trust has a Remuneration Committee which has responsibility to put in place formal, rigorous and transparent procedures for the appointment of Executive and Non-Voting Board Directors and to develop, maintain and implement a remuneration policy that will enable the Trust to attract and retain the best candidates for Executive and Non-Voting Director Board positions. The Committee reviews the structure, size and composition (including the skills, knowledge and experience) required of the Board and gives consideration to and is responsible for succession planning at senior level. The responsibility for carrying out these duties rests with the Remuneration Committee whilst the accountability for the actions of the Committee remains with the full Board. Executive and Non-Voting Board Directors are in senior positions that influence the decisions of the Trust as a whole.

### 4.2 Membership of the Remuneration Committee

The Remuneration Committee comprises the Chairman, Non-Executive Directors and the Chief Executive and chaired by the Senior Independent Director. The Chief Executive does not take part in the consideration of Executive and Non-Voting Board Directors appointments or salaries which are agreed by Non-Executive Directors only.

### 4.3 Membership and attendance at meetings of the Remuneration Committee during 2017/18

There were 2 meetings of the Remuneration Committee during 2017/18. Membership and attendance is set out below: -

| | **Record of attendance at each meeting (✓ = attended × = did not attend n/a = was not a member)** | |
|---|---|---|
| | **24 May 2017** | **19 October 2017** |
| Nicholas Bishop | ✓ | ✓ |
| Andy Copestake | ✓ | ✓ |
| Peter Hill | ✓ | × |
| Roger Hill | ✓ | ✓ |
| Steve Nowell (Chair) | ✓ | ✓ |
| Jemima Milton | ✓ | ✓ |
| Julie Soutter | ✓ | ✓ |
| Nerissa Vaughan | ✓ | ✓ |

### 4.4 Policy and guidance

In exercising its responsibilities, the Committee: -

- has regard for each individual's performance and contribution to the Trust and the performance of the Trust itself;
- takes into account benchmark information relating to remuneration of Executive Directors; and
- seeks professional advice from Oonagh Fitzgerald, Director of Human Resources

### 4.5 Remuneration of senior managers (Executive and Non-Voting Board Directors)

An element of variable pay for Executive Directors was introduced in 2013/14, having first introduced it for the Chief Executive in 2011/12. The Committee had a clear view that there must be a rigorous threshold to be achieved before payment of all or part of the variable element could be considered. The majority of the senior manager's salary is base pay, with a percentage as variable pay.

At the end of each year the Remuneration Committee considers whether the variable element is payable, as the variable element is only payable if clear threshold levels and objectives are achieved by the senior managers. In 2014/15 the Remuneration Committee suspended the variable pay element which remained suspended throughout 2015/16 and again throughout 2016/17 and 2017/18.

In May 2017 the Remuneration Committee undertook its annual review of remuneration of Executive and Non-Voting Board Directors, excluding the variable pay element which remains suspended. The Remuneration Committee wishes to ensure that Directors' remuneration reflects current market levels, thus enabling the Trust to continue to recruit and retain high calibre Directors. Benchmarking information relating to other Trusts was considered and basic pay was reviewed in line with benchmarking rates. No changes to the remuneration of Executive and Non-Voting Board Directors were made. However, Directors were awarded 1% uplift in line with the national NHS staff pay award.

The following steps were taken to ensure that the Committee satisfied itself that it was reasonable to pay one or more senior managers more than £150,000: -

- Comparison made of salaries of similar roles in similar organisations
- Consideration of vacancies across the NHS for similar roles
- Consideration of the likelihood of recruiting and retaining individuals in the current market

The Committee was satisfied that the salaries were reasonable for these roles in this organisation.

The variable pay scheme (suspended throughout 2015/16, 2016/17 and again in 2017/18) is as follows: -

| Components of the Remuneration Package for senior managers | How the component supports the short and long term strategic objectives of the Trust | How the component operates | The maximum which could be paid for the component | Amount (expressed in monetary terms or otherwise) that may be paid for minimum performance and any further levels of performance |
|---|---|---|---|---|
| Basic Pay | Basic pay for standard performance | | | |
| Variable Pay | Delivery of Plan | Threshold | 10% of basic pay | |
| | Delivery of stretch objectives | Individual specific objectives | | |

The scheme was suspended due to the Trust entering into enforcement undertakings, therefore the threshold component of the scheme was not achievable. The variable pay scheme will be reviewed in 2018/19.

Pension - The pension and other benefits for Executive and Non-Voting Board Directors is payable according to the NHS Pension Scheme and the Trust's Expenses Policy.

Claw back - Provisions for the recovery of sums paid to Directors, i.e. claw back provisions, are included in Executive and Non-Voting Board Directors contracts.

Policy - The difference between the Trust's policy on senior manager's remuneration and its general policy on employee's remuneration is that the Executive and Non-Voting Board Directors are on spot salaries whereas the rest of the organisation is on a pay scale with annual increments.

In considering Executive and Non-Voting Board Directors pay, relativities of senior manager pay were also taken into account. There was no consultation with employees when preparing the Executive and Non-Voting Board Directors remuneration policy.

### 4.6 Service contract obligations

There are no service contract obligations.

### 4.7 Performance of senior managers

The appraisal process for the Chief Executive and Executive and Non-Voting Board Directors involves an annual review of the objectives set and performance against those objectives. These are agreed by the Chairman and Chief Executive respectively and reported through the Remuneration Committee. The Committee receives a summary report from the Chief Executive into the performance of each Executive and Non-Voting Board Director.

### 4.8 Board of Directors' employment / engagement terms

Executive and Non-Voting Board Directors, but not the Chief Executive, are appointed by the Remuneration Committee. The Chief Executive and the Non-Executive Directors are nominated for appointment by a Joint Nominations Committee consisting of Governors and Non-Executive Directors. The Council of Governors approves the Chief Executive and Non-Executive Director appointments.

The Chief Executive and Executive and Non-Voting Board Directors have a contract with no time limit (with the exception of the Medical Director position which is for a fixed term of three years with an option to extend) and the contract can be terminated by either party with six months' notice as per NHS Employers standard Director contract. These contracts are subject to usual employment legislation. New Director contracts include claw back clauses for any variable payment and fit and proper person disqualification provisions. The Non-Executive Directors, which includes the Chairman, are appointed for terms of office not exceeding three years. They do not have contracts of employment, but letters of appointment with terms agreed by the Council of Governors. The Council of Governors may remove Non-Executive Directors at a general meeting with the approval of three quarters of the members of the Council of Governors.

The Trust's Constitution sets out the circumstances under which any Board Director may be disqualified from office. The policy for loss of office payment is that the Trust would normally pay not more than contractual notice period. Any exceptions would be considered at the Remuneration Committee on a case by case basis.

### 4.9 Senior managers with additional duties

Set out below (section 4.13 refers) is a table disclosing the single total figure of remuneration for each person occupying a director post. This includes all remuneration paid by the Trust to the individual in respect of their service for the Trust, including remuneration for duties that are not part of their management role.

Note that the element of remuneration from the Trust which relates to any clinical role is included. Where any individual received part of their remuneration from another body, the Trust's share of the individual's remuneration is listed only.

### 4.10 Remuneration of Non-Executive Directors

The Non-Executive Directors are paid an annual allowance, together with responsibility allowances for specific roles as set out in the table below: -

| | |
|---|---|
| **Chairman** | £42,500 |
| **Non-Executive Director** (basic which all receive except chairman) | £13,000 |
| **Deputy Chairman** | £1,000 |
| **Senior Independent Director** | £1,000 |
| **Audit, Risk & Assurance Committee Chair** | £3,000 |
| **Mileage** | In accordance with Trust scheme |
| **Expenses** | All reasonable and documented expenses in accordance with Trust's policy. |

Note that a Nominations and Remuneration Working Group consisting of Governors makes recommendations on allowances to the Council of Governors which sets the allowances for the Non-Executive Directors. There were no uplifts in allowances during 2017/18.

### 4.11 Annual Statement from the Chairman of the Remuneration Committee summarising the financial year

During the year the Committee reviewed the Chief Executive, Executive and Non-Voting Board Directors achievements against objectives for 2016/17 and objectives for 2017/18. There were no major decisions on senior managers' remuneration during 2017/18.

The Committee considered the Executive and Non-Voting Board Director composition of the Board and agreed plans around recruitment to the vacant post of Chief Operating Officer and latterly the post of Chief Nurse noting the forthcoming retirement of the current post holder.

The Committee appointed Jim O'Connell the Chief Operating Officer from 12 October 2017. The Committee also appointed Julie Marshman as Chief Nurse to take up post upon the retirement of Hilary Walker in May 2018.

During 2016/17 the Committee had reflected on the needs of the Board and agreed that the voting status of the Director of Strategy should be a voting position on the Board. This was implemented on 1 May 2017 when the Director of Strategy became the Director of Strategy and Community Services to reflect the portfolio of the post.

It is flagged that a majority of Non-Executive Directors positions remained on the Board, albeit that a vacancy for a Non-Executive Director position existed. The Council of Governors approved the appointment of Paul Lewis, who took up the office of Non-Executive Director from 1 April 2018.

During the year the Committee again considered the benefits of psychometric testing as part of any recruitment and selection process and reviewed how this could be provided in-house with staff being appropriately trained and skilled. In addition the Committee considered training and development for clinical leads and how they could be better supported in their role.

This report contains a summary of the work of the Remuneration Committee during 2017/18.

# Disclosures required by Health and Social Care Act

## 4.12 Expenses of Directors and Governors

### Expenses 2017/18 (unaudited)

Note - The total number of Board Directors in office during 2017/18 was 15 (2016/17: 17) and the total number of Governors in office was 23 (2016/17: 23)

| Name | Title | Expenses 2017/18 £ |
|---|---|---|
| Nicholas Bishop | Non-Executive Director | 1,878.75 |
| Andy Copestake | Non-Executive Director | 0.00 |
| Oonagh Fitzgerald | Director of Human Resources | 556.10 |
| Peter Hill | Non-Executive Director | 1,493.95 |
| Roger Hill | Chairman | 639.70 |
| Karen Johnson | Director of Finance | 202.90 |
| Jemima Milton | Non-Executive Director | 0.00 |
| Kevin McNamara | Director of Strategy & Community Services | 795.70 |
| Carole Nicholl | Director of Governance & Assurance (& Company Secretary) (non-voting) | 68.40 |
| Steve Nowell | Non-Executive Director | 423.00 |
| Jim O'Connell | Chief Operating Officer *(from 12.10.17)* | 38.70 |
| Guy Rooney | Medical Director & Deputy Chief Executive | 853.82 |
| Julie Soutter | Non-Executive Director | 760.65 |
| Nerissa Vaughan | Chief Executive | 816.75 |
| Hilary Walker | Chief Nurse | 777.55 |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| **Total** | | **£8,710.17** |

| Name | Title | Expenses 2017/18 £ |
|---|---|---|
| David Barrand | Nominated Governor | 0.00 |
| Penny Bowen | Public Governor | 0.00 |
| Claire Brooks | Public Governor | 0.00 |
| Anna Collings | Nominated Governor | 0.00 |
| Pauline Cooke | Public Governor | 336.60 |
| Brian Ford | Nominated Governor | 0.00 |
| Peter Hanson | Staff Governor *(until Jun-17)* | 0.00 |
| Karen Hawkins | Staff Governor *(from Nov-17)* | 0.00 |
| Louise Hill | Public Governor | 44.55 |
| Ian James | Nominated Governor | 0.00 |
| Janet Jarmin | Public Governor | 300.60 |
| Bill Kingdon | Public Governor *(from Jul-17 until Apr-18)* | 0.00 |
| Sheila Parker | Nominated Governor (until May-17) | 0.00 |
| Kevin Parry | Public Governor | 0.00 |
| Peter Pettit | Public Governor *(until Jun-17)* | 85.05 |
| Rosemarie Phillips | Public Governor | 0.00 |
| Martin Rawlinson | Public Governor *(until Nov-17)* | 0.00 |
| Roger Stroud | Public Governor *(from Nov-16)* | 0.00 |
| Abdelfattah Taha | Staff Governor *(from Aug-17)* | 0.00 |
| Ros Thomson | Public Governor | 0.00 |
| Sarah Watts | Staff Governor *(from Aug-17)* | 0.00 |
| Margaret White | Public Governor | 340.20 |
| Jerry Wickham | Nominated Governors (from Jul-17) | 0.00 |
| | | |
| **Total** | | **£1,107.00** |

## Expenses 2016/17

| Name | Title | Expenses 2016/17 £ |
|---|---|---|
| Robert Burns | Non-Executive Director *(until 31.01.17)* | 897.14 |
| Nicholas Bishop | Non-Executive Director *(from 01.08.16)* | 947.70 |
| Liam Coleman | Non-Executive Director *(until 31.12.16)* | 0 |
| Andy Copestake | Non-Executive Director *(from 01.07.16)* | 0 |
| Angela Gillibrand | Non-Executive Director *(until 30.06.16)* | 212.24 |
| Roger Hill | Chairman | 1004.96 |
| Jemima Milton | Non-Executive Director | 0 |
| Steve Nowell | Non-Executive Director | 421.64 |
| Julie Soutter | Non-Executive Director | 0 |
| | | |
| Douglas Blair | Director of Community Services (non-voting) *(until 30.06.16)* | 1014.68 |
| Oonagh Fitzgerald | Director of Human Resources | 709.16 |
| Karen Johnson | Director of Finance | 0 |
| Kevin McNamara | Director of Strategy (non-voting) | 996.67 |
| Carole Nicholl | Director of Governance & Assurance (& Company Secretary) (non-voting) *(from 01.11.16)* | 81.10 |
| Guy Rooney | Medical Director & Deputy Chief Executive | 1211.44 |
| Nerissa Vaughan | Chief Executive | 1377.36 |
| Hilary Walker | Chief Nurse | 443.59 |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| **Total** | | **£9317.68** |
| | | |

| Name | Title | Expenses 2016/17 £ |
|---|---|---|
| David Barrand | Nominated Governor | 0 |
| Orli Berman (previously known as Elizabeth Garcia) | Public Governor *(until 07.04.16)* | 0 |
| Penny Bowen | Public Governor *(from 06.09.16)* | 0 |
| Claire Brooks | Public Governor *(from Nov-16)* | 0 |
| Lisa Campisano | Staff Governor *(until Nov-16)* | 0 |
| Anna Collings | Nominated Governor | 0 |
| Pauline Cooke | Public Governor | 360.36 |
| Brian Ford | Nominated Governor *(from 01.09.16)* | 0 |
| Peter Hanson | Staff Governor | 0 |
| Louise Hill | Public Governor | 45.45 |
| Ian James | Nominated Governor | 0 |
| Janet Jarmin | Public Governor | 327.76 |
| Brian Mattock | Nominated Governor *(until 18.05.16)* | 0 |
| Phrynette Morrison | Nominated Governors *(until 11.11.16)* | 0 |
| Sheila Parker | Nominated Governor | 314.76 |
| Kevin Parry | Public Governor | 0 |
| Peter Pettit | Public Governor | 430.29 |
| Rosemarie Phillips | Public Governor *(from Nov-16)* | 0 |
| Martin Rawlinson | Public Governor | 0 |
| Roger Stroud | Public Governor *(from Nov-16)* | 0 |
| Ros Thomson | Public Governor | 0 |
| Margaret White | Public Governor | 997.92 |
| Robert Wotton | Public Governor *(until 11.05.16)* | 0 |
| | | |
| **Total** | | **£3080.32** |
| | | |

# Information subject to audit

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

### 4.13 Pension Benefits and Remuneration

#### Pensions Benefits 2017-18

| Name (alphabetical order) | Title | (a) Real Increase in Pension 2017-18 (Bands of £2500) | (b) Real Increase in Lump Sum 2017-18 (Bands of £2500) | (c) Total accrued pension at 31st March 2018 (Bands of £5000) | (d) Lump sum at pension age related to accrues pension at 31st March 2018 (Bands of £5000) | (e) Cash Equivalent Transfer Value at 1 April 2017 | (f) Real increase in Cash Equivalent Transfer Value | (g) Cash Equivalent Transfer Value at 31 March 2018 | (h) Employers Contribution to Stakeholder Pension |
|---|---|---|---|---|---|---|---|---|---|
| | | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Oonagh Fitzgerald | Director of Human Resources | 0-2.5 | 0-2.5 | 25-30 | 60-65 | 364 | 48 | 412 | - |
| Karen Johnson | Director of Finance | 2.5-5 | - | 15-20 | - | 144 | 35 | 179 | - |
| Kevin McNamara | Director of Strategy & Community Services | 0-2.5 | 0-2.5 | 15-20 | 30-35 | 156 | 30 | 186 | - |
| Carole Nicholl | Director of Governance & Assurance (non-voting) | 5-7.5 | - | 50-55 | - | 582 | 105 | 687 | - |
| Jim O'Connell | Chief Operating Officer | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a |
| Guy Rooney | Medical Director | 2.5-5 | 7.5-10 | 60-65 | 180-185 | 1,124 | 100 | 1,224 | - |
| Nerissa Vaughan | Chief Executive | 2.5-5 | 0-2.5 | 55-60 | 140-145 | 891 | 100 | 991 | - |
| Hilary Walker | Chief Nurse | 0-2.5 | 5-7.5 | 40-45 | 130-135 | 823 | 86 | 909 | - |

Note - Accrued Pension and Lump Sum relate to benefits accrued to date and are not a projection of future benefits. They will include any additional pension benefits that have been purchased to date.

Note - Membership of the Board during 2017-18 is referred to elsewhere in the Directors Report (Section 3 refers).

Note - CETV values are not applicable over age 60.

## Remuneration 2017/18

| Name | Title | A Salary & Fees (Bands of £5000) | B All Taxable Benefits £100 | C Annual Performance Related Bonuses (Bands of £5,000) | Long Term Performance Related Bonuses (Bands of £5,000) | Other Remuneration (Bands of £5000) | E Pension-Related Benefits (Bands of £2,500) | Total |
|---|---|---|---|---|---|---|---|---|
| | | 2017-18 | | | | | | |
| Nicholas Bishop | NED | 10-15 | - | - | - | - | - | 10-15 |
| Andy Copestake | NED | 10-15 | - | - | - | - | - | 10-15 |
| Peter Hill | NED | 10-15 | - | - | - | - | - | 10-15 |
| Roger Hill | Chairman | 40–45 | - | - | - | - | - | 40-45 |
| Steve Nowell | NED | 10-15 | - | - | - | - | - | 10-15 |
| Jemima Milton | NED | 10-15 | - | - | - | - | - | 10-15 |
| Julie Soutter | NED | 15-20 | - | - | - | - | - | 15-20 |
| | | | | | | | | |
| Oonagh Fitzgerald | Director of Human Resources | 105-110 | - | - | - | - | 32.5-35 | 140 -145 |
| Karen Johnson | Director of Finance | 125-130 | - | - | - | - | 37.5-40 | 165-170 |
| Kevin McNamara | Director of Strategy & Community Services | 115-120 | - | - | - | - | 30–32.5 | 145 - 150 |
| Carole Nicholl | Director of Governance & Assurance (non-voting) | 85-90 | - | - | - | - | 97.5-100 | 180-185 |
| Jim O'Connell | Chief Operating Officer | 65-70 | 20 | - | - | 5-10 | 0 | 75 - 80 |
| Guy Rooney | Medical Director & Deputy Chief Executive | 130-135 | - | - | - | 40-45 | 37.5-40 | 205-210 |
| Nerissa Vaughan | Chief Executive | 170-175 | - | - | - | - | 62.5-65 | 245-250 |
| Hilary Walker | Chief Nurse | 110-115 | - | - | - | - | 25-27.5 | 140-145 |

Note – In respect of Guy Rooney, other remuneration relates to his clinical role.
Note – Jim O'Connell's remuneration and expenses are part year (from 12 October 2017).
Note – The remuneration figures do not include any final bonus/performance related pay increases which are subject to agreement by the Remuneration Committee.

## Remuneration 2016-17

| Name | Title | A Salary & Fees (Bands of £5000) | B All Taxable Benefits £100 | C Annual Performance Related Bonuses (Bands of £5,000) | Long Term Performance Related Bonuses (Bands of £5,000) | Other Remuneration (Bands of £5000) | E Pension-Related Benefits (Bands of £2,500) | Total |
|---|---|---|---|---|---|---|---|---|
| | | 2016-17 | | | | | | |
| Robert Burns | NED | 15-20 | - | - | - | - | - | 15-20 |
| Nicholas Bishop | NED | 5-10 | - | - | - | - | - | 5-10 |
| Liam Coleman | NED | 10-15 | - | - | - | - | - | 10-15 |
| Andy Copestake | NEDF | 5-10 | - | - | - | - | - | 5-10 |
| Angela Gillibrand | NED | 0-5 | - | - | - | - | - | 0-5 |
| Roger Hill | Chairman | 40 – 45 | - | - | - | - | - | 40-45 |
| Steve Nowell | NED | 10-15 | - | - | - | - | - | 10-15 |
| Jemima Milton | NED | 10-15 | - | - | - | - | - | 10-15 |
| Julie Soutter | NED | 15-20 | - | - | - | - | - | 15-20 |
| Douglas Blair | Director of Community Services | 95-100 | - | - | - | - | 20-22.5 | 115-120 |
| Oonagh Fitzgerald | Director of Human Resources | 105-110 | - | - | - | - | 17.5-20 | 120-125 |
| Karen Johnson | Director of Finance | 125-130 | - | - | - | - | 45-47.5 | 170-175 |
| Kevin McNamara | Director of Strategy (non-voting) | 110-115 | - | - | - | - | 55-57.5 | 170-175 |
| Carole Nicholl | Director of Governance & Assurance (non-voting) | 75-80 | - | - | - | - | 102.5-105 | 180-185 |
| Guy Rooney | Medical Director & Deputy Chief Executive | 130-135 | - | - | - | 35-40 | 25-27.5 | 195-200 |
| Nerissa Vaughan | Chief Executive | 170-175 | - | - | - | - | 35-37.5 | 205-210 |
| Hilary Walker | Chief Nurse | 105-110 | - | - | - | - | 5-7.5 | 110-115 |

Note – In respect of Guy Rooney, other remuneration relates to his clinical role.
Note – The remuneration figures do not include any final bonus/performance related pay increases which are subject to agreement by the Remuneration Committee. None were approved for payment in 2015/16.
Note – Douglas Blair's remuneration and expenses are part year (until 28 February 2017) when he TUPE transferred to Wiltshire Health & Care LLP. However, he ceased to be a Board Member on 30 June 2017.

## Notes to Pension, Remuneration and Expenses Tables

- Non-Executive Directors do not receive pensionable remuneration.
- There are no Executive Directors who serve elsewhere as Non-Executive Directors and, therefore, there is no statement on retention of associated earnings.
- Salary includes employer NI and pension contributions. The above figures do not include any final bonus/performance related pay increase which is subject to agreement by Remuneration Committee.
- The accounting policies for pensions and other retirement benefits and key management compensation are set out in the notes to the accounts.
- The Remuneration Committee considered that the level of remuneration paid to Executive Directors needed to be sufficient to attract and retain Directors of the calibre and value required to run a foundation trust successfully. The Committee had previously decided to increase the remuneration of Executive Directors so that there were in line with current market levels.

## Cash Equivalent Transfer Value

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

A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme, or arrangements when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures show the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of the scheme at their own cost. CETV's are calculated within the guidelines and frameworks prescribed by the Institute and Faculty of Actuaries. The CETV is based on actual contributions to 31 March 2018.

## Real Increase in CETV

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

# Additional disclosures

### 4.14 Fair Pair Multiple

All NHS Foundation Trusts are required to disclose the relationship between the remuneration of the highest paid Director in their organisation and the median remuneration of the organisation's workforce. The median total remuneration above is the total remuneration of the staff member lying in the middle of the linear distribution of staff employed in the Trust, excluding the highest paid Director. This is based on an annualised full time total staff equivalent remuneration as at the reporting period date. There are no Executive Directors who have been released, for example to serve as Non-Executive Directors elsewhere and, therefore, there are no remuneration disclosures on whether or not the Director will retain such earnings.

| Executive Name and Title | Total Remuneration | |
|---|---|---|
| | **2017/18** | **2016/17** |
| Nerissa Vaughan, Chief Executive | **£172,500** | **£172,500** |

The above remuneration is on an annualised basis and is that of the highest paid Director. This includes salary, performance related pay, severance payments and benefits in kind where applicable, but excludes employer pension contributions.

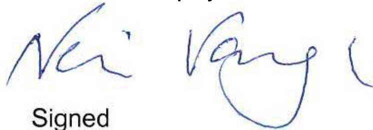
| Multiple Statement | 2017/18 (middle of band) | 2016/17 (middle of band) | % change |
|---|---|---|---|
| Highest paid Directors' total remuneration | **£172,500** | **£172,500** | 0% |
| Median total remuneration | **£27,635** | **£28,441** | (2.83%) |
| Ratio | **6.24** | **6.07** | 2.92% |

### 4.15 Payments for Loss of Office

There were no payments made for loss of office during 2017-18.

### 4.16 Payments to past senior managers

There were no payments made to past senior managers during 2017-18.



Signed

Nerissa Vaughan
Chief Executive

24 May 2018

# 5. Staff Report

## 5.1 Staff Numbers

We are committed to our organisation being a place that people want to work and would recommend to their family and friends. Our People Strategy sets out our journey of cultural change, ensuring that compassion and care are at the heart of our organisation, both for patients and our staff.

Every single person who works in our organisation plays an invaluable role in providing the high quality care and excellent service we strive for and we are committed to supporting our staff to achieve this through the six commitments outlined in our People Strategy.

As a Trust we are committed to developing our staff and strive to ensure that all our employees reach their full potential at work and are happy and motivated to do their job and contribute to our success as an organisation. We also continue to work towards improving how we recognise the hard work, loyalty, commitment and successes of our workforce and have raised the profile of achievement through the monthly and annual award scheme and in putting staff forward for national awards.

Average WTE of employees for 2017/18 was 5,150. The breakdown by professional group is listed below: -

| **Employee Group (WTE)** | 2017/18 | 2016/17 |
|---|---|---|
| Medical and Dental | 543 | 536 |
| Ambulance staff | 22 | 0 |
| Administration and estates | 1,097 | 1,068 |
| Healthcare assistants and other support staff | 1,014 | 860 |
| Nursing, midwifery and health visiting staff | 1,468 | 1,433 |
| Scientific, therapeutic and technical staff | 604 | 599 |
| **Substantive Total** | 4,749 | 4,496 |
| Agency and contract staff | 157 | 179 |
| Bank staff | 244 | 217 |
| Other | 0 | 0 |
| **Total average Numbers** | 5,150 | 4,892 |

An analysis of average staff numbers is included in Note 7 to the accounts, together with an analysis of staff with permanent employment contracts with the Trust and other staff engaged on the objectives of the organisation.

### 5.2 Staff Costs

Staff costs are included in Note 4.1 to the accounts.

### 5.3 Trust employees

A breakdown at 31 March 2018 of Trust employees is as follows: -

| | Female | Male | Total |
|---|---|---|---|
| Directors (senior managers) | 4 Executive Directors, 1 Non-Voting Board Director & 2 Non-Executive Directors | 3 Executive Director, & 5 Non-Executive Directors | **15** |
| Bank & Substantive Staff | 1,231 | 182 | **1,413** |
| Substantive Staff Only | 3,510 | 689 | **4,199** |
| Bank Staff only (includes Swindon Community Health Services) | 1,197 | 192 | **1,389** |
| **TOTAL** | **5,944** | **1,072** | **7,016** |

The Trust has agreed key workforce policies with the recognised trade unions on behalf of our employees in line with our People Strategy 2014-2019. These policies include recruitment and selection, conduct, capability, grievance, sickness absence and health and safety. The policies are reviewed regularly for effectiveness and outcomes are reported bi-annually through the Executive Committee and People, Performance and Place Committee. The HR Team members are aligned with the Clinical Divisions and meet regularly with the line managers to ensure that the relevant policies are implemented.

### 5.4 Sickness Absence

| Staff Sickness Absence | 2017/18 | 2016/17 | 2015/16 |
|---|---|---|---|
| Total days lost | 66,431 | 57,568 | 54,355 |
| Average working days lost per whole time equivalent | 8.96 days | 8.59 days | 7.82 days |

## Benchmarking

| | April 2017 | May 2017 | June 2017 | July2017 | August2017 | September2017 | October2017 | November 2017 | December 2017 |
|---|---|---|---|---|---|---|---|---|---|
| Royal Devon and Exeter NHS Foundation Trust | 3.58% | 3.79% | 3.95% | 4.20% | 4.17% | 4.08% | 4.49% | 4.55% | 4.92% |
| Royal United Hospitals Bath NHS Foundation Trust | 3.76% | 3.82% | 3.79% | 3.87% | 3.98% | 3.85% | 4.18% | 4.27% | 4.59% |
| North Bristol NHS Trust | 4.09% | 4.10% | 4.27% | 4.35% | 4.38% | 4.33% | 4.61% | 4.37% | 4.29% |
| Great Western Hospitals NHS Foundation Trust | 3.64% | 3.70% | 3.58% | 3.48% | 3.66% | 3.53% | 3.88% | 3.93% | 4.13% |
| Gloucestershire Hospitals NHS Foundation Trust | 3.49% | 3.39% | 3.40% | 3.38% | 3.44% | 3.45% | 3.68% | 3.83% | 4.04% |
| Salisbury NHS Foundation Trust | 3.15% | 3.46% | 3.37% | 3.53% | 3.49% | 3.92% | 3.65% | 3.73% | 4.03% |
| Average | 3.80% | 3.92% | 3.88% | 4.07% | 4.03% | 3.94% | 4.25% | 4.46% | 4.61% |

As you can see from the benchmarking data, the Trust is below the average sickness percentage for the local Trusts. (Data only available until December 17) data source NHS Digital published April.

Over the last 12 months the Trust has been focusing on a proactive sickness management utilising Health and Wellbeing advisor to conduct Health Assessment in hotspot departments. The Health Assessment consists of staff receiving a full assessment including, blood pressure, weight, BMI etc. and advice is provided for improving or maintaining a healthy lifestyle.

The HR Team conducts absence audits to ensure processes such as return to work meetings, regular 1-2-1, occupational referral and reasonable adjustments are being considered when required as supportive measure to improve attendance. The audit also measures the manager's approach to ensure consistency throughout departments and the Trust whilst considering each case individually.

In particular hotspot departments, the HR Team facilitates working groups and other interventions, utilising staff support service, Organisational Development , NHS elect etc. to improve absence rates that are sometimes linked to other performance indicators such as staff survey, culture, appraisal etc.

In persistent short term sickness or longer term episodes the Trust implements a supportive but structured process to improve employees attendance or consider adjustments to support a return to work.

## 5.5 Staffing related issues during the year

**International recruitment**

The national shortage for nurses continues to have an impact on the Trust and the nurse vacancy position remains a key focus. In 2017/18 the Trust recruited 69 international nurses (EU and Non EU) of which 28 are working as registered nurses, 17 are working as band 4 pre-registered nurses and 9 Non EU Nurses are undertaking their OSCE training.

International candidates are provided with a bespoke induction and on boarding programme to ensure they feel welcomed from the beginning. This includes connecting with members of the recruitment team and ward managers before arriving in the UK, welcome meetings from existing international candidates, tours of the Hospital and Swindon, Facebook and Whatsapp groups for keeping in contact and a forum for asking questions.

**International Candidate Feedback**

**"***I would like to extend my heartfelt gratitude for the assistance you have given me upon arrival to the UK. The strong sense of support extended to me and to my other co-recruits has been invaluable. It is so comforting to be treated as a family by the entire welcoming committee/team and if this is a sign of great things and enriching experiences to come, then I consider myself blessed to be at the receiving end of some generous and accommodating support staff. Thank you so very much. Thank you for guiding us through town yesterday and assisting us in sorting out our paperwork's. Our accommodation exceeds expectations and I love the flat appointed to me. Thank you so much. Your patience in answering all our queries is highly appreciated and I am really, truly, grateful".*

**Agency spend**
The Trust secured a 'master vendor' agreement in 2017 with ID Medical, an external contractor for the supply of agency workers. This agreement has led to some savings and a more robust supply of temporary staff. However demand for temporary staff has increased in year due to increasing demand on services and our ongoing vacancy position so the Trust continues to spend above the cap set by NHS Improvement.

**National Pay Rise**
A three year fully funded pay deal has been proposed nationally. The outcome of the consultation will be provided in June.

**Swindon Community Health Services**
In 2017/18 Swindon Community Health Services completed a management and back office restructure to ensure the service has the appropriate leadership and back office roles to support decision making and the ongoing development and integration of the service.

All Agenda for Change staff have moved to GWH terms and conditions of employment and have also had the opportunity to join the NHS pension scheme.

**Gender Pay Gap**
Under the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, the Trust is required to publish gender pay gap data on a government website and the Trust website.

The gender pay gap reporting uses six different standard measures and must be published by the 30th March 2018 (Public Sector Organisations) using a data snap shot from the 31st March 2017. Staff employed by the Trust on this date include Wiltshire Health and Care, GWH Acute Services and Swindon Community Health Services. The total number of staff included is 5,246 with a split of 816 (15.55%) male and 4,430 (84.45%) female.

The results show that if all staff are included, there is a pay gap with female staff being paid less (median 7.62%, mean 27.17%) on average than male staff. If medical staff are taken out of the figures, the gap reduces significantly with the mean pay gap 0.73% and the median -5.19%. This reflects the national picture across the NHS and should reduce over time as currently there are more female than male junior doctors going through training. This should mean an increase in the number of female consultants over time, which will reduce the gender pay gap.

**Bonus Pay Gender Pay Gap**
There is also a large difference between male and female for bonus pay (87.1%), which includes incentives, recruitment premia, Clinical Excellence Awards, Discretionary Points and Distinction Awards for doctors. If doctors are not included in the calculation, this figure reduces to 0% meaning that male and female staff are paid the same hourly rate. Once again, this reflects the number of senior male medical staff in receipt of these awards.

**Apprentices**
Over the 11 months from April 2017 to date, the Trust has a total of 90 new apprentices. This means we are likely to have 20% fewer starting apprenticeship last year than the previous year. Nationally the decrease is 41% fewer so GWH has performed significantly higher than the national average. This number include 42 new apprentices with our first Degree apprentice in Cardiac Physiology, 28 new starts for the Trainee Assistant Practitioner role to support shortages in Registered Nurses and 20 existing staff have embarked on development via an apprenticeship programme.

## 5.6 Policies for potential and existing disabled employees – engagement as an Employer of Choice with and for our community

The Trust has agreed key workforce policies with the recognised trade unions on behalf of our employees in line with our People Strategy 2014-2019. These policies include a range of employment situations e.g. recruitment and selection, conduct, capability, grievance and health and safety. The policies are reviewed regularly for effectiveness and outcomes are reported bi-annually through the Executive Committee and the Performance, People and Place Committee.

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

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

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

Actions taken in the financial year to provide employees systematically with information on matters of concern to them as employees include site communication with staff and “Staff Room” (a staff magazine) circulation.

Actions 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 are included elsewhere in this report under the Staff Survey information below.

To enable consultation with employees, the Trust has in place an employee partnership agreement. There is an Employee Partnership Forum made up of representatives from trade unions and management. The agenda covers Trust developments and financial information, listening to key issues as well as consultation on policies and change programmes.

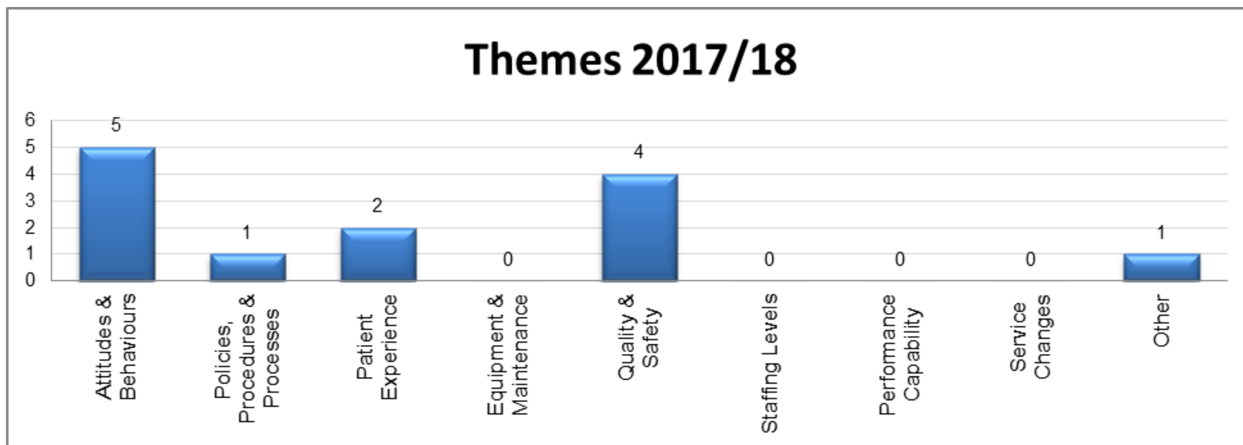
Actions taken in the financial year to encourage the involvement of employees in the Trust’s performance are included elsewhere in this report (Section 5.8 refers).

**Freedom to Speak Up**

The Trust has six appointed Guardians. Their role is to be responsible for providing confidential advice and support to staff in relation to any concerns about patient safety. They can also offer advice and support to ensure concerns raised are handled professionally and result in a clear outcome. All of the concerns that have been received are logged internally and responses given to the appropriate persons i.e. CQC or the employee directly, unless in cases where raised anonymously.

The Guardians have a quarterly meeting where cases are discussed and the learning/actions are reviewed. The Guardians are in the process of developing a feedback questionnaire to send to staff members who have raised a concern. The data is reported via the Quality and Performance report to the relevant Executive Committee and governance route and a quarterly report is sent to the National Guardians Office.

This financial year to date there has been 13 Freedoms to Speak Up concerns raised, 4 have been received direct from CQC and nine direct to a Freedom to Speak Up Trust Guardian. The graph details a breakdown of the nature of the concerns raised through Freedom to Speak Up.




**Fraud**

One of the basic principles of public sector organisations is the proper use of public funds. The Trust is a public funded organisation and consequently it is important that every employee and associated person acting for, or on behalf of, the Trust is aware of the risk of fraud, corruption and bribery; the rules relating to fraud, corruption and bribery and the process for reporting their suspicions and the enforcement of these rules. The Trust has a Fraud and Corruption Policy which includes a response plan for detected or suspected fraud, corruption or bribery. In addition the Board endorses the NHS Counter Fraud Strategy and subsequent guidance.

### 5.7 Policies for potential and existing disabled employees engagement as an Employer of Choice with and for our community

The Trust is signed up to the national "two ticks" symbol and supports the recruitment and development of disabled candidates/employees. To achieve this we show commitment to five key areas and work with our key partner Job Centre Plus as well as stakeholders within Swindon e.g. voluntary sector agencies, training providers and colleges.

The Trust interviews all disabled applicants who meet the minimum criteria for a job vacancy and to consider them on their abilities. The Trust makes every effort when employees become disabled to make sure they stay in employment. HR staff work with Occupational Health Specialist Advisers and Line Managers to seek appropriate roles for staff following a change in circumstances

### 5.8 Staff consultation and engagement / other consultations

The Trust has a strong relationship with its trade union colleagues and also the Employee Partnership Forum (EPF) which formally negotiates on changes to policies, pay, terms and conditions of employment. EPF is formally recognised under a Trade Union Recognition Agreement and continues to be the route for communication with Trade Union Representatives for Wiltshire Health and Care LLP.

Working in partnership with Trade Union Representatives, we have consulted with staff working in Swindon Community Health Services to move to the GWH payroll, GWH terms and conditions and restructures. Staff side have also been closely involved in the consultation of the TUPE transfer of Wiltshire Health and Care which is proposed to take place on the 1st April 2018.

We continue to embed the STAR organisation values, which are Service, Teamwork, Ambition and Respect (STAR). These values are embedded in our People Strategy 2014-2019, HR policy framework, recognition schemes and support recruitment decisions.

## 5.9 Communicating with staff

We have continued to extend the range of channels to strengthen communication between senior management and Trust staff:

- The Trust has a single intranet site for staff, providing an accurate and timely source of information across the various departments and empowering staff to take control of their own areas of the site to share information with colleagues. The intranet also features a 'Hot News' section which allows important information to be shared with staff in a timely manner. This has recently been updated and the new features include a news feed (Grapevine) which staff can add their own stories to directly, allowing teams to share news from their specific area with the whole Trust at the click of a button. Additionally, the intranet enables staff to view the Trust's active social media channels and the wealth of positive feedback left on the sites by patients and other visitors.

- The Staff Room is a newspaper for all staff and volunteers and is a new way of keeping in touch with what's happening across the Trust. We encourage individuals and teams to feature in an edition of *Staff Room* or, if staff thinks there's something we should be telling colleagues about, then we encourage staff to let us know. Copies of each issue of Staff Room are delivered to GWH and all the main community sites. It's also available electronically.

- The Trust has recently introduced Spotlight which is a way to thank someone who has gone the extra mile and then having this message shared with everyone in the Trust, in this new newsletter. The newsletter publishes thank you message from staff and patients with stories behind the thanks you messages. It also an opportunity to publish any local events for staff.

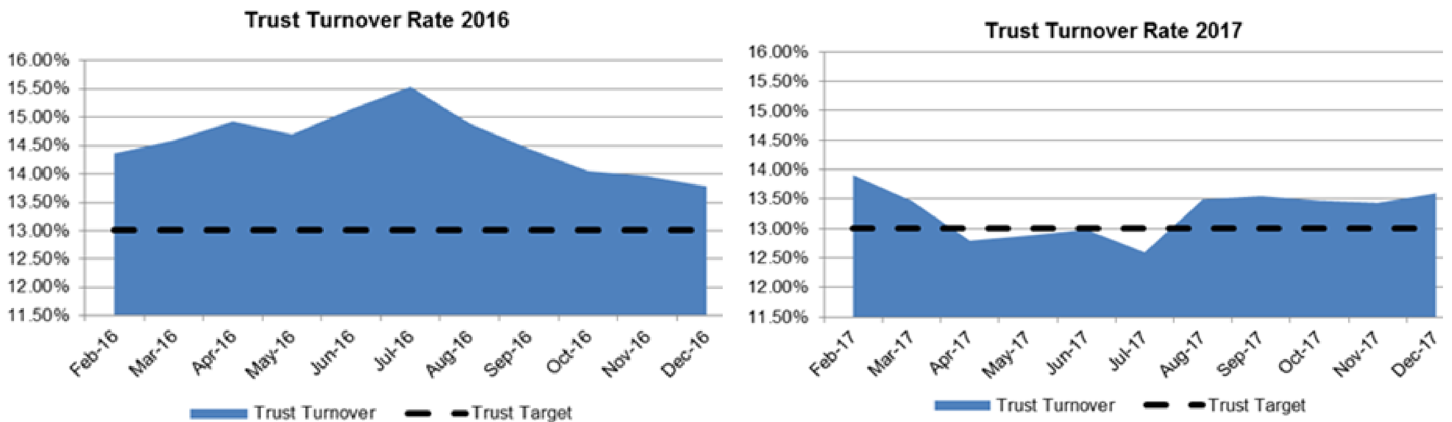
- The Trust also has an internet site for the public, current and future staff, members and Governors to access which provides useful information about services within the Trust, health care information and information about working for the Trust. The 'Working for us' section provides a series of information about career paths available, 'A day in the life of' and information about reward and benefits.

## 5.10 Workforce Key Performance Indicators (KPI's)

The Trust has a range of workforce KPI's which are monitored to understand the organisation's performance.

**Sickness absence –** Average Sickness absence levels were 3.85% for the period February 2017- January 2018. This is consistent with the national picture for similar NHS Trusts. This is an increase on the same period for the previous year which was 3.76%. The Employee Relations team continue to work closely with managers to review all long and short term sickness absences within the Divisions and support the managers to reduce absence across the Trust by supporting their staff and addressing any issues which affect absence.

**Turnover –** Turnover as at January 2018 was 14.07% excluding Wiltshire and 14.54% including Wiltshire (January 2017 was 14.61%). Voluntary turnover was 10.25% excluding Wiltshire and 10.96% including Wiltshire (January 2017 11.54%). This is due in part to the development of a Recruitment and Retention strategic plan to recruit and retain and provide the necessary development and reward to key areas experiencing turnover over and above the median for NHS Trusts. However, the Trust has seen an increase since December 2017.




**Vacancy levels –** As at February 2018 there were 477.87 WTE vacancies including Wiltshire Health and Care (9.09%), 372.30 WTE (8.58%) excluding Wiltshire Health and Care. These are again supported by individual plans to support growth and development.

**Appraisal rates -** The overall completion rate for the Trust is 78.21% in February 2018 (compared to 84.60% in February 2017). In 2018/19 the Trust will be focusing on improving the quality of the discussion and content of performance appraisals, as well as improving appraisal rates to ensure that staff feel that the appraisal was worthwhile and added value to them as an employee of the Trust.

## 5.11 Workforce Development

The Trust is committed to supporting and motivating current staff, trainees and future workforce, including students, with on-going learning and development. Despite challenging service pressures across the Trust, the Academy has been proactive in delivering training and in supporting staff and managers to engage with mandatory elements of training. Mandatory training compliance now stands at 86.7%. This is an increase of 2.5% since last March.

The Academy, which is our dedicated Learning and Development Centre, continues to deliver training and support in a number of locations across the Trust. Simulation activity has increased with multi professional simulation scenarios now applying a human factor approach to reducing risk and increasing competence and self-awareness. The aim has been to provide education solutions to support recruitment, retention, talent management, succession planning as well as competency development and support for advanced and specialist skills.

The Academy has focussed on a number of improvements to education and development opportunities available for staff:

As part of the Academy continuing professional development programmes (CPD), new courses have been created in-house. These programmes focus on areas such as cardiac care, acute stroke, mental health, management of long term conditions and end of life. These all focus on the patient pathway through different services in both acute and community settings. These programmes are multidisciplinary (for nursing/AHPs) promoting a cross service approach to learning and service delivery. These courses will be accredited at Masters level via Northampton University, commencing in June 2018.

Apprenticeships at GWH have continued to flourish, despite the challenges associated with the introduction of the apprenticeship levy, lengthy procurement and the lack of available apprenticeship standards that can be used to develop new and existing staff. The standard of our apprentices was recently acknowledged by HEE as one of our higher apprentices was awarded the SW region apprentice of the year 2017-18.

The pre-registration team continue to support the recruitment of non-medical students. As well as our traditional University students, we also embraced a number of additional programmes to encourage support staff to progress to undertaking professional qualifications in Nursing. Widening access Health Education England sponsored programme 8 students joined the Widening access Health Education England sponsored programme for adult nursing in January 2018. A further 4 HCAs joined the part time Open University adult nursing programme in September 2017.

The team have also continued to support those returning to the Nursing profession. In total, 8 students have commenced the Return to Practice programme in the last year and Trust has so far recruited 60% of them, the remaining 40% are still undertaking the programme. For the first time this year, we extended the Return to Practice offer to Allied Health Professionals and 3 were successfully returned to practice and were recruited by the Trust. The Trust has been successful in gaining access to money for bursaries and support for AHPs returning to practice as part of a Health Education England pilot.

In June 2017, the Academy embarked on a project to create a careers hub for Swindon, having successfully bid for funding from Health Education England. Working with schools and colleges across Swindon, and liaising with Swindon Borough Council, in addition to local and national authorities, the project has focused on increasing collaboration, sharing of information and presenting better visibility of health care careers events across the region for teachers and careers advisers in schools and colleges, to guide and advise students. The main outcome of the project has been a brand new website www.swindoncareershub.info which went live in February and has been showcased at the HEE Stakeholder Conference and Swindon Jobfest.

The Academy has continued to support one of the Trust’s biggest challenges- recruitment and turnover. Innovative projects that have supported recruitment include Return to the Acute setting (which saw the return of 9 Nurses to acute jobs, UK based overseas programme saw 2 nurses register with the NMC and work for the Trust and OSCE support and tutoring for our oversees nurses – with a success rate above the average of 80% pass over the past year

Post Graduate Medical Education continued to support the quality of postgraduate experience and education by employing innovation Fellows. The aim is to specifically address feedback that Foundation Drs needed help to support un-well surgical patients.

Post graduate recruitment in 17/18 was mixed with two Foundation Year 2 unfilled vacancies at training grade level. These were filled with non-training grade doctors (Clinical Fellows). In order to support the non-training grade doctors the Academy secured free access to the new e-portfolio system HORUS for Foundation Doctors. Overall the induction of the Junior Doctors by electronic induction has been successful and has yet again allowed the departments more dedicated time for local induction, which in turn has a positive impact on the Junior Doctor experience and patient safety.

The Trust's Organisational Development Manager delivered leadership training, mediation, coaching and team support across the organisation. Referrals for OD support come from managers, HR and individuals. Last year over 50 staff completed a clinical traineeship in leadership, and 45 managers completed the 3-day Leading Managers programme. Coaching continues to be a well-utilised resource for staff at all levels in the Trust and we are growing our capacity through training three additional coaches. Team support has been provided in all of our divisions, most recently in SwICC where a listening event was followed up with three half-day workshops, attended by the majority of staff.

The Academy has worked hard over the last year to update and increase the support from the Library in positively impacting patient care and outcomes. Our overall membership has increased by over 100 this year and we have moved to more electronic resources resulting in over 14,000 more titles available to staff. We have issued 2000 more books and supplied over 600 more documents in the last year. This well received upgrade of services was further endorsed by our recent LQAF audit which increased from 93% to 97%.

As a result of a successful Monitor visit by the University of Bristol on the 12th March and the development of the new Medical Degree programme, the Swindon Academy has been asked to accommodate a small increase in students from 2019. This will result in nominal increases across all years.

The Academy has continued to successfully attract students via the extensive and innovative SSC programmes and in turn has been able continue to support the Trust via the recruitment of Clinical Teaching Fellows (CTFs) for August 2018 with 22 offers having been made to date. In order to support the Trust in the retention of our Foundation doctors and improve our GMC survey feedback, the undergraduate department has developed the role of a Ward Based Educational Guardian (WBEG). These doctors will have a split role, 50% of their time will be spend undertaking clinical work and 50% supporting the Foundation doctor with their SLE's, core procedures as well as support medical students in the ward based environment.

The Academy has continued to expand our simulation training with Oxford Brookes University which encouraged effective multi-disciplinary working across professions within student groups.

## 5.12 Supporting our volunteers

**Context of being a Volunteer:**

The Trust is extremely fortunate to have 393 committed and enthusiastic volunteers who support delivery of services across our acute and community services. The volunteers provide an extremely valuable service to patients and provide support to staff. Volunteers can be found across the Trust in a variety of roles, such as patient befriending and assisting patients at mealtimes on the wards, supporting information points for patients in the Eye Clinic and Cancer Services, supporting patients on behalf of the Audiology Department, doing exercises with patients in Physiotherapy, assisting patients in Radiology, providing a way finding service, and even helping in the laboratories to archive specimen slides and records.
Volunteers also provide support to new mums who wish to breast feed in the maternity ward. Each volunteer has their own personal reasons for offering their time and as individuals they bring a wealth of experience. The Trust asks volunteers to commit to a minimum of three hours per week for a minimum of six months.

**Demographics:**

Volunteers form an essential part of the hospital team and are highly valued by patients and staff. There are consistently high levels of interest in applying to become a volunteer. There have been 231 new recruits since April 2017 and on average there are always approximately 80 people in the recruitment process at any one time. The Voluntary Services team interview on average 20 new applicants per month.

Gender profile:

| Total Headcount | 393 |
|---|---|
| Male Volunteers | 110 |
| Female Volunteers | 283 |

Age profile:

| Age Range - Years | % Workforce |
|---|---|
| 16-18 | 17% |
| 19-60 | 38% |
| 61-79 | 39% |
| 80 + | 6% |

**Opportunities:**

For many, volunteering is a step on the ladder to employment; an opportunity to experience the hospital environment before going to university or to gain a familiarity with the NHS before applying for a role. In the 2017/18 financial year 45 Volunteers became paid members of staff with the Trust into a wide range of roles including apprentice, midwife and radiographer. Many of our volunteers stay with the Trust for years, achieving awards for 5, 10, 15 and 20 years' service with some even accruing over 25 years of voluntary service.

**Recruitment Process:**

There is a robust recruitment process, including referencing and criminal records checks. Our volunteers attend Trust induction and other mandatory training as required and are then ready to start volunteering. All volunteers attend at least one half day training session in a 12 month period.

**Impact of the Volunteer Mentor:**

The majority of volunteers have their first shift with our Volunteer Mentor receiving introductory support with the key themes of being a volunteer including practical training, orientation around the hospital and discussing the importance of confidentiality. The impact of the Volunteer Mentor has been positive with retention rates in 2017/18 improving by 1.9% compared with 2016/17.

*Volunteer Feedback*:

*“I am really enjoying my volunteering on 'Meldon Ward'. When I began volunteering I was really scared but having the Volunteer Mentor there to support really helped and I gradually found my feet and now find it amazing. The staff are ever so helpful and often say ‘you are star’ and ‘thank you’. Seeing a patients smiling face even though they are suffering or them saying to other patient ‘she is very helpful and kind’ makes my Thursdays wonderful.”* ***Patient Befriender on Meldon Ward***

**Partnership working:**

Additionally, there is the opportunity to volunteer at the hospital via other organisations, such as British Red Cross, Changing Faces, Hospital Radio, Royal Voluntary Service and Swindon & Wiltshire Carers Support Services. We are also working more closely with local colleges and organisations such as the Harbour Project and the Volunteer centre in Swindon.

We are committed to supporting the community we serve and this is one way of enabling us to engage with our local towns and the people within them.

## 5.13 Health & Wellbeing

### Healthy Lifestyles Update

In 2018 the Trust has continued to focus on offering a package of health assessments for staff, increasing activity levels and supporting staff with weight management and healthy eating advice.

We have a dedicated Health and Wellbeing Advisor, who has a regular column in Staffroom Magazine to provide staff with information on leading a healthy lifestyle with tips for exercise and healthy recipes.

Health assessments are available for all staff which include cholesterol and blood pressure testing, height, weight and BMI and advice and information on exercise, weight management and stress management in 2017/18 240 have been completed. Staff can access these sessions in many settings both on the main Acute site and also the community venues at a time and date to suit the client. Department visits are available and encouraged to help improve team morale and provide a service tailored to department needs. Health Assessments were advertised on payslips in February providing another way to advertise this service to as many staff as possible.

Staff can access NHS discounted membership at 18 local gyms and leisure centres in Swindon and surrounding areas, currently over 300 members of staff are taking advantage of this.

To support staff in increasing activity levels annually a staff challenge takes place. In November, 44 staff took part in a step challenge, Staff had to record their daily step levels each week for 4 weeks, the winners were from the Finance department, staff reported feeling fitter and motivated to continue to make healthy lifestyle changes after increasing their activity levels

Health and Wellbeing promotional stand was held at the annual members meeting which included 20 blood pressures/lifestyle consultations carried out by health and wellbeing advisor

Health and Wellbeing Roadshow took place on 22nd January. There were stands from local gyms, fire safe and well advisor, Health and Wellbeing, Health and Safety, Manual Handling, Staff Support and Dieticians. This was well attended with stall holders reporting speaking to over 50 people. Staff were able to sign up for Health

Assessments and departments could book team visits. This was advertised with posters and leaflets and on our week ahead and on the intranet. Photos of the event were available later that day on the intranet home page

BBC Wiltshire sound launched the spring into summer walking campaign in May and interviewed health and wellbeing advisor to discuss the benefits of increasing activity levels and ways in which this could easily be done, the staff activity challenge, onsite walking route and stair use promotional signs were examples given of the positive work being done at GWH for staff and visitors

The "Weigh to Wellbeing" staff slimming club takes place monthly providing weight management education and exercise information along with weight and body composition measurements. In addition to this staff can access one to one appointments for weight management with health and wellbeing advisor.

The Trust has an Occupational Health and Physiotherapy Service which also provides a range of management and staff support packages. Staff can self-refer into these services to receive advice and treatment.

### Staff Support Services

2017/18 has been a busy year for the Service, with our referrals increasing by thirty-one per cent against the previous year. To date, the Service has provided approximately 1,830 client hours to acute and community staff and 317 staff accessed the service. The Staff Support offers therapies, group work, stress management sessions, drop in sessions and mini roadshows throughout the year. Sessions are currently available in Bath, Calne, Chippenham, Salisbury, Trowbridge, Warminster and Wroughton.

The team, which is made up of counsellors and mental health practitioners, have worked hard to have an impact on increasing mental health awareness and reducing the stigma attached to mental health. All Service leaflets have been audited and standardised, and new self-help leaflets created to support staff needs.

The four Staff Support information boards sited in staff areas in the Trust, are changed to a new theme every two months, any leaflets provided are replenished on a regular basis. Where there has been a national campaign the theme of the boards has reflected this, with an article about the topic going out on Site Communications. The boards are designed to be eye-catching to encourage staff to stop and read them.

A Communication Strategy was completed and includes all of the activities planned by the Team through to August 2018.

The Service has run two Mental Health First Aid courses (2 day courses), with a view to creating mental health first aiders across the Trust, who will be able to support staff. A further three courses are planned in 2018 - all are fully subscribed. The Service has also provided two stress management and two low mood groups, as well as a six week Stress Management course.

Staff Support has been proactive in supporting a variety of national campaigns throughout the year, including Mental Health Awareness Week, World Mental Health Day, National Stress Awareness Day and Time to Talk Day. These were celebrated with information stands, Ward and Department Walks, publicity through Site Communications and in Mental Health Awareness Week we did mini roadshows, taking these to Chippenham Community Hospital and Warminster Hospital. During these campaigns the Service has distributed over a thousand leaflets, thereby heightening staff awareness of the availability of the service.

### 5.14 Swine / seasonal flu vaccinations

For the 2017-18 the Trust achieved 85.6% KPI (including opt outs) and 76.9% excluding opt outs, which exceeds the 70% target. This is the highest results in the South West Region. The Trust has therefore achieved the CQUIN target for 2017 – 18. This is the highest uptake our Trust has had based on historical data. We are already developing a plan for next season's flu campaign to further increase our uptake figures.

### 5.15 Health and Safety, fire and security

The integration of Swindon Community Services into the health & safety culture of the Trust has been a major driver throughout the year and for the future. By introducing the Ulysses IR1 incident reporting system across the community sites, integrating the safety and security meetings and ensuring that Reps and Managers are sufficiently trained we have already established the foundations of a strong & supportive safety culture.

The Trust has received no prosecutions or Improvement Notices from the HSE, CQC or Wiltshire Fire & Rescue Service during 2017/18. This is an on-going excellent achievement which we have now maintained for many years by virtue of our high standards throughout the Trust for health & safety compliance.

A very busy year which has again seen several improvements made across the Trust's H&S, and Fire and Security management systems, which are highlighted below.

- During the year there were 13 RIDDOR reportable accidents reported to the HSE and root cause analysis investigations completed. These consisted of 6 slip/trip/fall incidents, 3 collisions with a moving object, 2 contact with a stationary object and only one Needle stick dangerous occurrence [potential exposure to BBV which was the biggest cause of RIDDOR reports last year with 5]. There were 11 RIDDOR incidents reported last year so a slight increase but this level of RIDDOR rate has again benchmarked considerably lower than all other comparable Trusts in the South West Region.

- Completion of our annual Health & Safety audit programme across all Departments within the Acute and Community sites. This has enabled central appraisal of Departmental risk assessments and safe systems of work and provision of feedback to Departments in order to achieve improvements.

- Trust Health & Safety Department have taken on responsibility for Site Security from Carillion Estates from November 2017 and have appointed a maintenance company to help manage the system Trust Local Security Management Specialist [LSMS] has continued to improve the service and the Trust remains committed to holding perpetrators of violent acts against our staff to account/ There were 3 custodial sentences of between 2 and 7.5 months detention for assault against our staff in 2018/18

- Fire Safety management improvements have continued during a very busy year in light of the Grenfell Towers tragedy and the resultant cladding investigations. Unwanted Fire Signal reduction [false fire alarm activations resulting in Fire & Rescue Service attendance] has also been improved by expanding the 5 minute internal investigation period and confirming if Fire Service is necessary before a call sent to 7 days per week during the dayshift period instead of just 5 working days. Significant attention on integrating the Swindon Community sites to the required fire safety levels necessary has also been a priority.

### 5.16 Expenditure on consultancy

Expenditure on consultancy in 2017/18 was £0.6m, forecast. Actual at month 11 £0.56m Consultancy advice provided to the Trust covered a number of different areas including: -

- PFI
- Governance and Well Led Review
- Sustainability & Transformation Plan (STP)
- Health Strategy Support
- Coding Review
- VAT services

## 5.17 Off Payroll Engagements

### TABLE 1: For all off-payroll engagements as of 31 March 2018, for more than £245 per day and that last longer than six months

| | Number |
|---|---|
| No. of existing engagements as of 31 March 2017 | 0 |
| Of which: | |
| No. that have existed for less than one year at time of reporting | 0 |
| No. that have existed for between one and two years at time of reporting | 0 |
| No. that have existed for between two and three years at time of reporting | 0 |
| No. that have existed for between three and four years at time of reporting | 0 |
| No. that have existed for four or more years at time of reporting. | 0 |

### TABLE 2: 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

| | Number |
|---|---|
| No. of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018 | 6 |
| Of which: | |
| Number assessed as within the scope of IR35 | 5 |
| Number assessed as not within the scope of IR35 | 1 |
| Of which: | |
| Number engaged directly (via PSC contracted to trust) and are on the Trust's payroll | 0 |
| Number of engagements reassessed for consistency / assurance purpose during the year | 6 |
| Number of engagements that saw a change to IR35 status following the consistency review | 0 |

### TABLE 3: For any off-payroll engagements of Board members, and/or senior officials with significant financial responsibility between 1 April 2016 and 31 March 2017

| | Number |
|---|---|
| No. of off payroll engagements of Board members, and/or senior officials with significant financial responsibility during the financial year | 0 |
| No. of individuals that have been deemed "Board members, and/or senior officials with significant financial responsibility" during the financial year. This figure must include both off-payroll and on-payroll engagements | 18 |

## 5.18 Reporting on Compensation Scheme and Exit Packages

### TABLE 1 Foundation trusts are required to disclose summary information of their use of exit packages agreed in the year

| | Number of compulsory redundancies | Cost of compulsory redundancies | Number of other departures agreed | Cost of other departures agreed | Total number of exit packages | Total cost of exit packages | Number of departures where special payments have been made | Cost of special payment element included in exit packages |
|---|---|---|---|---|---|---|---|---|
| Exit package cost band | Number | £000s | Number | £000s | Number | £000s | Number | £000s |
| <£10,000 | 2 | 9 | | | | 2 | 9 | |
| £10,00 – £25,000 | 1 | 21 | | | | 1 | 21 | |
| £25,001 – £50,000 | 1 | 39 | | | | 1 | 39 | |
| £50,001 – £100,000 | 2 | 161 | | | | 2 | 161 | |
| £100,000 – £150,000 | | | | | | | | |
| £150,001 – £200,000 | | | | | | | | |
| Total | 6 | 230 | 0 | 0 | 0 | 6 | 230 | 0 |

### TABLE 2 This note discloses the number of non-compulsory departures which attracted an exit package in the year, and the values of the associated payment(s) by individual type.

| | 2017/18 | 2017/18 |
|---|---|---|
| | Payments agreed | Total value of agreements |
| | Number | £000 |
| Voluntary redundancies including early retirement contractual costs | | |
| Mutually agreed resignations (MARS) contractual costs | 5 | 217 |
| Early retirements in the efficiency of the service contractual costs | | |
| Contractual payments in lieu of notice | | |
| Exit payments following Employment Tribunals or court orders | | |
| Non-contractual payments requiring HMT approval * | 1 | 20 |
| **Total** | 6 | 237 |
| Of which:<br>non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary | 0 | 0 |

## 5.19 IR35 Update

IR35 is also known as ‘intermediaries legislation’. It’s a set of rules that affects a workers Tax and National Insurance contributions if a worker is contracted to work for a client through an intermediary.

