NHS
Great Western Hospitals
NHS Foundation Trust

Great Western Hospitals NHS Foundation Trust
Annual Report and Accounts
2018/19

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

Contents

CHAIR AND CHIEF EXECUTIVE'S STATEMENT

Welcome to our Annual Report and Accounts for 2018/19.

This has been a year of continued transformation, hard work and success from our staff to meet the pressure of increasing demand alongside improvements in the quality of care we provide to our patients. We have also been working to build a more integrated approach to health and care in Swindon and Wiltshire, with Quality Improvement threading all our services together.

In December, the Care Quality Commission group visited the Trust and, following inspection, whilst in 80% of areas we were rated as good, our overall rating was again graded as 'Requires Improvement'. We are confident that the improvements we have made and our commitment to place patient safety and care at the centre of everything we do will mean that many more services will become rated as 'Good' as we continue our journey to become 'Outstanding'.

As you read through this report, you will see that there is much to celebrate and many areas of exemplary, innovative and quality care. These achievements are testament to the efforts and commitment of our over 5,000 dedicated staff working at the Great Western Hospital and across the community in Swindon.

We have spent this year working towards our 2018 goal to truly integrate our acute and community services, with many positive examples of new pathways and services which have seen patients out of hospital and back to their own homes quickly and efficiently, with dedicated follow-ups and support from out in the community. We are continuing to prioritise opportunities to further develop the Integrated Care System model in Swindon and are seeing positive results in reduced numbers of admissions through the work already made. Greater collaboration has been secured with the acute Trust and community services, with particular regard to older patients and reablement care which helps with independence in the home.

Within the hospital, 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, including an expansion to our Ambulatory Care Unit, the opening of new units and pioneering internal patient pathways.

The population in Swindon and the surrounding areas continues to grow at pace, and above the national average, and we have currently been constrained by capacity, size and flexibility. This year though, we were thrilled to have successfully secured a £30million bid from the national government. This funding will go towards improving services for our growing and ageing population by rightsizing our Emergency Department for the current demand that we are seeing, through the development of an Integrated Front Door and the development of alternative models of care such as intensive rehabilitation. We have seen a high demand on the Trust this year and are confident that this funding will help us make the necessary changes for the people of Swindon. Work is taking place behind-the-scenes and will continue to progress throughout this year and those that will follow.

Our Brighter Futures Team has worked incredibly hard over the last few years and has now hit the target of £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 will allow local patients to be seen in Swindon without the need to travel further afield. Brighter Futures have also hit their Special Care Baby Unit incubator appeal target this year, which will improve the care for all premature babies. A number of other fundraising projects have been successfully completed this year, which have helped to make improvements to a number of patients.

The Trust ended the 2018/19 financial year with a £1.3m deficit including Provider Sustainability Funding (PSF). This is £4m better than plan largely due to £4.7m incentive PSF awarded in Apr-19. However, the Trust has an underlying deficit position of £12.4m, principally caused by increasing levels of demand, bed capacity and agency staffing costs. Due to the situation of the Trust in deficit, we are on a continued mission to demonstrate improved financial governance and cost-savings across the Trust. A number of projects are underway which have not only shown considerable cost-saving, but also improved patient experience and staff work life. These projects are underlined by Quality Improvement, which is the golden thread running through everything we do as a Trust.

Following the collapse of Carillion in January 2018, the Trust worked hard to secure a safe transfer of services to Serco in June 2018. Given the potential for disruption, the transfer took place smoothly and since then we have been focussing our efforts on resolving outstanding legacy estates issues and improving day to day performance of Hard Facilities Management (FM) so that as we move towards the one year anniversary of the transfer we continue to focus on delivering improved compliance and maintenance of the estate.

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.

Liam Coleman
Chairman
5 June 2019

Nerissa Vaughan
Chief Executive
5 June 2019

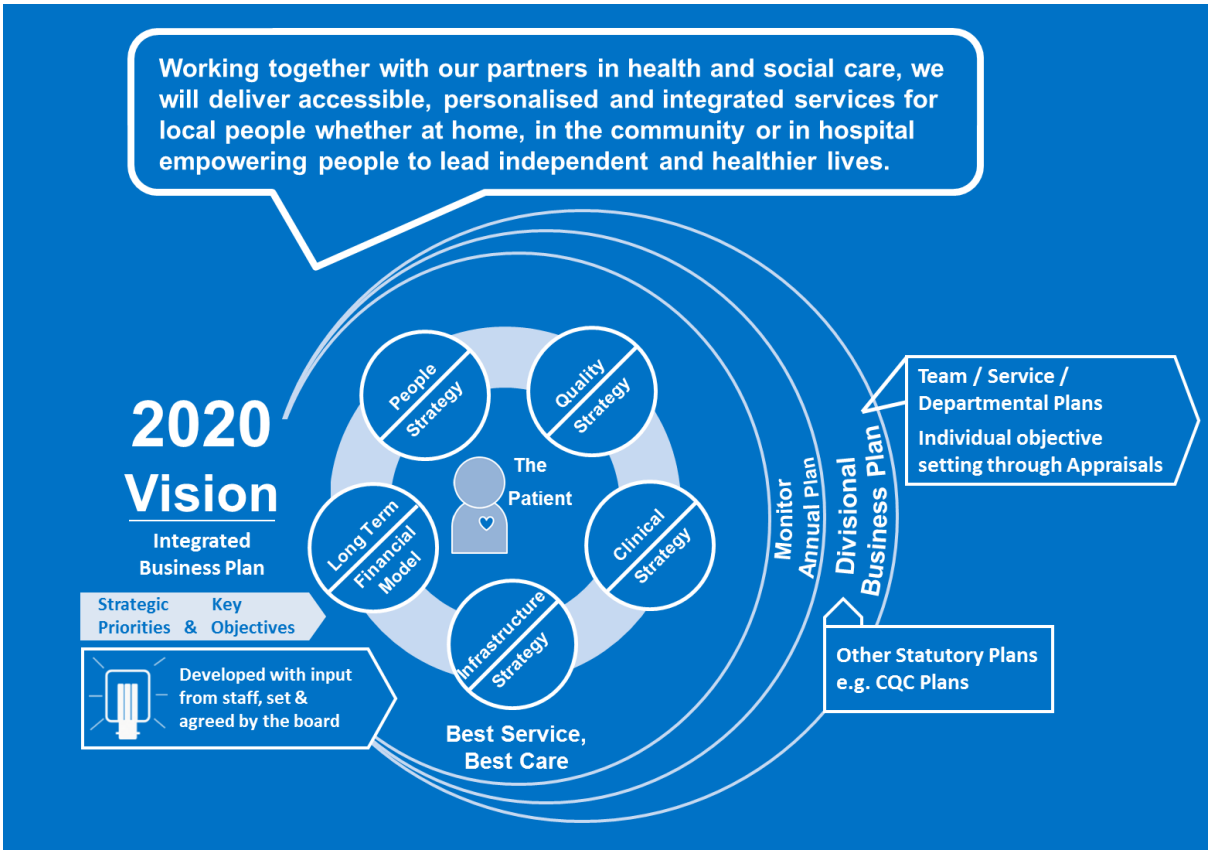
PERFORMANCE REPORT

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 including performing 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.

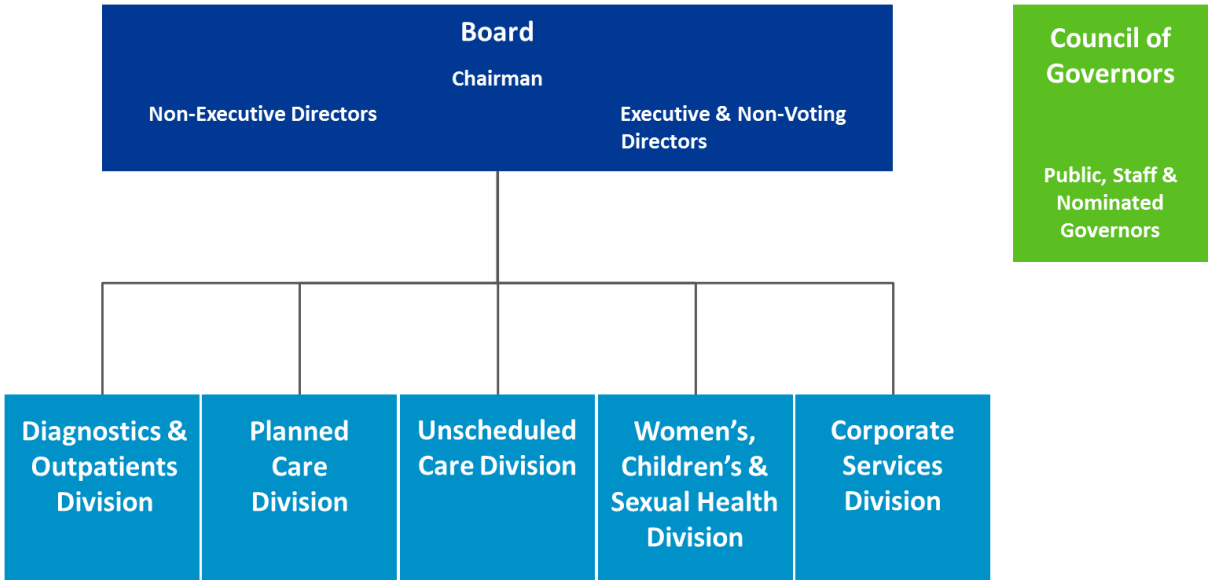
We are not directed by Government and so have greater freedom to decide, with our Governors and members, our own strategy and the way services are run. We can retain surpluses and borrow to invest in new and improved services for patients and service users. Borrowing is subject to the financial position of the Trust and will require approval of the Trust Board, NHS Improvement and Department of Health and Social Care.

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. The Council of Governors, amongst other things, is responsible for representing the views of members to inform decision making and for holding the Non-Executive Directors to account for the performance of the Board.

1.5 Organisational structure 2018/19



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
- Community services

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. 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.

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.

A summary of the principal risks and uncertainties facing the Trust during 2018/19 against our strategic objectives are set out below: -

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	Risk of failure to meet 4 hour wait Emergency Department performance
	Risk of inability to manage demand across the health economy
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
Strategic Objective 4 To secure the long-term financial health of the Trust	Failure to deliver recurrent savings impacting on financial sustainability
	Failure to hold agency costs to cap
	Inability to manage demand creating significant pressure and cost
	Continued pressure on the hospital impacting on ability to generate income from private patients
Strategic objective 5 To adopt new approaches and innovation to improve services as healthcare changes whilst continuing to become even more efficient	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	Lack of alignment of Trust plans and commissioner intentions

1.10 Going concern

The accounts have been prepared on a going concern basis. The Trust's Annual Plan forecasts a breakeven position for the year ending 31 March 2020. This includes the receipt of £6.8m from the Provider Sustainability Fund (PSF) and £0.6m from the Financial Recovery Fund (FRF). 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 2019/20 Annual Plan. The Trust has a loan repayment due of £4.9m in Nov-19. It is assumed that the repayment date will either be extended or alternative funding provision will be made by DHSC. This is in line with the letter dated 21 May 2019 from the DHSC Finance Director stating that there will be on-going availability of interim support to ensure NHS providers remain operationally viable. As with any Trust placing reliance on the DHSC for financial support, the directors acknowledge that there can be no certainty that this support will continue although, at the date of approval of these financial statements, they have no reason to believe that it will not do so. T

The NHS Foundation Trust Annual Reporting Manual 2018/19 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 Trust without the transfer of the services to another entity, or has no realistic alternative but to do so.

After making enquiries and considering the matters 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. Based on this assessment the Directors believe that it remains appropriate to prepare the accounts on a going concern basis. However, the matters referred to above represent a material uncertainty that may cast significant doubt on the Trust's ability to continue as a going concern and, therefore, to continue realising its assets and discharging its liabilities in the normal course of business. The financial statements do not include any adjustments that would result from the basis of preparation being inappropriate

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 2018/19 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 September 2018. The inspection showed areas of strength and areas for improvement. Our kind and compassionate care continued to be a strong theme for 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 were aware 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. On this inspection the CQC rated the Trust overall as 'Requires Improvement', however, the number of services now achieving a 'Good' rating had significantly improved to over 80%. The Trust is now in a great position to continue the work already underway to achieve a 'Good' overall rating on our journey to 'Outstanding'.

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 continuing 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. 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 Getting It Right First Time (GIRFT) afford the Trust and continuing to work collaboratively with the Sustainability and Transformation Partnership (STP). Transformation programmes continue, now with an increasing focus on Quality improvement to ensure that the Trust does not look at costs savings in isolation but also actively investigates pathway redesign and improved ways of working. The Business Improvement Group is now well 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 have continued with work to further integrate our secondary care services so that they are more joined-up 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 Swindon Community Health Services fully 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 when 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.

During 2018 the Trust has continued to work collaboratively with our Sustainability & Transformation Partnership (STP) partner organisations, including commissioners, public health and other providers, on the development of our STP.

STP Priority Programmes 2018/19

- Wellbeing & Health of Older People
  Deliver improved health for older people through strengths based working, prevention, early intervention and rapid reablement.

- Mental Health & Wellbeing
  Deliver better mental health through adoption of Bath & North East Somerset, Swindon and Wiltshire (BSW) STP Thrive approach.

- Integrated Care System (ICS)
  Develop & Implement a Programme of Change to deliver an STP wide commissioning & strategic planning function where this makes sense for patients and the taxpayer.

- Estates
  Develop an STP Estates Strategy to ensure both the effective utilisation of the NHS and local authorities estates are appropriate patient/user environments.

- Finance
  Deliver financial improvement plan to close the gap in BSW through better working together.

- Digital
  Enable better care at lower cost through the use of digital capabilities.

- Workforce
  Deliver the right workforce for the STP.

STP Wave 4 Capital Funding

In December 2018, the Trust was given the news that it had successfully secured funding to improve services at Great Western Hospital.

We are currently working hard to develop our plans for the full programme and these will continue to evolve as we take on board expert advice and clinical needs while ensuring the work we deliver is the most appropriate for today's environment and the challenges we are facing now.

The programme is focused on key projects that, instead of creating a bigger version of what we have today, will evolve a more integrated, streamlined and efficient health care system that will provide an effective balance of urgent and longer term care for patients' best interests. Our key areas of focus are to create an Integrated Front Door and expanded Emergency Department to ensure that we can provide safe and quality services to our patients. Currently our Emergency Department is operating under significant pressure and urgently requires additional capacity to meet today's demand. We are also looking at different models of care, such as Intensive Rehabilitation, to help with future demand pressures and to compliment investments we are making to our community services.

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 2018/19

During the 2018/19 financial year over 1,000 patients were recruited to 55 open studies, overseen by 43 individual Principal Investigators. There were a further 2,500+ patients being 'followed up' in studies now closed to recruitment.

Research activity at the Trust has grown steadily over the past 10 years, involving increasing numbers of doctors, nurses, allied health professionals and others. Over 20 clinical areas are currently involved in the delivery of clinical studies. Active participation in research continues to give our patients the opportunity to access new and innovative treatment pathways.

With funding received from the Department of Health via our Local Clinical Research Network (LCRN), research and innovation 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.

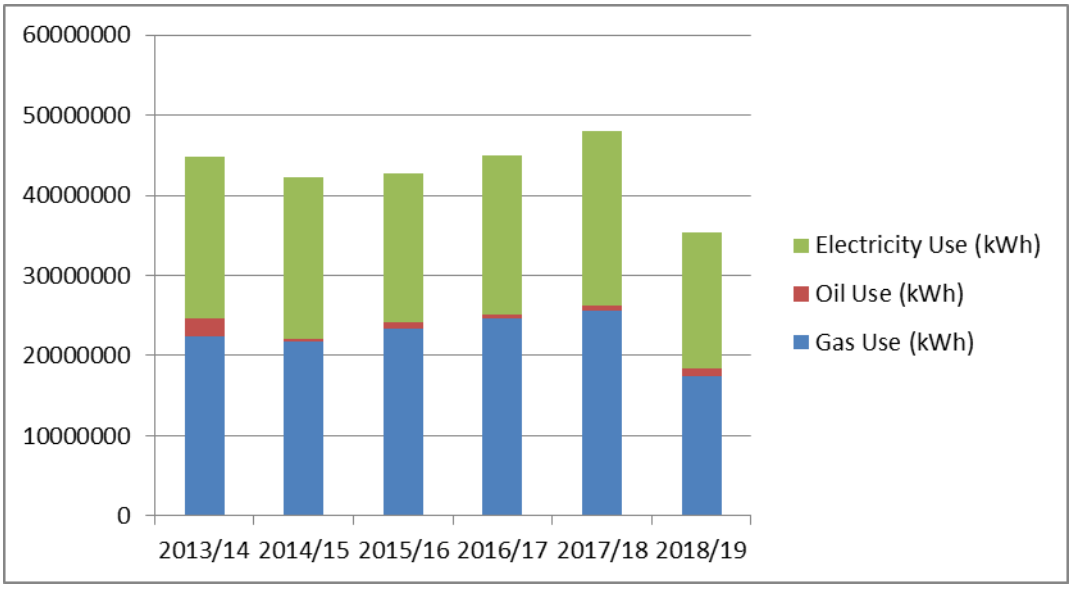
Environmental matters

The Great Western Hospitals NHS Foundation Trust recognises that there are many benefits to 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, but has reduced both the gas and electricity consumption to 2015/16 levels. This may be as a result of replacing plant with more energy efficient models and a slightly milder winter. 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.

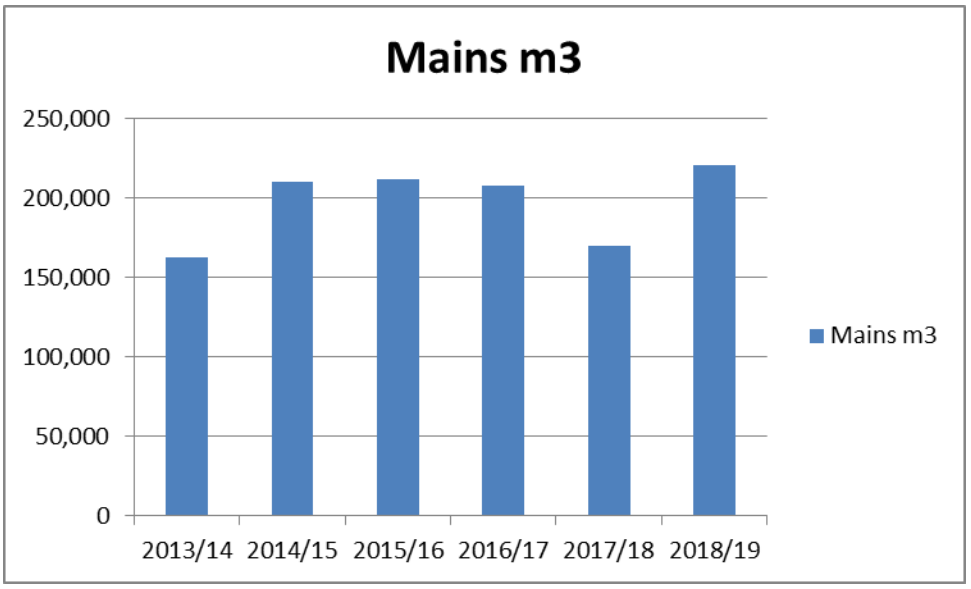
Graph 1 – Utility consumption (KwH)



Water

Due to a faulty meter usage information was not available for three months of last year, although modelling would anticipate water usage remained static, meaning consumption was in line with previous years.

Graph 2– Water consumption (m3)

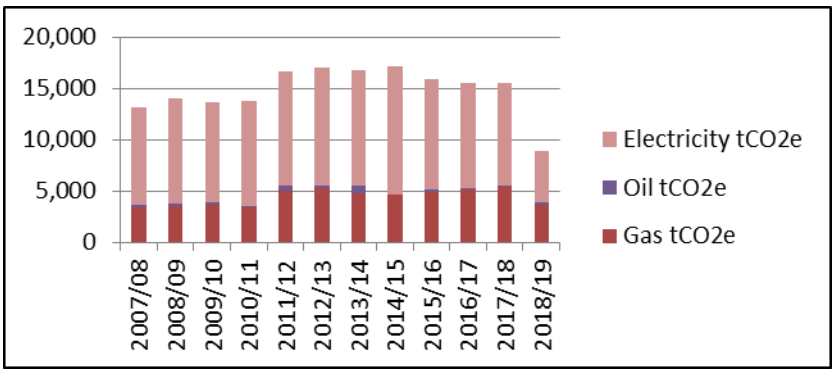


Carbon reduction

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 Act2. We are working towards achieving a percentage reduction in CO2e emissions each year which will assist the NHS as a whole with reaching the overall target of reducing 80% CO2e emissions by 2050. Graph 3 shows carbon emissions in tonnes from utility consumption for the Trust since the baseline year of 2007. The reduction in carbon emissions this year is due to a significant reduction in coal generation by the national grid and the increasing importance of renewables.

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.

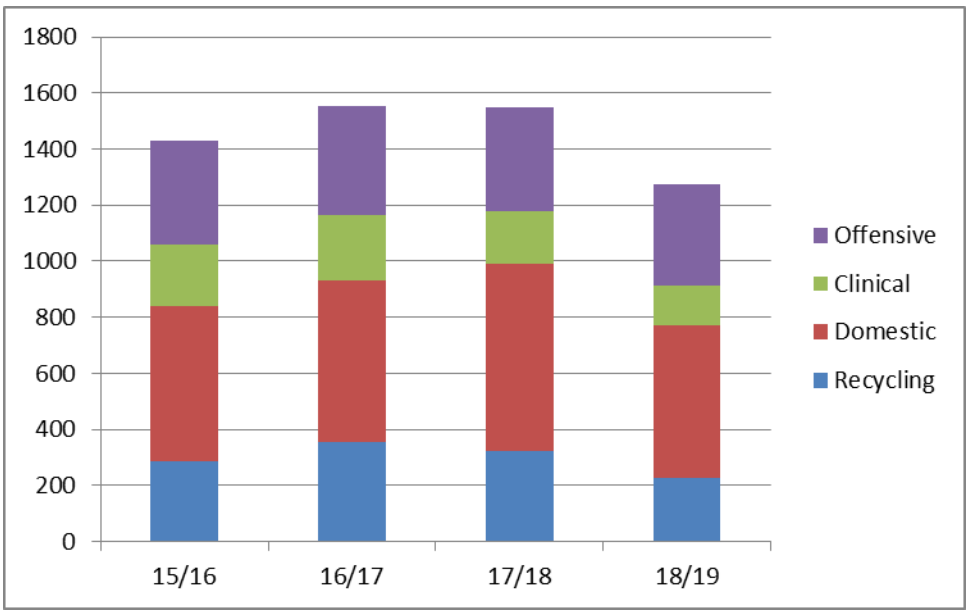
Graph 3– CO2e emissions for utility consumption (tonnes)



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, however again the Great Western Hospital is responsible for a significant part of the waste. Over the last 6 months, at the Great Western Hospital we have been trialling the use of re-usable sharps bins. This means that weight of clinical waste has reduced, as the plastic packaging associated with sharps disposal is no longer a single use item. Following the success of this project it has now been rolled out across the whole hospital and will be introduced into Community settings were possible over the coming 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 2018/19.

2.7 Consultations

There were no formal public or stakeholder consultations during 2018/19.

2.8 Main trends, developments or matters likely to impact on the Trust business in 2019/20

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.

The Trust has been actively engaging with staff, public and commissioners to inform the next strategy which will be rolled out from April 2019.

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 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 people with 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 2019/20 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 achieving a "good" rating for our services on our journey to an "outstanding" rating, and supporting our saving 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, maintenance and/or reduction of our wait list, and maintenance of DMO1 (6 week Diagnostic Wait) and Cancer performance.
- 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 in the development of an Integrated Accountable System to go live in 2021. This will include supporting:-

    - the Bath and North East Somerset, Swindon and Wiltshire (BSW) vision and priorities;
    - the implementation of new operating models; a single strategic commissioner (system) and placed based locality systems enabling the development of integrated care alliances (commissioning and provision);
    - developing capabilities to work as a system, and working more collaboratively to manage finances and performance;
    - establishing system-wide governance to work alongside the accountabilities of statutory organisations.

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 2019/20, specifically with controlling finances 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.

During 2019/20 the Trust will be developing plans to look at potential options available to meet increasing demand and addressing the key challenges ahead. The Trust was successful with the Wave 4 STP funding in 2018 and was awarded £29.6m. Plans are progressing to develop an Integrated Front Door and expanded Emergency Department. Plans are also progressing to look at other models of care, such as intensive rehabilitation, with a view to help support future demand alongside enhanced community 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.

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 2019/20, 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 in research and development, as access to EU funds 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.

The Trust is actively following all national guidance and requirements passed through the EU Exit control team. This includes situation reporting, preparedness planning across 5 domains including workforce, medication and clinical supplies, non-clinical supplies and repatriation. A dedicated response team is in place to manage this under the Trust's incident response set up.

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.

During the financial year 2018/19 the Trust has achieved its financial control total (prior to PSF) with support from the Health System to manage continued activity pressures, especially around winter and escalation and a short-fall on CCG quality, innovation, productivity and prevention (QIPP) delivery.

The Trust was set a control total of £5.6m deficit (including Provider Sustainability Fund (PSF)) along with activity trajectories for ED. The Trust achieved ED targets in Quarters 1, 2 & 3 along with PSF funding and final incentive funding so received a total of £11.1m of PSF in 2018/19.

The Trust ended the year with a £1.3m deficit including PSF and additional funding for winter, with an underlying deficit position of £12.4m. The underlying deficit position has moved adversely compared to the position in 2017/18 of £11.3m, this is principally reflective of increasing levels of demand, bed capacity and agency staffing costs, the latter linked to winter pressures and escalation.

During 2018/19 CIPs delivered at 65%, amounting to £7.5m savings/efficiencies. Of this £5.1m are recurrent and £2.4m are non-recurrent. This is in addition to just under £40m achieved over the previous three years. This delivery is against a background of continued service pressures. The Trust continues to seek transformational change to manage financial challenges, whilst maintaining and improving quality.

In 2018/19 the Trust continued to experience pressure with A&E activity with significant growth in demand around the winter period. The Trust has seen an increase in non-elective activity of 1%, elective inpatients of 1% and elective day-cases of 6%, with a reduction in outpatients of 2% compared to 2017/18. Agency spend was £10.4m, which is a reduction against 2017/18 (£15.3m), but was in excess of plan by £545k and NHS agency cap by £2.4m and will remain an area of focus for 2019/20.

The Trust charity, Brighter Futures, ended the year with £3.5m in funds, of which £3.4m is classed as restricted and £0.1m is unrestricted. This includes a £40k gain on investments. Income for the year was £1.2m compared with expenditure of £0.5m meaning the charity generated an overall surplus of £0.8m.

High level summary

- Income was £16.5m above plan. The main drivers were £4.7m final year end PSF settlement, Health System support for winter pressures of £4.4m received during March, £2.1m relating to CCG year-end income agreement on winter and additional activity and £3.5m of Other Income (including R&D and Education & Training).

- Expenditure was £12.8m above plan. This was driven by costs associated with additional activity, especially linked to the winter period and escalation. Drugs were overspent by £2.5m, clinical supplies by £3.7m and other costs by £6.3m. Pay expenditure was £176k above plan in total, although this is a combination of pressures around agency being off-set by vacancies being held, particularly in non-clinical areas.

- Savings delivered totalled £7.5m against a target of £11.6m, an achievement of 65% leaving a shortfall of £4.1m. Of the savings delivered £5.1m were achieved recurrently and £2.4m were delivered non-recurrently. In addition non-recurrent savings of £4m relating to recruitment lag were achieved.

- The cash balance at year end was £5.2m, which was £4.2 above plan. The year-end cash balance was after receipt of £11.7m borrowing from the Department of Health. This borrowing is to support the Trust's daily cash position.

What this means

Summary of the year End Position for Great Western Hospital

	Plan	Actual	Variance
Surplus/(Deficit) Reported in Statement of Comprehensive Income	**(£5,300)**	**£9,328**	**£14,628**
Revaluation	£0	(£9,780)	(£9,780)
NHS Charity	£0	(£849)	(£849)
Normalised Position including national support	**(£5,300)**	**(£1,301)**	**£3,999**
Sustainability & Transformation Fund	£7,126	£6,378	(£748)
Sustainability & Transformation Fund Incentive	£0	£4,711	£4,711
Total Income & Expenditure Position	**(£12,426)**	**(£12,390)**	**£36**
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	2018/19	Variance from last year %
New Outpatients	137,504	148,766	160,295	149,247	158,170	*164,426*	*160,529*	***173,021***	***7.8%***
Follow Up Outpatients	263,066	274,326	291,214	299,806	308,468	*306,409*	*300,051*	***329,357***	***9.8%***
Day Cases	27,320	27,838	30,969	33,059	33,934	*33,648*	*33,552*	***37,161***	***10.8%***
Emergency Inpatients	35,804	38,192	39,178	43,055	45,341	*47,633*	*50,359*	***52,847***	***4.9%***
Elective Inpatients	6,723	6,343	6,247	5,936	5,863	*5,607*	*5,203*	***5,602***	***7.7%***
Emergency Department Attendances	70,731	77,642	75,440	78,522	82,425	*84,232*	*74,456*	***82,560***	***10.9%***
Total	***541,148***	***573,107***	***603,343***	***609,655***	***634,201***	***641,955***	***624,150***	***680,548***	***9.0%***

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

Note – The increase in activity in 2018/19 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.

Our community data (for Swindon Community) is as follows:

	2017/18	2018/19
Admitted Patients	817	791
Community Contacts	186,767	190,129

Note that in previous years the Trust was responsible for delivering community services in Wiltshire, however this is no longer the case as these are provided by Wiltshire Health and Care as referred to elsewhere in this report (section 1.8 refers). Therefore data relating to Wiltshire Community Services is no longer included in the Trust's annual report.

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: -

- £1,000 to address Winter pressures
- £257k Clinical Excellence Awards
- £372k to support Overseas Recruitment
- £198k to support temporary additional computerised tomography (CT) capacity
- £89k New born Hearing Screening
- £94k investment in Medical Day Unit
- £75k to support Pharmacy Antimicrobial Stewardship Team to support delivery of Commissioning for Quality and Innovation (CQUIN)
- £54k to support Hospital at Night
- £75k investment in Pathology Blood Science Lab staffing model
- £44k investment in Safer Neonatal staffing

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

As at 31 March 2019 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 2019.

2.17 Charitable Donations

Total income through the Charitable Funds for 2018/19 was £1.2m of which £1.1m related to donations and legacies.

2.18 Future developments

The Trust has continued 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 are detailed below.

With a view to the future, the Trust has also engaged with staff, the public (through HealthWatch), Governors and Commissioners to inform the next Trust strategy which is planned to be rolled out from April 2019. This includes our ambitious plans to invest in the Great Western Hospital site (Integrated Front Door and enlarged Emergency Department) as well as in our community services and future models of care.

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.

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 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 contractual 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 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.

- The population in Swindon and the surrounding areas continues to grow at pace, and above the national average, and we have previously been constrained by capacity, size and flexibility. This year a £30million bid from the national government. This funding will go towards improving services for our growing and ageing population by rightsizing our Emergency Department for the current demand that we are seeing, through the development of an Integrated Front Door and the development of alternative models of care such as intensive rehabilitation. We have seen a high demand on the Trust this year and are confident that this funding will help us make the necessary changes for the people of Swindon. Work is taking place behind-the-scenes and will continue to progress throughout this year and those that will follow.

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.

(See also: **Transformation** below which sets out plans following award of STP Wave 4 Capital Funding).

Cancer

We are committed to delivering the NHS Standards for Cancer and we are actively working with our partners in the Thames Valley Alliance to deliver a number of key transformational schemes in the next two years covering early diagnostics, living with cancer and beyond cancer care.

Referral to Treatment (RTT)

There are considerable challenges in meeting referral to treatment times in most specialities. New reporting structures have been put in place with each specialty having a monthly trajectory and exception reporting process. Although our waiting list grew in 2018, based on recent performance we are confident that we will deliver our target in 2019/20.

Further information is included in the Quality Report (section 11 refers).

Future Improvements

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.

The Trust was most recently inspected by the Care Quality Commission (CQC) in August 2018. Prior to that there were inspections in March 2017 and September 2015.

The initial inspection showed areas of strength and areas for improvement and the Trust has been on a journey to ensure that high quality care is provided to our patients. On each inspection our kind and compassionate care was clear to the inspectors, who saw first-hand how we treat patients with dignity and respect. Inspectors have observed many examples of high quality care and an organisation with solid foundations, a clear vision and established leadership.

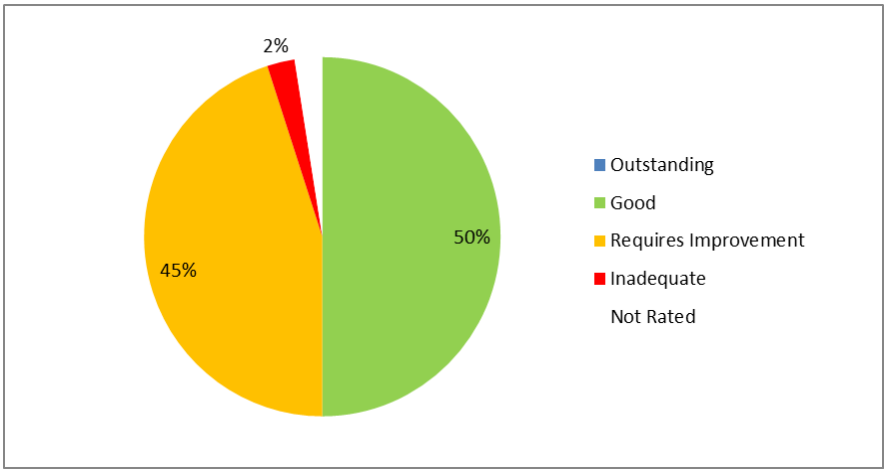
Examples of improvements are included in the Quality Report (section 11 refers).

Care Quality Commission Inspection Ratings 2015-2018

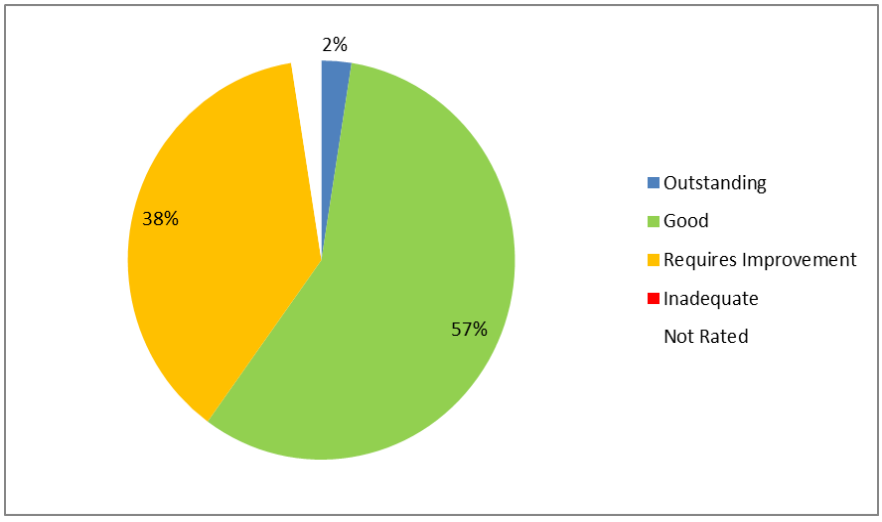
Although the Trust remains "requires improvement" we have continued to make improvements across out core services as shown in the charts below.

The CQC inspected the 'Effective' domain but did not rate it due to a lack of national data available.

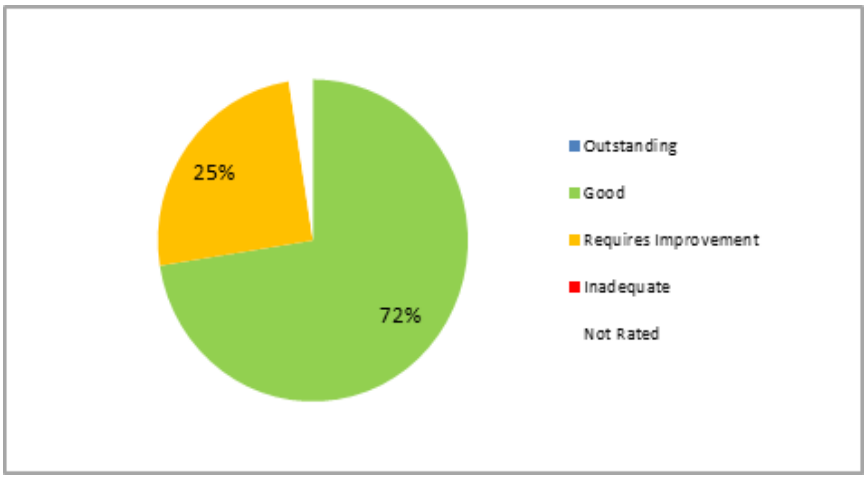
2015	SAFE	EFFECTIVE	CARING	RESPONSIVE	WELL LED	OVERALL
Urgent & emergency services	Inadequate	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Medical care	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Surgery	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
Critical care	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Maternity & Gynaecology	Requires Improvement	Good	Good	Good	Good	Good
Children & young people	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
End of life care	Good	Good	Good	Good	Good	Good
Outpatients & Diagnostic Imaging	Requires Improvement	Not Rated	Good	Requires Improvement	Requires Improvement	Requires Improvement
OVERALL	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

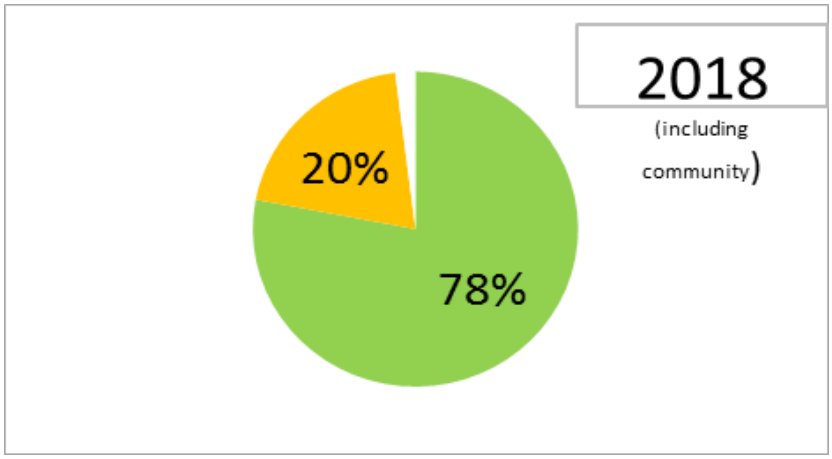


2017	SAFE	EFFECTIVE	CARING	RESPONSIVE	WELL LED	OVERALL
Urgent & emergency services	Requires Improvement	Good	Outstanding	Requires Improvement	Good	Requires Improvement
Medical care	Requires Improvement	Requires Improvement	Good	Requires Improvement	Good	Requires Improvement
Surgery	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
Critical care	Requires Improvement	Good	Good	Good	Good	Good
Maternity & Gynaecology	Requires Improvement	Good	Good	Good	Good	Good
Children & young people	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
End of life care	Good	Good	Good	Good	Good	Good
Outpatients & Diagnostic Imaging	Requires Improvement	Not Rated	Good	Requires Improvement	Good	Requires Improvement
OVERALL	Requires Improvement	Good	Good	Requires Improvement	Good	Requires Improvement



2018	SAFE	EFFECTIVE	CARING	RESPONSIVE	WELL LED	OVERALL
Urgent & emergency services	Requires Improvement ↔	Good ↔	Good ↓	Requires Improvement ↔	Good ↔	Requires Improvement ↔
Medical care	Requires Improvement ↔	Requires Improvement ↔	Good ↔	Requires Improvement ↔	Requires Improvement ↓	Requires Improvement ↔
Surgery	Requires Improvement ↔	Good	Good ↔	Requires Improvement ↔	Good ↑	Requires Improvement ↔
Critical care	Requires Improvement ↔	Good ↔	Good ↔	Good ↔	Good ↔	Good ↔
Maternity & Gynaecology	Requires Improvement ↔	Good ↔	Good ↔	Good ↔	Good ↔	Good ↔
Children & young people	Good ↑	Good ↔	Good ↔	Good ↑	Good ↑	Good ↑
End of life care	Good ↔	Good ↔	Good ↔	Good ↔	Good ↔	Good ↔
Outpatients & Diagnostic Imaging	Good ↑	Not Rated	Good ↔	Good ↑	Good	Good ↑
Community Health Services	Good ↑	Good ↑	Good ↑	Good ↑	Good ↑	Good ↑
Community Inpatient Services	Good ↑	Good ↑	Good ↑	Good ↑	Good ↑	Good ↑
OVERALL	Requires Improvement ↔	Good ↔	Good ↔	Requires Improvement ↔	Good ↔	Requires Improvement ↔





The Trust was already aware of the challenges highlighted in the most recent inspection and many improvements actions were already underway and are continuing.

Transformation

The Trust's transformation programme is aimed at delivering significant benefits to patient care and treatment whilst also realising efficiency savings. In conjunction with our health system partners the Trust is working toward Integrated Care focussed on more coordinated and combined forms of care provision with a shared commitment to improve patient care and experience through better coordination of services.

Using the recent award of STP Wave 4 Capital Funding (£29.6m) the Trust will be investing in an Integrated Front Door with enlarged Emergency Department capacity. This will transform the way we work and allow for an improvement in how flow through the hospital is managed. In addition we are investigating new models of care, such as Intensive Rehabilitation, which will ensure that, working alongside enhanced community services, we are best placed to manage future capacity requirements.

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.

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 Note 31 to the accounts.

Disclosures in respect of payment of creditors in line with Better Payment Practice Code are included in Note 11 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 2019 have been prepared in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006 in the form that NHS Improvement (the Independent Regulator of NHS Foundation Trusts) with the approval of the Treasury, has directed.

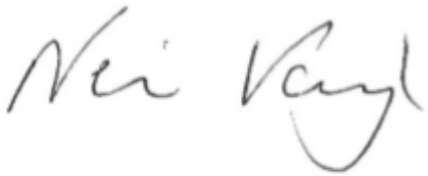
2.23 Preparation of the Annual Report and Accounts

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
5 June 2019

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 2018-19: -

Roger Hill	*Chair (to 31 January 2019)*
Liam Coleman	*Chair (from 1 February 2019)*
Nerissa Vaughan	*Chief Executive*
Dr Nicholas Bishop	*Non-Executive Director* *Senior Independent Director (from 1 February 2019)*
Andy Copestake	*Non-Executive Director*
Oonagh Fitzgerald	*Director of Human Resources (to 20 July 2018)*
Sally Fox	*Director of Human Resources (from 21 July 2018 to 31 January 2019) (interim non-voting Board Director)*
Sheridan Flavin	*Director of Human Resources (from 1 February 2019) (interim non-voting Board Director)*
Peter Hill	*Non-Executive Director* *Deputy Chairman (from 1 June 2018)*
Karen Johnson	*Director of Finance*
Paul Lewis	*Non-Executive Director (from 1 April 2018)*
Kevin McNamara	*Director of Strategy & Community Services*
Jemima Milton	*Non-Executive Director*
Carole Nicholl	*Director of Governance & Assurance (& Company Secretary) (non-voting Board Director)*
Steve Nowell	*Non-Executive Director (to 31 December 2018))* *Senior Independent Director (to 31 December 2018)*
Jim O'Connell	*Chief Operating Officer*
Dr Guy Rooney	*Medical Director & Deputy Chief Executive*
Julie Soutter	*Non-Executive Director* *Deputy Chairman (until 31 May 2018)*
Hilary Walker	*Chief Nurse (to 31 May 2018))*
Julie Marshman	*Chief Nurse (from 1 June 2018)*

3.2 Board of Directors

The Board of Directors or Trust Board consisting of Executive, Non-Executive Directors and Non-Voting Directors 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 Directors do not have executive powers. Brief biographies for Board Directors in 2018/19 are set out below.

3.3 Biography of individual Directors

Roger Hill, Chair (to 31 January 2019)

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 at which point Roger left the Trust.

In 2018/19 Roger was a member of the Remuneration Committee and the Joint Nominations Committee.

Liam Coleman, Chair (from 1 February 2019)

Liam took over as Chair of the Trust on 1 February 2019.

Liam has significant previous experience in the NHS, having previously been one of our Non-Executive Directors from 2009 to 2016.

Liam was previously the Chief Executive of the Co-Operative Bank plc.

His appointment as Chair comes at an exciting time for the Trust, and he will be heavily involved with its expansion following the £30million funding recently approved, and the establishment of radiotherapy services following the hugely successful Brighter Futures appeal.

He has a particular interest in the links between the Trust and the local community it serves, and he will be working to ensure that those links continue to strengthen.

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
Senior Independent Director (from 8 February 2019)

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 became a Non-Executive Director on 1 August 2016. On 8 February 2019, Nick was appointed as the Senior Independent Director of the Trust. During 2018/19 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
- Member of and the Audit, Risk & Assurance Committee
- Member of the Remuneration Committee becoming Chair from 8 February 2019

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 2018/19 Andy's membership on Board Committee was as follows: -

- Member of the Audit, Risk & Assurance Committee
- Member of the Performance, People & Place Committee
- Member of the Finance & Investment Committee becoming Chair from 10 January 2019
- Member of the Charitable Funds Committee
- Member of the Remuneration Committee

Sheridan Flavin, Interim Director of Human Resources (non-voting) (from 1 February 2019)

Sheridan Flavin took up the interim position until such time as a substantive Director of Human Resources is appointed.

Peter Hill, Non-Executive Director
Deputy Chairman (from 1 June 2018)

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.

Peter was appointed Deputy Chairman of the Trust on 1 June 2018. During 2018/19 Peter's membership on Board Committee was as follows: -

- Chair of the Performance, People & Place Committee
- Member of the Finance & Investment Committee
- Member of the Quality & Governance Committee
- Member of the Remuneration Committee.

Karen Johnson, Director of Finance

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 first joined the Trust in June 2013 but has worked in the NHS since 2010 working at that time as Acting Chief Finance Officer for Wiltshire Primary Care Trust.
Karen 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.

Paul Lewis, Non-Executive Director (from 1 April 2018)

Paul joined the Trust Board on 1 April 2018.
Paul is also a Regional Director for Lloyds Bank, and has held a number of senior positions in the private sector, including Regional Director for the Halifax, Customer Services Director for Zurich Financial Services, Capita (Life & Pensions) and Eagle Star Life, Hambro Life and Allied Dunbar.
Paul has also been a Vice President for the Institute of Customer Service, and has a breadth of experience in leading transformational change programmes, customer experience improvement, staff/colleague engagement, cultural change and risk & regulatory compliance.
Paul is a member of the Trust's Quality and Governance Committee; Finance and Investment Committee; and the Performance, People and Place Committee.

Julie Marshman, Chief Nurse (from 1 June 2018)

Julie is responsible for the clinical leadership for all nursing, midwifery, allied health professionals and healthcare science staff, and oversees quality governance and leads on the mental health and safeguarding agendas.
Julie is passionate about high quality care, excellent patient experience and staff well-being.
Julie has worked in a variety of nursing roles across acute and community in Swindon and Wiltshire, including Clinical Nurse Specialist, Matron, Divisional Director of Nursing and Deputy Chief Nurse.

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 and thereafter on 10 April 2014 Kevin was appointed to the substantive position. In May 2017, Kevin became a voting Director known as the Director of Strategy and Community Services. 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 has a strong focus on ensuring the Trust is clear about its future plans and is keen to progress new build opportunities.

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 2018/19 Jemima's membership of Committees was as follows: -

- Chair of the Charitable Funds Committee
- Member of the Performance, People & place Committee
- Member of the Quality & Governance Committee
- Member of the Mental Health Governance Committee
- Member of the Remuneration Committee

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

Carole has over 34 years' experience as a governance professional in the public sector. Carole first joined the Trust in 2011 as Head of Corporate Governance & Company Secretary having previously worked in local government managing a wide range of governance portfolios including elections, democratic services, licensing and various 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 as well as 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 / Governance Professional. Thereafter Carole studied in Oxford where she gained further qualifications including a Diploma in Management Studies.

Jim O'Connell – Chief Operating Officer

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. Guy's term of office as Medical Director has been extended into June 2019 when he will stand down as Medical Director to take up a new role as Medical Director for the Oxford Academic Health Science Network (AHSN).

Julie Soutter, Non-Executive Director
Deputy Chairman (until 31 May 2018)

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 was Deputy Chairman from 1 July 2016 until 31 May 2018. During 2017/18 Julie was re-appointed for a further three year term ending 31 December 2020.

During 2018/19 Julie's membership of Board Committees was as follows: -

- Chair of Audit, Risk and Assurance Committee
- Member of Finance & Investment Committee
- Member of the Performance, People & Place Committee
- Member of the Remuneration Committee
- Member of the Joint Nominations Committee

Oonagh Fitzgerald, Director of Human Resources (to 20 July 2018)

In 2018/19 Oonagh Fitzgerald, was the Director of Human Resources until 20 July 2018.
Oonagh joined the Trust in February 2008 and was responsible for recruiting, motivating and developing high-quality staff and maintaining safe staffing levels.

Sally Fox, Interim Director of Human Resources (non-voting)

Sally who was the Deputy Director of HR acted up as the interim Director of HR from 22 May 2018 until 31 January 2019.

Steve Nowell, Non-Executive Director and Senior Independent Director (to 31 December 2018)

Steve was a Non-Executive Director from 1 June 2014 and was appointed Senior Independent Director from 1 January 2017. During 2018/19 Steve was Chair of the Finance & Investment Committee and the Remuneration Committee, and a member of the Audit, Risk & Assurance Committee, the Quality & Governance Committee, the Mental Health Governance Committee and the Joint Nominations Committee. Steve left the Trust on 31 December 2018.

Hilary Walker, Chief Nurse (to 31 May 2018)

Hilary was the Chief Nurse for the Trust from May 2012 until she retired on 31 May 2018.
Hillary was responsible for the nursing workforce and focussed on strengthening the contribution of Nurses and Allied Health Professionals to modern healthcare as well as focussing on improving the safety and quality of care and patient experience.

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 2018/19.

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.

Name	First Term	Second Term
Roger Hill (Chairman)*1	01.02.14 – 31.01.17	01.02.17 – 31.01.19
Liam Coleman (Chairman)*2	01.02.19 – 31.01.22	
Nick Bishop	01.08.16 – 31.07.19	
Andy Copestake	01.07.16 – 30.06.19	
Peter Hill	01.04.17 – 31.03.20	
Jemima Milton	01.01.14 – 31.12.16	01.01.17 – 31.12.19
Paul Lewis*3	01.04.18 – 31.03.21	
Steve Nowell*4	01.06.14 – 31.05.17	01.06.17 – 31.12.18
Julie Soutter	01.01.15 – 31.12.17	01.01.18– 31.12.20

There were four changes to the Non-Executive Directors of the Board in 2018/19.

*1Note that prior to becoming Chairman in 2014, Roger Hill had served as a Non-Executive Director for terms from 1 May 2008. Roger Hill left the trust on 31 January 2019 with the recruitment for a replacement Chair undertaken and concluded in November 2018 when the Trust was pleased to welcome Liam Coleman as its new Chair from 1 February 2019.

*2Note that prior to becoming Chairman in 2019, Liam Coleman had served as a Non-Executive Director from or terms from 1 December 2008 to 31 December 2016.

*3Paul Lewis was appointed as Non-Executive Director from 1 April 2018.

*4Steve Nowell stood down as a Non-Executive Director (and Senior Independent Director) from 31 December 2018 in advance of the end of his term of office.

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

Note that during 2018/19 there was only one new Non-Executive Director appointment, namely the Chairman. 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 the appointment: -

- Skills and qualities identified as required;
- Composition of the Board mapped against Directors;
- Statutory and Code of Governance requirements;
- Independence;
- Qualifications and experience requirements;
- Refreshment of the Board;
- Time commitment for the role; and
- Term of appointment.

In addition appropriate due diligence was undertaken including consideration of the Fit and Proper Persons Test requirements which came into force during 2014.

