Great Western Hospitals NHS
NHS Foundation Trust

Great Western Hospitals NHS Foundation Trust
Annual Report and Accounts
2014/2015

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

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1 CHAIR AND CHIEF EXECUTIVE'S REPORT

This past year has been a particularly challenging one for the Trust. As demand for services has risen, with more emergency patients being seen than ever before, we have seen our financial position deteriorate significantly.

We started 2014/15 planning to deliver a surplus of £1.2m but ended the year with a deficit of £8.6m.

The main factors affecting our financial position are:

- Increased levels of demand – we are admitting 1,300 more emergency patients every month now than we were four years ago.
- Increased use of high cost agency staff to maintain safe staffing levels against a backdrop of national shortages in nursing staff.
- The impact of the marginal tariff which meant we were only paid 30% of the cost of treating the extra patients.
- Our Cost Improvements Plans (CIPs) were not delivered in full and a significant proportion of those plans that were delivered were on a non-recurrent basis.
- Over a busy winter period the financial impact of cancelled operations led to significant lost income

For the year ahead we forecast a deficit of £18.7m and we see this coming year as key to beginning our financial recovery over the next five years.

Our ability to meet the four hour Emergency Department indicator and the 18 week wait indicator has also been constrained. Partly through the growth in demand but also the impact of other parts of the sector and the inability to discharge medically fit patients to social or community care settings which impacts on beds availability.

Despite these tough times, our absolute priority and commitment to local people, patients, staff and volunteers is to not compromise the quality and safety of services we provide. We have delivered a number of significant improvements in quality which staff can be proud of. Most notable of these is our improvement in mortality with more lives being saved as a result of the good work teams across the Trust are doing to improve safety and focus on areas such as targeting sepsis.

In addition we have seen a big improvement in infection control with 19 cases against a threshold of 28 for the year. When seen in the context of the 1.5million patient contacts every year, this is a significant achievement. We have also delivered our cancer waiting times whilst many other Trusts have struggled. All of this, and much more can only be achieved through the hard work and commitment of staff working on the front line and behind the scenes doing their best for patients every year.

We recognise that as the pressure on services builds and demand grows so too does the pressure on staff. What once were winter pressures has now turned into year round pressure and we must support our staff to provide the best care they can so they are proud of the service they and their colleagues provide.

We will build on this work in 2015/16 and aim to go further. We see quality and safety together with financial sustainability as two sides of the same coin. We need to deliver safe, sustainable services for patients now and well into the future and as a Trust we are committed to that goal.

In April 2015, Monitor the health regulator had reasonable grounds to believe that the Trust is in breach of its licence to provide services to patients in Swindon and Wiltshire, because it lacks robust financial recovery plans and a plan to ensure it continues to provide services for patients in the long term. In particular, the Trust needs to increase its efficiency, for example by improving the way it manages the money spent on agency staff and how effectively it discharges patients once their treatment is complete. In recognition that the Trust cannot fix all of these problems alone, Monitor has been coordinating action between local health organisations to help reduce costs while ensuring patients across Swindon and Wiltshire continue to receive services. Monitor will continue to scrutinise the Trust's performance as it delivers plans to fix its problems, and will take further action for patients if necessary.

Yours sincerely

Roger Hill
Chairman
27 May 2015

Nerissa Vaughan
Chief Executive
27 May 2015

2 STRATEGIC REPORT

2.1 Trust Strategy

Our five year vision

Our five year vision is underpinned by four ambitions. By 2019 we aspire to achieve the following for our patients, users and staff:

'Working together with our partners in health and social care we will deliver accessible, personalised and integrated services for local people. We will provide high quality care whether at home, in the community or in hospital empowering people to lead independent and healthier lives.'

Our ambitions

In 2013 the Trust began the process of developing a clear and credible five year strategy for the organisation - one which sets out to proactively meet the challenges facing the Trust in the coming years. Through the process of engagement and the feedback received to develop the Trust strategy, the Trust has four simple yet clear ambitions:

a) **We will make the patient the centre of everything we do**
From the Board right through to the frontline and across clinical and non-clinical functions we want every member of staff to prioritise the patient. Ensuring systems, processes and pathways are designed with and for patients removing the barriers to good patient care.

b) **We will work smarter not harder to make best use of limited resources**
We know that more of the same is not going to protect us from the challenges we face. Our staff have worked tirelessly to maintain high standards under significant pressure and demand. With finances getting tighter we know we need to think carefully about how we use our existing resources in a different way to produce different outcomes. Reducing duplication, joining up and integrating care, more care closer to home, in community settings and seven day working are prime examples of how we will aim to deliver this.

c) **We will innovate and identify new ways of working**
New models of care are needed and new ways of doing things are key to our plans over the coming years. Examples include using new technology to provide care in different locations, releasing time to spend on direct patient care and partnering to pool resources and expertise will be priorities.

d) **We will build capacity and capability by investing in our staff, infrastructure and partnerships**
We have invested heavily in additional staffing over the past year to improve staffing levels and enhance the leadership capabilities of key groups of staff. To meet future challenges we need to expand this investment and also ensure that our staff have the tools at their disposal to deliver the best care possible. Removing barriers to work and providing the infrastructure they need to do their jobs will be key.

We also know that we are not experts at everything and we will not be able to meet all the challenges we face alone. We are therefore seeking to strengthen our approach to partnership by exploring the potential for new models of care through closer integration and potentially through joint ventures.

Note that the financial constraints of the Trust impact of the delivery of our ambitions.

2.2 Business Model

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

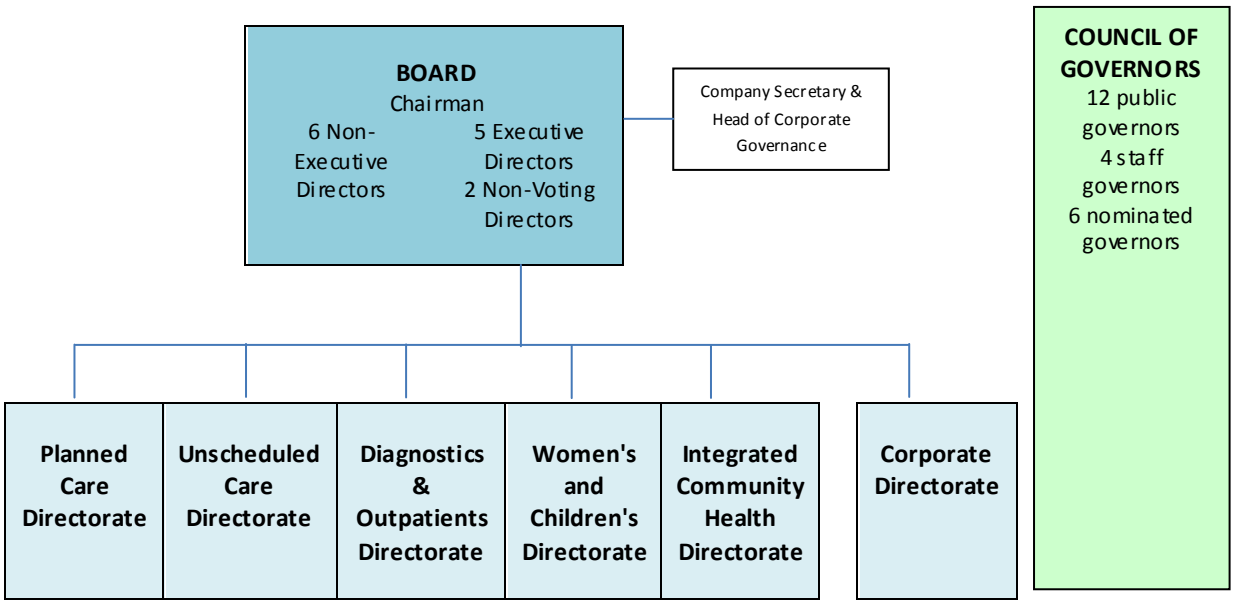
We are not directed by Government and so have greater freedom to decide, with our governors and members, our own strategy and the way services are run. We can retain surpluses and borrow to invest in new and improved services for patients and service users.

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

Monitor'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 approves the appointment of our Chief Executive and appoints the Chairman and Non-Executive Directors. The Non-Executive Directors appoint the Executive Directors and together they form the Board of Directors. The Board as a whole is responsible for decision making, whilst the Council of Governors, amongst other things, is responsible for holding the Non-Executive Directors to account for the performance of the Board and for representing the views of members to inform decision making.

2.3 Organisational structure 2013/14



2.4 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

All registered sites/locations and activities can be obtained by contacting the Trust.

2.5 Location of services

Great Western Hospitals NHS Foundation Trust has its main headquarters at the Great Western Hospital (GWH) in Swindon, but provides a range of community health services across a wide geographical area covering 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. The history of the Trust is referred to elsewhere in this report (*Section 0 – History of the Trust refers).*

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 led), 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

The Trust provides a number of services closer to patients' homes in the local community. Some of our other sites include Chippenham, Trowbridge, Savernake, , Warminster and Melksham Community Hospitals;; Hillcote;; Royal United Hospital Bath;; Erlestoke Prison; Amesbury Health Clinic; Salisbury Central Health Clinic; Devizes Health Centre, West Swindon Health Centre, Malmesbury Primary Care Centre, Tidworth Clinic, Swindon Health Centre (Carfax Street) and various GP practices.

2.6 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 took over the running of 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.

2.7 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. All risks inform the risk register.

Examples of principal risks and uncertainties facing the Trust during 2014/15 against our strategic objectives are set out below: -

Strategic Objective 1 (care)	*Not learning from patient safety incidents*
	Increase in non-elective admissions and GP referrals resulting in failure to meet KPIs - poor quality of care (e.g. Referral to Treatment (RTT) /cancer targets / Emergency Department 4 hour wait
	Failure to manage Hold Files / ability to meet demand
Strategic objective 2 (patient experience)	*Patient dissatisfaction if we cancel operations on the day of surgery.*
	Failure to learn from complaints. Claims and patient feedback
Strategic Objective 3 (staff)	*Failure to manage staff within the pay bill allocation – bank and agency spend / recruitment and retention*
	Failure to adequately communicate and engage with staff
	Failure to ensure 80% of staff attend mandatory training
Strategic objective 4 (finance)	*Non-payment for activity above contract for over performance and non-delivery of QIPP*
	Liquidity – non delivery of Cost Improvement Programmes resulting in inability to invest in redesign initiatives
	Cost pressures relating to locum and agency spend
Strategic objective 5 (innovation)	*Failure to deliver models of care*
	Failure to comply with the NHS Constitution, including 18 week waits
Strategic objective 6 (partnerships)	*Failure to work effectively with key stakeholders*
	Failure to maintain active and representative membership

2.8 Review of the Trust's Business - Development and Performance during the financial year

The Trust's Annual Plan submitted to Monitor (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 2014/15 which includes key developments, mapped against our six strategic objectives which guide the direction of the Trust. .

1. To deliver consistently high quality, safe services which deliver desired patient outcomes

In 2014/15 quality which includes safety, was again our top priority with the Trust continuing to aim to deliver the best care possible for patients across all sites. Again this year, the key challenge has been ensuring that there is sufficient capacity to meet demand and maintain high quality services.
Examples of achievements across the Trust during the year are as follows: -

- The Trust delivered increased activity in a number of areas as set out below:

Point of Delivery	2013-14 YTD Actual	2014-15 YTD Plan	2014-15 YTD Actual	Variance to 13-14	Variance to 14-15 Plan
Elective inpatients	6,658	6,111	5,944	(714)	(167)
Elective day case patients (Same day)	31,277	30,477	32,949	1,672	2,472
Non-Elective - acute	39,158	38,384	43,042	3,884	4,658
Non elective - community	7,671	3,180	2,310	(5,361)	(870)
Outpatients - first attendance	136,766	141,062	125,049	(11,717)	(16,013)
Outpatients - follow up	249,362	242,411	252,635	3,273	10,223
Outpatients - procedures	74,460	73,108	75,665	1,205	2,557
A&E - GWH ED	75,441	73,356	79,288	3,847	5,932
A&E - MIU	42,901	47,200	42,317	(584)	(4,883)

- Performance against national and local indicators continues to be good. Details on performance are included in the Quality Report.

- Notably successful compliance with nationally mandated cancer outcomes and service dataset (COSD); compliance with nationally mandated systematic anti-cancer therapy dataset (SACT) and delivery of mandated clinical audits (cancer services).

- The Oxygen Assessment Service continued to run as part of the 100 day challenge. This had a positive impact on the quality of life for patients with an oxygen requirement within the community.

- Improvements in safety are expected following the implementation of new staffing models on our community.

- There was a mismatch between capacity and demand for new gynaecological patients, noting that patients attending gynaecology outpatient services increased by 8% in 2014/15. However to address this recruitment for an additional consultant has taken place. In addition, there have been changes to consult job plans to include more Emergency Activity to reduce the need for outpatient appointments. Furthermore, a One Stop Urogynaecology Clinic has been introduced to reduce follow ups.

- To meet radiology demand, a second MRI scanner was commissioned in October.

During the year it was necessary to use a mobile MRI scanner to meet demand but this ended in November 2014.

- The Ophthalmology Service had to stop accepting new referrals in 2014 in order for the service to rebalance its capacity. Since then the department has increased its workforce by more than 10 full time posts and the number of overdue follow ups has been reduced from over 3000 to a minimum. The service has developed a community clinic at Eldene Health Centre which provides access to appointments and diagnostic assessment in the Swindon community. The service re-opened to referrals in January 2015.

It has been challenging for the Trust to manage demand within existing capacity. However, quality of care has not been compromised, but there has been an impact on the financial position of the Trust.

An additional challenge has been around maintaining a continued focus, pace and staff engagement to meet developments around safeguarding.

2. To improve the patient and carer experience for every aspect of the service and care that we deliver

Some examples of notable achievements during the year in improving patients and carer experience are as follows: -

- During the year there was a focus on the Trust's Hospital Standard Mortality Rate (HSMR) which showed a significant improvement at year end. The Trust's Mortality Group analysed mortality data in detail to determine the reasons for variations in performance and improvements were made. One area of improvement was around accurate coding particularly around co-morbidities. The HMSR for December (the most recent data available from Dr Foster) is 85.47. The Trust is still below 100 with the April to December 2014 relative risk of 86.92, (compared with 99.6 for a similar period last year), while the rolling twelve month period of January 2014 to December 2014 is 90.06

- In the community a "Named Nurse" model has been established, together with a formal direct referral system for all GP surgeries. All GP surgeries have a named nurse and this has had a positive impact on patient quality and experience.

- The Trust achieved Baby Friendly Level 3 across Children and Young People Services as well as maternity during 2014.

- Nursing and medical staff within Paediatrics worked more closely with the Emergency Department to ensure the early transfer of children to the right environment to meet their care needs, thus improving the patient experience and care provided.

- The Outpatient Parenteral Antibiotics Therapy (OPAT) service continued. This is a highly successful proof of concept scheme helping to reduce inpatient activity and support patients more effectively.

- In terms of cancer services, the Day Case Chemotherapy Services were extended to 6 days per week (with plans to move to 7 days per week, with investment already secured).

- Facilitation of local cancer patient / survivorship events in the local community has taken place.

- Refurbishment of Jupiter Ward at the Great Western Hospital has taken place introducing a dementia friendly environment for patients.

- The overall Family and Friends star rating has remain consistent throughout the year (4.7 or above out of a possible 5).

- Trauma & Orthopaedics appointed two locum consultants during 2014/15 and is now moving forwards with making permanent appointments. Trauma patients have a new ward facility within the Brunel Treatment Centre meaning that T&O services are close together. The service underwent a Trauma Peer Review early in 2015 with our service praised for providing joined up care. In particular the development of the Trauma Co-Ordinator Team has resulted in reduced length of stay and good compliance with national guidelines on the treatment of patients with fracture neck of femur (broken hip).

During 2014/15 there were issues associated with booking patients for follow up appointments and clinical capacity issues in terms of staff and space. To address this additional staff have been recruited; there is an 18 week Referral to treatment (RTT) programme which is ongoing; there have been clinic reviews and service reviews.

The number of patients waiting in excess of 18 weeks for their surgery has dropped by 440 patients through the year. We will continue to reduce this further in 2015/16 to ensure waits are at a minimum for patients who require surgery.

The demand for Rheumatology has outstripped capacity which resulted in the closure of the service to new patients.

Unfortunately, due to high levels of demand and problems with recruitment, we have had to stop accepting new referrals into the Orthodontic Service from 1 April 2015. This is to allow us to focus on reducing waiting times and treating patients who are already within the service. There is a clear action plan to address the issues within this service

Due to winter pressures we had to cancel more surgery than we would have wanted to (circa 600 cancellations due to winter pressure on the hospital bed base). Throughout this period we prioritised urgent and emergency care. In 2015/16 the Trust is moving forwards with escalation and capacity plans to try to prevent reoccurrence of this during next winter.

There are physical storage capacity issues in the mortuary in terms of frequency and duration and therefore contingency planning has been ongoing to improve flow.

3. To ensure that staff are proud to work for the Trust and would recommend the Trust as a place to work or receive treatment

Some examples of notable achievements during the year relating to staffing matters are as follows: -

- There has been a focus on improving community services with the appointment of a Director of Community Services. This has had a positive impact on the quality of services front line patients receive.

- 20 additional whole time equivalent time staff have been recruited in our community sites, with a further 20 staff planned to be recruited next year. This ensures urgent care is provided within one hour and enables collaborative working with primary care, ensuring a better quality service to patients.

- A nursing skills audit was undertaken within integrated teams, leading to a training plan

which is being rolled out, ensuring that our nursing staff have the appropriate skills to deliver high quality care. A skills audit of therapy has also taken place, the outcome of which will be a further training and development plan leading to staff being able to provide a wider range of care in the community.

- During 2014/15 two new types of professionals were developed in the community setting, namely non- clinical and clinical Care Coordinators roles and the Help to Live at Home Health Care Support Brokers.

- There was a review of the Ward Clerks within the Children's Unit ensuring cover is provided 7 days a week.

- Development programmes have been implemented for midwives to ensure succession planning on Delivery Suite and Hazel Wards.

- The Trust continued a centralised recruitment programme during the year. A recruitment plan was rolled out which included further overseas campaigns.

- There has been an ongoing focus on improving our employee recognition with a continuation of the successful Staff Excellence Awards annual scheme. Over 400 staff attended the awards night in June 2014. A monthly recognition scheme based on the Trust STAR values continues whereby staff can nominate colleagues who they feel are role modelling the Trust values. For the first time nominations for awards now include a "working behind the scenes" category.

  The values underpin management standards, recruitment processes, induction and appraisals to ensure the Trust has the right calibre of staff delivering not only the best clinical care, but the best customer service too.

- Towards the end of 2014 the Trust took part in the annual national NHS Staff Survey. An overview of the results is provided separately. However, examples of the staff survey results show that 91% of staff had been appraised in the last 12 months, compared to the national average of 85% and 81% of staff had received health and safety training in the last 12 months compared to the national average of 77%. Conversely, the survey results show that 25% of staff reported that there is good communication between senior management and staff compared to the national average of 30% and 88% of staff agree that their role makes a difference to patients compared to the national average of 91%.

All of the above achievements contribute towards making our Trust a good place to work and receive treatment.

Challenges in the year included the ongoing recruitment of staff, e.g. Recruitment of staff in the community to meet increased service capacity and ensure succession planning for an ageing / high skill set workforce has been difficult and recruitment to paediatric nursing posts has proved difficult.

A further challenge in the year has been the effectiveness of an electronic e-rostering system. Work has continued this year to make improvement to the system and its use to enable the ability to auto roster vacant shifts.

4. To secure the long term financial health of the Trust

The financial environment remains challenging and this challenge will continue to grow in the years ahead as the Trust seeks to reduce costs and maintain a high standard of care.

Examples of achievements during 2014/15 which impacted on the financial health of the Trust include: -

- £6.6m of savings were delivered in year but against a plan of £12m, resulting in a saving shortfall of £5.4m.

- There has been Clinical Commissioning Group approval of an Optimising Community Teams business case enabling investment in both capacity and capability of Integrated Teams.

- Funding was secured from the Improvements Fund towards improvements on the Bereavement Suite and from Charitable Funds toward improvements on the Woodland Suite.

- The Trust continues to offer a range of services for children and young people requiring both acute and secondary care living in Swindon and Wiltshire. In particular there has been significant investment in 2014 to develop a Paediatric Assessment Unit in conjunction with the Paediatric Emergency Department.

- Additional funding was made available for Health Visitors, School Nurses and the Family Nurse Partnership.

- Funding has been secured for a number of additional posts associated with Cancer Services (Chemotherapy Nurses; Cancer Dietician; Oncology Clinical Nurse Specialist).

The Trust has had a challenging year financially. High agency spend to meet the requirements for escalation beds and one to one patient care has been challenging during 2014/15. Separate projects are in place within Divisions and Trust-wide to focus on reducing agency spend, but agency spend reduction is balanced against the need to deliver safe high quality care for patients. Whilst a corporate approach to recruitment was adopted with a view to reducing agency spend as well as securing recruitment, it has not been possible to meet planned agency spend reductions. The two main reasons for this remained as vacancy levels largely due to national shortages and extra posts/ work to cope with increased demand on services. Associated with additional work, the Trust has incurred additional expenditure on drugs and supplies.

Delivery of Cost Improvement Programmes was not achieved to plan during 2014/15.

As the Wiltshire community contract is block, any efficiencies made have to be used to deliver the increased activity.

There has been an historic lack of investment in technology for the community. This has impacted on the clinical teams in terms of potential clinical time being absorbed with administrative processes. The Trust is working with Wiltshire Commissioners to find a solution to this challenge.

Given the Trust's financial position, capital investment was limited in 2014/15, resulting in delays in planned asset and equipment replacement across the Trust. The mechanism for

capital investment is under review.

Some of the Trust's estate requires investment or sale. Financial benefits have yet to be realised from the Trust's estate. This is being addressed through the Trust's Estates Working Group.

The Trust was again unable to secure substantial private patient income due to the inability to ring fence the Shalbourne Suite for private patients. In addition Wards have had their escalation beds full (over 90%) due to required elective capacity.

The Trust was unable to deliver against all of its Cost Improvement Plans (CIPs).

The Trust has three private financing initiatives (pfi) which year on year present a significant financial burden for the Trust.

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

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

The Trust ended the year in a deficit position of £8.644m compared to a surplus position of £1.196 meaning a variance of £9.840m to plan.

5. To adopt new approaches and innovation so that we improve services as healthcare changes, whilst continuing to become even more efficient

Due to the pressures on the Trust in terms of numbers and flow of patients, efforts have been concentrated on delivering safe high quality care and meeting existing demand. However, the Trust recognises that to be more efficient, new ways of working need to be achieved. The Trust continually looks at ways to become more efficient, delivering more with less. Examples of new approaches and innovation are: -

- Demand and capacity modelling for Women's and Children's services has been undertaken using the Intensive Support Team (IST) employing a nationally recognised model – Interim Management and Support (IMAS). This has identified gaps in capacity and demand and led to discussions with clinical teams to identify solutions for improving performance and ensuring patients are seen within a reasonable amount of time, meeting all national targets.

- In terms of gynaecology, the number of weeks each part of a pathway should take has been calculated. This has allowed the ideal capacity required to meet demand to be calculated and planned.

- An upgrade to Medway, our electronic patient record system was achieved during 2014. With the new Medway upgrade there were some technological problems to overcome. However, these were resolved and there is now greater confidence in the data being produced.

- Our Integrated Teams have benefited from a detailed service review and it is

recognised that service reviews are required for all other elements of our community sites.

- There has been a focus on piloting innovation and testing within the community. However, as a result of this approach, there has been a lack of clarity for long-term funding availability which has created challenges regarding recruitment in the short term and the planning of service delivery in the medium term.

- Work has continued to roll out plans to deliver 5 and 7 day working across service areas.

All of the above have made an improvement in patient care or patient experience in some way, either through identification of service improvements; more time for direct care of patients; ensuring the patient receives the right care in the right setting at the right time; or care is given in a timely way.

One challenge has been the need for Improvements to the Pharmacy Manufacturing Unit to ensure it is compliant with relevant guidelines and legislation and that it is fit for purpose for a future pharmacy service. A business case for improvement was approved during the year.

Another challenge during the year was that the E-requesting Pathology project had to be postponed due to lack of IT capacity. This has meant continuation of the paper based system. A steering group has been established to take forward the project and the existing system has been reviewed to make efficiency improvements.

During the year, the Trust decided not to bid to retain Children's and Young People's Community Health Services. The current contract will cease in January 2016.

6. To work in partnership with others so that we provide seamless care for patients

Examples of working in partnership include the following: -

- An Intermediate Care Team has been established with the appointment of a Strategic Lead for intermediate care in partnership with Wiltshire Council. This has enabled a greater focus on intermediate care, supporting discharge and step up and start of integration with Integrated Teams.

- Work has progressed to develop working relationships and common understandings with our partners. We have developed working relationships with the voluntary sector, notably with Parkinson's UK (PUK); the Motor Neurone Disease Association (MNDA) with a new specialist physiotherapist post created; and the Multiple Sclerosis Society (MSS). A representative from Integrated Community Health Division attends the Wiltshire Neurological Conditions Steering Group which enables us to take account of the views of the voluntary sector on community services.

- During 2014/15 we were requested to deliver escalation and step up in the community on a short term basis. The changes in commissioning requirements for numbers of beds have proved challenging to manage from a financial and human resources perspective.

- Demand in the community for health and social care continues to increase and Integrated Community Health Division is working in partnership with social care partners to meet these needs.

- There has been continued partnership working to improve Urgent Care Services seeing a reduction in ED attendance.

- Following the initiation of a procurement exercise by Wiltshire Clinical Commissioning Group (CCG), in September 2014, the Trust has been working with Royal United Hospitals Bath NHS Foundation Trust (RUHB) and Salisbury NHS Foundation Trust (SFT) to explore a future model for delivering Adult Community Services across Wiltshire.

Working in partnership helps each organisation in providing quality care for patients. Partnership working reduces delays in the patient pathway and results in efficiencies in care provision.

Supported by the Institute for Healthcare Improvement 'Conversation Project', Integrated Team staff are skilled in enabling End-of-Life patients' wishes to be discussed and realised. Performance in this area of work is excellent with 96% of community End of Life patients dying in their place of choice.

We continue to work with The Hospital Company and Carillion our private sector partners who own and manage the building and facilities at the Great Western Hospital in Swindon. The key challenges during 2014/15 were concerns raised regarding cleanliness standards and food hygiene standards. The Trust has worked with Carillion and The Hospital Company to review practices and monitoring arrangements to ensure cleaning standards and food hygiene are consistently maintained.

The Trust was unsuccessful in its bid to retain maternity services across Wiltshire and Bath and North East Somerset.

2.9 Research and development

The number of patients receiving relevant health services provided or sub-contracted by Great Western Hospitals NHS Foundation Trust in 2014/2015, that were recruited during that period to participate in research approved by a research ethics committee was 934 to the end of March 2015.

We currently have 85 actively recruiting Department of Health endorsed (portfolio) research projects. 1.5% of these are straight forward Band 1 studies with 52% being the more complex Band 2 studies and 23.5% are highly complex Band 3 studies. 23% of studies are commercially sponsored.

The R&D department is maintaining research activity. The team consisting of part time posts of R&D Manager, Facilitator and Administrator continue to ensure tight deadlines for approval of research projects are met. In addition to these tasks the focus has changed to incorporate more in depth support to recruitment of on-going studies. We are also focusing on ensuring we recruit the number of patients we agreed to recruit, in the timescales given.

Progress continues to be made across the Trust to promote further research activity. We now have 3.5 Trust-Wide Research Nurses who oversee research in key areas such as Obstetrics and Gynaecology and Cardiology and work to actively engage new areas in research. WE also have a new research nurse in the Emergency Department.

Commercially funded research has grown within the Trust with research posts continuing to be funded from this income. This money will also be used moving forward to cover any excess treatment costs incurred from important studies we feel we should participate in.

With funding received from the Department of Health through our Local Clinical Research Network (LCRN), R&D have been able to continue funding key research posts across the Trust in Cancer, Rheumatology, Dermatology and Orthopaedics. Support departments continue to receive funding for posts to allow them to carry out any additional tests etc that a research project may require.

All research staff in the Trust are supported with training and guidance through R&D and the LCRN's. All research nurses receive an induction pack and competency pack in addition to their standard induction information. Further support is also available through mentoring our increasingly experienced team here.

All SOPs (standard operating procedures) within the Research Support Services National Initiative have been implemented to ensure we are compliant with all governance standards

2.10 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.

2.11 Impact of the Trust's Business

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

Environmental Matters

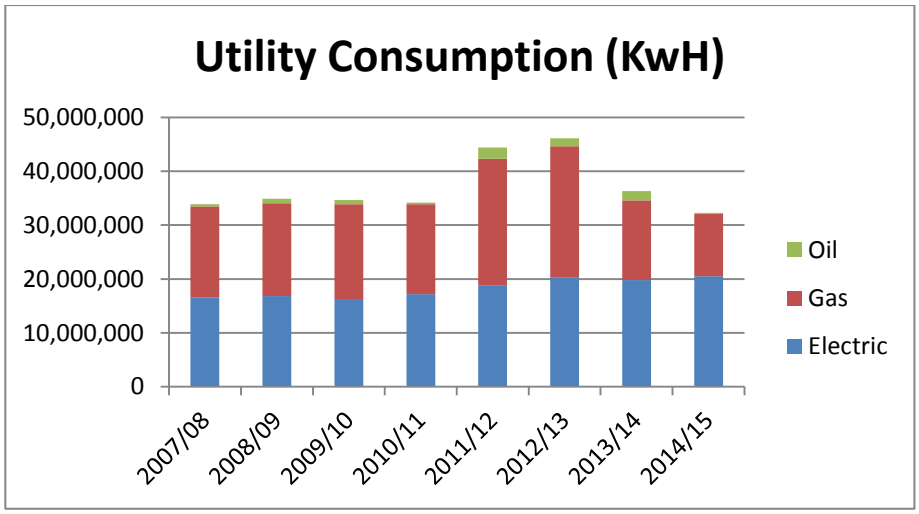
The Great Western Hospitals NHS Foundation Trust recognises that there are many benefits of having a strong focus on all aspects of sustainability, which means we continue to meet the needs of the present without compromising the needs of future generations. There are short, medium and long term advantages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

Sustainability has become increasingly important as the impact of peoples' lifestyles and business choices are changing the world in which we live. In order to fulfil our responsibilities to our patients, local communities and the environment and to embed sustainable processes and thinking into the Trust there is a Board approved Sustainable Development Management Plan. This plan details several commitments that we are now working hard to achieve.

Energy

Graph 1 shows energy consumption in kwH for the Great Western Hospital NHS Foundation Trust since 2007/08. In June 2011 the Great Western Hospitals NHS Foundation Trust merged with Wiltshire Community Health Services (WCHS). During the merger the Trust took over responsibility for several properties previously managed by WCHS. This correlates to the increase in consumption that is seen in this year and since. To help with energy conservation the Trust has become a Carbon & Energy Fund member and is utilising their framework agreement to work with a specialist contractor who will undertake a number of energy saving measures across a number of Trust owned properties, including a combined heat & power (CHP) installation at the Great Western Hospital.

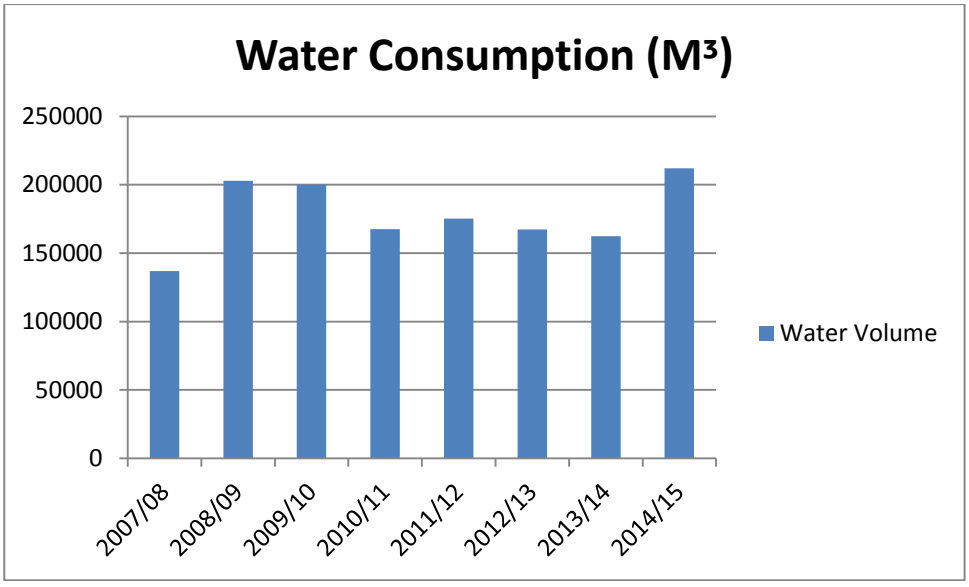
Graph 1 – Utility consumption (KwH)



Water

Water consumption has increased in the past year. A number of mechanical plant replacement schemes by The Hospital Company should see a reduction in water consumption in the coming year.

Graph 2– Water consumption (m^3)

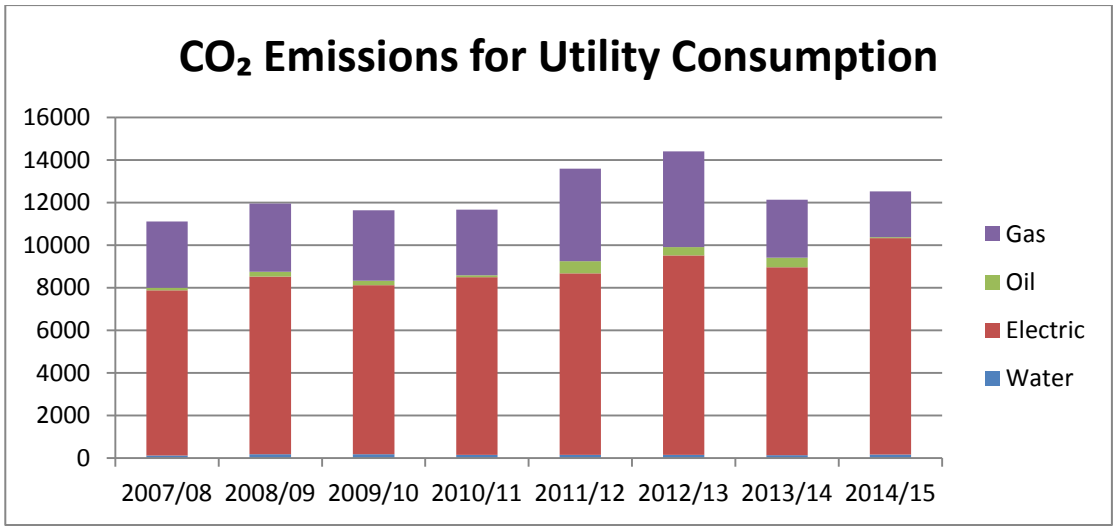


Carbon Reduction

Carbon reduction is one area where the Trust has legal targets. The target being focused on currently is achieving a 10% reduction in CO_2e emissions from a 2007 baseline by 2015. Achieving this target will assist the NHS as a whole with reaching the overall target of reducing 80% CO_2e emission by 2050. Graph 3 shows carbon emissions in tonnes from utility consumption for the Trust since the baseline year of 2007.

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

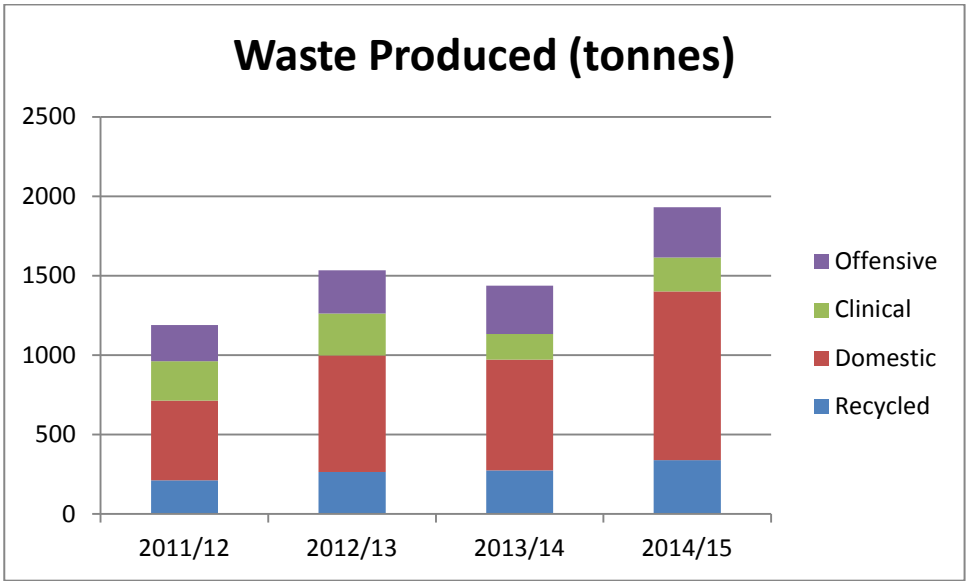
Graph 3– CO_2e emissions for utility consumption (tonnes)



Waste

At the Great Western Hospital all waste is now diverted from landfill with black bag waste being sent to a mixed waste recycling facility, and additional recycling containers have been distributed around the hospital site.

Graph 4 – Waste produced (tonnes)



Trust employees

A breakdown at year end of trust employees is as follows: -

	Male	Female
Directors (senior managers)	2 & 3 non-executive directors	6 & 3 female non-executive director
Bank & Substantive Staff	38	584
Substantive Staff Only	730	3867
Bank Staff only	125	766

The Trust has agreed key workforce policies with the recognised trade unions on behalf of our employees. These policies include recruitment and selection, conduct, capability, grievance and health and safety. The policies are reviewed regularly for effectiveness and outcomes are reported quarterly through the Executive Committee and Workforce Strategy Committee. The HR Team members are aligned with the Clinical Directorates and meet regularly with the line managers to ensure that the relevant policies are implemented.

Social community and human right issues

Equality duty

The Trust uses the Equality and Diversity System to help ensure the requirements of the public sector Equality Duty are met and that the Trust delivers services that are personal, fair and diverse.

The Equality and Diversity System (EDS) covers 18 outcomes grouped in to 4 objectives:

1. Better health outcomes for all
2. Improved patient access and experience
3. Empowered, engaged and included staff
4. Inclusive leadership

Our equality and diversity vision and objectives

In 2014/15 the Trust continued to work towards objectives agreed in 2012 to enhance equality and diversity across the Trust around developing positive attitudes; identifying data sets and identifying good and poor practice for people with learning disabilities. The Trust's equality vision and objectives, are set out below. Each has clear milestone actions to work towards their achievement which are monitored through the Equality and Diversity Working Group.

Equality Vision - *"Great Western Hospitals NHS Foundation Trust wants its services and opportunities to be as accessible as possible, to as many people as possible, at the first attempt"*

Equality and Diversity Objectives	Aim	Protected characteristics
1 Better health outcomes for all 2 Improved patient access and experience 3 Empowered, engaged and included staff 4 Inclusive leadership at all levels	1. Eliminate discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Act. 2. Advance equality of opportunity between people who share a protected characteristic and people who do not share a protected characteristic. 3. Foster good relations between people who share a relevant protected characteristic and those who do not share a protected characteristic.	• Age • Disability • Gender Re-assignment • Marriage and Civil partnership • Pregnancy and Maternity • Race including nationality and ethnicity • Religion or Belief • Sex • Sexual orientation

	Specific Objective	Rationale
1	To **build up data** relating to Equality & Diversity	This has the potential to improve outcomes 1 – 4 and to eliminate discrimination, advance equality of opportunity and foster good relationships.
2	To develop an **awareness** of Equality & Diversity considerations	This has the potential to improve outcomes 2 – 4 and to eliminate discrimination, advance equality of opportunity and foster good relationships.
3	To have regard to Equality & Diversity considerations when **decision making**	This has the potential to improve outcomes 1 – 4 to eliminate discrimination and advance equality of opportunity.

The Trust will be working towards achieving these objectives over the next four years and will be reviewing progress annually. This will be via quarterly meetings of the Equality and Diversity Group.

The Trust has in place an effective Equality and Diversity Policy which is managed through the Workforce Department which is tested through the staff survey results. There are equal opportunities for career progression and no discrimination cases have been lodged.

Policies for potential and existing disabled employees

The Trust has signed up to the national "two ticks" symbol and supports the recruitment and development of disabled candidates/employees. 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 works with Occupational Health to seek appropriate roles for staff following a change in circumstances. For staff that become disabled whilst in our employment, the Trust actively works with the Occupational Health Team to make reasonable adjustments to enable the member of staff to continue their employment with the Trust.

2.12 Consultations

There were no formal public or stakeholder consultations during 2014/15.

2.13 Main trends likely to impact on the Trust business in 2015/16

The trend likely to impact on the Trust in 2015/16 is the **continuing increase in activity**, versus the ongoing need to find efficiency savings. Achieving cost improvement plans is challenging against activity rises with the Trust treating more and more patient's year on year.

The trend going forward continues to be an **emphasis on more for less** and that delivering savings and efficiencies is extremely challenging. The Trust needs to continually consider new ways to deliver services, providing good value for money, whilst delivering high quality care and services.

Another trend continues to be pressure for **more joint working with partners** as this has a big influence on the patient pathway. Joint working provides the best approaches to delivering care to patients with joined up co-ordinated methods across providers and services. The Trust wants to ensure that pathways are fit for patients, streamlined and that there is parity between all partners. However, working with partners to optimise the patient journey is challenging due to differences in priorities, timing and financial constraints. There is a need for stronger links with partners to help discharge patients sooner from the acute hospital, fully understanding and utilising community support.

Locally the trend is an **increasing elderly and frail population** with long term conditions. Frailty is an area of priority to address going forward. There continues to be pockets of deprived areas within the Trust area with associated health care requirements around obesity, drug misuse and teenage pregnancy. The projected population figures show a steep increase in older people with the percentage of the population in Wiltshire aged 65 or over reaching 22.6% by 2021. This represents a 32% increase in the population in Wiltshire aged 65 or over during this 10 year period. The number of Wiltshire residents aged 85 years is projected to increase by 42.4%.

We have experienced significant **growth in acute paediatrics** over the past year of approximately 12%. With the population of Swindon changing with more houses being built and young families moving to the area, the work **in maternity and children services is likely to increase**.

The trend in maternity is an **increased number of patients with diabetes and obesity**. In addition there is an increase in patients generally with **mental health problems and dementia** and an increase in adult and children safeguarding considerations.

There is a growing trend in the **need for flexibility of staff and a need for a mixed skilled and better trained workforce.** However coupled with this is a continuing trend in the difficulty in recruiting and retaining staff and this is expected to continue for three to five years. There is a national shortage of staff and therefore there is a need for continued efforts in recruitment and retention.

Another trend is an **increased need for elective patient services to meet demand**. There is a need to provide increased private patient services, not due to any trend in demand but to take advantage of a marketing opportunity. Private patient income has a direct benefit link for the rest of the NHS service. Also, there is a need for increased orthodontic and oral surgery services in the community. This is to address demand rather than a trend in growth. However, there is an increasing trend of more demand for ophthalmic services which is directly linked to a growing elderly population.

Another trend is the growing **need to embrace new technologies**, such as electronic record systems and mobile working in the community, e-prescribing and e-rostering.

A growing trend in an **expectation for 7 day working** and in some areas 24/7 working and **increasing patient expectations generally**. A project is underway to develop plans to achieve 7 day working across core services.

There is a growing trend in the d**emand for supporting services and diagnostics** to match the current rise in activity and growth.

Finally, there is a growing trend of **more complex pharmacy requests**. This is linked to a frail elderly population with complex co-morbidities. This links to the growing trend of more cancer patients.

2.14 Opportunities for the year ahead

The Annual Plan details the overall plan for the next two years. However, listed below are some of the opportunities for the year ahead which have been identified as part of the business planning process for 2015/16: -

- Implementation of 7 day working across clinical areas in step with funding arrangements.
- Further community transformation (more partnership working / service redesign building on cluster modelling of community teams / optimising performance of Integrated Teams / additional staffing and as the optimising community service model develops it is likely that new staff roles will be developed).
- Enhanced use of Information Technology in the community, including electronic patient records.
- Closer working with Clinical Commissioning Groups / GPs around clinical pathways and to reduce the number of patients (e.g. we are setting up a Paediatric Consultant led advice line for Wiltshire patients).
- Further services reviews to improve efficiency and effectiveness (e.g. service reviews for Rheumatology, Dermatology, Outpatients and Diabetes are planned).
- Planning towards the introduction of a new cancer unit.
- Continued estates review.

2.15 Main risks and uncertainties facing the Trust in the future

The main risks and uncertainties facing the Trust for 2014/15 are included in the Trust's Annual Plan, together with proposed actions to mitigate those risks. Examples are included in the Annual Governance Statement *(Section 0 – Significant Risks refers).*

2.16 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 Foundation Trust Annual Reporting Manual.
The position of the business at the year-end was that the Trust and Charity reported a deficit of £8.6m resulting in a variance to plan of £9.8m.

The following financial summary relates to the Trust only.

Income was £6.4m above plan. The main drivers for income were day cases and non-elective acute activity. There were 2,472 day case spells above plan (primarily in haematology and gastroenterology). Acute non-elective spells increased from 2013/14 levels with more activity being counted and recorded in the surgical assessment unit. There were 3,887 spells, being an increase of 9.9% on 2013/14 figures.

Expenditure was £18.3m above plan. The main drivers for this were additional capacity and costs associated with additional activity (supplies and drugs). There was a pay overspend of £8.37m for the year, £3.97m clinical supplies overspend and £1.53m overspend on drugs.

Saving delivered totalled £6.6m against a target of £12m resulting in an underachievement of £5.4m. The main schemes which slipped were agency spend reductions and cash releasing efficiency savings.

The cash balance at year end was £2.1m for the Trust which was £1.4m below plan. This was after draw down of £5m from an approved loan of £10m. The main reasons for this include increased stock amounting to £0.8m; lower capital expenditure than plan; outstanding performance on NHS contracts in debtors; prepayments being higher than plan as the Public Finance Initiative (PFI) lifecycle capitalisation was lower than plan and creditor payments being managed within available cash.

2.17 Analysis using financial and key performance indicators

The earnings before interest, taxes, depreciation, and amortization (EBITDA) at year end was £15.179m resulting in a variance of £10,731m to plan. The EBITDA income percentage was 5.05% against a plan of 8.85%.

Creditors at year end amounted to £8.6m, resulting in a variance to plan of £10.8m. Creditor days averaged 35.2.

The Trust's Continuity of Service Risk Rating (CoSRR) at year end was 1, against a planned rating of 2. This is explained further in the Regulatory Report *(Section 8.8 - Risk Ratings refers).*

Information about the Trust's performance is included in the Quality Report *(Section 6.6 – Performance against National Priorities refers).*

2.18 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	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	Variance from last year
New Outpatients	87,441	90,852	94,587	96,456	137,504	148,766	160,295	**149,247**	**-6.9%**
Follow Up Outpatients	179,466	195,846	198,244	212,887	263,066	274,326	291,214	**299,806**	**3.0%**
Day Cases	26,102	28,508	28,053	27,813	27,320	27,838	30,969	**32,949**	**6.4%**
Emergency Inpatients	34,075	36,658	39,202	35,210	35,804	38,192	39,178	**43,042**	**9.9%**
Elective Inpatients	7,438	7,345	7,004	7,269	6,723	6,343	6,247	**5,943**	**-4.9%**
Emergency Department Attendances	60,583	62,628	66,262	68,618	70,731	77,642	75,440	**78,522**	**4.1%**
Total	***395,105***	***421,837***	***433,352***	***448,253***	***541,148***	***573,107***	***603,343***	***609,539***	***1.0%***

TABLE – Community Activity

Point of Delivery	2011/12	2012/13	2013/14	2014/15	Variance from last year
Minor Injuries Unit	46,507	41,755	42,884	**44,315**	**3.3%**
Admitted Patients	7,445	8,498	7,998	**2,311**	**-71.1%**
Community contacts including outpatients	803,545	789,473	804,341	**716,513**	**-10.9%**
Total	***857,497***	***839,726***	***855,223***	***763,139***	***-10.8%***

2.19 Contractual arrangements

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

2.20 Continued investment in improved services for patients

During 2014/15, the Trust agreed the following investments to improve services for patients: -

- £388k in the Paediatric Assessment Unit (PAU) to ensure children are seen in the most appropriate place quickly (funding for nursing staff and additional cover).
- £212k for additional Ear Nose and Throat consultants to deliver the Thyroid Service.
- £99k for an additional Breast consultant ensuring care for cancer patients.
- £316k for the Paediatric Emergency Department to provide nursing 24/7.
- £491k in Rheumatology to provide capacity to deliver national access targets and to allow the service to re-open.
- £979k for Optimising Community Nursing Teams, increasing the community Team to align with GP practices.
- £1.116m for Gastroenterology to provide capacity to address current pressures and meet growing demands.
- £104kfor Breast surgery to meet growing demands.
- £302kfor the Orthodontics Service to ensure capacity to meet demand.
- £482k for an additional Urology consultant and associated support.

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

As at 31 March 2015 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 extended the PFI scheme for Medway, which underwent a major upgrade and went live in May 2014.

The Trust secured a £10million loan for investment in healthcare.

2.22 Explanation of Amounts included in the annual accounts

On 1 June 2014 the Wiltshire Maternity Services Contract transferred to the Royal United Hospitals Foundation Trust, Bath following a competitive tendering exercise. The financial impact is included in the accounts (note 2 to the accounts refers).

2.23 Preparation of the Accounts

The accounts for the period ended 31st March 2015 have been prepared in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006 in the form that Monitor (the Independent Regulator of NHS Foundation Trusts) with the approval of the Treasury, has directed.

