Great Western Hospitals NHS
NHS Foundation Trust

Great Western Hospitals NHS Foundation Trust
Annual Report and Accounts
2013/2014

Great Western Hospitals NHS Foundation Trust
Annual Report and Accounts
2013/2014

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

CONTENTS

1 CHAIR AND CHIEF EXECUTIVE'S REPORT

This year has been busier than ever before. A growing and ageing population means we are caring for more elderly and frail patients, with a range of complex health needs. An increase in chronic diseases such as dementia, obesity and heart disease, also means many of our patients have lifelong conditions which require ongoing care. We know that this presents real challenges for us and the wider NHS and we cannot stand still. With funds getting tighter and pressures in the healthcare system growing, we need to change to do things differently and this past year has been the first step on that journey.

Working together with our partners and our commissioners in a more integrated way will help us meet these future challenges. The introduction of 29 Care Coordinators across Wiltshire is just one of the ways we are working with our partners and bringing healthcare closer to home for some of our most vulnerable patients. Care Coordinators are now a familiar point of contact for many local people, helping them stay healthy, avoid issues like isolation and putting them in touch with useful health, social and voluntary services. They work across health and social care in local GP practices, bringing much need coordination for patients and joining up the different parts of the system to help make the patient journey more seamless.

Whilst finances are tighter than ever, we continue to invest in new services and equipment which is making a real difference to patients. We are delighted with our new state-of-the-art emergency department which is now a much more pleasant, modern and comfortable environment for both patients and staff. The creation of a dedicated children's unit, means children and families are now waiting and being cared for in a calmer and more child-friendly environment, away from the busy general waiting area. The adults waiting area has also been refurbished with new seating, a TV screen and refreshments. As well as creating a much nicer environment for patients, the new layout is helping us to work more efficiently and provide an improved quality of care.

Along with the rest of the NHS we continue to face increased public scrutiny following the failings of care at Staffordshire Hospitals and quite rightly so. Throughout our recruitment drive we have been looking for people not only with the skills and professional qualifications we need, but who also have the qualities we value, integrity, kindness and compassion. We think these qualities are essential for building a culture where the patient always comes first. We now have almost 100 more nursing and midwifery staff on our wards and in the community than we did last year, but we still need more. Recruiting nurses in particular is a real challenge for the whole NHS due to a national shortage. We have recruited almost 70 nurses from Spain, Portugal and Ireland to increase staffing levels and our recruitment drive will continue until we have the staff we need, in the places we need them.

Building a culture of openness and transparency is also important and this year we launched our 'Say Something' campaign, to encourage staff to speak up if they see something they are concerned about. This supports our duty of candour to our patients and is the only way we can build a culture of true openness. Not only have we been encouraging staff to speak up if they have concerns but also when they have good ideas. We heard some fantastic ideas at our Dragons' Den event, some of which are now being implemented and making a difference to patients. This is important as we know the best ideas come from people who understand the challenges and rewards of a role, who talk to patients on a daily basis and who are passionate about providing high quality care - our staff.

The publication of our Quality Strategy and our People Strategy underpin the type of organisation we aspire to be. One which makes the patient the focus of everything we do and has the right staff with the right skills and values in post, doing all we can to help them give the best care possible.

Despite the challenges we face, as you read through this report you will see there is much to celebrate and none of these achievements would have been possible without the commitment and dedication of our staff. We have seen a fall in complaints by 19.9% because of our care and professionalism and we would like to thank all our amazing staff who, despite a challenging 12 months, have continued to provide a high quality service and care for patients with kindness and compassion.

We would also like to take this opportunity to wish a fond farewell to maternity staff in the Wiltshire community and also at the Princess Anne Wing at the Royal United Hospital in Bath, as our contract to provide these maternity services comes to an end. We are confident that our colleagues at the Royal United Hospital NHS Trust in Bath, who will provide these services from June 2014, will continue to offer local women and their families a high quality birth experience.

The next 12 months will again be the toughest the NHS has experienced but we are clear about what we need to deliver to be able to continue to provide high quality care for our patients across Swindon and Wiltshire.

Yours sincerely

Roger Hill
Chairman
28 May 2014

Nerissa Vaughan
Chief Executive
28 May 2014

2 STRATEGIC REPORT

2.1 Trust Strategy

2.1.1 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.'

2.1.2 Our ambitions

During 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, four simple yet clear ambitions were defined:

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.

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.

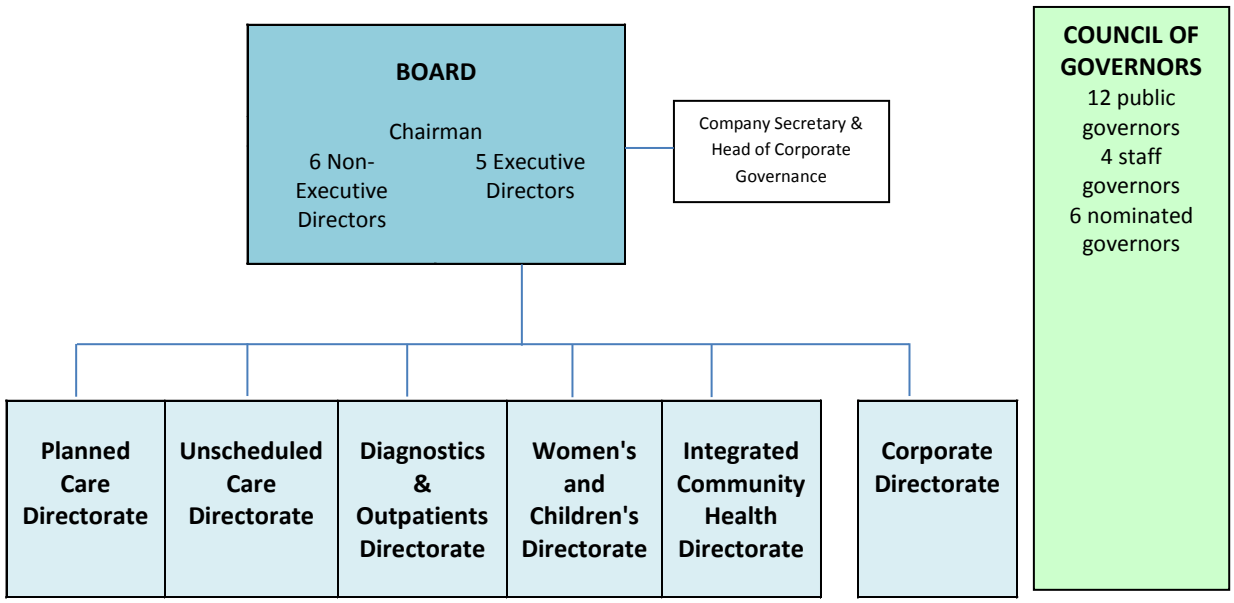
We are not directed by Government and so have greater freedom to decide, with our governors and members, our own strategy and the way services are run. We can retain surpluses and borrow to invest in new and improved services for patients and service users.

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

Great Western Hospitals NHS Foundation Trust has its main headquarters at the Great Western Hospital (GWH) in Swindon. In addition to this, the Trust also provides a range of community health and maternity services across Wiltshire and parts of Bath and North East Somerset covering a population of approximately 1,300,000 people. This includes providing services to residents of parts of Oxfordshire, West Berkshire and Gloucestershire. The Trust has a workforce circa 5,500 and the Trust's income was £307,799k in 2013/14. The history of the Trust is referred to elsewhere in this report (*Section 2.6 – History of the Trust refers*).

The regulated activities that the Trust is currently registered to provide are as follows: -

- 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. A full copy of our licence can be found at: www.gwh.nhs.uk.

2.5 Location of services

The Trust provides emergency, acute and community services to the local population at a number of sites including:

2.5.1 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.

2.5.2 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.

2.5.3 Within the Community

The Trust also provides a number of services closer to patients' homes in the local community. Some of our other sites include Chippenham, Trowbridge, Devizes, Fairford, Savernake, Shepton Mallet, Warminster, Melksham and Westbury Community Hospitals; Southgate House; Hillcote; Paulton Memorial Hospital; Princess Anne Wing, Royal United Hospital, Bath; Frome Victoria Hospital; 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.

As a Foundation Trust the organisation has greater freedom to run its own affairs, which offers financial advantages to invest in services for the future.

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 2013/14 against our strategic objectives are set out below: -

Strategic Objective 1 (care)	*Not learning from patient safety incidents*
	Higher than average Hospital Standardised Mortality Rate
	Harm to patients from hospital acquired infections
	Inadequate assurance framework and risk register
Strategic objective 2 (patient experience)	*Failure to meet 95% 4 hour wait in Emergency Department target*
	Failure to meet the 90% referral to treatment (RTT) target for elective patients
	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 2013/14 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 2013/14 quality which includes safety was our top priority with the Trust striving to provide the best care possible consistently to our patients across all our sites. Our key challenge during 2013/14 has been ensuring we have enough capacity to meet demand and maintain high quality services.
Examples of achievements across the Trust during the course of the year are as follows: -

- The Trust has in place a Nursing Together Strategy for improving patient care, the aims of which include leading the best patient, relative and care experience; strengthening leadership and professional practice; driving improvements in safety and quality of care; delivering effective and efficient services; leading a happy and healthy work life; measuring impact and improvement and delivering a workforce fit for the 21st Century.

  In 2013/14 the Trust rolled out the priorities in the Strategy which included staff training around dementia; improved compliance around safeguarding; cleanliness; productive and protected mealtimes; matron walkabouts; embedding of the supervisory role for Senior Sisters; consistent and high quality safety briefings and bedside handover; review of the Matron role; clinical supervision and succession planning and preparation for leadership roles; embedding consistent competence and practice in prevention and management of pressure ulcers and falls; close scrutiny of safe and effective medicines administration and recording; establishing nursing data sets and early warning systems; implementation of the Safer Nursing Care Tool; focus of quality improvements; and implementation of the reviewed Preceptorship Model.

- The Trust has continued to develop the Ambulatory Care Model resulting in patients not needing to stay in hospital, but are able to go home after recovery. This has been a massive success.

- Gynaecology Rapid Access Clinics and Abnormal Bleeding Clinics continue to excel. These are one stop services for women where only one attendance at hospital for treatment is required.

- Performance is good, with positive outcomes against national and local performance targets. Details on performance against key quality indicators are included in the Trust's Quality Report.

- Level 2 compliance with CNST Risk Management Standards was confirmed by a formal external assessment in May 2013 across the whole of maternity services.

- In the community the Care Coordinators have been appointed. This is a major investment with Wiltshire Clinical Commissioning Group to integrate teams with GP surgeries to ensure timely and appropriate patient care.

- A Surgical Discharge Unit was created on Meldon Ward where a team led by a Senior Nurse work to release inpatient beds quickly. The initiative has saved over 30 hours in length of stay. Plans are being developed to expand this service in 2014/15.

- In Intensive Care new monitors have been introduced throughout the unit and there are continued practice developments, such as new medicine prescription charts. An enhanced system for monitoring Ventilator Associated Pneumonia (VAP) and Catheter Related Blood Infections (CABI) was introduced.

- In respect of sterile services we successfully passed our annual audit. The service has expanded to include sterilisation to support endoscopy services and weekend and out of hour endoscopy services, as well as central sterilisation for community dentistry.

- The Trust's decision to move thyroid work to Ear Nose and Throat (ENT) resulted in the appointment of a new ENT Consultant. New ENT clinics have been introduced in Tetbury to support elective growth.

- In respect of General Surgery, we appointed two Colorectal Consultants and two Breast Consultants to cope with the significant growth both in outpatient and inpatient clinics. There has been joint working with Cheltenham and Gloucester NHS Trust associated with vascular networks and a Surgical Assessment Unit model has been introduced.

- The Trust has successfully maintained its JAG accreditation for Endoscopy. Furthermore, we have successfully accepted for 'Age extension' (BCSP) with weekend activity introduced. A pilot of rectal bleed clinics alongside the endoscopy facility was undertaken and nurse led preoperative assessments have helped to reduce "Do Not Attend" (DNA) rates.

- There have been capacity and demand in depth reviews of some services noting Gastro Services is currently underway and Respiratory, Sleep and Cardiology Services are scheduled within 2014.

- There has been an enhanced Emergency Department build including a new paediatric area. Work was completed ahead of schedule resulting in excellent ED facilities and accommodation. In addition consultant staffing in ED has been extended to cover up to 10pm 6 days a week. Furthermore, the ED Reception Service has been restructured and shift patterns altered to meet service demand.

- Outpatient services have been integrated to utilise nursing skills across all outpatient department areas

- There has been a successful MATS (Musculo Skeletal Assessment & Triage) Pilot supporting a reduction in referrals to Trauma and Orthopaedics

- One stop clinics are in place for some illnesses: e.g. 1 stop see and treat skin cancer clinics, breast clinics. Also open access follow up clinics have been introduced for breast cancer patients.

- A Mobile Chemotherapy Unit has been introduced.

- There has been an Electronic Holistic needs assessment pilot with the Adult Oncology Clinical Nurse Specialists and a service review with the Adult Oncology Clinical Nurse Specialists.

- There has been a growth in demand for Cancer Services. Activity is being shifted away from Clinical to Medical Oncology, partly accounting for the huge (46.2%) growth percentage. This rate of increase within Cancer and Haematological Services is unsustainable without additional financial and 'space' resources over the next year.

- There has been a growth in Plastic Surgery driven by an increase in follow ups, caused by the (skin) cancer incidence growth. These more complex cases result in more follow up appointments, which have been accommodated by shifting more routine activity to nurse-led Clinics.

- There have been Acute Physio increases which are largely attributable to the Musculo Skeletal Assessment and Triage (MATS) service, the rationale for which is premised on shifting activity away from Trauma and Orthopaedic and Rheumatology to Physio where possible.

- There have been significant increases in demand for the Blood Sciences Pathology Departments from both GPs via direct access and internally. Changes to national guidelines have led to an increase in cholesterol checking and renal function testing in Diabetics. Improved Dementia screening and changes to the Special Admission Unit (SAU) pathway have also contributed to the growth.

- There has been an increase in Magnetic Resonance Imaging (MRIs) which is internally driven and has resulted in an increase in waiting times (although 6 weeks is being achieved) and additional use of the mobile unit - the two new GI consultants and Neurology WLI's have contributed to this extra demand. The drivers behind the Computerised Tomography Scan (CT) growth are the same as for MRI, although increased demand from Cancer services as well as the pressures in A&E has also contributed significantly.

- The Trust has participated in a number of external assessments, peer reviews and quality assurance inspections continue as does compliance, accreditation and licensing to a large number of standards including Clinical Pathology Accreditation (CPA) – Pathology; Medicines and Healthcare Products Regulation Agency (MHRA) – Blood Regulations; Human Tissue Authority (HTA) – Mortuary Licensing; British Society of Echocardiography – Cardiac Physiology Echocardiography; Joint Accreditation Committee-ISCT (Europe) and EBMT (JACIE) – Stem Cell Transplantation and CQC – Ionising Radiation Medical exposure Regulations (IRMER) Compliance – Radiology.

All of the above achievements have made an improvement in patient care, either through reduced length of stay; quicker recovery; consistency in care; improved clinical outcomes; and additional appointments allowing us to see more patients.

A review of bed base requirements is needed to better understand and confirm these for the next one, three and five years. We have struggled during the year, particularly during the winter months, in that elective beds have been used for escalation capacity. This has impacted on the patient experience, length of stay and our financial positions along with regrettably the number of patients who have had their elective surgery cancelled. We need to combine this with robust planning to ensure we have the right staff in the right place at the right time.

Conversely, one challenge has been around theatre utilisation and lack of adequately equipped and resourced theatres. A theatre review has been undertaken to look at this and staff are currently being consulted on proposals and options. The theatre workforce review has had an adverse impact on referral to treatment times (RTT) on all specialities and held back progression of operating lists for private patients; any qualified provider activity and weekend

working.

During the year, the Trust bid to continue to provide community maternity services, but was unsuccessful. The service will therefore transfer to the Royal United Hospital, Bath on 1 June 2014.

The referral to treatment time (RTT) performance has been challenging, particularly in respect of Ear Nose and Throat (ENT). The lack of pooling amongst the consultant body has resulted in some delays in the individual feeding requests (INNF) processes. The impact of theatre workforce issues and winter pressures has had a negative effect on the RTT delivery.

In respect of Ophthalmology Services there were concerns regarding the clinical risk of the mismatch between capacity and demand leading to significant volumes of overdue follow up appointments. A service review was performed by the Royal College of Ophthalmology in September 2013. However, the time taken to achieve service change is slow and there has been continued poor referral to treatment time performance, partly due to a lack of flexible theatre capacity and practises within the workforce. Unfortunately there have been patient complaints about overdue appointments, continual turnover of junior medical staff and difficulty in recruitment has led to capacity shortfalls and on call gaps. Ophthalmology Services were closed to the choose and book service in Swindon to allow time to address the hold file back log and put in place plans to provide a sustainable Ophthalmology Service for the years ahead. The Trust has agreed investment of £1.6m to improve the service and the Royal College of Ophthalmology commended the Trust for all the work undertaken to date.

Oral Surgery's referral to treatment time (RTT) has deteriorated throughout the year with 60% of the waiting list exceeding 18 weeks. This is attributed to a range of factors including administrative error; special needs capacity; the switch from a Clinical Commissioning Group to a NHS England approval process and long outpatient waiting times.

A challenge has been coping with the 10% growth in Colonoscopy referrals and the ability to match capacity with demand. The Trust has relied on a Waiting List Initiative for base line capacity. A further pressure is ensuring surveillance backlog is proactively managed alongside the six week diagnostic demand.

Despite our significant enhancement in medical workforce for our inpatient areas, ward services are not currently configured to offer senior clinical cover 7 days per week, resulting in lower levels of discharges at weekends. Initiatives such as criteria led discharge have helped improve discharge at weekends along with a new medical handover process, but the impact of this is limited to those patients for whom a clearly defined assessment can be made.

The presence of a second medical registrar at weekends has facilitated improved weekend discharges along with overall patient safety, but requires support of other services to be most effective along with a cultural change in discharge planning.

One of the areas for further focus is the completion of our Electronic Discharge Summaries (EDS) for Day Therapy (DTC) and Coate Water (CWU) within 24hours of the patient receiving their treatment. Both areas provide a high volume of day case patient care. An action plan was produced which has enabled a more robust mechanism for capturing the metrics on a daily basis in order to provide evidence of our activity to our commissioners. We have improved our activity collation from 74% to 93% consistently, but our target is 100%.

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: -

- The roll out of the 24/7 Surgical Assessment Unit has dramatically improved the experience for the patient group, supported the Emergency Department and reduced admissions and length of stay.

- We launched a community sedation service for Dentistry allowing patients to be treated closer to home. A pilot of centralised sterilisation for dentistry was undertaken for two community sites. In addition dentistry waiting times at Erlestoke Prison were reduced.

- Two anaesthetic consultants were recruited with an enhanced recovery protocols for hip and knee replacements introduced.

- A new Consultant Orthodontist and new Orthodontic therapists were recruited resulting in a reduction in waiting times for new patient appointments.

- We appointed a new Consultant Anaesthetist with special interest in pain management to increase capacity. This resulted in reduced waiting times. In addition in relation to pain management we introduced a Ketamine Infusion Protocol and commenced nurse led follow up clinics allowing us to treat patients more quickly.

- Urology weekend ward rounds have been introduced and an out of hour's advice line deployed. This adds additional support for patients which continues once a patient has gone home. Furthermore a third Urology Consultant has been appointed to cope with additional demand allowing us to see more patients and reduce waiting times.

All of the above achievements have made an improvement in patient experience, either through reduced waiting times; reduced length of stay; treating patients closer to home; quicker recovery and support for patients when they return home.

Safeguarding and child protection activity has increased in the past few years with an increased focus on domestic abuse, substance misuse and mental health issues. This is an area for greater focus next year.

The Trust's Hospital Standard Mortality Rate (HSMR) shows an increase on last year and this is being investigated to better understand the reason for this. The Trust's Mortality Group analyses mortality data in detail to determine the reasons for variations in performance in order to make improvements. This leads to a review of both clinical coding and clinical care in areas highlighted as concerns on the Dr Foster analysis tool. One of the key elements identified is the requirement of accurate coding particularly around co-morbidities. To support this, the Trauma and Orthopaedic Team will be piloting a co-morbidity system for patients on elective emergency admission. However, in addition to reviewing the coding of deaths, going forward, the Trust will seek evidenced based initiatives from other organisations and published work. Furthermore a template will be developed to allow standardisation of review of all deaths and learning from all mortality reviews will be shared. Key themes that arise from our investigations / mortality reviews will be explored and appropriate actions to make improvements will be identified. Also, there will be monitoring of patients on the End of Life Pathway to ensure correct and appropriate reporting and clinical coding and we will work with our partners to develop an area wide plan in this area.

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

- In the community a senior leadership team has been recruited which will focus on community integration going forward.

- The Trust undertook a centralised recruitment programme during the year with 349 new starters across the whole of nursing and midwifery, 162 of which were Band 5 Registered Nurses. The Trust has taken part in recruitment fairs and open days in community hospitals. A number of vacancies remain and hence the trust will continue to explore alternative recruitment options. A recruitment plan for the year ahead is being developed, which might include further overseas campaigns.

- New ways to recruit were adopted with international recruitment initiatives in Spain, Portugal and Ireland. Since September 2013, 67 nurses and 9 midwives joined the Trust from overseas. Further international recruitment is likely.

- The Trust took part in the Transforming Leadership, Transforming Care Programme whereby 90 middle managers received training and development on planning, leadership and developing self-awareness. The Trust is looking at ways to roll out the learning for the benefit of other staff in the organisation.

- There has been continued development of nursing staff with extended roles within their sphere of practices.

- There has been a 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 2013. 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 2013 the Trust took part in the annual national NHS Staff Survey. The results, published in March 2014 place the Trust sixth from top for Acute Trusts in the South West. The results show that overall staff feel the Trust is a good place to work. There has been improvement in good communication between senior management and staff and support for immediate managers. Staff satisfaction has improved and staff appraisals are in place. However, levels of work pressure have increased, there is an increase in reporting errors, near misses or incidents and the percentage of staff experiencing harassment, bullying or abuse from patients has gone up.

  An overview of 2013 Staff Survey results is provided separately.

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

Challenges in the year included the recruitment of staff to positions in the community to meet increased service capacity and ensure succession planning for an ageing / high skill set workforce. Coupled with this was a greater challenge around recruitment generally. In view of

a national shortage of nurses and other staff, the Trust was innovative in its approach to recruitment and retention, with overseas recruitment in Spain, Portugal and Ireland, but going forward more innovative ways to recruit staff will be needed on an ongoing basis.

A further challenge in the year has been the lack of an electronic e-rostering system. Work has been underway during the year to rebuild complex rosters which will result in the ability to auto roster vacant shifts. This will offer significant time savings releasing staff time back to direct patient facing activities.

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.

As the Trust is also a provider of community services, this presents an opportunity for the Trust to control expenditure associated with care across the acute and community care pathway.

Building on work commenced in the latter part of 2012/13, the Trust has again adopted a robust approach to business planning in a challenging and changing environment. The primary focus on services remains around quality of care, but a strong factor is economic viability. The Trust has robust planning for identifying cost improvements plans and has introduced new processes for greater scrutiny and challenge around delivery of those plans. The Trust has placed great emphasis on identifying efficiencies to ensure the delivery of more services, for the same or less cost.

The Trust continues to review where further efficiencies can be realised in its services, estates and other areas. An Estates Strategy is being developed for adoption and implementation during 2014/15.

Examples of achievements during 2013/14 which impacted on the financial health of the Trust include: -

- In the community, capacity has been built through headroom. £1.65m funding for winter pressure projects has provided a mixture of substantive and pilot services.

- £14.81m of savings were delivered in year against a plan of £16m, resulting in a saving shortfall of £1.19m.

- In respect of oral and maxillofacial surgery, we made a capital investment in the 3D Cone Beam CT Scanner and established a functioning treatment room. Peripheral clinics were deployed at Tetbury and Chippenham, and the workforce was expanded within the department's laboratory to support the increased workload of maxfax and orthodontics.

- In the community setting Cost Reduction Efficiency Savings (CRES) of £604k have been achieved through productivity savings. Admissions avoided have been recorded.

One of the challenges in the community is the need for investment in equipment and estates to meet service and capacity demand. The lack of technology investment impacts on our clinical teams in terms of over burdensome administrative processes.

Whilst a corporate approach to recruitment was adopted with a view to reducing agency spend as well as securing recruitment, a challenge in year was the significant spend on agency staff.

The two main reasons for this were vacancy levels largely due to national shortages and extra posts/ work to cope with increased demand on services. This is an area for attention next year. The Trust has been unable to secure 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 for 90% of last year due to required elective capacity.

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

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

The Trust continually looks at ways to become more efficient, delivering more with less. Examples of new approaches and innovation are: -

- Change has commenced in community services to begin the transformation journey. There has been an internal assessment of our teams to benchmark working practices and changes have been made to working practices and methodologies improved within our community and ward teams. This will enable us to be more efficient and hence able to treat more patients.

- There was reconfiguration of internal structures, with the establishment of an Integrated Community Health Directorate initialised into the Great Western Hospitals Foundation Trust Corporate model. This ensures a focus on services to patients in the community with a focus on treating the right patient in the right place at the right time.

- Planning for the implementation of the Medway system continued in year. This is the main patient information system used throughout the Trust which is being upgraded to make it fit for the future. This will improve our documentation and accessibility of patient records. This will save time and effort allowing more time for direct patient care.

- The Trust proactively expanded its catchment area to achieve growth in both NHS and private patient services whilst also working with commissioners to deliver challenging demand management schemes. Work has commenced with spinal partners in Oxford to develop clinical networks which meet national recommendations. This will ensure patients requiring complex spinal surgical intervention are operated on in our hub whilst we as a district hospital can expand the routine case work and repatriate appropriate cases. This will allow more patients to be treated, reducing waiting times.

- Elective demand has increased slightly in the last year and further actions are planned to accommodate additional demand. Work has commenced to scope the creation of 23 hour length of stay beds to reduce patient length of stay.

- The Trust is taking part in the National Laparotomy Audit to review the use of intra-operative fluid management, as the consequent monitoring benefit translates into improved outcomes and reduced length of stay. This data will be used alongside clinical audits to review patient outcomes and identify required service improvements.

- The Active Patient List in the Unscheduled Care Directorate has been redesigned and a launch is currently underway. This will result in patients receiving appointments quicker.

- A Triage Assessment Bay (TAB) was piloted on the Medical Admissions Unit to streamline new attendances through a senior physician. This will ensure patients are directed appropriately for the care they need reducing admissions and length of stay.

- A Stroke Improvement Project was run seeing the stroke indicator improve over recent

months. This has resulted in better care for stroke patients.

- Chronic obstructive pulmonary disease (COPD) and Heart failure pathways have been reviewed, including implementation of BNP testing for Swindon facing patients (Primary care blood test to rule out heart failure). This helps improve clinical outcome and a better patient experience.

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.

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

Examples of working in partnership include the following: -

- In relation to community services, common understanding and relationships have been built between the Trust as a key service provider and Wiltshire Clinical Commissioning Group and Bath and North East Somerset Clinical Commissioning Group. In addition good relationships have been fostered with social care providers Wiltshire Council.

- The Trauma and Orthopaedic Department has successfully maintained its Trauma Unit accreditation status for the Thames Valley Trauma Network this year. The Spinal Team also became the only accredited spinal service for Swindon Clinical Commissioning Group and successfully appointed two new consultants in conjunction with our Clinical Network Partners in Oxford. Our Booking Team has run a successful pilot to improve the elective booking experience for our patients creating a walk in service for hip and knee patients. We have also expanded the number of physician assistants to improve ward cover for patients and support our junior doctors. Next year there will be a focus on our back pain service to create a further expanded service for patients.

- We successfully facilitated the transfer of emergency vascular surgery to our partners in Cheltenham and Gloucester in 2013/14. This means that major arterial surgery is carried out in the hub hospital where we still provide local outpatient assessments for patients by visiting Cheltenham and Gloucester vascular surgeons at the Great Western Hospital.

- The Discharge Assessment and Referral Team (DART) was launched from 1 November 2013 in partnership with SEQOL and Wiltshire Council.

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

- There has been partnership working for an outpatient dispensary service with a Boots pharmacy opening in the main hospital building in Swindon.

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.

One of the challenges of partnership working is that social care providers are a stretched resource impacting on our ability to deliver services.

Another challenge is the impact of resource reductions in local authority and voluntary sectors services which has caused increased demand on universal and interventional services. Commissioning arrangements and contract reviews will continue to be challenging with the number of commissioners for children and young people services.

Conversely, performance at the end of the patient pathway has been less positive. Challenges remain in discharging patients in a timely way, both as a result of internal processes and support from community partners. Recognising the importance of patient discharge, a Discharge Team has been funded to ensure patient discharge is timely and the appropriate support is put in place.

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 2013/14 that were recruited during that period to participate in research approved by a research ethics committee was 762 to end of March 2014.

We currently have 95 actively recruiting Department of Health endorsed (portfolio) research projects. 6% of these are straight forward Band1 studies with 42% being the more complex Band 2 studies and 43% are highly complex Band 3 studies. 8% of studies are commercially sponsored.

Under the direction of the Research and Development Director, the Research and Development Department continues to increase research activity at the Great Western Hospitals NHS Foundation Trust.

The team consisting of part time posts of Research and Development 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 ongoing studies.

Progress continues to be made in key topic areas such as Rheumatology and Orthopaedics with 10% of activity and 1.2 full time staff in these areas. Maternity research has grown and we have had our best recruiting study in Delivery Suite.

Commercially funded research has grown substantially within the Trust and some research posts continue to be funded from this income.

Funding received from the Department of Health through our Comprehensive Local Research Network (CLRN), has enabled Research and Development to continue funding key research posts across the Trust in Cancer, Rheumatology, Dermatology, Sexual Health, Orthopaedics and Intensive Care Unit (ICU). Support departments continue to receive funding for posts to allow them to carry out any additional tests etc. that a research project may require. We have now recruited 2 generic research nurses to enable us to improve research in less reactive research areas.

All research staff in the Trust are supported with training and guidance through Research and Development and the CLRN'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 Standard Operating Procedures (SOPs) 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.

2.11.1 Environmental Matters

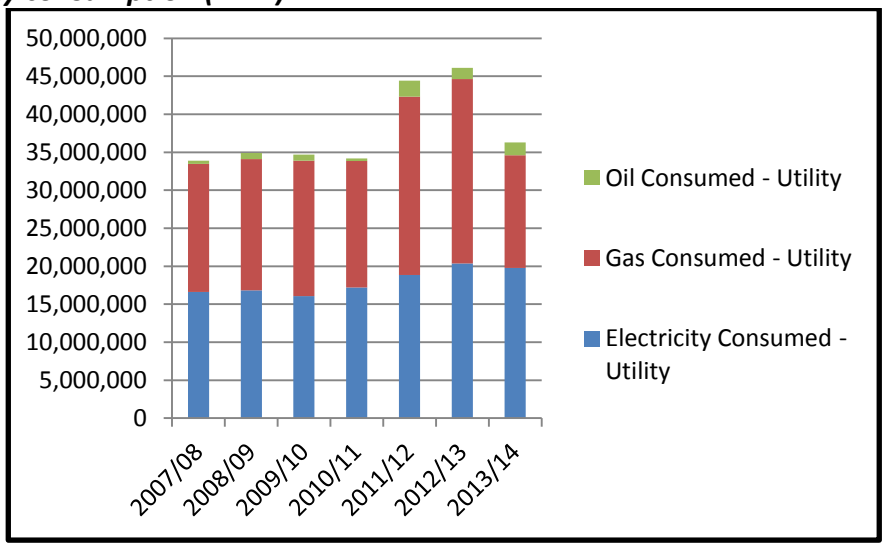
The Great Western Hospitals NHS Foundation Trust recognises that there are many benefits of having a strong focus on all aspects of sustainability, which means we continue to meet the needs of the present without compromising the needs of future generations. There are short, medium and long term advantages 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. An energy, water and waste policy is currently being consulted on prior to ratification and adoption.

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 is currently in the process of installing Voltage Optimisation at the Great Western Hospital, following a successful installation at Chippenham Community Hospital. Other projects such as LED lighting is being considered on all sites and smaller more visible changes such as the installation of PIR light switches in offices and store rooms has continued.

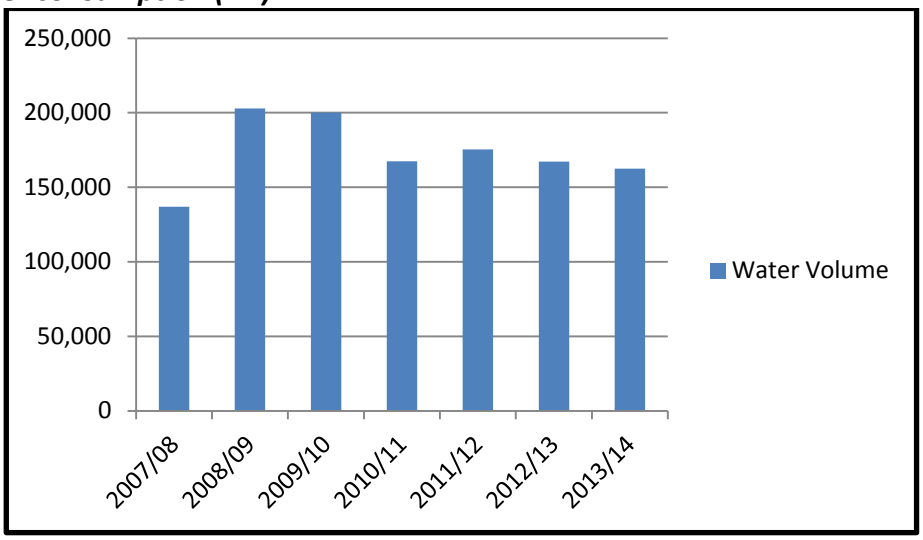
Graph 1 – Utility consumption (KwH)



Water

In the reporting period graph 2 shows a 3% reduction in water usage for the Trust, against a target of 2%. In conjunction with Thames Water we have held Water Wise days where staff and members of the public have been able to pick up information about water conservation and order water saving devices. The water meter has recently been replaced at the Great Western Hospital and so more accurate measurement of water will be available next year.