The Chairman appointment was 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 29 March 2019).

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 2018/19 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 and it was considered that strategic leadership and partnership working was needed. This was a key consideration in the appointment of a new Chairman. During 2018/19 the Joint Nominations Committee recommended to the Council of Governors one candidate for appointment, namely Liam Coleman who has the relevant experience and joined the Trust on 1 February 2019. 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. Changes to the structure are being developed for 2019/20 to reflect new areas of Trust business.

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 2018/19

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

	5 April 2018	3 May 2018	7 June 2018	28 June 2018 Joint Council of Governors and Board	5 July 2018	2 August 2018	6 September 2018	4 October 2018	1 November 2018	6 December 2018	10 January 2019	7 February 2019	7 March 2019
Executive Directors													
Oonagh Fitzgerald *(to 20-Jul-18)*	✓	✓	×	×	×	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Sally Fox *(from 22-May-18 to 31-Jan-19* (non-voting Director*)*	n/a	n/a	✓	n/a	×	×	×	✓	×	✓	✓	n/a	n/a
Sheridan Flavin *(from 1-Feb-19)* (non-voting Director)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	✓	✓
Karen Johnson	✓	✓	✓	×	✓	✓	✓	✓	×	✓	✓	✓	✓
Julie Marshman (from 1-June-18)	n/a	n/a	✓	✓	×	✓	✓	✓	✓	✓	✓	✓	✓
Kevin McNamara	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	✓	✓	✓
Carole Nicholl (non-voting Director)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	✓	×
Jim O'Connell	✓	✓	✓	×	✓	✓	✓	×	✓	✓	✓	✓	✓
Guy Rooney	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nerissa Vaughan	✓	×	✓	×	✓	✓	×	✓	✓	✓	✓	✓	✓
Hilary Walker *(to 31-May-18)*	✓	✓	✓	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Non-Executive Directors													
Nick Bishop	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Liam Coleman (Chair) *(from 1-Feb-19)*	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	✓	✓
Andy Copestake	✓	✓	✓	✓	✓	×	✓	✓	✓	✓	✓	✓	✓
Peter Hill	✓	✓	✓	✓	×	✓	✓	✓	✓	✓	✓	✓	✓
Roger Hill (Chair) *(to 31-Jan-19)*	✓	✓	✓	✓	✓	✓	✓	×	✓	✓	✓	n/a	n/a
Paul Lewis *(from 1-Apr-18)*	×	✓	✓	×	×	✓	✓	✓	✓	×	✓	✓	✓
Jemima Milton	✓	✓	✓	✓	✓	✓	×	✓	✓	✓	✓	✓	✓
Steve Nowell *(to 31-Dec-18)*	✓	✓	✓	✓	×	✓	×	✓	✓	✓	n/a	n/a	n/a
Julie Soutter	✓	✓	✓	✓	×	✓	✓	×	✓	✓	✓	✓	×

3.8 Decisions reserved for the Board of Directors

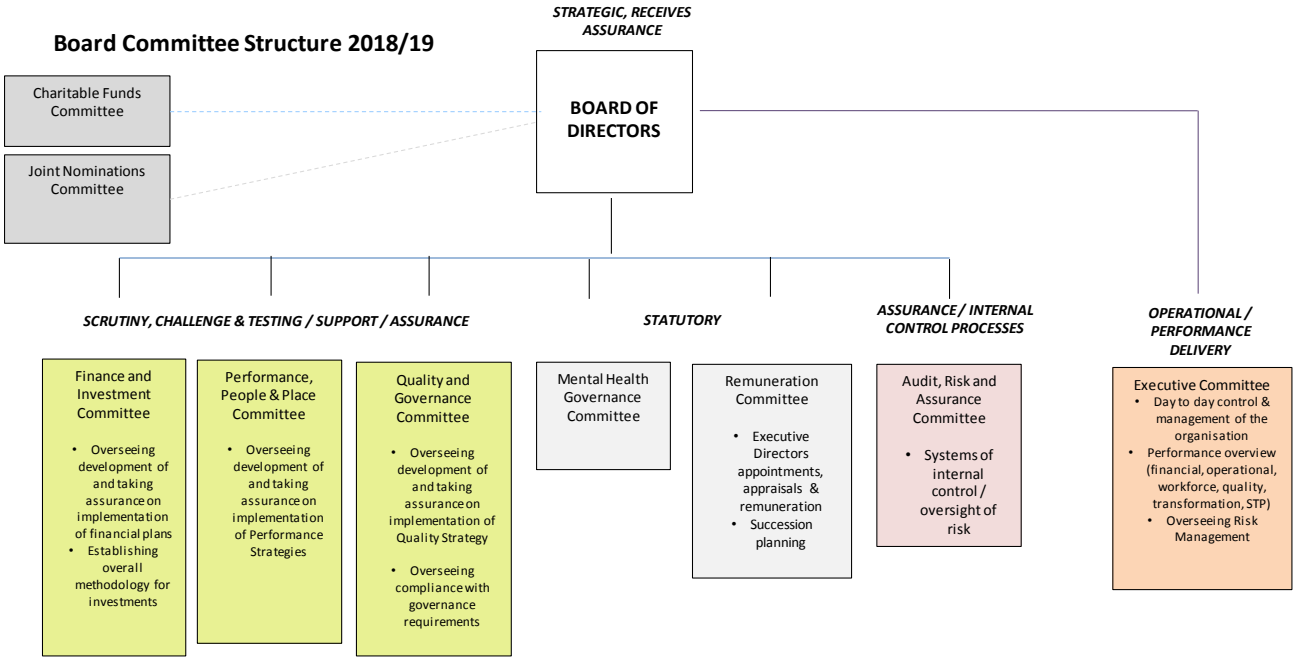
There are certain matters which are reserved for the Board of Directors to decide relating to regulation and control; appointments; strategic and business planning and policy determinations; direct operational decisions; financial and performance reporting arrangements; audit arrangements and investment policy. The Reservation of Powers to the Board was refreshed in March 2019 and will be refreshed again during 2019/20. A full copy can be obtained from the Company Secretary.

3.9 Significant commitments of the Chairman

There were no substantial changes to commitments during the year and the Chairs, Roger Hill to 31 January 2019 and Liam Coleman from 1 February 2019 were able to devote the appropriate time commitment to this role.

3.10 Committee structure

The structure of the Board committees during 2018/19 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 2019.

3.11 Accounting policies for pensions and other retirement benefits

Accounting policies for pensions and other retirement benefits are set out in Notes 1.5 & 9 to the accounts and details of senior employees' remuneration can be found in the remuneration report (Section 4.13 refers).

3.12 Well Led

Trust Boards are responsible for all aspects of leadership in 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) and this is planned for summer 2019.

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.

During 2018/19, the Trust was assessed by the Care Quality Commission under NHS Improvements well led framework and was rated as "Good" overall for being well led.

3.13 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 and also on the Trust's website.

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.

3.14 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.

3.15 Political donations

There were no political donations during 2018/19.

3.16 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 11 to the accounts.

3.17 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.

3.18 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).

3.19 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 11 refers) and in the Annual Governance Statement (section 10 refers).

During 2018/19 the Trust had in place a number of plans and processes which contributed 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. Key Performance Indicators are in place that focus on patient care, positive patient experiences and good clinical outcomes.

- An enhanced Quality Governance Framework has been implemented with a focus on bottom up Self-Assessments, Peer Assessments and Quality Reviews, which provide multiple layers of assurance.

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

- 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. A clinical Non-Executive Director is appointed to the Board who chairs the Quality and Governance Committee and the Mental Health 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. A programme for ensuring patient stories are shared at board is in place.

- 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 I D Medical and e-rostering.

- During 2018/19 the Trust was inspected by the Care Quality Commission (CQC). Core services are leading on addressing concerns raised as part of the inspection. Clear governance processes are in place to govern progress in addressing areas of concern. In addition to this the trust has identified

key pillars and themes that require specific focus on the on-going journey to improve the quality and safety of services provided.

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.

3.20 Development of services to improve patient care

We treat thousands of patients every year as outlined in the Performance Analysis Report (section 2.13 refers). Service improvements are also included (section 2.15 refers).

3.21 Performance against key healthcare targets

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

3.22 Arrangements for monitoring improvements in the quality of healthcare

Continuous monitoring of the Quality Accounts and improvement plan and national targets is reported monthly with underpinning indicators. 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.

3.23 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).

3.24 New or significantly revised services

Details of principal activities are included in the Overview of Performance Report (section 1.6 refers). There were no new or significantly revised services during 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.

3.25 Improvement in patient / carer information

This is referred to in the Quality Report (section 11 refers).

3.26 Focusing on the patient

How the Trust has focused on the patient, with examples, is included in the Quality Report referred to elsewhere in this document (section 11 refers).

3.27 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 11 refers).

3.28 Using patient experience to drive service improvements

This is referred to in the Quality Report (section 11 refers).

Stakeholder Relations

3.29 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 build on the progress already established with partnerships and strengthen close working relationships with a network of organisations across Swindon which will assist in the development of an Integrated Care System. 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 was a multi-million fundraising appeal, the Trust successfully reached its fundraising target of £2.9m at the end of 2018. Building work for the unit is likely to begin towards the end of 2019. Further work with OUH continues to develop a Pathology Network along with Milton Keynes University Hospital NHS Foundation Trust and Buckinghamshire Healthcare NHS Trust. This network approach will look to develop the service, identifying efficiencies from joint working and measures to enhance the service.

3.30 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 above (section 3.29 refers).

3.31 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.

3.32 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.

3.33 Public and patient involvement activities

Details of engagement events with the public and patients are included in the Disclosures set out in the NHS Foundation Trust Code of Governance Report (section 6.18 refers).

Additional disclosures

3.34 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.

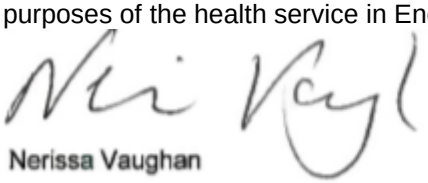
Relevant audit information means information needed by the auditor in connection with preparing their report. In taking all steps the Directors have made such enquiries of their fellow Directors and of the Trust's auditors for that purpose and they have taken such other steps for that purpose as are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

3.35 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.

3.36 Other income

Other income totalling £38m does not have a negative impact on provision of goods and services for the purposes of the health service in England.



Nerissa Vaughan 5 June 2019

Chief Executive

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 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 is 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 2018/19

There were 2 meetings of the Remuneration Committee during 2018/19. Membership and attendance is set out below: -

	Record of attendance at each meeting (✓ = attended × = did not attend n/a = was not a member)	
	25 July 2018	**26 September 2018**
Nicholas Bishop	✓	✓
Liam Coleman	n/a	n/a
Andy Copestake	✓	✓
Peter Hill	✓	✓
Roger Hill	✓	✓
Paul Lewis	✓	✓
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 the Director of Human Resources

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

The Trust does not have a variable pay scheme for Executive Directors. Instead each is paid a basic salary.

In 2018/19 the Remuneration Committee undertook its annual review of remuneration of Executive and Non-Voting Board Directors. 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 with the exception of one Director whose salary was increased to reflect market rates. However, Directors were each awarded £2,075 in line with the national Very Senior Managers (VSM) 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.

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. Executive Director contracts include claw back clauses for any variable payment and fit and proper person disqualification provisions.

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.

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.

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	£43,465
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 was uplift in the allowance payable to the Chairman from £42,500 to £43,465 during 2018/19 to bring the allowance in line with benchmark rates. There was no uplift to any of the other allowances.

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 performance against objectives for 2017/18 and objectives for 2018/19.

The Committee considered the Chief Executive, Executive and Non-Voting Board Directors remuneration and agreed the uplift of one Director's salary so that it was in line with benchmark rates. The Committee agreed that the national recommendations of the Very Senior Managers pay body be applied for 2018/19.

The Committee appointed Julie Marshman the Chief Nurse from 1 June 2018 who took up the post from Hilary Walker who retired in May 2018.

The Committee considered the Executive and Non-Voting Board Director composition of the Board and agreed plans around recruitment to the vacant post of Director of HR post following the resignation of Oonagh Fitzgerald in July 2018. The Committee also agreed the interim appointments to the vacant position.

During the year the Committee considered the implications of the Clinical Excellence Award (CEA) Scheme changes which came into effect on 1 April 2018 and the new guidelines adopted.

The Committee noted that the option to extend the Medical Director's term of office for a short period to June 2019 had been exercised and the Committee agreed the Deputy Chief Executive appointment to coincide with this. The Committee noted that recruitment would be undertaken for a replacement Medical Director.

This report contains a summary of the work of the Remuneration Committee during 2018/19.

Disclosures required by Health and Social Care Act

4.12 Expenses of Directors and Governors

Expenses 2017/18 & 2018/19 (unaudited)

Expense Disclosure	Total number in Office 2017/18	Total number in Office 2018/19	Total Receiving Expenses 2017/18	Total Receiving Expenses 2018/19	Aggregate sum of expenses paid 2017/18 (£00)	Aggregate sum of expenses paid 2018/19 (£00)
Directors	15	20	13	15	87	89
Governors	23	24	5	3	11	4

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 2018-19

Name (alphabetical order)	Title	(a) Real Increase in Pension 2018-19 (Bands of £2500)	(b) Real Increase in Lump Sum 2018-19 (Bands of £2500)	(c) Total accrued pension at 31st March 2019 (Bands of £5000)	(d) Lump sum at pension age related to accrues pension at 31st March 2019 (Bands of £5000)	(e) Cash Equivalent Transfer Value at 1 April 2018	(f) Real increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2019	(h) Employers Contribution to Stakeholder Pension
		£000	£000	£000	£000	£000	£000	£000	£000
Oonagh Fitzgerald	Director of Human Resources	0-2.5	0	25-30	60-65	411	72	483	
Sheridan Flavin	Interim Director of Human Resources	0-2.5	0	10-15	0	107	35	142	
Sally Fox	Interim Director of Human Resources	2.5-5	7.5-10	25-30	75-80	459	124	583	
Karen Johnson	Director of Finance	2.5-5	0	20-25	0	187	59	246	
Julie Marshman	Chief Nurse	7.5-10	22.5-25	35-40	105-110	547	233	780	
Kevin McNamara	Director of Strategy & Community Services	0-2.5	0	15-20	30-35	194	56	250	
Carole Nicholl	Director of Governance & Assurance (non-voting)	7.5-10	0	60-65	0	704	233	937	
Jim O'Connell	Chief Operating Officer	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
Guy Rooney	Medical Director & Deputy Chief Executive	0	0	60-65	180-185	1,276	100	1,376	
Nerissa Vaughan	Chief Executive	2.5-5	0-2.5	60-65	145-150	1016	179	1,195	
Hilary Walker	Chief Nurse	0	0	45-50	135-140	932	0	0	

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 2018-19 is referred to elsewhere in the Directors Report (section 3.1 refers).
Note - CETV values are not applicable over age 60.

Remuneration 2018-19

	2018-19

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
Nicholas Bishop	NED	10-15	-	-	-	-	-	10-15
Liam Coleman	Chairman	5-10						5-10
Andy Copestake**	NED	10-15	-	-	-	-	-	10-15
Peter Hill	NED	10-15	-	-	-	-	-	10-15
Roger Hill**	Chairman	35-40	-	-	-	-	-	35-40
Paul Lewis		10-15	-	-	-	-	-	10-15
Jemima Milton	NED	10-15	-	-	-	-	-	10-15
Steve Nowell**	NED	10-15	-	-	-	-	-	10-15
Julie Soutter	NED	15-20	-	-	-	-	-	15-20
Oonagh Fitzgerald**	Director of Human Resources	85-90	-	-	-	-	0	85-90
Sheridan Flavin**	Interim Director of Human Resources	115-120	-	-	-	-	20-22.5	135-140
Sally Fox**	Interim Director of Human Resources	80-85	-	-	-	-	67.5-70	150-155
Karen Johnson	Director of Finance	130-135	-	-	-	-	32.5-35	165-170
Julie Marshman**	Chief Nurse	105-110	-	-	-	-	167.5-170	270-275
Kevin McNamara	Director of Strategy & Community Services	115-120	-	-	-	-	25-27.5	145 - 150
Carole Nicholl	Director of Governance & Assurance (non-voting)	100-105	-	-	-	-	177.5-180	280-285
Jim O'Connell	Chief Operating Officer	140-145	-	-	-	-	0	140-145
Guy Rooney**	Medical Director & Deputy Chief Executive	125-130	-	-	-	-	0	125-130
Nerissa Vaughan	Chief Executive	175-180	-	-	-	-	55-57.5	230-235
Hilary Walker**	Chief Nurse	15-20	-	-	-	-	0	15-20

Note* – In respect of Guy Rooney, other remuneration relates to his clinical role.
Note** –Remuneration and expenses are part year

Remuneration 2017-18

	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
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
Jemima Milton	NED	10-15	-	-	-	-	-	10-15
Steve Nowell	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
Julie Marshman	Chief Nurse							
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 – The remuneration figures do not include any final bonus/performance related pay increases as none were approved for payment in 2018/19.
Note – Jim O'Connell's remuneration and expenses are part year (from 12 October 2018) when he joined the Trust.

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 Note 9 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 2019.

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	
	2018/19	**2017/18**
Nerissa Vaughan, Chief Executive	**£177,500**	**£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	2018/19 (middle of band)	2017/18 (middle of band)	% change
Highest paid Directors' total remuneration	**£177,500**	**£172,500**	2.90%
Median total remuneration	**£28,050**	**£27,635**	1.50%
Ratio	**6.33**	**6.24**	1.38%

The increase in the median salary can be largely explained by the implementation of the three year pay deal and changes to the pay structure in 18/19. The pay award would have benefited all trust staff on the agenda for change pay scales. During the year, the trust also passed over ownership of Wiltshire Health and Care. The average salary of Wiltshire Health and Care employees was calculated to be less than that of their Great Western counterparts, which has also contributed to the increase in median pay.

4.15 Payments for Loss of Office

There were no payments made for loss of office during 2018-19

4.16 Payments to past senior managers

There were no payments made to past senior managers during 2018-19.

Signed

Nerissa Vaughan
Chief Executive

5 June 2019

5. Staff Report

5.1 Staff Numbers

We are committed to our organisation being both a place that people want to work and one that they 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, 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 monthly and annual award schemes and by putting staff forward for national awards.

The average WTE of employees for 2018/19 was 4,380. The breakdown by professional group is listed below: -

Employee Group (WTE)	2018/19 (average M1-11)	2017/18	2016/17
Medical and Dental	554	543	536
Ambulance staff	20	22	0
Administration and estates	978	1,097	1,068
Healthcare assistants and other support staff	822	1,014	860
Nursing, midwifery and health visiting staff	1,223	1,468	1,433
Scientific, therapeutic and technical staff	420	604	599
Substantive Total	4,016	4,749	4,496
Agency and contract staff	120	157	179
Bank staff	244	244	217
Other	0	0	0
Total average Numbers	4,380	5,150	4,892

5.2 Staff Costs

Staff costs are included in Note 8 to the accounts.

5.3 Trust employees

A breakdown at 28 February 2019 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	1,297	178	**1,475**
Substantive Staff Only	2,667	620	**3,287**
Bank Staff only	1,226	192	**1,418**
TOTAL	**5,197**	**998**	**6,195**

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	2018/19 (Apr18-Feb19)	2017/18	2016/17	2015/16
Total days lost	49,162	66,431	57,568	54,355
Average working days lost per whole time equivalent	8.33 days	8.96 days	8.59 days	7.82 days

Benchmarking

		Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
Acute - Medium	Great Western Hosp F	4.13%	4.74%	4.18%	3.82%	3.62%	3.15%	3.18%	3.65%	3.75%	3.72%	3.82%	3.68%
	Royal Bournemouth & Christ F	4.43%	4.48%	3.76%	3.72%	3.85%	3.47%	3.86%	4.19%	4.34%	4.53%	4.80%	4.57%
	Royal United Bath	4.59%	4.62%	4.73%	4.19%	3.48%	3.34%	3.61%	3.93%	4.02%	3.81%	4.39%	3.95%
	Taunton & Somerset F	3.96%	4.57%	4.13%	3.89%	3.79%	3.65%	3.65%	3.80%	3.94%	3.86%	4.05%	3.98%
	Total	**4.28%**	**4.61%**	**4.21%**	**3.91%**	**3.68%**	**3.40%**	**3.58%**	**3.90%**	**4.01%**	**3.98%**	**4.27%**	**4.04%**
Community Provider Trust	Bristol Community	4.41%	4.83%	4.38%	3.67%	3.35%	3.23%	3.41%	3.73%	3.82%	3.98%	4.33%	4.47%
	Gloucestershire Care Services NHS Trust	4.68%	5.77%	5.06%	4.88%	4.42%	4.56%	4.64%	4.81%	4.49%	4.77%	4.98%	5.32%
	Livewell Southwest	5.58%	5.73%	5.30%	4.75%	4.19%	4.20%	4.56%	4.61%	4.82%	5.31%	4.92%	5.80%
	North Somerset Community	5.28%	5.87%	4.49%	4.04%	4.31%	3.79%	4.33%	3.80%	4.25%	4.67%	5.81%	6.63%
	Smile Dental CIC	4.76%	5.76%	8.80%	9.54%	8.70%	8.33%	9.27%	9.83%	7.80%	6.16%	5.59%	8.25%
	Total	**5.01%**	**5.57%**	**5.00%**	**4.57%**	**4.16%**	**4.13%**	**4.38%**	**4.48%**	**4.49%**	**4.82%**	**4.91%**	**5.48%**

As you can see from the benchmarking data, the Trust is below the average sickness percentage for the local Trusts. (Data only available until November 2018) 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 measures 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, 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 employee's 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 2018/19 the Trust recruited 45 Non-EU international nurses of which 32 are working as registered nurses. Out of the 32, 2 are UK Based Nurses. 10 are working as band 4 pre-registered nurses whilst undertaking their Objective Structured Clinical Examination [1](OSCE) training. 2 of the 10 are UK Based Nurses.

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, being introduced to cohorts who have already arrived and started in the UK and tours of the Hospital and Swindon.

International Candidate Feedback

“Thank you so much for all the support and love. I will never forget your warm welcome when we came here all fresh. Will always remember you in my prayers”

“Also, deeply appreciate you showing us the cheap and best places to buy groceries and clothing. It means a lot specially for us nurses coming from abroad to have a friendly and joyful face around. .It really does make the on boarding process in a new place so much easy and better when we feel valued and cared for.”

“Thank you once again for welcoming us with so much of warmth.”
“Love and appreciate everything you have done and are doing for us (including the welcome food goody bag) it was a real blessing after coming from a 17 hours flight.”

Agency spend

The Trust achieved a £2.7m reduction in agency spend in 2018/19 against a planned forecast of £3.2m (£500K overspent against plan). This was achieved by

- Improved vacancy position including international recruitment
- Improved control’s for agency approval
- Improved monitoring of agency spend
- Reduced turnover
- Improved control via E- Rostering
- Reduction in Admin and Clerical usage
- Moving Medical Agency to bank and substantive role

Agency reduction plan for 2019/20 is £1.5m.

Agenda for Change National Pay Rise

On the 27th June 2018 the NHS Staff Council agreed an Agenda for Change contract refresh, for a three year pay deal, a reform of the pay structure and changes to terms and conditions. The main changes were as follows:

- increase starting salaries
- reduce the number of pay points
- increments not automatic and requirement for appraisals to move through increments
- shorten the amount of time it takes to reach the top of the pay band for most staff
- closure of band 1 to new entrants from 1st December 2018 and move of band 1 staff to band 2
- changes to enhancements for bands 1 – 3
- changes to occupational pay for sickness absence

[1] Objective Structured Clinical Examination (OSCE) is an assessment method based on a student's performance that measure their clinical competence

Work has been on-going in closing the band 1 roles to new entrants and reviewing job roles so that staff have the choice to move to a band 2 role. The appraisal process and Policy have also been reviewed.

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 31st March 2019 (Public Sector Organisations) using a data snap shot from the 30th March 2018. 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 5,691 with a split of 893 (15.69%) male and 4,798 (84.31%) female.

The results show that if all staff are included, there is a pay gap with female staff being paid less (median 9.53%, mean 26.19%) on average than male staff. If medical staff are taken out of the figures, the gap reduces significantly with the mean pay gap 2.49% and the median -2.8% (this means that female staff are paid 2.8% more than male staff = -2.8%). 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 (75%), which includes incentives, recruitment premium, Clinical Excellence Awards, Discretionary Points and Distinction Awards for doctors. If doctors are not included in the calculation, this figure reduces to 27.27% meaning that males have received higher bonus pay than females.

Apprentices
The standard of our apprentices was recently acknowledged by Health Education England (HEE) when one of our higher apprentices was awarded the South West region apprentice of the year 2017-18. Apprenticeships have continued to grow in both numbers and breadth with 143 staff over 16 different apprenticeship standards ranging from level 2 to level 6 (degree) for new and existing staff, this includes the addition of leadership and management apprenticeships. The Trust exceeded the enterprise target, which requires public bodies to employ an average of 2.3% of their headcount as new apprenticeship starts and we had a figure of 2.5% placing us tenth out of 250 Healthcare providers in England.

5.6 Staff Policies and related actions

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.

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

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 5.7 refers).

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. 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.

5.7 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 were closely involved in the consultation of the TUPE transfer of Wiltshire Health and Care which took 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.

During the summer and autumn of 2018 the Trust carried out a number of staff engagement sessions, as well as sessions with Governors, HealthWatch and Commissioners regarding the future strategy of the Trust. Feedback from these sessions informed strategy development that will be implemented from April 2019.

5.8 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/posts 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 look and feel of the intranet was refreshed during 2018/19 following feedback from staff and the usability is now further enhanced.

- The Staff Room is a magazine 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 think 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 Hidden Heroes which is a way to thank someone who has gone the extra mile and then having this message shared with everyone in the Trust; many nominations are received from members of the public via social media.

- 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, this section has been updated during 2018/19 to align with a refreshed recruitment campaign.

5.9 Freedom to Speak Up

The Trust has seven appointed Guardians who are points of contact should anyone wish to raise a matter within the organisation. The Guardians operate independently, impartially and objectively, whilst working in partnership with individuals and groups throughout the organisation, including their senior leadership team to

- Seek guidance and support from and, where appropriate, escalate matters to, bodies outside their organisation
- Support, and contribute to, the national Freedom to Speak Up Guardian network, comply with National Guardian Office guidance, and support each other by providing peer-to-peer support and sharing learning
- Should be supported with the resources they need, including ring-fenced time, to ensure that they meet the needs of workers in their organisation. Their views on the impact of activities and decisions on Freedom to Speak Up should be actively sought.

Guardians 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, except for cases raised anonymously.

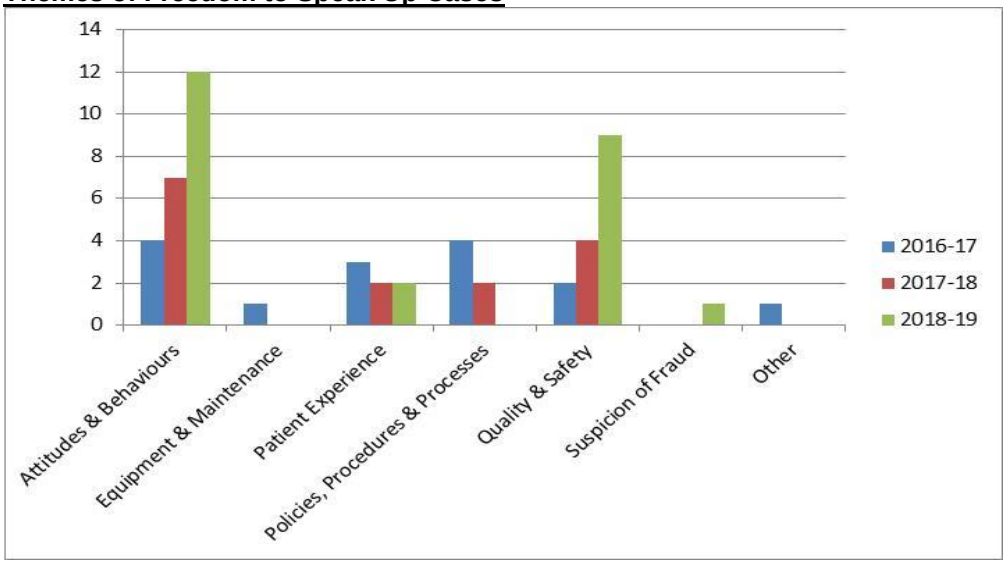
During 2018/19 the Trust appointed a new Executive Lead for Freedom to Speak Up. The Lead reviewed the governance in place and self-assessed the Trust for best practice using a national template. A number of actions were identified all of which were progressed. The Guardians meet quarterly to discuss best practice, case reviews and the learning/actions are considered and shared.

Feedback is sought from staff members who have raised concerns to ensure processes remain effective.

Information on Freedom to Speak Up cases is reported monthly to the Patient Quality and Performance Committee and also to the Board via the Quality Report. In addition information is reported to the Executive Directors by way of a quarterly report to their weekly management meeting. Furthermore, quarterly returns are made to the National Guardians Office.

In 2018/19 there were 24 Freedoms to Speak Up concerns raised compare to 15 in 2017/18. This is positive in that the Trust wishes to ensure individuals feel able to speak up about quality and other concerns within the Trust. The graph details a breakdown of the nature of the concerns raised through Freedom to Speak Up.

Themes of Freedom to Speak Up Cases

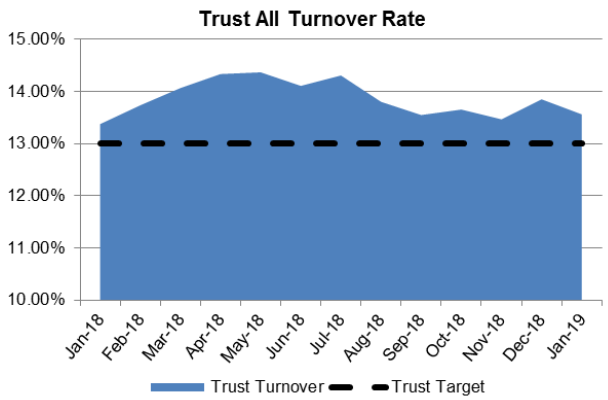


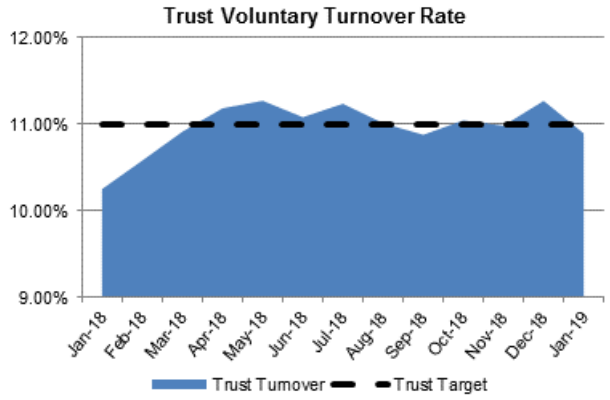
5.10 Workforce Key Performance Indicators (KPI's)

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

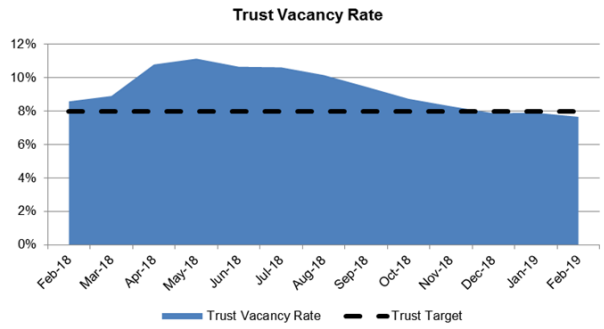
Sickness absence – Average Sickness absence levels were 3.78% for the 12 month period February 2018-January 2019. This is consistent with the national picture for similar NHS Trusts. This is a small increase on the same period for the previous year which was 3.77%. The HR Advisor Team continue to work in conjunction with managers in each of the Divisions to review absence data including both long term and short term absences. The HR Advisors provide support and guidance on supporting staff and addressing any potential issues to help to reduce absence across the Trust. In addition, the Advisors regularly undertake absence audits to ensure there is a consistent approach to absence management across the Trust.

Turnover – All Turnover as at January 2019 was 13.56% (January 2018 was 13.38%) against a Trust target of 13%. Voluntary turnover was 10.89% as at January 2019 (January 2018 was 10.25%) against a Trust target of 11%. The Trust continues to target departments to understand the reasons for turnover and ensure robust recruitment and retention plans are in place. At present the highest reason for staff turnover is work life balance and AHP's have the highest voluntary turnover.





Vacancy levels – As at February 2019 there were 339.49 WTE vacancies, this equates to a vacancy rate of 7.66%. For the same period last year there were 372.30 WTE vacancies (8.58%) against a Trust target of 8%. The Recruitment strategy for 2018 / 2020 is specifically focusing on attracting people to work for Great Western Hospitals (GWH) and to live in the local area. The Retention strategy is particularly focusing on retaining the older workforce and providing options available e.g. flexible retirement, change of career etc. Other focuses include health and wellbeing, improving leadership and engagement, job rotation and supporting our new starters.



Appraisal rates - The overall completion rate for the Trust is 74.22% in February 2019 (compared to 78.40% in February 2018) against a Trust target of 80%. During 2019 / 2020 the Trust will be focusing on the quality and impact of performance appraisals to ensure the employee feels supported with their career and development.

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 opportunities. 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 88.07%, against a Trust target of 85%. This is a slight increase on March 2018 when compliance was reported to be 86.7%.

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:

Work to develop the Masters level 40 credits course accredited via Northampton University has continued and the first course, Acute Adult Assessment and Examination Module (AAAE) will commence 2019. The course is aimed at staff wishing to progress to the award in Advanced Clinical practice and will be open to staff across our STP.

Apprenticeships at GWH have continued to flourish, despite the challenges associated with the introduction of the apprenticeship levy, which include lengthy procurement processes and the lack of available apprenticeship standards that can be used to develop new and existing staff.

Apprenticeships have continued to grow in both numbers and breadth with 143 staff over16 different apprenticeship standards ranging from level 2 to level 6 (degree level) for new and existing staff, this includes the addition of leadership and management apprenticeships. The Trust exceeded the enterprise target, which requires public bodies to employ an average of 2.3% of their headcount as new apprenticeship starts and GWH has achieved 2.5% placing us tenth out of 250 Healthcare providers in England.

The pre-registration team continue to support the placements of non-medical students. As well as our traditional University students, we have also continued to embrace a number of additional programmes to encourage support staff to progress to undertaking professional qualifications in Nursing. We continue to support 8 students who joined the Widening Access Health Education England sponsored programme for adult nursing in January 2018 and are due to complete in January 2020.

We also continue to offer the Open University nursing programme and a further 4 HCAs joined the part time Open University adult nursing programme in September 2018 and January 2019, meaning there are currently 9 GWH staff on the programme. The first cohort of 4 successfully graduated in October 2018 with all 4 of the original students completing the programme

The team have also continued to support those returning to the Nursing profession. In total, 6 students have commenced the Return to Practice programme in the last year (2018) and are still on the programme including 4 adult nurses and 2 paediatric nurses. There is another cohort planned for May with further interest from paediatric nurses and additional cohorts planned for September 2019 and January 2020.

We continue to offer Return to Practice to Allied Health Professionals and have the first biomedical scientist currently on placement. The Trust has continued to successfully access money for bursaries and support for AHPs returning to practice as part of a Health Education England pilot however this pilot.

GWH placements were nominated at Oxford Brookes placement of the year awards in June 2018. The Walk in Centre won Placement of the year 2018 for Adult nursing, along with the Health Education England, South West Winner and overall placement of the year 2018 across all of Oxford Brookes placement areas.

GWH also had highly commended for the following areas:

ACU, SAU, Meldon, Mercury, Theatres, Jupiter, Theatres and Trauma, as well as receiving 30 of the overall total of 120 nominations.

High quality resuscitation training, from basic to advanced level, continues to be delivered on a regular basis for all patient age groups with engagement from the multidisciplinary team and our non-clinical staff. The focus remains on identifying the deteriorating patient early and prompting early escalation to expert help to protect the most vulnerable patients, both in and out of the acute hospital.

The careers hub work continues with an Early Careers Advisor now in place substantively to facilitate early careers in the Trust by engaging with schools & colleges to scope out the provision of work experience and activities, with the aim of increasing our profile as an employer for the future workforce and identifying the careers opportunities that are available beyond nursing and medicine. Requests for work experience continue to increase and we are preparing for the implementation of T levels in 2021.

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 Objective Structured Clinical Examination (OSCE)[2] support and tutoring for our oversees nurses – with a success rate above the average of 95% 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 Doctors needed help to support un-well surgical patients.

The Trust continues to utilise HEE E HORUS e-portfolio for managing and recording Foundation Doctor Training record. The Trust has recently introduced a web based induction programme for Junior Doctors which has allowed the departments more dedicated time for local induction and has improved the on boarding experience for Junior Doctors.

Post Graduate Medical Education (PGME) continues to support Foundation Doctors and all other grades of Junior Doctors through offering educational opportunities and pastoral support. There is a pastoral team of three consultants who can provide support and advice should a Junior Doctor be facing difficulties. The administration team will soon going onto the Mental Health First Aid course so that they are equipped with all the tools to identify and signpost Junior Doctors.

The wider PGME team has a group of Clinical Innovation Fellows (CIFs) (part clinical and academic) who can be approached for advice on how to handle clinical commitments and prioritise these appropriately. Many Junior Doctors have approached the CIFs for advice in the past year. They are actively working on Quality Improvement projects and the Well and Resilient Doctors (WARD) project.

The PGME team also, part fund the Chief Registrars who are present within the hospital to have oversight of the problems that need to be resolved in clinical areas where Junior Doctors work. This has been effective in introducing the Hospital at Night initiative and improving the experience of Junior Doctors in Medical Outliers.

Finally, there are two F2/F3s (formal training pathway completing F2 over two years) they are part clinical and academic. They have been working on Quality Improvement projects as well as an internship scheme for overseas-qualified doctors to come and experience what it is like to work within the NHS.

Overall, in the past year there have been new initiatives being introduced in PGME and quality improvement projects completed to improve Junior Doctors experience within GWH.

The Academy Library was successful in achieving 95% in the 2018 Library Quality Assurance Framework (LQAF) audit which was a huge achievement in the absence of a Library manager for part of the year.

[2] Objective Structured Clinical Examination (OSCE) is an assessment method based on a student's performance that measure their clinical competence

The Library was involved in Health Information Week, with combined work with the academy and the Swindon Borough Council Outreach Librarian. This involved displays of wellbeing leaflets available to staff, patients, and the public.

The library staff continues to promote library resources – with staff setting up visits to wards and departments which have been very well received and supporting the many staff undertaking training with literature searches and general support. The team also produces Current Awareness Bulletins which are updated monthly.

As a result of a successful NHSI visit by the University of Bristol on the 22nd November 2018 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 Self Selected Components (SSC) programmes and in turn has been able continue to support the Trust via the recruitment of Clinical Teaching Fellows (CTFs) for August 2019 with 18 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 group.

5.12 Post graduate recruitment

Post graduate recruitment in 2018/19 was significantly improved from previous years, which resulted in only 11WTE Junior Doctors vacancies in August 2018 a reduction of 33.5WTE compared to August 2017. A number of the vacancies have been filled with non-training grade doctors (Clinical Fellows) through progression of Clinical Fellow F1s recruited from Prague in previous years who have been appointed to Trust F2 roles. In addition during 2018/19 the Trust received the benefit of a TERS (Targeted Enhanced Recruitment Scheme) funded by HEE, resulting in GP trainees receiving £20,000 supplement for training in the Swindon area. This improved the recruitment to GP trainee roles, further reducing the Trusts vacancy rates during placements at the Trust.

5.13 Supporting our volunteers

Context of being a Volunteer:

The Trust is extremely fortunate to have 396 committed and enthusiastic volunteers who support delivery of services across our acute and community services. The volunteers provide an extremely valuable service to patients as well as providing 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 228 new recruits since April 2018 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	**396**
Male Volunteers	119
Female Volunteers	277

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 2018/19 financial year 16 Volunteers became paid members of staff with the Trust. 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.

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 Route 66 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.

5.14 Health & Wellbeing

Healthy Lifestyles Update

In 2019 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.

The Trust is committed to supporting staff with health and wellbeing. 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.

The health and wellbeing advisor offers a package of health assessments for staff with a range of health tests and offers support and advice for increasing activity levels, weight management and healthy eating advice and referral to specialist stress management and smoking cessation services. 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

Staff can access NHS discounted membership at 20 local gyms and leisure centres in Swindon and surrounding areas, currently over 400 members of staff are taking advantage of this. Details of these facilities are advertised on the Health and Wellbeing intranet pages

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 the health and wellbeing advisor.

Health and Wellbeing promotional stands, road shows and awareness events are held at various times throughout the year with representation from local gyms, fire safe and well advisor, Health and Wellbeing, Health and Safety, Manual Handling, Staff Support, Mental Health awareness and Dieticians.

We are committed to supporting staff to quit smoking with particular focus and the Trust went smoke free on 1st January 2019. To support staff there have been 4 smoking cessation education events with attendance from the health and wellbeing advisor and local stop smoking service providers. Public Health England advisors have visited staff areas with a stop smoking advice trolley weekly in December 2018. Staff can access support for smoking cessation from the Health and Wellbeing Advisor and Occupational Health Nurses with onward referral to local pharmacy based services

Last winter the Trust took pro-active approach to support staff to look after themselves during an extremely busy period. A number of initiatives were designed to support staff understand the importance of self-care, taking breaks and looking after their own health and wellbeing, utilising the support available on site if required.

In January 2019 the Trust launched a tea/drinks round, where staff volunteer to accompany the trolley around the wards, every day, to give staff drinks on a daily basis during January – March. Senior Managers support the campaign and supported volunteer to the tea rounds and used the opportunity to speak to staff. The tea round will continue all year round (once a week) and will be themed depending on the year, for example mini Easter eggs will be offered to staff in April.

Pop up campaigns are run to highlight important topics such as taking a lunch break, in December 2018 we ran a soup ‘give away’ for staff at the Orbital and GWH with 400 pots of soup to give away to staff which was secured from Works Perks. Staff welcomed the chance to receive a free lunch.

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

The Staff Support Service 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.

The Service has run 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. To date 45 staff have received the training. The Trust is committed to extending this support mechanism and 2 counsellors are attending training to be "Mental Health Instructors" which will support the delivery of training to more staff across the organisation as "Mental Health First Aiders"

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 during Mental Health Awareness Week. During these campaigns the Service has distributed over a thousand leaflets, thereby heightening staff awareness of the availability of the service.

5.15 Swine / seasonal flu vaccinations

For the 2018/19 flu vaccination campaign the Trust achieved 90% KPI (including opt outs) and 86% excluding opt outs, which exceeds the 75% target. The Trust has therefore achieved the CQUIN target for 2018/19. This is the highest uptake the 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.

5.16 Health and Safety, fire and security

The Trust received no prosecutions or Improvement Notices from the HSE, CQC or Wiltshire Fire & Rescue Service during 2018/19.

This continues an on-going excellent achievement which we have now maintained for many years by virtue of our 'good Safety Culture' and the high standards throughout the Trust for health & safety compliance.

The Trust Incident Reporting culture also remains strong with a measured increase in reporting particularly by the Swindon Community Services. The Trust reported 11,420 Incidents [IRI's] during the year.

Swindon Community Services integration into the health & safety culture of the Trust has progressed well and very good Health & Safety audit scores have been achieved by many Community Departments confirming the integration to a high standard.

There have been on-going fire safety concerns regarding the SwICC building which were identified during inspections by our Trust Fire Safety Advisor and confirmed by Dorset & Wilts Fire & Rescue Service in response to the Grenfell fire. This was initially an NHS Improvement driven programme but an on-going improvement programme is now being progressed directly with NHS Property Services as the landlords of this building.

The Health & Safety, Fire and Security Management Team transferred to Trust Estates from August 2018 due to senior HR team changes and also ex-Carillion staff transferred over to Serco from 1st May 2018.

Despite these changes there were several issues identified and improvements made across the Trust's H&S, and Fire and Security management systems, which are highlighted below.

- During the year there were only 12 RIDDOR reportable accidents reported to the HSE compared to 14 last year and root cause analysis investigations have been completed or are in progress for all.

  This equates to a 14% decrease in relation to the previous year.

  The main categories consisted of 5 slip/trip/fall incidents, 2 manual handling injuries, 2 dangerous occurrence (1 needle stick and 1 sharps) 2 struck by object incidents, and 1 accidental release/escape of substances liable to cause harm.

  The main area of reduction has been with regards to persons in 'collision with stationary / moving objects which reduced from 5 to 2 this year. Since the Trust has definitely not become less busy or congested this would indicate improved care & attention whilst going about routine working roles.

- Our Trust's RIDDOR rate has again benchmarked considerably lower than all other comparable Trusts in the South West Region.

- The annual Health & Safety audit programme was completed across all Swindon Community Departments and the 'lower scoring' Acute Trust Departments from last year. Very good results were achieved with some Departments being presented Certificates by the Director responsible for Health & Safety for achieving 100%.

- The Health & Safety Department was also audited for its safety management systems in September 2018 by an external H&S Auditing Company called 'Empathy Environmental Consultants'. The findings were that there was a good assurance of a strong health & safety management system with a 'capable, competent and driven team producing excellent data and annual reports and a robust auditing procedure. However, the recent changes have meant that there is a need to review and develop new governance and reporting arrangements for the H&S team. A number of the health and safety policies also need updating to reflect changes in structure and arrangements'.
  An action plan is underway to rectify all issues identified.

- Trust Health & Safety Department have progressed the management of the Keri Site Security from Carillion and a large capital Keri Improvement project has been underway since December 2018 to improve the reliability and resilience of the system.

- The Trust Local Security Management Specialist [LSMS] has continued to improve the service and the Trust remains committed to reducing acts of violence and aggression against our staff.
  In conjunction with our local Police and SBC Legal injunction team we continue to hold perpetrators of violent acts against our staff to account and have again achieved further increases in custodial sentences, injunctions and other sanctions against perpetrators.

- Entonox [Nitrous Oxide] COSHH safety issues have been identified in 2018 during routine staff monitoring regarding exposure to this substance at levels higher than the Workplace Exposure Limit [WEL]. Subsequent ventilation modifications and improvements have been made by Serco / THC with extensive monitoring performed by H&S. Ventilation Group has been set up and an improvement project is on-going to improve ventilation governance.

5.17 Expenditure on consultancy

Expenditure on consultancy in 2018/19 was £0.8m (2017/18 £0.6m). Consultancy advice provided to the Trust covered a number of different areas including: -

- Staff Support
- Contracts Compliance
- Ophthalmology
- Governance
- Estates Management

5.18 Off Payroll Engagements

As part of the Staff Report we are required to provide details of Off Payroll engagements. An off payroll engagement is where the Trust employs a worker via an agency or third part rather than via the payroll and where they are in post for 6 month or more and ear more than £245 per day.

Paragraph 5.19 provides more information with regard to IR35 compliance.

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

	Number
No. of existing engagements as of 31 March 2019	2
Of which:	
No. that have existed for less than one year at time of reporting	2
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 2018 and 31 March 2019, 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 2018 and 31 March 2019	2
Of which:	
Number assessed as within the scope of IR35	2
Number assessed as not within the scope of IR35	0
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	2
Number of engagements that saw a change to IR35 status following the consistency review	0

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

	Number
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	20

5.19 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	1	10			1	10		
£10,00 – £25,000	1	20			1	20		
£25,001 – £50,000								
£50,001 – £100,000								
£100,000 – £150,000								
£150,001 – £200,000								
Total	2	30	0	0	2	30	0	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.

	2018/19	2018/19
	Payments agreed	Total value of agreements
	Number	£000
Voluntary redundancies including early retirement contractual costs		
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	0	0
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval *	0	0
Total	0	0
Of which: non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	0	0

5.20 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.

5.21 Staff Survey Report 2018/19

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

The response rate to the 2018 survey among trust staff was 44% (2017: 46%). Scores for each indicator together with that of the survey benchmarking group Combined Acute and Community Trusts are presented below.

	2018/2019		**2017/2018**		**2016/2017**	
	GWH	Benchmarking Group	**GWH**	Benchmarking Group	**GWH**	Benchmarking Group
Equality, diversity and inclusion	**9.1**	9.2	**9.2**	9.2	**9.3**	9.3
Health and wellbeing	**5.8**	5.9	**6.0**	6.0	**6.2**	6.1
Immediate managers	**6.8**	6.8	**6.8**	6.8	**6.8**	6.8
Morale	**6.1**	6.2	**-**	-	**-**	-
Quality of appraisals	**5.2**	5.4	**5.3**	5.3	**5.5**	5.4
Quality of care	**7.2**	7.4	**7.1**	7.5	**7.4**	7.5
Safe environment – bullying and harassment	**8.1**	8.1	**7.9**	8.1	**8.0**	8.2
Safe environment – violence	**9.5**	9.5	**9.4**	9.5	**9.5**	9.5
Safety culture	**6.7**	6.7	**6.7**	6.7	**6.8**	6.7
Staff engagement	**6.9**	7.0	**6.9**	7.0	**7.1**	7.0

5.22 Response rate comparison

The Trust was one of the 304 participating NHS organisations, and one of the 43 Combined Acute and Community Trusts that participated in the National Staff Survey in October 2018. There were 1,250 (25% of the workforce) randomly selected and given the opportunity to participate in the 2018 Staff Survey by an online staff survey through their NHS email. A total of 534 employees returned a completed questionnaire giving the Trust a response rate of **44%**. This was a decrease in last years (46%, 2017) but above the average response rate for Combined Acute and Community Trusts in England (40%, 2018).

Areas of improvement from 2017

The top five areas where the results have improved from the 2017 survey are;

- *Q4f. Have adequate materials, supplies and equipment to do my work 46% (42%, 2017)*
- *Q4h. Team members have a set of shared objectives 75% (70%, 2017)*
- *Q5g. Satisfied with level of pay 31% (26%, 2017)*
- *Q5h. Satisfied with opportunities for flexible working patterns 56% (51%, 2017)*
- *Q13a. Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public 74% (68%, 2017)*

Areas of deterioration from 2017

The top five areas where the results have declined from the 2017 survey are;

- *Q8b. Immediate manager can be counted on to help with difficult tasks 67% (72%, 2017)*
- *Q11a. Organisation definitely takes positive action on health and wellbeing 22% (27%, 2017)*
- *Q11c. Not felt unwell due to work related stress in last 12 months 57% (61%, 2017)*
- *Q13d. Last experience of harassment/ bullying/ abuse reported 43% (49%, 2017)*
- *Q22b. Receive regular updates on patient/s service user feedback in my directorate/department 51% (60%, 2017)*

5.23 Staff Engagement

The staff engagement score for the Trust has remained the same at 6.9 and is scoring marginally below the national average of 7.0. 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 overall the Trusts staff engagement score has remained the same this year, levels across the Trust's Divisions are variable and range from 6.6 to 7.2 out of a possible 10. Corporate Services and Diagnostic and Outpatients report the lowest levels of engagement at 6.6 with Planned Care and Swindon Community Health Services reporting the highest at 7.2.

5.24 Trade Union Facility Time 2017/18

In 2017 the government passed The Trade Union (Facility Time Publication Requirements) Regulations 2017 requiring public bodies to report each year on the agreed time off Trade Union Representatives who are employees have taken to carry out their trade union role.

Table 1
Relevant Union Officials

What was the total number of your employees who were relevant union officials during the relevant period?

Number of employees who were relevant union officials during the relevant period	*Full-time equivalent employee number*
16	15.4

Table 2
Percentage of time spent on facility time

How many of your employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?

Percentage of time	Number of Employees
0%	**1**
1-50%	**15**
51-99%	**0**
100%	**0**

Table 3
Percentage of pay bill spent on facility time

Provide the figures requested in the first column of the table below to determine the percentage of your total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.