2.24 Going concern

On 20 April 2015, following a review by Monitor, the Trust was found to be in breach of the following conditions of its licence: CoS3(1)(a) and (b), FT4(2) and FT4 (5)(a), (d),(e), (f) and (g) relating to financial sustainability, performance and governance. Notwithstanding this breach, a deficit for the year ending 31 March 2015 of £8.7 million and a forecast deficit for the year ending 31 March 2016 of £18.0 million, the accounts have been prepared on a going concern basis for the following reasons: -

- The Monitor NHS foundation trust annual reporting manual 2014/15 states that financial statements should be prepared on a going concern basis unless management either intends to apply to the Secretary of State for the dissolution of the NHS foundation trust without the transfer of the services to another entity, or has no realistic alternative but to do so.
- The Trust has prepared its annual plan, which includes a detailed cashflow forecast. The key assumptions within the plan are as follows: -
    - NHS Clinical Income is based on the Enhanced Tariff Option and includes assumptions on general population and demographic growth.
    - Delivery of costs improvement plans of £8m.
    - Cash injection of £3m in Q1 2015 and £2m in Q2 2015 which is expected to be provided by a further drawdown of an agreed loan of £10m and a further loan (to be secured) of circa £20m.

After making enquiries and considering the uncertainties described above, the Directors have a reasonable expectation that the Trust will secure adequate resources to continue in operational existence for the foreseeable future and continue to adopt the going concern basis in preparing the Annual Report and Accounts.

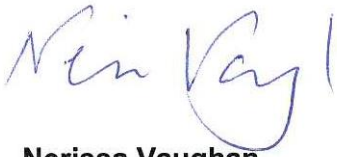
2.25 Preparation of the Annual Report and Accounts

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
Accounting Officer
27 May 2015

3 DIRECTOR'S REPORT

General Companies Act Disclosures

3.1 Directors of Great Western Hospitals NHS Foundation Trust

Directors of Great Western Hospital NHS Foundation Trust during 2014/15: -

Roger Hill	Chairman
Nerissa Vaughan	Chief Executive
Roberts Burns	Non-Executive Director
Liam Coleman	Non-Executive Director Senior Independent Director
Oonagh Fitzgerald	Director of Workforce and Education
Angela Gillibrand	Non-Executive Director Deputy Chairman
Karen Johnson	Acting Director of Finance (from 28 February 2015)
Michelle Kemp	Chief Operating Officer (from 30 October 2014 until 31 May 2015)
Jemima Milton	Non-Executive Director
Maria Moore	Deputy Chief Executive & Director of Finance and Performance (until 6 April 2015)
Steve Nowell	Non-Executive Director *(from 1 June 2014)*
Guy Rooney	Medical Director
Julie Soutter	Non-Executive Director *(from 1 January 2015)*
Hilary Walker	Chief Nurse

Non-Voting Board Members

Douglas Blair	Director of Community Services (from 11 August 2014)
Kevin McNamara	Director of Strategy (from 10 April 2014, previously interim Director of Strategy)

3.2 Market value of fixed assets

Where any market values of fixed assets are known to be significantly different from the values at which those assets are held in the Trust's financial statements, and the difference is, in the directors' opinion, of such significance that readers of the accounts should have their attention drawn to it, the difference in values will be stated with as much precision as is practical and reported in the notes to the accounts.

3.3 Donations

There are no political or charitable donations to disclose.

3.4 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.

Since the year end, Maria Moore, the Deputy Chief Executive and Director of Finance left the Trust on 6 April 2015 and the Michelle Kemp, Chief Operating Officer has resigned and will be leaving the Trust's employment on 31 May 2015.

Following a review by Monitor, in April the Trust was found to be in breach of the following conditions of its licence: CoS3(1)(a) and (b), FT4(2) and FT4(5)(a),(d),(e),(f) and (g) relating to financial sustainability, performance and governance.

3.5 Future Developments

An indication of likely future developments at the Trust is included in the Trust's Annual Plan. These include:

1) **Capacity Planning** – rightsizing capacity to better match demand so as to enable a more resilient local health economy over the next two years prior to the implementation of a new model of care for Swindon. Outpatient transformation and strengthening system discharge.
2) **Seven day working and implementing SAFER**- to improve patient outcomes and improve our way of working
3) **Cancer** – Due to projected growth, aligning capacity and demand, including Radiotherapy Centre development and building the case for a potential Cancer Centre development.
4) **New Models of Care** – Developing new models of delivery in both Swindon and Wiltshire in line with the Five Year Forward View.
5) **Wiltshire Community** – Working with external partners to transform community services.
6) **Corporate** – Programme to support Cost Improvement Plans, CQUIN and Best Practice Tariffs.
7) **Workforce** – delivery of the People Strategy, workforce transformation and planning to meet changing demand supported by recruitment and retention. Reduced agency & locum staffing.
8) **Finance improvement** – addressing the feedback from Monitor as part of the investigation, implementation of the recommendations of the Deloitte Financial Review, delivery of a medium term viability financial viability plan for the Trust and delivery of Service Line Reporting for the Trust to improve financial management.

3.6 Research and Development

An indication of any significant activities in the field of research and development is reported elsewhere in this report *(Section 2.9 – Research and Development refers).*

3.7 No Trust Branches outside UK

The Trust does not have branches outside the UK.

3.8 Employee Matters

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

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

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

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

Actions taken in the financial year to consult employees or their representatives on a regular basis so that the views of employees can be taken into account in making decisions which are likely to affect their interests are included elsewhere in this report under the Staff Survey Report *(Section* 0 *– Staff Survey Report refers).*

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 the trades unions and management. The agenda covers Trust developments and financial information, 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 under the Staff Survey Report *(Section* 0 *– Staff Survey report refers*).

All staff briefings are provided by the Chief Executive. Staff are encouraged to ask questions and seek further information directly. The Trust has also launched a "see something, say something" campaign to encourage feedback.

Actions taken in the financial year to achieve a common awareness on the part of all employees of the financial and economic factors affecting the performance of the Trust include site communication with staff and "Staff Room" (a staff magazine) circulation.

3.9 Notes to the Accounts

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

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

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

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 are discussed in more detail within the annual governance statement *(Section 0 – Quality Governance refers)* and the quality report *(Section* 6 *– Quality Report refers).*

3.10 Monitor's Quality Governance Framework

The Trust has had regard to Monitor'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 Monitor's Quality Governance Framework. Quality Governance is discussed in more detail elsewhere in this report namely in the Quality Report (*Section* 6 *– Quality Report refers*) and in the Annual Governance Statement *(Section 13 – Annual Governance Statement refers).*

During 2014/15 the Trust had in place a number of plans and processes which contribute to ensuring Quality Governance. Examples of this include: -

- Ongoing development of the Trust's business strategy with particular emphasis on quality. In addition sitting under the Trust Strategy is a Quality Strategy specifically focussed on patient care, a good patient experience and good clinical outcomes, in short quality. Staff were engaged in the formulation of the strategy which will be rolled out over the coming years.

- There was a governance review considering specifically how quality considerations are reported through the Trust. As a result reporting structures were refreshed and posts realigned / established with a focus on quality.

- Monthly reporting to the Board on risks and potential risks to quality, with action plans in place to address any gaps in assurance. A fresh approach has been taken to looking at risks with greater scrutiny and challenge at local levels. Over 100 drop in refresher training sessions have been held to raise awareness of the need to identify and manage risk, including risks which may compromise the Trust's ability to consistently deliver high quality care.

- 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.

- Promotion of a quality focused culture throughout the Trust evidenced by the roll of staff values and improved 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, with agreed rules determining which issues should be escalated. These rules cover, amongst other issues, escalation of serious untoward incidents and complaints. Robust action plans are put in place to address quality performance issues. In year the "See something, say something" campaign was launched with staff being actively encouraged to come forward with any areas of concern around the quality of care.

- A robust and effective Board Assurance Framework and Risks Management process, which provides a valuable tool for identifying risk, managing them, ensure controls are in place and addressing any gaps in those controls.

- Patient experience is important to the Trust. Each month the results of the Family and Friends Test and information from comments and complaints are reported, which includes areas for learning and themes of concerns.

- Quality information is analysed and challenged in a number of areas. The Board reviews a monthly 'dashboard' of the most important metrics and areas for focus are identified.

- During the course of the year, internal audit carried out audits of a number of areas associated with quality governance such as complaints management; safe staffing; CQC monitoring compliance; IG Toolkit and incident reporting and management.

Patient care

3.11 Development of services to improve patient care

We treat thousands of patients every year as outlined in the Strategic Report *(Section 0 – Additional Pressure on Finances refers).* Service improvements are also included in the Strategic Report *(Section 2.8 – Review of Trust's Business refers).*

3.12 Performance against key healthcare targets

Details of performance against key healthcare indicators is set out elsewhere in this report *(Section* **Error! Reference source not found.** *– Overview of the Quality of Care Offered 2014/15 refers).*

3.13 Arrangements for monitoring improvements in the quality of healthcare

Continuous monitoring of the Quality Account and Improvement Plan and National Targets is observed monthly. The improvement indicators and national targets inform the Safety and Performance Dashboard and are reported through to our Commissioners and Trust Board via an Executive Committee. The Quality Account improvement indicators also inform a Patient Safety Committee (formerly the Patient Quality and Safety Committee) each month.

Compliance Monitoring of the CQC regulations is undertaken through the Patient Safety Committee, Governance Committee and Executive Committee up to Trust Board. Exceptions in compliance or risks to compliance are identified and included in the Trust's Risk Register. Action plans are developed and progress is monitored to provide assurance of compliance.

3.14 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. Quarterly reporting on compliance with the national targets informs Monitor quarterly.

Progress towards targets as agreed with local commissioners, together with details of other key quality improvements are included elsewhere in this report *(Section* **Error! Reference source not ound.** *- Overview of the Quality of Care Offered 2013/14 refers).*

3.15 New or significantly revised services

Details of services throughout the year are included elsewhere in this report (Section - 2.8 – Review of the Trust's business refers).

Significantly the following are new or revised services: -

Ophthalmology Services – The Royal College of Ophthalmology was engaged in 2013/14 to support the Trust in its review of Ophthalmology Services not only to address current demand but to help develop a sustainable ophthalmology service for the future. The recommendations of that review were rolled out during 2014/15 with Ophthalmology Services expanded including the provision of services at another site.

Emergency Department / Paediatric Area – Emergency Care Intensive Support Team (ECIST) was engaged looking at emergency services, the recommendations of which have been rolled out enabling the Trust to deliver more efficient safe emergency care.

3.16 Improvement in patient / carer information

This is referred to in the Quality Report *(Section 0–National Inpatient Survey refers).*

3.17 Focusing on the patient

How the Trust has focused on the patient, with examples is included in the strategic report referred to elsewhere in this document (*Section 2.8 – Review of the Trust's Business refers*).

3.18 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 0– Improving Patient Experience and Reducing Complaints refers).*

3.19 Using patient experience to drive service improvements

This is referred to in the Quality Report *(Section 0– Friends and Family Test and Section 0 – National Inpatient Survey refer).*

Stakeholder Relations

3.20 Partnerships and alliances

During the course of the year we have continued to place significant emphasis in building strong relationships with local providers and commissioners. In respect of the Wiltshire health community, we have continued out active participant in the Health and Wellbeing Board which brings together commissioners, the local authority, other providers and GPs to work collaboratively on issues of joint interest.

Work has continued with our partners at the Oxford University Hospitals NHS Trust on plans to develop a local Radiotherapy Unit on the Great Western Hospital site in Swindon. Our Trust Board has made a clear commitment to support the development of this vital service, which will mean local people who require radiotherapy no longer need to travel to and from Oxford for treatment. Crucial to the development of the service will be a multi-million fundraising appeal which was launched in early 2015, led by our Trust.

3.21 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 working with partners to strengthen the services we provide is included in the strategic report *(Section 2.8 – Review of the Trust's Business refers).*

3.22 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.

3.23 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.

Additional disclosures

3.24 Accounting policies for pensions and other retirement benefits

Accounting policies for pensions and other retirement benefits are set out in note 1.3.2 to the accounts and details of senior employees' remuneration can be found elsewhere in this report in the remuneration report *(Section 4.13 – Pension Benefits and Remuneration refers).*

3.25 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 two registers one for directors and one for governors which are open to the public. Both registers are available from the Company Secretary.

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

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 Directors and to develop, maintain and implement a remuneration policy that will enable the Trust to attract and retain the best candidates. The Committee reviews the structure, size and composition (including the skills, knowledge and experience) required of the Board and gives consideration to and is responsible for succession planning. 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.

4.2 Membership of the Remuneration Committee

The Remuneration Committee is comprised of the Chairman, Non-Executive Directors and the Chief Executive and chaired by the Senior Independent Director. The Chief Executive does not take part in the consideration of Executive Director salaries which are agreed by Non-Executive Directors.

4.3 Membership and attendance at meetings of the Remuneration Committee during 2014/15

There were 2 meetings of the Remuneration Committee during 2014/15. Membership and attendance is set out below.

	Record of attendance at each meeting (✓ = attended × = did not attend n/a = was not a member)			
	9 May 2014	**18 November 2014**	**17 February 2015**	**12 March 2015**
Robert Burns	×	✓	✓	✓
Liam Coleman (Chair)	✓	✓	✓	✓
Angela Gillibrand	×	×	✓	✓
Roger Hill	✓	✓	✓	✓
Steve Nowell (member from 01.06.14)	n/a	✓	✓	✓
Jemima Milton	✓	✓	✓	✓
Julie Soutter (member from 01.01.15)	n/a	n/a	×	✓
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 from CAPITA relating to remuneration of Executive Directors; and
- seeks professional advice from Oonagh Fitzgerald, the Director of Workforce and Education.

4.5 Remuneration of senior managers (Executive Directors)

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

At the end of each year the Remuneration Committee considers whether the variable element was payable, as the variable element is only payable if clear threshold levels and objectives are achieved by the senior managers. In 2014/15 the Remuneration Committee undertook its annual review in respect of the previous year. As part of this the Committee, agreed that the variable pay scheme would apply for 2014/15, with the annual review due in May 2015. However in March 2015 the Remuneration Committee agreed that the variable scheme would be suspended.

In addition, as the Remuneration Committee wish to ensure that Directors' remuneration reflects current market levels, thus enabling the Trust to continue to recruit and retain high calibre Directors, the Committee again reviewed Executive Director Remuneration for 2014/15. Benchmarking information relating to other Trusts was considered and base salaries were reviewed.

Our policy on pay is to pay upper quartile pay for upper quartile performance in order to recruit and retain the very best people.

<table>
<tr><th>Components of the Remuneration Package for senior managers</th><th>How the component supports the short and long term strategic objectives of the Trust</th><th>How the component operates</th><th>The maximum which could be paid for the component</th><th>Amount (expressed in monetary terms or otherwise) that may be paid for minimum performance and any further levels of performance</th></tr>
<tr><td>Basic Pay</td><td colspan="4">Basic pay for standard performance</td></tr>
<tr><td rowspan="2">Variable Pay</td><td>Delivery of Plan</td><td>Threshold</td><td rowspan="2">10% of basic pay</td><td rowspan="2"></td></tr>
<tr><td>Delivery of stretch objectives</td><td>Individual specific objectives</td></tr>
</table>

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

Performance measures were chosen to ensure an appropriate balance between quality and financial considerations and included maintain Monitor Authorisation, maintain CQC registration, maintain a Continuity of Service Risk Rating (CoSRR) of 2, no formal regulatory action undertaken by Monitor which would trigger the Trust into Red, no criminal or HSE successful prosecutions or convictions during the year.

Provisions for the recovery of sums paid to directors, i.e. claw back provisions have been included in new Executive Director contracts.

The difference between the Trust's policy on senior manager's remuneration and its general policy on employee's remuneration is that the Executive Directors are on spot salaries whereas the rest of the organisation is on a pay scale with annual increments. Variable pay evolved providing focus for Executive Directors on stretch objectives. Furthermore, the remuneration of Executive Directors needs to be paid at a market rate in order to attract and retain Executive Directors and to recognise the level of expertise and commitment required.

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 Directors involves a 360 degree assessment of each Director against a range of competencies set by the NHS Leadership Qualities Framework and an assessment of performance against a set of objectives agreed with each individual. This provides an effective system for setting individual objectives and performance measures each year.

The Committee receives a summary report from the Chief Executive into the performance of each Executive Director.

During 2014/15, Deloitte was commissioned to undertake a review of effectiveness of the Board. A number of actions arising from the review have been implemented and ongoing support from Deloitte (Jay Bevington) is in place.

As in the previous year, during 2014/15 a number of Board Workshops were held to enable greater discussion and understanding of issue. Furthermore, the programme of joint Governor and Director training on the role and work of Divisions has continued.

With the appointment of new Non-Executive Directors, formalising their induction and training has commenced.

In 2014/15 the 360 degree assessment process was again rolled out to other senior staff in the Trust to help inform their performance and areas for development.

4.8 Board of Directors' employment terms

Executive Directors and non-voting Board Members, 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 comprised of Governors and Non-Executive Directors. The Council of Governors approves the Chief Executive and Non-Executive Director appointments.

The Chief Executive and Executive Directors have a contract with no time limit and the contract can be terminated by either party with six months' notice. These contracts are subject to usual employment legislation and new director contracts include claw back clauses for any variable payment and fit and proper person disqualification provisions and existing director contracts will be refreshed to include these also. The Non-Executive Directors, which includes the Chairman, are appointed for terms of office not exceeding three years. They do not have contracts of employment, but letters of appointment with terms agreed by the Council of Governors. The Council of Governors may remove non-executive directors at a general meeting with the approval of three quarters of the members of the Council of Governors.

The Trust's Constitution sets out the circumstances under which any Director may be disqualified from office.

4.9 Remuneration of Non-Executive Directors

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

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

Note that a Nominations and Remuneration Working Group comprised of Governors makes recommendations on allowances to the Council of Governors which sets the allowances for the Non-Executive Directors.

4.10 Annual Statement from the Chairman of the Remuneration Committee summarising the financial year

This report contains a summary of the work of the Remuneration Committee during 2014/15. There were no major decisions on senior managers' remuneration. However, a substantial change made during the year was to suspend the variable pay scheme for Directors.

Maria Moore, the Deputy Chief Executive and the Director of Finance left the Trust on 6 April 2015. Karen Johnson was appointed as the Acting Director of Finance.

Michelle Kemp, the Chief Operating Officer has resigned and will be leaving the Trust's employment on 31 May 2015. The Chief Operating Officer post is currently vacant.

Disclosures required by Health and Social Care Act

4.11 Expenses of Directors and Governors

Expenses 2014-15 (unaudited)

Name	Title	Expenses 2014-15 £
Robert Burns	Non-Executive Director	1,645
Liam Coleman	Non-Executive Director	0
Angela Gillibrand	Non-Executive Director	214
Roger Hill	Chairman	1,990
Jemima Milton	Non-Executive Director	961
Steve Nowell	Non-Executive Director	641
Julie Soutter	Non-Executive Director	0
Douglas Blair	Director of Community Services (non voting)	1,889
Oonagh Fitzgerald	Director of Workforce & Education	1,185
Karen Johnson	Acting Director of Finance	0
Michelle Kemp	Chief Operating Officer	2,042
Maria Moore	Deputy Chief Executive & Director of Finance	632
Kevin McNamara	Director of Strategy (non-voting)	1,319
Guy Rooney	Medical Director	1,492
Nerissa Vaughan	Chief Executive	1,339
Hilary Walker	Chief Nurse / Chief Nurse	699
Total		16,047

Name	Title	Expenses 2014-15 £
Shane Apperley	Staff Governor	0
David Barrand	Nominated Governor	0
Clive Bassett	Nominated Governor	0
Roger Bullock	Public Governor	0
Lisa Campisano	Staff Governor	0
Jon Elliman	Nominated Governor	0
Elizabeth Garcia	Public Governor	0
Mike Halliwell	Public Governor	139
Peter Hanson	Staff Governor	0
Louise Hill	Public Governor	246
Ian James	Nominated Governor	0
Janet Jarmin	Public Governor	927
Hayley Madden	Staff Governor	0
Brian Mattock	Nominated Governor	0
Sarah Merritt	Staff Governor	0
Sheila Parker	Nominated Governor	0
Kevin Parry	Public Governor	0
Peter Pettit	Public Governor	139
Ros Thomson	Public Governor	0
Margaret White	Public Governor	492
Edward Wilson	Nominated Governor	0
Robert Wotton	Public Governor	0
Total		1,942

The total number of directors in office during 2014/15 was 16 and the total number of governors in office was 22.
Note Michelle Kemp's expenses include a relocation sum.

Expenses 2013/14

Name	Title	Expenses 2013-14 £
Robert Burns	Non-Executive Director	1,219
Liam Coleman	Non-Executive Director	0
Angela Gillibrand	Non-Executive Director	723
Philippa Green	Non-Executive Director	734
Roger Hill	Non-Executive Director / Chairman	1,085
Janet Husband	Non-Executive Director	1,254
Bruce Laurie	Chair	2,271
Jemima Milton	Non-Executive Director	0
Oonagh Fitzgerald	Director of Workforce & Education	999
Maria Moore	Director of Finance & Performance	925
Kevin McNamara	Interim Director of Strategy (non-voting)	0
Hilary Shand	Interim Chief Operating Officer (non-voting)	0
Alf Troughton	Deputy Chief Executive & Medical Director	1,688
Nerissa Vaughan	Chief Executive	2,351
Hilary Walker	Chief Nurse / Chief Nurse	3,447
Total		**16,694**

Name	Title	Expenses 2013-14 £
Clive Bassett	Nominated Governor	0
Roger Bullock	Public Governor	223
Lisa Campisano	Staff Governor	0
Harry Dale	Public Governor	0
Jon Elliman	Nominated Governor	0
Elizabeth Garcia	Public Governor	0
Mike Halliwell	Public Governor	0
Peter Hanson	Staff Governor	0
Louise Hill	Public Governor	14
Ian James	Nominated Governor	0
Janet Jarmin	Public Governor	492
Srini Madhavan	Public Governor	0
Brian Mattock	Nominated Governor	0
Sarah Merritt	Staff Governor	0
Kevin Parry	Public Governor	0
Rosemary Phillips	Public Governor	0
Phil Prentice	Public Governor	59
Ros Thomson	Public Governor	0
Margaret White	Public Governor	166
Edward Wilson	Nominated Governor	0
Robert Wotton	Public Governor	0
Total		**955**

4.12 Off Payroll Engagements

TABLE 1: For all off-payroll engagements as of 31 March 2015, for more than £220 per day and that last longer than 6 months

	Number
No. of existing engagements as of 31 March 2015	7
Of which:	
No. that have existed for less than one year at time of reporting	6
No. that have existed for between one and two years at time of reporting	1
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

An assessment has been made as to which engagements are required to provide assurance. A letter is sent for all those engagements employed via personal service companies requesting assurance and associated contractual clauses.

TABLE 2: For all new off-payroll engagements, or those that reached 6 months in duration between 1 April 2014 and 31 March 2015, for more than £220 per day and that last for longer than 6 months

	Number
No. of new engagements, or those that reached six months in duration, between 1 April 2014 and 31 March 2015	13
No. of the above which include contractual clauses giving the Trust the right to request assurance in relation to income tax and National Insurance obligations	12
No. for whom assurance has been requested	1
Of which:	
No. for whom assurance has been received	1
No. for whom assurance has not been received	0
No. that have been terminated as a result of assurance not being received	0

Assurance has been requested only from those engagements via personal service companies

TABLE 3: For any off-payroll engagements of Board members, and/or senior officials with significant financial responsibility between 1 April 2014 and 31 March 2015

	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 should include both off-payroll and on-payroll engagements	**16**

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 table below.

4.13 Pension Benefits and Remuneration

Pensions Benefits 2014-15

Name (alphabetical order)	**Title**	**Real Increase in Pension 2014-15 (Bands of £2500)**	**Real Increase in Lump Sum 2014-15 (Bands of £2500)**	**Total accrued pension at 31st March 2015 (Bands of £5000)**	**Total accrued related lump sum at 31st March 2015 (Bands of £5000)**	**Cash Equivalent Transfer Value at 31st March 2015**	**Cash Equivalent Transfer Value at 31st March 2014**	**Real Increase in Cash Equivalent Transfer Value**	***Employers Contribution to Stakeholder Pensions***
		£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	***£000***
Douglas Blair	Director of Community Services	n/a	n/a	20-25	60-65	274	n/a	n/a	0
Oonagh Fitzgerald	Director of Workforce & Education	0-2.5	2.5-5	20-25	60-65	300	271	29	0
Karen Johnson	Acting Director of Finance	0-2.5	0-2.5	5-10	0-5	62	42	20	0
Michelle Kemp	Chief Operating Officer	n/a	n/a	15-20	50-55	289	n/a	n/a	0
Kevin McNamara	Director of Strategy (non-voting)	2.5-5	10-15	5-10	25-30	99	53	46	0
Maria Moore	Deputy Chief Executive & Director of Finance	0-2.5	2.5-5	25-30	80-85	443	407	36	0
Guy Rooney	Medical Director	n/a	n/a	50-55	155-160	970	n/a	n/a	0
Nerissa Vaughan	Chief Executive	2.5-5	7.5-10	45-50	135-140	754	681	73	0
Hilary Walker	Chief Nurse	0-2.5	2.5-5	35-40	115-120	726	681	45	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 2014/15 is referred to elsewhere in this report (*Section 3.13.1- Directors of Great Western Hospitals NHS FT refers*)

Note - CETV values are not applicable over age 60.

Remuneration 2014-15

		2014-15							
Name	**Title**	**Salary (Bands of £5000)**	**Arrears for 2013-14 paid in 2014-15 (Bands of £5,000)**	**Benefits in Kind Rounded to the Nearest £100**	**Annual Performance Related Bonuses (Bands of £5,000)**	**Long Term Performance Related Bonuses (Bands of £5,000)**	**Other Remuneration (Bands of £5000)**	**Pension-Related Benefits (Bands of £2,500)**	**Total**
Robert Burns	NED	15-20	-	-	-	-	-	-	15-20
Liam Coleman	NED	10-15	-	-	-	-	-	-	10-15
Angela Gillibrand	NED	10-15	-	-	-	-	-	-	10-15
Roger Hill	Chairman	40 – 45	-	-	-	-	-	-	40-45
Steve Nowell	NED	10-15	-	-	-	-	-	-	10-15
Jemima Milton	NED	10-15	-	-	-	-	-	-	10-15
Julie Soutter	NED	0-5	-	-	-	-	-	-	5-10
Douglas Blair	Director of Community Services	65-70	-	-	-	-	-	-	65-70
Oonagh Fitzgerald	Director of Workforce & Education	100-105	10-15	-	-	-	-	12.5-15	125-130
Karen Johnson	Acting Director of Finance	5-10						37.5-40	45-50
Michelle Kemp	Chief Operating Officer	45-50		-	-	-	-	-	45-50
Kevin McNamara	Director of Strategy (non-voting)	90-95	-	-	-	-	-	72.5-75	166-170
Maria Moore	Deputy Chief Executive & Director of Finance	120-125	10-15	-	-	-	-	10-12.5	145-150
Guy Rooney	Medical Director	125-130		-	-	-	35-40	-	165-170
Nerissa Vaughan	Chief Executive	175-180	15-20	-	-	-	-	37.5-40	225-230
Hilary Walker	Chief Nurse	110-115	5-10	-	-	-	-	7.5-10	125-130

Note - The remuneration figures do not include any final bonus/performance related pay increase which is subject to agreement by the Remuneration Committee**.**
Note - Pension Related Benefits relate to the increase in employer contributions from prior year.
Note - Douglas Blair and Kevin McNamara are non-voting Directors appointed in 2014-15 and therefore are excluded from the calculations above.
Note - Maria Moore left the Trust on 6 April 2015.

		2013-14					
Name	**Title**	**Salary (Bands of £5000)**	**Benefits in Kind Rounded to the Nearest £100**	**Performance Related Bonuses (Bands of £5,000)**	**Other Remuneration (Bands of £5000)**	**Pension-Related Benefits (Bands of £2,500)**	**Total**
Robert Burns	Non-Executive Director	10-15	-	-	-	-	10-15
Liam Coleman	Non-Executive Director	10-15	-	-	-	-	10-15
Angela Gillibrand	Non-Executive Director	10-15	-	-	-	-	10-15
Philippa Green	Non-Executive Director	5-10	-	-	-	-	5-10
Roger Hill	Non-Executive Director / Chairman	10-15 5-10	-	-	-	-	10-15 5-10
Janet Husband	Non-Executive Director	5-10 0-5	-	-	-	-	5-10 0-5
Bruce Laurie	Chairman	30-15	-	-	-	-	30-35
Jemima Milton	Non-Executive Director	0-5	-	-	-	-	0-5
Oonagh Fitzgerald	Director of Workforce & Education	100-105	-	-	-	42.5 - 45	160-164
Kevin McNamara	Interim Director of Strategy (non-voting)	20-25	-	-	-	-	20-15
Maria Moore	Director of Finance & Performance	120-125	-	-	-	65-67.5	210-215
Hilary Shand	Interim Chief Operating Officer (non-voting)	20-25	-	-	-	-	20-25
Alf Troughton	Deputy Chief Executive & Medical Director	125-130	-	-	55-60	30-32.5	220-225
Nerissa Vaughan	Chief Executive	175-180	-	-	-	80-82.5	285-290
Hilary Walker	Chief Nurse	110-115	-	-	-	177.5-180	305-310

Note - The remuneration figures do not include any final bonus/performance related pay increase which is subject to agreement by the Remuneration Committee**.**
Note - Pension Related Benefits relate to the increase in employer contributions from prior year. Chief Nurse increase is high as only in post from January 2013.
Note – Hilary Shand and Kevin McNamara were non-voting Directors appointed in 2013/14 and therefore are excluded from the calculations above.

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 are set out in note 1.3.2 to the accounts and key management compensation is set out in note 7.3 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 and the Committee's aspiration to offer top quartile remuneration for top quartile performance.

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 31st March 2015.

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

The Trust is required to disclose the median remuneration of its staff and the ratio between this and the mid-point of the banded remuneration of the highest paid director; whether or not this is the Accounting Officer or Chief Executive. The calculation is based on full-time equivalent staff of the Trust at the year-end on an annualised basis. This information is set out below together with an explanation of the calculation, including the causes of significant variances where applicable.

Executive Name and Title	**Total remuneration**	
	2014/15	**2013/14**
Nerissa Vaughan, Chief Executive	**£177,500**	
Dr A F Troughton, Deputy Chief Executive and Medical Director	**-**	£187,500

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	**2014/15**	**2013/14**	**% change**
Highest paid directors' total remuneration	**£177,500**	£187,500	-5.3%
Median total remuneration	**£26,043**	£27,759	-6.0 %
Ratio	**6.8**	6.75	0.7%

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 organisations 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. The median pay has reduced from 2013/14 due to staff turnover and recruitment at lower pay grades. Directors' pay has also reduced as the new Medical Director is not the highest paid Director.

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.

Signed

Nerissa Vaughan
Chief Executive 27 May 2015

5 NHS FOUNDATION TRUST CODE OF GOVERNANCE

5.1 Council of Governors

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

- To appoint and remove the chairman and non-executive directors.
- To decide on the remuneration, allowances and terms and conditions of office of the non-executive directors.
- To approve the appointment of the chief executive.
- To appoint and remove the external auditor.
- To hold the non-executive directors, individually and collectively, to account for the performance of the board of directors.
- To represent the members' interests and bring these to bear on strategy decisions.
- To approve significant transactions.
- To approve the Trust's Constitution.
- To input into the development of the annual plan.
- To receive the annual report and accounts and the auditors 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 *(Section 0 – Council of Governors Meetings Structure refers)*.

During 2014/15 the Council of Governors carried out or was involved in the following: -

- Appraisals of the Chairman and Non-Executive Directors.
- The re-appointment of one Non-Executive Director and the re-appointment of two new Non-Executive Directors.
- Re-appointment of the external auditor.
- Review and approval of the Constitution.
- Holding the Non-Executive Directors to account on a number of issues such as risk management, review of Neighbourhood Nursing Teams, Food Allergies Sufferers Service and Safer Staffing.

In 2014/15 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 Director will be resolved following the provisions in the Trust's Constitution.

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; and
- Gloucestershire and Bath and North East Somerset.

Governors for these areas 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 2014/15 by the independent Electoral Reform Services Ltd. There are 12 public governor positions (Swindon – 5, Northern Wiltshire – 2, Central Wiltshire – 2, Southern Wiltshire – 1, West Berkshire and Oxfordshire - 1, and Gloucestershire and Bath and North East Somerset – 1). In addition there are 4 elected staff governors and 6 governors nominated by organisations that have an interest in how the Trust is run. The number of public governors must be more than half of the total membership of the Council of 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.

There was an uncontested by-election for the West Berkshire & Oxfordshire Constituency in April 2014 with one candidate elected. A by-election was also held in April 2014 and an election in November 2014 for the Gloucestershire and Bath and North East Somerset Constituency but on both occasions, no candidates stood for election. The seat remains vacant. Furthermore, there is an insufficient number of members to trigger an election for the Southern Wiltshire Constituency.

Elected Governors in 2014/15 – Public Constituencies

Name	Constituency	Date first elected	Current Term of Office (date ending)	Attendance from 6 Council of Governor meetings
Ros Thomson	Swindon	Dec 2008	3 years (Nov 2016)	4/6
Kevin Parry	Swindon	Nov 2011	3 years (Nov 2016)	5/6
Louise Hill	Swindon	Nov 2013	3 years (Nov 2016)	6/6
Robert Wotton	Swindon	Nov 2013	3 years (Nov 2016)	3/6
Elizabeth Garcia	Swindon	Nov 2013	3 years (Nov 2016)	6/6
Michael Halliwell	Northern Wiltshire	Nov 2012	3 years (Nov 2015)	5/6
Roger Bullock	Northern Wiltshire	Jun 2013	Remainder of 3 years (Nov 2015)	2/6
Margaret White	Central Wiltshire	Jun 2011	3 years (Nov 2015)	5/6
Janet Jarmin	Central Wiltshire	Dec 2008	3 years (Nov 2015)	3/6
Peter Pettit	West Berkshire & Oxfordshire	Apr 2014	Remainder of 3 years (Nov 2017)	3/5

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.

Elected Governors in 2014/15 – Staff Constituency

Name	Staff Constituency – sub class	Date first elected	Current Term of Office (date ending)	Attendance from 6 Council of Governor meetings
Shane Apperley	Hospital Nursing & Therapy Staff	Nov 2013	3 years (Nov 2016)	6/6
Lisa Campisano	Administrators, Maintenance, Auxiliary and Volunteers	Nov 2012	3 years (Nov 2016)	5/6
Peter Hanson	Doctors & Dentists	Nov 2010	3 years (Nov 2016)	4/6
Sarah Merritt	Community Nursing & Therapy Staff	Nov 2013	3 years (was due to end Nov 2017 but resigned June 2014)	1/2
Hayley Madden	Community Nursing & Therapy Staff	Nov 2014	3 years (Nov 2017)	0/2

There was an uncontested election for the Community Nursing and Therapy Staff Sub Class, Staff Constituency in November 2014 with one candidate elected.

Nominated Governors in 2014/15

Name	Nominating Partner Organisation	Date first nominated	Current Term of Office (ending date)	Attendance from 6 Council of Governor meetings
Ian James	Swindon Clinical Commissioning Group	Aug 2013	3 years (Aug 2016)	3/6
Edward Wilson	Wiltshire Clinical Commissioning Group	Aug 2013	3 years (Aug 2013)	3/6
Brian Mattock	Local Authority – Swindon Borough Council	Nov 2011	3 years (Nov 2017)	4/6
Sheila Parker	Local Authority – Wiltshire Council	Nov 2014	3 years (Nov 2017)	0/2
Clive Bassett	Other Partnerships – Prospect Hospice	Nov 2011	3 years (was due to end Nov 2017, however resigned Feb 2015)	2/5
David Barrand	Other Partnerships – Prospect Hospice	Feb 2015	Remainder of 3 years (Nov 2017)	0/1
Jon Elliman	Other Partnerships – Swindon and North Wiltshire Health and Social Care Academy	Nov 2011	3 years (ended Nov 2014)	0/6

Sheila Parker was nominated representing Wiltshire Council. There had been a vacancy for this seat since January 2014. Clive Bassett resigned in February 2015 as he no longer met the eligibility criteria. David Barrand was nominated for the Governor seat for the remainder of the three year term. Jon Elliman's term of office ended in November 2014. A replacement Governor representing Swindon and North Wiltshire Health and Social Care Academy has yet to be nominated.

Attendance at meetings of the Council of Governors during 2014/15

There were 6 meetings of the Council of Governors in 2014/15. The table below shows governor and director attendance at those meetings: -

Attendee (✓ = attended X = did not attend)	**17/04/14**	**14/05/14**	**12/06/13**	**17.09.13**	**19/11/14**	**12/02/15**
Governors						
Shane Apperley	✓	✓	✓	✓	✓	✓
David Barrand	n/a	n/a	n/a	n/a	n/a	×
Clive Bassett	✓	✓	×	×	×	×
Roger Bullock	×	✓	×	×	×	✓
Lisa Campisano	✓	✓	×	✓	✓	✓
Jon Elliman	×	×	×	×	×	n/a
Elizabeth Garcia	✓	✓	✓	✓	✓	✓
Michael Halliwell	✓	✓	✓	×	✓	✓
Peter Hanson	✓	✓	✓	×	✓	×
Louise Hill	✓	✓	✓	✓	✓	✓
Ian James	×	×	✓	×	✓	✓
Janet Jarmin	×	✓	✓	×	×	✓
Hayley Madden	n/a	n/a	n/a	n/a	×	×
Brian Mattock	✓	✓	×	×	✓	✓
Sarah Merritt	×	✓	n/a	n/a	n/a	n/a
Sheila Parker	n/a	n/a	n/a	n/a	×	×
Kevin Parry	✓	✓	✓	×	✓	✓
Peter Pettit	n/a	×	✓	✓	✓	×
Ros Thomson	✓	✓	✓	✓	×	×
Edward Wilson	×	✓	✓	×	✓	×
Margaret White	✓	✓	✓	×	✓	✓
Robert Wotton	✓	×	✓	✓	×	×
Directors						
Douglas Blair	n/a	n/a	n/a	✓	✓	×
Robert Burns	✓	✓	✓	✓	✓	×
Liam Coleman (Senior Independent Director)	✓	✓	✓	✓	✓	×
Oonagh Fitzgerald	×	×	✓	✓	×	×
Angela Gillibrand (Deputy Chair)	✓	✓	✓	✓	✓	✓
Roger Hill (Chair)	✓	✓	×	✓	✓	✓
Michelle Kemp	n/a	n/a	n/a	n/a	×	×
Kevin McNamara (non-voting)	✓	✓	✓	✓	×	×
Jemima Milton	✓	✓	✓	✓	×	✓
Maria Moore	×	×	✓	✓	✓	✓
Steve Nowell	n/a	n/a	×	×	×	✓
Guy Rooney	✓	×	✓	✓	×	×
Nerissa Vaughan	×	✓	×	✓	×	✓
Hilary Walker	✓	×	✓	✓	×	×

Lead and Deputy Lead Governors

Ros Thomson and Mike Halliwell were Lead and Deputy Lead Governors respectively up until the meeting of the Council of Governor in November 20134 when, Ros Thomson was re-nominated as Lead Governor and Shane Apperley was nominated Deputy Lead Governor. 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.

Note that in 2014 the Trust amended it Constitution to allow any Governor to be the Lead or Deputy Lead Governor, noting that previously this was limited to public governors only.

Biography of individual governors

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

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 and the Council of Governors is the collective body through which the directors explain and justify their actions. The Board has a scheme setting out which decisions it will make itself, known as the Reservation of Powers to the Board (*Section 0 – Decisions Reserved for the Board*) and there is a Scheme of Delegation which sets out powers delegated to staff.

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

The Council of Governors has specific statutory powers and duties as set out above (*Section 5.1 – Council of Governors refers).*

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.

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 Board has taken the following steps to understand the views of governors and members: -

Non-Executive Director attendance at Council of Governors Meetings – During 2014/15 Non-Executive Directors attended Council of Governor meetings which enabled them to listen to Governor's concerns and to respond to any questions raised.

Presentations to the Council of Governors by Non-Executive Directors to Governors - 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, Investment and Performance Committee, the Audit, Risk and Assurance Committee and the Governance Committee.

Joint Board of Directors and Council of Governors Training – A programme to provide 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 2014/15. Four sessions were held whereby divisions explained the services they provide. 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 Lectures – To provide forums for members to meet governors, public health lectures were introduced in 2012/13 and have continued ever since whereby members and the public, are invited to attend a public lecture on a specific health topic and thereafter meet governors and share thoughts and views on healthcare. In 2014/15 five public health lectures were held as follows: -

- Thinking of having a baby (May 2014)
- A short history of tics, twitches and tremors (July 2014)
- How to survive your menopause (September 2014)
- Prostates, Bladders & Willies (November 2014)
- Organ Donation (February 2015)

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

"Listening to our patients" – An initiative previously known as "eyes and ears" but later changed to "listening to our patients" is in place whereby the Governors identify any issues of concern regarding the provision of services. Governors' feedback issues they have witnessed for themselves or those which have been reported to them.

Council of Governors Effectiveness Review – An effectiveness review of the Council of Governors was held in December 2014, led by the Company Secretary and Chairman. The outcome was a refreshed work plan, with agreement reached on a planned approach to hold Non-Executive Directors to account for the performance of the Board on priority areas linked to complaints, governors concerns and areas where further assurance is needed.

Governor Working Groups / Non-Executive Directors aligned – As referred to elsewhere in this report *(Section 0 – Council of Governors Meetings Structure refers),* 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. On request, Non-Executive Directors may attend meetings of working groups to provide information and receive feedback from Governors directly. Since 2013/14 Non-Executive Directors have been aligned to Working Groups providing a

clear link for governors to hold Non-Executive Directors individually for the performance of the Board in specific areas which those working groups consider.

Additional Briefing Sessions – The Chief Executive has held separate sessions with governors to discuss specific topics of interest, with other members of the Board present. In addition there have been additional briefing sessions and training including Trust Induction Sessions in August and November 2014; Complaint Handling Training in September 2014; Finance & Effectiveness Training in February 2015 and a Chippenham Hospital Site visit in March 2015.

Annual Members Meetings – In 2014/15 an Annual Members Meetings 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 meets 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.

Southwest Governor Exchange Network - In 2014/15 Governor representatives attended the Southwest Governor Exchange Network events held in July and November 2014, and March 2015. 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 workings of the Trust and to influence the decisions being made. A few examples in 2014/15 are: -

- Governor representative on the End of Life Committee Group.
- Joint workshops and training events with the Trust Board
- Governor involved in determining staff awards
- Patient Experience Working Groups
- Membership Working Groups
- Finance Workings Groups
- Nominations and Remuneration Working Groups
- Training and Development Working Groups
- Governor surgeries in local library

Council of Governors Meetings Structure

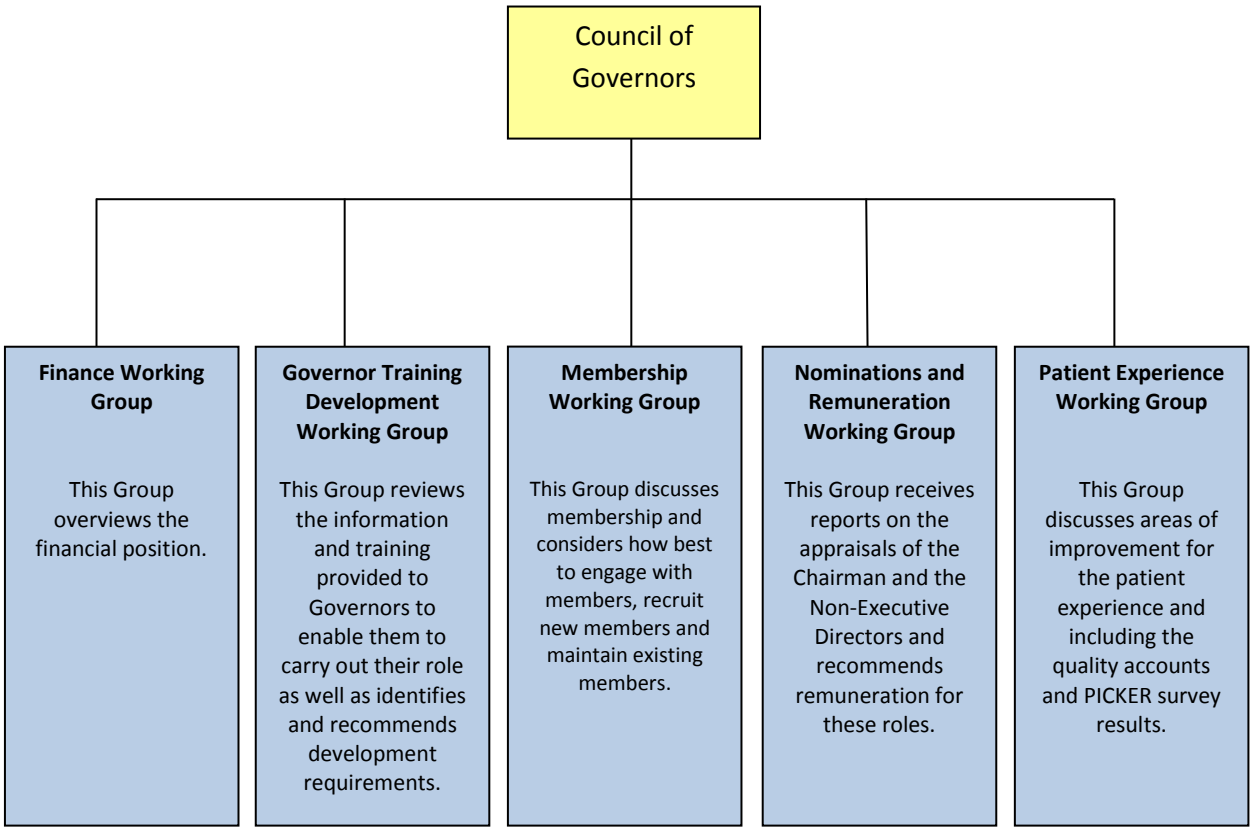
The Council of Governors has established the following working groups: -

- Finance Working Group
- Membership Working Group
- Nominations and Remuneration Working Group
- Patient Experience Working Group
- Training and Development Working Group

Working groups inform governors about activities and issues relevant to each area, thereby assuring governors about the performance of the Board. Governor 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 *(Section 0 – Joint Nominations Committee refers)*.
The meetings structure of the Council of Governors is shown below.

TABLE – Council of Governors Meeting structure



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 is comprised of five governors (three elected, one nominated and one staff). The Chairman is appointed by the Chairman of the Council of Governors who attends as appropriate with the Senior Independent Director attending as requested.

The Working Group has established the process for appraisal 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 2014/15, to undertake the annual chairman and non-executive directors' appraisals. There was also a review of the level of remuneration paid to the Chairman and the Non-Executive Directors having regard to market rates of those remuneration levels. The pay arrangements for Non-Executive Directors was originally fixed at Authorisation in December 2008 to reflect foundation trust responsibilities. No remuneration increases had been awarded since that time and it was therefore considered that the rates should be increased from 1 April 2014 to reflect rates elsewhere. Further information about the salaries of the Non-Executive Directors can be found in this report *(Section 4.13 – Pensions, Benefits and Remuneration refers).*

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.

5.2 Board of Directors

The Board of Directors

The Board of Directors or Trust Board is comprised of Executive, Non-Executive Directors and Non-Voting Members and has overall responsibility for the performance of the Trust. The Board determines strategy and agrees the overall allocation of resources and ensures that adequate systems and processes are maintained to measure and monitor the Trust's effectiveness, efficiency and economy as well as the quality of its healthcare delivery. The Board takes decisions consistent with the approved strategy. The Executive Directors are responsible for operational management of the Trust. Non-voting Board Members do not have executive powers. Brief biographies for Board Members in 2014/15 are set out below.

Biography of individual Directors

Roger Hill, Chairman

Roger was appointed to the Board in April 2008. Until 1999 he had been both the Chairman and Managing Director of the UK subsidiary of Intergraph Corporation, a large American computer company. Subsequently he was a Board Director of a number of IT services companies, both in the UK and Ireland. Until 2008 he was a Governor of Newbury College. Roger was re-appointed as a Non-Executive Director in January 2012 for a further term of three years ending 30 April 2015. Roger was appointed the Senior Independent Director of the Trust from 1 October 2012. In 2013/14 Roger was appointed Chairman of the Trust from 1 February 2014 for a three year term ending 31 January 2017 and therefore he ceased to be the Senior Independent Director. In 2014/15 Roger was a member of the Governance Committee until 31 May 2014. He was also a member of the Remuneration Committee and the Joint Nominations Committee.

Nerissa Vaughan, Chief Executive

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

Douglas Blair, Director of Community Services *(from 11 August 2014)*

Douglas was appointed to GWH as Director of Community Services in August 2014. Before this, he held local and regional roles in NHS England and the South West Strategic Health Authority. This included the establishment of Clinical Commissioning Groups and Commissioning Support Units. Douglas joined the NHS in 2006 in a Primary Care Trust commissioning role after spending eight years as a civil servant in central and regional government working on areas such as homelessness, rural issues and the Criminal Justice System.

Robert Burns, Non-Executive Director

Robert Burns' career has been largely focused on financial disciplines and financial management roles. Having trained as an accountant most of his career has been spent in complex multinationals ultimately in various senior Finance, and Sales Management roles. He is a Fellow of the Institute of Chartered Accountants in England and Wales (FCA) and was previously a Fellow of the Chartered Management Institute (FCMI). He was also a Board Member of Gloucester Probation Trust, part of the National Offender Management Service but resigned in June 2011 to enable him to dedicate more time to this Trust following the transition of Community Services. Robert joined the Board on 1 August 2008 and was re-appointed as a Non-Executive Director in January 2012 for a further term of three years ending 31 July 2015. In April 2015 Robert was again re-appointed for a further 1 year term ending 31 July 2016.

In 2014/15 Robert was Chair of the Audit, Risk and Assurance Committee and Chair of the Charitable Funds Committee until 1 January 2015. Robert was a member of the Remuneration Committee and the Finance, Investment and Performance Committee. He was also a member of the Mental Health Act/ Mental Capacity Act Committee from 8 August 2014.

Liam Coleman, Non-Executive Director and Senior Independent Director

Liam Coleman joined the Co-operative Bank in June 2013 as Treasurer, to deliver the Bank's recapitalisation and support its wider turnaround. On 1 September 2014, he assumed the role of Managing Director, Retail and Corporate Banking, reporting to Group CEO Niall Booker. Based predominantly in London, he continues as a member of the Bank's Executive Team.

Previous employers include Nationwide Building Society and RBS plc. He joined Nationwide in 1996, with his final position as Group Director (from 2009-11) and membership of their Executive Directors' Committee. His move to RBS in 2011 was as Deputy Group Treasurer, Head of Capital Management, responsible for four teams in Group Treasury.