The intermediary can be:

- your own limited company
- a service or personal service company
- a partnership

Following a consultation process the following changes came into force on 6 April 2017:

- Responsibility for determining IR35 status will sit with the end user (the Trust).
- In instances where it is determined that IR35 applies, the entity paying the intermediary will be required to deduct the appropriate amount of income tax and National Insurance Contributions (NIC’s) before paying the worker.
- The liability for any unpaid tax and NI contributions sits with the body that pays the intermediary.

The Trust is required to use the facts of each contract or engagement to decide if IR35 applies and decided the employment status for each contract by considering what that relationship would be if there wasn’t an intermediary involved. The Trust completes a check via the Gov.Uk website on a case by case basis.

## 5.20 Staff Survey Report 2017/18

As one of the 309 participating NHS organisations, in October 2016 the Trust made the decision that all staff employed would be given the opportunity to participate in the 2017 Staff Survey. This was also the first year Swindon Community Health Division took part in the Trust's survey. A total of 2446 employees returned a completed questionnaire giving the Trust a response rate of **46.5%.** This was a decrease in last years (49%) but above the average response rate for Combined Acute and Community Trusts in England (43%).

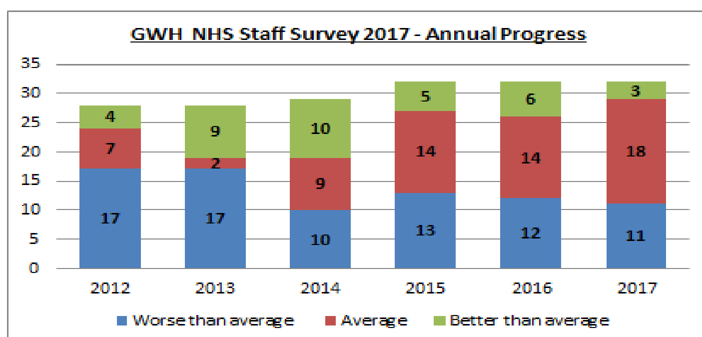
The latest NHS Staff Survey result is reflective of the current pressures and challenges facing the NHS and its workforce. This is also illustrated through a decline in the National results in relation to staff engagement from 3.80 in 2016 to 3.78 in 2017; this is comparable to the Trust's results of 3.78 in 2016 to 3.77 in 2017.

Despite the extreme pressures, 75% of GWH staff continues to remain enthusiastic about their job and 85% feel that the organisation acts fairly regarding career progression. These scores are significantly better than other similar organisations.

The Trust's overall position has declined compared with last year. This year the Trust is ranked 16th when benchmarking performance against organisations from across the South West (Appendix 1). The Trust was ranked 12th in 2016 and 10th in 2015, University Hospitals Bristol NHSFT, Royal Berkshire NHSFT and Royal United Hospital Bath NHS Trust have all improved their performance this year and moved ahead of the Trust. Oxford University Hospital NHSFT, Gloucestershire Hospital NHSFT and North Bristol NHS Trust remain below the Trust.

The Trust's annual staff survey performance is illustrated below for the period 2012 to 2017. The Trusts results for performing better than average has significantly decreased since 2013/2014 however, the number of areas where the Trust has performed worse than average has also reduced. It can be identified that overall the Trust's results are primarily within the average range of other Combined Acute and Community Trusts in 2017.

Annual Staff Survey Performance




Results analysis – key findings

There was one key area where staff experiences have improved since the 2016 staff survey (the organisation made adequate adjustments to me to carry out my work). There were 24 questions where the Trusts results were significantly better than other similar organisations. These questions were identified within the following sections of the staff survey 6/27 in your job, 5/11 in your managers, 10/30 in your health and wellbeing at work, 1/12 in your personal development, 1/7 in your organisation and 1/1 in background information.

The key areas where staff experiences have deteriorated since the 2016 staff survey is illustrated below,

- Staff Motivation of work
- Percentage of staff feeling unwell due to work related stress in the last 12 months
- Percentage of staff able to contribute towards improvements at work
- Staff satisfaction with level of responsibility and involvement
- Staff satisfaction with the quality of work and care they are able to deliver

### 5.21 National and regional comparisons

#### National

As one of the 309 participating NHS organisations, in October 2016 the Trust made the decision that all staff employed would be given the opportunity to participate in the 2017 Staff Survey. This was also the first year Swindon Community Health Division took part in the Trust's survey. A total of 2,446 employees returned a completed questionnaire giving the Trust a response rate of 46.5%. This was a decrease in last years (49%) but above the average response rate for Combined Acute and Community Trusts in England (43%).

The latest NHS Staff Survey result is reflective of the current pressures and challenges facing the NHS and its workforce. This is also illustrated through a decline in the National results in relation to staff engagement from 3.80 in 2016 to 3.78 in 2017; this is comparable to the Trust's results of 3.78 in 2016 to 3.77 in 2017.

Despite the extreme pressures, 75% of GWH staff continues to remain enthusiastic about their job and 85% feel that the organisation acts fairly regarding career progression. These scores are significantly better than other similar organisations.

The Trust's overall position has declined compared with last year. This year the Trust is ranked 16th when benchmarking performance against organisations from across the South West (Appendix 1). The Trust was ranked 12th in 2016 and 10th in 2015, University Hospitals Bristol NHSFT, Royal Berkshire NHSFT and Royal United Hospital Bath NHS Trust have all improved their performance this year and moved ahead of the Trust. Oxford University Hospital NHSFT, Gloucestershire Hospital NHSFT and North Bristol NHS Trust remain below the Trust.

The Trust's annual staff survey performance is illustrated below for the period 2012 to 2017. The Trusts results for performing better than average has significantly decreased since 2013/2014 however, the number of areas where the Trust has performed worse than average has also reduced. It can be identified that overall the Trust's results are primarily within the average range of other Combined Acute and Community Trusts in 2017.

#### Regional

There was one key area where staff experiences have improved since the 2016 staff survey (the organisation made adequate adjustments to me to carry out my work). There were 24 questions where the Trusts results were significantly better than other similar organisations. These questions were identified within the following sections of the staff survey 6/27 in your job, 5/11 in your managers, 10/30 in your health and wellbeing at work, 1/12 in your personal development, 1/7 in your organisation and 1/1 in background information.

The key areas where staff experiences have deteriorated since the 2016 staff survey is illustrated below,

- Staff Motivation of work
- Percentage of staff feeling unwell due to work related stress in the last 12 months
- Percentage of staff able to contribute towards improvements at work
- Staff satisfaction with level of responsibility and involvement
- Staff satisfaction with the quality of work and care they are able to deliver

| Acute Trusts (* Denotes Combined Acute & Community) | Response Rate | KF11 | KF12 | KF13 | KF20 | KF21 | KF28 | KF29 | KF30 | KF31 | KF17 | KF18 | KF19 | KF15 | KF16 | KF1 | KF4 | KF7 | KF8 | KF9 | KF14 | KF5 | KF6 | KF10 | KF2 | KF3 | KF32 | KF22 | KF23 | KF24 | KF25 | KF26 | KF27 | Total Score | Total Score % | 2016 Score |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| The Royal Bournemouth and Christchurch Hospitals NHS | 46% | G | G | G | A | G | G | G | G | G | G | G | G | G | G | G | G | G | G | G | G | G | G | G | G | G | G | G | A | A | G | G | G | 93 | 97% | 90 |
| University Hospital Southampton NHS Foundation Trust | 45% | G | G | G | A | G | G | A | G | G | G | G | G | G | G | G | G | G | G | G | G | G | G | G | G | G | G | A | G | A | G | G | R | 90 | 94% | 86 |
| Poole Hospital NHS Foundation Trust | 47% | G | G | G | A | G | R | G | G | G | G | G | G | G | G | G | G | G | G | G | G | G | G | G | G | G | G | R | A | G | A | G | G | 89 | 93% | 80 |
| Taunton and Somerset NHS Foundation Trust | 40% | G | G | G | G | G | G | A | G | G | G | G | G | G | G | G | G | G | G | G | G | G | G | G | G | G | G | R | A | A | A | G | R | 88 | 92% | 78 |
| Northern Devon Healthcare NHS Trust * | 38% | A | G | G | G | G | A | A | G | G | A | G | G | G | A | G | G | G | G | G | G | G | G | G | G | G | A | A | G | A | G | G | R | 86 | 90% | 87 |
| Royal Devon and Exeter NHS Foundation Trust | 50% | A | A | A | G | G | G | A | G | G | G | G | G | A | A | G | G | G | G | G | G | G | G | G | A | A | A | A | G | A | G | G | G | 85 | 89% | 88 |
| Royal Berkshire NHS Foundation Trust | 43% | G | G | A | R | R | G | R | G | G | G | G | A | G | A | G | G | G | G | G | G | G | G | A | G | G | G | G | G | R | G | G | A | 83 | 86% | 61 |
| Yeovil District Hospital NHS Foundation Trust | 58% | R | A | G | G | A | G | G | R | A | G | G | G | G | A | A | G | G | G | G | G | G | G | G | A | R | A | R | G | G | G | G | G | 81 | 84% | 73 |
| Salisbury NHS Foundation Trust | 46% | A | G | G | G | A | G | R | G | G | G | G | G | G | R | G | G | G | G | A | A | G | G | G | R | A | G | A | A | R | G | G | G | 81 | 84% | 86 |
| Portsmouth Hospitals NHS Foundation Trust | 59% | A | G | A | R | G | R | G | G | G | G | R | G | A | G | A | A | G | G | G | A | G | G | G | A | G | G | R | G | G | R | A | G | 78 | 81% | 77 |
| Dorset County Hospital NHS Foundation Trust | 49% | A | A | R | G | G | G | G | R | R | G | G | G | A | G | G | A | A | G | G | R | G | A | G | A | A | G | G | G | R | G | A | R | 75 | 78% | 61 |
| University Hospitals Bristol NHS Foundation Trust | 43% | R | A | R | R | G | R | G | G | R | G | G | G | R | R | G | R | G | G | G | A | G | G | A | R | A | G | G | A | A | G | G | A | 71 | 74% | 66 |
| Plymouth Hospitals NHS Trust | 57% | G | R | A | G | A | R | A | G | G | A | A | G | R | G | A | R | A | A | A | R | A | A | G | R | A | R | A | G | G | G | G | A | 68 | 71% | 57 |
| Torbay and South Devon Healthcare NHS Trust * | 37% | A | R | A | A | A | A | R | R | A | G | A | A | A | G | A | A | A | A | A | A | A | A | A | R | G | R | R | A | A | G | A | R | 61 | 64% | 73 |
| Royal United Hospital Bath NHS Trust | 45% | G | G | R | R | G | A | R | R | R | G | G | A | R | A | G | A | A | G | A | R | G | R | G | R | R | R | A | R | R | R | A | A | 59 | 61% | 60 |
| Great Western Hospitals NHS Foundation Trust * | 46% | R | A | A | A | A | R | G | A | G | A | R | A | A | R | A | A | A | A | R | R | A | R | A | R | R | A | A | A | G | R | R | A | 56 | 58% | 70 |
| Oxford University Hospitals NHS Trust | 39% | R | A | R | R | R | A | R | A | R | R | R | A | G | R | A | R | A | R | R | R | A | G | A | R | R | R | G | A | R | G | R | R | 49 | 51% | 80 |
| Royal Cornwall Hospitals NHS Trust | 56% | A | R | R | G | A | R | G | R | R | A | G | R | R | R | R | R | R | R | A | R | R | R | A | R | A | R | R | G | G | A | R | R | 49 | 51% | 41 |
| Gloucestershire Hospitals NHS Foundation Trust | 47% | A | R | R | A | A | A | R | R | R | A | R | R | R | G | R | R | R | R | R | R | R | R | R | R | R | R | R | G | G | R | A | A | 45 | 47% | 45 |
| North Bristol NHS Trust | 46% | R | R | R | G | A | R | R | R | R | R | R | R | R | G | R | R | R | R | R | R | R | R | R | R | R | R | R | A | A | A | A | G | 43 | 45% | 38 |
| Weston Area Health NHS Trust | 45% | R | R | A | R | R | R | G | R | R | R | R | R | R | A | R | R | R | R | A | R | R | R | R | R | R | R | R | R | A | R | R | G | 40 | 42% | 47 |
| Average | 47% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 70 | 73% | 69 |

| Mental Health & Learning Disabilities Trusts (* Denotes Combined MH/LD & Community) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Total Score | Total Score % | 2016 Score |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Dorset Healthcare University NHS Foundation Trust* | 49% | A | G | G | G | G | G | A | G | A | G | G | G | A | A | G | G | G | G | G | G | G | G | G | G | G | G | G | G | R | G | G | R | 87 | 91% | 81 |
| Berkshire Healthcare NHS Foundation Trust* | 46% | A | G | G | R | R | G | A | G | G | G | G | G | G | R | G | G | A | G | G | G | G | G | A | A | G | G | G | A | R | G | A | R | 79 | 82% | 79 |
| 2Gether NHS Foundation Trust | 40% | G | A | A | G | A | G | G | G | G | G | G | G | G | A | G | G | G | G | A | G | A | A | A | A | G | R | G | G | R | A | R | R | 78 | 81% | 78 |
| Devon Partnership NHS Trust | 62% | A | A | R | G | G | A | A | A | G | A | G | G | G | G | A | A | A | A | G | A | G | A | G | R | R | R | G | G | A | G | A | G | 74 | 77% | 74 |
| Oxford Health NHS Foundation Trust* | 50% | R | G | A | A | A | R | R | A | G | A | A | A | A | R | G | A | A | A | A | R | G | A | A | R | A | G | A | G | A | A | R | R | 62 | 65% | 64 |
| Cornwall Partnership NHS Foundation Trust* | 41% | G | A | G | G | A | G | A | R | A | R | G | R | R | R | R | G | A | A | A | A | A | A | G | R | A | R | G | G | R | R | R | R | 61 | 64% | 61 |
| Somerset Partnership NHS Foundation Trust* | 40% | A | R | R | G | G | A | A | R | A | G | A | A | A | R | A | A | R | R | A | A | R | R | R | R | R | R | A | G | R | R | A | G | 55 | 57% | 49 |
| Avon and Wiltshire Mental Health Partnership NHS Trust | 52% | A | R | R | A | A | R | R | R | R | R | A | R | A | A | R | R | R | R | R | R | R | R | A | R | R | R | A | A | A | R | R | A | 43 | 45% | 50 |
| Average | 48% | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 67 | 70% | 67 |

### 5.22 Survey 2017 - Divisional Results

Each Division has seen either in increase or decline in their results for this year. The Divisions who have identified improvements are Women's, Children and Sexual Health and Planned Care Division, the Divisions who have seen a decline in results are Corporate Services and Unscheduled Care.

| Key Heading | WHC | WCSH | PC | SCH | D&O | CS | USC |
|---|---|---|---|---|---|---|---|
| Your Job | A | G | A | A | R | R | R |
| Your Managers | G | G | G | A | A | R | R |
| Health and Wellbeing / Safety at Work | A | A | A | A | A | A | R |
| Personal Development | G | G | G | A | R | A | R |
| Your Organisation | G | A | G | R | A | A | R |
| Average Change per Question | 1.80% | 3.10% | 2.50% | -1.60% | -2.90% | -3.20% | -6.20% |

### 5.23 Results analysis – key findings

**Areas that require improvement**

There was one key area where staff experience has improved since the 2016 staff survey (the organisation made adequate adjustment(s) to enable me to carry out my work), and of the 88 questions 24 were significantly better than other similar organisations. However, the results have deteriorated since the 2016 survey and highlight some areas that are experienced challenges and some that need improvement.

| **Key Area** | **2015 Score** | **2016 Score** | **2017 Score** | **Change** (from previous year) |
|---|---|---|---|---|
| Staff motivation at work *(the higher the score the better)* | 4.09 | 4.02 (out of 5) | 3.93 (out of 5) | 0.09 |
| Percentage of staff feeling unwell due to work related stress in the last 12 months *(the lower the score the better)* | 36% | 33% | 38% | 5 |
| Percentage of staff able to contribute towards improvements at work *(the higher the score the better)* | 77% | 74% | 69% | 5 |
| Staff satisfaction with level of responsibility and involvement *(the higher the score the better)* | 3.97 | 3.95 (out of 5) | 3.88 (out of 5) | 0.07 |
| Staff satisfaction with the quality of work and care they are able to deliver *(the higher the score the better)* | 3.91 | 3.88 (out of 5) | 3.75 (out of 5) | 0.13 |

This year, GWH performed above average in 3 of the 32 Key Findings of the survey results, average in 18 and worse than average in 11 areas. Whilst we have seen a decline in GWH results it can be identified that overall the Trust's results are primarily within the average range against other Combined Acute and Community Trusts in 2017.

The staff engagement score for the Trust is 3.77 and continues to be high with the Trust scoring marginally below the national average (3.78). The areas used to measure the staff engagement score is based on staff recommending the organisation as a place to work or receive treatment, staff motivation at work and staff ability to contribute towards improvements at work. Whilst the Trusts staff engagement score has reduced slightly this year (previously 3.84 in 2016), this result is higher than the results of six other Trusts in the South West region.

Despite the extreme pressures, 75% of GWH staff continues to remain enthusiastic about their job and 85% feel that the organisation acts fairly regarding career progression. These scores are significantly better than other similar organisations. However, it is important to recognise that the results have declined since last year. It is evident from the results that staff are feeling under-resourced which can be linked to our recruitment challenges in some departments and this is likely to have impacted negatively on staff morale. GWH will continue to develop our recruitment and retention strategy to support with the vacancy position.

2017 was a very busy year at GWH and this has placed additional pressures on our staff who continue to go above and beyond what is expected of them to ensure the best possible experience for our patients. The health and wellbeing of our staff remains a priority, we will continue to work with our staff to create new initiatives to improve staff health and wellbeing including taking action against those who bully or harass staff.

### 5.24 Summary of staff survey results

## Table - Response Rate

| | **2016/17 (previous year)** | | **2017/18 (current year)** | | **Trust improvement / deterioration** |
|---|---|---|---|---|---|
| | Trust | Benchmarking group (trust type) average | Trust | Benchmarking group (trust type) average | |
| Response rate | 49% | 44% | 46.5% | 43% | 2.5% deterioration |

## Table – Summary of Performance

Those areas where the Trust has performed highly in comparison to the National results can be seen in the table below as well as those areas where further improvement is required.

The response rate in 2017/18 was 46.5% compared with 49% in 2016/17.

Results scores range between 1 being the lowest to 5 being the highest.

| **Top 5 ranking scores** | | | | |
|---|---|---|---|---|
| | **2017/17 (previous year)** | **2017/18 (current year)** | | **Trust improvement / deterioration** |
| | **Trust** | **Trust** | Benchmarking group (trust type) average | |
| Staff motivation at work<br>*(the higher the score the better)* | 4.01 | 3.74 | 3.67 | Deterioration |
| % of staff feeling unwell due to work related stress in the last 12 months<br>*(the lower the score the better)* | 33% | 72% | 67% | Improvement |
| % of staff reporting errors, near misses or incidents witnessed in the last month<br>*(the higher the score the better)* | 93% | 92% | 91% | Deterioration |
| % of staff / colleagues reporting most recent experience of harassment, bullying or abuse<br>*(the higher the score the better)* | 48% | 48% | 47% | No change |
| Staff confidence and security in reporting unsafe clinical practice<br>*(the higher the score the better)* | 3.75 | 3.76 | 3.73 | No change |

| Bottom 5 ranking scores | | | | |
|---|---|---|---|---|
| | **2016/17 (previous year)** | **2017/18 (current year)** | | **Trust improvement / deterioration** |
| | **Trust** | **Trust** | Benchmarking group (trust type) average | **Trust** |
| Staff satisfaction with resourcing and support *(the higher the score the better)* | 3.22 | 3.15 | 3.27 | 3.22 |
| % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months *(the lower the score the better)* | 30% | 31% | 27% | 30% |
| Staff satisfaction with the quality of work and care they are able to deliver *(the higher the score the better)* | 3.88 | 3.75 | 3.90 | 3.88 |
| Effective team working *(the higher the score the better)* | 73% | 75% | 71% | 73% |
| % of staff witnessing potentially harmful errors, near misses or incidents in the last month *(the lower the score the better)* | 91% | 89% | 90% | 91% |

### 5.25 Next steps / summary of actions / priorities for 2018/19

The feedback provided from our staff needs to be acted on and a short and longer term strategy will be adopted.

**Short Term:** Each Division develops a local action plan focusing on **3** key areas which will make the most impact based on the results for the Division. For Divisions to promote a 'listening into action' approach, empowering staff to be involved and contribute towards improvements in their Divisional staff survey results. It is recommended that Divisional action plans are developed and owned by key members of the Division and identified through listening groups to encourage staff involvement.

**Long Term:** The development of a Trust wide approach focusing on the big themes, **working with staff** to identify what actions need to be taken through 'big conversations. The key areas are:

- **Senior Management/Staff Engagement** – improving communication between senior management and staff, enabling and empowering staff to be involved and contribute towards improvements in patient experience and their own working environments
- **Resources** – continue to develop our recruitment and retention strategy to support with the vacancy position and to address the general equipment/resources issues identified by staff. Develop our communication strategy to ensure there is a clear understanding of establishments and temporary staff usage and a link to safer staffing.
- **Health and Wellbeing (**including Bullying and Harassment from Patient and members of the public/staff) – engaging staff in creating new initiatives to improve staff health and wellbeing and taking action against those who bully or harass staff

A positive improvement in these areas will have a direct impact on improving staff engagement and morale.

# 6. NHS Foundation Trust Code of Governance

## 6.1 Council of Governors

As an NHS Foundation Trust we have established a Council of Governors, which consists of up to 22 elected and nominated Governors who provide an important link between the Trust, local people and key stakeholders by sharing information and views that can be used to develop and improve health services. The Council of Governors is a valued part of the Trust's decision making processes to ensure that the Trust reflects the needs and wishes of local people. The Council of Governors also has the following roles and responsibilities: -

To:

- appoint and remove the Chairman and Non-Executive Directors.
- decide on the remuneration, allowances and terms and conditions of office of the Non-Executive Directors.
- approve the appointment of the Chief Executive.
- appoint and remove the External Auditor.
- hold the Non-Executive Directors, individually and collectively, to account for the performance of the Board of Directors.
- represent the members' interests and bring these to bear on strategy decisions.
- approve significant transactions.
- approve the Trust's Constitution.
- input into the development of the annual plan.
- receive the Annual Report and Accounts and the Auditor's opinion on them.

The Council of Governors has a duty to represent the views of foundation trust members and stakeholders, to the Board of Directors and the management of the Trust. The Trust keeps the Council of Governors fully informed on all aspects of the Trust's performance. This is done through formal Council meetings, and through working groups set up by the Council of Governors. These are explained below in this section.

During 2017/18 the Council of Governors carried out or was involved in the following: -

- Annual reviews of the Chairman and Non-Executive Directors performance.
- The appointment of one new Non-Executive Director (Paul Lewis).
- The re-appointment of two Non-Executive Directors
- Holding the Non-Executive Directors to account on a number of issues such as cleanliness and food hygiene, nursing in the community and financial management.

In 2017/18 the Council of Governors did not exercise its power to require one or more of the Directors to attend a Governors' meeting for the purpose of obtaining information about the Foundations Trust's performance of its function or the Directors' performance of their duties.

Any disagreements between the Council of Governors and the Board of Directors will be resolved following the provisions in the Trust's Constitution.

## 6.2 Members of the Council of Governors, Constituencies and Elections

Six public constituencies exist to cover the Trust's catchment area namely: -

- Swindon
- Northern Wiltshire
- Central Wiltshire
- Southern Wiltshire;
- West Berkshire and Oxfordshire
- Gloucestershire and Bath and North East Somerset

There are 12 public Governor positions (Swindon – 5, Northern Wiltshire – 2, Central Wiltshire – 2, Southern Wiltshire – 1, West Berkshire and Oxfordshire - 1, and Gloucestershire and Bath and North East Somerset – 1). In addition there are 4 elected staff Governors and 6 Governors nominated by organisations that have an interest in how the Trust is run. The number of public Governors positions must be more than half of the total membership of the Council of Governors.

Governors are elected by members of those constituencies in accordance with the election rules stated in the Trust's Constitution using the "first past the post" voting system. Elections were carried out on behalf of the Trust in 2016/17 by the independent Electoral Reform Services Ltd. In the event of an elected Governor's seat falling vacant for any reason before the end of a term of office, it shall be filled by the second (or third) place candidate in the last held election for that seat provided they achieved at least five percent of the vote and they will be known as reserve Governors.

The names of Governors during the year, including where Governors were elected or appointed and their length of appointments are set out in the following tables. The Trust held elections in all constituencies during the year for Governors whose terms of office expired and where there were vacancies.

### Elected Governors in 2017/18 – Public Constituencies

| | Name | Constituency | Date first elected | Current Term of Office (date ending) | Attendance from 5 Council of Governor meetings |
|---|---|---|---|---|---|
| 1 | Ros Thomson | Swindon | Dec-08 | 3 years *(term ends Nov-19)* | 5/5 |
| 2 | Kevin Parry | Swindon | Nov-11 | 3 years *(term ends Nov-19)* | 4/5 |
| 3 | Louise Hill | Swindon | Nov-13 | 3 years *(term ends Nov-19)* | 4/5 |
| 4 | Roger Stroud | Swindon | Nov-16 | 3 years (term ends Nov-19) | 5/5 |
| 5 | Rosemarie Phillips | Swindon | Nov-16 | 3 years (term ends Nov-19) | 5/5 |
| 6 | Pauline Cooke | Northern Wiltshire | Nov-15 | 3 years *(term ends Nov-18)* | 3/5 |
| 7 | Penny Bowen | Northern Wiltshire | Sept-16 | Remainder of 3 years *(term from Sep-16 ends Nov-18)* | 4/5 |
| 8 | Margaret White | Central Wiltshire | Jun-11 | 3 years *(term ends Nov-18)* | 4/5 |
| 9 | Janet Jarmin | Central Wiltshire | Dec-08 | 3 years *(term ends Nov-18)* | 4/5 |
| 10 | Martin Rawlinson | Gloucestershire, Bath & North East Somerset | Nov-15 | 3 years *(term ends Nov-17)* | 3/3 |
| 11 | Peter Pettit | West Berkshire & Oxfordshire | Apr-14 | 3 years *(term ends Nov-19 but resigned Jun-17)* | 1/2 |
| 12 | Bill Kingdon | West Berkshire & Oxfordshire | Jul-17 | Remainder of 3 years *(term for Jul-18 until Nov-19 but resigned Apr-18)* | 1/3 |

During 2017/18 elections were held for the Gloucestershire, Bath & North East Somerset Constituency governor seat and the Wiltshire Southern Constituency governor seat but no candidates stood.

At 31 March 2018 vacancies remained for the following public governor seats: -

- Gloucestershire, Bath & North East Somerset Constituency – 1 seat
- West Berkshire & Oxfordshire Constituency – 1 seat
- Wiltshire Southern Constituency – 1 seat

### Elected Governors in 2017/18 – Staff Constituency

| | Name | Staff Constituency – sub class | Date first elected | Current Term of Office (date ending) | Attendance from 5 Council of Governor meetings |
|---|---|---|---|---|---|
| 1 | Sarah Watts | Administrators, Maintenance, Auxiliary and Volunteers | Aug-17 | Remainder of 3 year term *(ending Nov-19)* | 2/2 |
| 2 | Peter Hanson | Doctors & Dentists | Nov-10 | 3 years *(term ends Nov-19 but retired Jun-17)* | 1/2 |
| 3 | Abdelfattah Amin Taha | Doctors & Dentist | Aug-17 | Remainder of 3 year term *(ending Nov-19)* | 2/2 |
| 4 | Claire Brooks | Allied Health Professionals | Nov-16 | 3 years *(term ends Nov-19)* | 3/5 *(absence approved)* |
| 52 | Karen Hawkins | Hospital Nursing and Therapy Staff | Nov-17 | Remainder of 3 year term *(ending Nov-19)* | 2/2 |

There are 4 staff Governor seats split into sub-classes.

In August 2017 there were uncontested elections for two vacant staff governor seats, namely the Administrators, Maintenance, Auxiliary and Volunteers governor seat, as well as the doctor and dentist governor seat Sarah Watts and Abdelfattah Amin Taha were duly elected. At that time elections were also held for the Hospital Nursing and Therapy Staff governor seat but no candidates stood.

In November 2017 there was an uncontested election for the Hospital Nursing and Therapy Staff governor seat with Karen Hawkins duly elected for the remainder of the 3 year term ending in Nov-19. The seat had been vacant.

At 31 March 2018 there were no vacancies for staff governor seats.

## Nominated Governors in 2017/18

| | Name | Nominating Partner Organisation | Date first nominated | Current Term of Office (ending date) | Attendance from 5 Council of Governor meetings |
|---|---|---|---|---|---|
| 1 | Ian James | Swindon Clinical Commissioning Group | Aug-13 | 3 years *(term end Aug-19)* | 2/5 |
| 2 | Anna Collings | Wiltshire Clinical Commissioning Group | Nov-15 | 3 years *(term ends Nov-18 but resigned Oct-17)* | 0/2 |
| 3 | | | | | |
| 4 | Brian Ford | Local Authority – Swindon Borough Council | Aug-16 | 3 years *(term end Aug-19)* | 1/5 |
| 5 | Sheila Parker | Local Authority – Wiltshire Council | Nov-14 | 3 years *(term ends Nov-17 but resigned May-17)* | 1/2 |
| 6 | Jerry Wickham | Local Authority – Wiltshire Council | Jul-17 | 3 years *(term ends Jun-20)* | 0/2 |
| 7 | David Barrand | Other Partnerships – Prospect Hospice | Feb-15 | 3 years *(term ends Nov-20)* | 3/5 |

There are 6 appointed Governor seats.

It has not been possible to secure a Governor representing Swindon & North Wiltshire Health and Social Care Academy. Therefore during 2018/19 the Trust will consider whether there is another more appropriate partner organisation.

Also during the year Anna Collings resigned in October 2017 as the Governor representing Wiltshire Clinical Commissioning Group. A replacement nomination has been sought to fill the vacancy.

Furthermore, Sheila Parker resigned in May 2017 as the Governor representing Wiltshire Council. A replacement nomination was sought to fill the vacancy with Jerry Wickham nominated in July 2017 to serve a three year term ending June 2020.

At 31 March 2018 vacancies remained for the following governor seats: -

- Swindon & North Wiltshire Health and Social Care Academy. – 1 seat
- Wiltshire Clinical Commissioning Group – 1 seat

## 6.3 Attendance at meetings of the Council of Governors during 2017/18

There were 5 meetings of the Council of Governors in 2017/18. The table below shows Governor and Board Director attendance at those meetings: -

| | **Attendee(✓ = attended X = did not attend)** | **2 Feb-17** | **20 Apr-17** | **27 Jul-17** | **9 Nov-17** | **05 Feb-18** |
|---|---|---|---|---|---|---|
| | **Governors** | | | | | |
| 1 | David Barrand | × | × | ✓ | ✓ | ✓ |
| 2 | Penny Bowen *(from Sep-16)* | × | ✓ | ✓ | ✓ | ✓ |
| 3 | Claire Brooks *(Note – absence from Council authorised)* | ✓ | ✓ | ✓ | n/a | n/a |
| 4 | Anna Collings *(resigned Oct-17)* | × | × | n/a | n/a | n/a |
| 5 | Pauline Cooke | × | ✓ | ✓ | ✓ | × |
| 6 | Brian Ford | × | ✓ | × | × | × |
| 7 | Peter Hanson *(resigned Jun-17)* | ✓ | × | n/a | n/a | n/a |
| 8 | Karen Hawkins *(from Nov-17)* | n/a | n/a | n/a | ✓ | ✓ |
| 9 | Louise Hill | ✓ | ✓ | ✓ | ✓ | × |
| 10 | Ian James | ✓ | ✓ | × | × | × |
| 11 | Janet Jarmin | × | ✓ | ✓ | ✓ | ✓ |
| 12 | Bill Kingdon *(from Jul-17 until Apr-18)* | n/a | n/a | ✓ | × | × |
| 13 | Kevin Parry | ✓ | ✓ | ✓ | × | ✓ |
| 14 | Sheila Parker *(resigned May-17)* | ✓ | × | n/a | n/a | n/a |
| 15 | Peter Pettit *(resigned Jun-17)* | × | ✓ | n/a | n/a | n/a |
| 16 | Rosemarie Phillips | ✓ | ✓ | ✓ | ✓ | ✓ |
| 17 | Martin Rawlinson *(resigned Nov-17)* | ✓ | ✓ | ✓ | n/a | n/a |
| 18 | Roger Stroud | ✓ | ✓ | ✓ | ✓ | ✓ |
| 19 | Abdelfattah Amin Taha *(from Aug-17)* | n/a | n/a | n/a | ✓ | ✓ |
| 20 | Ros Thomson | ✓ | ✓ | ✓ | ✓ | ✓ |
| 21 | Sarah Watts *(from Aug-17)* | n/a | n/a | n/a | ✓ | ✓ |
| 22 | Margaret White | ✓ | ✓ | × | ✓ | ✓ |
| 23 | Jerry Wickham | n/a | n/a | n/a | × | × |
| | **Directors** | | | | | |
| 1 | Nick Bishop | × | × | × | × | × |
| 2 | Andy Copestake | × | ✓ | × | × | ✓ |
| 3 | Oonagh Fitzgerald | × | × | × | × | × |
| 4 | Peter Hill | × | × | × | × | × |
| 5 | Roger Hill (Chair) | ✓ | ✓ | ✓ | ✓ | ✓ |
| 6 | Karen Johnson | ✓ | ✓ | × | ✓ | ✓ |
| 7 | Kevin McNamara | × | × | × | × | × |
| 8 | Jemima Milton | × | ✓ | × | ✓ | ✓ |
| 9 | Carole Nicholl | ✓ | ✓ | ✓ | ✓ | ✓ |
| 10 | Steve Nowell | × | × | × | × | × |
| 11 | Jim O'Connell *(from Oct-17)* | n/a | n/a | n/a | × | ✓ |
| 12 | Guy Rooney | × | × | ✓ | × | ✓ |
| 13 | Julie Soutter | ✓ | ✓ | × | ✓ | × |
| 14 | Nerissa Vaughan | × | × | × | ✓ | × |
| 15 | Hilary Walker | × | × | × | × | × |

### 6.4 Lead and Deputy Lead Governors

Margaret White was Lead Governor until Nov-17 and Peter Pettit was Deputy Lead Governor until Jun-17 when he resigned as a governor.

In November 2017, Roger Stroud and Pauline Cooke were appointed Lead and Deputy Lead Governor respectively. The Lead Governor is responsible for receiving from Governors and communicating to the Chairman any comments, observations and concerns expressed by Governors regarding the performance of the Trust or any other serious or material matter relating to the Trust or its business. The Deputy Lead Governor is responsible for supporting the Lead Governor in their role and for performing the responsibilities of the Lead Governor if they are unavailable. The Lead Governor regularly meets with the Chairman of the Trust both formally and informally. In addition the Lead Governor communicates with other Governors by way of regular email correspondence and Governor only sessions.

### 6.5 Council of Governors meetings structure

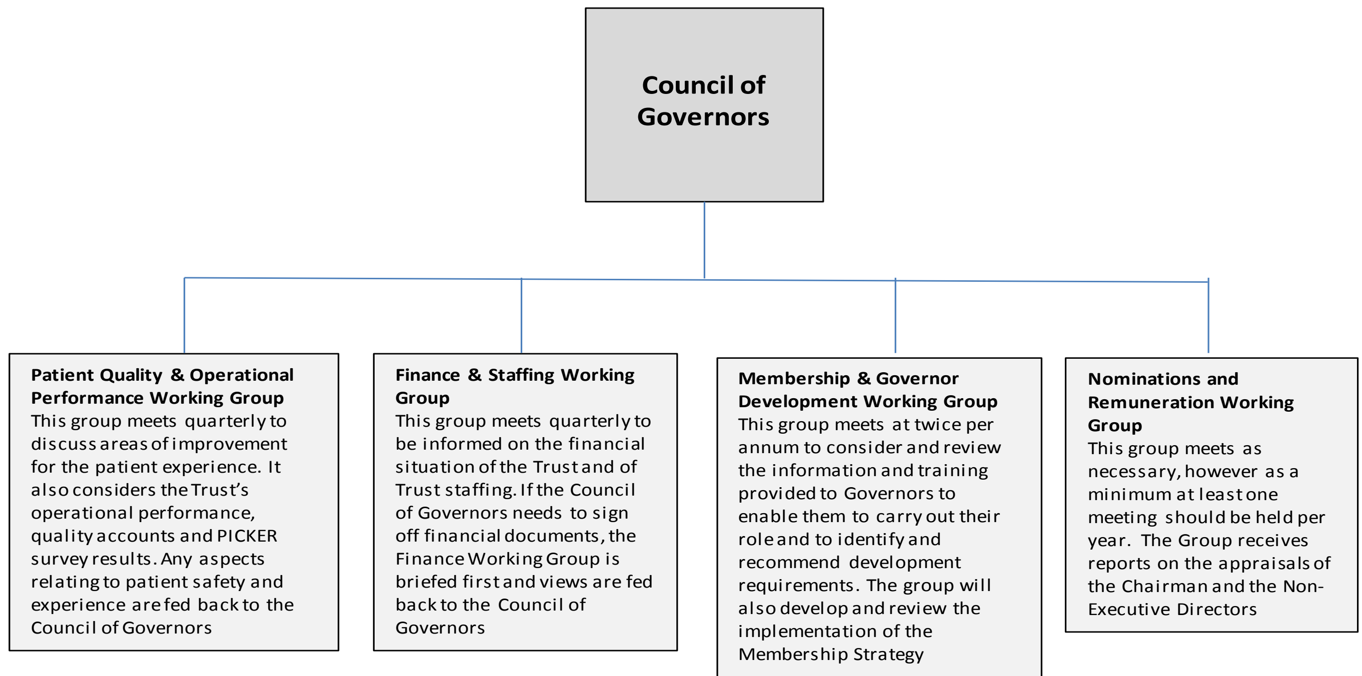
The Council of Governors has established a number of working groups which each have focussed attention for specific areas of work. During 2017/18 the following working groups were in place: -

- Patient Quality and Operational Performance Working Group
- Finance and Staffing Working Group
- Membership and Governor Development Working Group
- Nominations and Remuneration Working Group

Working groups inform Governors about activities and issues relevant to each area, thereby assuring Governors about the performance of the Board. Governors can feed in their views to inform decision making.

In addition there is a Joint Nominations Committee, established by the Council of Governors jointly with the Board of Directors, which considers nominations for Non-Executive Director appointments. The meetings structure of the Council of Governors is shown below.

***STRUCTURE – Council of Governors Meeting structure***




## 6.6 Biography of individual Governors

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

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

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

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

The Council of Governors has specific statutory powers and duties as set out above in this report.

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

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

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

**Non-Executive Director attendance at Council of Governors meetings** – During 2017/18 Non-Executive Directors attended Council of Governor meetings which enabled them to listen to Governors' concerns and to respond to any questions raised.

**Presentations to the Council of Governors by Non-Executive Directors** - Non-Executive Directors in their capacity as Chairs of Board Committees made presentations to the Council of Governors on the role and work of those Committees which provided an opportunity for Governors to express their views and question the Non-Executive Directors on the performance of the Board. Specifically, presentations were made regarding the work of the Finance and Investment Committee, the Audit, Risk and Assurance Committee and the Quality and Governance Committee.

**Joint Board of Directors and Council of Governors training** – Joint training for Non-Executive Directors and Governors (with Executive Directors invited) on the role and work of individual directorates within the Trust continued to be rolled out in 2017/18. The joint training provides an opportunity for the Non-Executive Directors to engage with the Governors and to better understand their views and concerns.

**Public health talks** – To provide forums for members to meet Governors, public health talks were introduced some years ago and are continuing. Members and the public are invited to attend public presentations and talks on a specific health topic and thereafter meet Governors and share thoughts and views on healthcare generally or on their experience in the Trust. In 2017/18 four public health lectures were held as follows: -

- Breast Cancer (Oct-17)
- Dizziness (Dec-17)
- Gynaecology (Feb-18)
- Obstructive sleep apnoea (Mar-18)

These continue to be well attended and welcomed by local people.

**Questions from governors and members of the public** – Questions and responses from governors and members of the public are reported through the Board and Council of Governors. This provides an opportunity to consider if further focus or action is needed to any issues raised. Questions relate to any Trust business.
**Council of Governors effectiveness review –** An effectiveness review of the Council of Governors was held in January 2018, led by the Chairman and Director of Governance & Assurance. Non-Executive Directors were

invited to join the review. The review resulted in a refresh of the work of the Council of Governors in terms of an updated work plan and a new approach to how Executive Directors report into the Council of Governors.

**Governor Working Groups / Non-Executive Directors aligned –** As referred to elsewhere in this section; there are a number of working groups of the Council of Governors, the work of which is supported by staff and directors. The joint working results in effective communication between the staff, Directors and Governors. Governors have an opportunity to input directly into the workings of the Trust either through working groups or through non-executive directors. On request, Non-Executive Directors may attend meetings of working groups to provide information and receive feedback from Governors directly. Non-Executive Directors are aligned to Working Groups providing a clear link for Governors to hold Non-Executive Directors to account individually and collectively for the performance of the Board.

**Additional briefing sessions** – The Council of Governors has received additional presentations and briefings on specific topics, such as the Care Quality Commission compliance framework and Adult Safeguarding.

**Governor walkabouts and visits** – The Governors undertake regular visits around the hospital to help them understand how different areas work and what there issues and successes might be. This provides governors with the necessary knowledge to understand information presented to them and to see work in practice. Governors also have the opportunity to talk to staff, patients and family which enables them to capture feedback to forward to the Board or to inform questions they might ask about Trust services.

**Annual Members Meeting** – In September 2017 an Annual Members Meeting was held in Swindon. The annual report and accounts were presented and a briefing given on the overall performance of the Trust in the previous year. This meeting allowed an opportunity for Governors to address members, seek questions on Trust business and provide feedback to the Board of Directors.

**Chairman** – The Chairman of the Trust and the Director of Governance & Assurance meet monthly with the Lead and Deputy Lead Governors to discuss their views on any matters currently being considered. The Lead and Deputy Lead Governors are representatives of the Council of Governors. Their advice and input is incorporated into the decision making process via the Chairman. The Lead and Deputy Lead Governor are able to feedback additional information on the workings of the Trust to other governors. The Lead and Deputy Lead Governors have introduced pre-meetings with Governors prior to the Council of Governor meetings to enable additional time to think about information and questions and discuss any areas of concern.

**South West Governor Exchange Network** - In 2017/18 Governor representatives attended the South West Governor Exchange Network events. These provide useful information to Governors and enable them to network with Governors from other trusts.

**Governor involvement in events / activities –** Governors are invited to attend a number of events throughout the year which allows them to be directly involved in the work of the Trust and to influence the decisions being made. A few examples in 2017/18 were: -

- Governor representative on the End of Life Committee
- Governor involvement in fundraising for Brighter Futures
- Governor representative on the Organ Donation Committee
- Governor representation at the Medical Revalidation Committee

### 6.9 Non-Executive Director Allowances and Annual Reviews – Nominations and Remuneration Working Group

The Nominations and Remuneration Working Group considers the performance of the Chairman and the Non-Executive Directors and determines their level of remuneration. The Working Group consists of five governors. The Chairman with the Senior Independent Director attend meetings as requested, namely to present their reports on the review of the Non-Executive Directors and the Chairman respectively.

The Working Group has established the process for review of the Chairman and the Non-Executive Directors and it considers reports from the Chairman and the Senior Independent Director on performance during the year.

The Working Group met once in 2017/18 to undertake the annual performance review of the Chairman and Non-Executive Directors. The pay arrangements for Non-Executive Directors were originally fixed at Authorisation in December 2008 to reflect foundation trust responsibilities. A remuneration increase was awarded during 2014 to reflect rates elsewhere. The rates were again reviewed in 2017/18 but no changes were made to the allowances. Further information about the remuneration of the Non-Executive Directors can be found in this report (section 4.10 refers).

### 6.10 Interests of Governors

Governors are required to declare any interests which are relevant and material to the business of the Trust; pecuniary interests in any contract, proposed contract or other matter concerning the Trust; and family interests of which the Governor is aware, irrespective of whether the interests are actual and potential, direct or indirect.

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

### 6.11 Non-Executive Director Appointments – Joint Nominations Committee

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

### 6.12 The work of the Joint Nominations Committee in discharging its responsibilities

In 2017/18 the Committee met three times during the year to consider existing Non-Executive Director re-appointments and new Non-Executive Director appointments and thereafter to consider feedback from interviews and recommend candidates for appointment to the Council of Governors.

When the Chairman or a Non-Executive Director reaches the end of their current term and being eligible wishes to be reappointed, the Joint Nominations Committee may nominate the individual for such reappointment without competition, subject to the Committee taking into account the result of any review of the individual's performance during their term of office and the balance of skills required on the Board of Directors.

The Joint Nominations Committee consists of the Chairman, two Non-Executive Directors and four Governors, hence a majority of Governors as required by the Code of Governance when nominating individuals for appointment

Expressions of interest for new Non-Executive Directors are invited by way of formal applications in response to open advertising. Candidates are shortlisted and interviewed by a panel consisting of Governors and Non-Executive Directors. The outcome of the panel interview is considered by the Joint Nominations Committee which recommends candidates for appointment to the Council of Governors.

During 2017/18 the Joint Nominations Committee re-appointed Steve Nowell and Julie Soutter as Non-Executive Directors each for a further term of 3 years. Furthermore, the Committee appointed Paul Lewis as a Non-Executive Director who took up post on 1 April 2018.

## 6.13 Attendance at the Joint Nominations Committee Meetings during 2017/18

| **Joint Nominations Committee Members** | Record of attendance at each meeting<br>✓ = Attended<br>✗ = Did not attend<br>n/a = not applicable as not member at that time | | |
|---|---|---|---|
| | 20 April 2017 | 12 October 2017 | 26 January 2018 |
| Roger Hill – Chairman | ✓ | ✓ | ✓ |
| Julie Soutter – Non-Executive Director | ✓ | ✗ | ✗ |
| Jemima Milton – Non-Executive Director | ✓ | ✓ | ✓(substitute for Julie Soutter) |
| Pauline Cooke – Governor | ✓ | ✓ | ✓ |
| Martin Rawlinson – Governor | ✓ | ✗ | ✗ |
| Peter Pettit– Governor | ✓ | ✗ | ✗ |
| Margaret White – Governor | ✓ | ✗ | ✓ |
| Steve Nowell – Non-Executive Director | n/a | ✓ (substitute for Julie Soutter) | ✓ |
| Bill Kingdon – Governor | n/a | (substitute for Martin Rawlinson) | n/a |
| Roger Stroud – Governor | n/a | n/a | ✓ |

Note: Non-Executive Directors are appointed to the Committee by the Board and Governors are appointed by the Council of Governors.

The Committee is chaired by a Governor when considering Chairman and Non-Executive Director appointments.

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

## 6.14 Membership

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

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

Members can only be a member of one constituency, therefore local people and patients can only be a member of one public constituency. Staff can only be members of one sub-class in the staff constituency. Members are able to vote and stand in elections for the Council of Governors provided they are 18 years old and over.

## 6.15 Public Members

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

Public members fall into constituencies based on where they live. The constituencies are periodically reviewed to ensure they reflect the Trust's geographical area and populations.

- Swindon
- North Wiltshire
- Central Wiltshire
- Southern Wiltshire
- West Berkshire and Oxfordshire
- Gloucestershire and Bath and North East Somerset

## 6.16 Staff Members

Staff members include Trust employees, Carillion Health employees and volunteers. The Trust has strong links with the local community, with over 360 volunteers. Staff automatically become members when:

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

Trust staff may opt out of membership if they wish.

The Trust has a wide range of staff undertaking a variety of roles and in a variety of professions, split into the following sub classes to reflect occupational areas: -

- Hospital Nursing and Therapy Staff
- Allied Health Professional
- Doctors and Dentists
- Administrators, Maintenance, Auxiliary and Volunteers

Details are contained elsewhere in this report section 6.2.2 refers.

### 6.17 Membership analysis

Being a member of our Foundation Trust gives local people opportunities to become involved and have their say in how our services are developed.

During the year, the Trust continued to recruit members. As at 31 March 2018, the membership of the Great Western Hospitals NHS Foundation Trust was as follows: -

| Total Number of Members across all Constituencies | 2016/17 | 2017/18 |
|---|---|---|
| Swindon | 3,334 | 3,149 |
| North Wiltshire | 1,335 | 1,274 |
| Central Wiltshire | 584 | 553 |
| Southern Wiltshire | 182 | 177 |
| West Berkshire and Oxfordshire | 361 | 342 |
| Gloucestershire and Bath and North East Somerset | 385 | 368 |
| Staff | 6,495 | 7,039 |
| **TOTAL** | **12,676** | **12,902** |

This shows an increase in overall membership of 226 (1.78% increase which is a deterioration on last year's increase of 7.8%)

| Public Constituency | 2016/17 | 2017/18 | 2018/19 *(aim is to maintain current numbers)* |
|---|---|---|---|
| At year start (1 April) | 5,371 | 6,185 | 5,863 |
| New Members | 992 | 43 | 365 |
| Members leaving | 182 | 365 | 365 |
| At year end (31 March) | **6,181** | **5,863** | **5,863** |

This shows a decrease in public members of 318 (5.14%)

| Staff Constituency | 2016/17 | 2017/18 | 2017/18 *(estimate based on 2016 staffing fluctuations* |
|---|---|---|---|
| At year start (1 April) | 6,386 | 7,103 | 7,039 |
| New Members | 1,290 | 1,692 | 1,290 |
| Members leaving | 1,181 | 1,756 | 1,181 |
| At year end (31 March) | **6,495** | **7,039** | **7,148** |

This shows an increase in staff members of 544 (8.37% increase)

The estimate for 2018/19 public members is based on an aim to ensure that the public membership does not deteriorate further. Regard has also been given to membership recruitment drives planned to take place in 2018/19 and an initiative to retain former staff as members, provided they meet the eligibility criteria.

The estimate for 2018/19 staff members is based on the 2016/17 actuals rather than 2017/18, because during 2017/18 there were unusual changes to staff numbers through the TUPE transfer of staff.

## 6.18 Numbers of members by age ethnicity and gender

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

| Age | 2016/17 | 2017/18 |
|---|---|---|
| 0-16 | 2 | 2 |
| 17-21 | 155 | 103 |
| 22+ | 5,967 | 5,716 |
| Unknown | 57 | 52 |
| **Total** | **6,181** | **5,863** |

| Ethnicity | 2016/17 | 2017/18 |
|---|---|---|
| White | 3,733 | 3,554 |
| Mixed | 26 | 26 |
| Asian or Asian British | 151 | 151 |
| Black or Black British | 54 | 51 |
| Other | 27 | 27 |
| Unknown | 2,190 | 2,057 |
| **Total** | **6,181** | **5,863** |

| Gender | 2016/17 | 2017/18 |
|---|---|---|
| Male | 2,177 | 2,053 |
| Female | 3,441 | 3,291 |
| Unspecified | 563 | 519 |
| **Total** | **6,181** | **5,863** |

The Trust uses information from the Office of National Statistics (Census 2012) to build up a picture of the population size and ethnicity for each constituency. This helps the Trust in its aims to make the membership reflective of its population. The Trust has also determined the socio-economic breakdown of its membership and the population from its catchment area.

## 6.19 Building a strong relationship with our members / engagement and canvassing views

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

The Trust fulfils this aim by communicating and engaging with members via the Trust's electronic newsletter, News in Brief, and hosting members' briefings and events such as monthly Public Health Talks. The Trust's website provides regular updates and information on meetings and events. The Trust has a Governance Officer position responsible for membership, to answer any questions from members or to provide additional information.

Examples of opportunities for engagement in 2017/18 included: -

- Public Health Talks (topics include Diabetes, Women's Health and the Deteriorating Patient)
- Governors talking to members and the public at local community events
- Public and member attendance at Council of Governor Meetings
- Mailings about upcoming events
- Direct mailings about key milestones or good news stories

Governors are reminded to canvass the opinion of members and the public and for nominated Governors, the organisations they represent on the Trust's operational plan, including its objectives, priorities and strategy. Views from governors feed into strategy development. For example, Governors' views were sought by the Board at the meeting of the Council of Governors held in February 2017, where an open discussion on proposals around community care in Swindon took place. Earlier in 2016/17 Governors' views were incorporated into strategic planning around Swindon 0Community Health Services.

Mailings to members have been sent out regarding Equality and Diversity, Swindon Radiotherapy Centre updates and newsletters to support the Brighter Future charity appeals, CQC Inspection Feedback and advertising Governor recruitment and Non-Executive Director vacancies.

## 6.20 Membership Strategy

To encourage membership, the Trust has in place a Membership Strategy which is reviewed annually to ensure that it reflects the needs of the members. The latest Membership Strategy focuses on how the Trust plans to engage and offer more to our existing members.

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

### 6.21 Membership development in 2017/18

In order to build a representative membership during 2017/18 the Trust undertook the following: -

- Recruitment drives in the hospital atrium
- An Annual Members Meetings was held in September 2017
- The Governance Officer attended various school and college careers events within the area
- Public health talks were increased from quarterly to monthly to respond to the needs of the population with topics discussed such as dizziness, female cancers, obesity, and sleep apnoea. Memberships stall were available at each to encourage membership sign up.
- Hospital information stands about the foundation trust model and recruitment of new members to seek their views on service improvements and developments.

The membership application form has been widely circulated with Governors taking a proactive approach to handing out forms in the community and engaging directly with members of the public at any social events, e.g. promoting the Trust through writing articles in local newspapers.

The Governance Officer hosts a stall in the atrium of the Great Western Hospital on a monthly basis talking to visitors and patients and recruiting new members.

### 6.22 Membership recruitment proposed for 2016/17

#### Engagement with existing forums

A Governance Administrator accompanied by governors will continue to engage with existing forums, such as parish and town councils, sports teams, carers groups etc. by attending meetings and presenting to them information about membership and encouraging new members.

#### Youth Membership Drive

A Governance Administrator will continue to develop and work with contacts within youth groups who are likely to be interested in the future of the hospital. Engagement with GCSE and A Level students is planned, working alongside the Trust's Academy. In addition there will be some focussed work on young person's transitioning into adult care and young carers.

A Governance Administrator will attend careers events along with the NHS Careers team to better engage and recruit members. Students will receive a presentation on the structure of foundation trusts, tied in with the politics and funding of healthcare. This will be an opportunity to increase our membership of younger people.

#### News In Brief

The Trust's quarterly newsletter 'News in Brief' is sent to members electronically.

#### Public Health Talks

A series of public health talks on a variety of topics is planned, with the Governance Officer in attendance to recruit new members.

#### Annual Members Meeting

An annual members meeting is planned to update existing members on issues affecting the Trust. This will be an opportunity to recruit new members as emphasis will be placed on advertising the meeting throughout the community.

#### Approach to large local employers

The Trust will continue to work with large local employers to promote membership, to send out health messages and hopefully attract more businesses to sign up to support the Trust.

### 6.23 Contacting the Governors and Directors

If any constituency member or member of the public generally wishes to communicate with a Governor or a Director they can do so by emailing the Foundation Trust email address: foundation.trust@gwh.nhs.uk. This email address is checked daily by the Governance Officer who will forward the email to the correct Governor and/or Director. Alternatively a message can be left for a Governor by ringing the Governance Officer on 01793 604185 or for a Director by ringing the Company Secretary on 01793 605171 or by sending a letter to:
Company Secretary, the Great Western Hospital, FREEPOST (RRKZ-KAYR-YRRU), Swindon, SN3 6BB.

### 6.24 Code of Governance Disclosure Statement

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

The Great Western Hospitals 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 Trust has been compliant with the Code with the exception of the following: -

B.6.2 The Code states that evaluation of the boards NHS foundation trusts should be externally facilitated every three years. The evaluation needs to be carried out against the board leadership and governance framework set out by Monitor. 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. During 2017/18 this did not take place, however in April 2018 an independent external facilitated supported the Board in its evaluation of strategy formulation.

D.2.3 The Code states that the Council of Governors 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. However, in view of the costs associated with this, the Council of Governors resolved that instead the Director of Human Resource should undertake a benchmarking exercise. During 2017/18 consideration was given to the remuneration levels of the non-executive directors using benchmarking date and no changes were made.

Compliance with the Code of Governance is monitored through the Trust's Quality and Governance Committee.

Other disclosures required under the Code of Governance are included in the Director's Report and the Remuneration Report.

## 6.25 Audit Committee Annual Report 2017/18

### Introduction

On behalf of the Audit, Risk & Assurance Committee (ARAC), I am delighted to present the Committee's Annual Report. The Committee operates under a Board delegation and approved Terms of Reference. It comprises three Non-Executive Directors, has met six times during the period and has reported to the Board and Council of Governors on its activities. The Committee also provides assurance in relation to the Annual Governance Statement made by the Trust's Chief Executive (CE) as Accountable Officer (AO) in respect of Great Western Hospitals NHS Foundation Trust for the year ending 31 March 2018. This report covers activities and accounts during the period 1 April 2017 to 31 March 2018.

### Terms of Reference

The Terms of Reference of the Committee were approved by the Board on 5 January 2017 following a refresh which included referencing against the Audit Committee Handbook published by the HFMA and Department of Health; the NHS Improvement's Code of Governance and current best practice. The Committee's Terms of Reference were again refreshed in March 2018 to ensure that they remained fit for purpose. The Committee acts in an advisory capacity and has no executive powers.
A copy of the terms of reference is available on request from the Company Secretary.

### Committee membership and attendance

The Committee has had at least three Non-Executive Directors acting as members during the financial year as follows: -

| | |
|---|---|
| Julie Soutter | Julie has been Chair of the Audit, Risk and Assurance Committee since 1 January 2016. Prior to that she was a member of the Committee from the time she joined the Trust in January 2015. During 2017/18 Julie was also the Deputy Chairman of the Trust. |
| Andy Copestake | Andy has been a member of the Committee since joining the Trust on 1 July 2016. |
| Nicholas Bishop | Nicholas has been a member of the Committee since 1 January 2017. Nicholas is the Chair of the Quality and Governance Committee and the Mental Health Governance Committee. |
| Steve Nowell *(from 1-Jan-18* | Steve has been a member of the Committee since 1 January 2018. However, Steve was previously a member of the Committee from 1 July to 31 December 2016. During 2017/18 Steve was the Chair of the Finance & Investment Committee; the Performance, People and Place Committee and the Remuneration Committee. Steve is also the Senior Independent Director. |

Note that from1 January 2018 the membership of the Committee increased from three Non-Executive Directors to four to ensure that there is a minimum attendance of three members at any meeting.

| **Attendances** Non-Exec Members | 25 May 2017 | 13 July 2017 | 14 September 2017 | 16 November 2017 | 18 January 2018 | 15 March 2018 |
|---|---|---|---|---|---|---|
| Julie Soutter *(Chair)* | ✓ | ✓ | ✓ | ✓ | ✓ | × |
| Andy Copestake | ✓ | ✓ | × | ✓ | ✓ | ✓ |
| Nick Bishop | × | ✓ | ✓ | × | ✓ | ✓ |
| Steve Nowell (from 1 Jan 2018) | n/a | n/a | n/a | n/a | n/a | ✓ |

n/a Not applicable, x not attended, ✓attended

Karen Johnson, Director of Finance (DoF), Dr Guy Rooney (Medical Director) and Carole Nicholl, Director of Governance & Assurance & Company Secretary (CoSec) or their representatives also attend. Additional attendees at all Committee meetings include representatives from Internal Audit and Counter Fraud (BDO) and External Audit (KPMG) who provide updates on activities, planning and reporting. KPMG also provide updates on technical or regulatory matters which the Committee should be made aware of.

Other senior managers or representatives from Internal and External Audit are invited to attend meetings to assist on matters of specific interest or relevance to the Committee's responsibilities as required. Other Non-Executive Directors may attend as observers.

### Audit Committee purpose and activity in discharging its responsibilities

The primary purpose of the Committee is to provide oversight and scrutiny of the Trust's risk management and assurance activity, internal financial and other control processes, including those related to service quality and performance. These controls underpin the Trust's Assurance Framework so as to ensure its overall adequacy, robustness and effectiveness. This approach should, therefore, address risks and controls that affect all aspects of the Trust's activity and reporting.

Operational oversight and scrutiny, in particular relating to service quality and patient care performance, is also provided through the Quality & Governance Committee. There is a direct link between the Quality & Governance Committee and the Audit Committee through committee membership and exception reporting. The Finance and Investment Committee provides oversight of financial management and planning. Again there is a direct linkage between this Committee and the Audit Committee through membership and exception reporting. Day to day performance management of the Trust's activity, risks and controls is the responsibility of the Executive Directors.

The Audit Committee has oversight of corporate governance and compliance and the performance and outcomes of Internal Audit, (including Counter Fraud services) and of External Audit. The Committee seeks to ensure that the relationship between Internal and External Audit is robust and effective and that all parties receive and provide adequate support to and from Trust management as required. Time is set aside for private discussion with Internal Auditors, External Auditors and Trust Finance Management Leads. Note that the Quality and Governance Committee also has oversight of corporate governance and governance generally, such as consideration of compliance with the Code of Governance.

## Risk and Governance Activity

The Committee met in May, July, September and November 2017, and also in January and March 2018. For the current financial year a minimum of six meetings are scheduled, commencing in May 2018 with the review and approval of the 2017/18 year-end Annual Report and Accounts. The major review areas addressed in the meetings in 2017/18 are summarised as follows: -

- At least three times per year the Board Assurance Framework and 15+ Risk Register are reviewed and risks and assurances challenged where appropriate by the Committee. The strategic objectives are aligned to the Board Committees with those Committees responsible for seeking assurances that strategic risks are being managed. A Risk Escalation Framework supported by a Risk Appetite Statement are in place.
    - The Audit Committee has continued to challenge embeddedness of risk management throughout the organisation and has supported further actions and areas for focus, such as the introduction of individual divisional presentations to the Committee on their risk management arrangements.
    - The Committee has oversight of risk management and the Board Assurance Framework to ensure they remain "fit for purpose", reflect risks that impact on strategic objectives and the assurance and mitigation provided, or, if none exist, prompt a suitable course of action to minimise the impact of risks.
    - The Committee welcomed the findings of an internal auditor review of risk maturity supporting the recommendations around introducing key performance indicators for risk management which will be rolled out during 2018/19.
- The Committee has reviewed Trust policies, including the Freedom to Speak Up policy and has sought to challenge how new policies are implemented and requested update reports. Notably, the Committee has sought additional information on the Staff Code of Conduct Policy and challenged how compliance rates can be improved.
- The Committee reviewed reports on Estates Compliance, the Fixed Asset Register; comparisons of International Healthcare Systems; cost collections, budget setting and cyber security. This included discussion on progress made and mitigating actions to control any future risks.
- The Committee has reviewed and approved reports of any single tender actions, contract extensions and reports of losses, including patient property, and any compensation paid. The Committee was instrumental in developing improved reporting and consequently improved visibility of areas for focus, resulting in different actions with a subsequent improvement to systems and processes.
- The Chair of the Committee has reviewed the Seal Register and sought any necessary explanations relating to the use of the Trust seal.
- The minutes of the Committee are submitted to the Board. The Chair of the Committee makes a verbal and written report to the Board in public after each meeting, providing visibility in the public domain of the work of the Committee and areas of focus.
- As indicated above, in May 2018 the Trust's Financial Accounts for 2017/18 and Annual Report, including the Quality Report, were reviewed and approved by the Committee for endorsement by the Board.
- The key issues in relation to the financial statement, operations and compliance are valuation of land and buildings and recognition of NHS and non NHS income. The Committee gains assurance on these through financial internal controls, internal and external audits and challenge of reports received.