First Column	*Figures*
Provide the total cost of facility time	*16317*
Provide the total pay bill	*194155117*
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	*0.01%*

Table 4
Paid trade union activities

As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	10.03%

As at 31 March 2019 there are 27 Trade Union Representatives who are employed by the Trust and the current data shows that employees have 244.5 hours on paid Trade Union Activities and 405.5 hours on paid Trade Union Facility Time. This is expected to rise with the Q4 information and at that point cost and % of employee time will also be calculated for 2018/19. The data is published by 31 July each year.

Regional Results – Appendix 1

Acute Trusts (* Denotes Combined Acute & Community)	Latest CQC Rating	Response Rate	Equality, diversity & inclusion	Health & Wellbeing	Immediate Managers	Morale	Quality of appraisals	Quality of care	Safe enviornment - bullying & harrassment	Safe environment - violence	Safety Culture	Staff engagement	Total Score
The Royal Bournemouth and Christchurch Hospitals NHS FT	Good	53%	9.2	6.4	7.3	6.6	6.1	7.7	8.4	9.5	7.2	7.5	75.9
University Hospital Southampton NHS Foundation Trust	Good	43%	9.2	6.3	7.0	6.4	5.8	7.5	8.2	9.5	7.0	7.4	74.3
Yeovil District Hospital NHS Foundation Trust	Requires Improvement	71%	9.2	6.7	7.2	6.4	5.7	7.5	8.2	9.3	6.7	7.3	74.2
Northern Devon Healthcare NHS Trust *	Requires Improvement	38%	9.4	6.0	7.3	6.5	5.3	7.5	8.2	9.6	6.8	7.3	73.9
Royal Devon and Exeter NHS Foundation Trust*	Good	53%	9.4	6.3	6.9	6.4	5.1	7.4	8.4	9.5	6.9	7.3	73.6
Dorset County Hospital NHS Foundation Trust	Good	49%	9.4	6.1	7.0	6.3	5.6	7.3	8.2	9.5	6.7	7.2	73.3
Royal Berkshire NHS Foundation Trust	Good	46%	8.9	6.2	6.9	6.2	5.8	7.6	8.0	9.5	6.9	7.3	73.3
University Hospitals Bristol NHS Foundation Trust	Outstanding	52%	9.2	6.0	6.8	6.3	5.5	7.3	8.2	9.6	6.8	7.2	72.9
Salisbury NHS Foundation Trust	Requires Improvement	39%	9.2	6.1	6.9	6.2	5.5	7.3	8.1	9.4	6.7	7.2	72.6
Taunton and Somerset NHS Foundation Trust	Good	38%	9.2	6.0	6.8	6.3	5.4	7.3	8.1	9.4	6.7	7.2	72.4
Poole Hospital NHS Foundation Trust	Good	50%	9.3	6.1	6.8	6.3	5.2	7.3	8.2	9.4	6.7	7.1	72.4
University Hospitals Plymouth NHS Trust	Requires Improvement	52%	9.1	6.1	7.0	6.2	5.1	7.1	8.1	9.4	6.8	7.0	71.9
Torbay and South Devon Healthcare NHS Trust *	Good	43%	9.2	6.0	6.8	6.3	4.9	7.3	8.2	9.5	6.6	7.1	71.9
Royal United Hospital Bath NHS Trust	Good	46%	9.2	6.0	6.8	6.1	5.6	7.1	8.0	9.5	6.4	7.1	71.8
Portsmouth Hospitals NHS Foundation Trust	Requires Improvement	57%	9.1	5.9	6.8	6.1	5.3	7.3	7.9	9.5	6.7	6.9	71.5
Great Western Hospital NHS Foundation Trust*	Requires Improvement	44%	9.1	5.8	6.8	6.1	5.2	7.2	8.1	9.5	6.7	6.9	71.4
Gloucestershire Hospitals NHS Foundation Trust	Good	46%	9.2	5.8	6.7	6.0	5.1	7.2	8.0	9.5	6.5	6.8	70.8
Oxford University Hospitals NHS Trust	Good	50%	8.9	5.7	6.7	5.9	5.3	7.3	7.9	9.5	6.6	6.9	70.7
North Bristol NHS Trust	Requires Improvement	41%	9.1	5.7	6.6	6.1	5.1	7.1	8.0	9.4	6.5	6.9	70.5
Weston Area Health NHS Trust	Requires Improvement	37%	9.1	5.7	6.4	5.8	5.2	7.3	7.8	9.3	6.3	6.7	69.6
Royal Cornwall Hospitals NHS Trust	Requires Improvement	36%	9.1	5.8	6.5	6.0	4.8	7.1	7.7	9.5	6.2	6.7	69.4
Average		47%	**9.2**	**6.0**	**6.9**	**6.2**	**5.4**	**7.3**	**8.1**	**9.5**	**6.7**	**7.1**	**72.3**

KEY
Above Average Score for this Group of Trusts
Average Score for this Group of Trusts
Below Average Score for this Group of Trusts

5.25 Future Priorities and Targets

Trust Wide
The development of a Trust wide approach will be implemented on four key focus areas, the Trust will work with staff through listening events and focus groups to identify relevant and meaningful actions.

The key priority areas for focus are;

- **Staff Engagement** (led by HRD and OD lead)
  - Refresh and re-launch of the People Strategy
  - Implement Engage to Change within agreed departments
  - Leadership Development
  - 'You Said' and 'We Did' communication to be done Trust Wide and Locally

- **Quality of Care** (led by Head of Quality)
  - Develop a new Quality Strategy
  - Implement a communication plan to support the Quality Strategy
  - Utilise the engage to change methodology for employee led improvements

- **Quality of Appraisals** (led by Head of Learning and Development)
  - Review Appraisal Policy and Training
  - Consider the implementation of an appraisal period (Summer)
  - Implement bespoke training for hotspot departments

- **Health and Wellbeing** (led by Head of Health and Wellbeing)
  - Review Health and Wellbeing strategy as part of the People strategy review
  - Implement wellness events utilising charitable funds
  - Review of staff benefits and how this is communicated to staff (Staff App)
  - Improving health and wellbeing guidance for managers

Divisional
Each Division will develop a local action plan focusing on **three key areas** which will make the most impact based on the results for the Division. The results will be shared through a 'listening into action' approach, empowering staff to be involved and contribute towards improvements in their Divisional staff survey results.

Monitoring arrangements
The Trust and each of the Divisions have commenced developing action plans aligned to the areas where their scores have deteriorated. Each of the priority areas will have named the three lowest scoring questions. The areas will be measured by an improvement on the score for these questions following the 2019 survey.

All Divisions will provide updates on the progress of the Divisional action plans quarterly at Executive Committee.

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 24 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 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 2018/19 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 a new Chair (Liam Coleman).
- 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.
- Input views and observations into the formulation of the Operational Plan and developing 5 Year Strategic Plan.
- Contribution towards the Trust's Inspection by the Care Quality Committee.
- Review of the Constitution to increase the number of governor seats in the Swindon Constituency and the agreement of an alternative partner organisation for the purposes of nominating a governor to the Council of Governors.
- Hosting of public lectures and support for member recruitment.

In 2018/19 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 14 public governor seats (Swindon – 7, 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 governor seats and 6 governor seats 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. In 2018/19 the number of governor seats in the Swindon Constituency was increased from 5 to 7 to ensure that this balance is maintained. However, the Council of Governors agreed that elections to the two new seats should take place as part of the normal planned elections for that constituency in November 2019 when all out elections for that consistency will be held.

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 2018/19 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 with the exception of the Swindon Constituency as it was agreed that the elections coincide with the planned elections in November 2019. This would also allow time for further promotion of the governor role to ensure that sufficient candidates come forward to fill the seats available.

Elected Governors in 2018/19 – Public Constituencies

	Name	Constituency	Date first elected	Current Term of Office (date ending)	Attendance from 6 Council of Governor meetings
1	Ros Thomson	Swindon	Dec-08	3 years *(term ends Nov-19)*	6/7
2	Kevin Parry	Swindon	Nov-11	3 years *(ending Nov-19 but resigned May-18)*	0/1
3	Louise Hill	Swindon	Nov-13	3 years *(term ends Nov-19)*	5/7
4	Roger Stroud	Swindon	Nov-16	3 years (term ends Nov-19)	5/7
5	Rosemarie Phillips	Swindon	Nov-16	3 years (term ends Nov-19)	6/7
6	Balbir Virik	Swindon	June-18	Remainder of 3 years (term ends Nov-19)	5/5
7	Pauline Cooke	Northern Wiltshire	Nov-15	3 years *(term ends Nov-21)*	6/7
8	Penny Bowen	Northern Wiltshire	Sept-16	3 years *(term ended Nov-18)*	3/5
9	Enam Chowdhury	Northern Wiltshire	Nov-18	3 years *(term ends Nov-21)*	2/2
10	Margaret White	Central Wiltshire	Jun-11	3 years *(term ended Nov-18)*	3/5
11	Janet Jarmin	Central Wiltshire	Dec-08	3 years *(term ends Nov-21)*	5/7
12	Bill Kingdon	West Berkshire & Oxfordshire	Jul-17	Remainder of 3 years *(ending Nov-19 but resigned Apr-18)*	0/0
13	Jane Turner	West Berkshire & Oxfordshire	Nov-18	3 years *(term ends Nov-21)*	1/2

During 2018/19 elections were held for:-

- Wiltshire Northern Constituency
- Wiltshire Central Constituency
- Wiltshire Southern Constituency
- West Berkshire & Oxfordshire Constituency
- Gloucestershire and Bath & North East Somerset Constituency

At 31 March 2019 vacancies remained for the following public governor seats: -

- Gloucestershire, Bath & North East Somerset Constituency – 1 seat
- Swindon Constituency – 2 seats
- Wiltshire Southern Constituency – 1 seat
- Wiltshire Central Constituency – 1 seat

Elected Governors in 2018/19 – Staff Constituency

	Name	Staff Constituency – sub class	Date first elected	Current Term of Office (date ending)	Attendance from 7 Council of Governor meetings
1	Sarah Watts	Administrators, Maintenance, Auxiliary and Volunteers	Aug-17	Remainder of 3 year term *(ending Nov-19)*	1/7
2	Abdelfattah Amin Taha	Doctors & Dentist	Aug-17	Remainder of 3 year term *(ending Nov-19 but left the Trust Feb-19)*	2/6
3	Claire Brooks	Allied Health Professionals	Nov-16	3 years *(term ends Nov-19)*	1/7 *(absence approved)*
4	Karen Hawkins	Hospital Nursing and Therapy Staff	Nov-17	Remainder of 3 year term *(ending Nov-19)*	4/7

There are 4 staff governor seats split into sub-classes. During 2018/19 one staff governor left the Trust and therefore a vacancy was created.

At 31 March 2019 there was one vacancy for a staff governor seat.

Nominated Governors in 2018/19

	Name	Nominating Partner Organisation	Date first nominated	Current Term of Office (ending date)	Attendance from 7 Council of Governor meetings
1	Ian James	Swindon Clinical Commissioning Group	Aug-13	3 years *(term ends Aug-19)*	5/7
2	Emmy Butcher	Wiltshire Clinical Commissioning Group	Oct-18	3 years *(term ends Oct-21)*	2/2
3	Brian Ford	Local Authority – Swindon Borough Council	Aug-16	3 years *(term ends Aug-19)*	3/7
4	Jerry Wickham	Local Authority – Wiltshire Council	Jul-17	3 years *(term ends Jun-20)*	3/7
5	David Barrand	Other Partnerships – Prospect Hospice	Feb-15	3 years *(Nov-20 but resigned Aug-18)*	0/4
6	Angela Gillibrand	Other Partnerships – Prospect Hospice	Nov-18	3 years *(term ends Nov-21)*	1/2
7	Sarah Snow	Other Partnerships – Oxford Brookes University	Sept-18	3 years *(term ends Sep-21)*	1/2

There are 6 appointed governor seats.

During 2018/19 the Trust changed partners from Swindon & North Wiltshire Health and Social Care Academy to Oxford Brookes University and Sarah Snow was nominated in September 2018 as the Governor representative.

Also during the year David Barrand resigned in August 2018 as the Governor representing Prospect House with Angela Gillibrand nominated in November 2018 as a replacement representative.

Furthermore, Emmy Butcher was nominated in October 2018 as Governor representative for Wiltshire Clinical Commissioning Group.

As 31 March 2019 there were no vacancies for appointed governor seats.

Attendance at meetings of the Council of Governors during 2018/19

There were 5 meetings of the Council of Governors in 2018/19, 1 joint meeting of the Board and Council of Governors and 1 joint meeting of the Council of Governors and the Members. The table below shows Governor and Board Director attendance at those meetings: -

	Attendee(✓ = attended X = did not attend)	26 Apr-18	28 Jun-18 Joint Board & COG	26 Jul-18	29 Aug-18	24 Sep-18 Joint COG & AMM	8 Nov-18	7 Feb-19
	Governors							
1	David Barrand *(resigned 13-Aug-18)*	X	X	X	X	n/a	n/a	n/a
2	Penny Bowen *(term ended Nov-18)*	✓	X	✓	X	✓	n/a	n/a
3	Claire Brooks *(Note – absence from Council authorised)*	n/a	n/a	n/a	n/a	n/a	n/a	✓
4	Emmy Butcher *(from 1-Oct-18)*	n/a	n/a	n/a	n/a	n/a	✓	✓
5	Enam Chowdhury *(from Nov-18)*	n/a	n/a	n/a	n/a	n/a	✓	✓
6	Pauline Cooke	✓	X	✓	✓	✓	✓	✓
7	Brian Ford	✓	✓	X	X	✓	X	X
8	Angela Gillibrand *(from Nov-18)*	n/a	n/a	n/a	n/a	n/a	x	✓
9	Karen Hawkins	✓	X	✓	X	X	✓	✓
10	Louise Hill	✓	✓	✓	X	X	✓	✓
11	Ian James	✓	✓	✓	X	X	✓	✓
12	Janet Jarmin	✓	✓	X	✓	✓	X	✓
13	Bill Kingdon *(resigned Apr-18)*	n/a	n/a	n/a	n/a	n/a	n/a	n/a
14	Kevin Parry *(resigned 31-May-18)*	X	n/a	n/a	n/a	n/a	n/a	n/a
15	Rosemarie Phillips	✓	X	✓	✓	✓	✓	✓
16	Sarah Snow *(from Sep-18)*	n/a	n/a	n/a	n/a	n/a	✓	X
17	Roger Stroud	✓	X	x	✓	✓	✓	✓
18	Abdelfattah Amin Taha *(left Feb-19)*	✓	X	x	X	X	✓	n/a
19	Ros Thomson	✓	✓	✓	✓	X	✓	✓
20	Jane Turner *(from Nov-18)*	n/a	n/a	n/a	n/a	n/a	X	✓
21	Balbir Virik *(from 28-Jun-18)*	n/a	n/a	✓	✓	✓	✓	✓
22	Sarah Watts	X	X	X	X	X	X	✓
23	Margaret White *(term ended Nov-18)*	X	✓	✓	✓	X	n/a	n/a
24	Jerry Wickham	X	X	✓	X	X	✓	✓
	Directors							
1	Nick Bishop	X	✓	X	X	✓	✓	X
2	Liam Coleman (Chair) *(from 1-Feb-19)*	n/a	n/a	n/a	n/a	n/a	n/a	✓
3	Andy Copestake	✓	✓	X	X	✓	✓	✓
4	Oonagh Fitzgerald *(resigned 20-Jul-18)*	X	X	n/a	n/a	n/a	n/a	n/a
5	Sheridan Flavin *(from 1-Feb-19)*	n/a	n/a	n/a	n/a	n/a	n/a	**X**
6	Sally Fox *(from 22-May-18 to 31-Jan-19)*	n/a	n/a	X	X	X	X	n/a
7	Peter Hill	X	✓	X	X	✓	X	✓
8	Roger Hill (Chair) *(term ended 31-Jan-19)*	✓	✓	✓	✓	✓	✓	n/a
9	Karen Johnson	✓	X	X	X	✓	✓	✓
10	Paul Lewis	X	✓	X	X	X	✓	✓
11	Julie Marshman *(from 1-Jun-18)*	n/a	✓	✓	✓	X	X	✓

	Attendee(✓ = attended X = did not attend)	26 Apr-18	28 Jun-18 Joint Board & COG	26 Jul-18	29 Aug-18	24 Sep-18 Joint COG & AMM	8 Nov-18	7 Feb-19
12	Kevin McNamara	X	✓	✓	X	X	X	✓
13	Jemima Milton	✓	✓	✓	X	X	✓	✓
14	Carole Nicholl	✓	✓	✓	✓	✓	✓	✓
15	Steve Nowell *(to 31-Dec-18))*	X	X	✓	X	X	✓	n/a
16	Jim O'Connell	✓	X	X	X	✓	X	✓
17	Guy Rooney	✓	✓	✓	X	X	✓	✓
18	Julie Soutter	X	✓	✓	X	X	X	✓
19	Nerissa Vaughan	X	X	X	X	✓	✓	✓
20	Hilary Walker *(to 31-May-18)*	X	X	n/a	n/a	n/a	n/a	n/a

6.3 Lead and Deputy Lead Governors

Roger Stroud and Pauline Cooke were Lead and Deputy Lead Governor respectively in 2018/19 being re-appointed in December 2018 for a further 12 months. 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.

6.4 Council of Governors meetings structure

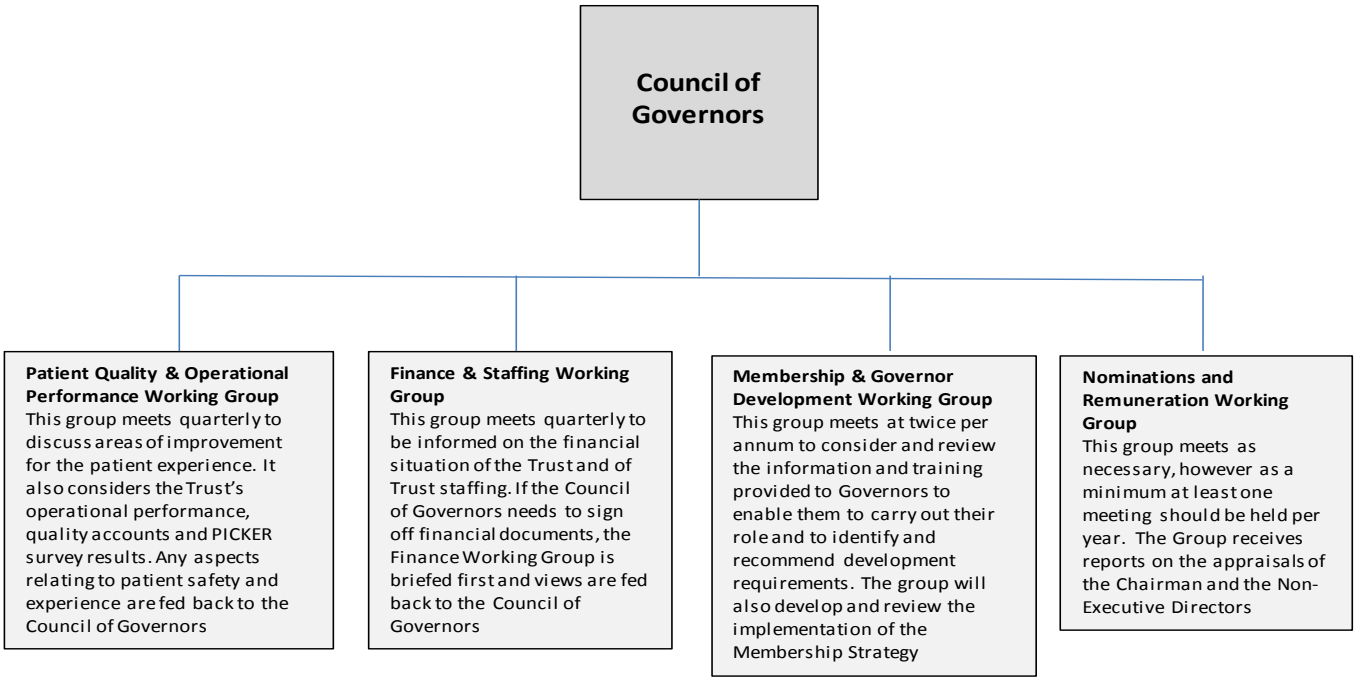
The Council of Governors has established a number of working groups which each have focussed attention for specific areas of work. During 2018/19 the following working groups were in place: -

- 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



6.5 Biography of individual Governors

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

6.6 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 Non-Executive Directors explain how they have sought to gain assurance around Trust performance from the Executive Directors. 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 Non-Executive 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.

6.7 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 2018/19 Non-Executive Directors attended Council of Governor meetings which enabled them to listen to Governors' concerns or comments 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 2018/19. 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 2018/19 six public health lectures were held as follows: -

- Stoma Care (Apr-18)
- COPD (Sep-18)
- Smoking Cessation (Oct-18)
- Carers (Dec-18)
- Pain Management (Jan-19)
- Red Bag Scheme (Mar-19)

These continue to be well attended by local people.

Questions from governors and members of the public – Questions from governors and members of the public and responses 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 December 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 Non-Executive Directors report into the Council of Governors. This will be rolled out during 2019/20.

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, Swindon Community Services, Unscheduled Care and Freedom to Speak Up. .

Governor walkabouts and visits – The Governors undertake regular visits around the hospital to help them understand how different areas work and what their 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 2018 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 2018/19 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 2018/19 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
- Governor representation on smoking cessation group

6.8 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 2018/19 to undertake the annual performance review of the Chairman and Non-Executive Directors. The pay arrangements for Non-Executive Directors are set to reflect foundation trust responsibilities. The rates were reviewed in 2018/19 and there were no changes made to the Non-Executive Directors allowances; however there was a slight change to the Chair's allowance as it was considered that the allowance rate paid was below the average/mean compared to other Trusts. Further information about the remuneration of the Non-Executive Directors can be found elsewhere in this report (section 4.10 refers).

6.9 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.

6.10 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.

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

In 2018/19 the Committee met twice during the year to consider feedback from interviews and recommend candidates for appointment to the Council of Governors, namely the appointment of a Chair, the appointment of a new Non-Executive Director to fill a vacancy and to consider the re-appointment of two Non-Executive Directors whose terms of office are due to end in 2019/20.

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.

In November 2018 the Joint Nominations Committee nominated for appointment Liam Coleman, as Chair of the Trust which was supported by the Council of Governors which also met in November 2018. In March 2019 the Joint Nominations Committee recommended the appointment of a new Non-Executive Director to the Council of Governors and considered the re-appointments of two Non-Executive Directors. The recommendations from the Joint Nominations Committee were approved by the Council of Governors in April 2019 with Lizzie

Abderrahim appointed for a three year term and Nick Bishop and Andy Copestake each re-appointed for a further three year term.

6.12 Attendance at the Joint Nominations Committee Meetings during 2018/19

Record of attendance at each meeting
✓ = Attended ✗ = Did not attend
n/a = not applicable as not member at that time

Joint Nominations Committee Members	Record of attendance at each meeting ✓ = Attended ✗ = Did not attend n/a = not applicable as not member at that time	
	20-Aug-18	7-Mar-19
Non-Executive Members		
Roger Hill – Chairman *(Committee member to 31-Jan-19)*	✗ *(substituted by Nick Bishop)*	n/a
Liam Coleman – Chairman *(Committee member from 1-Feb-19)*	n/a	✓
Steve Nowell – Non-Executive Director *(Committee member to 31-Dec-18)*	✗	n/a
Julie Soutter – Non-Executive Director	✓	✓
Peter Hill - Non-Executive Director (observer / Committee Member)	✓ (observer)	✓
Governor Members		
Pauline Cooke – Governor	✓	✗ *(substituted by Jane Turner)*
Louise Hill – Governor	✗ *(substituted by Ros Thomson)*	✓
Roger Stroud – Governor	✗	✗ *(substituted by Janet Jarmin)*
Jerry Wickham *(Committee member from 1-Nov-18)*	n/a	✗ *(substituted by Balbir Virik)*
Margaret White – Governor *(Committee member to Nov-18)*	✗ *(substituted by Brian Ford)*	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.

6.13 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.

6.14 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

6.15 Staff Members

Staff members include Trust employees, Carillion / SERCO 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. The staff constituency is 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

6.16 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	2017/18	2018/19
Swindon	3,149	2,860
North Wiltshire	1,274	1,154
Central Wiltshire	553	503
Southern Wiltshire	177	162
West Berkshire and Oxfordshire	342	311
Gloucestershire and Bath and North East Somerset	368	341
Staff	7,039	7,247
TOTAL	**12,902**	**12,578**

This shows a decrease in overall membership of 324 (2.51% **decrease** which is a deterioration on last year's increase of 1.78%) which was mainly due to a cleansing of the database due to the new EU General Data Protection Regulation (GDPR) implemented on 25 May 2018.

Public Constituency	2017/18	2018/19	Estimate for 2019/20
At year start (1 April)	6,185	5,863	5,331
New Members	43	71	75 (at 5%)
Members leaving	365	610	
At year end (31 March)	**5,863**	**5,331**	

This shows a decrease in public members of 532 (9.07%) many of which will have left under the new GDPR regulations.

The estimate for 2019/20 public members is based on an aim to ensure that the public membership is maintained and improved.

Staff Constituency	2017/18	2018/19
At year start (1 April)	7,103	7,039
New Members	1,692	1,159
Members leaving	1,756	951
At year end (31 March)	**7,039**	**7,247**

This shows an increase in staff members of 208 (2.95% increase)

6.17 Numbers of members by age ethnicity and gender

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

Age	**2017/18**	**2018/19**
0-16	2	1
17-21	103	66
22+	5,716	5,213
Unknown	52	51
Total	**5,863**	**5,331**

Ethnicity	**2017/18**	**2018/19**
White	3,554	3,148
Mixed	26	24
Asian or Asian British	151	146
Black or Black British	51	50
Other	27	26
Unknown	2,057	1,937
Total	**5,863**	**5,331**

Gender	**2017/18**	**2018/19**
Male	2,053	1,823
Female	3,291	2,989
Unspecified	519	519
Total	**5,863**	**5,331**

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.

6.18 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, which is currently being refreshed and will be re-launched in April 2019, 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 2018/19 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 June 2018, where an open discussion on proposals to refresh the Trust's Strategy took place.

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.

6.19 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 Membership Strategy is currently undergoing a review to focus on how the Trust plans to engage and offer more to our existing members for the next three years, 2019-2022.

The Council of Governors has established a sub-group, known as the Membership & Governor Development Working Group, whose aim is 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.

6.20 Membership development in 2018/19

In order to build a representative membership during 2018/19 the Trust undertook the following: -

- Recruitment drives in the hospital atrium
- An Annual Members Meetings was held in September 2018
- The Governance Officer attended various school and college careers events within the area
- Public health talks were held monthly to respond to the needs of the population with topics discussed such as Stoma Care, COPD, Smoking Cessation, Pain Management, Carers and the Red Bag Scheme. A membership stall was 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.

6.21 Membership recruitment proposed for 2019/20

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 will be 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.

6.22 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.

6.23 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: -

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 2018/19 consideration was given to the remuneration levels of the non-executive directors using benchmarking data.

E.1.1 The board of directors should make available a public document that sets out its policy on the involvement of members, patients and the local community at large, including a description of the kind of issues it will consult on. However, the Trust has a Communications Strategy which includes consultation and engagement and the Patient Liaison Service (PALs) has a Patient Experience and Engagement Strategy 2017-2022 Listen and Learn, which is on the Trust Website. PALS invite people to provide their views and experiences. There is also information on our website about making a complaint and we receive views from the public via social media channels. Furthermore the Trust has a Membership Strategy which sets out engagement with members.

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.

6.24 Audit Committee Annual Report 2018/19

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 2019. This report covers activities and accounts during the period 1 April 2018 to 31 March 2019.

Terms of Reference

The Terms of Reference of the Committee were approved by the Board on 1 March 2018 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 reviewed again in March 2019 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-Jan-16. Prior to that she was a member of the Committee from the time she joined the Trust in Jan-15. During 2018/19 Julie was also the Deputy Chairman of the Trust until 31-May-18.
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-Jan-17. Nick is the Chair of the Quality and Governance Committee and the Mental Health Governance Committee. Also Nick became the Senior Independent Director on 8-Feb-19 and the Chair of the Remuneration Committee.
Steve Nowell *(until 31-Dec-18)*	Steve was a member of the Committee from 1-Jan-18 until 31-Dec-18. However, Steve had previously a member of the Committee from 1-Jul to 31-Dec-16. During 2018/19 Steve was the Chair of the Finance & Investment Committee and the Remuneration Committee. Steve was also the Senior Independent Director.

Attendances **Non-Exec Members**	**24 May 2018**	**12 July 2018**	**13 September 2018**	**15 November 2018**	**17 January 2019**	**4 March 2019**
Julie Soutter *(Chair)*	✓	✓	✓	✓	✓	✓
Andy Copestake	✓	✓	✗ (Substituted by Paul Lewis)	✓	✓	✗
Nick Bishop	✓	✓	✓	✓	✓	✓
Steve Nowell (until 31-Dec-18)	✗	✗	✗	✓	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 2018, and also in January and March 2019. For the current financial year a minimum of six meetings are scheduled, commencing in May 2019 with the review and approval of the 2018/19 year-end Annual Report and Accounts. The major review areas addressed in the meetings in 2018/19 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 effectiveness of risk management throughout the organisation and has supported further actions and areas for focus, such as the continuation of individual divisional presentations to the Committee on their risk management arrangements. The Committee analysed risk themes and review accepted risks on safety. Furthermore, the Committee welcomed the refreshed approach to reporting, notably the introduction of a 15+ risk map providing greater visibility of top risks against key lines of enquiry. The Committee considered the effectiveness of risk management with oversight of the mechanisms in place to manage risk within the Trust. The Committee welcomed the introduction of further measures to strengthen processes including the introduction of a Risk Committee.

    - 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 refreshed Board Assurance Framework which includes strengthened alignment to the risk register and greater visibility of gaps and actions.

    - The Committee welcomed the roll out of key performance indicators for risk management which were recommended by an internal audit review of risk maturity.

- The Committee has again 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 ongoing information on the Staff Code of Conduct Policy and scrutinised the improvement in compliance rates which have improved.

- The Committee reviewed reports on stock management; discharge planning; workforce planning and agency controls; private patients debt; overseas visitors debt; Wiltshire Health & Care joint venture; e-rostering; business continuity; freedom to speak up; conflicts of interest; key financial systems; and the draft operational and strategic plans. These 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, waivers and reports of losses, including patient property, and any compensation paid. The improved reporting previously developed by the Committee continued in 2018/19 which allowed for 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 2019 the Trust's Financial Accounts for 2018/19 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 statements, operations and compliance are valuation of land and buildings, recognition of NHS and non NHS income and non-pay expenditure recognition. 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. The Committee reviewed and approved BDO's internal audit and counter-fraud plans for 2018/19 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 set 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 2018/19 the Trust's internal controls were assessed as **moderate** and that they provided overall Moderate Assurance.

During 2018/19 the outcomes of 9 internal audit reviews were reported to the Committee. Of those, four resulted in "limited" assurance, namely Consultant Job Planning; Performance Management, Contract Management and E-Rostering. The recommended actions to address weaknesses identified by the reviews are monitored by the Committee. All other internal audit reports provided **"moderate assurance"** (5 reviews).

During 2018/19 the opinion of the internal audit reviews reported to the Committee are as follows: -

Name of Review	Opinion	
	Design	Operational Effectiveness
Consultant Job Planning	Moderate	Limited
Performance Management	Moderate	Limited
Contract Management	Moderate	Limited
Discharge Planning	Moderate	Moderate
E-Rostering	Moderate	Limited
Sickness Management	n/a	n/a
Key Financial Systems	Satisfactory	Moderate
Stock Management	Moderate	Moderate
Business Continuity	Satisfactory	Moderate
General Data Protection Regulations (GDPR)	n/a	n/a
Contract Management – ID Medical	Moderate	Moderate

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. The Committee also considered a fraud risk assessment which set out any "hot spots" of fraud risk and the actions being taken to address areas of concern. In addition to regular reports, the Committee received advice on national fraud cases to ensure that any learning from those cases was highlighted. The Annual Fraud Risk Assessment was reported in May 2019 and the overall rating was **"Green".**

External Audit

KPMG were represented at all meetings of the Committee and submitted reports as needed, including their 2018/19 **unqualified audit opinion** on the Trust's Financial Accounts and their Annual ISA260 report. During the year, the Audit Committee considered the following significant audit risks identified by external audit:

- Management override of controls – valuation of Land and Buildings
- Fraudulent recognition of revenue
- Fraudulent recognition of non-pay expenditure
- Management Override of Controls.

The Audit Committee also considered the Value for Money - Financial Sustainability risk identified by external audit through risk assessment processes. External audit have provided a **qualified opinion** this year. Subject to the matters outlined in the following paragraphs the External Auditors were satisfied that in all significant respects the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources for the year ended 31 March 2019.

Basis for qualified conclusion

As at 31 March 2019 the Trust has reported a £12.4 million underlying deficit against a control total deficit of £5.3 million. This does not include receipt of £11.1 million of Transformation Funding.

The Trust required £44.8 million of revenue support borrowings to support the cash position and is expecting to require further borrowings in future periods. The Trust operational plan for 2019/20 forecasts an underlying deficit of £11.4 million (before Transformational Funding), and the Trust does not currently have plans in place to address the underlying deficit.

Whilst the Trust has identified efficiency schemes that will support the achievement of the Trust's short-term financial plans, its long-term plans are not yet sufficiently progressed to achieve a break-even position in the foreseeable future or an ability to repay loans.

This demonstrates weaknesses in the Trust's arrangements to plan its finances effectively to support the sustainable delivery of its strategic priorities and maintain its statutory functions.

The External Auditors identified a significant financial stability risk. Whilst the context of the financial challenges within the NHS is noted, the Trust's deficit presents a significant risk to the adequacy of arrangements in place at the Trust specifically in relation to planning finances effectively. The Trust continues to operate with an underlying deficit, with no medium term plans to return to a break even position, and is reliant on Department of Health & Social Care (DHSC) loans to support the cash position.

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 of Governance. 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:-

- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge; and
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

The auditor's detailed testing on the indicators resulted in the auditors giving a **clean limited assurance** opinion for the A&E indicators but a **qualified opinion** on the Cancer 62 Day Wait indicator due to finding 9 errors in a sample of 25.

The auditors work on the local selected indicator "Summary Hospital Mortality Indicator (SHMI)", as chosen by the Governors, has indicated three issues as part of the testing relating to coding or data input. This means that the auditors would not be able to provide a limited assurance opinion if they were required to do so.

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 2018/19 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 2018/19. 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 routinely refreshes 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 2018/19 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 Accounting Officer 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 2019/20 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.

Acknowledgements

The Committee acknowledges the support received from the Executive Directors and senior managers 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
5 June 2019

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 into the top Segment 1 where a Trust has maximum autonomy and lowest level of oversight appropriate. As at 31 March 2019, support has been identified as required in quality of care, finance & use of resources and operational performance. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

The Trust is not subject to any formal interventions.

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	4	4	4	3
Financial controls	Distance from financial plan	1	1	1	1
	Agency spend	3	3	3	3
Overall scoring		3	4	3	3

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.

The improvement in I&E margin in Q4 is largely driven by the award of £4.7m indicative PSF as at year end.

As part of the Care Quality Commission's Inspection in 2018 the Trust had its first joint NHS Improvement/CQC 'Use of Resources' assessment. Although the report found the Trust overall delivering efficient corporate, clinical support and emergency services, it gave an overall rating as 'Requires Improvement' due to the significant challenges with staffing and bed capacity as a result of significant growth in the catchment population, not meeting all the key constitutional standards and the deterioration in the financial performance.

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 – September 2018

In December 2018 the Trust received a report from the CQC following its inspection of Trust services during September and October 2018 which was part of the CQC's planned programme of inspections of healthcare providers. The overall rating was "requires improvement".

This inspection follows on from previous inspections in 2015 and 2017. To support the drive for improvement within the organisation the Trust established service level self-assessments frameworks which include action plans and monitoring compliance. Progress is monitored through Divisional governance arrangements reporting into an Assurance Committee with regular reporting to the CQC on milestone actions and sustainability of improvement. Examples of improvement are covered in the Quality Report (section 11 refers).

The Trust will continue to drive improvements in the quality of services provided. Internal support has been put in place for 2019/20 with strengthened self-assessments through an electronic tool developed by the Trust. Peer reviews are planned to support on-going monitoring.

Full Inspection Outcomes received December 2018

The ratings for both Acute and Community locations are summarised as follows which shows an improvement on the Trust's rating from March 2017, 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.

The CQC inspected the 'Effective' domain for Outpatients and Diagnostic Imaging but did not rate it due to a lack of national data available.

Our ratings for The Great Western Hospitals Foundation NHS Trust	
Overall Rating	Requires improvement

Core Service	Safe	Effective	Caring	Responsive	Well- led		Overall
Urgent and emergency services	Requires Improvement	Good	Good ⇩	Requires Improvement	Good		Requires Improvement
Medical Care (including older people's care)	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement ⇩		Requires Improvement
Surgery	Requires Improvement	Good	Good	Requires Improvement	Good ⇧		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	Good ⇧	Good	Good	Good ⇧	Good ⇧		Good ⇧
End of life care	Good	Good	Good	Good	Good		Good
Outpatients and diagnostic imaging	Good ⇧	Not Rated	Good	Good ⇧	Good		Good ⇧
Community Health Services for Adults	Good ⇧	Good ⇧	Good ⇧	Good ⇧	Good ⇧		Good ⇧
Community Health Inpatient Services	Good ⇧	Good ⇧	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.

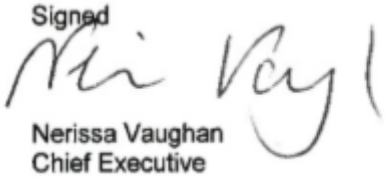
NHS Improvement, in exercise of the powers conferred on NHSI by the NHS Act 2006, has given Accounts Directions which require Great Western Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts 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 and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care 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
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable 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 5 June 2019

9. Auditor's opinion and certificate

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

KPMG

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 Group") for the year ended 31 March 2019 which comprise the Group and Trust Statements of Comprehensive Income, Group and Trust Statements of Financial Position, Group and Trust Statements of Changes in Equity and Group and Trust Statements 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 2019 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 2018/19 and the Department of Health and Social Care (DHSC) Group Accounting Manual 2018/19.

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 and Trust 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.

Overview	
Materiality: Group financial statements as a whole	£6.3m (2018:£6.6m) 1.8% (2018:2%) of income from operations
Materiality: Trust financial Statements	£6.2 million (2018:£6.5 million) 1.8 of total operating income (2018:1.9%)

Risks of material misstatement		vs 2018
Recurring risks	Material uncertainty related to going concern	◄►
	Valuation of land and buildings	◄►
	Recognition of NHS and non-NHS Income	◄►
Event driven	**New** Recognition of Non-Pay Expenditure	▲

2. Key audit matters: Material uncertainty related to going concern

	The risk	Our response
Going concern We draw attention to note 1 to the financial statements which indicates that the Group has current assets of £0.1 million as at 31 March 2019. The Group is also forecasting an underlying deficit of £11.5 million for the year ending 31 March 2020 and will require ongoing revenue loan support from the DHSC, and non-repayment of current funding in order to meet the future financial obligations of the Group. At present, there are no viable means for the Group to repay its existing DHSC support loans of £44.8 million, or any new ones which are received during 2019/20. 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 and the parent company's ability to continue as a going concern. Our opinion is not modified in respect of this matter.	**Disclosure quality** The financial statements explain how the Board has formed a judgement that it is appropriate to adopt the going concern basis of preparation for the Group and Trust. That judgement is based on an evaluation of the inherent risks to the Group's and Trust financial plan, including the impact of Brexit, and how those risks might affect the Group's and Trust's financial resources or ability to continue operations over a period of at least a year from the date of approval of the financial statements. The risk for our audit is whether or not those risks are such that they amount to a material uncertainty that may cast significant doubt about the ability to continue as a going concern. If so, that fact is required to be disclosed (as has been done) and, along with a description of the circumstances, is a key financial statement disclosure.	Our procedures included: **Funding assessment**: — We inspected and challenged the assumptions in the 2019/20 financial plan to ensure that adequate future loan funding is included. **Our NHS experience**: — We assessed the likelihood of NHS Improvement transferring services to other NHS bodies using our own NHS experience. — We assessed the likelihood of DHSC not demanding repayment of existing loans in the 12 month period under assessment. **Historical comparisons**: — We have assessed the Groups ability to meet the financial targets set in the 2018/19 financial plan, including Control Total, Agency Cap and Cost Improvement Programme. **Assessing transparency**: — We assessed the completeness and accuracy of the matters covered in the going concern disclosure. **Our findings** We found the disclosure of the material uncertainty to be balanced (2018 result: balanced).

3. 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. Going concern is a significant key audit matter and is described in section 2 of our report. We summarise below the, other key audit matters (one new key audit matter in 2019 relating to the fraudulent recognition of non-pay expenditure), 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 Trust's governors as a body may better understand the process by which we arrived at our audit opinion. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. In arriving at our audit opinion above, the key audit matters, in decreasing order of audit significance, were as follows:

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

	The risk	Our response
Land and Buildings (£181.8 million; 2018: £174.2m) *Refer to page 111 (Audit Committee Report), page 252 (accounting policy) and page 276 (financial disclosures)*	**Subjective valuation – Land and Buildings** 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 a 'modern equivalent asset'. 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. Valuation is completed by an external expert, engaged by the Group using construction indices and so accurate records of the current estate are required. Full valuations are completed every five years, with interim desktop valuations completed in interim periods. Great Western Hospitals NHS Foundation Trust last had a full valuation undertaken at 1 April 2016 by an external valuer. At 31 March 2019, the Group completed an indexation of Trust estate, based on indices supplied by the valuer resulting in a £9.8 million increase in the value of land and buildings. Valuations are inherently judgemental, therefore our work focused on whether the valuer's methodology, assumptions and underlying data, were appropriate and correctly applied. The effect of these matters is that, as part of our risk assessment, we determined that the valuation of land and buildings has a high degree of estimation uncertainty, with a potential range of reasonable outcomes greater than our materiality for the financial statements as a whole.	Our procedures included: — **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; — **Test of details**: We undertook the following tests of details: — We tested the completeness of the estate covered by the valuation to the Group's underlying estate records, including additions to land and buildings during the year; — We critically assessed the assumptions used within the valuation by assessing the assumptions used to derive the carrying value of assets against BCIS all in tender price index and industry norms; — 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 — 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. **Our findings** We found the resulting valuation of land and buildings to be balanced.

3. Key audit matters: our assessment of risks of material misstatement

	The risk	Our response
NHS and non-NHS Income (£335.4 million; 2018: £348.4m) *Refer to page 111 (Audit Committee Report), page 250 (accounting policy) and page 263 (financial disclosures)*	**Effects of Irregularities:** Of the Group's reported income, £297.3 million (2018: £321.0 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. 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. The Group reported total other income of £38.1 million (2018: £27.4 million) from other activities principally, Private Patient income, Provider Sustainability Funding and Education and Training. Much of this income is generated by contracts with other NHS and non-NHS bodies which are based on achieving financial targets, varied payment terms, including payment on delivery, milestone payments and periodic payments. Within other income the Group received Provider Sustainability Funding (PSF) from NHS Improvement. This is received on a quarterly basis subject to achieving defined financial and operational targets. The Group received £11.1 million of PSF (2018: £2.9 million).	Our procedures included: — **Control observations**: We tested the design and operation of process level controls over revenue recognition; — **Test of details**: We undertook the following tests of details: — We agreed commissioner income and income received to the signed contracts and selected a sample of the largest balances (comprising 96% of income from patient care activities) to the supporting invoice and payments to the bank receipts; — We inspected invoices for material income in the month prior to and following 31 March 2019 to determine whether income was recognised in the correct accounting period, in accordance with the amounts billed to corresponding parties; — We inspected confirmations of balances provided by the Department of Health as part of the AoB exercise and compared the relevant income recorded in the Group's financial statements to the expenditure balances recorded within the accounts of Commissioners. Where applicable we investigated variances and reviewed relevant correspondence to assess the reasonableness of the Groups's approach to recognising income from Commissioners — We assessed the judgements made to received the transformation funding recorded in the financial statements as part of the Group's performance against the required targets to confirm eligibility for the income and agreed bonus amounts to correspondence from NHSI; and — We tested material other income balances by agreeing a sample of income transactions through to supporting documentation and cash receipts. **Our findings** We found the resulting recognition of NHS and non-NHS income to be balanced.

3. Key audit matters: our assessment of risks of material misstatement

	The risk	Our response
Non-Pay Expenditure recognition (£102.3 million; 2018: £99.2m) *Refer to page 111 (Audit Committee Report), page 251 (accounting policy) and page 266 (financial disclosures)*	**Effects of Irregularities:** As most public bodies are net spending bodies, then the risk of material misstatement due to fraud related to expenditure recognition may be greater than the risk of fraud related to revenue recognition. There is a risk that the Group may manipulate expenditure to meet externally set targets and we had regard to this when planning and performing our audit procedures. This risk does not apply to all expenditure in the period. The incentives for fraudulent expenditure recognition relate to achieving financial targets and the key risks relate to the manipulation of recognition of non-pay expenditure at the year-end.	Our procedures included: — **Control observations**: We tested the design and operation of process level controls over expenditure approval; — **Test of details**: We undertook the following tests of details: — We agreed a specific item sample of non pay expenditure transactions to supporting evidence and cash; — We inspected invoices for material expenditure in the month prior to and following 31 March 2019 to determine whether expenditure was recognised in the correct accounting period relevant to when services were delivered; — We assessed the completeness and judgements made within the expenditure balance, specifically accrued expenditure; and — We inspected confirmations of balances provided by the Department of Health as part of the AoB exercise and compared the relevant payables recorded in the Group's financial statements to the receivables balances recorded within the accounts of other providers and other bodies within the AoB boundary. Where applicable we investigated variances and reviewed relevant correspondence to assess the reasonableness of the Group's approach to recognising expenditure with other providers and other bodies within the AoB boundary. **Our findings** We found the resulting recognition of non-pay expenditure to be balanced.

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

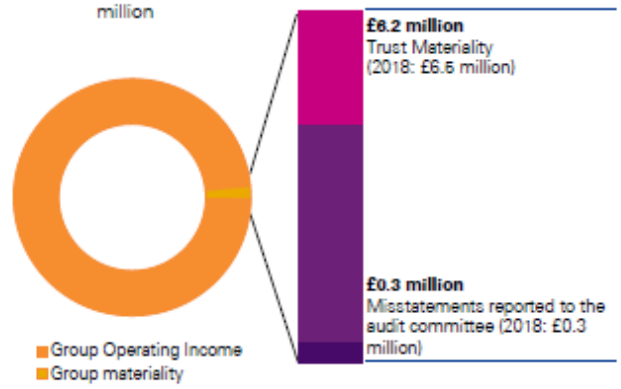
Materiality for the Group financial statements as a whole was set at £6.3 million (2018: £6.6 million), determined with reference to a benchmark of operating income (of which it represents approximately 1.8 (2018: 2%). We consider operating income to be more stable than a surplus- or deficit-related benchmark.

Materiality for the parent Trust's financial statements as a whole was set at £6.2 million (2018: £6.5 million), determined with reference to a benchmark of operating income (of which it represents approximately 1.8% (2018: 2%).

We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £0.3 million (2018: £0.3 million), in addition to other identified misstatements that warranted reporting on qualitative grounds.

Group Operating Income
£335.4 million (2018: £348.4 million

Group Materiality
£6.3m (2018: £6.6m)



5. 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 2018/19.

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 2018/19, 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.

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 their 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 Group'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 Group 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 2019.

Basis for qualified conclusion

As at 31 March 2019 the Group has reported a £12.4 million underlying deficit against a control total deficit of £5.3 million. This does not include receipt of £11.1 million of Transformation Funding.

The Group required £44.8 million of revenue support borrowings to support the cash position and is expecting to require further borrowings in future periods. The Group operational plan for 2019/20 forecasts an underlying deficit of £11.4 million (before Transformational Funding), and the Group does not currently have plans in place to address the underlying deficit.

Whilst the Group has identified efficiency schemes that will support the achievement of the Group's short-term financial plans, its long-term plans are not yet sufficiently progressed to achieve a break-even position in the foreseeable future or an ability to repay loans.

This demonstrates weaknesses in the Group's arrangements to plan its finances effectively to support the sustainable delivery of its strategic priorities and maintain its statutory functions

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

The Group 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 Group 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 Group'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 Group 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

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 Group'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 Group'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 Group, 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 risk identified during our risk assessment is set out on the next page with the findings from the work we carried out.

Significant Risk	Description	Work carried out and judgements
Financial sustainability	Whilst the context of the financial challenges within the NHS is noted, the deficit presents a significant risk to our assessment of the adequacy of arrangements in place at the Group specifically in relation to planning finances effectively The Group continues to operate with an underlying deficit, with no medium term plans to returned to a break even position, and is reliant on DHSC loans to support the cash position.	**Our work included:** — Considering the nature of cash support the Group is receiving from NHSI and its performance against any conditions attached to the support. — Assessing the Group's arrangements for managing working capital, including the processes for forecasting and monitoring cash flows and delivering cash savings. — Considering the arrangements in place to deliver recurrent cost improvements by assessing the Group CIP delivery against the planned CIP target and the use of recurrent and non-recurrent savings. — Comparing the Group use of agency staff against the agency cap set by NHS Improvement. — Evaluating the Group position as at 31 March 2019 against the forecast position and considering the future financial plans to assess the ongoing financial sustainability. **Our findings on this risk area:** — As at 31 March 2019 the Group has reported a £12.4 million underlying deficit against a control total deficit of £5.3 million. This does not include receipt of £11.1 million of Transformation Funding. — The cash balance at year end was £5.2 million, which was £4.2 million higher than plan. The Group cash position is supported by £16.7 million of additional support loans during the 2018/19. At the as at 31 March 2019 the Group had total revenue support of £44.8 million. — The 2019/20 operational plan agreed by NHS I forecasts a deficit position of £11.5 million before Transformation funding, highlighting the ongoing deficit the Group faces. The Group require further revenue funding of £4.2 million from DHSC in 2019/20, as well as their plan being reliant on current loans not being repaid, which total £44.9m at 31 March 2019. — The Group delivered £7.5 million of the £11.6 million Cost Improvement Plans for 2018/19, of which £4.3 million are recurrent savings. The plan for 2019/20 includes a CIP of £14.0 million, of which £8.8 million has been identified to date. — The Group incurred £10.4 million of agency expenditure against an agreed agency cap of £8.0 million. These findings demonstrated weaknesses in the Groups arrangements to plan its finances effectively to support the sustainable delivery of its strategic priorities and maintain its statutory functions.

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 Group. 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 Group, 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.

KPMG

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

Rees Batley
for and on behalf of KPMG LLP (Statutory Auditor)

Chartered Accountants
66 Queen Square, Bristol, BS1 4BE
6 June 2019

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 2019 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. Reminders of roles and responsibilities are included in risk reports, including prompt questions to aid discussion.

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. Furthermore, each month the Board Directors are provided with a 15+ risk map to ensure continuing oversight of high level risks.

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 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 2018/19 key performance indicators to support oversight of the effectiveness of risk management in the organisation were rolled out and reported to the Executive Committee and the Audit, Risk and Assurance Committee. This helps identify areas performing less well and enables targeted support.

Also during 2018/19 Divisional presentations continued 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.

Finally, during 2018/19 a Risk Committee was established to deep dive into risks. The role of this Committee is to challenge and test risk descriptions; scores, controls and actions. This Committee reports into the Executive Committee. Divisional representatives attend to explain the management of risks in details with Executive Directors questioning detail. This has supported greater learning around risk management and has been useful to the Divisional Managers in terms of improved mapping of information and stronger actions.

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 2018/19 there has been a focus on ensuring that there is adequate understanding and discussion of risks to ensure actions to mitigate are progressed. During 2019/20 there will be continued deep diving into risks through the Risk Committee with a view to enforcing the need for effective challenge and scrutiny of risks, scores, controls and actions.

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 2018. The Risk Tolerance Statement is explained below.