Liam is a member of the Chartered Institute of Bankers and the Association of Corporate Treasurers and holds an MBA from the University of Warwick.

Liam joined the Trust in December 2008 and in July 2012 he was re-appointed as a Non-Executive Director for a further term of three years ending 31 October 2015. Liam was appointed the Senior Independent Director from 1 March 2014 until 31 October 2015. In April 2015 Liam was again re-appointed for a further 3 year term ending 31 October 2018.

In 2014/15 Liam was Chair of the Finance and Investment Committee and Chair of the Remuneration Committee. Liam was a member of the People Strategy Committee and the Joint Nominations Committee.

Oonagh Fitzgerald, Director of Workforce and Education

Oonagh joined the Trust in February 2008. Oonagh had previously worked as Director of Human Resources and Organisation Development at Kingston Hospital, South West London and prior to that she was Deputy Director of Human Resources at Mayday Healthcare NHS Trust in Croydon, South London. She is a Fellow of the Chartered Institute of Personnel and Development. She originally studied law at university and gained a Masters in HR Leadership in 2005.

Angela Gillibrand, Non-Executive Director and Deputy Chair

Between 1984 and 1999 Angela was the Finance Director at the University of Cranfield's Shrivenham Campus, and helped set up one of the first PFIs - the academic contract between the University and the Ministry of Defence. Angela was the Head of Finance, Planning and Company Secretary at U.K. Nirex Ltd, the U.K.'s radioactive waste management company. Since 2003 Angela has combined a career as a Non-Executive Director in the NHS, Government and a Housing Association with work for a family company. Angela holds a degree in Physiology and Psychology from Somerville College, Oxford and a MBA from INSEAD, Fontainebleau, France.

Angela has been a member of the Board since 1 July 2004. Angela was re-appointed as a Non-Executive Director in January 2012 for a further term of two years ending 30 June 2014. In 2011/12 Angela was appointed Deputy Chairman of the Trust from 1 January 2012 until 30 June 2012 and with her re-appointment as a Non-Executive Director, Angela was also re-appointed Deputy Chairman of the Trust until 30 June 2014. Angela was again re-appointed for a further two year term in April 2014 ending 30 June 2016. Angela was also re-appointed Deputy Chairman for the same period.

In 2014/15 Angela was Chair of the Governance Committee and the Mental Health Act/Mental Capacity Act Committee. Angela was a member of the Audit, Risk and Assurance Committee, the Remuneration Committee and the Joint Nominations Committee. Up until 31 May 2014, Angela was also a member of the Finance and Investment Committee, the Workforce Strategy Committee and the Charitable Funds Committee.

Karen Johnson, Acting Director of Finance *(from 28 February 2015)*

Karen Johnson was appointed as the Acting Director of Finance in February 2015 after joining the Trust in June 2013 from her previous role as Acting Chief Finance Officer for Wiltshire PCT.

Karen became a member of the Chartered Institute of Management Accountants (ACMA) in 2001 and has over 23 years' experience in the public sector including; Ministry of Defence, Local Authority and the NHS.

Karen joined the NHS in January 2010 and is committed to ensuring the public sector provides good value for money whilst maintaining good quality services. Karen was appointed Acting Director of Finance on 28 February 2015.

Jemima Milton, Non-Executive Director

Jemima has been involved in Local Government for the last 15 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. In 2014/15 Jemima was a member of member of the Audit, Risk and Assurance Committee, the Governance Committee, the Mental Health Act/Mental Capacity Act Committee and the Remuneration Committee. Jemima was also Chair of the People Strategy Committee.

Kevin McNamara (Director of Strategy – Non Voting Board Member) *(from 10 April 2014, previous interim Director of Strategy from 2 December 2013)*

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

Kevin was appointed to the substantive position of Director of Strategy on 10 April 2014.

Steve Nowell, Non-Executive Director *(from 1 June 2014)*

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

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

Steve became a Non-Executive Director on 1 June 2014. During 2014/15 he was a member of the Finance, Investment and Performance Committee, Governance Committee, People Strategy Committee and Remuneration Committee. He was also a member of the Charitable Funds Committee up until 8 August 2014 when he was appointed Chair of that Committee.

Guy Rooney, Medical Director *(from 1 April 2015 replacing Alf Troughton as Medical Director)*

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 Rooney was also interim Medical Director for the period May 2011 to October 2011, when the then Medical Director acted up as Chief Executive pending the appointment of a substantive Chief Executive.

Dr Guy Rooney joined the Board as Medical Director on 1 April 2014 when the former Medical Director's term of office ended. He is keen to continue the drive for clinical engagement in all aspects of the work the Trust undertakes, in particular the transformation work recently outlined in Simon Stevens' (CEO NHS England) five-year vision for the NHS.

Julie Soutter, Non-Executive Director *(from 1 January 2015)*

Julie is currently Interim Chief Operating Officer for the Energy Systems Catapult, a technology and innovation centre, which transforms ideas into new products and services in the energy systems sector.
With management experience in a variety of roles in the professional, private and public sectors, Julie has been a Non-Executive Director since 1 January 2015.
Recent roles include Director of Finance and Operations for the Chartered Institute of Housing and Head of Operations at Innovate UK, an organisation which supports innovative businesses. Julie has also held senior positions in the NHS and has experience in organisational change, project management, and service improvement.
Julie became a Non-Executive Director on 1 January 2015. During 2014/15 she was a member of the Audit, Risk and Assurance Committee, Governance Committee, Mental Health Act/ Mental Capacity Act Committee, People Strategy Committee and Remuneration Committee.

Hilary Walker, Chief Nurse

Hilary has been a Registered Nurse since 1985 and has a particular interest in Trauma and Orthopaedic Nursing. She has held a number of corporate nursing roles since 2002, mainly in acute trusts but most recently as Interim Nursing Director at Dudley Primary Care Trust. Her previous role was Deputy Nursing Director at Royal Wolverhampton Hospitals NHS Trust. Hilary joined the Trust in May 2012 as interim Chief Nurse and thereafter was successful in securing the substantive Chief Nurse position from 1 January 2013.

Michelle Kemp, Chief Operating Officer *(from 3 November 2014 until 31 May 2015)*

Michelle was appointed to GWH as Chief Operating Officer in October 2014. Michelle has resigned and will be leaving the Trust's employment on 31 May 2015.

Maria Moore, Deputy Chief Executive and Director of Finance *(until 6 April 2015)*

Maria was appointed as Director of Finance and Performance in September 2008. Maria was appointed as Deputy Chief Executive from 1 April 2014. Maria left the Trust on 6 April 2015 to pursue new opportunities having worked at the Trust for 12 years.

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 2014/15. Appointments are shown from 1 December 2008, being the date of Authorisation as a Foundation Trust.

Name	First Term	Second Term	Third Term
Roger Hill	01.12.08 – 30.04.12	01.05.12 – 31.01.14	01.02.14 – 31.01.17
Robert Burns	01.12.08 – 31.07.12	01.08.12 – 31.07.15	01.08.15 – 31.07.16**
Liam Coleman	01.12.08 – 31.10.12	01.11.12 – 31.10.15	01.11.15 – 31.10.18**
Angela Gillibrand	01.12.08 – 30.06.12	01.07.12 – 30.06.14	01.07.14 – 30.06.16
Jemima Milton	01.01.14 – 31.12.16		
Steve Nowell	01.06.14 – 31.05.17*		
Julie Soutter	01.01.15 – 31.12.17*		

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.

*These Non-Executive Directors were appointed during 2014/15. **These Non-Executive Directors were re-appointed in April 2015. The process involved assessment by the Joint Nominations Committee. The following considerations were taken into account and matched against a job description and person specification in respect of each re-appointment / appointment: -

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

The appointments were approved by the Council of Governors.

As recommended by the Local Counter Fraud Service (LCFS), the names of all Trust Directors (Executive and Non-Executive) are cross-referenced with the Disqualified Directors Register on the Companies House website on an annual basis. No Trust Directors appeared on the Disqualified Directors Register (as of 31 March 2015).

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.

The Board is committed to reviewing its balance and composition in order to maintain its effectiveness. During 2014/15, the Trust again mapped the refreshment of the Board, looking in detail at the skills and qualities needed now and in the future and mapped the composition of the Board against desired experience and knowledge on the Board. In 2014/15 two Non-Executive Directors were appointed. The Trust may appoint up to seven Non-Executive Directors in addition to the Chairman.

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

During 2014/15 there was change and refreshment of the Board, which is continuing. The Trust appointed two new Non-Executive Directors starting in June 2014 and January 2015 respectively. A new Medical Director commenced on 1 April 2014, with a new Director of Strategy (non-voting) also appointed in April 2014 (previously interim appointment). Two new Director posts were created in 2014/15. Firstly a Director of Community Services (non-voting) was appointed in August 2014 and secondly, the Chief Operating Officer position was established as a Board Director with a substantive appointment made in November 2014.

During 2014 there was formal external evaluation of the Board's performance by Deloitte which is independent of the Trust. Recommendations arising out of the review are being progressed. In addition, 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.

For individual Non-Executive Directors, the Trust has in place a framework for their appraisal based on elements of the Hay Group work and best practice from other Foundation Trusts. In June 2014 a formal appraisal process for the Chairman and the Non-Executive Directors was undertaken by the Council of Governors. The evaluation of the Chair's performance was led by the Senior Independent Director with input from the Lead Governor 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 was evaluated by the Chairman taking account of Governors' and other Directors' input. The Executive Directors' appraisals were led by the Chief Executive in March/April 2015, and will be reported through the Remuneration Committee in May 2015 following a formal appraisal process using the Leadership Qualities Framework competencies. All appraisals involve 360 degree evaluation and feedback.

Attendance at meetings of the Board of Directors during 2014/15

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	03.04.14	24.04.14	29.05.14	26.06.14	30.06.14 (reconvened meeting)	31.07.14	25.09.14	30.10.14	27.11.14	16.12.14	29.01.15	26.02.15	26.03.15
Douglas Blair (from 11.08.14)	n/a	n/a	n/a	n/a	n/a	n/a	✓	✓	✓	✓	✓	✓	✓
Robert Burns	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Liam Coleman	✓	✓	✓	✓	✓	✓	✓	✓	×	✓	✓	✓	×
Oonagh Fitzgerald	✓	✓	×	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Angela Gillibrand	✓	✓	✓	✓	✓	×	✓	✓	✓	✓	✓	✓	✓
Roger Hill	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Karen Johnson (from 28.2.15)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	✓	✓
Michelle Kemp (from 03.11.14)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	✓	✓	✓	✓	×	✓
Kevin McNamara	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	✓	✓	✓
Jemima Milton	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Maria Moore	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	×
Steve Nowell (from 01.06.14)	n/a	n/a	n/a	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Guy Rooney	✓	✓	✓	×	×	✓	✓	✓	✓	✓	✓	✓	✓
Julie Soutter (from 01.01.15)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	✓	✓	✓
Nerissa Vaughan	✓	✓	✓	×	✓	✓	×	✓	✓	✓	✓	✓	✓
Hilary Walker	✓	✓	✓	✓	×	✓	✓	✓	✓	✓	✓	✓	×

There was a Joint Council of Governors and Board on 12 June 2014 (*Section 0 – Attendance at Council of Governors meetings)*.

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 2014 and will be refreshed again during 2015. A full copy can be obtained from the Company Secretary.

Interests of Directors

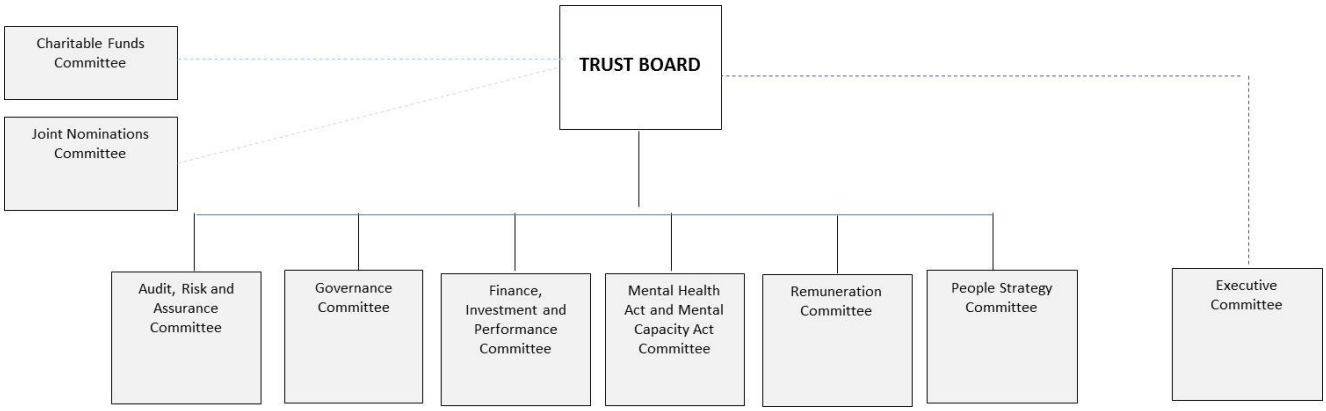
A Register of Interests of Directors is maintained, a copy of which can be obtained from the Company Secretary.

Significant Commitments of the Chairman

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

Committee structure

The structure of the Board committees during 2014/15 was as follows: -



Sitting below this top level structure are a number of working groups and other meetings. Note that the Terms of Reference for the Board Committees are refreshed each year.

Key Committees

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

The Board has established the following committees: -

- Charitable Funds Committee
- Audit, Risk and Assurance Committee*
- Governance Committee
- Finance Investment and Performance Committee
- Mental Health Act and Mental Capacity Act Committee*
- Remuneration Committee*
- People Strategy Committee.
- Executive Committee

* Statutory Committees

5.3 Audit Committee

GWH NHS FT AUDIT, RISK & ASSURANCE COMMITTEE
ANNUAL REPORT 2014/15

INTRODUCTION

1. On behalf of the Audit, Risk & Assurance Committee (ARAC), I am delighted to present the above Committee's annual report. The Committee operates under a Board delegation and approved terms of reference. The Committee consists of 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 year ended 31 March 2015. This report covers activities and accounts during the period 1 April 2014 to 31 March 2015.

TERMS OF REFERENCE

2. The Terms of Reference of the Committee have been reviewed against the Audit Committee Handbook published by the HFMA and Department of Health, Monitor's Code of Governance and current best practice. The Committee's current Terms of Reference have been endorsed by the Committee and reviewed and approved by the Great Western Hospitals NHS Foundation Trust Board on the 27 March 2014. 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

3. The Committee has had at least three non-executives acting as members during the financial year:

Robert Burns	1st April 2012 (ARAC Chair) (Member of Finance and Investment Committee from 1st February 2014)
Angela Gillibrand	1st October 2013 (Chair of Governance Committee and Member of Finance and Investment Committee)
Jemima Milton	From 1st January 2014 (Member of Governance Committee)
Julie Soutter	Appointed 1st January 2015 (Member of Governance Committee)

Attendances: **Non-Exec Members**	**22 May 2014**	**24 July 2014**	**11 September 2014**	**20 November 2013**	**16 January 2015**	**12 March 2015**
Robert Burns (Chair)	✓	✓	✓	✓	✓	✓
Angela Gillibrand	×	×	✓	✓	✓	✓
Jemima Milton	✓	✓	✓	✓	✓	✓
Julie Soutter	n/a	n/a	n/a	n/a	✓	✓

N/A Not applicable, x not attended, ✓attended

4. Nerissa Vaughan (CE and AO), Maria Moore (Finance Director (FD)), Dr Guy Rooney (Medical Director) or appropriate alternates also attend as does Carole Nicholl (Company Secretary (CoSec)). Additional attendees at all Committee meetings include representatives from Internal Audit and Counter Fraud (TIAA) and External Audit (KPMG) who all provide updates on current activities, planning and reporting. KPMG also provide regular updates on current technical or regulatory matters the Committee should be made aware of.

5. Other senior Trust managers or representatives from Internal and External Audit are invited to attend Audit, Risk and Assurance Committee meetings to assist on matters of specific interest or relevance to the Committee's responsibilities as required.

AUDIT COMMITTEE PURPOSE & ACTIVITY IN DISCHARGING ITS RESPONSIBILITIES

6. Purpose: The primary purpose of the Committee is to provide oversight and scrutiny of the Trust's risk management activity, internal financial control and all 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 process should address risks and controls that affect all aspects of the Trust's day to day activity and reporting.

(It should be noted that operational oversight and scrutiny, in particular relating to service quality and patient care performance is also provided through the Governance Committee. There is a direct linkage between the Governance Committee and ARAC through committee membership and exception reporting. Similarly the Finance and Investment Committee provides operational scrutiny and oversight of financial, planning and overall performance, and again there is a direct linkage between the Finance and Investment Committee and ARAC through committee membership and exception reporting. The ARAC Chair and Non-Executive members have also been party to all Board discussions relating to these matters. Day to day performance management of the Trust's activity, risks and controls is however the responsibility of the Executive).

The Committee also provides governance and audit oversight in relation to 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 Audit, External Audit and Trust Finance Management, should it be required, at the end of all committee meetings.

7. Risk and Governance Activity: The Committee met in May, July, September and November 2014, plus January and March 2015. For the current financial year a minimum of six meetings is currently scheduled, commencing in May 2015 with the review and approval of the 2014/15 year-end Annual Reports and Accounts. The major review areas addressed in the meetings in 2014/15 relating to Governance and Enterprise Risk Management (ERM) can be summarised as follows:

- At least on a quarterly basis the Trust's Assurance Framework and higher risk 15+ Risk Register, as presented by the FD and CS, have been reviewed and risks and assurances challenged where appropriate by the Committee with management. Lower rated risks or other risk registers have also been reviewed. When the Committee felt it necessary suggestions have been made and discussed for the ongoing development of ERM within the Trust to ensure Risk Management and the Trust's Assurance Framework remains "fit for purpose" and reflect any

risk that impact on the Trusts strategic objectives and the assurance and mitigation provided, or if none exist prompt a suitable course of action to minimise the impact therefrom.

- The Committee has during the period specifically reviewed the Trust's Risk Management Strategy, along with policies relating to Information Governance and Strategy and Fraud and Corruption. The Committee also reviewed reports relating to Legal Services, including claims management, and Information Governance during the period and discussed progress and mitigating actions taken to control any future risks.

- The Committee has reviewed and approved at least quarterly reports of any single tender actions or contract extensions and also reports of losses including patient property losses and any compensation paid.

- The Chair of the Committee at each meeting 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 for noting by the Board and the Chair of the Committee has given verbal updates on the work of the Committee and any current concerns to the Board as required.

- In November 2014 the Chair of the Committee has provided an update on the work of the Committee to the Governors whilst also providing an update relating current status of two IT system upgrades relating to Electronic Staff Rostering (ESR) and Medway (Acute system only) previously discussed as a potential financial, control or performance risk, but now implemented within the Trust

- During the reporting period the Committee received verbal updates on any issues of concern to Governance Committee and significant management issues including updates on forecast year end performance against plan, the borrowing facility application, and Monitors investigation into the Trust performance deficit and likely future course of action. Details of A&E performance pressures were also provided along with an outline of mitigating actions taken.

- Additionally as indicated above, in May 2015 the Trust's Financial Accounts for 2014/15 and Annual Report including the Quality Report were reviewed and approved by the Committee for endorsement by the Board.

- The committee has considered significant issues in relation to the financial statements, being the accounting policies relating the valuation of land and buildings and revenue recognition. These risks were also identified by the external auditors as part of the external audit plan presented to the March audit committee. The committee has reviewed the outcome of the work by external audit and accounting treatment for these items prior to the approval of the financial statements to address the potential issues identified.

Internal Audit and Counter Fraud: The Committee reviewed and approved TIAA's, internal audit and counter-fraud plans for 2015-16 to ensure the provision of support to the assurance framework and adequate review of internal control processes and any known areas of risk or concern. This included a review of planned chargeable days. The Committee monitors audit delivery and receives all finalised reports on audit and counter fraud activity, all findings and any other opinions concerning governance, control or risk management arrangements. The FD also provides comments at Committee meetings that confirm progress against the plan, areas of concern and the progress on resolving audit recommendations. The committee ensured that TIAA's audit planning also took account of areas of weakness or control identified by the Governance and Finance and Performance committees as worthy of a detailed audit review if not already so identified by Trust executive senior management.

The Audit Committee has considered and endorsed the Head of Internal Audit's 2014-15 Annual Report that assessed the Trust's internal controls as reasonable and that they provided overall Reasonable Assurance.
Following the 2013/14 reporting period several reports were presented to the Committee in May 2014 which were reviewed in detail in the July 2014 meeting. Two of these reports provided only Limited Assurance overall. The first related to the consistency of monitoring compliance with processes and policies around "Delayed Transfers of Care (DTOC)", the potential risks therefrom and the reporting thereof to the relevant forums, whilst the second concerned "Cost Improvement Programmes" relating in part to both Length of Stay and Nurse Agency Usage (where no assurance was possible). Trust management confirmed action plans and implementation timescales were agreed to address these concerns at that time, however, due to continuing operational pressures the combined impact of DTOC, Length of Stay and Nurse Agency Usage still continue as ongoing operational concerns and will receive ongoing performance scrutiny and monitoring by Trust management, the Finance and Investment committee in addition to oversight by ARAC.

It should be noted that each year there are areas of the internal audit plan work which are reported to the ARAC in the following financial year.

In addition to their agreed work plan for 2014/2015 TIAA has further issued two internal audit reports providing Limited Assurance relating to 2013/2014 to some specific aspects concerning "Private Patients income collection" and in relation to process weaknesses, documentation and record keeping re "Junior Doctors rota hours". Action plans and implementation timescales have been agreed to address all identified concerns which are subject to follow up reviews. All other internal audit reports provided Reasonable or Substantial assurance. In addition where the Trust agreed to reviews of its previous audits or requested other operational reviews which in turn identified further weaknesses in processes and practice Actions are in hand to address issues and improve processes and controls as required.

A number of internal audit reports for 2014/2015 are similarly carried over to 2015/2016 of these reports two provided only limited assurance, relating to an assurance review of PFI Contract management and Governance and a compliance review relating to Estates Compliance. All reports however have agreed action plans and will be subject to detailed review by the committee in July 2015.

9. External Audit: KPMG were represented at all meetings of the Committee and submitted reports as needed, including their 2014-15 **Unqualified Report** on the Trust's Financial Accounts and their Annual Audit letter.

In April 2015 Monitor reported that the Trust was failing to comply with a number of the provider licence conditions, in particular, those relating to financial reporting and financial governance, due to a failure to comply with its general duty to exercise its functions effectively, efficiently and economically. As a result, the external auditors have **qualified the Use of Resources certificate**. Furthermore, the external auditors have completed a review of 'percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period' as part of the requirements outlined within '2014/15 Detailed guidance for external assurance on quality reports'. As a result of the testing performed, issue have been identified and hence external audit have **not been able to provide a limited assurance opinion in relation to this indicator** on the Trust's Quality report. The 2014/15 year end audit plan has been reviewed and agreed, and performance will be monitored by the Committee. All significant points raised by the KPMG as a result of their audit work including any issues carried forward and their Use of Resources assessment have been discussed with the Committee, were considered by management and if needed appropriate responses have been made and control processes are to be strengthened. The Committee also reviews 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. In March 2015 the Council of Governors approved the appointment of KPMG for a further term, following a competitive tender exercise.

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

10. **Review of Effectiveness:** The Committee undertook a formal self-assessment during the year, and reviewed any outstanding prior year actions. An action plan was prepared and approved to address all weaknesses where identified, however no significant issues were so identified. It is planned that a formal self-assessment review will also be undertaken in 2015/16.

11. 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 auditors are 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 FT reporting requirements 2014-15 and the requirements reflected in the AO's Statement of Internal Control made by the CEO of the Trust.

  A letter of representation reviewed and approved by the Committee, has been provided to the External Auditors signed by the CEO on behalf of the Trust Board to this effect.

- The responsibilities of the External auditors are set out in their audit report as appended to the Annual Report of the Trust.

AUDIT COMMITTEE ASSURANCE

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

13. 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.

14. In 2015-16 we will continue to operate against our terms of reference, seek further assurance that steps are being taken to maintain effective risk management and mitigation, maintain sound systems of internal control and quality control, monitor actions planned to implement audit recommendations or strengthen controls in areas of concern.

ACKNOWLEDGEMENTS

15 The Committee and I acknowledge the support we have received from the Executive and senior management. We also warmly welcome the readiness of Trust management to cooperate with us and take action where it is indicated. Finally, we are grateful for the detailed work and application of both Internal and External Auditors.

Robert Burns – (Chair), AUDIT, RISK & ASSURANCE COMMITTEE
May 2015

5.4 Nominations Committee

The 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 to the Non-Executive Directors for appointment as the Chief Executive.

The work of the Joint Nominations Committee in discharging its responsibilities

In 2014/15 the Committee met during the year to consider new Non-Executive Director appointments and existing Non-Executive Director re-appointments and thereafter to consider feedback from interviews and recommend candidates for appointment to the Council of Governors.

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

The Joint Nominations Committee is comprised 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.

Before making any nomination for re-appointment / appointment, the Committee has regard to the performance of the individual during their term (as appropriate), the balance of qualifications, skills, knowledge and experience required on the Board of Directors.

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 comprised 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.

Attendance at the Joint Nominations Committee Meetings during 2014/15

Joint Nominations Committee Members	Record of attendance at each meeting ✓ = Attended × = Did not attend n/a = not applicable as not member at that time	
	7 May 2014	12 November 2014
Liam Coleman – Non-Executive Director	× (Robert Burns substitute)	× (Steve Nowell substitute)
Angela Gillibrand – Non-Executive Director	× (Jemima Milton substitute)	✓
Roger Hill – Chairman	✓	✓
Lisa Campisano– Governor	✓	× (Mike Halliwell substitute)
Elizabeth Garcia – Governor	✓	✓
Sarah Merritt – Governor	✓	n/a
Peter Pettit	n/a	✓
Ted Wilson – Governor	✓	✓

Note: Liam Coleman, Angela Gillibrand and Roger Hill are Non-Executive Directors appointed by the Board and Lisa Campisano, Elizabeth Garcia, Sarah Merritt (replaced by Peter Pettit) and Ted Wilson are Governors 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 Director) remuneration and has delegated authority for agreeing any annual pay review for these staff only.

5.5 Mental Health Act / Mental Capacity Act Committee

The Mental Health Act / Mental Capacity Act Committee

Under the terms of the Mental Health Act 1983, (MHA) the Trust has a key responsibility for looking after patients who come to the hospital with problems associated with their mental health and to ensure that that the requirements of the Act are followed.

The Trust must:

- ensure that patients are detained only as the Mental Health Act allows:
- ensure that patients' treatment and care accords fully with the provision of the Act;
- patients are fully informed of, and supported in, exercising their rights;
- patients' cases are dealt with in line with other relevant statutory legislation including the Mental Capacity Act 2005, Human Rights Act 1998, The Race Relations Act, Disability Discrimination Act 1995 or Data Protection Act 1998.

Membership of the Mental Health Act and Mental Capacity Act Committee

- 2 Non-Executive Directors
- Chief Nurse – Executive Lead for Mental Health Services
- Trust Operational Lead for Mental Health Services
- Mental Health Act Administrator
- Representative from Child and Adolescent Mental Health Service (CAMHS)
- Senior Representative from Adult Mental Health Services (AWP)
- Senior Representative from the Older People's Mental Health Services (AWP)
- Representative from Swindon Primary Care Trust
- Doctor representative

Meetings during 2014/15 attendance

The Mental Health Act / Mental Capacity Act Committee members		June 2014	September 2014	December 2014	March 2015
Angela Gillibrand (Chair) New Chair from March 2014	Non Executive Director	√	√	√	√
Jemima Milton (Deputy Chair) *New Deputy Chair of the Committee from 1st March 2014 – December 2014)*	Non Executive Director *Observer from December 2014*	√	-	√	√
Robert Burns *New Deputy Chair of the Committee from December 2014)*	Non Executive Director	-	-	√	√
Rob Nicholls - Left Trust	Deputy Chief Nurse	√	-	-	-
Hilary Walker	Chief Nurse, Executive Lead for Mental Health, GWH	-	-	√	Apologies given
Caroline Wretham Joined Committee September 2014	Matron Lead for Mental Health, GWH	-	√	√	√
Julie Marshman	Deputy Director Of Quality Governance, GWH	-	Apologies given	-	-
Joy Gobey	Mental Health Act and Safeguarding Adults at Risk Administrator, GWH	√	√	√	√
Kat Hitch *(Originally Lead for Acute Service, moved to ICHD February 2015)*	Safeguarding Adults at Risk Facilitator, GWH	√	√	√	√
Jonathan Newman *(Joined Trust January 2015)*	Safeguarding Adults at Risk Facilitator, Acute Service, GWH	-	-	-	√
Teresa Harding	General Manager, Women and Children's' Department, GWH	Apologies given	Apologies given	Apologies given	Apologies given
Joanne Smith	Matron for Paediatrics – deputy for Teresa Harding, GWH	√	Apologies given	Apologies given	Apologies given
Dick Eyre Attendance as either/both with Amanda Cadder.	Child Psychiatrist, Oxford Health	x	Apologies given	Withdrew as Committee member	-
Michelle Mcguire	Head of Service - Swindon, Wiltshire & Banes (CAMHS)	-	Apologies given	Apologises given	x
Mandy Round attends for Michelle Mcguire.	Service Manager Community CAMHS, Swindon, Wiltshire & Banes	-	Apologies given	√	x
Amanda Cadder Attendance as either/both with Dick Eyre.	Nurse Manager, CAMHS Unit, Oxford Health	x	x	x	-
Paula May	General Manager, Swindon AWP	Apologies given	Apologies given	Apologies given	Apologies given
Newlands Anning	Head of Professions and Practice Swindon Locality & Innovation Development Lead, AWP	Apologies given	Apologies given	√	Apologies given
Sandra Akintola Left AWP	Access Community Service Manager, AWP	√	Apologies given	Apologises given	-
Fiona Hamilton	Intensive Team Psychologist, AWP, for Sandra Akintola	-	-	√	-
Billy Luke, representing	Ward Manager, Applewood	-	√	-	-

The Mental Health Act / Mental Capacity Act Committee members		June 2014	September 2014	December 2014	March 2015
Paula May	Ward Sandalwood Court, AWP				
Leanne Hayward Joined meeting September 2014	Consultant Psychiatrist, Mental Health Liaison Team, AWP/GWH		√	√	√
Celia Moore	Manager for Mental Health Liaison Team – attended for Paula May	-	-	√	-
Jane Higgins for Joi Demery Jane left her post in Swindon	AMHP, Swindon Borough Council	x	--	-	-
Julie Dart	Mental Capacity Act Programme Manager Joint appointment with Swindon Borough Council and Swindon CCG, Adult Social Care	Apologies given	Apologies given	APOLOGIES GIVEN	Apologies given

The Mental Health Act and Mental Capacity Act Committee review the Trust's Mental Health Risk Register to ensure the needs and safety of patients with mental health issues are met. The Committee also receive a report of the Trust's applications for the authorisation of depriving a patient of their liberty under Deprivation of Liberty Safeguards.

Consultant Psychiatrist Post

A Consultant Psychiatrist has been recruited and commenced her role on the 1st May 2014 working in the Mental Health Liaison team which includes Adults and Working Age and Older People's Mental Health. The Consultant Psychiatrist is also Responsible Clinician for the Trust.

This post has made a good impact on the care of patients with mental health disorders ensuring a positive outcome for the patient's experience.

Application of the Mental Health Act (MHA) in the Trust

The Mental Health Act Administrator provides a three monthly report on the application of the Mental Health Act in the Trust. The report is considered by the Mental Health Act and Mental Capacity Act Committee at each meeting.

From 1st April 2014 – 31st March 2015 the Mental Health Act was used on **200** occasions in respect of **76** patients (these figures include those patients detained under Section 2 of the Mental Health Act to another Organisation and patients who have been issued with a patient information leaflet on detention).

TABLE - Use of the Mental Health Act at The Great Western Hospitals NHS Foundation Trust 1st April 2014 to 31st March 2015

Section	Type of Section	Number for use of the Mental Health Act
5(2)	Report on Hospital In-Patient	44
2	Compulsory Admission for Assessment	22
3	Compulsory Admission for Treatment	6
4	Emergency Admission for Assessment Section 4	0
17	Authorisation for Leave of Absence to GWH Section 17	27
19	Authority for Transfer from Hospital to Another Under Different Managers Section 19	16
23	Order of Discharge from Detention by Responsible Clinician Section 23	13
132	Record of Information Section 132	70
Other	Detained to Other Hospital under Section 2 of the Act whilst GWH inpatient	2
TOTAL	**Number of Patients**	**76**
TOTAL	**Use of the Mental Health Act including detained to other Hospital whilst GWH inpatient**	**200**

5.6 Membership

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.

Public members can only be a member of one constituency. Staff can only be members of 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.

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 come from 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

Staff Members

Staff members include Trust employees, Carillion Health employees and volunteers. The Trust has strong links with the local community, with over 500 volunteers. Volunteers 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 (i.e. Carillion Health) 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 professions, split into the following sub classes to reflect occupational areas: -

- Hospital Nursing and Therapy Staff
- Community Nursing and Therapy Staff
- Doctors and Dentists
- Administrators, Maintenance, Auxiliary and Volunteers

Membership analysis

During the year, the Trust again sought to increase membership numbers. As at 31 March 2015, the membership of the Great Western NHS Foundation Trust was as follows: -

Constituency	Member Count
Swindon	2854
North Wiltshire	1054
Central Wiltshire	398
Southern Wiltshire	42
West Berkshire and Oxfordshire	304
Gloucestershire and Bath and North East Somerset	235
Staff	6213
TOTAL	**11,100**

Public Constituency	2014/15	2015/16 (estimated based on 10% joining and 7.5% leaving)
At year start (1 April)	4751	4887
New Members	396	488
Members leaving	260	366
At year end (31 March)	4887	5009

Staff Constituency	2014/15	2015/16 (estimated – based on 20% leaving and joining)
At year start (1 April)	6,353	6213
New Members	1190	1242
Members leaving	1130	1242
At year end (31 March)	6213	6213

The estimates for 2015/16 public members are based on a prediction having regard to membership recruitment drives planned to take place in 2015/16 and an initiative to retain former staff as members, provided they meet the eligibility criteria.

The estimates for 2015/16 staff members are based on a prediction having regard to expected staff levels.

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

Age	Member Count
0-16	13
17-21	190
22+	4632
Unknown	52
Total	**4887**

Ethnicity	Member Count
White	3705
Mixed	26
Asian or Asian British	146
Black or Black British	53
Other	27
Unknown	930
Total	**4887**

Gender	Member Count
Male	2062
Female	2813
Unspecified	12
Total	**4887**

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 it 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.

Building a strong relationship with our members / engagement

It is the aim of the Trust to have a membership which will allow the Trust to develop 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 quarterly magazine Horizon and hosting members' briefings and events such as Public Lectures. The Trust's website provides regular updates and information on meetings and events. The Lead Governor writes a regular blog which aims to help people understand what happens in the Trust and also discusses topical national subjects. The Trust has a full time Governance Officer responsible for membership, to answer any questions from members or to provide additional information.

Examples of opportunities for engagement in 2014/15 include: -

- Public lectures
- Governor in local library
- Governors talking to members and the public at local community events
- Prospective candidate seminar
- Public and member attendance at Council of Governor Meetings
- Horizon pages

- Website link
- Mailings about upcoming events
- Governors were reminded to canvass the opinion of members and the public and for nominated governors, the organisations they represent on the Trust's forward plan, including its objectives, priorities and strategy and their views were communicated to the Board via a Governor Working Group held in May 2015, where an open discussion on proposals took place and governor comments were incorporated.

A fresh approach to member engagement was developed during 2014/15. A workshop with representatives from all Trust directorates was held in February 2014, with departments and service areas being asked to identify topics for engagement with members. Over 20 opportunities for engagement have been identified, such as finding out about what members feel about 7 day working and questionnaires have been drafted. Mailing to members have already been sent out regarding Undergraduate Pharmacy courses, posters to support the Brighter Future charity appeals, work experience as well as articles being published in the Horizon magazine.

Membership Strategy

To encourage membership, the Trust has in place a Membership Strategy which is reviewed annually to ensure that it reflects the needs of the members. The latest Membership Strategy focuses on three key areas:

- How the Trust hopes to engage and offer more to our existing members.
- The change in membership demographic due to the adoption of Wiltshire Community Health Services and the mechanisms the Trust will use to increase membership in the new territories.
- The changes to the Trust's Constitution in order for the Trust to be fully representative of the new areas it will serve.

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

Membership development in 2014/15

In order to build a representative membership during 2014/15 the Trust undertook the following: -

- The Governance Officer hosts monthly recruitment drives in the hospital atrium;
- The Governance Officer attended a Year 11 careers evening on 11 November 2014 in Swindon.
- The Governance Officer attended various Wiltshire Council public health events
- The Governance Officer attended the Swindon Indian Association's Holi Milan event.
- An Annual Members Meetings was held in September 2014
- A partnership has been formed with a number of sports teams in Wiltshire who are promoting Trust membership in their sports programmes and on their websites.
- Monthly health messages are being sent to various companies and councils to be distributed to their employees.

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. when in the library, at local parish council meetings and in doctor's surgeries.

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.

Membership application forms have also being trialled in discharge packs within the Great Western Hospital. .

Membership recruitment proposed for 2015/16

Engagement with existing forums
The Governance Officer will continue to engage with existing forums, such as Patient Participation Groups, 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
The Governance Officer is working to develop contacts with youth groups who are likely to be interested in the future of the hospital and is planning to engage with GCSE and A Level students, working alongside the Trust's Academy. The Governance Officer 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.

Horizon Newsletter
The Trust's quarterly magazine Horizon is sent to every member, either electronically or in the post. The newsletter contains dedicated membership pages, with a word from the Governors.

Public Lectures
A series of public lectures on a variety of topics from Breast Cancer to Diabetes are 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.

Information in Discharge Pack
The Trust will continue to include membership application forms in Discharge Packs following a successful trial period.

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.

5.7 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.

5.8 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 Workforce and Education should undertake a bench marking exercise. This was completed in Spring 2014.

E.1.6 – The Council of Governors, rather that the Board of Directors monitors how representative the NHS Foundation Trust's membership is and the level of effectiveness of member engagement, which is reported in the annual report. The Council of Governors has developed a membership strategy which focuses on recruitment and engagement and a Non-Executive Director is aligned to this working group reporting back to the Chairman. Furthermore, the minutes of the working group are received by the Council of Governors where non-executive directors attend and executive directors are invited to attend. The Trust therefore reflects the main principle of this Code of Governance provision.

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

6 QUALITY REPORTS

Part 1 - Statement on quality from the Chief Executive of the Great Western Hospitals NHS Foundation Trust

6.1 Statement on quality from the Chief Executive of the Great Western Hospitals NHS Foundation Trust

I am pleased to present our Quality Account for 2014/15. This is an honest account of recent improvements which affect the quality of care our patients experience and our priorities for the coming year.

Safety and quality is at the heart of everything we do. Our number one priority is to provide safe, high quality and effective care, offering the best possible experience and outcome for patients.

As you read about our progress over the last 12 months you will see there is much to be positive about. Every achievement is testament to our hardworking staff who put patients at the centre of every decision we make and everything we do.

Despite a challenging year financially, we have achieved some fantastic improvements in the quality of care we provide of which I am very proud.

We have seen a significant improvement in our mortality rates, meaning that more patients are surviving their illness than would be expected. To save more lives we are now focusing on making changes to how we treat conditions with typically high mortality rates. Notably, we have reduced the likelihood of dying from severe sepsis, with almost 80 per cent of patients now surviving, which is significantly better than the national average.

We've embraced the national Sign up to Safety pledges, to put safety first, continually learn, honesty, collaborate and support. Over the coming year we will be focusing on five areas to apply those principles and make a significant improvement to the quality of patient care. The areas we have identified are sepsis, falls prevention, rescue of deteriorating patients, acute kidney injury and pressure ulcer prevention. These are important priorities for us and you will find details of the work we are doing in each of these areas in our Quality Account.

I am delighted that our performance has been recognised nationally by CHKS, the country's leading provider of healthcare intelligence and quality improvement services, who nominated the Trust for the prestigious Patient Safety Award at their annual Top Hospital Awards. The award highlights outstanding performance from Trusts which have provided patients with a safe hospital environment.

I have seen first-hand some of the fantastic work which is taking place and recent feedback from the Friends and Family Test shows patients are noticing a difference, with the vast majority saying they would recommend our services.

I hope you enjoy reading about the progress we are making and our plans to further improve the quality of care for all of our patients.

Signed
Nerissa Vaughan
Chief Executive

27 May 2015

Quality of Care

At Great Western Hospitals NHS Foundation Trust we ensure the provision of safe, high quality, patient care is our number one priority.

We are passionate about getting things right and meeting the expectations of our patients and their families, for patients to have the right care at the right time in the right place provided by appropriately trained individuals. The Trust Board takes full responsibility for the quality of care and service provided to patients and fosters a culture that encourages people to take pride in their work. There are clear links to improved patient outcomes when there is consistent quality care.

Our aim is to set out clear quality improvement plans, building on current local and national quality improvement initiatives to meet quality and safety objectives and to provide the safest and most effective care to enhance the experiences of our patients.

Our Patient Quality Committee agrees the priorities that will help us improve the quality of care we provide to our patients. Some of the priorities agreed are important to our regulators and/or commissioners, all the priorities are discussed and agreed with our Council of Governors.

In March 2014 the Trust launched a Quality Strategy, which outlines the quality goals and ambitions the Trust aims to achieve. Our seven priorities for improvement are:

1. Delivering safe, effective care, delivering excellence
2. Leading the best patient experience
3. Releasing time to care
4. Visible inspirational leadership
5. Culture of innovation and embracing of continuous Quality Improvement
6. Measurement of essential quality standards, providing assurance of patient safety and clinical effectiveness
7. Staff will understand their contribution to the whole organisation

Going forward we will use the Quality Accounts to report against progress of the Quality Strategy, in addition to reporting against the Quality Accounts priorities.

The Great Western Hospitals NHS Foundation Trust provides acute hospital services (at the Great Western Hospital) and community health services across Wiltshire. Acute is generally defined as Inpatient beds within the Great Western Hospital site and Community is generally defined as Community inpatient beds and patients treated within their own homes.

Part 2 - Priorities for improvement and statements of assurance from the Board

6.2 Review of Priorities 2014/15

This section reflects on our priorities during 2014/2015 and whether we have achieved our goals. Where performance was below what we expected we explain what we are doing to improve in 2015/16

The areas identified for improvement during 2014/2015 were:

Safe Care

- Falls
- Pressure Ulcers
- Reduce Healthcare Infections
- To report zero Never Events
- Reduce Incidents and associated harm
- Patient Safety Thermometer, continue to Reduce:
    - Catheter Associated Urinary Tract Infections (CAUTIs)
    - Venous Thromboembolism (VTE)
- To reduce Medication Errors

Effective Care

- Hospital Standardised Mortality Ratios (HSMR)/Summary Hospital-level Mortality Indicator (SHMI)
- Early recognition of the deteriorating patient
- Dementia
- Safeguarding adults and children
- Review of patients who are being readmitted to hospital within 30 days of discharge
- Nutrition and hydration
- Stroke care
- Compliance NICE Publications

Patient Experience

- Implement a new Complaints System in April 2014
- National Inpatient Survey
- Staff Survey
- Equality and Diversity

SAFE CARE

Continue to Reduce Severe Harm Arising from Patient Falls

One of our priorities for 2014/2015 was to continue to support the highest risk wards in identifying learning from all reported falls incidents, not just those that result in requiring increased treatment due to a fall or actual permanent harm such as a fracture from a fall. (Moderate or severe harm)

The Trust Launched a Fall Safe Operational Group on 1st June 2014, which had a mandatory attendance of Ward Managers to further strengthen its importance.

This group's objectives were to reduce the number of falls in each individual ward, to put in place local falls reduction initiatives, and to learn from each other on what worked well on wards that experienced less falls. The group shared the learning from serious falls incident investigations, for instance, the identification of the root cause of each individual fall, including lessons learned and actions to prevent recurrence of similar causes.

Each month the five wards with the highest number of falls, presented their findings and learning at the Fall Safe Operational Group meeting. The highest wards also presented the number of patients with dementia who had fallen. The group discussed and supported these wards on what else could have been done to reduce the number of falls. This included sharing initiatives that were successfully trialled on other wards.

Examples of the ward based initiatives are:

- A local initiative trialled this year on the Trauma Unit was an After Action Review; this is where every fall was immediately looked at by the team and lessons learned were shared immediately to prevent the recurrence of a fall from similar causes
- Finishing tasks was tested on Jupiter Ward. This meant that staff stayed close by/with patients until they finished the task that they were carrying out with the patient, for example, when patients were assisted into the bathroom, the nurse was expected to stay outside and continued to reassure the patient that they were nearby and ready to assist when they were ready and if required
- Neptune Ward increased the frequency of monitoring patients (care rounding) at night, this is more frequent monitoring of patients who were at increased risk of falls, and ensured that they were assisted with their toileting/personal hygiene needs at regular intervals.
- We offered and assisted patients with their toileting needs at critical times, such as before going to bed at night, before meals, after visiting times and according to known individual patient's toileting patterns
- Use of red Zimmer Frames – A red Zimmer frame means that a patient was at risk of falls and needed assistance with their mobility. Therefore members of the Multi-Disciplinary Team would stop and assist those patients if they were seen to be moving independently

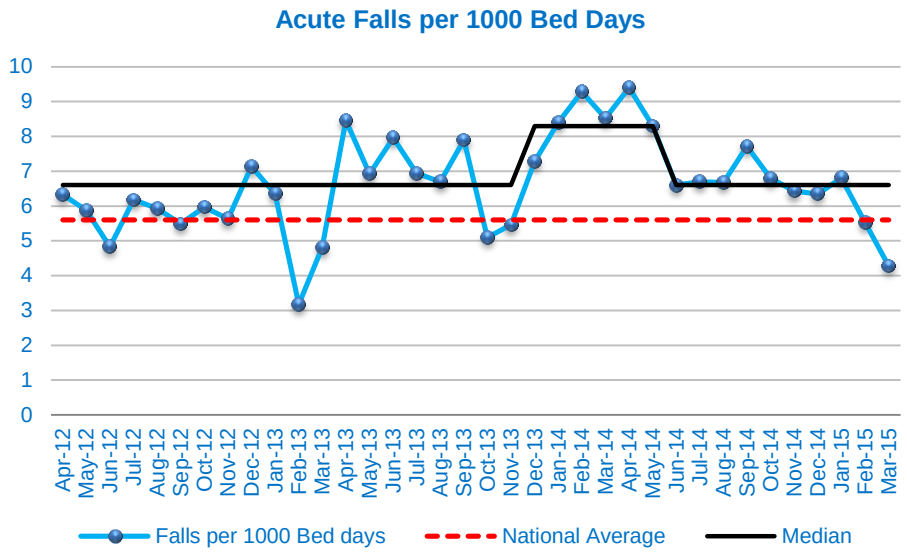
Another Trust wide initiative was to provide close support for patients deemed as very high risk of falls, particularly those with mental health, mental capacity concerns or acute confusion. Processes have been agreed to identify when additional staff are needed to provide close support.

Our Quality Improvement Plan for 2014/2015 was to be below (better than) the national average number of falls per 1000 occupied bed days, which is 5.6 for Acute and 8.6 for Community inpatients. This year's average was 7.3 for Acute and 10.6 for Community. The quality improvement plan has been driven by the newly formed Fall Safe Operational Group.

The Trust did not meet the national benchmarking standard of <5.6 falls per 1000 bed days, however, the Trust continues to strive towards reducing falls and harm resulting from a fall. Work has focussed

on transformational change via Sign up for Safety campaign and Falls Safe Operational group. The principles of the programme is to empower ward based staff to improve their standards of care, systems, process and team culture to continually reduce harm. The Falls Safe Operational group applies learning from literature and good practice from other Trusts. It should be noted the national average of 5.6 falls per 1000 beds days was set in 2009 by the National Patient Safety Association, given the ageing population and increase in dementia since this date it's unlikely this figure represents a realistic benchmark for acute Trusts.

Graph 1

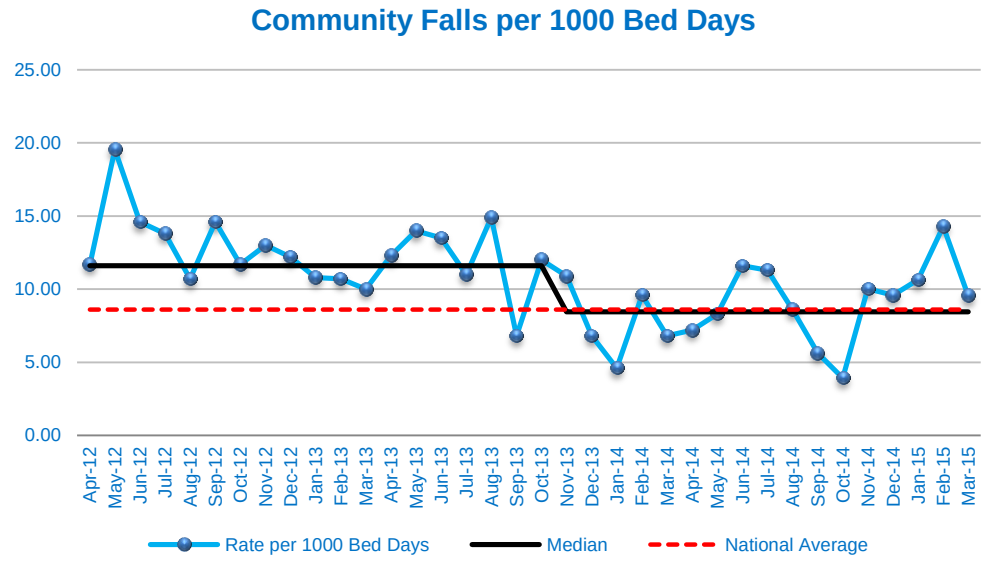


Graph 1 above shows the number of falls per 1000 bed days in the Acute hospital inpatient beds.

With the setup of the Fall Safe Operational Group on 1 June 2014 the number of falls per 1000 bed days within the Acute (GWH hospital inpatient beds) setting began to show a downward trend.

In March 2015, the Acute setting recorded 4.28 falls per 1000 bed days which is below a national average of 5.6 falls per 1000 bed days.
This achievement was mostly due to the Ward Managers working with their local teams in identifying root causes of falls incidents in their clinical areas and putting actions and processes in place to prevent recurrences.