- Trusts are required to maintain losses and special payments register in which details of losses and special payments are entered as they are known. This is then presented to Audit Risk and Assurance Committee on a quarterly basis for approval. Losses and Compensations covers debt write offs, ex gratia payments, loss of equipment and loss of cash. A regular review of all debts that are deemed uncollectable by the Trusts External Debt Advisors is carried out on a quarterly basis, and a summary is produced of those that are not collectable and are therefore proposed for Write Off. All compensation and ex gratia payments that have been approved in line with the Trust's Losses and Compensations Policy are also reported on a quarterly basis.

## Internal Audit and Counter Fraud

From 1 April 2017, the Trust's internal auditor has been BDO (previously TIAA). The Committee reviewed and approved BDO's internal audit and counter-fraud plans for 2017/18 to ensure the provision of support to the assurance framework and adequate review of internal controls and known areas of risk or concern. The Plan included a number of reviews but during the course of the year these were reviewed and re-prioritised as out below. The Committee ensured that audit planning also took account of areas identified by the Quality and Governance Committee and the Finance and Investment Committee as worthy of an audit review, together with consideration of those areas identified through the Board Assurance Framework.

The Committee monitors audit delivery and receives all finalised reports on audits and counter fraud activity, all findings and any other opinions concerning governance, control or risk management arrangements. The Director of Finance provides updates at meetings that confirm progress against the plan, areas of concern and the progress on resolving audit recommendations.

Each May the Audit Committee considers and endorses the Head of Internal Audit's Report. For 2017/18 the Trust's internal controls were assessed as moderate and that they provided overall Moderate Assurance.

During 2017/18 the outcomes of 11 internal audit reviews were reported to the Committee. Of those, four resulted in "limited" assurance, namely Workforce Planning; Cyber Security; Agency Expenditure and Medicines Management. The recommended actions to address weaknesses identified by the reviews are monitored by the Committee. All other internal audit reports provided **"moderate assurance"** (3 reviews) or were advisory in nature (4 reviews). The Trust demonstrated a very strong process for implementing actions within a timely manner.

During 2017/18 the opinion of the internal audit reviews reported to the Committee are as follows: -

| Name of Review | Opinion | |
|---|---|---|
| | Design | Operational Effectiveness |
| Risk Maturity | n/a | n/a |
| Key financial systems | Moderate | Moderate |
| Workforce planning | Moderate | Limited |
| Consultant job planning | *pending* | *pending* |
| Cyber Security | Moderate | Limited |
| Equipment management | Moderate | Moderate |
| IT architecture | n/a | n/a |
| Wiltshire Health & Care Partnership | n/a | n/a |
| Medicines management | Moderate | Limited |
| Data quality – Referral to Treatment Times (RTT) and Emergency Department 4 hour waits | Moderate | Moderate |
| Agency Expenditure | Moderate | Limited |

All reports have agreed action plans and were subject to detailed review by the Committee. It should be noted that each year there are areas of the internal audit plan work that are completed towards the end of the current financial year but reported to the ARAC in the following financial year.

The Committee also reviewed the work of Counter Fraud during the year. In addition to regular reports, it received advice on revised legal testing for dishonesty an a briefing paper on General Data Protection Regulation (GDPR) and fraud risk.  The Annual Fraud Risk Assessment was reported in May 2018 and the overall rating was “Green”.

## External Audit

KPMG were represented at all meetings of the Committee and submitted reports as needed, including their 2017/18 **unqualified audit opinion on the Trust’s Financial Accounts** and their Annual  ISA260 report.

In April 2015 Monitor reported that the Trust was failing to comply with a number of the provider licence conditions, in particular, those relating to financial reporting and financial governance, due to a failure to comply with its general duty to exercise its functions effectively, efficiently and economically.  During 2016/17 and into 2017/18 the enforcement undertakings remained in place.  The enforcement undertakings were lifted in October 2017 and as a result the external auditors **qualified the Use of Resources certificate**.

Based on the findings of our work, we have concluded that the Trust does not have adequate arrangements to secure economy, efficiency and effectiveness in its use of resources due to the following factors.

The External Auditors work considers the arrangements in place in relation to informed decision making, sustainable resource deployment and working with partner organisations. Whilst the External Auditors have not identified any concerns with the arrangements in place relating to informed decision making and working with partner organisations, they noted a significant risk relating to financial sustainability due to the ongoing financial challenges within the Trust, which has resulted in a qualified opinion.

As at 31 March 2018, the Trust also reported a £11.4 million deficit against a control total of £4.9 million, excluding Transformation or winter funding. The Trust required £12.1 million of revenue support borrowings in year, following repayment of £3.6 million to support the cash position and is expecting to require further borrowings in future periods, the borrowing as at 31/3/18 stands at £29.1 million. The Trust operational plan for 2018/19 forecasts a deficit of £12.4 million (before Transformational Funding), and the Trust does not currently have plans in place to return the Trust to a balanced financial position.

In addition to the financial challenges noted above, the Trust remained in breach of licence until October 2017, when NHS Improvement lifted the breach of licences conditions that had been in place since 2015/16. Until this date, the breach of licence indicates that NHS Improvement (NHSI) considers that the Trust has contravened and is failing to comply with certain conditions of the provider licence in relation to corporate governance and financial management and a failure to use its resources “effectively, efficiently and economically”.

The External Auditors are required to certify that they have completed the audit of the Trust financial statements in accordance with the requirements of the Code. If there are any circumstances under which they cannot issue a certificate, then they must report this to those charged with governance. There are no issues that would cause the External Auditors to delay the issue of their certificate of completion of the audit.

Furthermore, the external auditors have completed a review of the Trust’s Quality Accounts and have given a **clean limited assurance opinion on the content of the Quality Report**.  Two indicators were tested namely percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period (RTT); and percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge (A&E).  The auditor’s detailed testing on the indicators has concluded that the auditors are able to give a **clean limited assurance opinion on the presentation and recording of the four hour A&E wait**.  However the work conducted of **incomplete pathways within 18 weeks has resulted in a qualified opinion.**  The auditors sample testing for the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways for the year ended 31 March 2018 identified four issues from a sample of 20 pathways details of which are included in the Quality Account.

The auditors work on the local selected indicator chosen by the by the Governors on falls resulting in severe harm or death, has indicated that if the auditors were requested to provide an audit opinion they would be unable to issue and unmodified audit opinion. The reason for this is that the auditors sampled 25 falls from the year and found a number of issues within the testing.

In addition, the external auditors intended to issue an **unqualified Group Audit Assurance Certificate** to the National Audit Office regarding the Whole Government Accounts submission made through the summarisation scheduled to NHS Improvement.

The 2017/18 year-end audit plan was reviewed and agreed. All significant points raised by KPMG as a result of their audit work, including any issues carried forward, have been discussed with the Committee, were considered by management and, if needed, appropriate responses have been made and control processes identified for strengthening. The Committee also reviewed the fees charged by KPMG and the scope of work undertaken.

The effectiveness of the external audit process is reviewed when considering the appointment / re-appointment of the external auditor.

There were no material non-audit services provided by KPMG during the year which might impact KPMG's professional independence.

## Review of Effectiveness

Each year the Committee undertakes a formal review of its effectiveness. No major weaknesses were identified in 2017/18. The Chair of the Committee continues to work with the Director of Governance & Assurance to reflect on the effectiveness of the Committee and changes are made during the year as necessary. The Committee refreshed its forward planning of presentations and agenda items.

## Directors' responsibilities for preparing accounts and External Auditor's report

So far as the Directors are aware, there is no relevant material audit information of which the Auditor is unaware. The Directors have ensured that any such information has been brought to the Auditor's attention. The Directors are aware of their responsibilities for preparing the accounts and are satisfied that they meet NHS Foundation Trust reporting requirements 2017/18 and the requirements reflected in the Accounting Officer's Annual Governance Statement made by the Chief Executive of the Trust. A letter of representation reviewed and approved by the Committee, has been provided to the External Auditors signed by the Chief Executive on behalf of the Board to this effect.

The responsibilities of the External Auditors are set out in their Audit Report as included elsewhere in the Annual Report of the Trust.

## Audit Committee Assurance

Based on its work over this reporting period, the Committee is able to provide assurance on the adequacy of control processes, governance and Board Assurance Framework within the Trust and to provide assurances to the AO and the Board in respect of the audit assurances (internal and external), governance, risk management and accounting control arrangements operated.

There were no areas of concern to be disclosed in the Annual Governance Statement which have not already been disclosed. The Committee was of the opinion that there is full and frank disclosure of any material issues.

In 2018/19 the Committee will continue to operate against its Terms of Reference, seek further assurance that steps are being taken to maintain effective risk management and mitigation, sound systems of internal control

and quality control, monitor actions planned to implement audit recommendations or strengthen controls in areas of concern.

During 2017/18 there was a Quality Review of the Audit conducted by KPMG LLP of Great Western Hospitals NHS Foundation Trust for the year ended 31 March 2017. The Quality Review was undertaken by the Quality Assurance Directorate of the Institute of Chartered Accountants of England and Wales ('QAD'). There were no issues arising from the QAD review.

## Acknowledgements

The Committee acknowledges the support received from the Executive Directors and senior management Team and their readiness to co-operate with the Audit Committee and take action where it is indicated. The Committee is grateful for the detailed work and application of both Internal and External Auditors.

**Julie Soutter**

**Chair**
**Audit Risk and Assurance Committee**
**24 May 2018**

# 7. Regulatory ratings

## 7.1 Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needed. 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 licence.

## 7.2 Segmentation

All Foundation Trusts and NHS Trusts are allocated a Support Segment. The segment in which a provider is placed is determined by the level of support NHS Improvement decides is appropriate (universal, targeted or mandated). A segmentation decision is not a performance rating, and it does not determine the specifics of the support package in each case. The Trust is in Segment 2 (Targeted Support) which is defined as Support required in one or more areas to enable the Trust to move in to the top Segment 1 where a Trust has maximum autonomy and lowest level of oversight appropriate.

Details and actions from any formal interventions are set out below. This segmentation information is the Trust's position as at 31 March 2018. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

### Monitor Investigation and Enforcement undertakings April 2015

The Trust was subject to a Monitor (now NHS Improvement) investigation during 2014/15 which remained in place throughout 2016/17 and into 2017/18.

In April 2015, Monitor had reasonable grounds to suspect that the Trust had provided and was providing health care services for the purposes of the NHS in breach of the following conditions of its licence: CoS3(1)(a) and (b), FT4(2) and FT4(5)(a),(d), (e), (f) and (g). Monitor decided to accept from the Trust as Licensee enforcement undertakings in relation to financial performance and sustainability and financial governance.

Monitor had agreed to accept and the Trust as Licensee had agreed to give undertakings, pursuant to section 106 of the Health and Social Care Act 2012 in relation to financial sustainability, financial governance, distressed funding, reporting and general matters as follows: -

*1. Financial sustainability*

*1.1. The Licensee will take all reasonable steps to deliver its services on a financially sustainable basis, including but not limited to the actions in paragraphs 1.2 to 1.8 below.*

*1.2. The Licensee will develop and deliver a recovery plan for the 2015/16 financial year (the "Short-Term Recovery Plan") to be submitted to Monitor for agreement by 14 May 2015 or such later date as may be agreed with Monitor.*

*1.3. The Licensee will develop and agree with Monitor a realistic and robust long-term strategy for financial sustainability (the "Strategy") along with a realistic and robust supporting long-term financial recovery plan to address the five years following submission of the Short-Term Recovery Plan, or such other period as may be agreed with Monitor (the "Long-Term Recovery Plan"). The Licensee will submit the final Strategy and the final Long-Term Recovery Plan to Monitor by 1 October 2015 or such later date as may be agreed with Monitor. The Long-Term Recovery Plan should be aligned with commissioners' intentions and wider strategic developments impacting on the local health economy insofar as practicable.*

*1.4. The Licensee will keep the Strategy, the Recovery Plans and their delivery under review. Where matters are identified which materially affect the Licensee's ability to meet the requirements of paragraph 1.1, whether identified by the Licensee or another party, the Licensee will notify Monitor as soon as practicable and update and resubmit the Strategy and Recovery Plans within a timeframe to be agreed with Monitor.*

*1.5. The Licensee will develop and agree with Monitor Key Performance Indicators ("KPIs") to assess the effective delivery and impact of the Short-Term Recovery Plan by 14 May 2015, and for the Strategy and the Recovery Plans by 1 October 2015 or such later dates as may be agreed with Monitor.*

*1.6. If requested by Monitor, the Licensee will obtain assurance that delivery of the Short-Term Recovery Plan, the Long-Term Recovery Plan and the Strategy will enable it to meet the requirements of paragraph 1.1. The source, scope and timing of that assurance will be agreed with Monitor. If any such assurance takes the form of a review and report, the Licensee will provide copies of the draft and final report to Monitor within a timeframe to be agreed with Monitor.*

*1.7. The Licensee will provide assurance to Monitor that its leadership and management arrangements will ensure there is sufficient capacity and capability to develop and deliver effectively the Short-Term Recovery Plan, the Long-Term Recovery Plan and the Strategy. The source and scope of that assurance will be agreed with Monitor. The Licensee will submit the assurance in relation to the Short-Term Recovery Plan by 14 May 2015 and the assurance in relation to the Strategy and Long-Term Recovery Plan by 1 October 2015, or, in either case, such other date as may be agreed with Monitor.*

*1.8. The Licensee will demonstrate that it is able to deliver the Strategy and the Long-Term Recovery Plan, the evidence and timing of such to be agreed with Monitor.*

*2. Financial governance*

*2.1. The Licensee will take all reasonable steps to address the identified weaknesses in its financial governance, including but not limited to the actions in paragraphs 2.2 to 2.4 below.*

*2.2. The Licensee will develop and deliver a plan ("the Financial Governance Plan") to address the findings of the external review of its financial governance undertaken by Deloitte (the "Financial Governance Review"). The Licensee will agree the draft Financial Governance Plan with Monitor and submit the final Financial Governance Plan to Monitor by 14 May 2015 or such later date as may be agreed with Monitor.*

*2.3. If requested by Monitor, the Licensee will commission an external assurance review on the implementation of the Financial Governance Plan, from a source and according to a scope and timing to be agreed with Monitor. The Licensee will provide copies of the draft and final reports to Monitor.*

*2.4. The Licensee will keep the Financial Governance Plan and its delivery under review. Where matters are identified which materially affect the Licensee's ability to meet the requirements of paragraph 2.1, whether identified by the Licensee or another party, the Licensee will notify Monitor as soon as practicable and update and resubmit the Financial Governance Plan within a timeframe to be agreed with Monitor.*

*3. Distressed funding*

*3.1. Where interim support financing or planned term support financing is provided by the Secretary of State for Health to the Licensee pursuant to section 40 of the NHS Act 2006, the Licensee will comply with any terms and conditions which attach to the financing.*

*3.2. The Licensee will comply with any reporting requests made by Monitor in relation to any financing to be provided by the Licensee by the Secretary of State pursuant to section 40 or 42 of the NHS Act 2006.*

*4. Reporting*

*4.1. The Licensee will provide regular reports to Monitor on its progress in meeting the undertakings set out above, including reporting against the KPIs agreed pursuant to paragraph 1.5 and will attend meetings or, if Monitor stipulates, conference calls, to discuss its progress in meeting those undertakings. These*

*meetings shall take place once a month unless Monitor otherwise stipulates, at a time and place to be specified by Monitor and with attendees specified by Monitor.*

*5. General*

*5.1. The Licensee will implement sufficient programme management and governance arrangements to enable delivery of the following plans:*

*5.1.1. The Short-Term Recovery Plan;*

*5.1.2. The Long-Term Recovery Plan; and*

*5.1.3. The Financial Governance Plan.*

**Summary of Action taken to address the Enforcement Undertakings**

The Trust implemented recommendations arising out of an independent review of financial governance that included the following: -

- Improved forecasting and planning to enable a forward as well as a backward look at financial governance
- Movement of Committee dates to ensure flow of information to the Board
- Monthly reporting from the Chair of the Finance, Investment and Performance Committee to the Board
- Interim finance lead appointed to support and challenge the Project Management Office and divisional directors on progress
- Review of Finance Team structure in light of this report and gaps identified; recruitment plan developed and executed
- New finance report implemented and training complete with Finance Team
- Cost Improvement Programme linked with business as usual reporting and management
- Finance forecast based on most likely outturn not best case option introduced
- Consideration of whether planning assumptions were robust to inform future planning
- Independent review of structure to assess effectiveness and progress of Finance Team / Finance, Investment and Performance Committee commissioned
- Review of business planning guidance and process
- Recommendations made around priorities and reports presented to Finance, Investment and Performance Committee on underlying issues
- Scenario models and sensitivity analysis undertaken as part of the financial planning process
- Increased level of contact with external commissioners by the Director of Finance with programme of meetings established
- Formalised sign off end of month between divisional director and accountant
- Quarterly divisional performance meetings with whole Executive Team introduced
- Modified Divisional Performance Management meetings
- Cost Improvement Programme recommendations for future years made through Finance, Investment and Performance Committee
- Informatics action plan developed for implementation with key milestones

**During 2017/18 the Trust continued to embed robust financial governance and on 20 October 2017 the Trust was issued with a compliance notice and the enforcement undertakings were lifted as NHS Improvement was satisfied that sufficient improvements had been made around financial governance. The Trust will continue to work to ensure that the changes made remain sustained.**

## 7.3 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.

The Use of Resources looks at looks at Capital Service Cover, Liquidity, I&E Margin, I&E variance from plan and Agency usage. There are 4 levels with 1 being the best and 4 the lowest. 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 | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|---|
| Financial stability | Capital service capacity | 4 | 4 | 4 | 4 |
| | Liquidity | 4 | 4 | 4 | 4 |
| Financial efficiency | I&E margin | 2 | 4 | 4 | 4 |
| Financial controls | Distance from financial plan | 1 | 3 | 4 | 4 |
| | Agency spend | 4 | 4 | 4 | 4 |
| **Overall scoring** | | 3 | 4 | 4 | 4 |

The overriding rules mean that the Trust can be no more than an overall score of 3 as there is at least one indicator that scores 4.

## 7.4 Care Quality Commission Ratings

The Care Quality Commission (CQC) monitors, inspects and regulates health and social care services. The CQC publishes its findings, including ratings to help people choose care. The way the CQC regulates care services involves:

- Registering people that apply to the CQC to provide services.
- Using data, evidence and information throughout their work.
- Using feedback to help reach judgments.
- Inspections carried out by experts.
- Publishing information on judgments. In most cases the CQC also publish a rating to help patients choose care.
- Taking action when the CQC judges that services need to improve or to make sure those responsible for poor care are held accountable for it.

### Care Quality Commission (CQC) Inspection – March 2017

In August 2017 the Trust received a report from the CQC following its inspection of Trust services during March and April 2017 which was part of the CQC’s planned programme of inspections of healthcare providers. The overall rating was “requires improvement”. The Trust established Service level self-assessments frameworks which includes action plans to drive improvements which were rolled out during in 2017. Progress is monitored through and KLOE Assurance Committee with regular reporting to the CQC on milestone actions and sustainability of improvement.

## Full Inspection Outcomes March 2017

The ratings for both Acute and Community locations are summarised as follows which shows an improvement on the Trust's rating from September 2015, albeit the Trust remains overall as "requires improvement": Arrows in the table depict improvement or deterioration in rating for each key line of enquiry against the core services.

Our ratings for The Great Western Hospitals Foundation NHS Trust

| Core Service | Safe | Effective | Caring | Responsive | Well- led | | Overall |
|---|---|---|---|---|---|---|---|
| Urgent and emergency services | Requires Improvement ⇧ | Good ⇧ | Outstanding ⇧ | Requires Improvement | Good ⇧ | | Requires Improvement |
| Medical Care | Requires Improvement | Requires Improvement | Good | Requires Improvement ⇩ | Good ⇧ | | Requires Improvement |
| Surgery | Requires Improvement | Good | Good | Requires Improvement | Requires Improvement | | Requires Improvement |
| Critical Care | Requires Improvement | Good | Good | Good | Good ⇧ | | Good ⇧ |
| Maternity And gynaecology | Requires Improvement | Good | Good | Good | Good | | Good |
| Services for children and young people | Requires Improvement | Good | Good | Requires Improvement | Requires Improvement | | Requires Improvement |
| End of life care | Good | Good | Good | Good | Good | | Good |
| Outpatients and diagnostic imaging | Requires Improvement | Not Rated | Good | Requires Improvement | Good ⇧ | | Requires Improvement |
| Overall | Requires Improvement | Good ⇧ | Good | Requires Improvement | Good ⇧ | | Requires Improvement |

Our ratings for Community health services

| Core Service | Safe | Effective | Caring | Responsive | Well-led | | Overall |
|---|---|---|---|---|---|---|---|
| Urgent Care | Requires Improvement | Requires Improvement | Good | Good | Good | | Good |

Copies of the full reports for the Trust and each individual location inspected by the CQC are available publicly at the following website link http://www.cqc.org.uk/provider/RN3/reports

# 8. Statement of Accounting Officer's responsibilities

### 8.1 Statement of the Chief Executive's responsibilities as the Accounting Officer of Great Western Hospitals NHS Foundation Trust

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

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Great Western 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 view of the state of affairs of Great Western Hospitals NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the 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 judgments 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 him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

Signed

Nerissa Vaughan
Chief Executive

Date 24 May 2018

# 9. Auditor's opinion and certificate

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

# Independent auditor's report

## to the Council of Governors of Great Western Hospitals NHS Foundation Trust

### REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

#### 1. Our opinion is unmodified

We have audited the financial statements of Great Western Hospitals NHS Foundation Trust ("the Trust") for the year ended 31 March 2018 which comprise the Consolidated Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Tax Payers' Equity, Statement of Cash flows, and the related notes, including the accounting policies in note 1.

In our opinion:

— the financial statements give a true and fair view of the state of the Group and the Trust's affairs as at 31 March 2018 and of the Group and Trust's income and expenditure for the year then ended; and

— the Group and the Trust's financial statements have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, the NHS Foundation Trust Annual Reporting Manual 2017/18 and the Department of Health and Social Care Group Accounting Manual 2017/18.

Material uncertainty related to going concern

We draw attention to note 1.1.2 to the financial statements which indicates that the Group has net current liabilities of £14.2million as at 31 March 2018. The Group is also forecasting a deficit of £5.0 million, before Transformation funding, for the year ending 31 March 2019 and will require ongoing revenue loan support from the Department of Health and Social Care in order to meet the future financial obligations of the Group. These events and conditions, along with the other matters explained in note 1, constitute a material uncertainty that may cast significant doubt on the Group's and the parent Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

| Overview | | |
|---|---|---|
| **Materiality:** Group financial statements as a whole | £6.6 million (2017:£6.4 million)<br>2% of total income from operations (2017: 1.9%) | |
| **Risks of material misstatement** | | **vs 2017** |
| **Recurring risks** | Valuation of land and buildings | ◄► |
| | Recognition of NHS and non-NHS Income | ◄► |

*Key*

◄► Risk level unchanged from prior year

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Group in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

## 2. Key audit matters: our assessment of risks of material misstatement

Key audit matters are those matters that, in our professional judgment, were of most significance in the audit of the financial statements and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by us, including 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. We summarise below, the key audit matters, in decreasing order of audit significance, in arriving at our audit opinion above together with our key audit procedures to address those matters and our findings from those procedures in order that the Group's Governors as a body may better understand the process by which we arrived at our audit opinion. These matters were addressed, and our findings are based on procedures undertaken, in the context of, and solely for the purpose of, our audit of the financial statements as a whole, and in forming our opinion thereon , and consequently are incidental to that opinion, and we do not provide a separate opinion on these matters.

All of these key audit matters relate to the Group and parent Trust.

| | The risk | Our response |
|---|---|---|
| **Property, Plant and Equipment**<br><br>(£174.2 million; 2017: £198.7 million)<br><br>*Refer to page 110 (Audit Committee Report), page 247 (accounting policy) and page 264 (financial disclosures)* | **Subjective valuation - Land and Buildings**<br><br>Land and buildings are required to be held at current value in existing use. As hospital buildings are specialised assets and there is not an active market for them they are usually valued on the basis of the cost to replace them with an equivalent asset (Depreciated Replacement Cost).<br><br>When considering the cost to build a replacement asset the Group may consider whether the asset would be built to the same specification or in the same location. Assumptions about changes to the asset must be realistic. Great Western Hospitals NHS Foundation Trust last had a full valuation undertaken at 1 April 2016. At 31 March 2018, the Group completed a desktop valuation, based on indices supplied by the valuer resulting in a £10.6 million increase in the value of land and buildings.<br><br>Valuations are inherently judgemental, therefore our work focused on whether the methodology, assumptions (including the indices applied by the Group) and underlying asset data used within the desktop valuation, are appropriate and correctly applied. | Our procedures included:<br><br>— **Assessing valuer's credentials:** We considered the scope, qualifications and experience of the valuer, to identify whether the valuer was appropriately experienced and qualified to provide relevant indices;<br><br>— **Test of details:** We undertook the following tests of details:<br>— We tested the completeness of the estate covered by the valuation to the Trust's underlying records of the estate held, including additions to land and buildings during the year;<br>— We critically assessed the Trust's formal consideration of indications of impairment within its estate, including the process undertaken and the adequacy of the judgements made by management in determining whether assets are impaired or surplus to requirements;<br>— We re-performed the gain or loss on revaluation for all applicable assets and checked whether the accounting entries were consistent with the DHSC Group Accounting Manual; and<br>— For a sample of assets added during the year we agreed that an appropriate valuation basis had been adopted when they became operational and that the Group would receive future benefits.<br><br>**Our findings**<br><br>— We found the resulting valuation of land and buildings to be balanced. |

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## 2. Key audit matters: our assessment of risks of material misstatement

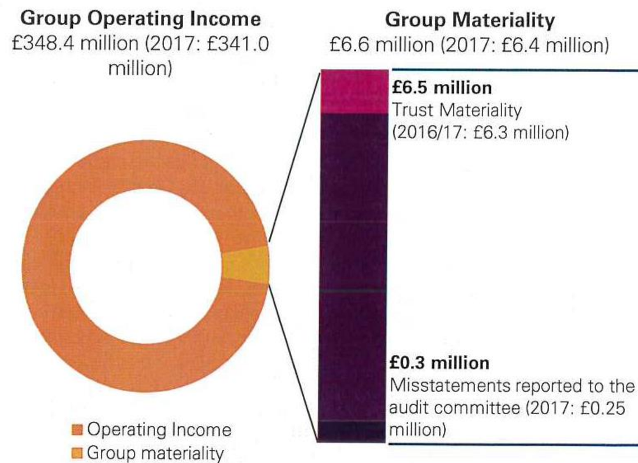
| | The risk | Our response |
|---|---|---|
| **NHS and non-NHS income**<br><br>(£348.4 million; 2017: £341.0 million)<br><br>*Refer to page 110 (Audit Committee Report), page 246 (accounting policy) and page 256 (financial disclosures).* | **2017/18 Income**<br><br>Of the Group's reported income, £311.6 million (2017, £291.9 million) came from commissioners (Clinical Commissioning Groups (CCG), other NHS Bodies and NHS England). Income from CCGs, other NHS Bodies and NHS England make up 89% of the Group's income. The majority of this income is contracted on an annual basis. Actual achievement is based on completing the planned level of activity and achieving key performance indicators (KPIs). If the Group does not meet its contracted KPIs then commissioners are able to impose penalties, reducing the level of income.<br><br>An agreement of balances exercise is undertaken between all NHS bodies to agree the value of transactions during the year and the amounts owed at the year end. 'Mismatch' reports are produced setting out discrepancies between the submitted balances and transactions between each party, with variances over £300,000 being required to be reported to the National Audit Office to inform the audit of the Department of Health and Social Care consolidated accounts.<br><br>In 2017/18, the Trust received Sustainability and Transformation Funding (STF) from NHS Improvement. This is received on a quarterly basis subject to achieving defined financial and operational targets. The Group received £2.9 million of STF (2017: £11.4 million).<br><br>The Group reported total income of £27.4 million (2017: £39.2 million) from other activities, principally Education and Research. Much of this income is generated by contracts with other NHS and non-NHS bodies which are based on varied payment terms, including payment on delivery, milestone payments and periodic payments.<br><br>These various income streams represent a risk of revenue recognition for the Ggroup. | Our procedures included:<br><br>— **Control observations:** We tested the design and operation of process level controls over revenue recognition;<br><br>— **Test of details:** We undertook the following tests of details:<br><br>— We agreed commissioner income and income received under the subcontract agreement with Wiltshire Health and Care LLP to the signed contracts and selected a sample of the largest balances (comprising 94% of income from patient care activities) to the supporting invoice and payments to the bank receipts;<br><br>— We inspected invoices for material income, in the month prior to and following 31 March 2018 to determine whether income was recognised in the correct accounting period, in accordance with the amounts billed to counterparties;<br><br>— We assessed the outcome of the agreement of balances exercise with CCGs and other NHS providers and compared the values reported to the value of income captured in the financial statements. We sought explanations for any variances over £300,000, and all balances in dispute, and challenged the Group's assessment of the level of income they were entitled to and the receipts that could be collected;<br><br>— We assessed the STF recorded in the financial statements and the Group' performance against the required targets to confirm eligibility for the income and agreed bonus amounts to correspondence from NHSI; and<br><br>— We tested material other income balances by agreeing a sample of income transactions through to supporting documentation and cash receipts.<br><br>**Our findings**<br><br>— We found the resulting estimates of NHS and non-NHS income to be balanced. |

## 3. Our application of materiality and an overview of the scope of our audit

Materiality for the Group financial statements as a whole was set at £6.6 million (2016/17: £6.4 million), determined with reference to a benchmark of operating income from continued operations (of which it represents approximately 2% (2016/17: 1.9%)). We consider operating income to be more stable than a surplus or deficit related benchmark.

Materiality for the parent Trust's financial statements as a whole was set at £6.5 million (2016/17: £6.3 million), determined with reference to a benchmark of Operating Income from continued operations (of which it represents approximately 2% (2016/17: 1.9%)).

We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £0.3 million (2016/17: £0.3 million), in addition to other identified misstatements that warranted reporting on qualitative grounds.




## 4. We have nothing to report on the other information in the Annual Report

The directors are responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information.

In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

### Remuneration report

In our opinion the part of the remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2017/18.

### Corporate governance disclosures

We are required to report to you if:

— we have identified material inconsistencies between the knowledge we acquired during our financial statements audit and the directors' statement that they consider that the annual report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Group's position and performance, business model and strategy; or

— the section of the annual report describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee; or

— the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18, is misleading or is not consistent with our knowledge of the Group and other information of which we are aware from our audit of the financial statements.

We have nothing to report in these respects.

## 5. Respective responsibilities

### Accounting Officer's responsibilities

As explained more fully in the statement set out on page 118, the Accounting Officer is responsible for: the preparation of financial statements that give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Group and parent Trust'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 they have been informed by the relevant national body of the intention to dissolve the Group and parent Trust without the transfer of its services to another public sector entity.

### Auditor's responsibilities

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 our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not 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 aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

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## REPORT ON OTHER LEGAL AND REGULATORY MATTERS

### We have nothing to report on the statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.
- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in these respects.

### Our conclusion on the adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources is qualified

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the use of resources.

### Qualified conclusion

Subject to the matters outlined in the basis for qualified conclusion paragraph below we are satisfied that in all significant respects Great Western Hospitals NHS Foundation Trust put in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources for the year ended 31 March 2018.

### Basis for qualified conclusion

The Trust has been in breach of its provider licence since 2015/16. NHS Improvement lifted the breach of licence conditions in October 2017. Until this date, the breach of licence indicates that NHS Improvement (NHSI) considers that the Trust has not fully complied with certain conditions of the provider licence in relation to corporate governance and financial management and a failure to use its resources "effectively, efficiently and economically".

As at 31 March 2018, the Trust also reported a £11.4 million deficit against a planned deficit of £4.5 million. The Trust launched a recovery plan in July, with revised forecast outturn of £11.4 million deficit.

The Trust required £29.3 million of revenue support borrowings in year to support the cash position and is expecting to require further borrowings in future periods. The Trust operational plan for 2018/19 forecasts a deficit of £12.4 million (before Transformational Funding), and the Trust does not currently have plans in place to return the Trust to a balanced financial position.

These issues are evidence of weaknesses in proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and the maintenance of statutory functions.

#### Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

The Trust is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

#### Report on our review of the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the use of resources.

Subject to the matters outlined in the basis for qualified conclusion paragraph below we are satisfied that in all significant respects Great Western Hospitals NHS Foundation Trust put in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources for the year ended 31 March 2018.

Report on our review of the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by guidance issued by the C&AG under Paragraph 9 of Schedule 6 to the Local Audit and Accountability Act 2014 to report on how our work addressed any identified significant risks to our conclusion on the adequacy of the Trust's arrangements to secure economy, efficiency and effectiveness in the use of resources. The 'risk' in this case is the risk that we could come to an incorrect conclusion in respect of the Trust's arrangements, rather than the risk of the arrangements themselves being inadequate.

We carry out a risk assessment to determine the nature and extent of further work that may be required. Our risk assessment includes consideration of the significance of business and operational risks facing the Trust, insofar as they relate to 'proper arrangements'. This includes sector and organisation level risks and draws on relevant cost and performance information as appropriate, as well as the results of reviews by inspectorates, review agencies and other relevant bodies.

The significant risks identified during our risk assessment are set out below together with the findings from the work we carried out on each area.

| Significant Risk | Description | Work carried out and judgements |
| --- | --- | --- |
| **Financial sustainability** | The nature of the financial challenges and underlying deficit, with no medium plans to return to a break even position, presents a significant risk to our assessment of the adequacy of arrangements in place at the Trust. | **Our work included:**<br>— Considering the nature of cash support the Trust is receiving from NHSI and its performance against any conditions attached to the support.<br>— Assessing the Trust's arrangements for managing working capital, including the processes for forecasting and monitoring cash flows and delivering cash savings.<br>— Considering the arrangements in place to deliver recurrent cost improvements by assessing the Trust CIP delivery against the planned CIP target and the use of recurrent and non-recurrent savings.<br>— Comparing the Trust use of agency staff against the agency cap set by NHS Improvement.<br>— Evaluating the Trust position as at 31 March 2018 against the forecast position and considering the future financial plans to assess the ongoing financial sustainability.<br>**Our findings on this risk area:**<br>— As at 31 March 2017 the Trust has reported a £11.4 million deficit against a control total deficit of £4.9 million. This does not include receipt of £2.9 million of Transformation Funding.<br>— The cash balance at year end was £1.4 million, which was £2.1 million higher than plan. The Trust cash position is supported by £29.3 million of revenue support borrowings as at 31 March 2018<br>— The 2018/19 operational plan agreed by NHS I forecasts a deficit position of £12.4 million before Transformation funding, highlighting the ongoing deficit the Trust faces. The Trust will continue to require revenue funding of £15.2m in the year to support the cash position.<br>— The Trust delivered £11.1 million of the £14.1 million Cost Improvement Plans for 2017/18, of which £8.4 million are recurrent savings. The plan for 2018/19 includes a CIP of £14.0 million, of which £8.8 million has been identified to date.<br>— The Trust has incurred £12.5 million of agency expenditure against an agreed agency cap of £8.7 million.<br>As a result of these matters, we are unable to satisfy ourselves that the Trust put in place proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and the maintenance of statutory functions in its use of resources for the year ended 31 March 2018. |

KPMG

| Significant Risk | Description | Work carried out and judgements |
|---|---|---|
| **Licence Conditions / special Measures** | In 2015, following a review by Monitor (now NHS Improvement), the Trust was found to be in breach of a number of conditions of its licence, relating to financial sustainability, performance and governance.<br><br>The nature of these breaches presents a significant risk for assessment of the adequacy of arrangements in place at the Trust. | On 20 October 2017 In accordance with paragraph 12(1) of Schedule 11 to the Health and Social Care Act 2012, NHS Improvement certified that the Licensee has complied with all of the Licensee's Enforcement Undertakings accepted by NHS Improvement on 20 April 2015.<br><br>**Our findings on this risk area:**<br><br>For 6 months of the 2017/18 financial year, the Trust has remained in breach of certain conditions of the provider license in relation to corporate governance and financial management. As a result of these matters, we are unable to satisfy ourselves that the Trust put in place proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and the maintenance of statutory functions in its use of resources for the year ended 31 March 2018. |

## THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006 and the terms of our engagement by the Trust. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report, and the further matters we are required to state to them in accordance with the terms agreed with the Trust, 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 of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

## CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Great Western Hospitals NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

**Rees Batley**
**for and on behalf of KPMG LLP (Statutory Auditor)**

*Chartered Accountants and Statutory Auditor*
*66 Queen Square, Bristol, BS1 4BE*
*25 May 2018*

# 10. Annual Governance Statement

## 10.1 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.

## 10.2 The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Great Western Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Great Western Hospitals NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

## 10.3 Capacity to handle risk

Leadership is given to the risk management process by the Director of Governance & Assurance. Executive Directors personally review the assurances against strategic risks aligned to strategic objectives on a quarterly basis as part of the Board Assurance Framework. They have oversight of the action taken to address gaps in controls and proactively identify evidence of assurance. Executive and Non-Executive Directors are trained on risk management and on their roles and responsibilities for leadership in risk management.

On a monthly basis the Executive Directors through the Executive Committee review the 15+ risks register to ensure risks are being managed and that the top risks for the Trust are reflected. Twice a year Directors receive oversight of 15+ risks at the Board meeting.

Risk Management is introduced into employee culture immediately upon employment. Employee education and training on risk management is carried out commensurate with employee roles. All new employees receive corporate induction, which includes risk management and incident reporting, alongside health and safety, manual handling and infection control training appropriate to their duties. Employees with applicable roles are provided with a one to one hour training session on how to use the risk register and manage risks before access to the electronic register is provided. Refresher training if required is offered on the same one to one basis to existing employees, or group drop in clinics if preferred.

Divisions are provided with a monthly risk register report detailing comparison and movement to the previous month. A Risk Escalation Framework implemented in August 2016 aims to ensure consistent systems and processes for the management of risk across the Trust.

Particular emphasis is given to the identification and management of risk at a local level. Discussions at Divisional meetings are required and at Departmental level meetings to consider risk are encouraged as part of the culture to agree upon the identified score of the risk, the appropriate mitigating actions and whether the risk is valid, or “accepted/tolerated “as business as usual (risks scoring 15 plus are to be accepted by the Board only) or can be closed as appropriate. Discussions at this level and frequency reduce the duplication of risks, encourage active discussion on what are tangible risks, what can be tolerated at a local level and that the description of the risk demonstrates the consequences should the risk materialise.

During 2017/18 key performance indicators were agreed which will support oversight of the effectiveness of risk management in the organisation. These will be reported to the Executive Committee and the Audit, Risk and Assurance Committee in 2018/19.

Also during 2017/18 Divisional presentations were introduced at the Audit, Risk and Assurance Committee with the intention that the Committee can support Divisions in their management of risk and gain assurance that controls and systems for the effective management of risk remain in place and are consistent.

### 10.4 The risk and control framework

#### Risk Management Strategy

The overall objective of the Risk Management Strategy is to ensure that robust risk management processes are in place which provide assurance to the Board that the Trust is discharging its responsibilities in ensuring good business and financial decision making leading to improvements in services and the quality of care provided.

To ensure that risk is identified, evaluated and controlled there are formal structures within the Trust. The Trust has a Risk Management Strategy which is continually reviewed and improved. This sets out how risk is managed within the organisation and the formal reporting processes. A Risk Escalation Framework is in place which includes refreshed reporting that identifies new risks; risks changes in score from the previous month; overdue actions and overdue risk reviews. Furthermore the reporting includes an overview of risk themes and risk types which supports the early identification of issues for focus. This encourages management of risks to systems and controls as well as specific risks that emerge. During 2017/18 there has been a focus on embedding use of the new reporting at local level and the analysis of trends and themes over time. This will continue into 2018/19.

Whilst the Board has overall responsibility for risk management, it has delegated responsibility to the Executive Committee, which scrutinises and challenges risk management, and the Audit, Risk and Assurance Committee which provides assurance that processes for risk management are effective.

The three main elements of our risk management strategy are:

- Risk assessment
- Risk register (know referred to within the organisation as the risk management tool)
- Board Assurance Framework

A risk tolerance statement aimed at supporting managers in decision making is in place. The statement sets out the Trust's appetite for risk and it is refreshed each year with the last refresh in December 2017. The Risk Tolerance Statement is explained below (section 10.4.6 refers).

#### Risk assessment

All Trust employees are responsible for identifying and managing risk. The Trust uses the National Patient Safety Agency (NPSA) Risk Matrix for Risk Managers to ensure risks are collectively scored objectively against the likelihood and the consequence of the risk materialising.

In addition a robust Incident Management Policy is in place and at corporate induction employees are actively encouraged to utilise the web-based incident reporting system. Incident reporting levels are comparable with other Trusts providing assurance that employees feel able to report incidents and risks.

## Risk register (risk management tool)

The risk register is a risk management tool whereby identified risks are described, scored, controls identified, mitigating actions planned and a narrative review is recorded. Data in the risk register is extractable into report format to provide an overall picture of risks to the Trust as well as thematic overviews.

The Trust has agreed that the most significant risks to the Trust, being those that score 15 and above (15+) should be reviewed monthly at the Executive Committee, with other risks reviewed through the Divisions. A register containing 15 plus risks is scrutinised and challenged by the Executive Committee (to ensure risks are being managed) and three times a year at the Audit, Risk and Assurance Committee (to ensure processes in place to manage risk are effective). This high-level register is informed both by those risks which score 15 and above in the Board Assurance Framework (top down) and risks identified from within the Divisions (bottom up).

There is a continual focus on maintaining effective management or risk with ongoing actions to support this including: -

- Monthly risk register training sessions for any members of staff
- Adhoc individual training sessions provided as well as group sessions
- Guides refreshed and widely circulated
- Monthly reporting of Divisional Risks Registers to Divisional Managers
- Review and update of Divisional governance arrangements for risk management
- Divisional risk leads refreshed
- Focussed meetings with Divisional and Departmental managers to scrutinise and challenge risks, controls, actions and reviews
- Electronic risk system reconfiguration to again update mandatory fields / change action reporting
- Electronic system reconfigured to continually remind handlers of risk actions
- Quarterly workshops held between the Director of Governance & Assurance, risk support staff and Divisional Governance Facilitators to review risk management, discuss barriers to effective risk management at local level and to agree further actions
- Risk support staff aligned to each Division to provide direct advice, guidance and support on risk management
- Introduction of key performance indicators (KPIs)
- Divisional presentations to the Audit, Risk and Assurance Committee

Risks are scrutinised locally at Divisional meetings and there is a strong emphasis from Executive Directors that managing all risks at Divisional level using the risk management system is essential. The Risk Escalation Framework is not fully embedded and there remain some areas managing their risks more effectively than others. The introduction of KPIs will support oversight of these. Work is on-going to ensure risks management continues to become embedded. The Trust has in place a log of on-going actions and training which is reported through the Audit, Risk and Assurance Committee. During 2017/18 there was a focus on timely completion of action and reviews plus improved banking of supporting documentation. This focus will continue.

In September 2017 an internal audit review of risk maturity concluded that the Trust scored favourably against the key indicators included within the audit scope against other acute Trusts. In particular the area of governance scored significantly higher than most and no areas of concern were identified.

## Board Assurance Framework

The Trust has in place a Board Assurance Framework which is set by the Executive Committee and approved by the Trust Board annually. The assurance framework sets out: -

- The principal objectives to achieving the Trust's overall goals,
- The principal risks to achieving those objectives,
- The key controls to mitigate against those risks,
- Gaps in controls;
- The assurances on those controls, and
- Any gaps in assurances.

The most recent internal auditor review of the Board Assurance Framework (including risk management) gave a "substantial" assurance opinion was given without recommendations (Jan-17). The audit found that the Board Assurance Framework (BAF) was embedded and is maintained as a "live" document.

The Board Assurance Framework includes the following: -

- Risks, controls and assurances reflect the 2020 Vision and the in-year Operational Plan published in January 2017 (refresh to reflect the Operational Plan published 30 April 2018 will be completed in 2018/19)
- Reporting through the Board Committees focuses on what the BAF is telling us
- Additional assurance reviews are undertaken (internally meeting with leads)
- Additional assurance reviews are identified to inform the Annual Audit Plan
- Strategic risks are aligned to the Care Quality Commission's Key Lines of Enquiry and NHS Improvement's Well Led Domains
- An overarching dashboard for all strategic risks is reported bi-annually to the Board
- Strategic risks are aligned to Board Committees with each responsible for seeking assurance for areas within its remit
- Assurance metrics added to the BAF to reflect the Single Oversight Framework, the Care Quality Commissions guidance of Use of Resources and NHS Improvement Well Led Framework

Risks to strategic objectives are aligned to Board Committees as follows: -

| | **Strategic Objective** | **Board Committee** |
|---|---|---|
| 1. | To deliver consistently high quality, safe services which deliver desired patient outcomes | Quality & Governance Committee |
| 2. | To improve patient and carer experience for every aspect of care we deliver | Performance, People & Place Committee |
| 3. | To ensure staff are proud to work at the Trust and would recommend the Trust as a place to work or receive treatment | Performance, People & Place Committee |
| 4. | To secure the long term health of the Trust | Finance & Investment Committee |
| 5. | To adopt new approaches and innovation so that we improve services as healthcare changes, whilst continuing to become more efficient | Performance, People & Place Committee |
| 6. | To work in partnership with others so that we provide seamless care for patients | Finance & Investment Committee |

## Risk appetite

The Board has a risk tolerance statement aimed at supporting managers in decision making. The statement sets out the Trust's appetite for risk and was refreshed in December 2017. A framework was developed which the Board uses to inform its view of risk tolerance. In 2017/18 the Board's appetite for organisational risk (value for money) reduced.

## Risk Tolerance Statement

The management of risk underpins the achievement of the Trust's objectives. Effective risk management is imperative to provide a safe environment and improve quality of care for patients. Risk management is also significant in the financial and business planning process where robust, sustainable financial health and public accountability in delivering health services is required. Risk management is the responsibility of all staff.

The Trust recognises that its long term sustainability depends upon the delivery of its strategic objectives and its relationships with its patients, the public and strategic partners. The Trust will not accept risks that impact on patient safety and is cautious to avoid risks which adversely impact on the financial position. The Trust has a medium tolerance for reputational impact, although this should be carefully considered and a greater appetite to take considered risks in terms of pursuing innovation and challenge current working practices where positive gains can be anticipated. The Trust has a minimal tolerance to not working within the constraints of the regulatory and legal environment. This is depicted in the chart below on the next page.

However, any consideration of risk needs to be in a broad context. Risk taking and decision making based on risk should not be considered in isolation or in "silos". There is often the potential for a greater impact of risks with wider organisational context or in relation to other decisions made.

To assist managers and staff in decisions which may involve or facilitate exposure to risk, the Trust Board has set out below its current attitude to risk.

This may change over time as internal and external circumstances change, but it provides an approved approach to support decision making by managers and staff. Decisions taken which would be contrary to this statement must be referred to the Executive Directors before implementation.

| Risk levels<br>Mapped against our objectives / Other | 0<br>**Avoid**<br>Avoidance of risk and uncertainty is a Key Organisational objective | 1<br>**Minimal**<br>(as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential | 2<br>**Cautious**<br>Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward. | 3<br>**Open**<br>Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM) | 4<br>**Seek**<br>Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk). | 5<br>**Mature**<br>Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust |
|---|---|---|---|---|---|---|
| **Risk to Patients** - Safety & Quality Outcomes / Patient Experience / Staffing | Avoidance of harm to patients is a key objective. We are not willing to accept any risk to patient safety, outcomes, or experience. | Only prepared to accept the possibility of minimal risk to patient safety, outcome or experience if essential. | Prepared to accept the possibility of some risk to patients. Patient safety is the primary concern but this is balanced against other considerations such as the best interest of the patient. | - | - | - |
| **Organisational Risk** - Financial/Value for Money (VfM) | Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern. | Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern. | Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments. | Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities. | Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach. | Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself. |
| **Opportunistic Risk** - New Approaches & Innovation & Partnership Working & Stakeholders & IT | Defensive approach to opportunities – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments. | Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations. | Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations. | Innovation supported with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved. | Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control. | Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice. |
| **Compliance & Legal Risk** - Compliance/ regulatory | Avoid anything which could be challenged, even unsuccessfully. | Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances. | Limited tolerance for non compliance. Want to be reasonably sure we would win any challenge. | Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences. | Chances of losing any challenge are real and consequences would be significant. | Consistently pushing back on regulatory burden. Front foot approach informs better regulation. |
| **Reputational Risk** - Reputation | No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern. | Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention. | Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest. | Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest, provided this has been thought through and understood. Prospective management of organisation's reputation. | Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation. | Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks. |
| **APPETITE** | **NONE** | **LOW** | **MODERATE** | **HIGH** | **SIGNIFICANT** | |

## Significant Risks 2017/18

There are a number of risks identified on the Board Assurance Framework and Risk Register. Examples of significant risks during 2017/18, together with the actions that have been taken to mitigate them are summarised as follows: -

| Risks | Actions to manage and mitigate, including how outcomes will be assessed |
|---|---|
| **Quality and Safety** | |
| Risk to patient safety through infection | A number of actions are in place:<br>▪ Clostridium difficile action plan developed to focus on isolation times, infection, prevention and control and mandatory training rates for Bank staff and continued monitoring of extended use of antibiotics.<br>▪ Review of positive cases to determine if avoidable and where practice could improve.<br>▪ SWARMS undertaken within 72 hours to address learning.<br>▪ Symptomatic C.diff action.<br>▪ Management plan of patient to reduce risk to patient and promote recovery. Antibiotic working group to monitor prescribing. |
| **Patient Experience** | |
| Risk of observations not being completed in a timely manner in the emergency department which could potentially result in failure to recognise a deteriorating patient. | ▪ Year-long project (funded externally) to embed SHINE checklist to enforce hourly observations.<br>▪ Trust wide introduction of E observations to support departmental overview of assessment.<br>▪ New cardiac monitors installed across department which includes blood pressure monitoring equipment.<br>▪ Observations displayed on posters in cubicle to embed learning around continual observations. |
| **Workforce** | |
| Inability to recruit and retain trained staff to deliver safe quality care to patients resulting in high agency spend outside set NHSI controls | A number of actions are in place: -<br>• Dedicated lead identified and plan put in place for each area of agency spend.<br>• Renewed Recruitment campaign.<br>• Rigour around recruitment plans using NHSI toolkit and action plan.<br>• EU recruitment completed with EU nurses working as pre-registered nurses whilst they completing their stepping up programme and competencies.<br>• A clear induction programme has been developed that includes induction for accommodation, local area, bank/GP appointment etc. Hospital/ward tours and training.<br>• Recruitment campaign (Non EU) with Yeovil NHS Trust.<br>• Roll out of electronic rostering.<br>• Standardisation of staff incentive schemes. |
| **Financial** | |
| Risk of cost improvement plans (CIPs) failing to materialise and not being sustainable on a recurrent basis | During 2017/18 CIPs performance was managed through a Transformation Board with identification of opportunities and delivery of progress tightly monitored through Executive led workstreams. If identified CIP opportunities fail to deliver, other ideas are sought to replace them. In addition monthly meetings were held with each of the Divisions and with Corporate areas to review progress on additional savings schemes that has been identified in year to meet shortfall in |

| Risks | Actions to manage and mitigate, including how outcomes will be assessed |
|---|---|
| | CIP delivery and offset the financial overspend.<br><br>During 2018/19 the CIP Programme will again be subject to Transformation Board oversight with management and Executive led workstreams with targets to deliver. Targets in 2018/19 are again challenging, and Divisions are working on both specific schemes and ones that will deliver transformational change. |

Assurances to strategic risks have been identified during 2017/18. Assurances are sought from a variety of sources including audits, external reviews or peer challenge as well as consideration of a number of key performance indicators (KPIs) and data metrics. When there are gaps in controls, actions are put in place to address these. If there are gaps in assurances, these are considered and efforts made to find assurances either through additional audits or reviews

New risks for 2018/19 have been identified through the operational planning process. Examples of future risks are set out below.

## Examples of Future risks

| Risks | Actions to manage and mitigate, including how outcomes will be assessed |
|---|---|
| **Financial Risk** | |
| Inability to meet Agency Cap Target | Agency spend in 2017/18 was lower than 2016/17 however is still higher than the cap set by NHS I and if it is not reduced in 2018/19 will result in the Trust not achieving Financial Control total and will impact on Use of Resources rating.<br>Agency spend is closely monitored through Finance & Investments Committee and Divisions have been given a monthly target to achieve to ensure agency spend is kept to plan.<br>Reasons for agency usage are monitored via Workforce reporting to Executive Committee and Performance People & Place Committee. |
| Winter Pressures result in inability to achieve Financial Control Total | The Trust experienced exceptional activity pressures over the winter period which resulted in a significant level of unplanned costs. Provision has been made in the 2018/19 financial plan to meet additional costs of winter; however these may not be sufficient if the Trust is to experience similar pressures to Winter 2017/18.<br><br>A Winter plan has been put in place and will be monitored by Executive Committee and Performance People & Place Committee with the financial impact reported via Finance & Investments Committee. . |
| **Non-Financial Risks** | |
| Risk of failure to meet cancer performance target | • Cancer Recovery Plan developed<br>• Cancer Recovery Steering Group established to oversee improvement<br>• Tumour site pathways being mapped with “pinch point” identified<br>• Networking with partners to establish effective processes and maximise efficiency<br>• Capacity modeling<br>• Additional clinics and prioritisation of cancer treatments |
| Inability to right size capacity as a result of significant population growth in Swindon | As a Trust we are aware of the population growth anticipated for Swindon and that it is likely to be significantly higher here than the national average. Our five year Integrated Business Plan (IBP) details this data and highlights that much of this development will surround the hospital site itself. We are integrating community services to make the best use of resources and services we have already, ensuring we maximise our capacity and capability. We are also looking to the future and have a number of projects looking at options around an integrated front door, an enlarged Emergency Department, alternative estate configurations and patient flow options with demand growth in mind. Discussions are ongoing with local commissioners and the local authority as well as at NHS England and NHS Improvement to ensure we continue to plan and implement the right choices together for Swindon. |

## 10.5 Organisation culture

Our Star Values "Service, Teamwork, Ambition, Respect" are at the heart of all we do

The Trust promotes a culture of putting the patient at the forefront of everything it does. Listening to patients is important and patient comments and complaints are considered and investigated to ensure the Trust learns from the feedback received. The Trust also learns from the Family and Friends Test, comment cards and social media.

The Trust has mechanisms in place to promote a culture in which employees are supported to be open with patients when things go wrong. The Trust has a Freedom to Speak Up Policy which encourages employees to come forward with concerns. This Policy has been based on support from National Guidance and feedback from both staff and patients.

### If you see something, say something

We are committed to dealing responsibly, openly and professionally with any genuine concerns raised and want staff to feel empowered to raise concerns at the earliest opportunity.

**If you see something, please say something!**

The Trust takes part in an annual staff survey (Section 5 refers). For 2016/17 areas for improvement around staff were identified and an action plan is being developed to address these. The Trust has a culture of listening to and responding to staff concerns and views. A People Strategy is in place against which there are milestone actions to drive changes.

The Trust has an Incident Management Policy whereby employees are required to report incidents and near misses. This helps the Trust to learn and form plans for improvements when things go wrong.

Reports to the Board and its Committees include a quality impact assessment for all papers, with any areas of concern highlighted and addressed. Quality as well as equality impact assessments are in place for policies and Trust wide procedural documents, thus ensuring that equality and quality considerations are core to the Trust's overall policy framework and business. In addition, the Board has agreed refreshed milestone actions for objectives around equality and diversity to ensure everyone is treated fairly and equally.

## 10.6 Information risk

Risks to information, including data confidentiality, integrity and availability, are being managed and controlled. A system of monitoring and reporting on data security risks is established under delegated authority of the Trust Board through the Information Governance Steering Group, which reports into the Board's Performance, People and Place Committee. The Trust has appointed an Executive Director as the Senior Information Risk Owner (SIRO) with responsibility and accountability to the Board for information risk policy.

The Information Risk Policy defines an overall structured approach to the management of information risk, in line with the Risk Management Strategy. A register of Information Assets is maintained. The business ownership of those assets is the responsibility of senior managers within the Trust, supported by staff with responsibility for operational management of the assets. These 'owners' and 'administrators' ensure that the principal risks are identified, assessed and regularly reviewed, and that annual assurance reports are provided on the satisfactory operation and security of the key information assets.

Where assessed as appropriate, risk treatment plans are actioned, additional controls are implemented, and prioritised risks are escalated to the appropriate Risk Register. As Accounting Officer I am committed to ensuring that immediate actions are taken where significant risks have been highlighted.

A range of measures is used to manage and mitigate information risks including: staff training, privacy impact assessments, physical security, data encryption, access controls, penetration testing, audit trail monitoring, departmental checklists and spot checks. In addition, a comprehensive assessment of information security is undertaken annually as part of the NHS Digital Information Governance Toolkit and further assurance is provided from Internal Audit and other reviews.

The effectiveness of these measures is reported to the Information Governance Steering Group. This includes details of any Information Governance Serious Incidents Requiring Investigation (IG SIRIs), the Trust's annual Information Governance Toolkit score, and reports of other information governance incidents, audit reviews and spot checks.

## 10.7 General Data Protection Regulations (GDPR)

The Information Commissioners Officer and the Information Governance Alliance have not finished the detail of what GDPR will mean for the NHS (or others) but instead have given a list of 12 outline actions any organisation should take that holds personal data.

The following is a summarised list of the core 12 action areas: -

1. Raise awareness within organisation; staff and management
2. Document personal data held
3. Review and update our existing Privacy Notice
4. Ensure we can meet requirements made by patients
5. Ensure subject access request admin is reviewed and able to meet requirements
6. Ensure and record a lawful basis for holding all the personal data we keep
7. Ensure we have correct informed consent where we need it.
8. Consider extra requirements for children's data (NB. This only applies where online services are being provided).
9. Ensure we have processes in place to investigate and report breaches.
10. Data protection by design; embed safe approach to personal data.
11. Appoint a Data Protection Officer with its expanded meaning to include GDPR independent overview.
12. Last point is for large organisations that operate across different countries.

The Trust has an outline work plan to address areas of focus with milestones and timescales. A key element will be training.

## 10.8 Data Security

The fundamental controls for cyber security are IT managed and include:

- Access rights linked to user names and passwords and physical access
- Clear segregation of systems and firewalls
- Anti-malware software usage and closing of software weakness with up to date patches
- Data backup

There are some secondary supportive element within the ambit of Information Governance which include

- IG training on data confidentiality and security covering secure passwords, changing them and not disclosing them
- Annual refresher training on the above
- Spot checks of practice around the Trust including screens being left on and unmanned

The Trust has a Data Quality Policy and Data Quality Strategy that refers to wider aspects of data safety.

At GWH, maintaining the security of our data is of primary importance to us. To safeguard our data, information and cyber security all of which we treat as interlinked, we take both technical and non-technical measures across 10 critical areas, including:-

1. Information Risk Management Regime
2. Network Security
3. User Education and Awareness
4. Malware Prevention
5. Removable Media Controls
6. Secure Configuration
7. Managing User Privileges
8. Incident Management
9. Monitoring
10. Home and Mobile Working

Our data security approach - a 10-Step Approach - is guided by a framework promoted by the UK National Cyber Security Centre (NCSC).

At a practical level, access to our data systems is controlled. We set up firewalls, install anti-virus programs, undertake backups, apply file filter, run intrusion detection and regularly update software and implement patches to improve the levels of our data, network and systems security.

In addition, we administer access rights, including user names and passwords and physical access to our data systems and networks, linked to job roles. We have in place mandatory information governance training, including annual refresher training, on data confidentiality and security covering secure passwords, changing them and not disclosing them and the handling of data in general. We undertake spot checks of practice around the organisation, and we encourage an information risk culture that promotes staff speaking out on data security-related matters and reporting incidents and risks so measures can be taken to continuously improve our data security.

## 10.9 Stakeholder involvement

As a foundation trust our membership is a resource for supporting risk management in the Trust. The membership is represented by Governors. Governors attend formal meetings of the Board of Directors to have an overview of Trust performance and influence decision making by representing the view of members. In particular the Governors hold the Non-Executive Directors to account for the performance of the Board. This is done through a series of working groups, such as the Patient Quality & Operational Performance Working Group and the Finance & Staffing Working Group (Section 6 refers). During 2017/18 the Council of Governors again agreed priority areas for focus and a series of presentations about how the Board manages these is being rolled out. The Non-Executive Directors are engaged in this process.

The Governors contributed to the development of the Trust's strategy via informal discussions with the Chairman and through formal Council of Governors meetings where quality was discussed in particular.

The Trust welcomes the input of wider stakeholders in the development of its Business Strategy as will be actively including the Governors and membership as part of a strategy refresh planned for 2018. The Chief Executive and the Chairman represent the Trust at a number of stakeholder forums. There is ongoing dialogue with Clinical Commissioning Groups, GPs, local authorities and other trusts, which has included shared thinking on future services focussing on quality of care to patients. To ensure Trust services match the needs and wishes of the local community, there has been shared information and learning with the Clinical Commissioning Groups via workshops. This has further developed through the Sustainability & Transformation Plan (STP) as we work across our footprint of Bath & North East Somerset (BANES), Wiltshire and Swindon. As this joined up approach continues we have also started work to look at the potential of an Integrated Care model for Swindon. This is in the early stages but will develop over the course of 2018 as we work closely with all of the organisations involved in health and care in the borough (includes Shrivenham).

### 10.10 Quality governance arrangements

Quality, operational performance and financial reports are considered monthly by the Board via an Executive Committee and thereafter Board Committees. In 2016/17 the Board Committee structure was refreshed resulting in three main scrutiny, challenge and support committees namely: -

- Quality & Governance Committee
- Performance, People & Place Committee
- Finance & Investment Committee

This ensures that all Trust business has a direct route to the Board via a committee.

Forward plans are in places for each committee to ensure all areas of business within their remit are considered. The reports on quality, operational performance and finance have been further developed during 2017/18 to ensure the key priorities are reported together with an Executive Director summary which highlights the main issues and exceptions. In addition the Chairs of the above Committees produce reports which are presented to the Board in public. These identify key issues and nuances from the Non-Executive Director perspective on business considered. The Committee challenges the issues in detail seeking assurance on behalf of the Board that risks are being mitigated and areas of business are managed effectively.

The Board seeks to ensure the robustness of data through audits. The Informatics Team has been reconfigured and there is improved data reporting now in place.

The Trust uses its Board Assurance Framework and Risk Register as tools to ensure risks are managed, including risks to quality.

In addition during 2016/17 the Trust commissioned an independent review under NHS Improvements Well Led Governance Framework with a focus on quality governance. A number of recommendations were suggested and actions have been rolled out during 2017/18 to deliver these, monitored through the Quality and Governance Committee and reported up to the Board.

During 2017/18 the Trust was inspected by the Care Quality Commission which concluded that overall the Trust is well led, which is an independent source of assurance that quality governance arrangements are robust.

### 10.11 Internal Care Quality Commission (CQC) Compliance Assessment arrangements

During 2017 the Trust's internal compliance assessment was informed by a range of information, including staff feedback sessions, mini inspections, service reviews and self-assessments.