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 of 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
- Key performance indicators (KPIs) in place to monitor risk management
- Divisional presentations to the Audit, Risk and Assurance Committee
- Risk Committee introduced in 2018/19 to enable Executive Director to deep dive into risks and scrutinise and challenge Divisional Managers on their mitigating actions
- 15+ Risk Map produced monthly (aligned to the CQC key lines of enquiry), circulated to Board Directors and reported to Executive Committee
- Risk management internal effectiveness reviews reported to Audit Committee (Mar-19) and the Board (Apr-19)

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. A Risk Escalation Framework is in place as well as KPIs which support oversight of risk management. Work is on-going to ensure risks management continues to remain 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 2018/19 there was a focus on timely completion of action and reviews plus improved banking of supporting documentation. This focus will continue.

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 without recommendations (Jan-17). The audit found that the Board Assurance Framework (BAF) was embedded and is maintained as a "live" document. It is highlighted that previously the Trust commissioned an internal review of risk management annually. However, the internal audits now commissioned are more in depth and detailed and therefore the frequency of audits is less.

The Board Assurance Framework includes the following: -

- Risks, controls and assurances reflect the 2020 Vision, the Operational Plan published in Jan-17, and the Operational Plan published Apr-18 (Note the BAF will be updated in 2019/20 to reflect the new 5 year strategy and Operational Plan 2019/20)
- 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
- A report on all strategic risks is reported bi-annually to the Board
- Strategic risks are aligned to Board Committees with each responsible for seeking assurance that strategic risks are being managed for areas within its remit
- Assurance metrics added to the BAF to reflect the Single Oversight Framework, the Care Quality Commissions guidance on Use of Resources and NHS Improvement Well Led Framework
- Additional assurance metrics added to reflect Model Hospital
- Stronger alignment to Trust risk register

Risks to strategic objectives are aligned to Board Committees as follows: -

	Strategic Objectives 2018/19	**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 2018. A framework was developed which the Board uses to inform its view of risk tolerance. In 2018/19 the Board's appetite for organisational risk remained the same as the previous year explained below.

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.

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 Mapped against our objectives / Other	0 **Avoid** Avoidance of risk and uncertainty is a Key Organisational objective	1 **Minimal** (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 **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	3 **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	4 **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	5 **Mature** 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 2018/19

There are a number of risks identified on the Board Assurance Framework and Risk Register. Examples of significant risks during 2018/19, together with the actions that have been taken to mitigate them are summarised as follows: -

Risks	Actions to manage and mitigate
Quality and Safety	
Due to the frequent overcrowding in the emergency department there is a risk to patients not being able to get to the right area of the department in times of deterioration and risk of harm to staff moving trollies around the department with limited space	▪ ED escalation Plan reviewed and in place for times of high capacity ▪ Emergency Care Improvement Programme reviewing Paediatric pathway ▪ Nurse in Charge roll established ▪ Manager of the Day introduced to provide leadership ▪ Medical Take diverted to Minor Emergency Unit to reduce patient numbers in ED ▪ Increase in Resus trolleys ▪ Ambulatory Care nurse in charge attends daily senior team brief with patients moved from ED to Ambulatory Care as appropriate ▪ Dedicated Site Team support
Patient Experience	
Risk of adverse patient outcomes and experience due to the Trust's inability to meet the National Cancer Performance indicators.	▪ Development of timed cancer pathways ▪ Development of timed pathway cancer dashboard and reporting ▪ Weekly oversight Cancer Meeting chaired by Director of Governance & Assurance to oversee delivery of improvement actions ▪ Clinical engagement in breach analysis, action formulation and delivery ▪ Thames Valley Cancer Network funder cancer pathway redesign project manager ▪ Monthly Elective Steering Group with representation from Clinical Commission Groups and NHS England
Workforce	
Risk around the ability of the consultant body to provide core medical services due to vacancies and difficulties recruiting	• Renewed Recruitment campaign resulting in engagement of an Associate specialist a DOME consultant and a Respiratory/Acute Medical Unit consultant • Locums engaged to support gaps • Recruitment premiums approved • Enhance job adverts • Additional middle grade posts agreed
Financial	
Significant financial risk associated with the use of agency staff due to gaps in trained staff both medical and nursing and AHPs/Scientific	• Use of E-Rostering system – safe staffing levels assessment and service needs • Centralised bank temporary staffing team • Temporary redeployment of staff on a day to day basis • Monitoring of spend • Review of agency framework • Recruitment and Retention Plans • Trust wide advertising strategy developed

Assurances to strategic risks have been identified during 2018/19. 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 2019/20 are being 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	
Cash shortage leading to difficulty in paying suppliers and staff	• Working Capital overdraft available • Cash position monitored through monthly Executive Committee & Finance & Investment Committee • Weekly Transformation Board to track delivery of savings plans • Monthly contract meeting • Cash Group monitors cash flow • Working with NHS Improvement around long terms solutions to cash position • Borrowing ability from the Department of Health
Non-Financial Risk	
Inability to right size capacity to meet demand as a result of significant population growth in Swindon	• System wide working to consider solutions to meet demand in terms of ensuring the patient is in the right place for care • Integrated community services • Enlarged Emergency Department – new build project • Estate configurations • Review of patient flow options with demand growth in mind

10.5 Organisation culture

Our Star Values - “Service, Teamwork, Ambition, and Respect” are at the heart of all we do:

Listening to patients - 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 Staff Survey Feedback, Family and Friends Test, and through a number of forums such as our staff side committee.

Freedom to speak up - The Trust has mechanisms in place to promote an open and supportive culture that encourages staff to speak up about any issues of patient care, quality or safe. The Trust has a Freedom to Speak Up Policy which is based on support from National Guidance and feedback from both staff and patients which sets out a framework for responding to issues raised. The Policy was refreshed in 2018/19.

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. The Trust has appointed a number of Guardians in 2018 with representation from various staff groups.

Staff survey - The Trust takes part in an annual staff survey (section 5.21 refers). For 2019/20 areas for improvement around staff were identified and an action plan is being developed to address these.

Incident reporting - 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.

Quality impact considered - 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 Audit, Risk and Assurance 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 Asset Risk Management 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, data protection 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 Data Security ad Protection Toolkit (DSPT) 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 serious Data Security and Protection Security Incidents, confirmation that the Trust meets the National Data Guardian Standards as set out and assessed via the DSPT, and reports of other information governance incidents, audit reviews and spot checks.

10.7 General Data Protection Regulations (GDPR)

Throughout 2018/19, the Trust has implemented actions on our GDPR workplan, which included the publication of a Data Protection Policy and an Information Governance Policy. The plan consisted of 66 actions divided into 12 work streams (detailed below) based on the guidance to prepare for the new data protection legislation, published by the Information Commissioner's Office. Most actions are now complete, and none of those remaining are considered to present a risk to the Trust if they are not fully achieved by the end of 2018/19. In March 2019, the Trust's internal auditors undertook an audit of the work that the Trust has completed relating to compliance with the new data protection legislation and the Trust will implement any recommendations made as a result of their report.

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

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 elements 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 observe formal meetings of the Board of Directors to have an overview of Trust performance and Governors 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 6.4 refers). During 2018/19 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 and will be actively including the Governors and membership as part of a strategy refresh planned for 2019. 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 development stages will be strengthen over the course of 2019 as we work closely with all of the organisations involved in health and care in the borough (includes Shrivenham).

10.10 Quality governance arrangements

Trust People Strategy

The Trust has a detailed People Strategy which outlines the Trust commitment to ensuring short, medium and long term workforce strategies are being delivered. The Trust Board receive a 6 monthly progress report to review improvements on the six commitments outlined in the Strategy. The People Strategy details a range of strategies to enable the Trust to plan its workforce for now and in the future. Key work streams underway include:

- Recruitment and Retention Strategy (including international recruitment)
- E-Roster Implementation
- Workforce Transformation
- Workforce Planning
- Procurement review sourcing of temporary staff
- Workforce Development
- Workforce Engagement
- Health and Wellbeing Strategy

Workforce Planning

The Trust establishment setting is completed annually and aligned to the Trust Business Planning Cycle. The establishment information is detailed in the monthly workforce report and any changes throughout the year are monitored via this report. A 6 monthly review is undertaken to identify any changes within service needs. The workforce planning cycle is led by clinical and operational leads, using available data and evidence to ensure capacity and demand is sufficient to provide safe and effective care.

Safer Staffing

The Trust has reviewed and implemented the NHSI recommendation detailed in the “Developing Workforce Safeguards” guidance. The Trust has a systematic approach to safer staffing which determines the number of staff and skills required to meet the needs of service users and ensure safe patient care. The Trust ensures compliance with the National Quality Board (NQB) via bi monthly “Safer Staffing” reports which are presented to Quality and Governance Committee and Trust Board. Each report includes a dashboard of key nursing quality indicators (acuity and dependency data, Care hours per Patient, Model Hospital Data comparison, staffing fill rates). The Trust undertakes a 6 monthly skill mix review which is approved by Executive Committee.

This process supports the Trust in its efforts to deploy sufficient suitably qualified, competent, skilled and experienced staff to meet care and treatment needs safely and effectively. The report includes national clinical guidance to inform decision making.

10.11 Internal Care Quality Commission (CQC) Compliance Assessment arrangements

Quality, operational performance and financial reports are considered monthly by the Board via an Executive Committee and thereafter Board Committees. In 2018/19 the Board Committee structure was comprised of 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 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 and the triangulation of information and soft intelligence. During 2019/20 there will be an independent internal review of the informatics function of the Trust.

The Trust uses its Board Assurance Framework and Risk Register as tools to ensure risks are managed, including risks to quality.

During 2018/19 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.

10.12 Internal Care Quality Commission (CQC) Compliance assessment arrangements

During 2018/19 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. Each area visited received a written report of findings against the KLOE to support their improvement plans.

The Trust underwent a planned inspection by the Care Quality Commission (CQC) in September 2018 with the final report published in December 2018. The report identified 24 actions that the Trust must do and 79 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 explained in the CQC Rating update (section 7.4 refers).

KLOE Compliance Assurance Frameworks are in place 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.

Towards the latter part of 2018/19 the Trust has developed an electronic self-assessment tool known as the Quality Governance Framework which now incorporates the KLOE self-assessments. Each department across the Trust is in the process of completing self-assessments against each quality domain. Outcomes from self-assessment will be incorporated into service action plans for roll out in 2019/20. There will be strengthened peer reviews across all core services commencing in the summer 2019

10.13 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 March 2019 to provide for the care of children with complex needs.

The Trust is fully compliant with the registration requirements.

10.14 Up to date Register of Interest for decision making staff

In accordance with the 'Managing Conflicts of Interest in the NHS policy' and NHS England's guidance decision making staff are required to declare any interests which are relevant and material to the business of the Trust, this includes financial interest, outside employment, shareholdings, family interests, gifts and hospitality interests of which the staff member is aware, irrespective of whether the interests are actual and potential, direct or indirect.

The Trust has achieved 86% compliance of decision making staff completing their declarations of interest against a Trust target of 80%.

In accordance with the 'Managing Conflicts of Interest in the NHS policy' and NHS England's guidance decision making staff (band 8c and above and all medical consultants)are required to declare any interests which are relevant and material to the business of the Trust, this includes financial interest, outside employment, shareholdings, family interests, gifts and hospitality interests of which the staff member is aware, irrespective of whether the interests are actual and potential, direct or indirect.

The register is updated annually and the most recent version be found on the Trust's website.

10.15 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.

However, the Trust has not undertaken risk assessments and does not have a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The trust plans to ensure that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with going forward. A review of resource to undertake this work will be progressed in 2019/20.

10.16 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 NHSI's Provider Licence conditions. The main risks to non-compliance with the provider licence are around governance and use of resources. See details in the following table.

Condition requirement	Controls & risks
To have regard to guidance issued by NHSI	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. 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 Dec-18. Leads have been identified for each and assurance is sought that there has been regard to the guidance. 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. Exceptions are reported to the Quality & Governance Committee with the last report considered in Dec-18. 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. 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. RISK - No specific risks have been identified to this condition. The Trust has regular contract meetings with the commissioners 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 about the options	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. RISK - No specific risks have been identified to this condition.

Condition requirement	Controls & risks
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. 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. RISK - No specific risks have been identified to this condition.
Good systems of governance	During 2018/19 the Trust had in place a Board of Directors consisting of Non-Executive (including the Chairman) and Executive Directors, plus a Non-Voting Board Director. 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 Trust has in place a Council of Governors with 24 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. Reviews of effectiveness were held in Dec-18 and Jan-19 and areas for focus for the year ahead were agreed which included new ways for the Governors to hold the Non-Executive Directors to account for the performance of the Trust. 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. In Sep-18 the Trust underwent a Care Quality Commission (CQC) inspection which resulted in a "good" rating overall for the "well Led" domain. RISK - No specific risks have been identified to this condition.
Shall at all times act in a manner calculated to secure that the Trust has access to the Required Resource.	Financial resource - The Trust has in place robust financial governance arrangements following the implementation of recommendations from an independent assessment. During 2018/19 the Trust revisited the recommendations to ensure that arrangements put in place remain fit for purpose. Notwithstanding this the financial position of the Trust remains challenged and the financial position is not sustainable due in part to an underlying structural deficit averaging £12.5m per annum. 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

Condition requirement	Controls & risks
	to deliver financial savings and drive efficiencies. 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. Workforce resource - The Trust carries vacancies and as such is reliant on agency and locum staff. There is a national shortage of nurses, doctors and clinical specialists and it is increasing difficult to attract staff to the Trust. The Trust has established a Retention and Recruitment Plan which continues to be rolled out. RISK - There is a risk to compliance with this licence condition in terms of both financial and workforce resources, notably the 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. There are risks associated with staffing levels and capacity to meet demand (see below).
Establishment and implementation of: - (a) effective Board and committee structures; (b) clear responsibilities for the Board, for committees and for staff reporting to the Board and those committees; (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. (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 scrutinise 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 of Directorate Board minutes and exception reporting. 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. 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-19.

Condition requirement	Controls & risks
	(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. 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-19. 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. 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. Performance is scrutinised and challenged through monthly performance review meetings, overseen by Executive Directors. Risk - No specific risks have been identified to this condition.
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. 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. 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.

Condition requirement	Controls & risks
	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). 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. 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. A monthly workforce report is produced which is overseen by the Performance, People and Place Committee. 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 a Recruitment and Retention Plan which is being rolled out.
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 Nov-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. 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.

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

The Trust has in place clear governance and accountability frameworks to enable the right level of assurance to be provided to the 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.

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 15+ 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 ongoing compliance in meeting the Care Quality Commission's (CQC) essential standards by the Quality & Governance Committee informed by the CQC Inspection Report Dec-18 and monthly quality reports;
- 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 Divisional Performance Meetings, to the Executive Committee and up to the Board;
- quarterly meetings with CQC relationship managers; and
- regular reporting to NHS Improvement through performance review meetings and regular dialogue with relationship managers.

10.18 Information Governance

NHS Digital has published assessment criteria and reporting guidelines for personal data breaches which are defined as any breach of security leading to the accidental or unlawful destruction, loss, alteration, unauthorised disclosure of, or access to personal data transmitted, stored or otherwise processed. This can include incidents that prevent access to, destruction of, or modification to the Trust's data. Such events are termed Data Security and Protection Incidents.

Trusts are required to take a risk-based approach which will determine the likelihood that adverse effect has occurred and the potential severity of the adverse effect that the incident has had on individuals. Any comparison with figures published in earlier years is therefore to be treated with considerable care.

There are three types of breaches:

(a) **Confidentiality** – unauthorised or accidental disclosure of or access to personal data;
(b) **Availability** - unauthorised access to or destruction of personal data, or data is unavailable or cannot be accessed;
(c) **Integrity** - unauthorised or accidental alteration of personal data

During 2018/19 there were a total of **63** such incidents, which were classified as follows:

Summary of data security and protection incidents in 2018/19		
	Breach type	
A	Confidentiality	46
B	Availability	14
C	Integrity	3
	Total	**63**

Notifiable breaches are those that are likely to result in a high risk to the rights and freedoms of the individual (data subject). During 2018/19 the Trust has reported one incident via the Data Security and Protection Toolkit incident reporting tool which has been notified to the Information Commissioner's Office, this was as follows:

Month of Incident	Nature of Incident	Number affected	How data subjects were informed	Lessons learned
Dec 2018	Inappropriate access to patient records held in an electronic system.	2	n/a (as the case is still on-going)	Information regarding the consequences of accessing records inappropriately has been disseminated to all staff via policies and information governance training materials.

10.19 Annual Quality Report

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 11 refers) and in the Annual Governance Statement (section 10 refers).

During 2018/19 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. Key Performance Indicators are in place that focuses on patient care, positive patient experiences and good clinical outcomes.

- An enhanced Quality Governance Framework has been implemented with a focus on bottom up Self-Assessments, Peer Assessments and Quality Reviews, which provide multiple layers of assurance.

- 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.

- 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. A clinical Non-Executive Director is appointed on the Board who chairs the Quality and Governance Committee and the Mental Health 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. A programme for ensuring patient stories are shared at board is in place.

- 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 audit of areas associated with quality governance such as e-rostering and ID medical contracting.

- During 2018/19 the Trust was inspected by the Care Quality Commission (CQC). Core services are leading on addressing concerns raised as part of the inspection. Clear governance processes are in place to govern progress in addressing areas of concern. In addition to this the trust has identified key

pillars and themes that require specific focus on the on-going journey to improve the quality and safety of services provided.

10.20 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. 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.
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. 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 Committees 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 2018/19 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 include Executive Director summaries of areas for attention.

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 is established 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 stroke and cancer performance.

The latest internal audit review of the Board Assurance Framework and risk management processes provided "substantial" assurance without recommendations (Mar-17). The audit found that the BAF was embedded in the governance structure of the Trust and is maintained as a "live" document.

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 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.

The CQC undertook a formal inspection in Sep-18. The outcome was that the Trust's overall rating remains "requires improvement" but improvement across a number of areas was recognised, notably in Children's and Young People Services and Outpatient Services. A number of must and should do actions were highlighted in the CQC report and these are being progressed by core service leads.

Reporting to NHS Improvement - Throughout 2018/19 the Trust continued to have 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 2018/19 the Trust undertook a self-assessment of compliance against NHS Improvement's well led governance requirements looking at Strategy and planning; capability and culture; process and structures and measurement. The Trust was inspected by the CQC in Sep-18 and the overall finding was that the Trust is "Good" under the well led domain.

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.

10.21 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

5 June 2019

11. Quality Report

11.1 Our Commitment to Quality – Statement from Nerissa Vaughan Chief Executive dated 5 June 2019

I am pleased to present our Quality Accounts for 2018-2019

This report provides a clear account of our work over the past 12 months to improve the quality of care we provide and shares our priorities for the year ahead.

A huge amount of work has taken place in the last year to better integrate hospital and community services across Swindon, so whether in hospital, in a community facility or at home, our goal is for care to feel well-coordinated and joined-up at every stage of a person's journey.

Our new pathway of care designed to meet the unique and often complex needs of older patients, is a good example of how quality of care has improved through health and social care professionals working together in a more structured way. Patients attending the Emergency Department are starting treatment sooner, are more likely to leave hospital the same day and are receiving specialist older person's care throughout their stay in hospital and beyond.

We are now exploring further opportunities to work more closely with GP practices, social care and voluntary organisations. This work aims to remove organisational barriers, improve communication and introduce more joint working, while improving the experience of patients and their families and creating a more rewarding working life for staff.

Like the rest of the NHS, we must transform local services to ensure we can consistently meet the needs of local people and maximise the value of every pound we receive. The golden thread of this work is quality, which remains at the heart of every decision we make and everything we do.

Our life saving work on sepsis continues and we're proud to be one of the top trusts in the country for identifying and treating this life threatening condition, with 80 per cent of patients making a full recovery. The work of our Acute Sepsis and Kidney Injury Team means we are also spotting the signs of acute kidney injury sooner and so more patients are surviving. These are just a couple of examples of how we are adopting international best practice, standardising processes and focusing on education to provide care which is safer and more effective than ever before.

Over the last year, quality improvement has become an integral part of our everyday work, alongside a culture of openness and learning from mistakes. As we look forward, this will form an even stronger focus, as a key theme throughout our new Trust strategy.

This approach to improvement was reflected in the results of our latest inspection by the Care Quality Commission. While we received a rating of 'requires improvement' overall, the vast majority (80 per cent) of our services were rated as 'good', with a number receiving 'good' across the board, including children's and young people's, outpatients and community. This shows the progress we're making, with just 50 per cent of services rated as 'good' three years ago.

As we look to the future, the expansion of some of our emergency and urgent care services will be a major part of our quality improvement work, helping us to meet the needs of a rapidly growing population, particularly at our busiest times. This is why we were delighted with our successful bid for £30 million national funding to support our new Way Forward Programme, which will help to address these challenges over the coming years.

This programme of work, together with developments like the new Radiotherapy Centre, made possible through the incredible fundraising achievements of local people, will result in a number of exciting changes on the Great Western Hospital site, helping to save more lives.

It is not only major developments like these that make a difference to patient care, there are many smaller scale initiatives designed to improve quality.

We are the first trust in the country to introduce the Hidden Disability Lanyard Scheme, which helps staff to recognise when someone has a hidden disability such as autism.

Our Red Bag Scheme is ensuring that care home residents experience a smoother arrival and discharge from hospital, with their belongings stored in one place.

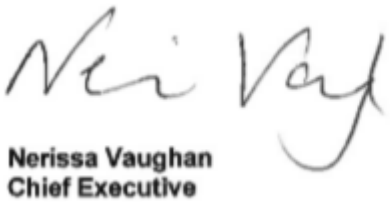
As the proud winner of the ‘Golden Hip Award’, we have seen hip fracture patients recovering more quickly and fewer deaths, following significant improvements to nutrition, surgery and mobilisation.

The CardioMEMS™ Heart Failure system is enabling doctors to remotely monitor cardiology patients and detect early signs of heart failure. This technology means changes to medication and other interventions can happen sooner, so patients are less likely to need hospital treatment and are experiencing a better quality of life.

As you read through this document, you will see many more examples of innovation, transformation and standardisation, all with safety and quality at the heart.

Looking ahead, our integrated approach to care means there will be more opportunities to help people stay healthy, do more to keep long-term conditions such as diabetes under control and prevent ill health, ultimately helping people to stay well.

I hope you enjoy reading about our progress and our plans to further improve the quality of care we provide across Swindon.



Nerissa Vaughan
Chief Executive

5 June 2019

11.2 Priorities for Improvement 2019/2020 & Review of 2018/19 Priorities

This section sets out our priorities for improvement during 2019/2020. Two of these priorities were identified in our 2018/19 Quality Accounts ('Improving effectiveness of nursing handover and timely discharge communication' and 'Increase Quality Improvement (QI) capacity through implementing a Trust-Wide programme of QI training'). For this reason a review of the previous year's progress as well as plans for 2019/20 are detailed in this section of the report.

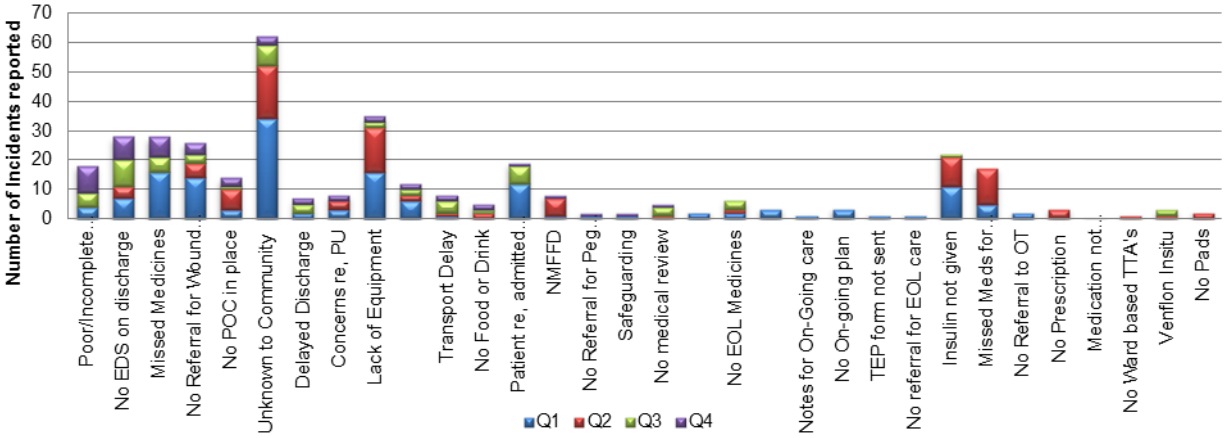
Our priorities for the forthcoming year have been influenced by national and local agenda's, our internal learning from experience, feedback from our staff and stakeholders (including partner organisation, patients and carers).
Our priorities are also agreed through our quality contracts with our local Clinical Commissioning Groups (CCG's) and take in to account intelligence we have from available data.
These priorities have been consulted on with the Trust Governors as patient/public representatives, Healthwatch and other key external stakeholders. Progress will be closely monitored and reported through our Patient Quality Committee, Quality Governance Committee and Trust Board.

Our Priorities for Quality Improvement – Our Focus for 2019/20

- Improving effectiveness of nursing handover and timely discharge communication
- Improve patient experience and engagement and improve complaint response timescales
- Increase Quality Improvement capacity through implementing a Trust-Wide programme of Quality Improvement training
- Develop the support provided to carers of a persons living with dementia
- Reduce our rates of Clostridium Difficile infection

Improving effectiveness of nursing handover and timely discharge communication

This priority was identified within the 2018/19 Quality Accounts and remains a key priority given on-going challenges in ensuring safe discharges which have been identified internally and by external partners. In quarter one, two and three our Patient Advice and Liaison Service highlighted that they were receiving a high number of calls relating to concerns around discharges. In quarter four the number has reduced and this has been evidenced by two recently undertaken audits.



The chart above demonstrates the number of handover and discharge related incidents each quarter during 2018/19 with 'unknown to community' associated incidents being the highest number reported. This data is reviewed as part of our Discharge Transformation Steering Group and alongside other evidence informs areas for improvement. Workstreams have been established to lead on improvements in key areas of concern during 2018/19 which will continue in to 2019/20. The work streams are:

- The Safer Discharge Project
- Community Referral Improvement Project
- Electronic Discharge Summary (EDS) Improvement Project
- Nurse Documentation Review

Safer Discharge Project

The safer discharge project has focused on ensuring that key safety milestones are achieved from the beginning of a patient's admission until the end. In the past year a Safer Discharge Checklist has been implemented on all in-patient areas across the acute and community settings. Towards the latter part of the year the checklist was reviewed and a decision was made to provide the assessment areas, excluding the Emergency Department, with a more tailored version of the checklist, to ensure it met the needs of those patients who are only with us for a very short period of time. In line with our adopted Quality Improvement (QI) Methodology this will be evaluated following a further period of testing.

Community Referral Improvement Project

During the previous year a revised community referral form has been implemented across the organisation. This has resulted in a recent drop in the number of clinical incidents reported, relating missed referrals to community services. Despite this our ambition is to reduce such incidents further and during the next year we will continue to closely monitor missed referrals to community services and use identified issues as opportunities to learn and further develop the safety of our services.

A key success story has been the reduction in the number of missed referrals to community services for those patients that require insulin administration. To take this further there is QI project underway within the community looking at the delivery service for those patients requiring insulin. The project is in its infancy stage at the moment.

Electronic Discharge Summary (EDS) Improvement Project

During the past year there we have received feedback from partner organisations (including G.P's) relating to the timely completion and quality of our EDS. In response to this a working group has been established with key people from the organisation and the community to review the process and manage compliance.

With the support of the trust QI Lead a Quality Improvement Project has been instigated to drive and support sustainable change. The project has had input from a wide range of professions and roles within the organisation and from external partners, including Consultants, Ward Administrators and G.P's. A number of processes were changed (including clarification of roles and responsibilities) and training was provided. Tests of change were implemented and improvements were seen on the wards involved. These improvements have been shared across the organisation and we have begun to see a ripple effect in the timeliness of EDS's being sent.

Despite the improvements described above we are committed to further improvements going in to the next year. To support this, the trust Medical Director has recently established an EDS Task and finish group to bring further focus on improvement going in to the next year.

Nurse Documentation

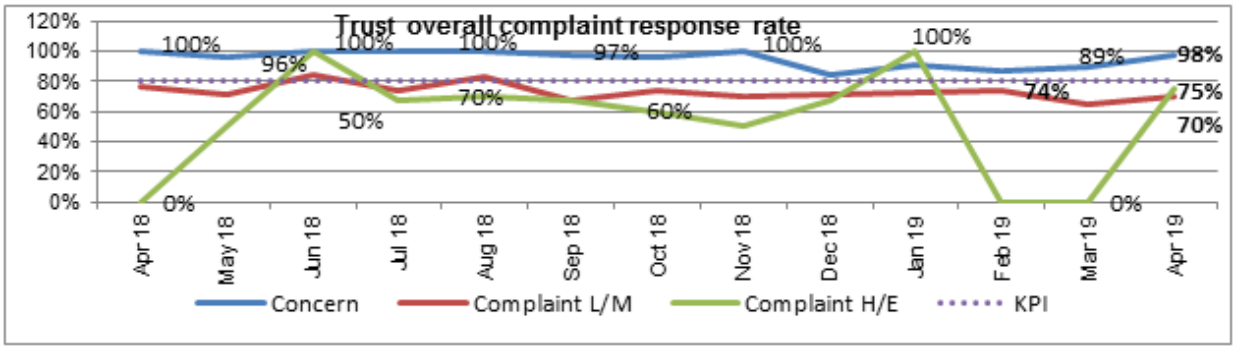
During 2019/20 we plan on further review nursing documentation used within the hospital. This is a key area to support not only safety during admission but also discharge planning and implementation.

Improve patient experience and engagement and improve complaint response timescales

During 2019/20 we plan on enhancing our approaches to engaging with patients and involving them in the development of the quality of our services, to ensure that we fully learn from the positive and negative experiences they have had, A key part of this will be to further refine our management of complaints to ensure that they are appropriately responded to in a timely manner. Key areas for improvement for 2029/20 are:

- Increase Friends and Family Response Rate
- Collaboratively develop and launch new Patient and Carer Involvement Strategy
- Further review processes to improve timeliness of responses to complaints

The table below shows the GWH Complaint response compliance for 2018/19. A complaint is considered as being responded to within timeframe when it is responded to within 25 working days. The exception to this is if an extension is applied in agreement with the complaint.



Increase Quality Improvement capacity through implementing a Trust-Wide programme of Quality Improvement training

This priority was identified during the 2018/19 Quality Accounts and remains a priority going in to 2019/20. Over the course of the past year QI skills have begun to develop across the organisation. Bronze level training has commenced and a training plan is in place to ensure increasing numbers of staff are given the opportunity to develop QI skills. Bronze training has also been incorporated into the leadership course (3 Cohorts per year) and the stepping up programme (Bi-Monthly). We are working with NHS Elect and they are providing us with a number of courses over the next 12 months that will develop our QI coaches. These sessions include Human Factors, difficult conversations and conflict resolution, leadership and coaching.

Fifteen members of staff have now joined the Health Foundation Q community, gaining access to regional networks and training opportunities.

A QI on line registration form and data base have now been developed which shows at a glance the number of projects, where they are taking place and who is leading on those projects.

We have joined a Delivery Improvement Network engaging with other organisations that are at different stages of the Quality Improvement journey. This enables us to network and bench mark ourselves with other organisations and learn from their experiences.

There are a number of NHSI projects in progress within the organisation these include Maternity and Neonates, Nutrition, Oral care, Frailty, Pressure Ulcers and Criteria Led Discharges.

Following the approval of the business case the QI Lead is now in post focusing on developing the Training plan, Trust wide Projects and supporting/coaching teams undertaking QI projects.

Staff are actively sign posted to external providers, such as the Academic Health Science Networks, for formal QI training QI 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.

On the 5th of November 2018 we held a QI day. All staff that have QI projects underway were invited to produce a poster to celebrate their projects. The aim of the poster day was to advertise the projects and the outcomes either achieved or potential outcomes and benefits.

Over 70 posters were on display with as many staff dropping in to talk about new ideas and fill our innovation tree. The trust Clinical Lead for Quality also presented at the Grand Round, inspiring our clinical teams to become involved with QI projects. We are planning a future event in June but opening it to the wider Quality Team.

Further improvements identified for 2019/20

- Continue to develop, deliver and evaluate the strategy and to build organisation wide knowledge and skills in quality improvement;
- Continue to develop and review the 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
- Identify key members of staff to apply for membership of the Health Foundations Q Community during the next application round.

Develop the support provided to carers of a persons living with dementia

During 2018/19 we have been working closely with Dementia UK who have part funded two Admiral nurses to work with our in patients and their carers and continue to support the patient and their carers when they are discharged in to the community. This is a two year pilot project and was officially launched on 21/01/19. The Admiral Nurses are also a valuable support to the ward teams sharing their knowledge and expertise in order to improve the safety and experience of our patients with dementia.

Going in to 2019/20 our admiral nurses and dementia leads will be continue to review the support available to carers, of people living with dementia, to ensure that they are well supported.

Reduce our rates of Clostridium Difficile infection

During 2018/19 we have introduced and maintained a number of initiatives to improve patient safety and they are detailed below. Despite this we have reported 27 cases of Clostridium Difficile, 2 more than 2017/18 and 8 above our nationally mandated goal for 2018/19. Each case has been investigated in conjunction with our Commissioners. Of the 27 cases, 15 have been deemed unavoidable and 11 have been deemed as avoidable and care improvement recommendations made. The review of the final episode is outstanding.

Moving in to 2019/20, we plan to continue monitoring and reducing risk factors for C.diff 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.

Review of 2017/18 Quality Account Priorities

This section provides a review of progress against the priorities identified in our 2017/18 Quality Accounts (excluding those which are included in this year's priorities).

Saving 500 Lives

The trust remains committed to deliver its ambition to save an extra 500 lives over 5 years, commenced in 2015, with the continuation of this ambition for 2019/20. We will continue to progress our safety improvement plans through projects to improve quality and safety which continues to be measured, monitored and reported through our Patient Quality Committee, Quality Governance Committee and Trust Board.

The overarching project plan, for delivery of Sign up to Safety, finished in March 2018. During 2017/18 this covered the following key areas of focus, a combination of national aspirations and our own specific improvement areas. The Trust is committed to continue to drive and continually improve these key areas during 2019/20.

- Reducing falls
- Reducing pressure ulcers
- Management of sepsis
- Recognition and rescue of the deteriorating patient
- Acute Kidney Injury (AKI)

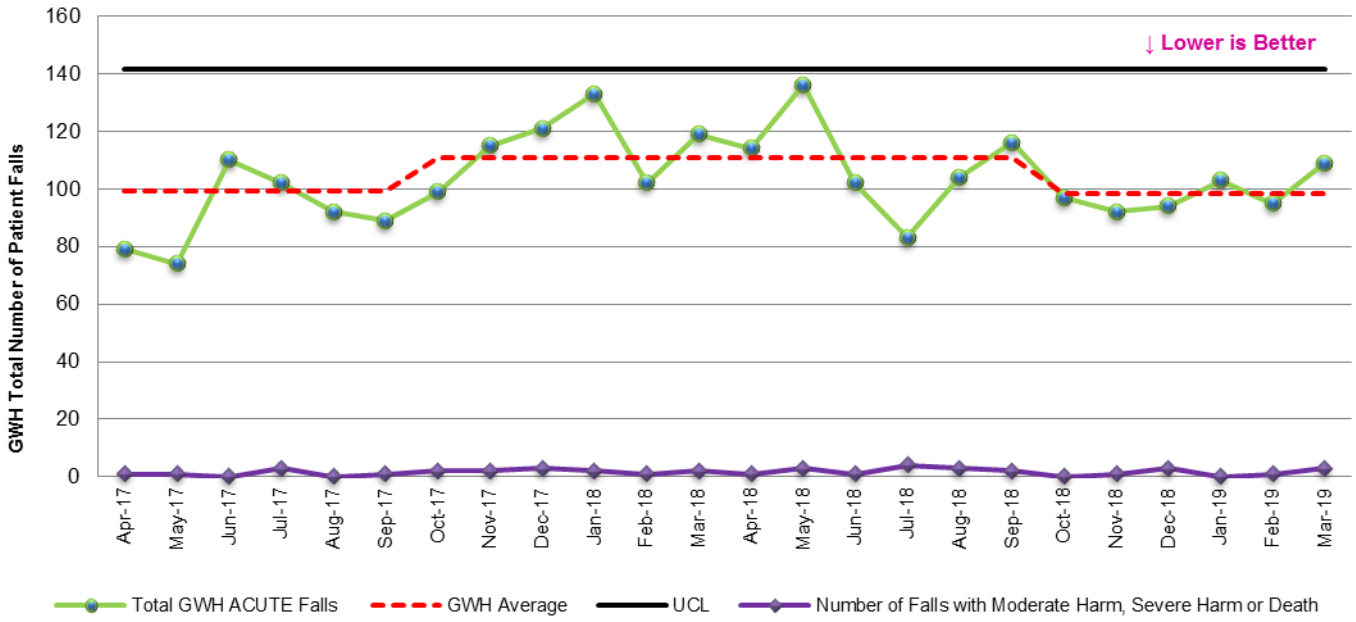
Reducing falls

Falls are one of the leading causes of harm in hospitals. The human cost of falling includes distress, pain and injury, loss of confidence and increased morbidity and mortality.

- On average 103 falls were reported within the Trust each month during 2018/19 which is comparable to the previous year.
- During 2018/19 we reported 22 falls resulting in moderate or severe harm, averaging fewer than 2 a month, sustaining the average compared to previous years, despite the increase in the number of admissions into the Trust.
- The Trust has not reported any patient deaths following a fall since 2016/17.

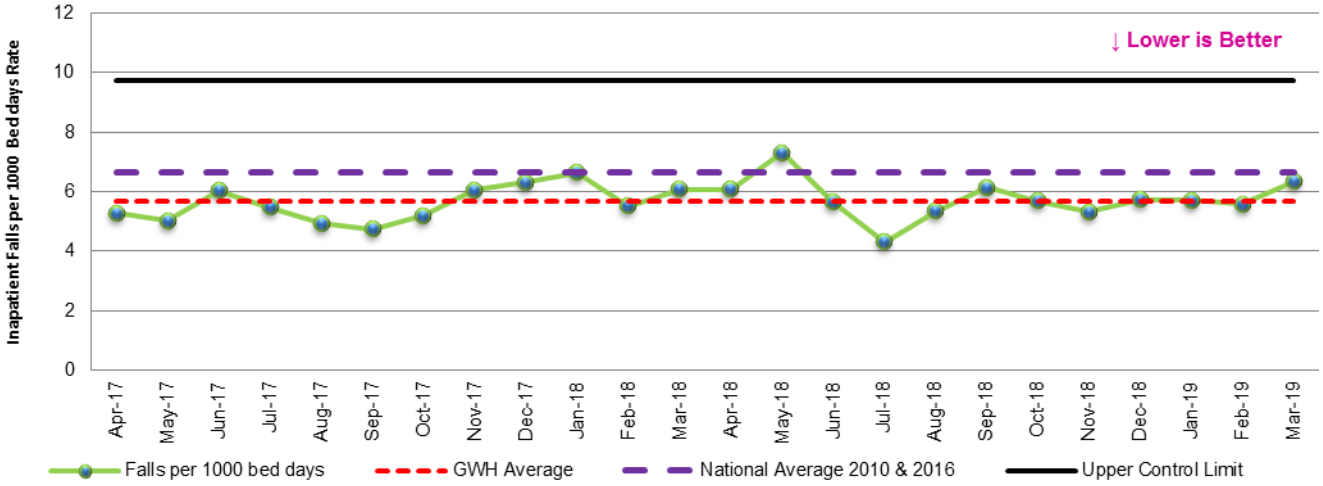
In February 2018, the Trust also opened an eight bedded area (Dorcan Unit) for additional capacity which is included in our reporting of Trust wide falls to ensure appropriate oversight.
Year on year our target is to continue to reduce the number of falls and in particular the number of falls which result in significant harm.

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 inpatient falls rate per bed days sits below the national average.

What improvements have we achieved?

We have been consistently below the national average rate for falls per 1000 bed days for 11 out of 12 months in 2018/19.There have been no deaths caused from inpatient falls reported in 2017/18 and in 2018/19

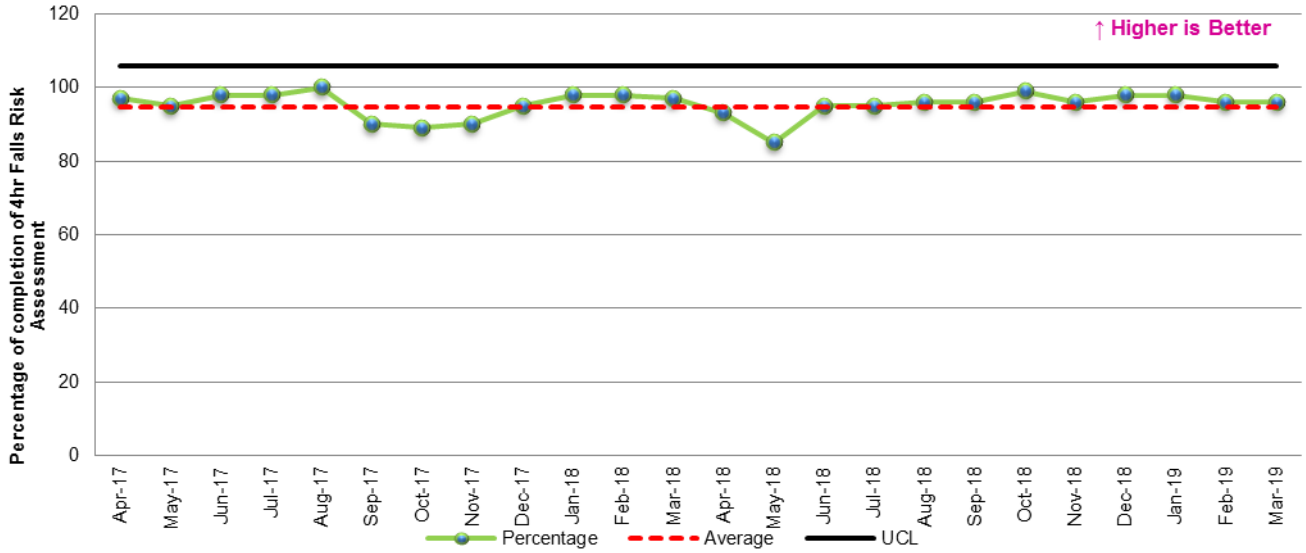
Over the last twelve months, our focus has been to embed an analytical approach to preventing falls based on clinical data and observations to help identify where we can improve our practice. The old post falls incident form design meant that there were numerous missing variables which made looking at patterns of falls very difficult. Many fields, such as the bed number, are now mandatory to ensure effective communication of hot spots on specific wards. The data obtained from the new post falls incident form has already allowed us to focus more on interventions that will help reduce falls and harm from falls, for example, looking at the effect of medication on falls, looking at environmental obstacles, looking at the type of footwear patients have on when they fall as well as the use of bedrails in patients who have fallen. All of this information is fed back to the Falls Operational Group and used to aid discussions on safety.

All Ward Managers/Allied Health Professionals are attending the monthly Falls Operational Group meetings to share learning Trust wide. The primary purpose of the Group is to identify, pilot, measure, implement, embed and sustain practices and processes that promote a safety culture around falls avoidance and reducing harm from falls. The Group regularly review fall trend analysis and reviews incidents resulting in harm from a fall, and any incident where there is learning.

The Trust made improvement in 6 out of 7 indicators of the National Falls Audit for the Royal College of Physicians (RCP) in May 2017, work continues during 2018/19 to further improve against these indicators. The organisation is participating in the RCP National Audit which commenced in January 2019 (results not yet issued).

The Trust completes regular snap shot audits every month to ensure every patient is assessed for their risk of a fall within 4 hours of admission or transfer to a ward. The compliance rate for the completion of the risk assessments has increased over the past 12 months, with a sustained improvement.

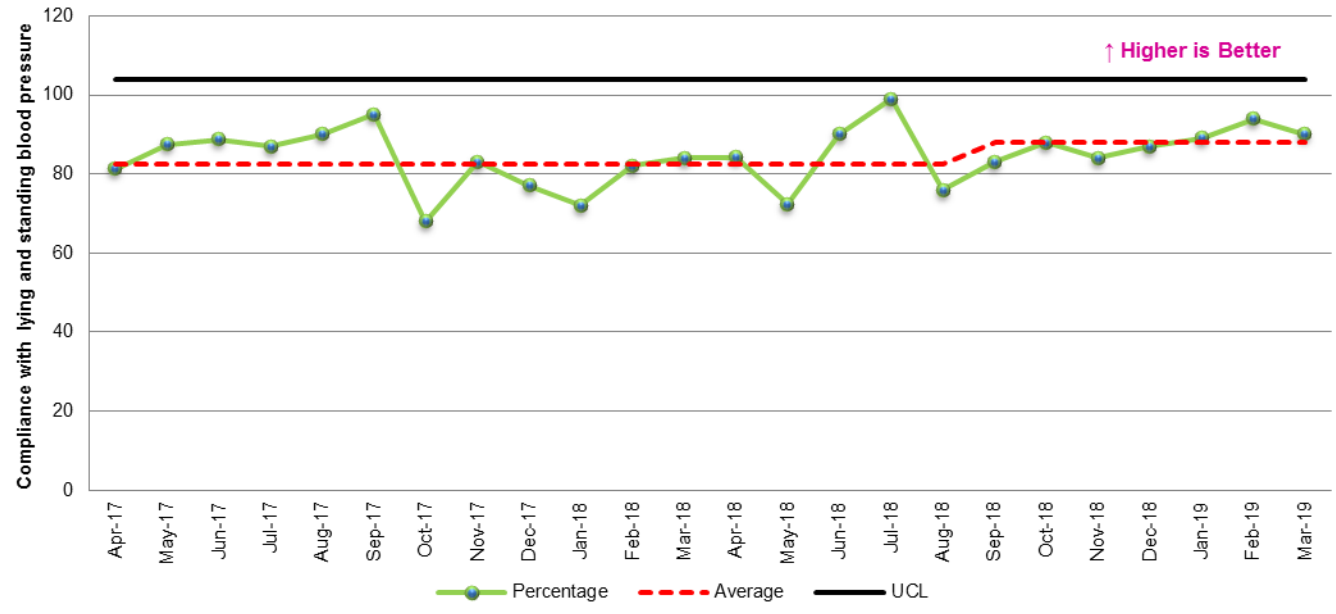
Falls Risk Assessment



The chart above demonstrates the Trusts percentage of completion of falls risk assessment with an average of 95% completion over the last 12 months. Assessment for a postural drop by taking a lying and standing blood pressure is also monitored via this snap shot audit.

The compliance rate for the completion of the lying and standing blood pressures and the identification of a postural drop have also both increased over the past 12 months with a sustained improvement.

Compliance with lying and standing blood pressure



This chart demonstrates the sustained improvement for the completion of a lying and standing blood pressure during the completion of the falls assessment, with the new average being 88.0%, and increase from 82.4%.

The identification and assessment for Delirium was an area when we scored lower than expected in the RCP audit of 2017, it has also been identified as one of the more common causes of inpatient falls. We have amended the post falls proforma completed by the medical staff which now includes assessing for delirium as a contributing factor to the fall. Identifying delirium in post fall assessments will inform the forward medical plan and allow us to better manage our confused patients, reducing the risk of a patient having multiple falls, reducing multiple admissions and prolonged stays in hospital. The Trusts Safety Rails policy has also been amended in line with best practice. Compliance for this will be monitored in the coming year.

Drivers for improvement

- Post Fall Proforma - designed by the junior doctors to ensure a standardised proforma provides consistency of documentation between doctors and increases confidence when dealing with a fall
- EDS to inform GP of a fall during the admission
- Joint working with Swindon CCG and partner organisations as part of Swindon Falls and Bone Health Collaborative
- Digital Reminiscence Therapy (Interactive multimedia to stimulate personalised memories) equipment is being 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 2019/20

- Review and update Falls Avoidance Policy and Falls Strategy.
- Participate in the Royal College of Physicians National Audit which commenced January 2019 looking at patients who have sustained a hip fracture while in hospital.
- Falls prevention measures form part of Ward Assessment and Accreditation Framework

Reducing avoidable pressure ulcers

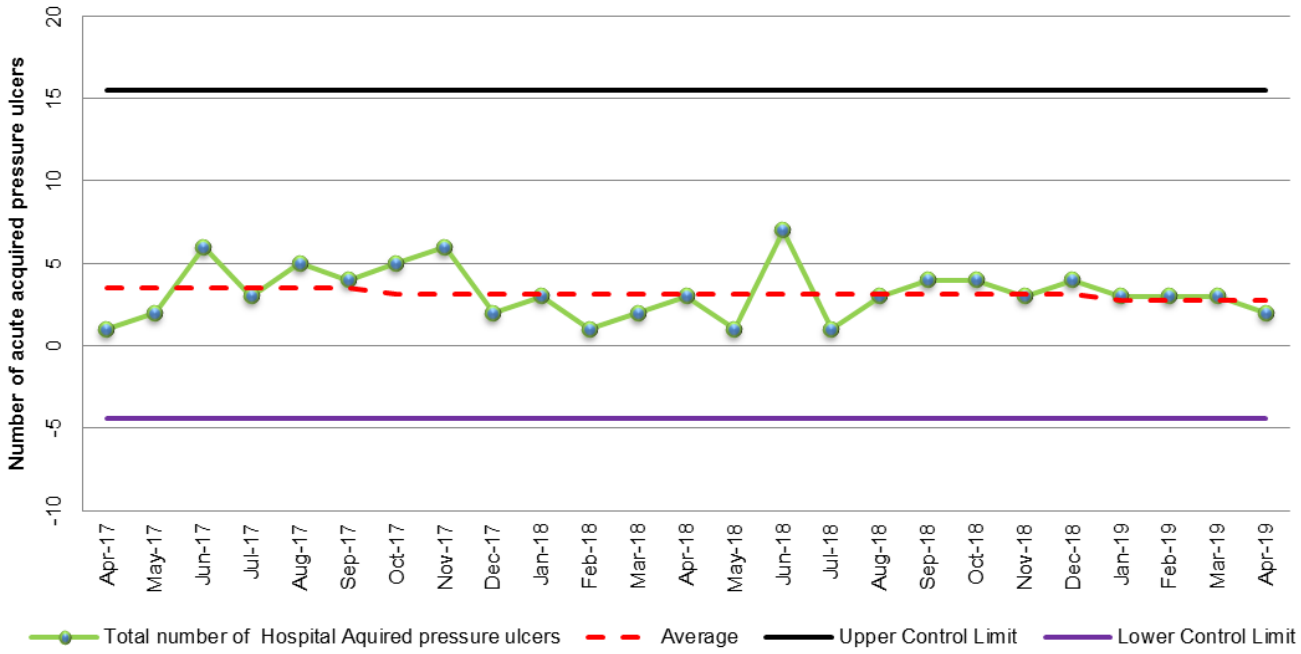
Pressure ulcers typically affect patients with health conditions that make it difficult to move, in particular patients sitting for long periods of time or confined to lying in bed.

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.