Graph 2



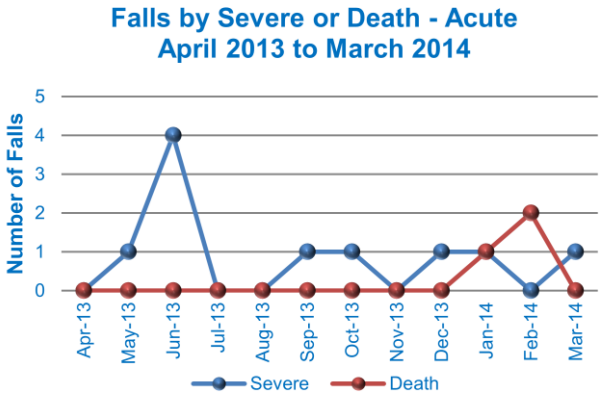
Graph 2 above shows the number of falls per 1000 bed days within the Community wards.

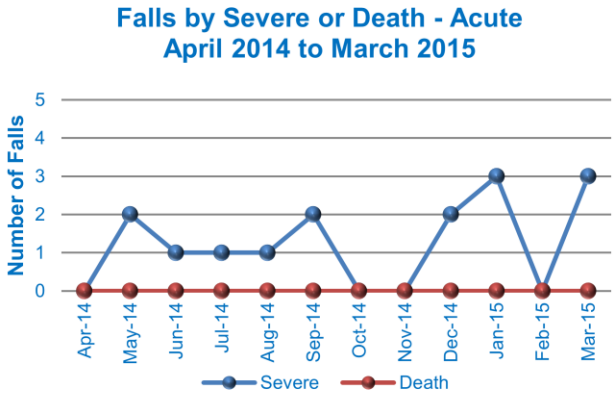
From April 2014 to March 2015, there were six months that the Community wards performed at or below the national average of 8.6 falls per 1000 bed days (April, May, June, August, September and October 2014). The other six months of the year, the Community wards performed above the national average.

The Community wards are also part of the Fall Safe Operational Group and we are working hard to support efforts to reduce the number of falls within the Community wards.

Reduce Severe Harm Arising from Patient Falls

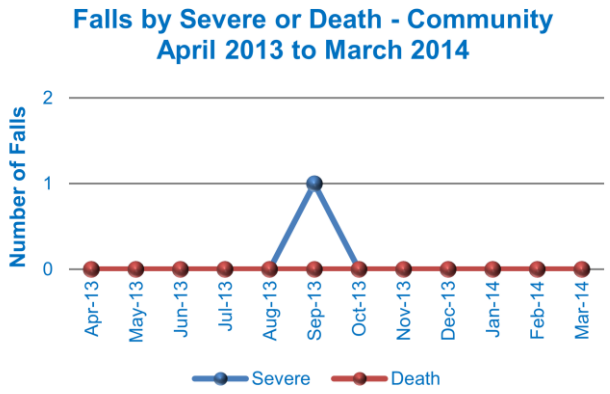
We are very keen to see a reduction in severe harm suffered by patients falling while in hospital across both the acute and community services.

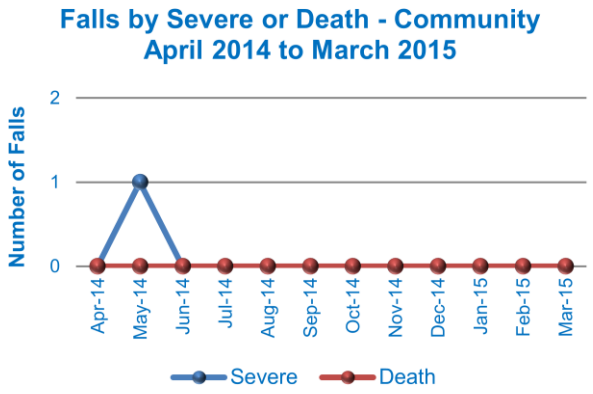




Though the number of falls per 1000 bed days within the Acute setting had significantly reduced for the year 2014/2015 as compared to year 2013/2014, the number of severe harm from falls has not seen the same reduction.

In 2013/2014, the Trust had 13 severe harm incidents including two deaths as a result of falls. There was a slight increase to 16 severe harm falls in the year 2014/2015 overall for Acute & Community. Though the number of severe harm from falls was slightly higher in 2014/2015, it is important to note that there were no deaths associated with falls within the Acute setting.





The Community saw less severe harm in both 2014/14 and 2014/215 as compared to the Acute setting. In 2013/2014, the Community wards had one fall which resulted in severe harm as well as in 2014/2015. There were no deaths associated with falls for either year.

Key Actions from serious incidents

- Continue with appropriate falls assessments within 4 hours of patient admission
- Appropriate frequency of care for patients at risk of falls
- Ward Managers continued working with their teams to identify times of the day that falls occur on their wards and to establish initiatives that they could put in place to reduce falls during those times.
- Use of close (individual) support where patients were at high risk of falls
- Appropriate use of low beds following SAFE assessments, as low beds are more appropriate and safer for those patients who are at risk of falling whilst getting into or out of bed

Our Priorities to further reduce falls in 2015/2016 are:

- Collaborative working roll out across all ward areas (involvement of the Multi-Disciplinary Team)
- Continue with Fall Safe Operational Group initiatives, which have contributed to the reduction of falls last year
- Use of close support for high risk patients
- Both Acute and Community falls per 1000 bed days to be at national average or better
- Review of care rounding tool to match the needs of patients at risk of falls
- Improvement in call bell answering times.

Continue to Reduce Healthcare Acquired Pressure Ulcers

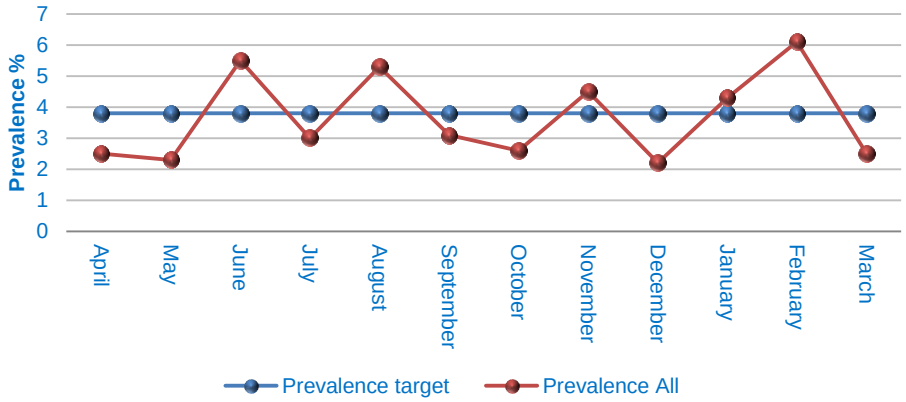
As an organisation we had two Commissioning for Quality and Innovation framework (CQUIN) targets for the reduction of healthcare acquired pressure ulcers:

The two CQUIN targets were:

1. NHS Swindon

The acute and community providers were required to develop a joint programme of delivering the 15% reduction in all old and newly acquired pressure ulcers within the system. To demonstrate an improvement we had to achieve a median of three consecutive monthly data points on the national 'Safety Thermometer' tool up to 31st December 2014.

Graph 1



Graph 1: To show the prevalence of pressure ulcers using the Safety thermometer data.

Safety Thermometer data includes all wards within the Acute Trust, Community Hospitals and the patients within the community (at home/care homes etc).

The Tissue Viability (TV) teams in both GWHFT and SEQOL worked closely on the following improvement plan:

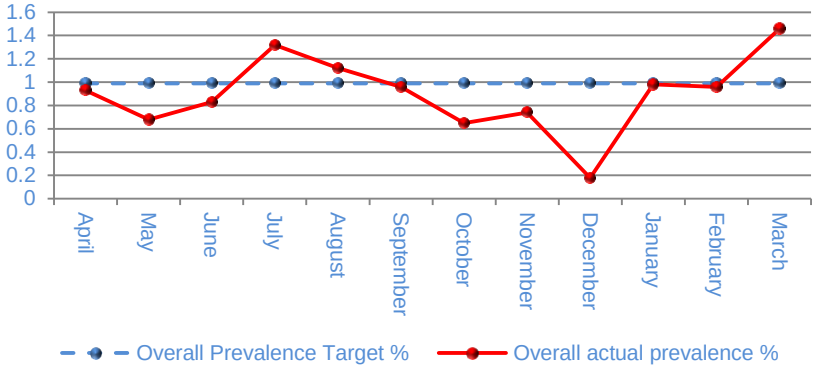
- Joint care pathway to ensure safe, timely and consistent referral to appropriate community service in Swindon for patients with complex wounds and Negative Pressure Wound Therapy.
- Raised awareness with all carers and patients across Swindon and Wiltshire communities with a Carers conference which was planned for May 2014 and involved Carer's charities offering support, education and advice.
- Developed a joint pressure ulcer investigation process with shared learning to include the investigation of any patient readmissions with a pressure Ulcer who had used both GWH and SEQOL services.
- To help reduce admissions to GWH of patients with pressure ulcers from Nursing Homes we took part in a joint 5 day Tissue Viability Course for nursing staff in Wiltshire and Swindon, which was run by the GWH TV team
- Pressure ulcer prevention education across GWH across acute and community services and available across SEQOL community services

2. NHS Wiltshire:

To reduce the prevalence of pressure ulcers, categories II, III and IV by 10% in the three consecutive months for October, November and December. This equated to a median prevalence of 0.99% across both acute and community services. For each month the total should not exceed

3.78 patients in the acute and 9 patients in the community service. This gave a monthly organisation total of 12.78 (13) patients and this was not a cumulative target.

Graph 2

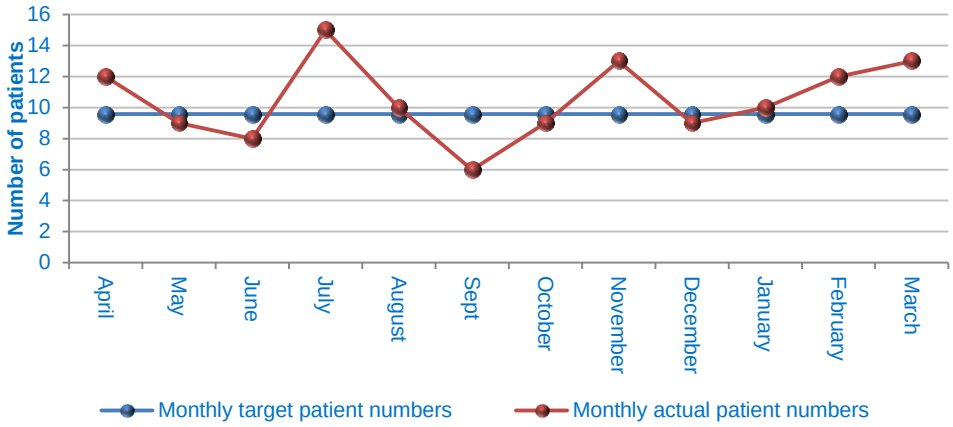


Graph 2: To show the prevalence of pressure ulcers using the Safety Thermometer data.

The target was achieved in October, November and December.

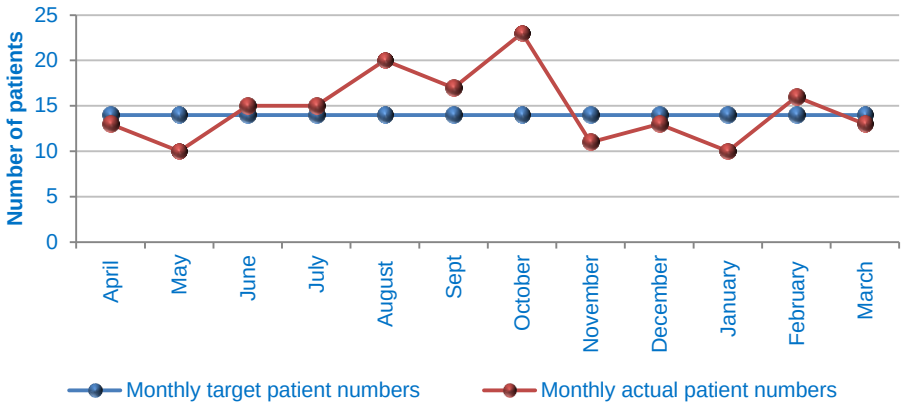
A further quality target was set by NHS Wiltshire to reduce the incidence of pressure ulcers by 10% across the organisation, the target was less than 286 patients who would go on to develop a pressure ulcer. This was divided up in the acute and community (ICHD) services with a target of less than 9.58 per calendar month in the acute wards and less than 14 in the community services.

Graph 3



Graph 3: The number of patients who developed a pressure ulcer per month in the acute wards.

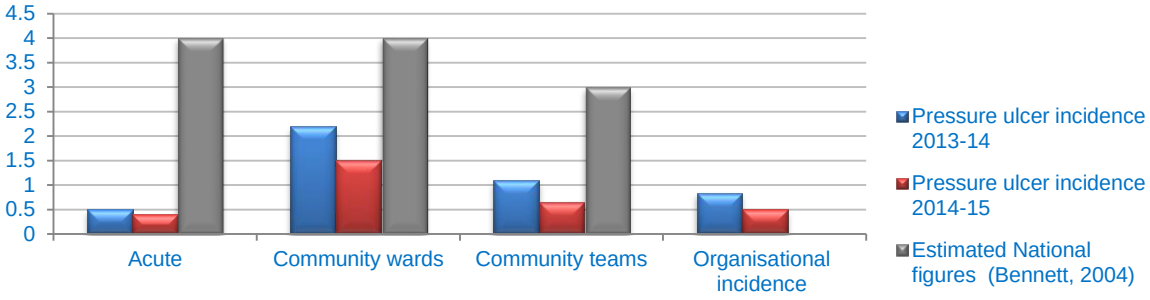
Graph 4



Graph 4: The number of patients who developed a pressure ulcer per month in the Integrated Community Health Division

However, the number of patients admitted in the organisation was significantly higher in the last year and there was a reduction in the percentage of patients who developed a health care acquired pressure ulcer from 0.84% to 0.5%, this means that 99.5% of patients who were admitted into the Trust did not develop a pressure ulcer and the incidence was lower than the estimated national average.

Chart



Organisational incidence is the overall combined figure for Acute & Community

The results show that as a Trust there were 51 Category III and Category IV pressure ulcers during 2014/2015 across both acute and community this gave a 0.5% incidence rate.

Priorities for 2015/2016 are:

The Tissue Viability Nurse Consultant (TVNC) is leading a Harm Free Care action plan to reduce pressure ulcers with 'Think Skin: Your Actions Relieve the Pressure'.

The actions include:

In-patient wards:

- Roll out of the Pressure Ulcer Risk Assessment Tool (PURAT), which is a new pressure ulcer prevention core care and wound documentation plan, is complete across the organisation and is being audited weekly by the TV team
- Provision of pressure relieving mattresses from point of entry (admission) within two hours of the risk assessment. This provision is being monitored with the Equipment Library Manager

- Completion of PURAT from all areas of admission including the Emergency Department
- Stepping down to a foam mattress for patients no longer requiring an air mattress in an attempt to use the equipment more effectively; this was linked to the 'Spring to Green' initiative and is being monitored with the Equipment Library Manager and audited by the Tissue Viability team in a new TV patient pathway audit
- Focus group for heel protectors took place on 30 March and a trial of new heel protectors is being organised for May 2015 on the wards with higher risk profiles.
- STOP, the pressure education programme will take place on 9 and 10 April in conjunction with the continence team, dietetics, medical photography and equipment library
- Cluster Root Cause Analysis investigations (RCA's) will commence from April 2015 for all hot spots
- Harm Free Care Collaborative is being planned with the Deputy Chief Nurse to work with the wards with higher risk profiles to establish why pressure ulcers are still occurring

For Integrated Community Head Division (ICHD):

- Embedding revised PURAT and wound documentation throughout ICHD. Measuring success of role of new documentation using the Tissue Viability Pathway audit. The first audit will take place during May 2015 across ICHD
- Focus group with Help to Live at Home care agencies is set up for 14 April 2015 to review the use of the SSKIN bundle tool across ICDH
- A cluster Root Cause Analysis will be carried out for the teams above with more than five pressure ulcers in one quarter
- Development of a comprehensive "Introduction to the community programme" with the aim for staff members to attend as soon as possible after start date. This will include training from experts from the clinical risk team, Tissue Viability etc., to set standards and expectations and support new team members
- The TV Lead to meet with the Therapy Lead to review the therapist input into patients at risk or with pressure ulceration
- Continue to work with patients who make their own choices with care, ensuring these are well informed choices.

Continue to Reduce Our Numbers of Healthcare Associated Infections

MRSA Bacteraemia

Reducing healthcare associated infection remains an important priority for us.

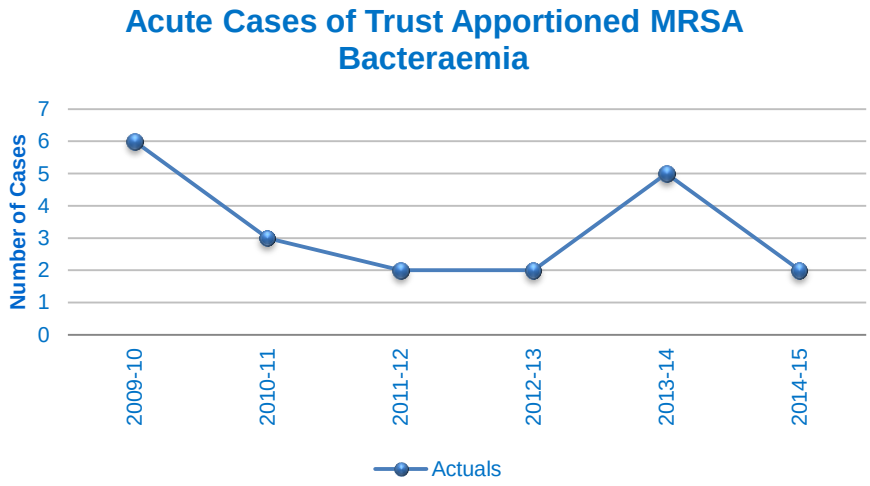
During 2014/2015 we reported two cases in total (both acute site attributable) against a national target of zero cases.

The Great Western Hospitals NHS Foundation Trust considers that this data is as described because it's mandatory for health Trusts to report all cases of blood stream infection caused by Meticillin resistant *Staphylococcus aureus* (MRSA) to Public Health England.

The Great Western Hospitals NHS Foundation Trust has taken the following actions to improve patient safety, and so the quality of its services, by implementing the following initiatives.

- Use of awareness poster for staff and enhanced training to improve communication for all members of staff at all levels.
- Management plans for patients with a history of a previous MRSA
- Clear focus on preventing any cross contamination between patients and families
- Working with our Occupational health team to support staff working in high risk areas
- Sepsis Six was implemented across the organisation. The programme provides early diagnosis and management of patients suffering from blood stream infections, and so far has saved 70 lives since the project started.

Graph



Clostridium difficile

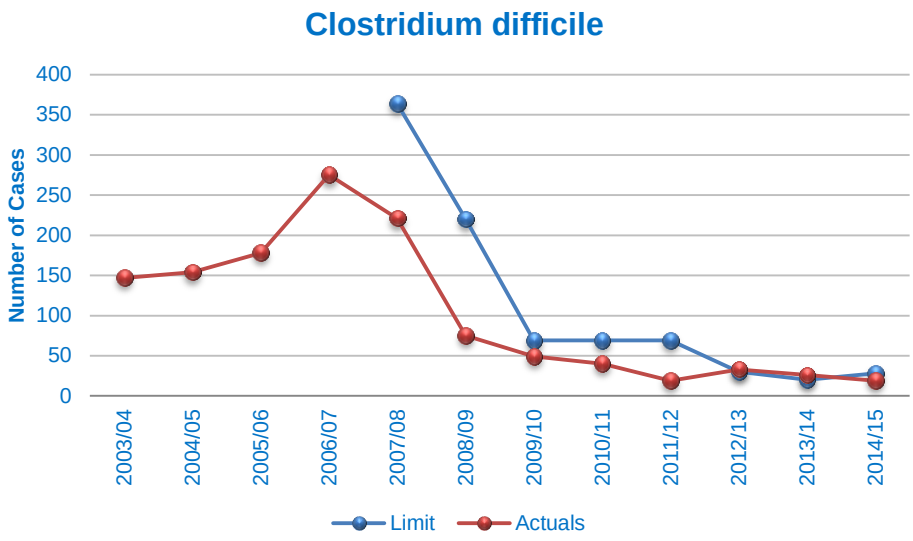
The Great Western Hospitals NHS Foundation Trust considers that this data is as described because as with MRSA above, in England it's mandatory for Trusts to report all cases of *Clostridium difficile (Cdiff)* to Public Health England.

The nationally mandated goal for 2014/2015 was to report no more than twenty eight cases of C.diff
We reported nineteen cases in total; seventeen *C.diff* infections were attributed to the Acute Hospital and two cases to the Community Hospitals. This was a great improvement for our patients.

The Great Western Hospitals NHS Foundation Trust has taken the following actions to improve patient safety, and so the quality of its services with the following local initiatives:

- Working with 'front door' services for prompt actions when patients attend with unexplained diarrhoea on admission.
- Ensuring our patients were 'isolated' within 2 hours of unexplained diarrhoea being reported
- We strive to achieve 100% for environmental cleaning, this remains a priority for 2015/2016
- We are trialling the use of hand hygiene/wipes for patients to use prior to meal, this will be rolled out trust wide during 2015/16
- We strived to improve antibiotic audit scores, which included adherence to antibiotic guidelines, recording the duration of the course and indication for their use; this improved in all areas, there were improvements still to be made and it is anticipated electronic prescribing will improve our work on this even further in 2015/16
- We fully implemented our cleaning strategy and also set up an environmental cleaning standards group. This group focused on ensuring consistency of cleanliness through the triangulation of housekeeping audits, matron inspections and ward audits, friends and family feedback and managerial audits.
- With our business partner, Carillion, we have developed an assurance framework for cleaning to meet National requirements and cross referenced all high risk rooms within lower risk departments, such as procedure rooms within outpatients departments. This was to ensure the cleaning was delivered at the correct frequency and audit expectations were set appropriately to capture this.

Graph



Priorities for 2015/2016

The focus for the coming year will be on the Clostridium difficile improvement plan, which focuses ward/department ownership of local cleaning standards. This includes patient care equipment and promoting antibiotic stewardship, all of which is specifically aimed at preventing avoidable cases of Clostridium difficile.

PATIENT SAFETY

Report Zero Never Events

Never Events are serious, largely preventable Patient Safety Incidents that should not occur if the available preventative measures have been put in place. The NHS England Never Event Framework 2012 includes 25 specific incidents that are considered to be 'Never Events'

Our aspiration for 2014/2015 was to report zero never events.

We reported a total of two never events between April 2014 to March 2015, a decrease from 4 reported during the same period in 2013/14.
They were:

- Wrong site surgery – reported in October 2014
- Retained foreign body – reported in March 2015

The incidents which have occurred have been investigated, reported and managed through the Trust Incident Management and Clinical Governance structures. Action plans have been developed, with implementation closely monitored by our Patient Quality Committee.

Final reports for the incidents were also shared with our Commissioners, the CQC and Monitor.

Our Priorities for 2015/2016 to reduce the risk of further 'never Events' are:

- As a direct result of these incidents a Trust wide review of the use of the WHO check list will be completed during the early part of 2015/16
- Ensure all recommended measures are in place to mitigate the risk of each of the 'Never Events' identified in the Revised Never Events Policy and Framework (March 2015).

Reduce Incidents and Associated Harm

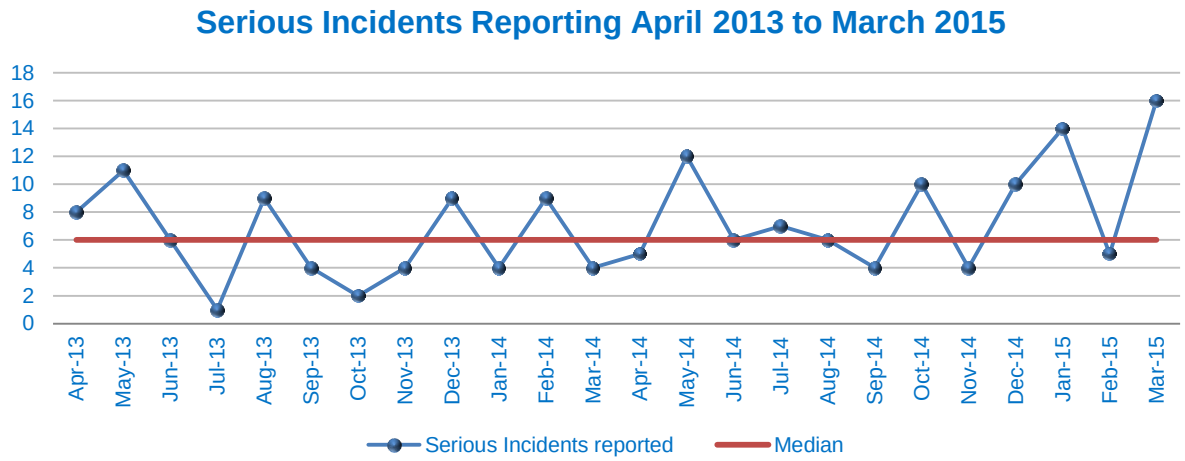
The Great Western Hospitals NHS Foundation Trust considers that this data is as described because:

- All incidents reported were reviewed on a daily basis by the Clinical Risk and Health and Safety Departments
- All patient safety incidents that were reported within the Trust were submitted to the National Reporting and Learning System, 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 Incident Reporting

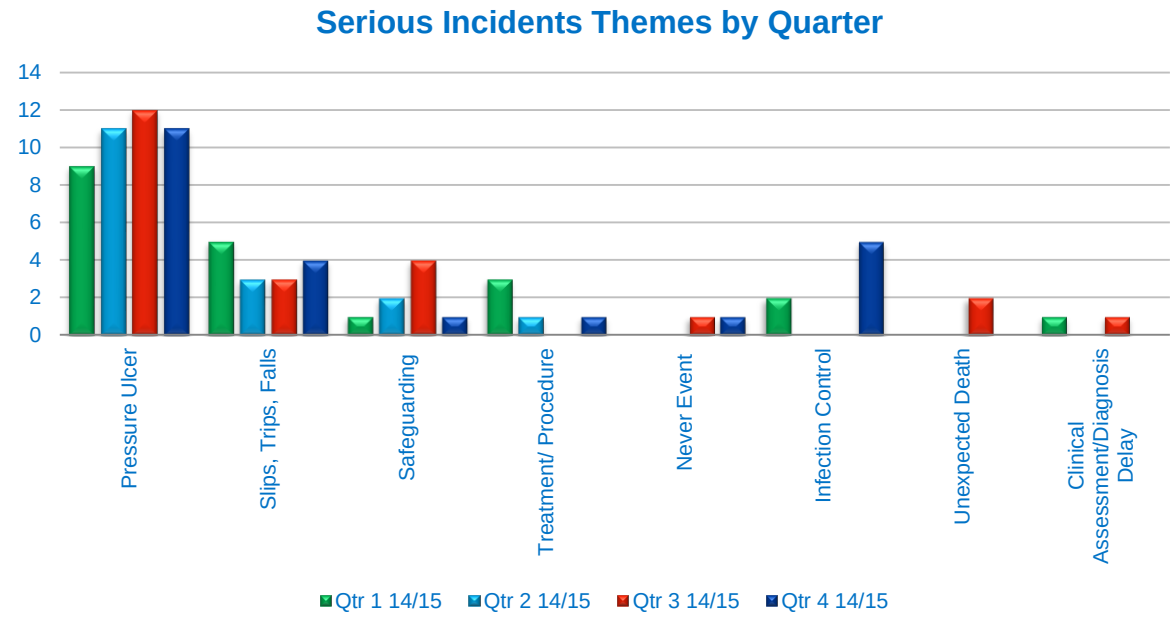
A total number of 99 serious incidents were reported and investigated during the period April 2014 to March 2015; an increase of 28 from 2013/14.The increase in serious incidents resulted in part due to enhanced reporting and an increased level of patients seen and treated across the Trust in 2014/2015.

Graph



Serious Incidents by type per Quarter 2014/2015

Graph



Review of 2014/2015

We have taken the following actions to improve patient safety, and so the quality of its services,

- Delivering a mechanism to measure the safety culture within the organisation (safety culture analysis/ culture barometer)
- To support the delivery of measurable improvement activities relating to the NHS Safety Thermometer Harm Free Care
- Support the delivery of the Quality Improvement Strategy

Priorities for 2015/2016

As an organisation we officially 'signed up' to the national campaign Sign up for Safety on 20th November 2014. Sign up for Safety is a national campaign that aims to make the NHS safer, building on the recommendations of the Berwick Advisory Group; Sign up for Safety has an ambition of halving avoidable harm in the NHS over the next three years and saving 6,000 lives.

Our priority during 2015/16 is to support clinical collaborative teams to progress quality improvement in these areas, demonstrating change in practice through the use of methodology and measurement and building capability and capacity in quality improvement for frontline clinicians and teams.

The NHS Safety Thermometer

This is a national initiative that records the presence of four harms on all patients on one day every month. The rationale for focusing on the four harms is because they are common and because clinical consensus is that they are largely preventable through appropriate patient care. Whilst all four harms are equally important we agreed as part of our indicators for the Quality Accounts to report in 2014/2015 on Catheter Associated Urinary Tract Infections (CAUTI) and Venous Thromboembolism, which are below. The other harms, falls and pressure ulcers have been reported as separate indicators.

Continue to Reduce Catheter Associated Urinary Tract Infections

Urinary tract infection (UTI) is the most common hospital acquired infection with many attributable to having a urinary catheter inserted. This can lead to delays in recovery and discharge home for some patients.

We have been working with the Oxford Academic Health Science Network to look at some benchmarking across organisations. We are aiming to raise standards across the organisation with the use of 'The High Impact Intervention Care Bundle tool'. Overall results of how well we are doing are reported through the Infection Control Committee and were used by the Trust CAUTI group to benchmark improvements as the project progressed.

We will continue to work with the Oxford Academic Health Science Network project throughout 2015/16.

Continue to Reduce Healthcare Acquired Venous Thromboembolism and that these Risks are Managed Appropriately

People who are unwell, frail and have reduced mobility are at increased risk of developing venous thromboembolism (VTE). This is the development of small blood clots in the veins, which can lead to serious complications such as a pulmonary embolism (blood clot in the lung) if part of the clot breaks off and travels downstream towards the heart. It is therefore very important that we assess patients to identify those at risk of developing a VTE and ensure that we provide the necessary care to prevent this complication occurring. An important VTE preventative measure is to ensure VTE prophylaxis (prevention medication) is given to those considered to be at risk.

VTE Risk Assessments

The Great Western Hospitals NHS Foundation Trust considers that this data is as described because data is collated from the electronic nursing care 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 weekly and information disseminated to all clinical areas so that any under performance is highlighted and able to be rectified.

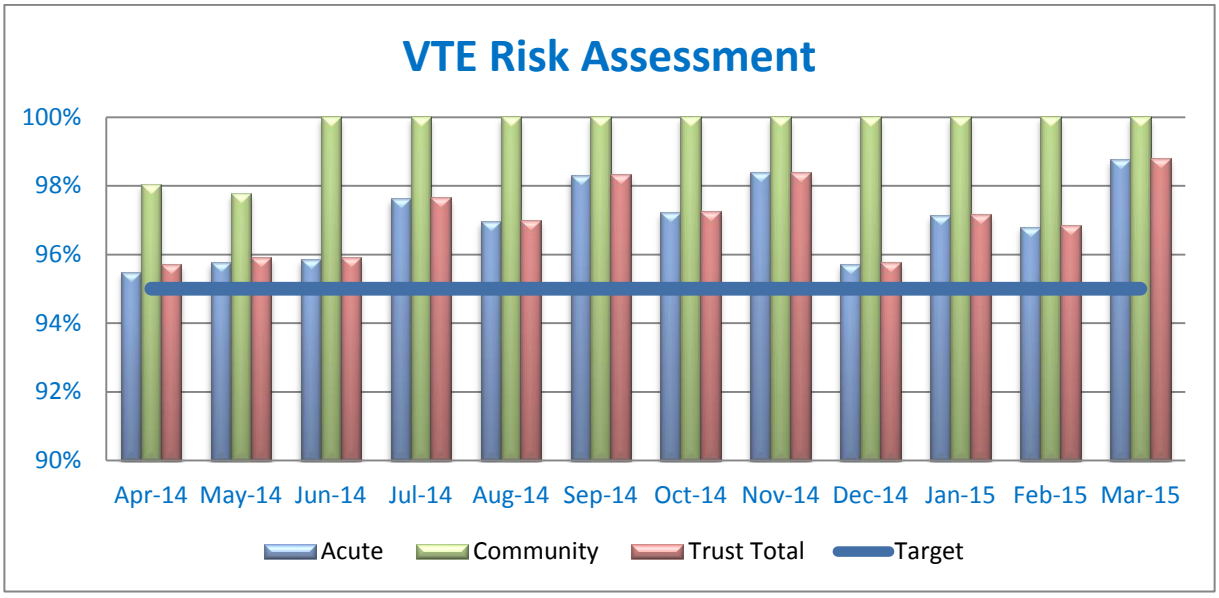
We have achieved the target set by the Department of Health of 95% across the whole year.

The Great Western Hospitals NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by:

- Continued education sessions at Trust Induction for both the acute and community settings
- Making VTE training available electronically on the Trust's intranet site
- Monitoring progress throughout the month ensuring that any performance concerns can be highlighted and action plans put in place
- Raising awareness with patients and relatives by means of information boards and displays
- We have also worked closely with our community partners in healthcare provision to introduce VTE risk assessments into the community for patients who are discharged home with VTE prophylaxis.

The chart below shows the total percentage of patients that have had a VTE risk assessment on admission to hospital for 2014/2015

Chart



Acute: Acute Inpatient beds
Community: Community Inpatient beds

Hospital Acquired Thrombosis

We also looked at the number of Hospital Acquired VTE events (HAT) which related to a thrombosis (either deep vein thrombosis or pulmonary embolism) that occurs within 90 days of a hospital admission. Data has been collected since 2010 and the number of VTE events has reduced by 10% in GWH Community.

Reduce Medication Errors

There are approximately 500,000 prescriptions written each year in the Trust, and around 2.5 million doses administered each year. Sometimes there are errors in the prescribing, supply or administration of these medicines, and although nationally it is estimated that 97% of these errors result in little or no harm, the Trust has clearly defined processes for reporting incidents and learning from any medicine incidents to reduce the risk of harm, or reoccurrence of the incident in the future. The main parts of this process are:

- Having a comprehensive medicine policy, medicine administration procedures and training about medicine usage
- investigation of, and learning from incidents, both locally and nationally
- audit of medicine usage to identify possible problems
- the use of new technology to minimise risk

The group within the Trust that focuses on medicines safety is the Medicines Governance Group. This is a Multi-Disciplinary group that has membership consisting of nurses, doctors, pharmacists. It met regularly during the year, and is the group where medicine safety issues were discussed. Although all reported medicine incidents were investigated at the time of their occurrence, the Medicines Governance Group reviewed any common themes or trends, and also reviewed any incidents which either had, or could have had a major risk of harm.

The development of a Medicines Safety Officer post was part of a national initiative to develop medicine safety by improving the reporting of incidents, and the communication of medicine safety messages within the organisation. The Trust has had a designated Medicine Safety Officer for the last two years, who is part of the national information sharing network. The Medicines Safety Officer role also ensured that there is a prompt response to national medicine alerts, and medicine recalls and hazards.

New Technology

The Trust began implementing an Electronic Prescribing and Medicine Administration (EPMA) system in which the paper medicine charts used for the prescribing and recording the administration of medicines on wards is replaced by an electronic system. This was a huge change to how medicines are used within the Trust, and the project, which started early in 2014, is expected to be in use on all the main wards at the Great Western Hospital by the end of June 2015. Many of the areas where medicine errors could occur will be resolved by this change, including unclear handwriting, ambiguous dosing, and unclear abbreviations.

Review of 2014/2015

During 2014/2015 there were 876 reported medicine incidents, which included all areas of the Trust. This included acute and community wards, community nursing, the prison. Of these incidents 870 were reported as causing either no harm or minor harm. Six incidents were categorised as moderate harm there were no reported incidents of severe harm or death

Priorities for 2015/2016

The main priorities for 2015/2016 in relation to medicine safety:-

- To ensure that the EPMA system is fully embedded in the prescribing and administration of medicines within the Trust
- To use the data that is available from the EPMA system to create a comprehensive program of medicine safety audits

- To fully participate in Regional and National Medicine Safety network activity, and to ensure that messages and processes that result in risk reduction in relation to medicines are fully implemented within the Trust
- To continue to learn from medicine safety incidents. The Trust does not want to see a reduction in the number of reports as the reporting of incidents is fundamental to improving medicine safety.
- To see a reduction in the number of incidents that cause harm, or significant risk of harm.

EFFECTIVE CARE

Preventing People from Dying Prematurely

Continue to Sustain our Hospital Standardised Mortality Ratio (HSMR)

The Hospital Standardised Mortality Rate (HSMR) is an external validated method of calculating and comparing mortality rates. This information is analysed and presented to all Trusts by Dr Foster. Dr Foster is 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.

Therefore 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.

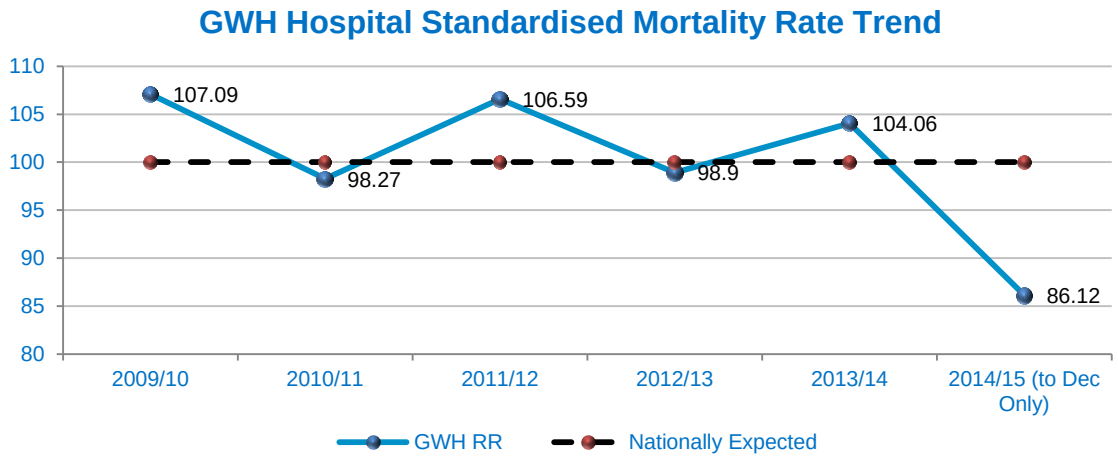
In 2014 the Trust set a target to reduce our mortality rates measured by HSMR (Hospital Standardised Mortality ratio) and to be one of the Trusts with the lowest HSMR value. We are ahead of our planned schedule in delivering this improvement. Our work has resulted in a reduction in the number of deaths and we now 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
- 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

The Graph below shows the year on year HSMR following rebasing. This shows a general improvement over time.

Graph



CQC Mortality Alerts

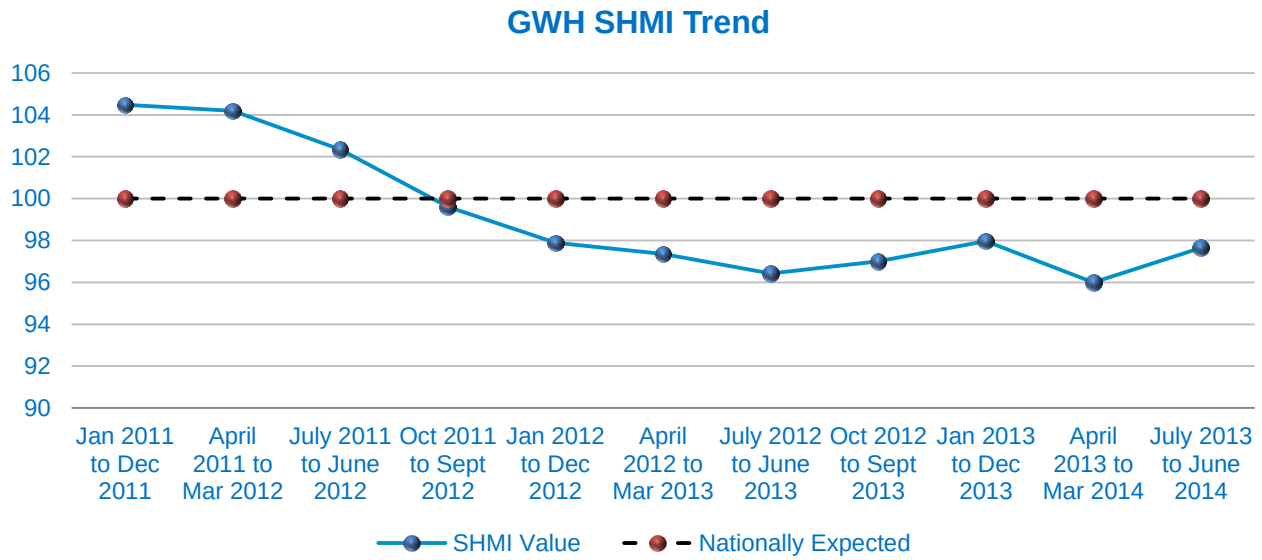
The CQC identified two mortality alerts for the Trust in 2014/2015 based on figures that suggested there may be an excess of deaths in two different categories. These were deaths due to myocardial infarction (heart attack) and deaths due to pathological fracture (a broken bone where the bone was weak to start with). As a Trust we therefore investigated both of these alerts by reviewing the care of patients who had died from these conditions. No avoidable deaths were identified in either category. Together with CQC we have continued to monitor mortality rates in these categories and there have been no further alerts. On-going monitoring shows improved mortality rates (HSMR) in these groups to lower than expected levels suggesting that the actions taken following investigation were effective. The CQC has notified us that they are satisfied that there is no longer a concern in these areas.

Standardised Hospital Mortality Indicator (SHMI)

We also monitor the SHMI performance and this is reported to the Trust Mortality Group. The indicator is produced by the Health and Social Care Information Centre. It is similar to HSMR but counts deaths both in hospital and those patients that die within 30 days post discharge from hospital. The Great Western Hospitals NHS Foundation Trust considers that this data is as described because SHMI is the ratio of observed number of deaths to the expected number of deaths by provider. The trend closely follows the Trust HSMR figures and is published with a longer time lag on a quarterly basis.

The graph below shows our latest published performance in rolling year periods. Our performance shows an improving trend with the rate being below the expected national average. Given its similarity to HSMR the SHMI performance is likely to continue to be below expected in the latter part of the year.

Graph



Priorities for 2015/2016

The Great Western Hospitals NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by:

- The 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
- The Trust has put plans in place to take a more proactive approach to reviewing the care of patients who die.
- The Trust also plans to feedback to clinical teams the lessons learned from mortality reviews to ensure that there is continuous improvement in the quality of care delivered to our patients
- For 2015/2016, the “Sign up to Safety” work programme, which we have joined, is targeting five key areas with the potential to improve mortality rates. These areas are sepsis, acute kidney injury, falls, pressure ulcers and recognition of deteriorating patients. Work streams are linked with the work of the Mortality Group and should contribute to further improvement in HSMR and SHMI values.

Early Recognition of the Deteriorating Patient (SOS/NEWS for Adults and PEWS for Paediatrics)

Early identification of the deteriorating patients and patients whose condition may be worsening plus early escalation of care and appropriate treatment is vital to ensure good outcomes for patients.

Currently for adults we use a ‘tool’ called the Swindon Outreach Scoring System (SOS); an early warning scoring system, to help members of the multidisciplinary team to identify deteriorating patients. The SOS system has been used throughout all our adult inpatient areas. Within our ‘front door services’ (the emergency department and acute assessment wards) we use a different scoring system, the ‘National Early Warning Scoring system’ (NEWS), which is more appropriate to these acute areas. The Patient Quality Committee recommended that one system should be used across the Trust, and a system that is recognised nationally. Therefore we are changing our early warning scoring system to NEWS for all our clinical areas.

For the children we care for we will be using the national 'Paediatric Early Warning Scoring System' (PEWS). The triage process in our new purpose built Children's Emergency Department will include the new PEW score to improve the early intervention and recognition of the sick child.

Continue to Enhance the Quality of Life for Patients with Dementia

Our Dementia Strategy focuses on six key priorities as shown below. Delivery of the key objectives is overseen by the Dementia Strategy Group. Since the new Clinical Lead for Dementia came to post in July 2014, the Dementia Strategy Group has increased the frequency of meetings; the full committee now meets every two months. In addition, the Dementia Strategy Group has a lead person for each of the six key priorities; these work stream leads meet every two months. A huge amount of progress has been made with regards to our dementia priorities in 2014.

1. Raising Awareness

We held Dementia Champion Forums in April and October and these were well attended. Work took place to increase the number of attendees, to maintain momentum and effect change at ward level. A 'reasonable adjustments' alert has been created on the hospital Medway computer system, which alerts staff to an individual's specific requirements. This allowed the delivery of personalised care for patients with dementia.

A recent audit into the use of specific dementia tools 'This is Me' document and Forget-Me-Not Flowers (both advocated by the Alzheimer's Society) highlighted areas for improvement in their use and the actions from this audit continue to be implemented throughout 2015.

2. Education & Training

We provide dementia training to all hospital staff in accordance with Health Education England's requirements. A dedicated Dementia Training Lead coordinated and implemented this extensive training programme. The new SCOPE course, which was introduced in 2014, included advanced dementia care training on topics such as challenging behaviours, delirium and appropriate environments.

3. Dementia Friendly Environments

GWH opened the first dementia friendly ward in November 2014 after a £98,000 refurbishment project, which was funded by a grant from the Brighter Futures Charity. This specialist ward enables patients with dementia to be cared for in an environment which supports their complex needs and improves their hospital experience. A programme to introduce meaningful activities for inpatients with dementia is underway e.g., music therapy and sociable meal times.

We continue to work in close partnership with Carillion, our private sector partner and estates manager, to ensure that routine updates to hospital fixtures and fittings are carried out in accordance with The King's Fund dementia friendly principles.

4. Dementia Care Pathway

A key priority for 2015 is the development of a whole hospital pathway for patients with dementia from admission to discharge. The aim was to dovetail this work within the acute trust with the community dementia services to ensure continuity of care for patients with dementia between the hospital and community settings.

5. Valuing Carers

The GWH Dementia Strategy Group continues to work in close collaboration with the Trust's Carers Committee to improve support for carers of people with dementia. The Dementia Strategy Group has carer representation within the attendees. A new carer feedback survey was introduced to ensure that we understand the needs of those who care for individuals with

dementia so that we can support them in the most appropriate way. Our new OWLS (Outpatient Welcome & Liaison Service) helps people with dementia and their carers to navigate their outpatient appointments with greater ease.

6. **Benchmarking Services**
   GWH continues to ensure that all our dementia services and work adhere to national and regional standards and recommendations. We are due to participate in the National Dementia Audit in 2016.

Safeguarding for Adults & Children

Safeguarding Adults at Risk

During 2014/2015 we have further strengthened our Safeguarding Team to ensure the greater well-being and safety of our patients through Safeguarding procedures.

The recruitment of a Safeguarding Adults at Risk Lead for the Acute Services in January 2015 has enabled the Safeguarding Adults Team to support both the Integrated Community Health Directorate (ICHD) and the Acute Services in awareness raising and supporting the raising of multi-agency safeguarding adults referrals. The Safeguarding Adults Leads provide training at Day 1 of the Trust Induction programme, bespoke training to staff/areas and undertake quality assurance on incidents raised with relevant feedback as required.

Neglect is the highest alerted category of harm reported by the Trust during the year with Physical, Financial, Psychological and Emotional being the next highest reported categories.

Safeguarding Children

We take the safeguarding of children very seriously; we have a dedicated Safeguarding Children Team who provides training, advice and support to all services both in the hospitals and across the community. We have continued to work in partnership with Local Authorities to safeguard children. Each Local Authority has its own Local Safeguarding Children's Board (LSCB) made up of nominated Lead Officers from key organisations and GWH had senior representation on Swindon and Wiltshire LSCBs. We also have a statutory duty under Section 11 of the Children's Act 2004 to protect children from harm as part of the wider work of safeguarding and promoting their welfare.

This means we work in partnership with other agencies to: protect children; identify health and development needs early to ensure the right level of support to safeguard children and young people; ensure children grow up in circumstances consistent with provision of safe and effective care; and ensure processes are in place to learn from events.

We aimed to fulfil our commitment to safeguarding and promoting the welfare of children by:

- Ensuring there was Senior Management commitment
- Ensuring there were clear lines of accountability and structures
- Supporting a culture that enables safeguarding issues and promotion of children's welfare to be addressed and ensuring that accurate records are made
- Ensuring staff receive adequate training to safeguard children

Review of 2014/2015

The following priorities for safeguarding children were identified in the 2014/2015 work plan:

- Improve staff access to safeguarding children training

- Ensure support and safeguarding supervision is in place for staff that have a particular responsibility to safeguard children
- Ensure a robust audit programme is in place to oversee safeguarding practice and learning

Progress was achieved in all 3 of these priority areas.

- The organisational Safeguarding Children & Young People Training Strategy was reviewed to ensure that the organisation fully met the requirements of the "Intercollegiate Document: 'Safeguarding Children & Young People: Roles and Competencies for Health Care Staff. Intercollegiate Document' published in March 2014. The review identified that a substantial cohort of staff (1,400), particularly within the acute setting, needed Level 3 training and these staff would have previously only accessed Level 2 training. A realistic work plan was developed to reflect how the Organisation will achieve the necessary compliance over 2015-16.
- The Trust supervision policy was reviewed and a supervision model developed to ensure that staff working with children had access to a framework of support and supervision. A model of group and individual supervision is now embedding within community services. Training for supervisors within acute services is completed and supervision was in the process of being implemented.
- The organisational safeguarding audit programme was implemented for 2014-15 and included an audit of social care referrals, safeguarding supervision and understanding and knowledge of escalation policy.