Peer visits are spot checks of compliance against the CQC Regulations and Key Lines of Enquiry (KLOE). The purpose of these is to provide continued focus on service delivery, to assist service leads in ensuring compliance and to ensure awareness of any improvement requirements.

The KLOE Peer visits are another mechanism for highlighting areas for improvement across the Trust. The visits enable any issues to be raised with the appropriate managers ensuring that all risk assessments, patient safety and care quality assurances are in place. Improvements are identified and actions put in place, with learning shared across teams.

The Trust underwent a planned inspection by the Care Quality Commission (CQC) in March 2017 with the final report published in August 2017. The report identified 24 actions that the Trust must do and 43 actions that the Trust should do. Additionally, the report identified other areas for improvement that the organisation would like to address. The overall rating was "requires improvement". This is referred to in the Rating Report (Section 7 refers).

KLOE Compliance Assurance Frameworks have been developed for monitoring compliance against CQC recommendations and to continue deliver improvement. Monthly exception and escalation reports are produced to monitor key deliverables. This includes the scrutiny of evidence of progress against the action plans to

identify and review key issues and risks that might prevent or delay the achievement of the improvement. Action progress is delivered through core service teams and overall progress is monitored via a KLOE Committee chaired by an Executive Director.

### 10.12 CQC registration

Compliance with CQC registration is on a rolling program of review. This work is on-going with updates to registration made as required. Processes are in place to ensure on-going monitoring of registration requirements. The Great Western Hospitals NHS Foundation Trust registration was updated in November 2017 to add the following Location – Swindon Walk in Centre

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

### 10.13 Other control measures

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

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

The 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.

### 10.14 Principal risks to compliance with NHS Foundation Trust Condition 4 of Provider Licence

The Trust has a provider licence and condition 4 relates to the Trust's governance arrangements.

The Trust has processes in place to record and monitor compliance with Monitor's Provider Licence conditions. In April 2015, the Trust was reported as in breach of licence conditions CoS3 (1) (a) and (b) (standards of corporate governance and financial management), FT4 (2) and FT4 (5) (a), (d), (e), (f) and (g) (relating to Foundation Trust governance). Throughout 2015/16, 2016/17 and into 2017/18 the Trust remained in breach of these licence conditions. During this time the Trust worked closely with NHS Improvement, the regulator of NHS Trusts who maintained oversight of actions associated with the enforcement undertakings. A certificate of compliance was issued to the Trust on 20 October 2017 and the enforcement undertakings were lifted.

The main risks to non-compliance with the provider licence are around governance and use of resources. She details in the following table.

| Condition requirement | Controls & risks |
|---|---|
| To have regard to guidance issued by Monitor | The Trust has in place system to ensure it meets the requirement of licence condition G5 (1) in that a register of guidance is maintained with dedicated leads for each and assurance sought that regard is had to the guidance.<br><br>On the NHS Improvement website there is a dedicated section where all the mandatory guidance for Foundation Trusts is published. The Trust uses this as the basis for its register. The Trust maps this information to its own Register of Guidance on a regular basis (at least annually). The register was last updated in March 2018. Leads have been identified for each and assurance is sought that there has been regard to the guidance.<br><br>RISK - No specific risks have been identified to this condition. |
| Procedures in place to comply with the licence | The Trust has a schedule which documents each of the licence conditions, the controls in place, the assurances that the controls are robust and if there are any gaps or risks to being able to meet the conditions of the Licence. Where appropriate, risks of being able to comply with the Licence are managed via the Risk Register.<br><br>Exceptions are reported to the Quality & Governance Committee with the lasted report considered in Feb-18.<br><br>Since 2015/16 the Trust worked to deliver the recommendations of a financial governance review undertaken by Deloitte to deliver improvements in governance and financial sustainability. During this time the Trust worked closely with NHS Improvement and in October 2017 a certificate of compliance was issued.<br><br>Risk - The Trust is at risk of being in breach of FT4 (7) relating to the ability to ensure the existence and effective operation of systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of the licence. This is because the Trust is currently carrying a high number of vacancies and there is a national shortage of nursing and medical staff.<br><br>This risk is mitigated through roll out of a recruitment and retention plan and use of bank and agency staff. |
| Set out, apply and publish a transparent eligibility and selection criteria | The Trust complies with the Prior Approval Policies (only treat patients if prior approval is received) and the Criteria Based Policies (only treat patients who meet the criteria) established by Wiltshire and Swindon Clinical Commissioning Groups.<br><br>RISK - No specific risks have been identified to this condition. The Trust has regular contract meetings with the commissioner to ensure that the Trust is adhering to their requirements. |
| At the point where a patient has a choice of providers, the patient should be notified of this and told where information can be found | The Trust will refer a patient back to the care of the GP for onward referral to a different speciality. At this point the patient will have a choice of provider from Choose and Book.<br><br>RISK - No specific risks have been identified to this condition. |

| Condition requirement | Controls & risks |
|---|---|
| about the options | |
| The Trust shall not cease to provide or materially alter the specification or provision of any Commissioner Requested Service | No services provided are Commissioner Requested Services. However, controls to ensure continuation of services include a Chief Operating Officer and Divisional Management Teams who oversee operational performance.<br><br>Regular contract meetings are held with Clinical Commissioning Groups to discuss performance with areas of concern highlighted and discussed. Performance Review meetings are held monthly with Divisions where changes to services are considered.<br><br>RISK - No specific risks have been identified to this condition. |
| Good systems of governance | During 2017/18 the Trust had in place a Board of Directors consisting of Non-Executive (including the Chairman) and Executive Directors, plus Non-Voting Board Directors. The Chief Executive leads on executive arrangements and the Chairman leads the Non-Executive Directors in holding the Executive Directors to account for their performance. The composition of the Board was strengthened during 2017/18 with the appointment of a substantive Chief Operating Officer and the addition of a further non-executive director who took up post from 1 April 2018.<br><br>The Trust has in place a Council of Governors with 22 Governor positions who hold the Non-Executive Directors to account for the performance of the Trust. A programme of areas for focus by the Governors is developed and refreshed each year having regard to key risks, performance areas and finance. A review of effectiveness was held in January 2018 and areas for focus for the year ahead were agreed.<br><br>The Trust has an internal audit function and an external audit function that both provide assurance to the Trust on an on-going basis about the systems of internal control. An Internal Audit Programme is agreed each year having regard to the Trust's Board Assurance Framework and advice from Executive Directors on areas for focus.<br>In March 2015 the Trust entered into enforcement undertakings with NHS Improvement for breach of governance conditions. A certificate of compliance was issued on 20 October 2017.<br><br>During 2016/17 the Trust commissioned an independent Well Led Governance review under NHS improvements Well Led Framework. The independent review was widened to include a review of Divisional governance. The review resulted in recommendations which led to an action plan which was rolled and signed off as completed in 2017/18.<br><br>In March 2017 the Trust underwent a Care Quality Commission (CQC) inspection which resulted in an improved rating overall for the "well Led" domain.<br><br>RISK - No specific risks have been identified to this condition. |

| Condition requirement | Controls & risks |
|---|---|
| | |
| Shall at all times act in a manner calculated to secure that the Trust has access to the Required Resource. | The Trust has implemented recommendations from an independent financial governance review to improve financial governance arrangements and improve financial sustainability. In addition the Trust has worked with NHS Improvement to implement improvements with regular performance review meetings. In October 2017, a certificate of compliance was issued to the Trust indicating that the Regulators are now satisfied with the systems of internal control in place.<br><br>Notwithstanding this the financial position of the Trust remains challenged and the financial position not sustainable due in part to an underlying structural deficit averaging £12.5m per annum.<br><br>The Trust has in place a Finance Team with robust monitoring and reporting processes. In addition, the Trust has in place a Project Management Office that focuses on driving the Cost Improvement Programme. Processes are now embedded and continue with a weekly Transformation Board consisting of Executive Directors who challenge the Divisional leads on progress to deliver financial savings and drive efficiencies.<br><br>The Trust has in place a Finance and Investment Committee which meets monthly to scrutinise and challenge financial governance and sustainability with monthly reporting to the Board. A report from the Chair of that Committee is presented to the Board in public each month outlining the key points to discuss.<br><br>RISK - There is a risk to compliance with this licence condition even though the Trust is making progress to financial recovery. This is because NHS Improvement has not yet lifted the enforcement undertakings.<br><br>There is a risk around ability to deliver further Cost Improvement Programmes going forward as it is becoming increasingly challenging to identify and implement schemes without investment. Furthermore there are risks to achieving the conditions attached to the Sustainability & Transformational Funding going forward which will continue to be reported through the Trust's Finance and Investment Committee. |
| Establishment and implementation of: -<br>(a) effective Board and committee structures;<br>(b) clear responsibilities for the Board, for committees and for staff reporting to the Board and those committees;<br>(c) clear reporting lines and accountabilities throughout the organisation | (a) The Board has agreed a schedule of powers it reserves for itself *"Powers Reserved to the Board"* and this is refreshed annually.<br><br>(b) Sitting under the Board are a number of committees, each with areas of responsibility. These committees are composed of Non-Executive and Executive Directors and they oversee performance by scrutinising and challenging planned action and progress, but also offer support. For example, there is a Performance, People & Place Committee to ensure Board Committee oversight of operational, workforce, communications, estates and IT business of the Trust. The Audit, Risk and Assurance Committee scrutinises and challenges processes in place for management of services and has a strong focus on risk management. There is an Executive Committee which oversees operational management of the Trust. The membership of this Committee consists of Executive Directors only, with the most senior managers in the organisation in attendance. Key operational management decisions are made and there is oversight of directorate issues through receipt |

| Condition requirement | Controls & risks |
|---|---|
| | of Directorate Board minutes and exception reporting.<br><br>The minutes of the Board Committees are submitted to the Board at each meeting and the Chairs of those committees draw to the attention of the Board any issue of concern. In addition the Chairs of the Board Committees submit separate reports to the Board in public, highlighting significant points.<br><br>The Terms of Reference of the Board Committees are refreshed annually to ensure they are fit for purpose and that all areas of Trust business are reflected. The latest refresh was in Mar-18.<br><br>(c) Sitting under the Board Committees are a number of sub-committees and working groups. These have been mapped to ensure reporting lines and accountabilities are in place and that there are mechanisms to ensure issues are escalated to the Board. Minutes / reports of these meetings are presented to the respective Board Committees and any areas of concern are highlighted for discussion.<br><br>The Trust has in place a high level "*Scheme of Delegation*", supported by a detailed appendix which sets out the authority delegated to individuals and the remit within which that delegated authority can be exercised. Each year the Scheme is refreshed to ensure it is up to date and fit for purpose and that all areas of Trust business are reflected. The latest refresh was in Mar-18.<br><br>The Trust has in place a trust wide policy and procedural documents framework. Policies and procedures give staff direction on how to manage services and functions. The documents are stored and archived electronically and are accessible to all staff. A robust approval system is in place with a two stage approach whereby documents are approved from a governance perspective via a Policy Governance Group and thereafter ratified by a specialist group, which ensures that the policy framework under which we expect staff to operate is clear, accessible and up to date.<br><br>In terms of accountability, the senior managers in the organisation (Executive and Non-Voting Board Directors) have agreed threshold targets and specific measurable objectives linked to their areas of responsibility and aimed at delivering the Trust's Strategy. The appraisal of the senior managers is overseen by the Remuneration Committee each year. Sitting under this is a robust appraisal process for all staff, which is monitored and reported through a monthly workforce report.<br><br>Performance is scrutinised and challenged through monthly performance review meetings, overseen by Executive Directors.<br><br>In 2017/18 a Quality Governance Framework was rolled out to support the standardisation of governance arrangements across the Trust.<br><br>Risk - No specific risks have been identified to this condition. |

| Condition requirement | Controls & risks |
| --- | --- |
| | |
| Systems must ensure a capable Board; decision making which takes account of quality of care; there is up to date data on quality of care; the Board considers data on quality of care and there is accountability for quality of care. | The Trust has a capable Board. The Non-Executive Directors are appointed by the Council of Governors and they are accountable to Governors for the performance of the Trust. When a vacancy arises consideration is given to the skills needed and also to the balance and composition on the Board in terms of knowledge and experience. The composition is mapped to ensure there is a sufficient spread of expertise to cover all Board areas of responsibility.<br><br>Executive Director summaries are produced for the main reports (finance, operational performance and quality). Furthermore the Chairs of all Board Committee submit written reports to the Board in public on the issues to highlight from a Non-Executive Director perspective.<br><br>Each month the Board considers up to date information and data about the quality of care in the form of performance indicators and achievement against targets.<br><br>The Board recognises that it is accountable for the quality of care. A Quality and Governance Committee is in place to seek assurance on behalf of the Board that quality care is delivered. The Committee obtains assurance that the necessary governance structures and processes (relating to quality not internal control) are in place for the effective direction and control of the organisation so that it can meet all its objectives including specifically the provision of safe high quality patient care and comply with all relevant legislation, regulations and guidance that may from time to time be in place. Sitting under the Quality & Governance Committee is a Patient Quality Committee (PQC).<br><br>Risk - No specific risks have been identified to this condition. |
| Must ensure that there are enough sufficient qualified people to comply with this licence | The Trust has a capable Board. Please see above.<br><br>There are difficulties in sustaining sufficient numbers of trained clinical staff. The Trust has a number of controls in place including recruitment plans, training, retention measures and staff support.<br><br>A monthly workforce report is produced which is overseen by the Performance, People and Place Committee.<br><br>RISK - There is a risk that the Trust may not meet the requirements of this condition. The Trust continues to have a number of nursing and doctor vacancies and is unable to recruit to the desired levels. This shortage is national. The Trust has launched a refreshed Recruitment and Retention Strategy. |

| Condition requirement | Controls & risks |
| --- | --- |
| | |
| Submission of statement of compliance with provider licence | The Board assures itself of the validity of its corporate governance statement required under its licence condition in that it has in place a compliance schedule which is reviewed and scrutinised by the Quality & Governance Committee (latest review Feb-18). The Trust has identified the controls in place to ensure the licence conditions are met; the reporting mechanisms of those controls and has gathered assurances against each as evidence of compliance. Gaps in controls or assurances are identified and action planned to address any gaps is highlighted and monitored through the Quality & Governance Committee. Leads for each licence condition have been identified.<br><br>This informs the Board which approves the corporate governance statement confirming compliance with the governance condition and anticipated compliance with this condition going forward, specifying any risks to compliance and any action proposed to take to manage risks as part of NHS Improvement's annual governance submissions. |

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

In April 2015 Monitor reported that the Trust was failing to comply with a number of the provider licence conditions, in particular, those relating to financial reporting and financial governance, due to a failure to comply with its general duty to exercise its functions effectively, efficiently and economically. As a result, the external auditors qualified the Use of Resources certificate.

The Trust Board responded to this in a pro-active and positive manner, putting in place clear governance and accountability frameworks by adopting a structured approach to enable the right level of assurance to be provided for Trust Board, focusing on the use of resources and the importance of the scale of medium-term cost savings required in the current economic and operating environment. Strengthening and embedding processes and systems has continued throughout 2016/17 and into 2017/18. In October 2017 the Trust was issued with a certificate of compliance.

The processes outlined below are well established and ensure the effectiveness of the systems of internal control through:

- Board Committees seeking assurance on behalf of the Board that controls are in place for the management of strategic risks, with relevant extracts of the Board Assurance Framework considered by the respective Committees on a quarterly basis;
- Board of Directors reviewing the Board Assurance Framework at least twice a year, including the risk register and Internal Audit reports on its effectiveness;
- Audit, Risk and Assurance Committee, working with the Board Committees to review the effectiveness of the Trust's systems and processes of internal control;
- review of progress in meeting the Care Quality Commission's (CQC) essential standards by the Quality & Governance Committee informed by the CQC Inspection Report Aug-17;
- Clinical Audits;
- National Patient and Staff Surveys;
- Internal audits of effectiveness of systems of internal control;
- Business Investment Group – check and challenge panel to understand the implications of any investment from a financial, use of resources and impact on patient experience/safety prior to submission to Executive Committee;
- Transformation Board – weekly review of the Cost Improvement Programmes and the Quality Impact Assessments;
- regular reporting to the Board on key performance indicators including finance, operational performance, quality indicators and workforce targets;
- monthly scrutiny and challenge of financial, operational and quality targets by the Finance &, Investment Committee, the Performance, People & Place Committee and the Quality & Governance Committee;
- monthly reporting to the Executive Committee on directorate and Trust performance;
- monthly monitoring and reporting within Directorates which feeds into the Executive Committee and up to the Board; and
- regular reporting to NHS Improvement through performance review meetings and regular dialogue with relationship managers.

Sitting below the Operational Plan are divisional plans and capacity plans which specific objectives and milestones to deliver actions. Monthly Divisional Performance Meetings are held whereby the Executive Directors oversee operational delivery at divisional level. Value for money is an important component of the internal and external audit plans. These provide assurance to the Trust that the processes in place are effective and efficient in the use of resources. The reference cost index for GWH for 2016/17 is 94. This is the RCI after deducting the cost impact of the Trust's market forces factor (MFF) of 7.49% to reflect the variability of local costs. This means that GWH is 6% lower than national average across all NHS provider Trusts. There has been a 1% point movement from the reference cost index for 2015/16 (93). The reference cost index before adjusting for market forces is 95.

Procedures are in place to ensure all strategic decisions are considered at Executive and Board level and there is wider consultation with Governors and stakeholders.

The emphasis of Internal Audit work is around providing assurances on internal controls, risk management and governance systems to the Audit, Risk and Assurance Committee, through to the Board Committees and to the Board.

## 10.16 Information Governance

NHS Digital has published assessment criteria and reporting guidelines for incidents involving data loss or confidentiality breach. Such events are termed Information Governance Serious Incidents Requiring Investigation (IG SIRIs). The criteria has been revised from time to time, such that more incidents of a minor nature are now reportable. Any comparison with figures published in earlier years is therefore to be treated with considerable care.

Each IG SIRI is graded as either:
- (a) Lower severity Level 1 – to be reported statistically in the Annual Report, or
- (b) Higher severity Level 2 – to be reported to the Information Commissioner's Office and detailed individually in the Annual Report.

During 2017/18 there were no IG SIRIs at the higher severity Level 2, and so no incidents were required to be reported to the Information Commissioner's Office.

IG SIRIs classified at the lower severity Level 1 are aggregated and reported below in the specified format. During 2017/18 there were a total of 76 such incidents.

| **Summary of other personal data related incidents in 2017/18 (severity Level 1)** | | |
|---|---|---|
| **Category** | **Breach type** | **Total** |
| A | Corruption or inability to recover electronic data | - |
| B | Disclosed in error | 47 |
| C | Lost in transit | - |
| D | Lost or stolen hardware | 1 |
| E | Lost or stolen paperwork | 19 |
| F | Non-secure disposal – hardware | - |
| G | Non-secure disposal – paperwork | 2 |
| H | Uploaded to website in error | 1 |
| I | Technical security failing (including hacking) | 6 |
| J | Unauthorised access/disclosure | - |
| K | Other | - |

Notes:

| | |
|---|---|
| B | Most incidents relate to letters sent to the wrong address, e.g. where a patient has moved but not informed the Trust. |
| D | Incident related to a digital dictation machine which was stolen from a car. |
| E | Most incidents relate to misplaced paperwork which was later recovered and disposed of securely. |
| G | Most incidents relate to paper-based information placed into the wrong waste stream. |
| H | Incident related to personal details uploaded to the NHS jobs website in place of a job description. |
| I | These incidents relate to data sent via ordinary unencrypted email. There were no incidents of systems being hacked or data being intercepted. |

## 10.17 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. Steps which have been put in place to assure the Board that the Quality Report presents a balanced view and that there are appropriate controls in place to ensure the accuracy of data include the following: -

- The Chief Nurse is the Executive lead for the Quality Account with designated personal leadership for patient safety and quality on behalf of the Trust Board. The Trust has in place a Quality Improvement Strategy which provides details on roles and responsibilities for quality and safety and defines the key focus for the Annual Quality Accounts. The Board considers progress in delivering the Quality Strategy at least twice a year.
- The Annual Quality Account Report 2017/18 provides a narrative of progress toward achieving the quality improvement indicators agreed by the Executive Committee, the Patient Safety Committee and the Trust Board.
- The Trust has a robust process for scrutinising and revising local policies and monitoring compliance with NICE and other best practice guidelines. Annual audit programmes include the assessment of compliance with best practice guidance at both local and national level. This provides assurances to the Board that the quality of clinical care provided is based on the best clinical practice recognised nationally and that policies are up to date, appropriate and meet our legislative obligations. The Medical Director is the Executive lead for Clinical Audit and has led annual reviews of the clinical audit programme to ensure there is clear focus on priority audits with meaningful outcomes. The review in 2016/17 has provided greater clarity for on-going audit work throughout 2017/18.
- The Quality Account is compiled following both internal and external consultation to inform the improvement indicators. Data is provided by nominated leads in the Trust. These leads are responsible for scrutinising the data they provide to ensure accuracy. The Chief Nurse is ultimately accountable to Trust Board and its committees for the accuracy of the Quality Account Report.
- The Quality Account is subject to robust challenge at the Governance Committee on both substantive issues and also on data quality. Where variance against targets is identified the leads for individual metrics are held to account by the Governance Committee. Following scrutiny at that committee, the Quality Account is reported to Trust Board which is required to both attest to the accuracy of the data and also ensure that improvements against the targets are maintained.
- Directors' responsibilities for the Quality Account Report are outlined separately in this report.
- The Quality Account Report has been prepared in accordance with Monitor's annual reporting guidance as well as the standards to support data quality for the preparation of the Quality Report. No material weaknesses in the control framework associated with Quality Accounts have been identified.
- The Trust has a Data Quality Group responsible for reviewing the way data is captured and recorded to ensure its accuracy and robustness. Internal and external data audits are undertaken focusing on data quality and associated process and procedures and the Data Quality Group reviews internal and external data quality dashboards. This Group feeds into an Information Governance Group which overviews information governance across the Trust.
- During 2017/18 the Trust had concerns around the accuracy of data of the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of reporting period (Referral to Treatment Times - RTT). To address this, work carried out around RTT has changed and overall the Board is confident in the RTT data for patients on an incomplete pathway. In recognition of the work required we have expanded our RTT validation function including a new Head of Access post to monitor and support the clinical Divisions in managing pathways and patients ensuring constitutional targets and patient expectations are met. We have continued the joint collaboration via an RTT Steering Group with our Clinical Commissioning Groups.

### 10.18 Review of effectiveness

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

The processes that have been applied in maintaining and reviewing the effectiveness of the system of internal control include the following: -

| Process | | Role and Conclusions |
|---|---|---|
| Board | - | The Board leads the organisation throughout the year with regular reporting on finance, operational and quality performance and workforce. It receives minutes of Committees, with concerns and issues escalated by the Committee Chairs either verbally when the minutes are presented or through the Chair's reports to the Board in public.<br><br>The Board has a forward plan which supports ensuring that the Board considers progress on Trust business in a planned way, such as bi-annual updates on strategies which underpin the Trust's Vision and quarterly updates on other matters such as workforce.<br><br>In April 2017 the Board held a workshop to reflect on how the new Board Committees were working and to consider if Board meetings and Board Committees could be more effective ensuring a balance of focus on quality, performance, finance, workforce and strategy. As part of this review the Directors considered the levels of challenge versus support and the balance between reassurance and assurance. The Board also considered the balance of business considered by the Board to ensure that there is adequate time spent on finance versus quality and strategy discussions. In 2017/18 bi-monthly Board workshop sessions were held to focus on strategy formulation to address the need for transformation in order to make best use of resources and meet the activity pressures going forward. |
| Audit, Risk and Assurance Committee | - | The Committee provides scrutiny of internal controls, including the review and challenge of the Board Assurance Framework and Risk. |
| Internal audits | - | Internal audits are carried out which look at the effectiveness of systems of internal control. Audit findings are presented to the Audit, Risk and Assurance Committee and the Board through the Audit, Risk and Assurance Committee minutes.<br>A programme of internal audits is agreed each year having regard to the key risks to achieving the Trust's strategic objectives. The Board Assurance Framework informs the Audit Plan. |
| Clinical audits | - | Clinical Audit is a key component of clinical governance and it aims to promote patient safety, patient experience and to improve effectiveness of care provided to patients. The Trust is compliant with the Trust Clinical Audit plan. The NICE lead is responsible for actively disseminating and monitoring NICE compliance. Progress with the clinical audit programme is reported to a Patient Quality Committee each month and highlights are included in the Quality Report considered by the Board. |
| Other Committees | - | A number of Board Committee have been established with a clear timetable of meetings and forward plans in place to ensure that the Committees seeks assurance on behalf of the Board that all areas of business within their remit are being managed effectively. |

Terms of reference for each Board Committee are refreshed each year to ensure ongoing effectiveness and to ensure that an appropriate level of delegation and reference back to the Board is in place. There are three main Committees to scrutinise and challenge Trust performance as well as an audit committee looking at systems, controls and processes.

During 2017/18 Chairs of the Committees reported to the Board on the work of the Committees in the public part of the agenda with a focus on providing a Non-Executive Director perspective of the issues discussed, including key areas for focus, challenges and risks. These reports are in addition to any other reports which would normally be reported to the Board (such as the Finance Report or the Quality Report) and in addition to the minutes of the Committee meetings. Furthermore, reports to Committees and the Board were strengthened by the inclusion of Executive Director summaries.

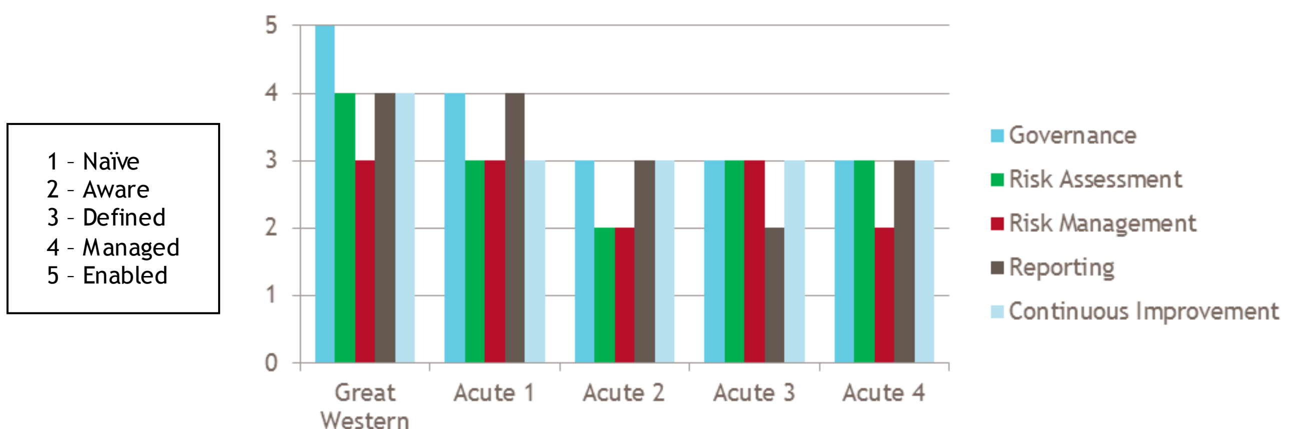
Board Assurance Framework / Risk Management -

The Board Assurance Framework (BAF) provides a structure and process that enables the Trust to focus on those risks which might compromise the achievement of the Trust strategic objectives and to identify and record the controls in place to mitigate any risk identified. The Audit, Risk and Assurance Committee scrutinises the BAF at least three times per year to confirm to the Board that the systems and processes in place for the management of risks are effective.

Strategic risks are aligned to priorities and strategic objectives are mapped against the Care Quality Commission's (CQC) Key Lines of Enquiry and NHS Improvements quality domains under their Well Led Framework. Sources of assurance have been identified, with metrics added which reflect the Single Oversight Framework, the latest NHS Improvement guidance on Use of Resources and the latest CQC Well Led guidance. A formal programme of reporting has been rolled out whereby the Board Committees seek assurance on behalf of the Board on a quarterly basis that processes and systems are in place to mitigate risks. The Committees consider the sources of assurance and risks within their remit and provide a risk rating on the strategic risks. The BAF informs the Committees' forward plan and the audit plan. The BAF enables oversight of trends, showing whether metrics are improving or deteriorating on a quarterly basis. The BAF has been instrumental in "predicting" future risks, notably around financial performance, recruitment and retention, equipment and more recently a dip in cancer performance.

The latest internal audit review of the Board Assurance Framework and risk management processes provided "substantial" assurance without recommendations (March-17). The audit found that the BAF was embedded in the governance structure of the Trust and is maintained as a "live" document.

The Internal Auditors BDO have undertaken a risk maturity assessment. The Trust scores strongly against the key indicators in the report (governance, risk assessment, risk management, reporting and continuous improvement). In particular the area of governance scored significantly higher than other trusts as illustrated in the graph below. Overall management of risk registers was consistent and other findings were generally consistent.



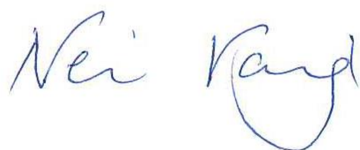
| | |
|---|---|
| Care Quality Commission (CQC) standards / CQC Inspection Report | The Trust monitors compliance with Care Quality Commission (CQC) standards through mini visits across the Trust. Areas for improvement are identified and led by the areas inspected. The Trust's CQC Compliance Manager works with leads to help them better understand the requirements of the Regulations and the key lines of enquiry which form part of the CQC assessment framework.<br><br>The CQC undertook a formal inspection in March 2017. The outcome was that the Trust's overall rating remained "requires improvement" but significant improvement across a number of areas was recognised, notably in Emergency Services and governance across the organisation. A number of must and should do actions were highlighted in the CQC report and these are being progressed by core service leads using a new Key Lines of Enquiry Framework (KLOE) reporting into a KLOE Committee. |
| Reporting to NHS Improvement | Throughout 2017/18 the Trust continued to have regular performance review meetings with NHS Improvement focused on delivering improvements to financial governance and performance but also to focus on operational performance. |
| Well Led Governance Review | During 2017/18 the Trust developed a framework to ensure systematic review of compliance against NHS Improvement's well led governance requirements looking at Strategy and planning; capability and culture; process and structures and measurement. Actions arising from the framework will be considered by the Directors in 2018/19 with progress reported through the Quality & Governance Committee. |

The Trust will continue to review all risks and where necessary will take appropriate actions to either reduce or eliminate these. Actions taken will be monitored through the appropriate Committees of the Board, and where necessary the Chair of the Committee will escalate concerns to Board.

## 10.19 Conclusion

I have not identified any material weaknesses in our systems for internal control as part of my review. My review confirms that Great Western Hospitals NHS Foundation Trust has generally sound systems on internal control that supports the achievement of its policies, aims and objectives.

Signed



Nerissa Vaughan
Chief Executive 24 May 2018

# 11. Quality Report

## 1 Our Commitment to Quality

### 11.1 Our Commitment to Quality – Statement from Nerissa Vaughan Chief Executive dated 24 May 2018

I am pleased to present our Quality Accounts for 2017/18.

This report provides the public with a clear account of our work over the past 12 months to improve the quality of care we provide to patients and shares our priorities for the year ahead.

This has been a year of continued transformation and hard work by our staff to meet the pressure of increasing demand alongside improvements in the quality of care we provide to patients and working to build a more integrated approach to health and care in Swindon.

Over the last year the response to improvement work following our Care Quality Commission inspection in 2015 was evident in the positive feedback received during our follow-up inspection in 2017. There remain a number of areas to improve on but we continue to move in the right direction, with nearly two thirds of our services now rated as good or outstanding, as we rightly place patient safety at the centre of everything we do. There is much to celebrate and many examples of exemplary and innovative care.

These achievements are testament to the efforts and commitment of our 4,500 dedicated staff working at the Great Western Hospital and across the community in Swindon.

We have continued good work helping us to identify deteriorating patients sooner, implementing and embedding the national Early Warning Score across the Trust, including community areas.

We've had zero hospital MRSA blood stream infections during 2017/18 and we've seen a 13% reduction in hospital attributable E.coli blood stream infections. A gram negative reduction plan has been implemented across both acute and community services with the intention of reducing risk factors associated with the development of all gram negative blood stream infections.

Looking forward, as the population of Swindon, as well as surrounding areas, continues to grow at pace and above the national average we are constrained by the size, capacity and flexibility of our estate and face a considerable equipment replacement programme. Therefore addressing our capacity gaps from both a physical space and a workforce perspective are top priorities to continue to deliver high quality care for local people.

Continuing as we are is not an option so we are prioritising opportunities to further develop the Integrated Care System model in Swindon, following local development of an operating model during 2017. As is the case across the UK, health, social care and community services in Swindon are currently being delivered within a fragmented and complex system, which is as a result of a complex web of services developing not as a system but independently. While good progress has been made in terms of understanding the gaps in service, the challenge to redesign services to ensure a more integrated and efficient approach to the delivery of care across the health and social care system will feature as a key aim for 2018/19.

Following stabilisation of the Swindon Community Health Service during 2017/18, greater collaboration is now required with the acute hospital with particular regard to integrating urgent and ambulatory care, older people and stroke pathways.

Demand in our Emergency Department continues to be high, particularly over the winter months, but despite this our performance against the 4 hour standard was better in the first three months of 2018 compared to same

period in 2017, February was 9% better and placed us 26th in country out of 133 Trusts, this was largely due to the hard work and commitment from our staff.

Our Brighter Futures team have worked incredibly hard over the last few years and have now raised £2.2 million of the £2.9 million needed to help bring radiotherapy to Swindon. This service, to be run by Oxford University Hospitals on the GWH site, will massively improve patient care and we aim to reach our target by the end of the summer which we hope will coincide with the start of the building work for the centre.

As we move into 2018/19 we will increase the capability for quality improvement within the organisation so that it becomes an embedded way of working across everything we do. We will continue to look at new ways of working and how technology can help, such as improving translation services. We will be engaging with our communities at a number of listening groups and working with other partners in the health and care system to further integrate services and improve patient experience.

**Nerissa Vaughan**
**Chief Executive** **4 May 2018**

## 11.2 Priorities for Improvement 2018/2019

This section reflects on the priorities for improvement we will set for 2018/2019 and progress made since the publication of 2016/2017 quality report.

### Our Priorities for 2018/19

Our 2018/19 priorities are informed by both national and local priorities including the Sign up to Safety Campaign, learning from incidents, projects supported by external NHS and professional bodies. These priorities are also agreed through our quality contracts with our local Clinical Commissioning Groups, taking into consideration the data available on the quality of care relevant to all of our health services we provide. These priorities have been shaped using feedback, comments and learning through investigation processes. This practice includes our patients, carer's, service users and staff. These priorities have been shared with agreement sought from the Trust Governors as patient/public representatives, Local Healthwatch organisations and other key external stakeholders.

**Our Priorities for Quality Improvement**

**Our Focus for 2018/19**

- Reduction in pressure ulcers by working collaboratively with community services
- Recognition and rescue of the deteriorating patient through the implementation of electronic observation system
- Improving outcomes from Acute Kidney Injury (AKI)
- Improving effectiveness of Nursing handover and discharge communication
- Implementation of the 16 Ward Assessment and Accreditation Framework standards over 18 months (launched April 2018)
- Incorporate community services into all current and future improvement work streams where appropriate
- Increase the capability for quality improvement within the organisation.

## Saving 500 Lives and Quality Improvement

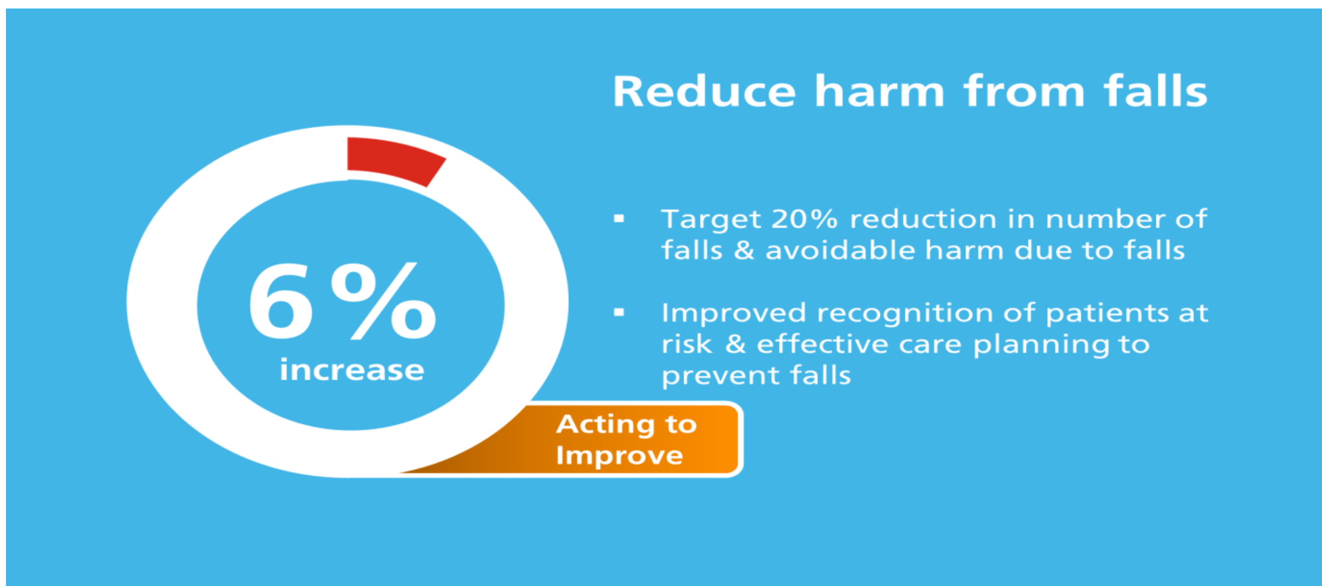
## Sign up to Safety

The Trust continues to deliver its ambition to save an extra 500 lives over 5 years, we have continued to progress our safety improvement plans through projects to improve quality and safety which continues to be measured through our quality improvement steering groups and monitored and reported through our Patient Quality Committee, Quality Governance Committee and Trust Board.

As part of this over-arching campaign the Trust has continued in its commitment to the national Sign Up To Safety programme. During 2017/18 this covered the following key areas of focus, a combination of national aspirations and our own specific improvement areas:

- Reducing falls
- Reducing pressure ulcers
- Management of sepsis
- Recognition of the deteriorating patient
- Acute Kidney Injury (AKI)

## Reducing falls

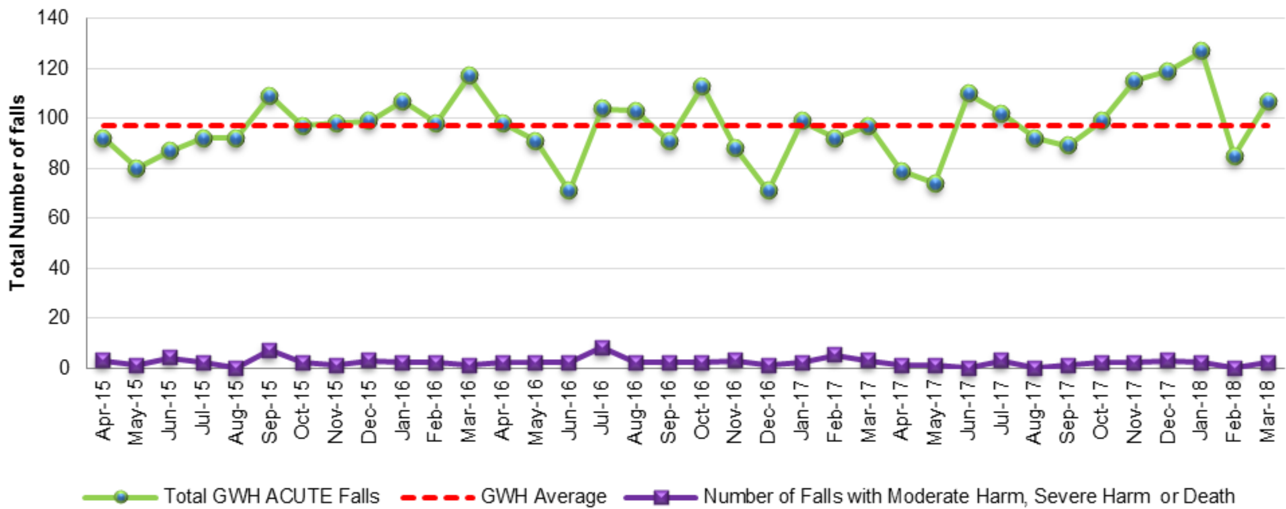



Falls are one of the leading causes of harm in hospitals. They can lead to injury, loss of confidence, independence, and prolonged hospital stays.

- On average 99 falls were reported within the Trust each month during 2017/2018. This is an increase on the previous year where we reported an average of 93 falls for 2016/2017.
- Our level of harm has reduced by 50% during 2017/2018 where we reported 18 falls resulting in moderate or severe harm compared to 34 falls during 2016/2017.

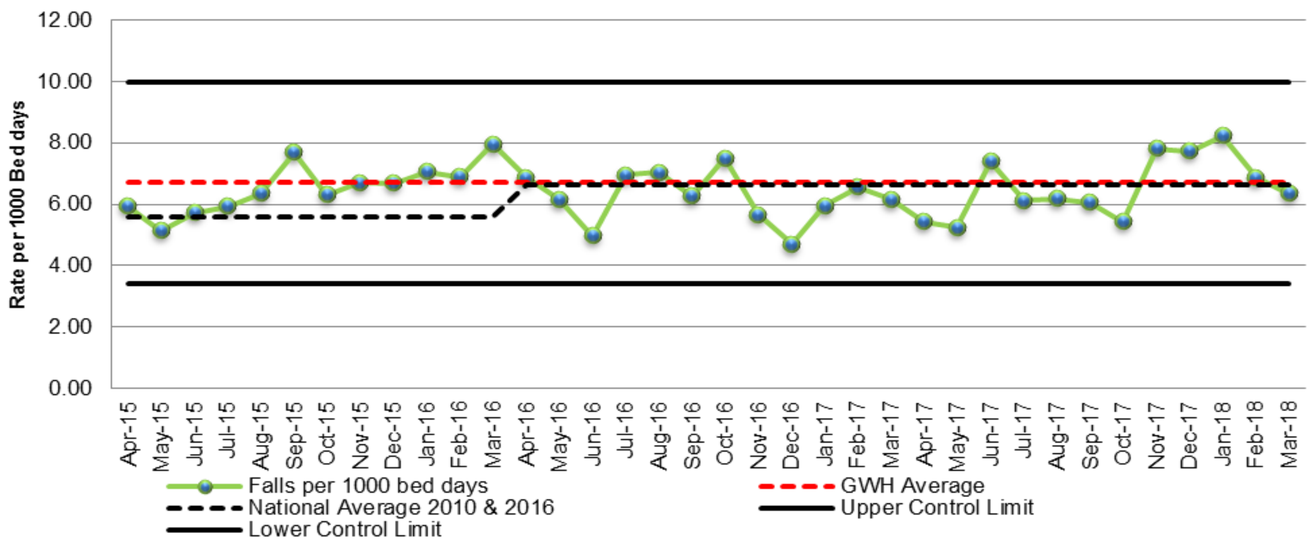
Although the Trust has experienced an increase in the number of falls the level of harm reported for 2017/18 has reduced by 50%. In July 2017 the Trust merged with Swindon Community Health Services which included the reporting of two rehabilitation wards.

## Total falls across the Trust




The chart above shows the total number of falls reported by the Trust each month and the number of falls resulting in moderate or severe harm.

## Falls Rate per 1000 Bed Days




The chart above demonstrates the Trusts fall rate per bed days with an average rate of 6.56 for 2017/2018.

## What improvements have we achieved?

In 2017/18 we reported 8 falls as moderate harm, 50% less than last year (16 falls), 10 as severe harm, 33% decrease on the previous year (15 falls) and zero deaths (2 were reported during 2016/17).

### Drivers for improvement

- The Trust made improvement in 6 out of 7 indicators of the National Falls Audit for the Royal College of Physicians in May 2017, work will continue during 2018/19 to further improve against these indicators.
- Revision of the post falls incident form providing valuable data by identifying time, location and patterns of falls along with identification of factors causing falls. This information allowed staff to change and improve on how they care for patients at risk of falling.
- All Ward Managers/Allied Health Professionals are attending our monthly Falls Operational Group meetings to share learning.
- Joint working with Swindon CCG and Bone Health Collaborative.
- Digital Reminiscence Therapy (Interactive multimedia to stimulate personalised memories) equipment was used across the Department of Medicines for the Elderly (DOME) wards.
- Quality improvement projects for preventing deconditioning syndrome (an improvement project to get patients up, get dressed and keep moving) in various wards.

### Further Improvements identified and our priorities for 2018/19:

- Review and update Falls Avoidance and Safety Rails Policy
- Review national falls audit from Royal College of Physicians and adopt recommendations
- Falls prevention measures form part of Ward Assessment and Accreditation Framework

## Reducing avoidable pressure ulcers

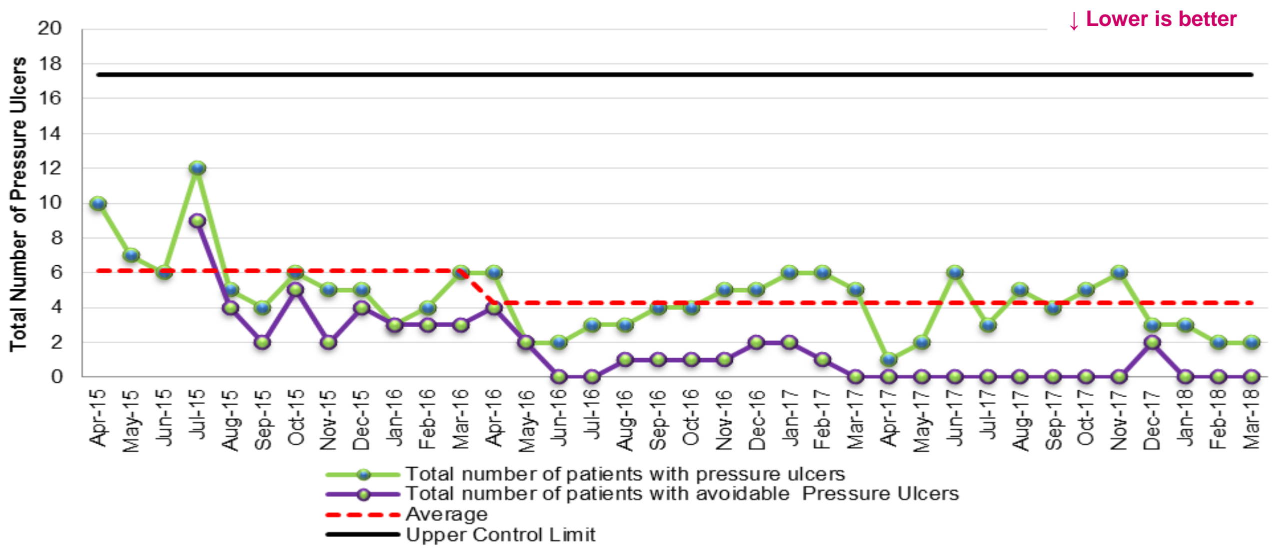
Pressure ulcers typically affect patients with health conditions that make it difficult to move, in particular patients sitting for long periods of time or confined to lying in bed.

The development of a pressure ulcer can have a negative impact on our patient's quality of life by causing pain, emotional distress and loss of independence. They also increase the risk of infection and prolong hospital stays. In the most serious of cases pressure ulcers increase a patient's risk of death.

Many pressure ulcers can be prevented through effective risk assessment and care planning for our patients, and ensuring our patients are kept mobile, changing positions wherever possible.

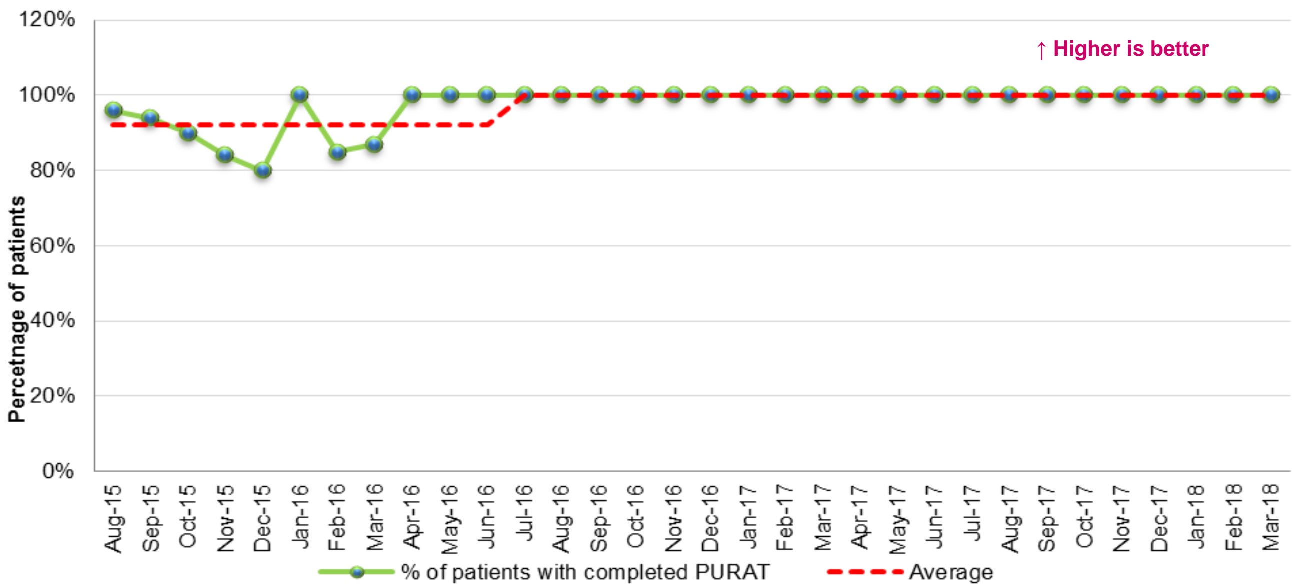
- We reported an average of 3 patients per month with pressure ulcers during 2017/2018 which is a slight increase on 2016/2017 where we reported 1. This still remains below our objective and on target. Of these pressure ulcers 2 were avoidable (1 Category III and 1 Category IV) pressure ulcers in acute inpatients per month'.

### Total number pressure ulcers (category II, III, IV for all acute inpatients)




The chart above demonstrates the total number of avoidable and unavoidable category II, III and IV Pressure Ulcers in acute inpatients.

### Percentage of acute patients with a completed Pressure Ulcer Risk Assessment Tool (PURAT)




The graph above shows the percentage of at risk inpatients that have had a pressure ulcer prevention core care plan completed. Since April 2016, 100% of acute at risk inpatients in a sample of 25 patients records reviewed per month have had a pressure ulcer prevention core care plan in place.

This data is taken from our monthly audits of the 5 hot spot wards which are wards where pressure ulcers are most frequently reported.

### What improvements have we achieved?

- Tissue Viability Nurses (TVNs) conduct monthly audits for Hot Spot Wards (wards where pressure ulcers are most frequently reported)

These audits include:

1. Percentage of patients that have a Pressure Ulcer Risk Assessment (PURAT) completed within 2 hours of admission to the ward.
2. Percentage of patients with a Pressure Ulcer Prevention Core Care Plan completed
3. Percentage of patients with the correct pressure relieving mattress
4. Percentage of patients that have a Wound Assessment and Management Care Plan completed
5. Percentage of patients with the frequency of repositioning documented on the Pressure Ulcer Prevention Core Care Plan
6. Percentage of patients who have the Intentional Rounding Tool (an assessment tool to determine a patients level of risk of pressure ulcer development) in place

- TVN's investigate wounds and pressure ulcers incidents. For each category II pressure ulcer and above, the TVN's work with the relevant ward manager to review the patient journey.
- Annual wound audit
- TVN's reviewed and updated Hot Spot Wards in July 2018

### Further improvements identified and priorities for 2018/19

- Joint working - with acute and community TVN's to develop wound management course for community services
- Review of the discharge documentation - support the review of the discharge paperwork (Led by Acute and Community Matrons) and on-going referrals on discharge from acute care to community and GP practice nursing teams.

- Trial and roll out E-referral - to the Tissue Viability Service along with springboard pointers (prompts within e-referral system)
- Education and learning from incidents - Educational poster raising pressure ulcer awareness to be printed and distributed Trust wide.
- Educational sessions to continue supporting the Academy with on-going programmes - Health Care Assistant mandatory training; the Stepping up programme; Care of the older person's course; Accelerated return to learning and Trainee Assistant Practitioner course.
- Pressure Ulcer Working Group to be established with TVN's from both the Community and Acute services.

## Acute Kidney Injury (AKI)

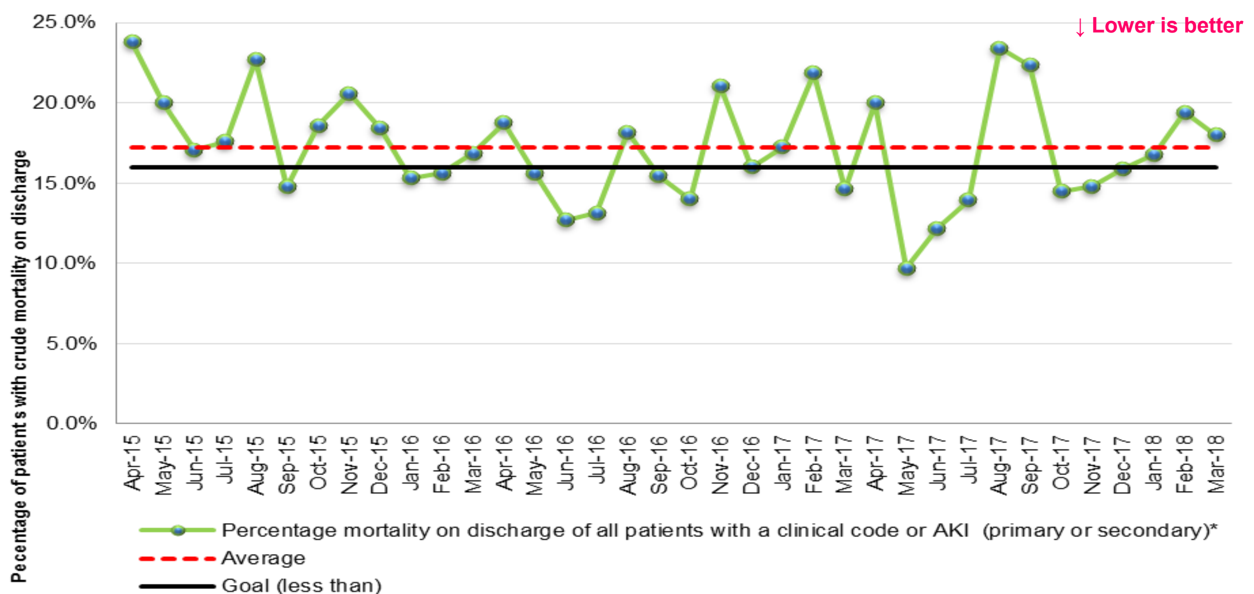
Acute Kidney Injury (AKI) is a sudden deterioration in kidney function that affects up to 20% of patients (1 in 5) admitted to hospital. It can range from minor loss of kidney function to complete kidney failure, and in the most serious cases can lead to death.

With early detection and the right care at the right time, both the risk of death and long term damage to the kidneys is greatly reduced.

As a common and potentially life threatening condition, we are passionate about proactively improving care and saving lives.

- During 2017/18 we reported an average of 16% of our patients die each year in our hospital with Acute Kidney Injury. This is a decrease on last year where we reported an average of 16.6% and have sustained our objective.

### Crude mortality on discharge: patients with a clinical code of AKI (primary or secondary)




The chart above shows the crude mortality on discharge with patients who have a clinical code of AKI (Primary or secondary.

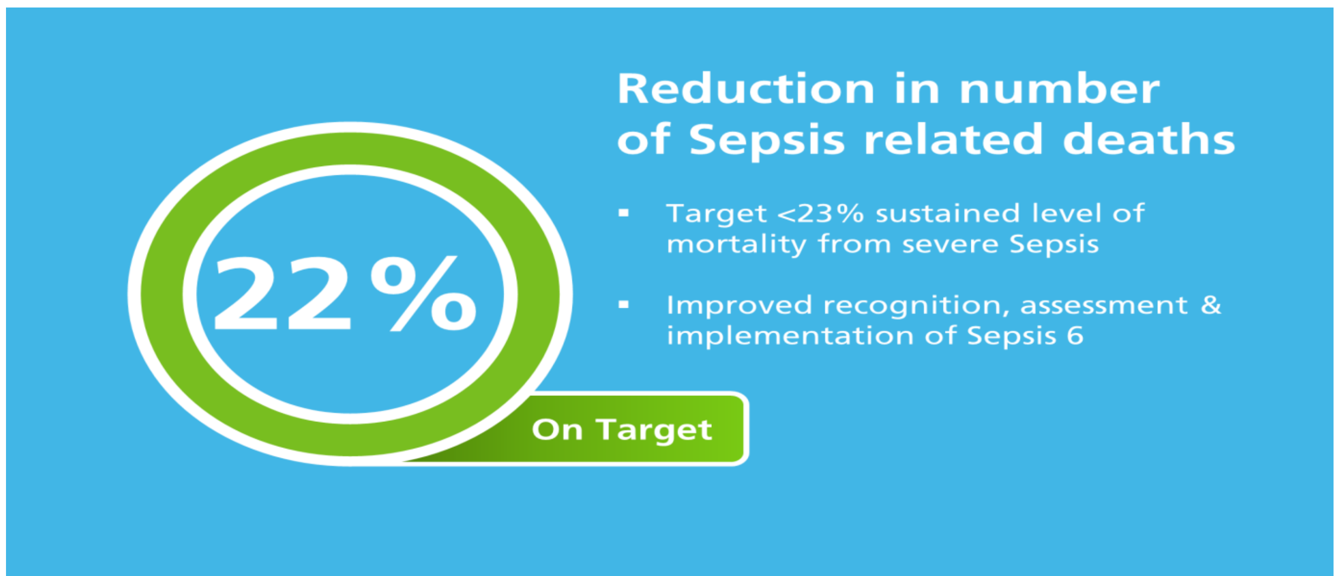
### What improvements have we achieved?

- Developed online AKI training modules for nursing and medical teams to equip clinical staff with the knowledge and skills to improve recognition and treatment of AKI.
- Implemented the AKI Kidney 5 Care Bundle which focuses on early treatment of Sepsis, Hypovolaemia, Obstruction, Urine Analysis and review for nephrotoxins (SHOUT). Patients flagged with AKI receive five standard elements of care proven to be effective in managing AKI and complex patients are managed with input from our on-site Nephrologist Dr Tanaji Dasgupta (Project Lead) so that patients with tertiary care are identified for timely transfer.
- Ward pharmacists carry out medicine reviews of all patients flagged with AKI to determine the most appropriate medication to manage their AKI and aid recovery.
- A new Acute Sepsis and Kidney Injury (ASK) Team was recruited and launched in October 2016 with support of Brighter Futures and charitable funds. Made up of five specialist nurses the ASK team are responsible for ensuring all patients with acute kidney injury are treated using the same set of clinical interventions which are based on international best practice. Funded by Brighter Futures the team also work with staff across the organisation and healthcare partners such as GPs to raise awareness of the signs and symptoms.
- Data from our Trust is shared with the Renal Registry as part of national benchmarking and we are also participating in regional quality improvement initiatives in collaboration with the Oxford Academic Health Science Network.

### Further improvements identified and priorities for 2018/19

- To continue to improve on the use of the AKI care bundle with the support of the ASK Team.
- We will develop care pathways with GPs and community healthcare providers to improve prevention of Acute Kidney Injury with our patients before coming into hospital and support appropriate care to aid their recovery once home.

## Sepsis




Sepsis is a common and life threatening condition caused by the body's own response to infection. Sepsis occurs when severe infection in the body triggers widespread inflammation, swelling and organ failure.

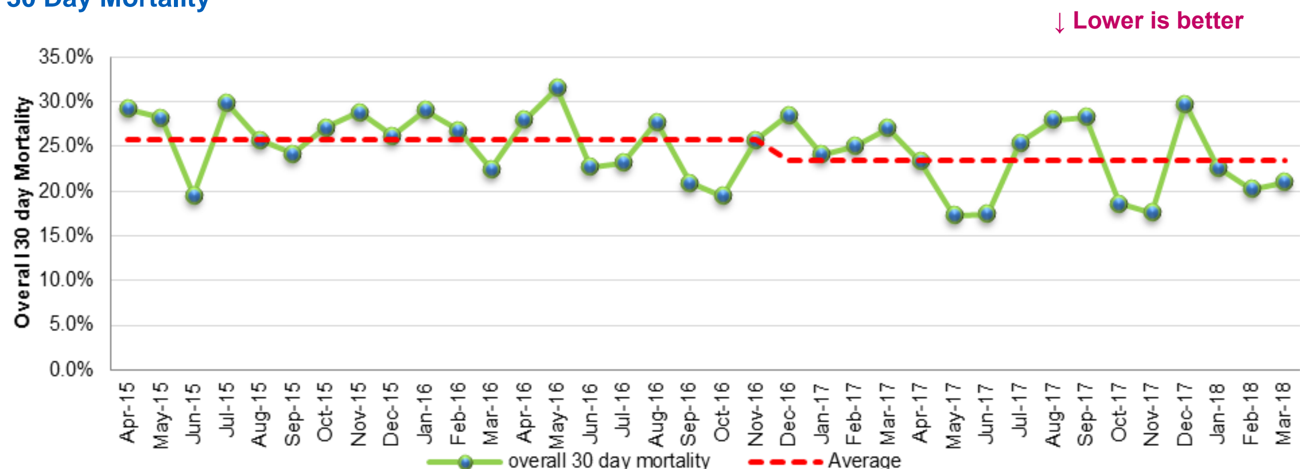
Each year in the UK, it is estimated that more than 250,000 people are admitted to hospital with sepsis and at least 46,000 people will die as a result of the condition. (UK Sepsis Trust 2017).

Effective delivery of the Sepsis Care Bundle (Sepsis 6 UK Sepsis Trust) increases patients' chance of survival by up to 30%. Overall national mortality rate for patients admitted with severe sepsis is 35%. (UK Sepsis Trust 2014) Changes to the way we diagnose and classify sepsis came into use during 2016, and is likely to continue to adapt and develop over the coming years.

In 2014/2015 we reported an average of 25% of patients admitted with severe sepsis that die within 30 days of discharge. We used this first year of data collection to set our annual mortality target to less than 23% sustained level of mortality from severe sepsis until 2018.