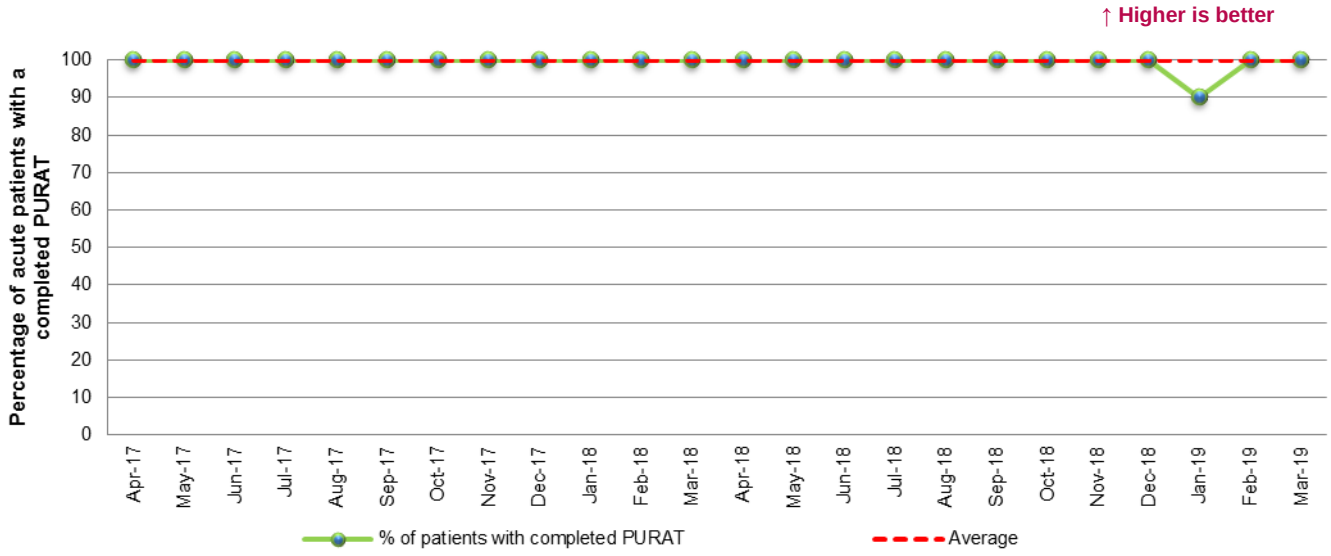
- We reported an average of 3 acute patients per month with pressure ulcers during 2018/19 sustaining the average on previous years. 1 category 3 pressure ulcer was reported during 2018/19, this remains the same as 2017/2018.

Total number of acute inpatient pressure ulcers (category 2, 3, 4 for all acute inpatients)



The chart above demonstrates the total number of avoidable and unavoidable category 2, 3 and 4 Pressure Ulcers in acute inpatients.

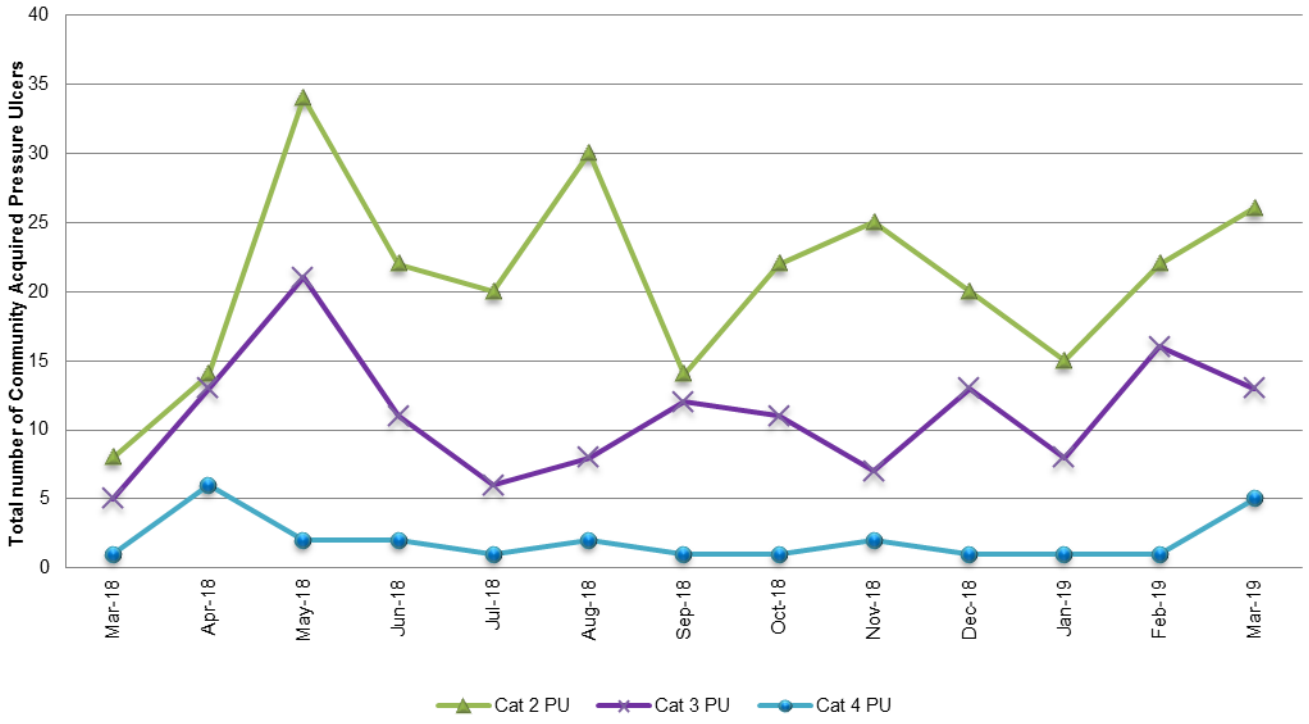
Percentage of acute patients on hotspot wards with a completed Pressure Ulcer Risk Assessment Tool (PURAT)



The chart above shows the percentage of at risk inpatients that have had a pressure ulcer prevention core care plan completed. We consistently achieved 100% for acute, at risk inpatient's who have had a pressure ulcer prevention core care plan in place (in samples of 25 patients records reviewed per month). There was one month where this reduced to 90%.

This data is taken from our monthly audits of the 5 hot spot wards which are wards where pressure ulcers are most frequently reported.

Total number of community acquired pressure ulcers (category 2, 3, 4)



The chart above shows the number of acquired pressure ulcers reported within community services during 2018/19 with category 2 being the highest.

What improvements have we achieved?

- New E-referral process to the Tissue Viability Service has been developed in conjunction with Nerve centre and is about to evaluated on two wards prior to distribution to all clinical areas. The aim is to improve timely referrals and safeguard the process, reducing errors.
- Tissue Viability Nurses (TVN's) investigate complex 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.
- Following the guidance in June 2018 from NHS Improvement re the standardisation of terminology, documentation and the reporting process of all Pressure Ulcers a quality improvement plan across the organisation was commenced. Being an integrated trust and Tissue Viability team has improved this process, offering standardised approaches, seamless working and a consensus approach, this has also been re- enforced with the consensus approach across the Tissue Viability Teams within the STP.

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

- An Annual wound audit is conducted.
- Successful Integration of a Tissue Viability service across both acute and community division's joint meetings and training are taking place with joint working on pathways and seamless patient journeys.
- Educational sessions 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.
- Re-implementation of the wound care link nurse meetings to champion knowledge on the wards, with dissemination of updates and new dressings. The meetings are quarterly.

Further improvements identified and priorities for 2019/20

- Integration of the link group with community link nurses (community and practice nursing)
- Development of 2 databases one for the reporting of hospital acquired pressure ulcers, the patient journey and if there are any missed opportunities in care, and one for the reporting of patients who have been discharged into Swindon Community with skin integrity issues, we look and reflect on each IR1 individually and update each incident accordingly. The data bases are updated monthly.
- Implementation of the E referral process across the organisation (acute division) following completion of trial - this will ensure referrals are more efficient between the ward and the Tissue Viability Service.
- Quarterly newsletter designed and sent out trust wide to keep staff updated about the service
- 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, Trainee Assistant Practitioner course and medical staff.
- Implementing and embedding of the NHSI new categorisation of pressure ulcers, to include unstageable, moisture associated skin damage, device related and deep tissue Injuries which will be reported on monthly.
- Education on the use of Kerrapro to all wards and departments which is a silicone pressure relieving aid can be applied in strips, squares, sacrum and heel shaped and assists in relieving pressure on pressure points such as heels, sacrum, spine, hips and any other pressure areas. The strips can also be used under medical devices such as oxygen behind the ears, or over the nose for example.
- Mattress Audits are carried out prior to bank holidays to ensure the appropriate use of dynamic mattresses across the trust. Every ward is audited to see whether a patient could be stepped down, thus ensuring sufficient resources and effective use of equipment.

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.

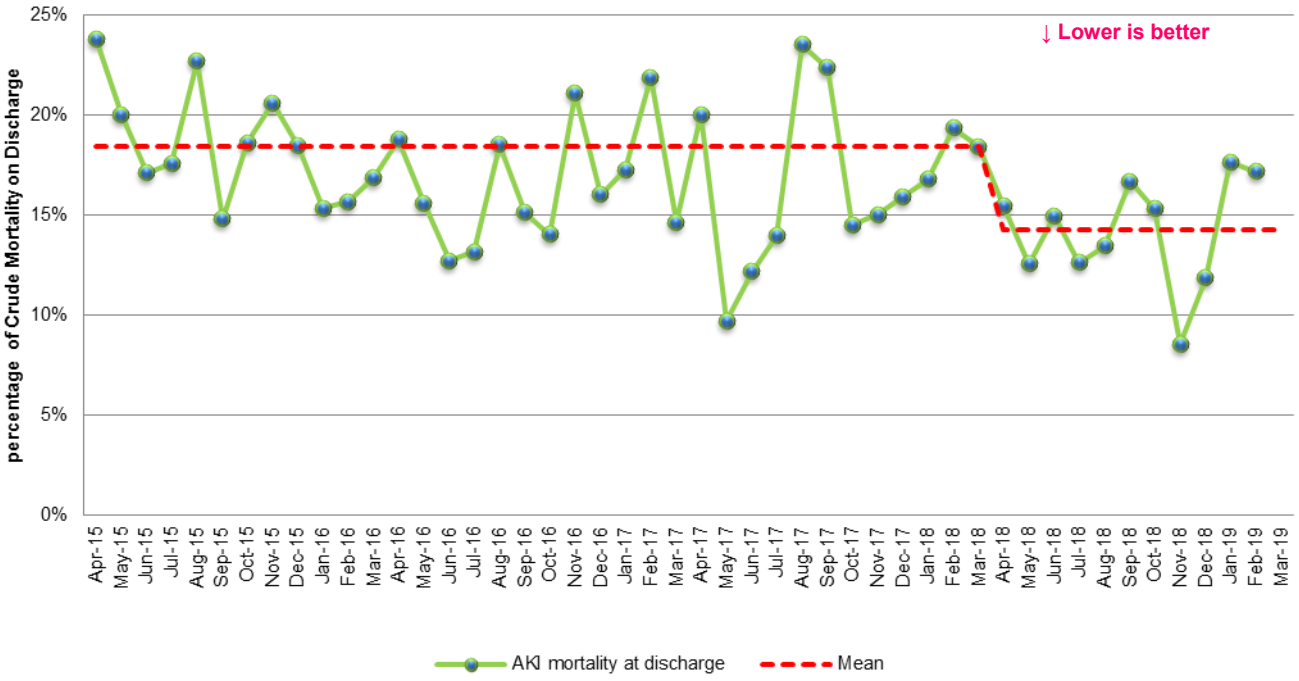
With early detection and the right care at the right time, both the risk of death and long term damage to the kidneys is greatly reduced.

As a common and potentially life threatening condition, we are passionate about proactively improving care and saving lives.

- During 2018/19 we reported an average of 14.7% 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%.

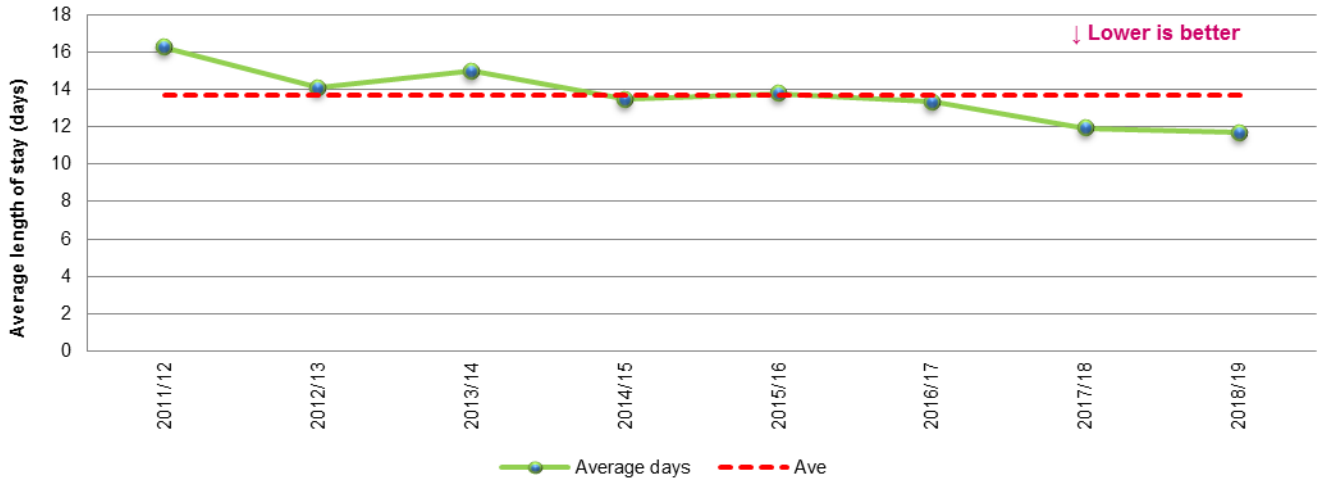
Time period	Average mortality at discharge with AKI
April – Dec 2015	19.28%
2016/17	16.58%
2017/18	16.79%
2018/19	14.69%

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.

Average length of stay (days)



The chart above demonstrates average length of stay a patient stays in hospital with a diagnosis of AKI. A decrease in length of stay can be seen from 2013/2014 since awareness work started demonstrating that early recognition and treatment of AKI results in a shorter stay in hospital.

What improvements have we achieved?

- 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.
- The Acute Sepsis and Kidney Injury (ASK) Team continue with their responsibility for ensuring all patients with AKI are treated using the same set of clinical interventions which are based on international best practice. The team work with staff across the organisation and healthcare partners 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.
- AKI flagging direct to GP surgeries commenced in early 2019.

Further improvements identified and priorities for 2019/20

- 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.
- We will bring electronic flagging of AKI into real-time alerting using the NerveCentre e:observations system. This will ensure increased awareness amongst clinical staff and should encourage timely delivery of the Kidney 5 SHOUT care bundle

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 52,000 people will die as a result of the condition. (UK Sepsis Trust 2018).

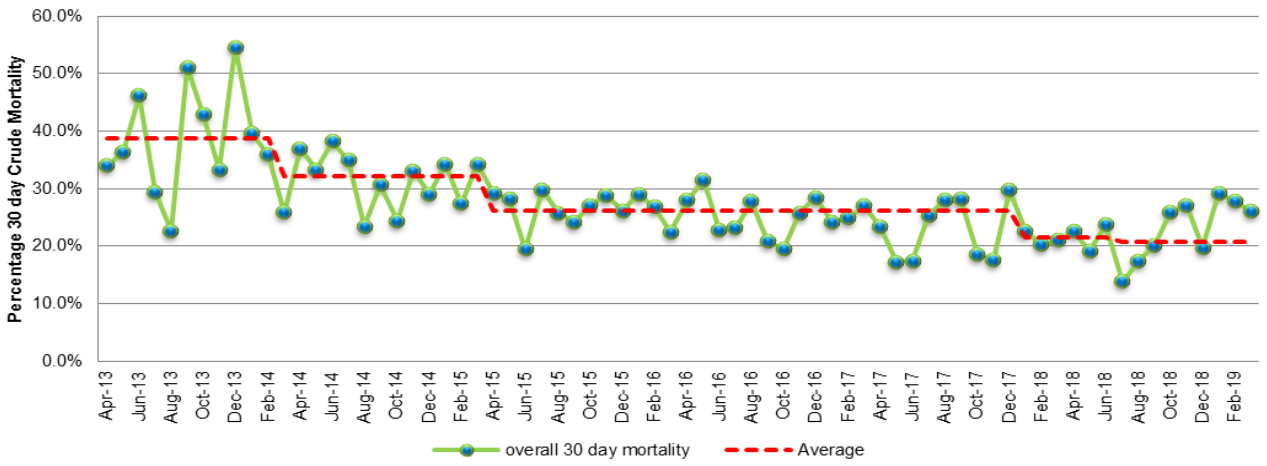
Effective delivery of the Sepsis Care Bundle (Sepsis 6 UK Sepsis Trust) increases patients' chance of survival by up to 30%. Overall national mortality rate for patients admitted with severe sepsis is 35%. (UK Sepsis Trust 2014) Changes to the way we diagnose and classify sepsis came into use during 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.

In 2018 we revised the way we collected data on Sepsis which widened the category of patients included. This has led to the data showing an increase in our percentage of patients admitted with sepsis who died within 30 days of discharge, from 15% (2016/17) to 22% (2017/28). Despite the change to the way the data is collected 22% remains below our initial annual mortality target of 23%, which was set using the previous data collection method. This achievement is as a result of the significant service developments described below.

30 Day Mortality

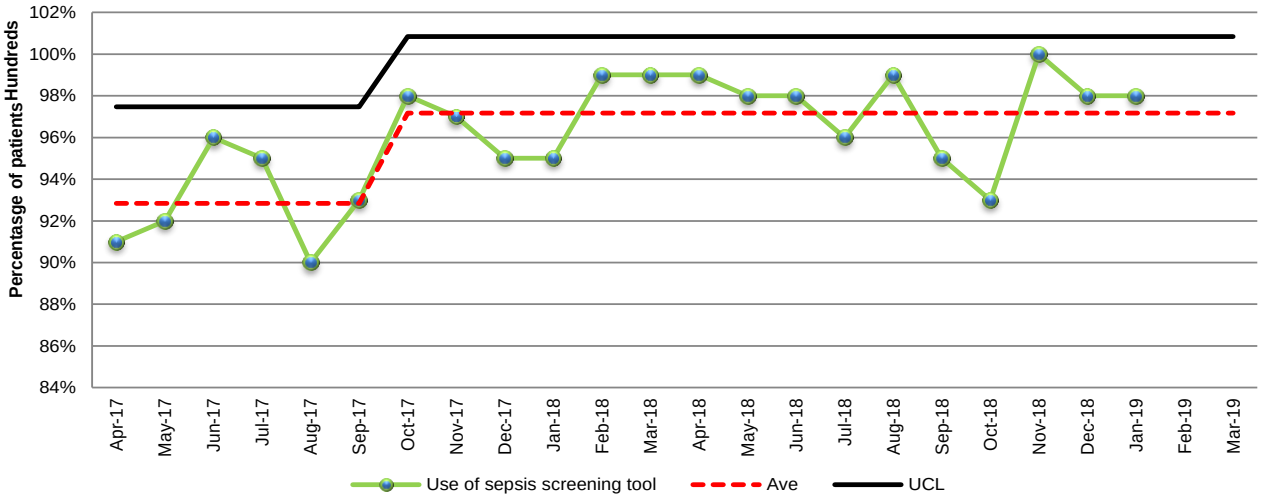
↓ Lower is better



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

↑ Higher is better



What improvements have we achieved?

- ASK Specialist Nurses Team has achieved a seven-day service consistently running since November 2017.
- Individual ward focussed/ simulation teaching. Training has been recently delivered to Falcon Ward, Shalbourne Ward and Teal Ward in February.
- Sepsis Grab Bag trial currently running on Beech, Neptune, SWICC and Meldon using the red (penicillin) and blue (penicillin allergy) bag. The grab-bag trial has been extended to ACAT within the medical admissions service.
- Physical presence of ASK Team daily in ED, SAU and ACAT/ AMU
- 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.
- NEWS2 rollout has completed, with ED moving onto Eobs during October 2018.

Further improvements identified and priorities for 2019/20

- Planned to launch in May of 2019 will be the sepsis module of our electronic observations system NerveCentre.
- ALL patients observations will be screened for the presence of “red-flags” according to the NICE 2016 guidelines for sepsis (https://www.nice.org.uk/guidance/ng51)
- Linking out to Community services – Training commenced/planned for 2019: Swindon Community Teams, Goatacre Nursing Home.
- Education sessions for Oxford Brookes Nursing students, now planning further sessions in 2019.

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.

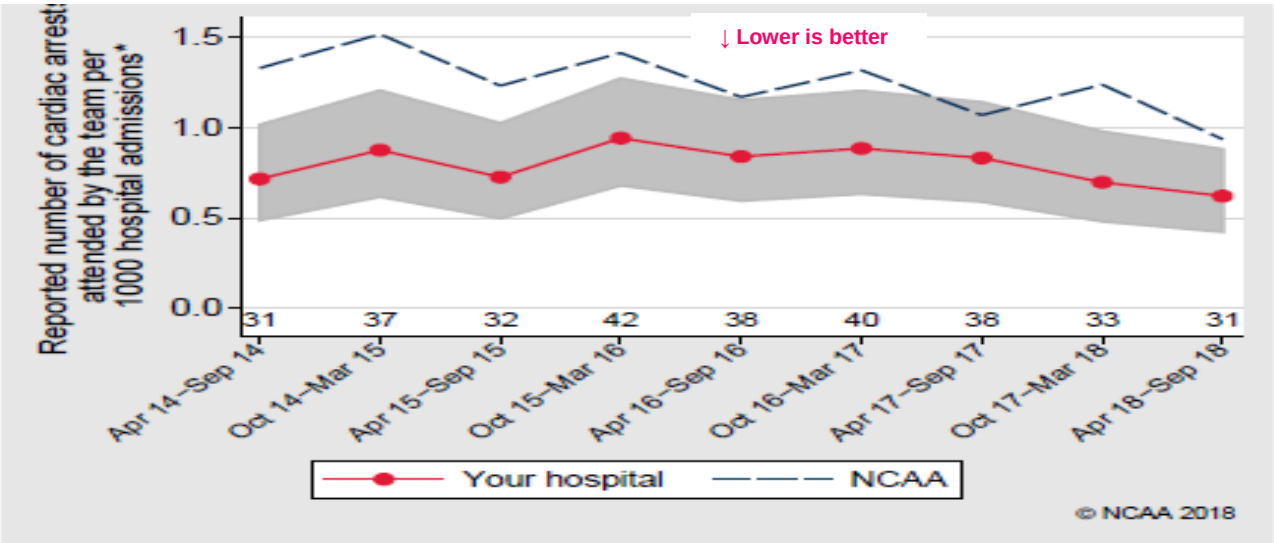
A Deteriorating Patient working group to reduce harm from failures to recognise and respond to acute physical deterioration has been established and leads for individual projects are identified.
A nursing and medical lead jointly leads the group. Monthly meetings have been arranged and each project group have an assigned date and time to feed back their progress.

Key points from the National Cardiac Arrest Audit (NCAA) (2018/19) Quarter 2 report 01/04/2018 – 30/06/2018

Please note Quarter 4 and year end was not available at the time of this report being finalised.

- Number of incidents for quarter 2 = 15 (Q1:16)
- Incidence (per 1000 admissions) for quarter 2 = 0.67 (Q1:0.64)
- Number of potential non-arrests for quarter 2 = 0 (Q1:0)
- Survival to hospital discharge for quarter 2 = 14.2% (Q1:13.3%)
- National survival rate 2016 = 20.1%

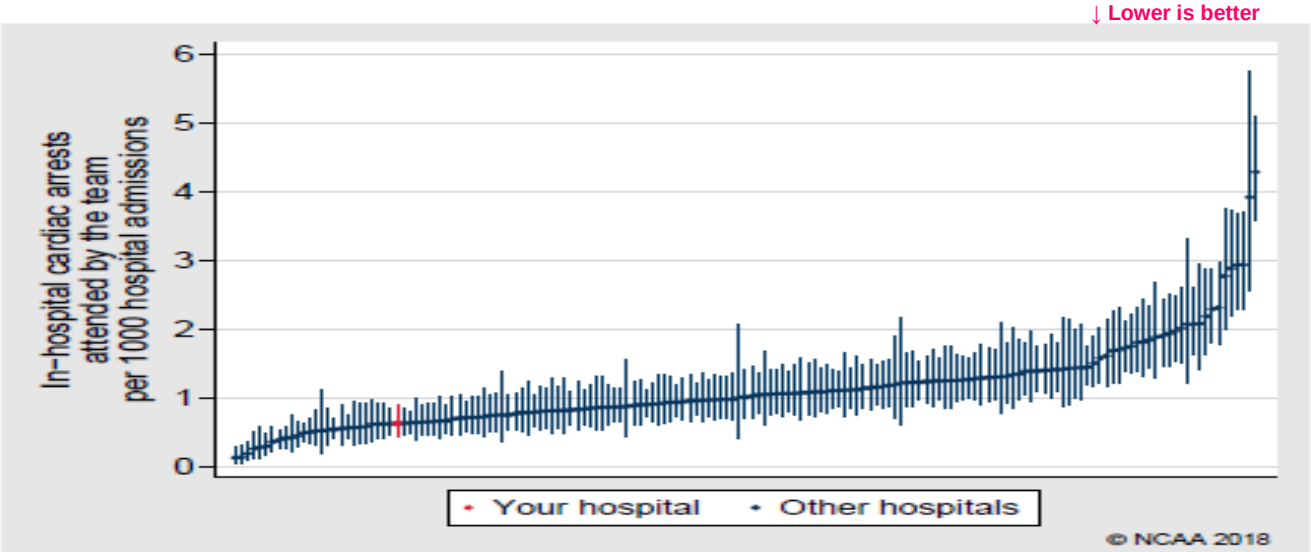
Rate of Cardiac Arrests per 1000 hospital admissions



The chart above shows our cardiac arrests per 1000 hospital admissions for the period of 01 April 2018 – September 2018 in comparison to National Cardiac Arrest Audit (NCAA).

Rate of in-hospital Cardiac Arrests

↓ Lower is better



The chart shows the reported number of in-hospital cardiac arrests attended by the team per 1000 hospital admissions for adult, acute hospitals in NCAA with the red line depicting Great Western Hospitals FT.

The data overall shows that the Trust continues to reduce the number of cardiac arrests per 1000 admissions, and 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 0.67 for April 2018 – June 2018 compared to 0.79 for April 2017 – March 2018.

NEWS 2

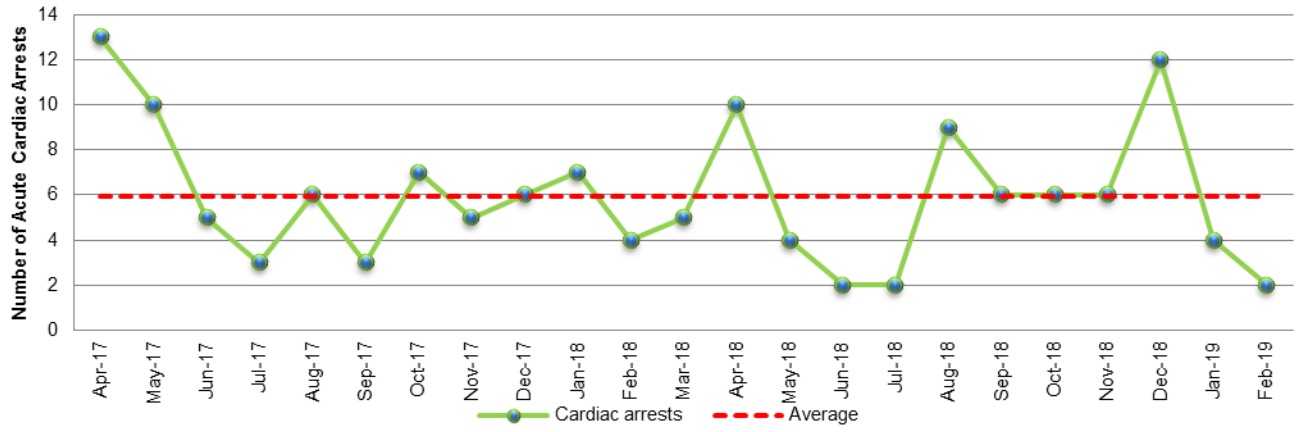
The Trust introduced Nerve-centre; an electronic-Observations (E-Obs) system has been introduced. NEWS2 has been incorporated into software and now the GWH is fully NEWS 2 compliant. The Trust has stopped the monthly audits of Percentage of Patients with a NEWS score calculated correctly due to the introduction of E-Obs

Nerve-centre data on frequency of observations and escalation will now be collected and presented monthly at the Deteriorating Patient board meeting.

Although MET calls have increased since October 2017, the overall rate of actual cardiac arrests have remained below the median rate of 0.87 cardiac arrests per 1000 admissions, 6 cardiac arrests occurred in January, equating to a rate of 0.77 per 1000 bed days.

As part of the deteriorating patient project inpatient cardiac arrests within the Trust are now being reviewed routinely to ascertain if avoidable or unavoidable. For the period May – September 2018, 0 cardiac arrests were found to be avoidable.

Number of Acute Cardiac Arrests –Excluding ED and Outpatient areas



The graph above shows the number of acute cardiac arrests excluding the Emergency Department and Outpatient areas, demonstrating no significant change to previous years.

What improvements have we achieved?

- Fully implemented and embedded the standardised National Early Warning Score 2 (NEWS2) Trust Wide, including community areas
- Introduction of Nerve-centre – Electronic Observations. Electronic capture, calculations of NEWS2, and automated cascading escalations to ensure recognition is followed by rescue.
- 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 – introduction of Advanced Clinical Practitioners (ACP) to Hospital at Night (H@N) to allow a multidisciplinary team based approach to managing the escalating care needs of adult inpatients overnight, 7 days a week.

Percentage of Observations with NEWS Score Calculated Correctly

All observations are now performed via the E-Obs system which automatically calculated the NEWS 2 score

Further improvements identified and priorities for 2019/20

- Joint medical & nursing lead to continue to lead the deteriorating patient project
- To continue to learn from events and develop care
- To promote TEP within the Trust
- Continuation of ward-based simulation training & introduction of short trolley teaching rounds carried out on ward area's planned.
- Hospital at night system which will manage all patient tasks out of hours to support staff and ensure all work is triaged by the hospital at night practitioner.

Ward Assessment and Accreditation Framework (WAAF)

The Ward Accreditation and Assessment Framework is a way of ensuring patients receive consistently safe and high quality care, and will enable wards to be inspected and graded against a range of quality standards, with each one representing a different aspect of patient care. It was one of our key priorities for 2018/19 and will remain a key tool to drive improvement during 2019/20. The Framework is based on our Trust values and incorporates best practice Quality Improvement Priorities), national guidance (NICE), including but not limited to: Leading Change, Adding Value (National Nursing Strategy), Care Quality Commission Core Standards and key

There are 16 separate standards included in the framework, covering areas such as:

- Governance
- Leadership
- Person-centred care
- Harm-free care
- Communication
- End of life care

Performance against each standard is assessed, with the scores then added together to give a ward a rating of red, amber, green or gold. The journey towards reaching gold is expected to take anything up to three years, with the top rating only being awarded when all 16 standards have been met.

Achievements 2018/19

- All acute wards have now completed standard 10 'Recognising and managing the deteriorating patient'
- All acute wards have commenced Standard 5: 'Management of Sepsis' Standard 6: 'Diagnosis and Treatment of Acute Kidney Injury AKI' Standard 12; 'Pressure ulcer avoidance' Standard 9: 'Contribute to reducing avoidable falls' and Standard 11: 'Medicines management'
- Commencement of Standard 16: 'Effective patient flow commenced autumn and winter 2018/19 and it is anticipated that this standard will continue for a number of months whilst work streams are imbedded.

Our priorities for 2019/20

- WAAF being supported by our new Deputy Chief Nurse, and put on hold in February 2019 whist ward undertake their self-assessments for co regulation of the KLOE quality indicators.
- WAAF will need to be aligned or integrated with quality governance framework (departmental self-assessment and peer assessment)to reduce duplication and improve outcomes

11.3 Statement 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 2018-19 the Great Western Hospitals NHS Foundation Trust provided and/or subcontracted 6 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 2018/19 represents 98% of the total income generated from the provision of relevant health services by the [Great Western Hospitals NHS Foundation Trust] for [2018-19].

Participation in Clinical Audits

During 2018/19, 56 national clinical audits and 2 national confidential enquiries were conducted which covered relevant health services provided by Great Western Hospitals NHS Foundation Trust. The Trust participated in **98%** 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 2018/19 are as follows:

No.	Project Name	Relevant	Participation	% Data Submission
1	Adult Cardiac Surgery	No	Na	Na
2	Adult Community Acquired Pneumonia	Yes	Yes	In Progress
3	BAUS Urology Audit - Cystectomy	No	Na	Na
4	BAUS Urology Audit – Female Stress Urinary Incontinence (SUI)	Yes	Yes	In Progress
5	BAUS Urology Audit - Nephrectomy	Yes	Yes	In Progress
6	BAUS Urology Audit - Percutaneous Nephrolithotomy (PCNL)	No	Na	Na
7	BAUS Urology Audit – Radical Prostatectomy	No	Na	Na
8	Cardiac Rhythm Management (CRM)	Yes	Yes	In Progress
9	Case Mix Programme (CMP)	Yes	Yes	100%
10	Child Health Clinical Outcome Review Programme : Long Term Ventilation in Children, Young People and Young Adults	Yes	Yes	100%
11	Elective Surgery (National PROMs Programme)	Yes	Yes	100%
12	Falls and Fragility Fractures Audit Programme (FFFAP)* - Inpatient Falls	Yes	Yes	100%
13	Falls and Fragility Fractures Audit Programme (FFFAP)* - Hip Fracture Database	Yes	Yes	100%
14	Falls and Fragility Fractures Audit Programme (FFFAP)* - Fracture Liaison Service	No	Na	Na
15	Feverish Children (care in emergency departments)	Yes	Yes	100%
16	Inflammatory Bowel Disease programme / IBD Registry	Yes	Yes	100%
17	Learning Disability Mortality Review Programme (LeDeR)	Yes	Yes	100%
18	Major Trauma Audit	Yes	Yes	100%
19	Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	Yes	Yes	100%

No.	Project Name	Relevant	Participation	% Data Submission
20	Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal Mortality Surveillance	Yes	Yes	100%
21	Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths)	Yes	Yes	100%
22	Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal mortality surveillance	Yes	Yes	100%
23	Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal morbidity and mortality confidential enquiries	Yes	Yes	100%
24	Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal Mortality Review Tool	Yes	Yes	100%
25	Medical and Surgical Clinical Outcome Review Programme - Pulmonary embolism 2018/19	Yes	Yes	100%
26	Medical and Surgical Clinical Outcome Review Programme - Acute Bowel Obstruction 2018/19	Yes	Yes	100%
27	Mental Health Clinical Outcome Review Programme	Yes	Yes	100%
28	Myocardial Ischaemia National Audit Project (MINAP)	Yes	Yes	100%
29	National Asthma and COPD Audit Programme*	Yes	Yes	100%
30	National Audit of Anxiety and Depression	Yes	Yes	100%
31	National Audit of Breast Cancer in Older People	Yes	Yes	100%
32	National Audit of Cardiac Rehabilitation	Yes	Yes	100%
33	National Audit of Care at the End of Life (NACEL)	Yes	Yes	100%
34	National Audit of Dementia	Yes	Yes	100%
35	National Audit of Intermediate Care	Yes	Yes	100%
36	National Audit of Percutaneous Coronary Interventions (PCI)	Yes	Yes	100%
37	National Audit of Pulmonary Hypertension	No	Na	Na
38	National Audit of Seizures and Epilepsies in Children and Young People	Yes	Yes	100%
39	National Bariatric Surgery Registry (NBSR)	No	Na	Na
40	National Bowel Cancer Audit (NBOCA)	Yes	Yes	100%
41	National Cardiac Arrest Audit (NCAA)	Yes	Yes	100%
42	National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	Yes	Yes	100%
43	National Clinical Audit of Psychosis	No	Na	Na
44	National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	Yes	National Audit Did Not Commence	Na
45	National Comparative Audit of Blood Transfusion programme*: Re-audit of the 2016 audit of red cell and platelet transfusion in adult haematology patients 2018/19	Yes	National Audit Did Not Commence	Na
46	National Comparative Audit of Blood Transfusion programme*: Audit of Patient Blood Management in Scheduled Surgery - Re-audit September 2016 (see web link in column L for 2015 report) 2018/19	Yes	National Audit Did Not Commence	Na
47	National Comparative Audit of Blood Transfusion programme*: Use of Fresh Frozen Plasma and Cryoprecipitate in neonates and children	Yes	No - Not enough patients for inclusion	0%
48	National Comparative Audit of Blood Transfusion programme*: Management of massive haemorrhage	Yes	Yes	100%
49	National Congenital Heart Disease (CHD)	No	Na	Na
50	National Diabetes Audit – Adults*: National Diabetes Foot Care Audit 2018/19	Yes	Yes	100%

No.	Project Name	Relevant	Participation	% Data Submission
51	National Diabetes Audit – Adults* : National Diabetes Audit Transition 18/19 (17/18 data)	Yes	No	Na
52	National Diabetes Audit – Adults* :National Diabetes Audit – Adults -NaDIA-Harms - reporting on diabetic inpatient harms in England 2018/19	Yes	Yes	In Progress
53	National Diabetes Audit – Adults*: National Pregnancy in Diabetes 2018	Yes	Yes	100%
54	National Emergency Laparotomy Audit (NELA)	Yes	Yes	100%
55	National Heart Failure Audit	Yes	Yes	100%
56	National Joint Registry (NJR)	Yes	Yes	100%
57	National Lung Cancer Audit (NLCA)	Yes	Yes	100%
58	National Maternity and Perinatal Audit (NMPA)	Yes	Yes	100%
59	National Mortality Case Record Review Programme	Yes	Yes	
60	National Neonatal Audit Programme (NNAP)	Yes	Yes	100%
61	National Oesophago-gastric Cancer (NAOGC)	Yes	Yes	100%
62	National Ophthalmology Audit	Yes	Yes	100%
63	National Paediatric Diabetes Audit (NPDA)	Yes	Yes	100%
64	National Prostate Cancer Audit	Yes	Yes	100%
65	National Vascular Registry	No	Na	Na
66	Neurosurgical National Audit Programme	No	Na	Na
67	Non-Invasive Ventilation - Adults	Yes	Yes	In Progress
68	Paediatric Intensive Care (PICANet)	No	Na	Na
69	Prescribing Observatory for Mental Health (POMH- UK)*	No	Na	Na
70	Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)*	Yes	Yes	100%
71	Sentinel Stroke National Audit programme (SSNAP)	Yes	Yes	100%
72	Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	Yes	Yes	100%
73	Seven Day Hospital Services	Yes	Yes	100%
74	Surgical Site Infection Surveillance Service	Yes	Yes	100%
75	UK Cystic Fibrosis Registry	No	Na	Na
76	Vital Signs in Adults (care in emergency departments)	Yes	Yes	100%
77	VTE risk in lower limb immobilisation (care in emergency departments)	Yes	Yes	100%

The reports of 41 national clinical audits were reviewed by the provider in 2018/19. As a result of these audits the following actions are planned to improve the quality of healthcare provided –

In Respiratory Services – Consideration is going to be given to recruiting additional admin support with the aim of achieving best practice tariff; achieving this is a surrogate marker for Chronic Obstructive Pulmonary Disease (COPD) patients receiving best practice evidence based interventions. Improvements also include: Provision of respiratory review within 24hours, improve provision of Non-Invasive ventilation (NIV) and the implementation of national recommendations from the National Confidential Enquiries Patient Outcome Programme (NCEPOD). The service also intends to scope the utility of introducing clinical risk scoring i.e. Stratifying risk and identification of early discharge (DECAF) and predicting 90 day readmission risk or death without readmission to best target post discharge intervention (PEARL).

In Ophthalmology Services – Although the assessment of overall local results from the national audit provided reasonable assurance, the service has agreed to peer review data collection of key fields and outcomes of key metrics in order to share and learn from best practice. Improvements will continue to be monitored and any reoccurring gaps to be actioned accordingly.

In Hip Fracture Services – Although the service was awarded the "Golden Hip Award" for the most impressive and sustained improvements in Hip Fracture Care, the team are going to continue their on-going involvement in the National Audit and review of national data. There will also be a continuation of local Quality Improvement (QI) and priorities for the forthcoming year include: Embedding reduced pre-operative starvation times and pre-operative carbohydrate loading, Increase the number of patients operated within <36hrs to 90%, and to improve the best practice tariff achievements in 2018.

In Acute Medical Unit Services – There is to be a prolonged evening consultant presence on the Acute Medical Unit, thus managing 'today's take' today; a physician of the day will be present from 10.00-22.00hours to improve on the current 49% consultant review time within the 14hour target time. There will also be an on-call physician starting earlier to reflect the influx of patients coming through later on the day. The 'medically expected' unit (MEU) will have a dedicated nursing assistant to monitor early warning scores on patient arrival within 30mins to improve the early warning score current level of compliance of around 57%. There is also to be a dedicated Junior Doctor to review direct admissions to the medically fit unit; the service is currently split across admissions situated on the ground floor and the MEU situated on the 3rd floor.

The reports of 134 local clinical audits were reviewed by the provider in 2018/19 and Great Western Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided –

Results from the Blood Observation Audit – improvements recommended include, that all registered practitioners administering blood components must hold a 'once only' competency. Those who currently have a 'renewable three yearly' competency must convert to the 'once only' competency. There is to be an improved awareness of the poor recording of observations at 15 minutes in and the end of transfusion should be highlighted to matrons, ward managers and all practitioners administering blood transfusions.
The lack of use of 'Bloodhound' system for recording these observations are also be highlighted. There will also be a bedside checklist card which is to be issued to staff administering blood impresses on them the legal requirement to record traceability of the component. Measures to improve compliance with the documentation of consent is another focus for improvement; it is intended for this to become part of the work being undertaken to comply with the CAS alert (Central Alerting System) issued from the Department of Health in November 2017 concerning a bedside checklist. Prescribers will also be required to continue to be educated on the nationally recommended haemoglobin (Hb) thresholds for red cell transfusion in non-bleeding patients. Alternatives to transfusion, particularly in iron deficient patients are to be highlighted and a pathway for referring these patients for treatment created.

Results from the Safeguarding Adults Audit – Whilst compliance demonstrated extremely good results, there are plans to deliver the Mental Capacity Act (MCA) training strategy; this also includes a structured work plan to improve the consistent application of safeguarding and MCA, improving documentation around respect and informed consent, utilising documentation in respect of 'best interests' decisions and ensure consistency and alignment of trust wide processes for adults unable to consent to care and treatment. There is also to be a focus on the appropriateness of referrals to IMCA service 100% of the time with a further audit to be undertaken in 2019 to measure success of improvements and identification of further improvements required.

Results from the Neutropenic Sepsis Audit – Teaching sessions for both medical and nursing staff are to be carried out frequently, with the aim to provide monthly sessions; mainly on the acute medical unit but also to include Emergency Department (ED), where patients who have suspected Neutropenic sepsis also attend. This will focus on the importance of: Patients receiving antibiotics within an hour of arriving at hospital; Use of the Patient Held Prescription for First Line Antibiotics for Adult Patients presenting with Suspected Neutropenic Sepsis (PANTS) Policy and Procedure card and ensuring when this is used, it is documented in the clerking notes. Locally, it is also aimed to review the Neutropenic Sepsis data on a monthly basis; to enable us to monitor: If our teaching sessions are effective in ensuring patients are receiving antibiotics within an hour; Greater accuracy in collating the data. There are also plans to work more closely with the medical team on Ambulatory Care Unit (AMU) to discuss/review the Neutropenic Sepsis (NS) pathway.

Results from Outpatient Parenteral Antibiotic Therapy (OPAT) Service - The service is focussing on reducing the inpatient stay by aiming to review and assess patients sooner and discharge once medically fit for discharge (MFFD). Improvements also include keeping the readmission rate below 5% by continuing to provide robust management plan and follow up every patient who is discharged with Outpatient Parenteral Antimicrobial Therapy (OPAT). Patients will also receive an OPAT management plan-when an OPAT nurse is not available, this will be send to the patients at the earliest date possible, and development of the service with additional staff to cover absences in order to aim for 7 days service and to avoid delays in discharge at weekends.

Results from Discharge Experience of Patients with Dementia from the Acute Trust Audit – Improvements include the early initiation of discharge planning, ideally within 24 hours of admission; including discharge dates, plans and medically fit for discharge status, which are to be discussed widely with the multidisciplinary team (MDT) at the board round and recorded in the patient's medical and nursing notes. A health/social care needs assessment will be completed when requested to support discharge planning and where appropriate, a referral to an Independent Mental Capacity Advocate (IMCA) to be undertaken when the person is unbefriend and decisions are being made in relation to serious treatment, changes to accommodation arrangements, or if there is a dispute in relation to the medical and/or care plans between clinical staff and family members. There will be a focus on the documentation of the 'medically fit' status in the patient's medical notes and also the communication with relatives/carers; advising of the discharge date and time to ensure that suitable arrangements are in place to facilitate a safe discharge and with conversations to be documented in nursing notes. The Mental Capacity 2 stage Assessments are to be undertaken to ascertain mental capacity for all in-patients for whom this in doubt; this will ensure all steps are taken to ensure the person is as involved as they can be in decision making for their care.

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 over 1,000 to 31st March 2019

During the 2018/19 financial year over 1,000 patients were recruited to 55 open studies, overseen by 43 individual Principal Investigators. There were a further 2,500+ patients being 'followed up' in studies now closed to recruitment.

Research activity at the Trust has grown steadily over the past 10 years, involving increasing numbers of doctors, nurses, allied health professionals and others. Over 20 clinical areas are currently involved in the delivery of clinical studies. Active participation in research continues to give our patients the opportunity to access new and innovative treatment pathways.

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

Use of the CQUIN payment framework

A proportion of Great Western Hospitals NHS Foundation Trust income in 2018-19 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. While the CQUIN has been achieved from a financial perspective, the achievement rate from a quality/patient outcome perspective is yet to be finalised.

Financial Summary of CQUIN (£m)

	Plan	Actual	%	Plan	Actual	%	Plan	Forecasted Actual	%	Plan	Forecasted Actual	%
	2015-2016			2016-2017			2017-2018			2018-2019		
Total CQUIN	£6,007	£4,507	75%	£4,845	£3,973	82%	£5,566	£4,762	86%	£ £5,804	£5704	98%

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 August & September 2018. 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 reviewed in January 2019 no changes

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, August & September 2018

In response to the CQC must do- should do actions and to support the Trust in co-regulation, a Quality Governance Framework was 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 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 from our December 2018 inspection.

Type	Date	Health and Social Care Act 2008 Regulation
Compliance Action	August 2018	Regulation 12 Safe care & treatment
Compliance Action	August 2018	Regulation 10 Dignity & respect
Compliance Action	August 2018	Regulation 15 Premises & equipment
Compliance Action	August 2018	Regulation 17 Good governance

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 2018

	Safe	Effective	Caring	Responsive	Well led	Overall
Urgent & Emergency Care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Medical care (including older people's care)	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Require improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Critical Care	Requires improvement	Good	Good	Good	Good	Good
Maternity	Requires improvement	Good	Good	Good	Good	Good
Services for Children and young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients	Good	Not rated	Good	Good	Good	Good
Community Health Services for Adults	Good	Good	Good	Good	Good	Good
Community Health Inpatient Services	Good	Good	Good	Good	Good	Good

The CQC inspected the 'Effective' domain but did not rate it due to a lack of national data available.

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 2018 to January 2019 (the most recent data available) 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
98.8% 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
99.6% for accident and emergency care.

Data Security & Protection Toolkit 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.

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 that 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.

There is corporate leadership of information governance, the Director of Finance having overall responsibility. The Information Governance Steering Group (IGSG) oversees information governance issues, and monitors all IG activities and performance with responsibilities delegated from the Audit, Risk & Assurance Committee on behalf of the Trust Board.

The 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 Trust's Information Governance Policy sets out best practice in data protection and confidentiality and is based on four key principles which are openness, information quality assurance, information security assurance, and legal compliance.

These corporate and operational arrangements ensure that information governance is 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 Data Security & Protection (DSP) Toolkit. These assessments and the information governance measures themselves are regularly validated through independent internal audit.

For 2018-19, the Toolkit underwent a significant update to incorporate legislative changes such as the introduction of the General Data Protection Regulation (GDPR) and Data Protection Act 2018 (DPA 2018), as well as integrating more data and cyber security elements. The DSP Toolkit assessment is based on the National Data Guardian's Security Standards, which at a heading level are:

- Personal Confidential Data
- Staff Responsibilities
- Training
- Managing Data Access
- Process Reviews
- Responding to Incidents
- Continuity Planning
- Unsupported Systems
- IT Protection
- Accountable Suppliers

Great Western Hospitals NHS Foundation Trust Information Governance Assessment Report overall score for 2018/19 was graded as 'Standards Met'.

- 100 of 100 mandatory evidence items provided
- 40 of 40 assertions confirmed

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 2018/19.

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

- Annual review of the Trust data quality strategy
- Review awareness of key staff on their responsibilities around data quality and propose approach to achieve improvement if necessary
- Monitoring monthly of national DQ measures
- Reviewed specific data sets (Referral to Treatment PTL & Maternity Services Dataset) with specific regard to data quality.

Great Western NHS Foundation Trust will be taking the following actions forward to continue with our improvement around data quality

- Annual review of the Trust data quality strategy (to ensure relevance)
- Establish quarterly Trust Data Quality group meetings, a sub group of the Information Governance Steering Group.
- Review awareness of key staff on their responsibilities around data quality and propose approach to achieve improvement if necessary
- Review scope of material internal data sets with specific regard to data quality and summarise those known with their main characteristics, any known DQ issues and owners in overview.

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.

11.4 Reporting against Core Indicators

The table below shows core quality data for 2018/19 and the previous 4 years.