Priorities for 2015/2016

- Ensure that compliance for level 1, 2 and 3 safeguarding training increases to 90%.
- Embed safeguarding supervision model across the Trust.
- Develop a robust safeguarding children performance dashboard across Trust and monitor at safeguarding forum.

Learning Disabilities

Access to Healthcare for people with a Learning Disability

This was a new target for 2014/15 and was mandated by Monitor, for Foundation Trust regulation, for completion from quarter 3, 2014. The target relates to six indicators six criteria for meeting the needs of people with a learning disability, based on recommendations set out in 'Healthcare for all' (DH, 2008). The following targets have been met:

- Does the NHS foundation trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients?
- Does the NHS foundation trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities?
- Does the NHS foundation trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff?
- Does the NHS foundation trust have protocols in place to encourage representation of people with learning disabilities and their family carers?

The following targets are partially achieved.

- Does the NHS foundation trust provide readily available and comprehensible information to patients with learning disabilities about the following criteria:
    - treatment options
    - complaints procedures
    - appointments

The Trust will be fully compliant with these standards by quarter 1, 2015/16.

- Does the NHS foundation trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports?

The Trust has protocols in place and will be publishing reports publically via Trust Board annually from quarter 1 in 2015/16**.**

Review of Patients who are being re-admitted to Hospital within 28/30 Days of Discharge

We carry out audits on patient re-admissions to highlight any gaps in care for patients who have been readmitted within 28 and 30 days respectively to find out if there was anything that we could have done better to prevent patients being re-admitted, especially if their re-admission is related to their previous condition.

The Great Western Hospitals NHS Foundation Trust considers that this data is as described as we have undertaken a review of all patients (74 in total) over the age of 18 who had an emergency admission with a discharge date during two specific time periods in the year and who subsequently had an emergency readmission within 28 days.

- Pneumonia acquired whilst in the Community was highlighted as the most common initial diagnosis. Overall 86% of patients had multiple illnesses. The patients' length of stay (LOS) varied from less than 24 hours to 59 days with an average of seven days per admission.

- Most of the patients were readmitted having attended the Emergency Department (ED) and in 50% the re-admitting diagnosis was the same as that for the original admission.

- The readmission LOS averaged six days. Many of the patients had repeated readmissions with nineteen patients having more than four admissions within the previous six months, a proportion of these readmissions were for mental health concerns.

- Overall 63% of the readmissions were felt to be unavoidable; 18% may have been prevented by actions in secondary care, 10% by actions in the community and 9% would have required a combination of acute and community actions to prevent their re-admission.

The actions that might have prevented re-admission within the secondary care sector included:

- Arranging for bloods to be rechecked and acted upon in a timely fashion;
- Better communication with primary care;
- Ensuring an advanced care plan in place;
- Ensuring mental health and/or an alcohol liaison review was in place prior to discharge.

The community actions that might have prevented readmission included:

- GP review,
- Community nurse review
- Mental health input.

The Great Western Hospitals NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services by putting in place a process/plan to highlight the issues identified, educate medical and nursing staff on strategies to reduce readmissions and re-audit to measure progress.

30 Day Readmission Comparative Data 2014/2015

	Apr 14	May 14	June 14	July 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	March 15
Emergency Re-admission within 30 days of discharge	7.8%	8.0%	9.8%	9.6%	9.8%	10.2%	9.8%	9.1	8.9%	8.9%	9.5%	10%

28 Day Readmission Comparative Data 2014/2015

Month of Original Discharge	Total Spells			Crude Re-Admission Numbers			Crude Re-Admissions Percentage		
	0-15yrs	16yrs+	Total	0-15yrs	16yrs+	Total	0-15yrs	16yrs+	Total
Apr 13	782	5612	6394	58	422	480	7.4%	7.5%	7.5%
May 13	632	5740	6372	42	475	517	6.6%	8.3%	8.1%
Jun 13	644	5493	6137	50	440	490	7.8%	8.0%	8.0%
Jul 13	667	5830	6497	37	454	491	5.5%	7.8%	7.6%
Aug 13	634	5652	6286	52	478	530	8.2%	8.5%	8.4%
Sep 13	701	5666	6367	61	442	503	8.7%	7.8%	7.9%
Oct 13	804	6164	6968	48	461	509	6.0%	7.5%	7.3%
Nov 13	727	5827	6554	55	445	500	7.6%	7.6%	7.6%
Dec 13	771	5671	6442	74	411	485	9.6%	7.2%	7.5%
Jan 14	748	6215	6963	77	460	537	10.3%	7.4%	7.7%
Feb 14	618	5443	6061	70	364	434	11.3%	6.7%	7.2%
Mar 14	690	5776	6466	68	423	491	9.9%	7.3%	7.6%
Year 2013/14	**8418**	**69089**	**77507**	**692**	**5275**	**5967**	**8.2%**	**7.6%**	**7.7%**
Apr 14	706	5794	6500	50	451	501	7.1%	7.8%	7.7%
May 14	865	6136	7001	53	493	546	6.1%	8.0%	7.8%
Jun 14	680	5608	6288	62	530	592	9.1%	9.5%	9.4%
Jul 14	685	6120	6805	49	583	632	7.2%	9.5%	9.3%
Aug 14	566	5553	6119	39	550	589	6.9%	9.9%	9.6%
Sep 14	728	5897	6625	62	605	667	8.5%	10.3%	10.1%
Oct 14	707	6021	6728	66	579	645	9.3%	9.6%	9.6%
Nov 14	715	5374	6089	65	481	546	9.1%	9.0%	9.0%
Dec 14	877	5398	6275	76	505	581	8.7%	9.4%	9.3%
Jan 15	698	5385	6083	72	454	526	10.3%	8.4%	8.6%
Feb 15	699	4868	5567	74	447	521	10.6%	9.2%	9.4%
Mar 15	692	5642	6334	67	550	617	9.7%	9.7%	9.7%
Year 2014/15	**8618**	**67796**	**76414**	**735**	**6228**	**6963**	**8.5%**	**9.2%**	**9.1%**

Helping People to Recover from Episodes of Illness or Following Injury

Nutrition & Hydration

All in-patients must be screened for nutritional risk on admission to hospital using an approved and validated tool. We use the Malnutrition Universal Screening Tool ("MUST") which is the most commonly used nutritional screening tool in England and recommended by a number of national bodies. Exclusions to this include those who are under 18 years, at the end of life or within maternity.

Since we started using a tool to screen for malnutrition in 2010 the amount of screening performed has increased from 33% and has been maintained at about 81%. On-going audits and screening reviews have shown the prevalence of malnutrition at GWH is 39% which is similar to national figures. These patients are found to be at risk on admission to hospital so this means factors affecting nutritional status are largely occurring in the community. A screening programme using "MUST" and pathway was introduced across Wiltshire & Swindon focussing initially on community hospitals community teams and care homes

Progress and areas for improvement have been captured in the Nutrition & Hydration Steering Group annual work plan/strategy and will be used as a basis for quality and service improvements.

Review of 2014-2015

- Improving (or maintaining) compliance with and accuracy of the "MUST", nutrition care plans and documentation of fluid balance
- Streamlining admission documentation: "MUST" is only one of a number of screening and assessment tools ward staff are required to complete on admission and a new admission document combining these is being piloted to help to streamline their workload. This should help to improve compliance and accuracy of "MUST".
- Improving in-patients meal-times experience including meals quality, appropriate choice and assistance with meals as required. This includes observational "audits" of meal times with feedback to ward manager and matrons in relation to the protected meal time standards by the dietetic assistant.
- Mandatory training for ward and other key staff now includes Nutrition, Food Hygiene and Hydration

Stroke Care

The National Stroke Strategy was published in 2007, outlining best practice standards for stroke care in hospitals and the community for rehabilitation; we are audited by the Sentinal Stroke National Audit Programme [SSNAP].

A specialist stroke unit was established on Falcon Ward in 2009 with stroke specialist nurses and therapists [provided by SEQOL, an external organisation]. Partnership working with commissioners and other service providers has been established to develop pathways of care for these patients and their carers'.

The British Association of Stroke Physicians states that *"All stroke patients benefit from immediate admission to a Stroke Unit. The target is > 90% of patients with stroke to be admitted directly to the Stroke Unit from the ED or home, and to spend 90% of their length of stay in specialist stroke bed. Patients are to be admitted to the Stroke Unit within 4 hours of hospital arrival."* The demands and pressures on the Emergency Department have meant this has been difficult to achieve, but wherever possible and appropriate Stroke patients have taken a priority with recent performance being an

average of 72.8% of patients going direct to our stroke care ward, Falcon. The percentage average achieved is not as hoped and a reflection of inpatient pressures and demands for beds. Improvement of this performance continues to be a top priority.

The challenges for the future are to create a 7 day therapy service, which includes a clinical psychologist.

Continue to Monitor and Maintain NICE Compliance

The National Institute for Health and Care Excellence (NICE) provides national guidance and recommendations which healthcare organisations are expected to follow. This means there is an agreed standard of health and social care which is required to be given to patients and service users, to improve their treatment, recovery and overall experience.

Every month, NICE publish their guidelines for healthcare organisation to assess and/or put into place. Since 1 April 2014, we have received 117 published NICE guidelines; all of which have been sent to the relevant clinical leads and divisions to check against their current practice.

To date, 39 out of the 117 guidelines have been deemed not applicable to the organisation, and full compliance has been confirmed with at least 36 guidelines. Of the recent publications, a response is awaited for 20 guidelines; and a further 15 are in the process of being reviewed to check prescribing protocols, pathways or where funding is to be confirmed. There are action plans currently being implemented or are in the process of being formulated for the remaining 7 guidelines

We have maintained a compliance rate of 98.6%, and this is based on the initial assessment of all relevant guidelines.

PATIENT EXPERIENCE

Friends & Family Test

The Great Western Hospitals NHS Foundation Trust considers that this data is as described because the Friends and Family Test is commissioned nationally by NHS England. All providers of NHS-funded services are required to offer the Friends and Family Test (FFT) to their patients.

We first introduced FFT in early 2013 in our acute inpatient services, A&E and our maternity services in line with the national timetable. In October 2014, it was extended into our outpatient services and the day case services, and then in January 2015 we completed the roll-out to include community services.

The Friends and Family Test was also part of our Commissioning for Quality and Innovation (CQUIN) framework that aims to secure improvements in the quality of services and better outcomes for patients

The wealth of patient information received from this source is invaluable for improving services and quality of care to our patients. With the introduction of Friends and Family Champions throughout the Trust towards the end of this financial year, Friends and Family has received a refreshed approach into the collection of patient feedback. It has been encouraging to see the positive feedback about the services we strive to provide and we have met our targets, which we set out at the beginning of this financial year. We will continue with this approach and hope to make further improvements using the patient feedback we receive.

We have maintained a standard of 4.72 - 4.8 stars out of 5 throughout the whole year which reflects how well our patients and users rate the services we provide

The Great Western Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage and so the quality of its services, as follows:

- To continue to promote Friends and Family Champions throughout the Trust.
- To display “you said; we did” feedback in all of our areas throughout GWH and Community Sites.
- To look at other methods of collection of Friends and Family comments for Outpatients and the Emergency Department areas.
- To fully engage and collate comments from Children and Young on their overall Patient Experience.

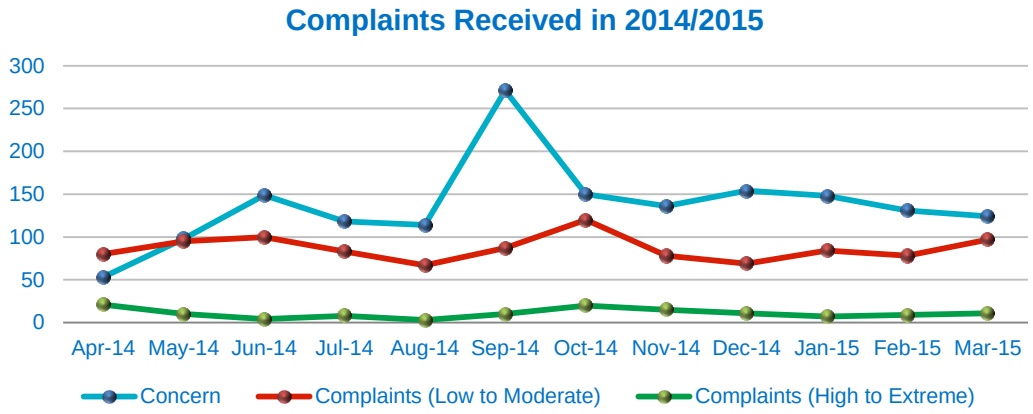
During 2014/2015 a total of 6380 comments were received through the Friends and Family Test from Acute and Community Inpatients against a total of 20852 total discharges. There were also 8450 comments received from the Emergency Department against a total of 41901 patients who were seen and discharged the same day.

Improving Patient Experience & Reducing Complaints

Improving Patient Experience is a key priority for us; we have robust methods of collating Patient Feedback and want to build on this throughout 2015/2016. 'Listening to Patients' and understanding their concerns is very important to us and we have held two "Listening Events" throughout 2014/2015 in Swindon and Devizes. We plan throughout 2015/2016 to hold further events and look to introduce additional Patient Participation Groups.
We want to improve on patient information provided so we are reviewing all the information we currently use with our aim to have all documents produced and published in a Plain English format throughout 2015/2016.

Throughout the year we have made changes to the way that we respond to complaints, the majority of comments made are answered within 24/48 working hours as a concern rather than escalating through the complaints process. The graph below gives a comparison on concerns/complaints received for 2013/2014 and 2014/2015.

Graph



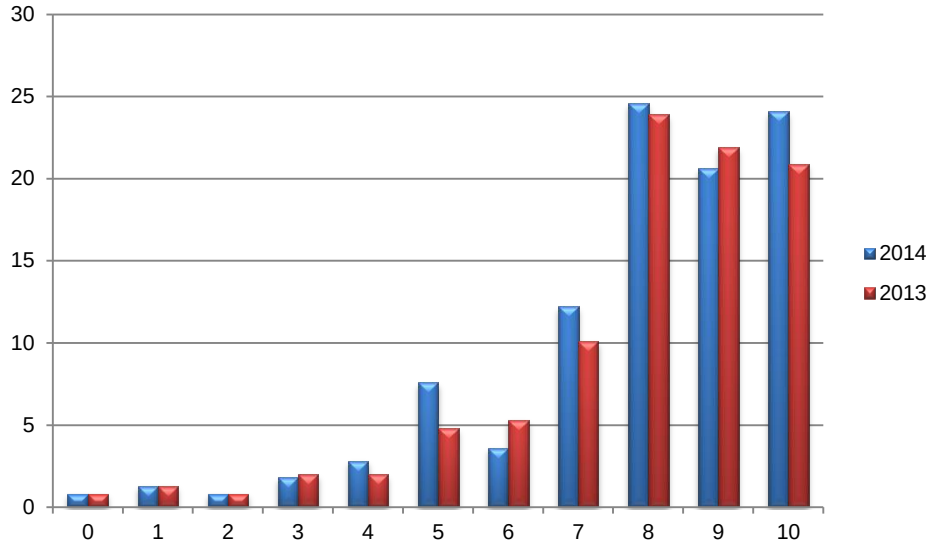
Further changes include:

- Improving response times to complaints.
- Ensuring that learning and changes to services take place.
- A service available to all which offers support and guidance to patients.

National Inpatient Survey

The National Inpatient Survey was carried out in quarter three of 2014 by the Picker Institute. The chart below shows the year on year comparison of how those who took part in the survey rated the quality of the care they received.

Chart - National Inpatient Survey, question H2 - (Please rate your experience on a scale of 0 – 10)



The chart above shows that, overall, patients have continued to rate their experiences highly with ten being the highest rating.

This Patient Experience rate also reflects in our Friends and Family score which remain at 4.7 stars out of a possible 5 stars at the end of 2014/2015.

The Great Western Hospitals NHS Foundation Trust considers that this data is as described because it is a reliable, externally validated measure reflecting the experience of our patients, it is objective and provides an annual snapshot telling us how we are doing from our patients perspectives and where we have improved and where we need to focus further improvements.

Question	Target	2012/13 %	2013/14 %	2014/2015 %
Were you involved as much as you wanted to be in decisions about your care and treatment?	**GWH** GWH target 52% or more responding 'Yes, definitely'	51	53.2	51.4
Did you find someone on the hospital staff to talk to about your worries and fears?	**GWH** GWH target 43% or more responding 'Yes, definitely'	37	37.1	28.6
Were you given enough privacy when discussing your condition or treatment?	**GWH** GWH target 73% or more responding 'Yes, definitely'	73	70.8	74.2
Did a member of staff tell you about medication side effects to watch for when you went home?	**GWH** GHW target 40% or more responding 'Yes, completely'	30	33.7	32.1
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the hospital?	**GWH** GWH target 63% or more responding 'Yes'	67	67.2	66.2

Implement Plans to Improve Results of the National Inpatient Survey

Our aims for 2014/2015 were:

- Implement a new feedback system and improve the quality of customer feedback
- Develop a new Patient Information policy
- Develop a robust Trust wide action plan to address the areas within the National Inpatient Survey report, where improvements are required.
- Significantly improve the individual score for patients not being asked to give views on the quality of care (Question H3).

Throughout 2014/2015 our focus has been the collection of patient feedback on the services we provide. Detailed analysis is reported monthly on Patient Experience, for example comments from Friends and Family cards, Voicebook messages. Engagement/Listening events have been held throughout the year working in partnership with Healthwatch within the Swindon and Wiltshire area. This information has been shared with the relevant areas for improvements to be made to services.

We have commenced work on reviewing all of our Patient Information Leaflets and now have a Lay Readership Panel who will review all leaflets before being published. 'Plain English' training has been made available to staff to help with the creation of new patient information leaflets.

Friends and Family Champions have been introduced in each ward/clinic area; this has contributed to the increase in cards received and provides more detailed feedback of what patients are saying about the care they have received. Throughout the year we have maintained a consistent star rating (Friends & Family national rating system). We are especially proud of the feedback we have received during a time of increased challenges and pressures across the NHS.

Work has been carried out on areas that were identified in the Inpatient Survey results 2013 particularly related to food; call bell answering within a set timeframe; patient feedback and information being made available on how to make a complaint.

The Great Western Hospitals NHS Foundation Trust intends to take the following actions to improve this patient feedback, and so the quality of its services, by introducing 'Patient User Groups'.

During 2015/2016 we will also:

- Continue to improve feedback via Friends and Family cards.
- Create a robust Trust wide action plan in response to priorities identified in the National Inpatient Survey report published in 2015/2016, with close monitoring of progress.
- Explore other methods of Patient Feedback particularly in Outpatient and Emergency Department settings.
- Introduction of Patient User Groups.
- The completion of the Patient Information project.

Staff Survey Summary 2014/15

See Section 7 – Staff Survey Report.

Friends and Family

This year also saw the introduction of the Staff Friends and Family test. This survey provides our staff with an opportunity to submit feedback regarding whether they would recommend the Trust as a place for treatment and a place of work.

Table – Staff Friends & Family Response Rate

Would you recommend the Trust as a place for treatment	Extremely Likely or Likely
Staff Friends & Family Test Quarter 1 (April – June 2014)	70%
Staff Friends & Family Test Quarter 2 (July – September 2014)	76.4%
Staff Friends & Family Test Quarter 3 (October – December 2014)	N/A
Staff Friends & Family Test Quarter 4 (January – March 2015)	80%

6.3 Our Priorities for 2015/16

Our commitment to quality will continue through a number of priorities for 2015/2016 which are informed by both national and local priorities and as such, are driven through the Commissioning for Quality Improvement Contracts agreed with our local Clinical Commissioning Groups. These priorities have been shared with agreement sought from the Trust Governors as patient/public representatives, Local Healthwatch Organisations and other key external stakeholders.

Priorities for 2015/2016 are summarised below and they have been set out in the NHS Outcome Framework which focuses on patient outcomes and experience. We are developing detailed plans with timescales and targets to ensure we deliver these improvement priorities.

Implementing a Safety Improvement Plan – Sign Up to Safety

Set within the strategic aims of the Quality Strategy the Trust Board has committed to ensuring quality and safety remains the focus of everything we do. As part of this commitment the Trust formally signed up to the National Sign Up to Safety Campaign.

A Safety Improvement Plan has been developed which builds on the campaign's five key pledges, below:

1. Put safety first. Commit to reduce avoidable harm in the NHS by half and make public our goals and plans developed locally.
2. Continually learn. Make our organisation more resilient to risks by acting on the feedback from patients and by constantly measuring how safe our services are.
3. Honesty. Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.
4. Collaborate. Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patient uses.
5. Support. Help people understand why things go wrong and how to put them right.

As part of this plan a number of safety priorities have been agreed, which are aligned to the national topic areas within the Sign Up to Safety campaign. These safety priorities have clear objectives, against which we will measure progress and as such will form our priorities for 2015/16.

2015/2016 Priorities

1. **Reducing Falls - to reduce the rate of falls and avoidable harm due to falls by 20% within 3 years (2017/2018)**
2. **Reducing Pressure Ulcers - Reducing avoidable pressure ulcers to <5 per month**
3. **Management of Sepsis - Reduction of mortality from severe sepsis to 23% by 2017.**
4. **Recognition of The Deteriorating Patient - To reduce 'in hospital' cardiac arrests by 10% each year by 2018**
5. **Acute Kidney Injury - Reduction of avoidable AKI by 30% in the next two years**

6.4 Statements of assurance from the Board

During 2014/15 the Great Western Hospitals NHS Foundation Trust provided and/or sub-contracted 7 relevant health services.

The Great Western Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 7 of these relevant health services through its performance management framework and quality governance processes..

The income generated by the relevant health services reviewed in 2014/15 represents 100 per cent of the total income generated from the provision of relevant health services by the Great Western Hospitals NHS Foundation Trust for 2014/15.

Review of services and participation in clinical audits and national confidential enquiries

Clinical audit is a quality improvement process that looks to improve patient care and outcomes by regularly reviewing current practice against specific standards and implementing change where required.

During 2014/15, 34 National Clinical Audits and 4 National Confidential Enquiries covered relevant health services that Great Western Hospitals NHS Foundation Trust provides.

During 2014/15 Great Western Hospitals NHS Foundation Trust, participated in 100% (34/34) national clinical audits and 100% (4/4) national confidential enquiries of the national clinical audits and national confidential enquiries, which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Great Western Hospitals NHS Foundation Trust was eligible to participate in during 2014/15 are as follows: (see list entitled National Clinical Audits and National Confidential Enquiries below).

The national clinical audits and national confidential enquires that the Great Western Hospitals NHS Foundation Trust participated in during 2014/15 are as follows: (see again list entitled National Clinical Audits and National Confidential Enquiries below).

The national clinical audits and national confidential enquires that Great Western Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2014/15, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audits and National Confidential Enquiries List

	National Clinical Audits	Participated	% Data Submission
1	Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	Data collection/submission still in progress
2	Adult Community Acquired Pneumonia	Yes	Data collection/submission still in progress
3	British Society for Clinical Neurophysiology (BSCN) and Association of Neurophysiological Scientists (ANS) Standards for Ulnar Neuropathy at Elbow (UNE) testing	NA	NA
4	Bowel cancer (NBOCAP)	Yes	100%
5	Cardiac Rhythm Management (CRM)	Yes	Data collection/submission still in progress

National Clinical Audits		Participated	% Data Submission
6	Case Mix Programme (CMP)	Yes	Data colle7ction/submission still i8n progress
7	Chronic Kidney Disease in primary care	NA	9NA
8	Congenital Heart Disease (Paediatric cardiac surgery) (CHD)	NA	10NA
9	Coronary Angioplasty/National Audit of PCI	Yes	Data collection/submission still in progress
10	Diabetes (Adult)	NA	No Data Collection required during 14/15
11	Diabetes (Paediatric) (NPDA)	Yes	100%
12	Elective surgery (National PROMs Programme)	Yes	Data collection/submission still in progress
13	Epilepsy 12 audit (Childhood Epilepsy)	Yes	100%
14	Falls and Fragility Fractures Audit Programme (FFFAP)	Yes	100%
15	Fitting child (care in emergency departments)	Yes	100%
16	Head and neck oncology (DAHNO)	Yes	100%
17	Inflammatory Bowel Disease (IBD) programme	Yes	Data collection/submission still in progress
18	Lung cancer (NLCA)	Yes	100%
19	Major Trauma: The Trauma Audit & Research Network (TARN)	Yes	100%
20	Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	100%
21	Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes	Data collection/submission still in progress
22	Mental health (care in emergency departments)	Yes	100%
23	National Adult Cardiac Surgery Audit	NA	NA
24	National Audit of Dementia	NA	National Audit did not proceed during 14/15
25	National Audit of Intermediate Care	Yes	100%
26	National Cardiac Arrest Audit (NCAA)	Yes	100%
27	National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	NA	NA
28	National Comparative Audit of Blood Transfusion programme	Yes	100%
29	National Emergency Laparotomy Audit (NELA)	Yes	Data collection/submission still in progress
30	National Heart Failure Audit	Yes	Data collection/submission still in progress
31	National Joint Registry (NJR)	Yes	Data collection/submission still in progress
32	National Ophthalmology Audit	NA	National Audit did not commence
33	National Prostate Cancer Audit	Yes	Data collection/submission still in progress
34	National Vascular Registry	NA	NA
35	Neonatal Intensive and Special Care (NNAP)	Yes	100% (missing information which is being inputted by 2nd March 2015)
36	Non-Invasive Ventilation – adults	NA	National Audit did not commence

National Clinical Audits		Participated	% Data Submission
37	Oesophago-gastric cancer (NAOGC)	Yes	Data collection/submission still in progress
38	Older people (care in emergency departments)	Yes	100%
39	Paediatric Intensive Care Audit Network (PICA Net)	NA	NA
40	Pleural Procedure	Yes	100%
41	Prescribing Observatory for Mental Health (POMH)	NA	NA
42	Renal replacement therapy (Renal Registry)	Yes	100%
43	Pulmonary Hypertension (Pulmonary Hypertension Audit)	NA	NA
44	Rheumatoid and Early Inflammatory Arthritis	Yes	Data collection/submission still in progress
45	Sentinel Stroke National Audit Programme (SSNAP)	Yes	Data collection/submission still in progress
46	Sentinel Stroke National Audit Programme (SSNAP)	Yes	Data collection/submission still in progress
47	Sentinel Stroke National Audit Programme (SSNAP)	Yes	Data collection/submission still in progress
48	Specialist rehabilitation for patients with complex needs	NA	National Audit did not commence

Confidential enquiries		Participated	% Data Submission
1	Medical and surgical clinical outcome review programme: National confidential enquiry into patient outcome and death : Sepsis	Yes	100%
2	Medical and surgical clinical outcome review programme: National confidential enquiry into patient outcome and death : Acute Pancreatitis	Yes	Data collection/submission still in progress
3	Mental health clinical outcome review programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)	NA	NA
4	Child health clinical outcome review programme (CHR-UK)	Yes	100%
5	Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	100%

National clinical audits

The reports of 20 national clinical audits were reviewed by the provider in 2014/15 and Great Western Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- For Diabetes inpatient care - Collaborative working with the catering services to review and improve the menu choices available for diabetic inpatients. Promote the profile of the podiatry services and review the training and education provided for staff; with a view of incorporating this within mandatory training.
- Improve the provision of Stroke services within the Integrated Community Health Division, improved involvement of specialist therapies (physiotherapy and speech and language) and improved screening, reviews and multidisciplinary rehabilitation goals.
- There are improvements to be made in the pathway for women with heavy menstrual bleeding by having appropriate treatment being undertaken in both primary and secondary care. The

pathways will be revised as required to support the guidelines, which will be done collaboratively with all the appropriate teams.

- For the management of asthma in children, it has been agreed to implement a patient information leaflet for 'wheezy' children which will be provided on discharge, furthermore, a 'discharge sticker' to place on the front of the patient notes will help prompt effective discharge advice.
- There are proposed plans to review the current cardiac rehabilitation services; looking at all the relevant stages of the patient pathway to ensure all standards and core components are fully met, this will ensure patients attending cardiac rehabilitation are fully supported and thereby reducing the risk of associated readmission.
- There are plans to increase the capacity of the epilepsy service in order to support patients with chronic epilepsy and who frequently attend the emergency department. The development of care plans, and improvements in the referral process to the alcohol liaison services will help prevent recurrent emergency attendances and reduce the need for admission.
- There is to be an appointment of a designated, named, clinical lead for asthma services, who will be responsible for formal training in the management of acute asthma. Planned improvements for patients who have attended the emergency department two or more times with an asthma attack in the previous 12 months are to have a follow-up appointment after every attendance at an emergency department (or out-of hour's service) and follow-up care to be arranged after every hospital admission for asthma.

Local clinical audits

The reports of 46 local clinical audits were reviewed by the provider in 2014/15 and the Great Western Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- **Community Patients have an Estimated Date of Discharge (EDD) in their care plans (4th Re-audit):** To ensure the estimated date of discharge (EDD) as set within 24hours of admission, to ensure the EDD was recorded on the contact assessment page within the patient notes, to ensure a MDT/Nursing Team meeting has discussed the appropriate options to timely discharge.
- **Treatment of Hypoglycaemia:** The results from this audit identified the need to update current hypoglycaemia protocol to ensure it is in line with the new national guidelines.
- **Counting of Swabs/Needles/Tampons Before and After Perineal Suturing (4th Re-Audit - March 2014):** Weekly spot check, swab audits and monthly reporting to continue to ensure improved practice continues. Any non-compliance found on spot check to be reported to Department Manager and/or supervisor so further training support can be given.
- **WHO Safety Checklist – Cardiology June/July 2014:** Improve documentation to avoid misinterpretation to the various questions that are sometimes not applicable to the procedure or the patient's recovery; adapt current form and implement a checklist for specific procedures. The audit results were disseminated to the Cardiology department to highlight the areas of non-compliance and address the improvements required.
- **Audit of the management and documentation of gram negative bacteraemias:** Sepsis 6 charts are to be completed within the trust. Improve adherence to the Sepsis 6 protocol and monitor by the Trust's sepsis nurse; Monitor gram negative organism's resistance pattern over 6 months to ensure that empirical sepsis antibiotic protocol appropriate.
- **NICE CG149 Antibiotics for early-onset neonatal infection:** Advice letters for parents to be made available on the postnatal wards. A tick box is to be developed within the documentation to indicate when parents have been provided with a letter at discharge and to ensure they fully understand the information. Actions also include developing a discharge summary on babies at discharge through the BADGER system (neonatal/patient administration system).
- **Mortality Reviews Q1 - 2014/2015:** Actions include, all patients having their Resuscitation Status reviewed on admission and when their condition changes (improves or deteriorates). The quality of documentation is to be monitored by spot checks/audit as part of the 'walkabout'.

6.4.1 Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by Great Western Hospitals NHS Foundation Trust in 2014/15, that were recruited during that period to participate in research approved by a research ethics committee was 934 to end March 2015. *(See also Section 3.6 – Research and Development).*

6.4.2 Goals Agreed with Commissioners - Use of the CQUIN Framework

A proportion of The Great Western Hospitals NHS Foundation Trusts income in 2014/15 was conditional on achieving quality improvement and innovation goals agreed between The Great Western Hospitals NHS Foundation Trust and the agreements and contracts for the provision of NHS services, through the Swindon and Wiltshire Clinical Commissioning Groups for Quality and Innovation payment framework.

Further details on the agreed goals for 2014/15 and the following twelve month period are available electronically by request.

The monetary total for the amount of income in 2014/15 conditional upon achieving Quality Improvement and Innovation Goals, and a monetary total for the associated payment in 2014/15 is summarised in the table below.

TABLE - Financial Summary of CQUIN for Quality

TOTAL CQUIN	Plan	Actual	Percentage
2014/15	**£5,722k**	**£4,505k**	**78.72%**
2013/14	£5,366k	£4,353k	81%

6.4.3 Registration with Care Quality Commission (CQC) and periodic / special reviews

Care Quality Commission Registration

An extensive review of our CQC registration was undertaken across the acute and community sites in June 2014 to ensure that our CQC registration is adequate for the regulated activities undertaken across the sites.

Great Western Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is “registered” without conditions. Great Western Hospitals NHS Foundation Trust has the following conditions on registration – none.

The Care Quality Commission has not taken enforcement action against The Great Western Hospitals NHS Foundation Trust during 2014/15.

Periodic / Special Reviews

The Great Western Hospitals NHS Foundation Trust has not participated in special reviews or investigations by the Care Quality Commission during the reporting period.

Due to the new CQC Inspection Process there has not been a further GWH CQC New Style Inspection as yet. The last CQC Unannounced Inspection at the GWH Site took place in October 2013 for which there are no outstanding actions.

CQC Intelligence Monitoring Tool (IMT) Report

In October 2013 the Trust received its first quarterly CQC Hospital Intelligent Monitoring Report which incorporated 84 out of the 118 surveillance indicators and were assigned a Band 3 Trust summary banding. The indicators reviewed relate to the five key domains asked of all services (safe, effective, caring, responsive and well-led).

An overall summary risk banding of 1 to 6 is given to the Trust, with band 1 representing highest risk and band 6 with the lowest. These bands have been assigned based on the proportion of indicators that have been identified as 'risk' or 'elevated risk', if there are known serious concerns (e.g. trusts in special measures) trusts are categorised as band 1.

Since the report was published the Trust has received a total of four CQC IMT reports which has highlighted various risks (see the table below).

From October 2013 to October 2014, we have been rated as follows:

Indicator category	CQC KLOE (safe, effectiveness, caring, responsive or well led)	Key Risk Indicators	CQC Report October 2013	CQC Report March 2014	CQC Report June 2014	CQC Report October 2014
Banding 1 = High Risk (worst) to 6 = Low Risk (best)		N/A	3	6	3	5

All risks highlighted within the CQC IMT Report have been investigated; reported on and if appropriate have been put on the risk register.

During May 2015 the CQC published their latest Intelligent Monitoring Tool, in which the Trust was rated as Band 2. This report is being reviewed by the Trust with an action plan being drawn up. This will be monitored throughout the coming year and acted upon as required.

6.4.4 Information Governance

Information is a key asset, both in terms of the clinical management of individual patients and the management of services and resources throughout the Trust. It is therefore of utmost importance that appropriate policies, procedures and management accountability provide a robust governance framework for the efficient management of information. There is corporate leadership of information governance, the Director of Finance having overall responsibility. The Information Governance Steering Group oversees information governance issues, with responsibilities delegated from the Audit, Risk & Assurance Committee on behalf of the Trust Board.

The Information Governance Management Framework is documented within the Information Governance Strategy and Policy. The four key principles are openness, information quality assurance, information security assurance, and legal compliance. Confidentiality, security, and data quality play an important role in the safeguarding of information within the Trust. This includes organisational and staff information as well as patient information. The Trust has agreements with healthcare organisations and other agencies for the sharing of patient information in a controlled manner, which ensures the patients' and public interests are upheld. It is essential for the delivery of the highest quality health care that accurate, timely and relevant information is recorded and maintained. As such it is the responsibility of all staff to promote data quality and confidentiality.

The Trust's Information Governance Steering Group 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 Data Quality Group, which reports to the Steering Group, provides a quarterly data quality and completeness report, including the results of data accuracy tests. The Data Quality Group also undertakes a Data Quality Work Programme, which includes data quality reporting, training and awareness, clinical coding, and policies and procedures. These corporate and operational arrangements ensure that information governance and data quality are prioritised at all levels of the Trust.

Each year the Trust completes a comprehensive self-assessment of its information governance arrangements by means of the HSCIC Information Governance Toolkit. The main Toolkit headings are:

- Information Governance Management
- Confidentiality and Data Protection Assurance
- Information Security Assurance
- Clinical Information Assurance – Health Records and Information Quality
- Secondary Use Assurance
- Corporate Information Assurance – Records Management and Freedom of Information.

These assessments and the information governance measures themselves are regularly validated through independent internal audit. The Trust's Information Governance Assessment Report overall score for 2014/15 was 77% and was graded Satisfactory ('green'), with a satisfactory rating in every heading of the Information Governance Toolkit.

6.4.5 Explanatory Note for Clinical Coding

The Clinical Coding Audit carried out by the Audit Commission takes a sample of 100 patients from a selected specialty, in this year's audit, Trauma and Orthopaedics, as well as 100 patients randomly selected across all specialties. The samples are therefore small and the results of the audit should not be extrapolated further than the actual sample audited.

Clinical Coding Error Rate

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

Auditor	Primary Diagnosis	Secondary Diagnosis	Primary Procedure	Secondary Procedure
PbR Audit Commission	95.0%	91.2%	93.8%	89.3%

The Clinical Coding Audit carried out by the Audit Commission/Information Governance auditors takes total sample of 200 patients from selected specialities. The samples are therefore small and the results of the audit should not be extrapolated further than the actual sample audited

Great Western Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during the reporting period as part of the national Data Assurance Framework. However an Information Governance coding audit was undertaken, the error rates reported in this latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

Auditor	Primary Diagnosis	Secondary Diagnosis	Primary Procedure	Secondary Procedure
Information Governance-External auditors	94.0%	89.3%	90.4%	81.8%

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

This year's Information Governance audit, consisted of 200 patients selected from the following specialities/areas

- Day surgery
- Endoscopy
- ENT
- General Medicine
- General Surgery
- Paediatrics

These results achieved Attainment Level 2 in the Information Governance Toolkit. The Great Western Hospitals NHS Foundation Trust will be taking the following actions to improve Data Quality: The audit identified areas for improvement and these have been included in an action plan that will be implemented in the course of the year.

6.4.6 Quality Data

Data quality is essential for the effective delivery of patient care, for improvements to patient care we must have robust and accurate data available.

The Great Western Hospitals NHS Foundation Trust submitted records during 2014/2015 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:

- 99.2% for admitted patient care
- 99.3% for outpatient care
- 95.2% for accident and emergency care

The lower performance in accident and emergency care is attributed to the completeness of this data item at the Minor Injury Units in Wiltshire and the Trust's Information Department is working to ensure improvement with this.

Also included the patient's valid General Practitioner Registration Code this was:
99.9% for admitted patient care
99.9% for outpatient care
99.5% for accident and emergency care.

The Great Western Hospitals NHS Foundation Trust Information Governance Assessment Report overall rating for 2014/2015 was **"Satisfactory 77%"**

The Great Western Hospitals NHS Foundation Trust will be taking the following actions to improve data quality:

- The Trust Data Quality Group will continue to manage and monitor a work programme that targets identified areas of poor data quality and progress will be reported to the Trust's Information Governance Steering Group. The Trust Data Quality Group has increased the Operational Division's representation and is re-focussing on how it can provide support for operational staff to improve data quality.
- The actions from internal and external audits and benchmark reports associated with data quality will be reviewed by the Data Quality Group and acted on and monitored by the Trust Data Quality Group where appropriate.

- Data quality reports and issues raised by Commissioners will be reviewed and any required action taken.
- Training programmes associated with the implementation of the new Medway PAS have allowed a general refresher training of users and training will continue as the system is implemented and upgraded during the year.
- Development of refresher training programmes for staff involved in data collection and data entry will continue.

6.4.7 Information Governance Tool Kit Attainment Levels

Information is a key asset, both in terms of the clinical management of individual patients and the management of services and resources throughout the Trust. It is therefore of utmost importance that appropriate policies, procedures and management accountability provide a robust governance framework for the efficient management of information. There is corporate leadership of information governance, the Director of Finance having overall responsibility. The Information Governance Steering Group oversees information governance issues, with responsibilities delegated from the Audit, Risk & Assurance Committee on behalf of the Trust Board.

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The Trust's Information Governance Steering Group 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 Data Quality Group, which reports to the Steering Group, provides a quarterly data quality and completeness report, including the results of data accuracy tests. The Data Quality Group also undertakes a Data Quality Work Programme, which includes data quality reporting, training and awareness, clinical coding, and policies and procedures. These corporate and operational arrangements ensure that information governance and data quality are prioritised at all levels of the Trust.

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- Information Governance Management
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- Clinical Information Assurance – Health Records and Information Quality
- Secondary Use Assurance
- Corporate Information Assurance – Records Management and Freedom of Information.

These assessments and the information governance measures themselves are regularly validated through independent internal audit. The Trust's Information Governance Assessment Report overall score for 2014/2015 was 77% and was graded Satisfactory ('green'), with a satisfactory rating in every heading of the Information Governance Toolkit.

Part 3 - Other Information

6.5 Reporting against Core Indicators

		2010/ 2011	2011/ 2012 Data includes Community	2012/ 2013	2013/ 2014	2014/ 2015	National Average	What does this mean	Trusts with the highest and lowest score	Source of measure	Definition
1 - Reducing Healthcare Associated Infections	MRSA Bed Days as well *provisional as at 02/05/14	3	2	2	5	2	0.96*	Zero is aspirational	Low- 0; High- 11	IP&C	National definition
	C.*Diff*	40	17	33	23	19* *combined previously acute/ community split	Not applicable	Zero is aspirational	Low-0; High-121	IP&C	National definition
	C.Diff 100,000 bed days*	20.1*	7.3*	13.4*	12.5*	9.60	15.03	Lower is better	Regionally Low:7.46 High: 24.19	HPA	National Definition
2 - Patient Falls in Hospital resulting in severe harm		15	17	16	23	16	Not available	Low number is excellent		IR1's	NPSA
3 – Reducing Healthcare Acquired Pressure Ulcers		40	31	28	28 (Category III & Category IV)	51 (Category III & Category IV)	4% incidence	Low number is better	--	IR1's	National Definition (from Hospital database)
4 – Percentage of VTE Risk Assessments completed		85.1%	92.7%	95.3%	95.5%	97.1%	90%	Higher number better	Low - 91.3; High - 100	Crescendo nursing care plan and manual data collection from LAMU, Day Surgery, and ICU	National Definition (from Hospital database)
5 – Percentage of patients who receive appropriate VTE Prophylaxis		90% (No audit for Surgical actioned in Q2 & Q3 therefore YTD based on Medical only)	94.5%	93.9% (Apr-Oct)	95%	91.6%	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)

		2010/	2011/	2012/	2013/	2014/	National	What does	Trusts with	Source of measure	Definition

		2011	2012 Data includes Community	2013	2014	2015	Average	this mean	the highest and lowest score		
6 – Never Events that occurred in the Trust		0	3	3	4	2	**NHS England** 2014-15 Average 2.16	Zero tolerance	Highest - 9 Low - 0	IR1's	NPSA
7 – Mortality Rate (HSMR)	HSMR	97.9	106.2	91.8	97.3	90.3	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)	93% GWH only	96% GWH only	91%	95% (April – Dec (9 months)	90%	Not available	Higher number is better	--	Audit	Audit criteria (50 patients per month)
	Paediatric Early Warning Score (Children)	--	--	74.2%	87.75%	92.25% (Average yearly compliance)	Not applicable	Higher number is better	--	Audit	Audit criteria (5 patients per month)
10 – Percentage of Nutritional Risk Assessments	Using MUST	70% Acute only	87.8% Combined	84%	82%	81%	Not available	Higher % is better	--	Crescendo	National definition
11 – Were you involved as much as you wanted to be in decisions about your care and treatment?		48.1%	46.9%	51%	53.2%	51.4%	54.8%	Higher is better	Low: 6.1 High: 9.2 GWH: 7.1	Picker Survey	National definition
12 – Did you find someone on the hospital staff to talk to about your worries and fears?		23%	22.5%	37%	37.1%	28.6%	38.4%	Higher is better	Low: 4.3 High: 8.2 GWH: 4.9	Picker Survey	National definition
13 – Were you given enough privacy when discussing your conditions or treatment?		68.5%	66.8%	73%	70.8%	74.2%	72.7%	Higher is better	Low: 7.5 High: 9.4 GWH: 8.5	Picker Survey	National definition
14 – Did a member of staff tell you about medication side effects to watch for when you went home?		22.9%	24.3%	30%	33.7%	32.1%	40%	Higher is better	Low: 3.7 High: 7.6 GWH: 4.3	Picker Survey	National definition
15 – Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?		65.6%	66.6%	67%	67.2%	66.2%	69.8%	Higher is better	Low: 6.4 High: 9.7 GWH: 7.6	Picker Survey	National definition

The above [c.*diff*] rates have been calculated on the Trust's actual bed days. This will of course be different to the rates calculated by the HPA (now Public Health England) over previous years, as their calculations are estimated figures based on the previous year's bed numbers. We do not have these figures to base our calculations on. The HPA rates are provided on a quarterly basis and they do not produce an annual rate per Trust.

6.6 Performance against key national priorities

An overview of performance in 2014/15 against the key national priorities from the Department of Health's Operating Framework is set out below. Performance against the relevant indicators and performance thresholds are provided.

Indicator	2010/2011 GWH	2011/2012 Trust	2012/2013 Trust	2013/2014 Trust	2014/2015 Trust	2014/2015 Target	Achieved/ Not Met
Clostridium Difficile - meeting the *Clostridium Difficile* objective	40	19	33	23	17 Acute 19 All	28 or less (Acute)	Achieved
MRSA - meeting the MRSA objective	3	2	2	5	2	0 or less Contract Monitor de minimis 6	Monitor de minimis achieved
Cancer 31 day wait for second or subsequent treatment – surgery - 94%	98.5%	98.4%	98.4%	98.4%	99.0	94.0%	Achieved
Cancer 31 day wait for second or subsequent treatment - anti cancer drug treatments – 98%	100%	100%	100%	100%	99.7	98.0%	Achieved
Cancer 62 Day Waits for first treatment from urgent GP referral for suspected cancer – 85%	92.4%	89.3%	90.0%	89.0%	88.4	85.0%	Achieved
Cancer 62 Day Waits for first treatment from NHS cancer screening service referral - 90%	100%	98.4%	96.2%	98.9%	98.4	90.0%	Achieved
Cancer 31 day wait from diagnosis to first treatment	99.0%	98.7%	98.1%	98.8%	98.6	96.0%	Achieved
Cancer 2 week wait from referral to date first seen, all urgent referrals (cancer suspected) – 93%	97.0%	97.1%	95.3%	94.7%	94.0	93.0%	Achieved
Cancer 2 week wait from referral to date first seen, symptomatic breast patients (cancer not initially suspected) – 93%	97.2%	97.1%	96.0%	95.6%	96.8	93.0%	Achieved
Maximum time of 18 weeks from point of referral to treatment in aggregate, admitted patients	95.1%	96.1%	95.3%	94.9%	88.6%	90.0%	Not Met

Indicator	2010/2011 GWH	2011/2012 Trust	2012/2013 Trust	2013/2014 Trust	2014/2015 Trust	2014/2015 Target	Achieved/ Not Met
Maximum time of 18 weeks from point of referral to treatment in aggregate, non-admitted patients	97.9%	98.2%	98.3%	96.3%	95.6%	95.0%	Not Met
Maximum time of 18 weeks from point of referral to treatment in aggregate, patients on incomplete pathways	--	--	96.1%	94.8%	90.5%	92.0%	Not Met
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge - 95%	97.4%	97.0%	95.6%	94.1%	91.9%	95.0%	Not Achieved
Data completeness community services: referral to treatment information	--	--	80.0%	88.2%	88.5%	50.0%	Achieved
Data Completeness community service information: referral information	--	--	80.0%	81.5%	81.0%	50.0%	Achieved
Data completeness community services information: treatment activity information	--	--	85.0%	96.0%	98.2%	50.0%	Achieved

6.6.8 Patient Reported Outcome Measures (PROMs)

The Great Western Hospitals NHS Foundation Trust considers that this data is as described because patients who undergo surgery for, hip, knee, groin hernia and varicose vein surgery are sent questionnaires before and after surgery to assess the improvement in their conditions following surgery. An Independent company analyses the questionnaires and reports the results to the Health & Social Care Information Centre. This data is then benchmarked against other Trusts.

Our PROMS report shows that there has been a reduction in the overall scores for 2014/2015 in all areas but particularly for groin hernia surgery and hip replacement surgery. The Great Western Hospitals NHS Foundation Trust will take the following actions to improve this percentage, and so the quality of its services by the Planned Care Division reviewing the data to understand why there has been such a reduction in patient reported outcomes. We will review our services, patient pathways and our own patient experience data to understand what further investigation is required, in order to fully understand this drop in standards.

6.7 Statement of Directors' responsibilities in respect of the Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that 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:

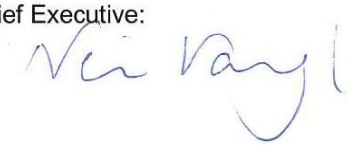
- The content of the Quality Report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual;*
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2014 to 27 May 2015;
    - Papers relating to Quality reported to the Board over the period April 2014 to 27 May 2015;
    - Feedback from the Swindon Clinical Commissioning Group dated 27 May 2015;
    - Feedback from the Wiltshire Clinical Commissioning Group dated 27 May 2015;
    - Feedback from Governors – dated 27 May 2015;
    - Feedback from Swindon Healthwatch dated 22 May 2015;
    - Feedback from Wiltshire Healthwatch dated 22 May 2015;
    - Feedback from Bath & North East Somerset Healthwatch dated 22 May 2015;
    - Feedback from Swindon Overview & Scrutiny Committee dated 26 May 2015;
    - Feedback from Wiltshire Overview & Scrutiny Committee dated 27 May 2015
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, reported to Trust Board monthly;
    - The September 2014 national patient survey dated February 2015;
    - The 2014 national staff survey dated October 2015;
    - The Head of Internal Audit's annual opinion covering the 2014/2015 period;
    - Care Quality Commission Intelligent Monitoring tools from April 2014 to April 2015

- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- The performance information reported in the Quality Report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Account regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275)

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report

By order of the Board

Chairman:  Date 27 May 2015

Chief Executive:  Date 27 May 2015

6.8 Statements from Clinical Commissioning Groups, Governors, Local Healthwatch and the Overview and Scrutiny Committee

6.8.1 Statements from Clinical Commissioning Groups

Statement from Swindon Clinical Commissioning Group dated 27 May 2015

Statement from Swindon Clinical Commissioning Group dated May 2015

NHS Swindon Clinical Commissioning Group (CCG) has reviewed the information provided by Great Western Hospital NHS Foundation Trust in its 2014-2015 Quality Account. In so far as we have been able to check the factual details, our view is that the Quality Account is materially accurate and is presented in the format required by the NHS England 2014/2015 Presentation Guidance.

The Quality Account provides information across a wide range of quality measures and gives a comprehensive view of the quality of care provided by the Trust, as set out within the three quality domains of safe care, effective care and patient experience.