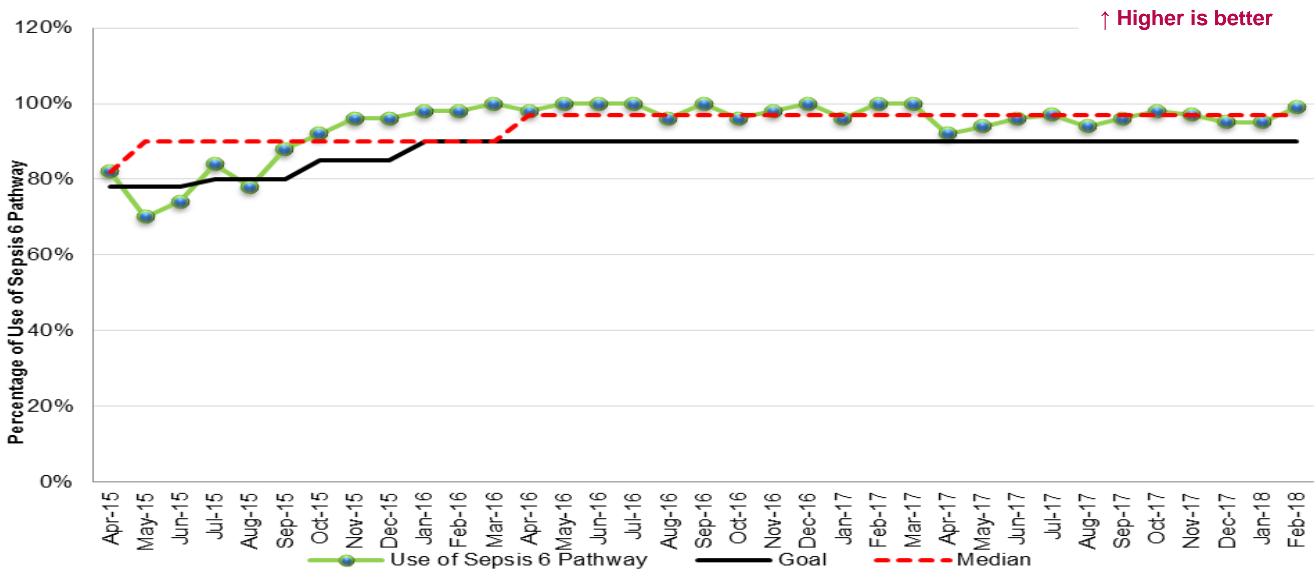
Throughout 2017/18 we reported an average of 22% patients admitted with severe sepsis died within 30 days of discharge. Whilst this is an increase on the previous year, where we reported an average of 15%, the percentage remains under our target of <23%.

### 30 Day Mortality




The chart above shows 30 day crude mortality from severe sepsis.

## Percentage of patients who have documented evidence of the use of the sepsis six pathway



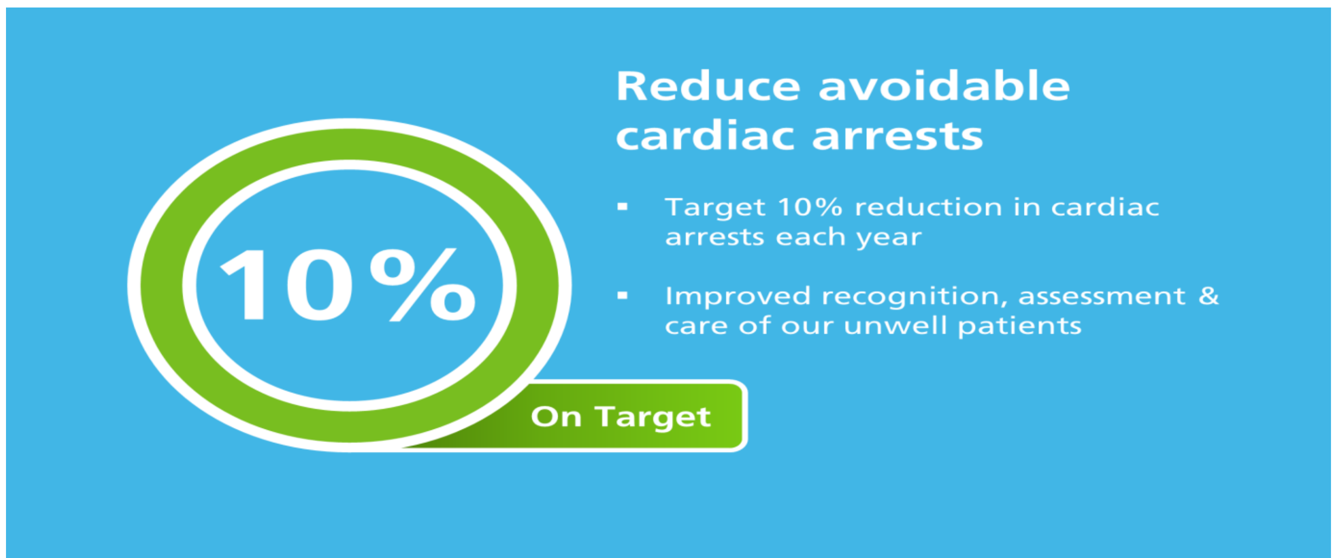

## What improvements have we achieved?

- ASK Specialist Nurses Team have now been fully recruited. Seven-day service has been running since November 2017.
- Focussed teaching around Sepsis Management and Sepsis Tools is on-going and was recently delivered to our gynaecology and acute stroke wards.
- Our sepsis campaign has had significant success in the early identification and response to this life threatening condition.
- This has brought both local and national recognition with our Sepsis Team winning a national Patient Safety Award in December 2015.
- We have continued to monitor and improve usage of our standardised Sepsis screening tool and Sepsis 6 Care Bundle for all emergency admissions to the Trust.
- Audit of all patients in our Surgical Assessment Unit (SAU) receiving Sepsis Screening.
- Extended sepsis screening to surgical patients having an emergency laparotomy.

## Further improvements identified and priorities for 2018/19

- Adapt our sepsis working group to incorporate AKI and the patient perspective.
- Continue to provide ward-based simulation training on the management of Sepsis and use of Sepsis 6 Care Bundle
- Continue our trial of an antibiotic review at 72 hours on acute inpatient wards.
- Increase compliance with the Sepsis 6 Care Bundle to continue to improve early recognition and management of severe sepsis and septic shock.
- We will develop care pathways with GPs and our community services to improve prevention of sepsis of patients before coming into hospital and appropriate care to aid recovery once home.
- Expand the trial with the use of antibiotic grab bags (pre-prepared fully inclusive sepsis package) to reduce the time taken to administer antibiotics. In addition we are also planning a grab-bag for penicillin allergic patients.

## Recognition and Rescue of the Deteriorating Patient.




Recognition and appropriate timely management of the deteriorating patient has been recognised nationally as an area of concern. Numerous reports since the 1990s have identified patients are physiologically deteriorating, however that deterioration is not recognised appropriately or acted on as required, resulting in potential harm to the patient. In the worst case scenario this can result in the patient having an avoidable cardiac arrest.

Our improvement work aims to identify the range of contributory factors underpinning this aspect of patient care and implement changes in practice to improve patient outcomes.

A Deteriorating Patient working group to reduce harm from failures to recognise and respond to acute physical deterioration has been established and leads for individual projects are identified. A nursing and medical lead jointly leads the group. Monthly meetings have been arranged and each project group have an assigned date and time to feed back their progress.

- During 2017/2018 we reported an average of 0.79 cardiac arrests per 1000 Bed Days. This is an improvement on last year where we reported an average of 0.88 cardiac arrests per 1000 Bed Days.

### What improvements have we achieved?

- Fully implemented and embedded the standardised National Early Warning Score (NEWS) Trust Wide, including community areas – monthly audits continue to provide assurance on compliance and accuracy
- Imminent introduction of Nervecentre – Electronic Observations (Summer 2018) Electronic capture, calculations of NEWS, and automated cascading escalations to ensure recognition is followed by rescue.
- Simple Observation Capture (A hand held device for easy capture of observations that automatically calculates News scores)

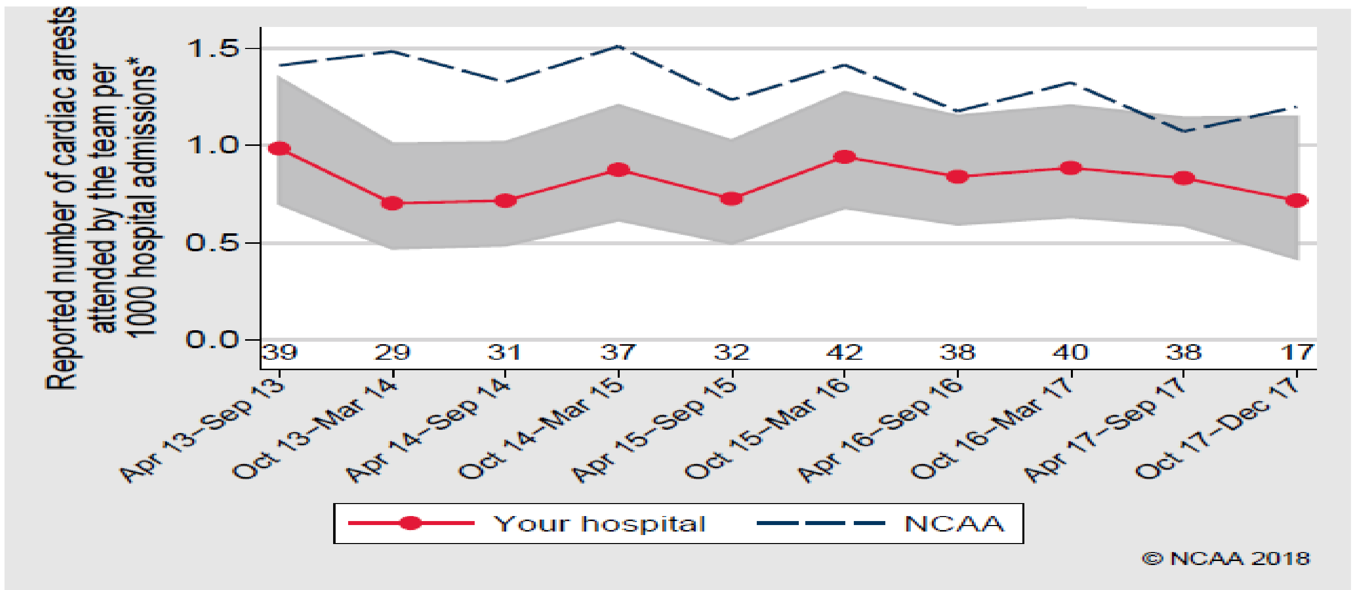
- Immediate Alerts
- Due and Overdue Reminders
- Adults and Paediatrics
- Cascading Escalations
- Once Electronic-Observation has been introduced the Trust will switch over to NEWS2 by end of September 2018. (NEWS2 is the next evolution of early warning scoring)
- New Matron lead for 24/7 Critical Care Outreach Team
- All cardiac arrest within the Trust are reviewed to assess if they were avoidable / unavoidable
- Introduction of the Ward Assessment and Accreditation framework, which rates each clinical area on their effectiveness in responding to the deteriorating patient.
- Hospital at Night – As of January 2018 an advanced clinical practitioner (ACP) has been rostered every night to support medical ward work until the end of March 2018. This supported the Foundation Year 1 Doctors (FY1) to manage their work load and provide support on the wards.
- The following tasks were allocated to the ACP, which allowed the FY1 to review the more unwell and deteriorating patients on the wards:

    - Escalating NEWS score / deteriorating patient
    - Cannulation / venepuncture
    - Review of Intravenous fluids
    - Confirmation of death
    - Catheterisation
    - NG tube insertion

A case for permanent ACP to provide Hospital at Night cover has been established and results from this current trial will be collated.

## Rate of Cardiac Arrests per 1000 hospital admissions

↓ Lower is better

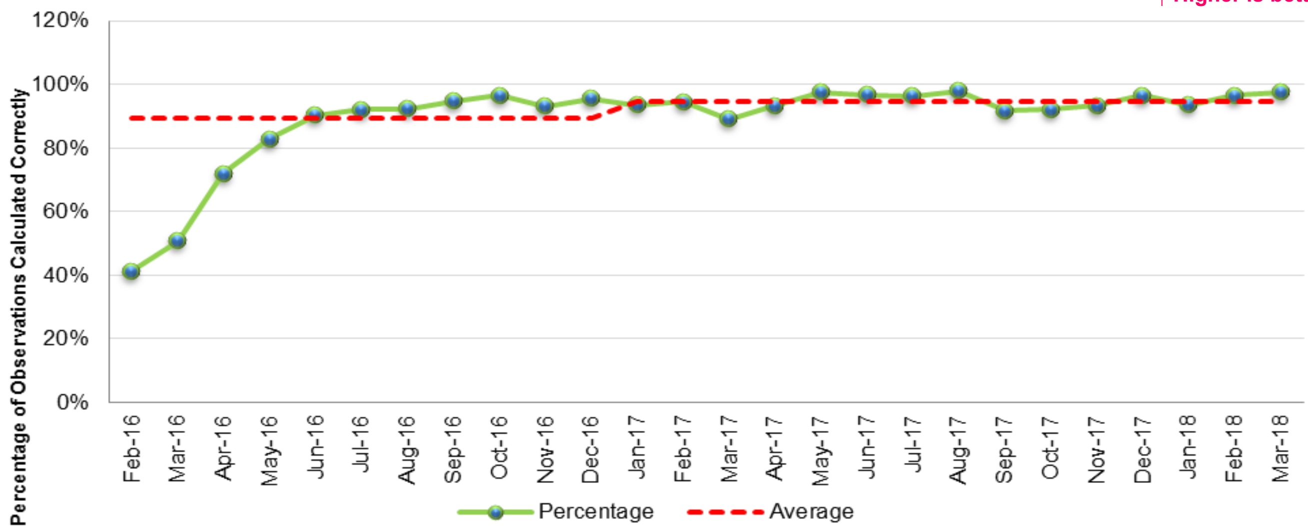



The chart above shows our cardiac arrests per 1000 hospital admissions for the period of 01 April 2017 – 31 December 2017 in comparison to National Cardiac Arrest Audit (NCAA).

Whilst we continue to work to reduce the number of cardiac arrests, the chart demonstrates that the Trust's cardiac arrest numbers are fewer than the number that is reported nationally through the NCAA. The Trust's average rate of cardiac arrest per 1000 admissions is 0.79 for April 2017 – March 2018.

## Percentage of Observations with NEWS Score Calculated Correctly

↑ Higher is better




The chart above shows the percentage of patients Trust wide with a NEWS Score calculated correctly. We have achieved an average of 95% and above from January 2017.

### Further improvements identified and priorities for 2018/19

- Joint medical & nursing lead to continue to lead the deteriorating patient project
- To introduce and embed Electronic -Observations into the acute Trust
- To move to the next stage of electronic observation (NEWS2) by the end of September 2018
- Business case for Advanced Clinical Practitioner to support 'hospital @ night' project to be presented
- Continuation of ward-based simulation training & introduction of short trolley teaching rounds carried out on ward area's planned.

## Quality Improvement Capability and Capacity

Quality improvement skills are beginning to develop within the organisation; Staff are actively sign posted to external providers such as the Academic Health Science Networks for formal QI training. Quality Improvement toolkits have been developed and are available on the Trust Intranet site.

Many more staff are developing QI skills and expertise through involvement in projects at local and regional level.

Six members of staff have joined the Health Foundations QI Community, gaining access to regional networks and training opportunities.

### Further improvements identified for 2018/19

A business case setting out proposals to increase capacity to develop and deliver a plan to build the organisations quality improvement capability and capacity has been drafted.

Progression of this business case during 2018/19 will be a key to achieving the following priorities:-

- Development, delivery and evaluation of a strategy and plan to build organisation wide knowledge and skills in quality improvement;
- Assessment of organisational quality improvement capability and capacity;
- Delivery of a coordinated programme of training to provide staff with the skills and knowledge to use QI methodology in practice
- Provision of coaching support to individuals and teams undertaking quality improvement projects;
- Project leadership for high risk Trust wide projects such as Handover, delaying change and improvement

Identify key members of staff to apply for membership of the Health Foundations Q Community during the next application round.

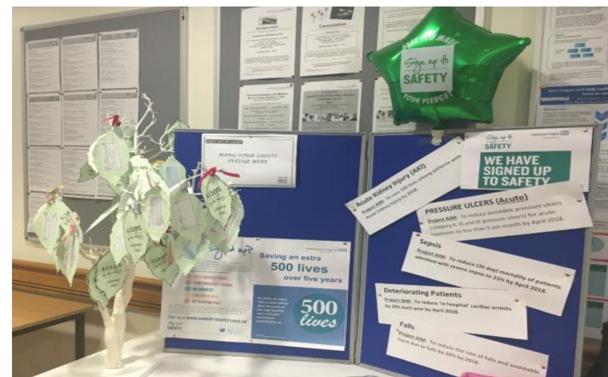
## Celebrating Success

Due to the success of our first Speak out on Safety Event held in September 2016 where 75 members of staff and external stakeholders attended the event and Martin Bromley, Chair of the Clinical Human Factors Group was a guest key speaker, we are holding our 2nd Speak out on Safety Event on 8th June 2018.

This full day event with have guest key speakers Adrian and Emma Plunkett 'Learning from Excellence' and Jonathan Peach @Art of Brilliance'.

This event will also cover key quality improvement work streams under our Sign up to safety campaign and opportunities for staff to share their success stories, safety pledges and the amazing work that they are doing every day.

11.3



## 11.4 Reporting against core indicators

## Continue to reduce our numbers of healthcare associated infections

### *Clostridium difficile*

The Great Western Hospitals NHS Foundation Trust considers that this data is as described because as with MRSA, in England it's mandatory for Trusts to report all cases of *Clostridium difficile (Cdiff)* to Public Health England.

In England, it is mandatory for Trusts to report all cases of *Cdiff* and MRSA bloodstream infections to Public Health England (PHE).

The nationally mandated goal for 2017/2018 was to report no more than 20, Acute or Community Hospital, cases of C.diff. We have reported 25 cases, 4 more than 2016/2017. Each case has been investigated in conjunction with our Commissioners. Of the 25 cases, 16 have been deemed unavoidable and five have been deemed as avoidable and care improvement recommendations made. 4 cases remain pending an investigation outcome.

We have introduced and maintained a number of initiatives and taken the following actions to improve patient safety, including improvements as a result of learning from our investigations throughout 2017/2018.
These include:

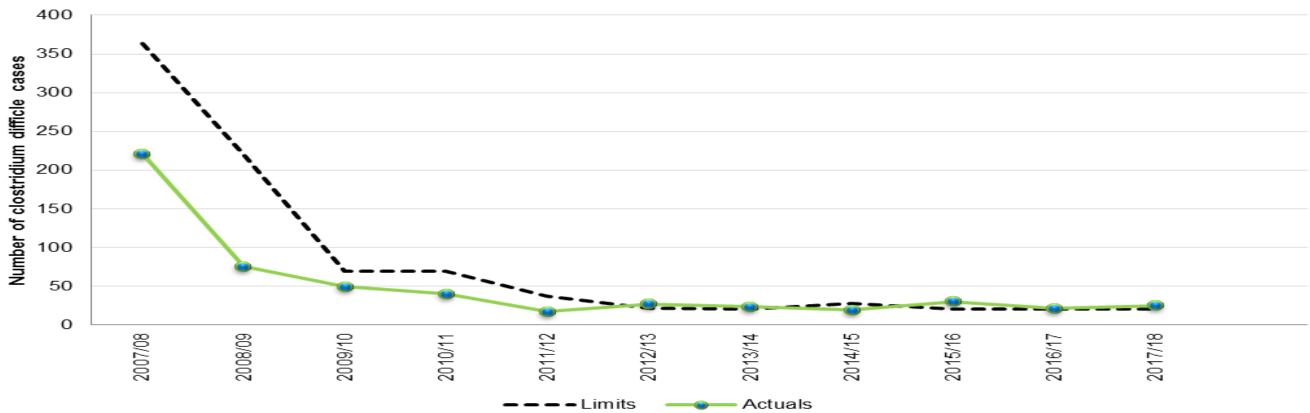
- Development of a *Cdiff* infection reduction plan – this is monitored on a regular basis to ensure it reflects identified areas of concern
- A multi-disciplinary team reviews each inpatient on a C.diff ward round weekly to ensure appropriate on-going management.

- Periods of observed practice undertaken on wards to gain assurance that staff consistently comply with standard infection control precautions the *Cdiff* policy, which had in particular focused on hand hygiene and cleaning patient care equipment
- Wards ensuring compliance with IPC mandatory training attains a minimum of 85%, this includes the nurse bank

- Auditing the time to isolation of patients and the timeliness of specimen taking patients when loose stools develop. For patients with known C.diff, this includes keeping side room doors closed and completion of *Cdiff* care bundle daily
- Close monitoring of the use of higher risk antibiotics by the prescriber with support from the microbiologist and pharmacy team
- Commencing an early huddle type multi-disciplinary review which is underpinned by root cause analysis conducted on each *Cdiff* case. This enables clinicians involved in the patients care to identify areas of improvement and ensure prompt and timely lessons learnt that are shared with all staff concerned

## Number of *clostridium difficile* cases 2017/2018

↓ Lower is better




The graph above shows the numbers of reported *Cdiff* cases in from 2007 through to 2017/18.

## Our priorities for 2018/19

We plan to continue monitoring and reducing risk factors for *Cdiff* including promoting antibiotic stewardship, rapid isolation and sampling.

Recommendations identified through the 2017/18 time to isolation & specimen taking audit will be implemented through quality improvement methodology. In addition, ward/departmental ownership of local cleaning standards, including patient care equipment, antibiotic prescribing needs to continue with the aim of preventing avoidable cases of C.diff.

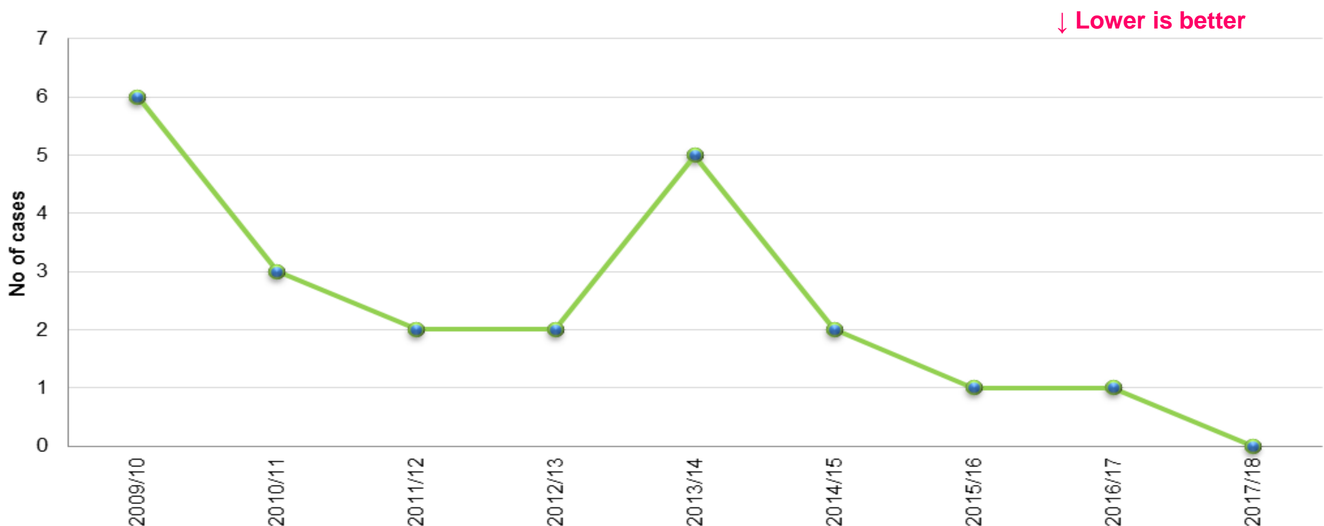
### Methicillin Resistant Staphylococcus Aureus (MRSA)

During 2017/18, the Trust met the national target of reporting zero cases of MRSA bloodstream infections.

In addition to the standard practice of screening all emergency and specific categories of elective patients for MRSA, isolating and decolonising patients with positive results, the Trust has taken the following actions to improve patient safety:

- On-going monitoring of compliance to hand hygiene, standard precautions and MRSA policy across all professions
- Timely application of appropriate decolonisation regimes through education and introduction staff friendly instruction leaflets. Compliance with decolonisation is monitored through audit
- Blood culture contamination rates are reviewed monthly and a quality improvement initiative implemented in the Emergency Department which has reduced blood culture contaminant rates
- Prompt management of patients displaying red flags for sepsis.

### Acute Cases of Trust Apportioned MRSA Bacteraemia



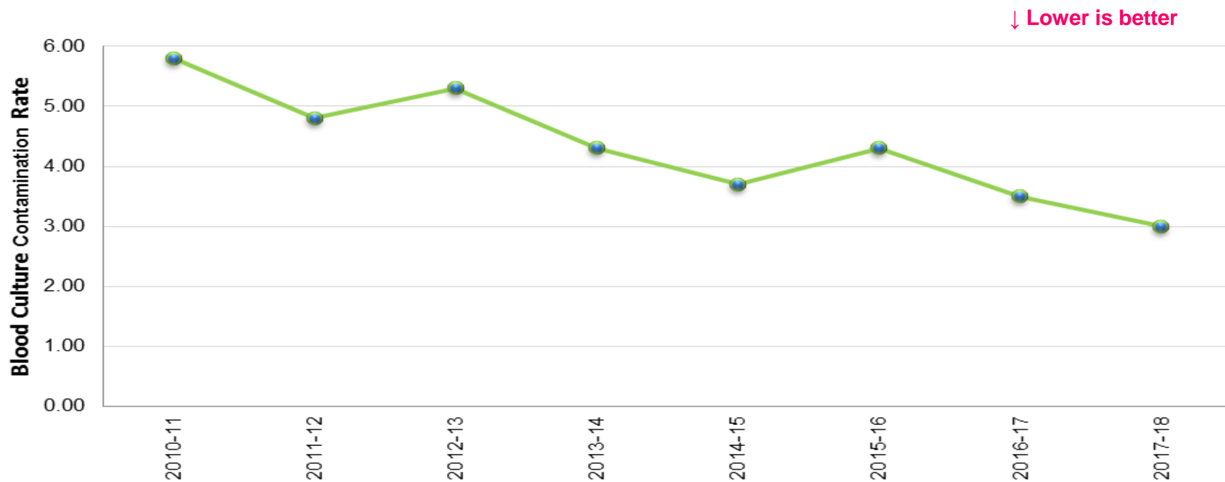

The graph above shows the number of cases of Trust apportioned MRSA bacteraemia to Great Western Hospitals NHS Foundation Trust up until 2017/18.

### Our priorities for 2018/19

We plan to continue prompt management of patients displaying red flags for sepsis.

In addition, we will monitor the screening regime currently in place to provide assurance that all MRSA positive patients are managed appropriately. Ward/departmental ownership of local cleaning standards, including patient care equipment, will also continue.
The focus for 2018/19 will be on sustaining the reduction in blood culture contamination rates which is recommended to be below 3%.
In 2017/18 the average contamination rate was 3%. Rates have been reducing on a year on year basis since 2012/13.

### Trust-wide Blood Culture Contamination Rate 2010 -2018

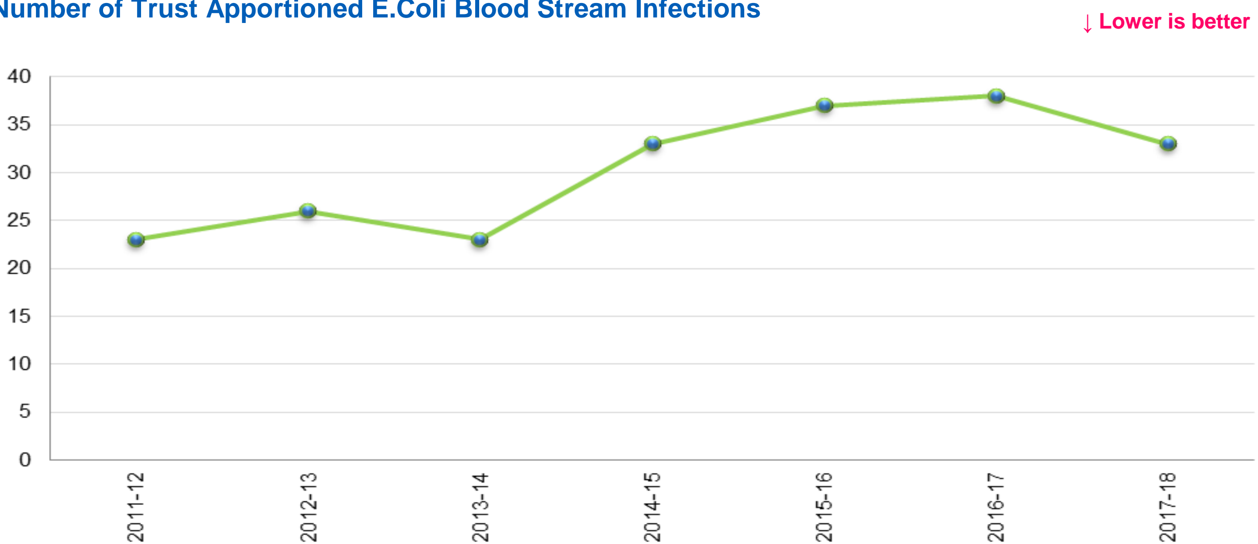



The graph above demonstrates the Trust's blood culture contamination rate from 2010 through to 2017/18 where the Trust achieved the recommend rate of 3%.

In line with national requirements, the submission of E.coli data to Public Health England (PHE) has become mandatory. From April 2017, it became mandatory to report data on other gram negative blood stream infections, Klebsiella spp and Pseudomonas aeruginosa.

During 2017/18, no targets were set for E.coli, Klebsiella spp and Pseudomonas aeruginosa blood stream infections (BSI). A total of 33 E.coli BSI, eleven Klebsiella spp BSI and 18 Pseudomonas aeruginosa BSI have been reported in acute trust patients, this encompasses patients in whom the specimen was taken 48 hours after admission to hospital, during 2017/18.

### Number of Trust Apportioned E.Coli Blood Stream Infections




The graph above shows the number of cases of Trust apportioned E.coli BSI to Great Western Hospitals NHS Foundation Trust up until 2017/18.

Following the introduction of a Commissioners quality premium to reduce healthcare associated Gram-negative blood stream infections (healthcare associated GNBSIs) by 50% by March 2021, the Trust has worked with our commissioners to review local data and compare this against the national picture of known healthcare associated risk factors.

In order to reduce preventable gram negative blood stream infections across both acute and community services provided by Great Western hospital a gram negative reduction plan has been implemented, with the intention of reducing, where safe to do so, risk factors associated with the development of GNBSI.

Progress is monitored through the Infection Control Committee and surveillance continues to identify risk factors and key areas for improvement. The Catheter associated UTI work stream underpins much of the reduction plan and involves close links with the Oxford Academic Health Science Network.

### Our priorities for 2018/19

We plan to continue monitoring the gram negative reduction plan and increasing our understanding of risk factors associated with GNBSI, through surveillance and reporting, as we work towards a 50% reduction by March 2021.

Specific programmes of work across acute and community services commenced in 2017/18 will continue including effective surveillance, prudent antibiotic prescribing in line with guidelines, promotion of hydration, CAUTI work stream, reaffirming best practice in Infection Prevention and Control policies, and enhancing patient education and information when discharged with invasive devices.

## 11.5 Patient Safety

## Never Events

The Great Western Hospitals NHS Foundation Trust considers that this data is as described because it is required that all NHS Trusts report all Never Events to NHS Improvement, National Learning and Reporting System (NRLS) and local commissioners in line with the Never Events Policy and Framework.

Never Events are Serious Incidents are wholly preventable. There is guidance (Never Events Policy and Framework) which was recently updated in April 2018 that provides strong systemic protective barriers that are available at a national and local level and should be implemented by all healthcare providers.

Each Never Event type has the potential to cause serious patient harm or death. However, serious harm, or death, does not have to be the overall outcome of an incident for it to be categorised as a Never Event under the NHS Never Events framework.
We have reported one never event between April 2017 to March 2018. We see no significant variance in the reporting of Never Events as we reported one Never Event for the same time period in 2016/2017. The following Never Event was reported in April 2017:

- Wrong site surgery

The incident has been reported and investigated and managed through the Trusts Incident Management and Clinical Governance process. An action plan was developed, with implementation of recommendations monitored by our Patient Quality Committee. The final incident report was also shared with the patient, our Commissioners, the CQC and Monitor.

The Great Western Hospitals NHS Foundation Trust has taken the following actions to improve the number of Never Events reported and the quality of its services, the actions specifically relate to the wrong site surgery never event reported in April 2017;

- Current methods of tooth identification prior to dental extraction was reviewed. Where it was not practicable to mark tooth or teeth, then alternative marking processes were considered.
- A pause and check process has been implemented immediately prior to each individual extraction. Allowing the dental surgeon time to concentrate and confirm the exact tooth for extraction.
- The pause and confirmation step is a verbal read back from a second person (Normally Dental Nurse) to confirm the location of the tooth for extraction according to the Radiological investigations available, and as per the patient's signed consent.
- The WHO Surgical Safety checklist has been reviewed, and amended to include a pictorial diagram of a jaw, and is completed during "Time Out" to confirm the location and number of the teeth to be extracted.

## Continually learn - Reduce Incidents and Associated Harm

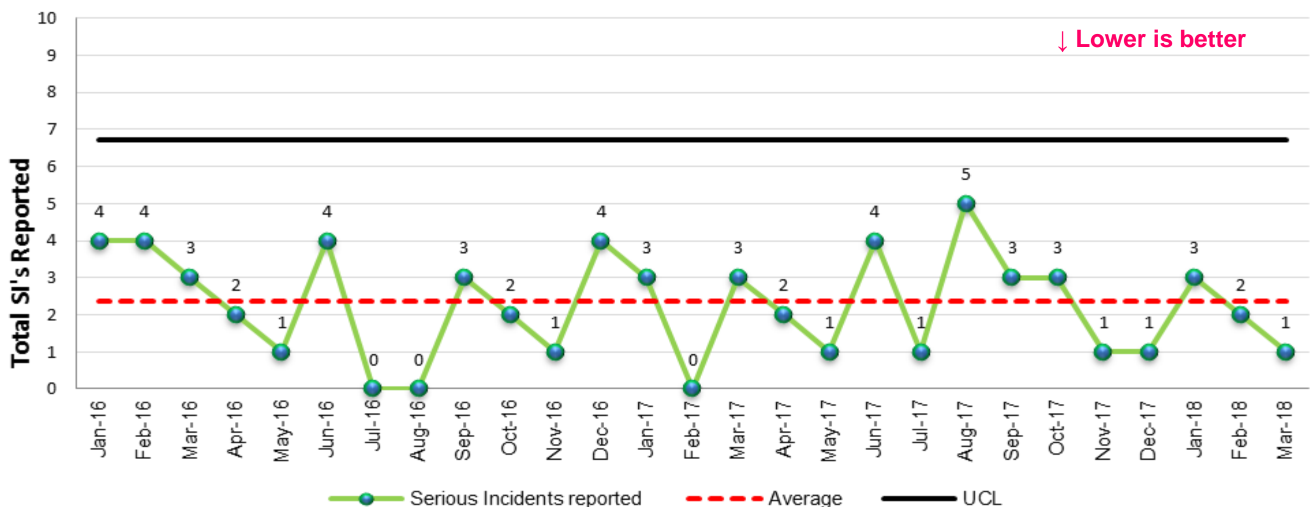
### Serious incident reporting

The Great Western Hospitals NHS Foundation Trust considers that this data is as described because it is required that all NHS Trusts report all serious incidents their local commissioners and the NRLS in line with the Serious Incident Framework.

A total number of 27 serious incidents were reported and investigated during the period April 2017 to March 2018. This is an increase of 1 serious incident compared to 2016/17.

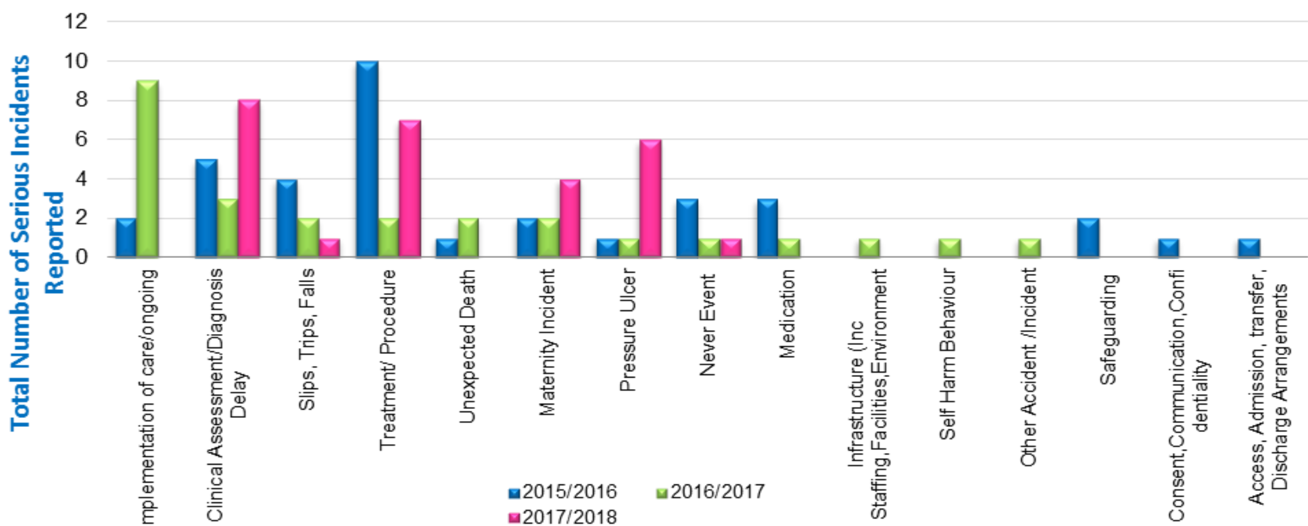
- All patient safety incidents that were reported within the Trust were submitted to the National Reporting and Learning System. Our reporting performance is evaluated against other medium acute Trusts within the cluster group biannually following the publication of the NRLS Organisational reports.
- All Serious Incidents were reported to our Clinical Commissioning Groups and to the Strategic Executive Information System (STEIS) system.

### Serious incidents reported 2017/18




The graph above shows the number of serious incidents reported in 2017/18.

### Serious incidents reported by type in from 2015/16 – 2017/18



The graph above shows the Trust's serious incidents reported by in 2017/18 compared to previous years broken down by category.

The most frequently reported types of serious incident are:-

Problems with Clinical Assessment which includes delays in Diagnosis, Interpretation and response to diagnostic procedures and tests;

- Treatment Procedure
- Pressure Ulcer's

The increased number of incidents involving problems with Clinical Assessment which includes delays in Diagnosis, Interpretation and response to diagnostic procedures and tests is due in part to improved reporting of incidents and Human Factors.

We reviewed all Serious Incidents and incidents with contributing factors involving problems with clinical assessment which includes delays in diagnosis to identify commonalities directly informed Patient Quality Improvement projects relating to improved Clinical Assessment, Diagnosis and interpretation of diagnostics.

The Great Western Hospitals NHS Foundation Trust has taken the following actions to improve the number of Never Events reported and the quality of its services, the actions specifically relate to clinical assessment, delays in diagnosis and interpretation and response to diagnostic procedures and tests:

- Develop a Child and Adolescent Therapeutic Holds and Restraint Policy, to include advice in relation to children and the use of therapeutic holds to enact treatment plans.
- Recruitment of 2 further consultant radiologists, this will support a reduction of work load per consultant.
- Radiology plan to work in line with the Royal Collage of Radiologists recommendations in the Clinical radiology workload: Guidance. The department will have a plan in place to meet the requirements regarding image review by June 2018.
- To revise process for removal of dressings used in Negative Pressure Wound Therapy Management.

We disseminated learning from serious incidents to all speciality groups and Clinical Governance Leads where assessment and relevance of recommendations from all incidents have been shared to ensure that appropriate actions were taken to improve similar processes in their own departments.

The Great Western Hospitals NHS Foundation Trust intends to take the following actions to improve the number of serious incidents reported and the quality of its services, by

- Continue to theme incidents to identify key trends that could influence change which will be shared through all quality improvement work streams to inform work stream initiatives.
- We will continue to share recommendations and learning from serious incidents Trust-wide which inform improvements to systems and processes within specialities.

### Incident reporting and benchmarking

The Great Western Hospitals NHS Foundation Trust considers that this data is as described because it is required that all NHS Trusts report all patient safety incidents to the National Reporting and Learning System (NRLS).

The Trust uploads all reported patient safety incident forms to the (NRLS) on a daily basis. The number of incidents we have reported in the last 7 financial years are as follows:

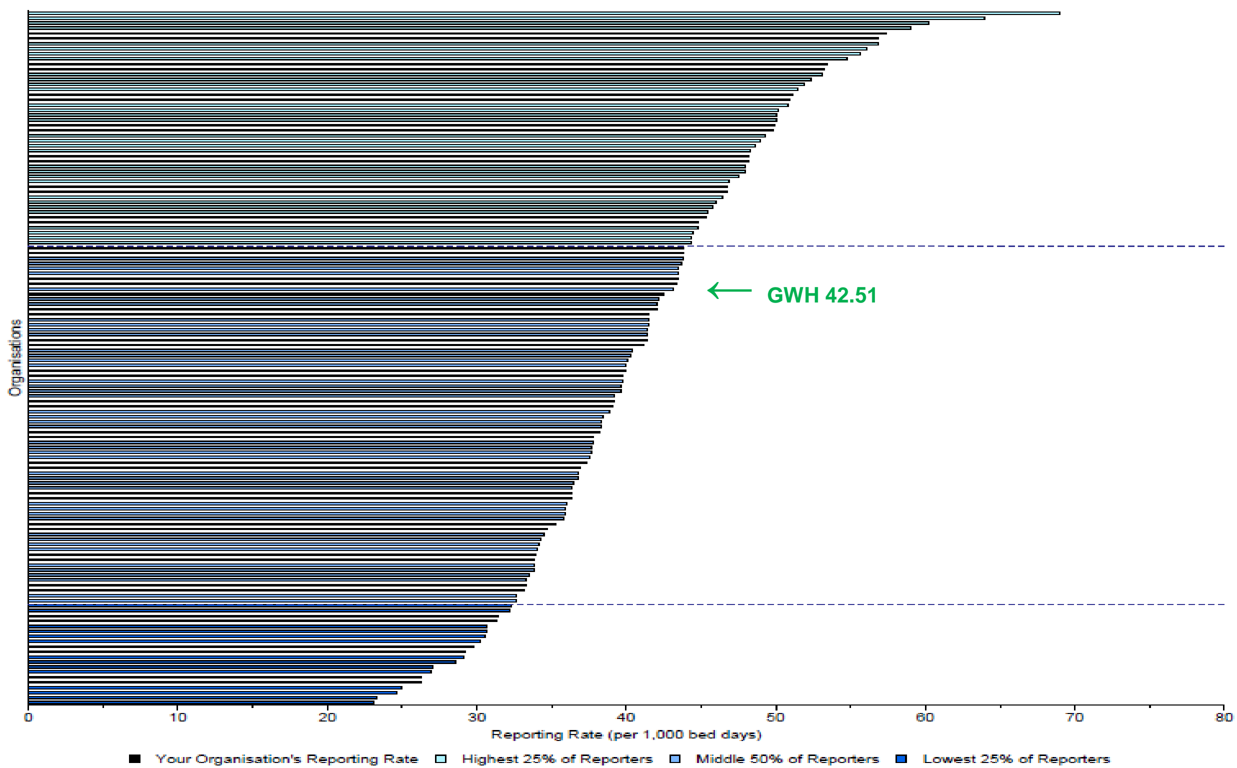
| Reporting Year | Non clinical incidents / Health and Safety | Patient Safety Incidents reported to NRLS | Total |
|---|---|---|---|
| 2011/2012 | 2493 | 6513 | 9006 |
| 2012/2013 | 2405 | 6928 | 9333 |
| 2013/2014 | 3596 | 6967 | 10563 |
| 2014/2015 | 4164 | 6678 | 10842 |
| 2015/2016 | 4801 | 6274 | 11075 |
| 2016/2017 | 4457 | 8373 | 12830 |
| 2017/2018 | 3627 | 7632 | 11259 |

### How do we compare with other organisations?

NHS England National Reporting and Learning System (NRLS) release an Organisational Patient Safety Incident report twice a year providing organisational and comparative incident data.

### Comparative reporting rate per 1000 bed days for 134 acute (non-specialist) organisations

### 01 October 2016 – 31 March 2017



The Trust reported 3831 incidents between 1st October 2016 to 31st March 2017 with a rate of 42.51 per 1000 bed days. The median reporting rate for this cluster is 40.14 incidents per 1000 bed days.

The Trusts reporting rate has increased from the previous reporting period 01 April 2017 30 September 2017 when 38.44 incidents per 1000 bed days were reported .

During 2017/18 our focus was on improving our reporting culture throughout the Trust through our rebranding of incident reporting from IR1's to Safety Incident Forms. We also devloped a safety video involving a range of staff across the Trust on the benefits and importance of reporting safety incidents and obtaining feedback to aid learning with individual reporters and trust-wide.

The Great Western Hospitals NHS Foundation Trust intends to take the following actions to improve the reporting of all safety incidents and the quality of its services, by

- Delivering incident awareness road shows throughout the year Trust-wide, to promote the benefits of incident reporting which can have positive impacts on improving patient safety.
- To continue to review and embed all types of feedback mechanisms which aids the sharing of learning from all incidents to individual reporters as well as teams and Trust-wide.
- Safety incident video's about individual investigations to aid shared learning and promote awareness Trust-wide.

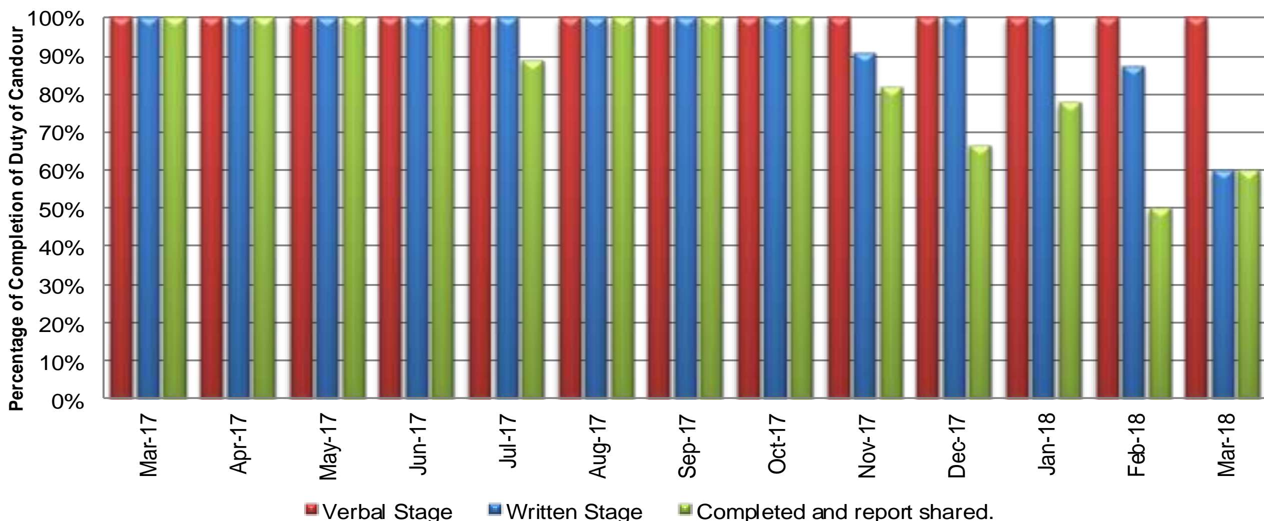
## Duty of Candour

Duty of Candour is a legal duty which came into force in April 2015. As a trust we are legally obliged to inform and apologise to our patients if there have been mistakes in their care that have led to significant harm. Duty of Candour aims to help our patients receive accurate, truthful information and providing reasonable support and an apology when things go wrong. Errors occur at the best hospitals and clinics - despite the best efforts of talented and dedicated professionals.

Duty of candour means 'being open' as soon as possible after an incident:

- Informing the patient or their family that an incident has occurred
- Acknowledging, apologising and explaining the incident – and confirming this in writing
- Providing information
- Providing reasonable support
- Inform the patient in writing of the original notification and the results of any further enquiries.
- Saying sorry is not an admission of liability and is the right thing to do.

### Compliance with each stage of Duty of Candour




The graph above shows the compliance at each of the three stages of Duty of Candour. Some cases are still currently under investigation and will be shared with the patient, family or relatives upon completion.

To continue to improve on Duty of Candour and the support we provide to our patients, their family and relatives following errors, the following improvements have been put in place:-

- Revised Duty of Candour (Being Open Policy)
- Duty of Candour E-Learning training tracker released in June 2016, all new employees are required to complete the training after induction. The Trust's compliance is currently recorded as 88.88%.
- The Trust's incident reporting system allows us to record Duty of Candour against individual incidents
- Template letters embedded into the incident reporting system to support managers.
- Data extraction facility within the Trust's incident reporting system, which enables us to record and monitor compliance with all significant harm cases. This facility helps to identify any areas of non-compliance.
- The Duty of Candour leads and division are then supported to complete the required elements
- Duty of Candour compliance is monitored at divisional level and within the Patient Safety and Clinical Risk Team with any exceptions reported to divisional boards and our Patient Quality Committee.

### Priorities for 2018/19

- To continue our modular training programme for Root Cause Analysis (RCA) including Duty of Candour training.

## Venous Thromboembolism (VTE) risk assessment and hospital acquired thrombosis events

The Great Western Hospitals NHS Foundation Trust considers that this data is as described because data is collated in a variety of ways including the electronic prescribing system and compared to the total number of admissions during any given month. For clinical areas that do not use the electronic system, manual collation is used and validated by the lead for VTE and the informatics team.

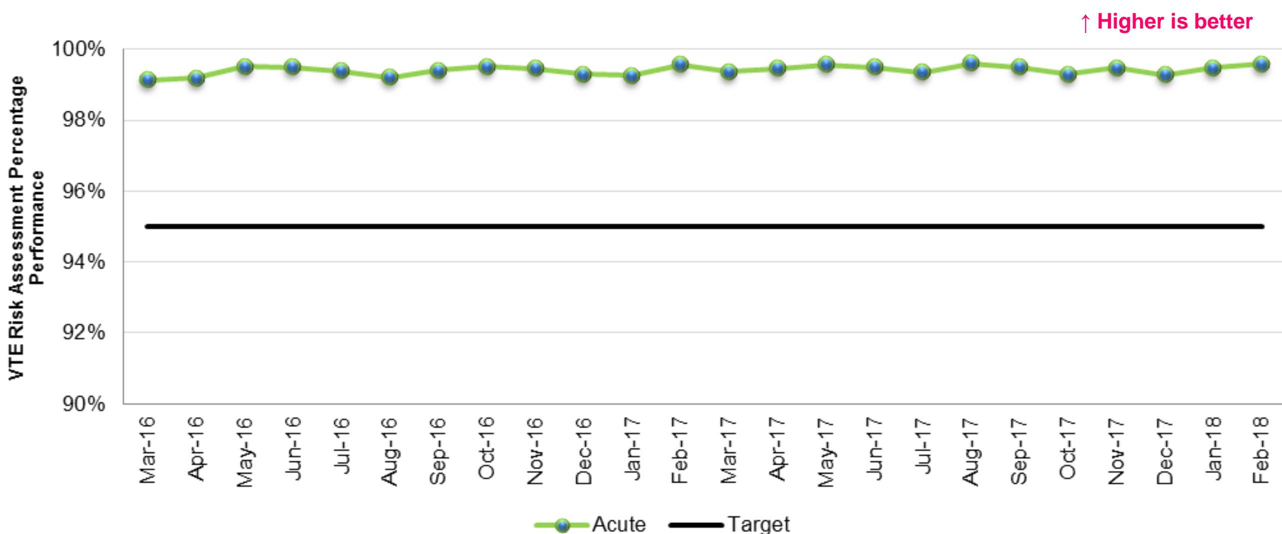
This validation is undertaken bi-monthly and information disseminated to all clinical areas so that any performance requiring review is highlighted.

All adult patients who are admitted to our trust should undergo a risk assessment to determine their risk of developing a VTE related episode (For example a blood clot such as deep vein thrombosis (DVT) or pulmonary embolus (PE)).

The national target is set at 95%, which means that at least 95% of patients admitted to hospital should be risk assessed on admission.

We can now more easily access data via our electronic prescribing system which is in place on the majority of the wards at our acute site. The system allows us to audit the process more easily and can identify which patients have had a risk assessment and what time this was undertaken. The name of the clinician completing the assessment is clear which enables us to inform clinical leads in a timely manner when parts of the assessment have not been fully completed.

### VTE risk assessment performance March 2016 – March 2018




The graph above shows the Trust's VTE Risk Assessment performance, we have consistently achieved above 99% for 24 months.

## Appropriate Prevention and Hospital Acquired Thrombosis Events

The Great Western Hospitals NHS Foundation Trust intends to take the following actions to maintain this score and so the quality of its services, by continuing to ensure that the processes in place that help us to achieve our target are maintained and provide high quality care for our patients in preventing blood clots whilst they are hospitalised.

- Once patients have had a risk assessment we want to ensure that they receive the appropriate preventative treatment. We monitor this using a national audit tool called the “safety thermometer”.

- This looks at all patients in the hospital on one day each month and checks for a number of patients on each ward that have a VTE risk assessment and how many patients receive the appropriate preventative treatment. We currently give appropriate preventative treatment to 90-95% of patients.

- For all hospital acquired thrombosis events we carry out a root cause analysis first to make sure that a risk assessment has been carried out and also if the patient received the treatment they should have. If part or either of these points have not been done then a more detailed root cause analysis is carried out to determine why and to make sure that we learn from the findings to help prevent the same thing happening again.

- Some cases are unavoidable and these are documented which allows us to look at certain specialities where we need to consider providing more preventative treatment for longer.

## Effective Care

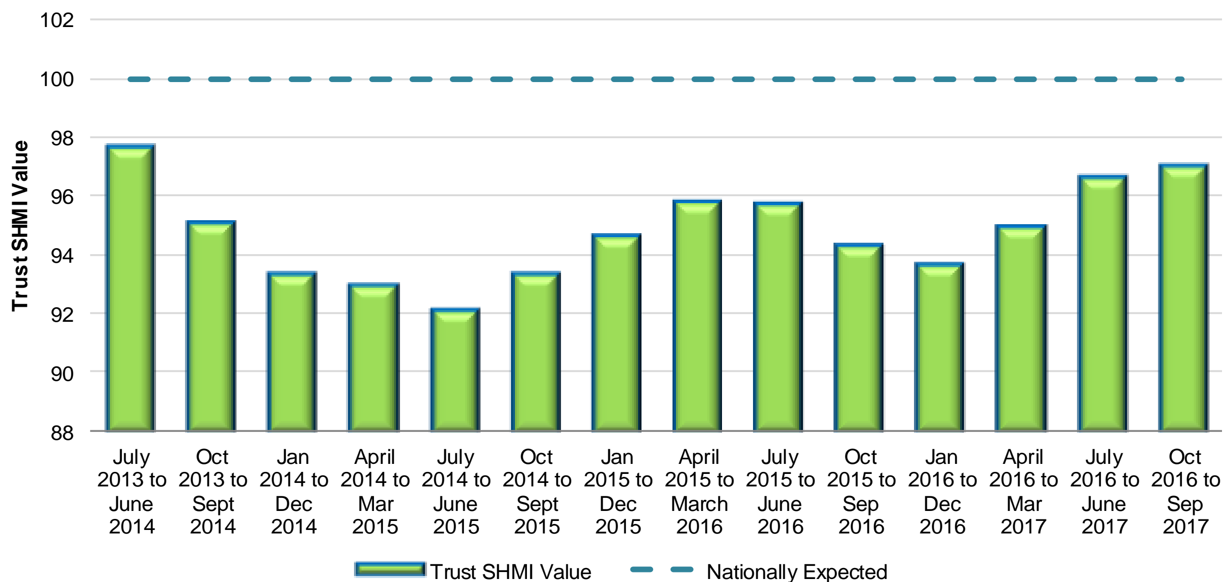
### Summary Hospital Mortality Indicator (SHMI)

The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at Trust level across the NHS in England. This indicator is produced and published quarterly as an experimental official statistic by the Health and Social Care Information Centre (HSCIC).

The SHMI is the ratio between the actual number of patients who die following treatment at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

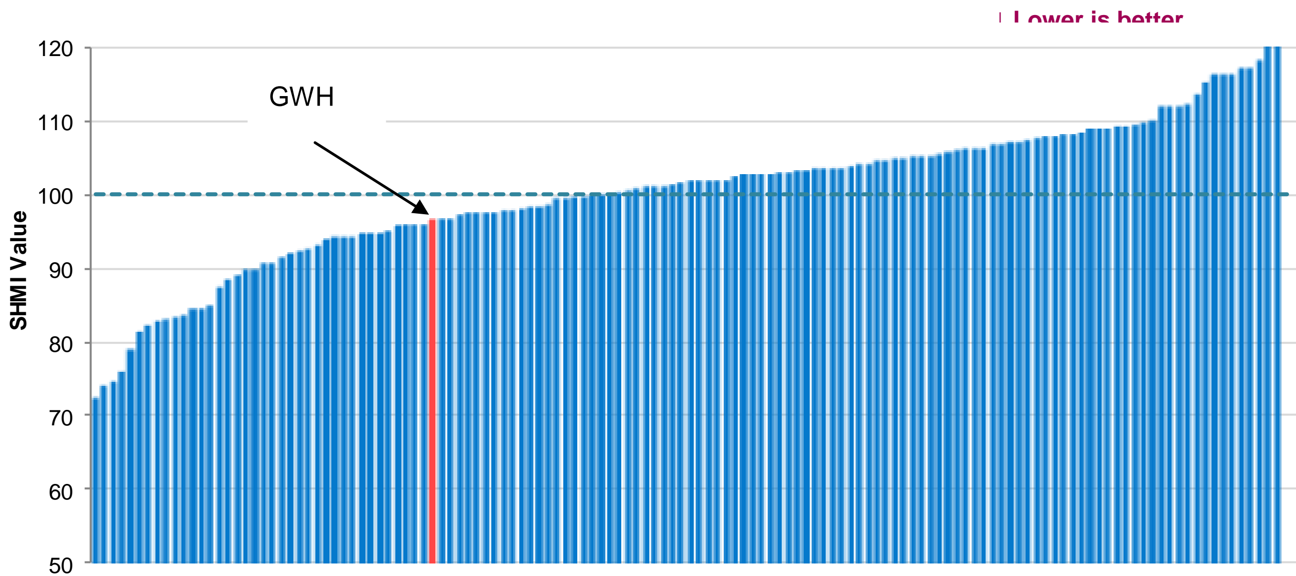
The Trust's SHMI for the rolling 12 month period of July 2016 to June 2017 is 96.65, with the confidence limits 92.14 to 101.33 giving the Trust an 'As Expected' rating. The SHMI for this period is lower (better) than the nationally expected value of 100, and is similar to the previous 12 month period (January 2016 to December 2016). This is showing a similar trend to the HSMR figures.

### Summary Hospital Mortality Indicator (SHMI) GWH




NB the SHMI is always at least 6 -9 months in arrears

**National SHMI October 2016 – September 2017**




The chart above shows how the Trust's SHMI compares nationally and demonstrates the Trust was positioned within the lower (better) half overall between October 2016 – September 2017. The red line depicts GWH, and the green horizontal line is the nationally expected norm.

The Great Western Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- The data is reviewed on a monthly basis by the Trust Mortality Group and the Patient Quality Committee
- The data is included in the Trust quality and performance dashboards which are reviewed by the Trust Executive Committee and Board as well as relevant CCG Committees
- It is a key indicator of the quality of care we provide
- This indicator is produced and publicised by the HSCIC

## Hospital Standardised Mortality Rate (HSMR)

The Hospital Standardised Mortality Rate (HSMR) is an external validated method of calculating and comparing mortality rates. This information is analysed and presented to all Trusts through Dr Foster; an independent benchmarking organisation specialising in healthcare analysis including mortality rates. HSMR is measured by a Relative Risk (RR) score, which is a ratio derived from the number of deaths in specific groups of patients divided by the risk-adjusted expected number of deaths and then multiplied by 100.

A local RR figure of 100 indicates that the mortality rate is exactly as expected; whilst a local figure of less than 100 indicates a mortality rate lower (better) than expected. The Care Quality Commission (CQC) uses HSMR values to monitor performance of hospitals and identify areas of practice where improvements in care may be needed.

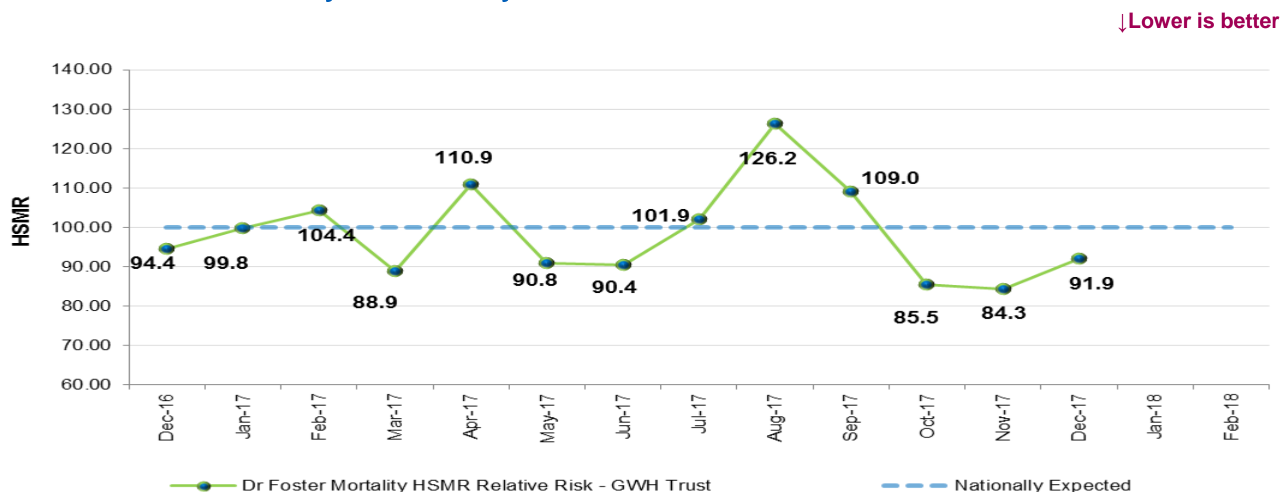
In 2014 the Trust set a target to reduce our mortality rates measured by HSMR (Hospital Standardised Mortality ratio) and to be one of the Trusts with the lowest HSMR value. We remain on our schedule to deliver this improvement. Our continued work has resulted in a lower number of deaths and we have one of the lowest HSMR values in Southern England.

The Great Western Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- The data is sourced from Dr Foster and is widely used in the NHS
- The data is refreshed on a monthly basis
- The data is reviewed on a monthly basis by the Trust Mortality Group and the Patient Quality Committee
- The data is included in the Trust quality and performance dashboards which are reviewed by the Trust

- Executive Committee and Board as well as relevant CCG Committees
- It is a key indicator of the quality of care we provide

## Trust HSMR Trend January 2017 January 2018

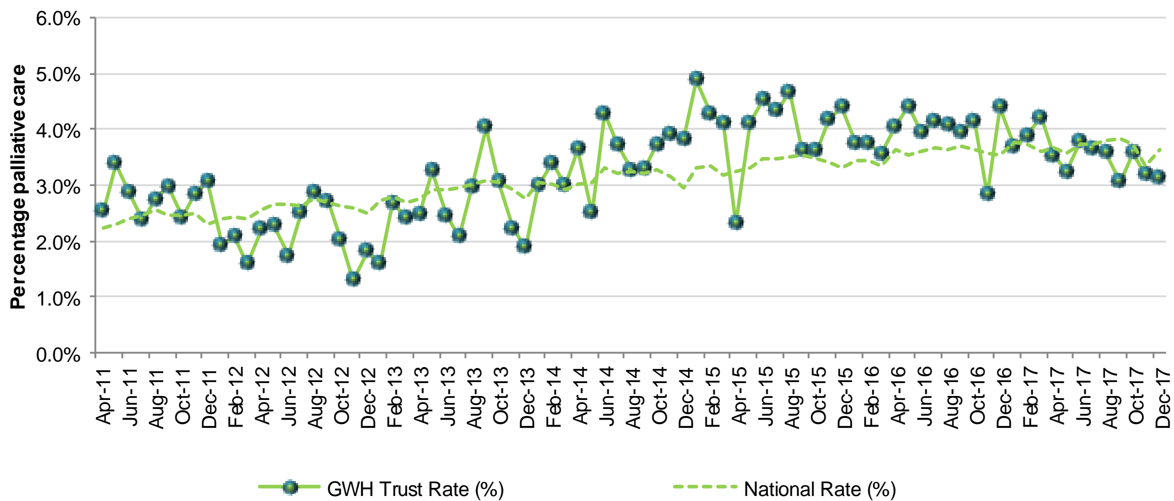



The graph above shows the year on year HSMR following rebasing. This shows a general improvement over time.