		2014/ 2015	2015/ 2016	2016/ 2017	2017/ 2018	2018/ 2019	National Average	What does this mean	Trusts with the highest and lowest score	Source of measure	Definition
1 - Reducing Healthcare Associated Infections	MRSA	2	2	1	0	3	0.96	Zero is aspirational	Low- 0; High- 11	IP&C	National definition
	C.diff	19* *combined previously acute/ community split	30 Trust-wide	21	25	27	N/A	Zero is aspirational	Low-0; High- 121	IP&C	National definition
	C.diff 100,000 bed days	9.60	14.7	11.1	11.8	14.2	15.01	Lower is better	Regionally Low:8.71 High: 28.02	PHE	National Definition
2 - Patient Falls in Hospital resulting in severe harm		16	13	12	10	12	Not available	Lower is better	--	Incident form	NPSA
3 – Reducing Healthcare Acquired Pressure Ulcers		51 Category III & Category IV	3 Category III 5 Category IV	50 Cat II	40 Category II 2 Category III	38 Category 2 1 Category 3	4% incidence	Lower is better	--	Incident form	National Definition (from Hospital database)
6 – Never Events that occurred in the Trust		2	3	1	1	9	NHS England 2014-15 Average 2.16	Zero tolerance	Highest - 9 Low - 0	IR1's	NPSA
Hospital-level mortality indicator (SHMI) (SHMI)		92.99	95.83	94.34 (Oct 15 to Sep 16 –)	97 (Oct 16 to Sep 17 –	85.6(Oct 17 to Sept 18) most recent available	-	Lower than 100 is good	-	National NHS Information Centre	National NHS Information Centre
7 – Mortality Rate (HSMR) HSMR		90.3	89.0	97.97 (Apr 16 – Dec 16 provisional figure)	98.3 (Apr 17 – Dec 17 provisional figure)	90.1(Apr 18 – Dec 18) 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)	90%	85% April – Dec 9 months	Average 96%	Average 95%	Average 97%	Not available	Higher number is better	--	Audit	Audit criteria (10 patients per ward per month)
	Paediatric Early Warning Score (Children)	92.25% Average yearly compliance	85% April - Sept 6 months	Average 86%	Average 85%	Average 95%	N/A	Higher number is better	--	Audit	Audit criteria (5 patients per month)

		2014/ 2015	2015/ 2016	2016/ 2017	2017/ 2018	2018/ 2019	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**	90.9%	100% HSCIC Provisional data	100% HSCIC Provisional data	Currently Un available	No longer measured as part of PROMs	80%	Higher is better	Not available (more than one Contractor for this service)	DoH/ HSCIC	National Definition
	Groin Hernia surgery	57.6%	42.9% HSCIC Provisional data	54.5% HSCIC Provisional data	Currently Un available	No longer measured as part of PROMs	80%	Higher is better		DoH/ HSCIC	National Definition
	Hip Replacemen surgery (Oxford Hip Score)	61.5%	93.9% HSCIC Provisional data	91.9% HSCIC Provisional data	96.7% HSCIC Provisional data	96.6% HSCIC Provisional data	80%	Higher is better		DoH/ HSCIC	National Definition
	Knee Replacement Surgery (Oxford Knee Score)	94.4%	97% HSCIC Provisional data	95.3% HSCIC Provisional data	95.3% HSCIC Provisional data	95.4% HSCIC Provisional data	80%	Higher is better		DoH/ HSCIC	National Definition
19 – Readmissions – 30 days	7.9%	9.7%	9.8% (Apr 16 to Feb 17)	11.2%	Local target (7.1%)	10.2%	Lower is better	--		National Definition	
19 – Readmissions – 28 days	7.7%	9.6	9.8% (Apr 16 to Sep 16)	10.9% Apr 17 – Feb 18	SW Region 6.9%	9.68%	Lower is better	Low: 5.12; High:10.91	Dr Foster	Dr Foster	
19 – Re-admissions 28 days **Ages 0-15** **Ages 16+**	9% 7.5%	9.02 10.02	9.5% 0-15 & 9.9% 16+ (Apr 16 to Sep 16)	-	Dr Foster	0-15 8.91% 16+ 9.79%	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** **Ages 0-15** **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?**	51.4%	51.8%	51.1%	55.4%	54.4%	Under embargo	Higher is better	Under embargo	Picker Survey	National definition
	Did you find someone on the hospital staff to talk to about your worries and fears?	28.6%	33.0%	32%	34.6%	17.3%	Under embargo	Higher is better	Under embargo	Picker Survey	National definition
	Were you given enough privacy when discussing your conditions or treatment?	74.2%	72.6%	75.6%	72.5%	75%	Under embargo	Higher is better	Under embargo	Picker Survey	National definition

		2014/ 2015	2015/ 2016	2016/ 2017	2017/ 2018	2018/ 2019	National Average	What does this mean	Trusts with the highest and lowest score	Source of measure	Definition
	Did a member of staff tell you about medication side effects to watch for when you went home?	32.1%	29.8%	35.3%	38.6%	23.1%	Under embargo	Higher is better	Under embargo	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?	66.2%	68.0%	65.6%	65.9%	65.3%	Under embargo	Higher is better	Under embargo	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		70%	68%	68%	68%	69.9%	69.8%	Higher is better	-	NHS Staff survey	National Definition
23 - VTE	4 Percentage of VTE Risk Assessments completed	97.1%	98.3%	99.4%	99%	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	91.6%	95.2	97.4%	94.9%	89%	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)

		2014/ 2015	2015/ 2016	2016/ 2017	2017/ 2018	2018/ 2019	Nationa l Avera ge	What does this mean	Trusts with the highes t and lowest score	Source of measure	Definition
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	5.2	5.1	--	Lower is better	--	Informatic s & Clinical Risk
	Number of Patient Safety Incidents per 100 Bed Days	3.00	3.07	3.3	4.4	3.8	3.6	--	Lower is better	--	Informatic s & Clinical Risk
	Number of Incidents	0.03	0.04	0.01	0.01	0.02	0.02	--	Lower is	--	Informatic s

	resulting in Severe Harm or Death per 100 Bed Days								better		& Clinical Risk
	Percentage of Combined Severe Harm and Death	0.56%	0.80%	0.55%	0.26%	0.24 %	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 availa ble	31.1% (Oct 15 to Sep 16, most recent data availab le)	30.1 % (Feb 18 to Jan 19, most recent data availa ble)	30.8 % (Oct 16 to Sep 17, most recent data availa ble)	25.3 %	Lower is better	Low:0; High: 49.4	HSCIC

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 (C.diff)* to Public Health England.

In England, it is mandatory for Trusts to report all cases of *C.diff* and MRSA bloodstream infections to Public Health England (PHE).

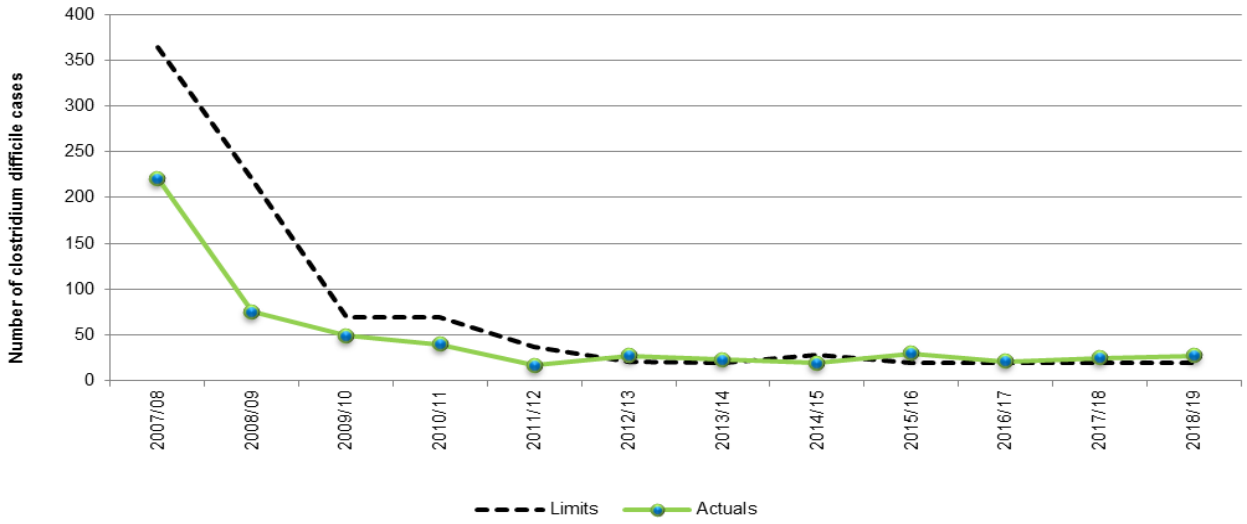
The nationally mandated goal for 2018/19 was to report no more than 19, Acute or Community Hospital, cases of C.diff. We have reported 27 cases, 2 more than 2017/18. Each case has been investigated in conjunction with our Commissioners. Of the 27 cases, 15 have been deemed unavoidable and 11 have been deemed as avoidable and care improvement recommendations made. The review of the final episode is outstanding.

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 C.diff 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 C.diff policy, which had in particular focused on hand hygiene and cleaning patient care equipment
- Wards ensuring compliance with Infection Prevention and Control (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 C.diff 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 C.diff 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 2018/19

↓ Lower is better



The graph above shows the numbers of reported *C.diff* cases in from 2007 through to 2018/19.

Our priorities for 2019/20

We plan to continue monitoring and reducing risk factors for C.diff 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.

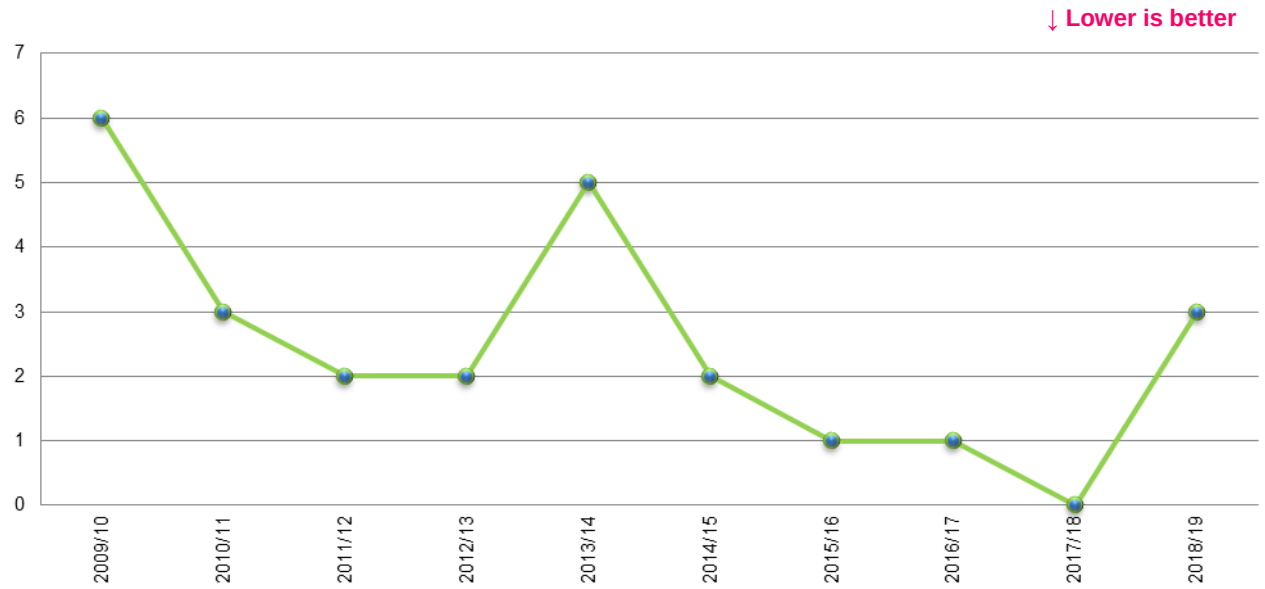
Methicillin Resistant Staphylococcus Aureus (MRSA)

During 2018/19, the Trust reported three MRSA bloodstream infections, above the national target of zero.

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



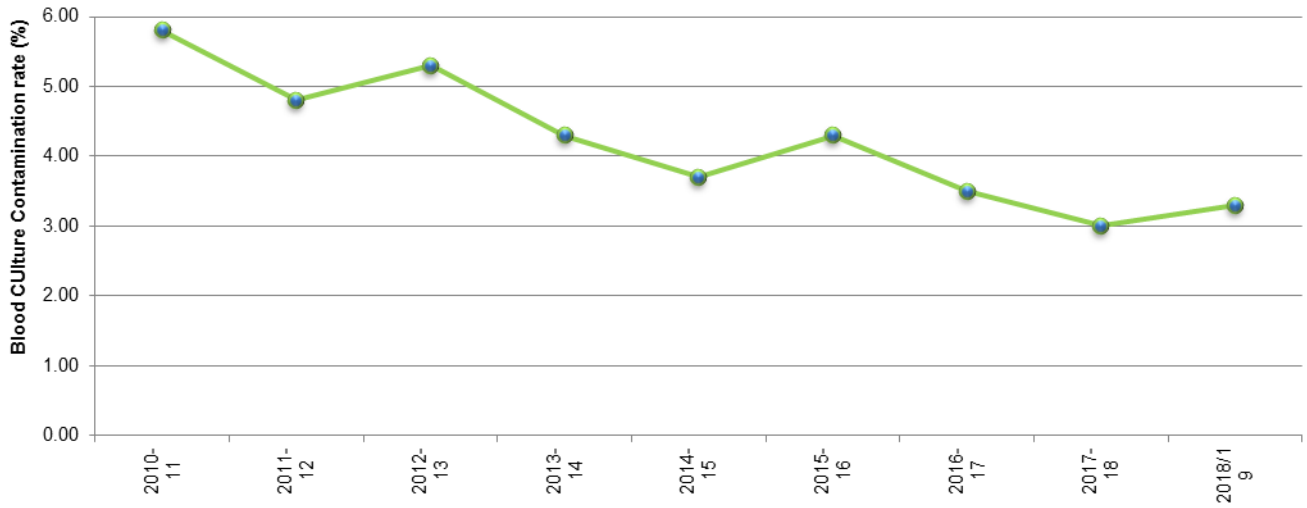
The graph above shows the number of cases of Trust apportioned MRSA bacteraemia to Great Western Hospitals NHS Foundation Trust up until 2018/19**.**

Our priorities for 2019/20

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.

Trust-wide Blood Culture Contamination Rate 2010 -2019



The graph above demonstrates the Trust's blood culture contamination rate from 2010 through to 2018/19, where the Trust achieved a rate of 3.3% (1st April 2018 – 17th March 2019). The recommended rate is 3.0% and this was achieved in 2017/18, however, this year has shown a small increase.

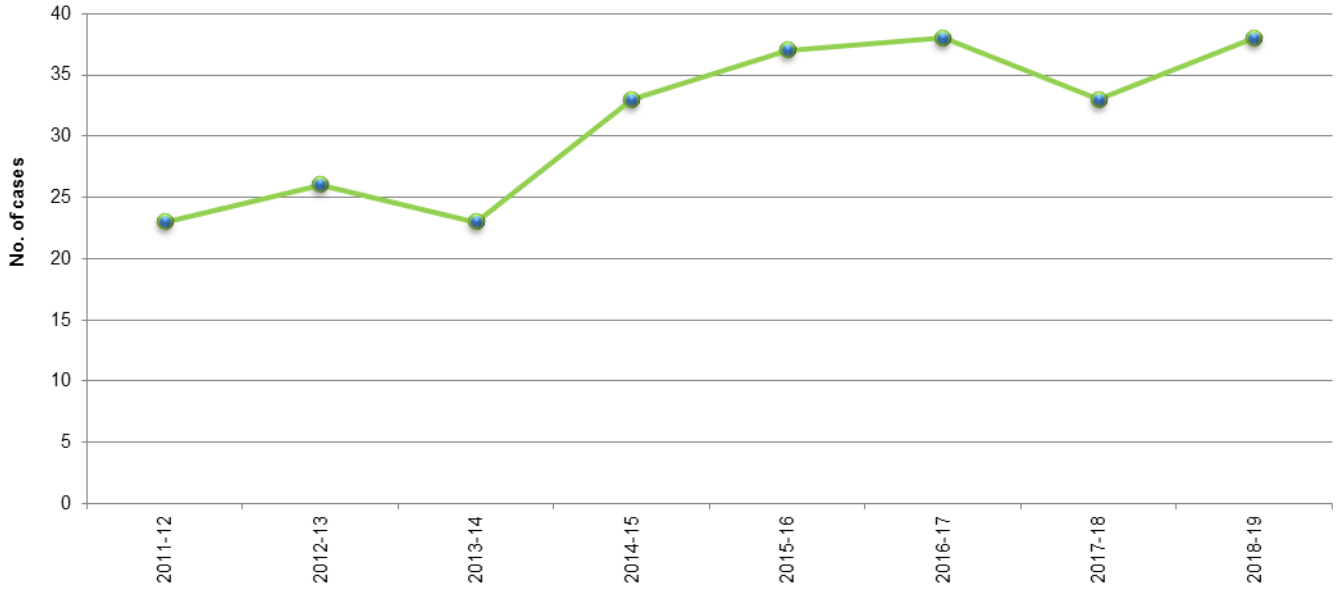
In line with national requirements, the submission of E.coli data to Public Health England (PHE) has become mandatory. From April 2017, it became mandatory to report data on other gram negative blood stream infections, Klebsiella spp and Pseudomonas aeruginosa.

During 2018/19, no targets were set for E.coli, Klebsiella spp and Pseudomonas aeruginosa blood stream infections (BSI).

A total of 38 E.coli BSI (2017/18 = 33), 18 Klebsiella spp BSI (2017/18 = 11) and 2 Pseudomonas aeruginosa BSI (2017/18 = 18) have been reported in acute trust patients. This encompasses patients in whom the specimen was taken 48 hours after admission to hospital.

Number of Trust Apportioned E.Coli Blood Stream Infections

↓ Lower is better



The graph above shows the number of cases of Trust apportioned E.coli BSI to Great Western Hospitals NHS Foundation Trust up until 2018/19.

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 2019/20

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.

Continually learn - Reduce Incidents and Associated Harm

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.

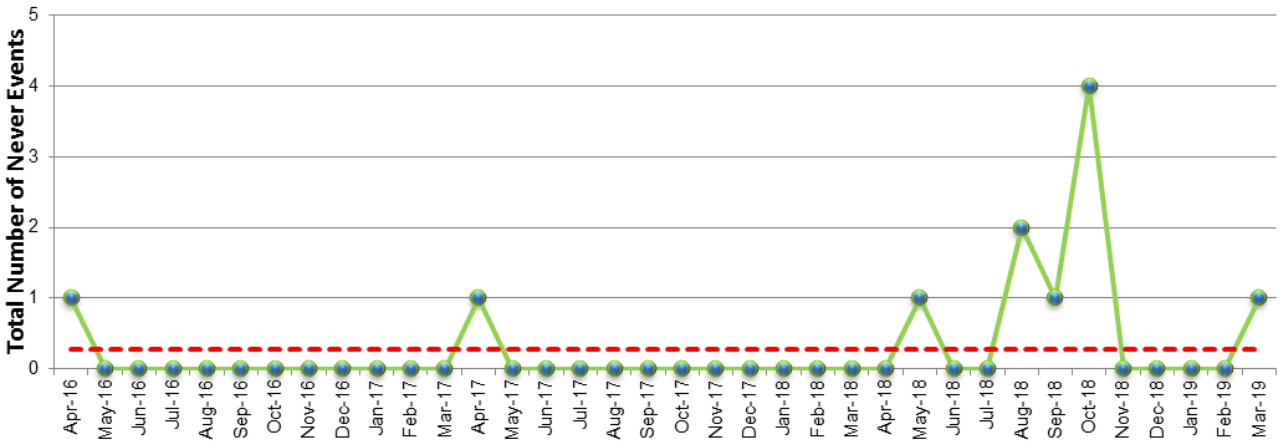
Never Events are Serious Incidents are wholly preventable. There is guidance (Never Events Policy and Framework) which was recently updated in April 2018 that provides strong systemic protective barriers that are available at a national and local level and should be implemented by all healthcare providers.

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 9 Never Events between April 2018 and March 2019. The following categories of Never Events have been reported:

- Wrong Site Surgery. 1
- Wrong Implant/Prosthesis 7
- Retained Foreign Object Post Surgery 1

Total number of Never Events reported



The chart above shows the total number of Never Events reported by Great Western Hospitals Foundation Trust during 2018/19 by month.

Following the Never Events reported in August and September 2018 with regards to an implant/plate used for forearm fractures a review took place of all completed forearm implants/plates over the last 12 months. This showed a further 5 cases where the same incorrect fixation used. In total 7 cases have been reported. Action plans were developed, with implementation closely monitored by our Patient Quality Committee. Final reports for the Never Events are also shared with the patients, Commissioners, the CQC and Monitor.

Furthermore the Trust has worked closely with NHSI and a Patient safety Alert which was published in early 2019 to aid/support other organisations to not repeat the same or similar incidents. The Trust has been praised and thanked for its proactive response to the initial concern, investigation and transparency.

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 relating to wrong site surgery and wrong implant/prosthesis:

Key Learning Points and Actions taken:

- Surgical Planning Group and theatre coordinator to ensure x-rays are always available when required. Additional training for theatre staff to support radiographer enabling theatre staff to use image intensifiers.
- On a new operator joining a procedure a pause should take place so site and procedure can be re, confirmed. A standard operating procedure has been written and is in place.
- Sterile cockpit concept to be applied and followed and to include a time out when if a new operator joins a procedure. Regular audit of the WHO checklist completed and shared at governance meetings.
- Surgical Site marking policy amended to reflect recommendations
- Recon plates removed from fragment sets.
- Multidisciplinary working group to review and agree a standard safety process to be introduced to provide further assurance that any surgical plate intended to be retained and part of a clinical plan is correctly selected and confirmed as correct.
- Swab, instrument and needle Counts Policy to be reviewed and updated to reflect changes.

Serious incidents

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.

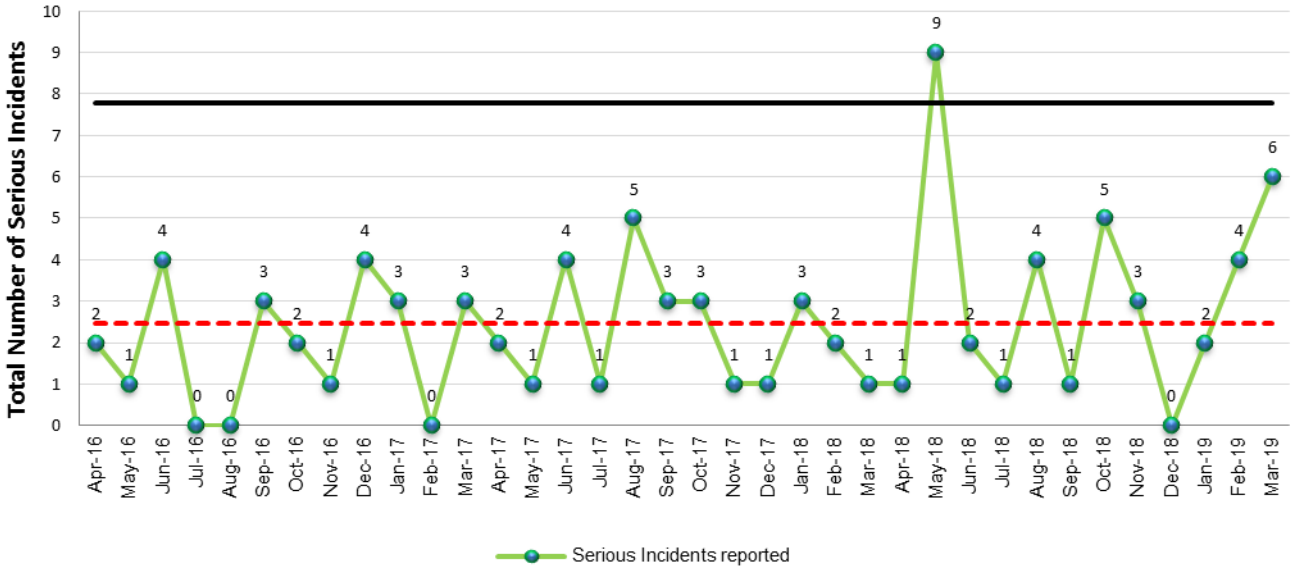
A total number of 38 serious incidents were reported and investigated during the period April 2018 to March 2019. This is an increase of 9 serious incident compared to 2017/18.

- 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.

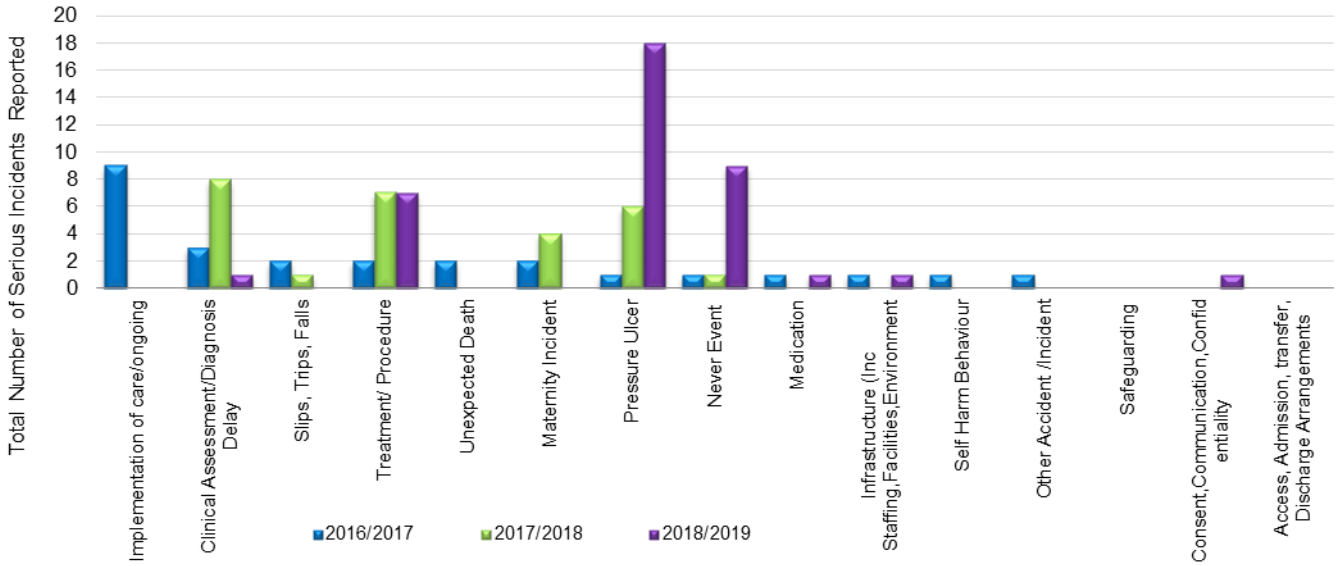
Serious incidents reported 2018/19

↓ Lower is better



The graph above shows the number of serious incidents reported in 2016/19.

Serious incidents reported by type in from 2015/16 – 2018/19



The graph above shows the Trust's serious incidents reported broken down by category in 2018/19 compared to previous years.

The most frequently reported types of Serious Incidents including Never Events are:-

- Pressure Ulcer's
- Never Events
- Implementation of care/on-going

The increased number of serious 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. It should be noted that the increase in pressure also is attributable to the inclusion on Swindon Community Health Service data and the spike in Never Events is attributable to 7 Never Events relating to the same failure in process.

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

- Created and embedded new processes in Theatres to support with identification, selection and placement of Trauma and Orthopaedic plates.
- Updated key policies and procedures to support change.
- Ensured and tracked NatSSIPs and LocSSIP activity across the Trust

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.

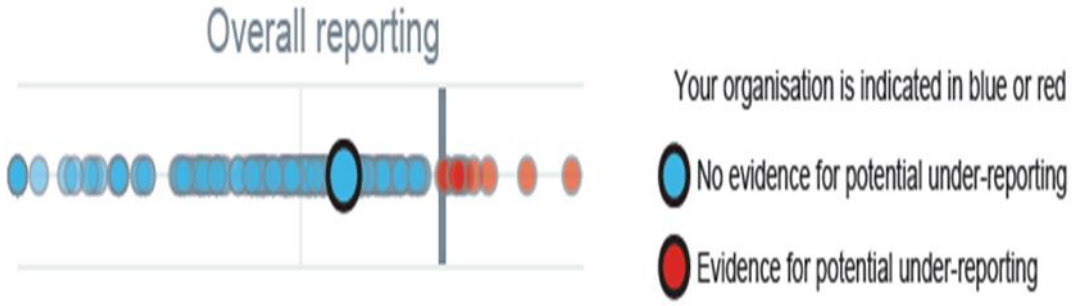
Incident reporting and benchmarking

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 numbers of incidents we have reported in the last 7 financial years are as follows:

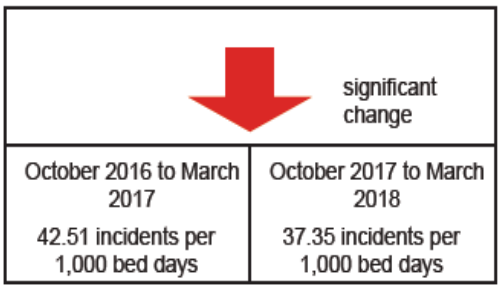
Reporting Year	Non clinical incidents / Health and Safety	Patient Safety Incidents reported to NRLS	Total
2011/2012	2493	6513	9006
2012/2013	2405	6928	9333
2013/2014	3596	6967	10563
2014/2015	4164	6678	10842
2015/2016	4801	6274	11075
2016/2017	4457	8373	12830
2017/2018	3627	7632	11259
2018/2019	3022	8398	11420

NHS Improvement National Reporting and Learning System (NRLS) release an Organisational Patient Safety Incident report twice a year providing organisational and comparative incident data. NHSI and the NRLS revised their incident summary report during 2018 so that organisations can better understand the incidents we report and if we could be more effective in improving our safety culture.



The graph above demonstrates potential under-reporting of incidents during the reporting period of October 2017 – March 2018. Currently GWH FT is placed within the BLUE suggesting that there is no evidence of potential under reporting at our Trust.

GWH FT reporting rate per 1000 bed days comparison



Actions for your organisation

- Investigate the reasons for any significant change in reporting using your more detailed local incident data.
- Is this a general change, or are certain types of incidents being reported more or less frequently?

The chart above demonstrates reporting rate per 1000 bed days comparison year on year and suggests that there has been significant change. Our reporting rate has decreased to 37.35 per 1000 bed days compared to 42.51 Oct 16 to March 17. The median reporting rate for the acute cluster comprising of 134 organisations is 42.0.

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

- Providing incident management and awareness sessions throughout the year. These sessions will continue to promote the benefits of incident reporting, and how they make positive impacts on improving patient safety.
- To work with key managers and their deputies across the Trust to support with grouping, theming and trending incidents as to identify key Quality Improvement activity.
- Promote a 'You Said' 'We Did' approach to learning from incidents.

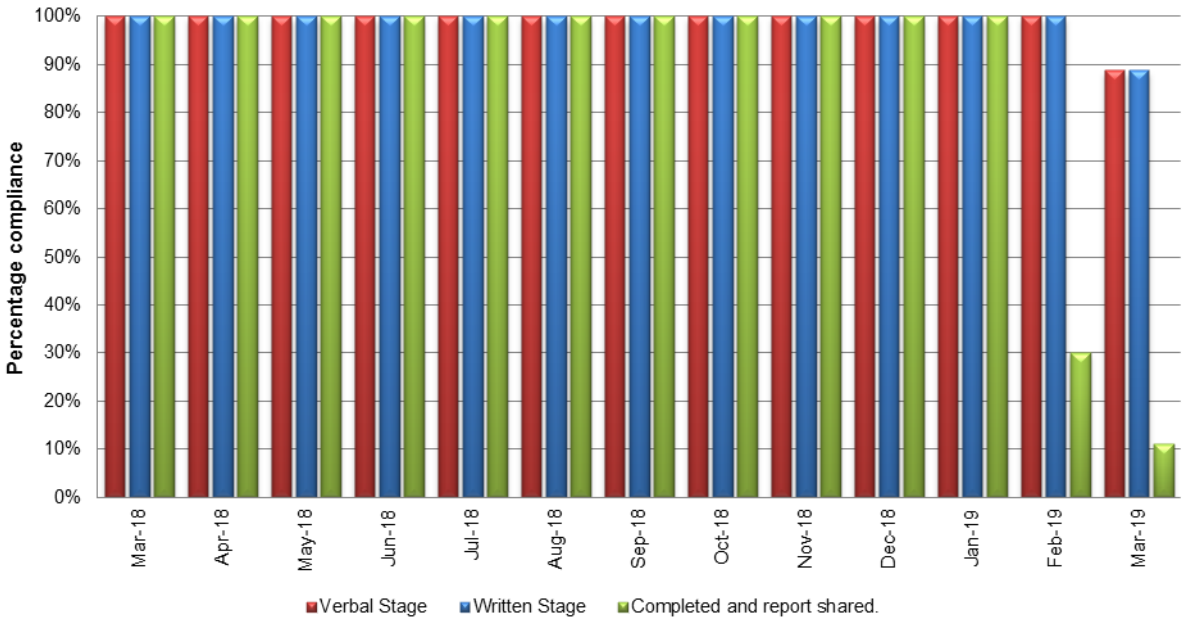
Duty of Candour

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 depicts the Trusts Duty of Candour compliance at each of the three stages of Duty of Candour, this being 1, a formal apology 2, formal written apology from the Trust and 3, sharing of the incident investigation. Some cases are still currently under investigation and will be shared with the patient, family or relatives upon completion. All outstanding Duty of Candour cases are currently due to be completed within the deadline of 60 working days from reporting the incident on STEIS.

To continue to improve staff recognition of what level of 'harm' initiates the need for full formal Duty of Candour, how this is applied to support our patients and staff and to ensure that patients and their families are fully informed, and to promote 'Candour' we support our staff, patients, their family and relatives following errors, the following improvements have been completed:-

- Duty of Candour training is included in all investigation, Human Factors and RCA training courses.
- The Duty of Candour E-Learning training tracker was released in June 2016 whereby the expectations are that all new employees are required to complete the training after induction. The Trust's compliance is currently recorded as 95.69%
- The Trust's incident reporting system allows us to record Duty of Candour against individual incidents
- There is a data extraction facility within the Trust's central incident reporting system, which enables the Trust to record and monitor formal Duty of Candour compliance. This facility also helps to identify any areas of non-compliance reported on a monthly basis that can then be operational rectified.
- Duty of Candour compliance is monitored at Divisional and Trust level by the Patient Safety and Clinical Risk Team. All Duty of Candour exceptions are reported at all Divisional boards and via the Trusts Patient Quality Committee.
- Duty of Candour leads receive coaching from the Clinical Risk Team who also provide support and oversight of the process to ensure that stage1, 2 and 3 are completed.
- Revised Duty of Candour (Being Open Policy) – This policy has been reviewed (February 2019)

Priorities for 2019/20

- To develop a Trust wide Human Factors Training programme for the organisation.
- The Trust will continue to develop a 'Just Culture'.
- Ensure that we as an organisation are 'Reporting' and 'Celebrating Excellence' across the Acute and Community Services.
- Continue to work in conjunction with the Trusts Academy as to effectively deliver Root Cause Analysis (RCA) and Duty of Candour training for staff.

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.

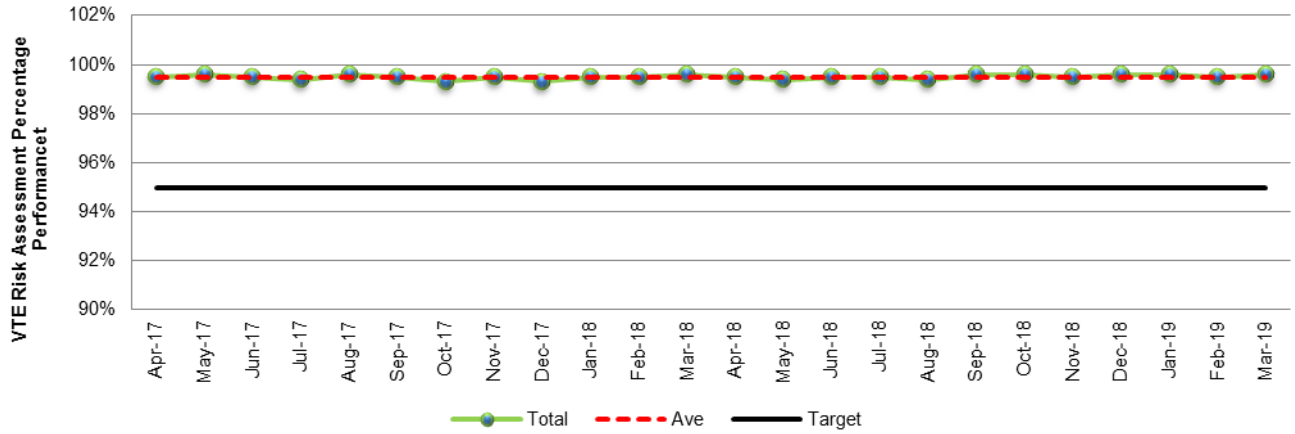
This validation is undertaken bi-monthly and information disseminated to all clinical areas so that any performance requiring review is highlighted.

All adult patients (over 16 years) 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 April 2017 – March 2019



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 an audit tool similar to the previously used "safety thermometer" data
This looks at 10 patients on each ward in the hospital on one day each month and checks if they have had a VTE risk assessment and how many patients receive the appropriate preventative treatment. Since the implementation of this we have had some difficulty with the completion of the form and are currently looking at ways to improve the data collection form to ensure we are getting accurate information. It is hoped that we will be able to link it to one of the electronic systems in place to save duplication of information. Whilst we can't provide an accurate figure at the moment we can be reassured that the number of patients who develop a hospital acquired thrombosis has not increased.

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

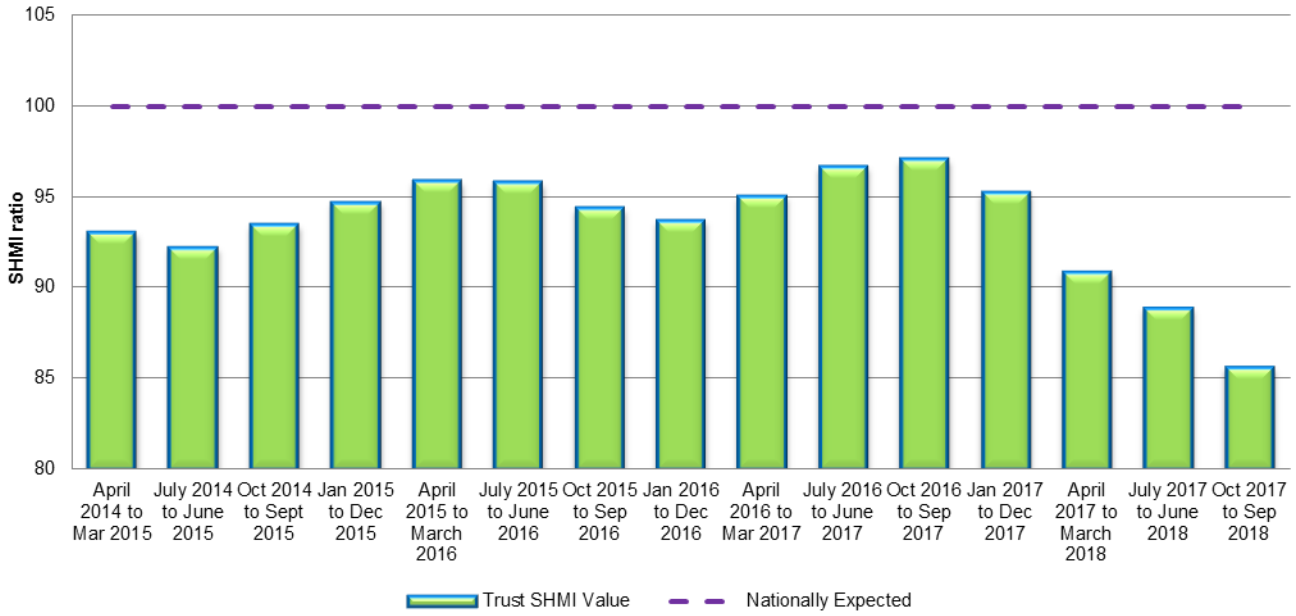
Summary Hospital Mortality Indicator (SHMI)

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.

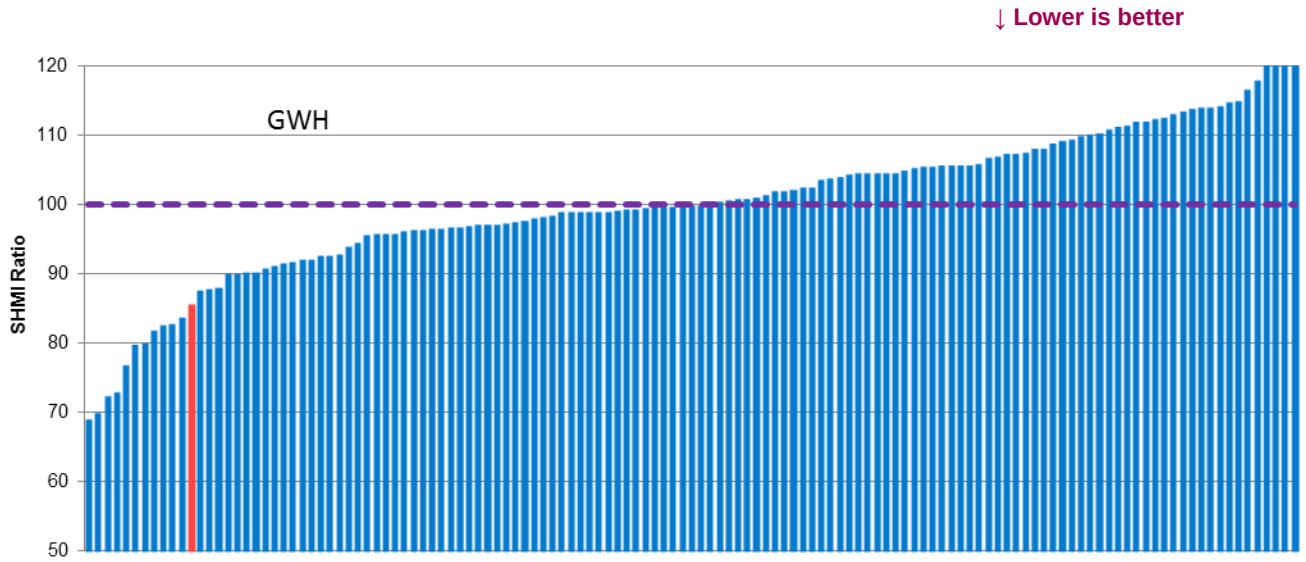
The Trust's SHMI for the rolling 12 month period of October 2017 to September 2018 is 85.56, with the confidence limits 81.62 to 89.64 giving the Trust a 'Better than Expected' rating. The SHMI for this period is lower (better) than the nationally expected value of 100, and is similar to the previous 12 month period (July 2017 to June 2018).

Summary Hospital Mortality Indicator (SHMI) GWH



NB the SHMI is always at least 6 -9 months in arrears

National SHMI October 2017 – September 2018



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 2017 and September 2018. The red line depicts the GWH, and the dotted 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 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.

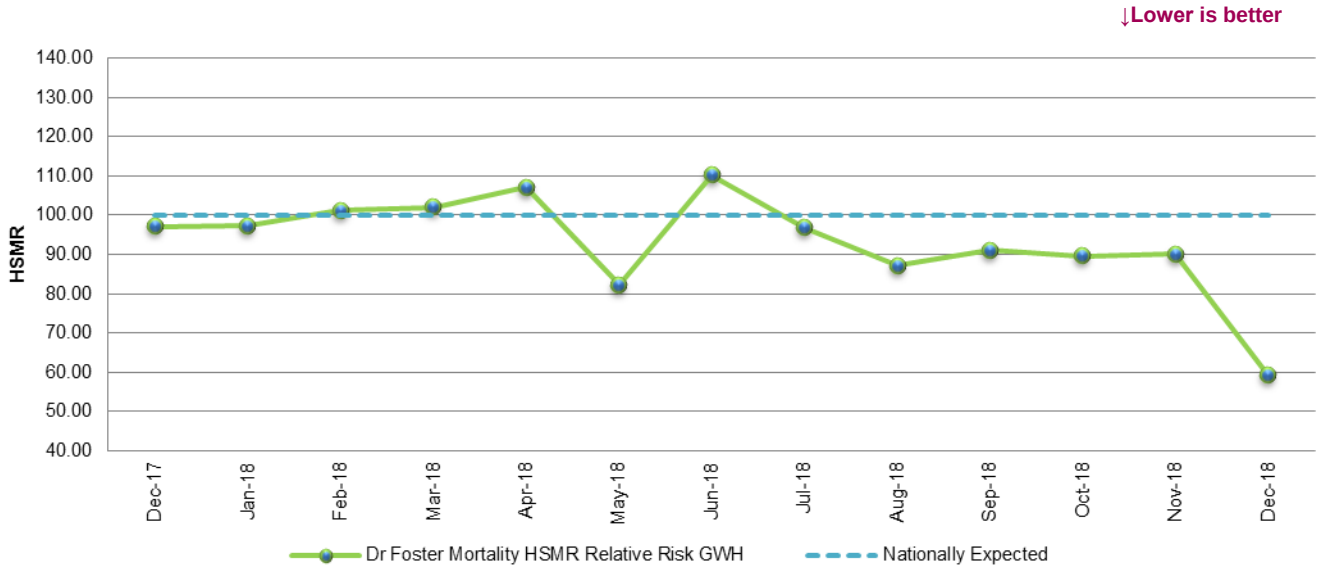
A local RR figure of 100 indicates that the mortality rate is exactly as expected; whilst a local figure of less than 100 indicates a mortality rate lower (better) than expected. The Care Quality Commission (CQC) uses HSMR values to monitor performance of hospitals and identify areas of practice where 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 December 2017 December 2018

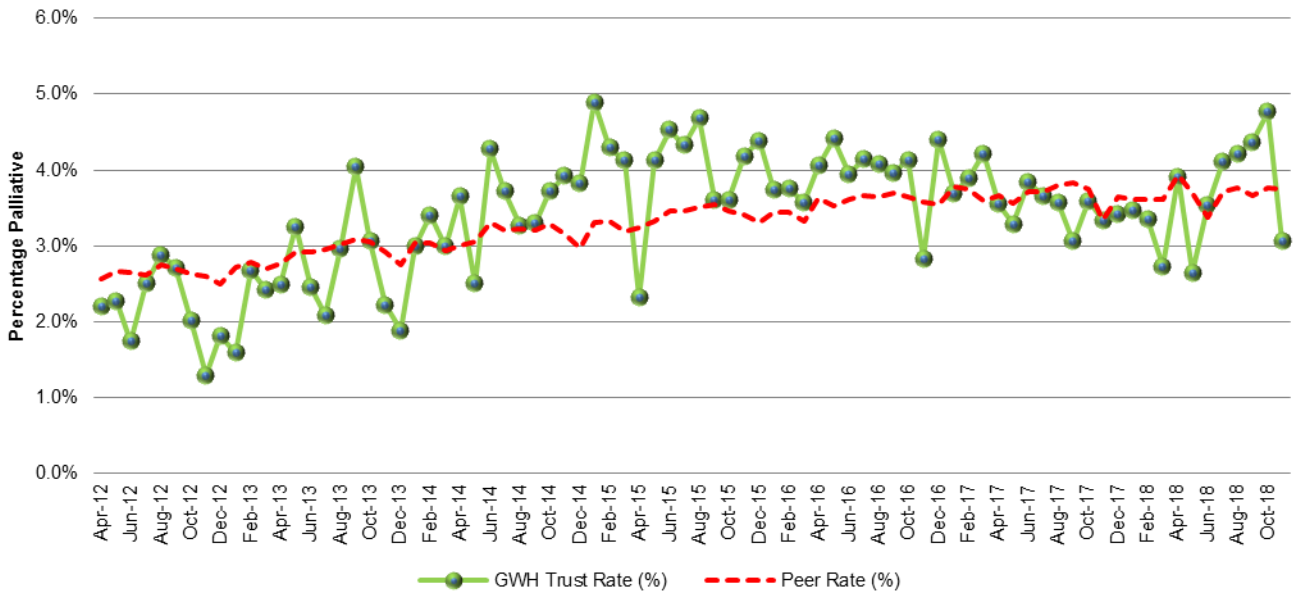


The graph above shows the Trust HSMR December 2017 – December 2018 following rebasing. This shows a general improvement over time with HSMR remaining under the nationally expected since July 2018.

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 2018



The chart above shows the levels of Palliative Care coding against the national average since April 2012. 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, from early 2014 there was an increase in the levels of coding although the Trust is now reporting just around or above the national average. Within the southern region the Trust is only slightly below average for the twelve month period January 2018 to December 2018.

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 2019/20

- 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, 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 2018/19, the Trust has continued to use the Structured Judgement Review (SJR) process for mortality reviews that was introduced in 2017/18. The lessons learned from this have been shared with all hospitals in the West of England as part of a collaborative group that was used to introduce the new process.

National guidance lists a number of categories (for example, deaths following elective surgery, and where families have raised concerns) where a review must be undertaken. At the Great Western Hospital, between 7 and 14% of deaths fall into these 'mandatory' categories. Data on mortality reviews is reported quarterly at Trust Board meeting.

All deaths are screened to identify which fall into the mandatory categories. Overall, approximately 25% of all deaths are subject to SJR. The numbers reported are always three months in arrears as the review process can take place up to three months after a death occurs.

Monthly reports have been in place to report mortality rates at both the mortality surveillance group and the patient quality committee for the last ten years. Mortality review performance has been added to these reports.

A database developed to collect information on mortality reviews and for reporting purposes is used to produce reports at departmental and trust level. These are used at the mortality surveillance group to share lessons learned from mortality reviews and to identify any themes where improvement work is required.

During 2018/19, 1269 of the Great Western Hospital's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 306 in the first quarter; 281 in the second quarter; 342 in the third quarter; 340 in the fourth quarter.

By 31st March 2019, 245 case record reviews and one investigation have been carried out in relation to 245 of 1269 deaths. In one case 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: 79 in the first quarter; 71 in the second quarter; 78 in the third quarter; 17 in the fourth quarter.

0 representing 0% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of: 0 representing 0% for the first quarter 0 representing 0% for the second quarter; 0 representing 0% for the third quarter; 0 representing 0% for the fourth quarter.

These numbers have been estimated using the Structured Judgement Review process. There were two deaths initially identified as more likely than not to have been due to problems in the care provided to the patient. Both have been investigated as serious incidents. After investigation, one case was no longer considered to be due to problems in care. The other case is still under investigation.

0 case record reviews and 0 investigations completed after April 2018 which related to deaths which took place before the start of the reporting period.

0 representing 0% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the Structured Judgement Review process.

0 representing 0% of the patient deaths during 2018/19 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Implementation of Priority Clinical Standards for Seven day Hospital Services.

The Trust remains focussed on the 4 priority clinical standards for 7 Day Services. Until recently these have been actively monitored through the twice yearly national audits. However, going forward they will be monitored more in real time and from regular reports to the Trust Board

Over the last 6 months the Trust has seen a big improvement in the number of patients seeing a consultant within 14 hours of emergency admission. In addition it shows good reporting of those patients who need to be seen once or twice a day once admitted to the inpatient wards.

The diagnostic and interventional access is also good; with extra MRI and US sessions being available since the report last year.

The only real issue is the availability of cardiac echocardiography over the weekend. Part of the issue here is national lack of staff able to do this. The Trust is still on track to achieve compliance by March 2020.

Freedom to Speak Up

NHS staff across the country are being encouraged to speak up and raise concerns following the introduction of a new policy launched by NHS Improvement: Freedom to speak up: raising concerns (whistleblowing) policy for the NHS.

The nationwide policy aims to help make raising concerns the norm in NHS organisations and standardise how NHS organisations support staff when concerns are raised. It's also one of a number of outcomes from the review by Sir Robert Francis into the NHS which aims to improve the experience of staff who speak up.

At Great Western Hospital we want our staff to feel confident, safe and supported to say something if they have a concern.

Another key outcome from the Sir Robert Francis included the appointment of Freedom to Speak Up Guardians in trusts.

The Guardian's Role

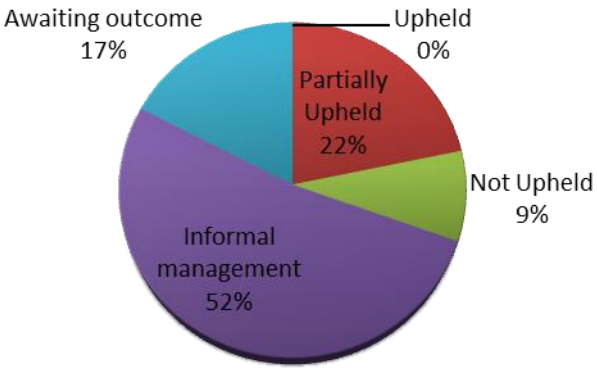
Led by an allocated Executive Director and Non-Executive Director the Trust's Guardians are responsible for providing confidential advice and support to staff in relation to any concerns about patient safety. They can also offer advice and support to ensure concerns raised are handled professionally and result in a clear outcome. We currently have 7 Freedom to Speak Guardians within the Trust with different backgrounds and experiences and a Freedom To Speak Up Co-ordinator supporting staff across the trust with their concerns and feedback and outcomes. Staff can raise a concern via an online form, by phone or in writing. They can also contact one of the guardians directly. All concerns raised are treated confidentially and thoroughly investigated, and action taken where necessary.

Freedom to Speak Up concerns, trends and themes are closely monitored by Patient Quality Committee, Governance and Trust Board.

Key themes arising from cases reported since April 2018 to March 2019

The chart above shows the number of cases and themes of cases received April 2018 – March 2019

FTSU Alert Outcomes April 2018 to March 2019



The chart above shows the outcomes of cases during April 2018 – March 2019.

GWH continues to raise the profile of Freedom to Speak Up through various communications channels including:

- Increased awareness via regular communication to all staff
- FSUG regularly meet up to develop understanding of speaking up
- Quarterly FTSU updates for all staff via communications team / intranet
- Recruitment - Increased number of Guardians 7 now recruited across the Trust from various staff groups
- F2SU screensavers across the organisation
- Freedom to speak up posters in every Staff room
- Freedom to speak up drop in sessions
- Business cards for each F2SU guardian
- Regional network meeting to be held at GWH in October

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.