Graph 2– Water consumption (m^3)

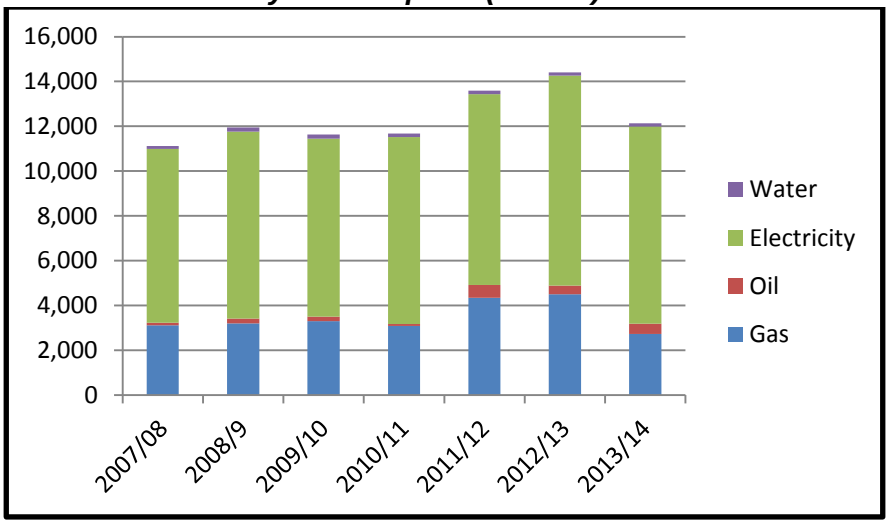


Carbon Reduction

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)

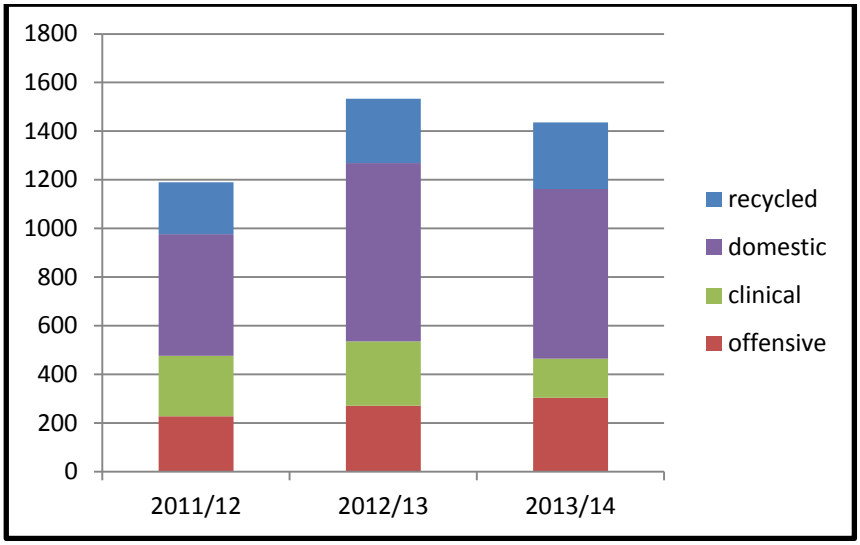


Waste

During the year the Trust's Waste Policy was ratified and adopted across the whole Trust. Offensive waste has continued to be rolled out in the Community Hospitals, reducing the amount of clinical waste that is being produced. At the GWH the offensive waste is sent to an energy from waste plant, and options other than landfill are being reviewed with the waste contractor in the Community.

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)



2.11.2 Trust employees

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

	Male	Female
Directors (senior managers)	2 4 non-executive directors	4 1 female non-executive director
Employees - All Staff (Including Bank Staff)	848	5306
Bank Staff only	726	724

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.

2.11.3 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 2013/14 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. However, a fresh approach was taken to ensuring an equality and diversity culture. The Equality and Diversity Group chaired by the Chief Executive looked again at the objectives and considered in detail what would embed an equality culture. The Board agreed an equality vision and objectives, as set out below, with clear milestone actions.

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.

2.11.4 Policies for potential and existing disabled employees

The Trust has signed up to the national "two tick" 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 2013/14. Nevertheless, the Trust regularly engages with local stakeholders regarding issues relevant to the Trust. However, there were internal consultations / reviews.
At the end of the year a Theatres Clinical Leadership Review consultation process was launched seeking feedback before any decisions are made about the future structure of the department. In addition there was a Royal College Review of Ophthalmology Services, part of which involved consultation with staff about service proposals.

2.13 Main trends likely to impact on the Trust business in 2014/15

A continuing trend likely to impact on the Trust in 2014/15 is the **ongoing increase in activity**, versus the continued need to find efficiency savings. Achieving cost improvement plans is increasingly difficult whilst 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 becoming more 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 is 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 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. There is a growing increase in outpatient activities with more than 11000 additional outpatient appointments in 2013/14 which is continuing.

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 in more detail which have been identified as part of the business planning process for 2014/15: -

- Electronic patient records in the community.
- Mobile working in the community.
- Greater stock management leading to savings, such as redistribution of stock assets; revision of stock systems; stock taking and benchmarking.
- Community transformation (community teams / community wards / optimising beds / different models of care / specialist teams and integrated patient pathways with the acute hospitals / partnership working).

- The Trust has agreed a People Strategy 2014-19 with a number of priorities around commitments to have the right people; to listen to people, to empower people; to look after people, to develop people and to lead our people. The aim of the Strategy is to ensure that the Trust has the right people now and in the future with the right values, skills and knowledge to deliver changing pathways of care and services.
- An estates review could potentially provide many opportunities for the Trust in terms of alternative sites for services and income generation.
- Efficiency savings through a reduction in staff travel costs due to better ways of working and improved IT systems A GPS System is being considered to ensure staff travel in the most efficient and cost effective way.
- In relation to Gynaecology services, promotion of women's centred service and continuation of our Ambulatory Service, Advance Nurse Practitoners Leading Services, and Enhanced Recovery Programme.
- 7 day working.

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.

2.16 Position of the business at the year end

The financial figures reported in pages 214-250 of 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 £17.366m. This includes the impact of a revaluation exercise carried out following the transfer of community assets to the Trust (deficit £17.463m) and a deficit on the NHS Charity of £0.143m. The financial position for the year of the Trust only before the revaluation adjustment was a surplus of income over expenditure of £0.24m against a trajectory of £2m resulting in a variance to plan of £1.76m.

The following financial summary relates to the Trust only.

Income was £10.09m above plan. The main drivers for income were admitted patient care, outpatients and day cases, and community / maternity. Outpatients and day cases showed the greatest growth above 2012/13 levels. GP referral growth contributed to over performance. At the end of the year, GP consultant responsible referrals were significantly higher than 2012/13 levels with general surgery remaining the biggest growth speciality. In addition acute non-elective spells increased from 2012/13 levels within paediatrics, general medicine and geriatric medicine.

Expenditure was £13.87 above plan. The main drivers for this were additional capacity and escalation totalling £6.06m and premium costs of agency for normal capacity totalling £2.55m. At the year end the number of contracted staff had increased by 256.93 whole time equivalents since April 2013 and the Trust ended the year with an average temporary staff to permanent staff ratio of 6.4% compared with 4.7% at the beginning of the year. Furthermore, £1.84m was spent on clinical supplies relating to additional activity pressures. The Trust spent £2.29m above plan on clinical and non-clinical supplies (laboratory equipment; NICE technologies; MRI scanning; theatre consumables; cardiology pacemakers; hearing aids; escalation beds and wheelchairs). Furthermore, the Trust spent £1.05m above plan on drugs due to increased activity, particularly in cancer and haematology; neurology; gastroenterology; and rheumatology, offset by savings achieved from commencement of the Boots pharmacy contract.

Saving delivered totalled £14.81m against a target of £16m resulting in an underachievement of £1.19m. The main schemes which slipped were length of stay reductions of which £0.57m was achieved against a target of £1.68m; staff flow amounting to £0.23m; theatre utilisation amounting to £0.57m; and agency costs reduction of £0.90m. These have been partly offset through non-recurrent delivery of additional savings (vat recovery, contract reductions and rates).

The cash balance at year end was £4.4m for the Trust which was £5.6m below plan. The main reasons for this include increased stock amounting to £0.4m; outstanding performance on NHS contracts in debtors amounting to £0.5m; additional expenditure of agency staff and clinical supplies totalling £5m and capital expenditure of £0.3m below plan as the Public finance initiative (PFI) lifecycle capitalisation was lower than plan.

The Trust had a loss on revaluation of property, plant and equipment totalling £17.1m.

2.17 Analysis using financial and key performance indicators

The Trust has in place a patient safety and quality dashboard through which performance against key performance indicators (KPI) is monitored. Some indicators are set nationally by Monitor, the Trust's Regulator, some by the Care Quality Commission (CQC) and some set locally by commissioners. Of the 16 national indicators which the Trust uses to benchmark itself against other trusts, at the end of year two were underachieved as follows: -

Clostridium Difficile - The Trust had 23 incidences of *Clostridium Difficile* against a trajectory of 20. The Infection Prevention and Control Team continues to promote the appropriate collection of stool specimens and early isolation of patients. Antibiotic prescribing and duration in line with local guidance has been improved to reduce the incidence of antibiotic related cases and is being monitored.

4 hour wait in A&E - The percentage of patients who stayed a maximum of 4 hours in A&E was 94.1% against a target of 95%. The Emergency Care and Intensive Support Team (ECIST) is working with the Trust to improve patient flow in order to improve the patient experience by reducing the wait in A&E. A whole system emergency care diagnostic has been undertaken.

2.18 Additional activity creating pressure on finances

2013/14 was the busiest year to date for the Trust with additional demand for services, over and above the levels we are contracted to provide by our Commissioners. 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	Variance from last year
New Outpatients	87,441	90,852	94,587	96,456	137,504	148,766	160,295	***11,529***
Follow Up Outpatients	179,466	195,846	198,244	212,887	263,066	274,326	291,214	***16,888***
Day Cases	26,102	28,508	28,053	27,813	27,320	27,838	30,969	***3,131***
Emergency Inpatients	34,075	36,658	39,202	35,210	35,804	38,192	39,178	***986***
Elective Inpatients	7,438	7,345	7,004	7,269	6,723	6,343	6,247	***-96***
Emergency Department Attendances	60,583	62,628	66,262	68,618	70,731	77,642	75,440	***-2,202***
Total	***395,105***	***421,837***	***433,352***	***448,253***	***541,148***	***573,107***	***603,343***	***30,236***

TABLE – Community Activity

Point of Delivery	2011/12	2012/13	2013/14	Variance from last year
Minor Injuries Unit	46,507	41,755	42,884	***1,129***
Admitted Patients	7,445	8,498	7,998	***-500***
Community contacts including outpatients	803,545	789,473	804,341	***14,868***
Total	***857,497***	***839,726***	***855,223***	***15,497***

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

Over the past year the Trust made significant investment totalling over £6m into a number of services, including the redesign of the Emergency Department including a new paediatric area; additional medical consultant staff to support current inpatient ward cover; additional nursing staff to enhance the nurse: patient ratio in all clinical in patient areas and substantive establishment of Woodpecker Ward into a medical ward.

There has been significant investment into the Unscheduled Care Directorate to enhance the in-patient areas nursing and medical models.

With increasing pressures on resources investment in large capital projects continues to be challenging. As a Foundation Trust we do not have other sources of funding and therefore we rely on delivering ambitious savings programmes to free up money to invest in new equipment and services. This is becoming increasingly pressing as some of the equipment purchased at the time of opening the Great Western Hospital 11 years ago is now coming to the stage where it needs to be replaced.

In 2013/14 the Trust generated a small surplus to allow investment in services and equipment thus ensuring that we continue to improve care for our patients both at the GWH, out in the community and in the home. Going forward, the Trust will aim to continue to make a surplus each year to fund investment in services.

The Trust has in post a Fund Raising Manager whose role is essential in generating charitable funds which are used for specific one off projects which would otherwise not be achievable.

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

As at 31 March 2014 the Trust has three PFI schemes, Great Western Hospital, System C Medway Integrated Clinical Information System and Savernake Hospital. Savernake Hospital transferred to the Trust on 1 April 2013 as part of the transfer of community assets from Wiltshire Primary Care Trust (PCT). The Trust has extended the PFI scheme for Medway, which is undergoing a major upgrade and is due to go live in May 2014.

We may be borrowing in the future e.g. Health & Wellbeing Centre so if it is forward looking this would need to be included.

2.22 Explanation of Amounts included in the annual accounts

Transfer of Community Assets and Asset Revaluation

The Community Assets that were previously owned by Wiltshire Primary Care Trust (PCT) are used by the Trust in delivering services transferred to the Trust from 1 April 2013. Details of the transfer are included in note 24 to the accounts.

In order to ensure a consistent valuation basis, all of the Trust's land and buildings were revalued by the District Valuer on 1 April 2013. This resulted in a reduction in the value of the buildings of £20.6m. The amount in excess of that in the revaluation reserve was charged to operating expenditure in year and resulted in a deficit of £17m.

Charitable Funds

In 2013/14 the Great Western Hospitals NHS Foundation Trust Charity was consolidated in to the Trust's accounts in accordance with IAS 27. Until April2013, the Treasury had directed that IAS 27 should not be applied to NHS charities. That direction has now been removed and IAS 27 requires that consolidated accounts are prepared. This is because the Trust is the corporate trustee of Great Western Hospitals NHS Charity and the charity's objectives are for the benefit of the Trust. The Trust's accounts for 2013/14 are presented both as a Group, including the Charity and the Trust where appropriate.

2.23 Preparation of the Accounts

The accounts for the period ended 31st March 2014 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

After making enquiries the directors have a reasonable expectation that the Great Western Hospitals NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing for the 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
28 May 2014

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 2013/14: -

Bruce Laurie	Chairman *(until 31 January 2014)*
Roger Hill	Chairman *(from 1 February 2014)* Non-Executive Director *(until 31 January 2014)* Senior Independent Director *(until 31 January 2014)*
Nerissa Vaughan	Chief Executive
Roberts Burns	Non-Executive Director
Liam Coleman	Non-Executive Director Senior Independent Director *(from 1 March 2014)*
Oonagh Fitzgerald	Director of Workforce and Education
Angela Gillibrand	Non-Executive Director Deputy Chairman
Philippa Green	Non-Executive Director *(until 30 November 2013)*
Dame Janet Husband	Non-Executive Director *(until 31 October 2013)*
Jemima Milton	Non-Executive Director *(from 1 January 2014)*
Maria Moore	Director of Finance and Performance
Alf Troughton	Medical Director and Deputy Chief Executive
Hilary Walker	Chief Nurse

Non-Voting Board Members

Kevin McNamara	Interim Director of Strategy *(from 2 December 2013)*
Hilary Shand	Interim Chief Operating Officer *(from 2 December 2013 until 17 March 2014)*

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.

3.5 Future Developments

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

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 7 – 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 7 – 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 13.4.9 – Quality Governance refers)* and the quality report *(Section 6 – Quality Report refers).*

The Trust continues to maintain a strong focus on quality. Through the work programmes developed to consolidate and focus activity across the Trust, the Trust continues to drive further improvements in the quality of care provided to patients.

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).*

In November 2012, the Trust commissioned an independent audit which provided assurance regarding the Trust's Quality Governance arrangements, but identified areas for improvement. The audit confirmed that the Board had demonstrated a focus on quality although improvements should

be made to ensure a quality focused culture in the organisation, through active leadership and engagement. An action plan was drawn up to address the recommendations in the audit report, which included the launch and implementation of a revised Quality Strategy, staff engagement and ensuring robustness of quality information and data. This work progressed in 2013/14 with many of the action completed but action will continue into 2014/15.

During 2013/14 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.

- 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. A clinical advisor to the Board was appointed, whose remit includes a focus on the quality of care.

- 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.

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 2.18 – 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 6.4 – Overview of the Quality of Care Offered 2013/14 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 a Clinical Standards Group, the Patient Safety Committee, Governance Committee and Executive Committee up to Trust Board. Compliance monitoring is informed by the CQC Quality and Risk Profile. 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 6.4 - 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 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.

Community Care Co-ordinators – There was a major initiative with Wiltshire Clinical Commissioning Group to integrate community teams with GP surgeries to ensure timely and appropriate care.

Emergency Department / Paediatric Area – There was building work to provide a new Emergency Department / Paediatric Area at the Great Western Hospital to ensure an efficient ED service, where patients can be cared for in a modern setting, designed specifically for ED care. The ED reception service was restructured and shift patterns of staff amended to meet service demand.

3.16 Improvement in patient / carer information

The Trust has now introduced a new bedside guide in the Great Western Hospital and aspires to take it Trust-wide during 2014/15. These bedside guides are personalised to each ward and contain specific information such as meal and visiting times, specific to that ward.

During the last year the Trust recruited to the role of Customer Service Training and Projects Lead, and by doing so brought capacity to lead on the development of patient information. Starting in a small pilot area, the patient information project aims to test different approaches and ensure that the resources needed to transform the Trust will be wisely spent in the future.

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

Over the last year, the Trust has made an even greater effort to listen to and understand its customers, predominantly patients. By using the information provided by its customers, the Trust has been able to develop services because of their feedback.

When things have gone wrong, or if we have not lived up to expectations, then it is often our complaints process which can help us to work out what we can do differently or better next time. Complaints must be seen as a positive. On a personal level, being honest and open improves our relationship with the people we serve. From an organisational perspective, complaints information is an excellent source of insight into how we provide care.

In 2012/13 the Trust proactively re-branded the Patient Advice and Liaison Service (PALS) as the 'Customer Service Team' and this has continued to embed along with the team's vision and mission:

Our Vision

To turn concerns and complaints into service improvements by listening to the patients, their carers and families to improve the overall patient experience and become a provider of choice.

Our Mission

We aim to maintain a high standard by placing the needs of customers at the heart of our service and for our customer service delivery to be the standard against which all other departments are measured.

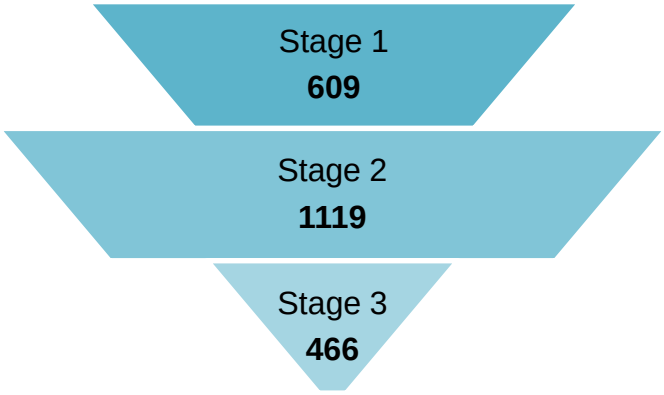
The team has, once again, been through a number of changes over the past year however, the values placed upon the team members by the vision and mission remain at the heart of their work.

3.18.1 Formal complaints

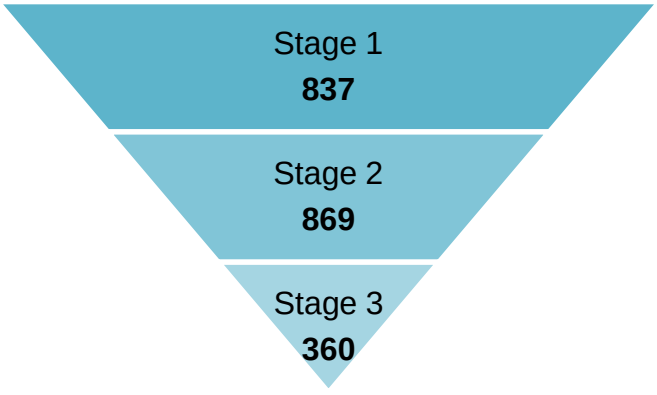
During 2013/14 the Trust received a total of 1866 comments, concerns and complaints, which is a combined total from all stages of the complaints process. This was a 15% reduction on the previous year. The Trust also reduced secondary complaints by 41%, which demonstrates improved quality.

In the last annual report, the Trust set out how it aimed to bring complaints back into proportion, dealing with fewer complaints at each stage of the process. We have nearly achieved this aim, closing the year in a much stronger position. The graphics below show the change of position from 2012/13 and 2013/14 for the make-up of complaints within the complaints process.

Complaints in 2012/13



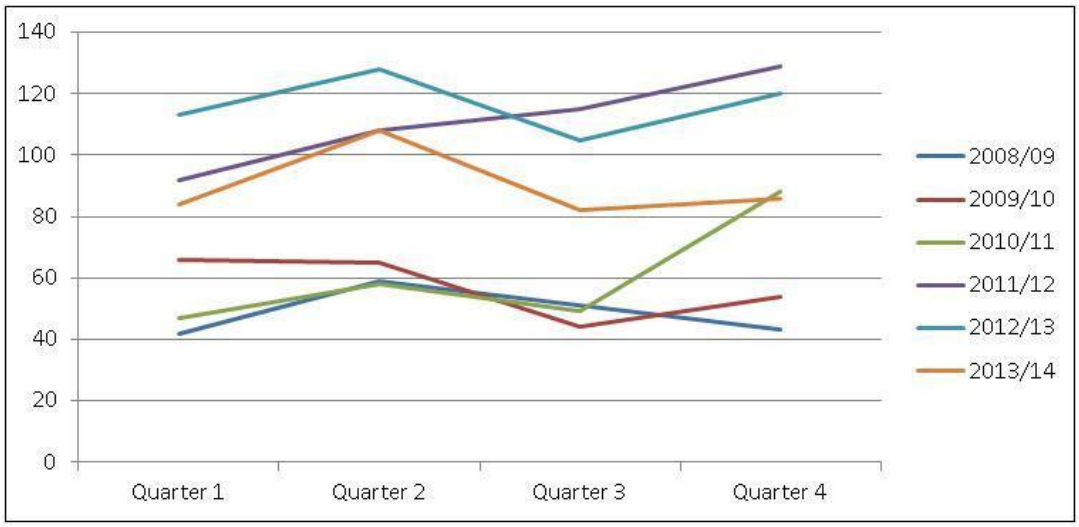
Complaints on 2013/14



Stage Three, or 'formal' complaints fell by over 20% to 360. This equates to just 0.024% of the total number of patients seen, treated or admitted during 2013/14.

The graph below compares the number of Formal Complaints received during 2013/14 along with data from between 2012/13, and 2008/09. The jump in numbers since 2011 relates to the merger with Wiltshire Community Health Service.

Chart - Number of Formal Complaints received by Quarter



Response times for formal complaints have also dramatically improved over the year and will continue to be a focus into 2014/15.

Over the course of the year, the Trust improved performance from answering an average of 81% of complaints on time during April 2013, to answering just over 90% during March 2014. This represents the Trust best-ever performance and will be further pushed in 2014/15

Last year, we made a promise to keep listening to our customers. This year we repeat that promise as we launch a new complaints process designed to make it easier for customers and the organisation to interact and communicate.

We've also been busy implementing a number of other service improvements to enhance patient experience and even more are planned for 2014/15:

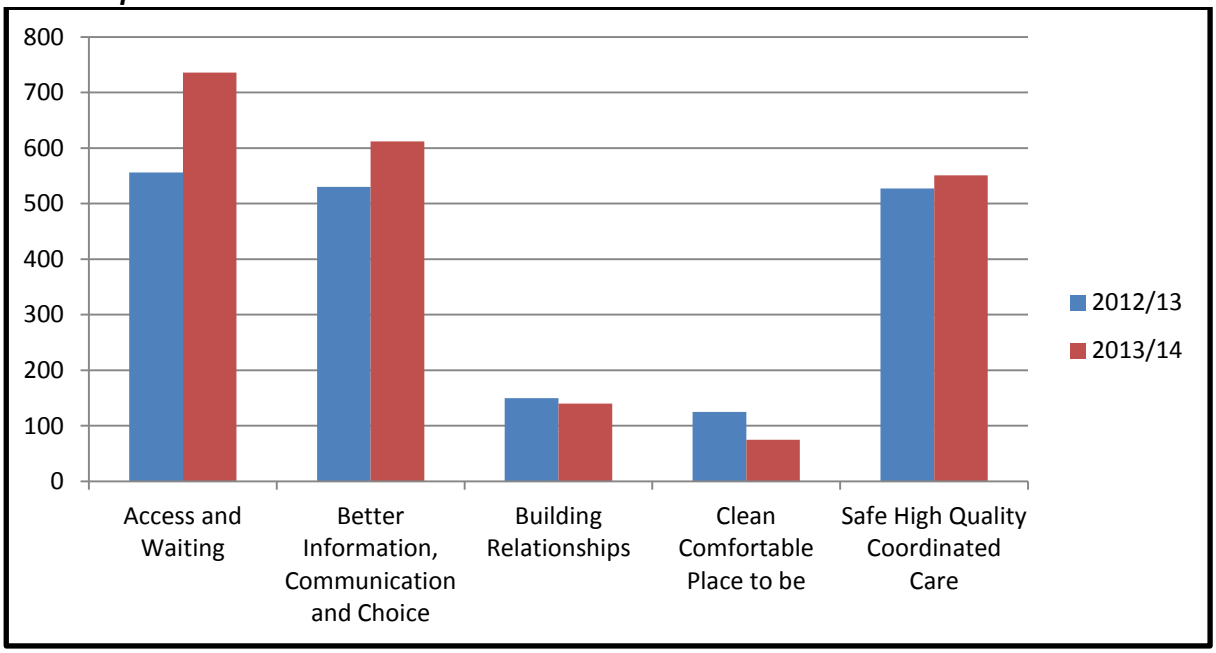
- Launch of a new case management system
- Development of a 'Patient Information Project' trial in selected areas
- Enhanced Customer Service Training
- Continued development of the Bedside Guide with roll out to community sites
- VoiceBook – a talking comments book

3.18.2 Key Complaint Themes

'Access and Waiting' themed complaints increased sharply during 2013/14, closely followed by complaints about information and choice. The other top-level themes stayed mostly the same as the previous year.

The chart below shows the comparison between the last two years, in respect of our top complaint themes.

Table - Complaints Themes



3.18.3 Parliamentary and Health Service Ombudsman (PHSO)

14 complaints were investigated by the PHSO during 2013/14. From the 14 cases, seven have been closed with no further action.

The Ombudsman have requested that action plans be produced for two cases copied to the Care Quality Commission, Monitor and CCG for improvements to be made to Trust services. One of the two cases was awarded financial redress totalling £400.

3.18.4 Learning from patient experience

The problems customers told us about last year	What we have done as a result
Visiting hours were too restrictive and didn't mean patients and visitor's needs and expectations. This was particularly raised in connection with the Surgical Assessment Unit and Ampney Ward	Since receiving this feedback, the Planned Care directorate have reviewed visiting times, and are currently trialling open visiting on Ampney Ward, meaning visitors are welcome from 10am until 8pm. So far this is proving successful and is being considered for further implementation across the Trust.
Car parking has been a recurrent theme with problems over capacity, flow and barrier operation. Disabled drivers were also concerned with the availability and design of 'blue badge' spaces.	Additional spaces have been made available, new staff parking arrangements implemented and a special project undertaken to try to improve the car park operation.
The Customer Service meeting rooms were looking tired and patients using them frequently told us about how unwelcoming the décor furniture and lighting was.	The meeting rooms were repainted, artwork put up and new furniture purchased. Since the rooms were overhauled, the reaction has been excellent with positive comments made about the changes.
Families and patients were becoming increasingly confused over ward visiting times and 'protected mealtimes'. Many relatives wanted to help with food, but felt that it would be unwelcome.	The Trust has implemented a new bedside handbook providing clearer guidance on what 'protected mealtimes' means and how they can help. Posters and publicity in relation to visiting hours and mealtimes have also been reviewed.
Some of our deaf patients were finding it difficult to contact us because calls were either not connecting, or the operator was unsure how to manage calls being made through a third party, or video relay service.	The Trust sought the advice of the experts to help develop better training, systems and processes to help all our deaf customers. We were also able to work with those customers having difficulties to find a resolution in partnership.

3.19 Using patient experience to drive service improvements

3.19.1 The Friends and Family Test

Great Western Hospitals has developed its use of the Friends and Family test at a much faster rate that mandated. The 'test' has now been implemented in most areas including:

- Inpatients
- Community Inpatients
- Outpatients
- Minor Injuries Units
- Emergency Department
- Day Services
- Maternity

The test is given to every patient, and asks one mandated question; 'how likely are you to recommend the ward/service/clinic to a friend or family member'. We also provide a free-text box for patients to record hand written comments about their experiences, so that we can understand why a response was selected.

Responses are measured nationally as a 'Net Promoter Score' which must be reported publicly. The Net Promoter Score is a metric that is mainly used in the private sector to gauge the loyalty of a business' customers and relationships.

A NPS of above +70 is considered a good score and is in line with other trusts.

GWH Trust-wide Net Promoter Score. Our NPS results were:

Month	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
NPS	+77	+78	+77	+74	+72	+72	+75	+73	+77	+75	+76	+74
Responses	699	1019	1739	1154	1043	3764	3190	2810	2534	2288	2440	2172

The Trust has begun trialling new methodologies including the use of tablets to collect patient feedback. During 2013/14 the Trust has received overwhelmingly positing feedback, along with some comments that have helped us to develop services.

3.19.2 Patient Surveys

During 2013/14 the Trust carried out the mandatory Inpatient and Maternity surveys, managed externally by the Picker Institute.

Due to the introduction of the 'Friends and Family Test' the Trust has reduced its use of Picker Institute managed surveys. We have however signed up to take part in the national Neonatal Survey during 2014/15.

3.19.3 Inpatient Surveys

The Annual Inpatient Survey was carried out in quarter three of 2013/14.

This survey is a national survey with core questions mandated. The results for these core questions are published by the Care Quality Commission (CQC) and compare the Trust against the best and worst performers nationally.

The results of the surveys are used to monitor five elements of Commissioning for Quality and Innovation (CQUIN) relating to patient experience at the Trust. The table below shows the CQUIN results gathered from the Annual Inpatient surveys.

TABLE – CQUIN Results

Question	Target	2012/13 %	2013/14 %
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**
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**
Were you given enough privacy when discussing your condition or treatment?	**GWH** GWH target 73% or more responding 'Yes, definitely'	**73**	**70.8**
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**
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**

This year's results show that in most cases, the Trust either has improved or is continuing to strive to improve performance to meet or exceed its aims.

The survey also maps trends and in many areas, the problems highlighted by complainants and online feedback corroborate survey data as areas for improvement. These are set out below.

TABLE – Problems identified in survey

Area	Problems Identified in Survey
Hospital and Ward	Noise at night from other patients and staff
Hospital and Ward	Delays in call bells being answered
Doctors	Communication
Nurses	Staffing levels, communication,
Leaving Hospital	Discharge delays, information
Overall	Not being asked to give feedback

3.19.4 Other

Call Bells

Call bell response times within the acute hospital site continue to be closely monitored. Matrons receive data for their clinical areas every week to enable very regular monitoring at local level and the Senior Nurse Operational Group maintain an overview of progress and achievement.

While many departments do achieve a response within 5 minutes for over 90% of patients, a number of the inpatient areas continue to strive to achieve this target, with some achieving over 80% but others achieving less than 80%.

This is a significant measure for ward performance and many initiatives are being introduced to improve this patient experience with some wards seeing a sustained improvement over the last few months.
It is anticipated that as additional nurses are recruited to the ward teams following agreed investment, greater consistency and further sustained improvement will be achieved.

Within our inpatient wards across community settings the technology to replicate this work is not currently available. Senior Nurses providing leadership across these settings will this year establish a mechanism by which to provide some performance data and assurance.

Patient Reported Outcome Measures (PROMs)

PROMS are a national initiative which measures the quality of care provided in hospitals from the perspective of the patient. They help to measure improvement experienced by a patient following an operation, and this is captured through surveys being completed before and after surgery.

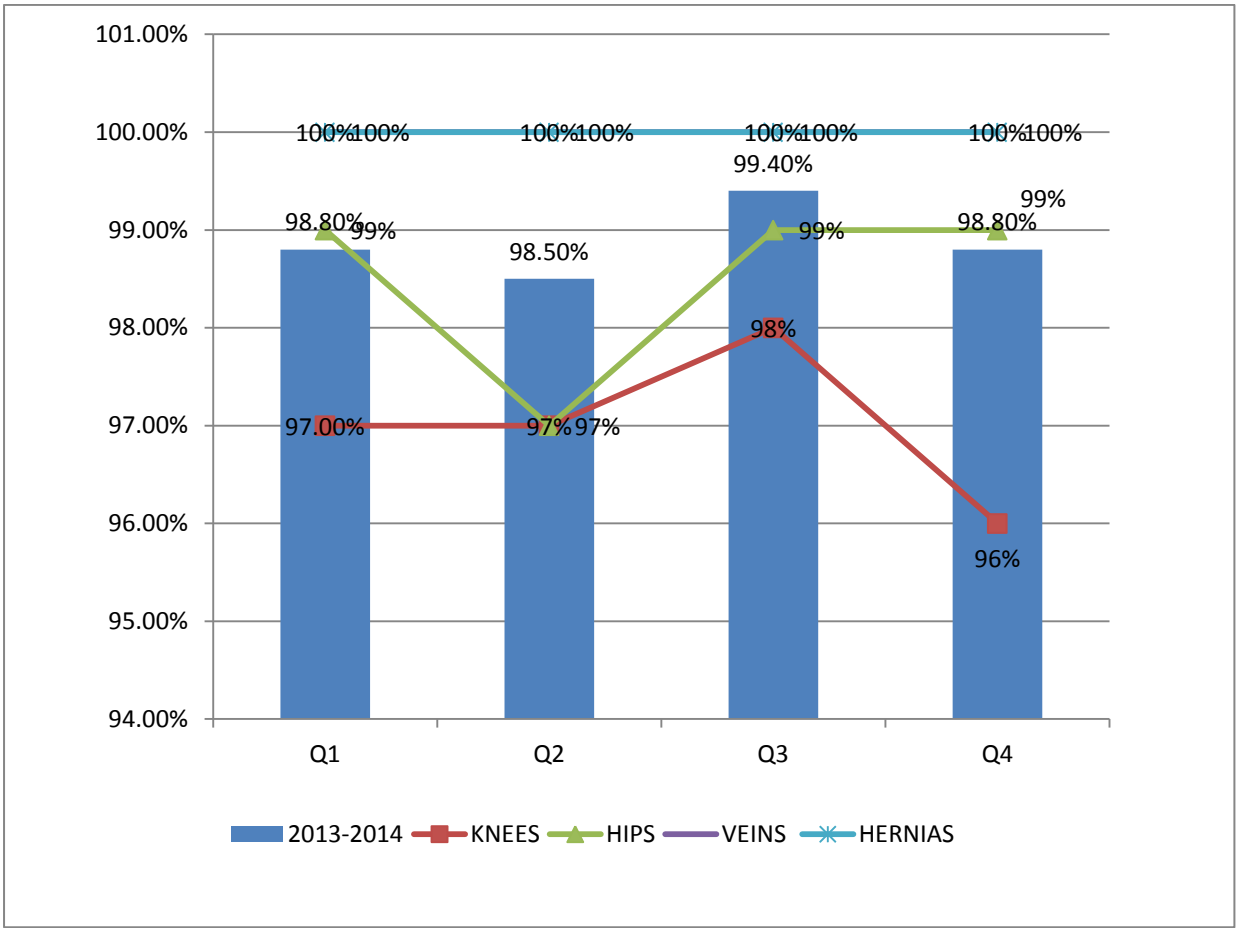
A PROMs assistant is managed within the PALS Department and currently collects the data for the following procedures within the Cherwell Unit: no longer correct.
The PROMS process is managed by Cherwell administration staff and currently collects the data for the following procedures within the Cherwell Unit:

- Hip
- Knee
- Hernia
- Varicose Veins

Completed surveys are sent to the National PROMS team for analysis. They monitor the feedback against the number of historic procedures recorded on the HES (Hospital Episode Statistics) system. As this information is historic, it gives an indication on performance rather than up to date information. There is work underway nationally to improve the information that is gathered through these questionnaires to ensure that meaningful data is available for Trusts to use to improve services.

The PROMS Assistant monitors the number of completed surveys through the clinic lists of the Cherwell Pre-Assessment Unit -incorrect. The graph below shows the percentage of completed surveys in the Cherwell Unit.

CHART - Percentage of patients who completed a PROMS questionnaire



3.19.5 Customer Service Training

The start of 2014 has seen responsibility for Customer Service Training transfer from The Academy to the Trust's Customer Services Team. Being best placed to draw on real-time customer feedback both from within and outside the Trust, the team is leading a programme of needs-led training over the coming year.

This commenced in February with bespoke sessions for the Trust's Human Resources department. Having recently gone through a major departmental restructure, senior managers were keen to ensure key recruitment and employee relations specialists were equipped with the knowledge and tools to deliver customer service excellence consistently. This approach has helped the department to more fully understand their customers' needs, take ownership of the issues raised, and commit to a realistic but challenging service improvement plan.

The Customer Services Team will be working with teams and services across the Trust to roll-out further tailored sessions over the coming year.

Stakeholder Relations

3.20 Partnerships and alliances

During the course of the year we have placed significant emphasis in building strong relationships with local providers and commissioners. Most notably in the Wiltshire health community, we are an 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.