Safe Care

Swindon CCG fully supports the Trust's commitment to ensuring quality and safety of care is at the heart of everything it does. During 2014/15 a number of quality improvement initiatives aimed at preventing avoidable harm and improving quality of life have been successfully implemented, with key achievements noted in the reduction of mortality rates and reduction in the incidence of *clostridium difficile* infections, falls and pressure ulcers. There has also been a noted improvement in the number of patients receiving appropriate VTE assessments.

Following the key successes demonstrated in 2014/15, the CCG notes the five priorities identified within the Trust's safety improvement plan for 2015/16, which builds on the national Sign Up to Safety Campaign's five key pledges. A continued focus on reducing falls and pressure ulcers is welcomed, together with ensuring further improvements in the care and management of patients with a diagnosis of sepsis and acute kidney injury. These key priorities are also being driven by national CQUINs during 2015/16, and the CCG will continue to work collaboratively with the Trust in order to improve patient care and ensure better outcomes.

Effective Care

A skilled workforce with robust leadership is key to delivering services safely and effectively. In response to the 2014/15 staff survey, Swindon CCG notes the challenges in relation to available workforce and the continued need to focus on recruitment and retention of staff. Therefore in 2015-2016, a continued emphasis will be placed on monitoring medical, nursing, midwifery and other clinical skill mixes in light of the impact that staff shortages have on patient experience, safety and outcomes.

During 2014/15 the CCG continued to monitor the Trusts ability to deliver an effective stroke care service. This included the need for appropriate patients to be admitted directly to the dedicated stroke ward (Falcon Ward). As illustrated within the quality account the CCG notes the challenges experienced due to bed pressures and will continue to work with the Trust in order to resolve issues and improve care for patients.

Provision of high quality care for people with a diagnosis of dementia is a key priority for the CCG. Given the ageing population and increasing numbers of people with a diagnosis of dementia, the CCG commends the good progress made with regards to dementia care within the Trust, including the investment in staff training and creation of a dementia friendly ward. Ensuring an understanding of these interventions, including an improvement in reported patient outcomes, remains a key priority in 2015/16.

Patient Experience

The Trust has set out a number of feedback mechanisms aimed at collating patient experience feedback. The CCG is pleased to note the increase in uptake of the Friends and

Family Test which reflects how well patients and service users rate the quality of services. However, the results of the annual inpatient survey has allowed the Trust to identify areas for improvement and the CCG welcomes the Trust's approach to ensuring this work stream is a priority for 2015/16.

Monitoring in regards to equality and diversity and patient engagement across the nine protected characteristics will also be a focus in the coming year; to reflect both new statutory requirements and NHS Swindon Clinical Commissioning Group's objectives to promote inclusion and monitoring of actions as required.

We welcome the Trust's focus for 2015/16 as set out in the identified priorities aimed at improving safe, effective care that improves patient experience. Going forward, the CCG will also be seeking assurance against the achievements of the conversation project; aimed at improving engagement and care for patients at the end of their life. This builds on the work already implemented as part of CQUIN during 2014/15. In line with national guidance, the CCG will also monitor the Trust's Safeguarding Children action plan, developed in recognition of the need to increase uptake of level 2 and 3 safeguarding training for all relevant staff.

Swindon CCG is committed to ensuring continued collaborative working with Great Western Hospitals NHS Foundation Trust in order to achieve these goals and support the provision of high quality care across the whole health and social care economy.

Gill May
Executive Nurse
NHS Swindon CCG

Dr Peter Mack
Clinical Vice Chair
NHS Swindon CCG

Statement from Wiltshire Clinical Commissioning Group dated 27 May 2015

NHS Wiltshire Clinical Commissioning Group has reviewed the 2014/2015 Quality Account provided by Great Western Hospital NHS Foundation Trust. In doing so, we have reviewed the factual details and our view is that the report is materially accurate and is presented in the format required by the NHS England 2014/2015 Presentation Guidance. This information supports key quality indicators and assurances sought at monthly Clinical Quality Review Meetings. Our contract covers two key areas: Acute services and Community services in Wiltshire. The trust also provided community maternity services for April and May 2014, prior to transfer to another provider. Although this report contains intelligence related to community services, the predominant area of focus is on the inpatient services at Great Western Hospital.

The Trust has embraced the national Sign up to Safety pledges, focusing on five identified areas. The CCG is supportive of the priorities and are keen to see improvements in all areas, specifically pressure ulcer prevention in the community, which the CCG are supporting through a local CQUIN scheme for 2015/2016. In addition, Sepsis and Acute Kidney Injury have been identified as national priorities and are also included as a national CQUIN scheme across acute providers.

The CCG acknowledge that during 2014/2015 the trust have reported challenges in recruitment and staffing levels. Therefore, continued emphasis will be placed on monitoring safer staffing levels, clinical skill mix and the impact that staff shortages have on patient safety and experience. In addition, the CCG notes the importance of exit interviews and will continue to seek and review assurance with regards to staff and patient feedback.

The CCG recognises the challenges in demand faced by the trust, but welcomes the commitment to continue to prioritise access for stroke patients to the specialist ward. The CCG will continue to monitor this and other important stroke indicators, looking for significant improvement through the SSNAP audits and trust improvement plan.

The CCG support the actions that the trust has highlighted in relation to preventing re-admissions for inpatients and patients in the community. This will be further strengthened through the implementation of the 2015/2016 avoidable admissions CQUIN scheme.

Over the next year, the CCG look forward to supporting the trust to further explore trust wide learning and embed improvements from safety incidents, patient contacts and complaints and the development of ambulatory care services.

The CCG will increase the frequency of Quality Assurance visits to the trust to enable the trust to showcase improvements and identify areas on which to focus improvements and embed learning trust wide.

6.8.2 Statement from Local Healthwatch Organisations

Statement from Healthwatch Bath & North East Somerset, Healthwatch Swindon and Healthwatch Wiltshire dated 22 May 2015

This statement is provided on behalf of the local Healthwatch organisations that exist in the areas in which the Great Western Hospital Foundation Trust operates or serves. The role of Healthwatch is to promote the voice of patients and the wider public in respect to health and social care services and we welcome the opportunity to comment.

During the past year, we have continued to work with the trust to ensure that patients and the wider community are appropriately involved in providing feedback and that feedback is taken seriously by the trust. As well as being represented at a number of its forums, we welcomed the opportunity to co-host listening events in Swindon and Wiltshire and look forward to supporting further activities throughout the coming year.

We acknowledge the progress made against the priorities identified for improvement last year but note that there are still a higher number than average falls both in the acute and community ward setting and, although it is reassuring to see that there is a downward trend in the acute setting, no such trend is as yet occurring in the community setting. In addition to this, whilst we recognise the impact of initiatives such as the Fall Safe Operational Group, we would welcome expanded insight into the learning's made and outcomes of the initiatives to reassure the public and patients, particularly as the figures for severe harm from falls has not improved since last year (in the acute setting).

Similarly with Pressure ulcers, although improvements have been made, further work is required to achieve consistently low numbers of healthcare acquired pressure ulcers particularly in the community setting.

We do recognise that a number of actions and new initiatives have been put in place and welcome the introduction of further initiatives, which we hope brings about improvements for patients. We will be closely monitoring the situation over the coming year and glad to see that the trust continues to prioritise on reducing falls and reducing pressure ulcers.

We welcome all of the work that is being done in respect of improving care for patients who have dementia and their relatives and carers. In particular, the opening of the first dementia friendly ward in November 2014 and the introduction of a whole hospital dementia pathway from admission to discharge that aims to ensure continuity of care for patients between the hospital and community settings.

In addition, we applaud the increased focus on carers through their representation on the dementia strategy group and the Jupiter Dementia project to explore learning for inpatients with dementia to receive appropriate nutrition and hydration care. We will be interested to understand patient and family experiences of these initiatives and how learning will be shared across the organisation.

We note that the prevalence of malnutrition at GWH is 39% (similar to national figures) but recognise that the patients' poor nutritional status occurs largely before admission. We therefore applaud the introduction of nutritional screening across the community areas (community hospitals, by community teams and in care homes). We hope that this action impacts positively on malnutrition rates, particularly in community settings and therefore on patient care. We continue to receive feedback regarding inpatient mealtimes experience and welcome the invite to be involved in the Nutrition and Hydration Steering Group as a platform to raise these concerns.

We welcome the introduction of champions for the Friends and Family Test throughout the trust and are pleased to see that the Trust has achieved and maintained a consistent standard throughout the year. It would be beneficial to know the percentage of responses received to understand any

requirement and initiatives to increase the completion rate. We are also encouraged to note that the Trust plan to fully engage with children and young people on their overall patient experience.

Although some results from the national patient survey show that patients rate their experiences highly, it is concerning to see that only 28.6% of patients responded
'yes definitely', to the question 'did you find someone on the hospital staff to talk to about your worries and fears?' We are therefore glad to see that a trust-wide action plan to address the areas within the national inpatient survey that require improvement, is part of an agreed improvement plan for the coming year.

Patient experience is key and we were pleased to see a review of a new complaints procedure during 2014. However our own work on complaints and direct feedback
suggests that further work needs to be done around the complaints procedure to raise awareness and make it easier for patients to understand and request support without fear of impact on current or future heath care.

We are concerned to see that the patient reported outcomes measures that look at perceived improvements in a patient's condition post-surgery have dropped in all measured areas but particularly for groin hernia surgery and total hip replacement surgery. We would like to see an improvement over the coming year and will be monitoring the situation.

Considering the crucial role that staff play in the patient experience, it is also a concern that there are some downward trends in results of the national staff survey, especially the reduction in response rate. This may be expected given the difficult year that the Trust has experienced and we note key areas for improvement have been identified and prioritised and hope that improvements in these area will impact positively on patient care.

We acknowledge the Care Quality Commission (CQC) summary and note that the CQC undertook an extensive review of the Trust's registration, which revealed gaps. We see that the Trust have now notified the CQC of the variations required to current registered sites and is awaiting revised registration from the CQC.

We are aware that the Trust has had a challenging year both financially and in terms of meeting national targets for patient care. We note the efforts made by the trust to improve this situation but feel that there is still more to be done if the Trust is to achieve its targets. We very much hope that the work that is being done impacts positively on patient care over the coming year. We will be closely monitoring the progress of the Trust and will continue to raise concerns should we feel that the quality of patient care is being compromised.

Pete Rowe
Manager
Healthwatch Swindon

On behalf of:

healthwatch Bath and North East Somerset
healthwatch Swindon
healthwatch Wiltshire

6.8.3 Health Overview and Scrutiny Committee Statements

Statement from Swindon Health Overview & Scrutiny Committee dated 26 May 2015

The Swindon Health, Adult and Children's Services Overview & Scrutiny Committee is encouraged by the work that is already being undertaken to improve services for quality improvement.

The Health, Adult and Children's Services Overview & Scrutiny Committee is committed to having a good working relationship with the Great Western Hospital NHS Foundation Trust and, based on the Committee's knowledge, endorses the Quality Account for 2014/15.
The Committee welcomes attendance and regular reporting at its committee meetings and hopes that this will continue throughout 2015/16.

The Committee looks forward to continuing to work with the Great Western Hospital NHS Foundation Trust to provide improving mental health services for the residents of Swindon and the region.

Sally Smith, Scrutiny Officer
On behalf of the Chair of the Health, Adults and Children's Services Overview & Scrutiny Committee

Statement from Wiltshire Health Overview & Scrutiny Committee dated 27 May 2015

Wiltshire Council Health Select Committee Response to the Great Western Hospital Quality Account 2014/15

The Wiltshire Council Health Select Committee would like to thank the Great Western Hospital for readily communicating and attending meetings as appropriate, this has proved to be most useful.

The Committee wish to highlight that it is felt that GWH have identified too many priorities which could be detrimental to their success and achievement of targets.

The areas that were identified in the Quality Account for improvement are supported by the Committee as key areas that require due care and attention in order to achieve sufficient improvements for patients. However, the Committee would like to highlight the following issues and concerns:

- The number of falls that resulted in severe harm to a patient went from 13 last year to 15 this year, however it is noted that the number of deaths from such falls were reduced from 2 to 0;
- The target for preventing pressure ulcers and in particular the escalation of the severity of ulcers has not been achieved;
- Further improvements are required to ensure better results in the national inpatient survey, it is commended that GWH strives to provide care that patients and staff would want to receive themselves and recommend to others. It is noted that the results of the staff survey were much poorer resulting in GWH falling by 8 places in the ranking system;
- A focus on improving mortality ratios is certainly deemed appropriate

- It is commended that a new complaints system has been put in place, the Committee wish to emphasise the importance of the patient voice.

The Committee noted that there have been only 2 cases of MRSA and a reduction in the number of cases of C. difficile as well as good results from the sepsis 6 campaign enabling 70 lives to be saved.

The Committee is concerned that the Quality Account reports only 2 never events for the period when it has previously been listed as 4, it is said that this is due 2 occurring in maternity services which have been awarded to the Royal United Hospital.
Concern was also raised in respect of an increase of 28 additional serious incidents from last year.

Finally, the Committee wish to congratulate GWH on the opening of their dementia friendly ward in November last year. This work is highly commended by the Committee and was endorsed by the Review of Dementia Services Task Group who did detailed work on the topic.

Signed
Emma Dove

6.8.4 Statement from Governors

Statement from Council of Governors dated 27 May 2015

Statement made by Ros Thomson, Lead Governor on behalf of the Council of Governors 27 May 2015

The Council of Governors has been consulted on the Great Western Hospitals NHS Foundation Trust's Quality Account 2014-15 and is satisfied that the Account includes the priorities identified by the Council of Governors.

In the opinion of Governors, the Quality Account represents a fair reflection of the information received by governors over the year on the Trust's performance. The Governors have acknowledged that the Trust did not achieve the 95% target for a maximum waiting time of 4 hours in A&E (91.9% against a target of 95%) and Referral to Treatment Times, but are satisfied with the efforts being undertaken towards addressing these and note that the Trust's performance is not dissimilar to many other Trusts.

The Governors noted that the Trust has experienced an increase in attendance in A&E compared with last year and this undoubtedly impacted on the performance indicators.

The Trust has made a number of achievements as set out in the Quality Account, notably around infection control and cancer waits. In addition other achievements which contribute towards improved patient experience, clinical outcome and patient care are noted by the Governors.

Ros Thomson
Lead Governor on behalf of the Council of Governors

6.9 Independent Auditor's Report to the Council of Governors of Great Western Hospitals NHS Foundation Trust on the Annual Quality Report

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST ON THE 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 2015 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2015 subject to limited assurance consist of the following two national priority indicators:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways ("Referral to Treatment – incomplete pathways"); and
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers ("62 day cancer waits").

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 Monitor.

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;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed Guidance for External Assurance on Quality Reports 2014/15 ('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 for the period April 2014 to May 2015;

- Papers relating to Quality reported to the Board over the period April 2014 to May 2015;
- Feedback from the Commissioners dated May 2015;
- Feedback from Governors dated May 2015;
- Feedback from local Healthwatch organisations dated May 2015;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, reported to Trust Board monthly;
- The 2014/15 national patient survey dated February 2015;
- The 2014/15 national staff survey dated October 2014;
- Care Quality Commission intelligent monitoring reports 2014/15; and
- The 2014/15 Head of Internal Audit's annual opinion over the Trust's control environment.

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 2015, 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 indicators;

- 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.

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.

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.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015:

- 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 "62 day cancer waits" indicator in the Quality Report subject to limited assurance has 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.

We identified weaknesses in the design of the control environment in regard to the "referral to treatment – incomplete pathways" indicator. As a result of our testing of this indicator we also identified data errors, where data included within the indicator could not be agreed to supporting patient records. As a result we are not able to issue a limited assurance opinion in respect of the "referral to treatment – incomplete pathways" indicator.

Jonathan Brown
KPMG LLP
100 Temple Street
Bristol
BS1 6AG
28 May 2015

7 STAFF SURVEY REPORT

7.1 Our staff

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

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

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

At the end of February 2015 we had 5,212 staff in the organisation. The breakdown by professional group is listed below.

	Headcount of Staff
Admin and Clerical	1139
Allied Health Professionals	502
Medical and Dental	521
Non-Clinical Support	169
Registered Nursing and Midwifery	1770
Scientific, Therapeutic & Technical	445
Unregistered Nursing and Midwifery	666
Grand Total	**5212**

The sample size was 828 surveys sent to staff with a return rate of 456 (55%).

7.2 Staff satisfaction

We recognise that a more satisfied and motivated workforce provides better patient care. Therefore we place significant emphasis on exploring ways to improve and enhance motivation so that staff are satisfied in their work whether they are looking after patients in our hospitals, schools, community centres or in patients' homes.

To help us understand how staff are feeling, the results of the annual staff survey are examined by the Trust to identify any areas for improvement, to share good practice and implement changes

Our staff scores received in March 2015 benchmarks the Trust as thirteenth across twenty-two Trusts in the South West of England, including Royal Berkshire. Last year the Trust benchmarked in fifth position so this is a downward trend.

Through our 'You Said We Did' programme, The Great Western Hospitals NHS Foundation Trust has taken the following actions to improve in the areas identified within last year's staff survey:

You Said: Only 5 out 10 staff felt the Trust treats staff involved in an error or incident fairly.

We Did: In August 2014, we launched the Respect Us campaign, a reminder to the public that any form of verbal or physical abuse against staff will not be tolerated and abusive patients, relatives or other members of the public will face tough penalties. In or 2014 Staff Survey, we saw improvements in each of these areas.

You Said: 24% of staff feel there are enough staff in the organisation to do their job properly.
We Did: over the last year the Trust has continued to place significant focus on recruitment. The 2014 Staff Survey showed a slight improvement to 27% in this area.

You Said: 61% would be happy with the standard of care provided by the Trust if a friend or relative needed treatment.
We Did: This year saw the introduction of the Staff Friends & Family Test (SFFT) giving staff the opportunity every quarter to tell us what it is like to work here. Since last year's survey, we have asked our Staff this question on three occasions; the results from the SFF show a positive improvement, with around 70% of staff saying they would recommend GWH to friends and family if they needed treatment. However this year's staff survey saw a slight decrease to 58%.

You Said: Improvements are needed in the sharing of team objectives and closer communication between teams to achieve objectives.

We Did: 96% of you in this year's Staff Survey said that they work as part of a team and 74% agreed that their teams had a shared set of objectives. Further improvements are still needed in this area and this will be one of the key priorities for the Trust this year.

Overall, the Trust is measured against the four staff pledges from the NHS Constitution with an additional theme of staff satisfaction. These indicators break down into 29 key findings and results show that staff at GWH report that their experience of working at GWH places us in the Top 20% of Acute Trusts in UK for 1 out of 29 indicators regarding the amount of staff who have received an appraisal in the last 12 months.

Staff Survey Scores 2014	Answers
Top 20%	1
Above (Better than) Average	9
Average	9
Below (Worse than) Average	7
Bottom 20%	3
Total	29

We are better than average for 9 out of 29 indicators including training, support from managers and staff motivation at work. We are average for 9 out of 28 indicators relating to job satisfaction and staff feeling able to contribute towards improvements at work.

The Trust are worse than average in 7 out of 28 indicators including staff being unsatisfied with the quality of work and patient care they are able to deliver, pressure of work and extra hours being worked. All these areas are connected to our staffing levels which we have a plan to improve.

Our staff survey results will be presented to the Executive Committee and Trust Board to enable us to determine which areas to focus on so that we could improve the experience of our staff. Each division will be provided with a staff survey information pack which sets out the key priorities for the Trust and division and how these are aligned to the People Strategy.

Development and training opportunities
The vast majority of staff said that they had received training, learning or development opportunities over the past 12 months however our results in this section have decreased slightly since last year.

It has been an incredibly busy year which has made it difficult for some of our staff to attend training, however we recognise the importance of this and we will make this a priority for the coming year.

This year, it was great to see that 91 per cent of staff said they had taken part in a Performance Review (appraisal); this is compared to the national average of 84 per cent. We acknowledge that we still have further development to do in this area to ensure that our appraisals are helping our staff to improve how they do their job, and most importantly leave them feeling valued. We are currently reviewing this process to make sure it is adding value to our staff and is providing them with the support they need.

Working together and making a difference
The majority of staff (96 per cent) agreed that they work as part of a team in their roles, with 74 per cent agreeing that they have a set of team objectives. This is a great start but we need to do more to support our staff to work together and to give them the opportunities to meet regularly to discuss team effectiveness and ideas for improvements.

Over the past year we have placed significant emphasis on recruitment and have been working hard to increase our staffing levels in many areas. This has been reflected in our results this year, with more of our staff agreeing that there are enough people in the organisation to do their job properly. We have also seen an increase the number of staff feeling that they are able to do their job to a standard that they are personally pleased with which is really positive.

Feeling supported
We have seen a slight decrease in the number of staff feeling senior managers are involving them in important decisions and acting on feedback. We have also seen a decrease in the amount of staff who feel that the communication between senior management and staff is effective. All our staff should experience the right level of support and involvement from both the Trust and their manager and we need to make sure this is happening in practice.

Health, well-being and safety at work
Our staffs health and wellbeing is really important to us and we recognise that our people can only provide high quality care if they feel supported in their own health and well-being. We have seen improvements in this area with less of our staff experiencing harassment, bullying or abuse whilst at work and more staff reporting incidents if they do occur. This is following the successful ‘Respect Us’ campaign that was launched in August last year which reminded the public that any form of verbal or physical abuse against staff will not be tolerated.

7.3 Summary of staff survey results

Table - Response Rate

2013		2014		Trust Improvement/ Deterioration
Trust	National Average	Trust	National Average	
67%	49%	55%	42%	12% deterioration

Table – Summary of Performance

		2013		2014	
		Trust	**National Average**	**Trust**	**National Average**
Top 5 Ranking Scores	Question: KF7. Percentage of staff appraised in the last 12 months *(the higher the score the better)*	92%	84%	**91%**	85%
	Question: KF14. Percentage of staff reporting errors, near misses or incidents witnessed in the last month *(the higher the score the better)*	88%	90%	**93%**	90%
	Question: KF10 Percentage of staff receiving health and safety training in last 12 months *(the higher the score the better)*	82%	76%	**81%**	77%
	Question: KF9. Support from immediate managers *(the higher the score the better)*	3.75	3.64	**3.69**	3.65
	Question: KF26. Percentage of staff having equality and diversity training in the last 12 months (*the higher the score the better)*	74%	60%	**68%**	63%
Bottom 5 Ranking Scores	Question: K29. Percentage of staff agreeing that feedback from patients / service users is used to make informed decisions in their directorate / department *(the higher the score the better)*	**-**	**-**	**49%**	56%
	Question: KF2. Percentage of staff agreeing that their role makes a difference to patients (*the higher the score the better)*	92%	91%	**88%**	91%
	Question: KF6. Percentage of staff receiving job-relevant training, learning or development in the last 12 months *(the higher the score the better)*	79%	81%	**78%**	81%
	Question: KF3. Work pressure felt by staff *(the lower the score the better)*	3.16	3.06	**3.17**	3.07
	Question: KF21. Percentage of staff reporting good communication between senior management and staff (*the higher the score the better)*	30%	29%	**25%**	30%

The four key areas of concern from this year's Staff Survey results are personal development and training opportunities for staff, performance appraisal, staff engagement and communication between senior management and staff. These will form the Trust's key priorities for 2015/16.

The Great Western Hospitals NHS Foundation Trust will take the following actions to improve these scores, and so the quality of its services, by:

Summary of Actions:

- Review the provision of training to all staff, as appropriate to job role and responsibilities, in relation to health and safety; equality and diversity; violence and aggression management; and infection control.
- Undertake further work on the quality of training and its relevance to staff, particularly in relation to patient/service user experience and assisting staff to do their job more effectively.
- Check on the coverage of appraisals and reviews, particularly amongst hard to reach groups, and take steps to increase coverage and to monitor the provision of appraisals.
- Assess the way in which appraisals and reviews are conducted in order to ensure staff leave the review feeling that their work is valued by their organisation.
- Put in place specific arrangements in each work group to ensure that staff receive regular, clear feedback on how well they have performed their work, outside of the appraisal system. Ensure this is linked to planned goals and objectives.
- Review work planning and scheduling in order to reduce conflicting work demands on staff.
- Where appropriate, ensure that senior managers involve staff in important decision making processes.
- Work directly with staff to understand why some would not recommend the organisation as a place to work – and take action accordingly.
- Identify the location of spikes in violent incidents from patients and the public, by drilling down into your data where possible.
- Improve awareness of the need to report bullying and harassment in a confidential fashion

Priorities for 2015/2016

- Review of Appraisal process
- Review of Trust Induction and provision of training
- Review of Staff Survey Provider, size of sample and accessibility for completion of survey
- Three Key priorities defined for each division with quarterly review against progress
- Increase response to amongst top 5 and in line with national average
- Improve overall results so in line with or above national average

7.4 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 pay, terms and conditions of employment. EPF reviews its effectiveness annually to ensure that it continues to learn and improve as a method of formal negotiation.

In Quarter 3, our Head of Recruitment and Resourcing facilitated a ‘Recruitment and Retention’ workshop with Employee Partnership Forum members, HR colleagues and senior managers from across the Trust.

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.

7.5 Communicating with staff

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

- Over the past year the Trust has built on the success of quarterly magazine Horizon by providing space for regular features on different areas within the organisation and highlighting the achievements of staff including educational attainment and awards. In each issue the Trust ensures there is a wide selection of features from across the Trust providing representation from both the acute and community settings. The magazine also provides a good source of news items for the local media.

- The Trust also 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 new intranet features web chat and video podcasts in the future to provide important information in a more easily digestible format.

- Hosting a number of Chief Executive 'road shows' across the Trust to provide staff with an opportunity to meet the Chief Executive and ask questions. These events included sessions at a number of the community sites across Wiltshire.

- The ***Staff Room*** is a newspaper for all staff and volunteers and is a new way of keeping in touch with what's happening across the Trust. We encourage individuals and teams to feature in an edition of ***Staff Room*** or if staff 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.

7.6 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 - Sickness absence levels were 3.76% for the period of April 2014 – March2015. This is a significant decrease on the previous year which was 4.45%. The ER team continue to review all long and short term sickness absences within the Divisions to support the managers at reducing the length of time off that an employee requires.

Turnover - Voluntary turnover at the end of the year was 14.11%.

Vacancy levels - We ended the year with 213 vacancies which equates to 4.60% of our total staffing levels.

Appraisal rates - The overall completion rate for the Trust is 87.36%. This is an area of improvement for us since last year as we focus on ensuring that our staff have clear direction and feedback as well as a robust plan for their development.

7.7 Workforce Development

The Trust is committed to supporting and motivating current staff, trainees and future workforce, including students with on-going learning and development.

Despite challenging service pressures, 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 85%. The subjects with the lowest compliance rates are now highlighted in the monthly board report and a separate action plan to deliver 95% child protection level 3 compliance has initial approval.
As the level for a 'green compliance' rating staff sits at 80% the Trust has now achieved this year on year for the last 3 years. Academy will add a stretch to 85% and then 90% by the end of the next year.

The Academy 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 Academy has aimed to support the Trust in a proactive way conducting a skill assessment and seeking the views of staff and service leads to provide education solution to support succession planning and talent management for hard to recruit pots, competency development and support for high quality specialist skills and flexibility for skills between care settings and is to continue to align provision to the Trust's staffing challenges with closer working with HR.

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

- Seeking academic accreditation for a range of 5 patient pathway education modules from Oxford Brookes University.
- Devising new patient pathway multidisciplinary (CPD programme) - Advance respiratory care, Fundamentals of acute stroke and treatment, GI nursing, Enhanced learning for excellence in chemotherapy treatment and spot, treat observe and prevent.
- An increase in apprenticeships to support both existing and staff new to the healthcare work force to develop and maximise their potential.
- Support of students to develop as caring, competent registrants and to successfully apply for positions within this Trust.
- Our Continuing Professional Development (CPD) spend continues to be firmly aligned to service requirement with a panel made of key managers from each Directorate determining it's spend.
- Delivery of the Resuscitation Treatment escalation plan project where a common understanding and document has now been agree between the CCGs and all health care providers in the region, preventing inappropriately hospital admission and treatment.
- Experiences are continually measured after an educational event and to identify the impact of education. This feedback is used to inform future educational approaches. This year this has revealed that over 92% feel the service has been very good or excellent.
- Support from the Academy for leadership development with a new competency based leadership development programme, investment in workforce planning skills, and coaching and mentoring training to support the launch of a GWH coaching register.

Post Graduate Medical Education has started moving into a new phase with the changes to the way Junior Doctors are funded, and the updated 'Tomorrow's Doctors' from the GMC due out this year. Broadening Foundation has meant that we have had to strengthen our Community based provision for our Foundation Doctors.

Our library has continued to improve the quality of service offered with NHS Library Quality Assurance Framework (LQAF) peer review demonstrating compliance of 100% against a mean percentage compliance by our South West NHS library services of 95%.

Research & Development continues to gain momentum across the Trust with increased activity in Cardiology and the Emergency Department, offsetting a reduction in recruitment from our Cancer studies. Therefore recruitment remains consistent with 7 new Commercial research projects being opened this year.

The increased investment in support for newly qualified and overseas staff has enable development of essential, high quality skills in a safe simulate environment to our patients and supported staff both pastorally and with their specific development needs within the clinical setting enabling these staff to meet our standards in an efficient time frame.

Undergraduate Education continued its expansion when the Year 3 students started in September 2014, feedback from the University continues to be positive. 2014/15 saw the successful deployment of Clinical Teaching Fellows (CTF) across the Trust, strategically deployed to ED, AAU & Paediatrics; helping to reduce locum spend, improve ED waiting times and overall patient safety. CTF recruitment was made possible by income generation. Work continues to expand the CTF programme to support education both in the classroom and in practice, for 2015/16.

7.8 Supporting our volunteers

We are extremely fortunate to have so many committed and enthusiastic volunteers who support delivery of services across our acute and community services. The volunteers provide an extremely valuable service to patients and prised support to staff. They form an essential part of the hospital team and are greatly appreciated.

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. Many of our volunteers stay with us for years, with many having achieved awards for five and ten years' service and some have accrued over 25 years' of voluntary service. Each volunteer has their own personal reasons for offering their time.

We ask our volunteers to commit to a minimum of three hours per week for a minimum of six months. They come through a robust recruitment process, including referencing and criminal records checks. Our volunteers sit alongside new members of staff at the Trust induction and in any other relevant training they need before they start volunteering with us. Following induction, all volunteers attend at least one half day training session in each 12 month period.

Volunteers can be found across the Trust in a variety of roles, such as patient befriending and assisting patients at mealtimes on the wards, manning information points for patients in the Eye Clinic and Cancer Services, doing exercises with patients in Physiotherapy, assisting patients in Radiology, providing a way finding service, and even helping in the laboratories helping to archive specimen slides and records.

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 the Friends of Savernake Hospital & Community.

7.9 Occupational Health

Our approach to our staff's health and wellbeing is to ensure we are offering all staff the opportunity to speak to an Occupational Health (OH) specialist who can guide them in the right direction and signpost them to the most appropriate support agency in a timely manner, e.g. Staff Support Services at Wroughton.

The Occupational Health department continues to work closely with managers and HR to reduce time lost due to sickness absence. The two key areas that have been addressed are Musculoskeletal Disorder (MSD) issues and reducing stress related absence.

The Occupational Health team now has an advisor who is a Registered Mental Health Nurse. This nurse complements the Occupational Health Nurses already in post and can offer full mental health assessments on a one to one basis. Group sessions are offered to those employees on long-term sick or with ongoing mental health issues. She is also working alongside the Staff Support Service, which offer a range of counselling and support therapies.

The Physiotherapy Service has increased provision by taking on a new staff member, who is on rotation from the Main Physiotherapy Department, thus increasing our cooperative work practices. We continue to offer drop-in advice on MSD problems and physiotherapy assessment / treatment via management referrals.

The Musculoskeletal Disorder Team and the Occupational Health team including physiotherapy input have worked closely together to carry out workplace assessments along with early intervention treatment.

Over the past 12 months there has been some correlation between the number of referrals received within Occupational Health from line managers and the number of staff off sick. We have also seen increased Staff Support referrals and including support offered to staff in community services.

7.10 Swine / Seasonal Flu Vaccinations

The seasonal flu campaign obtained a 50% uptake across the Trust in 2014/15 which correlates to similar Trusts in the Southwest.

7.11 Health and Safety

Further improvements have been made across the Trust's Health and Safety (H&S) management system throughout the year in the spirit of continuous improvement and the Trust has had no prosecutions or Improvement Notices from the HSE OR Wiltshire Fire & Rescue Service.

Specific targeted achievements this year have included:

- A comprehensive Health & Safety audit programme across all Departments within the Community and Acute sites which enables central appraisal of Departmental risk assessments and safe systems of work. From this, further analysis and audits have been possible to achieve improvements

- Only 9 RIDDOR reportable accidents were reported to the HSE during the last financial year and root cause analysis investigations have been completed. This level of RIDDOR rate has benchmarked considerably lower than all other comparable Trusts in the South West region.

- Trust Laser Protection and management systems have been improved during the past year.

- Continual fire safety management improvements in reducing Unwanted Fire Signals [false fire alarm activations resulting in Fire & Rescue Service attendance] have been made reducing totals at GWH from 30 last year to only 19 this year.

- Health & Safety Department have also taken on the responsibility for Trust Security Management over the past 6 months and have made several improvements via the Trust Security Advisory Group in promoting the reporting of violence & aggression incidents.

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

8 REGULATORY RATINGS REPORT

8.1 Monitor the Independent Regulator

As a Foundation Trust, we are regulated by Monitor, the sector regulator of health services in England. Monitor's role is to protect and promote the interests of patients by ensuring that the whole sector works for their benefit. Monitor promotes the provision of services which are effective, efficient and economical and which maintain or improve their quality.

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

Monitor has agreed to accept and the Trust as Licensee has agreed to give undertakings, pursuant to section 106 of the Health and Social Care Act 2012 in relation to financial sustainability, financial governance, distressed funding, reporting and general matters. Details of the enforcement undertakings are available on Monitor's website and also set out below *(Section 8.10 – Details and actions from any formal interventions).*

8.2 Provider Licence

From 1 April 2013, Monitor issued a provider licence to the Great Western Hospitals Foundation Trust which is the tool used by Monitor for regulating providers of NHS services. This replaced the Trust's authorisation. The licence sets out a range of conditions that the Trust must meet so that it plays its part in continually improving the effectiveness and efficiency of NHS health care services, to meet the needs of patients and taxpayers today and in the future. The licence allows Monitor to fulfil its new duties to:

- Set prices for NHS funded care in partnership with NHS England;
- Enable integrated care;
- Safeguard choice and prevent anti-competitive behaviour that is against the interests of patients; and
- Support commissioners to protect essential health care services for patients if a provider gets into financial difficulty.

Monitor ensures that the Board of directors of the Trust focuses on good leadership and governance.

8.3 Risk Assessment Framework

Monitor has created a risk-based system of regulation designed to identify actual and potential financial and non-financial problems in a manner that allows Monitor to deal with them effectively.

Once licensed, each NHS foundation trust is assigned a Monitor relationship manager. The relationship manager ensures that where an NHS foundation trust is in breach of its licence, the Trust's Board takes the appropriate remedial action.

Monitor uses a number of methods to assess the Trust's compliance with its licence conditions. Monitor's Risk Assessment Framework describes in detail how Monitor will consider each the Trust's compliance with:

- the ***continuity of services risk condition*** (staying solvent and maintaining the continuity of services provided by the Trust); and

- the ***NHS foundation trust governance condition*** (being well governed from a financial, operational and quality perspective).

The Risk Assessment Framework replaced the Compliance Framework and describes in detail how compliance with a licence is monitored. Monitor's Quality Governance Framework measures the structures and processes in place to ensure effective, trust-wide, oversight and management of quality performance.

Where the Risk Assessment Framework indicates that the Trust is breaching, or potentially breaching, its continuity of services or governance conditions, Monitor will consider whether formal investigation is required in order to assess the scale and scope of the breach and what, if any, regulatory action is appropriate. Details of this process and Monitor's enforcement powers are included in Enforcement Guidance.

8.4 Foundation Trust planning and reporting

Monitor requires that the Board submits an annual plan and quarterly and ad hoc reports. These are used to assess risk on a forward-looking basis and to hold the Board to account.

Monitor publishes sector summaries based on these submissions, on a quarterly and annual basis, and assigns each NHS foundation trust with an annual and quarterly risk rating. These risk ratings are designed to indicate the risk of a failure to comply with the continuity of services and governance licence conditions.

8.5 Risk Ratings

Monitor publishes two risk ratings for each NHS foundation trust, on:

- governance; and
- continuity of services.

Previously, Monitor published a governance risk rating and a financial risk rating for each NHS foundation trust. During 2013/14 the Trust was rated against the old and new ratings.

8.6 Regulatory action

Based on these risk ratings, the intensity of monitoring and the potential need for regulatory action is considered on a case-by-case basis. This also applies where a foundation trust is performing well, for example moving from the usual quarterly monitoring to six-monthly monitoring.

When Monitor identifies a risk of an NHS foundation trust breaching its licence it might seek further information and/or open a formal investigation. The issues found are likely to drive a regulatory response from Monitor – for instance Monitor may seek an agreed recovery plan to return the Trust to compliance. However, if the need for action is time-critical, Monitor's Board will consider using its formal powers to intervene (take regulatory action).

In addition, Monitor works closely with a number of organisations, including the Care Quality Commission (CQC), in order to carry out its role. The CQC is responsible for safeguarding appropriate standards of quality and safety within adult health and social care in England.

8.7 Financial and Governance ratings

Set out below is a table comparing the former Compliance Framework with the new Risk Assessment Framework. While the principles are the same, some details have changed to reflect the different scope of Monitor's risk assessment. Key changes are summarised.

<table>
<tr><th>Risk Assessment Framework
(from 1 January 2014)</th><th>Compliance Framework</th></tr>
<tr><td>Continuity of Services risk rating
Two metrics:
1. Liquidity days (50%)
2. Capital Service Capacity (50%)

Intended to reflect short/medium term financial issues (i.e. flag risks to solvency over a 12-18 month period) at any provider of Commissioner Requested Services</td><td>Financial Risk Rating (FRR)
Weighted basket of 5 metrics:
1. EBITDA margin (25%)
2. % of plan EBITDA margin delivered (10%)
3. I&E surplus margin (20%)
4. Net return on capital (20%)
5. Liquidity days (25%)

Reflects the broad financial situation of a foundation trust</td></tr>
<tr><td colspan="2">Monitoring is via a Forward plan:
- submission of forward-looking financial information
- calculation & publication of risk rating</td></tr>
<tr><td colspan="2">In-year monitoring:
- quarterly
- year-to-date risk rating published</td></tr>
<tr><td>'Overrides' triggered by material financial events, e.g.
- planned major transaction (before formal sign-off)
- predicted material loss of income (e.g. loss of a large block contract)
- predicted material increase in costs (e.g. to meet a CQC requirement to meet safety standards)
- significant negative trends in performance (i.e. material underperformance against plan)</td><td>The Compliance Framework did not explicitly use overrides, although the transaction assessment process calculated risk ratings while Monitor could investigate material financial issues brought to their attention via exception reporting.</td></tr>
<tr><td colspan="2">Monitor may request a reforecast/'re-plan' and adjust the risk rating accordingly – depending on the revised rating further action may be taken</td></tr>
<tr><td>4-point scale Risk Rating

4: no evident concerns (quarterly monitoring)
3: minor concerns (potential monthly monitoring)
2: concerns (potential breach of licence; higher monitoring frequency)
1: high risk (use of CoS and other regulatory powers may be likely; higher monitoring frequency)</td><td>5-point scale Risk Rating

5: no concerns (potential 6-monthly monitoring)
4: no concerns
3: no concerns (but monthly monitoring if recovering from FRR 2)
2: concerns – escalate for consideration of potential significant breach
1: concerns – escalate for consideration of potential significant breach</td></tr>
</table>

Risk Assessment Framework *(from 1 January 2014)*	**Compliance Framework**
Governance Risk Rating Monitoring six categories: 1. CQC concerns: - e.g. warning notices, civil/criminal action 2. Delivery of access targets (Mandate, Constitution): - A&E, 18 weeks, cancer waits etc. 3. Meeting national outcomes (from the NHS Outcomes Framework): - Including MRSA, C.difficile and potentially others 4. Third party concerns: - e.g. patient group concerns, MPs' complaints, etc. 5. Quality governance metrics - including staff & patient surveys, trends in never events 6. Financial performance	**Governance Risk Rating** Monitoring five categories: 1. CQC concerns: - e.g. warning notices 2. Delivery of access targets (from Operating Framework): - A&E, 18 weeks, cancer waits, etc. 3. Meeting national outcomes (from the Operating Framework): - MRSA, C.difficile, - CPA follow-up & reviews, ambulance response times, community services' data quality 4. Third party concerns: - NHSLA risk management ratings. In theory, any credible third party concern, although in practice not used 5. Financial performance: NHS foundation trusts in significant breach for finances usually received a red governance risk rating as this reflects poor governance as well as financial risk.
<u>Monitoring</u> Quarterly and annually where available/necessary (e.g. for staff/patient surveys)	

8.8 Risk Ratings 2014/15

Set out below is a summary of rating performance throughout the year and comparison to prior year with analysis of actual quarterly rating performance compared with expectation in the annual plan and comparison to prior year.

	Annual Plan 2013/14	Q1 2013-14	Q2 2013-14	Q3 2013-14	Q4 2013-14
Under the Compliance Framework					
Financial Risk Rating	**3**	3	3		
Governance Risk rating	**Amber/ Red**	Amber/Green	Green		
Under the Risk Assessment Framework					
Continutity of Service Risk Rating				2	2
Governance Risk rating				Plans are sufficient	Plans are sufficient

	Annual Plan 2014/15	Q1 2014-15	Q2 2014-15	Q3 2014-15	Q4 2014-15
Under the Risk Assessment Framework only					
Continuity of Service Risk Rating	2	1	1	1	1
Governance Risk rating	Plans are sufficient	Plans are sufficient	Plans are sufficient	Plans are sufficient	Plans are sufficient

Quarters 2 onwards were reported as variances to plan.

8.9 Explanation for differences in actual performance versus expected performance at the time of the annual risk assessment

Quarter 1

In Quarter 1 the Board confirmed a Continuity of Service Risk Rating (CoSRR) of 2 which the Trust expected to sustain moving forward. (It should be noted that it was not possible for the Trust to maintain a financial risk rating of at least 3 over the year based on the compliance Framework. This was because the Trust has a Public Finance Initiative and therefore the highest rating the Trust could hope to achieve was be no more than 2*).

In Quarter 1 the Trust did not achieve the A & E 4 hour wait target. Actual performance was 93.2% against a target of 95%. The Trust has continued to see large volumes of patients presenting at the Emergency Department (ED) requiring treatment and/or admission. Daily attendances had remained high, peaking at 304 and overall attendances were up by 1.4% in comparison to Quarter 1 2013/14.

The Trust had worked with the Emergency Care Intensive Support Team (ECIST) along with our partners to address performance. Following the visit by the ECIST a number of recommendations were made which were implemented as follows: -

- See and Treat Model in place for minor injuries.
- Nursing and medical staff flexed across all areas to provide support during times of peak activity.
- ED escalation plan finalised.
- All breaches reviewed on a daily basis by an ED consultant and the learning from this process fed back to the Team.
- Standing Operating Procedures in place for Majors, Minors and Nurse co-ordinator drafted and circulated for implementation.
- Additional administrative support in Majors.

Business plans for future developments around ECIST recommendations were completed as part of the Trust's Operational Resilience Plan to include:

- Additional ED consultants to provide extended hours of senior decision making.
- Additional Emergency Nurse Practioners to provide see and treat.
- Additional staffing for Paediatric ED enabling this service to be provided 24/7.
- Additional ED Administrative support freeing up nursing/medical time.
- Dedicated supervisory nurse in charge.

There were no exceptional matters that occurred in quarter 1 that required reporting to Monitor as part of the quarterly submission which had not already been reported.

In Quarter 1 the Board confirmed that it was satisfied that plans in place were sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework and a commitment to comply with all known targets going forward.

Quarter 2

In Quarter 2 the Trust reported a CoSRR of 1 and forecast that it would remain at 1 until the year-end prior to any borrowing.

The Trust achieved the 4 hour wait performance target for A & E in Quarter 2, but did not achieve the Referral to Treatment Target (RTT) for admitted and incomplete Pathways targets.

Actual performance in respect of the 4 hour wait in A&E target was 96.7% against a target of 95%. The Trust had continued to see large volumes of patients presenting at the Emergency Department (ED) requiring treatment and/or admission. Daily attendances remained high and overall attendances were up by 2% in comparison to Quarter 2 2013/14.

The Trust did not achieve the following RTT targets in Q2:

- Admitted Patients Reported performance for Q2 was 76.1% against a target of 90%.
- Incomplete Pathway Reported performance for Q2 was 90.8% against a target of 92%. The Trust had previously notified Monitor that these targets would not be met in Q2 as work was being carried out in July to September to address the RTT back log, which would therefore impact on achieving the target.
- The Trust was still working through data migration issues which impact on the RTT incomplete pathways performance.

There were no exceptional matters that occurred in quarter 2 that required reporting to Monitor as part of the quarterly submission which had not already been reported.

In Quarter 2 the Board confirmed that it was satisfied that plans in place were sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework and a commitment to comply with all known targets going forward.

Quarter 3

In Quarter 3 the Trust reported a CoSRR of 1 and forecast that this would remain until year-end prior to any borrowing.

Furthermore, the Trust did not achieve the 4 hour wait performance target for A & E in Quarter 3. Actual performance was 89.9% against a target of 95%. The Trust had continued to see large volumes of patients presenting at the Emergency Department (ED) requiring treatment and/or admission. Daily attendances remained high and overall attendances were up by 8.7% in comparison to Quarter 3 2013/14. During this time additional areas were used for escalation including SAU and Ambulatory Care further impacting on flow, thus resulting in all medical and surgical patients presenting through the ED.

There was a Never Event during the quarter relating to a procedure carried out on the wrong site. The incident was reported to both the Care Quality Commission (CQC) and Monitor on 21 October 2014. The incident was investigated which identified that the local checklist did not follow WHO safety checklist standard procedure and recommendations were identified and progressed to prevent reoccurrence.

There were no exceptional matters that occurred in quarter 3 that required reporting to Monitor as part of the quarterly submission which had not already been reported.

The Board confirmed that it was satisfied that plans in place were sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework and a commitment to comply with all known targets going forward.

In Quarter 3 the Board confirmed that it was satisfied that plans in place were sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework and a commitment to comply with all known targets going forward.

Quarter 4

In Quarter 4 the Trust reported a CoSRR of 1 as forecast since Quarter 2. The Trust did not achieve the 4 hour wait performance target for A & E in Quarter 4. Furthermore, the Trust did not achieve performance targets for Referral to Treatment or the performance target relating to access to healthcare for patients with a Learning Disability. In addition the Trust reported a Never Event that occurred in March 2015.

The Trust failed to achieve the A & E 4 hour wait target with actual performance at 87.3% against a target of 95%. The Trust had continued to see large volumes of patients presenting at the Emergency Department (ED) requiring treatment and/or admission. Daily attendances had remained high and overall attendances were up by 1.6% in comparison to Quarter 4 2013/14. During this time additional areas were used for escalation including SAU and Ambulatory Care further impacting on flow, thus resulting in all medical and surgical patients presenting through the ED. A detailed Action Plan to address performances and ensure compliance with the 4 hour target was implemented. Daily checks were carried out at an operational level and fortnightly reviews were carried out by the Chief Operating Officer.

All three RTT targets were not achieved in Q4, due to a fall in performance in March 15. Performance against each of the targets was as follows:

- Admitted 83.2% against a target of 90%
- Non-Admitted 89.2% against a target of 95%
- Incomplete 84.9% against a target of 92%

Failure of RTT standards was part of a predicted failure within Quarter 4 in 2014/15. Admitted backlog had reduced to fewer than 500 patients at the end of the Quarter but performance remained challenging. An RTT Improvement Plan was being prepared for consideration by the Strategic Resilience Group in May 2015 and work was continuing with the Elective Intensive Support Team around the support it could offer to the organisation.

Access to Healthcare for People with a Learning Disability was a new target for 2014/15 and was mandated for completion from Q3 onwards. The target relates to six indicators, setting out criteria for meeting the needs of people with a learning disability, based on recommendations set out in 'Healthcare for all' (DH, 2008). The Trust was able to report achievement of four indicators, but partial completion with two others relating to readily available and comprehensible information and protocols being in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports. The Trust was expecting to be fully compliant with these standards by quarter 1 2015/16 and that the Trust would have protocols in place and would be publishing reports publically via Trust Board annually from quarter 1 in 2015/16.

In quarter 4 a Never Event incident occurred on 6 March 2015 relating to the retention of a foreign object in a patient after a surgical /invasive procedure. The incident occurred during an Oral Surgery procedure due to a retained 'throat pack'. The incident was investigated.

In Quarter 4 the Board noted that the Risk Assessment Framework (RAF) indicates that by having 4 or more metrics in breach in a quarter or the A&E target breached in any 2 quarters of any 4 quarter period it will represent a governance concern which might require further investigation by Monitor.

There were no exceptional matters that occurred in quarter 4 that required reporting to Monitor as part of the quarterly submission which had not already been reported.

In Quarter 4 the Board confirmed that it was satisfied that plans in place were sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework and a commitment to comply with all known targets going forward.

8.10 Details and actions from any formal interventions.

The Trust was subject to a Monitor investigation during 2014/15. This was because the Trust's Continuity of Risk Rating was a 1 flagging high risk.

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

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

1. Financial sustainability

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

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

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

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

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

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

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

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

2. Financial governance

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

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

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

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

3. Distressed funding

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

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

4. Reporting

4.1. The Licensee will provide regular reports to Monitor on its progress in meeting the undertakings set out above, including reporting against the KPIs agreed pursuant to paragraph 1.5 and will attend meetings or, if Monitor stipulates, conference calls, to discuss its progress in meeting those undertakings. These meetings shall take place once a month unless Monitor otherwise stipulates, at a time and place to be specified by Monitor and with attendees specified by Monitor.

5. General

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

5.1.1. The Short-Term Recovery Plan;

5.1.2. The Long-Term Recovery Plan; and

5.1.3. The Financial Governance Plan.

8.11 The Care Quality Commission

The Care Quality Commission (CQC) makes sure hospitals, care homes, dental and GP surgeries and all other care services in England provide people with safe, effective, compassionate and high quality care, and encourages these services to make improvements. The CQC does this by inspecting services and publishing the results on its website to enable members of the public to make better decisions about the care they receive.