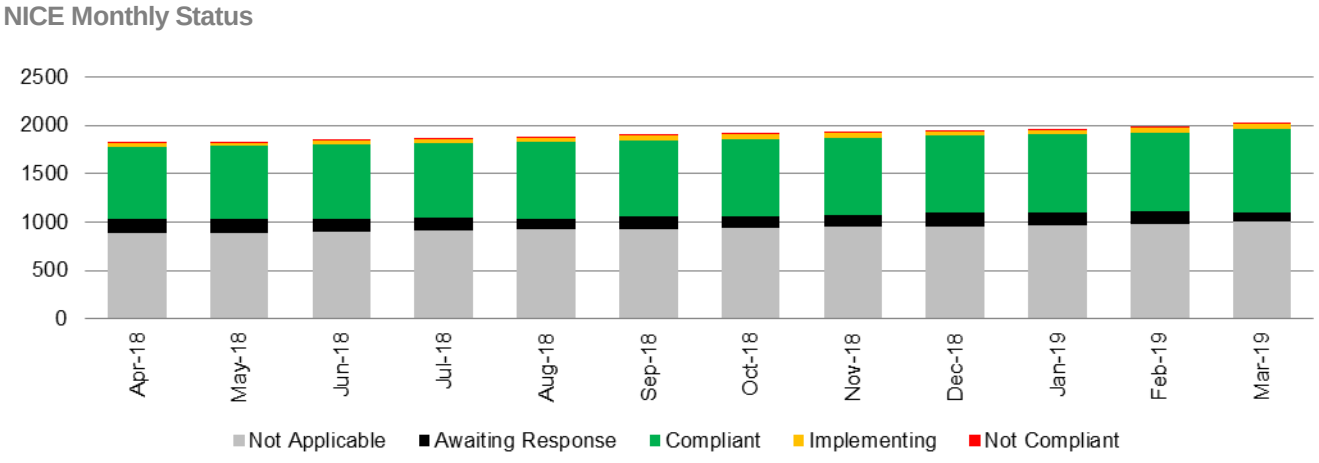
An independent company analyses the questionnaires and reports the results to NHS Digital; this data is then benchmarked against other Trusts.

We have currently received a provisional PROMS report for Hip and Knee Replacement which covers the period April 2018 – March 2019. This shows that we are above the average scores in two of the measures. However, it needs to be recognised that this data is un-validated and we have yet to receive detailed data in order to review and understand specifics within this.

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 922 guidelines were assessed as relevant and of which up to 861 have been assessed as compliant (93.38%).

During 2018/19, the trust has received up 224 published guidelines, of which, up to 91 responses (40.63%) have confirmed they are not relevant to the services, up to 76 guidelines have been confirmed relevant, of which, 62 (81.58%) guidelines have been assessed and confirmed compliant. Up to 13 guidelines have action plans in place, bringing the overall number of guidelines being implemented to 49. Following assessment, there have been no guidelines identified as not complying with recommends which means the overall number of non-compliant guidelines remains at 11. There are up to 57 guidelines which are still in the process of waiting to be assessed and responded to.



Referral to Treatment 18 weeks (RTT)

The waiting list size trajectory (which stated that the waiting list size should be no higher in March 2019 than in March 2018) was not achieved at the end of 2018/19. The Trust reported 21,558 patients on the RTT incomplete PTL, against a trajectory of 20,790 (+768).

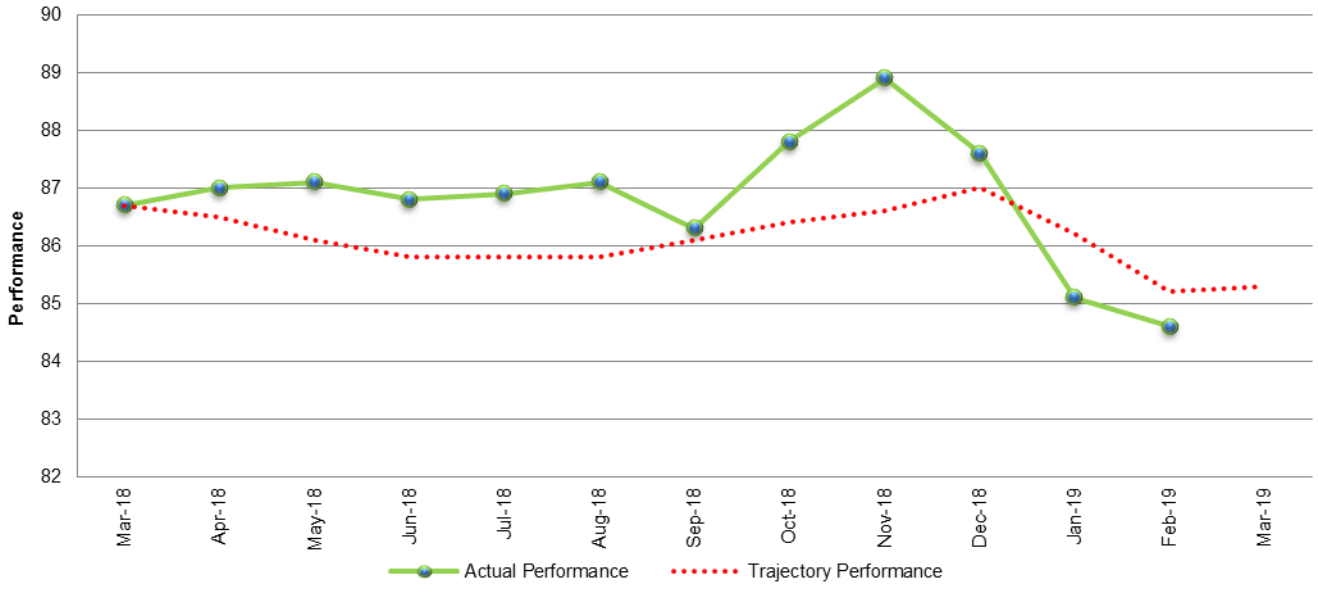
Following an increase in waiting list size in the first quarter, specialty trajectories were put into place, which resulted in a reducing waiting list size between July and November, and the position remaining below trajectory in December and January, despite winter pressures. The main reason for not achieving the trajectory in March was significant operational deterioration in waiting list size in February. Through internal analysis we have identified opportunities to improve the way that we predict waiting lists sizes which will enable us to be more responsive to demand going forward.

In quarter 4 the Trust also made several reporting changes on RTT counting following discussion with the NHSI/E Intensive Support Team in February 2019. Whilst this did not materially impact on missing the waiting list trajectory it was an additional consideration for teams at this time.

The 2018/19 guidance to halve and where possible eliminate patients waiting over 52 weeks was achieved; 10 patients were reported as waiting over 52 weeks in March 2018, and none were reported as waiting over 52 weeks in March 2019. There was an increased number of patients waiting over 52 weeks throughout the year due to a combination of the temporary cessation of corneal graft operating, reporting issues related to the Appointment Slot Issue list and patient choice at the end of long pathways, but these were cleared by the end of March 2019.

In response to the deterioration in waiting list size over quarter 4, the Trust has commissioned NHS Elect to undertake an external review on why this happened. An internal action plan is also in place between operational and informatics teams to resolve the issues identified to date.

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 2018/19 Accident and Emergency Department achieved 89.6% of patients having a maximum of 4 hours wait. Our agreed trajectory with NHS Improvement was 90.42% and the national target still remains at 95%. We validate our data daily and utilising our re-validation standard operating procedures further validation takes place for each submission of data.

40% of the GWH's overall performance is attributable to WH&C performance, which relates to Chippenham and Trowbridge Minor Injury Units (MIUs). In April 2018 WH&C staff moved from sitting under GWH payroll system to sitting under their own. As per 4 hour rules this took the MIU's performance out of GWH performance. In response to this it was agreed with both NHSI and NHSE that instead of the GWH losing this performance, 40% would be attributed to GWH and 60% would be attributed to Royal United Hospitals Bath, based on the geographical location of both of the units.

Delivery of the 4 hour target remains challenging for the Trust however type 1 performance over the last year has improved with a number of initiatives supporting this. The Trust was supported with capital funding from NHSI to redevelop the Clover Building which previously housed Ambulatory Care and the Urgent Care Centre (UCC). The development has increased the foot print of the Urgent Care Centre, improved the layout of the Ambulatory Care Centre and created Ambulatory Care and Triage (ACAT) which is now the initial triage space for all medically expected patients. This reduces clinical risk for patient who were previously arriving directly onto Linnet ward our Ambulatory Care Unit (LAMU).

• The Medically Expected Unit reported in the last version of this report remains open reducing crowding within the Emergency Department (ED). It has been enhanced to include a sitting area for patients offering greater flexibility of the space.

• Since the Unscheduled Care Division has taken ownership of the Urgent Care Centre (UCC) a trial of working hours successfully proved the need to change the opening hours to align with the demand profile for the service. This change has been substantively adopted and resulted in a reduction in the number of patients waiting longer than 4 hours in the UCC.

• The Trust has continued caretaking management of the Walk In Centre (WIC) embedding best practice working policy and procedures. The challenge will be during 2019/20 when the WIC is closing the walk in element of the service and reconfiguring how patients access the services. It will no longer be operated by the Trust but has the potential to increase demand on the acute site.

• It has been identified that 1st assessment breaches are a contributor to the current under performance, in response the Trust has realigned the staffing costs from UCC to ED providing a 24/7 ENP service for the minors stream to prevent non admitted breaches. Also this realignment has provided band 7 streaming nurses 4 days a week to ensure patients are treated in the right place and increase streaming to the UCC. There has also been an adjustment to the consultant rota to ensure increased consultant capacity at the weekends.

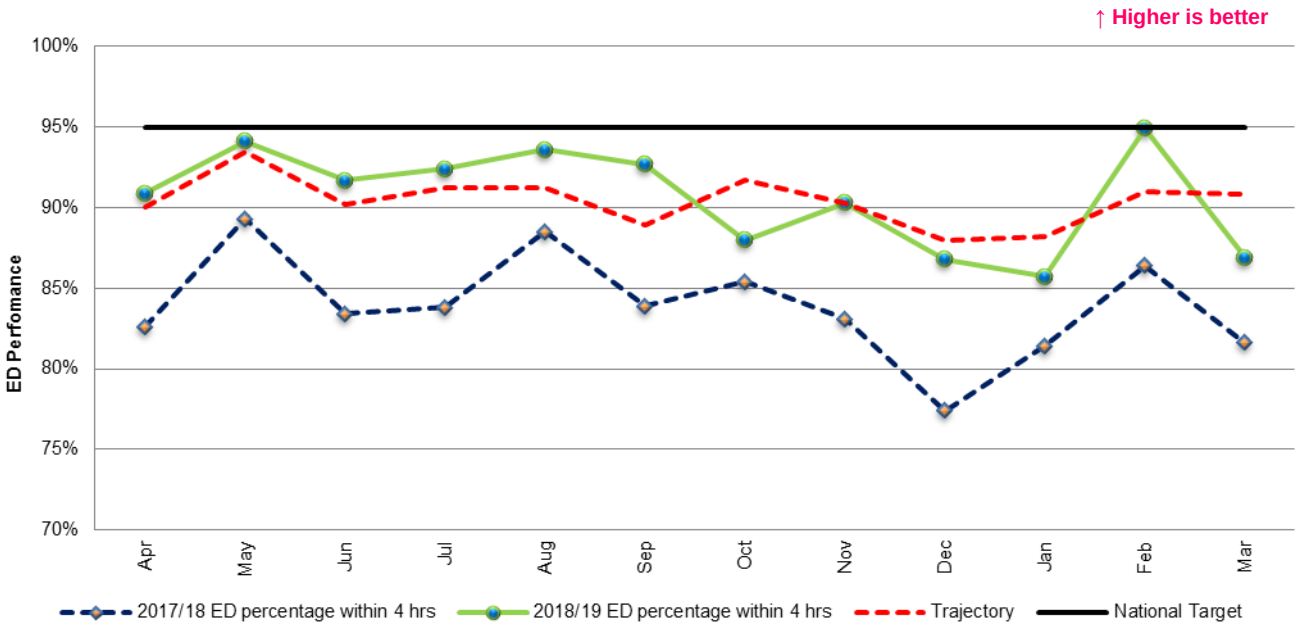
The Trust has been operating Dorcan Ward (8 beds) for medically fit patients. The purpose is to crease acute bed capacity for ED flow whilst the final arrangements for a patients discharge are completed.

The Trust acknowledges that flow of patients out of the ED, especially early morning flow, is critical in managing performance, patient experience and safety.
Audits have demonstrated that when the ED becomes crowded the ability of the clinical teams to assess and treat patients is impacted, resulting in further crowding of the department due to exit block and caring for patients that should be in an inpatient areas. Referred patients are then discharged from ED as they have had a significant amount of treatment improving their condition that should be provided as an inpatient. In support of the need to improve flow the Trust is driving the Emergency Care Intensive Support team (ECIST) principles of identifying a patients Predicted Date Medically Stable (PDMS) for discharge.

This is a new initiative to the Trust but is targeting at making sure all patients have a target discharge date and actions are taken to remove all blocks to the patient achieving the planned discharge date. This process also supports identification of the next day's discharges so that preparations can be made to achieve the discharge early in the day.

In addition the Trust was successfully awarded £30M to invest in a redevelopment of the ED and bringing some of the 'front door' services located around the hospital to the ground floor creating a truly integrated front door service and providing the capacity for onward flow of patients. Planning for this work has commenced and construction work is planned to start by the beginning of 2021.

All Emergency Department performance for GWH



The chart above demonstrates Emergency Department performance for 2018/19 in comparison to 2017/18 against the national target of 95%.

The Great Western Hospitals NHS Foundation Trust intends to take the work carried out this year and enhance this for 19/20 alongside the preparation work for the 'front door' redevelopment project.

62 day national cancer standard

The Great Western Hospitals NHS Foundation Trust considers that this data is as described as there are strong governance processes in place within the trust that monitor and manage this data.

The cancer waiting times service standards include a maximum 62 days from receipt of urgent GP referral for suspected cancer to 'First Definite Treatment' of cancer as per Operational Standard of 85%.

Performance Indicator	Standard	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Cancer 62 Days	≥85%	89.2%	80.8%	86.9%	93.1%	76.7%	84.0%	81.7%	90.9%	92.4%	83.6%	77.1%	86.4%	88.7%

Actions across all Divisions to support 62 day cancer performance

1. Delivery of National "10 High Impact Actions". Work continues on delivery of timed pathways by tumour site with breach analysis identifying risks to pathway delivery and where required inter trust referral by day 37 in a patient pathway.
2. Executive Oversight of Cancer performance with weekly meetings with teams demonstrating actions to manage each identified risk.
3. Breach analysis for all patients who have breached 62 day treatment target
4. Proactive management of Cancer Patient Tracking List (PTL), meeting with Heads of Service and Diagnostic teams
5. Proactive review of 72day+ patients on PTL by clinical lead and weekly oversight by Medical Director to reduce risk of 104 day breaches
6. With increasing cancer activity; review of treatment numbers for cancer trajectory for 2019
7. Collaborative working with CCG & Macmillan GP to support GP training and audit on use of 2WW referral
8. Working with tertiary providers on managing PTL and dating patients for treatment.
9. Development of Cancer Dashboard following successful bid to TVCA innovation bid to monitor performance of timed pathway by tumour site.
10. Thames Valley Cancer Alliance (TVCA) Transformation projects including pathway redesign project manager to support development for lung, colorectal, urology and Upper GI pathways.
11. Review of internal audit process of 62 day performance and Cancer Access Policy (e-RS /2ww referrals management in Booking Centre)

National standard achieved in March with performance of **88.7%** with 106 treatments and 12 breaches. Breaches were noted in Colorectal (5), Gynae (0.5), Haematology (2), Lung (1.5) and Urology (3).
5 breaches related to GWH pathway, 2 breaches related to OUH PET scanning delays; 2 breaches had tertiary involvement in pathway (2 ITR in time); 3 breaches related to the tertiary "all options" urology patients. We have seen an increase in 2ww referrals for breast, breast symptomatic, colorectal and gynaecology. Outpatient and diagnostic capacity has been under pressure to deliver requirements with additional clinics arranged to meet demand.
PET scanning delays of at least 4 weeks due to FDG stability (National issue). The impact of these delays has been raised with NHSE.

Review of patients readmitted to hospital within 30 days of discharge

For the 18/19 position the audit with the local CCG has yet to occur and will be carried out in May 2019. On terms of the current position the trust is showing an improvement on 17/18 position of 10.1% readmission rate at 30 days compared to 11.2% the previous year. This remains high when benchmarked through Dr Foster with a low position being 5.12% and a high position being 10.91%.

There still remains a challenge within the data set with Ambulatory Care still remaining within the numbers as well as a number of planned readmission's being coded incorrectly. In order to ascertain the true impact of readmissions a local audit was conducted by the Unscheduled Care Division in October 2018 reviewing all readmissions where the admitting ward had been an Unscheduled Care ward. This was done using all patients 'classified' as a readmission during September 2018 with 1 clear questions asked of the team when carrying out the audit.

'Was the first admissions clinically related to the readmission'

297 patient's notes were reviewed as part of the audit with the following findings

- 188 patients first admission was related clinically to their second admission (45%)
- 103 patients first admission was NOT related clinically to their second admission (52%)
- 6 Patients had complex conditions where it was unclear if the admissions were clinically related

This is in contrast to the contractual position where we assume that 70% of readmissions are accurate. A further audit is to commence in April 2019 based on January readmission data covering Unscheduled Care, Planned Care and Women's and Children's.

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
2017/18	**10906**	**72653**	**83559**	**1042**	**8476**	**9518**	**9.6%**	**11.7%**	**11.4%**
Apr 18	920	6268	7188	77	768	845	8.4%	12.3%	11.8%
May 18	962	6608	7570	78	824	902	8.1%	12.5%	11.9%
Jun 18	873	6611	7484	77	787	864	8.8%	11.9%	11.5%
Jul 18	890	6630	7520	60	697	757	6.7%	10.5%	10.1%
Aug 18	821	6686	7507	64	676	740	7.8%	10.1%	9.9%
Sep 18	929	6315	7244	78	650	728	8.4%	10.3%	10.0%
Oct 18	1017	6719	7736	109	710	819	10.7%	10.6%	10.6%
Nov 18	1110	6784	7894	126	656	782	11.4%	9.7%	9.9%
Dec 18	935	6594	7529	85	670	755	9.1%	10.2%	10.0%
Jan 19	971	6929	7900	83	678	761	8.5%	9.8%	9.6%
Feb 19	888	6197	7085	97	609	706	10.9%	9.8%	10.0%
Mar 19	1003	6802	7805	71	404	475	7.1%	5.9%	6.1%
2018/19	**11319**	**79143**	**90462**	**1005**	**8129**	**9134**	**8.9%**	**10.3%**	**10.1%**

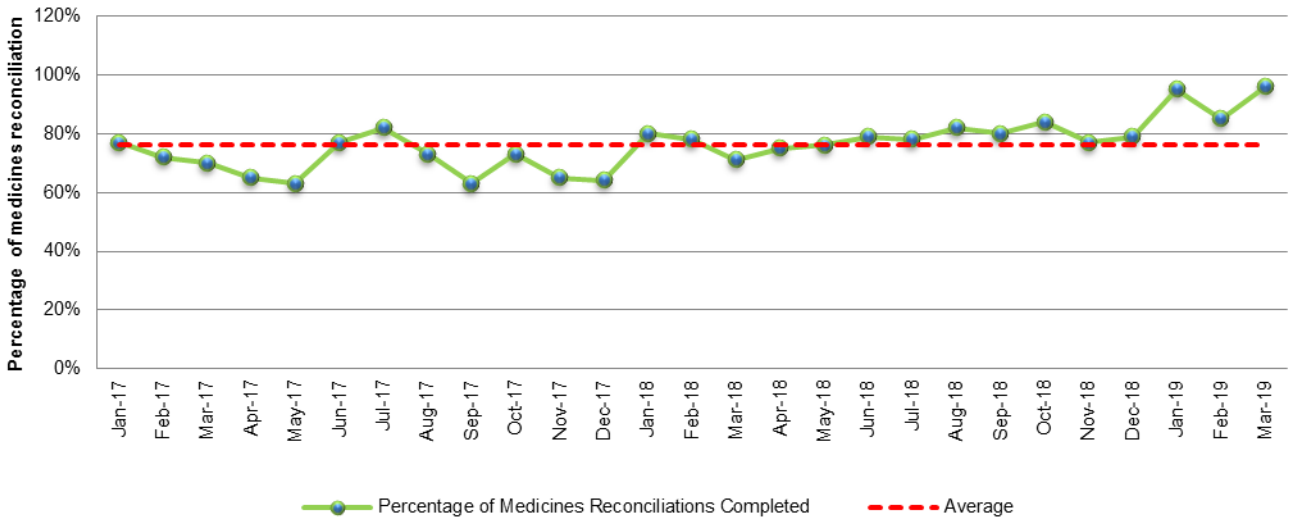
Medicines Safety

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 progressive increase in patients with completed medicines reconciliations, which is an important marker in ensuring patient and medication safety.

Percentage Medicines Reconciliations completed

↑ Higher is better

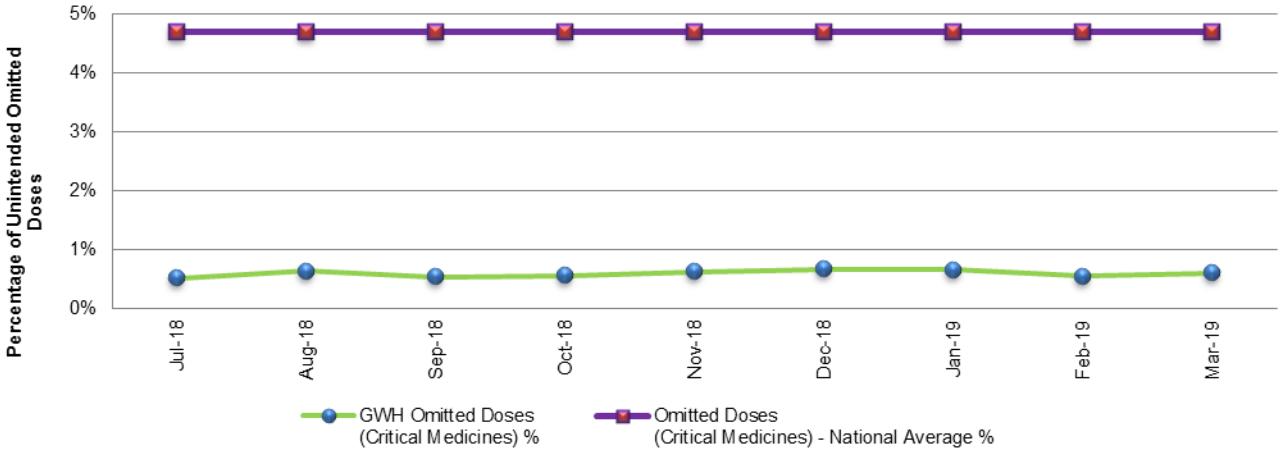


Missed/Omitted Doses

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.

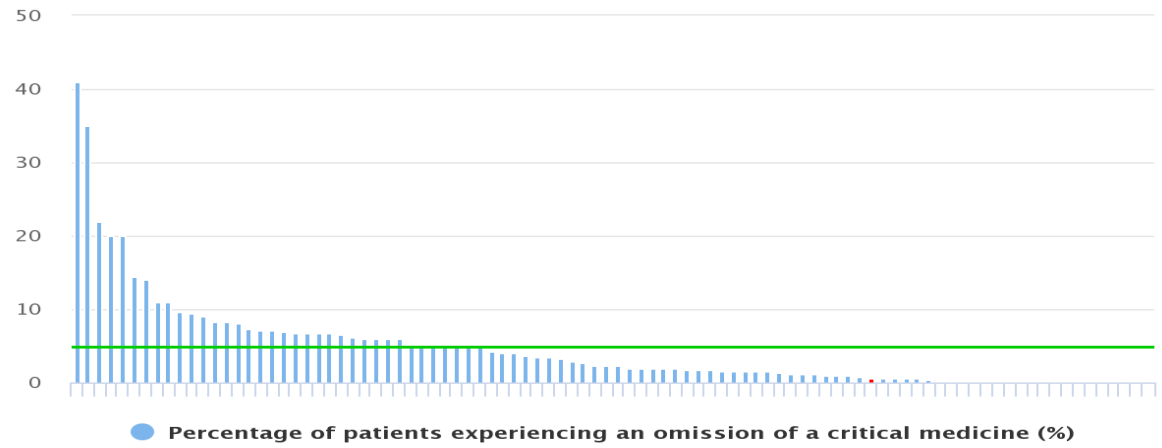
Percentage of Omitted Doses (Critical Medicines) against National Benchmarking

↓Lower is better



The chart above shows the percentage of unintended omitted critical medicines, as a percentage the total number of administrations of all medicines per month, at GWH is lower than the national average of acute hospital trusts

Percentage of patients experiencing an omission of a critical medicine



The chart above (GWH as the red line) shows that through national benchmarking data that the percentage of GWH patients experiencing an omission of critical medicines is significantly lower than the national average.

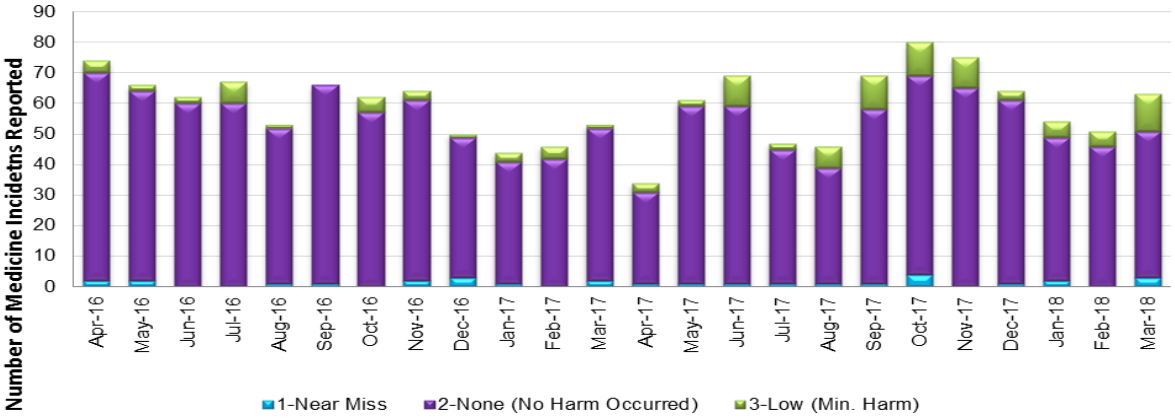
Learning from Incidents and Reduce Harm from Medication Incidents

Medication incidents 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 shared through Medicines Safety bulletins. Examples issued in 18/19:

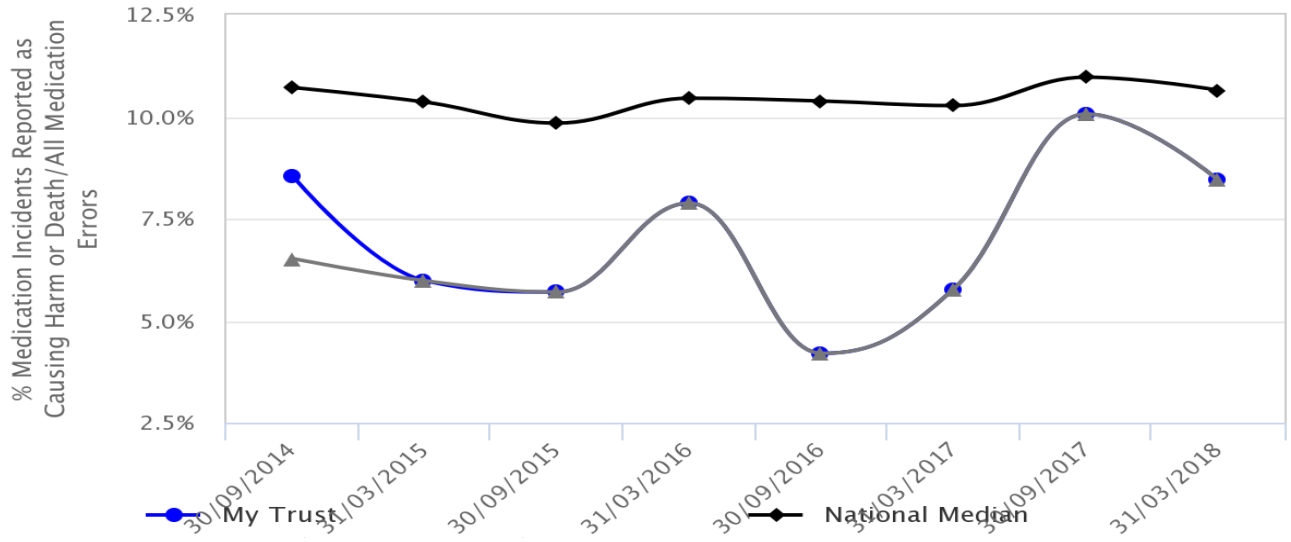
- Safe Storage of Medicines
- Ensuring Patients get their Medicines in a timely manner
- Correct Use of Oxygen Cylinders
- Urgent Antibiotics

Number of Medicines Incidents Reported Including Level of Harm



The chart above shows the number of medicines incidents reported at GWH with the level of harm along with consistency in reporting.

Percentage of medication incidents reported as causing harm or death (GWH vs. national distribution)



The chart above demonstrates that GWH (blue line) continues to report medication incidents well, and remains below the national average of medication incidents causing harm.

Together this data provides assurance that for medicines safety GWH is safe, has good systems in place for medicines safety and importantly learns from incidents.

Improving Patient Experience & Reducing Complaints

The Friends and Family Test is commissioned nationally by NHS England as a form of data collection for patients to provide feedback on our services who have been discharged from our care.

Our overall response rate remains low for the Friends and Family Test; however feedback that is received is acted on and highlights areas of excellence and areas where improvements can be made.

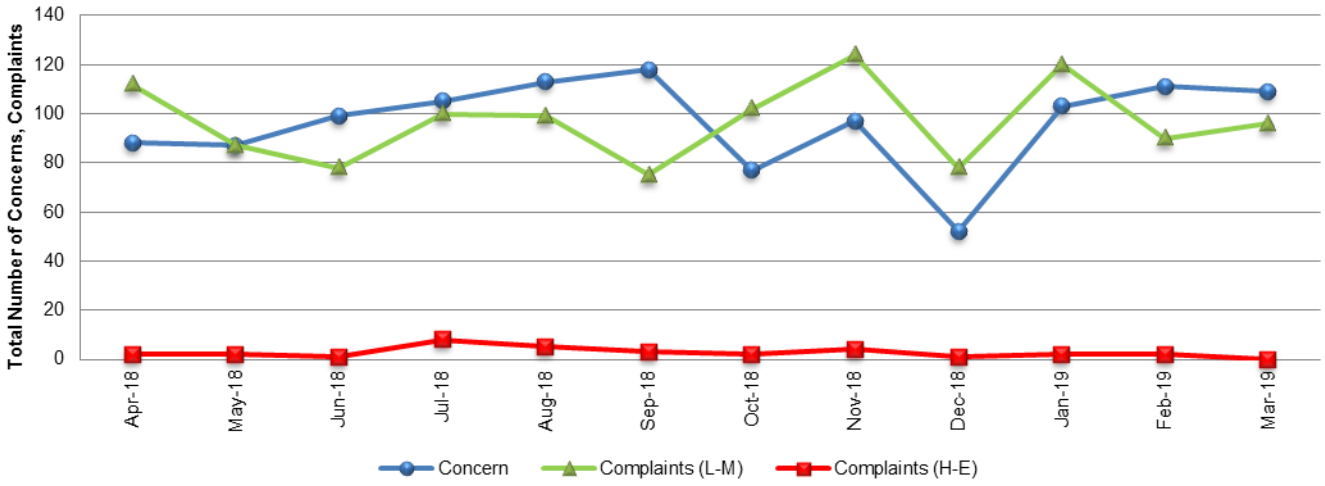
Feedback from the Friends and Family Test includes changes to tea rounds, ward routines in the format of bedside guides, changes in the Children's food menus, prompt repairs and cleaning to seating clinic areas/waiting areas.

Percentages of patient recommendation scores are high and have remained consistent in the high 90% throughout 2018/19.

Cards are available for patients to complete; these cards are also available in other formats to include Large Print, Child friendly and Easy Read.

Every aim is to improve the overall response rates for completed cards. We are aware within some areas once a patient has been discharged they are wanted to return home as soon as possible, therefore a text messaging service is in place for the Emergency Department patients, plans are in place to introduce this into all Inpatient areas throughout 2019/2020.

Concerns and Complaints received in 2018/19 Trust-Wide



The graph above gives a comparison on concerns/complaints received Trust-Wide services over a 12 month period for 2018/19.

Low/medium cases are complaints where service or patient experience is below reasonable expectations. High/extreme cases require a more in-depth investigation.

Themes from complaints are highlighted and actions developed and implemented in the format of "you said, we did".

Patient Experience and Engagement

Engagement with patient groups has taken place throughout 2018/19 gaining views on our services and changes made to enhance service delivery. Plans are in place for this worked to continue throughout 2019/2020.

National Inpatient Survey

Questionnaires were sent out to patients who had recently stayed at the Great Western Hospital, the initial mailing was sent out in October 2018. 539 patients responded. The overall response rate was 46%.

The results for 2018 are detailed below against the key objectives agreed to benchmark each year to monitor performance.

Communication	**2014**	**2015**	**2016**	**2017**	**2018**
Care: Staff did not contradict each other	66%	62%	68%	68%	65%
Care: Was involved as much as wanted in decisions	88%	88%	88%	91%	91%
Care: Had confidence in the decisions made	92%	92%	92%	94%	94%
Care: Right amount of information given on condition or treatment	77%	77%	78%	78%	76%
Enough emotional support from hospital staff	81%	82%	84%	82%	84%
Doctors: Got clear answers to questions	95%	92%	96%	93%	94%
Doctors: Not talked in front of patients as if they were not there	74%	73%	75%	76%	77%
Nurses: Got clear answers to questions	95%	94%	94%	95%	95%
Received information explaining how to complain	23%	23%	18%	26%	14%

Discharge Planning	**2014**	**2015**	**2016**	**2017**	**2018**
Discharge: Given clear written/printed information about medicines	85%	83%	88%	88%	80%
Discharge: Family given enough information to help care	72%	67%	70%	72%	70%
Discharge: Told who to contact if worried	74%	73%	73%	73%	73%
Discharge: Felt involved in decisions about discharge from hospital	86%	84%	88%	85%	84%
Discharge: Was not delayed	56%	52%	55%	58%	56%
Discharge: Patients given written/printed information about what they should or should not do after leaving hospital	65%	59%	60%	57%	54%
Discharge: Told purpose of medications	90%	87%	89%	87%	91%
Discharge: Told side-effects of medications	52%	49%	55%	56%	51%

Hospital, Care, Overall	**2014**	**2015**	**2016**	**2017**	**2018**
Hospital: Offered a choice of food	93%	92%	92%	94%	93%
Found staff member to discuss concerns with	67%	70%	75%	70%	71%
Asked to give views on quality of care	18%	15%	14%	17%	9%

Our Priorities 2019/20

- Continue with the recruitment of Trust Bank Interpreters.
- The introduction of IPads for Skype Interpreting for deaf patients.
- The introduction of using an app for language interpreting on trust iPod's/tablets.
- Review finance for changes to PALS Structure.
- Review of National Surveys to change provider.
- Slicker and escalation processes to be in place for improved complaint handling.
- Complaint themes and outcomes to link with QI projects to ensure learning takes place and shared trust wide.
- Scoping exercise for Easy Read documents to be produced in house.
- Procurement for the Friends and Family Test.
- Considerations for a Patient Experience team to be formed.
- Engagement with Community Groups, listening events to be held throughout 2019/2020/2021.
- Review process for gathering real time patient experience and engagement feedback

Staff Survey 2018/19

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

The response rate to the 2018 survey among trust staff was 44% (2017: 46%). Scores for each indicator together with that of the survey benchmarking group Combined Acute and Community Trusts are presented below.

	2018		2017		2016	
	GWH	Benchmarking Group	**GWH**	Benchmarking Group	**GWH**	Benchmarking Group
Equality, diversity and inclusion	**9.1**	9.2	**9.2**	9.2	**9.3**	9.3
Health and wellbeing	**5.8**	5.9	**6.0**	6.0	**6.2**	6.1
Immediate managers	**6.8**	6.8	**6.8**	6.8	**6.8**	6.8
Morale	**6.1**	6.2	**-**	-	**-**	-
Quality of appraisals	**5.2**	5.4	**5.3**	5.3	**5.5**	5.4
Quality of care	**7.2**	7.4	**7.1**	7.5	**7.4**	7.5
Safe environment – bullying and harassment	**8.1**	8.1	**7.9**	8.1	**8.0**	8.2
Safe environment – violence	**9.5**	9.5	**9.4**	9.5	**9.5**	9.5
Safety culture	**6.7**	6.7	**6.7**	6.7	**6.8**	6.7
Staff engagement	**6.9**	7.0	**6.9**	7.0	**7.1**	7.0

The Trust was one of the 304 participating NHS organisations, and one of the 43 Combined Acute and Community Trusts that participated in the National Staff Survey in October 2018. There were 1,250 (25% of the workforce) randomly selected and given the opportunity to participate in the 2018 Staff Survey by an online staff survey through their NHS email. A total of 534 employees returned a completed questionnaire giving the Trust a response rate of **44%**. This was a slight decrease in last years (46%, 2017) but above the average response rate for Combined Acute and Community Trusts in England (40%, 2018).

National and regional response comparisons

National

NHS England released the results of the 2018 NHS Staff Survey on Tuesday 26 February 2019. Over 497,000 NHS staff took part in the survey with a National response rate of 45.7 per cent and just fewer than 10,000 more people shared their views compared to the 2017 survey. GWH demonstrated a similar trend to the national results with a reduction in response rates.

2018 Results Analysis

Areas of Improvement from 2017
The top five areas where the results have improved from the 2017 survey are;

- Q4f. Have adequate materials, supplies and equipment to do my work 46% (42%, 2017)
- Q4h. Team members have a set of shared objectives 75% (70%, 2017)
- Q5g. Satisfied with level of pay 31% (26%, 2017)
- Q5h. Satisfied with opportunities for flexible working patterns 56% (51%, 2017)
- Q13a. Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public 74% (68%, 2017)

Areas that have deteriorated from 2017
The top five areas where the results have declined from the 2017 survey are;

- Q8b. Immediate manager can be counted on to help with difficult tasks 67% (72%, 2017)
- Q11a. Organisation definitely takes positive action on health and wellbeing 22% (27%, 2017)
- Q11c. Not felt unwell due to work related stress in last 12 months 57% (61%, 2017)
- Q13d. Last experience of harassment/ bullying/ abuse reported 43% (49%, 2017)
- Q22b. Receive regular updates on patient/s service user feedback in my directorate/department 51% (60%, 2017)

Regional

The Trust was ranked 16th out of 21 Trusts in 2018 when benchmarking against the ten National Staff Survey themes against organisations from across the South West. Gloucestershire Hospitals NHS Foundation Trust, Oxford University Hospital NHS Trust and North Bristol NHS Trust remain below the Trust.

When compared against the STP group, Salisbury NHS Foundation Trust ranked 9th and Royal United Bath Hospital ranked 14th.

Due to the changes in the way the national results are reported we are unable to obtain a regional comparison against last year's results.

Staff Engagement

The staff engagement score for the Trust has remained the same at 6.9 and is scoring marginally below the national average of 7.0. 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 remained the same this year, against a regional comparison the Trust engagement score is higher than three other Trusts and scored the same as four other Trusts in the South West region.

Staff engagement levels across the Trust are variable and range from 6.6 to 7.2 out of a possible 10. Corporate Services and Diagnostic and Outpatients report the lowest levels of engagement at 6.6 with Planned Care and Swindon Community Health Services reporting the highest at 7.2.

Our priorities for 2019/2020

The development of a Trust wide approach will be implemented on four key focus areas, the Trust will work with staff through listening events and focus groups to identify relevant and meaningful actions.

The key priority areas for focus are;

Staff Engagement (led by HRD and OD lead)
- Refresh and re-launch of the People Strategy
- Implement Engage to Change within agreed departments
- Leadership Development
- 'You Said' and 'We Did' communication to be done Trust Wide and Locally

Quality of Care (led by Head of Quality)
- Develop a new Quality Strategy
- Implement a communication plan to support the Quality Strategy
- Utilise the engage to change methodology for employee led improvements

Quality of Appraisals (led by Head of Learning and Development)
- Review Appraisal Policy and Training
- Consider the implementation of an appraisal period (summer)
- Implement bespoke training for hotspot departments

Health and Wellbeing (led by Head of Health and Wellbeing)
- Review Health and Wellbeing strategy as part of the People strategy review
- Implement wellness events utilising charitable funds
- Review of staff benefits and how this is communicated to staff (Staff App)
- Improving health and wellbeing guidance for managers

Divisional
Each Division will develop a local action plan focusing on three key areas which will make the most impact based on the results for the Division. The results will be shared through a 'listening into action' approach, empowering staff to be involved and contribute towards improvements in their Divisional staff survey results. Updates on the progress of the Divisional action plans will be presented quarterly at Executive Committee.

Monitoring arrangements
The Trust and each of the Divisions have commenced developing action plans aligned to the areas where their scores have deteriorated. Each of the priority areas will have named the three lowest scoring questions. The areas will be measured by an improvement on the score for these questions following the 2019 survey.

All Divisions will provide updates on the progress of the Divisional action plans quarterly at Executive Committee.

Trade Union Facility Time

In 2017 the government passed The Trade Union (Facility Time Publication Requirements) Regulations 2017 requiring public bodies to report each year on the agreed time off Trade Union Representatives who are employees have taken to carry out their trade union role.

As at 31 March 2019 there are 27 Trade Union Representatives who are employed by the Trust and the current data shows that employees have 244.5 hours on paid Trade Union Activities and 405.5 hours on paid Trade Union Facility Time. This is expected to rise with the Q4 information and at that point cost and % of employee time will also be calculated for 2018/19. The data is published by 31 July each year.

NHS Doctors and Dentists- Rota Gap and Improvement Plan

In August 2017 there were 30 junior doctor vacancies with a further 16.5 pending starters appointed, this was reduced significantly to just 14.5 vacancies in August 2018 with 2 pending starters appointed. This has remained at a low level throughout this year but increased slightly in April and May 2019, there are currently 9.84 junior doctor vacancies across the Trust with a further 5 pending starters.

The reduction in vacancies for junior doctors has been achieved, despite an overall increase in posts, by using a number of different methods; all have contributed in different ways.
Internal factors:
We conduct an annual recruitment trip to a European university that has now been running for 4 years. We recruit F1 level clinical fellow doctors directly during this trip that are of a high standard. These doctors often then stay on for a 2nd year to work at F2 level before either taking on training roles with HEE or continuing to work for the Trust in more senior clinical fellow roles. This is of significant importance, as whilst we don't struggle to recruit F1 level doctors, having them stay on to work at F2 level has been of great value to the Trust and helped reduce our vacancies at this level.

In 2018 we took out a BMJ subscription meaning we can advertise all our medical vacancies through their online portal which has a large number of views Nationally and Internationally by doctors looking for work. We also have access to use their printed journal for advertising but this is reserved for Consultant recruitment campaigns since usage is limited.

For the last 4-5 years we have also recruited additional teaching roles through the Academy, these doctors work in teaching or innovation roles but also undertake clinical duties on a 50/50 split. Funding comes from the Academy for the increase in headcount needed to support the reduction in clinical capability from each of the appointed doctors.

Vacancies are reviewed regularly at monthly Medical Staffing Group meetings and in Quarterly Guardian reports. We also take the opportunity to work with the Junior Doctors forum to promote roles that might interest their members and gain feedback on improvements that could be made to make roles more attractive.

External factors:
HEE introduced a payment for GP trainees in the area for specific roles to boost recruitment and encourage doctors to take on those roles. These payments are funded by HEE and have no financial impact on the Trust other than positive by filling more of the roles.

All remaining vacancies are covered by internal bank locums or agency locums, however the fill rate for bank locums is high.

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 2018/19 against the key national priorities from the Single Oversight Framework. Performance against the relevant indicators and performance thresholds are provided.

Indicator	2014/ 2015 Trust	2015/ 2016 Trust	2015/ 2016 Target	2016/ 2017 Target	2016/ 2017 Trust	2017/ 2018 Target	2017/ 2018 Trust	2018/ 2019 Target	2018/ 2019 Trust	Achieved/ Not Met
Maximum time of 18 weeks from point of referral to treatment in aggregate, patients on incomplete pathways	90.5%	88.9%	92.0%	92.0%	91.1%	92%	86.7%	86.7%	83.45%	Not Met
Maximum time of 18 weeks from point of referral to treatment in aggregate, admitted patients	88.6%	82.5%	90%	90%	61.6%	90%	69.1%	69.1%	66.33%	Not Met
Maximum time of 18 weeks from point of referral to treatment in aggregate, non-admitted patients	95.6%	89.2%	95%	95%	89%	95%	89.3%	89.3%	89.45%	Not Met
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge - 95%	91.9%	91.1%	95.0%	95.0%	86.6%	95%	87.2%	National 95%	89.6%	Not Met
Cancer 31 day wait for second or subsequent treatment – surgery - 94%	99%	94.%	94%	94%	100%	94%	98.7%	94%	97.6&	Achieved
Cancer 31 day wait for second or subsequent treatment - anti cancer drug treatments – 98%	98%	99.7%	98%	98%	99.6%	98%	100%	98%	100%	Achieved
Cancer 62 Day Waits for first treatment from urgent GP referral for suspected cancer – 85%	88.4%	87.70%	85.00%	85%	86.5%	85%	82%	85%	85.7%	Achieved
Cancer 62 Day Waits for first treatment from NHS cancer screening service referral - 90%	98.4%	98.10%	90.00%	90%	96.7%	90%	97.6%	90%	95.1%	Achieved
Cancer 31 day wait from diagnosis to first treatment	98.6%	98.00%	96.00%	96%	97.1%	96%	98.4%	96%	98.4%	Achieved
Cancer 2 week wait from referral to date first seen, all urgent referrals (cancer suspected) – 93%	94.0%	94.30%	93.00%	93%	88.4%	93%	93.4%	93%	94.8%	Achieved
Cancer 2 week wait from referral to date first seen, symptomatic breast patients (cancer not initially suspected) – 93%	96.8	95.50%	93.00%	93%	91.8%	93%	78.5%	93%	93.6%	Achieved
Maximum 6-week wait for diagnostic procedures	99.5%	99%	99.1%	99%	97.0%	99%	96.2%	99%	92.77%	Not Met

Statement from the Council of Governors dated 12th May 2019

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 89.6% of persons attending A&E were seen within 4 hours, was marginally below the agreed trajectory with NHS Improvement of 90.42% and the national target of 95%. The Governors consider these figures to be consistent with those of the majority of other Trusts and are reflective of the pressures brought about by increased attendance.

It should be noted that these figures are an improvement on last year and that a number of improvement initiatives were introduced this year. The Trust intends to take the work carried out this year and enhance this for 2019/2020, alongside the preparation work for the 'front door' redevelopment project, for which the Trust was successfully awarded £30M to invest in a redevelopment of the ED and to bring some of the 'front door' services located around the hospital to the ground floor creating a truly integrated front door service and providing the capacity for onward flow of patients.

Within the Quality Report the Trust has reported a number of achievements including-

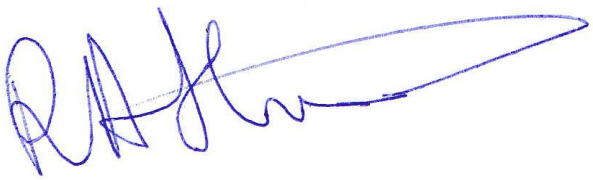
The Venous Thromboembolism (VTE) risk assessment, carried out on adult patients who are admitted to the Trust, to determine their risk of VTE related episode has for the last two years been consistently greater than 99%, against the national target of 95%.

The Trust's Summary Hospital-level Mortality Indicator (SHMI), October 2017 to September 2018 is 85.56, lower than the nationally expected value of 100 and nationally falls in the first decile.

Acute Kidney Injury (AKI) Average Mortality Rate at Discharge – During 2018/19 14.7% of patients died in GWH with Acute Kidney Injury. This is a decrease on the previous year where the figure was 16.8% and over the last four years has decreased from 19.28% to 14.69%.

Medicine Safety – The Electronic Prescribing and Medicines Administration System (EPMA) report regarding medicines reconciliation shows that data over the last 2 years has shown progressive increase in patients with completed medicine reconciliations, which is an important marker in ensuring patient and medication safety. In addition, the percentage of unintended omitted doses of critical medicine, as a percentage of the total number of administrations of all medicines per month, at GWH, -0.7% is lower than the national average of acute hospital trusts of -4.8%.

These achievements combine to help achieve an improving experience for our service users and are noted by the Governors.



Roger Stroud

Lead Governor on behalf of the Council of Governors

Statement from Swindon Clinical Commission Group dated 17th May 2019

Swindon Clinical Commissioning Group (CCG), as lead co-ordinating commissioner for the GWHFT, welcomes the opportunity to review and comment on the GWHFT Quality Account for 2018/2019. 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 2018/2019 presentation guidance.

The CCG recognises and commends the Trust's commitment to delivering its safety improvement plans, which has evidenced a reduction in acute kidney injury (AKI) mortality, the number of unexpected cardiac arrests and improved compliance with key sepsis management processes. It is also positive to note that the number of reported inpatient falls remains below the national average, supported by demonstrable improvements in compliance with falls risk assessments and lying and standing blood pressure monitoring. This work will be further supported by the national falls CQUIN (commissioning for quality and innovation) for 2019/20. A continued focus on preventing deconditioning of frail patients during their hospital stay is welcomed and will be monitored in year to ensure patients maintain independence in hospital. GWH (acute and community) are a valued contributor to the Swindon Falls and Bone Health Collaborative, which has implemented a number of improvement initiatives across the wider falls pathway.

GWHFT reported a breach in the numbers of Clostridium difficile infections (CDI) during 2019/19, reporting 27 against a trajectory of no more than 19. Reviews involving GWHFT, Swindon CCG and Wiltshire CCG determined 11 to be avoidable. With reporting definitions changing nationally during 2019/20, it is essential that the Trust continues its aim in reducing the incidence of CDIs in the hospital and community setting. The CCG also welcomes the Trusts' continued focus in supporting plans to reduce reported gram-negative bloodstream infections (GNBSI) across the wider health and social care economy during 2019/20, which will contribute towards meeting both the national and local 50% reduction target by 2021.

During 2019/20 the SCCG will continue to monitor the prevalence of pressure ulcers, with a particular focus on prevention and management of those pressure ulcers reported for patients cared for in their own home.

The Care Quality Commission's (CQC) inspection of GWHFT during August and September 2018 resulted in an overall rating of requires improvement. During 2018/19, a key focus for the CCG has been the quality and safety of care within the emergency department, particularly when attendances increased within the department during the winter period. The CCG would therefore request that these safety workstreams provided by GWHFT to the commissioner are also evidenced within future quality accounts. The CCG would also request that an additional element for the quality account going forward would be the inclusion of reported mixed sex accommodation breaches. The CCG is in receipt of the Trust's CQC Improvement Plan and will continue to monitor progress via formal contract quality review meetings and quality visits throughout 2019/20.

The CCG recognises the increased number of 9 never events reported during 2018/19, with the majority (7) related to incidents categorised as 'wrong implant'. A number of these cases were identified as a result of the full review into the first reported case. The commissioners commend the Trust for conducting a proactive and transparent investigation, which has enabled this patient safety issue to be highlighted nationally to support wider learning. The CCG has sought and received assurance from the Trust on the actions being taken to prevent reoccurrence and will continue to monitor progress and patient outcomes.

The Summary Hospital Mortality Indicator (SHMI) and Hospital Standardised Mortality Rate (HSMR) are key indicators of the quality of care provided. The CCG is assured by the SHMI data for the rolling 12-month period of October 2017-September 2018, giving the Trust a 'better than' expected rating. In addition, the Trust is meeting its target to reduce mortality rates measured by hospital standardised mortality rate (HSMR), demonstrating one of the lowest HSMR rates in Southern England. The CCG welcomes the Trust's priority for 2019/20 to increase the number of structured judgement reviews aimed at supporting thematic analysis and further learning.