## Palliative Care – Coding Levels

Palliative care is the holistic care of a patient who has been diagnosed with a life limiting illness with the goal of maintaining a good quality of life until death. By definition patients receiving palliative care have a higher risk of in-hospital death than that of non-palliative patients. Trusts which provide specialist palliative care services have a higher proportion of patients admitted purely for palliative care rather than treatment compared to Trusts without specialist services. To account for this, the Hospital Standardised Mortality Ratio (HSMR) adjusts for patients who have received specialised palliative care when calculating the expected risk of death of a patient.

### Percentage palliative care Coded Spells (HSMR Basket Only) to December 2017




The charts above shows the levels of Palliative Care coding against the national average since April 2011. The GWH Trust rate is expected to follow the national rate.

For the period December 2012 through to the end of 2013 the level of Palliative Care coding was generally below the national rate, but since early 2014 there has been a marked improvement in the levels of coding and the Trust is now above the national average. Within the southern region the Trust is just below average for the twelve month period January 2017 to December 2017.

Note that the data for the most recent month should be considered as provisional.

The Great Western Hospitals NHS Foundation Trust intends to take the following actions to continue to improve the effectiveness of care and so the quality of its services by:

### Priorities for 2018/19

- Our Trust Mortality Group will continue to review a range of Dr Foster mortality indicators each month and investigate Dr Foster mortality alerts as well as agreeing any other investigations or initiatives prompted by the data and trends.
- Having introduced the new National process of Structured Judgement Review (see section below), the priority is to increase the number of reviews taking place. Thematic analysis of the areas with low rating scores as well as the narrative collected for each case will be used to ensure lessons are learned and shared within the organisation and more widely.

## Learning from Deaths

During 2017/18, the Trust has introduced a new process for mortality reviews. This has been as part of a collaborative with all hospitals in the West of England. The trusts all worked with the Royal College of Physicians (RCP) as pilot sites for introduction of the Structured Judgement Review (SJR) methodology for undertaking mortality reviews.

At the Great Western Hospital, a new database was established for SJR data entry, for reporting and monitoring and to allow analysis of global data. Reports are produced monthly for both the mortality surveillance group and the patient quality committee. Mortality review performance has been reported at trust board since quarter two. This is reported a quarter in arrears (as reviews cannot be completed until after a patient has died. The data presented below is therefore only for the first three quarters of the 2017/18 year.

As part of the SJR assessment process, in the pilot, the Royal College of Physicians included a scale of avoidability of death. This was subsequently removed from the methodology as published evidence shows that each death needs to be reviewed by five separate reviewers before there is enough agreement to make this judgement valid.

As the reporting requirements include the number of deaths judged to be more likely than not to have been due to problems in care, the data collection tool includes a rating for each death of whether it was more than 50% avoidable. The policy at the Great Western Hospital is that deaths judged to be avoidable are treated as a serious incident. Where care is rated as poor or very poor, this is also treated as a reportable incident.

During 2017/2018 1220 of Great Western Hospitals NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 212 in the first quarter; 355 in the second quarter; 332 in the third quarter; 362 in the fourth quarter. By 28/03/2018, 294 case record reviews and investigations have been carried out in relation to 1220 of the deaths.

In 4 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: 67 in the first quarter; 112 in the second quarter; 71 in the third quarter; 11 to date in the fourth quarter.

These numbers have been estimated using the Structured Judgement Review as recommended in guidance issued by the National Quality Board.

A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified. As the SJR process has only been introduced in this financial year, no strong themes have been identified. Now that there are about 300 cases in the database, the mortality surveillance group is starting to explore themes at the monthly meeting. The collaborative work across the West of England has identified end of life care as an area for improvement and wider work on this is being taken forward by the West of England Academic Health Science Network (WEAHSN)

A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period.

The theme around end of life care has been picked up locally by the end of life working group, which is chaired by the Medical Director. A collaborative event organised by the West of England Academic Health Science Network is due to take place on 7th June to take this work forward on a wider scale.

An assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period. As the process has only recently been introduced, a measurable impact on patient outcomes is yet to be seen.

Great Western Hospitals NHS Foundation Trust has made a decision not to use the avoidably scale which was originally set out by the RCP within the National Mortality Case Record Review Programme but removed as it was not appropriate to use rates of avoidability to compare organisations. Alternatively we have asked reviewers if they considered a death was more than 50% avoidable.
So far Great Western Hospitals NHS Foundation Trust has reported 0 deaths due to problems in care.

## Implementation of Priority Clinical Standards for Seven day Hospital Services.

Currently the Trust is focussed on the 4 priority clinical standards for 7 Day Services. These have been actively monitored through the twice yearly national audits. A focus is currently underway on the key standard for review in 14 hours, with a review of the rota of the Acute Medical Physicians.

GWH already performs reasonably well on National figures for inpatients being seen as appropriate either once or twice a day throughout the 7 day period.

There is still some work to go for providing routine ultra sonography over the weekend; this is limited by the availability of radiographer staff. Pathways also still need to be confirmed regarding some interventional radiology. However, in summary when benchmarked nationally the Trust services perform reasonably well. Whilst the Trust has a plan to implement 7 day services this is not without cost and the Trust would need to work with Commissioners in order to explore funding routes.

## Patient Reported Outcome Measures (PROMS)

The Great Western Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

The Trust takes part in PROMS which measures health gain in patients undergoing hip replacement, knee replacement, varicose vein and groin hernia surgery in England. This data and information is gathered via responses to questionnaires before and after surgery to assess patient's condition following surgery and whether it has improved.

An independent company analyses the questionnaires and reports the results to NHS Digital; this data is then benchmarked against other Trusts.

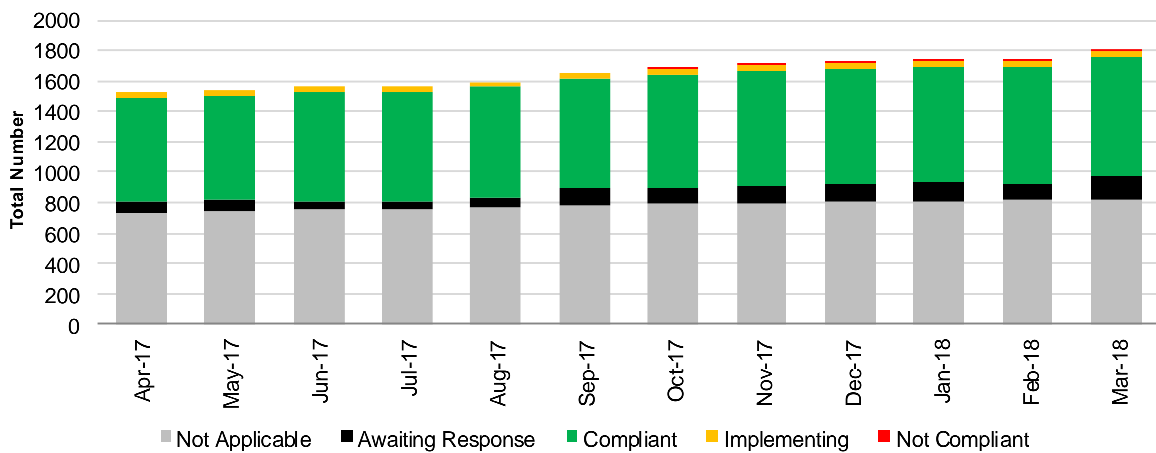
We have currently received a provisional PROMS report for Hip and Knee Replacement which covers the period April 2016 – March 2017. This shows that we were slightly below the average scores in two of the measures. However, this data is un-validated and we have yet to receive detailed data in order to review and understand if there are any specific concerns.

## Continue to Monitor and Maintain NICE Compliance

NICE publish evidence based recommendations and standards which healthcare organisations are required to assess and implement where required. Overall, the trust has been assessing NICE guidelines since August 2007 from which time, up to 830 guidelines were assessed as relevant and of which, up to789 have been assessed as compliant (95%).

This year, the Trust has received up 297 published guidelines, of which, up to 103 responses (35%) have confirmed they are not relevant to the services, up to 73 guidelines have been confirmed relevant, of which, 65 (89%) guidelines have been assessed and confirmed compliant. Up to 3 guidelines have action plans in place, bringing the overall number of guidelines being implemented to 33. Up to 5 guidelines this year have been assessed and found that the Trust are not following recommendations, bringing the overall number of non-compliant guidelines to 8. There are up to 121 guidelines which are still in the process of waiting to be assessed and responded to.

### NICE Monthly Status



## Referral to Treatment 18 weeks (RTT)

The first three months of 2017/18 saw gradual improvement in the Referral to Treatment standard, with the 92% target met in June 2017. However, performance since then has declined. As a result of vacancies and increased demand in some specialities, performance dipped during the summer months but began to stabilise above 90%. However, significant site pressures in December 2017 coupled with the national steer to cancel routine elective activity in January 2018, which continued in to February 2018 for some specialities, resulted in further deterioration in performance.

The Great Western Hospitals NHS Foundation Trust considers that this data is as described because RTT performance had significantly increased and the 92% target had been achieved until June 2017. Variances had been identified from October 2017 to December 2017 as a result of an internal audit mostly due to a system issue which was rectified internally.

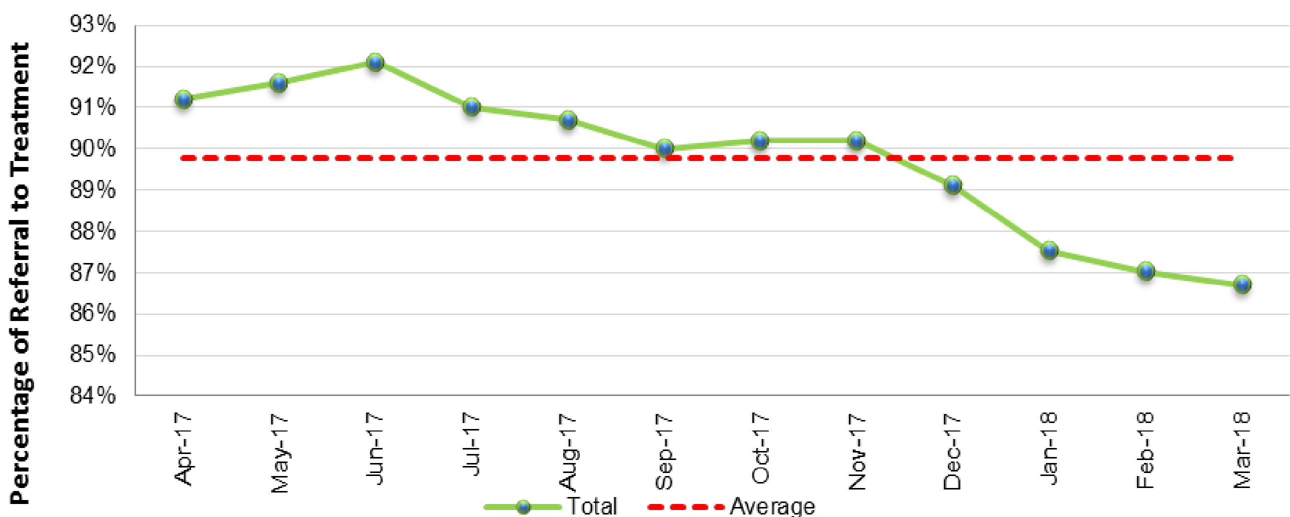
In February 2018, an RTT recovery programme was launched across the Trust. This coincided with the change to national guidance which states that the waiting list should be no higher in March 2019 than in March 2018 and, where possible, should be reduced and that the number of patients waiting more than 52 weeks for treatment should be halved by March 2019 and eliminated where possible. As such, plans will focus on the delivery of these metrics in 2018/19. To support this, detailed demand and capacity modelling will be carried out in Q1 for specialities requiring improvement to inform the capacity required to deliver a sustainable waiting list. Draft activity and performance trajectories have been completed for the year and focus on maximising capacity ahead of winter, whilst also aiming to maintain a greater level of activity over the winter period than was achieved in 2017/18.

Additional capacity through outsourcing, short term increased workforce and efficiencies are also considered as part of this.
The Great Western Hospitals NHS Foundation Trust intends to take the following actions to improve this performance and so the quality of its services by;

- An RTT recovery programme has been launched across the Trust since February 2018 which coincides with the change to national guidance stating that the waiting list should be no higher in March 2019 than in March 2018 and, where possible, should be reduced and that the number of patients waiting more than 52 weeks for treatment should be halved by March 2019 and eliminated where possible.

- Detailed demand and capacity modelling will be carried out in Q1 for specialities requiring improvement to inform the capacity required to deliver a sustainable waiting list.

### RTT Performance waiting time for patients still waiting (incomplete pathways)



## A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge

The Great Western Hospitals NHS Foundation Trust considers that this data is as described because for the period 2017/18 Accident and Emergency Department achieved 87.2% of patients having a maximum of 4 hours wait. Our agreed trajectory with NHS Improvement was 87.1%. We validate our data daily and utilising our re-validation standard operating procedures further validation takes place for each submission of data.

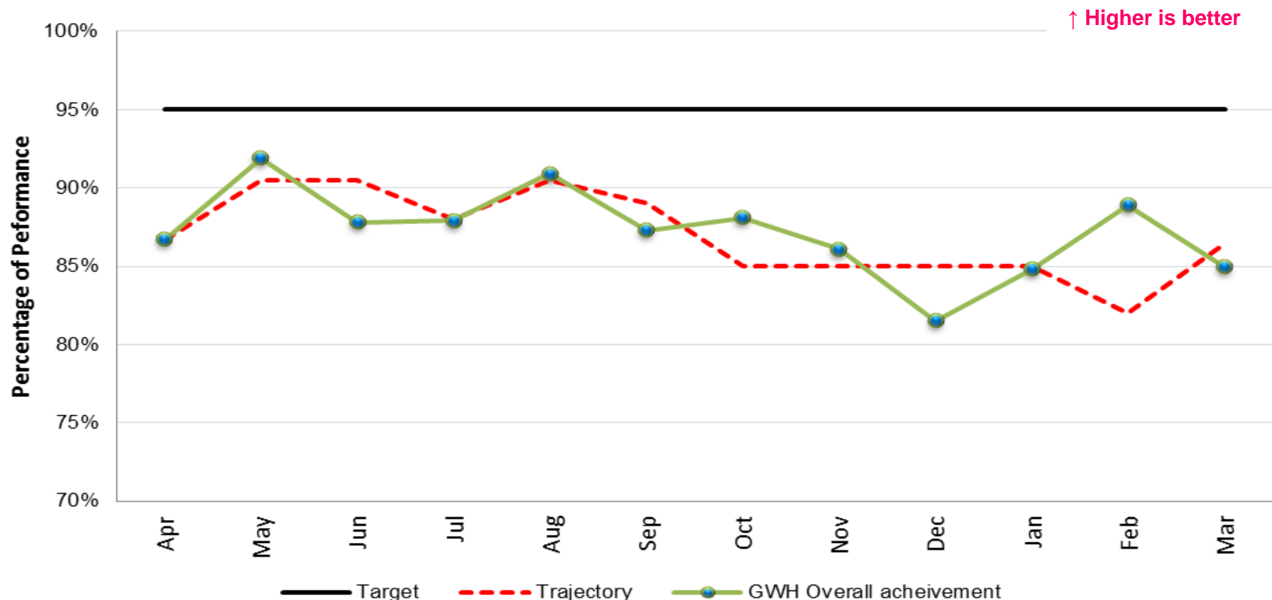
During 2017/18 the Trust built on the initiatives implemented the previous year as these are nationally recognised approaches to improve flow of patients through the hospital which should improve performance against the 4 hours Emergency Department Target. Health and Social Care services across Swindon and Wiltshire are under great pressure and this is recognised by health regulators NHS Improvement.

In the previous Quality Accounts the Trust committed to implementing effective patient streaming using all front door departments to ensure patients are seen by the appropriate teams on arrival to the organisation and improvements to the back door discharge process to ensure earlier safe discharge.

The Trust implemented the following initiatives to deliver the commitments made in our 2016/17 report:

- Introduction of our Ambulatory Care Unit (which was opened in Q4 of 2016/17).
- Implemented a Medically Expected Unit (MEU) so that GP referred patients did not have to attend the Emergency Department if they had already been accepted by the Acute Medical Team
- Completed the re-design of the ED Observations Unit
- Commenced Management of the Urgent Care Centre and harmonising working practices and skills with the Emergency Department.
- Commenced caretaker management of the Walk In Centre in the centre of Swindon.
- Implemented an Integrated Discharge Service which is a team of staff dedicated to improving back door flow.
- Opened a new 10 bed unit for Medically Fit patients awaiting onward care.

### All Emergency Department performance for GWH




The Great Western Hospitals NHS Foundation Trust intends to take the following actions to improve this performance and so the quality of its services by delivery of a number of initiatives that were trialled during 2017/18 which will be reviewed and where appropriate implemented to improved Emergency Department performance.

An example of the initiatives trailed are provided below, this is not an exhaustive list;

- Re-alignment of capacity within the Urgent Care Centre to match demand
- Supported additional ED Registrar at night to ensure better management of patient flow
- Revised process for the streaming of patients who arrive in the Emergency Department to all services
- Developed criteria led discharge on medical wards to support improved weekend discharge
- Green Chest Pain Pathway further development to reduce delays in ED and LOS
- Redesign and Development of the ED Observation Unit to support improved pathways for Mental Health and Low Risk Chest Pain Patients
- Golden Patient Initiative (Identification of patients who are fit and ready to go home the following day with everything in place for discharge) to support early morning flow
- Protected appointments within Neurology/Cardiology Clinics (hot clinics) have been implemented to support earlier discharge of patients to be then followed up in these clinics.
- ED consultant rota changes to provide greater senior presence at evenings and weekends
- High Sensitivity Troponin (a test for cardiac muscle damage) implemented to expedite the cardiac pathway

## Review of patients readmitted to hospital within 30 days of discharge

The Great Western Hospitals NHS Foundation Trust considers that this data is as described because in previous years we have carried out annual audits on patient readmissions within 30 days of being discharged in order to identify if anything could have been done to better prevent patients being re-admitted, especially if their readmission is related to their previous condition.

An audit was undertaken during 2017/18 and readmission within 30 days of discharge overall has increased from the previous year from 9.8% to 11.2%. In 2014/15 and 2015/16 the majority of patients had readmissions due to the same diagnoses. However the 2017/18 review has identified that more patients have been presenting with new episodes and deterioration of existing conditions. An audit was not completed in 2016/17.

There were 2 recommendations from the 2017/18 audit:

1. Consideration given to the validity of rerunning this audit until front door revamp is complete and a locally agreed tariff (and thus means of identification) is arrived at for Ambulatory Care activity
2. A specific audit on Treatment, Escalation Plan (TEP) forms – focusing on appropriateness and adherence to treatment plan re: decision to admit or not

And 2 learning points:

1. Coding of Ambulatory Care activity may have a negative impact on the accuracy/relevance of this audit
2. Front Door revamp is an essential component of driving down non-elective readmission rate

### Monthly 30 day readmission by age group

**Outline:** These figures are based on the crude emergency re-admissions within 30 days of the original date of discharge.

These figures are considered to be crude as they take no account of the original discharge specialty (or condition, diagnoses & procedures) nor the reason (or specialty & diagnoses) for re-admission. The age is calculated from the date of the original discharge

| Month of Original Discharge | Total Spells | | | Readmission Within 30 Days | | | Readmissions Percentage Within 30 Days | | |
|---|---|---|---|---|---|---|---|---|---|
| | 0-15yrs | 16yrs+ | Total | 0-15yrs | 16yrs+ | Total | 0-15yrs | 16yrs+ | Total |
| Apr 17 | 834 | 5489 | 6323 | 75 | 576 | 651 | 9.0% | 10.5% | 10.3% |
| May 17 | 950 | 6171 | 7121 | 92 | 604 | 696 | 9.7% | 9.8% | 9.8% |
| Jun 17 | 869 | 6045 | 6914 | 89 | 619 | 708 | 10.2% | 10.2% | 10.2% |
| Jul 17 | 895 | 6067 | 6962 | 80 | 667 | 747 | 8.9% | 11.0% | 10.7% |
| Aug 17 | 825 | 5942 | 6767 | 71 | 618 | 689 | 8.6% | 10.4% | 10.2% |
| Sep 17 | 927 | 5908 | 6835 | 119 | 645 | 764 | 12.8% | 10.9% | 11.2% |
| Oct 17 | 980 | 6114 | 7094 | 91 | 774 | 865 | 9.3% | 12.7% | 12.2% |
| Nov 17 | 1034 | 6260 | 7294 | 95 | 784 | 879 | 9.2% | 12.5% | 12.1% |
| Dec 17 | 985 | 5971 | 6956 | 100 | 766 | 866 | 10.2% | 12.8% | 12.4% |
| Jan 18 | 922 | 6332 | 7254 | 75 | 807 | 882 | 8.1% | 12.7% | 12.2% |
| Feb 18 | 823 | 5981 | 6804 | 84 | 746 | 830 | 10.2% | 12.5% | 12.2% |
| Mar 18 | | | 0 | | | 0 | | | 0.0% |
| **2017/18** | **10044** | **66280** | **76324** | **971** | **7606** | **8577** | **9.7%** | **11.5%** | **11.2%** |

## Medicines Safety

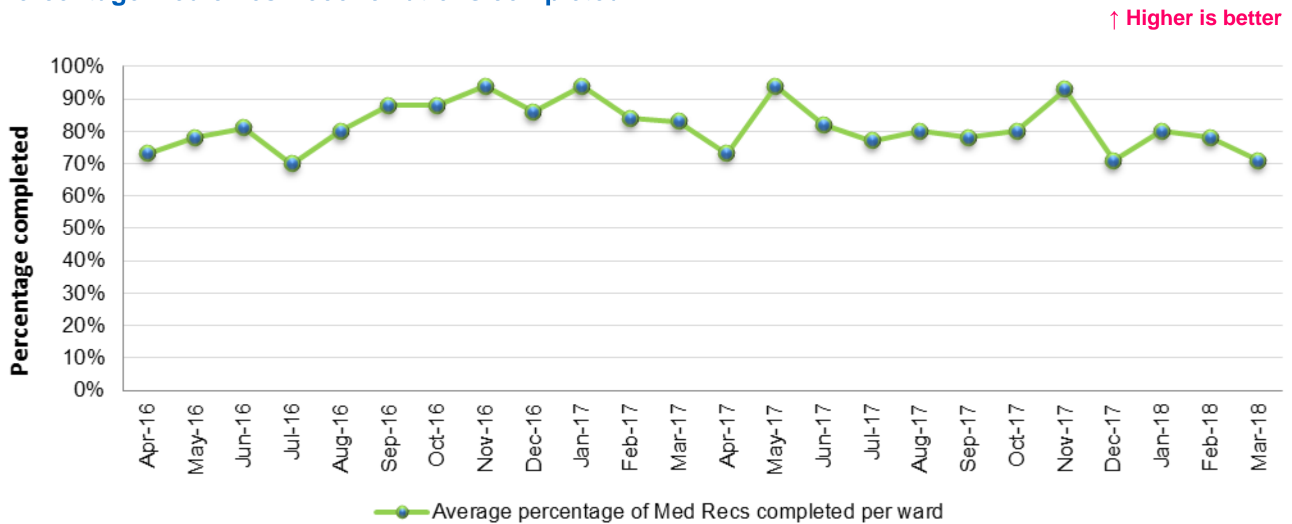
**Develop & utilise medicines safety audits to improve practice.**

The graph below shows the monthly data reported to clinical areas from an Electronic Prescribing and Medicines Administration system (EPMA) report regarding medicines reconciliation.

Data over the last 2 years has shown a sustained level of patients with completed medicines reconciliations.

### Percentage Medicines Reconciliations completed

↑ Higher is better

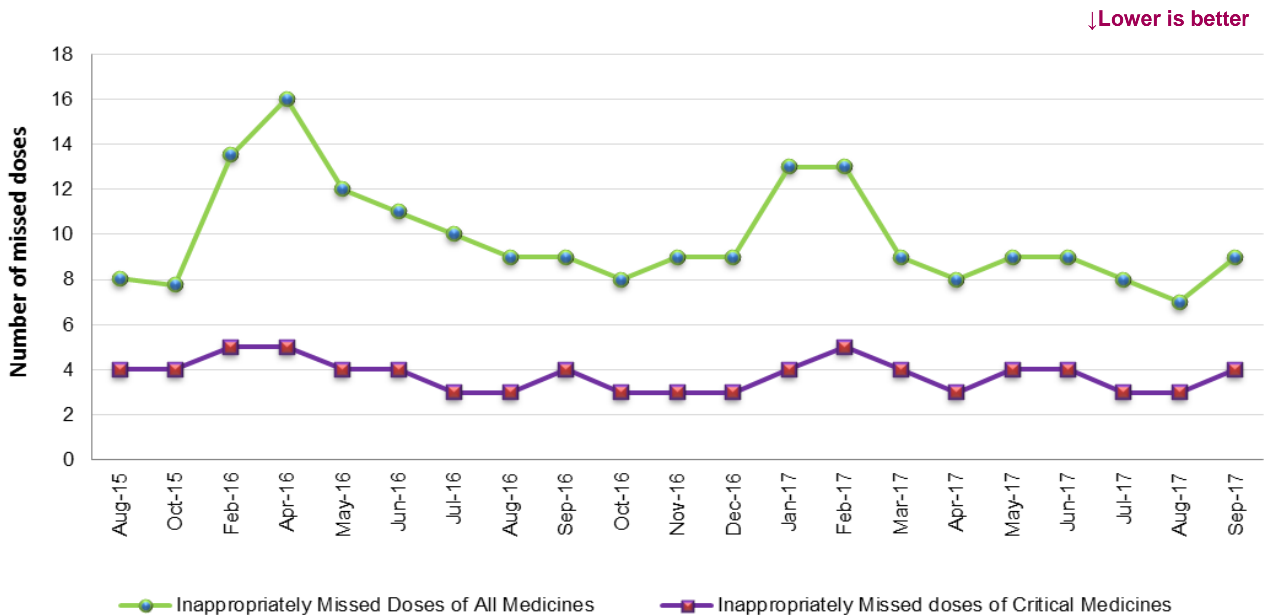



### Missed/Omitted Doses

The National Patient Safety Agency (NPSA) rapid response report on omitted and delayed medicines in hospitals guides organisations to identify a list of critical medicines where timeliness of administration is crucial. It is intended as an aid to support a local list and is not intended as a replacement. The NPSA also provides a series of actions which may help Trusts to reduce the number of omitted doses.

### Average Inappropriately Missed Doses

↓Lower is better



The chart above shows the number of inappropriately missed doses per ward over time. Data has not been available since late Q3 due to problems with the complex Electronic Prescribing and Medicines Administration system report. The missed dose process has been made simpler for clinical staff and reporting, and is anticipated to provide full data during 2018/19.

### Percentage of inappropriate omitted doses of total number of administrations by ward

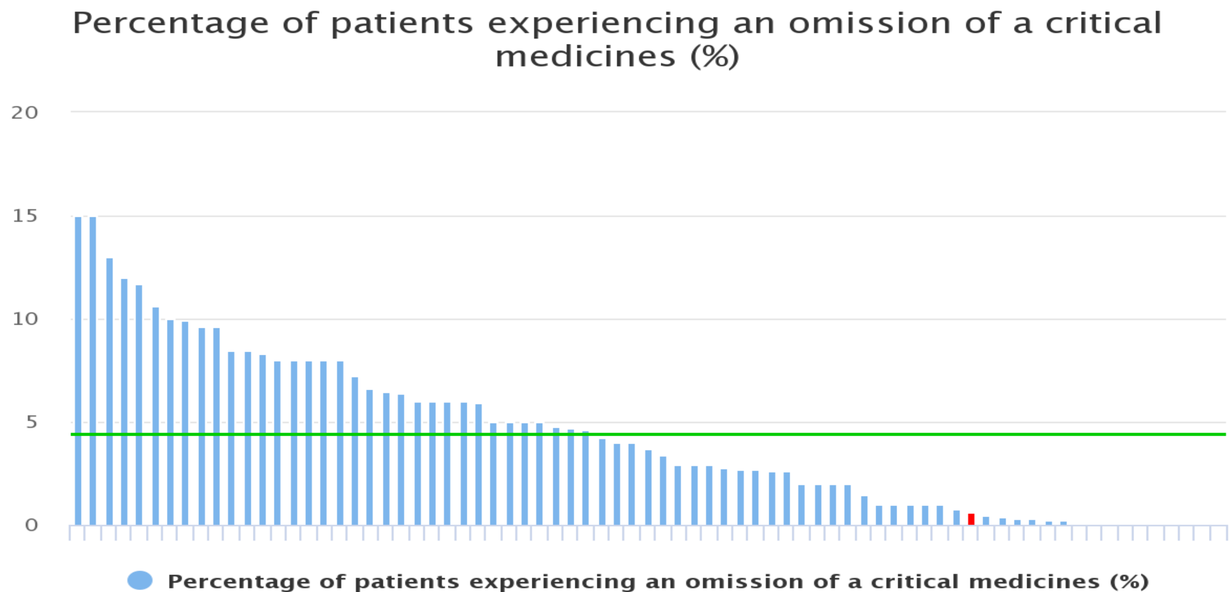
| Ward | Total number of administrations | Number of inappropriately omitted doses | Number of inappropriately omitted doses of critical medicines | Percentage of inappropriately omitted doses (%) | Percentage of inappropriately omitted doses of critical medicines (%) |
|---|---|---|---|---|---|
| Aldbourne | 305 | 1 | 1 | 0.33 | 0.33 |
| Ampney | 465 | 1 | 1 | 0.22 | 0.22 |
| Beech | 196 | 4 | 3 | 2.04 | 1.53 |
| Cardiology | 235 | 0 | 0 | 0.00 | 0.00 |
| Dove | 258 | 5 | 0 | 1.94 | 0.00 |
| Falcon | 265 | 3 | 0 | 1.13 | 0.00 |
| Jupiter | 1153 | 12 | 9 | 1.04 | 0.78 |
| LAMU | 650 | 33 | 13 | 5.08 | 2.00 |
| Meldon | 629 | 11 | 10 | 1.75 | 1.59 |
| Mercury | 1130 | 13 | 7 | 1.15 | 0.62 |
| Neptune | 721 | 9 | 4 | 1.25 | 0.55 |
| Saturn | 771 | 7 | 1 | 0.91 | 0.13 |
| SAU | 191 | 17 | 6 | 8.90 | 3.14 |
| Shalbourne | 215 | 2 | 0 | 0.93 | 0.00 |
| Teal | 684 | 3 | 2 | 0.44 | 0.29 |
| Trauma | 1783 | 6 | 2 | 0.34 | 0.11 |
| Woodpecker | 914 | 23 | 7 | 2.52 | 0.77 |
| **Trust Wide Average** | **621** | **8.82** | **4** | **1.76** | **0.71** |

The table above shows the number of medication administrations that have been prescribed for patients on the ward for a single day as captured on the electronic prescribing system (EPMA). The third column gives the number of medicine doses which have been omitted for a 24hr period and the fourth column the percentage of which were for critical medicines.

Results from figures 2 & 3 compare favourably with the National Data from the NPSA medicines Safety Thermometer where GWH has a lower rate of missed doses of 1.76% compared to the 8.3% national figure.

The National Data is provided below on the medication Safety Thermometer Dashboard.

### Medications Safety Thermometer Dashboard




The chart above shows national data from the NPSA Medicines Safety Thermometer through national benchmarking data that the percentage of GWH patients experiencing an omission of a critical medicines is significantly lower than the national average. The red line depicits GWH agains all other organisations

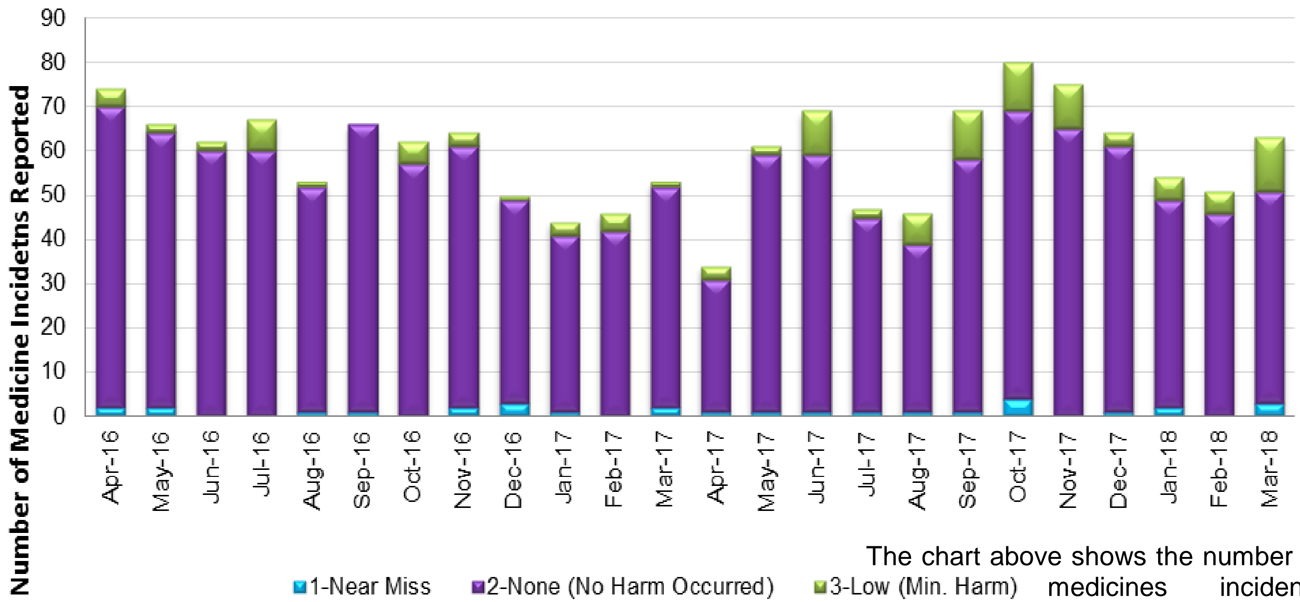
### Learning from Incidents and Reduce Harm from Medication Incidents

Medication incidents are reviewed and reported through Medicines Safety Group (MSG) meetings to ensure lessons are learnt & shared. MSG meets every 2 months as a direct report to the Medicines Assurance Committee (MAC).

Learning from incidents are shared through Medicines Safety bulletins. Examples of bulletins issued:

- Safe Storage of Medicines
- Oral Steroid Treatment
- Allergy Fact Sheet
- Withdrawing Insulin From Pen Devices

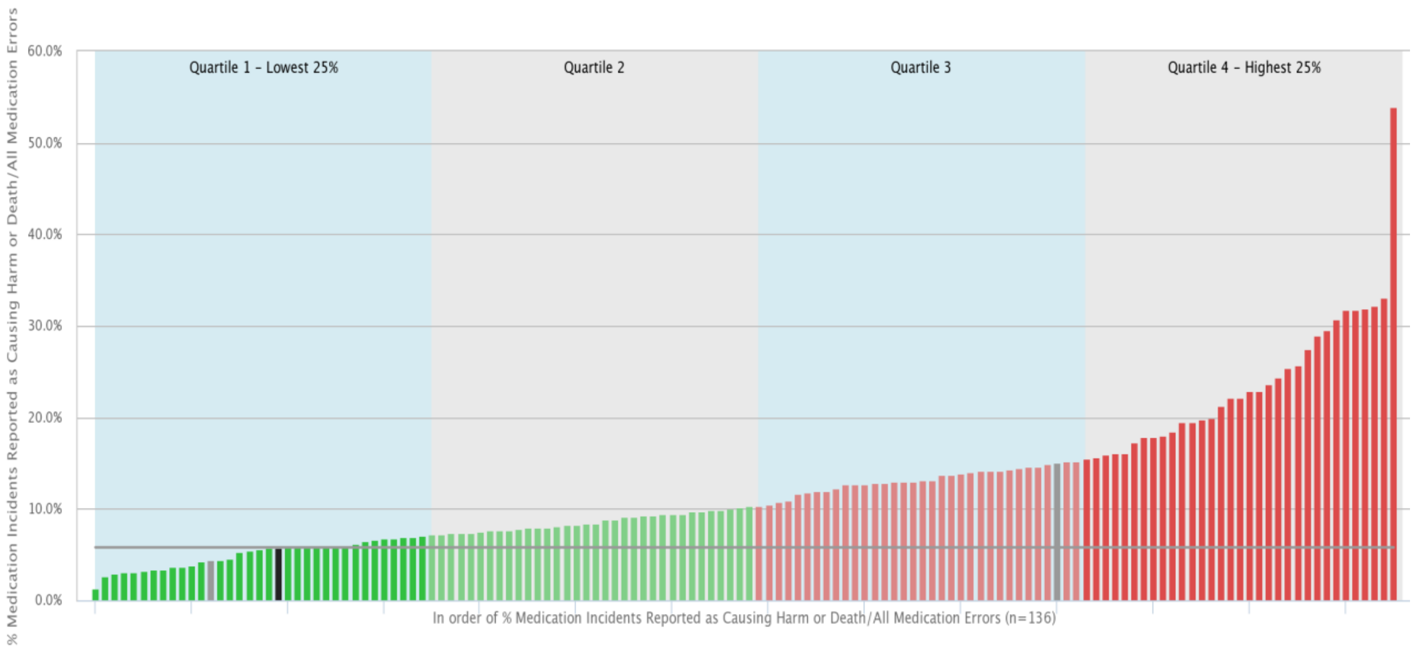
## Number of Medicines Incidents Reported Including Level of Harm




The chart above shows the number of medicines incidents reported at GWH and the level of harm.

Percentage of medication incidents reported as causing harm or death (GWH vs. national distribution)

## Percentage of medication incidents reported as causing harm or death (GWH vs. national distribution)




The chart above demonstrates that GWH (black line) is in the lowest quartile in terms of a national distribution of medication incidents causing harm, which provides assurance that for medicines safety GWH is both safe and learns from incidents.

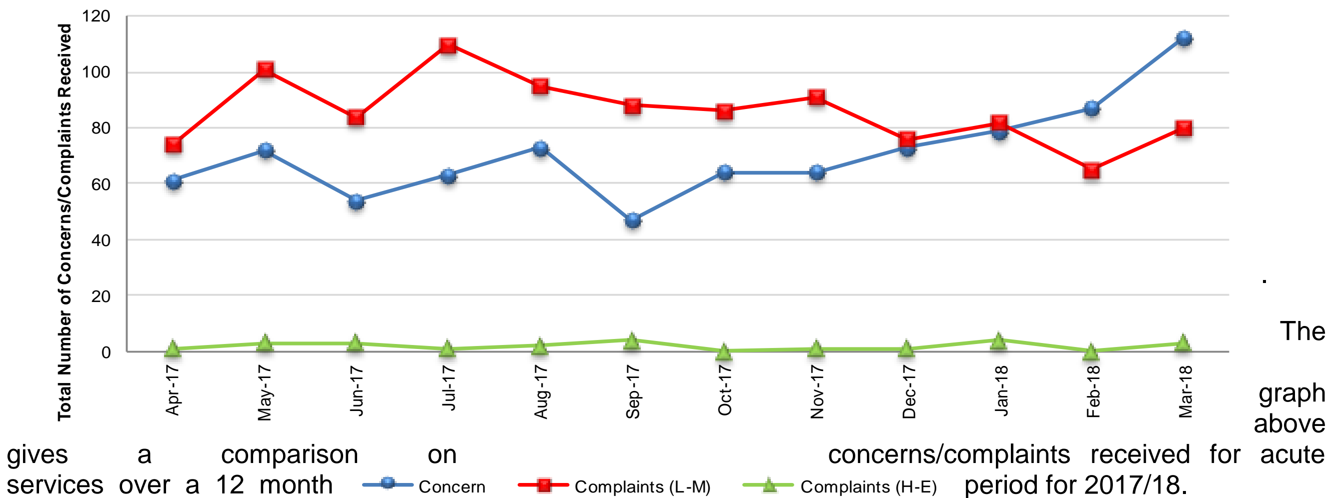
## Improving Patient Experience & Reducing Complaints

The Friends and Family Test is commissioned nationally by NHS England. All providers of NHS-funded services are required to offer the Friends and Family Test (FFT) to all patients that have been cared for or have used a GWH service at the point of discharge from hospital.

We are aware that sometimes patients want to receive their care and return home as quickly as possible particularly in the Emergency Department (ED). Text messaging (SMS) for FFT feedback was introduced in April 2017 giving all consenting patients the opportunity to provide feedback once in their home environment. Although this has seen a limited amount of feedback, despite it an effective method for other organisations, text messaging has positively contributed to the overall ED response rate.

Feedback from Friends and Family is shared with all service areas, themes and trends identified are passed to the relevant committees for discussion and implementation of changes to service. Changes and improvements to services have been made as a direct result of the feedback received and reported in the format of "you said, we did " for example changes to cleaning rotas, information detailing the ward routines, extra fruit available on tea rounds and options for decaffeinated drinks.

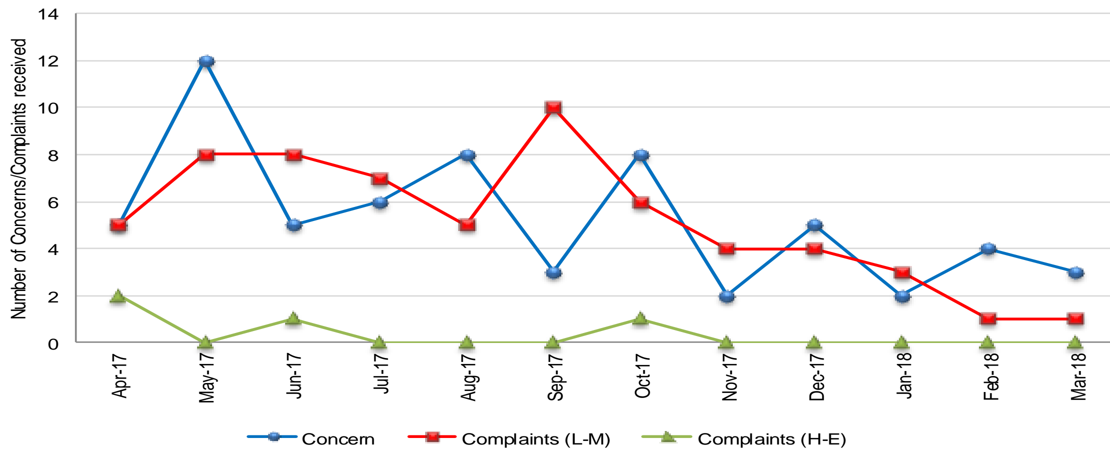
### Concerns and Complaints received in 2017/18 Acute Services




. The graph above gives a comparison on concerns/complaints received for acute services over a 12 month period for 2017/18.

Low/Medium cases are complaints where service or patient experience is below reasonable expectations, but not causing lasting problems. High/Extreme cases are complaints where significant issues regarding standards, quality of patient care issues that may cause long-term damage to an individual, such as grossly substandard care, professional misconduct or death. This level of complaint will require immediate and in-depth investigation.

## Concerns and Complaints received in 2017/18 Community Services




The graph above gives a comparison on concerns/complaints received for our community services over a 12 month period for 2017/18.

### Patient Experience

The Trust's Patient Engagement strategy was launched in September 2017; engagement with specific user groups has taken place throughout 2017/2018 and will continue throughout 2018/19 to hear the views of service users. Focusing on building on existing work, the Trust Board is committed to improving patient experience by:

- Role modelling and consistently applying the Trust STAR values
- Having quality champions throughout the Trust
- Recognising the link between staff and patient experience
- Engaging with patients, their carers and key stakeholders
- Using patient feedback meaningfully
- Ensuring that the Trust collects and reports high quality patient information
- Delivering reliable, safe, high quality care seven days a week
- Promoting wellbeing for both staff and patients
- Empowering people at all levels to drive change and value innovation
- Adequately resourcing service redesign that improves experience

### National Inpatient Survey

Questionnaires were sent out to patients who had recently stayed at the Great Western Hospital NHS Foundation Trust, the initial mailing was sent out in October 2017. 531 patients responded, 25% of patients were on a waiting list/planned in advance and 72% came as an emergency or urgent case. The overall response rate was 42.7%.

The Trust reviewed the survey results of 2016 and introduced changes following feedback from the 2016 results, with the review and re-launch of bedside guide for the inpatient wards, detailing key information our patients said they wanted to know.

On-going work is being undertaken to improve the discharge process, which has seen the development of revised community nurse and practice nurse letter, this has been developed with the support of all stakeholders.

Providing timely communication to patients, about their progress and discharge plans following the morning board rounds has started not made a marked difference to the results seen in the 2017 survey, however the on-going work during 2018 to improve discharge planning will aim to develop this further, aiming to ensure the patient feels more involved.

The Trust has responded to feedback on the 2016 survey in the way it orders and provides patient meals, with the reintroduction of the menu cards. Finger foods have been introduced, alongside a red tray system to identify patients who need extra support at mealtimes. Carers are encouraged and support to assist at mealtime if they wish, and protected mealtimes are endorsed, to ensure no unnecessary clinical procedures occur during meal times.

The results for 2017 are detailed below against the key objectives agreed to benchmark each year to monitor performance

*Lower scores are better*

| | **Communication** | **2015** | **2016** | **2017** | **Position from 2016 results** |
|---|---|---|---|---|---|
| Q33 | Staff contradict each other | 38% | 32% | 32% | Same |
| Q38 | Could not always find staff member to discuss concerns with | 67% | 68% | 65% | Better |
| Q37 | Not enough (or too much) information given on condition or treatment | 23% | 22% | 21% | Better |
| Q39 | Not always enough emotional support from hospital staff | 50% | 44% | 44% | Same |
| Q35 | Wanted to be more involved in decisions | 48% | 49% | 45% | Better |
| Q36 | Did not always have confidence in the decisions made | 32% | 28% | 27% | Better |
| Q25 | Doctors: did not always give clear answers to questions | 39% | 31% | 34% | Worse |
| Q27 | Doctors: talked in front of patients as if they were not there | 27% | 25% | 24% | Better |
| Q28 | Nurses: did not always give clear answers to questions | 37% | 37% | 30% | Significantly Better |
| Q76 | Did not receive any information explaining how to complain | 65% | 68% | 58% | Significantly Better |

*Lower scores are better*

| **Discharge Planning** | | **2015** | **2016** | **2017** | **Position from 2016 results** |
|---|---|---|---|---|---|
| Q53 | Did not feel involved in decisions about discharge from hospital | 50% | 44% | 46% | Worse |
| Q55 | Discharge was delayed | 48% | 45% | 42% | Better |
| Q61 | Not given any written/printed information about what they should or should not do after leaving hospital | 41% | 40% | 43% | Worse |
| Q62 | Not fully told purpose of medications | 35% | 29% | 30% | Worse |
| Q63 | Not fully told side-effects of medications | 70% | 65% | 61% | Better |
| Q64 | Not told how to take medication clearly | 34% | 26% | 26% | Same |
| Q65 | Not given completely clear written/printed information about medicines | 34% | 29% | 27% | Better |
| Q66 | Not fully told of danger signals to look for | 65% | 64% | 61% | Better |
| Q68 | Family not given enough information to help | 57% | 54% | 52% | Better |
| Q69 | Not told who to contact if worried | 25% | 24% | 25% | Worse |

*Lower scores are better*

| **Hospital, Care, Overall** | | **2015** | **2016** | **2017** | **Position from 2016 results** |
|---|---|---|---|---|---|
| Q23 | Not offered a choice of food. | 27% | 28% | 23% | Better |
| Q38 | Could not always find staff member to discuss concerns with. | 67% | 68% | 65% | Better |
| Q75 | Not asked to give views on quality of care | 77% | 75% | 72% | Better |

The 2017 survey results have highlighted the many positive aspects of the patient experience:-

- Clearer communication given by Nurses
- Communication and information of complaints process was made clearer to patients
- Choice of food was given to patients
- Patients could locate staff easily.

## Our Priorities 2018/19

- Analyse our National Inpatient Survey results for 2017 in the same format as previous years, working with the relevant service areas in the Trust to allow improvements to be made from patient's feedback.
- Engagement with Community Groups, listening events to be held throughout 2018/2019 & 2019/2020.
- Working in line with the Patient Experience and Engagement Strategy, ensuring that I statements are in place and displayed in public areas.
- The introductions of IPads and other technology for interpreting and translation i.e. Skype for patients who require support with communication needs.
- Project with NHS Resolution - Learning from aggregated analysis of complaints, claims and incidents.
- Review the Friends and Family Test improvement plan to improve the Trust response rate.

## 11.6 Staff Survey 2017/18

The NHS Staff Survey is an important source of information allowing the Trust to gather the views on staff experience about what it is like to work in the Health Service in England. The Trust is keen to hear from our staff about what it is like to work for us and what we can do to make things better.

The 2017 survey involved 309 NHS Organisations from across the country and achieved 487,227 responses. The NHS Staff Survey results are utilised by Trusts to support local improvements in staff experience and well-being.
They are also examined by external organisations such as the CQC and NHS Improvement and widely publicised on the dedicated staff survey website.

As one of the 309 participating NHS organisations, in October 2017 the Trust made the decision that all staff employed would be given the opportunity to participate in the 2017 Staff Survey.

This was also the first year Swindon Community Health Division took part in the Trust's survey.

A total of 2446 employees returned a completed questionnaire giving the Trust a response rate of **46.5%**. This was a decrease in last years (49%) but above the average response rate for Combined Acute and Community Trusts in England (43%).

### National and Regional comparisons

### National

The latest NHS Staff Survey result is reflective of the current pressures and challenges facing the NHS and its workforce. Despite the extreme pressures, 75% of GWH staff continues to remain enthusiastic about their job and 85% feel that the organisation acts fairly regarding career progression. These scores are significantly better than other similar organisations.

The Trust results are below average in relation to staff feeling that there were enough staff within the organisation to carry out their job properly (24% compared to the National Result 30%)

However, results were significantly better than other similar organisations in "staff confidence and security in reporting unsafe clinical practice" 3.74 compared to national average 3.67 and the "percentage of staff/colleagues reporting most recent experience of violence" 72% compared to the 67% national average.

As to be expected in such a pressured working environment, the survey does highlight some areas of staff concern and scores are below the national average on the percentage of staff experiencing harassment bullying or abuse from patients, relatives or the public in the last 12 months (31%) compared to 27% national average and the percentage of staff working additional extra hours (75%) compared to 71% national average.

### Regional

Whilst the Trust's response rate was high, the Trusts overall position has declined compared with last year. This year the Trust is ranked 16th out of 21 Trusts when benchmarking performance against organisations from across the South West.

The Trust was ranked 12th out of21 Trusts in 2016 and 10th out of 21 Trusts in 2015, University Hospitals Bristol NHSFT, Royal Berkshire NHSFT and Royal United Hospital Bath NHS Trust have all improved their performance this year and moved ahead of the Trust. Oxford University Hospital NHSFT, Gloucestershire Hospital NHSFT and North Bristol NHS Trust remain below the Trust.

When compared against local STP groups**,** the organisation's performance is ranked 3rd out of 4 other Trust.

This year, the Trust performed above average in 3 of the 32 key findings of the survey results, average in 18 and worse than average in 11 areas. The Trusts results for performing better than average has decreased since last year however, the number of areas where the Trust has performed worse than average has also reduced. It can be identified that overall the Trust's results are primarily within the average range of other Combined Acute and Community Trusts in 2017.

There has been a decline in the National results in relation to staff engagement from 3.80 in 2016 to 3.78 in 2017; this is comparable to the Trusts results of 3.78 in 2016 to **3.77 in 2017.** Overall, the staff engagement score continues to be high with the Trust scoring marginally below the national average. The areas used to measure the staff engagement score is based on staff recommending the organisation as a place to work or receive treatment, staff motivation at work and staff ability to contribute towards improvements at work.

The Trust's staff engagement score has reduced this year (previously 3.84 in 2016), this result is within the national average for Acute and Community Trust's and is higher than the results of six other Trusts in the South West region.

### Key Findings

The results from this year's Staff Survey provide some very encouraging findings regarding the experiences of staff, however it also highlights some areas that are experiencing challenges and some that need improvement.

There was one key area where staff experiences have improved since the 2016 staff survey.

| Key Area | 2016 Score | 2017 Score | Change |
|---|---|---|---|
| Disability – organisation made adequate adjustment (s) to enable me to carry out my work | 62% | 77% | 15% |

The key areas where staff experiences have deteriorated since the 2016 staff survey is illustrated below, the data highlights an overall decline in staff satisfaction whilst at work, staffs motivation at work and an increase of staff feeling unwell due to work related stress.

The Trust's recruitment challenges are likely to have impacted on these scores.

| Key Area | 2016 Score | 2017 Score | Change |
|---|---|---|---|
| Staff motivation at work *(the higher the score the better)* | 4.02 (out of 5) | 3.93 (out of 5) | 0.09 |
| Percentage of staff feeling unwell due to work related stress in the last 12 months *(the lower the score the better)* | 33% | 38% | 5% |
| Percentage of staff able to contribute towards improvements at work *(the higher the score the better)* | 74% | 69% | 5% |
| Staff satisfaction with level of responsibility and involvement *(the higher the score the better)* | 3.95 (out of 5) | 3.88 (out of 5) | 0.07 |
| Staff satisfaction with the quality of work and care they are able to deliver *(the higher the score the better)* | 3.88 (out of 5) | 3.75 (out of 5) | 0.13 |

### Summary of staff survey response rates

| 2016 | | 2017 | | Trust Improvement / Deterioration |
|---|---|---|---|---|
| Trust | National Average | Trust | National Average | 2.5% Deterioration |
| 49% | 44% | 46.5% | 43% | |

### Our priorities for 2018/2019

**Short Term:** Each Division develops a local action plan focusing on **3** key areas which will make the most impact based on the results for the Division. For Divisions to promote a 'listening into action' approach, empowering staff to be involved and contribute towards improvements in their Divisional staff survey results. It is recommended that Divisional action plans are developed and owned by key members of the Division and identified through listening groups to encourage staff involvement.

**Long Term:** The development of a Trust wide approach focusing on the big themes, **working with staff** to identify what actions need to be taken through 'big conversations. The key areas are:

- **Senior Management/Staff Engagement** – improving communication between senior management and staff, enabling and empowering staff to be involved and contribute towards improvements in patient experience and their own working environments

- **Resources** – continue to develop our recruitment and retention strategy to support with the vacancy position and to address the general equipment/resources issues identified by staff. Develop our communication strategy to ensure there is a clear understanding of establishments and temporary staff usage and a link to safer staffing.
- **Health and Wellbeing** (including Bullying and Harassment from Patient and members of the public/staff) – engaging staff in creating new initiatives to improve staff health and wellbeing and taking action against those who bully or harass staff

A positive improvement in these areas will have a direct impact on improving staff engagement and morale.

## 11.7 Statements of Assurance

This section provides nationally requested content to provide information to our public which will be common across all Quality Accounts.

## Information on the Review of Services

During the reporting period of 2016/2017 the Great Western Hospitals NHS Foundation Trust provided and / or sub-contracted 7 relevant health services.

The Great Western Hospitals NHS Foundation Trust has reviewed all the data available on the quality of care in 100% of the relevant health services.

The income generated by the relevant health services reviewed in 2016/2017 represents 98% of the total income generated from the provision of relevant health services by the Great Western Hospitals NHS Foundation Trust for 2016/2017.

## Participation in Clinical Audits

During 2017/18, 76 national clinical audits and 14 national confidential enquiries were conducted which covered relevant health services provided by Great Western Hospitals NHS Foundation Trust. The Trust participated in **100%** of the national clinical audits and 100% of the national confidential enquiries of which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Great Western Hospitals NHS Foundation Trust was eligible to participate in during 2017/18 are as follows:

| No. | Title | Work stream | Relevant | Participation | % Data Submission |
|---|---|---|---|---|---|
| 1 | Adult Cardiac Surgery | N/A | No | NA | NA |
| 2 | British Association of Urological Surgeons (BAUS) Urology Audits - Female Stress Urinary Incontinence Audit | N/A | Yes | Yes | Still in progress |
| 3 | BAUS Urology Audits - Radical Prostatectomy Audit | N/A | No | NA | NA |
| 4 | BAUS Urology Audits - Cystectomy | N/A | No | NA | NA |
| 5 | BAUS Urology Audits - Nephrectomy audit | N/A | Yes | Yes | 100% |
| 6 | BAUS Urology Audits - Percutaneous Nephrolithotomy (PCNL) | N/A | No | NA | NA |
| 7 | BAUS Urology Audits - Urethroplasty Audit | N/A | No | NA | NA |
| 8 | Cardiac Rhythm Management (CRM) | N/A | Yes | Yes | Still in progress |
| 9 | Case Mix Programme | N/A | Yes | Yes | 100% |

| No. | Title | Work stream | Relevant | Participation | % Data Submission |
|---|---|---|---|---|---|
| 10 | Child Health Clinical Outcome Review Programme | Chronic Neurodisability | Yes | Yes | 100% |
| 11 | Child Health Clinical Outcome Review Programme | Young People's Mental Health | Yes | Yes | 100% |
| 12 | Child Health Clinical Outcome Review Programme | New Topic - Long-term ventilation in children, young people and young adults | Yes | Yes | Still in progress |
| 13 | Elective Surgery (National PROMs Programme) | N/A | Yes | Yes | 100% |
| 14 | Endocrine and Thyroid National Audit | N/A | Yes | Yes | 100% |
| 15 | Falls and Fragility Fractures Audit programme (FFFAP) | Fracture Liaison Service Database | No | NA | NA |
| 16 | Falls and Fragility Fractures Audit programme (FFFAP) | Inpatient Falls | Yes | Yes | 100% |
| 17 | Falls and Fragility Fractures Audit programme (FFFAP) | National Hip Fracture Database | Yes | Yes | 100% |
| 18 | Fractured Neck of Femur (care in emergency departments) | N/A | Yes | Yes | 100% |
| 19 | Head and Neck Cancer Audit | N/A | Yes | Yes | 100% |
| 20 | Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit. | N/A | Yes | Yes | 100% |
| 21 | Learning Disability Mortality Review Programme (LeDeR) | N/A | Yes | Yes | 100% |
| 22 | Major Trauma Audit | N/A | Yes | Yes | 100% |
| 23 | Maternal, Newborn and Infant Clinical Outcome Review Programme | Perinatal Mortality Surveillance (reports annually) | Yes | Yes | 100% |
| 24 | Maternal, Newborn and Infant Clinical Outcome Review Programme | Perinatal Mortality and Morbidity confidential enquiries (reports every second year) | Yes | Yes | 100% |
| 25 | Maternal, Newborn and Infant Clinical Outcome Review Programme | Maternal Mortality surveillance and mortality confidential enquiries (reports annually) | Yes | Yes | 100% |
| 26 | Maternal, Newborn and Infant Clinical Outcome Review Programme | Maternal morbidity confidential enquiries (reports every second year) | Yes | Yes | 100% |
| 27 | Medical and Surgical Clinical Outcome Review Programme | Non-invasive ventilation | Yes | Yes | 100% |
| 28 | Medical and Surgical Clinical Outcome Review Programme | Acute Heart Failure | Yes | Yes | 100% |
| 29 | Medical and Surgical Clinical Outcome Review Programme | Cancer in Children, Teens and Young Adults | Yes | Yes | 100% |

| No. | Title | Work stream | Relevant | Participation | % Data Submission |
|---|---|---|---|---|---|
| 30 | Medical and Surgical Clinical Outcome Review Programme | Perioperative diabetes | Yes | Yes | 100% |
| 31 | Medical and Surgical Clinical Outcome Review Programme | Pulmonary embolism | Yes | Yes | 100% |
| 32 | Medical and Surgical Clinical Outcome Review Programme | Acute Bowel Obstruction | Yes | Yes | Still in progress |
| 33 | Mental Health Clinical Outcome Review Programme | Suicide by children and young people in England(CYP) | No | NA | NA |
| 34 | Mental Health Clinical Outcome Review Programme | Suicide, Homicide & Sudden Unexplained Death | No | NA | NA |
| 35 | Mental Health Clinical Outcome Review Programme | Safer Care for Patients with Personality Disorder | No | NA | NA |
| 36 | Mental Health Clinical Outcome Review Programme | The Assessment of Risk and Safety in Mental Health Services | No | NA | NA |
| 37 | Myocardial Ischaemia National Audit Project (MINAP) | N/A | Yes | Yes | 100% |
| 38 | National Audit of Breast Cancer in Older People (NABCOP) | N/A | Yes | Yes | 100% |
| 39 | National Audit of Care at the End of Life (NACEL) | N/A | Yes | Yes | 100% |
| 40 | National Audit of Dementia (in General Hospitals) | Dementia care in general hospitals | Yes | Yes | 100% |
| 41 | National Audit of Intermediate Care (NAIC) | The project has both a Commissioner level audit and a Provider level audit where organisational level metrics are collected. The Provider level audit also has a service user audit and a Patient Reported Experience Measure (PREM). | No | NA | NA |
| 42 | National Audit of Percutaneous Coronary Interventions (Coronary Angioplasty) | N/A | Yes | Yes | 100% |
| 43 | National Audit of Pulmonary Hypertension | N/A | No | NA | NA |
| 44 | National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12) | N/A | This audit did not run in 2017. Data collection commences in April 2018. | | |
| 45 | National Bariatric Surgery Registry (NBSR) | N/A | No | NA | NA |
| 46 | National Bowel Cancer (NBOCA) | N/A | Yes | Yes | 100% |
| 47 | National Cardiac Arrest Audit (NCAA) | N/A | Yes | Yes | 100% |

| No. | Title | Work stream | Relevant | Participation | % Data Submission |
|---|---|---|---|---|---|
| 48 | National Chronic Obstructive Pulmonary Disease (COPD) Audit programme | Pulmonary rehabilitation | No | NA | NA |
| 49 | National Chronic Obstructive Pulmonary Disease (COPD) Audit programme | Secondary Care | Yes | Yes | 100% |
| 50 | National Chronic Obstructive Pulmonary Disease (COPD) Audit programme | Primary Care (Wales) | No | NA | NA |
| 51 | National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis . | N/A | This audit did not run in 2017. Data collection commences in April 2018. | | |
| 52 | National Clinical Audit of Anxiety and Depression | Core audit | No | NA | NA |
| 53 | National Clinical Audit of Anxiety and Depression | Psychological Therapies for Anxiety and Depression | No | NA | NA |
| 54 | National Clinical Audit of Psychosis | Core audit | No | NA | NA |
| 55 | National Clinical Audit of Psychosis | EIP spotlight audit | No | NA | NA |
| 56 | National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI) | Specialist rehabilitation level 1 and 2 | No | NA | NA |
| 57 | National Comparative Audit of Blood Transfusion programme | Re-audit of the 2016 audit of red cell and platelet transfusion in adult haematology patients | Yes | Yes | 100% |
| 58 | National Comparative Audit of Blood Transfusion programme | 2017 National Comparative Audit of Transfusion Associated Circulatory Overload (TACO) | Yes | Yes | 100% |
| 59 | National Comparative Audit of Blood Transfusion programme | Audit of Patient Blood Management in Scheduled Surgery - Re-audit September 2016 (see weblink in column L for 2015 report) | Yes | Yes | 100% |
| 60 | National Congenital Heart Disease (CHD) | Paediatric, Adult | No | NA | NA |
| 61 | National Diabetes Audit - Adults | National Diabetes Foot Care Audit | Yes | Yes | 100% |
| 62 | National Diabetes Audit - Adults | National Diabetes Inpatient Audit (NaDia) - reporting data on services in England and Wales | Yes | Yes | 100% |
| 63 | National Diabetes Audit - Adults | National Core Diabetes Audit | Yes | No | 0% |
| 64 | National Diabetes Audit - Adults | National Pregnancy in Diabetes Audit | Yes | Yes | 100% |

| No. | Title | Work stream | Relevant | Participation | % Data Submission |
|---|---|---|---|---|---|
| 65 | National Emergency Laparotomy Audit (NELA) | N/A | Yes | Yes | 100% |
| 66 | National Heart Failure Audit | N/A | Yes | Yes | 100% |
| 67 | National Joint Registry (NJR) | N/A | Yes | Yes | 100% |
| 68 | National Lung Cancer Audit (NLCA) | Lung Cancer Clinical Outcomes Publication | Yes | Yes | 100% |
| 69 | National Maternity and Perinatal Audit (NMPA) | N/A | Yes | Yes | 100% |
| 70 | National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP) | N/A | Yes | Yes | 100% |
| 71 | National Oesophago-gastric Cancer (NOGCA) | N/A | Yes | Yes | 100% |
| 72 | National Ophthalmology Audit | Adult Cataract surgery | Yes | Yes | 100% |
| 73 | National Paediatric Diabetes Audit (NPDA) | N/A | Yes | Yes | 100% |
| 74 | National Prostate Cancer Audit | N/A | Yes | Yes | 100% |
| 75 | National Vascular Registry | N/A | No | NA | NA |
| 76 | Neurosurgical National Audit Programme | N/A | No | NA | NA |
| 77 | Paediatric Intensive Care Audit Network (PICANet) | N/A | No | NA | NA |
| 78 | Pain in Children (care in emergency departments) | N/A | Yes | Yes | 100% |
| 79 | Prescribing Observatory for Mental Health (POMH-UK) | Use of depot/LA antipsychotics for relapse prevention | No | NA | NA |
| 80 | Prescribing Observatory for Mental Health (POMH-UK) | Prescribing antipsychotics for people with dementia | No | NA | NA |
| 81 | Prescribing Observatory for Mental Health (POMH-UK) | Assessment of side effects of depot and LA antipsychotic medication | No | NA | NA |
| 82 | Prescribing Observatory for Mental Health (POMH-UK) | Monitoring of patients prescribed lithium | No | NA | NA |
| 83 | Prescribing Observatory for Mental Health (POMH-UK) | Prescribing for bipolar disorder (use of sodium valproate) | No | NA | NA |
| 84 | Prescribing Observatory for Mental Health (POMH-UK) | Rapid tranquilisation | No | NA | NA |
| 85 | Prescribing Observatory for Mental Health (POMH-UK) | Prescribing high-dose and combined antipsychotics on adult psychiatric wards | No | NA | NA |
| 86 | Prescribing Observatory for Mental Health (POMH-UK) | Prescribing Clozapine | No | NA | NA |
| 87 | Procedural Sedation in Adults (care in emergency | N/A | Yes | Yes | 100% |

| No. | Title | Work stream | Relevant | Participation | % Data Submission |
|---|---|---|---|---|---|
| | departments) | | | | |
| 88 | Sentinel Stroke National Audit programme (SSNAP) | N/A | Yes | Yes | 100% |
| 89 | Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme | N/A | Yes | Yes | 100% |
| 90 | UK Parkinson's Audit: (incorporating Occupational Therapy Speech and Language Therapy, Physiotherapy Elderly care and neurology) | N/A | Yes | Yes | 100% |

The reports of 65 national clinical audits were reviewed by the provider in 2017/18. As a result of these audits Great Western Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Stroke Services – improve direct admission to stroke unit, nursing and consultant levels to cover primary stroke prevention clinics and weekend cover.