The development of the role of Care Coordinators in Wiltshire was a priority during the year and is helping join up care for patients between primary care, social care and the acute Trusts. These posts have been developed in partnership with Wiltshire Clinical Commissioning Group (CCG) and are a key part of the local health strategy to keep people well and looked after out of hospital.

We have developed local partnerships to bring care closer to home. This includes working with a local charity “Hope for Tomorrow” in providing a mobile chemotherapy unit at Savernake Hospital.

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. These plans are being considered by Oxford University Hospitals NHS Trust Board and 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. We are hopeful the full business case for the Radiotherapy Unit will be approved in 2014. Crucial to the development of the service will be a multi-million fundraising appeal to be launched in early 2015 which will be led by our Trust.

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 challenge during the past year in this area has been concerns regarding cleanliness standards which were identified as part of a Care Quality Commission (CQC) inspection in October 2013. Since that time we have worked with Carillion and The Hospital Company to review practices and revamp the audit and monitoring arrangements to ensure cleaning standards are being delivered.

3.20.1 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).*

3.21 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.

The Francis Inquiry into care failings at Mid-Staffordshire Hospital which was published in February 2013, made clear the importance of effective scrutiny in ensuring high quality services. Our approach has always been to be open and honest with the HOSC and to provide local context to national issues and our focus is on helping the HOSC build good local knowledge about our services – both strengths and weaknesses to support them in carrying out effective scrutiny on behalf of local people.

Briefings to the relevant HOSCs have covered topics including the development of the Nursing Strategy, the Trust response and action plan to CQC inspections, nurse and midwifery recruitment and the Ophthalmology Department which has been the subject of a review and a subsequent action plan. Their scrutiny and insight helps inform our own plans and offers a fresh perspective on issues we are dealing with, therefore attendance at these meetings is valuable to us.

Visits have also been hosted for members of the Committee to provide a behind the scenes look at key services including our Emergency Department and ambulatory care service and we will continue to actively engage with both bodies in the year ahead.

3.22 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.

In October the Trust attended the formal launch of the Wiltshire Healthwatch where there was an opportunity to meet local people and for them to hear about future plans. The Trust has hosted a number of visits and has sought to engage with the Healthwatch as part of the PLACE assessments – the patient led assessments of the care environment looking at the quality of the estates and cleanliness.

The Trust has met with Swindon Healthwatch to discuss how we can work together going forward following the establishment of a new management committee and changes in personnel. In 2014, with Swindon Healthwatch, the Trust will jointly host a 'listening event' which will be open to the public with a view to a sharing of their experiences of care provided by our Trust. This work will be used to improve services and inform plans to prepare for the intensive CQC inspection which the Trust will have over the next year.

Additional disclosures

3.23 Accounting policies for pensions and other retirement benefits

Accounting policies for pensions and other retirement benefits are set out in note 1.3 to the accounts and details of senior employees' remuneration can be found elsewhere in this report in the remuneration report *(Section 4.10 – Pension Benefits and Remuneration refers).*

3.24 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 regularly reviews the structure, size and composition (including the skills, knowledge and experience) required of the Board and gives consideration to, and make plans 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.
Membership of the Committee in 2013/14 was as follows: -

Robert Burns	Member
Liam Coleman	Member / Chairman *(Chairman from 1 March 2014)*
Angela Gillibrand	Member
Philippa Green	Member *(part year until 30 November 2013)*
Roger Hill	Chairman / Member *(Chairman until 31 January 2014 and thereafter Member)*
Janet Husband	Member *(part year until 31 October 2013)*
Bruce Laurie	Member *(part year until 31January 2014)*
Jemima Milton	Member *(part year from 1January 2014)*
Nerissa Vaughan	Member

4.3 Attendance at meetings of the Remuneration Committee during 2013/14

There were 5 meetings of the Remuneration Committee during 2013/14.

	Record of attendance at each meeting (✓ = attended × = did not attend n/a = was not a member)				
	30 May 2013	**27 June 2103**	**26 September 2013**	**31 October 2013**	**17 January 2014**
Robert Burns	✓	×	✓	✓	✓
Liam Coleman (Chair – from 1 March 2014)	✓	✓	✓	✓	✓
Angela Gillibrand	✓	✓	✓	✓	×
Philippa Green	×	✓	×	✓	n/a
Roger Hill (Chair – until 31 January 2014)	✓	✓	✓	✓	✓
Janet Husband	✓	×	✓	×	n/a
Jemima Milton	n/a	n/a	n/a	n/a	✓
Bruce Laurie	✓	✓	✓	✓	✓
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 any applicable guidance from Hay Group (appointed by the Trust to advise on aspects of executive remuneration) or other external bodies, that may from time to time be issued relating to remuneration of Executive Directors; and
- seeks professional advice from Oonagh Fitzgerald, the Director of Workforce and Education.

The Hay Group was appointed by the Remuneration Committee following a rigorous selection process. Peter Smith, Hay Group has no connection with the Trust. Part of the selection criteria included receipt of objective, professional, expert advice. No payment was made in 2013/14 because the framework set originally is ongoing.

4.5 Remuneration of senior managers (Executive Directors)

In 2012/13 the Committee introduced an element of variable pay for Executive Directors, having 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. In 2013/14 variable pay for Executive Directors was applied with the Remuneration Committee agreeing base salaries and variable elements which had clear threshold levels and objectives.

The Remuneration Committee had previously recognised that Directors' remuneration did not in all cases reflect current market levels and therefore to ensure the Trust could continue to recruit and retain high calibre Directors, the Committee again reviewed Executive Director Remuneration during 2013/14. Benchmarking information relating to other Trusts was considered in compiling the review.

That majority of the senior manager's salary is base pay, but there is a percentage to be determined annually by the Remuneration Committee for variable pay. The Remuneration Committee assessed the relativities of direct reports of senior managers to ensure pay was positioned appropriately. Our policy on pay is to pay upper quartile pay for upper quartile performance in order to recruit and retain the very best people.

Going forward, in May 2014, the Remuneration Committee will assess benchmark information to test salaries again and will consider up to date information on succession planning.

4.6 Performance of senior managers

The appraisal process adopted in 2009/10 for the Chief Executive and Executive Directors involved a 360 degree assessment of each Director against a range of competencies based on those devised by Hay Group for Foundation Trust Directors 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. This process continued to be used in 2013/14 through the NHS Leadership Qualities Framework was used for the 360 element.

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

The Committee reviewed approaches to Board assessment and development and commissioned the National Institute for Innovation and Improvement, who had developed a Board Development Tool (BDT) for Foundation Trusts to undertake a review of its effectiveness. This was undertaken in the summer of 2011 and has continued with a Board workshop by Deloittes in June 2012. The Committee was also keen to ensure that the Trust established a longer term relationship with Deloittes (Jay Bevington) as members felt that this would be beneficial in the Board's ongoing development. In 2013/14 we introduced more Board Workshops to enable greater discussion and understanding. There has been a programme of joint governor and director training on the role and work of directorates and the Trust has recruited a Head of Education and Development who has commenced work on drawing up a formal Non-Executive Director induction and training programme.

In 2013/14 the 360 degree assessment process was rolled out to other senior staff in the Trust to help inform their performance and areas for development.

4.7 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 three 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.

Disclosures required by Health and Social Care Act

4.8 Expenses of Directors and Governors

Expenses 2013-14 (unaudited)

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

The total number of directors in office during 2013/14 was 15 and the total number of governors in office was 24.

Expenses 2012-13

Name	Title	Expenses 2012-13 £
Robert Burns	Non-Executive Director	1,309
Liam Coleman	Non-Executive Director	0
Angela Gillibrand	Non-Executive Director	923
Philippa Green	Non-Executive Director	198
Roger Hill	Non-Executive Director / Chairman	482
Janet Husband	Non-Executive Director	156
Bruce Laurie	Chair	3,219
Jemima Milton	Non-Executive Director	n/a
Oonagh Fitzgerald	Director of Workforce & Education	1,936
Maria Moore	Director of Finance & Performance	1,704
Kevin McNamara	Interim Director of Strategy (non-voting)	n/a
Hilary Shand	Interim Chief Operating Officer (non-voting)	n/a
Alf Troughton	Deputy Chief Executive & Medical Director	3,769
Nerissa Vaughan	Chief Executive	2,116
Hilary Walker	Chief Nurse / Chief Nurse	2,123
Total		**14,166**

Name	Title	Expenses 2012-13 £
Ros Thomson	Public Governor	0
Kevin Parry	Public Governor	0
Harry Dale	Public Governor	0
Rosemarie Phillips	Public Governor	0
Phil Prentice	Public Governor	458
Elizabeth Garcia	Public Governor	0
Louise Hill	Public Governor	0
Robert Wotton	Public Governor	0
Margaret White	Public Governor	742
Janet Jarmin	Public Governor	719
Mike Halliwell	Public Governor	0
Roger Bullock	Public Governor	0
Srini Madhavan	Public Governor	0
Vicki Barnett	Staff Governor	0
Peter Hanson	Staff Governor	0
Lisa Campisano	Staff Governor	0
Shane Apperley	Staff Governor	0
Sarah Merritt	Staff Governor	0
Edward Wilson	Nominated Governor	0
Ian James	Nominated Governor	0
Brian Mattock	Nominated Governor	0
Jemima Milton	Nominated Governor	0
Clive Bassett	Nominated Governor	0
Jon Elliman	Nominated Governor	0
Total		**1,919**

4.9 Off Payroll Engagements

TABLE 1: For all off-payroll engagements as of 31 March 2014, for more than £220 per day and that last longer than 6 months

	Number
No. of existing engagements as of 31 March 2014	**7**
Of which:	
No. that have existed for less than one year at time of reporting	**5**
No. that have existed for between one and two years at time of reporting	**2**
No. that have existed for between two and three years at time of reporting	
No. that have existed for between three and four years at time of reporting	
No. that have existed for four or more years at time of reporting.	

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 2013 and 31 March 2014, 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 2013 and 31 March 2014	**8**
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	**8**
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	
No. that have been terminated as a result of assurance not being received	

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 2013 and 31 March 2014

	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	**15**

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.

4.10 Pension Benefits and Remuneration

Pensions Benefits 2013-14

Name	Title	Real Increase in Pension 2013-14 (Bands of £2500)	Real Increase in Lump Sum 2013-14 (Bands of £2500)	Total accrued pension at 31st March 2014 (Bands of £5000)	Total accrued related lump sum at 31st March 2014 (Bands of £5000)	Cash Equivalent Transfer Value at 31st March 2014	Cash Equivalent Transfer Value at 31st March 2013	Real Increase in Cash Equivalent Transfer Value	*Employers Contribution to Stakeholder Pensions*
		£000	£000	£000	£000	£000	£000	£000	*£000*
Nerissa Vaughan	Chief Executive	5-7.5	12.5-15	40-45	125-130	681	592	88	0.0
Oonagh Fitzgerald	Director of Workforce and Education	2.5-5	7.5-10	15-20	55-60	271	226	45	0.0
Maria Moore	Director of Finance and Performance	2-5.5	10-12.5	25-30	80-85	407	339	68	0.0
Alf Troughton	Medical Director and Interim Chief Executive	n/a	7.5-10	65-70	195-200	0	1,470	n/a	0.0
Hilary Walker	Chief Nurse	7.5-10	25-27.5	35-40	110-115	681	509	171	0.0
Kevin McNamara	Interim Director of Strategy (non-voting)	n/a	n/a	0-5	10-15	53	n/a	n/a	0.0
Hilary Shand	Interim Chief Operating Officer (non-voting)	n/a	n/a	30-35	90-95	613	n/a	n/a	0.0

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

Note - Membership of the Board during 2013/14 is referred to elsewhere in this report (*Section 3.13.1- Directors of Greta Western Hopsitals NHS FT refers*)

Note - CETV values are not applicable over age 60.

Remuneration 2013-14

		2013-14						
Name	**Title**	**Salary (Bands of £5000)**	**Arrears for 2012-13 paid in 2013-14 (Bands of £5,000)**	**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	NED	10-15	-		-	-	-	10-15
Liam Coleman	NED	10-15	-		-	-	-	10-15
Angela Gillibrand	NED	10-15	-		-	-	-	10-15
Philippa Green	NED	5-10	-		-	-	-	5-10
Roger Hill	NED / Chairman	10-15 5-10	-		-	-	-	10-15 5-10
Janet Husband	NED	5-10 0-5	-		-	-	-	5-10 0-5
Bruce Laurie	Chairman	30-35	-		-	-	-	30-35
Jemima Milton	NED	0-5	-		-	-	-	0-5
Alf Troughton	Deputy Chief Executive & Medical Director	125-130	5-10		-	55-60	30-32.5	220-225
Nerissa Vaughan	Chief Executive	175-180	25-30		-	-	80-82.5	285-290
Oonagh Fitzgerald	Director of Workforce & Education	100-105	15-20		-	-	42.5-45	160-164
Maria Moore	Director of Finance & Performance	120-125	20-25		-	-	65-67.5	210-215
Hilary Walker	Chief Nurse	110-115	15-20		-	-	177.5-180	305-310
Kevin McNamara	Interim Director of Strategy (non-voting)	20-25	-	-	-	-	-	20-25
Hilary Shand	Interim Chief Operating Officer (non-voting)	20-25	-	-	-	-	-	20-25

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 are non-voting Directors appointed in 2013-14 and therefore are excluded from the calculations above

		2012-13					
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	NED	10-15		-	-	-	10-15
Liam Coleman	NED	10-15		-	-	-	10-15
Angela Gillibrand	NED	10-15		-	-	-	10-15
Philippa Green	NED	10-15		-	-	-	10-15
Roger Hill	NED / Chairman	10-15		-	-	-	10-15
Janet Husband	NED	10-15		-	-	-	10-15
Bruce Laurie	Chairman	35-40		-	-	-	35-40
Jemima Milton	NED	n/a		-	-	-	n/a
Alf Troughton	Deputy Chief Executive & Medical Director	120-125		-	55-60	7.5-10	190-195
Nerissa Vaughan	Chief Executive	145-150		-	-	10-12.5	160-165
Oonagh Fitzgerald	Director of Workforce & Education	85-90		-	-	2.5-5	90-95
Maria Moore	Director of Finance & Performance	105-110		-	-	2.5-5	110-115
Hilary Walker	Chief Nurse	65-70 20-25		-	-	n/a	65-70 20-25
Kevin McNamara	Interim Director of Strategy (non-voting)	n/a	-	-	-	n/a	n/a
Hilary Shand	Interim Chief Operating Officer (non-voting)	n/a	-	-	-	n/a	n/a

Note – Pension Related Benefits relate to the increase in employer contributions from prior year. Chief Executive increase is high as only in post from October 2012.
Note - Hilary Shand and Kevin McNamara are non-voting Directors appointed in 2013-14 and therefore are excluded from the calculations above

4.10.1 Notes to Pension, Remuneration and Expenses Tables

- Non-Executive Director (NED)

- 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 the notes 1.3 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, retain and motivate directors of the calibre and value required to run a foundation trust successfully. Furthermore, in the case of this Trust, reflect directors' increased portfolios noting that there were only five executive directors. 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. In 2013/14 the Executive Directors remuneration was uplifted to reflect these decisions noting that for a number of years executive director salaries had been below market levels.

4.10.2 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 2014.

4.10.3 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.

4.10.4 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	
	2013/14	2012/13
Dr A F Troughton, Deputy Chief Executive and Medical Director	£187,500	£182,500

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	2013/14	2012/13	% change
Highest paid director's total remuneration	£187,500	£182,500	2.7%
Median total remuneration	£27,759	£27,625	0.5%
Ratio	6.75	6.61	2.2%

All NHS Foundation Trusts are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce. The median total remuneration above is the total remuneration of the staff member lying in the middle of the linear distribution of staff employed in the Trust, excluding the highest paid director. This is based on an annualised full time total staff equivalent remuneration as at the reporting period date. The small movement in the above ratio of 0.2% reflects impact of pay award in 2013/14.

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

28 May 2014

5 NHS FOUNDATION TRUST CODE OF GOVERNANCE

5.1 Council of Governors

As an NHS Foundation Trust we have established a Council of Governors. The Council of Governors consists of 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 and it 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 2013/14, the Council of Governors carried out or was involved in the following: -

- Appraisals of the Chairman and non-executive directors.
- The appointment of a new Chairman.
- The appointment of a new non-executive director.
- Re-appointment of the external auditor.
- Review and approval of the Constitution.
- Held the Non-Executive Directors to account on a number of issues such as incident management, review of ophthalmology services and improvement in the physiotherapy services.

In 2013/14 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.

5.1.1 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 2013/14 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.

In 2013/14 the Staff Constituency was split out into sub-classes to better reflect the staff base of the Trust.

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. Additionally, a by-election was held for the Northern Wiltshire Constituency in June 2013 and the average turnout was 31.7%. In addition there were elections in November 2013. There was an average turnout of 20.6% for the Swindon Constituency.

5.1.2 Elected Governors in 2013/14 – Public Constituencies

Name	Constituency	Date elected	Term of Office	Attendance from 7 Council of Governor meetings
Ros Thomson	Swindon	Nov 2013	3 years (re-elected)	6/7
Kevin Parry	Swindon	Nov 2011	3 years (re-elected)	57
Harry Dale	Swindon	Nov 2010	3 years (ended Nov 2013)	4/6
Rosemarie Phillips	Swindon	Nov 2012	1 year (ended Nov 2013)	5/6
Phil Prentice	Swindon	Nov 2012	1 year (ended Nov 2013)	X6/6
Elizabeth Garcia	Swindon	Nov 2013	3 years	2/2
Louise Hill	Swindon	Nov 2013	3 years	2/2
Robert Wotton	Swindon	Nov 2013	3 year	1/2
Michael Halliwell	Northern Wiltshire	Nov 2012	3 years	7/7
Roger Bullock	Northern Wiltshire	Jun 2013	Remainder of 3 years	3/3
Margaret White	Central Wiltshire	Nov 2012	3 years	4/7
Janet Jarmin	Central Wiltshire	Nov 2012	3 years	4/7
Srini Madhavan	West Berkshire, and Oxfordshire	Nov 2011	3 years (resigned Oct 2013)	4/5

There are currently three vacant governor positions. (1) Gloucestershire, Bath and North East Somerset Constituency – no candidates stood at the last elections; (2) West Berkshire and Oxfordshire Constituency – governor resigned; and (3) Southern Wiltshire Constituency - insufficient membership to trigger an election.

Elections are planned for June 2014 to fill the two existing vacancies and a plan to increase the membership of the Southern Wiltshire Constituency is continuing.

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.

5.1.3 Elected Governors in 2013/14 – Staff Constituency

Name	Staff Constituency – sub class	Date elected	Term of Office	Attendance from 7 Council of Governor meetings
Peter Hanson	Staff	Nov 2010	3 years	4/6
Vicki Barnett	Staff	Nov 2011	2 years (resigned August 13)	2/2
Lisa Campisano	Staff	Nov 2012	1 year	6/6
Shane Apperley	Hospital Nursing & Therapy Staff	Nov 2013	3 years	2/2
Lisa Campisano	Administrators, Maintenance, Auxiliary and Volunteers	Nov 2013	3 years	7/7
Peter Hanson	Doctors & Dentists	Nov 2013	3 years	4/7
Sarah Merritt	Community Nursing & Therapy Staff	Nov 2013	3 years	2/2

Elections were held in November 2013 with only the sub-class for Administrators, Maintenance, Auxiliary and Volunteers being contested. The average turnout was 18.6%.

5.1.4 Nominated Governors in 2013/14

Name	Nominating Partner Organisation	Date nominated	Term of Office	Attendance from 7 Council of Governor meetings
Ian James	Swindon Clinical Commissioning Group	Aug 2013	3 years	3/4
Edward Wilson	Wiltshire Clinical Commissioning Group	Aug 2013	3 years	2/4
Brian Mattock	Local Authority – Swindon Borough Council	Nov 2011	3 years	5/7
Jemima Milton	Local Authority – Wiltshire Council	Nov 2011	3 years (term ceased when appointed a Non-Executive Director – vacancy exists)	5/6
Clive Bassett	Other Partnerships – Prospect Hospice	Nov 2011	3 years	6/7
Jon Elliman	Other Partnerships – Swindon and North Wiltshire Health and Social Care Academy	Nov 2011	3 years	5/7

Jemima Milton was appointed as a Non-Executive Director of the Trust and therefore ceased to be a governor on 31 December 2013. A replacement nominated governor from Wiltshire Council is being sought.

5.1.5 Attendance at meetings of the Council of Governors during 2013/14

There were 6 meetings of the Council of Governors in 2013/14. The table below shows governor and director attendance at those meetings: -

Attendee (✓ = attended X = did not attend)	**18/04/13**	**13/05/13**	**20/06/13**	**11.09.13**	**2/10/13**	**21/11/13**	**13/2/14**
Governors							
Shane Apperley	n/a	n/a	n/a	n/a	n/a	✓	✓
Vicki Barnett	✓	n/a	n/a	n/a	n/a	n/a	n/a
Clive Bassett	✓	✓	✓	✓	✓	✓	×
Roger Bullock	n/a	n/a	n/a	×	✓	✓	✓
Lisa Campisano	✓	✓	✓	✓	✓	✓	✓
Harry Dale	✓	✓	×	×	✓	✓	n/a
Jon Elliman	✓	✓	✓	×	×	✓	✓
Elizabeth Garcia	n/a	n/a	n/a	n/a	n/a	✓	✓
Michael Halliwell	✓	✓	✓	✓	✓	✓	✓
Peter Hanson	✓	×	✓	✓	×	✓	×
Louise Hill	n/a	n/a	n/a	n/a	n/a	✓	✓
Ian James	n/a	n/a	n/a	×	✓	✓	✓
Janet Jarmin	✓	×	×	×	✓	✓	✓
Srini Madhavan	✓	✓	✓	✓	×	n/a	n/a
Brian Mattock	✓	×	✓	✓	✓	✓	×
Sarah Merritt	n/a	n/a	n/a	n/a	n/a	✓	✓
Jemima Milton	✓	✓	✓	✓	✓	×	n/a
Kevin Parry	✓	×	✓	×	✓	✓	✓
Rosemarie Phillips	✓	✓	✓	✓	✓	×	n/a
Phil Prentice	✓	✓	✓	✓	✓	✓	n/a
Ros Thomson	✓	✓	×	✓	✓	✓	✓
Edward Wilson	n/a	n/a	n/a	×	✓	✓	×
Margaret White	✓	×	✓	×	×	✓	×
Robert Wotton	n/a	n/a	n/a	n/a	n/a	✓	×
Directors							
Robert Burns	✓	✓	×	×	✓	✓	✓
Liam Coleman	×	×	×	×	✓	✓	×
Oonagh Fitzgerald	×	×	×	×	✓	×	✓
Angela Gillibrand	×	✓	×	×	×	✓	✓
Philippa Green	×	✓	×	×	×	n/a	n/a
Roger Hill	✓	✓	✓	✓	✓	✓	✓
Janet Husband	✓	✓	×	×	×	n/a	n/a
Bruce Laurie (Chair)	×	✓	✓	×	✓	✓	n/a
Jemima Milton	n/a	n/a	n/a	n/a	n/a	n/a	✓
Maria Moore	×	✓	×	✓	✓	×	✓
Alf Troughton	×	✓	×	✓	×	✓	×
Nerissa Vaughan	✓	✓	×	✓	✓	×	×
Hilary Walker	×	✓	✓	✓	×	×	×
Kevin McNamara (non-voting)	n/a	n/a	n/a	n/a	n/a	n/a	✓
Hilary Shand (non-voting)	n/a	n/a	n/a	n/a	n/a	n/a	×

5.1.6 Lead and Deputy Lead Governors

Harry Dale and Ros Thomson were Lead and Deputy Lead Governors respectively up until the meeting of the Council of Governor in November 2013, when, Ros Thomson was nominated as Lead Governor (having previously been a deputy lead governor for two consecutive years) and Mike Halliwell 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.

5.1.7 Biography of individual governors

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

5.1.8 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 5.2.7 – Decisions Reserved for the Board5.2.7 refers*) 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 authorisation. 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.

5.1.9 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 2013/14 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.

Joint Board of Directors and Council of Governors Training – A programme was introduced in 2013/14 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. Bi-monthly sessions are held whereby a directorate details what they do, the areas they cover and the services they provide. When all directorates have been covered, training topics will be rolled out bi-monthly and refresher directorate sessions. The joint training provides an opportunity for the Non-Executive Directors to engage with the governors and to better understand their views and concerns.

Joint Board of Directors and Council of Governor Strategy Workshop – Similar to previous years, to allow an open discussion about future strategy a joint workshop was held enabling directors to seek governors' views on the development and delivery of strategy in terms of what they believed members, patients and the public generally wanted from healthcare services in this area now and in the future. The workshop enabled the governors to better understand the challenges facing the Trust and to input into strategy formulation.

Public Health Lectures – To provide forums for members to meet governors, public health lectures were introduced in 2012/13 and continued throughout 2013/14 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. Five public health lectures were held which continue to be well attended and welcomed by local people. A programme of public health lectures has already been agreed for next year.

"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, 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 here 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. In 2013/14 Non-Executive Directors were 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 / Governor representative inclusion in review – The Chief Executive has held separate sessions with governors to discuss specific topics of interest, with other member of the Board present and governors have been included in review of services discussions.

Annual Members Meetings – In 2013/14 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 attends most meetings of the working groups of the Council of Governors. He listens to the comments raised at these meetings and he feeds them back to the Board of Directors. In addition the Chairman 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.

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 2013/14 are: -

- Governor representative on Car Parking Advisory Group looking at car parking at the Great Western Hospital site
- Governor representative on Nutrition Steering Group looking at hydration and nutrition
- Joint workshops and training events with the Trust Board
- Governor representative on the Hearing and Vision Focus Group
- 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
- Governor invitation to participate in Patient Lead Assessments of the Care Environment
- Governor involvement in judging the Emergency Department's picture competition
- Governor representative on Patients association's observations of care project

5.1.10 Council of Governors Meetings Structure

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

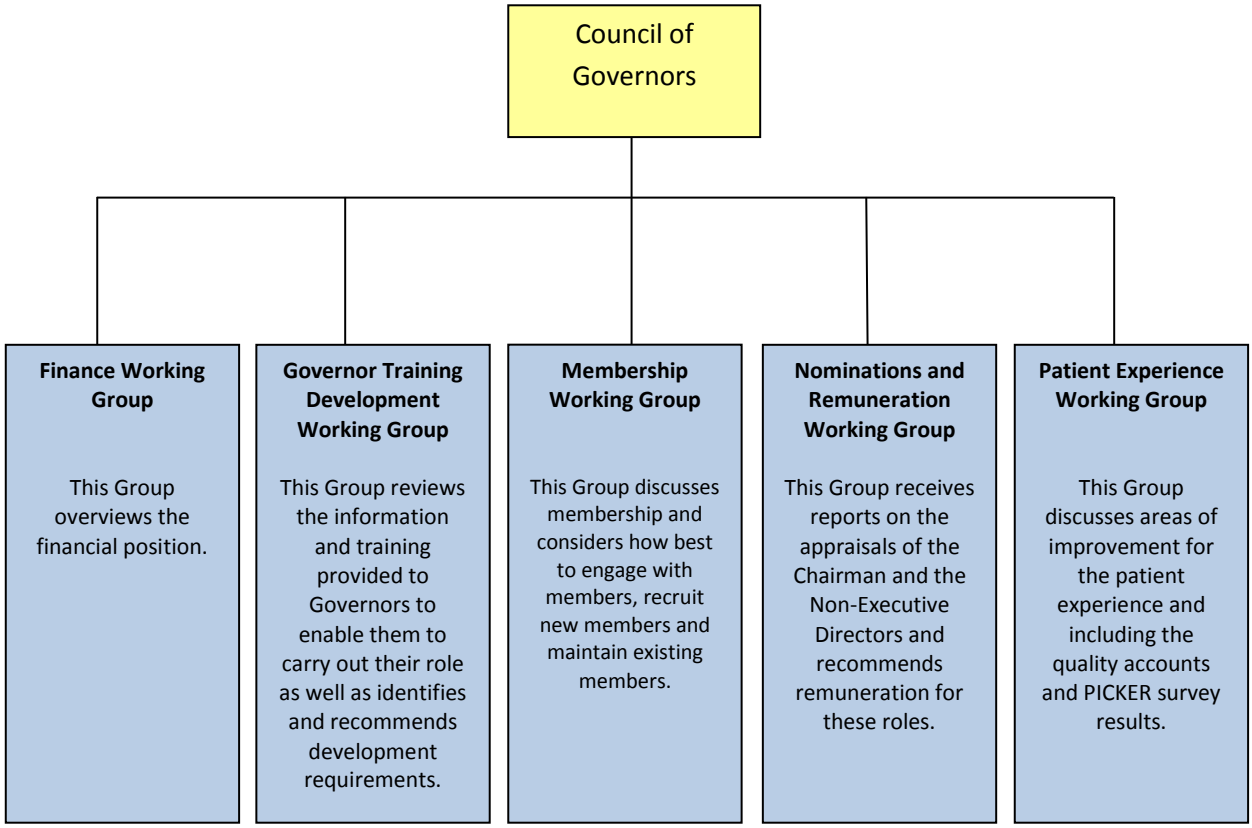
- Finance Working Group
- Membership Working Group
- Nominations and Remuneration Working Group
- Patient Experience Working Group
- Training and Development Working Group *(new in 2013/14)*

Working groups inform governors about activities and issues relevant to each area, thereby assuring governors about the performance of the Board.

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 5.4.1 – Joint Nominations Committee refers).*

The meetings structure of the Council of Governors is shown below.

TABLE – Council of Governors Meeting structure



5.1.11 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 twice in 2013/14, to undertake the annual review of the chairman and non-executive directors' appraisal process and to consider the outcomes of those appraisals. There was an annual review of the level of remuneration paid to the Chairman and the Non-Executive Directors and at least every three years there is market testing of those remuneration levels. The current pay arrangements for Non-Executive Directors were fixed at Authorisation in December 2008 to reflect foundation trust responsibilities. No salary increases have been awarded to the Non-Executive Directors since that time. Further information about the salaries of the Non-Executive Directors can be found elsewhere in this report *(Section 4.10 – Pensions, Benefits and Remuneration refers).*

5.1.12 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

5.2.1 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. The Board must ensure 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 2013/14 are given below.

5.2.2 Biography of individual Directors

Bruce Laurie, Chairman *(until 31 January 2014)*

Bruce was Chair of Newbury and Community PCT from 2001 until 2006 where he established the new West Berkshire Community Hospital working closely with West Berkshire Council. He was appointed a Non-Executive Director of Berkshire Healthcare NHS Foundation Trust, leading on commercial matters and saw the transition to Foundation Trust. He is also a Trustee Director of Connexions Berkshire, working with young people on employment, education, training and support and is a Fellow of the University of West London where he leads a Masters Course in Managing Technological Innovation. Bruce joined the Trust in February 2008 and led it successfully to Foundation Trust status and is proud to be associated with the acquisition of Wiltshire Community Health Services in June 2011. Prior to being involved in the NHS he was Group Services Director of BG plc having held a number of board level positions in the gas regions and in the international business. In 2011 Bruce was re-appointed Chairman of the Trust for a further term of two years ending 31 January 2014. Bruce was Chair of the Trust from 1 February 2008 until 31 January 2014 when his term of office ended. In 2013/14 Bruce was Chair of the Mental Health Act / Mental Capacity Act Committee and the Joint Nominations Committee and was a member of the Remuneration Committee.

Roger Hill, Non-Executive Director and Senior Independent Director *(until 31 January 2014)* **and Chairman** *(from 1 February 2014)*

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 Chair 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 2013/14 Roger was a member of the Finance and Investment Committee and Chair of the Workforce Strategy Committee until 28 February 2014. He was Chair of the Remuneration Committee up until 28 February 2014 and thereafter a member of that Committee. He was also a member of the Joint Nominations Committee. From 1 March 2014 Roger was a member of the Governance 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.

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. In 2013/14 Angela was Chair of the Governance Committee; a member of the Audit, Risk and Assurance Committee, the Finance and Investment Committee; the Remuneration Committee, the Joint Nominations Committee and the Charitable Funds Committee. Angela was also a member of the Mental Health Act/Mental Capacity Act Committee until 28 February 2014, at which point she became Chair of that Committee.

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 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 2013/14 Robert was Chair of the Audit, Risk and Assurance Committee and a member of the Remuneration Committee. Robert was also Chair of the Charitable Funds Committee.

Liam Coleman, Non-Executive Director

Liam Coleman is currently Treasurer at the Cooperative Bank. Prior to that Liam was Deputy Group Treasurer of the Royal Bank of Scotland Group and before that Group Director, Treasury at Nationwide Building Society. Prior to joining Nationwide, Liam worked in banking roles at Mitsubishi Bank, Hambros Bank and National Westminster Bank. Liam holds a BA Honours degree from the University of Manchester and an MBA from Warwick Business School. He is also a member of the Chartered Institute of Bankers and the Association of Corporate Treasurers. 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. In 2013/14 Liam was Chair of the Finance and Investment Committee and a member of the Workforce Strategy Committee. Liam was also a member of the Remuneration Committee up until 28 February 2014 when he became Chair of that committee to coincide with his appointment as Senior Independent Director.

Philippa Green, Non-Executive Director *(until 30 November 2013)*

Philippa has a successful career in the private sector, with her most recent position with British Gas. Philippa worked at BT as a highly accomplished senior executive for the past 11 years, latter holding the position of Resource Supply Director. Praised as an inspirational leader, Philippa has a proven track record of delivering sustainable results. Philippa has also established a new corporate procurement organisation which delivered procurement savings of £170 million per annum. Philippa, who lived in Wiltshire for 17 years before moving to Berkshire, is an executive coach and mentor and is keen to use her business experience to help the Trust further improve patient services. Philippa joined the Trust in January 2013 but resigned from the Trust on 30 November 2013 due to work commitments which had not been foreseen at the time of her appointment. In 2013/14 Philippa was a member of the Governance Committee, the Remuneration Committee and the Workforce Strategy Committee.

Janet Husband, Non-Executive Director *(until 31 October 2013)*

Janet is a renowned Consultant Radiologist who has worked for prestigious organisations, including the Royal Marsden NHS Foundation Trust and the Institute of Cancer Research, in a career spanning over 40 years. Since retiring from full time clinical practice in 2007, Janet has held a number of high profile positions. She is currently Chair of the National Cancer Research Institute, Emeritus Professor of Radiology at the Institute of Cancer Research and Founder and Trustee of the International Cancer Imaging Society. Her extensive experience in healthcare includes three years as Medical Director at the Royal Marsden NHS Foundation Trust, where she worked as a Consultant Radiologist from 1980 until 2007. Janet has given lectures around the world, published six books and won numerous awards for her ground-breaking work. In 2002 she was awarded an OBE and received her DBE in 2007. Janet joined the Trust in January 2013 but resigned from the Trust on 31 October 2013 due to family circumstance which had not been foreseen at the time of her appointment. However, Janet was appointed as an external advisor to the Board so that the Trust could continue to benefit from her knowledge and experience in clinical practice and healthcare. In 2013/14 Janet was a member of the Audit, Risk and Assurance Committee, the Governance Committee and the Remuneration Committee.

Jemima Milton, Non-Executive Director *(from 1 January 2014)*

Jemima has been involved in Local Government for the last 14 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 2013/14 Jemima was a member of member of the Audit, Risk and Assurance Committee, the Governance Committee and the Remuneration Committee. Jemima was a member of the Mental Health Act/Mental Capacity Act Committee from 1 March 2014 and she became Chair of the Workforce Strategy Committee from 1 March 2014.