The CQC carries out its role in the following ways:

- Setting national standards of quality and safety that people can expect whenever they receive care.
- Registering care services that meet national standards.
- Monitoring, inspecting and regulating care services to make sure they continue to meet the standards.
- Protecting the rights of vulnerable people, including those whose rights are restricted under the Mental Health Act.
- Listening to and acting on patient experiences.
- Involving people who use services.
- Working in partnership with other organisations and local groups.
- Challenging all providers, with the worst performers getting the most attention.
- Making fair and authoritative judgements supported by the best information and evidence.
- Taking appropriate action if care services are failing to meet the standards.
- Carrying out in-depth investigations to look at care across the system.
- Reporting on the quality of care services, publishing clear and comprehensive information, including performance ratings to help people choose care.

8.12 Care Quality Commission (CQC) registration

Providers of healthcare services are required to register with the CQC through a registration system.

To be registered, trusts must meet specific standards, which cover important issues for patients such as treating people with respect; involving them in decisions about care; keeping clinical areas clean, and ensuring services are safe.

The Trust is registered with the CQC without additional conditions attached to the registration.

9 INCOME DISCLOSURES

9.1 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.

10 OTHER DISCLOSURES IN THE PUBLIC INTEREST

10.1 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.

10.2 Serious incidents involving data loss or confidentiality breach

On 1 June 2013 the Health and Social Care Information Centre (HSCIC) published revised assessment criteria and reporting guidelines for incidents involving data loss or confidentiality breach. Such events are termed Information Governance Serious Incidents Requiring Investigation (IG SIRIs). The new criteria mean that more incidents of a minor nature are now reportable. Any comparison with figures published in earlier years is therefore to be treated with considerable care.

The assessment criteria were further modified by HSCIC on 7th November 2014, such that incidents reported during 2014/15 were assessed using the criteria applicable on that date.

Each IG SIRI is graded as either:

(a) Lower severity Level 1 – to be reported statistically in the Annual Report, or
(b) Higher severity Level 2 – to be reported to the Information Commissioner's Office and detailed individually in the Annual Report.

During 2014/15 there were no IG SIRIs at the higher severity Level 2, and so no incidents were required to be reported to the Information Commissioner's Office.

IG SIRIs classified at the lower severity Level 1 are aggregated and reported below in the specified format. During 2014/15 there were a total of 72 such incidents.

Summary of other personal data related incidents in 2014/15 (severity Level 1)		
Category	**Breach type**	**Total**
A	Corruption or inability to recover electronic data	0
B	Disclosed in error	48
C	Lost in transit	3
D	Lost or stolen hardware	0
E	Lost or stolen paperwork	15
F	Non-secure disposal – hardware	0
G	Non-secure disposal – paperwork	1
H	Uploaded to website in error	0
I	Technical security failing (including hacking)	3
J	Unauthorised access/disclosure	2
K	Other	0

Notes:

B Most incidents relate to letters sent to the wrong address, e.g. where a patient has moved but not informed the Trust.

E Most incidents relate to misplaced paperwork which was later recovered and disposed of securely.

I Incidents relate to PCs left unattended, or data sent via ordinary email. There were no incidents of systems being hacked or data being intercepted.

10.3 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 put in place 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.

Disclosures in this section are not subject to audit

11 STATEMENT OF ACCOUNTING OFFICER'S RESPONSIBILITIES

11.1 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 Monitor.

Under the NHS Act 2006, Monitor has directed Great Western Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of 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 *NHS Foundation Trust Annual Reporting Manual* and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgments and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; and
- prepare the financial statements on a going concern basis.

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

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

Signed 

Nerissa Vaughan
Chief Executive

27 May 2015

12 AUDITOR'S OPINION AND CERTIFICATE

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

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST ONLY

Opinions and conclusions arising from our audit

1 1 Our opinion on the financial statements is unmodified

We have audited the financial statements of Great Western Hospitals NHS Foundation Trust ("the Trust") for the year ended 31 March 2015 set out on pages 200 to 240. In our opinion:

- The financial statements give a true and fair view of the state of the Group's and the Trust's affairs as at 31 March 2015 and of the Group's and the Trust's income and expenditure for the year then ended; and
- The financial statements have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2014/15.

2 Our assessment of risks of material misstatement

In arriving at our audit opinion above on the financial statements the risks of material misstatement that had the greatest effect on our audit were as follows:

Valuation of land and buildings - £200.1 million

Refer to page 76 (Audit Committee Report), page 207 (accounting policy) and pages 224 to 226 (financial disclosures).

The risk: Land and buildings are initially recognised at cost and subsequently measured at fair value. For non-specialised property assets in operational use 'fair value' is interpreted by the FT Annual Reporting Manual (ARM) as market value in existing use, whilst for specialised assets where no market value is readily available, fair value is determined using the Depreciated Replacement Cost (DRC) basis of valuation. For an asset that is newly acquired or constructed, a formal revaluation is carried out only when there is an indication that the initial cost is significantly different to its fair value. Otherwise, the asset is re-valued on the next occasion when all assets of that class are re-valued. Monitor's Foundation Trust Annual Reporting Manual requires that asset values be kept up to date and that the frequency of revaluation will need to reflect the volatility of asset values, with annual revaluations required where assets are subject to significant volatility.

The Group undertook a desk-top revaluation exercise which incorporated all of land and buildings at 31 March 2015, based on indices supplied by the District Valuer Services,

There is a high degree of judgement required to undertake the land and buildings desk-top revaluation, in particular in regard to the assumptions made on the basis of use or condition of assets and indices applied to the assets in order to assess potential increases in valuations or impairment.

Our Response: In this area our audit procedures included:

- Assessing the qualifications, objectivity and expertise of District Valuer Services to provide relevant and appropriate indices for management to perform the desk-top revaluation exercise;
- Challenging the appropriateness of the valuation bases and assumptions applied to individual assets by reference to property records held by the Group, including reconciliation of details provided for revalued assets to the fixed asset register and indices applied to the revaluation with reference to third party data; and
- Undertaking work to understand the basis upon which any revaluations to land and buildings have been recognised in the financial statements and determining whether they complied with the requirements of the FT Annual Reporting Manual through assessing the current year revaluations for each asset against previous revaluations within the financial statements.

We also considered the adequacy of the Group's disclosures in respect of property, plant and equipment.

NHS Income Recognition - £300.8 million

Refer to page 76 (Audit Committee Report), page 205 (accounting policy) and pages 217 (financial disclosures).

The risk: The main source of income for the Group is the provision of healthcare services to the public under contracts with NHS commissioners, which make up (91%) of income. The Group participates in the national Agreement of Balances (AoB) exercise which is mandated by the Department of Health for the purpose of ensuring that intra-NHS balances are eliminated on the consolidation of the Department's resource Accounts. The AoB exercise identifies mismatches between receivable and payable balances recognised by the Trust and its commissioners at the balance sheet date.

Mis-matches can occur for a number of reasons, but the most significant arise where the Trust and commissioners fail to agree the level of estimated accruals for completed healthcare spells which have not yet been invoiced, accruals for non-contracted out-of-area treatments are not recognised by commissioners or there is a lack of agreement over proposed contract penalties for non-performance. In addition to this contract income for patient activity, other income from commissioning bodies is also recognised. Commissioners are often under pressure to spend the resources available to them in any financial year. There is a risk that amounts billed to the commissioning bodies and recognised as income may be in respect of activity that either does not exist or has been delivered after the date of payment.

We do not consider NHS income to be at high risk of significant misstatement, or to be subject to a significant level of judgement. However, due to its materiality in the context of the financial statements as a whole NHS income is considered to be one of the areas which had the greatest effect on our overall audit strategy and allocation of resources in planning and completing our audit.

Our response: In this area our audit procedures included:

- Reconciling the income recorded in the financial statements to signed contracts with material commissioners and reviewing material variations agreed throughout the year to supporting activity, supported by explanations from the Trust;
- Assessing whether the Group was in formal dispute or arbitration in relation to any material income balances and examining the supporting correspondence, including - if appropriate - any legal advice, for consistency with the treatment of these balances within the financial statements;
- Inspecting third party confirmations from commissioners, including the results of the Agreement of Balances (AoB) exercise with other NHS organisations and comparing the values disclosed within their financial statements to the values recorded in the Group's financial statements through the national Agreement of Balances exercise mandated by the Department of Health;
- Carrying out testing of invoices raised around the financial year-end to determine whether income had been recognised in the appropriate period.

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

The materiality for the financial statements was set at £5.8m, determined with reference to a benchmark of income from operations (of which it represents 2%). We consider income from operations to be more stable than a surplus-related benchmark.

We report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £0.2, in addition to other identified misstatements that warrant reporting on qualitative grounds.

The Group has two reporting components and both of them were subject to audits for group reporting purposes performed by the Group audit team at one location in Swindon. These audits covered 100% of group income, surplus for the year and total assets. The audits performed for group reporting purposes were all performed to Group materiality levels.

4 Our opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts is unmodified

In our opinion:

- The part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2014/15; and
- The information given in the Strategic Report and the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

5 We have nothing to report in respect of the following matters on which we are required to report by exception

Under ISAs (UK and Ireland) we are required to report to you if, based on the knowledge we acquired during our audit, we have identified other information in the Annual Report that contains a material inconsistency with either that knowledge or the financial statements, a material misstatement of fact, or that is otherwise misleading.

In particular, we are required to report to you if:

- We have identified material inconsistencies between the knowledge we acquired during our audit and the directors' statement that they consider that the Annual Report and Accounts taken as a whole is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the Group's performance, business model and strategy; or
- The 'GWH NHS FT Audit, Risk & Assurance Committee Annual Report 2014/15' does not appropriately address matters communicated by us to the Audit Committee.

Under the Audit Code for NHS Foundation Trusts we are required to report to you if in our opinion:

- The Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014/15, 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.
- The Trust has not made proper arrangement for securing economy, efficiency and effectiveness in its use of resources

We have nothing to report in respect of the above responsibilities.

6 Other matters on which we report by exception - adequacy of arrangements to secure value for money

Under section 62(1) of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Monitor considers that the Trust has contravened and is failing to comply with the provider licence condition CoS3: Standards of corporate governance and financial management paragraphs (1)a and FT4: NHS foundation trust governance arrangements paragraphs 2 and 5(a), (c), (d), (f) and (h) relating to using its resources "effectively, efficiently and economically" and that these contravention and failures are significant.

As a result of these matters we are unable to conclude that the Trust made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2015.

Certificate of audit completion

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

Our certificate is qualified in accordance with paragraph 5.12 of the Audit Code as:

- Whilst we have issued a limited assurance opinion in relation to the content of the quality report and one of the mandated indicators (62 day Cancer Waits), we have not issued an opinion in relation to the Trust's other mandated indicator (18 week Referral to Treatment target); and
- We have been unable to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Respective responsibilities of the accounting officer and auditor

As described more fully in the Statement of Accounting Officer's Responsibilities on page 174 the accounting officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the UK Ethical Standards for Auditors.

Scope of an audit of financial statements performed in accordance with ISAs (UK and Ireland)

A description of the scope of an audit of financial statements is provided on our website at www.kpmg.com/uk/auditscopeother2014. This report is made subject to important explanations regarding our responsibilities, as published on that website, which are incorporated into this report as if set out in full and should be read to provide an understanding of the purpose of this report, the work we have undertaken and the basis of our opinions.

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. 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 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.

Jonathan Brown

Jonathan Brown
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
100 Temple Street, Bristol, BS1 6AG
28 May 2015

13 ANNUAL GOVERNANCE STATEMENT

13.1 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.

13.2 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 2014 and up to the date of approval of the annual report and accounts.

13.3 Capacity to handle risk

Leadership is given to the risk management process by the executive director's. Risk management forms part of the executive director job descriptions, annual appraisal and personal development plans. Executive directors personally review the assurances against strategic objectives within their remit on a quarterly basis as part of the Board Assurance Framework. They ensure action is taken to address gaps in controls and proactively identify evidence of positive assurance. All Executive and Non-Executive Directors have been trained on risk management and on their roles and responsibilities for leadership in risk management.

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. This was introduced during 2014/15 as additional support in management of risks for managers. Particular emphasis is given to the identification and management of risk at a local level. Discussions at Divisional meetings 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.

13.4 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 will be managed within the organisation and it sets out formal reporting processes. 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 checks that processes for risk management are effective.

The three main elements of our risk management strategy are:

- Risk Assessment
- Risk Register
- Board Assurance Framework

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 there is a robust Incident Management Policy in place and at corporate induction employees are actively encouraged to utilise the web-based incident reporting system. A healthy incident reporting culture has been maintained for a number of years providing assurance that employees feel able to report incidents and risks. A Being Open Policy, based on National Patient Safety Agency guidance, is also in place and regularly reviewed. The Care Act 2014 introduced a statutory Duty of Candour on the 1 of October 2014, the CQC are charged with policing compliance and taking action where breaches with the duty are found. The Trusts Clinical Risk Team has been diligently embedding this Act into practice at the Trust.

An annual audit is undertaken by the Health and Safety Team of all wards and departments which demonstrates risk assessment and risk management in practice.

Risk Register

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 which score 15 and above (15+) should be reviewed monthly at the Executive Committee. 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).
In 2014/15 the Audit, Risk and Assurance Committee overviewed the 12+ risk register to be assured that processes for managing risks are consistent whatever the risk scores. Risks are scrutinised locally at Divisional meetings and there is a strong focus that managing all risks is in place. The

housekeeping of the risk register has improved upon the 2013/14 period and the risk register has seen a reduction is risks as duplicates, and business as usual risks etc. have been archived. However further work required to ensure the risk register is well managed and updated frequently, so that reports received by the Committees are well informed and up to date.

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,
- the assurances on those controls, and
- any gaps in assurances.

An internal audit undertaken in April 2015 granted the Trust substantial (green) assurance on the design and implementation of the board assurance framework, without recommendations. The Framework has been commended by the Trust's auditors as an example of good practice for recommendation to other Trusts. Notwithstanding this, the Trust continues to look at how the framework can be developed further to ensure it remains an effective tool for managing risk.

Significant Risks

There are a number of risks identified on the board assurance framework and risk register. Examples of significant risks identified during 2014/15, together with the actions that have been taken to mitigate them are summarised as follows: -

Risk	How risk was mitigated
Workforce • Continued local and national shortage of clinical roles. • Recruitment to meet today and the future demand • Costs to cover vacancies and workforce shortfalls. • Employee satisfaction and retention	The Trust developed a five year People Strategy in 2014 to support delivery of the Quality Strategy with a focus on working smarter not harder, employing the right people for the right job and promoting capacity and capability by investing in staff, infrastructure and partnerships. The People Strategy is underpinned by the Recruitment and Retention Plan which includes the following risk mitigation- • Seek the retention of existing employees and continue international clinical recruitment including countries outside the UK. • Seek partnership with other health care providers. • Continuation of E-Rostering to improve the rostering of substantive employees and therefore reduce Bank and Agency spend. • Identify alternative 'skill mix' and work force models as part of the Workforce Programme which includes the delivery of agency reduction. • Seek to reduce use of temporary staffing to 2% in 2015/16 with stretch plans being worked up to deliver 1%. Interim plans to negotiate favourable terms with agency suppliers.
Risk of not being able to balance demand and capacity challenges	• Modelling of capacity verses demand / future sustainability considered • Workforce and accommodation planning • Discussions with Clinical Commissioning Groups about future services • Look to expand the number of ambulatory care conditions which can be seen, treated and discharged from this service.

Risk	How risk was mitigated
	• Seek to cap elective services in line with contracts agreed with commissioners whilst scoping the potential impact and adverse consequences before taking the decision. • Establishment of early trigger metrics to be agreed with Commissioners to alert both parties when the demand exceeds the contracted activity levels. • Corrective action in line with the contract guidance.
Risk of non-delivery of Cost Improvement Plans (CIPs) resulting in inability to invest in service redesign initiatives and to achieve a balanced financial position	• Creation of Transformation Board to ensure appropriate scrupulousness around the delivery of CIPs. • Ensure financial support to Divisions is sufficient to provide the necessary information and challenge around developing and monitoring against CIPs. • Financial and governance review undertaken. • Recovery plan has been agreed by the Trust and presented to Monitor.
Equipment purchased under the PFI scheme, threat to provision of service and patient experience	• Finance, Investment and Performance receive monthly reports detailing risks where the demise or 'ill health' of equipment is the hazard to patient care or continued provision of service. • Divisions working closely with Divisional Accountants • CIPs/QIPP delivery essential for service redesign and equipment investment • Reliance on Trust charity to fund service innovations
Failure to meet 95% ED 4 hour wait target	• Capacity Management plan (including) ED saturation being implemented in Spring 2015 • Introduction of Spring to Green Innovation, joining up with health and social care organisations across Swindon and Wiltshire to improving the way patients flow through the hospital and the wider health and social care system. • Monthly reporting to Executive Committee and Trust Board • ECIST invited in to undertake review and recommend areas for improvement
Patient Flow	• Introduction of Spring to Green Innovation, joining up with health and social care organisations across Swindon and Wiltshire to improving the way patients flow through the hospital and the wider health and social care system. • Deliver the recommendations which come out of the ECIST Review to be in a stronger position ahead of next winter.

Assurances and gaps in those assurances have been identified during 2014/15. Assurances and gaps are sought from a variety of sources including audits, external reviews or peer challenge. As at the end of March 2015, there were 53 gaps in assurances identified. This compared with 36 gaps at the end of March 2014 and 17 in March 2013. Whilst there are gaps in assurances, there are action plans in place to address them. Gaps demonstrate that the Trust is using the Board Assurance Framework as an effective tool for managing risks to achieving our strategic objectives.

New risks for 2015/16 have been identified through the annual plan process and will be added to the Assurance Framework. Major future risks, (which include significant clinical risks) for 2015/16 including the following: -

TABLE – Examples of Future risks

Risks	Actions to manage and mitigate, including how outcomes will be assessed
Quality and Safety	
Adverse impact on quality and safety due to financial constraints.	Safety Improvement Plan has been developed and approved setting out clear and measurable safety priorities together with clear principles underpinning our approach. Quality Impact Assessments before and during a change is essential to monitor the impact with sign off at Executive level from both the Chief Nurse and Medical Director key before a change is made. Additional transformation support has been secured to support the Trust in equipping divisions with the skills and ideas to help identify opportunities to deliver savings as well as drive quality. Our process for Strategic Service Reviews will also help identify different ways of working and areas for disinvestment without a material impact on quality and safety. Senior Quality representation will be involved in reviewing the Divisional outputs. A Communications Plan for 2015/16 is being delivered to ensure the focus for staff remains on quality and safety and that whilst the drive to deliver savings is a key priority, it must not impact on the quality and safety of patient care. Visible leadership and strong visibility on issues of quality and safety throughout the year will be key to reinforcing the culture we aim for.
Demand in some of the smaller specialties outstrips capacity resulting in longer waits.	Strategic Service Reviews are now underway with the aim of delivering output by mid-July 2015. These will help identify significant 'pinch points' in services and identify opportunities to resolve them including new ways of working, partnership opportunities and informing commissioners of changing demand profiles or service arrangements.
Workforce	
Agency spend continues at the same or higher level due to inability to recruit substantive staff in significant numbers.	A Recruitment and Retention Plan is being implemented detailing an 18 month trajectory which is closely monitored. Management controls have been strengthened over recent months and spend against pay bill is closely scrutinised at Divisional Performance Review meetings, Optimising Nursing and Midwifery Programme Board and the Senior Clinical Staffing Group. This allows opportunity to identify deviation and reasons early enough to take action.
Early indicators from staff survey highlighting concerns around communications and engagement which continue to deteriorate impacting on morale and ultimately quality of care.	Following the staff survey results for 2014, staff engagement and communication is a key priority for the Trust with the aim of improving the communication score between senior management and staff to at least better than average. A communications plan for 15/16 has been developed and endorsed by the Executive Committee setting out a range of activity which will take place to strengthen communications so our staff understand the future direction and the part they can play in helping us get there.

Risks	Actions to manage and mitigate, including how outcomes will be assessed
	The Trust will continue to invest time and resource into staff engagement to build on the mechanisms in place including: • Team Development and listening projects • Ward and department based deep dive listening projects • The ongoing development of See Something, Say Something – and the 'Nipping Things In The Bud' programme so that staff and leaders can feel free to express and have difficult conversations • Team or Department based confidential surveys • Ensuring all projects and change management has engagement at the core • Ensuring a strong, visible leadership within the Trust.
System	
Some gaps in alignment between Trust plans and commissioners resulting in risk in relation to demand management and capacity plans.	Significant work has taken place in development of this plan to bridge the gaps in alignment and some positive progress has been made. The Trust is mitigating this risk by developing a robust capacity plan to provide resilience within the Trust to cope with demand. The Trust is actively involved in influencing CCG decisions making through a System Resilience Group and Strategy Group and is supporting the CCG in a long term aim to transform the health economy in Swindon.
Financial	
CIP plans do not materialise and are not sustainable on a recurrent basis.	The Trust is actively working towards a fully identified and costed plan.
Cash position – ability to pay our suppliers and workforce.	This will form part of the Trust's recovery plans and will be closely monitored through the Finance, Investment and Performance Committee.

Organisation Culture

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 learns from the Family and Friends Test, comment cards and social media.

The Trust introduced Voice book in May 2014. This is a 24 hour message service whereby 'customer' (patients, family, carers, and visitors)' of the Trust can leave a voicemail message to provide feedback about the Trust. All messages are be listened to by Customer Services and each month a balanced selection is played to relevant service areas and the Board.

In 2014/15 the Family and Friends Test was rolled out to employees and additional questions were included focussing on making improvements. Results are published in the NHS Choices webpage.

The Trust has mechanisms in place to promote a culture in which employees are supported to be open with patients when things go wrong. The Trust has a Being Open Policy and a Whistle Blowing Policy which encourages employees to come forward with concerns. A "See Something, Say

Something Campaign" was introduced in 2013/14 to encourage employees to come forward with any concerns.

The Trust takes part in an annual staff survey (*Section* 0 *– Staff Survey Report refers*). For 2014/15 areas for improvement around staff were identified and an action plan is being developed to address these. The Trust has a culture of listening to and responding to staff concerns and views. In 2014/15 the People Strategy was developed and this continues to be rolled out with updates on milestone actions reported to the Board.

The Trust has an Incident Management Policy whereby employees are required to report incidents and near misses. This helps the Trust to learn and form plans for improvements when things go wrong.

Reports to the Board and its Committees include a quality impact assessment for all papers, with any areas of concern highlighted and addressed. Quality, as well as equality impact assessments have also been introduced 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 objectives around equality and diversity to ensure everyone is treated fairly and equally (*Section 0 – Social and community rights issues refers*

During 2014/15 risk register reporting was formalised and reactive to the Division's needs outside of the reports to the Board and Executive Committee, providing weekly, monthly, comparison, for Divisional meetings, Divisional Directors of Nursing, or based upon themes, such as falls, pressure ulcers etc.

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 Board has a Senior Information Risk Owner (SIRO) with responsibility for information risk policy, who is deputy chair of the Steering Group.

The Information Risk Policy defines an overall structured approach to the management of information risk, in line with the Risk Management Strategy. A register of Information Assets is maintained. The business ownership of those assets is the responsibility of senior managers within the Trust, supported by staff with responsibility for operational management of the assets. These 'owners' and 'administrators' ensure that the principal risks are identified, assessed and regularly reviewed, and that annual assurance reports are provided on the satisfactory operation and security of the key information assets.

Where assessed as appropriate, risk treatment plans are actioned, additional controls are implemented, and prioritised risks are escalated to the appropriate Risk Register. As Accounting Officer I am committed to ensuring that immediate actions are taken where significant risks have been highlighted.

A range of measures is used to manage and mitigate information risks, including: staff training, privacy impact assessments, physical security, data encryption, access controls, penetration testing, audit trail monitoring, departmental checklists and spot checks. In addition, a comprehensive assessment of information security is undertaken annually as part of the Information Governance Toolkit and further assurance is provided from Internal Audit and other reviews.

The effectiveness of these measures is reported to the Information Governance Steering Group. This includes details of any Information Governance Serious Incidents Requiring Investigation (IG SIRIs),

the Trust's annual HSCIC Information Governance Toolkit score, and reports of other information governance incidents, audit reviews and spot checks.

Stakeholder involvement

As a foundation trust our membership is a resource for supporting risk management in the Trust. The membership is represented by governors. Governors attend formal meetings of the Board of Directors to have an overview of Trust performance and influence decision making by representing the view of members. In particular the governors hold the Non-Executive Directors to account for the performance of the Board. This is done through a series of working groups, such as the Patient Experience Working Group and the Finance Working Group (*Section 0 – Council of Governors Meetings Structure refers*). During 2014/15, 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 a governor working group in May 2015, through 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. 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 matches the needs and wishes of the local community, there has been shared information and learning with the Clinical Commissioning Groups via workshops.

Quality Governance Arrangements

In November 2012, the Trust was assessed as compliant with Level 2 National Health Service Litigation Authority (NHSLA) Risk Management Standards for Acute Trusts. In addition, the Trust was assessed as compliant with level 2 for Clinical Negligence Scheme for Trusts (CNST) Risk Management Standards for maternity in May 2013.

Since 2011, the Trust has had robust arrangements in place to ensure that there is a corporate governance overview of trust wide policies and procedural documents. As part of the revised requirements, authors must carry out an equality impact assessment and a quality impact assessment of the reviewed document to ensure that any issues of concern relating to equality and quality are highlighted and addressed.

The Trust uses its Board Assurance Framework and Risk Register as tools to ensure risks are managed, including risks to quality. However, the Trust has developed a Quality Governance Assurance Framework specifically to assist the Trust in ensuring that there is continual focus on Monitor's domains of quality. Using Monitor's Quality Governance Framework and advice from a previous independent assessment of quality, the Trust has considered in detail the controls it has in place to ensure that required standards are achieved; there is investigation and action taken in respect of sub-standards performance; there is planning and a drive for continuous improvement; there is identification, sharing and ensuring delivery of best practice and risks to quality of care are identified and managed. This Quality Assurance Framework is an additional tool by which the Board gains assurance to quality from ward to Board and any gaps in controls are identified and addressed. The Quality Assurance Framework is reported through the Trust's Governance Committee and has also been considered by the Audit, Risk and Assurance Committee.

Internal CQC Compliance Assessment arrangements

The Trust's internal compliance judgement is informed by a range of information. During 2014/15 the processes for gaining assurance of compliance have been and continue to be restructured to reflect the 'New Wave' inspection framework of the Care Quality Commission (CQC).

Intelligent Monitoring Tool

On a quarterly basis the CQC release an intelligent monitoring tool. This report draws in data from a number of sources which the CQC analyse to identify areas of potential non-compliance and inform the CQC when, where and what to inspect. Risks arising from within the Divisions of the Trust, inform the relevant risk registers and are linked to the CQC regulations where appropriate. The Intelligence Monitoring Tool is now actively used to sign post issues or areas for attention. Specific improvements are made and further investigations and subsequent actions identified. These improvement plans are developed and monitored within Divisions.

Key Lines of Enquiry (KLOEs)

As part of the CQC's new approach to inspections, inspectors follow key lines of enquiry (KLOEs). These are specific key questions around whether a service is safe, effective, well led, responsive and caring. The KLOEs are underpinned by prompts that give examples of how the KLOEs can be followed by each core service lead.

Leads have been identified for each of the cores services to help them understand the KLOE and to ensure that they are aware of the best practice around good governance.

Folders owned and maintained by the core service leads are being developed. These are used by the leads and used to store relevant evidence to support compliance in preparedness for the forthcoming CQC new style inspection. This is an area for focus by the Compliance & Regulation Manager but in a measured way which supports the leads, with accountability for evidence collection remaining with the leads.

Core services mini visits

Mini visits are spot checks of compliance against the CQC Regulations and KLOE. The purpose of these is to provide "fresh eyes" on service delivery, to assist service leads in ensuring compliance. The purpose is to ensure awareness of any improvement requirements. The focus is on "business as usual" and not just because of the Trust's pending CQC Inspection later in 2015/16.

The mini visits are showing that there are areas for improvement across the Trust and have led to action to address these. The visits have also identified lots of good practice. Furthermore, shared learning enables other areas to check whether the findings apply to them. The visits provide knowledge on areas for focus, for example, our visit to Day Surgery in November highlighted challenges within this area when used for escalation and especially with appropriate facilities for patients as an inpatient area. The visit enabled these issues to be raised with the appropriate managers ensuring that all risk assessments, patient safety and care quality assurances were in place. Improvements were identified and actions put in place.

Registration

During 2014/15, the Trust undertook a fundamental review of its registration with the CQC to ensure compliance. Processes were put in place to ensure ongoing refresh and a better understanding of registration requirements have been gained. The Trust is fully compliant with the registration requirements of the Care Quality Commission.

Other

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 foundation trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

13.5 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. Set out below are the components of this condition and an explanation of the principal risks to non-compliance and what actions have been identified to mitigate those risks.

During 2014/15 the Trust asked the internal auditors to audit the processes in place to ensure that compliance with Monitor's Provider Licence is regularly monitored and reported upon to the appropriate committee and any exceptions are risk-assessed. The auditors gave **substantial assurance** commenting that the Trust has comprehensive processes in place to record, monitor and report on compliance with Monitor's Provider Licence conditions. Monitoring processes are overseen by the Governance Committee who receives regular reports on compliance and any outstanding actions relating to the detailed supporting assurance evidence. The Trust was reported as in breach of licence conditions in April 2015 and the audit review noted that the Provider Licence Compliance schedule was reporting finance-related conditions as red rated due to the Trust's deteriorating financial position during the year. There were no recommendations attached to the audit opinion.

Condition requirement	Controls	Risk
Good systems of governance	The Trust has a Board of Director comprised of (7) Non-Executive (including the Chairman) and (5) Executive Directors, plus 2 Non-Voting Directors. The Chief Executive leads on executive arrangements and the Chairman leads the Non-Executive Directors in holding the Executive Directors to account for their performance. The Trust has in place a Council of Governors with 22 governor positions who hold the Non-Executive Directors to account for the performance of the Trust. A programme of areas for focus by the Governors has been developed having regard to key risk, performance areas and finance. The Trust has an internal audit function and an external function who both provide assurance to the Trust on an ongoing basis about the systems on 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. During 2014 an audit was conducted looking specifically at the internal processes for ensuring compliance with our provider licence. The audit commended the processes in place for monitoring compliance. During 2014/15 the Trust commissioned an independent review of its financial governance arrangements given the financial position of the Trust. The final report and findings were received in March 2015 and the arising actions have been pulled together in an action plan for roll out over the coming months. Furthermore, because of the Trust's financial position and the resultant Continuity of Service Risk Rating reducing to 1, an investigation was automatically triggered by Monitor, the Independent Regulator. Part of this investigation includes looking at systems of governance. Monitor is working with the Trust to deliver an improved financial position.	On 20 April 2015, following a review by Monitor, it was considered that the Trust was in breach of the following conditions of its licence: CoS3(1)(a) and (b), FT4(2) and FT4 (5)(a), (d),(e), (f) and (g) relating to financial sustainability, performance and governance. The Trust lacked robust financial recovery plans and a plan to ensure it continues to provide services for patients in the long term. Action plans are in place to address this.
Establishment and implementation of: - (a) effective Board and committee structures; (b) clear responsibilities for	(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 comprised of Non-Executive and Executive Directors and they oversee performance by scrutinising and challenging planned action and progress. For example, there is a Finance and Investment Committee (Finance, Investment and	The arrangements for meetings under Board Committees are continually refreshed, for example during 2014/15, the Trust considered again the governance of the reporting arrangements into the Governance Committee. The

Condition requirement	Controls	Risk
the Board, for committees and for staff reporting to the Board and those committees; (c) clear reporting lines and accountabilities throughout the organisation	Performance from 1 April 2014) which considers in detail the financial performance of the Trust and a Governance Committee which considers Governance issues, including a high level overview of the governance arrangements for patient quality and safety. The Audit, Risk and Assurance Committee scrutinises and challenges processes in place for management of services. There is an Executive Committee chaired by the Chief Executive which oversees operational management of the Trust. The membership of this Committee is comprised of Executive Directors only, with the highest 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. 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. 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. (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 Trust has in place a trust wide policy and procedural documents framework. The policies and procedures give staff direction on how to manage services and functions. The documents are stored and archived using an electronic document management system and are available on the Trust's intranet. 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 Board Directors) have agreed threshold targets and specific measurable objectives linked to their	Trust had established a Patient Experience Committee and a Patient Safety Committee reporting into the Governance Committee, but this is being refreshed to provide for one committee under the Governance Committee looking at quality considerations. An issue previously identified was that not all managers are knowledgeable of the Scheme of Delegation provisions and that there is a potential for staff to make decisions outside of their delegated powers. It was planned that a training programme be rolled out during 2014/15 but this did not take place and is therefore flagged for action in 2015/16. Development of the training material has commenced. During the latter part of 2014/15, as part of the review of financial governance arrangements, it was considered that improvements could be made to performance monitoring and reporting via Divisional Directors, up through Board Committees and onto the Board. Therefore escalation arrangements are being reviewed and meeting timetables reconsidered.

Condition requirement	Controls	Risk
	areas of responsibility and aimed at delivering the Trust's Strategy. The appraisal of the senior managers is undertaken by the Remuneration Committee each year. Sitting under this is a robust appraisal process for all staff, which is monitored through the People Strategy Committee to ensure compliance. An Accountability Framework is in place for the highest managers in the organisation where agreements have been signed setting out what is expected in terms of performance and measurable outcomes. Performance is scrutinised and challenged through monthly performance meetings, overseen by Executive Directors.	
Systems to operate scrutinise and oversee operations; comply with standards; manage finances; give timely information for decision making; develop and monitor business plans and comply with law.	As above. In terms of developing and monitoring business plans, the Trust has in place a business planning timetable. This includes a requirement for all divisions to prepare a business plan / capacity which specifically identifies how planned action will contribute to the Trust's overall strategy and it feeds into the budget setting process. One, three and five year actions are specified which link to the overall Trust Strategy. During 2014/15, the Trust sought to deliver its overall Trust Strategy through the roll out of sub strategies. Regular reporting was made through to the Board setting out achievements against agreed milestone actions. During 2014/15 the Trust approved a Clinical Strategy. In terms of timely information, Committees and the Board receive information each month about finance and performance in terms of key performance indicators. Workforce information is considered quarterly. During 2014/15, the Trust developed improved reporting to address the need for timely information at ward level, presented in an understandable and usable form to assist managers in the management of their wards. The Trust commissioned a financial governance review to gain assurance around its internal processes. A number of recommendations have arisen out of the review which will be actioned.	A risk remains in that two sub strategies sitting under the overall Trust strategy still need to be developed, namely the Medium Term Viability Strategy and the Infrastructure Strategy.

Condition requirement	Controls	Risk
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 on the performance of the Board. 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. 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. Areas of success are noted and areas for improvement are reviewed and action in place to address these scrutinised. Patient experience in the form of complaints, themes and trends, family and friends test results and comment card feedback is also reviewed. The Board recognises that it is accountable for the quality of care but to ensure that the Board is assured that quality care is delivered, a Governance Committee has been established. The Governance Committee obtains assurance on behalf of the Board that the necessary structures and processes 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 Governance Committee are a patient Experience Committee and a Patient Safety Committee.	
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 Governance Committee. 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 identified to address any gaps is highlighted and monitored through the Governance Committee. Leads for each licence condition have been identified. This informs the Board which will approve a corporate governance statement confirming compliance with the governance condition and anticipated compliance with this condition for the next financial year, specifying any risks to compliance with this condition in the next financial year and any action proposes to take to manage such risks as part of Monitor's annual governance submissions.	Risks to compliance with the licence are considered by the Governance Committee. During 2014/15 areas of concern were flagged in connection with 9 licence conditions, either because obtaining evidence of compliance was challenging, actions were being completed (such as CQC registration was pending) or because of the Trust's financial position, notably the Trust's ability to comply with condition COS 7 – availability of resources.

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

The Trust has arrangements in place for agreeing targets and actions to deliver the Trust's strategic objectives. Each year the Trust produces an Annual Plan which sets out planned action for the year and risks against achieving those actions. The Trust aims to ensure that its Annual Plan is dynamic but realistic and achievable, aimed at reducing costs, driving efficiencies whilst promoting good clinical outcomes, a good patient experience and patient safety. Quality of care is at the forefront of the Trust's business planning.

Sitting below the Annual Plan are divisional plans and capacity plans which detail specific objectives and milestones to deliver actions. To ensure delivery of the planned action, there is continual review of progress against division plans within directorates and cost savings plans are scrutinised by the Finance, Investment and Performance Committee to ensure achievement (whilst maintaining and improving quality and safety). In 2014/15 the remit of the Finance, Investment and Performance Committee was expanded to formally include performance monitoring to ensure there is high level overview of performance management.

In 2014/15 the Trust commissioned an independent financial and governance review to gain assurance around internal processes and controls. Arising out of this the Trust is seeking to strengthen its internal monitoring and delivery of business and capacity plans with additional performance meetings reporting through the Trust's Executive Committee as well as the Finance, Investment and Performance Committee. Formal structures are being developed to ensure ongoing assurance processes are in place.

Senior Managers have signed up to an accountability framework which provides focus on the delivery of objectives. In turn individual members of staff have annual performance appraisals to ensure there is an organisation wide approach to delivering business plans and meeting objectives.

Performance against objectives is monitored and actions identified through a number of channels:

- approval of annual budgets by the Board of Directors;
- monthly reporting to the Patient Safety Committee on patient safety and quality indicators; patient safety and clinical risk; incidents; clinical effectiveness and regulation;
- monthly reporting to the Patient Experience Committee on patient experience and complaints; (Note going forward there will be one committee looking at patient safety and patient experience)
- regular reporting to the Board on key performance indicators including finance, activity, patient safety and human resources targets;
- monthly review of financial targets and contract performance by the Finance, Investment and Performance Committee, which is a committee of the Board;
- monthly reporting to the Executive Committee on directorate and Trust performance;
- monthly monitoring and reporting within Directorates which feeds into the Executive Committee and up to the Board; and
- quarterly reporting to Monitor, via the Finance, Investment and Performance Committee and Governance Committee on compliance with the Risk Assessment Framework.

Value for money is an important component of the internal and external audit plans. These provide assurance to the Trust that processes in place are effective and efficient in the use of resources.

Procedures are in place to ensure all strategic decisions are considered at Executive and Board level and there is wider consultation with governors and stakeholders.

The emphasis in Internal Audit work is providing assurances on internal controls, risk management and governance systems to the Audit, Risk and Assurance Committee and to the Board.

In April 2015 Monitor reported that the Trust was failing to comply with a number of the provider licence conditions, in particular, those relating to financial reporting and financial governance, due to a failure to comply with its general duty to exercise its functions effectively, efficiently and economically. As a result, the external auditors have qualified the Use of Resources certificate.

13.7 Annual Quality Report

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

Steps which have been put in place to assure the Board that the Quality Report presents a balanced view and that there are appropriate controls in place to ensure the accuracy of data include the following: -

- The Chief Nurse is the Executive lead for the Quality Account with designated personal leadership for patient safety and quality on behalf of the Trust Board. The Trust approved a refreshed Quality Improvement Strategy in 2013/14 which provides details on roles and responsibilities for quality and safety and defines the key focus for the Annual Quality Accounts. The Board considers progress in delivering the Quality Strategy at least twice a year.

- The Annual Quality Account Report 2s014/15 provides a narrative of progress toward achieving the quality improvement indicators agreed by the Executive Committee, the Patient Safety Committee and the Trust Board.

- The Trust has a robust process for scrutinising and revising local policies and monitoring compliance with NICE and other best practice guidelines. Annual audit programmes include the assessment of compliance with best practice guidance at both local and national level. This provides assurances to the Board that the quality of clinical care provided is based on the best clinical practice recognised nationally and that policies are up to date, appropriate and meet our legislative obligations. During 2014/15 there was a fundamental review of the clinical audit programme to ensure a greater focus on priority audits with meaningful outcomes.

- The Quality Account is compiled following both internal and external consultation to inform the improvement indicators. Data is provided by nominated leads in the Trust. These leads are responsible for scrutinising the data they provide to ensure accuracy. The Chief Nurse is ultimately accountable to Trust Board and its committees for the accuracy of the Quality Account Report.

- The Quality Account is subject to robust challenge at the Governance Committee on both substantive issues and also on data quality. Where variance against targets is identified the leads for individual metrics are held to account by the Governance Committee. Following scrutiny at that committee, the Quality Account is reported to Trust Board which is required to both attest to the accuracy of the data and also ensure that improvements against the targets are maintained.

- Directors' responsibilities for the Quality Account Report are outlined separately in this report.

- The Quality Account Report has been prepared in accordance with Monitor's annual reporting guidance as well as the standards to support data quality for the preparation of the Quality

Report. No material weaknesses in the control framework associated with Quality Accounts have been identified.

- The Trust has a Data Quality Group responsible for reviewing the way data is captured and recorded to ensure its accuracy and robustness. Internal and external data audits are undertaken focusing on data quality and associated process and procedures and the Data Quality Group reviews internal and external data quality dashboards. This Group feeds into an Information Governance Group which overviews information governance across the Trust.

To gain further assurance the Trust has commissioned a due diligence exercise around data quality looking at a number of data areas including discharge planning software; CQUINs information flow; improved data quality and capture; the data warehouse; modelling, demand and capacity; dashboards; and benchmarking.

The external auditors have completed a review of 'percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period' as part of the requirements outlined within '2014/15 Detailed guidance for external assurance on quality reports'. As a result of the testing performed, issue have been identified and hence external audit have not been able to provide a limited assurance opinion in relation to this indicator.

In December 2014 the Trust commissioned an independent review of its management and reporting of Referral to Treatment (RTT) from the Elective Care Intensive Support Team and the feedback from this visit and ongoing support has been used to develop a RTT Improvement Plan. Actions include supporting the protection / ring fencing of elective activity; an improved governance structure; additional monitoring; capacity solutions, pathway redesign and demand management initiatives that will contribute to sustainable delivery of the RTT standards going forward.

13.8 Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers 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 and clinical performance. It receives minutes of committees, with concerns and issues escalated by the Committee Chairs. In March 2014 the Board refreshed again the terms of references for Board Committees to ensure that the Trust's system of internal control reflects the current needs of the organisation and to ensure that appropriate reporting and decision making mechanisms are in place. There will be a further refresh in 2015.

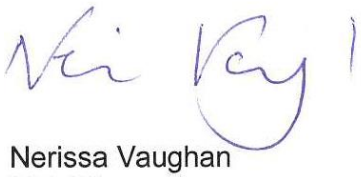
Audit, Risk and Assurance Committee	-	The Committee provides scrutiny of internal controls, including the review and challenge of the Board Assurance Framework and Corporate Risk *(Section 5.3 – Audit Report refers)*
Internal audits	-	Internal audits are carried out which look at the effectiveness of 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.
Clinical audits	-	Clinical Audit is a key component of clinical governance and is aims to promote patient safety, patient experience and to 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. Trust wide compliance of 96-100% has been attained throughout this year.
Other Committees	-	All Board Committees have a clear timetable of meetings and a clear reporting structure to allow issues to be raised. 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.
Assurance Framework	-	Provides assurance that the effectiveness of the controls to manage the risks to the organisation in achieving its principal objectives has been reviewed. An internal audit in April 2015 provided substantial assurance without recommendations to the risk management process of the Trust and the Assurance Framework has been commended by the Audit, Risk and Assurance Committee and external and internal auditors.
Care Quality Commission (CQC) standards	-	The Trust monitors compliance with CQC standards through mini visits across the Trust. Areas for improvement are identified and led by the areas inspected. The Trust's CQC Compliance lead works with leads to help them better understand the requirements of the Regulations and the key lines of inquiry which form part of the CQC new style inspections. The CQC will undertake a formal inspection in September 2015. External NHSLA Risk Management Standards (Acute) – level 2 (November 2012) External CNST Risk Management Standards (Maternity) – level 2
Reporting to Monitor	-	Declarations are considered by the Executive Committee and the Finance, Investment and Performance Committee and thereafter approved by the Board on a quarterly basis prior to submission to Monitor. In addition during 2014, the Trust made monthly reports to Monitor.

The Trust will continue to review all risks and where necessary will take approach 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.

13.9 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 a generally sound system of internal control that supports the achievement of its policies, aims and objectives.

Signed



Nerissa Vaughan
Chief Executive

27 May 2015

14 GLOSSARY OF TERMS

Abbreviation	Definition
A&E	Accident & Emergency
ANTT	Aseptic non-touch technique
BARS	Blood Audit and Release System
C.diff	Clostridium Difficile - Bacteria naturally present in the gut
Carillion	The company that owns and runs the fabric of the site
CAUTIs	Catheter Associated Urinary Tract Infections
CCG	Clinical Commissioning Groups
CETV	Cash Equivalent Transfer Value
CLRN	Comprehensive Local Research Network
CNST	Clinical Negligence Scheme for Trusts
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
DVT	Deep Vein Thrombosis
E&D	Equality & Diversity
ED	Emergency Department
EPF	Employee Partnership Forum
GWH	Great Western Hospitals NHS Foundation Trust
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
HSCIC	Health & Social Care Information Centre
HSMR	Hospital Standardised Mortality Rates
IP&C	Infection, Prevention & Control
JACIE	Joint Accreditation Committee
LAMU	Linnet Acute Medical Unit
LSCB	Local Safeguarding Children's Board
MCQOC	Matrons Care Quality Operational Group
MHRA	Medicines and Healthcare products Regulatory Agency (MHRA)

Abbreviation	Definition
MIU	Minor Injuries Unit
MRSA or MRSAB	Meticillin-Resistant Staphylococcus Aureus Bacteraemia - a common skin bacterium that is resistant to a range of antibiotics
MUST	Malnutrition Universal Screening Tool
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
NHSLA	National Health Service Litigation Authority
NICE	National Institute for Clinical Excellence
NPSA	National Patient Safety Agency
NRLSA	National Reporting & Learning System Agency
PALS	Patient Advice & Liaison Service (Now Customer Services)
PAW	Princess Anne Wing (Maternity Department in the Royal United Hospital)
PbR	Payment by Results
PCR	Polynerase chain reaction (a method of analysing a short sequence of DNA or RNA)
PLACE	Patient Led Assessment of the Care Environment
PEAT	Patient Environment Action Teams
PSQC/PSC	Patient Safety & Quality Committee – now the Patient Safety Committee
PUs	Pressure Ulcers
PURAT	Pressure Ulcer Risk Assessment Tool
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
SAFE	Stratification and Avoidance of Falls in the Environment
SEQOL	Social Enterprise Quality of Life (an NHS organisation)
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

Abbreviation	Definition
SWICC	South West Intermediate Care Centre
TVSNs	Tissue Viability Specialist Nurses
UTI	Urinary Tract Infection
VAP	Ventilated Acquired Pneumonia
VTE	Venous Thromboembolism
WCHS	Wiltshire Community Health Service
WHO	World Health Authority

15 FOREWORD TO THE ACCOUNTS

15.1 Foreword to the accounts for the year ending 31 March 2015

These accounts for the period ended 31 March 2015 have been prepared by Great Western Hospitals NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 of the National Service Act 2006 in the form than Monitor, the Independent Regulator of NHS Foundation Trusts, with the approval of the Treasury, has directed.

Signed

Nerissa Vaughan
Chief Executive

27 May 2015

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2015

		Group		Trust	
		Year Ended 31 March 2015	Year end 31 March 2014	**Year Ended 31 March 2015**	Year end 31 March 2014
	Notes	**£000**	£000	**£000**	£000
Operating Income from continued operations	3 - 4	**300,764**	308,102	**300,396**	307,799
Operating Expenses of continued operations	5	**(294,438)**	(309,167)	**(293,889)**	(308,699)
Operating surplus/(deficit) from continued operations		**6,326**	(1,065)	**6,507**	(900)
Finance Costs					
Finance income	10	**28**	280	**28**	280
Finance expense - financial liabilities	11	**(14,164)**	(15,471)	**(14,164)**	(15,471)
Finance expense - unwinding of discount on provisions		**(36)**	(38)	**(36)**	(38)
Public Dividend Capital Dividends payable		**(979)**	(1,094)	**(979)**	(1,094)
Net finance costs		**(15,151)**	(16,323)	**(15,151)**	(16,323)
Movement in fair value of investments		**54**	22	**0**	0
SURPLUS/(DEFICIT) FOR THE YEAR		**(8,771)**	(17,366)	**(8,644)**	(17,223)
Other comprehensive income					
Items that are not subsequently reclassified to income and expenditure					
Gain from transfer by absorption from demising bodies		**0**	34,848	**0**	34,848
Revaluation	13.3	**0**	(3,164)	**0**	(3,164)
Total comprehensive income for the year		**(8,771)**	14,318	**(8,644)**	14,461
Note:					
Surplus/(deficit) for the year as shown above		**(8,771)**	(17,366)	**(8,644)**	(17,223)
Less net impairment gain charged to Operating Income	13.3	**0**	17,463	**0**	17,463
Adjust for (surplus)/deficit on Charitable Funds consolidation		**127**	143		
Surplus before impairments and consolidation of Charity		**(8,644)**	240	**(8,644)**	240

All income and expenditure is derived from continuing operations.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2015

	Notes	Group 31 March 2015 £000	31 March 2014 £000	Trust 31 March 2015 £000	31 March 2014 £000
Non-Current Assets					
Intangible assets	12	**2,389**	1,094	**2,389**	1,094
Property, Plant and Equipment	13	**204,040**	205,333	**204,040**	205,333
Other investments	15	**861**	820	**0**	0
Total non-current assets		**207,290**	207,247	**206,429**	206,427
Current Assets					
Inventories	16	**6,316**	5,779	**6,316**	5,779
Trade and other receivables	17	**28,469**	20,969	**28,526**	21,098
Cash and cash equivalents	19	**2,261**	4,891	**2,064**	4,438
Total current assets		**37,046**	31,639	**36,906**	31,315
Current Liabilities					
Trade and Other Payables	20	**(35,133)**	(28,627)	**(35,129)**	(28,623)
Borrowings	23	**(4,318)**	(1,989)	**(4,318)**	(1,989)
Provisions	24	**(153)**	(153)	**(153)**	(153)
Tax Payable	22	**(1,613)**	(1,649)	**(1,613)**	(1,649)
Other liabilities	21	**(2,302)**	(545)	**(2,302)**	(545)
Total current liabilities		**(43,519)**	(32,963)	**(43,515)**	(32,959)
Total assets less current liabilities		**200,817**	205,923	**199,820**	204,783
Non-Current Liabilities					
Trade and Other Payables	20	**0**	0	**0**	0
Borrowings	23	**(128,430)**	(125,895)	**(128,430)**	(125,895)
Provisions	24	**(1,486)**	(1,733)	**(1,486)**	(1,733)
Other Liabilities	21	**(1,474)**	(1,588)	**(1,474)**	(1,588)
Total non-current liabilities		**(131,390)**	(129,216)	**(131,390)**	(129,216)
Total assets employed		**69,427**	76,707	**68,430**	75,567
Financed by Taxpayers' Equity					
Public dividend capital		**30,386**	28,895	**30,386**	28,895
Revaluation reserve		**29,828**	29,828	**29,828**	29,828
Income and expenditure reserve		**8,216**	16,779	**8,216**	16,844
Charitable fund reserves		**997**	1,205	**0**	0
Total taxpayers' equity		**69,427**	76,707	**68,430**	75,567

Signed.....
Nerissa Vaughan
Chief Executive

Date.... 27-5-15

The notes on pages 205-235 form part of the financial statements

Great Western Hospitals NHS Foundation Trust
Accounts for the year ended 31 March 2015

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

Group	NHS Charitable funds reserve	Public Dividend Capital	Revaluation Reserve - Tangible assets	Income and Expenditure Reserve	**Total**
	£000	£000	£000	£000	**£000**
Taxpayers' Equity at 1 April 2013	**1,401**	**27,511**	**20,462**	**11,631**	**61,005**
Surplus/(deficit) for the year	(143)	0	0	(17,223)	(17,366)
Transfers by modified absorption: gains/(losses) on 1 April transfers from demising bodies	0	0	0	34,848	34,848
Transfers by modified absorption: transfers between reserves	0	0	12,530	(12,530)	
Revaluation gains/(losses) and impairment losses property, plant and equipment	0	0	(3,164)	0	(3,164)
Public Dividend Capital received	0	884	0	0	884
PDC adjustment for cash impact of payables/receivables transferred from legacy teams	0	500	0	0	500
Other reserve movements - charitable funds consolidation adjustment	(53)	0	0	53	0
Taxpayers' Equity at 31 March 2014	**1,205**	**28,895**	**29,828**	**16,779**	**76,708**
Surplus/(deficit) for the year	(127)	0	0	(8,644)	(8,771)
Public Dividend Capital received	0	1,491	0	0	1,491
Other reserve movements - charitable funds consolidation adjustment	(81)	0	0	81	0
Taxpayers' Equity at 31 March 2015	**997**	**30,386**	**29,828**	**8,216**	**69,427**

NHS Charity is separately identifiable above.