Neonatal services – improve the quality of recording data onto electronic systems; particularly elements of records during admission and upon discharge, for example, completion of daily summaries, culture results and type of feeding at discharge etc.

Maternity Services – to implement a quality improvement project 'Maternity Connections' which is aimed at building bridges from women in our care and Maternity Services to other specialities, including Endocrinology, with consideration of how referral/review may be achieved quicker and how pathways for referral can be publicised to Primary Care in particular those offering community support to those with Diabetes (e.g. General Practitioners, Local Surgery Nurse Lead Clinics).

For patients with Acute Pancreatitis -Enhance service and capacity to improve compliance with Early Warning Scores; Identify urgent patients during out of hours requiring ultrasound scan, Explore feasibility of Hot Gallbladder lists, Implementation of e-prescribing (part of trust wide service development).

For patients with a GI haemorrhage - Establish a working group to the implementation of an action plan incorporating NCEPOD, NICE CG141, SIGN 2008 standards and recommendations to improvement the management of Upper and Lower GI bleeds.

Emergency Laparotomy services - monitor the care of elderly patients, monitor key processes to look for sustainability, introduce generic boarding card for all emergency cases.

Monitor the effect on emergency laparotomy information. Embedding data entry in trainee surgeons. FLO-E:A trial should improve cardiac output monitoring.

Vision Assessment: GWH is to approach the best performing Trusts in relation to vision assessments to evaluate if good practice can be shared between Trusts. Actions going forward will be based on this evaluation.

Delirium: Although a significant improvement has been achieved since 2015 (+18%) the documentation and assessment require further improvement to achieve the national average.

The Delirium work stream is clinically led by the Trust lead for Dementia and there are plans to introduce practice guidance to medical and other clinical staff in 2018.

To continue to educate and support junior doctors and nursing staff, while also developing and testing new systems to reduce prescribing and medication management errors Trust-wide.

Revise the hemoglobin threshold for active pre-operative anaemia investigations and treatment to 120g/l for females and 130g/l for males. IV iron can potentially be given to more patients hopefully reducing the number and volume of post-operative transfusion, thus reducing hospital stays. Consider ways to obtain pre-operative Hbs earlier in the pathway for orthopaedic patients in order to ensure supportive investigation and therapy can be carried out in a timely fashion reducing wasted appointments and resulting in less delays in surgery.

Consider the use of TXA in patients with #NOF – this will need to be risk assessed and research studied on the possible adverse effects of this - benefits must outweigh the risks. A protocol change should be considered in conjunction with the Orthopaedic teams and anaesthetics.

The reports of 209 local clinical audits were reviewed by the provider in 2017/18 and Great Western Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

New assessment tool to be considered for trial for patients in Labour, explore and possibly develop a care bundle for ‘at risk’ women to include measures like Sorbsan or PICO, which is a technique used in evidence based practice , Negative Pressure Wound Therapy (NPWT) or Hibiscrub wash prior to transfer to Theatre and for quarterly rates of post-operative infection to be displayed where appropriate in close location to Maternity Theatre or notice board in sitting room where morning meeting takes place.

To implement TEP becoming a clinical note with mandatory fields, at each stage, and if possible allow an Alert to be raised automatically on Medway at the time the document is raised.

Include TEP on any discharge check list so that it can be reviewed and communication confirmed prior to discharge.

Documentation audit - Raise further awareness within Quality Reports and Newsletter around the requirement to ensure that the patient identifiers (name, D.O.B, hospital number) are clearly recorded on all pages within the notes and to raise awareness around the need to time and date all entries, and to sign and print your name.

Ensure new doctors and locums are fully aware of the electronic mental health assessment and referral process. Deliver the MCA training strategy to ensure a consistent application of safeguarding and MCA.

Communication to antenatal clinic staff to raise awareness of the importance of plotting SFH measurement on designated graph once measured via SMART News feature and team meetings.

Community midwives to be reminded of the importance of documenting Assessments of VTE, booking bloods, to be taken, taken or results, Vitamin D discussed, Downs Screening Result, IOL leaflet given and Antenatal Risk Assessments at 28 weeks.

All relevant team members should be reminded of the Neutropenic sepsis pathway and the use of MASCC scoring and consider a revision in admissions from triage line referrals. Admittance to the hospital through the proposed Triage bay should be given a target date for completion and to achieve better compliance with the `Golden Hour`; currently, just under half of patients (48%) receive an antibiotic within the first hour of admission, rising to 55% when allowed an extra 6 minutes for flexibility.

A new electronic tracking system is being tested and validated. This will enable blood components to be administered using an electronic process more frequently than is currently possible. It is anticipated that this will increase compliance with fating the blood components and reduce workload in tracing components not fate.

All Non-Medical Prescribing (NMP) to have a yearly appraisal; All staff to clearly document scope of prescribing intent within their yearly appraisal, at their 1:1, or using the NMP scope of practice document with a copy forwarded to the pharmacy administrator and NMP lead and administrator to review the NMP database and ensure that all staff have attended an annual update or can provide evidence of maintenance of professional development (prescribing) within the last year.

Continue to raise staff awareness of dementia tools and promote staff engagement with the tools. Develop business case for the appointment of Dementia Specialist Nurse at GWH to facilitate on-going staff education and implementation of gold standard care for patients with dementia whilst they are in hospital. Weekly check of tool use within all clinical areas has been implemented and we have incorporated the use of the tools into the ward admission document and into nursing handover paperwork.

SAU to be a protected area, Only 3 days out of 28 SAU assessment area had patient flow, due to being bedded down with medical outliers.

Patients in pain / unwell that ED sent to SAU who would usually have access to a trolley required to lay down in SAU clinic rooms this reduced the number of triage rooms for nursing staff and medical staff to examine patients.

In reviewing patients with Type 1 diabetes in the clinical setting at GWH, particularly those with a high Body Mass Indicator (BMI) or high insulin requirements, consider checking C-peptide to clarify diagnosis.

In reviewing patients with Type 2 diabetes with suboptimal glycaemic control on multiple medications, consider C-peptide to help guide to the next stage in treatment whether it be insulin or further insulin sensitising medication.

In some patients with Type 2 diabetes who are difficult to engage or motivate, C-peptide may be used to demonstrate insulin resistance and persuade them to change their lifestyle. Or conversely, those who you feel require insulin but are reluctant to start; C-peptide can demonstrate insulin deficiency and persuade them of the clinical need to start insulin. Improvements required in C-peptide sample handling - find out whether modern immunoassay is a possibility to collect samples for C-peptide in EDTA tubes which is stable in room temperature for 24-48 hours.

Continue tracking NIPE checks for all babies 3 times weekly and follow SOP to address any concerns where required. Report any babies without NIPE check close to breaching 72hr to area responsible and reporting any breach via an incident form.

Education to all staff on the Standard operating procedure for HIV testing in the Intensive Care Unit, Nurse video teaching via non-mandatory training, Highlighted as a key topic at message of the day/week at daily risk assessments and Posters in staff areas.

A sticker to be placed in the medical notes for all community acquired pneumonia patients indicating the requirement for compliance with the Standing Operating Procudure on HIV testing. .

To review the dissemination, monitoring and reporting of National Institute of Clinical Excellence (NICE) Guidance Policy and Assessment Proforma To undertake a re-audit once policy review and actions have been embedded.

Divisions are to design a uniformed factual report for NICE guidance which shows clearly all outstanding NICE Guidance requiring attention on a month by month basis.

To educate staff in Swindon Intermediate care Centre (SwICC) to correctly complete the ‘MUST’ tool;  educate staff in SwICC on how to correctly interpret the results of the ‘MUST’ tool; highlight the importance of completion of the ‘MUST’ tool as per NICE and CQC regulations;  highlight the importance of weekly weights to be completed to ensure completion of the ‘MUST’ tool; adapt the ‘MUST’ pathway and Nutrition Care Plans to make them more applicable for SwICC inpatients;  educate staff in SwICC on how to correctly document in and use Nutrition Care Plans and train staff to understand when referrals need to be made to the dietetic service.

Provide learning to all ED clinicians regarding the need to code patients appropriately and in a detailed manner. This will be done in the weekly doctors teaching sessions and in handovers daily as a reminder. To explore with IT whether the mental health diagnosis recorded on the Mental Health Risk Assessment and Referral Form in Medway, where it is a mandatory field, can be included in the discharge coding.

All newly appointed and existing junior and senior medical staff should be provided with targeted training at induction and mandatory training on the need to consider the least restrictive legal frame work when considering need to detain a patient in hospital against their permission and clearly document in medical records all decision making principles regarding patient care.

All consideration involving consideration for the use of MCA or MHA must be clearly recorded in the patient’s notes.

To improve patient meal times, operating procedures for mealtimes are to be displayed on wards by Ward Managers by end of April 2018. Ward Managers are to also implement bell ringing 15 minutes prior to mealtimes to alert patients, staff and carers to get ready for meals by end of April 2018.

## Research & Development (R & D)

The number of patients receiving relevant health services provided or sub-contracted by Great Western Hospitals NHS Foundation Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 1207 to end March 2018. Another year in which we successfully met and even exceeded our set target.

We currently have 67 actively recruiting Department of Health endorsed (portfolio) research projects. We also participate in a number of studies which are more difficult to recruit to given the complex nature of the inclusion and exclusion criteria. We believe it is important to have these studies open in order to give our patients the opportunity of participating in such studies should they be eligible. We run observational studies together with interventional studies.

We continue to attract commercial companies and our reputation, particularly within cardiology and rheumatology remains strong.

Every effort is made to ensure we achieve recruitment to time and target.
Research continues to gives our patients more opportunities to participate in and access to new and innovative treatment pathways.

With funding received from the Department of Health through our Local Clinical Research Network (LCRN), R&I have and will continue to provide strong research support throughout the Trust.

## Goals agreed with commissioners

### Use of the CQUIN payment framework

A proportion of Great Western Hospitals NHS Foundation Trust income in 2017-18 was conditional on achieving quality improvement and innovation goals agreed between Great Western Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Details of proportion of payments achieved is available on request

Further details of the agreed goals for 2017-18 and for the following 12-month period are available electronically on request.

| Financial Summary of CQUIN (£m) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Plan | Actual | % | Plan | Actual | % | Plan | Forecasted Actual | % |
| | 2015-2016 | | | 2016-2017 | | | 2017-2018 | | |
| Total CQUIN | £6,007 | £4,507 | 75% | £4,845 | £3,973 | 82% | £5,566 | £4,762 | 86% |

## Care Quality Commission Registration

The Great Western Hospital NHS Foundation Trust has an overall rating of “Requires Improvement” since the last inspection that took place during 2017. A quarterly review of our CQC registration is undertaken across the acute and community sites to ensure that our CQC registration is adequate for the regulated activities undertaken across the sites.

The Great Western Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is “registered” without conditions.

By law all Trusts must be registered with the CQC under section 10 of the Health and Social Care Act 2008 - to show they are meeting essential quality standards.

NHS Trusts have to be registered for each of the regulated activities they provide at each location from which they provide them.

The Trust is registered for all of its regulated activities, without conditions.

Without this registration, we would not be allowed to see and treat patients.

The Great Western Hospitals NHS Foundation Trust registration was updated in November 2017 to add the following service - Swindon Walk in Centre.

### Periodic/Special Reviews 2017/18

The Care Quality Commission (CQC) inspected The Great Western Hospitals Foundation Trust as part of its routine inspection programme. The inspection was carried out between, 21 and 23 March 2017

In response to the CQC must do- should do actions and to support the Trust in co-regulation, Key Line of Enquiry (KLOE) Compliance assurance frameworks were developed to provide a mechanism for continuous self-assessment of the KLOE indicators by the core service leads, to ensure the monitoring of the quality of care as viewed by the CQC.

A monthly KLOE Committee was formed, to prioritise, manage and monitor the progress of the KLOE compliance assurance frameworks, The Improvement Committee facilitates and supports the implementation approaches to test changes, and to seek assurance improvements are embedded.

The table below identifies the Compliance Actions identified form our December 2017 inspection.

| Type | Date | Health and Social Care Act 2008 Regulation |
|---|---|---|
| Compliance Action | August 2017 | Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect |
| Compliance Action | August 2017 | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment |
| Compliance Action | August 2017 | Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment |
| Compliance Action | August 2017 | Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints |
| Compliance Action | August 2017 | Regulation 17 HSCA (RA) Regulations 2014 Good Governance |
| Compliance Action | August 2017 | Regulation 18 HSCA (RA) Regulations 2014 Staffing |

Feedback from the CQC recognised there had been significant changes and improvements since their last inspection, feedback also raised some further areas for improvement which the Core Service leads have commenced action groups.

## Our Ratings for the Great Western Hospital from 2017

| | Safe | Effective | Caring | Responsive | Well led | Overall |
|---|---|---|---|---|---|---|
| Medical care (including older people's care) | Requires improvement | Requires improvement | Good | Requires improvement | Good | Requires improvement |
| Urgent and emergency services (A&E) | Requires improvement | Good | Outstanding ☆ | Requires improvement | Good | Requires improvement |
| Surgery | Requires improvement | Good | Good | Requires improvement | Requires improvement | Requires improvement |
| Intensive/critical care | Requires improvement | Good | Good | Good | Good | Good |
| Maternity and gynaecology | Requires improvement | Good | Good | Good | Good | Good |
| Services for children & young people | Requires improvement | Not rated | Not rated | Not rated | Requires improvement | Requires improvement |
| End of life care | Good | Good | Good | Good | Good | Good |
| Outpatients | Requires improvement | Not rated | Good | Requires improvement | Good | Requires improvement |

Copies of the full reports for the Trust and each individual location inspected by the CQC are available publicly online here: http://www.cqc.org.uk/provider/RN3/reports.

## Hospital Episode Statistics

The Great Western Hospitals NHS Foundation Trust submitted records during 1st April 2016 to March 2017 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number was:

99.7% for admitted patient care
99.9% for outpatient care and
98.9% for accident and emergency care.

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

99.9% for admitted patient care;
99.9% for outpatient care; and
99.9% for accident and emergency care.

## Information Governance Tool Kit Attainment Levels

Information is a key asset, both in terms of the clinical management of individual patients and the management of services and resources throughout the Trust.

It is therefore of utmost importance that appropriate policies, procedures and management accountability provide a robust governance framework for the efficient management of information.

There is corporate leadership of information governance, the Director of Finance having overall responsibility. The Information Governance Steering Group oversees information governance issues, with responsibilities delegated from the Performance, People & Place Committee on behalf of the Trust Board.

The Information Governance Management Framework is documented within the Information Governance Strategy and Policy. The four key principles are openness, information quality assurance, information security assurance, and legal compliance.

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

The Trust's Information Governance Steering Group (IGSG) undertakes an Information Governance Work Programme covering the full range of information governance elements, and ensures that appropriate policies and management arrangements are in place. The IGSG, reviews a data quality and completeness report, including the results of data accuracy tests on a quarterly basis.

These corporate and operational arrangements ensure that information governance and data quality are prioritised at all levels of the Trust.

Each year the Trust completes a comprehensive self-assessment of its information governance arrangements by means of the NHS Digital Information Governance Toolkit.

These assessments and the information governance measures themselves are regularly validated through independent internal audit. The main Toolkit headings are:

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

The Trust's Information Governance Assessment Report overall score for 2017/18 was 77% and was graded 'Not Satisfactory' ('red').

The 'Not Satisfactory' rating was solely due to a failure to reach the required level in respect of one requirement, i.e. that at least 95% of all employees and volunteers have completed their Information Governance 'annual refresh' training within the current financial year (the actual training figure at the end of the year being 81%).

It should be noted that the Trust has produced an improvement plan to rectify this deficiency during 2017/18, in line with the new Data Security and Protection Toolkit which has replaced the Information Governance Toolkit.

It is confirmed that all new staff receive the appropriate Information Governance training when they join the Trust.

## Clinical Coding Error Rate

Great Western Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during the reporting period of 2017/18 by the Audit Commission.

## Data Quality

Data quality is essential for the effective delivery of patient care. For improvements to patient care we must have robust and accurate data available.

Great Western NHS Foundation Trust has completed the following in the last year towards improve data quality

- Review of the Trust's data quality policy
- Development of a Trust data quality strategy
- Developed a data quality report that focuses on monitoring the national DQ measures and identify actions from areas below national averages
- A role has been assigned responsibility for monitoring data quality within the Trust
- Review of terms of reference for the Trusts Data Quality group

Great Western NHS Foundation Trust will be taking the following actions forward to continue with our improvement around data quality

- Review of the Trust data quality strategy (to ensure relevance)
- Establish regular Trusts Data Quality group meetings
- Review communicate and education of staff on their responsibilities around data quality
- Explore areas of data quality with the aim to identify areas that need some dedicated improvements with key benefits

Great Western NHS Foundation Trust will continue to monitor and work to improve data quality by using the above mentioned data quality report, with the aim to work with services /staff to educate and improve data quality, which in turn improves patients records thus patient care

## 11.8 Reporting against Core Indicators

| | | 2013/ 2014 | 2014/ 2015 | 2015/ 2016 | 2016/ 2017 | 2017/ 2018 | National Average | What does this mean | Trusts with the highest and lowest score | Source of measure | Definition |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **1 - Reducing Healthcare Associated Infections** | **MRSA Bed Days** | 5 | 2 | 2 | 1 | 0 | 0.96 | Zero is aspirational | Low- 0; High- 11 | IP&C | National definition |
| | **C.Diff** | 23 | 19* *combined previously acute/ community split | 30 Trust-wide | 21 | 25 | N/A | Zero is aspirational | Low-0; High- 121 | IP&C | National definition |
| | **C.Diff 100,000 bed days** | 12.5 | 9.60 | 14.7 | 11.1 | 11.8 | 15.01 | Lower is better | Regionally Low:8.71 High: 28.02 | PHE | National Definition |
| **2 - Patient Falls in Hospital resulting in severe harm** | | 23 | 16 | 13 | 12 | 10 | Not available | Lower is better | -- | Incident form | NPSA |
| **3 – Reducing Healthcare Acquired Pressure Ulcers** | | 28 Category II & Category IV | 51 Category I & Categor IV | 8 Category III 6 Category IV | 50 Cat II | 40 Category II 2 Category III | 4% incidence | Lower is better | -- | Incident form | National Definition (from Hospital database) |
| **6 – Never Events that occurred in the Trust** | | 4 | 2 | 3 | 1 | 1 | NHS England 2014-15 Average 2.16 | Zero tolerance | Highest - 9 Low - 0 | IR1's | NPSA |
| **Hospital-level mortality indicator (SHMI) (SHMI)** | | 96.00 | 92.99 | 95.83 | 94.34 (Oct 15 to Sep 16 – most recent data available) | 97 (Oct 16 to Sep 17 – most recent data available | - | Lower than 100 is good | - | National NHS Information Centre | National NHS Information Centre |
| **7 – Mortality Rate (HSMR) HSMR** | | 97.3 | 90.3 | 89.0 | 97.97 (Apr 16 – Dec 16 provisional figure) | 98.3 (Apr 17 – Dec 17 provisional figure) | 100 | Lower than 100 is good | Low -74.2; High -128.8 | Dr Foster | National NHS Information Centre |
| **8 – Early Management of deteriorating patients - % compliance with Early Warning Score** | **Early Warning Score (Adults)** | 95% April – Dec 9 months | 90% | 85% April – Dec 9 months | Average 96% | Average 95% | Not available | Higher number is better | -- | Audit | Audit criteria (10 patients per ward per month) |
| | **Paediatric Early Warning Score (Children)** | 87.75% | 92.25% Average yearly compliance | 85% April - Sept 6 months | Average 86% | Average 85% | N/A | Higher number is better | -- | Audit | Audit criteria (5 patients per month) |

| | | 2013/ 2014 | 2014/ 2015 | 2015/ 2016 | 2016/ 2017 | 2017/ 2018 | National Average | What does this mean | Trusts with the highest and lowest score | Source of measure | Definition |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **18– Patient Reported Outcome Measures** | **Varicose Vein surgery** | 100% | 90.9% | 100% HSCIC Provisional data | 100% HSCIC Provisional data | Currently Un available | 80% | Higher is better | Not available (more than one Contractor for this service) | DoH/ HSCIC | National Definition |
| | **Groin Hernia surgery** | 100% | 57.6% | 42.9% HSCIC Provisional data | 54.5% HSCIC Provisional data | Currently Un available | 80% | Higher is better | | DoH/ HSCIC | National Definition |
| | **Hip Replacement surgery (Oxford Hip Score)** | 98.5% | 61.5% | 93.9% HSCIC Provisional data | 91.9% HSCIC Provisional data | 96.7% HSCIC Provisional data | 80% | Higher is better | | DoH/ HSCIC | National Definition |
| | **Knee Replacement Surgery (Oxford Knee Score)** | 97% | 94.4% | 97% HSCIC Provisional data | 95.3% HSCIC Provisional data | 95.3% HSCIC Provisional data | 80% | Higher is better | | DoH/ HSCIC | National Definition |
| **19 – Readmissions – 30 days** | 7.9% | 9.4% | 9.7% | 9.8% (Apr 16 to Feb 17) | 11.2% | Local target (7.1%) | Lower is better | -- | | National Definition | |
| **19 – Readmissions – 28 days** | 7.7% | 9.2% | 9.6 | 9.8% (Apr 16 to Sep 16) | 10.9% Apr 17 – Feb 18 | SW Region 6.9% | Lower is better | Low: 5.12; High:10.91 | Dr Foster | Dr Foster | |
| **19 – Re-admissions 28 days**<br><br>**Ages 0-15**<br>**Ages 16+** | 9%<br>7.5% | 8.5%<br>9.2% | 9.02<br>10.02 | 9.5% 0-15 & 9.9% 16+ (Apr 16 to Sep 16) | - | Dr Foster | Lower is better | 0-15 yrs: Low: 0.8; High: 15.8 16+ yrs: Low: 5.0; High: 11.1 | Dr Foster | Dr Foster | **19 – Re-admissions 28 days**<br><br>**Ages 0-15**<br>**Ages 16+** |
| **20 – The Trusts responsiveness to the personal needs of its patients during the reporting period.** | **Were you involved as much as you wanted to be in decisions about your care and treatment?** | 53.2% | 51.4% | 51.8% | 51.1% | 55.4% | 57.1% | Higher is better | Low: 6.1 High: 9.2 GWH: 7.1 | Picker Survey | National definition |
| | **Did you find someone on the hospital staff to talk to about your worries and fears?** | 37.1% | 28.6% | 33.0% | 32% | 34.6% | 39.3% | Higher is better | Low: 4.3 High: 8.2 GWH: 4.9 | Picker Survey | National definition |
| | **Were you given enough privacy when discussing your conditions or treatment?** | 70.8% | 74.2% | 72.6% | 75.6% | 72.5% | 77.0% | Higher is better | Low: 7.5 High: 9.4 GWH: 8.5 | Picker Survey | National definition |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Did a member of staff tell you about medication side effects to watch for when you went home?** | 33.7% | 32.1% | 29.8% | 35.3% | 38.6% | 39.3% | Higher is better | Low: 3.7 High: 7.6 GWH: 4.3 | Picker Survey | National definition |
| | **Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?** | 67.2% | 66.2% | 68.0% | 65.6% | 65.9% | 70.8% | Higher is better | Low: 6.4 High: 9.7 GWH: 7.6 | Picker Survey | National definition |
| **21 – Percentage of staff employed by or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends** | | 58% | 70% | 68% | 68% | 68% | 69.8% | Higher is better | - | NHS Staff survey | National Definition |
| **23 - VTE** | **4 Percentage of VTE Risk Assessments completed** | 95.5% | 97.1% | 98.3% | 99.4% | 99% | 90% | Higher number better | Low - 91.3; High - 100 | EPMA and manually for those areas not using the electronic prescribing system | National Definition (from Hospital database) |
| | **5 Percentage of patients who receive appropriate VTE Prophylaxis** | 95% | 91.6% | 95.2 | 97.4% | 94.9% | N/A | Higher number better | -- | One day each month whole ward audit for one surgical ward and one medical ward | National Definition (from Hospital database) |
| **25 - The number and where available, rate of patient safety incidents and the number and percentage of such patient safety incidents that resulted in severe harm or death** | **Number of Incidents per 100 Bed Days** | 4.55 | 4.98 | 5.9 | 6.7 | 5.1 | -- | Lower is better | -- | Informatics & Clinical Risk | - |
| | **Number of Patient Safety Incidents per 100 Bed Days** | 3.00 | 3.07 | 3.3 | 4.4 | 3.6 | -- | Lower is better | -- | Informatics & Clinical Risk | - |
| | **Number of Incidents resulting in Severe Harm or Death per 100 Bed Days** | 0.03 | 0.04 | 0.01 | 0.01 | 0.02 | -- | Lower is better | -- | Informatics & Clinical Risk | - |
| | **Percentage of Combined Severe Harm and Death** | 0.56% | 0.80% | 0.55% | 0.26% | 0.41% | -- | Lower is better | -- | Informatics & Clinical Risk | - |

| | 2013/ 2014 | 2014/ 2015 | 2015/ 2016 | 2016/ 2017 | 2017/ 2018 | National Average | What does this mean | Trusts with the highest and lowest score | Source of measure | Definition | 2013/ 2014 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **25 - The number and where available, rate of patient safety incidents and the number and percentage of such patient safety incidents that resulted in severe harm or death** | **Number of Incidents per 100 Bed Days** | 4.55 | 4.98 | 5.9 | 6.7 | 5.1 | -- | Lower is better | -- | Informatics & Clinical Risk | - |
| | **Number of Patient Safety Incidents per 100 Bed Days** | 3.00 | 3.07 | 3.3 | 4.4 | 3.6 | -- | Lower is better | -- | Informatics & Clinical Risk | - |
| | **Number of Incidents resulting in Severe Harm or Death per 100 Bed Days** | 0.03 | 0.04 | 0.01 | 0.01 | 0.02 | -- | Lower is better | -- | Informatics & Clinical Risk | - |
| | **Percentage of Combined Severe Harm and Death** | 0.56% | 0.80% | 0.55% | 0.26% | 0.41% | -- | Lower is better | -- | Informatics & Clinical Risk | - |
| **The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period** | | 26.0% | 26.5% | 31.7 % Oct 14-Sept 15 Most recent data available | 31.1% (Oct 15 to Sep 16, most recent data available) | 30.8% (Oct 16 to Sep 17, most recent data available) | 25.3% | Lower is better | Low:0; High: 49.4 | HSCIC | National Definition |

## 11.9 Other Information

This section provides information about other services we provide, through a range of selected quality measures. These measures have been selected to reflect the organisation and shows data relevant to specific services as well as what our patients and public tell us matters most to them.

## Performance against key national priorities

An overview of performance in 2017/18 against the key national priorities from the Single Oversight Framework. Performance against the relevant indicators and performance thresholds are provided.

| Indicator | 2013/ 2014 Trust | 2014/ 2015 Trust | 2015/ 2016 Trust | 2015/2016 Target | **2016/ 2017 Target** | **2016/ 2017 Trust** | **2017/ 2018 Target** | **2017/ 2018 Trust** | Achieved/ Not Met |
|---|---|---|---|---|---|---|---|---|---|
| Maximum time of 18 weeks from point of referral to treatment in aggregate, patients on incomplete pathways | 94.8% | 90.5% | 88.9% | 92.0% | 92.0% | 91.1% | 92% | 86.7% | Not Met |
| Maximum time of 18 weeks from point of referral to treatment in aggregate, admitted patients | 94.9% | 88.6% | 82.5% | 90% | 90% | 61.6% | 90% | 69.1% | Not Met |
| Maximum time of 18 weeks from point of referral to treatment in aggregate, non-admitted patients | 96.3% | 95.6% | 89.2% | 95% | 95% | 89% | 95% | 89.3% | Not Met |
| A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge - 95% | 94.1% | 91.9% | 91.1% | 95.0% | 95.0% | 86.6% | 95% | 87.2% | Not Met |
| Cancer 31 day wait for second or subsequent treatment – surgery - 94% | 98.4% | 99% | 94.% | 94% | 94% | 100% | 94% | 98.7% | Achieved |
| Cancer 31 day wait for second or subsequent treatment - anti cancer drug treatments – 98% | 100% | 98% | 99.7% | 98% | 98% | 99.6% | 98% | 100% | Achieved |
| Cancer 62 Day Waits for first treatment from urgent GP referral for suspected cancer – 85% | 89.0% | 88.4% | 87.70% | 85.00% | 85% | 86.5% | 85% | 82% | Not Met |
| Cancer 62 Day Waits for first treatment from NHS cancer screening service referral - 90% | 98.9% | 98.4% | 98.10% | 90.00% | 90% | 96.7% | 90% | 97.6% | Achieved |
| Cancer 31 day wait from diagnosis to first treatment | 98.8% | 98.6% | 98.00% | 96.00% | 96% | 97.1% | 96% | 98.4% | Achieved |

| Indicator | 2013/ 2014 Trust | 2014/ 2015 Trust | 2015/ 2016 Trust | 2015/2016 Target | **2016/ 2017 Target** | **2016/ 2017 Trust** | **2017/ 2018 Target** | **2017/ 2018 Trust** | Achieved/ Not Met |
|---|---|---|---|---|---|---|---|---|---|
| Cancer 2 week wait from referral to date first seen, all urgent referrals (cancer suspected) – 93% | 94.7% | 94.0% | 94.30% | 93.00% | 93% | 88.4% | 93% | 93.4% | Achieved |
| Cancer 2 week wait from referral to date first seen, symptomatic breast patients (cancer not initially suspected) – 93% | 95.6% | 96.8 | 95.50% | 93.00% | 93% | 91.8% | 93% | 78.5% | Not Met |
| Maximum 6-week wait for diagnostic procedures | 99.7% | 99.5% | 99% | 99.1% | 99% | 97.0% | 99% | 96.2% | Not Met |

## 11.10 Statements

### Statement from the Council of Governors dated 9th May 2018

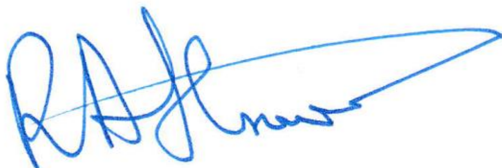
The Governors are of the opinion that the Quality Account is a realistic representation of the Trust's performance as presented to the governors over the past year. The Governors have acknowledged that unfortunately the Trust did not achieve some targets, notably the percent of persons attending A & E seen within 4 hours against the target of 95% but were pleased to see that in March 2018 the figure reached 85%, the trajectory figure agreed with NHS I and in April reached 91.9%. Governors consider these figures to be consistent with those of the vast majority of other Trusts and are reflective of the pressures brought about by increased attendance.

The Governors are aware that the Trust continues to take action to address this issue and the consequential effects on other performance indicators. Nonetheless we are aware that several proposed actions are dependent on partner organisations delivering on their commitments. Within the Quality Report the Trust has reported a number of achievements such as a 50% reduction in moderate harm falls and a 53.3% reduction in severe harm falls, a below average mortality rate and in many other areas. These achievements are noted by the Governors and combine to help achieve an improving experience for our service users.

The Governors have had opportunities to undertake safety and quality visits across the hospital, enabling Governors to meet and talk directly to staff and patients in clinical areas, gaining an insight in how the Governor role can support the business of the Trust. The visits provided Governors with direct oversight of patient care and improvements made throughout the year, plus added to the Governors knowledge and understanding of patient experience, along with staff and patient feedback. A continuing programme of visits has been set up for 2018/19.

The Governors Patient Quality and Operational Performance Working Group is working very well and there are detailed presentations and reports and Governors have the opportunity to consider in detail specific issues and areas of improvement.

During the last year Governors have worked with staff to build on the good work within the Quality Accounts and focussed on safeguarding, food hygiene, winter pressures preparation, e-rostering and the management of overseas patients. The Governors are looking forward to continuing to build on this good work in the coming year, focusing on a number of areas including Risk Management, Activity Planning and Increasing Demand and Equality and Diversity. In addition the Local Governors selected Indicator for 2018/19 was Falls (Medicines Reconciliation on admission and after a fall has taken place).



**Roger Stroud**

**Lead Governor on behalf of the Council of Governors**

## Statement from Swindon Clinical Commission Group dated 16th May 2018

Swindon Clinical Commissioning Group (CCG), as lead co-ordinating commissioner for the Great Western Hospitals NHS Foundation Trust (GWHFT) welcomes the opportunity to review and comment on the GWHFT Quality Account for 2017/2018. Swindon CCG has also sought the view of NHS Wiltshire CCG in order to provide a joint commissioner response. In so far as the CCG has been able to check the factual details, the view is that the Quality Account is materially accurate in line with information presented to the CCG via contractual monitoring and quality visits and is presented in the format required by NHS Improvement 2017/2018 presentation guidance.

In June 2017, the GWHFT were commissioned to provide community health services for the population of Swindon (SCHS) and this has resulted in the Trust reporting data for additional services within its quality accounts for 2017/18.

A key priority for the Trust during 2017/2018 was to build on the success of the Sign up to Safety programme. The CCG acknowledges the sustained progress that has been made within these important quality improvement workstreams, focusing on the key priorities relating to inpatient falls; pressure ulcers; reduction in the number of deaths relating to acute kidney injury (AKI), management of sepsis and recognition of the deteriorating patient. The CCG's have a sepsis commissioning for quality and innovation (CQUIN) scheme in contract for 2017-2019 which will support continued focus on reducing the sepsis 30-day mortality rate.

Although the Trust has reported an increase in the number inpatient falls, the CCG notes the reported 50% reduction in the level of harm experienced. During 2017/18 the Trust also reports it has exceeded its target to reduce the number of avoidable pressure ulcers to less than 5 per month. The CCG will continue to monitor the quality improvement workstreams aimed at preventing inpatient falls and pressure ulcers, including the SCHS inpatient wards, but would also welcome more detailed information within the quality accounts of the lessons learned as a result of the individual and thematic reviews of the Trust's investigations into all reported falls and pressure ulcers.

As identified in both national and local learning from incidents, the Trust has continued to build on education and training plans aimed at recognising the deteriorating patient and ensuring timely treatment. The Trust has fully implemented and embedded the standardised National Early Warning Score (NEWS) Trust Wide (including community areas). The CCG notes the delay in the Trust being able to introduce the E-Observations system during 2017/18, but now awaits the outcomes of its planned introduction in the summer of 2018.

During 2017/18, the Trust experienced a sustained increase in elective and non-elective demand, resulting in delays within the Emergency Department (ED) and the Trust having continued difficulties in achieving the 18-week referral to treatment target. These NHS constitutional targets continue to be a national challenge across NHS organisations and are regularly monitored by the CCG. The CCG will continue to work with the Trust to monitor the quality of care and treatment for patients, including outcomes of plans to improve performance, safety and patient experience and quality assurance visits.

The Trust reported a breach in the numbers of Clostridium difficile infections reported during 2017/18 (25 against a trajectory of no more than 20) but was able to demonstrate no outbreaks of infection during this period.

5 of the 25 cases were assessed as avoidable and learning has been shared with the relevant CCGs and infection prevention and control committees, in order to support year on year reductions. Of note, no hospital acquired meticillin resistant staphylococcus aureus blood stream infections (MRSA) were reported during the year. The CCG welcomes the Trusts' continued focus on reducing reported gram negative bloodstream infections (GNBSI) across the wider hospital and community settings during 2018/19, where there is now a national initiative aimed at ensuring a 50% reduction in the number of GNBSIs reported by 2021.
The CCG is aware that during 2017/18 the Trust has introduced a new process for mortality reviews, which has been developed as part of a collaborative with all hospitals in the West of England. The Trusts have all worked with the Royal College of Physicians (RCP) as pilot sites for the introduction of the Structured Judgement Review (SJR) methodology for undertaking mortality reviews. The CCG welcomes the priority for 2018/19 to now increase the number of reviews taking place, whereby thematic analysis and narrative collected for each case will be used to ensure learning from deaths continues to be shared within the organisation and more widely.

We recognise the ongoing work by the Trust to monitor and improve patient experience and note the outcomes of the 2017 patient survey, demonstrating that a number of survey questions have had an improved score from the previous year. Going forward, the CCG will continue to work with the Trust to gain assurance on actions being taken to improve those areas where feedback scoring has worsened, particularly regarding discharge planning.

The results of the NHS Staff Survey for 2017, demonstrates the Trusts overall position in the region has declined compared with last year. A total of 2446 employees returned a completed questionnaire giving the Trust a response rate of 46.5%. This was a decrease in last years (49%) but above the average response rate for Combined Acute and Community Trusts in England (43%). With 75% of GWH staff continuing to remain enthusiastic about their job and 85% feeling that the organisation acts fairly regarding career progression, it is recognised that these scores are significantly better than other similar organisations. However, overall, the staff engagement score shows the Trust is marginally below the national average. The areas used to measure the staff engagement score is based on staff recommending the organisation as a place to work or receive treatment, staff motivation at work and staff ability to contribute towards improvements at work. The CCG welcomes the Trust's commitment to achieving its identified short and long term priorities aimed at improving staff engagement and morale and will work with the Trust to monitor progress during 2018/19.

The CCG is pleased to note that the Trust has reported progress within the field of research and development and that the Trust successfully met it's set target for 2017/18. To support these statements further, the CCG would welcome additional information with regards to the positive impact and outcomes that are being achieved through the research and development workstreams.

Swindon CCG welcomes the quality priorities outlined by GWHFT for 2018/19, including the commitment to increase quality improvement (QI) capability within the organisation and incorporate all community services into all current and future improvement workstreams. In addition, the CCG will be seeking further assurances during 2018/19 in relation to the quality impact of any cost improvement plans (CIPs), including impact on workforce. Monitoring of the actions identified within both the Trust's sepsis workstreams and patient experience feedback regarding discharge will also be a key focus for the CCG.

Going forward, NHS Swindon CCG would request that more detailed information is provided for all community services as part of future GWHFT Quality Accounts.

As the lead co-ordinating commissioner, Swindon CCG is committed to sustaining its strong working relationship with GWHFT, together with local clinical commissioning groups and wider stakeholders, ensuring continued collaborative working that can support achievement of the identified priorities for 2018/19 across the whole health and social care system.

**Gill May**
**Executive Nurse, NHS Swindon CCG**

## Statement from Healthwatch, Swindon and Healthwatch Wiltshire dated 8th May 2018.

This statement is provided on behalf of Healthwatch Wiltshire and Healthwatch Swindon and together they welcome the opportunity to comment on the Great Western Hospitals NHS Foundation Trust's quality account for 2017/18. The role of Healthwatch is to promote the voice of patients and the wider public with respect to health and social care services. Local Healthwatch have continued to meet regularly with the Trust over the past year and remain committed to continuing this relationship and working with the Trust over the coming year.

We are happy to see the priorities for the coming year have been drawn from local learning and national concerns, and that patient/public Governor representatives have been involved in the process.

We are pleased that the Trust only reported one never event during the period of 2017/18 and that they have clearly laid out how they intend to ensure learning from the incident will be used to ensure such similar events don't happen in the future.

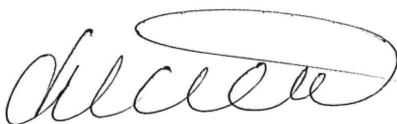
We recognise the work that the Trust has done to improve the Emergency Department (A&E) 4 hour wait target and acknowledge that the percentage of patients having a maximum of 4 hours wait is above their agreed trajectory target of 87.1%. We understand that the breaches in the Emergency Department (A&E) wait times are a national issue and we would encourage local people to share their experiences of using the Emergency Department (A&E) services with us to enable their continued engagement with patients.

For parts of this year the Trust's performance in meeting referral to treatment within 18 weeks has declined. The Trust started the year on target but performance dipped during the summer due to vacancies and a demand on specialities. We recognise that the Trust continued to experience a decline in performance during the winter period but that this was partly due to the national steer to cancel routine elective activity to meet demand over during the period of 2017/18 this period. We would again encourage local people to share their experiences of receiving routine elective surgery so that the impact of long waits for services can be identified.

We are pleased to see the continued progress made by the Trust on the areas highlighted by the Care Quality Commission's inspection dated December 2017 and we recognise the Trust's ambition to save an extra 500 lives by their engagement in the 'Sign up to Safety' initiative.

It is reassuring to see that patients are being given a variety of options to complete the national Friends and Family Test questionnaire including a text messaging service for all consenting patients to provide feedback once they are back home. The Trust have also been able to demonstrate improvements which have been implemented as a result of feedback shared through Friends and Family Test.

Healthwatch Wiltshire and Healthwatch Swindon are pleased that the Trust launched their engagement strategy this year and that they worked with various groups to inform the strategy. We would be pleased to work with the Trust in the future on the strategy action plan and implementation across the Trust. We look forward to working with the Trust over the coming year to ensure that the experiences of patients, their carers, and families are heard and taken seriously.



**Lucie Woodruff**
**Manager**

## Statement from Swindon Health Overview & Scrutiny Committee dated 23rd May 2018

I welcome the production of the Quality Account for Great Western Hospital Foundation Trust and the opportunity to comment. We commend you on implementing policies to reduce falls in hospital and despite a small increase; the number of falls resulting in severe harm has reduced. We also note good performance in relation to MRSA and reducing Health Care acquired Pressure Ulcers. It is also pleasing that there has been a small rise in patients saying they are involved in decisions about care and treatment.

We acknowledge the challenges the Trust faces in further reducing falls, the continued improvement needed in infection control and the increase in re-admission rates. We would welcome a further breakdown of admissions rates amongst older people rather than a measure of 16+.

We note that there is no mention of the work of the Trust in relation to safeguarding children and adults and would encourage the Trust to cover this in future

Swindon Adults, Health and Housing Scrutiny Committee welcomes the active engagement of the Trust in its meetings and the regular reports the Committee receives.

**Sue Wald**
**Corporate Director of Adult Social Services**

## Statement from Wiltshire Health Overview & Scrutiny Committee dated 17th May 2018

The Wiltshire Health Select Committee has been given the opportunity to review the draft Quality Account for Great Western Hospital Trust 2017/18.

The committee last received a report from Great Western Hospital in November 2016 and overall the committee was satisfied with the improvement plan put in place by the Trust.

On 5 September 2017, the committee considered the CQC report following the re-inspection of Great Western Hospital Trust and noted that the trust had been rated as Good for being effective, caring and well led, and as Requires Improvement for being safe and responsive to people's needs. It was also noted that CQC had not changed the overall rating of the trust following this focused inspection – which remained at Requires Improvement.

In early 2019, the committee would welcome an update from Great Western Hospital on the delivery of their priorities for improvement 2018/2019.

**Cllr Christine Crisp**
**Chairman of the Wiltshire Health Select Committee**

## 11.11 2017/18 Statements of Directors' Responsibilities in Respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 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 report.

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

The content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2017/18 and supporting guidance

The content of the Quality Report is not inconsistent with internal and external sources of information including:

- Board minutes and papers for the period **1st April 2017 to 24th May 2018**.
- Papers relating to quality reported to the board over the period **1st April 2017 to 24th May 2018.**
- Feedback from Swindon and Wiltshire commissioners dated: **16th May 2018**
- Feedback from governors dated: **9th May 2018**
- Feedback from local Healthwatch organisations dated: **8th May 2018**
- Feedback from Swindon Overview and Scrutiny Committee dated: **23rd May 2018**
- Feedback from Wiltshire Overview and Scrutiny Committee dated: **17th May 2018**
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, reported to Board monthly.
- The [latest] national inpatient survey **February 2018**
- The [latest] national staff survey **March 2018**
- The Head of Internal Audit's annual opinion over the trust's control environment dated: **May 2018.**
- CQC inspection report dated **March 2017.**

The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered 2017/18.

The performance information reported in the Quality Report is reliable and accurate

There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

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

By order of the Board

Chairman Date 24 May 2018

Chief Executive Date 24 May 2018

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

We have been engaged by the Council of Governors of Great Western Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Great Western Hospitals Quality Report for the year ended 31 March 2018 (the 'Quality Report') and certain performance indicators contained therein.

**Scope and subject matter**

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the following two national priority indicators:

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period (the 18 week RTT indicator); and
- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge (the 4 hour A&E indicator).

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

**Respective responsibilities of the directors and auditors**

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by NHS Improvement.

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

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the *Detailed requirements for quality reports for foundation trusts 2017/18* ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the *Detailed Requirements for external assurance for quality reports for foundation trusts 2017/18* (the Guidance).

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

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

- 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 16 May 2018;

- feedback from governors, dated 7 May 2018;
- feedback from local Healthwatch organisations, dated 17 May 2018;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the latest national patient survey, dated October 2017;
- the latest national staff survey, dated October 2017;
- Care Quality Commission Inspection, dated 4 August 2017;
- the 2017/18 Head of Internal Audit's annual opinion over the Trust's control environment, dated April 2018.

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of Great Western Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Great Western Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

**Assurance work performed**

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

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

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

### Limitations

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

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

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Great Western Hospitals NHS Foundation Trust.

### Basis for qualified conclusion on the 18 week RTT indicator

Our sample testing on the 18 week RTT indicator identified four issues from a sample of 20 pathways:

- One case where the service was nurse-led and therefore shouldn't have been included as a pathway;
- One case where no date stamp on the referral letter was identified for the clock start date;
- One case where an incorrect stop date was identified;
- One case where a duplicate pathway was identified.

### Conclusion

Based on the results of our procedures, except for the effects of the matters described in the 'Basis for qualified conclusion on the 18 week RTT indicator' section above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

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

KPMG LLP
Chartered Accountants
66 Queen Square
Bristol
BS1 4BE
25 May 2018

# OTHER REPORTING

# 13. Voluntary Disclosures

## 13.1 Equality reporting

Details of Equality reporting are included in the Quality Accounts (section11 refers)

## 13.2 Slavery and Human Trafficking Statement 2017/18

This statement is made pursuant to Section 54, Part 6 of the Modern Slavery Act 2015 and sets out the steps the Trust has taken to ensure that slavery and human trafficking is not taking place in our supply chains or in any part of our business.

### Supply Chain Overview

The breadth, depth and interconnectedness of the NHS supply chain make it challenging to effectively manage business and sustainability issues. Respecting human rights and environmental issues in the supply chain is ultimately our suppliers' responsibility.

### Supply chain due diligence processes

We ask our suppliers to make a self-declaration when supplying goods that they have taken measures within their organisation in relation to modern slavery and human trafficking.

### Policies

The Trust has a number of policies relevant to exploitation and human trafficking and has joint guidance for services run in partnership with other providers, such as our Wiltshire Health and Care LLP and Swindon Community Services. Our Safeguarding Adults at Risk and Child Protection policy have sections and guidance on trafficking and our HR processes have robust pre-employment checks and assurance processes.

### Area of our business where there is a risk of slavery and human trafficking

The majority of our healthcare provision is through direct contact with clinical staff. Our HR processes and professional registration requirements provide the checks to ensure that our workforce is compliant. Areas of greater risk would include supply chains of certain products and equipment. When procuring suppliers we ask for evidence of measures taken in line with slavery and human trafficking.

### The effectiveness of our approach

We currently monitor each clinical area against the requirement to train staff in all aspects of safeguarding training appropriate to the clinical environment, with most of our clinical area achieving 100% compliance.

## Training

All clinical staff received safeguarding training appropriate to their role, which includes training about slavery and human trafficking. Our safeguarding team receive specialist training and act as a resource to the workforce on slavery and human trafficking concerns.

# 14. Glossary of Terms

| Abbreviation | Definition |
|---|---|
| A&E | Accident & Emergency |
| AHSN | Academic Health Science Network |
| AKI | Acute Kidney Injury |
| ANTT | Aseptic non-touch technique |
| ACO | Accountable Care Organisation |
| AO | Accounting Officer |
| BARS | Blood Audit and Release System |
| C.diff | Clostridium Difficile - Bacteria naturally present in the gut |
| Carillion | The company that owns and runs the fabric of the site |
| CAUTIs | Catheter Associated Urinary Tract Infections |
| CCG | Clinical Commissioning Groups |
| CETV | Cash Equivalent Transfer Value |
| CLRN | Comprehensive Local Research Network |
| CNST | Clinical Negligence Scheme for Trusts |
| $CO^2e$ | Carbon Dioxide Equivalent (standard unit for measuring carbon footprint) |
| COPD | Chronic Obstructive Pulmonary Disease |
| CQC | Care Quality Commission |
| CQUIN | Commissioning for Quality and Innovation Payment |
| Crescendo | An NHS IT system |
| CUSUM | Cumulative Sum Control Chart |
| D&O | Diagnostics & Outpatients |
| DNA – CPR | Do Not Attempt – Cardiopulmonary Resuscitation |
| DNAR | Do Not Attempt Resuscitation |
| DTOC | Delayed Transfer of Care |
| DOC | Duty of Candour |
| DVT | Deep Vein Thrombosis |
| E&D | Equality & Diversity |
| ED | Emergency Department |
| EDD | Estimated Date of Discharge |
| EDS | Equality Delivery System |
| EPF | Employee Partnership Forum |
| EPMA | Electronic Prescribing and Medicines Administration |
| FFT | Friends and Family Test |
| GWH | Great Western Hospitals NHS Foundation Trust |
| HAT | Hospital Acquired Thrombosis |

| Abbreviation | Definition |
|---|---|
| HCAI | Healthcare Associated Infections |
| HDU | High Dependency Unit |
| HMIP | Her Majesty’s Inspector of Prisons |
| HPA | Health Protection Agency – now NHS England |
| HSCA | Health & Social Care Act |
| HSCIC | Health & Social Care Information Centre |
| HSMR | Hospital Standardised Mortality Rates |
| ICHD | Integrated Community Health Division |
| IP&C | Infection, Prevention & Control |
| JACIE | Joint Accreditation Committee |
| KLOE | Key Lines of Enquiry |
| LAMU | Linnet Acute Medical Unit |
| LCRN | Local Clinical Research Network |
| LQAF | Library Quality Assurance Framework |
| LSCB | Local Safeguarding Children’s Board |
| MCQOC | Matrons Care Quality Operational Group |
| MFF | Market Factor Forces |
| MHRA | Medicines and Healthcare products Regulatory Agency (MHRA) |
| MIU | Minor Injuries Unit |
| Monitor | The NHS Foundations Trust’s Regulator now part of NHS Improvement |
| MRSA or MRSAB | Methicillin-Resistant Staphylococcus Aureus Bacteraemia - a common skin bacterium that is resistant to a range of antibiotics |
| MUST | Malnutrition Universal Screening Tool |
| NEWS | National Early Warning System |
| NHS | National Health Service |
| NPSA | National Patient Safety Agency |
| NBM | Nil by mouth |
| NED | Non-Executive Director |
| NEWS | National Early Warning System |
| NHS | National Health Service |
| NHSG | Nutrition & Hydration Steering Group |
| NHSI | NHS Improvement |
| NHSLA | National Health Service Litigation Authority |
| NICE | National Institute for Clinical Excellence |
| NPSA | National Patient Safety Agency |
| NRLSA | National Reporting & Learning System Agency |
| PALS | Patient Advice & Liaison Service (Now Customer Services) |
| PAW | Princess Anne Wing (Maternity Department in the Royal United Hospital) |
| PbR | Payment by Results |

| Abbreviation | Definition |
|---|---|
| PCR | Polymerase chain reaction (a method of analysing a short sequence of DNA or RNA) |
| PDSA | Plan, Do, Study, Act |
| PE | Pulmonary Embolism |
| PEAT | Patient Environment Action Teams |
| PLACE | Patient Led Assessment of the Care Environment |
| POPPI | Projecting Older People Population Information |
| PROMS | Patient Recorded Outcome Measures |
| PSQC/PSC | Patient Safety & Quality Committee – now the Patient Safety Committee |
| PUs | Pressure Ulcers |
| PURAT | Pressure Ulcer Risk Assessment Tool |
| QI | Quality Improvement |
| RAP | Remedial Action Plan |
| R&D | Research & Development |
| RCA | Root Cause Analysis |
| RCM | Regulatory Control Manager |
| RCOG | Royal College of Gynaecologists |
| REACT | Rapid Effective Assistance for Children |
| RR | Relative Risk |
| RTT | Referral to Treatment |
| SAFE | Stratification and Avoidance of Falls in the Environment |
| SAFER | Patient Flow Bundle |
| SBAR | Situation, Background, Assessment, Recommendation |
| SEQOL | Social Enterprise Quality of Life (an NHS organisation) |
| SHMI | Summary Hospital Level Mortality Indicator |
| SHOUT | Sepsis, Hypovolemia, Obstruction, Urine Analysis, Toxins |
| SMART | Smart, Measureable, Attainable,, Realistic, Timely |
| SOPs | Standard Operating Procedures |
| SOS | Swindon Outreach Scoring System |
| SSKIN | Surface Skin Keep Moving Incontinence Nutrition |
| SSNAP | Sentinel Stroke National Audit Programme |
| STEIS | Strategic Executive Information System |
| SWICC | South West Intermediate Care Centre |
| STP | Sustainability & Transformation Partnership |
| TEP | Treatment Escalation Plan |
| TV | Tissue Viability |
| TVNC | Tissue Viability Nurse Consultant |
| TVSNs | Tissue Viability Specialist Nurses |
| UTI | Urinary Tract Infection |

| Abbreviation | Definition |
| --- | --- |
| VAP | Ventilated Acquired Pneumonia |
| VTE | Venous Thromboembolism |
| WCH | Wiltshire Community Health (New joint venture 2016 to provide community services) |
| WCHS | Wiltshire Community Health Service |
| WHO | World Health Authority |
| WRES | Workforce Race Equality Standard |

# 15. Foreword to the Accounts

## 15.1 Foreword to the accounts for the year ending 31 March 2018

These accounts for the period ended 31 March 2018 have been prepared by Great Western Hospitals NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Service Act 2006 and are presented to Parliament pursuant to Schedule7. Paragraph 25 (4) (a) of the National Health Service Act 2006.

Signed

Nerissa Vaughan
Chief Executive

24 May 2018

**Great Western Hospitals NHS Foundation Trust**
**Accounts for the year ended 31 March 2018**

## Statement of Comprehensive Income

| | Note | Group 2017/18 | Group 2016/17 | Trust 2017/18 | Trust 2016/17 |
|---|---|---|---|---|---|
| | | £000 | £000 | £000 | £000 |
| Operating income from patient care activities | 3 | 321,014 | 301,647 | 321,014 | 301,647 |
| Other operating income | 4 | 27,386 | 39,378 | 26,506 | 38,277 |
| Operating expenses | 5,7 | (340,348) | (306,385) | (339,698) | (306,105) |
| **Operating surplus from continuing operations** | | **8,052** | **34,640** | **7,822** | **33,819** |
| Finance income | 11 | 68 | 62 | 33 | 26 |
| Finance expenses | 12 | (14,718) | (15,146) | (14,718) | (15,146) |
| PDC dividends payable | | (908) | (953) | (908) | (953) |
| **Net finance costs** | | **(15,558)** | **(16,037)** | **(15,593)** | **(16,073)** |
| Other gains / (losses) | 15 | (144) | 290 | - | |
| Gains / (losses) arising from transfers by absorption | 33 | (28,612) | - | (28,612) | - |
| **(Deficit)/surplus for the year** | | **(36,262)** | **18,893** | **(36,383)** | **17,746** |
| **Other comprehensive income** | | | | | |
| **Will not be reclassified to income and expenditure:** | | | | | |
| Impairments | 14 | (2,000) | (2,282) | (2,000) | (2,282) |
| Revaluations | 14 | 2,086 | 12,851 | 2,086 | 12,851 |
| **Total comprehensive (expense)/income for the period** | | **(36,176)** | **29,462** | **(36,297)** | **28,315** |
| **(Deficit)/surplus for the period attributable to:** | | | | | |
| Great Western Hospitals NHS Foundation Trust | | (36,262) | 18,893 | (36,383) | 17,746 |
| **TOTAL** | | **(36,262)** | **18,893** | **(36,383)** | **17,746** |
| **Total comprehensive (expense)/income for the period attributable to:** | | | | | |
| Great Western Hospitals NHS Foundation Trust | | (36,176) | 29,462 | (36,297) | 28,315 |
| **TOTAL** | | **(36,176)** | **29,462** | **(36,297)** | **28,315** |

Great Western Hospitals NHS Foundation Trust
Accounts for the year ended 31 March 2018

## Statement of Financial Position

| | Note | Group 31 March 2018 £000 | Group 31 March 2017 £000 | Trust 31 March 2018 £000 | Trust 31 March 2017 £000 |
|---|---|---|---|---|---|
| **Non-current assets** | | | | | |
| Intangible assets | 13 | 2,169 | 2,721 | 2,169 | 2,721 |
| Property, plant and equipment | 14 | 191,266 | 221,894 | 191,266 | 221,894 |
| Other investments / financial assets | 15 | 849 | 1,112 | - | - |
| **Total non-current assets** | | **194,284** | **225,727** | **193,435** | **224,615** |
| **Current assets** | | | | | |
| Inventories | 18 | 5,511 | 5,363 | 5,511 | 5,363 |
| Trade and other receivables | 19 | 26,584 | 30,613 | 26,560 | 30,613 |
| Cash and cash equivalents | 20 | 3,217 | 7,273 | 1,377 | 5,854 |
| **Total current assets** | | **35,312** | **43,249** | **33,448** | **41,830** |
| **Current liabilities** | | | | | |
| Trade and other payables | 21 | (36,202) | (43,577) | (36,141) | (43,577) |
| Borrowings | 23,24 | (10,577) | (12,104) | (10,577) | (12,104) |
| Provisions | 25 | (149) | (149) | (149) | (149) |
| Other liabilities | 22 | (2,579) | (2,710) | (2,579) | (2,710) |
| **Total current liabilities** | | **(49,507)** | **(58,540)** | **(49,446)** | **(58,540)** |
| **Total assets less current liabilities** | | **180,089** | **210,436** | **177,437** | **207,905** |
| **Non-current liabilities** | | | | | |
| Borrowings | 23,24 | (130,444) | (124,948) | (130,444) | (124,948) |
| Provisions | 25 | (1,225) | (1,403) | (1,225) | (1,403) |
| Other liabilities | 22 | (1,132) | (1,246) | (1,132) | (1,246) |
| **Total non-current liabilities** | | **(132,801)** | **(127,597)** | **(132,801)** | **(127,597)** |
| **Total assets employed** | | **47,288** | **82,839** | **44,636** | **80,308** |
| **Financed by** | | | | | |
| Public dividend capital | | 31,520 | 30,895 | 31,520 | 30,895 |
| Revaluation reserve | | 27,156 | 40,397 | 27,156 | 40,397 |
| Income and expenditure reserve | | (14,040) | 9,016 | (14,040) | 9,016 |
| Charitable fund reserves | 17 | 2,652 | 2,531 | - | - |
| **Total taxpayers' equity** | | **47,288** | **82,839** | **44,636** | **80,308** |

The Annual Accounts were approved by the Board of Directors on 24 May 2108 and signed on its behalf by:

Name
Position

Date 24 May 2018

The notes of pages 245 – 279 form part of these accounts.