Dr Alf Troughton, Medical Director and Deputy Chief Executive

Alf has been Medical Director at the Trust since 1 April 2006. He has been a consultant radiologist at the Trust since 1994 and was the Clinical Director of Radiology for five years. He was the Radiology President at the Royal Society of Medicine between 2003 and 2005. Alf obtained his degree in medicine in 1978 from the University of Bristol and became a member of the Royal College of Physicians (MRCP) in 1984. Subsequently Alf became a fellow of the Royal College of Radiologists (FRCR) in 1989 and a fellow of the Royal College of Physicians (FRCR) in 1997. Despite his managerial commitments Alf continues to practice as a Radiology consultant part time as this helps him to keep in touch first hand with the clinical services provided by the Trust. During 2011/12 Alf Troughton was appointed interim Chief Executive following the resignation of Lyn Hill-Tout who left the Trust in June 2011. He returned to his substantive post in October 2011 when Nerissa Vaughan joined the Trust as Chief Executive.

Alf's term of office as Medical Director ends on 31 March 2014 and his successor will be Guy Rooney, currently an Associate Medical Director.

Maria Moore, Director of Finance and Performance

Maria was appointed as Director of Finance and Performance in September 2008. She had previously held the Deputy Director of Finance post at the Trust having joined in March 2003. Maria has over 19 years' experience in the NHS which she joined as a Regional Finance Management Trainee in 1994. Since completing her training, she has worked in several acute Trusts. Maria graduated from London University with a degree in Mathematics and is a member of the Chartered Institute of Management Accountants (ACMA).

Recently, Maria has been appointed as Deputy Chief Executive and will take up this position on 1 April 2014.

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.

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.

Kevin McNamara (Interim Director of Strategy – Non Voting Board Member) *(interim 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.

Hilary Shand (Interim Chief Operating Officer – Non Voting Board Member) *(from 2 December 2013 to 17 March 2014)*

Hilary first joined the Trust in 2010 having had a career of over 20 years in Healthcare General Management for a number of health organisations both in Scotland and England. In her earlier career Hilary had roles in education, training and development before moving into general management in acute settings, a specialist children's hospital, community services and an integrated Trust which include mental health services. Hilary ceased to be the Interim Chief Operating Officer on 17 March 2014.

5.2.3 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 2013/14. Appointments are shown from 1 December 2008, being the date of Authorisation as a Foundation Trust.

Name	First Term	Second Term	Third Term
Bruce Laurie (Chair)	01.12.08 – 01.01.12	01.02.12 – 01.01.14 term now ended	n/a
Angela Gillibrand	01.12.08 – 30.06.12	01.07.12 – 30.06.14	
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	
Liam Coleman	01.12.08 – 31.10.12	01.11.12 – 31.10.15	
Janet Husband	01.01.13 – 31.10.14** Resigned	n/a	
Philippa Green	01.01.13 – 31.12.15** Resigned	n/a	
Jemima Milton	01.01.14 – 31.12.16*		

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 either re-appointed / appointed during 2013/14. 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 re-appointment / appointments were approved by the Council of Governors.
**The terms of office of these Non-Executive Directors ended and they ceased to be Non-Executive Directors of the Trust.

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 2014).

5.2.4 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 2013/14, 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 2013/14 the term of office of the Chairman of the Trust ended and he did not seek re-appointment. One of the existing Non-Executive Director was appointed as the new Chairman resulting in a Non-Executive Director vacancy. In addition, two Non-Executive Directors resigned before their end of term due to unforeseen personal circumstances. One new Non-Executive Director was appointed. At the year-end two Non-Executive Director vacancies remain which will be recruited to in May/June 2014.

5.2.5 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 2013/14 there was significant change and refreshment of the Board, which is continuing. The Trust appointed a new Chairman, one new Non-Executive Director and a new Medical Director. Furthermore, a new interim Director of Strategy (non-voting) (subsequently permanently appointed in April 2014) and a new interim Chief Operating Officer were appointed. There remain two non-executive director vacancies and the recruitment for the substantive Chief Operating Officer is due to commence. It was therefore decided that the Board will undertake formal evaluation of its own performance in 2014/15. Notwithstanding this, the Board has considered its effectiveness during 2013/14 in terms of decision making and has refreshed its reserved powers, the Scheme of Delegation and the Terms of Reference of the Board Committees.

As there has been no external evaluation of the Board, there is no external facilitator to identify in this report or their connection to the Trust.

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 2013 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 2014, and will be reported through the Remuneration Committee in May 2014 following a formal appraisal process using the Leadership Qualities Framework competencies. All appraisals involve 360 degree evaluation and feedback.

5.2.6 Attendance at meetings of the Board of Directors during 2013/14

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

	25.04.13	30.05.13	27.06.13	25.07013	26.09.13	31.10.13	28.11.13	09.01.14	15.01.14 (additional meeting)	30.01.14	27.02.14	27.03.14
Robert Burns	✓	✓	×	✓	✓	✓	✓	✓	✓	✓	✓	✓
Liam Coleman	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Oonagh Fitzgerald	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Angela Gillibrand	✓	✓	✓	✓	✓	✓	✓	✓	×	✓	✓	✓
Philippa Green (until 30.11.13)	✓	×	✓	✓	✓	✓	✓	n/a	n/a	n/a	n/a	n/a
Roger Hill	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	×
Janet Husband (until 31.10.13)	✓	✓	×	✓	✓	✓	n/a	n/a	n/a	n/a	n/a	n/a
Bruce Laurie (until 31.01.14)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	n/a	n/a
Jemima Milton (from 01.01.14)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	✓	✓	✓	✓	✓
Maria Moore	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Alf Troughton	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nerissa Vaughan	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Hilary Walker	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Kevin McNamara (from 02.12.13 non-voting member)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	✓	✓	✓	✓	✓
Hilary Shand (from 02.12.13 until 17.03.14 non-voting member)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	×	×	✓	✓	✓

5.2.7 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. A full copy can be obtained from the Company Secretary.

5.2.8 Interests of Directors

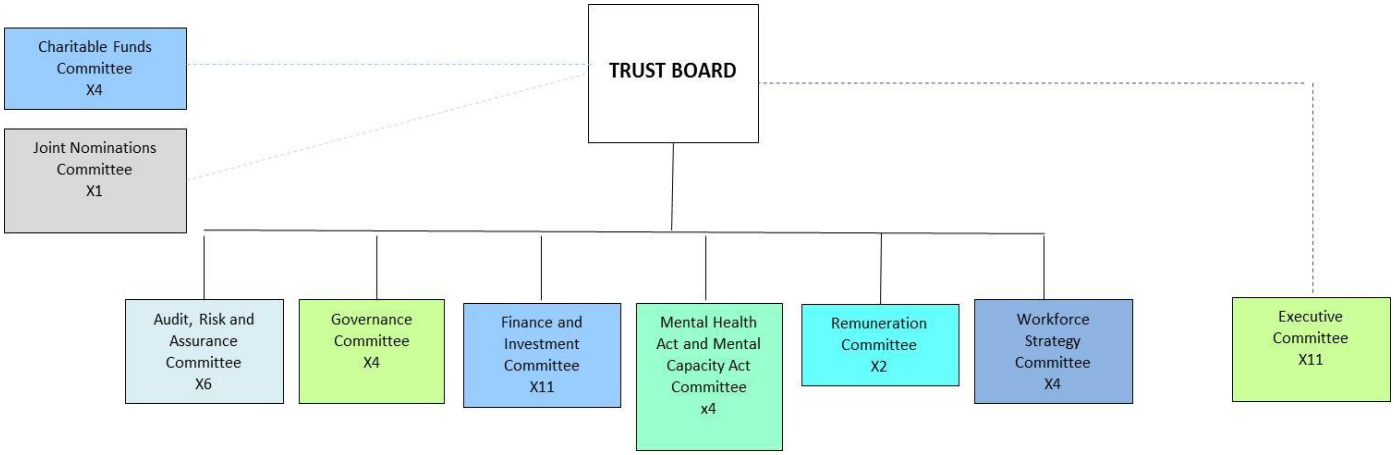
A Register of Interests of Directors is maintained, a copy of which can be obtained from the Company Secretary.

5.2.9 Significant Commitments of the Chairman

There were no substantial changes to commitments during the year and the former Chairman, Bruce Laurie was able to devote the appropriate time commitment to this role. This situation is the same for the new Chairman, Roger Hill who took up the position on 1 February 2014. Roger did not disclose any other significant commitments before appointment and no changes have been reported to the Council of Governors since.

5.2.10 Committee structure

The structure of the Board committees during 2013/14 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. Going forward there will be a Finance, Investment and Performance Committee to expand the remit of the Finance and Investment and ensure focus on the delivery of performance measures. Also there will be a People Strategy Committee, replacing the Workforce Strategy Committee to focus on overseeing the delivery of the Trust's People Strategy agreed in March 2014.

5.2.11 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 and Investment Committee
- Mental Health Act and Mental Capacity Act Committee*
- Remuneration Committee*
- Workforce Strategy Committee.
- Executive Committee

* Statutory Committees

5.3 Audit Committee

GWH NHS FT AUDIT, RISK & ASSURANCE COMMITTEE
ANNUAL REPORT 2013/14

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 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 2014. This report covers activities and accounts during the period 1 April 2013 to 31 March 2014.

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 four 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)
Dame Janet Husband DBE	Appointed 1st January 2013, resigned 31st October 2013. (Member of Governance Committee)
Jemima Milton	Appointed 1st January 2014

Attendances: Non-Exec Members	23 May 2013	23 July 2013	19 September 2013	21 November 2013	23 January 2014	20 March 2014
Robert Burns (Chair)	✓	✓	✓	✓	✓	✓
Angela Gillibrand	✓	✓	✓	✓	✓	✓
Janet Husband	✓	✓	✓	N/A	N/A	N/A
Jemima Milton	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 Alf Troughton (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 (Parkhill, now 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 2013, plus January and March 2014. For the current financial year a minimum of five meetings is currently scheduled, commencing in May 2014 with the review and approval of the 2013/14 year-end Annual Reports and Accounts. The major review areas addressed in the meetings in 2013/14 relating to Governance and Enterprise Risk Management (ERM) can be summarised as follows:

- At least on a quarterly basis the Trust's Board Assurance Framework and higher risk 15+ Risk Register, as presented by the FD and CoSec, 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 Board Assurance Framework remains "fit for purpose" and reflects any risks that impact on the Trust's strategic objectives and the assurance and mitigation provided, or if none exist prompt a suitable course of action to minimise the impact.

- The Committee has during the period, specifically reviewed the Trust's Scheme of Delegation and the policies relating to Information Governance and Strategy. 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.

- The Chair of the Committee has provided an update on the work of the Committee to the Governors, whilst also providing an explanation relating to a then current concern of the committee around the consistency of risk recording within the Trust and the approach being taken towards mitigation by the Executive team.

- The Committee had taken particular interest in delays in the implementation of two IT systems upgrades relating to Electronic Staff Rostering (ESR) and Medway (Acute system only), either of which may present financial, control or performance risk to the Trust. Medway has been the subject of direct main Board scrutiny and progress reporting whilst ESR implementation progress has been reported to the Committee. This upgrade incorporates improvements needed to address outstanding Audit issues dating from both 2012 and 2013. Both upgrades are currently on trajectory, but still subject to close oversight.

- Additionally as indicated above, in May 2014 the Trust's Financial Accounts for 2013/14 and Annual Report including the Quality Report were reviewed and approved by the Committee for endorsement by the Board.

8. Internal Audit and Counter Fraud: In October 2013 Parkhill merged with TIAA who with the exception of our counter-fraud specialist has presented a new team to takeover Internal Audit work with the Trust's agreement. Subsequently, the Trust has decided to use the option to extend the existing Parkhill contract with TIAA for a further year.

The Committee reviewed and approved Parkhill's, now TIAA's, internal audit and counter-fraud plans to ensure the provision of support to the Board 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 ARAC has considered and endorsed the Head of Internal Audit's 2013-14 Annual Report that assessed the Trust's systems of internal control as generally sound in terms of design and are operating in a way that gives a reasonable likelihood that the system's objectives will be met and that they provided overall Significant Assurance.

During the course of their agreed work plan, TIAA has issued two internal audit reports providing Limited Assurance relating to some specific aspects concerning "ESR Implementation" described above and in relation to process weaknesses, documentation and record keeping regarding "18 week Capacity Planning Referral to Treatment (RTT)". 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 Adequate or Substantial assurance. In addition the Trust requested a review of its "Estates Documentation" practices which identified some specific weaknesses in processes and practice resulting in a decision to defer a full audit. However, actions are in hand to address issues and improve processes and controls.

9. External Audit: KPMG were represented at all meetings of the Committee and submitted reports as needed, including their 2013-14 **Unqualified Report** on the Trust's Financial Accounts, their Annual Audit letter and also a **Limited Assurance** (i.e. unqualified) on the Trust's Quality report. The 2013/14 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.

In the April, May and July 2013 the Trust requested KPMG to undertake one piece of work which was a "CIP Programme assessment" to examine the Trust's savings plans included in the 2013/14 financial budget target. This work represented a non-audit service provision to the value of £53,337.10. KPMG were selected in a competitive bid process. However, the staff and management engaged were not involved in the Statutory Audit activity or its management and the Trust assessed the costs as not likely to be material to the independence of KPMG in carrying out its External Audit responsibilities. The Committee has also discussed its concerns over Auditor independence with KPMG and received assurances that this has not been compromised.

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

10. **Review of Effectiveness:** The Committee undertook a formal self-assessment during the year and an action plan was prepared to address weaknesses where identified. It is planned that a formal self-assessment review will also be undertaken in 2014/15.

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 2013-14 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 and are no significant areas of concern to be disclosed in the Annual Governance Statement. The Committee was of the opinion that there is full and frank disclosure of any material issues.

14. In 2014-15 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 2014

5.4 Nominations Committee

5.4.1 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.

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

In 2013/14 the Committee met during the year to consider the process and timetable for new Chairman and Non-Executive Director appointments and thereafter to consider feedback from interviews and recommend candidates for appointment to the Council of Governors.

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

The Joint Nominations Committee 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 a new Chairman and 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.

5.4.3 Attendance at the Joint Nominations Committee Meetings during 2013/14

Joint Nominations Committee Members	Record of attendance at each meeting ✓ = Attended × = Did not attend		
	10 September 2013	13 November 2013	Reconvened meeting held on 21 November 2013
Angela Gillibrand – Non-Executive Director	✓	✓	✓
Roger Hill - Non-Executive Director	✓	×	× (Robert Burns substitute)
Bruce Laurie – Chairman	× (Janet Husband substitute)	×	× (Liam Coleman substitute)
Clive Bassett – Governor	× (Janet Jarmin substitute)	×	×
Lisa Campisano– Governor	✓	×	✓
Harry Dale – Governor	× (Mike Halliwell substitute)	✓	× (Mike Halliwell substitute)
Phil Prentice – Governor	✓	✓	✓

Note: Angela Gillibrand, Roger Hill and Bruce Laurie are Non-Executive Directors appointed by the Board and Clive Bassett, Lisa Campisano, Harry Dale and Phil Prentice are Governors appointed by the Council of Governors.

The Chair of the Committee is Bruce Laurie, Chairman of the Trust. However, as the Committee was considering his successor appointment he did not attend any meetings of the Committee, which was chaired by Angela Gillibrand, the Deputy Chairman of the Trust.

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

5.5.1 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
- Deputy Chief Nurse – Trust Lead for Mental Health Services
- Mental Health Act Administrator
- Representative from Child and Adolescent Mental Health Service (CAMHS) x three (General Manager/Clinician/Nurse)
- Senior Representative from Adult Mental Health Services (AWP)
- Senior Representative from the Older People's Mental Health Services (AWP)
- Senior Nurse/Matron (Great Western Hospital)
- Representative from Swindon Primary Care Trust
- Doctor representative

5.5.2 Meetings during 2013/14 attendance

The Mental Health Act / Mental Capacity Act Committee members		June 2013	Sep 2013	Dec 2013	Mar 2014
Bruce Laurie (Chair) *Bruce Laurie left the Trust in 31st January 2014*	Chairman of the Trust	×	✓	×	-
Angela Gillibrand (Chair) *New Chair of the Committee from 1st March 2014*	Non-Executive Director	✓	×	✓	✓
Jemima Milton (Deputy Chair) *New Deputy Chair of the Committee from 1st March 2014*	Non-Executive Director	-	-	-	✓
Robert Nicholls	Deputy Chief Nurse	✓	✓	✓	×
Joy Gobey	Mental Health Act Administrator	×	✓	✓	✓
Teresa Harding Joanne Smith, Senior Nurse Paediatrics - Deputy	General Manager, Women and Children's' Department	× ✓	× ×	× ×	✓
Dick Eyre Attendance as either / both with Amanda Cadder	Child Psychiatrist	×	×	×	×
Amanda Cadder Attendance as either/both with Dick Eyre	Nurse Manager	×	×	×	×
Neil Mason *Neil has moved roles and no longer a member of the Committee*	Community Service Manager and Adults Service Manager Avon and Wiltshire Mental Health Partnership NHS Trust (Liaison)	✓	×	×	×
Paula May	General Manager Swindon Locality, AWP Avon and Wiltshire Mental Health Partnership NHS Trust	×	✓	×	-
Newlands Anning Deputy for Paula May	Head of Professions and Practice Swindon Locality & Innovation Development Lead, Avon and Wiltshire Mental Health Partnership NHS Trust	×	-	✓	×
Jane Higgins for Joi Demery	Social Work Lead Swindon Borough Council/Avon and Wiltshire Mental Health Partnership NHS Trust	×	×	×	✓
Julie Dart	Joint appointment with Swindon Borough Council and Swindon Clinical Commissioning Group Adult Social Care	✓	×	✓	✓

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 commencing her role on the 1st May 2014. The post is with Avon and Wiltshire Mental Health Partnership NHS Trust but the Consultant will work with the Mental Health Liaison Team at the Great Western Hospital which will include the Responsible Clinician for the Trust. Dr Haywood will lead the Dementia work progressing in the Trust.

5.5.3 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 2013 – 31st March 2014 the Mental Health Act was used on 133 occasions in respect of 52 patients (including 9 patients under Section 2 detained to another Organisation).

TABLE - Use of the Mental Health Act at The Great Western Hospitals NHS Foundation Trust 1st April 2013 to 31st March 2014

Section	Type of Section	Number for use of the Mental Health Act
5(2)	Report on Hospital In-Patient	21
2	Compulsory Admission for Assessment	19
3	Compulsory Admission for Treatment	1
4	Emergency Admission for Assessment Section 4	1
17	Authorisation for Leave of Absence to GWH Section 17	21
19	Authority for Transfer from Hospital to Another Under Different Managers Section 19	18
23	Order of Discharge from Detention by Responsible Clinician Section 23	3
132	Record of Information Section 132	40
Other	Detained to Other Hospital under Section 2 of the Act whilst GWH inpatient	9
TOTAL	**Number of Patients**	**52**
TOTAL	**Use of the Mental Health Act including detained to other Hospital whilst GWH inpatient**	**133**

5.6 Membership

5.6.1 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.

5.6.2 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

5.6.3 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. In 2013/14 the Trust split the staff constituency into sub classes to reflect occupational areas as follows: -

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

5.6.4 Membership analysis

During the year, the Trust sought to increase membership numbers but at the year end, the position is less members. However, this is considered to be partly due to a cleanse of existing data. The Trust procured a new database system for the management of membership data, part of which included removal of members (deceased people and movers). As at 31 March 2014, the membership of the Great Western NHS Foundation Trust was as follows: -

Constituency	Member Count
Swindon	2,786
North Wiltshire	1,033
Central Wiltshire	384
Southern Wiltshire	39
West Berkshire and Oxfordshire	308
Gloucestershire and Bath and North East Somerset	201
Staff	6,353
TOTAL	**11,104**

Public Constituency	2013/14	2014/15 (estimated)
At year start (1 April)	5,009	4,751
New Members	407	712
Members leaving	665	356
At year end (31 March)	4,751	5,107

Staff Constituency	2013/14	2014/15 (estimated)
At year start (1 April)	6,483	6,353
New Members	1,326	1,270
Members leaving	1,456	1,905
At year end (31 March)	6,353	5,718

The estimates for 2014/15 public members are based on a prediction having regard to membership recruitment drives planned to take place in 2014/15 and an initiative to retain former staff as members, provided they meet the eligibility criteria.

The estimates for 2014/15 staff members are based on a prediction having regard to expected staff levels and noting that approximately 350 staff will transfer to Royal United Hospital Bath NHS Trust with the transfer of maternity services in June 2014.

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

Age	Member Count
0-16	22
17-21	202
22+	4,508
Unknown	19
Total	**4,751**

Ethnicity	Member Count
White	3,636
Mixed	25
Asian or Asian British	146
Black or Black British	49
Other	28
Unknown	867
Total	**4,751**

Gender	Member Count
Male	2,006
Female	2,710
	35
Total	**4,751**

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.

5.6.5 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 2013/14 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
- Governor's Blog
- 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 joint workshop, where an open discussion on proposals took place and governor comments were incorporated.

Plans for a fresh approach to member engagement in 2014/15 are being developed. 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 whether members want a "hot tots" clinic in Swindon and the Governance Officer is working with directorates to develop a schedule of engagement throughout the year on a number of Trust topics and to feedback comments received.

5.6.6 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 GWH 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.

5.6.7 Membership development in 2013/14

In order to build a representative membership during 2013/14 the Trust undertook the following: -

- The Governance Officer hosts monthly recruitment drives in the hospital atrium;
- The Governance Officer attended Veterans Day in Trowbridge on 29 June 13
- The Governance Officer attended Party in the Park in Melksham on 13 July 2013
- The Governance Officer attended Swindon Pride on 10 August 2010
- Held an Annual Members Meetings in September 2013, in Swindon
- The Governance Officer attended a Year 11 careers evening on 10 October 2013 in Swindon.

In the last twelve months the Trust has worked on increasing its members as well as engaging its' members. The revised 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 GWH on a monthly basis talking to visitors and patients and recruiting new members.

The Trust acknowledges that the number of members has decreased in 2013/14 due to a data cleanse of all members onto the newly procured membership database.

5.6.8 Membership recruitment proposed for 2014/15

Engagement with existing forums
The Governance Officer will continue to engage with existing forums, such as Patient Participation Groups, parish and town councils, 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 Human Resources Department 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 Stress to Pregnancy 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 is exploring approaching large local employers to promote membership.

Link with other NHS Trusts
An agreement is being discussed with other Trusts which overlap our geographical area to secure a reciprocal membership arrangement.

Information in Discharge Pack
The Governance Officer will approach the project for Discharge Assessment and Referral Team (DART) to investigate the practicalities and benefit of including information about membership in the patient discharge pack.

Bedside Guide
Information about membership to encourage recruitment and engagement has been developed and will be included in the Bedside Guide for all inpatients from 1 May 2014.

Radio Advert
Script for an inpatient radio advert about membership and engagement has been drafted and a radio advert will be recorded in May, with a view to live broadcast from June onwards at both the Great Western Hospital in Swindon and at the Chippenham Community site. The advert is being developed by young people with the opportunity taken to recruit younger new members and develop an advert which might engage a younger age group.

5.6.9 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.

Monitor, the independent regulator for Foundation Trusts, published the NHS Foundation Trusts Code of Governance, a revised version of which was published in early 2014. The way in which the Trust applies the principles within the Code of Governance are set out in this report, and the Directors consider that in 2013/14, the Trust has been compliant with the Code with the exception of the following: -

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. However, going forward to ensure the Board has direct oversight of membership and engagement, a governance report will be presented to the Board periodically covering this information and other areas falling under the remit of the Council of Governors.

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

At the Great Western Hospital NHS Foundation Trust, patient safety continues to be at the heart of everything we do. We continue to focus our energies on improving safety, patient experiences and staff satisfaction by providing the highest quality care.

The past year has been extremely challenging, however, it has also been an extremely positive and rewarding year and provided opportunity for us to develop and improve the quality of care we provide within the acute and community health care settings for which we are responsible.

We have regularly monitored our quality improvement plans during 2013/2014 through our Patient Safety Committee and newly formed Patient Experience Committee through to Trust Board. We have presented progress to our Council of Governors and we have also ensured our quality improvement plans have been informed by national priorities and our locally agreed quality improvement contracts agreed between our clinical teams and commissioners on behalf of our local population.

This year's Quality Accounts have been driven against a background of significant challenge. The Francis report highlighted the effects on Health Care Providers which fail to deliver safe services for its patients and hence provides a clear focus for all of us to continuously strive to improve and provide the safest care possible. During 2013/2014 we have taken the opportunity to consult widely with staff and patients and develop and finalise our Quality Strategy and ensure it is informed by the findings and recommendations within the Francis Report.

Our specific priorities for quality improvement set out in the Quality Accounts have been chosen to reflect our goals.

- To promote and improve the safety of our patients and prevent avoidable harm.
- To ensure the care we provide is clinically effective and in the best interest of our patients
- To improve the experiences and satisfaction of our patients.

As a consequence of our quality improvement programme, we have improved care in many areas and delivered some significant service improvements and continued to develop our services.

We are proud of our achievements in reducing the numbers of pressure ulcers developing in patients within our care and have significantly reduced the numbers of the more serious pressures ulcers developing within the acute hospital.

Due to the early recognition and prompt management of patients presenting with infectious gastro intestinal illness (Norovirus) we have been able to minimise the number of ward and bay closures needed to contain the virus and hence maximise the use of beds on wards throughout the year particularly during a very busy winter period

The delivery of safe and effective care must be coupled with the experiences of our patients. We have listened to our patients, heard their experiences and continue to share and use this information and the learning from incidents, complaints and audits to continuously improve the patient

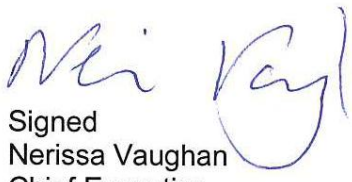
experiences. I am particularly pleased that our annual in-patient survey shows that patients continue to rate their experiences, whilst in our care, highly overall.

The commitment of our staff in delivering high quality care is reflected in our recently published staff survey results. As a Trust we are committed to being an exemplar employer and strive to ensure that all our employees reach their full potential at work and are happy and motivated. Our staff survey shows that our staff reported that their experience of working at the GWH places us in the top 20% of Acute Trusts in the UK for 13 of the 28 measures. These include staff motivation levels, training, appraisals and equal opportunities for promotion.

There are some important and priority elements of patient care where we want to review practice and make improvements over the next 12 months. These are included within our Quality Account improvement plans 2014/15 and Quality Strategy and include:

- Reducing hospital mortalities
- Reducing harm from patient falls
- Zero reporting of Never Events

None of the above would have been possible without the hard work and dedication of our staff and volunteers, along with colleagues working in other allied organisations. Change is needed and is inevitable if we are to continue to improve what we do both inside and outside hospitals and to deliver better care for the population we serve. However, we are confident that our staff will continue to meet the challenges ahead.



Signed
Nerissa Vaughan
Chief Executive

28 May 2014

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

6.2 Priorities for improvement

Within its business plan, the Great Western Hospitals NHS Foundation Trust sets out that the provision of safe, high quality, patient care, is its number one priority.

The Trust's aim is to set out a clear quality improvement plan building on current local and national quality improvement initiatives to meet its quality and **safety** objectives and to provide the safest and most **effective** care to enhance the **experiences** of our patients. Where these improvement priorities are informed by our local contractual agreement with our commissioners, this is cited accordingly.

6.2.1 Priorities 2013/14

Safe Care

- Continue to reduce healthcare associated infections including MRSA and *Clostridium difficile*
- Continue to reduce harm associated with patient falls
- Continue to reduce hospital and community acquired pressure ulcers
- Continue to reduce avoidable mortality, disability and chronic health through improved assessment and management of venous thromboembolism (CQUIN contract)
- Continue to reduce Catheter Associated Urinary Tract Infections (CAUTIs)
- Continue to reduce the incidents of Never Events

Effective Care

- Improve the care and management of patients through progressing implementation of the Trust's Nutrition and Hydration action plans
- Continue to sustain our Hospital Standardised Mortality Ratio (HSMR) to below 100
- Improve the management of the deteriorating patient by full completion of the Early Warning Score
- Continue to enhance the quality of life for patients with Dementia
- Continue to adhere to Regulations and Standards for Safeguarding for Adults & Children.
- Carry out a review of Patients who are re-admitted to hospital within 30 days of discharge
- Continue to improve on Stroke Care
- Continue to monitor and maintain compliance with national best practice guidelines published by the National Institute for Clinical Excellence

Patient Experience

- Review, assess and improve on feedback arising from the Friends and Family Test – patient recommendations
- Continue to monitor and reduce and learn from complaints
- Ensure that Equality & Diversity is fully established within the organisation

6.2.2 Priorities 2014/15

Our commitment to quality will continue through a number of priorities for 2014/2015 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 2014/2015 are summarised below and they have been set out in the NHS Outcomes Framework which focuses on patient outcomes and experience. We are developing detailed plans with timescales and targets to ensure we deliver these improvement priorities.

NHS Domain	Darzi Element	Focus	Priority	Rationale
1	Effective care	Preventing people from dying prematurely	• Hospital Standardised Mortality Ratios (HSMR)/Summary Hospital-level Mortality Indicator (SHMI)	CQC Priority/ Contract/Local priority
			• Early recognition of the deteriorating patient	CQC Priority Contract/National priority
2	Effective care	Enhancing quality of life for people with long term conditions	• Dementia	CQUIN/Contract
			• Safeguarding adults and children	CQC Priority Contract/Regulation/ CQC priority
			• Review of patients who are being readmitted to hospital within 30 days of discharge	National/Contract/ CCG priority
3	Effective Care	Helping people to recover from episodes of ill health or following injury	• Nutrition and hydration	CQC Priority Contract/Regulation
			• Stroke care	National/Contract/ Regulation
			• Compliance NICE Publications	CQC Priority Contract
4	Patient Experience	Ensuring people have a positive experience of care	• Friends and family test – patient recommendations	CQUIN/Contract
			• Complaints Implement a new Complaints System in April 2014 and in doing so, build capability in wards and departments to support local resolution, therefore: • Improving response times • Demonstrating early resolution • More robust investigations and responses leading to less complaints to the Parliamentary & Health Service Ombudsman	CQC Priority / Local Focus on friends and family is the priority
			• Equality and Diversity	Contract/Regulation/ New project developing
5	Safe care	Treating and caring for people in a safe environment and protecting them from avoidable harm	• Reduce Healthcare Infections	CQC Priority National/Contract/ Regulation/Local
			• to report zero Never Events • Reduce Incidents and associated harm	CQC Priority Contract/ Local/Regulation
			• Patient safety thermometer - continue to reduce the following: Falls Pressure ulcers Catheter Associated Urinary Tract Infections (CAUTIs) VTE	CQC Priority CQUIN/Contract/ Local
			• To reduce Medication Errors	CQC Priority Contract/Local priority
	GOVERNANCE **All of the above are relevant to these indicators**		• To strengthen and progress full compliance with the CQC regulations	CQC Priority Contract/Regulatory requirement and priority
			• Implement plans to improve results of the national staff survey	CQC Priority Contract/Regulatory requirement and priority

6.3 Statements of assurance from the Board

During 2013/2014 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.

The income generated by the relevant health services reviewed in 2013/14 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 2013/2014.

6.3.1 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 2013/14, 32 National Clinical Audits and 5 National Confidential Enquiries covered relevant health services that Great Western Hospitals NHS Foundation Trust provides.

During 2013/14 Great Western Hospitals NHS Foundation Trust, participated in 100% (32/32) national clinical audits and 100% (5/5) 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 2013/14 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 2013/14 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 2013/14, 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	Yes	100%
2	Adult cardiac surgery audit	NA	NA
3	Adult critical care (Case Mix Programme)	Yes	100%
4	Bowel cancer	Yes	100%
5	Cardiac arrhythmia	Yes	100%
6	Chronic Obstructive Pulmonary Disease	Yes	Commences Jan 14
7	Congenital heart disease (Paediatric cardiac surgery)	NA	NA
8	Coronary angioplasty	Yes	Data collection/submission still in progress

National Clinical Audits		Participated	% Data Submission
9	Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	Yes	100%
10	Diabetes (Paediatric)	Yes	Data collection/submission still in progress
11	Elective surgery (National PROMs Programme)	Yes	Data collection/submission still in progress
12	Emergency use of oxygen	Yes	100%
13	Epilepsy 12 audit (Childhood Epilepsy)	Yes	Data collection/submission still in progress
14	Falls and Fragility Fractures Audit Programme, includes National Hip Fracture Database	Yes	Data collection/submission still in progress
15	Falls and Fragility Fractures Audit Programme (FFFRAP) - Pilot audit of inpatient falls. Feasibility study	Yes	Data collection/submission still in progress
16	Falls and Fragility Fractures Audit Programme (FFFRAP) - Pilot audit of Fracture liaison service	NA	NA
17	Head and neck oncology	Yes	100%
18	Heart failure	Yes	100%
19	Inflammatory bowel disease	Yes	100%
20	Lung cancer	Yes	100%
21	Moderate or severe asthma in children (care provided in emergency departments)	Yes	Data collection/submission still in progress
22	National audit of schizophrenia	NA	NA
23	National Audit of Seizure Management (NASH)	Yes	100%
24	National Cardiac Arrest Audit	Yes	Data collection/submission still in progress
25	National comparative audit of blood transfusion	Yes	100%
26	National emergency laparotomy audit	Yes	Data collection/submission still in progress
27	National Joint Registry	Yes	Data collection/submission still in progress
28	National Vascular Registry, including CIA and elements of NVD	NA	NA
29	Neonatal intensive and special care	Yes	100%
30	Oesophago-gastric cancer	Yes	100%
31	Paediatric asthma	Yes	Data collection/submission still in progress
32	Paediatric bronchiectasis	NA	NA
33	Paediatric intensive care	NA	n/a
34	Paracetamol Overdose (care provided in emergency departments)	Yes	Data collection/submission still in progress
35	Prescribing Observatory for Mental Health (POMH-UK) (Prescribing in mental health services)	NA	NA
36	Pulmonary hypertension	NA	NA
37	Renal replacement therapy (Renal Registry)	Yes	100%
38	Rheumatoid and early inflammatory arthritis	Yes	Commences Feb 14
39	Sentinel Stroke National Audit Programme (SSNAP), includes SINAP	Yes	Data collection/submission still in progress
40	Severe sepsis & septic shock	Yes	Data collection/submission still in progress
41	Severe trauma (Trauma Audit & Research Network)	Yes	Data collection/submission still in progress

National Clinical Audits		Participated	% Data Submission
Confidential enquiries		**Participated**	**% Data Submission**
1	Medical and surgical clinical outcome review programme: National confidential enquiry into patient outcome and death : Tracheostomy Care	Yes	100%
2	Medical and surgical clinical outcome review programme: National confidential enquiry into patient outcome and death : Lower Limb Amputation	Yes	100%
3	Medical and surgical clinical outcome review programme: National confidential enquiry into patient outcome and death : Gastrointestinal Haemorrhage	Yes	100%
4	Mental health clinical outcome review programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)	NA	NA
5	Child health clinical outcome review programme (CHR-UK)*	Yes	100%
6	Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	100%

National clinical audits

The reports of 37 national clinical audits were reviewed by the provider in 2013/2014 and Great Western Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- GWH Laboratory staff routinely aim to provide group specific blood issued within fifteen minutes which, national results show that hospitals able to provide group specific blood within this time use up to 50% less emergency 'O Rhesus D negative' red cells.
- The appointment of three extra Gastro-Intestinal Surgeons to facilitate next day referral to specialist care to avoid out of hours emergencies. This will also increase the provision of specialist on call surgeons. It is planned to provide a provision for colonic stenting at GWH.
- All rectal cancer patients will have a pre-operative appointment and made aware of the potential outcomes of a temporary ileostomy with a Clinical Nurse Specialist.
- Laparoscopic surgery is to be considered in all suitable cases by two additional colorectal surgeons accredited in colorectal laparoscopic techniques, strengthening the current team to five colorectal surgeons.
- Within the Stroke Services, there are two areas which are currently being improved upon; the percentage of patients who are directly admitted from the Accident and Emergency department to the Acute Stroke Unit within 4 hours of admission; the national performance for this indicator is 57%. GWH performance at October 2013 was 75%.
- The percentage of patients who are achieving 90% length of stay on a Stroke Unit; the national performance for this indicator is 84%. GWH performance at October 2013 was 90%.
- A review of the current services provided for patients with alcohol related liver disease is planned, which includes establishing a new Multi-disciplinary team with clinical lead, and a robust process of joint working with Primary Care services.
- Recruitment of specialist clinician/consultant to ensure that all patients admitted with alcohol-related liver disease receive early specialist input and continued management.