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2015

	Notes	Group Year Ended 31 March 2015 £000	Year Ended 31 March 2014 £000	Trust Year Ended 31 March 2015 £000	Year Ended 31 March 2014 £000
Cash flows from operating activities					
Operating surplus/(deficit) from continuing operations		**6,326**	(1,065)	**6,507**	(900)
Depreciation and amortisation		**8,671**	8,646	**8,671**	8,646
Impairments		**0**	17,463	**0**	17,463
Increase in inventories		**(537)**	(417)	**(537)**	(417)
Increase in trade and other receivables		**(7,945)**	(3,125)	**(7,776)**	(3,104)
Increase in trade and other payables		**7,376**	2,006	**7,376**	2,068
Increase/(Decrease) in other liabilities		**1,643**	(817)	**1,643**	(817)
NHS charitable funds - net adjustments for working capital movement		**94**	0	**0**	0
Decrease in provisions		**(283)**	(389)	**(283)**	(389)
Net Cash Generated from Operations		**15,344**	22,302	**15,600**	22,550
Cash flows from investing activities					
Interest received		**28**	280	**28**	280
Purchase of Intangible assets		**(351)**	(209)	**(351)**	(209)
Purchase of Property, Plant and Equipment		**(7,455)**	(7,702)	**(7,455)**	(7,702)
Net cash used in investing activities		**(7,778)**	(7,631)	**(7,778)**	(7,631)
Cash flows from financing activities					
Public Dividend Capital received		**1,491**	884	**1,491**	884
Public dividend capital received (PDC adjustment for modified absorption transfers of payables/receivables)		**0**	500	**0**	500
Loans received from the Independent Trust Financing Facility		**5,000**	0	**5,000**	0
Capital element of Private Finance Initiative Obligations		**(1,864)**	(4,983)	**(1,864)**	(4,983)
Interest paid		**(45)**	(50)	**(45)**	(50)
Interest element of Finance Leases		**(26)**	(31)	**(26)**	(31)
Interest element of Private Finance Initiative Obligations		**(14,093)**	(15,390)	**(14,093)**	(15,390)
PDC dividends paid		**(526)**	(2,027)	**(526)**	(2,027)
Cash flows from other financing activities		**(196)**	(130)	**(196)**	(102)
Cash and cash equivalents transferred by normal absorption		**63**		**63**	
Net cash used in financing activities		**(10,196)**	(21,227)	**(10,196)**	(21,199)
Decrease in cash and cash equivalents		**(2,630)**	(6,556)	**(2,374)**	(6,280)
Cash and cash equivalents at 1 April 2014		**4,891**	11,447	**4,438**	10,718
Cash and cash equivalents at 31 March 2015	19	**2,261**	4,891	**2,064**	4,438

ACCOUNTING POLICIES

1 Basis of Preparation

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the FT ARM 2014/15 issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered in relation to the accounts.

On 20 April 2015, folowing a review by Monitor, the Trust was found to be in breach of the following conditions of its licence: CoS3(1)(a) and (b), FT4(2) and FT4 (5)(a), (d), (e), (f) and (g) relating to the financial sustainability, performance and governance of the Trust. Notwithstanding this breach, a deficit for the year ending 31st March 2015 of £8.7m and a forecast deficit for the year ending 31 March 2016 of £18.7m, the accounts have been prepared on a going concern basis.

The Monitor NHS Foundation Trust Annual Reporting manual 2014/15 states that financial statements should be prepared on a going concern basis unless management either intends to apply to the Secretary of State for the dissolution of the NHS FT without the transfer of the services to another entity, or has no realistic alternative but to do so.

The Trust have prepared their annual plan, which includes a detailed cashflow forecast. The key assumptions within the plan are as follows:

- NHS Clinical Income is based on the Enhanced Tariff Option and includes assumptions on general population and demographic growth
- Delivery of costs improvement plans of £8m
- Cash injection of £3m in Q1 2015 and £2m in Q2 2015 which is expected to be provided by a further drawdown of an agreed loan of £5.0m and application for a further loan in 2015/16.

After making enquiries and considering the uncertainties described above, the Directors have a reasonable expectation that the Trust will secure adequate resources to continue in operational existence for the foreseeable future and continue to adopt the going concern basis in preparing the Annual Report and Accounts.

1.1 Accounting Convention

These accounts have been prepared under the historical cost convention, on a going concern basis modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.1.1 **Consolidation**

Great Western Hospitals NHS Foundation Trust Charitable Fund

The NHS Foundation Trust is the corporate trustee to Great Western Hospitals NHS Foundation Trust Charitable Fund. The Foundation Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Foundation Trust has the power to govern the financial and operating policies of the charitable fund so as to obtain benefit from its activities for itself, its patients or its staff.

Prior to 2013/14 the FT ARM permitted the NHS Foundation Trust not to consolidate the charitable

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Generally Accepted Accounting Principles (UK GAAP). On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

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

The key accounting policy for the Charity is in relation to investments. The Corporate Trustee has determined the investment policy to, in so far is reasonable, avoid undue risk to the real value of the capital and income of the portfolio, after allowing for inflation so the investments are held at fair value. The investment policy, also requires that all monies not required to fund working capital should be invested to maximise income and growth.

1.1.2 **Subsidiaries**

Subsidiary entities are those over which the Trust has the power to exercise control or a dominant influence so as to gain economic or other benefits. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

Until 31st March 2013, NHS Charitable Funds considered to be subsidiaries were excluded from consolidation in accordance with the accounting direction issued by Monitor.

1.2 Income

Income in respect of services provided is recognised when, and to the extent that, performance
Income relating to patient care spells that are part-completed at the year end are apportioned
Income from the sale of non-current assets is recognised only when all material conditions of sale
Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

1.3 Expenditure on Employee Benefits

1.3.1 Short term Employee Benefits

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

ACCOUNTING POLICIES (continued)

1.3.2 Pension Costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under direction of the Secretary of State, in England and Wales. It is not possible for the Trust to identify its share of the underlying scheme liabilities. Therefore the scheme is accounted for as a defined contribution scheme.

Employers pension cost contributions are charged to the 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 Superannuation Scheme

Some employees are members of the Local Government Superannuation 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 accounts. The assets are measured at fair value, and the liabilities at the present value of future obligations.

National Employment Savings Trust (NEST)

As part of the governments pension reform the Trust commenced auto-enrolment in July 2013. Staff not eligible to join the NHS pension scheme are automatically enrolled in NEST

The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised in the income and expenditure reserve and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

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1.4 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.

1.5 Property, plant and equipment

1.5.1 Recognition

Property, plant and equipment is capitalised where:

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

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

ACCOUNTING POLICIES (continued)

1.5.2 Measurement

Valuation

All property, plant and equipment are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Land and Property assets are valued every 5 years with a 3 yearly interim valuation also carried out. Annual impairment reviews are carried out in other years. The 3 and 5 yearly interim revaluations are carried out by a professionally qualified valuer in accordance with the Royal Chartered Institute of Surveyors (RICS) Appraisal and Valuation Manual. The valuations are carried out on the basis of a Modern Equivalent Asset as required by HM Treasury. The annual reviews are carried out using the most appropriate information available at the date of the review. A revaluation was carried out on 1 April 2013. This was a full revaluation.

Equipment assets values are reviewed annually internally to determine the remaining life based on past and forecasted consumption of the economic useful life of the asset.

Property used for the Trust's services or for administrative purposes are stated in the Statement of Financial Position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the Trust and the cost of the item can be determined reliably.

Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been classified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Leasehold properties are depreciated over the primary lease term.

Equipment is capitalised at current cost and depreciated evenly over the estimated lives of the asset.

	Years
Plant and Machinery	5 to 15
Furniture and Fittings	10
Information Technology	5
Transport Equipment	6

ACCOUNTING POLICIES (continued)

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 been previously 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 FT ARM, impairments that are due to a loss of economic benefit or 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 charges to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment arising from a loss of economic benefit or 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 income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'Held for Sale' once all the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales
- the sale must be highly probable i.e.

  management are committed to a plan to sell the asset;

  an active programme has begun to find a buyer and complete the sale;
  the asset is being actively marketed at a reasonable price;
  the sale is expected to be completed in within 12 months of the date of classification as 'Held for Sale' and
  the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

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

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the assets economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

ACCOUNTING POLICIES (continued)

1.6 Donated, government grant and other grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor imposes 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 property, plant and equipment.

1.7 Private Finance Initiative (PFI) Transactions

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 IAS17, the underlying assets are recognised as property, plant and equipment at their fair value together with an equivalent financial liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contractual payments are apportioned between the repayment of the liability, a finance cost and the charges for services.

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

1.7.1 Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

1.8 Intangible assets

1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

ACCOUNTING POLICIES (continued)

1.8.2 Software

Software which is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of the hardware e.g. application software is capitalised as an intangible asset.

1.8.3 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at fair value. Revaluation gains and losses and impairments are treated in the same manner as for Property, Plant and Equipment.

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

1.8.4 Valuation and economic useful lives

The valuation basis is described in note 1.5 to the accounts. There is no active market for the Trust's intangible assets and there is no revaluation reserve.

PFI Intangible Assets are depreciated over the life of the PFI Contract.
Economic useful lives of intangible assets are finite and amortisation is charged on a straight line basis:

	Minimum useful life Years	Maximum useful life Years
Software	5	5
Licences and trademarks	5	12

1.9 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.

ACCOUNTING POLICIES (continued)

1.10 Financial instruments and financial liabilities

1.10.1 Recognition

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

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

De-recognition

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

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

1.10.2 Classification

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

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

Financial assets and financial liabilities at 'fair value through the income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short term. Derivatives are also categorised as held for trading unless they are designated as hedges. Assets and liabilities in this category are classified as current assets and current liabilities.

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

1.10.4 Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets. The Trust's loans and receivables comprise current investments, cash and cash equivalents, NHS debtors, accrued income and other debtors.

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

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

1.10.5 Other financial liabilities

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

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

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

1.10.6 Determination of Fair Value

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

ACCOUNTING POLICIES (continued)

1.10.7 Impairment of financial assets

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

1.10.8 Accounting for derivative financial instruments

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through income and expenditure. They are held at fair value, with any subsequent movement recognised as gains or losses in the Statement of Comprehensive Income.

1.11 Leases

1.11.1 Finance Leases

Where substantially all of the risks and rewards of ownership of a lease 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 minimum value of the lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property, plant and equipment.

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

1.11.2 Operating Leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

1.11.3 Lease 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.

ACCOUNTING POLICIES (continued)

1.12 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 discount rates published and mandated by HM Treasury.

1.12.1 Clinical Negligence Costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed in note 23 on page 29 but is not recognised in the Trust's accounts.

1.12.2 Non-Clinical Risk Pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.13 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 25 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 25, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.14 Public Dividend Capital

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the 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), and (ii) average daily cash balances with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding any cash balances held in GBS accounts that relates to a short term working capital facility and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the accounts.

ACCOUNTING POLICIES (continued)

1.15 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.16 Corporation Tax

The Trust does not have a corporation tax liability for the year 2014/15. 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.

1.17 Foreign exchange

The functional and presentational currencies of the Trust is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the date of the transaction. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Statement of Comprehensive Income in the period in which they arise.

1.18 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.

1.19 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However, the note on losses and special payments is compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

1.20 Transfers of functions from other NHS bodies

For functions that have been transferred to the Trust from another NHS body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain corresponding to the net assets transferred is recognised within income, but not within operating activities.

The net gain corresponding to the net assets transferred from Wiltshire PCT on 1st April 2013 is recognised within the income and expenditure reserve.

For property plant and equipment assets and intangible assets, the Cost and Accumulated Depreciation / Amortisation balances from the transferring entity's accounts are preserved on recognition in the trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

ACCOUNTING POLICIES (continued)

1.21 Critical Accounting Estimates and Judgements

International accounting standard IAS1 requires estimates, assumptions and judgements to be continually evaluated and to be based on historical experience and other factors including expectation of future events that are believed to be reasonable under the circumstances. Actual results may differ from these estimates. The purpose of the evaluation is to consider whether there may be a significant risk of causing a material adjustment to the carrying value of assets and liabilities within the next financial year, compared to the carrying value in these accounts. The following significant assumptions and areas of estimation and judgement have been considered in preparing these financial statements.
Value of land, buildings and dwellings £142m, 2013-14 (£146m): 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.

Income for an inpatient stay can start to be recognised from the day of admission, but cannot be precisely calculated until after the patient is discharged. For patients occupying a bed at the 2014/15 financial year end, the estimated value of partially completed spells is £1,327k (2013-14 £1,420k). An estimate relating to maternity pathway income has also been included within deferred income in 2014/15 due to a change in income recognition. The value of this estimate is £1,376k.

Untaken annual leave: salary costs include an estimate for the annual leave earned but not taken by employees at 31 March 2015, to the extent that staff are permitted to carry up to 5 days leave forward to the next financial year. For 2014-15 this was £561k (2013-14 £558k).

Provisions: Assumptions around the timing of the cash flows relating to provisions are based upon information from the NHS Pensions Agency and expert opinion within the Trust and from external advisers regarding when legal issues may be settled.

1.25 New Accounting Standards

Accounting standards that have been issued but have not yet been adopted

The following accounting standards, amendments and interpretations have been issued by the IASB and IFRIC but are not yet required to be adopted:

Effective for the next financial year ending 31 March 2016	**Effective Date**	
IFRS 9 Financial Instruments	Uncertain	
IFRS 13 Fair Value Measurement	2015/16	not yet adopted by HM Treasury
IAS 36 Impairment of Assets - recoverable amount disclosure	2015/16	
IAS 19 Employee Benefits - employer contributions to defined benefit pension schemes	2015/16	
IFRIC 21 Levies	Uncertain	not yet adopted by HM Treasury
Annual improvements 2012	2015/16	not yet adopted by HM Treasury
Annual improvements 2013	2015/16	not yet adopted by HM Treasury

The Trust has considered the above new standards, interpretations and amendments to published standards that are not yet effective and concluded that they are either not relevant to the Trust or that they would not have a significant impact on the Trust's financial statements, apart from some additional disclosures.

The Trust has not early adopted any new accounting standards, amendments or interpretations.

2. Segmental Analysis
Group

The Trust's Board has determined that the Trust operates in three material segments which is Great Western Hospitals, Wiltshire Community Health Services and the NHS Charity.

2014-15

	GWH	WCHS	Charity	Total
Operating Income	**£'000**	**£'000**	**£'000**	**£'000**
NHS Clinical Income	211,976	56,203	0	268,179
Private Patients	2,907	0	0	2,907
Other Non Mandatory/Non Protected Revenue	3,057	24	0	3,081
Research & Development Income	822	0	0	822
Education and Training Income	9,424	39	0	9,463
Misc Other Operating Income	9,452	6,492	368	16,312
Total Income	**237,638**	**62,758**	**368**	**300,764**

2013-14

	GWH	WCHS	Charity	Total
Operating Income	**£'000**	**£'000**	**£'000**	**£'000**
NHS Clinical Income	204,423	73,155	0	277,578
Private Patients	2,869	0	0	2,869
Other Non Mandatory/Non Protected Revenue	2,597	85	0	2,682
Research & Development Income	737	0	0	737
Education and Training Income	8,413	48	0	8,461
Misc Other Operating Income	9,852	5,620	303	15,775
Total Income	**228,891**	**78,908**	**303**	**308,102**

NHS Charity is separately identifiable above.

2014 /15 Included within NHS Clinical Income - RUH maternity services - contract transferred to RUH NHSFT with effect from 1st June 2014 £3,355k

2013/14 - Included within NHS Clinical Income - RUH maternity services - contract transferred to RUH NHSFT with effect from 1st June 2014 £19,803k

3. Income
Group and Trust

3.1 Income from Activities (by Type)

	Year Ended 31 March 2015	Year Ended 31 March 2014
	£000	£000
NHS Foundation Trusts	**1,585**	237
NHS Trusts	**889**	94
CCGs and NHS England	**261,071**	273,360
Local Authorities	**6,311**	3,888
Private Patients	**2,896**	2,869
Non-NHS: Overseas patients (non-reciprocal)	**201**	61
NHS Injury Cost Recovery scheme	**807**	992
	273,760	281,501

NHS Injury Cost Recovery scheme income is shown gross and is subject to a provision for doubtful debts of 18.9% (2013/14 15.8%) to reflect expected rates of collection.

3.2 Income from Activities (by Class)

	Year Ended 31 March 2015	Year Ended 31 March 2014
	£000	£000
Elective income	**40,092**	38,592
Non elective income	**71,541**	72,660
Outpatient income	**45,591**	44,770
A & E income	**8,245**	7,617
Other NHS clinical income	**51,099**	50,174
Community contract income	**54,296**	64,819
Private patient income	**2,896**	2,869
	273,760	281,501

The decrease on Community Contract relates to the transfer of Maternity services to RUH on 1st June 2014.

3.3 Commissioner Requested Services

The table below shows the split of Commissioner Requested Services (CRS).

	Year Ended 31 March 2015	Year Ended 31 March 2014
	£000	£000
Total CRS	**269,856**	277,579
Total Non CRS	**3,904**	3,922
Total Income from Activities	**273,760**	281,501

4. Other Operating Income	**Year ended**	Year ended
Group	**31 March**	31 March
	2015	2014
	£000	£000
Research and Development	**822**	737
Education and Training	**9,463**	8,461
Charitable and other contributions to expenditure	**495**	1,072
Non-patient care services to other bodies	**1,680**	2,268
Staff recharges	**1,409**	1,613
Other Income	**12,768**	12,147
NHS Charitable Funds: Incoming resources excluding investment income	**368**	303
	27,005	26,601

4.1 Other Income includes		
Car Parking (Staff & Patients)	1,554	1,452
Estates recharges	2,359	2,371
IT recharges	14	48
Pharmacy sales	82	30
Clinical Excellence Awards	175	267
Catering	118	123
Property Rentals	1,752	1,859
Payroll & Procurement Services	71	195
Occupational Health Service	312	262
Dietetics	7	27
Ultrasound Photo Sales	62	62
Heart Improvement Programme	0	1,065
Transport services	264	254
Staff accommodation	130	126
Domestic services	116	124
Maternity improvement funding	0	494
Pathology	168	147
Other	5,584	3,241
Total	12,768	12,147

NHS Charity Income is separately identifiable above.

4.2 Overseas visitors (relating to patients charged directly by the NHS foundation trust)

	2014/15	**2013/14**
	£000	**£000**
Income recognised this year	201	61
Cash payments received in-year	139	21
Amounts added to provision for impairment of receivables	13	28
Amounts written off in-year	24	9

5. Operating Expenses **Group**	**Year Ended 31 March 2015** **£000**	Year ended 31 March 2014 £000
Services from Foundation Trusts	**2,583**	976
Services from other NHS Trusts	**1,197**	9,085
Services from CCGs and NHS England	**0**	0
Services from other NHS bodies	**0**	0
Purchase of healthcare from non NHS bodies	**1,015**	240
Employee Expenses - Executive Directors	**1,054**	1,047
Employee Expenses - Non-Executive Directors	**123**	118
Employee Expenses - Staff	**188,151**	187,100
Drug Costs	**22,510**	19,927
Supplies and services - clinical	**27,897**	25,985
Supplies and services - general	**3,575**	2,794
Consultancy services	**432**	393
Establishment	**4,970**	5,132
Research and development	**666**	737
Transport	**362**	251
Premises - business rates payable to local authorities	**1,960**	1,527
Premises - other	**7,801**	7,333
Increase / (decrease) in bad debt provision	**156**	(495)
Rentals Under operating Leases	**341**	389
Depreciation on property, plant and equipment	**8,247**	8,183
Impairments of property, plant and equipment	**0**	17,463
Amortisation on intangible assets	**424**	462
Audit services (Statutory audit)	**73**	73
Audit services (Other Assurance Services)	**89**	57
Clinical negligence	**4,457**	4,407
Patient travel	**277**	1,185
Car parking and security	**87**	78
Insurance	**237**	243
Hospitality	**37**	39
Legal Fees	**280**	292
Training courses and conferences	**937**	629
Other Services	**13,937**	13,039
Losses, ex gratia & special payments	**18**	14
NHS Charitable Funds - other resources expended	**545**	464
	294,438	309,167

Expenditure on NHS Charity is separately identifiable above.

Staff Exit Packages
The Trust has not agreed any staff exit packages in 2014/15 (31 March 2014: £nil).

Services Provided by NHS Trusts

The decrease in Services provided by NHS Trust's relates mainly to the transfer of Maternity Services to RUH on 1st June 2014. Also, the increase in Services from Foundation Trusts reflects the reclassification of RUH from NHS Trust to Foundation Trust in year.

Purchase of Healthcare from Non NHS Bodies

The increase in Healthcare purchased from NHS Bodies relates to services provided by SEQOL relating to Therapies.

Supplies and Services
Supplies and Services Costs have increased in 2014/15 reflecting additional patient activity.

Drug Costs
Drug Costs have increased in 2014/15 reflecting additional patient activity. In particular additional expenditure has been incurred on exception and NICE drugs.

Other Services

Other Services - includes cleaning, catering, portering, housekeeping and estates services.

6. Operating leases - as Lessee

Group and Trust	**Year Ended 31 March 2015 £000**	Year ended 31 March 2014 £000
Minimum lease payments	**341**	389
	341	389

Total future minimum lease payments	**Year Ended 31 March 2015**	Year Ended 31 March 2014
Payable:	**£000**	£000
Not later than one year	**328**	379
Between one and five years	**504**	648
After 5 years	**91**	241
Total	**923**	1,268

7. Employee costs and numbers

Group and Trust

7.1 Employee Expenses	**Year Ended 31 March 2015**			Year Ended 31 March 2014		
	Total	**Permanently Employed**	**Other incl agency**	Total	Permanently Employed	Other incl agency
	£000	**£000**	**£000**	£000	£000	£000
Salaries and wages	**147,626**	**146,125**	**1,501**	146,867	145,457	1,410
Social security costs	**11,337**	**11,337**	**0**	11,408	11,408	0
Pension costs - defined contribution plans Employers contributions to NHS pensions	**18,090**	**18,090**	**0**	18,124	18,124	0
Agency and contract staff	**12,772**		**12,772**	12,262	0	12,262
	189,825	**175,552**	**14,273**	188,661	174,989	13,672

7.2 Average number of employees (WTE)	**Year Ended 31 March 2015**			Year Ended 31 March 2014		
	Total	**Permanently Employed**	**Other incl agency**	Total	Permanently Employed	Other incl agency
	Number	**Number**	**Number**	Number	Number	Number
Medical and dental	**502**	**469**	**33**	457	431	26
Administration and estates	**1,105**	**1,064**	**41**	1,122	1,026	96
Healthcare assistants and other support staff	**845**	**750**	**95**	735	735	0
Nursing, midwifery and health visiting staff	**1,582**	**1,468**	**114**	1,600	1,518	82
Nursing, midwifery and health visiting learners	**16**	**16**	**0**	10	10	0
Scientific, therapeutic and technical staff	**568**	**555**	**13**	605	569	36
	4,618	**4,322**	**296**	4,529	4,289	240

7.3 Key Management Compensation	**Year Ended 31 March 2015**	Year Ended 31 March 2014
	£000	£000
Salaries and short term benefits	**840**	840
Social Security Costs	**100**	103
Employer contributions to NHSPA	**115**	104
	1,055	1,047

Key management compensation consists entirely of the emoluments of the Board of Directors of the NHS Foundation Trust. Full details of Directors' remuneration and interests are set out in the Directors' Remuneration Report which is a part of the annual report and accounts.

There are currently five Directors to whom pension benefits are accruing under defined benefit schemes.

7.4 Highest Paid Director

Executive Name & Title Salary	**Total remuneration**	
	2014/15	**2013/14**
Mrs N Vaughan, Chief Executive	**£177,500**	
Dr A F Troughton, Medical Director		£187,500

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

7.5 Multiple Statement

	2014/15	**2013/14**	**% change**
Highest paid director's total remuneration	**£177,500**	£187,500	-5.3%
Median total remuneration	**£26,093**	£27,759	-6.0%
Ratio	**6.80**	6.75	0.7%

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 organisations 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. The median pay has reduced from 2013/14 due to staff turnover and recruitment at lower pay grades. Directors' pay has also reduced as the new Medical Director is not the highedt paid Director.

8. Retirements due to ill-health
Group and Trust

During the year to 31 March 2015 there were 6 early retirements from the Trust agreed on the grounds of ill-health (31 March 2014 - 2 early retirements). The estimated additional pension liabilities of these ill-health retirements will be £337,739 (31 March 2014 - £225,590). The cost of these ill-health retirements will be borne by the NHS Pensions Agency.

9. Better Payment Practice Code
Group and Trust

9.1 Better Payment Practice Code - measure of compliance

	Year Ended 31 March 2015		Year ended 31 March 2014	
	Number	**£000**	Number	£000
Total trade bills paid in the year	**63,547**	**137,998**	61,486	114,606
Total trade bills paid within target	**15,977**	**70,103**	26,923	74,157
Percentage of trade bills paid within target	**25.14%**	**50.80%**	43.79%	64.71%
Total NHS bills paid in the year	**2,072**	**12,784**	2,415	29,168
Total NHS bills paid within target	**424**	**1,291**	1,241	14,844
Percentage of NHS bills paid within target	**20.46%**	**10.10%**	51.39%	50.89%

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.

9.2 The Late Payment of Commercial Debts (Interest) Act 1998

The Trust was charged £45,331 in the year for late payment of commercial debts (31 March 2014 £7,845).

10. Finance Income
Group and Trust

	Year Ended 31 March 2015	Year Ended 31 March 2014
	£000	£000
Interest on bank accounts	**28**	280
	28	280

11. Finance Expense
Group and Trust

	Year Ended 31 March 2015	Year Ended 31 March 2014
	£000	£000
Working Capital Facility Fee	0	42
Interest on late payment of commercial debt	45	8
Interest on obligations under Finance leases	26	31
Interest on obligations under PFI	14,093	15,390
	14,164	15,471

12. Intangible Assets
Group and Trust
12.1 2014/15:

	Computer software - purchased	Licences and trademarks	Intangible assets under construction	Total
	£000	£000	£000	£000
Gross cost at 1 April 2014	1,740	1,329	121	3,190
Additions purchased	351	0	1,368	1,719
Reclassifications	0	121	(121)	0
Gross cost at 31 March 2015	**2,091**	**1,450**	**1,368**	**4,909**
Amortisation at 1 April 2014	780	1,316	0	2,096
Provided during the year	385	39	0	424
Amortisation at 31 March 2015	**1,165**	**1,355**	**0**	**2,520**
Net book value				
Purchased	926	95	1,368	2,389
Total at 31 March 2015	**926**	**95**	**1,368**	**2,389**

12.2 2013/14:

	Computer software - purchased	Licences and trademarks	Intangible assets under construction	Total
	£000	£000	£000	£000
Gross cost at 1 April 2013	1,652	1,329	0	2,981
Additions purchased	88	0	121	209
Gross cost at 31 March 2014	**1,740**	**1,329**	**121**	**3,190**
Amortisation at 1 April 2013	429	1,205	0	1,634
Provided during the year	351	111	0	462
Amortisation at 31 March 2014	**780**	**1,316**	**0**	**2,096**
Net book value				
Purchased	960	13	121	1,094
Total at 31 March 2014	**960**	**13**	**121**	**1,094**

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13. Property, plant and equipment

Group and Trust

13.1 2014/15:	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Gross cost at 1 April 2014	35,962	163,622	5,492	6,782	36,074	58	17,135	3,270	268,395
Transfers by absorption - Normal	0	0	0	0	(136)	0	0	0	(136)
Additions Purchased	0	494	0	1,636	959	0	3,896	31	7,016
Revaluation	0	0	0	0	0	0	0	0	0
Gross cost at 31 March 2015	**35,962**	**164,116**	**5,492**	**8,418**	**36,897**	**58**	**21,031**	**3,301**	**275,275**
Depreciation at 1 April 2014	0	22,327	733	0	26,730	58	10,596	2,618	63,062
Transfers by absorption - Normal	0	0	0	0	(73)	0	0	0	(73)
Provided during the year	0	4,587	123	0	2,003	0	1,178	356	8,247
Depreciation at 31 March 2015	**0**	**26,914**	**856**	**0**	**28,660**	**58**	**11,774**	**2,974**	**71,235**
Net book value									
- Purchased at 31 March 2015	35,962	137,203	4,636	8,418	8,237	0	9,257	327	204,040
- Donated at 31 March 2015	0	0	0	0	0	0	0	0	0
Total at 31 March 2015	**35,962**	**137,203**	**4,636**	**8,418**	**8,237**	**0**	**9,257**	**327**	**204,040**
Asset Financing									
Net book value									
- Owned	35,962	21,537	53	8,418	8,237	0	9,257	327	83,791
- Finance Leased	0	115,666	4,583	0	0	0	0	0	120,249
Total at 31 March 2015	**35,962**	**137,203**	**4,636**	**8,418**	**8,237**	**0**	**9,257**	**327**	**204,040**

Transfer by absorption adjustment relates to assets transferred on divestment of Maternity Services to RUH on 01.06.14

13. Property, plant and equipment

Group and Trust

13.2 Prior year 2013/14:	**Land**	**Buildings excluding dwellings**	**Dwellings**	**Assets under construction**	**Plant and Machinery**	**Transport Equipment**	**Information Technology**	**Furniture & fittings**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Gross cost at 1 April 2013	20,800	158,485	5,206	5,101	34,183	58	13,969	3,029	240,831
Transfers by absorption - Modified	15,032	23,703	130	0	456	0	608	193	40,122
Additions Purchased	0	2,347	0	1,681	1,435	0	2,558	48	8,070
Revaluation	130	(20,913)	156	0	0	0	0	0	(20,627)
Gross cost at 31 March 2014	**35,962**	**163,622**	**5,492**	**6,782**	**36,074**	**58**	**17,135**	**3,270**	**268,396**
Depreciation at 1 April 2013	0	17,922	578	0	24,626	58	9,428	2,267	54,879
Provided during the year	0	4,405	155	0	2,104	0	1,168	351	8,183
Reversal of Impairments	0	0	0	0	0	0	0	0	0
Depreciation at 31 March 2014	**0**	**22,327**	**733**	**0**	**26,730**	**58**	**10,596**	**2,618**	**63,062**
Net book value									
- Purchased at 31 March 2014	35,962	141,295	4,759	6,782	9,218	0	6,539	652	205,207
- Donated at 31 March 2014	0	0	0	0	126	0	0	0	126
Total at 31 March 2014	**35,962**	**141,295**	**4,759**	**6,782**	**9,344**	**0**	**6,539**	**652**	**205,333**
Asset Financing									
Net book value									
- Owned	35,962	21,144	93	6,782	9,344	0	6,539	652	80,516
- Finance Leased	0	120,151	4,666	0	0	0	0	0	124,817
Total at 31 March 2014	**35,962**	**141,295**	**4,759**	**6,782**	**9,344**	**0**	**6,539**	**652**	**205,333**

Reclassification Relates to Capitalisation of Assets under Construction

13. Property, plant and equipment (cont.)

13.3 Revaluation

The Trust has not revalued land, buildings and dwellings in 2014/15 as there has not been any significant changes to asset base and an interim valuation will be carried out next year as part of the Trust's rolling programme of asset valuations.
The Trust revalued land, buildings and dwellings at 1st April 2013 in accordance with Note 1.5.2. This resulted in a decrease in the value of buildings and dwellings and a small increase in land value. The overall impact was a decrease in land, buildings and dwellings of £20,627k which was charged to Revaluation Reserve to the value of the carrying balance associated with the relevant properties (£3,164k) with the remaining balance charged to Operating Expenses (£17,463k). All other assets are valued at depreciated replacement cost with no indexation in year due to the current economic climate.

13.4. Non-current assets held for sale

The Trust has no non-current assets held for sale (31 March 2014: £nil).

14. Capital commitments

There are no commitments under capital expenditure contracts at the end of the period (31st March 2014: £nil), not otherwise included in these financial statements.

15. Investments

	Group		**Trust**	
	Year Ended 31 March 2015 £000	Year end 31 March 2014 £000	**Year Ended 31 March 2015 £000**	Year end 31 March 2014 £000
Financial Assets designated as fair value through profit & loss	**861**	820	**0**	0
	861	**820**	**0**	**0**

All Investments are non-current.

16. Inventories

Group and Trust

	31 March 2015 £000	31 March 2014 £000
Materials	**6,316**	5,779
	6,316	5,779

Inventories carried at fair value less costs to sell where such value is lower than cost are nil (31 March 2014 - £nil).

	31 March 2015 £000	31 March 2014 £000
Inventories consumed (recognised in expenses)	**(53,082)**	(48,832)
	(53,082)	(48,832)

17. Trade and other receivables

Group
(All Receivables are Current)

	31 March 2015 £000	31 March 2014 £000
NHS receivables	7,288	6,573
Other receivables with related parties	3,399	2,004
Provision for impaired receivables	(1,236)	(1,080)
Prepayments	3,443	3,407
Lifecycle prepayment	7,464	3,008
Accrued Income	2,780	2,867
Other receivables	5,110	3,653
NHS Charitable Funds: Other receivables	8	(129)
PDC receivable	213	666
	28,469	20,969

NHS Charity is separately identifiable above.

18.1 Provision for impairment of receivables

Group and Trust

	31 March 2015 £000	31 March 2014 £000
Balance at 1 April	**1,080**	1,241
Increase in provision	**156**	(545)
Amounts utilised	**0**	334
Unused amounts reversed	**0**	50
Balance at 31 March	**1,236**	1,080

18.2 Analysis of Impaired Receivables

	31 March 2015 £'000	31 March 2014 £'000
Ageing of impaired receivables		
0-30 days	**28**	25
30-60 days	**35**	13
60-90 days	**17**	15
90-180 days	**204**	250
over 180 days	**952**	777
	1,236	1,080

	31 March 2015 £'000	31 March 2014 £'000
Ageing of non-impaired receivables past their due date		
0-30 days	**1,631**	2,058
30-60 days	**1,280**	2,758
60-90 days	**546**	302
90-180 days	**1,034**	278
over 180 days	**3,755**	3,764
	8,246	9,160

	Group		Trust	
19. Cash and cash equivalents	**31 March 2015**	31 March 2014	**31 March 2015**	31 March 2014
	£000	£000	**£000**	£000
Balance at 1 April	**4,891**	11,447	**4,438**	10,718
Transfers by absorption - NORMAL	**63**	0	**63**	0
Net change in year	**(2,693)**	(6,556)	**(2,437)**	(6,280)
Balance at 31 March	**2,261**	4,891	**2,064**	4,438
Made up of				
Cash with Government Banking Service	**2,251**	4,883	**2,054**	4,430
Commercial banks and cash in hand	**10**	8	**10**	8
Cash and cash equivalents as in statement of financial position	**2,261**	4,891	**2,064**	4,438
Bank overdraft - Government Banking Service	**0**	0	**0**	0
Bank overdraft - Commercial banks	**0**	0	**0**	0
Cash and cash equivalents as in statement of cash flows	**2,261**	4,891	**2,064**	4,438

20. Trade and other payables

Group	**Current**	
	31 March 2015	31 March 2014
	£000	£000
NHS payables	**3,880**	2,525
Trade payables - capital	**2,029**	2,469
Other trade payables	**18,180**	12,929
Other payables	**4,909**	4,733
Accruals	**6,131**	5,967
Receipts in advance	**0**	0
NHS Charitable Funds: Trade and other payables	**4**	4
	35,133	28,627

Other payables include outstanding pension contributions of £2,495,727. (31 March 2014: £2,518,546).

NHS Charity is separately identifiable

21. Other liabilities	**Current**		**Non-current**	
Group and Trust	**31 March 2014**	31 March 2013	**31 March 2014**	31 March 2013
	£000	£000	**£000**	£000
Deferred income	**2,302**	545	**1,474**	1,588
	2,302	545	**1,474**	1,588

22. Tax Payable

Tax payable of £1,612,857 (31 March 2014: £1,649,737) consists of employment taxation only (Pay As You Earn), owed to Her Majesty's Revenue and Customs at the period end.

23. Borrowings
Group and Trust

23.1 PFI lease obligations

Amounts payable under PFI on SoFP obligations:	**31 March 2015**	31 March 2014
	£000	£000
Gross PFI liabilities	235,383	245,655
Of which liabilities are due		
Within one year	9,608	12,744
Between one and five years	63,638	57,785
After five years	162,137	175,126
Less future finance charges	(108,377)	(118,160)
	127,006	127,495
Net PFI liabilities		
Of which liabilities are due		
Within one year	4,116	1,876
Between one and five years	22,343	16,965
After five years	100,547	108,654
	127,006	127,495
Included in:		
Current borrowings	4,116	1,876
Non-current borrowings	122,890	125,619
	127,006	127,495

23.2 Finance lease obligations

Amounts payable under Finance lease obligations:	**31 March 2015**	31 March 2014
	£000	£000
Gross Finance lease liabilities	317	456
Of which liabilities are due		
Within one year	139	139
Between one and five years	178	317
After five years	0	0
Less future finance charges	(41)	(67)
	276	389
Net Finance lease liabilities		
Of which liabilities are due		
Within one year	119	113
Between one and five years	157	276
After five years	0	0
	276	389
Included in:		
Current borrowings	119	113
Non-current borrowings	157	276
	276	389

23.3 Loan obligations

Amounts payable under Loan obligations

Net Loan liabilities	**31 March 2015**	31 March 2014
Of which liabilities are due	£000	£000
Within one year	83	0
Between one and five years	2,633	0
After five years	2,750	0
	5,466	0

23.4 Charges to expenditure

The total charged in the year to expenditure in respect of the service element of On-Statement of Financial Position PFI contracts was £11,747 (£11,891k 2013/14)

The Trust is committed to the following annual charges

	31 March 2015	31 March 2014
PFI commitments in respect of service element:	**£000**	£000
Not later than one year	**11,611**	11,623
Later than one year, not later than five years	**50,604**	49,473
Later than five years	**145,794**	158,425
Total	**208,009**	219,521
PFI commitments present value in respect of service element:		
Not later than one year	**11,218**	11,230
Later than one year, not later than five years	**44,849**	43,847
Later than five years	**101,490**	108,362
Total	**157,557**	163,439

The estimated annual payments in future years are expected to be materially different from those which the Trust is committed to make during the next year as the service payment is increased annually in accordance with the increase in the Retail Price Index (RPI).

24. Provisions

	Current		**Non current**	
Group and Trust	**31 March 2015**	31 March 2014	**31 March 2015**	31 March 2014
	£000	£000	**£000**	£000
Pensions relating to other staff	**125**	125	**950**	1,053
Legal claims	**0**	0	**73**	84
Other	**28**	28	**463**	596
	153	153	**1,486**	1,733

	Pensions relating to other staff	**Legal claims**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**
At 1 April 2014	1,178	84	624	1,886
Arising during the year	0	0	0	**0**
Used during the year	(123)	(11)	(149)	**(283)**
Reversed unused	0	0	0	**0**
Unwinding of discount	20	0	16	**36**
At 31 March 2015	**1,075**	**73**	**491**	**1,639**
Expected timing of cash flows:				
Within one year	125	0	28	**153**
Between one and five years	521	73	250	**844**
After five years	429	(0)	213	**642**
	1,075	73	491	**1,639**

The provision under 'legal claims' relates to outstanding Employment Tribunal Claims £73,000 (31 March 2014: £84,000). The provisions under 'other' includes Injury Benefit Provision £473,000 (31 March 2014:£494,000).

Provisions within the annual accounts of the NHS Litigation Authority at 31 March 2015 include £59,824,439 in respect of clinical negligence liabilities of the Trust (31 March 2014 - £40,117,222).

The Trust has not made a provision under the Carbon Emissions Scheme as the Trust is not required to be registered in 2014/15 as the properties managed by the Trust are below the threshold. This is not anticipated to change in 2015/16

25. Contingencies
Group and Trust
There are no contingent assets and liabilities for the period ended 31 March 2015

26. Related party transactions
Group and Trust

Great Western Hospitals NHS Foundation Trust is a body incorporated by the issue of a licence of authorisation from Monitor.

The Trust is under the common control of the Board of Directors. During the year none of the Board Members or members of the key management staff or parties related to them, has undertaken any material transactions with the Great Western Hospitals NHS Foundation Trust.

The Department of Health is regarded as a related party. During 2014/15 the Trust has had a significant number of material transactions with other entities for which the Department is regarded as the Parent Department. These entities are listed below.

	Receivables	Payables	Revenue	Expenditure
	£000	**£000**	**£000**	**£000**
NHS England	657	753	35,584	720
Swindon CCG	2,216	1,215	113,329	0
Wiltshire CCG	726	162	96,020	0
BANES CCG	8	0	1,413	0
Newbury and District CCG	116	0	5,754	0
Bristol CCG	0	0	150	0
Gloucestershire CCG	866	0	7,476	0
Royal United Hospital Bath NHS Trust	376	178	923	478
Oxfordshire CCG	135	0	3,096	0
Somerset CCG	6	0	523	0
Health Education	0	0	9,386	52
NHS Litigation Authority	0	4	0	4,457
NHS Pension Scheme	0	2,496	0	18,090
Total	5,106	4,808	273,654	23,797

The Trust has also received revenue payments from a number of charitable funds, certain of the Trustees for which are also members of the Trust Board. The audited accounts of these Funds held on Trust are not included in this annual report and accounts and will be audited and published at a later date. A copy of these will be available on the Trusts' internet site.

Payables for NHS England, Swindon CCG and Wiltshire CCG relate to adjustments to income mainly relating to the recognition of Maternity patients as deferred income.

27. Private Finance Initiative contracts

Group and Trust

27.1 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, however, 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 form 1st April 2013 as part of the transfer of Community assets following the closure of PCT's. 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.

28 Financial instruments and related disclosures

Group and Trust

The key risks that the Trust has identified relating to its financial instruments are as follows:-

28.1 Financial risk

The continuing service provider relationship that the Trust has with Clinical Commissioning Groups (CCGs), and the way they are financed has not exposed the Trust to the degree of financial risk faced by business entities. The change to CCGs and NHS England has not increased the risk to the Trust. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Finance & Investment Committee.

28.2 Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

28.3 Credit risk

The majority of the Trust's income comes from contracts with other public sector bodies, resulting in a low exposure to credit risk. The maximum exposures as at 31 March 2014 are in receivables from customers, as disclosed in note 17 to the accounts. The Trust mitigates its exposure to credit risk through regular review of debtor balances and by calculating a bad debt provision at the period end.

The following shows the age of such financial assets that are past due and for which no provision for bad or doubtful debts has been raised:

	31 March 2015	31 March 2014
	£000	£000
By up to three months	**1,826**	1,080
By three to six months	**1,035**	2,058
By more than six months	**3,754**	2,758
	6,615	5,896

The Trust has not raised bad or doubtful debt provisions against these amounts as they are considered to be recoverable based on previous trading history.

28.4 Liquidity risk

The NHS Trust's net operating costs are incurred under annual service agreements with local CCG's, 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. It should also be noted that the Trust has an Overdraft Facility of £10 million available within its terms of authorisation as an NHS Foundation Trust which reduces its liquidity risk still further.

28.5 Fair Values of Financial Instruments

All the financial assets and all the financial liabilities of the Trust are measured at fair value on recognition and subsequently at amortised cost.

The following table is a comparison by category of the carrying amounts and the fair values of the Trust's financial assets and financial liabilities at 31 March 2015 and 31 March 2014.

	Carrying Value 31 March 2015 £000	**Fair Value 31 March 2015 £000**	Carrying Value 31 March 2014 £000	Fair Value 31 March 2014 £000
Current financial assets				
Cash and cash equivalents	**2,064**	**2,064**	4,438	4,438
NHS Charitable funds: financial assets	**861**	**861**	820	820
Loans and receivables:				
Trade and receivables	**24,159**	**24,159**	18,915	18,915
	27,084	**27,084**	24,173	24,173
Non-current financial assets				
Loans and receivables:				
Trade and other receivables	**0**	**0**	0	0
Total financial assets	**32,467**	**32,467**	24,173	24,173
Current financial liabilities				
Financial liabilities measured at amortised cost:				
Obligations under PFI	**4,116**	**4,116**	1,876	1,876
Obligations under Finance Leases	**119**	**119**	113	113
Trade and other payables	**33,494**	**33,494**	26,863	26,863
	37,729	**37,729**	28,852	28,852
Non-current financial liabilities				
Financial liabilities measured at amortised cost:				
Loans from Independent Trust Financing Facility	**5,383**	**5,383**	0	0
Obligations under PFI	**122,890**	**122,890**	125,619	125,619
Obligations under Finance Leases	**157**	**157**	276	276
	128,430	**128,430**	125,895	125,895
Total financial liabilities	**166,159**	**166,159**	154,747	154,747
Net financial assets	**(133,692)**	**(133,692)**	(130,574)	(130,574)

The following table reconciles the financial assets and financial liabilities that fall within the scope of IAS 39 to the relevant on-Statement of Financial Position amounts. Cash and cash equivalents and finance lease liabilities fall wholly within the scope of IAS 39.

	Current		**Non-current**	
	31 March 2015 £000	31 March 2014 £000	**31 March 2015 £000**	31 March 2014 £000
Trade and other receivables:	**372**	0	**0**	0
Non-financial assets	**0**	0	**0**	0
Prepayments	**10,907**	6,415	**0**	0
	11,279	6,415	**0**	0
Trade and other payables:				
Taxes payable	**3,335**	4,168	**0**	0
Non-financial liabilities	**0**	0	**0**	0
	3,335	4,168	**0**	0
Provisions:				
Financial liabilities	**0**	0	**0**	0
Provisions under legislation	**153**	153	**1,363**	1,670
	153	153	**1,363**	1,670

The provisions under legislation are for personal injury pensions £479,493 (31 March 2014: £494,286) and early retirement pensions £1,037,240 (31 March 2014: £1,139,355). These liabilities are not contracted, but are defined by legislation and are owed to the NHS Pensions Agency.

29. Third Party Assets

Group and Trust

The Trust held £3,223 cash at bank and in hand at 31 March 2015 (31 March 2014: £8,335) which relates to monies held by the NHS Trust on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts.

30. Losses and Special Payments

Group and Trust

	31 March 2015		31 March 2014	
	No.	**£000**	**No.**	**£000**
Losses				
Cash losses	**6**	**2**	6	1
Bad debts and claims abandoned	**50**	**48**	60	21
Total Losses	**56**	**50**	66	22
Special Payments				
Compensation payments	**24**	**13**	23	47
Ex gratia payments	**11**	**9**	23	8
Total Special Payments	**35**	**22**	46	55
Total Losses and Special Payments	**91**	**72**	112	77

There were no clinical negligence, fraud, personal injury, compensation under legal obligation or fruitless payment cases where the net payment or loss for the individual case exceeded £100,000. (2013/14 - 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.

31. Pooled Budget - Integrated Community Equipment Service

Group and Trust

	31 March 2015	31 March 2014
Income:	**£000**	**£000**
Swindon Borough Council	490	502
Paediatrics	5	38
NHS Swindon	333	244
Great Western Hospitals NHS Foundation Trust	146	152
Total Income	**974**	**936**
Expenditure	961	1,009
Total Surplus/(Deficit)	**13**	**(73)**

The above disclosure is based on month 12 management accounts provided by Swindon Borough
It should be noted that these figures are un-audited.

Share of Surplus (Deficit):		
Swindon Borough Council	7	(41)
Swindon CCG	4	(24)
Great Western Hospitals NHS Foundation Trust	2	(7)
Total Surplus/(Deficit)	**13**	**(73)**

32. Charitable fund balances

	2015
	£000
Restricted funds	**704**
Unrestricted funds	**293**
	997

Restricted funds are funds that are to be used in accordance with specific restrictions imposed by the

Unrestricted income funds comprise those funds that the Trustee is free to use for any purpose in furtherance of the charitable objects. Unrestricted funds include general funds, where the donor has not specified or restricted the use the Charity may make of their donation. General funds additionally generate income from Gift Aid, investment income, interest and donations given specifically to cover running costs.

Great Western Hospitals NHS
NHS Foundation Trust

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