GWHFT has evidenced full implementation of the Freedom to Speak Up requirements following the learning identified in The Gosport War Memorial Hospital Independent Panel report. The account specifies how staff are able to raise concerns and details key themes arising from concerns raised. In line with national requirements, the CCG would request more information regarding learning and actions taken and that this is provided within future quality accounts.

Patient experience and engagement has been identified as a priority for the Trust and the outcomes of the 2018 patient survey are noted. In order to ensure the patient voice is heard and acted upon, the CCG will continue to work with the Trust to gain assurance on actions being taken to improve those areas where feedback scores have worsened, particularly regarding 6 out of the 8 specific questions relating to discharge planning; information explaining how to complain (14%) and the number of patients asked to give views on quality of care (9%).

It is recognised that during 2018/19 GWHFT experienced a sustained increase in non-elective demand, resulting in the Trust having continued difficulties in achieving the 18-week referral to treatment target. These NHS constitutional targets continue to be a 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.

The CCG notes the GWHFT's priorities for 2019/20 and will work with the Trust to support the achievement of better outcomes for patients as a result of improving nursing handover and timely discharge; reducing rates of clostridium difficile; improving patient engagement, increasing support for carers of a person living with dementia and implementing a Trust wide programme of quality improvement training. The CCG would also request that nationally set CQUINS are also prioritised, with outcomes described in the GWHFT annual account for 2019/20.
Swindon CCG, together with associated co-commissioners, is committed to sustaining strong working relationships with GWHFT and together with wider stakeholders, aims to continue collaborative working that can support achievement of the identified priorities for 2019/20 across the whole health and social care system.

Gill May

Director of Nursing and Transformation, NHS Swindon CCG

Statement from Healthwatch Swindon and Healthwatch Wiltshire dated 17th May 2019

Healthwatch Swindon and Healthwatch Wiltshire welcome the opportunity to comment on the draft Quality Account again this year. We are pleased to see the proposals for improvement in 2019/20 and have some comments on the past year based on the feedback we have received from local residents.

Complaint handling
We look forward to seeing the outcome of the review of processes to improve timeliness of responses to complaints. We met with GWH colleagues to discuss some of the issues local people raise with us and will be happy to cooperate with the review. One commentator asking us for advocacy support said, "I have ongoing NHS complaints which are not being investigated properly."

Support to carers
We welcome the initiative to review the support available to the carers of those living with dementia. We have begun a discussion with the GWH carers lead about gaining more feedback from carers about their experience with the Trust and expect to pursue with the Trust during 2019/20.

End of Life Care
We have received feedback about the use of the Treatment Escalation Plan (TEP) during 2018/19 and hope that the promotion of the TEP within the Trust during 2019/20 and clear public understanding of its use will be beneficial.

Research
The number of patients and staff involved with current or closed research studies is impressive, but we were concerned to read an article in Swindon Advertiser in March 2019 where, "in a report to GWH's executive board, research and innovation director Dr Badri Chandrasekaran and team manager Catherine Lewis-Clarke said they were not getting enough help from the hospital's top table."

Waiting List
It is regrettable that, "the 92% standard and stable waiting list size were not achieved at the end of 2018/19". We look forward to seeing the results of the action to improve performance as delays (and cancellations) are undoubtedly of concern. One commentator told us, "There was a long wait for referral but the experience was good once we got there".

Patient Experience and Engagement.
We are pleased that consideration is being given to establishing a patient experience team. We would like to see which specific patient groups have been engaged with during 2018/19 and we can support work to increase engagement. Some of our volunteers have contributed at the nutrition and hydration group, the eye care reference group, the cancer services group and the falls collaborative.

During 2018/19 Healthwatch Swindon received 60 negative and 30 positive comments from local people about the Trust's services. The range of feedback we receive from patients is wide and includes both the acute and community services provided by the Trust.

For example one commentator said, "online booking works well. It is ironic that it's people with hearing problems who can't use it for audiology at GWH because only telephone booking is possible". One said, "when my husband was in hospital he needed his tablets at certain times; he was often kept waiting an hour before he got his pain relief because they needed two doctors to sign off to get it, and very often one doctor was elsewhere". Another referred to the effective integration of acute and community services: "I had great service from GWH even though it was a lengthy wait I felt well cared for by all the nurses and surgeon. My aftercare was a concern. I needed to have my leg re-dressed every two days and it was a complete nightmare trying to see a nurse at my GP surgery. I regularly went to the Walk-in Centre which I received outstanding care from but some days it was a very very long wait…."

We hope that the "slicker and escalation processes to be in place for improved complaint handling" will bear fruit given the experience of some patients we have supported through our independent health advocacy service.

Healthwatch Wiltshire received few comments about the acute trust in this period, and most of these were related to difficulty in getting to appointments. We also received some comments relating to delayed

discharges: “After being told ready to be discharged my friend was waiting a further 2 hours to be discharged. This included a long delay waiting at the pharmacy for medication.”

Conclusion

We acknowledge the work undertaken by all those involved with the Trust at all levels and often in very difficult circumstances. One commentator told us, “I have so much praise for GWH and all the staff that were very professional and helpful. I can’t thank them enough from the paramedics to the nurses and doctors that work for the NHS keeping up the fantastic work”

Healthwatch Swindon and Healthwatch Wiltshire look forward to helping to contribute to continued improvements in the delivery of the Trust’s services.

Carol Willis
Team Manager
Healthwatch Swindon

Stacey Plumb
Manager
Healthwatch Wiltshire

Statement from Swindon Health Overview & Scrutiny Committee dated 8th May 2019

We welcome the focus on improving safe discharges from hospital and reduce re-admission rates. We also congratulate the Trust on the improvements which have been made.

We look forward to working with the Trust on the Quality Improvement work and believe we can make a contribution to the methodology given our transformation in adult social care.

We would recommend an executive summary of achievements and continued areas of development in future reports

Sue Wald
Corporate Director of Adult Social Services

Statement from Wiltshire Health Overview & Scrutiny Committee dated 20/5/2019

Overall the committee felt that this was a detailed report, although at the time members of the committee met to review the Quality Accounts the document was incomplete (version 5 was considered). Version 8 was sent to Wiltshire Council on Friday 17 May.

For ease of access for members of the public the committee would suggest that a simple executive summary is included with the quality accounts, which would offer an overview of the improvements achieved in the past year against the trust's priorities for that same year, as well as the areas requiring more work. Both would include numbers, i.e. showing the rate of improvement(s) achieved against the measures selected. The executive summary could also list the quality priorities identified by the trust for the year ahead and the proposed measurements.

Members also felt that it was difficult to establish the severity of some of the issues highlighted as there were no local or national comparator offered. For example, it is hard to weigh the significance of the figures for pressure ulcers without national comparator / average.

It would also be helpful if figures such as number of admissions were included, especially where there has been an increase reporting of an issue. For example, the total falls across the trust; it is mentioned in the text above the table that there had been an increase in the number of admissions to the trust, but this is not reflected in the graph.

The committee noted that the number of Clostridium Difficile cases were higher than the previous year (2017/18) and 8 above the trust's mandated goal for 2018/19; and was therefore glad to see that reducing the rate of Clostridium Difficile infection remained a priority for 2019/20.

The committee appreciated that the trust had participated in 56 national clinical audits (98% of relevant clinical audits) and 2 national confidential enquiries covering health services provided by the trust and that actions had been agreed to improve the quality of healthcare provided based on the reports from the audits.

The committee also noted that the December 2018 CQC inspection had resulted in many of the Core Services being rated as good but that three had been rated as Requires improvement: Urgent & Emergency Care, Medical care (including older people's care) and Surgery.

The committee noted that the trust's number of patients safety incidents were either the same as national average or marginally above.
It was also noted that there had been 3 cases of MRSA bloodstream infections in 2018-19, above the national target of 0.

It was noted that 1 wrong site surgery, 7 wrong implant/prosthesis and 1 retained foreign object post-surgery had been reported as Never Events between April 2018 and March 2019. Although concerned about the Never Events, the committee was pleased to see that the trust had been proactive in ensuring that other organisations did not repeat the same or similar incidents with regards to the wrong implant / plate used for forearm fractures.

It was also noted that there had been an increase of 9 serious incidents from the previous year, with a total of 38 serious incidents reported and investigated in 2018-19; with the most frequently reported serious incidents being:
Pressure ulcers,
Never Events,
Implementation of care / on-going.

The committee hoped that the awarded £30M to be invested in the Emergency Department and into creating an integrated front door service would help the trust achieve its 4 hours maximum waiting time from arrival to admission / transfer / discharge (89.6% achieved for 2018-19 against a set target of 90.42% and a national target of 95%).

The committee would be grateful for an update to be provided in 6 to 9 month time, detailing:

progress on the priorities for Quality Improvement identified by the trust for 2019-20:
Improving effectiveness of nursing handover and timely discharge communication,
Improve patient experience and engagement and improve complaint response timescales,

Increase Quality Improvement capacity through implementing a trust-wide programme of Quality Improvement training,
Develop the support provided to carers of a person living with dementia,
Reduce the rates of Clostridium Difficile infection.

Actions implemented to address issues highlighted by the December 2018 CQC inspection, in particular for:
Urgent & Emergency Care,
Medical care (including older people's care), and
Surgery

Implementation of key learning points and actions taken with regards to Never Events (if possible number of Never Events reported to date) and serious incidents.

Developments to the Emergency Department and integrated front door service (£30M funding awarded).

Cllr Howard Greenman
Chairman of the Wiltshire Health Select Committee

11.5 Statement of Directors' Responsibilities in Respect on the Quality Report dated 5 June 2019

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 arrangement 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 2018/19 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 May 2018 to 4th May 2019
- Papers relating to quality reported to the board over the period 1st May 2018 to 4th May 2019
- Feedback from Swindon and Wiltshire commissioners dated: 17th May 2019.
- Feedback from Governors dated: 12th May 2019.
- Feedback from local Healthwatch organisations dated: 17th May 2019.
- Feedback from Swindon Overview and Scrutiny Committee dated: 8th May 2019.
- Feedback from Wiltshire Overview and Scrutiny Committee dated: 20th May 2019
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, report to Board monthly.
- The [latest] national inpatient survey: March 2019
- The [latest] national staff survey February 2019
- The Head of Internal Audits annual opinion over the Trust's control environment dated: May 2019
- CQC inspection report dated: 21st December 2018

The Quality Report presents a balances picture of the NHS foundation Trust's performance over the period covered 2018/19.

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.

Liam Coleman
Chairman

5 June 2019

Nerissa Vaughan
Chief Executive

5 June 2019

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

We have been engaged by the Council of Governors of Great Western Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Great Western Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2019 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the following two national priority indicators:

- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge; and
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

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 2018/19* ('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 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 1 April to 4 May 2019
- papers relating to quality reported to the board over the period 1 May 2018 to 4 May 2019.
- feedback from Swindon and Wiltshire commissioners, dated 17 May 2019;
- feedback from Governors, dated 12 May 2019;
- feedback from local Healthwatch organisations, dated 17 May 2019;
- feedback from Swindon Overview and Scrutiny Committee, dated 8 May 2019;
- feedback from Wiltshire Overview and Scrutiny Committee, dated 20 May 2019;
- 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 March 2019;
- the latest national staff survey, dated February 2019;
- Care Quality Commission Inspection, dated 21 December 2019
- the 2018/19 Head of Internal Audit's annual opinion over the trust's control environment, dated May 2019; and
- any other information included in our review.

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 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the 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 maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers indicator

As a result of our procedures performed in relation to the maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers indicator, we have not been able to gain assurance over the six dimensions of data quality as required by NHS Improvement. We identified 9 issues from a sample of 25.

- One case where the clock start date recorded was incorrectly, based on the underlying records;
- One case where the clock stop date recorded was incorrect based on the underlying records;
- One case where there was no evidence to support the clock start date;
- Four cases where no date stamp on the referral letter was identified for the clock start date; and
- Two cases where patients had been incorrectly included on the pathway following upgrades.

Qualified conclusion

Based on the results of our procedures, except for the effects of the matters described in the 'Basis for qualified conclusion on the maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers indicator' section above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- 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

5 June 2019

OTHER REPORTING

12. Voluntary Disclosures

12.1 Equality reporting

Details of Equality reporting are included in the Quality Accounts (section 11 refers)

12.2 Slavery and Human Trafficking Statement 2018/19

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.

13. 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
BSW	Bath and North East Somerset, Swindon and Wiltshire
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

Abbreviation	Definition
HAT	Hospital Acquired Thrombosis
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
ICS	Integrated Care System
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
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)

Abbreviation	Definition
PbR	Payment by Results
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
PSF	Provider Sustainability Fund
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

Abbreviation	Definition
TVSNs	Tissue Viability Specialist Nurses
UTI	Urinary Tract Infection
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

14. Foreword to the Accounts

14.1 Foreword to the accounts for the year ending 31 March 2019

These accounts for the period ended 31 March 2019 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

5 June 2019

Statement of Comprehensive Income

		Group		Trust	
		2018/19	2017/18	2018/19	2017/18
	Note	£000	£000	£000	£000
Operating income from patient care activities	3	297,332	321,014	297,332	321,014
Other operating income	4	38,110	27,386	36,872	26,506
Operating expenses	6, 8	(320,131)	(340,348)	(319,667)	(339,698)
Operating surplus/(deficit)		**15,311**	**8,052**	**14,537**	**7,822**
Finance income	12	103	68	68	33
Finance expenses	13	(14,870)	(14,718)	(14,870)	(14,718)
PDC dividends payable		(1,036)	(908)	(1,036)	(908)
Net finance costs		**(15,803)**	**(15,558)**	**(15,838)**	**(15,593)**
Other gains / (losses)	14	40	(144)	-	-
Gains / (losses) arising from transfers by absorption		-	(28,612)	-	(28,612)
(Deficit) for the year		**(452)**	**(36,262)**	**(1,301)**	**(36,383)**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Impairments	7	-	(2,000)	-	(2,000)
Revaluations	17	9,780	2,086	9,780	2,086
Total comprehensive income / (expense) for the period		**9,328**	**(36,176)**	**8,479**	**(36,297)**
Surplus/ (deficit) for the period attributable to:					
Great Western Hospitals NHS Foundation Trust		(452)	(36,262)	(1,301)	(36,383)
TOTAL		**(452)**	**(36,262)**	**(1,301)**	**(36,383)**
Total comprehensive income/ (expense) for the period attributable to:					
Great Western Hospitals NHS Foundation Trust		9,328	(36,176)	8,479	(36,297)
TOTAL		**9,328**	**(36,176)**	**8,479**	**(36,297)**

All activities are from continuing operations.

Statement of Financial Position

	Note	Group 31 March 2019 £000	Group 31 March 2018 £000	Trust 31 March 2019 £000	Trust 31 March 2018 £000
Non-current assets					
Intangible assets	15	2,595	2,169	2,595	2,169
Property, plant and equipment	16	199,164	191,266	199,164	191,266
Other investments / financial assets	19	20	849	-	-
Total non-current assets		**201,779**	**194,284**	**201,759**	**193,435**
Current assets					
Inventories	21	5,631	5,511	5,631	5,511
Receivables	22	34,482	26,585	34,471	26,559
Cash and cash equivalents	23	8,768	3,217	5,207	1,377
Total current assets		**48,881**	**35,313**	**45,309**	**33,447**
Current liabilities					
Trade and other payables	24	(34,228)	(36,203)	(34,137)	(36,140)
Borrowings	26	(11,698)	(10,577)	(11,698)	(10,577)
Provisions	28	(149)	(149)	(149)	(149)
Other liabilities	25	(2,697)	(2,579)	(2,697)	(2,579)
Total current liabilities		**(48,772)**	**(49,508)**	**(48,681)**	**(49,445)**
Total assets less current liabilities		**201,888**	**180,089**	**198,387**	**177,437**
Non-current liabilities					
Borrowings	26	(141,693)	(130,444)	(141,693)	(130,444)
Provisions	28	(1,316)	(1,225)	(1,316)	(1,225)
Other liabilities	25	(1,018)	(1,132)	(1,018)	(1,132)
Total non-current liabilities		**(144,027)**	**(132,801)**	**(144,027)**	**(132,801)**
Total assets employed		**57,861**	**47,288**	**54,360**	**44,636**
Financed by					
Public dividend capital		32,765	31,520	32,765	31,520
Revaluation reserve		36,936	27,156	36,936	27,156
Income and expenditure reserve		(15,341)	(14,040)	(15,341)	(14,040)
Charitable fund reserves	20	3,501	2,652	-	-
Total taxpayers' equity		**57,861**	**47,288**	**54,360**	**44,636**

The notes of pages 248 - 292 form part of these accounts.

The Annual Accounts were approved by the Board of Directors on 5 June 2019 and signed on its behalf by:

Name
Chief Executive

Date 5 June 2019

Statement of Changes in Equity for the year ended 31 March 2019

Group	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 2018 - brought forward	**31,520**	**27,156**	**(14,040)**	**2,652**	**47,288**
Surplus/(deficit) for the year	-	-	(1,301)	849	**(452)**
Revaluations	-	9,780	-	-	**9,780**
Public dividend capital received	1,245	-	-	-	**1,245**
Taxpayers' and others' equity at 31 March 2019	**32,765**	**36,936**	**(15,341)**	**3,501**	**57,861**

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

Group	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**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health 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 trust.

Charitable funds reserve
This reserve comprises the ring-fenced funds held by the NHS charitable funds consolidated within these financial statements. These reserves are classified as restricted or unrestricted; a breakdown is provided in note 20

Statement of Cash Flows

		Group		Trust	
		2018/19	2017/18	2018/19	2017/18
	Note	£000	£000	£000	£000
Cash flows from operating activities					
Operating surplus		15,311	8,052	14,537	7,822
Non-cash income and expense:					
Depreciation and amortisation	6	7,055	7,328	7,055	7,328
(Increase) / decrease in receivables and other assets		(4,904)	7,332	(4,904)	7,332
(Increase) in inventories		(120)	(148)	(120)	(148)
(Decrease) in payables and other liabilities		(1,971)	(7,570)	(1,971)	(7,570)
Increase / (decrease) in provisions		89	(179)	89	(179)
Movements in charitable fund working capital		43	68	-	-
Other movements in operating cash flows		41	35	7	-
Net cash flows from operating activities		**15,544**	**14,918**	**14,693**	**14,585**
Cash flows from investing activities					
Interest received		68	33	68	33
Purchase of intangible assets		(1,158)	(25)	(1,158)	(25)
Purchase of PPE and investment property		(6,592)	(7,627)	(6,592)	(7,627)
Net cash flows from charitable fund investing activities		869	89	-	-
Net cash flows (used in) investing activities		**(6,813)**	**(7,530)**	**(7,682)**	**(7,619)**
Cash flows from financing activities					
Public dividend capital received		1,245	625	1,245	625
Net increase in loans from DHSC	26	15,549	8,469	15,549	8,469
Capital element of finance lease rental payments		(142)	(77)	(142)	(77)
Capital element of PFI, LIFT and other service concession payments		(4,521)	(4,420)	(4,521)	(4,420)
Interest on loans		(568)	(369)	(568)	(369)
Other interest		(9)	-	(9)	-
Interest paid on finance lease liabilities		(36)	(7)	(36)	(7)
Interest paid on PFI, LIFT and other service concession obligations		(14,206)	(14,323)	(14,206)	(14,323)
PDC dividend (paid)		(493)	(1,341)	(493)	(1,341)
Net cash flows (used in) financing activities		**(3,181)**	**(11,443)**	**(3,181)**	**(11,443)**
Increase / (decrease) in cash and cash equivalents		**5,550**	**(4,055)**	**3,830**	**(4,477)**
Cash and cash equivalents at 1 April - brought forward		**3,218**	**7,273**	**1,377**	**5,854**
Cash and cash equivalents at 31 March	23	**8,768**	**3,218**	**5,207**	**1,377**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation
NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts

Note 1.1.1 Accounting convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern
The accounts have been prepared on a going concern basis. The Trust's Annual Plan forecasts a breakeven position for the year ending 31 March 2020. This includes the receipt of £6.8m from the Provider Sustainability Fund (PSF) and £0.6m from the Financial Recovery Fund (FRF). 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 2019/20 Annual Plan. The Trust has a loan repayment due of £4.9m in Nov-19. It is assumed that the repayment date will either be extended or alternative funding provision will be made by DHSC. This is in line with the letter dated 21 May 2019 from the DHSC Finance Director stating that there will be on-going availability of interim support to ensure NHS providers remain operationally viable. As with any Trust placing reliance on the DHSC for financial support, the directors acknowledge that there can be no certainty that this support will continue although, at the date of approval of these financial statements, they have no reason to believe that it will not do so.
The NHS Foundation Trust Annual Reporting Manual 2018/19 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 Trust without the transfer of the services to another entity, or has no realistic alternative but to do so.
After making enquiries and considering the matters 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. Based on this assessment the Directors believe that it remains appropriate to prepare the accounts on a going concern basis. However, the matters referred to above represent a material uncertainty that may cast significant doubt on the Trust's ability to continue as a going concern and, therefore, to continue realising its assets and discharging its liabilities in the normal course of business. The financial statements do not include any adjustments that would result from the basis of preparation being inappropriate

Note 1.3 Consolidation
NHS Charitable Funds
The trust is the corporate trustee to Great Western Hospitals NHS Foundation Trust charitable fund. The trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

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

The 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 1.4.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

The Trust does not receive income where a patient is readmitted within 30 days of discharge from a previous planned stay. This is considered an additional performance obligation to be satisfied under the original transaction price. An estimate of readmissions is made at the year end this portion of revenue is deferred as a contract liability.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. At contract inception, the Trust assesses the outputs promised in the research contract to identify as a performance obligation each promise to transfer either a good or service that is distinct or a series of distinct goods or services that are substantially the same and that have the same pattern of transfer. The Trust recognises revenue as these performance obligations are met, which may be at a point in time or over time depending upon the terms of the contract.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.4.2 Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.4.3 Other income

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

Note 1.5 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.
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'.

Director Benefits
Directors received no other benefits such as advances, credits or guarantees.

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

Note 1.7.1 Recognition
Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Note 1.7.2 Measurement

Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

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. The estate was revalued as at 31 March 2019 using indices supplied by a MRICS Registered Valuer of the

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the services being provided.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as ‘held for sale’ cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.7.3 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable ie:

- management are committed to a plan to sell the asset
- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
- the actions needed to complete the plan indicate it is unlikely that the plan will be abandoned or significant changes made to it.

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

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.7.4 Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.8 Private Finance Initiative (PFI)

PFI transactions that meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability.

The annual unitary payment is separated into the following component parts, using appropriate estimate techniques where necessary:

• payment for the fair value of services received

• repayment of the finance lease liability, including finance costs, and

• payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Note 1.8.1 Services Received

The cost of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

Note 1.8.2 PFI assets, liabilities and finance costs

The PFI assets are recognised as property, plant and equipment when they come into use. The assets are measured initially at fair value or, if lower, at the present value of the minimum lease payments, in accordance with the principles of IAS 17. Subsequently, the assets are measured at current value in existing use.

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the initial value of the assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'finance costs' within the Statement of Comprehensive Income'.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

Note 1.8.3 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 measured initially at cost.

The element of the annual unitary payment allocated to the 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 accrual 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 operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Note 1.8.4 Useful lives of property, plant and equipment

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

	Min life Years	**Max life Years**
Buildings, excluding dwellings	2	59
Dwellings	40	40
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 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 1.9 Intangible assets

Note 1.9.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
• the trust intends to complete the asset and sell or use it
• the trust has the ability to sell or use the asset
• how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
• adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and
• the trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Note 1.9.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

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

Amortisation

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

Note 1.9.3 Useful economic life of intangible assets

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

	Min life Years	Max life Years
Software licences	1	5
Licences & trademarks	5	10

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 assets and financial liabilities

Note 1.12.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

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

Note 1.12.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets are classified as subsequently measured at fair value through income and expenditure.

Financial liabilities are classified as subsequently measured at fair value through income and expenditure.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Note 1.12.2 Classification and measurement continued

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

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

The Trust has identified three main classes of receivables: Overseas, Non-NHS and NHS. The Trust has recognised an impairment allowance for overseas and Non-NHS receivables based on past experience of what is likely to be collectable. There are no credit losses expected in relation to NHS bodies.
For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.12.3 Derecognition

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

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

Note 1.13 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.13.1 The trust as lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

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

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.13.2 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 28.2 but is not recognised in the Trust’s accounts.

Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any “excesses” payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.15 Contingencies

Contingent assets (that is, 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 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed, 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.

The Trust has no contingent assets or liabilities.

Note 1.16 Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.17 Value added tax
Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.18 Corporation tax
The NHS foundation trust does not have a corporation tax liability for the year 2018/19 (2017/18 £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 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 1.20 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 1.21 Pooled Budgets

The Trust has entered into a pooled budget arrangement with NHS Swindon and Swindon Borough Council [in accordance with section 75 of the NHS Act 2006]. Under the arrangement, funds are pooled for providing equipment to members of the community to assist with discharge from hospital. Note 34 provides details of the income and expenditure. The pool is hosted by Swindon Borough Council.
The Trust accounts for its share of the assets, liabilities, income and expenditure arising from the pooled budget, identified in accordance with the pooled budget agreement.

Note 1.22 Operating Segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the Trust.

Note 1.23 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 1.24 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 1.25 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

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.

The value of land, buildings and dwellings is £184m. 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.

It is impracticable to disclose the extent of the possible effects of an assumption or another source of estimation uncertainty at the end of the reporting period. On the basis of existing knowledge, outcomes within the next financial year that are different from the assumption around the valuation of our land, property, plant and equipment could require a material adjustment to the carrying amount of the asset or liability recorded in note 16.

The Trust has considered the implications of IFRS 15 in relation to the determination of transaction price and the satisfaction of performance obligations over time. There are no material elements of Trust income that involve assumptions beyond existing transactional estimates.

Note 1.26 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

Note 1.27 Standards that have been issued but have not yet been adopted

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2018-19. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2019-20, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

• IFRS 16 *Leases* - Application required for accounting periods beginning on or after 1 January 2020, but not yet adopted by the FReM. Early adoption is therefore not permitted.
• IFRS 17 *Insurance Contracts* - Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM. Early adoption is therefore not permitted.
• IFRIC 23 *Uncertainty over Income Tax Treatments* - Application required for accounting periods beginning on or after 1 January 2019.

Note 2 Operating Segments

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.

On 01/04/18 Wiltshire Health & Care (WH&C) separated from the Trust. When comparing year-on-year balances this has some implications of note. Total income attributable to WH&C in 2017/18 was £42.487m, of which £41.937m related to NHS Clinical Income and £0.94m related to Other Income. A similar corresponding amount of £42.487m is attributable expenditure, of which £31.675m related to pay costs and £10.812m related to non-pay costs.

2018-19

	GWH	Swindon Community Services	Charity	Total
Operating Income	**£'000**	**£'000**	**£'000**	**£'000**
NHS Clinical Income	270,097	19,205	0	289,302
Private Patients	3,975	0	0	3,975
Other Non Mandatory/Non Protected Revenue	1,409	0	0	1,409
Research & Development Income	690	0	0	690
Education and Training Income	10,715	0	0	10,715
Misc Other Operating Income	28,113	0	1,238	29,351
Total Income	**314,999**	**19,205**	**1,238**	**335,442**

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**

NHS Charity is separately identifiable above.

Note 3 Operating income from patient care activities (Group)

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.1

Note 3.1 Income from patient care activities (by nature)	2018/19 £000	2017/18 £000
Acute services		
Elective income	41,742	39,222
Non elective income	85,555	84,961
First outpatient income	20,399	20,025
Follow up outpatient income	21,077	20,761
A & E income	12,490	10,838
High cost drugs income from commissioners (excluding pass-through costs)	2,145	2,651
Other NHS clinical income	83,351	71,025
Community services		
Community services income from CCGs and NHS England	21,579	22,079
Income from other sources (e.g. local authorities)	922	42,885
All services		
Private patient income	3,975	3,430
Agenda for Change pay award central funding	2,690	-
Other clinical income	1,407	3,137
Total income from activities	**297,332**	**321,014**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2018/19 £000	2017/18 £000
NHS England	38,851	39,275
Clinical commissioning groups	246,205	230,303
Department of Health and Social Care	2,690	-
Other NHS providers	950	1,406
NHS other	95	42,045
Local authorities	3,329	3,608
Non-NHS: private patients	3,975	3,430
Non-NHS: overseas patients (chargeable to patient)	166	88
Injury cost recover scheme	839	631
Non NHS: other	232	228
Total income from activities	**297,332**	**321,014**

NHS Injury Scheme income is subject to a provision for doubtful debts of 21.89% (2017/18 - 22.84%) to reflect expected rates of collection based upon historical experience.

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

	2018/19	2017/18
	£000	£000
Income recognised this year	166	88
Cash payments received in-year	84	200
Amounts added to provision for impairment of receivables	307	-
Amounts written off in-year	154	143

Note 4 Other operating income (Group)

	2018/19	2017/18
	£000	£000
Other operating income from contracts with customers:		
Research and development (contract)	690	658
Education and training (excluding notional apprenticeship levy income)	10,311	10,139
Non-patient care services to other bodies	6,902	311
Provider sustainability / sustainability and transformation fund income (PSF / STF)	11,089	2,858
Other contract income*	7,476	12,540
Other non-contract operating income:		
Education and training - notional income from apprenticeship fund	404	-
Charitable fund incoming resources	1,238	880
Total other operating income	**38,110**	**27,386**

*Other contract income includes property rental, estates charges, car parking income and clinical excellence awards

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2018/19
	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	2,579
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-

Note 5.2 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2018/19	2017/18
	£000	£000
Income from services designated as commissioner requested services	297,332	321,014
Income from services not designated as commissioner requested services	38,110	27,386
Total	**335,442**	**348,400**

Note 6.1 Operating expenses (Group)

	2018/19	2017/18
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	2,641	2,921
Purchase of healthcare from non-NHS and non-DHSC bodies	298	1,343
Staff and executive directors costs	196,832	221,102
Remuneration of non-executive directors	148	137
Supplies and services - clinical (excluding drugs costs)	30,763	32,663
Supplies and services - general	2,509	2,637
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	31,814	29,561
Consultancy costs	800	669
Establishment	9,653	8,252
Premises	8,166	7,715
Transport (including patient travel)	837	1,541
Depreciation on property, plant and equipment	6,757	6,921
Amortisation on intangible assets	298	407
Movement in credit loss allowance: contract receivables / contract assets	156	-
Audit fees payable to the external auditor		
audit services- statutory audit	71	69
audit related assurance services	13	13
Internal audit costs	79	134
Clinical negligence	9,320	6,750
Legal fees	393	497
Insurance	31	207
Education and training	2,021	1,357
Rentals under operating leases	948	798
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	13,155	12,624
Car parking & security	-	3
Hospitality	27	52
Losses, ex gratia & special payments	20	17
Other services, eg external payroll	-	908
Other NHS charitable fund resources expended	460	647
Other	1,921	403
Total	**320,131**	**340,348**

Note 6.2 Other auditor remuneration (Group)

	2018/19	2017/18
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	13	13
Total	**13**	**13**

Note 6.3 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £1m (2017/18: £1m).

Note 7 Impairment of assets (Group)

	2018/19	2017/18
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Total net impairments charged to operating surplus / deficit	**-**	**-**
Impairments charged to the revaluation reserve	-	2,000
Total net impairments	**-**	**2,000**

Note 8 Employee benefits (Group)

	2018/19 Total £000	2017/18 Total £000
Salaries and wages	141,711	159,590
Social security costs	14,889	16,413
Apprenticeship levy	742	810
Employer's contributions to NHS pensions	18,135	20,447
Pension cost - other	66	67
Temporary staff (including agency)	21,289	23,775
Total staff costs	**196,832**	**221,102**

Note 8.1 Retirements due to ill-health (Group)

During 2018/19 there were 2 early retirements from the trust agreed on the grounds of ill-health (2 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £88k (£5k in 2017/18).

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

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

Note 10 Operating leases (Group)

Note 10.1 Great Western Hospitals NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Great Western Hospitals NHS Foundation Trust is the lessee.

	2018/19	2017/18
	£000	£000
Operating lease expense		
Minimum lease payments	948	798
Total	**948**	**798**

	31 March 2019	31 March 2018
	£000	£000
Future minimum lease payments due:		
- not later than one year;	1,141	1,187
- later than one year and not later than five years;	1,829	1,835
- later than five years.	28	152
Total	**2,998**	**3,174**

Note 11 Better Payment Pratice Code

	Year Ended 31 March 2019		Year Ended 31 March 2018	
	Number	£000	Number	£000
Total non-NHS paid in the year	**60,617**	**210,017**	**81,098**	**243,839**
Total non-NHS bills paid within target	**15,990**	**129,762**	**25,640**	**151,201**
Percentage of non-NHS bills paid within target	**26.38%**	**61.79%**	**31.62%**	**62.01%**
Total NHS bills paid in the year	**1,482**	**11,219**	**2,047**	**54,756**
Total NHS bills paid within target	**341**	**1,573**	**890**	**41,340**
Percentage of NHS bills paid within target	**23.01%**	**14.02%**	**43.48%**	**75.50%**

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. This is carefully managed to ensure continuation of services, and a number of agreements are in place with key suppliers allowing for longer credit terms.

Note 12 Finance income (Group)

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

	2018/19	2017/18
	£000	£000
Interest on bank accounts	68	33
NHS charitable fund investment income	35	35
Total finance income	**103**	**68**

Note 13.1 Finance expenditure (Group)

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

	2018/19	2017/18
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	614	384
Finance leases	37	7
Interest on late payment of commercial debt	11	3
Main finance costs on PFI and LIFT schemes obligations	9,510	9,912
Contingent finance costs on PFI and LIFT scheme obligations	4,696	4,411
Total interest expense	**14,868**	**14,717**
Unwinding of discount on provisions	2	1
Total finance costs	**14,870**	**14,718**

Note 13.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015 (Group)

	2018/19	2017/18
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	11	3

Note 14 Other gains / (losses) (Group)

	2018/19	2017/18
	£000	£000
Total gains / (losses) on disposal of assets	**39**	**-**
Fair value gains / (losses) on charitable fund investments & investment properties	1	(144)
Total other gains / (losses)	**40**	**(144)**

Note 15.1 Intangible assets - 2018/19

Group and Trust	Software licences	Licences & trademarks	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2018 - brought forward	**2,557**	**2,818**	**753**	**6,128**
Additions	1,158	-	-	**1,158**
Reclassifications	-	-	(434)	**(434)**
Valuation / gross cost at 31 March 2019	**3,715**	**2,818**	**319**	**6,852**
Amortisation at 1 April 2018 - brought forward	**1,945**	**2,014**	**-**	**3,959**
Provided during the year	298	-	-	**298**
Amortisation at 31 March 2019	**2,243**	**2,014**	**-**	**4,257**
Net book value at 31 March 2019	**1,472**	**804**	**319**	**2,595**
Net book value at 1 April 2018	**612**	**804**	**753**	**2,169**

Note 15.2 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**
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 16.1 Property, plant and equipment - 2018/19

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 2018 - brought forward	**24,900**	**154,343**	**3,200**	**2,937**	**41,063**	**58**	**20,861**	**3,316**	**250,678**
Additions	-	1,079	-	-	1,891	-	1,374	97	**4,441**
Revaluations	-	9,780	-	-	-	-	-	-	**9,780**
Reclassifications	-	969	-	(535)	-	-	-	-	**434**
Valuation/gross cost at 31 March 2019	**24,900**	**166,171**	**3,200**	**2,402**	**42,954**	**58**	**22,235**	**3,413**	**265,333**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**8,120**	**160**	**-**	**33,196**	**58**	**14,579**	**3,299**	**59,412**
Provided during the year	-	4,111	80	-	1,313	-	1,187	66	**6,757**
Accumulated depreciation at 31 March 2019	**-**	**12,231**	**240**	**-**	**34,509**	**58**	**15,766**	**3,365**	**66,169**
Net book value at 31 March 2019	**24,900**	**153,940**	**2,960**	**2,402**	**8,445**	**-**	**6,469**	**48**	**199,164**
Net book value at 1 April 2018	**24,900**	**146,223**	**3,040**	**2,937**	**7,867**	**-**	**6,282**	**17**	**191,266**

Note 16.2 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 - as previously stated	**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)**
Revaluations	-	2,202	-	-	-	-	-	-	**2,202**
Reclassifications	-	7,328	-	(2,004)	(814)	-	(4,340)	-	**170**
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 - as previously stated	**-**	**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**

Note 16.3 Property, plant and equipment financing - 2018/19

Group and Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019								
Owned - purchased	24,900	15,819	(0)	2,402	7,074	6,469	48	**56,712**
Finance leased	-	-	-	-	1,371	-	-	**1,371**
On-SoFP PFI contracts and other service concession arrangements	-	138,121	2,960	-	-	-	-	**141,081**
NBV total at 31 March 2019	**24,900**	**153,940**	**2,960**	**2,402**	**8,445**	**6,469**	**48**	**199,164**

Note 16.4 Property, plant and equipment financing - 2017/18

Group and Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018								
Owned - purchased	24,900	3,482	(0)	2,937	7,867	6,282	17	**45,485**
Finance leased	-	-	-	-	-	-	-	**-**
On-SoFP PFI contracts and other service concession arrangements	-	142,741	3,040	-	-	-	-	**145,781**
NBV total at 31 March 2018	**24,900**	**146,223**	**3,040**	**2,937**	**7,867**	**6,282**	**17**	**191,266**

Note 17 Revaluations of property, plant and equipment

The Trust carried out an indexation review of building assets, that have not or are not proposed to be transferred to NHS Property Services, for the period 2016/17, 2017/18 and 2018/19 since the last full revaluation was as at 1 April 2016. Overall buildings have increased in value by 3.3% in 2016/17 and 4.9% in 2017/18 which have been recognised in previous years statements. The indexation recognised in 2018/19 was 6.2%. This included smoothing of the location factor to mitigate volatility. All other assets are valued at depreciated replacement cost with no indexation in year due to the current economic climate.

Note 18 Joint venture
Wiltshire Health & 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 2018-19, Wiltshire Health and Care LLP reported a break even position resulting in a net asset value of nil (2017-18 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 2019/20.

Note 19 Other investments / financial assets (non-current)

	Group and Trust	
	2018/19	**2017/18**
	£000	**£000**
Carrying value at 1 April - brought forward	**849**	**1,112**
Movement in fair value through income and expenditure	1	(174)
Disposals	(830)	(89)
Carrying value at 31 March	**20**	**849**

Note 20 Analysis of charitable fund reserves

	31 March 2019 £000	31 March 2018 £000
Unrestricted funds:		
Unrestricted income funds	114	37
Restricted funds:		
Other restricted income funds	3,387	2,615
	3,501	**2,652**

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 objectives. 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 21 Inventories

	Group and Trust	
	31 March 2019 £000	31 March 2018 £000
Drugs	805	955
Consumables	4,512	4,443
Energy	137	93
Other	177	20
Total inventories	**5,631**	**5,511**

Inventories recognised in expenses for the year were £48,853k (2017/18: £30,671k). Write-down of inventories recognised as expenses for the year were £0k (2017/18: £0k).

Note 22.1 Receivables

	Group and Trust	
	31 March 2019	**31 March 2018**
	£000	**£000**
Current		
Contract receivables*	23,734	
Trade receivables*		3,644
Accrued income*		6,995
Allowance for impaired contract receivables / assets*	(1,489)	
Allowance for other impaired receivables	-	(1,515)
Prepayments (non-PFI)	1,980	3,014
PFI lifecycle prepayments	10,246	6,987
PDC dividend receivable	-	251
VAT receivable	-	549
Other receivables	-	6,634
receivables	11	26
Total current receivables	**34,482**	**26,585**

*Following the application of IFRS 15 from 1 April 2018, the trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15. The Trust has no contract assets.

Note 22.2 Allowances for credit losses - 2018/19

	Group and Trust	
	Contract receivables and contract assets	**All other receivables**
	£000	**£000**
Allowances as at 1 Apr 2018 - brought forward		**1,515**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	1,515	(1,515)
New allowances arising	450	-
Changes in existing allowances	(294)	-
Utilisation of allowances (write offs)	(182)	-
Allowances as at 31 Mar 2019	**1,489**	**-**

Note 22.3 Allowances for credit losses - 2017/18

the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	Group and Trust
	£000
Allowances as at 1 Apr 2017 - as previously stated	**2,136**
Amounts utilised	(621)
Allowances as at 31 Mar 2018	**1,515**

Note 23.1 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	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000	£000
At 1 April	**3,217**	**7,273**	**1,377**	**5,854**
Net change in year	5,551	(4,056)	3,830	(4,477)
At 31 March	**8,768**	**3,217**	**5,207**	**1,377**
Broken down into:				
Cash at commercial banks and in hand	3,571	1,866	10	26
Cash with the Government Banking Service	5,197	1,351	5,197	1,351
Total cash and cash equivalents as in SoFP	**8,768**	**3,217**	**5,207**	**1,377**
Total cash and cash equivalents as in SoCF	**8,768**	**3,217**	**5,207**	**1,377**

Note 23.2 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 Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	Group and Trust	
	31 March 2019	31 March 2018
	£000	£000
Monies on deposit	-	2
Total third party assets	**-**	**2**

Note 24.1 Trade and other payables

	Group and Trust	
	31 March 2019	**31 March 2018**
	£000	**£000**
Current		
Trade payables	10,186	14,655
Capital payables	2,594	2,856
Accruals	14,474	11,607
Social security costs	3,563	3,840
VAT payables	30	1
Other taxes payable	-	-
PDC dividend payable	292	-
Accrued interest on loans*	-	58
Other payables	2,998	3,123
NHS charitable funds: trade and other payables	91	63
Total current trade and other payables	**34,228**	**36,203**
Of which payables from NHS and DHSC group bodies:		
Current	3,404	4,748

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note 26. IFRS 9 is applied without restatement therefore comparatives have not been restated.

Note 25 Other liabilities

	Group and Trust	
	31 March 2019	31 March 2018
	£000	£000
Current		
Deferred income: contract liabilities	2,697	2,579
Total other current liabilities	**2,697**	**2,579**
Non-current		
Deferred income: contract liabilities	1,018	1,132
Total other non-current liabilities	**1,018**	**1,132**

Note 26 Borrowings

	Group and Trust	
	31 March 2019	31 March 2018
	£000	£000
Current		
Loans from DHSC	6,160	6,057
Obligations under finance leases	166	-
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	5,372	4,520
Total current borrowings	**11,698**	**10,577**
Non-current		
Loans from DHSC	38,623	23,073
Obligations under finance leases	1,070	-
Obligations under PFI, LIFT or other service concession contracts	102,000	107,371
Total non-current borrowings	**141,693**	**130,444**

Note 26 Borrowings continued

Loan type	Loan Drawn Down Date	Borrowing	Balance remaining at start of financial year	Borrowed in Year	IFRS 9 Adjustment	Repaid In year	O/S Total	O/S Current	O/S Non Current
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Capital and revenue funding	19/01/15	5,000							
(ITFF Loan)	18/05/15	2,500							
	20/07/15	1,400	7,330		12	(1,047)	6,295	1,058	5,237
	15/05/15	500							
	20/07/15	600	825		4	(110)	719	114	605
		10,000	**8,155**	**0**	**16**	**(1,157)**	**7,014**	**1,172**	**5,842**
Interim Working capital facility	12/10/15	2,000							
	17/10/16	2,000	2,000				2,000		2,000
	13/03/17	4,450	2,022				2,022		2,022
	17/07/17	2,597	2,597				2,597		2,597
		11,047	**6,619**	**0**	**0**	**0**	**6,619**	**0**	**6,619**
Distressed funding	11/01/16	3,900	3,900		27		3,927	3,927	0
	14/03/16	1,000	1,000				1,000	1,000	0
	15/01/18	3,339	3,339		10		3,349	10	3,339
	18/03/18	6,117	6,117		3		6,120	3	6,117
	15/10/18	4,171		4,171	29		4,200	29	4,171
	11/01/19	3,757		3,757	12		3,769	12	3,757
	11/03/19	8,778		8,778	7		8,785	7	8,778
		31,062	**14,356**	**16,706**	**88**	**0**	**31,150**	**4,988**	**26,162**
		52,109	**29,130**	**16,706**	**104**	**(1,157)**	**44,783**	**6,160**	**38,623**

Note 26.1 Reconciliation of liabilities arising from financing activities

Group and Trust	Loans from DHSC	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2018	**29,130**	**-**	**111,891**	**141,021**
Cash movements:				
Financing cash flows - payments and receipts of principal	15,549	(142)	(4,521)	**10,886**
Financing cash flows - payments of interest	(568)	(36)	(14,206)	**(14,810)**
Non-cash movements:				
Impact of implementing IFRS 9 on 1 April 2018	58	-	-	**58**
Additions	-	1,377	4,698	**6,075**
Application of effective interest rate	614	37	9,510	**10,161**
Carrying value at 31 March 2019	**44,783**	**1,236**	**107,372**	**153,391**

Note 27 Finance leases

Note 27.1 Great Western Hospitals NHS Foundation Trust as a lessee

Obligations under finance leases where the trust is the lessee.

	Group and Trust	
	31 March 2019	31 March 2018
	£000	£000
Gross lease liabilities	**1,397**	**-**
of which liabilities are due:		
- not later than one year;	201	-
- later than one year and not later than five years;	739	-
- later than five years.	457	-
Finance charges allocated to future periods	(161)	-
Net lease liabilities	**1,236**	**-**
of which payable:		
- not later than one year;	166	-
- later than one year and not later than five years;	645	-
- later than five years.	425	-

The Trust has recognised three new finance leases in the 2018/19 (none in 2017/18). These include an ultrasound machine, a spinal operating microscope and 600 patient beds.

Note 28.1 Provisions for liabilities and charges analysis (Group and Trust)

Group	Pensions: early departure costs	Pensions: injury benefits*	Legal claims	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2018	**717**	**445**	**169**	**44**	**1,375**
Arising during the year	-	-	261	-	**261**
Utilised during the year	(116)	(38)	-	-	**(154)**
Reversed unused	-	-	-	(19)	**(19)**
Unwinding of discount	2	-	-	-	**2**
At 31 March 2019	**603**	**407**	**430**	**25**	**1,465**
Expected timing of cash flows:					
- not later than one year;	120	29	-	-	**149**
- later than one year and not later than five years;	483	378	430	25	**1,316**
- later than five years.	-	-	-	-	**-**
Total	**603**	**407**	**430**	**25**	**1,465**

* In 2018/19 the analysis of provisions has been revised to separately identify provisions for injury benefit liabilities. In previous periods, these provisions were included within other provisions

Note 28.2 Clinical negligence liabilities

At 31 March 2019, £161,088k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Great Western Hospitals NHS Foundation Trust (31 March 2018: £136,636k).

Note 29 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.

Note 30 On-SoFP PFI, LIFT or other service concession arrangements

Note 30.1 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 2019 £000	31 March 2018 £000
Gross PFI, LIFT or other service concession liabilities	**172,127**	**185,926**
Of which liabilities are due		
- not later than one year;	14,473	14,000
- later than one year and not later than five years;	61,421	61,003
- later than five years.	96,233	110,923
Finance charges allocated to future periods	(64,755)	(74,035)
Net PFI, LIFT or other service concession arrangement obligation	**107,372**	**111,891**
- not later than one year;	5,372	4,520
- later than one year and not later than five years;	30,667	33,073
- later than five years.	71,333	74,298

Note 30.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

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

	Group and Trust	
	31 March 2019 £000	31 March 2018 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**442,826**	**482,667**
Of which liabilities are due:		
- not later than one year;	37,294	36,642
- later than one year and not later than five years;	156,733	154,994
- later than five years.	248,799	291,031

Note 30.3 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	
	2018/19 £000	2017/18 £000
Unitary payment payable to service concession operator	**36,803**	**35,268**
Consisting of:		
- Interest charge	9,510	9,912
- Repayment of finance lease liability	4,521	4,420
- Service element and other charges to operating expenditure	13,155	12,624
- Capital lifecycle maintenance	1,429	1,017
- Revenue lifecycle maintenance	-	-
- Contingent rent	4,696	4,411
- Addition to lifecycle prepayment	3,492	2,884
Total amount paid to service concession operator	**36,803**	**35,268**

Note 31 Financial instruments and related disclosures

Group and Trust

The key risks that the Trust has identified relating to its financial instruments are as follows:-

Note 31.1 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.

Note 31.2 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.

Note 31.3 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 2019 are in receivables from customers, as disclosed in note 22 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 2019	31 March 2018
	£000	£000
By up to three months	**4,060**	5,715
By three to six months	**873**	180
By more than six months	**3,257**	1,982
	8,190	7,877

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.

Note 31.4 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 32 Carrying values of financial assets

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

Group and Trust	Held at amortised cost	Total book value
	£000	£000
Carrying values of financial assets as at 31 March 2019 under IFRS 9		
Trade and other receivables excluding non financial assets	22,245	**22,245**
Cash and cash equivalents	5,207	**5,207**
Consolidated NHS Charitable fund financial assets	3,586	**3,586**
Total at 31 March 2019	**31,038**	**31,038**

Group and Trust	Loans and receivables	Assets at fair value through the I&E	Total book value
	£000	£000	£000
Carrying values of financial assets as at 31 March 2018 under IAS 39			
Trade and other receivables excluding non financial assets	11,031	-	**11,031**
Cash and cash equivalents	1,377	-	**1,377**
Consolidated NHS Charitable fund financial assets	2,715	-	**2,715**
Total at 31 March 2018	**15,123**	**-**	**15,123**

Note 32.1 Carrying values of financial liabilities

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

Group and Trust	Total book value
	£000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9	
Loans from the Department of Health and Social Care	**44,783**
Obligations under finance leases	**1,236**
Obligations under PFI, LIFT and other service concession contracts	**107,372**
Trade and other payables excluding non financial liabilities	**27,839**
Consolidated NHS charitable fund financial liabilities	**91**
Total at 31 March 2019	**181,321**

Group and Trust	Total book value
	£000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39	
Loans from the Department of Health and Social Care	**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**

Note 32.2 Maturity of financial liabilities

	Group and Trust	
	31 March 2019	31 March 2018
	£000	£000
In one year or less	39,628	48,359
In more than one year but not more than two years	17,493	5,678
In more than two years but not more than five years	52,441	48,098
In more than five years	71,759	70,124
Total	**181,321**	**172,259**

Note 33 Losses and special payments

	2018/19		2017/18	
Group and trust	**Total number of cases Number**	**Total value of cases £000**	**Total number of cases Number**	**Total value of cases £000**
Losses				
Cash losses	1	4	3	5
Bad debts and claims abandoned	455	357	189	192
Total losses	**456**	**361**	**192**	**197**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	3	1
Ex-gratia payments	27	47	29	19
Total special payments	**27**	**47**	**32**	**20**
Total losses and special payments	**483**	**408**	**224**	**217**
Compensation payments received		-		-

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 £300,000. (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 34 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

	31 March 2019	31 March 2018
Income:	**£000**	**£000**
NHS Swindon	393	368
Great Western Hospitals NHS Foundation Trust	97	92
Total Income	**490**	**460**
Expenditure	**543**	**533**
Total (Deficit)	**(53)**	**(73)**

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	**(27)**	**(38)**
Swindon CCG	**(22)**	**(5)**
Great Western Hospitals NHS Foundation Trust	**(4)**	**(30)**
Total (Deficit)	**(53)**	**(73)**

Note 35.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £58k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £0k decrease in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classifiction of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £631k.

Note 35.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

There has been no material impact on the Trust due to the application of IFRS 15.

Note 36 Related parties

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 and Social Care is regarded as the parent party and thus a related party.

Related parties may include but are not limited to:

- Department of Health and Social Care ministers
- Board members of the trust
- The Department of Health and Social Care
- Other NHS providers
- CCGs and NHS England
- Other health bodies
- Other Government departments
- Local authorities
- NHS charitable funds (where not consolidated)

Great Western Hospitals
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