Local clinical audits

The reports of 258 local clinical audits were reviewed by the provider in 2013/2014 and the Great Western Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- Introduction of a Deep Vein Thrombosis risk assessment form to be completed by clinicians to ensure patient risk factors have been clearly identified
- Introduce mandatory training to ensure thorough knowledge and understanding of the Do Not Attempt Cardio-Pulmonary Resuscitation (DNA-CPR) policy is embedded amongst all staff
- Introduction of a chest pain pro-forma in the Acute Medical Unit to ensure patients are clearly identified; treated appropriately and referred to specialist teams where appropriate
- It is planned for all 29 state senior schools in Wiltshire have a weekly school nurse drop in/open access session during term time
- It is planned to revise the paper incident forms to include a section for documenting 'being open' communication, additionally, instructions will be included on the electronic incident form to prompt staff to document accordingly. Exploration of options to include 'Being Open' as part of clinical staff induction
- To introduce a new Serious Incident reporting checklist to ensure all reporting requirements are completed by the Clinical Risk Team within a required timeframe. To monitor department level investigations to ensure they are completed within 14 days, reporting exceptions to Patient Safety Committee and Directorate Management. To review and amend induction/mandatory training for all Trust staff

As a Department of Health directive towards driving quality, safety and evidence through Clinical Audits, the Trust aims to ensure that it meets all professional, regulatory, monitory and national requirements. This includes the assessment and implementation of all National Institute for Health and Care Excellence (NICE) guidance where relevant to the organisation.

The Clinical Audit and Effectiveness department continues to see an increasing number of registered audits which are fundamental in promoting the quality, safety and effectiveness of patient care, for example, to avoid incidents that should never happen, reviewing the management and clinical care for patients who die in hospital, avoiding unnecessary length of stays for inpatients and avoiding readmissions into hospital after discharge.

The varied number of projects registered with the department is a reflection of the organisation and health care professional's dedication to providing assurances with evolving evidence based practices and promoting patient safety and outcomes with a remarkable 116 service evaluation projects and 73% of clinical audits leading to change in practice.

To provide additional assurance to the Trust Board, a total of 18 reviews were undertaken as a result of the Trust's internal monitoring process for increased inpatient mortalities, readmissions and length of stays, furthermore, additional 3 reviews provided assurances to the Care Quality Commission.

The results of clinical audits will continue to be presented when required and activity reports will continue to be produced by the department summarising audit outcomes. All key learning, recommendations and actions from these audits will continue to be reported to the Directorate Clinical Governance meetings, Executive Committee, and any exceptions will be continue to be reported to the Patient Safety Committee.

The Clinical Audit and Effectiveness department has an established robust process for audit activity and providing evidence for assurances within the Trust and will continue to strengthen these processes and reporting systems.

6.3.2 Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by Great Western Hospitals NHS Foundation Trust in 2013/2014, that were recruited during that period to participate in research approved by a research ethics committee was 762 to end March 2014. *(See also Section 3.6 – Research and Development).*

6.3.3 Goals Agreed with Commissioners - Use of the CQUIN Framework

A proportion of The Great Western Hospitals NHS Foundation Trusts income in 2013/14 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 2013/14 and the following twelve month period are available electronically by request.

The monetary total for the amount of income in 2013/2014 conditional upon achieving Quality Improvement and Innovation Goals, and a monetary total for the associated payment in 2013/2014 is summarised in the table below.

TABLE - Financial Summary of CQUIN for Quality Paper

TOTAL CQUIN	Plan	Actual	Percentage
2013/14	£5,366k	£4,353k	81%
2012-13	£6,064k	£5,036k	83%

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

Registration

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 2013/2014.

CQC Registration update

All registered sites/locations and activities were reviewed during 2012 and a new certificate of registration was then dated 18 October 2012 and subsequently issued by the CQC on 2 November 2012.

The ten sites currently registered with the CQC are as follows:

- Great Western Hospital
- Chippenham Community Hospital
- Trowbridge Community Hospital
- Savernake Community Hospital
- Warminster Community Hospital
- Paulton Memorial Hospital
- Princess Anne Wing – Royal United Hospital
- Shepton Mallet Community Hospital
- Frome Victoria Hospital
- Hillcote

As a result of the registration review (in consultation with the CQC in 2012 and following CQC registration guidance) some community sites were deemed as satellite services (rather than a designated registered site). The Trust is however registered to provide CQC regulated activities at these community sites and these are contained within table 1.

The satellite sites are as follows:

- HMP Erlestoke
- Melksham Hospital
- Southgate House
- West Swindon Health Centre
- Westbury Community Hospital
- Swindon Health Centre
- Tidworth Clinic
- Central Health Clinic
- Amesbury Health Clinic

Hillcote amendments to registration have been submitted as formally agreed by the Trust Board. These amendments include the removal of the regulated activity for ‘Nursing Care’ with the addition of ‘Accommodation for person who require nursing or personal care’ and ‘Treatment of Disease, Disorder and Injury’ (in line with the CQC inspectors guidance).

The CQC certificated regulated activities per location are shown below: -

Registered Sites	Regulated Activities														
10 Registered sites with satellite services in addition	Treatment of disease, disorder or i	Family Planning Services	Diagnostic and Screening procedure	Maternity and Midwifery Services	Nursing Care	Surgical procedures	Assessment or medical treatment for persons detained under the Mental Health Act 1983	Management of supply of blood and blood products	Accommodation for people require treatment for substance misuse	Accommodation and nursing or personal care in the further education sector	Accommodation for people who require nursing or personal care	Services in slimming clinics	Personal Care	Transport services, triage and medical advice provided remotely	Termination or pregnancies
Warminster Community Hospital	✓		✓												
Trowbridge Community Hospital	✓		✓	✓											
Chippenham Community Hospital	✓		✓	✓											
Frome Victoria Hospital			✓	✓											
Shepton Mallet Community Hospital			✓	✓											
Paulton Memorial Hospital			✓	✓											
Princess Anne Wing-RUH (Maternity)			✓	✓											
Hillcote					✓										
Savernake Community Hospital	✓		✓												
GWH Satellite Services (as documented within Certificate of Registration)															
HMP Erlestoke	✓		✓												
Melksham Community	✓		✓												
Southgate House	✓		✓		✓										
West Swindon Health Centre	✓		✓												
Westbury Community Hospital	✓		✓												
Swindon Health Centre	✓		✓												
Tidworth Clinic	✓		✓												
Central Health Clinic	✓		✓												
Amesbury Health Clinic	✓		✓												

Periodic / Special reviews 2013/14

The Great Western Hospitals NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2013/2014 as below. GWH intends to take the following action to address the conclusions or requirements reported by the Care Quality Commissioner [see below]. GWH has made the following progress by 31 March 2014 in taking such action

CQC Unannounced Inspection GWH Site (October 2013)

The CQC undertook an unannounced responsive inspection at the Trust in Swindon during October 2013. The visit was conducted over 4 days where they visited 9 different wards and areas at GWH.

CQC also undertook a table top exercise where they reviewed outcomes relating to governance and staffing.

The team of inspectors were very complimentary about the caring staff – particularly the nursing staff they came across.

During the inspectors' time on the wards and departments they found areas which were not meeting the CQC standards, these included Cleanliness and Infection Control Practices, Staffing and Governance.

The CQC have published the formal inspection report in December 2013, the report highlights that GWH was not fully meeting the standards for the following outcomes:

Outcome 8 Cleanliness and infection control
Outcomes 13 Staffing
Outcome 16 Governance (Assessing and monitoring the quality of service provision)

The Great Western Hospitals NHS Foundation Trust intends to take the following actions to address the conclusions or requirements reported by the Care Quality Commission (following October inspection at GWH).

An overarching CQC action plan has been developed to address the areas where standards are not being fully met. This was submitted to the CQC in December 2013. This plan has been approved by the Governance Committee.

Detailed action plans to support the Trust wide plan are being progressed and monitored by the Regulatory Compliance Group and Patient Safety Committee. Formal reporting on progress with these improvement plans informs Trust Board via Trust Governance Committee which meets every other month.

The overarching action plan (improvement actions) is due for completion at the end of May 2014. The Trust would then consider that compliance has been achieved. Monitoring of some actions will continue (within the sub plans) to progress additional internally identified quality improvement measures.

The CQC returned to Princess Ann Wing in July 2013, to review progress on the maternity actions required (as per submitted action plan) post December 2012 inspection.

As a result, the CQC declared all outcomes were compliant as meeting the required standards.
The actions were monitored (as per plan) until declared fully completed in January 2014.

CQC Special Reviews - Dr Foster alerts and subsequent investigations

Acute myocardial infarction alert
On 11 November 2013, the CQC notified the Trust about a mortality outlier alert for Acute Myocardial Infarction
The Great Western Hospitals NHS Foundation Trust has taken the following action to address the conclusions or requirements reported by the Care Quality Commission:

- Submission of a report based on 12 case notes (already reviewed) of which no avoidable deaths were subsequently identified
- Coding and death certification improvement actions in place were reviewed and will continue, as these cases were complex

Pathological Fractures Mortality Outlier
On, 5 November 2013 the CQC notified the Trust about a mortality outlier alert for Pathological Fractures

The Great Western Hospitals NHS Foundation Trust has taken the following action to address the conclusions or requirements reported by the Care Quality Commission:

- A review of case notes was undertaken, to identify any issues related to clinical coding and the quality of clinical care, which demonstrated no clearly avoidable deaths
- Incorrect coding in 14 of the 15 cases reviewed were found to be driven by a change in the local Coroner and their request of death certification practice : subsequent actions included liaison with the Coroner for death certification clarity (and medical staff education update post agreement)
- Updating medical documentation (used to record hip fractures)
- Coding review by Consultants for all patients who are identified as suffering a pathological fracture

Other External Reviews

The following non CQC external reviews which have taken place during 2012/2013 are listed in the Table below.

External Review	Review area/service	Site/sites	Date
MHRA	Blood transfusion inspection	GWH	3 April 2013
PLACE (previously PEAT)	Environment, Food, Privacy & Dignity	Great Western Hospital, Frome, Paulton Birthing Centre, PAW, Chippenham Community Hospital, Warminster Community Hospital, Hillcote House, Trowbridge, Savernake Hospital	April-June 2013

External Review	Review area/service	Site/sites	Date
National Cancer Peer Review	Transition Delivery Partner in the NHS Commissioning Board (NHSCB) (previously the Cancer Peer Review)	GWH	24 June 2013
HMIP	Health unit	Erlestoke Prison	September/October 2013
Child safeguarding	Community	Various	October 2013
CQC	Various departments	GWH	October and November 2013
Surveillance assessment of Quality Management Systems	Quality Management Systems for Cellular Pathology and Microbiology	GWH	19 and 20 November 2013
Clinical Pathology Accreditation	Blood Sciences	GWH	23 May 2013
CCG visits			
Wiltshire CCG		Savernake Hospital	29 July 2013
Wiltshire CCG	Birthing Unit	Trowbridge	20 June 2013
Wiltshire CCG	Birthing Unit	PAW	19 September 2013

NHSLA Risk Management Standards - Acute and Maternity Standards

NHSLA Acute

Following the achievement of NHSLA level 1 and 2 Assessment in 2012, a full gap analysis was undertaken and completed to establish any shortfalls and gaps between level 2 and 3.

Following the findings of the gap analysis an options appraisal was provided to Patient Safety Committee and the Executive Committee regarding the option to proceed for a Level 3 assessment either in 2013, 2014 or 2015.

It was decided by the Executive Committee in May 2013 that in light of the NHSLA consultation, and uncertainty about assessments that the NHSLA Working Group should continue to monitor progress with the project plan working towards the minimum standard to achieve Level 3. A further analysis of our position will then be presented again in May 2014.

Currently all the policies relating to NHSLA had their monitoring tables reviewed during 2013 and monitoring against those requirements is being progressed.

The NHSLA are currently undergoing consultation and are reviewing their entire structure and processes. The NHSLA has indicated that there will no longer be risk management standards or formal assessments. Organisational claims history may be analysed in the future to assess service safety and to calculate the Trust's Litigation Authority contributions.

Maternity Clinical Negligence Scheme for Trust Assessment (CNST) 23 & 24 May 2013

Maternity Services demonstrated compliance passing 46 out of the 50 standards and the Trust attained Level 2 CNST. Level 2 Assessment focused on and examined the implementation of maternity services policies and processes.

There were four areas where compliance was not awarded:

Shoulder Dystocia
A new Royal College of Gynaecologists (RCOG) Surgeons pro-forma was introduced in January 2013 and although all required information was documented in the health records this could not be demonstrated in all cases on the new pro-forma.

Obesity
The level 1 guideline was not compliant against national recommendation. Areas requiring further work include introduction of management plans, manual handling forms and the use of proformas. Whilst the service does not meet the national guidelines the local policy has been amended to ensure that care is as safe as possible for women who are obese in pregnancy.

Patient Information
There was insufficient documentation within the health records of the information given to mothers. The CNST assessor suggested the service had set the bar too high and suggested amending the level 1 guideline to reflect this. This will be completed when the service has finalised the patient information to be given out to mothers.

Newborn life support
Gaps were identified in the neonatal resuscitation daily equipment check lists; this indicated a need for more robust checking and the monitoring of this check. This has been actioned and audit results demonstrate this strategy is working.

Quality Data

Great Western Hospitals NHS Foundation Trust submitted records during 2013/2014 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: 99.7for admitted patient care; 99.9% for outpatient care; and 94.1 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 data quality group is working on improving this.

- Which included the patient's valid General Practitioner Registration Code was 99.9% for admitted patient care; 99.7% for outpatient care; and 99.4% for accident and emergency care.

Great Western Hospitals NHS Foundation Trust Information Governance Assessment Report overall score for 2013/2014 was 77% and was graded satisfactory / green.

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 been re-structured to have a second group made up of operational staff who work through some of the key areas where data quality can be improved by standardising procedures or by identifying blockages to good data quality.
- The actions from internal and external audits and benchmark reports associated with data quality will be acted on and monitored by the Trust Data Quality Group.
- 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.

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 & Performance 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 2013/2014 was 77% and was graded Satisfactory ('green'), with a satisfactory rating in every heading of the Information Governance Toolkit.

6.3.5 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

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

These results achieved Attainment Level 2 in the Information Governance Toolkit. 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.

The Trust continues to work towards developing compliance with the pseudonymisation initiative and maintains a log of patient identifiable data flows from key departments. The audit serves both to log the flows and to audit their compliance with pseudonymisation and data protection rules. This work will maintain its level of focus as changes to data flows are requested by Clinical Commissioning Groups.

6.3.6 Staff Survey Summary 2013/2014

We are very proud of our staff who work incredibly hard and are committed to providing the highest care possible to our patients and their carers'. As a Trust we are committed to being an exemplar employer 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

As an organisation that provides a public service, we have also focused on ensuring that our staff have the right knowledge and skills to provide high standards of care to our patients and their carers but also the right values so that they provide care in a compassionate way to local people.

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.

We have been trying to engage with our staff in a different way over the course of the year so that they are more involved in organisational change at an early stage and also so that we are actively getting staff ideas and suggestions on ways to deliver care differently.

Following last year's staff survey the Trust published a Trust-wide staff survey action plan which focused on improving visibility of senior staff, recruiting additional staff as part of the skill mix review work, improving how the Trust designs roles and enhancing leadership capability. Each Directorate also produced their own action plan, based on their Directorate results. These actions plans were reviewed quarterly by the board.

Summary of Performance

Table - Response Rate

2012		2013		Trust Improvement/ Deterioration
Trust	**National Average**	**Trust**	**National Average**	
63%	50%	67%	49%	**4% improvement**

Table – Summary of Performance

	2012		2013		Trust Improvement/ Deterioration
Top 4 Ranking Scores	**Trust**	**National Average**	**Trust**	**National Average**	
Question: KF19. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months *(the lower the score the better)*	25%	24%	20%	24%	**5% improvement**
Question: KF7. Percentage of staff appraised in the last 12 months *(the higher the score the better)*	86%	78%	92%	84%	**6% improvement**
Question: KF9. Support from immediate managers *(the higher the score the better)*	3.63	3.61	3.75	3.64	**0.12 improvement**
Question: KF8. Percentage of staff having well-structured appraisals in the last 12 months *(the higher the score the better)*	37%	36%	44%	38%	**7% improvement**

	2012		2013		Trust Improvement/ Deterioration
Bottom 4 Ranking Scores	**Trust**	**National Average**	**Trust**	**National Average**	
Question: KF18. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months *(the lower the score the better)*	28%	30%	32%	29%	**4% deterioration**
Question: KF3. Work pressure felt by staff *(the lower the score the better)*	3.03	3.08	3.16	3.06	**0.13 deterioration**
Question: KF14. Percentage of staff reporting errors, near misses or incidents witnessed in the last month *(the higher the score the better)*	92%	90%	88%	90%	**4% deterioration**
Question: KF6. Percentage of staff receiving job relevant training, learning or development in the last 12 months *(the higher the score the better)*	81%	81%	79%	81%	**2% deterioration**

Response rate compared with prior year
In the 2013 Staff Survey we saw a 4% increase in our response rate from 63% in 2012 to 67%.

The Trust considers that the staff survey response data is as described as the Trust works with an independent organisation called Quality Health who have undertaken staff surveys in the NHS for over 15 years. Quality Health is the largest provider for the NHS National Staff Survey.

The Trust has taken the following actions to improve in the areas identified within last year's staff survey:

Areas of improvement from the prior year and deterioration
Last year the Trust recognised that we need to improve visibility of senior management in the organisation, particularly across community services and a plan is being agreed to ensure that visits have the maximum impact. We also needed to recruit to the additional staff agreed as part of the Skill Mix Review work, which supports the Nursing Strategy and demonstrated that we needed to invest in our qualified nursing workforce. The Trust also agreed to invest in the midwifery workforce to ensure that staffing levels meet the needs of our patients. This investment will improve our staff's confidence so that they feel more satisfied with the quality of work and patient care they are able to deliver and will recommend us more highly as an employer of choice.

The Trust also needed to focus on how we design our jobs and how we deploy our staff to ensure that we are getting maximum benefit from our workforce and so that staff have maximum job satisfaction.

Since last year's staff survey the Trust has also invested in improving our management capability, whereby the commissioned Ashridge Business School designed and delivered a bespoke leadership programme for 93 of our nursing and midwifery leaders. The Transforming Leadership, Transforming Care Programme ensured that our managers were well equipped to support staff through change as we improve pathways and efficiencies in the way we work.

Key areas of improvement

Our staff scores received in March 2014 benchmarks the Trust as fifth across 23 Trusts in the South West of England, including Royal Berkshire and Oxford hospitals. Last year the Trust benchmarked in third position so this is a small downward trend.

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 28 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 13 out of 28 indicators including staff motivation levels, training, appraisals and equal opportunities for promotion.

Staff Survey Scores 2013	Answers
Top 20%	13
Above (Better than) Average	4
Average	2
Below (Worse than) Average	6
Bottom 20%	3
Total	28

We are better than average for 4 out of 28 indicators including work related stress and agreeing that their role makes a difference to patients. We are average for 2 out of 28 indicators relating to effective team working and reporting good communication between senior management and staff. The Trust are worse than average in 9 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.

Future priorities and targets

Statement of key priority areas
The Trust received the full results and management report for the 2013 Staff Survey at the end of February 2014. From the summary results of 2013 staff survey received to date the Trust's key priorities should be:

Recruiting staff with the qualities we value – service, teamwork, ambition and respect - and ensuring they are fully supported in their roles continues to be a priority.

56% of staff who completed the staff survey said they would recommend the Trust as a place to work. The Trust would like to increase this score in the coming year and will do so by focusing on the following areas:

Staffing
Our recruitment drive means we have almost 100 more nursing and midwifery staff than we did this time last year, however we still need more. Recruiting nurses in particular is a real challenge for the whole NHS due to a national shortage. However, we are doing all we can, even going as far afield as Spain, Portugal and Ireland and this effort will continue until we have the staff we need, in the places we need them.

Teamwork
The heart of effective teamwork is communication. Currently only six in every ten staff meet often to discuss team effectiveness. As many staff are not computer based, face-to-face meetings are often the only chance to catch up, discuss the team's effectiveness, ask questions and share ideas.

There has been a slight reduction in teams having a shared set of objectives (76%) which is essential to ensure we are all working towards the same thing. Fewer staff also said that they had to communicate closely with other team members to achieve team objectives (76%).

Raising concerns and feeling informed about errors, incidents and near misses
Only half of staff said they are informed when things go wrong (52%). We will encourage our staff to be open and sharing mistakes to enable us to learn and take action to prevent the same thing happening again.

60% of our staff either agreed or strongly agreed that they would be happy with the standard of care provided by the organisation if a friend or relative needed treatment. The percentage of staff either agreeing or strongly agreeing with this statement has continued to decline over the last two years. In 2011 66% of our staff either agreed or strongly agreed with this statement, which decreased to 64% in 2012.

In April 2014 the Trust introduced the Staff Friends and Family Test which will monitor the response to this question on a quarterly basis. We will use this information to help us understand the reasons for this decline and what actions we can take to improve this going forward.

Development of Action Plan and Monitoring arrangements

Following this year's staff survey results, the Executive Committee will agree which areas the Trust should focus on so that the Trust can improve the experience of staff. They will also agree this year's monitoring arrangements, which is likely to follow on from last year's quarterly action plan updates

Part 3 - Other Information

6.4 Overview of the quality of care offered 2013/14

Safe Care

Priority 1 – To Continue to Reduce Our Numbers of Healthcare Associated Infections

MRSA Bacteraemia

Reducing healthcare associated infection remains an important priority for us and our patients at both local and national level.

During 2013/2014 we reported five (all acute) cases in total.

The Great Western Hospital considers that this data is as described for the following reasons:

In England it is mandatory for health Trusts to report all cases of blood stream infection caused by Meticillin resistant *Staphylococcus aureus* (MRSA) to Public Health England.

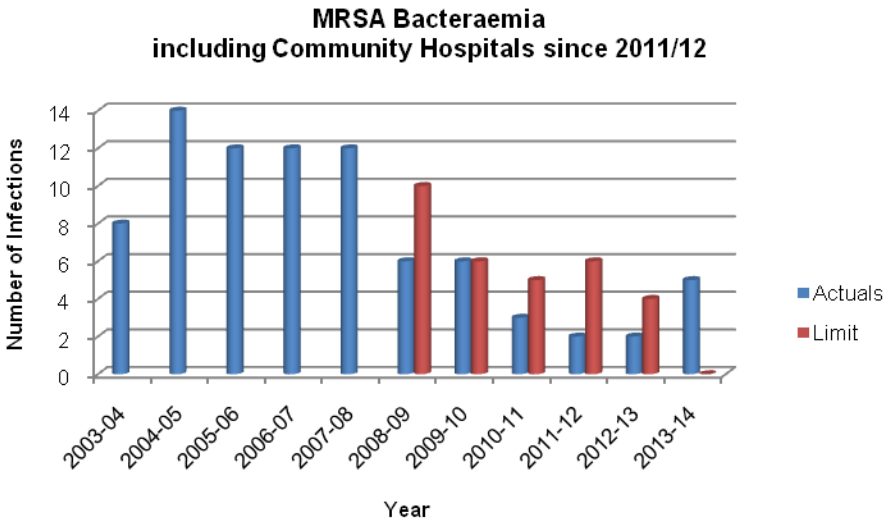
In 2008, all NHS Acute and Foundation Trusts had Trust specific targets set by the Department of Health to reduce the number of health care acquired infections year on year. In 2013 a zero tolerance approach was introduced for Meticillin-Resistant Staphylococcus Aureus Bacteraemia (MRSAB).

All reported cases have been investigated using the Post Infection Review tool in line with national guidelines.

The Great Western Hospital has taken the following actions to improve patient safety, and so the quality of its services, by:

Local initiatives to reduce MRSA bloodstream infections have included:

- Continued use of care bundles, (which is a method of measuring and improving clinical care), for peripheral intravenous lines and urinary catheters, driving practice improvements in areas with low compliance scores
- Refresher training for taking blood culture samples, using aseptic non-touch technique (ANTT) has been, and will continue to be provided for medical, nursing and emergency department practitioner staff. This has been supported by the company which provides our IV cannulation and venepuncture products. This will also be provided by the IP&C nurses when following up contaminated blood culture samples and through drop in sessions held within the Academy on days such as 'World Sepsis Six day' in September.
- Ensuring Infection Control admission risk assessments are completed on all patients and acted upon, including the community inpatient beds
- Daily monitoring of MRSA admission screening of elective and emergency patients, with follow up isolation and decolonisation regimens. This has ensured that over 94% of patients are screened for MRSA skin colonisation on or prior to admission
- Continued improvement of care for patients with diabetes thus helping to reduce complications such as infected ulcers that are often associated with MRSAB's
- Introduction of a 'Sepsis Six checklist' (see Priorities 2014/2015 below for Sepsis Six), providing best care for patients who are admitted showing signs of generalised infection
- Thorough investigation of all MRSAB's and allows feedback to clinical staff of any areas where practice is to be improved.



Our learning from our reported MRSA Bacteraemias 2013-14 shows that we need to make improvement in the following areas as priority during **2014/2015**

- Ensuring MRSA screening includes all appropriate sites, including urine samples if a catheter is in situ. Specifying to the laboratory if the urine sample is for MRSA screening
- Improve communication pathways between multi-disciplinary teams and consider proactive management plans for patients with history of MRSA. For example treatment/prophylaxis prior to invasive procedures including urinary catheterisation
- Maintaining consistent IP&C standard precautions and adherence to correct Intravenous care practice and Aseptic Non Touch Technique (ANTT) to prevent cross contamination
- Instigating appropriate re-screening of previously colonised staff working in high risk areas, such as Theatres, ICU and SCBU
- Trust wide role out of a Sepsis Six will provide early diagnosis and management of patients suffering from infections, particularly blood stream infections
- Continuing on-going MRSA screening for elective and emergency admissions, as per IP&C risk assessments

Clostridium difficile

The Great Western Hospital considers that this data is as described for the following reasons:

In England it is mandatory for health Trusts to report all cases of *Clostridium difficile* to Public Health England.

The nationally mandated goal for 2013/2014 was to report no more than twenty Acute Trust apportioned cases and with no Community Hospital apportioned cases.

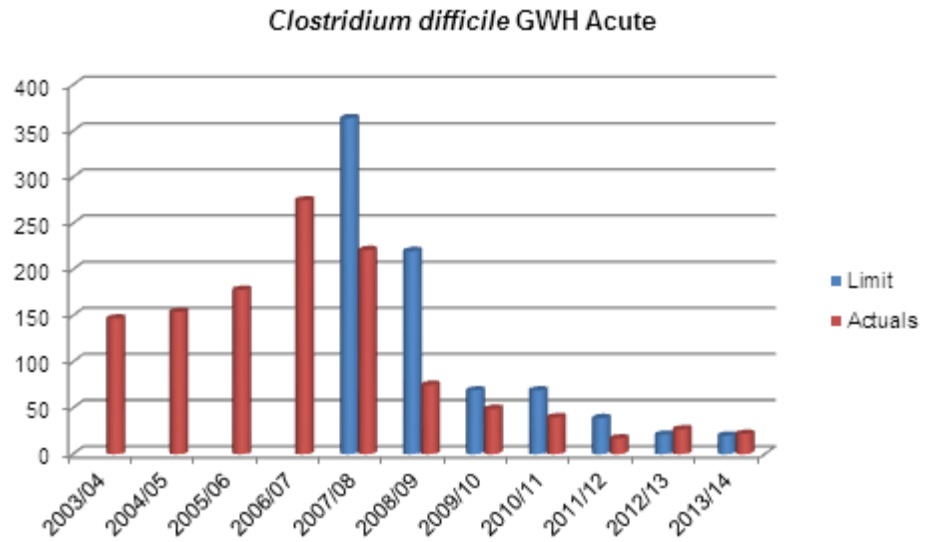
The Trust has reported twenty three *Clostridium difficile* infections within the Acute Hospital and three within the Community Hospitals. *Clostridium difficile* shows a downward trend overall, although during 2011/2012 there was a significant reduction in the number of cases attributed to the Trust and the CCG cases identified through the GWH laboratory. The laboratory revised its *Clostridium difficile* test algorithm during 2012/2013 in response to an external control failure and in consideration to Department of Health updated published guidance on the diagnosis and reporting of *Clostridium difficile.* A more sensitive test was introduced as a result which adheres to the Department of Health

two stage test algorithm. This has resulted in an increased number of cases in 2012/2013 but the trust has seen a reduction in total number of cases during 2013/2014.

The Great Western Hospital has taken the following actions to improve patient safety, and so the quality of its services, by:

Local initiatives to ensure we continue to reduce these infections have included:

- Promotion of prompt isolation of patients with suspected infective diarrhoea
- Continuation of weekly *Clostridium difficile* specialist review including a Microbiologist, Gastroenterologist visiting patients with *Clostridium difficile* infections, including teleconferences for any positive patients within our community beds
- Inclusion of Polymerase chain reaction (PCR) laboratory test; this is a test for the presence of *Clostridium difficile* capable of causing infection. This test is aimed to support appropriate management, preventing cross-infection and environmental contamination, of those people carrying this infection in their stools (faeces), but not necessarily adversely affected by *Clostridium difficile*
- Review of antibiotic guidelines particularly in 'at risk groups' including pre and post-surgical guidance – in line with NICE Surgical Site Infection guidance
- Promotion of *Clostridium difficile* awareness through Trust newsletters, face to face training on wards, mandatory updates
- Pharmacy antibiotic team are proactively monitoring antibiotic prescribing and promoting the Department of Health's 'Start Smart and Focus' actions, thus engaging staff to reduce antibiotic usage and the incidence of *Clostridium difficile*
- "When to take a stool (faeces) specimen" guidance has been rolled out across the Trust. This provides staff with advice on when to take optimal specimens
- IP&C cleanliness spot checks are carried out across the wards with feedback provided to ward managers and matrons to action and make improvements
- Developed and agreed an assurance framework for cleaning and agreed with Carillion to meet National requirements



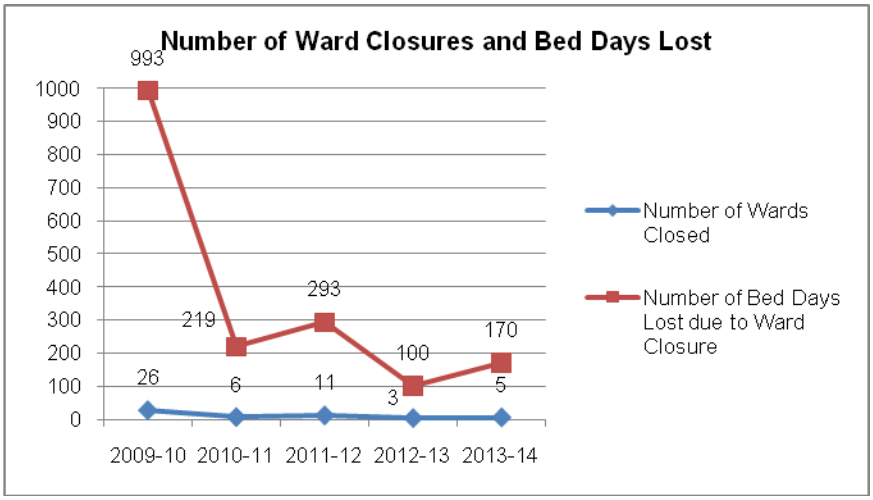
Priorities for 2014/15 following our learning during 2013/14 include:

- Encouraging front door services (ED and LAMU) to send prompt stool specimens when patients experience unexplained diarrhoea on admission
- Isolating patients within 2 hours of unexplained diarrhoea being reported, to reduce the risk of cross infection
- Striving for environmental cleaning inspections to be 100% to reduce the risk of cross infection
- Promoting the use of hand hygiene/wipes for patients to use prior to meals (EPIC 3) to reduce the risk of cross infection
- Decrease high risk antibiotic prescribing, to reduce the risk of antibiotic related diarrhoea
- Improve antibiotic audit scores, which include adherence to antibiotic guidelines, recording the duration of the course and indication for use
- Consider proactive management of long stay patients (more than 14 days) to reduce the risk of developing *Clostridium difficile*
- The appropriate and effective use of PCR testing for the identification of *Clostridium difficile* carriage amongst patients will be reviewed.
- We will fully implement our cleaning strategy and have also set up an environmental cleanliness working group. This group will focus on ensuring consistency of cleanliness throughout our hospitals.

Ward Closures due to Outbreaks of Norovirus

Each winter most hospitals are affected by an increased prevalence of norovirus. This infection causes acute diarrhoea and vomiting and spreads very easily. This often necessitates either full or partial ward closures. Patients in hospital are more susceptible to these infections, which are usually brought into the hospital by visitors, patients, contractors or staff and then spread very quickly. We have been working hard with our staff and visitors over the past few years to reduce the impact of this seasonal virus. Antiviral hand gel and asking friends and relatives to refrain from visiting if they have been recently unwell, has had a positive impact on reducing the number of wards closed due to this infection.

The chart below shows the number of ward closures each year and the associated impact on the number of empty bed days accumulated during these closures. The winter of 2009/2010 was particularly difficult with many wards being closed for long periods of time. Since 2011-2012 the data also includes the GWH community wards and it can be seen that due to the proactive management and isolation of patients, and early bay closures, the numbers of wards we have needed to close has reduced considerably along with the number of bed days lost due to full ward closure.



Numbers of bed days lost can vary considerably, depending on the type of ward (medical versus orthopaedic) and the period of time the ward is closed (on average, ward closure lasts approximately 7 days often with bay closures for several days beforehand). Bed days lost, are reported once a ward closes to admissions. Bed days lost is the number of beds empty each day within the ward; that cannot be used to admit a new patient due to the outbreak.

A ward that discharges patients more quickly than another (due to its speciality) may experience more bed days lost than a ward that has more long stay patients.

If a ward is managed by bay closures only – bed days lost are not reported within this report. They are reported within the IP&C Annual Report.