Great Western Hospitals NHS Foundation Trust
Accounts for the year ended 31 March 2018

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

| Group and Trust | Public dividend capital | Revaluation reserve | Income and expenditure reserve | Charitable fund reserves | Total |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 |
| **Taxpayers' and others' equity at 1 April 2017 - brought forward** | **30,895** | **40,397** | **9,016** | **2,531** | **82,839** |
| **Surplus/(deficit) for the year** | **-** | **-** | **(36,383)** | **121** | **(36,262)** |
| Transfers by absorption: transfers between reserves | - | (13,327) | 13,327 | - | **-** |
| Impairments | - | (2,000) | - | - | **(2,000)** |
| Revaluations | - | 2,086 | - | - | **2,086** |
| Public dividend capital received | 625 | - | - | - | **625** |
| **Taxpayers' and others' equity at 31 March 2018** | **31,520** | **27,156** | **(14,040)** | **2,652** | **47,288** |

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

| Group and Trust | Public dividend capital | Revaluation reserve | Income and expenditure reserve | Charitable fund reserves | Total |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 |
| **Taxpayers' and others' equity at 1 April 2016 - brought forward** | **30,895** | **29,828** | **(8,730)** | **1,384** | **53,377** |
| Surplus for the year | - | - | 17,574 | 1,319 | **18,893** |
| Impairments | - | (2,282) | - | - | **(2,282)** |
| Revaluations | - | 12,851 | - | - | **12,851** |
| Public dividend capital received | 1,558 | - | - | - | **1,558** |
| Public dividend capital repaid | (1,558) | - | - | - | **(1,558)** |
| Other reserve movements | - | - | 172 | (172) | **-** |
| **Taxpayers' and others' equity at 31 March 2017** | **30,895** | **40,397** | **9,016** | **2,531** | **82,839** |

### Information on reserves

#### NHS charitable funds reserves
This balance represents the ring-fenced funds held by the NHS charitable funds consolidated within these accounts. NHS Charity is separately identifiable above. These reserves are classified as restricted or unrestricted.

#### Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. Additional PDC may also be issued to NHS foundation trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable to the Department of Health 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.

#### Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the NHS foundation trust.

**Great Western Hospitals NHS Foundation Trust**

**Accounts for the year ended 31 March 2018**

## Statement of Cash Flows

| | | Group | | Trust | |
|---|---|---|---|---|---|
| | | **2017/18** | **2016/17** | **2017/18** | **2016/17** |
| | **Note** | **£000** | **£000** | **£000** | **£000** |
| **Cash flows from operating activities** | | | | | |
| Operating surplus / (deficit) | | 8,052 | 34,640 | 7,822 | 33,819 |
| **Non-cash income and expense:** | | | | | |
| Depreciation and amortisation | | 7,328 | 7,741 | 7,328 | 7,741 |
| Net impairments | | - | (13,705) | - | (13,705) |
| (Increase)/decrease in receivables and other assets | | 7,332 | (3,790) | 7,332 | (3,790) |
| (Increase)/decrease in inventories | | (148) | 416 | (148) | 416 |
| Increase/(decrease) in payables and other liabilities | | (7,570) | 135 | (7,570) | 119 |
| Increase/(decrease) in provisions | | (179) | (150) | (179) | (150) |
| Movements in charitable fund working capital | | 68 | 13 | - | - |
| Other movements in operating cash flows | | 35 | (1) | - | 29 |
| **Net cash flows from / (used in) operating activities** | | **14,918** | **25,299** | **14,585** | **24,479** |
| **Cash flows from investing activities** | | | | | |
| Interest received | | 33 | 26 | 33 | 26 |
| Purchase of intangible assets | | (25) | (1,012) | (25) | (1,012) |
| Purchase of PPE and investment property | | (7,627) | (4,602) | (7,627) | (4,602) |
| Net cash flows from charitable fund investing activities | | 89 | - | - | - |
| **Net cash flows from / (used in) investing activities** | | **(7,530)** | **(5,588)** | **(7,619)** | **(5,588)** |
| **Cash flows from financing activities** | | | | | |
| Public dividend capital received | | 625 | 1,558 | 625 | 1,558 |
| Public dividend capital repaid | | - | (1,558) | - | (1,558) |
| Movement on loans from DHSC | | 8,469 | 5,817 | 8,469 | 5,817 |
| Capital element of finance lease rental payments | | (77) | (76) | (77) | (76) |
| Capital element of PFI, LIFT and other service concession payments | | (4,420) | (4,692) | (4,420) | (4,692) |
| Interest paid on finance lease liabilities | | (7) | (13) | (7) | (13) |
| Interest paid on PFI, LIFT and other service concession obligations | | (14,323) | (14,806) | (14,323) | (14,806) |
| Other interest paid | | (369) | (324) | (369) | (324) |
| PDC dividend (paid) / refunded | | (1,341) | (680) | (1,341) | (680) |
| Cash flows from (used in) other financing activities | | - | 36 | - | 22 |
| **Net cash flows from / (used in) financing activities** | | **(11,443)** | **(14,738)** | **(11,443)** | **(14,752)** |
| **Increase / (decrease) in cash and cash equivalents** | | **(4,056)** | **4,973** | **(4,478)** | **4,139** |
| **Cash and cash equivalents at 31 March** | 20 | **3,217** | **7,273** | **1,377** | **5,854** |

**Great Western Hospitals NHS Foundation Trust**
**Accounts for the year ended 31 March 2018**
## 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. 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 accounts have been prepared on a going concern basis. The Trust's Annual Plan forecasts a deficit of £5.0m for the year ending 31 March 2019. This includes the receipt of £7.1m from the Provider Sustainability Fund (PSF formerly Sustainability and Transformation Fund). In addition the Trust has identified a borrowing requirement to maintain a minimum monthly cash balance of at least £1m and this is also set out in the Trust's 2018/19 Annual Plan. The Trust has £6.1m of DHSC borrowing due to be repaid in 2018/19, however DHSC have indicated that the repayment of £4.9m can be deferred to 2019/20 leaving borrowing to be repaid in 2018/19 of £1.2m.
The NHS Improvement NHS Foundation Trust Annual Reporting Manual 2017/18 states that financial statements should be prepared on a going concern basis unless management either intends to apply to the Secretary of State for the dissolution of the NHS FT without the transfer of the services to another entity, or has no realistic alternative but to do so.
There is a material uncertainty related to events or conditions that may cast significant doubt on the entity's ability to continue as a going concern and that it may therefore be unable to realise its assets and discharge its liabilities in the normal course of business.
After making enquiries and considering the material uncertainties described above, there are no plans to transfer the service elsewhere and the Directors have a reasonable expectation that the Trust will secure adequate resources to continue in operational existence for the foreseeable future and continue to adopt the going concern basis in preparing the Annual Report and Accounts.

**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:

**Note 1.2.1 Sources of estimation uncertainty**
International accounting standard IAS1 requires estimates, assumptions and judgements to be continually evaluated and to be based on historical experience and other factors including expectation of future events that are believed to be reasonable under the circumstances. Actual results may differ from these estimates. The purpose of the evaluation is to consider whether there may be a significant risk of causing a material adjustment to the carrying value of assets and liabilities within the next financial year, compared to the carrying value in these accounts. The following significant assumptions and areas of estimation and judgement have been considered in preparing these financial statements.
Value of land, buildings and dwellings £177m. This is the most significant estimate in the accounts and is based on the professional judgement of the Trust's independent valuer with extensive knowledge of the physical estate and market factors. The value does not take into account potential future changes in market value which cannot be predicted with any certainty. The Trust has chosen to apply local indexation to it's major building asset GWH in the light of the significant increases that have occurred over the two years since the District Valuer carried out their last major review.

**Note 1.3 Consolidation**

Great Western Hospitals NHS Foundation Trust Charitable Fund
The NHS Foundation Trust is the corporate trustee to Great Western Hospitals NHS Foundation Trust Charitable Fund. The Foundation Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Foundation Trust has the power to govern the financial and operating policies of the charitable fund so as to obtain benefit from its activities for itself, its patients or its staff.
From 2013/14, the Foundation Trust has consolidated the charitable fund and has applied this as a change in accounting policy.
The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Generally Accepted Accounting Principles (UK GAAP). 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.

The key accounting policy for the Charity is in relation to investments. The Corporate Trustee has determined the investment policy to, in so far is reasonable, avoid undue risk to the real value of the capital and income of the portfolio, after allowing for inflation so the investments are held at fair value. The investment policy, also requires that all monies not required to fund working capital should be invested to maximise income and growth.
The key accounting policy for the Charity is in relation to investments. The Corporate Trustee has determined the investment policy to, in so far is reasonable, avoid undue risk to the real value of the capital and income of the portfolio, after allowing for inflation so the investments are held at fair value. The investment policy, also requires that all monies not required to fund working capital should be invested to maximise income and growth.
**Joint Ventures**
Joint ventures are arrangements in which the trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. Joint ventures are accounted for using the equity method. The Trust entered a Joint Venture Arrangement, Wiltshire Health & Care LLP, with Royal United Hospital Bath NHS FT and Salisbury NHS FT on 1st July 2016. All profits or losses are shared equally between the three Trusts. No initial consideration was paid for the share of this investment.

**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. For patients occupying a bed at the 2017/18 financial year end, the estimated value of partially completed spells is £1,373k (2016/17 £1,347k). An estimate relating to maternity pathway income has also been included within deferred income in 2017/18. The value of this estimate is £1,474k (2016/17 £1,567k).

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 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 are not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. There, the schemes are accounted for as though they are defined contribution schemes.

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.

**Local Government Pension Scheme**
Some employees are members of the Local Government Pension Scheme which is a defined benefit pension scheme. The scheme assets and liabilities attributable to these employees can be identified and are recognised in the trust’s accounts. The assets are measured at fair value, and the liabilities at the present value of future obligations.

The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The net interest cost during the year arising from the unwinding of the discount on the net scheme liabilities is recognised within finance costs. Remeasurements of the defined benefit plan are recognised in the income and expenditure reserve and reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

**National Employment Savings Trust (NEST)**

As part of the Government's pension reform the Trust commenced auto-enrolment in July 2013. Staff not eligible to join the NHS pension scheme are automatically enrolled in NEST.

**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**

***Recognition***
Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.
• form part of the initial equipping and setting-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or colective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

**Measurement**
**Valuation**

All property, plant and equipment are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.
Land and Property assets are valued every 5 years with a 3 yearly interim valuation also carried out. Annual impairment reviews are carried out in other years. The 3 and 5 yearly interim revaluations are carried out by a professionally qualified valuer in accordance with the Royal Chartered Institute of Surveyors (RICS) Appraisal and Valuation Manual. The valuations are carried out on the basis of a Modern Equivalent Asset as required by HM Treasury. The annual reviews are carried out using the most appropriate information available at the date of the review. A revaluation was carried out on 1 April 2016. For GWH assets this was a full revaluation. A desktop revaluation was carried out for Wiltshire Community Estates. The estates was revalued as at 31 March 2018 using indices supplied by District Valuer.

Equipment assets values are reviewed annually internally to determine the remaining life based on past and forecasted consumption of the economic useful life of the asset.

Property used for the Trust's services or for administrative purposes are stated in the Statement of Financial Position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period.

***Subsequent expenditure***
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the 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’.

**Note 1.7 Property, plant and equipment continued**

*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.

*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.

***Donated, government grant and other grant funded assets***
Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor 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.

**Private Finance Initiative (PFI) Transactions**
PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM*, are accounted for as ‘on-Statement of Financial Position’ by the trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services.

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

**Note 1.7 Property, plant and equipment continued**
**Lifecycle replacement**

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

***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 | Max life |
|---|---|---|
| | Years | Years |
| Plant & machinery | 5 | 15 |
| Information technology | 5 | 12 |
| Furniture & fittings | 5 | 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**

*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 Intangible Assets continued**

***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.

**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 | Max life |
|---|---|---|
| | Years | Years |
| Software | 5 | 5 |
| Licences & trademarks | 5 | 12 |

**Note 1.9 Government Grants**

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

**Note 1.10 Inventories**

Inventories are valued at the lower of cost and net realisable value. Pharmacy stocks are valued at average cost, other inventories are valued on a first-in first-out basis. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks. Work-in-progress comprises goods and services in intermediate stages of production.

## Note 1.11 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 the Trust’s cash management. Cash, bank and overdraft balances are recorded at current values.

**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 above/below.
All other financial assets and financial liabilities are recognised when the trust becomes a party to the contractual provisions of the instrument.

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

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

***Classification and measurement***
Financial assets are categorised as fair value through income and expenditure, loans and receivables.
Financial liabilities are classified as fair value through income and expenditure or as other financial liabilities.

***Financial assets and financial liabilities at "fair value through 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. . 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.

The trust's loans and receivables comprise: 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.

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

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

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or 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 current 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 directly.

**Note 1.13 Leases**

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

**Note 1.13.1 The Trust as lessee**

**Finance leases**

Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental 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 1.13.2 The Trust as lessor**

**Finance leases**

Amounts due from lessees under finance leases are recorded as receivables at the amount of the trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

**Operating leases**

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

**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 25.2 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, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 31 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 31, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

**Note 1.16 Public dividend capital**

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health (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**

The NHS foundation trust does not have a corporation tax liability for the year 2017/18 (2016/17 £nil). Tax may be payable on activities as described below:
the activity is not related to the provision of core healthcare as defined under Section 14(1) of the HSCA. Private healthcare falls under this legislation and is therefore not taxable.
the activity is commercial in nature and competes with the private sector. In house trading activities are normally ancillary to the core healthcare objectives and are therefore not subject to tax.
the activity must have annual profits of over £50,000.

**Note 1.19 Foreign exchange**

The functional and presentational currency of the trust is 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 other NHS bodies**

For functions that the trust has transferred to NHS Property Services Ltd., the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss / gain corresponding to the net assets/ liabilities transferred is recognised within expenses / income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve.

**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**

The DHSC GAM for 2018/19 was published on 27 April 2018. This contains the final guidance on the implementation of new accounting standards for NHS Group bodies in 2018/19 and the Trust will review and implement this guidance for that period.

| Effective in future years | Effective Date | |
|---|---|---|
| IFRS 9 Financial instruments | 2017/18 | Not yet adopted by FReM |
| IFRS 14 Regulatory Deferral Accounts | 2016/17 | Not applicable to DH |
| IFRS 15 Revenue from contracts with customers | 2017/18 | Not yet adopted by FReM |
| IFRS 16 Leases | 2019/20 | Not yet adopted by FReM |
| IFRS 17 Insurance Contracts | 2020/21 | Not yet adopted by FReM |
| IFRIC 22 Foreign Currency Transactions and Advance Consideration | 2017/18 | Not yet adopted by FReM |
| IFRIC 23 Uncertainty over Income Tax Treatments | 2018/19 | Not yet adopted by FReM |

**Great Western Hospitals NHS Foundation Trust**
**Accounts for the year ended 31 March 2018**
**Note 2 Operating Segments**
**Group**

The Trust's Board has determined that the Trust operates in three material segments which is Great Western Hospitals (GWH), Swindon Community Services and the NHS Charity.

**2017-18**

| | GWH | Swindon Community Services | Charity | Total |
|---|---|---|---|---|
| **Operating Income** | **£'000** | **£'000** | **£'000** | **£'000** |
| NHS Clinical Income | 294,755 | 19,692 | 0 | 314,447 |
| Private Patients | 3,430 | 0 | 0 | 3,430 |
| Other Non Mandatory/Non Protected Revenue | 3,135 | 2 | 0 | 3,137 |
| Research & Development Income | 658 | 0 | 0 | 658 |
| Education and Training Income | 10,134 | 5 | 0 | 10,139 |
| Misc Other Operating Income | 15,412 | 297 | 880 | 16,589 |
| **Total Income** | **327,524** | **19,996** | **880** | **348,400** |

**2016-17**

| | GWH | WCHS | Swindon Community Services | Charity | Total |
|---|---|---|---|---|---|
| | | To 30/6/17 | From 1/10/16 | | |
| **Operating Income** | **£'000** | **£'000** | | **£'000** | **£'000** |
| NHS Clinical Income | 274,886 | 10,378 | 10,992 | 0 | 296,256 |
| Private Patients | 3,077 | 0 | 0 | 0 | 3,077 |
| Other Non Mandatory/Non Protected Revenue | 4,513 | 3 | 0 | 0 | 4,516 |
| Research & Development Income | 597 | 0 | 0 | 0 | 597 |
| Education and Training Income | 9,677 | 6 | 56 | 0 | 9,739 |
| Misc Other Operating Income | 24,846 | 534 | 187 | 1,273 | 26,840 |
| **Total Income** | **317,596** | **10,921** | **11,235** | **1,273** | **341,025** |

NHS Charity is separately identifiable above.

From 1st July 2016 the contract for Wiltshire Community Services (WCHS) has been held by a Joint Venture Wiltshire Health & Care LLP (WH&C LLP). GWH are subcontracted by WH&C LLP to provide these services and the income associated with this is included with GWH totals in the table above.

Following a tender exercise by Swindon CCG, in 2016 GWH were named preferred bidder for running Adult Community Health Services in Swindon. GWH initially took the contract on in a caretaker capacity from 1st October 2016. In January 2017 GWH Trust Board agreed to take the services on and the caretaker period came to an end on 31/5/17. The services are contracted under a separate Community Contract with Swindon CCG and therefore is a distinct segment for reporting purposes.

**Great Western Hospitals NHS Foundation Trust**

**Accounts for the year ended 31 March 2018**

**Note 3 Operating income from patient care activities (Group)**

**Note 3.1 Income from patient care activities (by nature)**

| | Group and Trust | |
|---|---|---|
| | **2017/18** | **2016/17** |
| | **£000** | **£000** |
| Elective income | 39,222 | 40,924 |
| Non elective income | 84,961 | 77,571 |
| Outpatient income | 40,786 | 46,391 |
| A & E income | 10,838 | 10,436 |
| Other NHS clinical income | 119,698 | 96,359 |
| Community services income from CCGs and NHS England | 22,079 | 26,715 |
| Private patient income | 3,430 | 3,251 |
| **Total income from activities** | **321,014** | **301,647** |

**Note 3.2 Income from patient care activities (by source)**

| | **2017/18** | **2016/17** |
|---|---|---|
| **Income from patient care activities received from:** | **£000** | **£000** |
| Clinical commissioning groups and NHS England | 269,578 | 260,929 |
| Other NHS providers | 1,406 | 1,328 |
| NHS other | 42,045 | 31,020 |
| Local authorities | 3,608 | 2,968 |
| Non-NHS: private patients | 3,430 | 3,251 |
| Non-NHS: overseas patients (chargeable to patient) | 88 | 324 |
| NHS injury scheme | 631 | 1,457 |
| Non NHS: other | 228 | 370 |
| **Total income from activities** | **321,014** | **301,647** |

**Note 3.3 Income from activities arising from commissioner requested services**

Under the terms of its provider licence, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

| | **2017/18** | **2016/17** |
|---|---|---|
| | **£000** | **£000** |
| Income from services designated as commissioner requested services | 271,562 | 265,320 |
| Income from services not designated as commissioner requested services | 49,452 | 36,327 |
| **Total** | **321,014** | **301,647** |

**Great Western Hospitals NHS Foundation Trust**

**Accounts for the year ended 31 March 2018**

**Note 3.4 Overseas visitors (relating to patients charged directly by the provider)**

| | 2017/18 | 2016/17 |
|---|---|---|
| | £000 | £000 |
| Income recognised this year | 88 | 324 |
| Cash payments received in-year | 200 | 145 |
| Amounts added to provision for impairment of receivables | - | 139 |
| Amounts written off in-year | 143 | 47 |

**Note 4 Other operating income (Group)**

| | 2017/18 | 2016/17 |
|---|---|---|
| | £000 | £000 |
| Research and development | 658 | 597 |
| Education and training | 10,139 | 9,739 |
| Charitable and other contributions to expenditure | - | 10 |
| Non-patient care services to other bodies | 311 | 33 |
| Support from the Department of Health and Social Care for mergers | - | - |
| Sustainability and transformation fund income | 2,858 | 11,379 |
| Income in respect of staff costs where accounted on gross basis | - | 335 |
| Charitable fund incoming resources | 880 | 1,273 |
| Other income | 12,540 | 16,012 |
| **Total other operating income** | **27,386** | **39,378** |

| | 2017/18 | 2016/17 |
|---|---|---|
| **4.1 Other Income includes** | **£000** | **£000** |
| Car Parking (Staff & Patients) | 1,704 | 1,828 |
| IT recharges | 23 | 67 |
| Pharmacy sales | 15 | 214 |
| Clinical Excellence Awards | 273 | 271 |
| Catering | 92 | 71 |
| Property Rentals | 2,265 | 2,285 |
| Payroll & Procurement Services | 57 | 63 |
| Occupational Health Service | 54 | 186 |
| Dietetics | 142 | 280 |
| Ultrasound Photo Sales | 25 | 61 |
| Transport services | 381 | 450 |
| Staff accommodation | 114 | 190 |
| Domestic services | 80 | 126 |
| Pathology | 229 | 16 |
| Cancer Drug Fund | 0 | 1,940 |
| Other | 7,086 | 7,964 |
| **Total Other Income** | **12,540** | **16,012** |

NHS Charity Income is separately identifiable above.

Cancer Drug Fund now part of NHS Clinical Income, £1,255k in 17/18

**Great Western Hospitals NHS Foundation Trust**
**Accounts for the year ended 31 March 2018**
**Note 5.1 Operating expenses (Group)**

| | 2017/18 | 2016/17 |
|---|---|---|
| | £000 | £000 |
| Purchase of healthcare from NHS and DHSC bodies | 2,921 | 2,168 |
| Purchase of healthcare from non-NHS and non-DHSC bodies | 1,343 | 278 |
| Staff and executive directors costs | 221,102 | 204,338 |
| Remuneration of non-executive directors | 137 | 140 |
| Supplies and services - clinical (excluding drugs costs) | 32,663 | 30,641 |
| Supplies and services - general | 2,637 | 2,611 |
| Drug costs (drugs inventory consumed and purchase of non-inventory drugs) | 29,561 | 27,458 |
| Consultancy costs | 669 | 1,823 |
| Establishment | 8,252 | 5,140 |
| Premises | 7,715 | 8,390 |
| Transport (including patient travel) | 1,541 | 1,667 |
| Depreciation on property, plant and equipment | 6,921 | 7,248 |
| Amortisation on intangible assets | 407 | 493 |
| Net impairments | - | (13,705) |
| Increase/(decrease) in provision for impairment of receivables | - | 133 |
| Change in provisions discount rate(s) | - | 81 |
| Audit fees payable to the external auditor | | |
| Statutory Audit Services | 66 | 68 |
| Other Auditor Remuneration | | |
| (a) Auditing of Accounts of any Associates | 3 | 3 |
| (b) Audit Related Assurance Services | 13 | 13 |
| (c)Taxation Compliance Services | 0 | 0 |
| (d) All Taxation Advisory Services not falling in (c) above | 0 | 6 |
| Internal audit costs | 134 | 97 |
| Clinical negligence | 6,750 | 4,821 |
| Legal fees | 497 | 372 |
| Insurance | 207 | 212 |
| Research and development | - | 637 |
| Education and training | 1,357 | 1,459 |
| Rentals under operating leases | 798 | 707 |
| Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis | 12,624 | 12,315 |
| Car parking & security | 3 | 3 |
| Hospitality | 52 | 25 |
| Losses, ex gratia & special payments | 17 | 17 |
| Other services, eg external payroll | 908 | 3,339 |
| Other NHS charitable fund resources expended | 647 | 277 |
| Other | 403 | 3,110 |
| **Total** | **340,348** | **306,385** |

**Staff Exit Packages**
The Trust has agreed 6 staff exit package, total of £229k in 2017/18 (31 March 2017: £237k).

**Supplies and Services**
Supplies and Services Costs have increased again in 2017/18 reflecting additional costs associated with the full year provision of Swindon Community Services.

**Employee Expenses - Staff**
Employee Expenses - Staff have increased due to Trust having Swindon Community Services and associated Staff for the full year in 2017-18. In 2016-17 it was from 1st October 2016.

**Establishment**
Establishment expenses have increased as costs previously classified as Other have been allocated here in 2017/18.

**Net Impairment of Property, Plant & Equipment**
There is no Net Impairment of Property, Plant & Equipment in 2017-18. Last year it relates to reversal of impairment on GWH assets following revaluation on 1st April 2016.

**Other Services**
Other Services - includes cleaning, catering, portering, housekeeping and estates services.

**Great Western Hospitals NHS Foundation Trust**

**Accounts for the year ended 31 March 2018**

**Note 5.2 Other auditor remuneration (Group)**

| | 2017/18 | 2016/17 |
|---|---|---|
| | £000 | £000 |
| **Other auditor remuneration paid to the external auditor:** | | |
| 1. Audit of accounts of any associate of the trust | 3 | 3 |
| 2. Audit-related assurance services | 13 | 13 |
| 3. Taxation compliance services | - | - |
| 4. All taxation advisory services not falling within item 3 above | - | 6 |
| 5. Internal audit services | - | - |
| 6. All assurance services not falling within items 1 to 5 | - | - |
| 7. Corporate finance transaction services not falling within items 1 to 6 above | - | - |
| 8. Other non-audit services not falling within items 2 to 7 above | - | - |
| **Total** | **16** | **22** |

**Note 5.3 Limitation on auditor's liability (Group)**

The Board of Governors has appointed KPMG LLP as external auditors. The engagement letter signed on 14 April 2015 states that the liability of KPMG LLP, its members, partners and staff (whether in contract, negligence or otherwise) shall in no circumstance exceed £2m in the aggregate in respect of all services (£2m in 2016/17).

**Note 6 Impairment of assets (Group)**

| | 2017/18 | 2016/17 |
|---|---|---|
| | £000 | £000 |
| **Net impairments charged to operating surplus / deficit resulting from:** | | |
| Changes in market price | - | (15,898) |
| Other | - | 2,193 |
| **Total net impairments charged to operating surplus / deficit** | **-** | **(13,705)** |
| Impairments charged to the revaluation reserve | (2,000) | 2,282 |
| **Total net impairments** | **(2,000)** | **(11,423)** |

**Great Western Hospitals NHS Foundation Trust**
**Accounts for the year ended 31 March 2018**
**Note 7 Employee benefits (Group)**

| | 2017/18 | 2016/17 |
|---|---|---|
| | Total | Total |
| | £000 | £000 |
| Salaries and wages | 168,019 | 155,118 |
| Social security costs | 16,413 | 14,780 |
| Apprenticeship levy | 810 | - |
| Employer's contributions to NHS pensions | 20,447 | 18,969 |
| Pension cost - other | 67 | - |
| Temporary staff (including agency) | 15,346 | 16,068 |
| **Total gross staff costs** | **221,102** | **204,935** |

**Note 7.1 Retirements due to ill-health (Group)**

During 2017/18 there were 2 early retirements from the trust agreed on the grounds of ill-health (2 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £5k (£115k 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 (Group)**

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.

**Great Western Hospitals NHS Foundation Trust**

**Accounts for the year ended 31 March 2018**

**Note 9 Operating leases (Group) as a Lessee**

This note discloses costs and commitments incurred in operating lease arrangements where Great Western Hospitals NHS Foundation Trust is the lessee.

| | 2017/18 | 2016/17 |
|---|---|---|
| | £000 | £000 |
| **Operating lease expense** | | |
| Minimum lease payments | 798 | 707 |
| **Total** | **798** | **707** |

| | 31 March 2018 | 31 March 2017 |
|---|---|---|
| | £000 | £000 |
| **Future minimum lease payments due:** | | |
| - not later than one year; | 1,187 | 693 |
| - later than one year and not later than five years; | 1,835 | 1,805 |
| - later than five years. | 152 | 13 |
| **Total** | **3,174** | **2,511** |

**Note 10 Better Payment Pratice Code**

| | Year Ended 31 March 2018 | | Year Ended 31 March 2017 | |
|---|---|---|---|---|
| | Number | £000 | Number | £000 |
| Total trade bills paid in the year | 81,098 | 243,839 | 69,245 | 174,487 |
| Total trade bills paid within target | 25,640 | 151,201 | 17,039 | 99,490 |
| Percentage of trade bills paid within target | 31.62% | 62.01% | 24.61% | 57.02% |
| | | | | |
| Total NHS bills paid in the year | 2,047 | 54,756 | 1,674 | 12,692 |
| Total NHS bills paid within target | 890 | 41,340 | 790 | 4,846 |
| Percentage of NHS bills paid within target | 43.48% | 75.50% | 47.19% | 38.18% |

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

The deterioration of the Better Payment Practice Code measures is as a result of an increase in creditors due for payment as a result of in year cash management.

**Great Western Hospitals NHS Foundation Trust**

**Accounts for the year ended 31 March 2018**

**Note 11 Finance income (Group)**

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

| | 2017/18 | 2016/17 |
|---|---|---|
| | £000 | £000 |
| Interest on bank accounts | 33 | 26 |
| NHS charitable fund investment income | 35 | 36 |
| **Total** | **68** | **62** |

**Note 12.1 Finance expenditure (Group)**

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

| | 2017/18 | 2016/17 |
|---|---|---|
| | £000 | £000 |
| **Interest expense:** | | |
| Loans from the Department of Health and Social Care | 384 | 279 |
| Other loans | - | 42 |
| Finance leases | 7 | 13 |
| Interest on late payment of commercial debt | 3 | 3 |
| Main finance costs on PFI and LIFT schemes obligations | 9,912 | 10,337 |
| Contingent finance costs on PFI and LIFT scheme obligations | 4,411 | 4,469 |
| **Total interest expense** | **14,717** | **15,143** |
| Unwinding of discount on provisions | 1 | 3 |
| **Total finance costs** | **14,718** | **15,146** |

**Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015**

| | 2017/18 | 2016/17 |
|---|---|---|
| | £000 | £000 |
| Total liability accruing in year under this legislation as a result of late payments | - | - |
| Amounts included within interest payable arising from claims made under this legislation | 3 | - |
| Compensation paid to cover debt recovery costs under this legislation | - | - |

**Great Western Hospitals NHS Foundation Trust**
**Accounts for the year ended 31 March 2018**

**Note 13.1 Intangible assets - 2017/18**

| Group and Trust | Software licences | Licences & trademarks | Intangible assets under construction | Total |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| **Valuation / gross cost at 1 April 2017 - brought forward** | **2,624** | **2,818** | **831** | **6,273** |
| Additions | 25 | **-** | **-** | **25** |
| Reclassifications | (92) | - | (78) | **(170)** |
| **Valuation / gross cost at 31 March 2018** | **2,557** | **2,818** | **753** | **6,128** |
| | | | | |
| **Amortisation at 1 April 2017 - brought forward** | **1,758** | **1,794** | **-** | **3,552** |
| Provided during the year | 187 | 220 | - | 407 |
| Reclassifications | - | - | - | - |
| **Amortisation at 31 March 2018** | **1,945** | **2,014** | **-** | **3,959** |
| | | | | |
| **Net book value at 31 March 2018** | **612** | **804** | **753** | **2,169** |
| **Net book value at 1 April 2017** | **866** | **1,024** | **831** | **2,721** |

**Note 13.2 Intangible assets - 2016/17**

| Group and Trust | Software licences | Licences & trademarks | Intangible assets under construction | Total |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| **Valuation / gross cost at 1 April 2016 - as previously stated** | **2,274** | **2,818** | **-** | **5,092** |
| Additions | 181 | - | 831 | **1,012** |
| Reclassifications | 169 | - | - | **169** |
| **Valuation / gross cost at 31 March 2017** | **2,624** | **2,818** | **831** | **6,273** |
| | | | | |
| **Amortisation at 1 April 2016 - restated** | **1,485** | **1,574** | **-** | **3,059** |
| Provided during the year | 273 | 220 | - | **493** |
| **Amortisation at 31 March 2017** | **1,758** | **1,794** | **-** | **3,552** |
| | | | | |
| **Net book value at 31 March 2017** | **866** | **1,024** | **831** | **2,721** |
| **Net book value at 1 April 2016** | **789** | **1,244** | **-** | **2,033** |

Great Western Hospitals NHS Foundation Trust

Accounts for the year ended 31 March 2018

**Note 14.1 Property, plant and equipment - 2017/18**

| Group and Trust | 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** | **39,660** | **160,616** | **3,340** | **2,302** | **41,285** | **58** | **24,800** | **3,316** | **275,377** |
| Transfers by absorption | (12,760) | (16,820) | (140) | - | - | - | - | - | **(29,720)** |
| Additions | - | 1,017 | - | 2,639 | 592 | - | 401 | - | **4,649** |
| Impairments | (2,000) | - | - | - | - | - | - | - | **(2,000)** |
| Reclassification | | 7,328 | | (2,004) | (814) | | (4,340) | | **170** |
| Revaluations | - | 2,202 | - | - | - | - | - | - | **2,202** |
| **Valuation/gross cost at 31 March 2018** | **24,900** | **154,343** | **3,200** | **2,937** | **41,063** | **58** | **20,861** | **3,316** | **250,678** |
| | | | | | | | | | |
| **Accumulated depreciation at 1 April 2017 - brought forward** | **-** | **4,819** | **80** | **-** | **31,940** | **58** | **13,386** | **3,200** | **53,483** |
| Transfers by absorption | - | (1,108) | - | - | - | - | - | - | **(1,108)** |
| Provided during the year | - | 4,293 | 80 | - | 1,256 | - | 1,193 | 99 | **6,921** |
| Revaluations | - | 116 | - | - | - | - | - | - | **116** |
| **Accumulated depreciation at 31 March 2018** | **-** | **8,120** | **160** | **-** | **33,196** | **58** | **14,579** | **3,299** | **59,412** |
| | | | | | | | | | |
| **Net book value at 31 March 2018** | **24,900** | **146,223** | **3,040** | **2,937** | **7,867** | **-** | **6,282** | **17** | **191,266** |
| **Net book value at 1 April 2017** | **39,660** | **155,797** | **3,260** | **2,302** | **9,345** | **-** | **11,414** | **116** | **221,894** |

**Asset Financing**

**Net book value**

| | Land | Buildings excluding dwellings | Dwellings | Assets under construction | Plant & machinery | Transport equipment | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|---|
| - Owned | 24,900 | 3,482 | (0) | 2,937 | 7,867 | - | 6,282 | 17 | **45,485** |
| - Finance Leased | - | 142,741 | 3,040 | - | - | - | - | - | **145,781** |
| **Total at 31 March 2018** | **24,900** | **146,223** | **3,040** | **2,937** | **7,867** | **-** | **6,282** | **17** | **191,266** |

**Great Western Hospitals NHS Foundation Trust**

**Accounts for the year ended 31 March 2018**

**Note 14.2 Property, plant and equipment - 2016/17**

| Group and Trust | 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 - brought forward** | **35,962** | **166,278** | **5,622** | **7,887** | **39,637** | **58** | **21,864** | **3,316** | **280,624** |
| Additions | - | 1,198 | - | 829 | 834 | - | 319 | - | **3,180** |
| Impairments | - | (141) | (2,282) | (2,193) | - | - | - | (1) | **(4,617)** |
| Revaluations | 3,698 | (7,339) | - | - | - | - | - | - | **(3,641)** |
| Reclassifications | - | 620 | - | (4,221) | 814 | - | 2,617 | 1 | **(169)** |
| **Valuation/gross cost at 31 March 2017** | **39,660** | **160,616** | **3,340** | **2,302** | **41,285** | **58** | **24,800** | **3,316** | **275,377** |
| | | | | | | | | | |
| **Accumulated depreciation at 1 April 2016 - brought forward** | **-** | **31,551** | **979** | **-** | **30,390** | **58** | **12,680** | **3,109** | **78,767** |
| Provided during the year | - | 4,821 | 80 | - | 1,550 | - | 706 | 91 | **7,248** |
| Impairments | - | (16,040) | - | - | - | - | - | - | **(16,040)** |
| Revaluations | - | (15,513) | (979) | - | - | - | - | - | **(16,492)** |
| **Accumulated depreciation at 31 March 2017** | **-** | **4,819** | **80** | **-** | **31,940** | **58** | **13,386** | **3,200** | **53,483** |
| | | | | | | | | | |
| **Net book value at 31 March 2017** | **39,660** | **155,797** | **3,260** | **2,302** | **9,345** | **-** | **11,414** | **116** | **221,894** |
| **Net book value at 1 April 2016** | **35,962** | **134,727** | **4,643** | **7,887** | **9,247** | **-** | **9,184** | **207** | **201,857** |

**Asset Financing**

**Net book value**

| | Land | Buildings excluding dwellings | Dwellings | Assets under construction | Plant & machinery | Transport equipment | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|---|
| - Owned | 39,660 | 22,412 | 140 | 2,302 | 9,329 | - | 11,414 | 116 | **85,373** |
| - Owned (donated) | - | 3,390 | - | - | 16 | - | - | - | **3,406** |
| - Finance Leased | - | 129,995 | 3,120 | - | - | - | - | - | **133,115** |
| **Total at 31 March 2017** | **39,660** | **155,797** | **3,260** | **2,302** | **9,345** | **-** | **11,414** | **116** | **221,894** |

## Note 14.3 Revaluation

The Trust carried out an indexation review of building assets, that have not or are not proposed to be transferred to NHS PS, for the period 2016/17 and 2017/18 since the last full revaluation as at 1 April 2016. Overall buildings have increased in value by 3.3% in 2016/17 and 4.9% on 2017/18. All other assets are valued at depreciated replacement cost with no indexation in year due to the current economic climate.

### Note 15 Investments

| | Group | | Trust | |
|---|---|---|---|---|
| | 2017/18 | 2016/17 | 2017/18 | 2016/17 |
| | £000 | £000 | £000 | £000 |
| **Carrying value at 1 April** | **1,112** | **822** | **-** | **-** |
| Movement in fair value | (174) | 290 | - | - |
| Disposals | (89) | - | - | - |
| **Carrying value at 31 March** | **849** | **1,112** | **-** | **-** |

### Note 16 Joint Venture

**Wiltshire Health and Care**

During 2016-17 the Trust became a one third partner in Wiltshire Health and Care LLP. The other equal partners being Royal United Hospitals Bath NHS Foundation Trust and Salisbury NHS Foundation Trust. Wiltshire Health and Care is focused solely on delivering improved community services in Wiltshire, which GWH had previously been contracted to deliver, and enabling people to live independent and fulfilling lives for as long as possible. From 1 July 2016, Wiltshire Health and Care has contracted with GWH for the provision of these services.

GWH has not invested any capital sum in this partnership.

In 2017-18, Wiltshire Health and Care LLP reported a break even position resulting in a net asset value of nil (2016-17 nil). Consequently, there was no share of any profits or assets to be reported in the Trust's accounts.

Wiltshire Health and Care LLP are planning a break even position for 2018/19.

### Note 17 Analysis of charitable fund reserves

| | 2018 | 2017 |
|---|---|---|
| | £000 | £000 |
| **Unrestricted funds:** | | |
| Unrestricted income funds | 37 | 104 |
| **Restricted funds:** | | |
| Other restricted income funds | 2,615 | 2,427 |
| | **2,652** | **2,531** |

Restricted funds are funds that are to be used in accordance with specific restrictions imposed by the donor, or where the donor has restricted the use of their donation to a specified ward, patients', nurses' or project fund. Where the restriction requires the gift to be invested to produce income but the trustees have the power to spend the capital, it is classed as expendable endowment.

Unrestricted income funds comprise those funds that the Trustee is free to use for any purpose in furtherance of the charitable objects. Unrestricted funds include general funds, where the donor has not specified or restricted the use the Charity may make of their donation. General funds additionally generate income from Gift Aid, investment income, interest and donations given specifically to cover running costs.

**Note 18 Inventories**

| | Group and Trust | |
|---|---|---|
| | **31 March 2018** | **31 March 2017** |
| | **£000** | **£000** |
| Drugs | 955 | 1,065 |
| Consumables | 4,443 | 4,124 |
| Energy | 93 | 113 |
| Other | 20 | 61 |
| **Total inventories** | **5,511** | **5,363** |

Inventories recognised in expenses for the year were £30,671k (2016/17: £27,837k). Write-down of inventories recognised as expenses for the year were £0k (2016/17: £0k).

**Note 19.1 Trade receivables and other receivables**

| | Group and Trust | |
|---|---|---|
| | **2018** | **2017** |
| | **£000** | **£000** |
| **Current (All Receivables are Current)** | | |
| Trade receivables | 3,644 | 5,793 |
| Accrued income | 6,995 | 10,094 |
| Provision for impaired receivables | (1,515) | (2,136) |
| Prepayments (non-PFI) | 3,014 | 1,143 |
| PFI lifecycle prepayments | 6,987 | 3,960 |
| PDC dividend receivable | 251 | - |
| VAT receivable | 549 | 445 |
| Other receivables | 6,633 | 11,314 |
| NHS charitable funds: trade and other receivables | 26 | - |
| **Total current trade and other receivables** | **26,584** | **30,613** |

**Note 19.2 Provision for impairment of receivables**

| | Group | |
|---|---|---|
| | **2017/18** | **2016/17** |
| | **£000** | **£000** |
| **At 1 April** | **2,136** | **2,003** |
| Increase in provision | - | 133 |
| Amounts utilised | (621) | - |
| **At 31 March** | **1,515** | **2,136** |

**Note 19.3 Credit quality of financial assets**

| | 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 | 25 | 61 |
| 30-60 Days | 19 | 82 |
| 60-90 days | 45 | 59 |
| 90- 180 days | 64 | 126 |
| Over 180 days | 2,261 | 1,808 |
| **Total** | **2,414** | **2,136** |
| **Ageing of non-impaired financial assets past their due date** | | |
| 0 - 30 days | 4,922 | 4,962 |
| 30-60 Days | 480 | 1,291 |
| 60-90 days | 313 | 394 |
| 90- 180 days | 180 | 370 |
| Over 180 days | 1,982 | 1,990 |
| **Total** | **7,877** | **9,007** |

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## Note 20.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

| | Group | | Trust | |
|---|---|---|---|---|
| | 2017/18 | 2016/17 | 2017/18 | 2016/17 |
| | £000 | £000 | £000 | £000 |
| **At 1 April** | **7,273** | **2,300** | **5,854** | **1,715** |
| Net change in year | (4,056) | 4,973 | (4,477) | 4,139 |
| **At 31 March** | **3,217** | **7,273** | **1,377** | **5,854** |
| **Broken down into:** | | | | |
| Cash at commercial banks and in hand | 1,866 | 24 | 26 | 24 |
| Cash with the Government Banking Service | 1,351 | 7,249 | 1,351 | 5,830 |
| **Total cash and cash equivalents as in SoFP** | **3,217** | **7,273** | **1,377** | **5,854** |
| **Total cash and cash equivalents as in SoCF** | **3,217** | **7,273** | **1,377** | **5,854** |

## Note 20.2 Third party assets held by the trust

Great Western 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.

| | Group and Trust | |
|---|---|---|
| | 31 March 2018 | 31 March 2017 |
| | £000 | £000 |
| Monies on deposit | 2 | - |
| **Total third party assets** | **2** | **-** |

## Note 21 Trade and other payables

| **Group** | **31 March 2018 £000** | **31 March 2017 £000** |
|---|---|---|
| **Current** | | |
| Trade payables | 14,655 | 22,132 |
| Capital payables | 2,856 | 2,807 |
| Accruals | 11,607 | 9,931 |
| Social security costs/Other Taxes Payable | 3,840 | 3,252 |
| VAT payables | 1 | - |
| PDC dividend payable | - | 182 |
| Accrued interest on loans | 58 | 37 |
| Other payables | 3,122 | 5,236 |
| NHS charitable funds: trade and other payables | 63 | - |
| **Total current trade and other payables** | **36,202** | **43,577** |

Other payables include outstanding pension contributions of £2,802,688 (31 March 2017 £2,465,788)

NHS Charity is separately identifiable

## Note 22 Other liabilities

| | **Group and Trust** | |
|---|---|---|
| | **2018** | **2017** |
| | **£000** | **£000** |
| **Current** | | |
| Deferred income | 2,579 | 2,710 |
| **Total other current liabilities** | **2,579** | **2,710** |
| | | |
| **Non-current** | | |
| Deferred income | 1,132 | 1,246 |
| **Total other non-current liabilities** | **1,132** | **1,246** |

**Great Western Hospitals NHS Foundation Trust**
**Accounts for the year ended 31 March 2018**

**Note 23 Borrowings**

| | Group and Trust | |
|---|---|---|
| | 31 March 2018 £000 | 31 March 2017 £000 |
| **Current** | | |
| Loans from DHSC | 6,057 | 7,607 |
| Obligations under finance leases | - | 77 |
| Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle) | 4,520 | 4,420 |
| **Total current borrowings** | **10,577** | **12,104** |
| **Non-current** | | |
| Loans from DHSC | 23,073 | 13,056 |
| Obligations under PFI, LIFT or other service concession contracts | 107,371 | 111,892 |
| **Total non-current borrowings** | **130,444** | **124,948** |

| Loan Type | Date drawn down | Amount Borrowed £'000 | Balance at 31/3/17 £'000 | Borrowed in Year £'000 | Repaid £'000 | Outstanding at 31/3/18 £'000 | Interest Rate % | Repayable over Years |
|---|---|---|---|---|---|---|---|---|
| Working Capital Loan | 19/01/15 | 5,000 | | | | | | |
| | 18/05/15 | 2,500 | | | | | | |
| | 20/07/15 | 1,400 | | | | | 1.53 | 10 |
| | | **8,900** | **8,377** | **0** | **(1,047)** | **7,330** | | |
| Capital Loan | 18/05/15 | 500 | | | | | | |
| | 20/07/15 | 600 | | | | | 1.53 | 10 |
| | | **1,100** | **935** | **0** | **(110)** | **825** | | |
| Working Capital Facility | 01/10/16 | 2,000 | | | | 2,000 | | |
| | 18/03/17 | 4,450 | | | | 4,450 | | Expires 18/7/20 |
| | 18/04/17 | | | | (2,428) | (2,428) | 3.5 | |
| | 17/07/17 | 2,597 | | 2,597 | | 2,597 | | |
| | | **9,047** | **6,450** | **2,597** | **(2,428)** | **6,619** | | |
| Distressed Funding | 11/01/16 | 3,900 | | | | 3,900 | | |
| | 14/03/16 | 1,000 | | | | 1,000 | 1.5 | 2 |
| | | **4,900** | **0** | | **0** | **4,900** | | |
| Interim Funding | 05/01/18 | 3,339 | | 3,339 | | 3,339 | 1.5 | 2 |
| | 28/02/18 | 6,117 | | 6,117 | | 6,117 | | |
| | | **9,456** | **0** | **9,456** | **0** | **9,456** | | |
| **Total Loans Outstanding** | | | | | | **29,130** | | |

**Great Western Hospitals NHS Foundation Trust**

**Accounts for the year ended 31 March 2018**

**Note 24 Finance leases**

Obligations under finance leases where the trust is the lessee.

| | Trust | Trust |
|---|---|---|
| | 31 March 2018 | 31 March 2017 |
| | £000 | £000 |
| **Gross lease liabilities** | **-** | **84** |
| of which liabilities are due: | | |
| - not later than one year; | - | 84 |
| - later than one year and not later than five years; | - | - |
| - later than five years. | - | - |
| Finance charges allocated to future periods | - | (7) |
| **Net lease liabilities** | **-** | **77** |
| of which payable: | | |
| - not later than one year; | - | 77 |
| - later than one year and not later than five years; | - | - |
| - later than five years. | - | - |
| **Total of future minimum sublease payments to be received at the reporting date** | **-** | **-** |
| | | **77** |

**Note 25.1 Provisions for liabilities and charges analysis (Group and Trust)**

| | Pensions - early departure costs | Legal claims | Other | Total |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| **At 1 April 2017** | **833** | **192** | **528** | **1,552** |
| Utilised during the year | (117) | (23) | (39) | **(179)** |
| Reversed unused | - | - | - | **-** |
| Unwinding of discount | 1 | - | - | **1** |
| **At 31 March 2018** | **717** | **169** | **489** | **1,374** |
| **Expected timing of cash flows:** | | | | |
| - not later than one year; | 117 | - | 32 | **149** |
| - later than one year and not later than five years; | 600 | 169 | 457 | **1,226** |
| - later than five years. | - | - | - | **-** |
| **Total** | **717** | **169** | **489** | **1,374** |

**Note 25.2 Clinical negligence liabilities**

At 31 March 2018, £136,636k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Great Western Hospitals NHS Foundation Trust (31 March 2017: £119,404k).

The Trust has not made a provision under the Carbon Emissions Scheme as the Trust is not required to be registered in 2017/18 as the properties managed by the Trust are below the threshold. This is not anticipated to change in 2018/19.

**Note 26 Private Finance Initiative contracts**

**Group and Trust**

**PFI schemes on-Statement of Financial Position**

The Trust has 3 PFI schemes which are deemed to be on-Statement of Financial Position at the period end. These are the Main Hospital and Brunel Treatment Centre and Downsview Residences (treated as one agreement), Savernake Hospital and the agreement in place with Systems C.

**Great Western Hospital**

The contract commenced on 5 October 1999 for a period of 30 years until 4 October 2029. In terms of the contract the operator company was obliged to build the Great Western Hospital, which was completed in November 2002, for subsequent occupation and use by the Trust. The Trust pays the operator company a quarterly availability fee for the occupation of the hospital and a quarterly service fee for the services provided by the operator such as portering and catering. In October 2003 the Trust entered into a variation of the original agreement for the construction of the Brunel Treatment Centre which is an extension to the original hospital. The construction of the Treatment Centre has resulted in increased availability and service charges, however the main terms of the contract including the termination date remain unchanged. Subsequently, in September 2006, the Trust entered into a refinancing agreement which resulted in a reduction in the annual availability payment again with no change to the contract term. The amount of the availability payment is determined annually and increased based on a combination of the annual increase in the Retail Price Index (RPI) and a fixed percentage increase of 2.5%. The operator is obliged to maintain the buildings and replace lifecycle elements of the buildings where necessary. At the end of the contract term the hospital buildings revert back to the Trust for Nil consideration. The nature of the contract meets the criteria for treatment as a service concession under IFRIC 12. Accordingly the hospital buildings are treated as an asset under property, plant and equipment with the resultant liability being treated as a finance lease under IAS 17.

**Downsview Residences**

The contract commenced on 5 October 1999 for a period of 30 years until 4 October 2029. In terms of the contract the operator company was obliged to build the Downsview staff residences on the Hospital site for the provision of housing to hospital staff. At commencement of the contract the Trust made a capital contribution of £649k towards the construction cost of the building. The residences are managed by the operator company who rent the accommodation units to, primarily, Trust staff. The Trust does not pay the operator company an availability fee. Instead a monthly service fee is paid for the servicing of the units which is based on usage. The operator is responsible for maintaining the buildings over the contract term. At the end of the contract term the accommodation buildings revert back to the Trust for Nil consideration. The nature of the contract meets the criteria for treatment as a service concession under IFRIC 12. Accordingly the residences are recognised as an asset under property, plant and equipment. The cost of the building less the capital contribution has been accounted for as deferred income and is released to income equally over the entire contract term.

**System C**

The Trust has a PFI contract in respect of the Integrated Clinical Information System which meets the criteria for recognition as a service concession agreement as envisaged under IFRIC 12 and has, accordingly, been treated as on statement of financial position. The contract was dated 27 May 2002 with an effective date of 13 November 2001. The contract was for 12 years and was due to expire on 12 November 2013. The contract has been extended to November 2020 and has been varied to include a system refresh and removal of network and telephony elements. The contract is for the supply of computer hardware and software together with the provision of ongoing support and system management services. The revised contract commenced in May 2014.

**Savernake Hospital**

Savernake Hospital was transferred to the Trust from 1st April 2013 as part of the transfer of Community assets following the closure of PCTs. As part of the transfer the Trust took over the PFI contract that was entered into by Wiltshire PCT. The contract commenced on 21 November 2003 for a period of 30 years until 2034. The Trust pays the operator company a monthly fee that covers both the availability for the occupation of the hospital and a service fee that covers the services provided by the operator such as portering and catering.

The operator is responsible for maintaining the buildings over the contract term. At the end of the contract term the accommodation buildings revert back to the Trust for Nil consideration. The nature of the contract meets the criteria for treatment as a service concession under IFRIC 12. Accordingly the residences are recognised as an asset under property, plant and equipment. The cost of the building less the capital contribution has been accounted for as deferred income and is released to income equally over the entire contract term.

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**Accounts for the year ended 31 March 2018**
**Note 27 On-SoFP PFI**

**Note 27.1 Imputed finance lease obligations**

The following are obligations in respect of the finance lease element of on-Statement of Financial Position PFI :

| | Group and Trust | |
|---|---|---|
| | **31 March 2018** | **31 March 2017** |
| | **£000** | **£000** |
| **Gross PFI, LIFT or other service concession liabilities** | **185,926** | **200,201** |
| **Of which liabilities are due** | | |
| - not later than one year; | 14,000 | 14,275 |
| - later than one year and not later than five years; | 61,003 | 60,153 |
| - later than five years. | 110,923 | 125,773 |
| Finance charges allocated to future periods | (74,035) | (83,889) |
| **Net PFI, LIFT or other service concession arrangement obligation** | **111,891** | **116,312** |
| - not later than one year; | 4,520 | 4,420 |
| - later than one year and not later than five years; | 33,073 | 29,678 |
| - later than five years. | 74,298 | 82,214 |

**Note 27.2 Total on-SoFP PFI commitments**

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

| | Group and Trust | |
|---|---|---|
| | **31 March 2018** | **31 March 2017** |
| | **£000** | **£000** |
| Total future payments committed in respect of the PFI, LIFT or other service concession arrangements | 482,667 | 507,534 |
| **Of which liabilities are due:** | | |
| - not later than one year; | 36,642 | 35,266 |
| - later than one year and not later than five years; | 154,994 | 149,306 |
| - later than five years. | 291,031 | 322,962 |

**Note 27.3 Analysis of amounts payable to service concession operator**
This note provides an analysis of the unitary payments made to the service concession operator:

| | Group and Trust | |
|---|---|---|
| | **2017/18** | **2016/17** |
| | **£000** | **£000** |
| Unitary payment payable to service concession operator | 35,268 | 34,387 |
| **Consisting of:** | | |
| - Interest charge | 9,912 | 10,337 |
| - Repayment of finance lease liability | 4,420 | 4,691 |
| - Service element and other charges to operating expenditure | 12,624 | 12,315 |
| - Capital lifecycle maintenance | 3,901 | 2,575 |
| - Revenue lifecycle maintenance | - | - |
| - Contingent rent | 4,411 | 4,469 |
| **Total amount paid to service concession operator** | **35,268** | **34,387** |

## Note 28 Financial instruments and related disclosures

**Group and Trust**

The key risks that the Trust has identified relating to its financial instruments are as follows:-

### 28.1 Financial risk

The continuing service provider relationship that the Trust has with Clinical Commissioning Groups (CCGs), and the way they are financed has not exposed the Trust to the degree of financial risk faced by business entities. The change to CCGs and NHS England has not increased the risk to the Trust. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Finance & Investment Committee.

### 28.2 Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations. The Trust, therefore, has low exposure to currency rate fluctuations.

### 28.3 Credit risk

The majority of the Trust's income comes from contracts with other public sector bodies, resulting in a low exposure to credit risk. The maximum exposures as at 31 March 2017 are in receivables from customers, as disclosed in note 17 to the accounts. The Trust mitigates its exposure to credit risk through regular review of debtor balances and by calculating a bad debt provision at the period end.

The following shows the age of such financial assets that are past due and for which no provision for bad or doubtful debts has been raised:

| | **31 March 2018** | 31 March 2017 |
|---|---|---|
| | **£000** | £000 |
| By up to three months | **5,715** | 6,647 |
| By three to six months | **180** | 370 |
| By more than six months | **1,982** | 1,990 |
| | **7,877** | 9,007 |

The Trust has not raised bad or doubtful debt provisions against these amounts as they are considered to be recoverable based on previous trading history.

### 28.4 Liquidity risk

The NHS Trust's net operating costs are incurred under annual service agreements with local CCGs, which are financed from resources voted annually by Parliament. The Trust also largely finances its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

### Note 29.1 Carrying values of financial assets

| **Group and Trust** | **Total book value** |
|---|---|
| **Assets as per SoFP as at 31 March 2018** | **£000** |
| **Current and financial assets** | |
| Trade and other receivables excluding non financial assets | 11,031 |
| Cash and cash equivalents | 1,377 |
| Consolidated NHS Charitable Fund financial assets | 2,715 |
| **Total at 31 March 2018** | **15,123** |

| **Group and Trust** | **Total book value** |
|---|---|
| **Assets as per SoFP as at 31 March 2017** | **£000** |
| **Current and financial assets** | |
| Trade and other receivables excluding non financial assets | 27,495 |
| Cash and cash equivalents | 5,854 |
| Consolidated NHS Charitable Fund financial assets | 2,531 |
| **Total at 31 March 2017** | **35,880** |

### Note 29.2 Carrying values of financial liabilities

| **Group and Trust** | **Total book value** |
|---|---|
| **Liabilities as per SoFP as at 31 March 2018** | **£000** |
| **Current and Non Current financial liabiliites** | |
| Borrowings excluding finance lease and PFI liabilities | 29,130 |
| Obligations under PFI, LIFT and other service concession contracts | 111,891 |
| Trade and other payables excluding non financial liabilities | 31,238 |
| **Total at 31 March 2018** | **172,259** |

| **Group and Trust** | **Total book value** |
|---|---|
| **Liabilities as per SoFP as at 31 March 2017** | **£000** |
| **Current and Non Current financial liabiliites** | |
| Borrowings excluding finance lease and PFI liabilities | 20,663 |
| Obligations under finance leases | 77 |
| Obligations under PFI, LIFT and other service concession contracts | 116,312 |
| Trade and other payables excluding non financial liabilities | 28,185 |
| **Total at 31 March 2017** | **165,237** |

### Note 29.3 Maturity of financial liabilities

| | **Group and Trust** | |
|---|---|---|
| | **31 March 2018** | **31 March 2017** |
| | **£000** | **£000** |
| In one year or less | 48,359 | 42,457 |
| In more than one year but not more than two years | 5,678 | 9,954 |
| In more than two years but not more than five years | 48,098 | 19,724 |
| In more than five years | 70,124 | 93,102 |
| **Total** | **172,259** | **165,237** |

All the financial assets and all the financial liabilities of the Trust are measured at fair value on recognition and subsequently at amortised cost.

**Note 30 Events after the reporting period**

**Note 30.1 Wiltshire Community Estate**

Following the transfer of Wiltshire Community Services to Wiltshire Health & Care LLP, the Trust commenced the proces to transfer all of the Wiltshire Community Assets to NHS Property Services. The non PFI assets transferred on 1st July 2017 leaving Savernake owned by GWH. It s expcted that Savernake will transfer in 2018/19.

| The Assets are as follows | Net Book Value at 31/03/18 | Revaluation Reserve at 31/03/18 |
|---|---|---|
| Category | £'000 | £'000 |
| Land | 2,200 | 408 |
| Buildings (incl dwellings) | 5,577 | 909 |
| **Total** | **7,777** | **1,317** |

| **Effect on Financial Statements** | **£'000** |
|---|---|
| **Statement of Financial Position** | |
| Non Current Assets | 7,777 |
| | |
| Current Lease Liability | (133) |
| Non Current Lease Liability | (4,003) |
| **Increase in Total Assets Employed** | **3,641** |
| | |
| Revaluation Reserve | 1,317 |
| Income & Expenditure Reserve | 2,324 |
| **Increase in Total Taxpayers Equity** | **3,641** |

In the 2018-19 financial statements the transaction will be accounted for using the absorption accounting requirements outlined in the DH GAM.

**Note 30.2 Wiltshire Community Services**

The staff employed in providing Wiltshire Community Adults Services, employed by GWH in 2017/18 were transferred by TUPE transfer to Wiltshire Health & Care LLP on 1st April 2018.

The total number of staff that transferred was 1,103.

**Note 31 Contingencies**
**Group and Trust**
There are no contingent assets and liabilities for the period ended 31 March 2018

**Note 32 Related party transactions**

**Group and Trust**

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

The Trust is under the common control of the Board of Directors. During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with the Great Western Hospitals NHS Foundation Trust.

The Department of Health is regarded as a related party. During 2016/17 the Trust has had a significant number of material transactions with other entities for which the Department is regarded as the Parent Department. These entities are listed below.

| | Receivables | Payables | Revenue | Expenditure |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| NHS England | 2,071 | - | 42,017 | 2 |
| Swindon CCG | 2,431 | 2,248 | 149,568 | 24 |
| Wiltshire CCG | 629 | 469 | 58,682 | 271 |
| Wiltshire Health and Care LLP | 955 | - | 42,487 | - |
| Newbury and District CCG | 46 | 54 | 7,214 | - |
| Gloucestershire CCG | 159 | 0 | 9,927 | - |
| Royal United Hospital Bath NHS FT | 205 | 281 | 1,395 | 971 |
| Oxfordshire CCG | 23 | - | 3,614 | - |
| Health Education | 26 | 15 | 9,861 | 15 |
| NHS Resolution | - | 12 | - | 6,880 |
| NHS Pension Scheme | - | 2,704 | - | 20,447 |
| **Total** | **6,545** | **5,783** | **324,765** | **28,610** |

The Trust has also received revenue payments from a number of charitable funds, certain of the Trustees for which are also members of the Trust Board. The audited accounts of these Funds held on Trust are not included in this annual report and accounts and will be audited and published at a later date. A copy of these will be available on the Trust's internet site.

**Note 33 Transfers by absorption**

Following the transfer of Wiltshire Community Services to Wiltshire Health & Care LLP, the Trust has transfered all of the non PFI Wiltshire Community Assets to NHS Property Services. The date of transfer was 1st July 2017 and the transfer was accounted for as a Transfer by Absorption.

| The Assets are as follows | Net Book Value at 30/6/17 | Revaluation Reserve at 30/6/17 |
|---|---|---|
| Category | £'000 | £'000 |
| Land | 12,760 | 4,131 |
| Buildings (incl dwellings) | 15,852 | 9,196 |
| **Total** | **28,612** | **13,327** |

| **Effect on Financial Statements** | **£'000** |
|---|---|
| **Statement of Financial Position** | |
| Non Current Assets | 28,612 |
| | |
| Revaluation Reserve | 13,327 |
| Income & Expenditure Reserve | 15,285 |
| **Increase in Total Taxpayers Equity** | **28,612** |

**Note 34 Losses and Special Payments**
**Group and Trust**

| | 31 March 2018 | | 31 March 2017 | |
|---|---|---|---|---|
| | **No.** | **£000** | **No.** | **£000** |
| **Losses** | | | | |
| Cash losses | **3** | **5** | **2** | **3** |
| Bad debts and claims abandoned | **189** | **192** | **863** | **238** |
| **Total Losses** | **192** | **197** | **865** | **241** |
| **Special Payments** | | | | |
| Compensation payments | **3** | **1** | **3** | **7** |
| Ex gratia payments | **29** | **19** | **49** | **27** |
| Special Severance Payments | **-** | **-** | **1** | **20** |
| **Total Special Payments** | **32** | **20** | **53** | **54** |
| **Total Losses and Special Payments** | **224** | **217** | **918** | **295** |

There were no clinical negligence, fraud, personal injury, compensation under legal obligation or fruitless payment cases where the net payment or loss for the individual case exceeded £100,000. (2016/17 - nil cases).

Losses and special payments are compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

**Note 35 Pooled Budget - Integrated Community Equipment Service**
Great Western Hospitals NHS Foundation Trust and NHS Swindon have entered into a pooled budget arrangement, hosted by Swindon Borough Council. Payments are made to the Council by the Swindon Community Equipment Service.
**Group and Trust**

| **Income:** | **31 March 2018 £000** | **31 March 2017 £000** |
|---|---|---|
| Swindon Borough Council | **-** | 490 |
| Paediatrics | **-** | - |
| NHS Swindon | 368 | 345 |
| Great Western Hospitals NHS Foundation Trust | 92 | 92 |
| **Total Income** | **460** | **927** |
| **Expenditure** | **533** | **1,155** |
| **Total (Deficit)** | **(73)** | **(228)** |

The above disclosure is based on month 12 management accounts provided by Swindon Borough Council, but have not yet provided a Pooled Budget Memorandum account.
It should be noted that these figures are un-audited.

| **Share of Surplus (Deficit):** | | |
|---|---|---|
| Swindon Borough Council | **(38)** | **(104)** |
| Swindon CCG | **(5)** | **(98)** |
| Great Western Hospitals NHS Foundation Trust | **(30)** | **(26)** |
| **Total (Deficit)** | **(73)** | **(228)** |

Great Western Hospitals
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