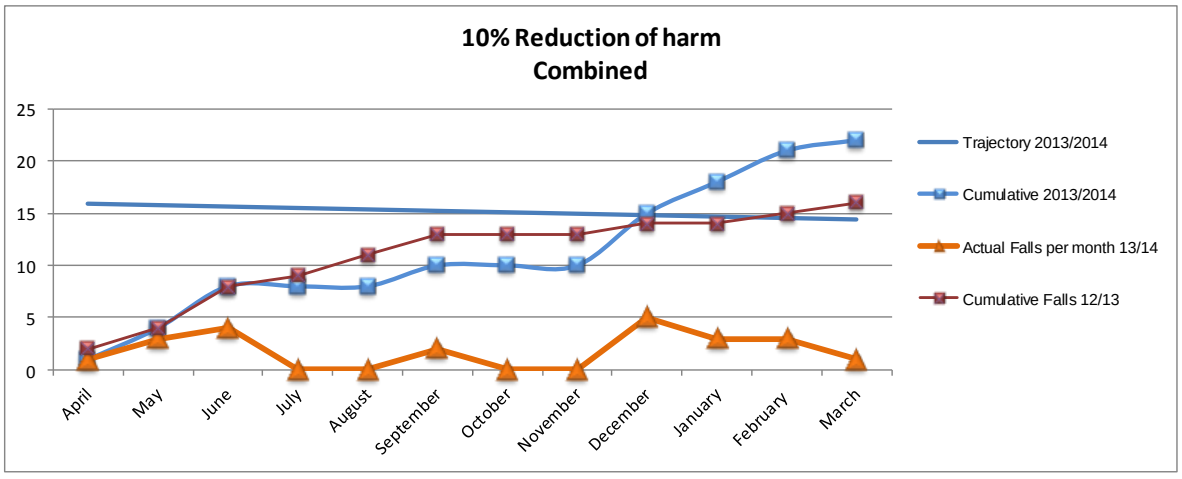
Priority 2 - To Reduce Severe Harm Arising from Patient Falls

Reduce Severe Harm Arising from Patient Falls

A reduction in severe harm suffered by those patients falling while in hospital continues to be a high priority across both the acute and community services. Our overall aim has been a 10% reduction in the number of patients that sustain severe harm from a fall compared with last year, this equated to less than 10 for the Acute hospital and less than 4 across the Community inpatient services. For the year 2013/2014, the key actions from all our serious incidents (SI) have been summarised below.

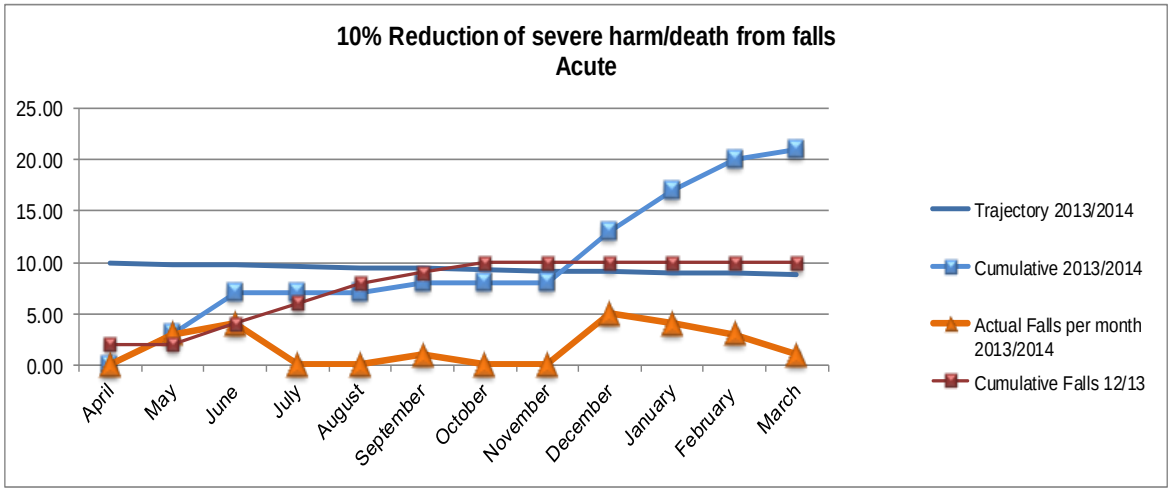
Definitions:
Severe Harm Where permanent harm, such as disability, was likely to result from the fall.

Combined Target: A reduction of 10% from the actual for 2012/2013 – trajectory 14



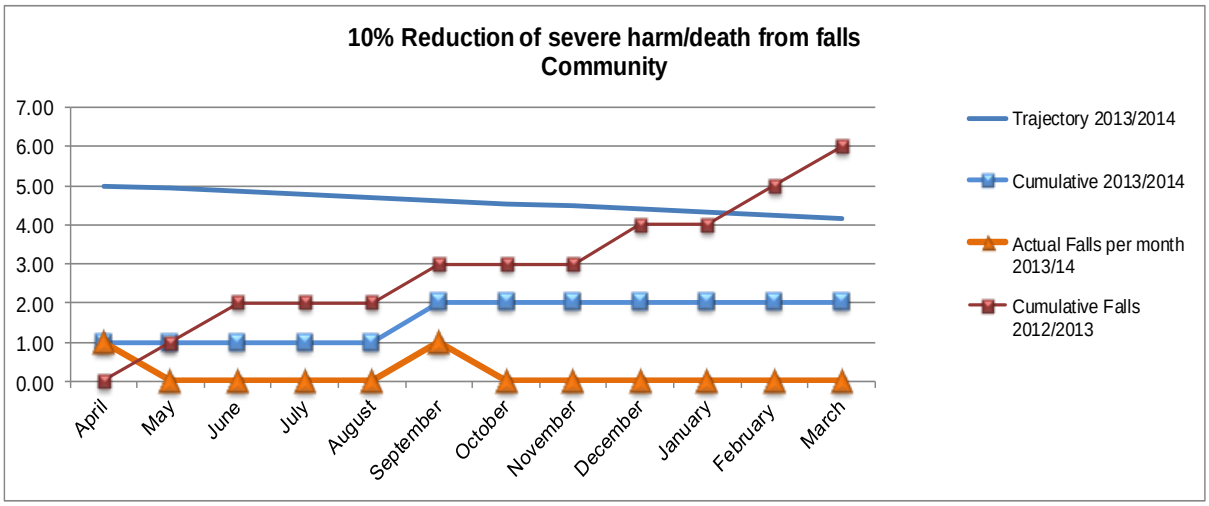
The above graph shows that the Trust reported seven more patient falls during 2013/2014 where severe harm occurred, compared with 2012/13. This is a 30% increase compared with 2012/2013. This year our rate of severe harm from falls is 1.5% compared with last year's 1.1%.

Acute Target: A reduction of 10% from the actual for 2012/2013 which was 10



The graph above shows that the falls reduction trajectory within the acute GWH was not achieved i.e., 21 such incidents were reported again a reduction trajectory of 10.

Community Target: A reduction of 10% from the actual for 2012/2013 which was 5



The graph above shows that during 2013/2014, we achieved the community falls reduction trajectory i.e., we reported 2 incidents against a trajectory 4.

During July and January the Trust carried out a detailed review of all incidents of falls where patients sustained severe harm or death. The panel concluded that five of the twenty one incidents were unavoidable. The learning and recommendations of the other sixteen have been shared with all wards, the falls prevention group and presented to the Patient Safety Committee. Details of the learning are provided below.

Key Actions from serious incidents
A key focus across community wards has been monitoring the impact of bed sensor alarms, which detect patients moving from beds, to reduce the level of repeat falls reported from the same patients. This has resulted in a 10% reduction in falls occurring by repeat fallers. This data has been used as evidence to support a case of need to purchase some sensor alarms for the community wards. Overall the four community wards have reported 50 less reported falls this year compared with last year.

The severe harm investigations discovered some gaps in the falls policy being followed and incomplete documentation in some cases. Embedding the Stratification and Avoidance of Falls (SAFE) tool has been a key focus through monitoring compliance across all 21 inpatient wards; the average score to date this year being 88% compliant, aiming for 95% Trust wide compliance. Compliance is monitored and promoted by each individual Ward Manager based on their specific information. This audit provides assurance that every inpatient is being assessed for falls risks within 4 hours of admission, and an appropriate care plan is being put into place fully and reviewed timely.

All acute and community wards this year have received monthly reports on their falls data, which contain shared learning from all falls resulting in harm. For example one ward has identified more falls were occurring at specific times of the day. This ward has now trialled a different way of working around this time of day which has seen a reduction in incidents at this peak time.

Priorities for 2014/2015

- Continue to support the highest risk wards in identifying learning from all reported falls incidents, not just those that result in moderate or severe harm.
- Three wards have already started new initiatives such as more frequent care rounding for all patients at night time, monitoring of patients who are at increased risk of falls and ensuring that they are assisted with their toileting/personal hygiene needs
- Our Quality Improvement Plan for 2014/2015 is 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 being 7.3 for Acute and 10.6 for Community. The quality improvement plan will be driven by the newly formed Fallsafe Operational Group (accountable to the Falls Prevention Group). This is a forum for all ward managers to share learning and give assurance around their care and practices/processes regarding reduction of falls in their areas

Priority 3 - To Reduce Healthcare Acquired Pressure Ulcers

The reduction in the number of health care acquired pressure ulcers is an organisational patient safety priority and the focus of the Pressure Ulcer Strategy. This ultimately strives to achieve zero avoidable healthcare acquired pressure ulcers by 2015. This strategy focuses on the care we provide to our patients, especially those who are at high risk of developing a pressure ulcer due to immobility.

Every second Wednesday of the month, all wards in the acute and community hospitals and the community nursing teams complete a data collection form. This form includes the number of patients, who develop a pressure ulcer including categories II, III and IV (category II is a superficial wound and a category IV is the deepest category, potentially down to bone). This form is then sent to the Clinical Risk Team who put the information on a national monitoring system called the NHS Safety Thermometer. The safety thermometer was developed for the NHS by the NHS as a point of care survey instrument which measures the proportion of patients with a pressure ulcer on one day per month for all patients receiving NHS funded healthcare. This provides a 'temperature check' on harm that can be used to measure local and system improvement.

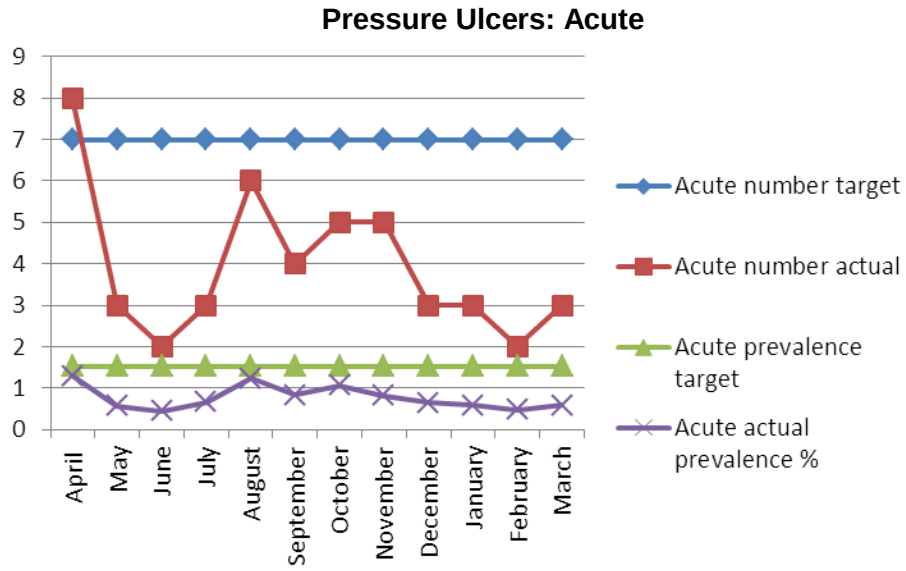
The Tissue Viability Team aim to verify every patient with a pressure ulcer to ensure that it is a pressure ulcer and not caused by moisture or trauma and that is categorised correctly. This data is analysed by the Tissue Viability Nurse Consultant and triangulated (compared) with the Clinical Risk Team data (as each pressure ulcer is also reported in the Incident Management System) to ensure robust data collection.

The organisation has two Commissioning for Quality and Innovation payment framework (CQUIN) targets for the reduction of healthcare acquired pressure ulcers: A CQUIN enables Commissioners to reward improvement, by linking a proportion of English Healthcare Providers' income to the achievement of local quality improvement goals.

The two CQUIN targets were:

- Swindon Clinical Commissioning Group (SW CCG). To reduce the prevalence (safety thermometer data) of pressure ulcers, categories II, III and IV by 10% for the acute GWH hospital. The mean number of patients who acquired pressure ulcer per month for 2013/14 was 8.2 therefore the development of less than 7 pressure ulcers (prevalence of 1.5%) was required each month and specifically required in September 2013 and February 2014 to meet the CQUIN/our local improvement plan.

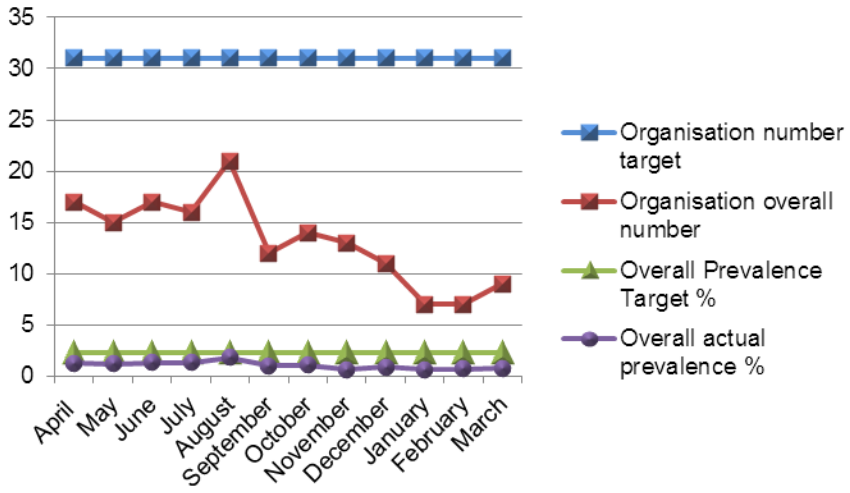
- The graph below shows the number of new pressure ulcers (PU's) that developed each month, from April 2013 to March 2014 using the safety thermometer data, showing that the improvement plans have been achieved each month except April 2013.



Wiltshire Clinical Commissioning Group (Wilts CCG).
To reduce the prevalence (safety thermometer) of pressure ulcers, categories II, III and IV by 30% by month 11, across the organisation. The mean number of patients who acquired pressure ulcer per month for 2012/2013 was 44 therefore less than 31 pressure ulcers (prevalence of 2.3%) were acquired per month to meet the CQUIN target/our improvement plan

The graph below shows the numbers of new pressure ulcers that developed each month, from April 2013 to March 2014, using the safety thermometer data.

Pressure ulcers (all sites)
Prevalence data



Priorities for improvement:

- The Tissue Viability Specialist Nurses (TVSN's) will continue to verify every pressure ulcer to ensure accurate categorisation and that each patient receives an effective response i.e. care planning and equipment. Verification may be undertaken using medical photography.
- The Pressure Ulcer Prevention and Management policy and Pressure Ulcer Strategy are now embedded in practice. The Tissue Viability team are now embedding a competency based programme with the Trust to ensure that all staff are competent in assessing and managing patients are high risk of developing pressure related skin damage. This will be complete by July 2014
- To support an annual pressure ulcer conference in partnership with NHS England with delegates from SEQOL, Sirona, Royal United Hospitals Trust and GWH NHS Foundation Trust to enhance cross boundary working
- A robust root cause analysis for all pressure ulcers (Category III and IV) is carried out and presented to the Pressure Ulcer Investigation Panel. This is led by the Nurse Consultant with Commissioners, safeguarding leads and clinical risk team to establish an effective action plan
- To roll out of the SSKIN Bundle tool (Surface Skin Keep Moving Incontinence Nutrition) which is an assessment and monitoring tool for patients in their own home. This includes the (SSKIN) Bundle which is a national tool used for pressure ulcer assessment and reduction. This is now being used across the community in all patients' homes who are assessed as being at high or medium risk for pressure ulcer development by the community nursing team and is completed by Social Service carers and Trust Health Care Professionals

Priority 4 - To ensure patients are assessed for the risk of developing venous thromboembolism and that these risks are managed appropriately

People who are poorly and have reduced mobility are at increased risk of developing venous thromboembolism (VTE). This is the development of small blood clots in the veins in the leg 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 for the following reasons:

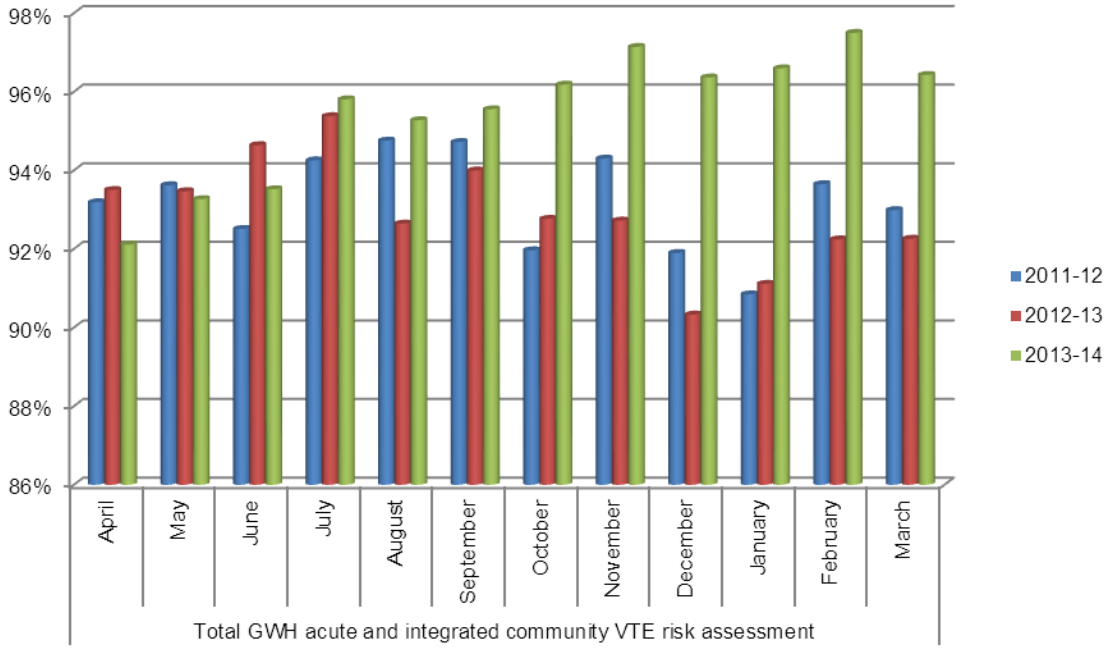
Data is collated from the electronic nursing care system and compared to the total number of admissions during any given month. For clinical areas that do not use the electronic system, manual collation is used and validated by the lead for VTE and the informatics team. This validation is undertaken weekly and information disseminated to all clinical areas so that any under performance is highlighted and able to be rectified.

The % target set by the Department of Health increased from April 2013 to 95% and we agreed a trajectory for GWH acute towards this percentage, aiming to achieve 95% by November 2013 which was achieved. For the community hospitals we achieved more than 95% for both general in-patients and maternity patients.

The Great Western Hospitals NHS Foundation Trust has taken the following actions to improve this:

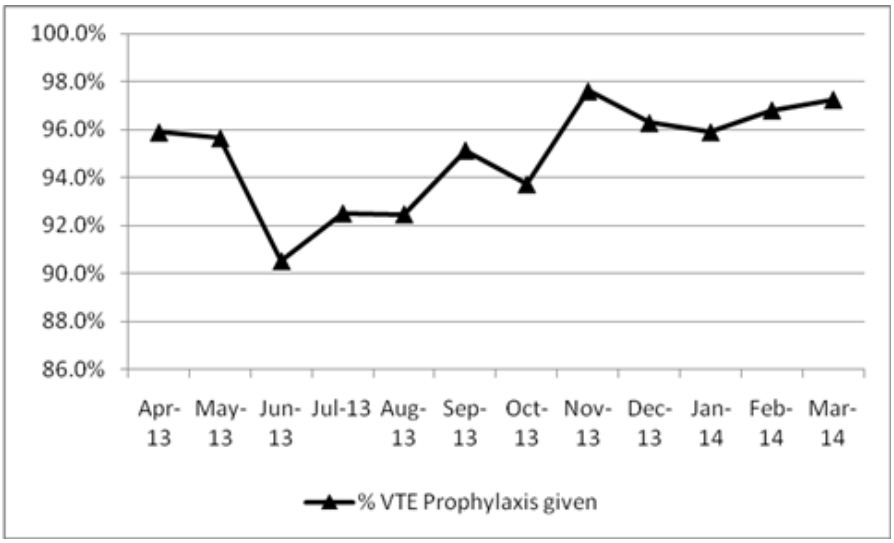
- Continued education sessions at Trust Induction for both the acute and community settings
- Making VTE training available electronically on the Trust's intranet site
- Daily monitoring of the completion of VTE risk assessments through Crescendo, the nursing electronic documentation system, providing daily reports to each ward
- For those areas not using the electronic nursing care system we have utilised the ward clerks in updating the system once the nurse has ensured the risk assessment has been completed, this has led to significant improvements in areas like the Linnet Acute Medical Unit (LAMU)
- Introduction of a weekly report showing the numbers of patients with and without a VTE risk assessment allowing us to monitor progress throughout the month ensuring that any poorer performing areas 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. This will also enable patients who deteriorate at home to be reassessed and for them to receive appropriate VTE prophylaxis, if at risk of a stroke. This is not mandated in the NICE clinical guideline (CG92) but is good clinical practice and has been embraced by the community

The chart below shows the total percentage of patients that have had a VTE risk assessment on admission to hospital and includes data for the community since June 2011.



Administering appropriate VTE thromboprophylaxis

Compliance with VTE prophylaxis has been maintained between 90-100% for the last 12 months. Audits evaluating the quality of the risk assessments and appropriate thromboprophylaxis are undertaken each month utilising the Patient Safety Thermometer Tool. This graph shows the number of in-patients on one day in a month along with the number of patients receiving appropriate thromboprophylaxis.



Hospital Acquired Thrombosis

We also look at the number of Hospital Acquired VTE events (HAT) which relate to a thrombosis (either deep vein thrombosis or pulmonary embolism) that occurs within 90 days of a hospital admission. This is now a CQUIN target which has enabled us to focus on the quality of thromboprophylaxis provided for patients.

We also look at the number of Hospital Acquired VTE events (HAT) which relate to a thrombosis (either deep vein thrombosis or pulmonary embolism) that occurs within 90 days of a hospital admission. This is now a CQUIN target which has enabled us to focus on the quality of thromboprophylaxis provided for patients.

Data has been collected since 2010 and the number of VTE events has reduced by 10% in GWH Community and has currently reached a plateau.

Priorities for 2014/2015 are:

- To sustain the percentage of patients who have a VTE risk assessment > 95%
- To ensure a root cause analysis is carried out for all hospital acquired thrombosis events where a VTE risk assessment and/or received appropriate prophylaxis have not been observed
- To set an achievable, continuous and sustainable improvement outcome

Priority 5 - To Continue to Reduce Catheter Associated Urinary Tract Infections (CAUTIs)

Urinary tract infection (UTI) is the most common hospital acquired infection with many attributable to an indwelling catheter. This can lead to delays in patient recovery and subsequent discharge.

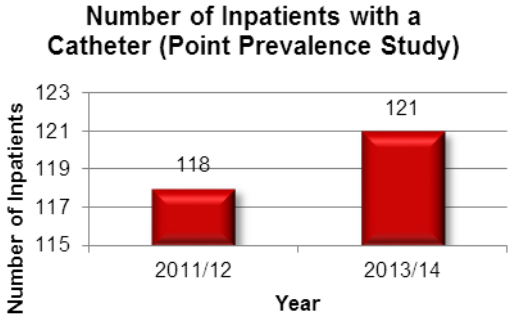
A point prevalence survey was carried out in September 2011 with a follow up survey in 2013-2014 to quantify the number of patients catheterised and the number of patients with a urinary tract infection.

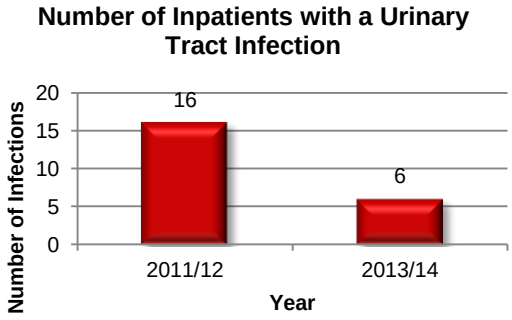
It was felt that the best way to decrease the number of patients with CAUTIs would be to reduce the number of days a urinary catheter was in situ. To achieve this aim a CAUTI Group has been set up meeting 4-6 weekly. The aim of the Group is to assess the risk factors of catheters in general providing training and education. Use of the care bundle tools will facilitate monitoring of catheter care within the Trust.

A tool for monitoring catheter days, approved by the Policy Governance Group, has been rolled out within the Acute site replacing the care bundles for insertion and on-going care by the end of 2013 with plans to roll out to Community sites in early 2014. This is being progressed using the Patient Safety Thermometer tool. Implementation will involve student nurses visiting clinical areas and physically removing all paper copies of old urinary catheter documentation, then the Trust will uniformly be using the same documentation.

It is planned to repeat the point prevalence study in 2014-2015 to assess catheter usage and urinary infection rates. The priority will be to reduce catheter days and influence staff attitude towards catheter usage.

When comparing the two Point Prevalence Studies, it shows that although the number of patients with catheters has increased slightly, the number of urinary tract infections has decreased. It should be taken into account that these were Point Prevalence Studies (and only carried out in those years within the graphs) and only a snap shot of inpatients on the day of collecting the data.





Priorities for 2014/2015

The priority for 2014/2015 is the on-going drive to reduce catheter days and thus reduce the risk of urinary tract infections where possible. This could potentially reduce the length of a patient's hospital stay. Patients with urinary tract infections can often require intravenous antibiotics as a line of treatment and other medical conditions can manifest from urinary tract infections increasing the length of stay. We are implementing a tool for staff to document catheter usage and on-going care, thereby ensuring that catheters are inserted and reviewed daily for patients who have a clinical requirement or are admitted into hospital with a long term indwelling catheter.

Priority 6 - Continue to Reduce the Incidents of Never Events

Never Events

Never Events are serious, largely preventable Patient Safety Incidents that should not occur if the available preventative measures have been implemented by Health Care Providers. There are 25 Never Events specified in the NHS in England.

A total of four never events were reported recorded by the Trust between April 2013 to March 2014. All four occurred within the Maternity Department:-

- Retained foreign object post-operation April 2013
- Retained foreign object post-operation August 2013
- Retained foreign object post-operation February 2014
- Retained foreign object post-operation February 2014

The incidents which occurred in April and August 2013 were investigated, reported and managed through the Trust Incident Management and Clinical Governance structures. In addition following the incident in August 2013 the Trust invited a member of the NHS England RCA Academy to advise on the investigation findings. Agreeing to the involvement of NHS England in turn enabled the Trust to contribute to the national deep dive exercise which is currently reviewing effectiveness of investigations within organisations across the NHS. Action plans were developed, with implementation closely monitored by the Clinical Risk Department, reporting through the Patient Safety Committee.

Final reports for the incidents occurring in April and August 2013 have been shared with our Commissioners, the CQC and Monitor. Details of the action plans can be found in the incident investigation reports held in the Clinical Risk Department. The key learning and actions included:

- To improve the format of maternity health records to enable improved record keeping of needle, swab and instrument counts

- To improve training and education for all maternity and obstetric staff across both sites to improve knowledge around swab counting processes
- To improve the governance arrangements for introducing new patient documentation, which should be more robust and subject to scrutiny
- Governance processes in place must be improved to ensure that where discrepancies in assurance exist, for example in the completion of actions from previous serious incidents, that these discrepancies are identified and acted upon. The directorate needs to have systems in place that provide assurance that safety has improved as a result of harm

Following the incidents which occurred in February 2014 the Trust commissioned an external investigator; this investigation is now underway, with final report due in May 2014. An interim improvement plan is in place, monitored by the Directorate and Patient Safety Committee.

Priorities/ 2014/2015

- To monitor and ensure the application of the safety measures put in place in 2013/2014, with regard to the learning from Never Events
- To complete the gap analysis of all safety measures nationally defined to prevent Never Events in order to ensure best practice is in place and promoted

Effective Care

Priority 7 - To Meet Patients' Nutritional Needs

Meet Patients' Nutritional Needs

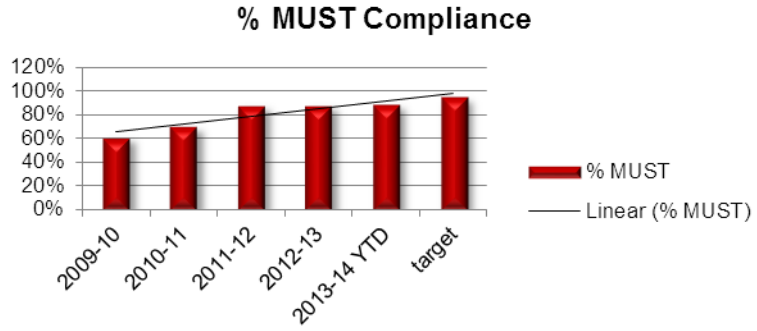
Many of our inpatients are elderly and frail; require assistance with their eating and drinking and consequently are at additional risk of clinical deterioration. 33% of people over 65 years old are malnourished or at risk of malnutrition on admission to hospital. Additional stresses from any acute illness or trauma and the unfamiliarity of their surroundings and foods can further impact adversely on their nutrition and hydration status

Nutritional screening is essential to identify those requiring nutritional support to sustain their nutritional and hydration needs. This includes ensuring appropriate quality and choice of food offered and the meals service itself, such as providing preparation and assistance as required and an appropriate environment.

Our priorities this year have been to focus on:

1. Improving (or maintaining) compliance with and accuracy of the Malnutrition Universal Screening Tool (MUST), nutrition care plans and documentation of fluid balance (see Graph below)
2. Improving in-patients meal-time experience including meals quality, appropriate choice and assistance with meals as required. Any additional capacity required to support this progressing is being pursued.

Compliance with MUST as measured via crescendo

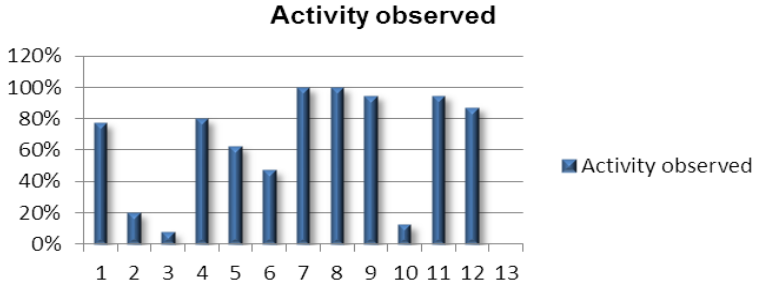


A summary of some of the progress with the Nutrition and Hydration action plan

Improving patients' mealtime experience has been a priority this year. The Dietetics team have been working with four wards in particular, as part of a pilot project to improve this and to support the Protected Meal-times Policy, which has now been published.

The meal time observations show 100% compliance (see Graph below) with providing assistance to patients with their meals, checking nil by mouth (NBM) status and ensuring no patients are missed.

Activities observed via meal times observations



Other areas of good practice but which need to be more consistent include;

- Ordering and serving meals individually (ensures meals are served at the correct temperatures)
- Use of red trays (denotes patients which require assistance with feeding and hydration etc)
- Ensuring patients are given enough time to eat their meals with minimal disturbance

The lowest compliance relates to

- Following the protected mealtime's policy throughout
- The use of the drugs trolley during meal service
- Preparing patients and tables for the meal service
- The number of ward staff supporting the meal service

Feedback from the patient food survey ("diary") undertaken during March 2013 via PALS is being used to review and support menu changes. Particular areas of concern were the lack of choice and quality at supper time (i.e. just soup and sandwich).

- The Dietetics and Catering teams are working together with Carillion to improve meal services and quality of food and extending patient choice for evening meals
- Feedback on meal time observations and soup and sandwich quality improvement have been reported at February Patient Experience Committee
- Good feedback was received regarding the levels of assistance at mealtimes. Also other satisfaction surveys e.g. new Friends and Family Test and Senior Managers walkabouts have provided positive patient feedback and experiences
- The current menu meets existing standards; the dieticians have completed checks to confirm this. A more detailed review and analysis of all the hospital menus is planned for 2014 to meet new guidance which requires provision of meals for those who are nutritionally well (i.e. healthy options) as well those at nutritional risk
- Dieticians have produced a comprehensive check list of all menu items for the GWH ward areas indicating presence of allergens (e.g. gluten) as well as suitability for specific dietary needs such as low potassium or low sodium

In addition a Wiltshire and Swindon wide nutrition screening and care community pathway has been developed and was rolled out from January 2014. The associated care plans have been adapted for each community setting i.e. hospital, care home or patient's own home.

Hydration

1. All patients at risk of poor hydration have red-lidded jugs
2. The Hydrant assessment tool and information for staff and patients has been published
3. The mealtimes observations include review of red lids and patients views on drinks as well as meals

Priorities for 2014/15

- To secure funding for continuation of GWH based dietetic staffing. If team not funded alternative means of managing at risk patients and progressing actions plan such as auditing meals service and quality will be progressed
- To set up more robust and accurate audit of MUST compliance (quarterly manual audit of compliance and accuracy) as Crescendo audit is purely a count of completion frequently providing an underestimate and incomplete picture as not all areas use this system
- To continue to support wards at meal times including rolling out of meal time observations and triage of dietetic referrals by band 3 dietetic assistant
- To complete a review of GWH menu (dietetics and Carillion alongside appropriate ward areas) to ensure it meets new standards and to improve quality and choice for patients. Its suitability for special diets will also need to be reviewed
- To update integrated Nutrition & Hydration Policy

Progress will be reviewed quarterly by Nutrition & Hydration Steering Group and D&O Directorate Board

Priority 8 - To Continue to Sustain our Hospital Standardised Mortality Ratio (HSMR) to below 100

Hospital Standardised Mortality Ratio (HSMR)

The Great Western Hospital considers that this data is as described for the following reasons

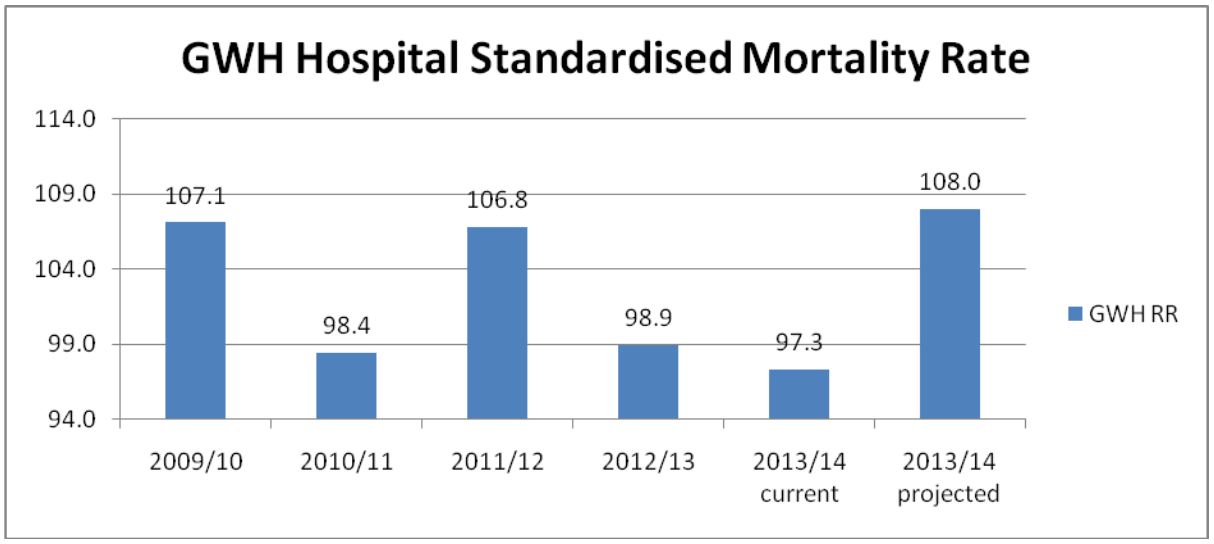
- The data is sourced from Dr Foster and is widely used in the NHS;
- The data is refreshed on a monthly basis
- The data is reviewed on a monthly basis by the Trust Mortality Group;
- The data is included in the Trust quality and performance dashboards which are reviewed by the Trust Executive Committee and Board as well as relevant CCG Committees.
- It is a key indicator of the quality of care we provide

The 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. HMSR 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.

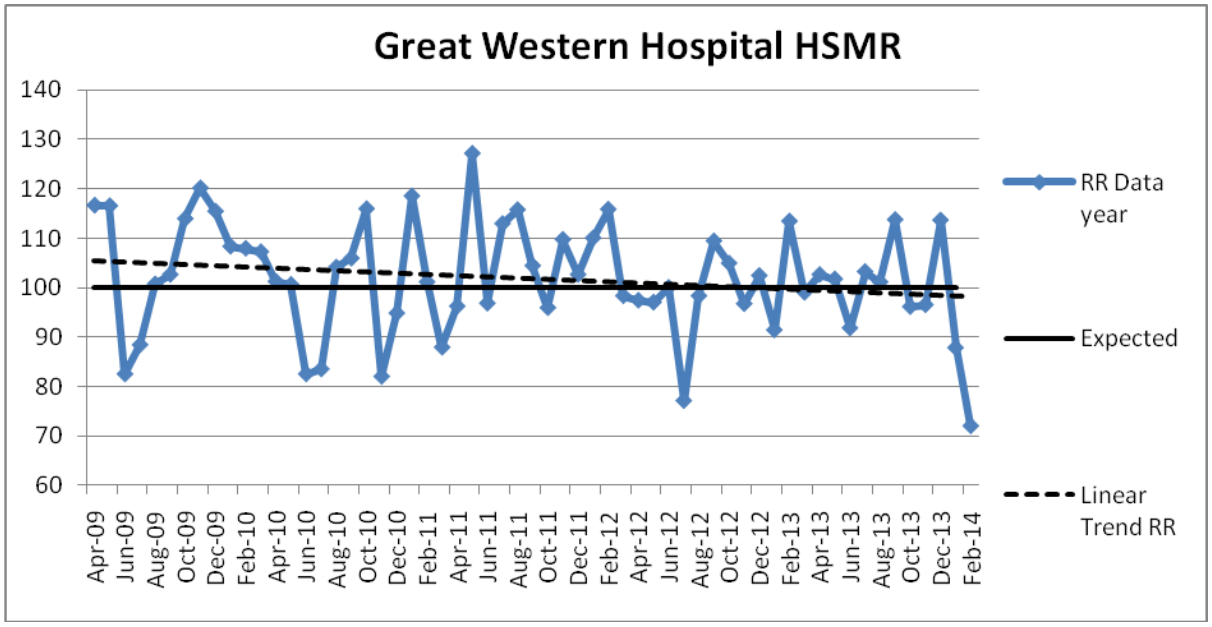
Therefore a local RR figure of 100 indicates that the mortality rate is exactly as expected; whilst a local figure of less than 100 indicates a mortality rate lower (better) than expected. The Care Quality Commission (CQC) uses HSMR values to monitor performance of hospitals and identify areas of practice where improvements in care may be needed.

Each year the risk adjusted element of the RR is rebased (recalculated) by Dr Foster on the expectation that improvements in standards of care and new clinical methods should be reducing the number of hospital deaths on a year on year basis. Therefore for any given financial year the national HSMR Relative Risk will be 100 but when compared to the previous year the RR will appear to be lower. Because of this, Dr Foster normally plots the RR against the risk adjusted element for the year being measured (termed the Data Year).

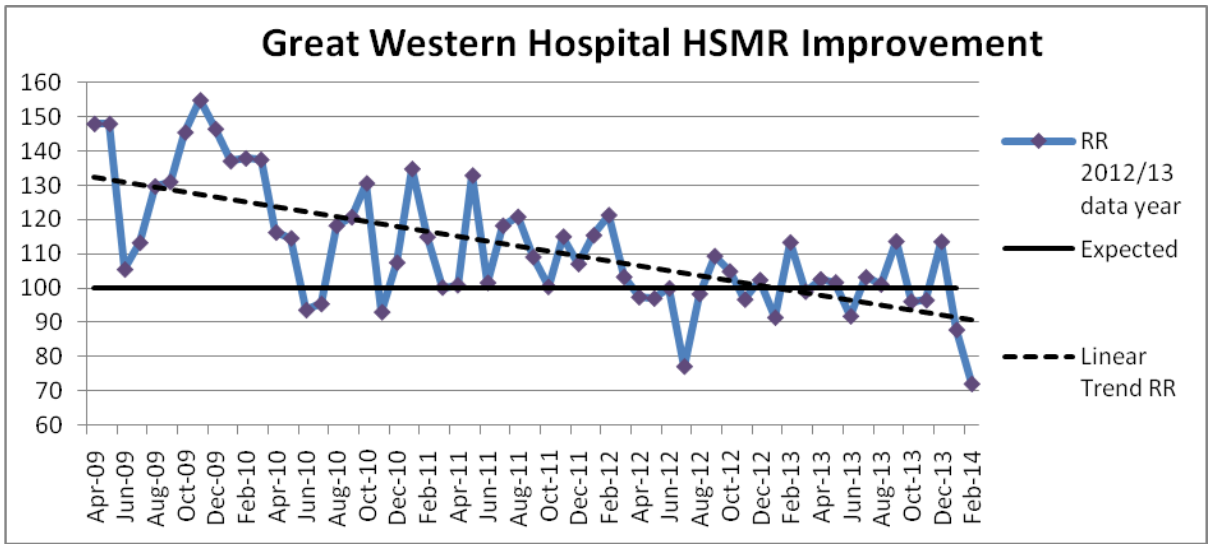
The Graph below shows the year on year HSMR following rebasing which shows a general improvement over time but with a projected outturn in 2013/2014 that is at odds with this improving trend. The current figure of 97.3 for 2013/2014 is prior to rebasing and so is benchmarked against 2012/2013 while the projected figure of 108.0 is Dr Foster's estimate of what the rebased performance will be once the year has ended. (*Note – The Trust is actively reviewing those areas where mortality rates appear high and validating the clinical coding that is used in producing the relative risk figure and this may reduce the projected outturn. In addition the Dr Foster rebase in 2012/2013 was about 6 points and the current 10 point shift is unusually high and is being followed up with Dr Foster)*



The chart below shows the RR monthly trend and is based on the Data Year. It can be seen that the overall trend is downwards yet the actual RR scores for each month are closely set either side of the expected 100 line and variation is reducing.



It is clear from the chart below that by comparing the RR trend for the Trust over the last 5 years using the current base year of 2012/2013 across the whole period that major improvements in the RR score for mortality have been made. That said, because the baseline is being recalculated every year it means that the benchmark is always being lowered (albeit by smaller amounts year on year) so the Trust can never be complacent about the RR performance. This chart tracks HSMR across the Trust's acute and community inpatient activity although the community element is only within the activity from June 2011 onwards.



CQC Alerts

The CQC identified two mortality alerts for the Trust in the last year 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). The Trust 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.

For patients with heart attacks, it was found that a number of patients had been diagnosed as dying from a heart attack due to an elevated level of a marker of heart disease (troponin) in the blood. When these cases were reviewed by a cardiologist there was generally another explanation for the abnormality in the blood. Changes have been put in place to ensure that raised troponin levels are interpreted correctly.

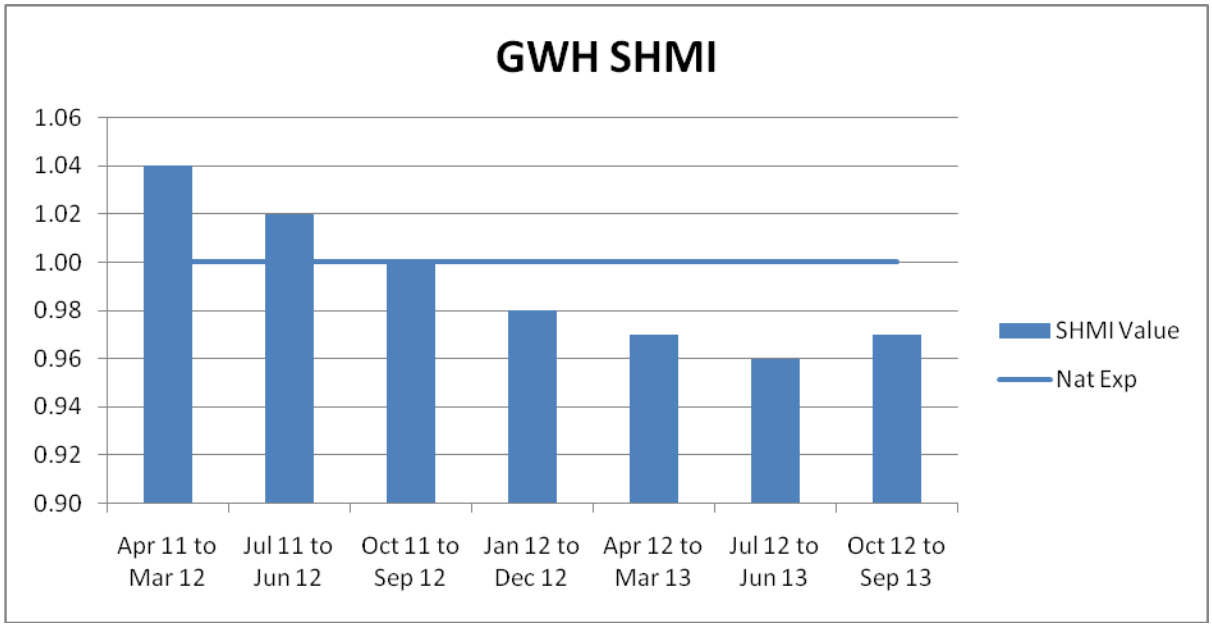
For patients coded as being admitted with a pathological fracture, investigation identified that there had apparently been an increase in the number of cases admitted with this condition. The explanation for this apparent increase was that the coroner had requested that osteoporosis (thinning of the bones) was listed as a factor contributing to hip fractures in elderly patients following falls. These patients should be coded as traumatic fractures for the HSMR calculations but had been allocated to the wrong diagnosis group.

Actions following these investigations have resulted in improvement in the HSMR rates for these diagnoses to lower than expected levels.

Standardised Hospital Mortality Indicator (SHMI)

The Trust also monitors its 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. 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 the latest published performance for the Trust in rolling year periods. The performance shows an improving trend with the Trust with the rate being below the expected national average rate. Given its similarity to HSMR the SHMI performance is likely to track upwards in the later part of the year.



The Great Western Hospital 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 investigates 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. This will give the opportunity to validate coding before it is uploaded to the Dr Foster system.
- 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."
- Clinical coders are piloting working more closely with clinicians, including joining ward rounds, to encourage better understanding of the documentation used and codes derived from the information recoded by clinicians

Priority 9 - To Continue to Improve the Management of the Deteriorating Patient by Full Completion of the Early Warning Score (SOS for Adults and PEWS for Paediatrics)

Adults Early Warning Score – SOS

Early identification of deteriorating patients, early escalation of care and appropriate intervention is vital to ensure optimal outcomes for both patients and resource deployment within the Trust. Currently the Trust uses the Swindon Outreach Scoring System, a modified early warning scoring system, to help members of the multidisciplinary team to identify deteriorating patients.

In July 2013, The Royal College of Physicians launched a National Early Warning Scoring system (NEWS). While the College is supporting the use of NEWS, there is currently no mandatory requirement for Trusts to change to this system and uptake nationally has been variable, with particular concerns regarding the oversensitivity of the tool. As compliance with the existing Swindon Outreach Score (SOS) system remains consistently over 90%, both within the Great Western Hospital (96%) and within the Wiltshire hospitals (92.5%), the decision has been made to put the Trust wide introduction of NEWS on hold temporarily. The aim will be to evaluate validity and reliability feedback from other Trusts during 2014/2015, particularly in Trusts with a similar catchment of both acute and community areas to ultimately decide if changing from one system to another would be of benefit. NEWS has however been incorporated within the triage tool used by the emergency department and is also being trialled as part of a triage tool by LAMU where a raised level of sensitivity at initial patient assessment and medical prioritisation is deemed appropriate.

A case note review of ten sets of notes has been undertaken during December 2013 and January 2014 by the Critical Care Outreach Nurse Consultant. This audit has shown that the current SOS system is consistently being used across the Trust both before and after an episode of critical illness requiring a patient's admission into Intensive Care/High Dependency.

Until 2013 compliance with the Swindon Outreach Score was monitored through an annual audit of 200 randomly selected observation charts from across the Trust. From April 2013 this audit has been divided into smaller quarterly audits of 50 charts from a cross section of acute ward areas (A), and 50 charts from the community (C). This provides a consistent snapshot of overall compliance with the tools use across the Trust. Quarter 1 (April – June), Quarter 2 (July – September) and Quarter 3 (October – December) data is included in this report. As compliance has remained over 90% current action plans are being maintained in the form of clinical staff training at induction, at annual mandatory training updates and through courses such as the REACT course.

	2007	2008	2009	2010	2011	2012	2013	2014 (A)	(C)
SOS Scoring compliance	75%	80%	86%	90%	93%	96%	92% (SOS rolled out to Wilts)	Q1 96%	92.5%
								Q2 92%	96%
								Q3 98%	95%

Priorities for 2014-2015

GWH will continue to use the SOS scoring system with a view to considering switching to NEWS. Compliance will continue to be monitored using a quarterly audit of observation charts in both acute and community areas.

Paediatrics Early Warning Scores (PEW)

Children are nursed at The Great Western Hospital in the Children's Unit, Day Surgery Unit (DSU), Shalbourne Suite (Private Patients Unit) and Emergency Department (ED).

The Paediatric Early Warning (PEW) Scoring system has now been in place for several years and the approach to compliance expanded across all areas. The month of January 2014 saw the opening of a Children's area in the Emergency Department – an exciting opportunity to ensure all children will have a PEW from the minute they access the hospital.

During the last 12 months we have adapted our charts and audited the response to include writing age related parameters for each individual child. The tables reflecting this have always been part of the paperwork. They have also been adapted to include space for addressograph labels on all pages since identification of a child required further enhancement. Alongside that the frequency of recording the observations is also written on the chart.

Ensuring actions are also being recorded has also been monitored carefully and an improvement shown reflected in quarterly audit reports.

Year after year we have looked at the way in which we are recognising the stability and also deterioration in children who present to our hospital. Children who are going to become more unwell will, unlike adults, deteriorate rapidly so the PEW scoring must be robust and failsafe and intervention must be immediate if required. During the winter months in particular we see a sharp increase in children requiring high dependency care (HDU) and during the year of 2014 it is the intention to introduce an already adapted Bristol PEW scoring system for babies less than 1 year of age. The intention will be to introduce this for use with older children.

PEW will now start at point of contact in the Emergency Department (ED). This will be completed by an experienced Paediatric Nurses. The Shalbourne suite (Private Patients Department) has appointed a permanent Paediatric nurse this year to ensure its compliance there. Auditing these areas as well as introducing in DSU is the intention alongside the Children's Unit audits.

Priorities for 2014/2015

For the year ahead the focus will be to:

- Elect a PEW working group to raise awareness and ensure priorities are met, including a nurse from Day Surgery Unit (DSU), ED and Shalbourne
- Ensure compliance with quarterly audits and introduce to other areas including ED, DSU, and Shalbourne
- Introduce the Bristol Children's approach to PEW for children up to one year of age
- Continue to complete High Dependency Unit (HDU) national audit on all children that meet the criteria.
- To attend the annual Paediatric Advisory Group to share good practise in all district general hospitals as well as designated children's hospitals

Priority 10 - To continue to enhance the quality of life for Patients with Dementia

Patients with Dementia

Progress against the Trust Dementia action plan continues however; the Dementia Strategy Group recognises that the pace of progress seen in the 2012/2013 has been reduced this year. Key achievements have, however, been sustained such as the use of the 'Forget Me Not' flower on wards and patients notes; the use of 'This is Me' document; basic changes to the environment such as signage and changes of toilet seats and the dementia champions programme. The following actions have been agreed by the Strategy Group and are included in the Trust Strategy Document which was presented to the Patient Experience Committee April 2014.

- Consultant Psychiatrist and Dementia Lead – the new position includes key responsibilities around dementia care. The position has been recruited into by Avon and Wiltshire Mental Health Partnership NHS Trust. The consultant will work closely with the Elderly Care Consultants and Mental Health Liaison nurses, and will join the Trust on 4 May 2014.
- A pain assessment tool, that will support staff in assessing pain experience by patients with dementia, has been developed and trialled. The draft policy is being review following comments from the policy and procedure group
- Standard requirements for dementia friendly wards will be developed and included in the Trust strategy. There is still reserved funding that will meet the needs of basic and essential improvement to the environment.
- Dementia training programme is in place. However, Level 1 awareness training is achieved within the Trust induction programme. Level 2 training, that requires more detailed face to face engagement, is not well attended. The main issue is around the release of staff to attend face to face training. The Trust Academy will benchmark training against other Trusts in the South West and implement any new innovations. More emphasis will be placed on training in clinical areas; enhancing the skills of dementia champions and including dementia training on overseas nurses' induction programme and newly qualified nurses' preceptorship courses. Oxford Brookes University has implemented a Dementia module for student nurses. Bespoke training is led by the Mental Health Liaison Nurses and the Dementia Lead
- Dementia champions met in October 2013 to present some innovative ideas that were implemented locally. Some ideas such as a memory corner that have items such a puzzles and old photograph, will be put forward, to be accessible by wards and departments. A case of need is to be submitted to the Charitable Funds. This is included in the new Dementia Strategy

Priorities for 2014/2015

- The New Dementia Strategy 2014-2016 captures the Trust ambitions for the next 3 years. There is a Strategy implementation timeframe and this will be reported on. The strategy was presented to the Patient Experience Committee in April 2014 and then the Governance Committee

Priority 11 - Continue to ensure that adherence to Regulations and Standards for Safeguarding for Adults & Children is maintained

Safeguarding Adults at Risk

- Funding was agreed in early 2013 for a Safeguarding Facilitator's role and a Safeguarding Administrator's role and appointments were made to these positions. There is an interim Safeguarding Adults appointment for GWH community services in Wiltshire. It is envisaged that the substantive position will be advertised in the next 4 to 6 months. These two new safeguarding positions have been recruited into and will help to drive forward all aspects of the Trust ambition to embed a safeguarding culture across the organisation. Interviews for the Community safeguarding facilitator's position were held on 17 April 2014, for which an appointment has been offered.
- A Safeguarding Children and Adults Performance Framework has been development and will be used to provide outcome measures on key areas of focus. The performance framework is in place and agreed by the Governance Committee and a dashboard is in development
- The number of safeguarding referrals made by the Trust has increased significantly compared to the same period 2012/13. The Trust made a total of 11 referrals between April to September 2012/13 and 23 referrals during the same period in 2013. The focus this year on raising staff awareness of safeguarding adults; enhanced training for managers and a revised policy would have contributed to the increase in the referrals.

Priorities for 2014/2015

- GWH has teamed up with Gloucestershire NHS Foundation Trust to conduct an on-site peer review of system and processes around learning disabilities and safeguarding. An onsite peer review involving multi-agencies was conducted on 28 March; the reports have not yet been shared.

Safeguarding Children

The Trust is committed to the well-being of all people using their services and takes the safeguarding of children very seriously. The Trust has a dedicated Safeguarding Children Team provide training, advice and support to all services both in the hospitals and across the community.

The Trust works 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 has senior representation on Swindon, Wiltshire and Bath & North East Somerset (B&NES) LSCBs.

The Trust has 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 working 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
- Processes are in place to learn from events

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

- Ensuring there is Senior Management commitment
- Having 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.

Training

All staff have a responsibility to safeguard and promote the welfare of children and to fulfil these responsibilities all health staff should have access to appropriate safeguarding training. This training needs to be renewed every 3 years. As at the end of year the training uptake for safeguarding was:

Level 1 – 97.57%
Level 2 – 61.54%

The organisation recognises that the training compliance for level 2 is not satisfactory, and issues such as data quality and access to training, particularly multiagency training, are currently being reviewed. The Trust has an action plan in place to ensure compliance is improved and the aim is to improve level 2 up take to 90% in 2014

Named professionals

The Trust has named professionals who lead on issues in relation to safeguarding.
The total numbers of professionals are broken down by discipline, as follows:

- WTE* named nurse for safeguarding children – community
- 0.4 WTE* named nurse for safeguarding children - acute
- 0.2 WTE* named doctor for safeguarding children
- WTE* named midwife for safeguarding children

* Whole Time Equivalent (1 WTE = 1 full time member of staff)

Assurance framework

The Trust has a Safeguarding Forum in place which has senior representation from each of the Directorates and reports to Trust Board. This forum oversees safeguarding performance, activity and audit, and sets the safeguarding priorities for the organisation.

Processes are in place to learn from events. This includes the monitoring and investigation of safeguarding incidents and case reviews including multi-agency case reviews as requested by LSCBs. The Trust has contributed to 2 Multiagency Serious Case Reviews in the last year and is implementing the action plan from a third. All actions are currently on target to be achieved.

Priorities for 2014-2015

The following priorities have been identified for safeguarding children for 2014-15:

- 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

Priority 12 - To carry out a Review of Patients who are Re-admitted to Hospital within 30 Days of Discharge

The Great Western Hospitals NHS Foundation Trust considers that this data is as described for the following reasons,

A readmission to hospital can be a result of less than optimal care provided whilst patients are in hospital and/or less than optimal care provided by supporting services after a patient is discharged home.

The Great Western Hospitals NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services.

Hospital readmissions can be avoided if good local arrangements are in place. In August 2013 a review of emergency readmissions was undertaken in collaboration with our Swindon and Wiltshire commissioners.

The aim of the review was to identify how many patient readmissions were linked to the original in patient care provided and to identify areas for improvement across both acute and community services. This will help to prevent potentially avoidable readmissions in the future.

The review looked in detail at the medical admission notes of a sample of patients originally admitted during May 2013 with a subsequent emergency readmission during June 2013. Patient notes were reviewed using a purposely designed form for the data collection. These notes were reviewed jointly by our lead clinicians and our Swindon and Wiltshire Commissioners. The review was based on thirty sets of patient notes.

Twelve of the patients re-attended via the Emergency Department, seven were referred by an out-of-hours GP, two were ‘planned’ readmissions to a clinical decision unit and two were admitted direct from an out-patient clinic. Twenty-one patients were readmitted from their own home, two from residential care, and one each from a Community Hospital and a Nursing Home.

In the opinion of the reviewing team, 17 (63%) of the patient readmissions were felt to be unavoidable whilst 9 (33%) of re-admissions were felt to be potentially avoidable. Of these, one potentially avoidable re-admission was within the control of GWH; four within the control of Community Services; and four within the control of Primary Care. Actions arising from the review are being progressed within the GWH and one of these specifically relates to the cardiology department appointing an additional locum Consultant to address waiting times.

The report has also been shared with the Commissioners so that key actions can be taken forward to improve the quality of care for patients provided by primary care

30 Day Readmission Comparative Data 2013/2014

	Apr 13	May 13	June 13	July 13	Aug 13	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	March 14
Emergency Re-admission within 30 days of discharge	8.4%	8.5%	8.1%	7.6%	8.5%	8.0%	7.5%	7.5%	7.9%	7.7%	7.4%	7.6%

28 Day Re-admissions

The Great Western Hospitals NHS Foundation Trust considers that this data is as described for the following reasons, see above Priority 12 – 30 day Re-admissions.

The data made available to the NHS Foundation Trust by the Health & Social Care information Centre with regard to:
The percentage of patients aged

- 0-15 and
- 16 or over re-admitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reported period.

These figures are based on the crude emergency re-admissions within 28 days of the original date of discharge. These figures are considered to be crude as they no account of either the original discharge speciality (or condition, diagnosis and procedures) nor the reason (or specialty and diagnoses) for readmission. The age is calculated from the date of the original discharge

The Great Western Hospitals NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services. See commentary under Priority 12 for 30 Day Re-admissions (immediately above).

28 Day Readmission Data April 2012 – March 2013 and April 2013 – February 2014

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 12	783	4884	5667	63	390	453	8.0%	8.0%	8.0%
May 12	888	5759	6647	89	478	567	10.0%	8.3%	8.5%
Jun 12	749	5058	5807	49	403	452	6.5%	8.0%	7.8%
Jul 12	873	5474	6347	60	444	504	6.9%	8.1%	7.9%
Aug 12	721	5361	6082	59	404	463	8.2%	7.5%	7.6%
Sep 12	778	5000	5778	61	354	415	7.8%	7.1%	7.2%
Oct 12	796	5659	6455	66	403	469	8.3%	7.1%	7.3%
Nov 12	718	5442	6160	53	457	510	7.4%	8.4%	8.3%
Dec 12	713	4886	5599	61	423	484	8.6%	8.7%	8.6%
Jan 13	737	5192	5929	78	342	420	10.6%	6.6%	7.1%
Feb 13	607	5084	5691	55	378	433	9.1%	7.4%	7.6%
Mar 13	731	5318	6049	83	428	511	11.4%	8.0%	8.4%
Year 2012/13	**9094**	**63117**	**72211**	**777**	**4904**	**5681**	**8.5%**	**7.8%**	**7.9%**
Apr 13	749	5443	6192	64	434	498	8.5%	8.0%	8.0%
May 13	664	5515	6179	56	449	505	8.4%	8.1%	8.2%
Jun 13	668	5326	5994	49	416	465	7.3%	7.8%	7.8%
Jul 13	719	5802	6521	45	434	479	6.3%	7.5%	7.3%
Aug 13	691	5515	6206	57	455	512	8.2%	8.3%	8.3%
Sep 13	792	5471	6263	68	425	493	8.6%	7.8%	7.9%
Oct 13	811	6085	6896	62	444	506	7.6%	7.3%	7.3%
Nov 13	699	5722	6421	66	423	489	9.4%	7.4%	7.6%
Dec 13	763	5488	6251	78	389	467	10.2%	7.1%	7.5%
Jan 14	706	6042	6748	81	428	509	11.5%	7.1%	7.5%
Feb 14	653	5214	5867	90	333	423	13.8%	6.4%	7.2%
Mar 14	711	5593	6304	77	388	465	10.8%	6.9%	7.4%
Year 2013/14	**8626**	**67216**	**75842**	**793**	**5018**	**5811**	**9.2%**	**7.5%**	**7.7%**

Priority 13 - To Continue to Improve on Stroke Care

The National Stroke Strategy was published in 2007, outlining best practice standards for stroke care in hospitals and the community for rehabilitation.

A specialist stroke unit was established on Falcon Ward at The Great Western Hospital in 2009 with stroke specialist nurses [GWH] and therapists [provided by SEQOL]. Partnership working with commissioners and other service providers was established to develop pathways of care for these patients and their carers'.

Performance has been monitored though national audits and now GWH has a new extensive Sentinal Stroke National Audit Programme [SSNAP] audit tool to capture acute in-patient care and elements of community care. GWH has a dedicated Stroke Information Manager who is responsible for capturing, analysing and reporting very detailed data for every patient admitted with stroke/out-patient Transient Ischemic Attack (TIA [mini strokes where the symptoms come and go]) and this is reported nationally.

We recruited a Stroke Specialist Consultant in August 2013 and a Project Manager to manage the Stroke Improvement Programme at GWH.

These two new posts have created a new focus on stroke care and the detailed audit we are required to perform and submit to SSNAP, which in turn enables us to monitor very closely each patient's pathway from coming into hospital, to discharge or transfer for further rehabilitation and to identify where improvements are needed.

The number of stroke patients presenting here are slowly increasing by an average of 3 patients per month from April 2011; the range of admitted patients is 30-51 patients per month. TIAs are increasing very slightly over the same period; if these are well treated, the number of strokes can be expected to reduce in time.

New working parties to support this improvement work have been set up by The Project Manager and the GWH Stroke Improvement Group meets monthly to drive forward clinical pathway improvements. From September 2013, The Stroke Strategy Improvement Group was established to meet with CCGs and other providers along the stroke pathway and meets every 2-4 months according to need.

Joint Health and Social Care Plan

The Stroke strategy requires us to develop a document that will provide a clear joint care plan – from the patient's perspective including health and social care needs and 85% of patients should have a copy of this on discharge. this plan will involve the patient and their family and respond to the individual's particular circumstances and aspirations and will include working together with other services such as transport and housing as needed. The care plan belongs to the patient and will accompany them to rehabilitation or home on discharge from hospital and can be used by rehab services too. This Document is used by all healthcare professionals and can be used in the community too. The care plan was launched here in December 2013 and was reviewed in April 2014 with healthcare professionals and patients and carers. Feedback is very positive from patients, carers and professionals.

Service evaluation from stroke survivors and carers

Consultation events took place 2008 – 2010 run by NHS Swindon incorporating the whole pathway of care and these helped to shape local developments in stroke care. Previously there was a dedicated Stroke Carers lead post appointed with NHS Swindon funded through the Swindon Carers Centre with National funding as a pilot and whilst highly successful, funding was not able to continue this beyond 2011. We need to ensure that Carers of Stroke survivors are well supported because they play such a crucial role in supporting people at home after a stroke.

A consultation event for patients and carers took place in February 2014 to evaluate their experiences specifically around their acute hospital admission to GWH and gather these and plan improvements as required. External and Internal stake holders helped to facilitate group discussions and reflections of the patient's experience. The event was opened by the Chief Executive demonstrating the value placed on this consultation.

Generally the feedback was very good especially about the nursing care on Falcon Ward

- "They offered help rather than waiting to be asked"
- The carers and family members felt immediately well cared for on Falcon
- "Everything was well explained to me"
- "The nursing team were just excellent!" "Such a helpful team of nurses!" "The nurses were very good at explaining what was going on but I couldn't always remember the detail"
- The new joint care plan was very well evaluated and people wished they had had this information on their admission – no suggested changes were identified
- Some good examples of doctors and nurses phoning relatives at home to update them on care and diagnosis which made them feel well-informed and updated on what was happening

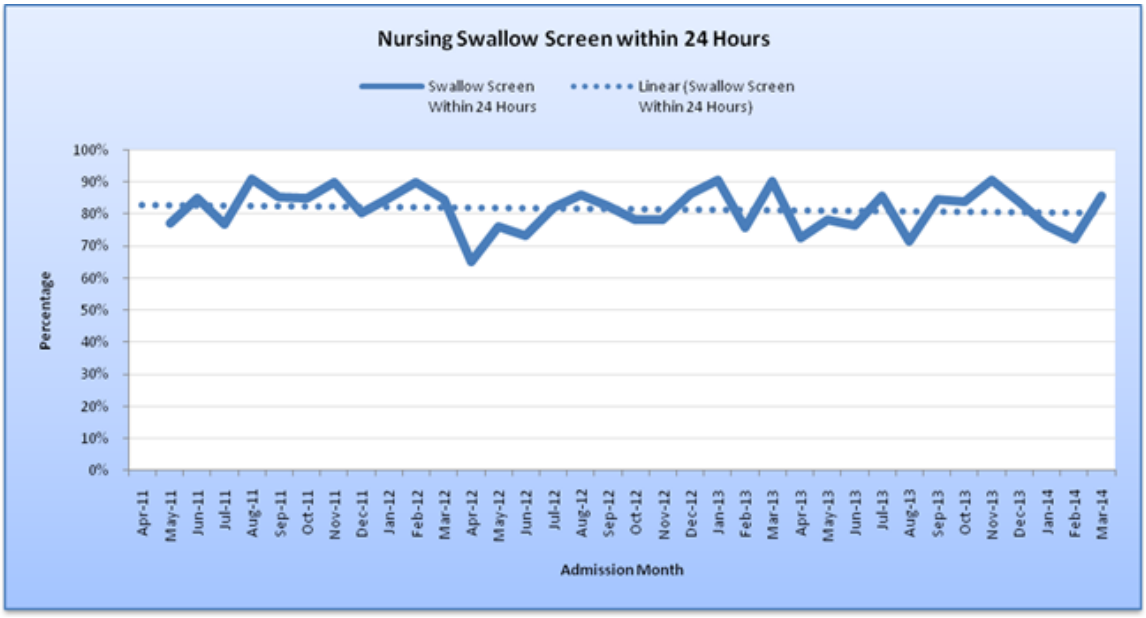
Feedback for action:

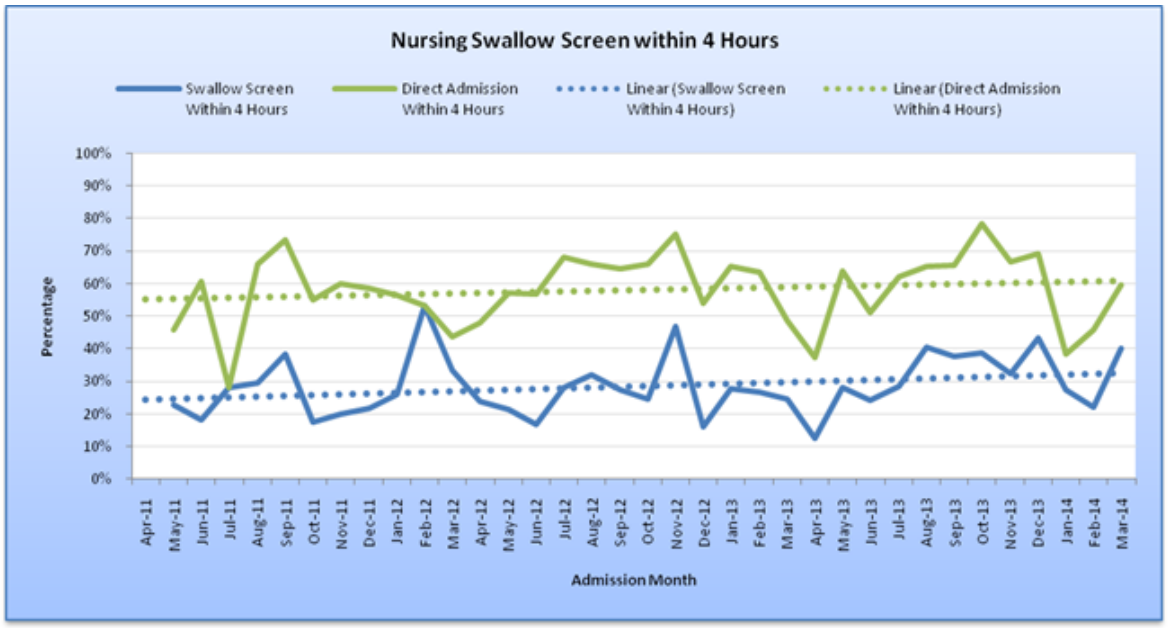
- Weekends felt very quiet and all patients would have liked more therapy at weekends
- Advice needed on managing fatigue for patients and carers
- The carers needed to know as much as the patient, to help support the patient in hospital and at home –very often the person who has had the stroke cannot retain information
- The role of carers – all agreed they did not know what to expect until they got home and more support for them was needed. They said that an event like this to meet other carers was really helpful – just to talk to other carers and get more information from professionals. Discharge from Falcon happens usually in 7-10 days and having someone with a stroke home so soon was scary for most carers and many felt "just left to get on with it" without enough knowledge and experience in what was expected of them
- The role of the community stroke co-ordinator needs to be introduced to each patient/carer so they know about this role and the community support available and that they can make contact directly
- Noise and environment for recovery - "The ward was noisy after 10pm at night and this added to my exhaustion!" "Patients with dementia should not be on the same ward – too disruptive and took a lot of nursing time which meant I had to wait too long for care" "staff need to tell people to turn off their mobile phones!"
- The Ward Sister and Ward Manager and Matron need to be better identified and these staff need to introduce themselves to patients and their families – this will help with seeking information and knowing who is in-charge & helping families better prepare for discharge
- "The 6 week follow-up hospital appointment should be used to better connect with patient and carers needs – just a medical review"

The Ward Manager and Matron will be responsible for making changes to improve care based on this feedback. An action plan for this will be taken to the Stroke Improvement Group in April 2014. The Project Manager will explore options of better care for carers with our partner organisations in the community and commissioners. It was agreed by patients and carers that a consultation event like this should be an annual event.

Swallow- Screening in 4 and 24 hours

This is to ensure that if patients cannot swallow as a result of their stroke that they are promptly well hydrated with nasogastric or intravenous fluids. We do well in the 24 hour assessments (graph immediately below), but less well in the assessment required within 4 hours of admission (second graph below). This is an indicator from the National Institute for Clinical Excellence (NICE) Quality Standards which is included as a SSNAP key indicator. The national performance for assessment in 4hours is 60% and GWH to date is 30%.





The graph above also demonstrates that performance improves when patients are admitted *directly* to Falcon Ward. Improvement is noted from February 2014.

In October 2013, designated A&E nurses attended a specifically commissioned training session to increase the numbers of staff able to assess patients and the stroke registrar is also now trained. They now attend people with suspected stroke in ED and so this will increase the ability to assess patients in ED. Additionally there is a big drive to move people with suspected or diagnosed stroke directly to Falcon Ward and all the registered nurses there can assess for swallowing and there is a

bleep system in place so that stroke specialist clinicians go down into ED to assess people for stroke including swallowing. The Project Manager and Clinician will review case by case to ensure that those responsible for providing this assessment are challenged about needing to provide this service and in turn this can be expected to improve the percentage of assessments. There will be some patients where if anxiety is present, or there are other underlying conditions, that a swallow assessment is not immediately appropriate within the 4hours and proceeding with the test could provide a false negative. These cases will now be well documented in the notes and captured in the audit.
However, swallow assessments in 24hrs is consistently high so we know that all patients do have an assessment within 24hrs. This is best delivered when the patient is on Falcon ward by those most experienced in this assessment.

Provision of 7-day therapy – introducing physiotherapy at weekends

Specialist stroke therapy is provided by SEQOL for stroke specialist therapists for physiotherapy, occupational therapy and speech and language therapy in normal working hours. Patients must be seen in 72hrs following admission by all therapists and we achieve this for 90 – 100%% of patients.

NICE Quality Statement recommends patients with stroke are offered a minimum of 45 minutes of each active therapy that is required, for a minimum of 5 days a week, at a level that enables the patient to meet their rehabilitation goals for as long as they are continuing to benefit from the therapy and are able to tolerate it. The availability of therapy needs to increase to improve this aspect of patients care.

This standard is complex, as many patients simply cannot manage this level of input in the early days following their stroke and others with less severe strokes may not require this level of therapy. Clearly some patients will benefit from this level of input too which is why it has been recommended.

The therapy team works closely with their community colleagues to aid continuity of care and develop care plans to restore as much function as is possible.

A pilot of a Saturday morning therapy service was provided by SEQOL therapists from February to May 2014 on Falcon Ward. This pilot was evaluated looking at outcomes and the service from a patient, carer, therapy and medical and nursing perspective. The Health Psychology Team from Bath University assisted us with this through staff and patient interview and their report will be included in the evaluation. This work is part of a Masters Level dissertation. This study was funded through ward charitable funds and will be used to inform a business case for a weekend model of therapy.

Priorities for 2014/15

The swallow assessment in 4 hours need to improve and this will be audited and action planned accordingly.

We need to secure funding to enable additional weekend therapy and review weekday therapy against the 45 minutes/day standard and the cost of better achieving this. Additionally, a business case has been developed by the project manager to provide stroke specialist stroke consultant week-end ward rounds to ensure better stroke specialist care at weekends for new admissions. This links to the Trusts 7-day working plan.

To further support improvement with the above Stroke Quality Indicators we will also be looking to improve our performance of the 80/90% target [80% of patients spending 90% of their time on the acute stroke unit] through promoting direct admissions to Falcon ,the Acute Stroke Unit. This is because we know that this has a positive effect on all aspects of stroke care.

Priority 14 - Continue to Monitor and Maintain NICE Compliance

The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve outcomes for people using the NHS and other public health and social care services. They are accountable to the Department of Health, but operationally they are independent of government.

Their guidance and other recommendations are made by independent committees which provide health and social care professionals with reliable information for clinical and cost effective treatments to raise standards of health and social care. Health care organisations are expected to follow NICE guidance for services and treatments they provide.

Internal monitoring of NICE guidance at The Great Western Hospital NHS Foundation Trust commenced in September 2007 and compliance is based on the initial assessment of all NICE guidance published thereafter. We have a robust internal compliance assessment process which is informed by Senior Clinicians and checked within each directorate prior to advising the Patient Safety & Quality Committee (PSQC) and our Commissioners on compliance. Where exceptions occur these inform our Commissioners and agreement on funding is sought or exceptions agreed based on risk analysis.

To strengthen our current systems, a new purposely dedicated NICE database was created and implemented at the start of April 2013. This was designed specifically to capture comprehensive information relating to all NICE related activity for each Directorate within the organisation and to enable more robust monitoring. Furthermore, the new system means we are able to produce enhanced reports tailored to specific requirements for the Directorates, the organisation and local commissioners.

Areas of exceptions or non-compliance identified continue to be escalated in the first instance to the relevant directorate, and subsequently to the monthly Patient Safety Committee. For additional assurances, action plans and risk assessments are required to be completed and thereafter registered onto the directorate risk register.

All NICE related activity continues to be regularly monitored in accordance with the Trust policy

Priorities for 2014/2015

One of the priorities for next year is to review the process for assessing compliance with NICE and the reliability of data.

Priority 15 & 16 – Improving Patient Experience & Reducing Complaints

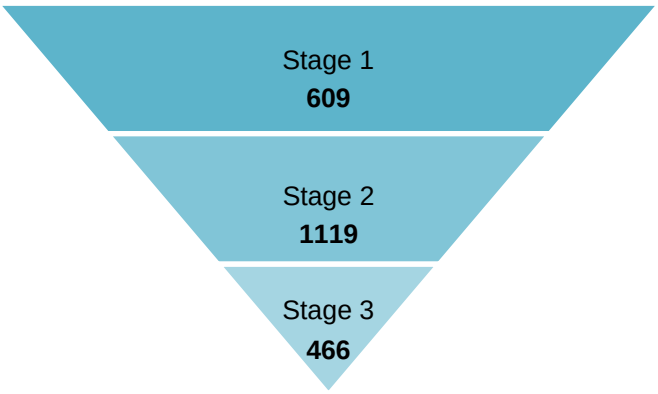
Improving ‘Patient Experience’ and customer satisfaction is a key priority for the Trust. We want our customers, patients and all stakeholders to become advocates for the Trust and the services we offer.

Over the last year we have developed a more rounded way of understanding what our patients think of our service. We are now operating the Friends and Family test in all major Trust areas. We have been working hard on developing a new complaints system, in consultation with patients, and have used feedback from patients to change and develop services.

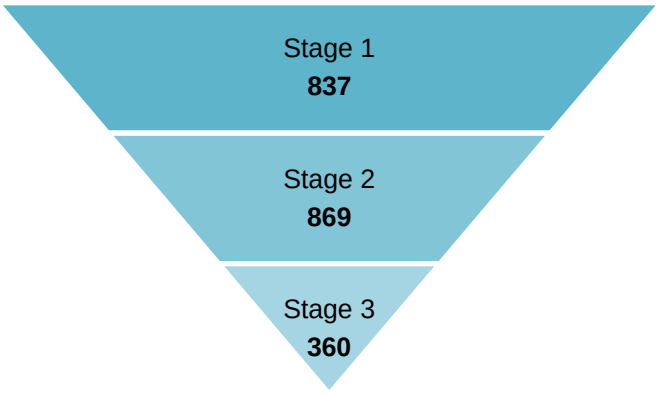
In last year’s Quality Account, we set out that we wanted to reduce complaints, and specifically return to a position of fewer complaints progressing through the complaints process with better early resolution.

We have nearly achieved this aim, closing the year in a much stronger position. The graphics below show the change of position from 2012/2013 and 2013/2014 for the makeup of complaints within the complaints process.

Complaints Received in 2012/2013



Complaints Received in 2013/2014



Further changes include:

- redesigning the complaints process
- removing unnecessary administration
- improving response times
- empowering and supporting staff to resolve issues at ward departmental level.

We have now consulted with major stakeholders and have redesigned the complaints process. The new process, which was implemented on 1 April 2014, simplifies the process for customers and staff. Based on actions rather than paperwork, it strips out unnecessary administration and improves experience.

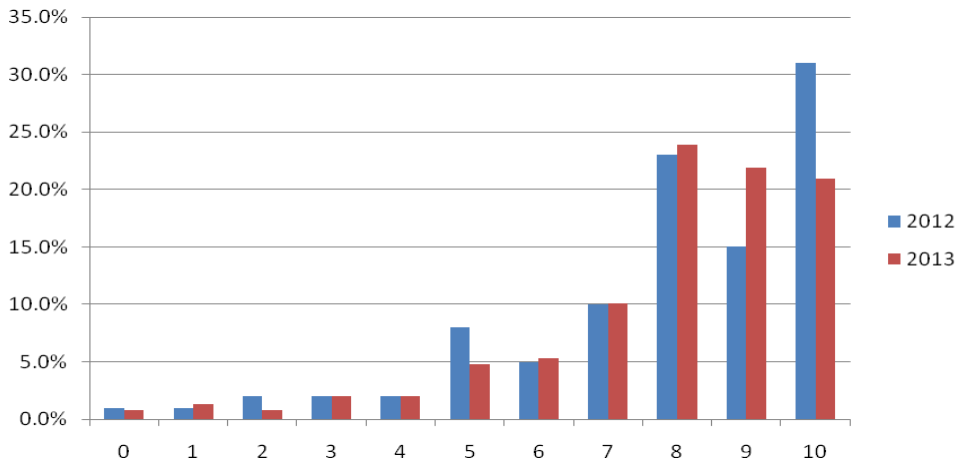
We have also tendered for a new casework and feedback management system to manage customer feedback. For many years a 'risk management' system was used that did not address the 'experiences' of our patients. The new system will enable us to engage much more effectively and dramatically improve patient experience as well as improving administration and staff empowerment.

During the year we have also recruited a new 'Training and Projects Lead' within the Customer Service Team, demonstrating our commitment to learning from what our customers are telling us.

National Inpatient Survey

The National Impatient Survey was carried out in quarter three of 2013 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.

Other highlights from the survey in the table below, show that in most cases, the Trust has either improved or is continuing to strive to improve performance to meet or exceed its aims.

The Great Western Hospitals NHS Foundation Trust considers that this data is as described for the following reasons because it is a reliable, externally validated measure reflecting the experience of our patients, it is objective and provides and annual snapshot and tell 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 %
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**
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**
Were you given enough privacy when discussing your condition or treatment?	**GWH** GWH target 73% or more responding 'Yes, definitely'	**73**	**70.8**
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**
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**

Friends and Family Test

As in other Trusts, the Friends and Family test has been implemented in most areas including:

- Inpatients
- Community Inpatients
- Outpatients
- MIUs
- A&E
- Day Services
- Maternity

The 'test' should be given to every patient in each group of patients, and asks one mandated question; 'how likely are you to recommend the ward/service/clinic to a friend or family member'. We also provide a free text box to understand why a response was selected, as well as asking other related questions.
Responses are measured are nationally as a 'Net Promoter Score' which must be reported publicly.

The Net Promoter Score (NPS) is a metric that is mainly used in the private sector to gauge the loyalty of a business' customers and relationships.

Hospital Trusts can achieve an overall Friends and Family Test score between minus (-)100 and plus (+) 100. A NPS of above +70 is considered a good score and is in-line with other Trusts.

- Our Trust's Friends and Family Test score for April 2014 was +76. This was based on 2009 responses.
- This equates to our Trust scoring 4.78 out of 5 stars (Friends & Family rating system) for April

This information is available on the GWH website and is updated monthly with the previous months NPS and Trust Scoring.

GWH Trust-wide Net Promoter Score:

Month	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
NPS	+77	+78	+77	+74	+72	+72	+75	+73	+77	+75	+76	+74
Responses	699	1019	1739	1154	1043	3764	3190	2810	2534	2288	2440	2172

Priorities for 2014/2015

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

Over the next year, we intend to make our ability to capture and use all kinds of feedback as easy as possible. Using technology, we will reduce jargon, simplify process and help the Trust to deliver a service customer really wants. We will provide better information and make our service as accessible as possible.

During 2014/2015 we will also:

- Implement a new feedback system
- Improve the quality of customer feedback information we hold
- Develop a new Patient Information policy
- Improve the quality of the information we produce
- Improve the Friends and Family NPS
- Primarily to develop a robust Trust wide action plan to address the areas within the Picker Survey report, where improvements are required

Priority 17 - Ensure that Equality & Diversity is fully established within the organisation

Great Western Hospitals' vision for 2014-2017 is: "it wants its services and opportunities to be as accessible as possible, to as many people as possible, at the first attempt"

Our objectives to ensure established Equality and Diversity are; better health outcomes for all; improved patient access and experience; empowered, engaged and included staff; inclusive leadership at all levels:

We aim to provide this by eliminating discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Act; advance equality of opportunity between people who share a protected characteristic and people who do not share a protected characteristic; 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

The Trust has an active Equality and Diversity (E & D) Working Group with Health Care representatives from across the Trust. The purpose of the group is to develop an awareness of Equality & Diversity considerations, which have the potential to improve outcomes to eliminate discrimination, advance equality of opportunity and foster good relationships. To enhance this we have developed a series of significant actions to deliver specific objectives over the next 12months, which are all incorporated into an action plan and monitored and tracked accordingly. A selection of the high level actions are:

1. E&D Directorate Champions – Members of E&D working group to be "champion" within their directorate for advice on E&D protected characteristics and E&D considerations
2. Trust Board knowledge – Board training session to be hosted and Executive leadership knowledge; provide training at an Executive Away Day on protected characteristics and E&D responsibilities
3. To review and update the Equality Diversity data set for patients and staff
4. To link Equality Diversity Champions within Directorates to Trust Quality Champions
5. Directorate training - Training sessions for directorates as part of directorate meeting (annual ½ hour session)
6. Matron training – Training tool to be developed to include hard hitting examples related to Trust experience with view to matrons feeding this into wards.
7. Include E & D assessment within the Senior Nurse Ward Inspection Tool and the Trust Executive Safety Walkabout
8. Patients - Develop appropriate messaging tools to explain E&D / tolerance of inappropriate behaviour towards staff and others with protected characteristics
9. Linking E&D into staff appraisals in the same way as the Trust Service, Team, Ambition and Respect (STAR) values
10. Review of the current Trust Equality Impact Assessment and check that it is fit for purpose and embed within business planning process

11. Incidents & Complaints – Process to ensure any incidents or complaints relating to E&D are identified. This will ensure Trust addresses any feedback / listens to its staff and will increase Trust knowledge.
12. Networking Groups – Establish groups with specialist focus to provide advice / views of these considerations to assist decision making / awareness and to maintain momentum in addressing these.

The Priority for 2014/2015 is to continue to build on the work taking place during 2013/2014.

Clinical Incidents- Serious Incidents and Incident Reporting

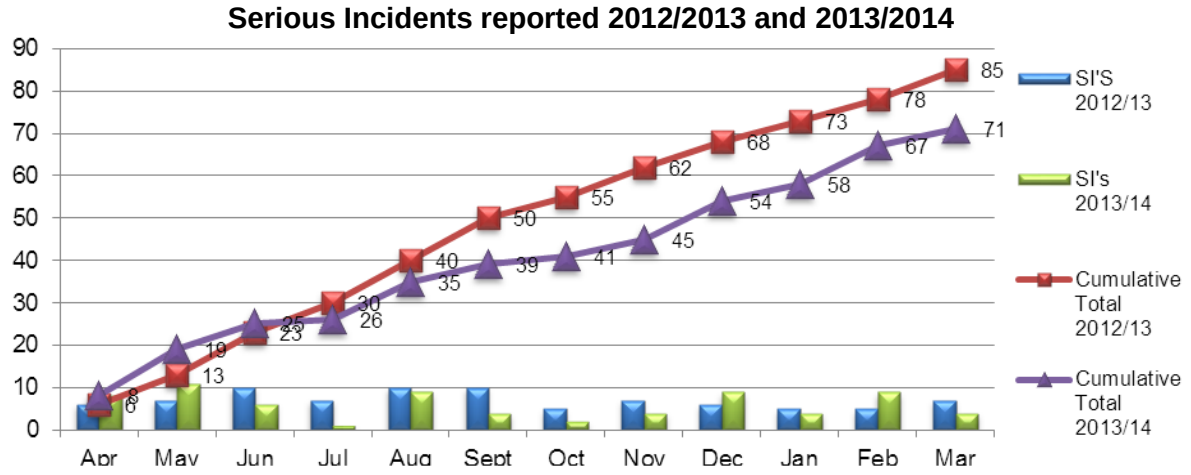
The Great Western Hospital considers that this data is as described for the following reasons:

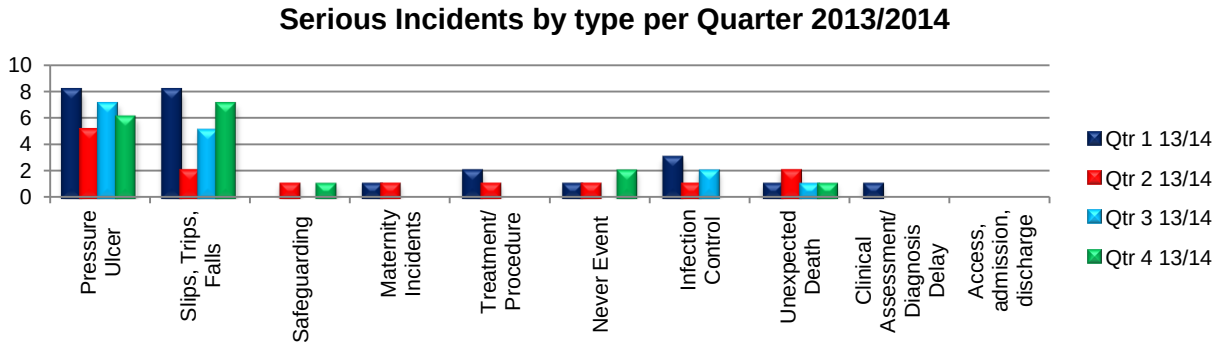
- To drive forward quality improvement through incident investigations and shared learning
- The Trust's Incident Management Policy complies with the requirements of the National framework for reporting and learning from serious incidents requiring investigation March 2010 and the NHS England Serious Incident Framework March 2013
- Compliance with the Trust Incident Management Policy is audited with a resulting improvement plan biannually
- All incidents reported are reviewed on a daily basis by the Clinical Risk and Health and Safety Departments
- All patient safety incidents reported within the Trust are 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

Serious Incident Reporting
The National Framework for Reporting and Learning from Serious Incidents Requiring Investigation was published by the NPSA in March 2010. The framework provided a consistent approach to reporting and management of Serious Incidents, and a clear definition for serious harm. A serious incident requiring investigation is defined as an incident that occurred in relation to NHS-funded services and care resulting in one of the following:

- Unexpected or avoidable death of one or more patients, staff, visitors or members of the public;
- Serious harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm (this includes incidents graded under the NPSA definition of severe harm);
- A scenario that prevents or threatens to prevent a provider organisation's ability to continue to deliver healthcare services, for example, actual or potential loss of personal/organisational information, damage to property, reputation or the environment, or IT failure;
- Allegations of abuse;
- Adverse media coverage or public concern about the organisation or the wider NHS;
- One of the core set of 'Never Events'

A total number of 71 serious incidents were reported and investigated during the period April 2013 to March 2014; a reduction of 14 from 2012/2013.



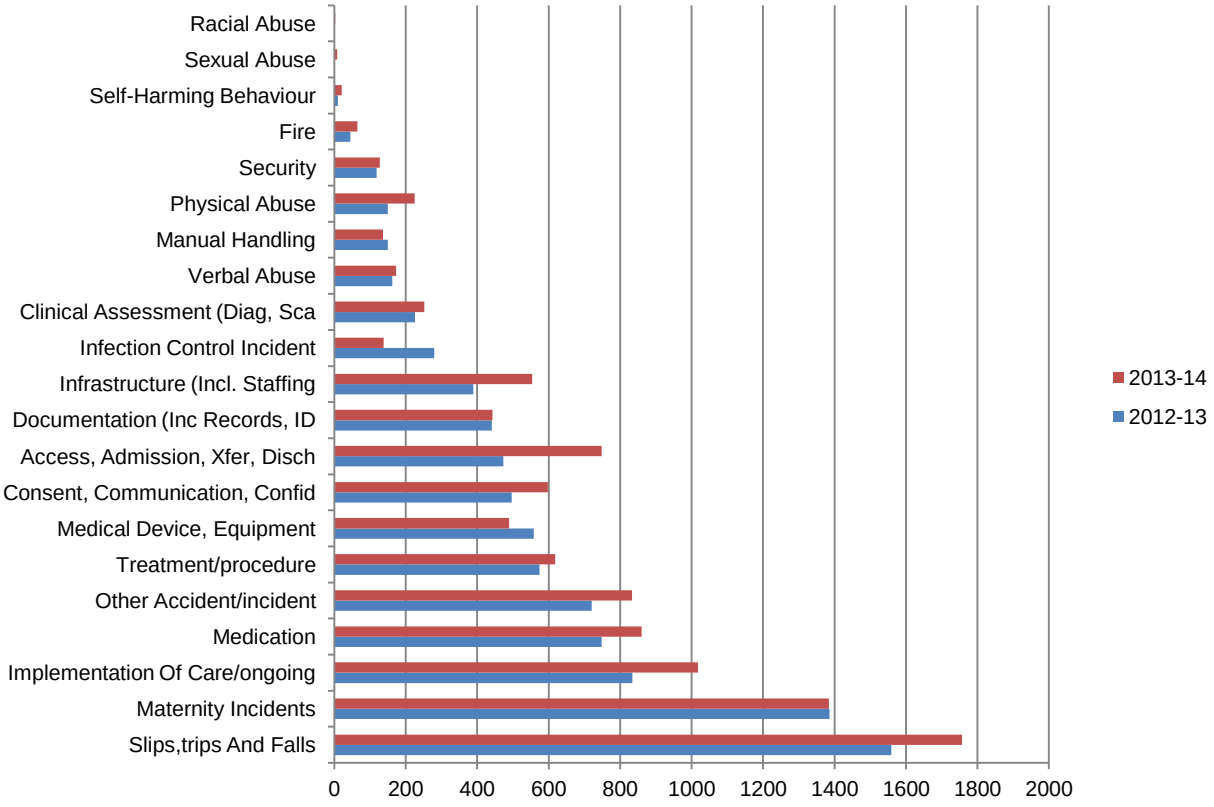


Incident Reporting

The Trust uploads all reported patient safety incident forms to the National Reporting and Learning System (NRLS) on a weekly basis. The National Reporting and Learning System release an Organisational Patient Safety Incident report twice a year, providing organisational and comparative incident data. The report for the period 1 Apr 2013 to 30 Sept 2013 has been postponed from the March 2014 publication date, due to the NRLS transferring to NHS England. This report is now expected to be published at the end of April 2014.

What types of incidents are reported in our organisation?

	Non clinical incidents/Health and Safety	Patient Safety Incidents reported to NRLS
2011/2012	8991	6507
2012/2013	9320	6920
2013/2014	10452	6741



Patient safety incidents by degree of harm April 2013 to October 2013 (national comparative data not yet released)

Year	2-None (No Harm Occurred)	3-Low (Min. Harm)	4-Moderate (Short Term Harm)	5-Severe (Permanent Or Long Term Harm)	6-Death (Caused By The PSI)	Grand Total
Apr 12 - Sept 12	2145 (66%)	800 (25%)	275 (8%)	18 (0.5%)	5 (0.2%)	3243
Oct 12 - Mar 13	2303 (63%)	1080 (29%)	275 (7.5%)	18 (0.5%)	1 (0.02%)	3677
Apr 13 - Sept 13	2237 (64%)	1028 (29%)	216 (6%)	18 (0.5%)	4 (0.1%)	3503
Oct 13 - Mar 14	1980 (61%)	958 (30%)	283 (9%)	10 (0.3%)	7 (0.2%)	3238

The chart above shows the degree of harm following all patient safety incidents. National data is not yet available to benchmark against for the second twelve months of the year (see previous two charts).

Priorities for 2013/2014

The Great Western Hospital has taken the following actions to improve patient safety, and so the quality of its services, by:

1. **Our Aim:** Improve compliance with the Incident Management Policy and evidence of sustainable changes as a result of serious incident investigations.

Our Actions: We have introduced a number of improvements during 2013/2014:-

- Introduced a 6 monthly audit cycle to assess compliance with the Incident Management Policy.
- Serious Incident reporting checklists to ensure all reporting requirements are completed by the Clinical Risk Team within timeframe.

- Serious Incident Panel process, the function and role of which is continuing to be developed.
- Amended the Serious Incident Monitoring Table to document date of knowledge of an incident within the organisation.
- The Clinical Risk team monitor that department level investigations are completed within 14 days and report exceptions to PSC and Directorate Management.
- We have improved staff information on incident reporting provided at Trust induction.
- Documented clear standard operating procedures for incident management within the Clinical Risk and Health and Safety Departments, including clear definitions of actual harm.
- Provided guidance for staff on risk assessment (via hyperlink) on the electronic incident form via hyperlink

Our Achievements:

Criterion	Standard	Exceptions	Compliance April 2013	Re-Audit Compliance Nov 2013	Compliance
All incidents are reported to external agencies within timeframe (as defined in Appendix D of Incident Management Policy)	100%	No exceptions	59%	70%	⇧
All department level investigations for low, moderate and high risk incidents investigated within 14 working days.	100%	No exceptions	39%	72%	⇧
All incidents reported on Trust incident form within 24 hours	100%	No Exceptions	70%	81%	⇧

In March 2013 the Clinical Risk Department commenced a review of previously closed serious incident investigations, including the never events which occurred in 2012/2013, seeking assurance that action plans had been implemented and evidence of sustained changes in practice. A number of actions were found to have a reduced level of assurance that they had been fully implemented, the report was escalated to the Patient Safety Committee, and actions completed. A rolling audit of previously closed action plans is now in place, aiming to gain assurance of continued change in practice following learning from serious incidents.

2. **Our Aim:** Improve compliance with the Being Open Policy for all serious incidents to demonstrate commitment to Duty of Candour

Our Actions: We have made a number of improvements to the process during 2013/2014 to raise awareness of Being Open and Duty of Candour, which is defined in Robert Francis' report as: "The volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made."

- Introduced a 6 monthly audit cycle to assess compliance with the Being Open Policy
- Included the concept of Being Open and Duty of Candour at Trust Induction for all new staff

- Created a page on the Great Western Hospitals NHS Foundation internet pages for members of the public to provide members of the public with information on the Trust's commitment to Being Open, and link to Trust policy
- Implemented a mandatory requirement to complete the Information Provided to Patients and Relatives field on the Trust's electronic incident reporting form
- Introduced a help function on the Trust's electronic incident reporting form, providing staff with a quick reference on Trust requirements for Being Open
- Developed a Being Open/Duty of Candour training tracker module, due to go live in April 2014

Our Result: The Trust has maintained a 100% compliance rate for documentation of Being Open communications following serious incidents. During 2014/15 improvement needs to focus on coordination of communication with patients and their relatives following serious incidents, quality of content of communication and timely delivery. In addition improvement is required to meet requirements of the Being Open Policy for incidents resulting in low and moderate harm.

3. **Our Aim:** Development and delivery of patient safety related training programmes

Our Actions: -

- Introduced monthly incident management system trouble shooting sessions available for staff across all settings
- Revised 1 hour incident investigation training for managers and staff with investigation responsibilities
- Laminated investigation quick reference guide for all managers
- Development of Being Open training tracker, due for launch in April 2014
- Development of Root Cause Analysis training in house, due for launch 2014
- Improved access to Clinical Risk and Patient Safety Advisors for 1:1 coaching and support during incident investigations and quality improvement activities

Our Result: Improved access to training for department level incident management and specialist support during serious incident investigations.

4. **Our Aim:** To monitor compliance with all recommended control measures described within the Never Event Framework are in place within the organisation. To ensure that all control measures are in place.

Our Action: In January 2013 the Clinical Risk Department commenced a scheduled audit programme, testing compliance with the recommended control measures described within the national Never Event framework, identifying gaps and making recommendations to strengthen controls. The programme of audits continued during 2013/2014, to ensure that adequate control measures are in place to reduce the risk of all 25 of the listed never events.

Our Result: Nine audits have now been completed, with actions underway to address and gaps in control measures. Each of the never event topics are being added to the annual audit plan for continued monitoring of compliance.

5. **Our Aim:** To describe the process for supporting staff involved in an incident, complaint or claim within a revised policy document. To monitor compliance with this document, to provide assurance of an effective process, which meets both needs of Trust staff and NHSLA requirements.

Our Action: The Incident Management Policy has been revised describing the process for staff support arrangements following a serious incident

Our Result: On-going improvements to staff support arrangements in conjunction with the Occupational Health and Human Resources Departments. The Clinical Risk Department now have a process in place to inform the Occupational Health Department when an incident has occurred. The Occupational Health Department proactively contact the Department Manager to offer staff support if required. This process is recorded on the Serious Incident Monitoring documentation within the Clinical Risk Department.

The Clinical Risk and Human Resources Departments have commenced discussions on developing a process to share learning from individual incidents, and to provide information to enable the Human Resource team to follow up on individual staff support and development requirements

Priorities for 2014/2015

- To deliver a mechanism to measure the safety culture within the organisation(safety culture analysis/ culture barometer)
- To provide a programme of patient safety education which includes Root Cause Analysis, Being Open/Duty of Candour, Quality Improvement methodology and tools
- To provide directorates with the systems to analyse incident trends and themes
- 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
- To continue to develop the programme of Executive Patient Safety Visits, to include reporting mechanisms and measurable outcomes to demonstrate impact.
- To continue to develop Trust wide mechanisms for sharing learning from patient safety incidents and communication of other patient safety related topics
- To improve serious incident investigations, increasing assurance that root causes have been identified, and SMART actions agreed
- To support individual managers and directorates to implement action plans arising from serious incident investigation
- To ensure that Trust Policy enables the organisation and its clinical staff to achieve their responsibilities with regard to Duty of Candour

6.5 Performance against Trust's Selected Metrics

		2010/ 2011	2011/ 2012 Data includes Community	2012/ 2013	2013/ 2014	National Average	What does this mean	Source of measure	Definition
1 - Reducing Healthcare Associated Infections	MRSA Bed Days as well *provisional as at 02/05/14	3	2	2	5	0.96*	Zero is aspirational	IP&C	National definition
	C.*Diff*	40	17	33	23	Not applicable	Zero is aspirational	IP&C	National definition
	C.Diff 100,000 bed days* **Provisional – not published as yet	20.1%	7.3%	13.4%	12.5%	12-15%**	Lower is better	HPA	National Definition
2 - Patient Falls in Hospital resulting in severe harm		15	17	16	23	Not available	Low number is excellent	IR1's	NPSA

		2010/ 2011	2011/ 2012 Data includes Community	2012/ 2013	2013/ 2014	National Average	What does this mean	Source of measure	Definition
3 – Reducing Healthcare Acquired Pressure Ulcers		40	31	28	28 (grade 3 and 4)	Not available	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%	90%	Higher number better	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%	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)
6 – Never Events that occurred in the Trust		0	3	3	4	SW Regional never events 2009 - 7 2010-17 2011-33 2012-32	Zero tolerance	IR1's	NPSA
7 – Mortality Rate (HSMR)	HSMR	97.9	106.2	91.8	97.3	100	Lower than 100 is good	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)	Not available	Higher number is better	Audit	Audit criteria (50 patients per month)
	Paediatric Early Warning Score (Children)				87.75%			Audit	Audit criteria (5 patients per month)
10 – Percentage of Nutritional Risk Assessments	Using MUST	70% Acute only	87.8% Combined	84%	82%		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%	54.8%	Higher is better	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%	38.4%	Higher is better	Picker Survey	National definition

		2010/ 2011	2011/ 2012 Data includes Community	2012/ 2013	2013/ 2014	National Average	What does this mean	Source of measure	Definition
13 – Were you given enough privacy when discussing your conditions or treatment?		68.5%	66.8%	73%	70.8%	72.7%	Higher is better	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%	40%	Higher is better	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%	69.8%	Higher is better	Picker Survey	National definition
16 – Patient Reported Outcome Measures	Varicose Vein surgery	Awaited	Awaited	100%	100%	80%	Higher is better	DoH	National Definition
	Groin hernia surgery	Awaited	Awaited	96.9%	100%	80%	Higher is better	DoH	National Definition
	Hip Replacement surgery	Awaited	Awaited	96%	98.5%	80%	Higher is better	DoH	National Definition
	Knee Replacement Surgery	Awaited	Awaited	95.6%	97%	80%	Higher is better	DoH	National Definition
17 – Readmissions – 30 days		n/a	7.4%	8.1%	7.9%	Local target (7.1%)	Lower is better		National Definition
18 – Readmissions – 28 days		6.9%	7.3%	7.9%	7.7%	SW Region 6.9%	Lower is better	Dr Foster	
18 – Re-admissions 28 days Ages 0-15 Ages 16+					9% 7.5%		Lower is better	Dr Foster	

*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 2013/2014 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	2013-14 Target	Achieved/ Not Met
Clostridium Difficile - meeting the *Clostridium Difficile* objective	40	19	33	23	20 or less (Acute)	Not Met
MRSA - meeting the MRSA objective	3	2	2	5	0 or less Contract Monitor de minimis 6	Monitor de minimis achieved
Cancer 31 day wait for second or subsequent treatment - surgery	98.5%	98.4%	98.4%	98.4%	94.0%	Achieved
Cancer 31 day wait for second or subsequent treatment - anti cancer drug treatments	100%	100%	100%	100%	98.0%	Achieved
Cancer 62 Day Waits for first treatment (urgent GP referral for suspected cancer)	92.4%	89.3%	90.0%	89.0%	85.0%	Achieved
Cancer 62 Day Waits for first treatment (from NHS cancer screening service referral)	100%	98.4%	96.2%	98.9%	90.0%	Achieved
Cancer 31 day wait from diagnosis to first treatment	99.0%	98.7%	98.1%	98.8%	96.0%	Achieved
Cancer 2 week wait from referral to date first seen, all urgent referrals (cancer suspected)	97.0%	97.1%	95.3%	94.7%	93.0%	Achieved
Cancer 2 week wait from referral to date first seen, symptomatic breast patients (cancer not initially suspected)	97.2%	97.1%	96.0%	95.6%	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%	90.0%	Achieved
Maximum time of 18 weeks from point of referral to treatment in aggregate, non-admitted patients	97.9%	98.2%	98.3%	96.3%	95.0%	Achieved
Maximum time of 18 weeks from point of referral to treatment in aggregate, patients on incomplete pathways			96.1%	94.8%	92.0%	Achieved
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge	97.4%	97.0%	95.6%	94.1%	95.0%	Not Achieved
Data completeness community services: referral to treatment information			80.0%	88.2%	50.0%	Achieved
Data Completeness community service information: referral information			80.0%	81.5%	50.0%	Achieved
Data completeness community services information: treatment activity information			85.0%	96.0%	50.0%	Achieved

Commentary related to previous table (not within main body of the Report)

Patient Reported Outcome Measures (PROMs)

The Great Western Hospital NHS foundation Trust considers that this data is as described for the following reasons:

This information is derived from Patient Survey forms which are reviewed and analysed by the HSCIC and data is provided nationally.

The Great Western Hospital NHS foundation Trust will take the following actions to improve this percentage, and so the quality of its services;

Performance for Varicose Veins and Groin Hernia Surgery is at 100% for 2013/2014; GWH will continue to monitor these services to ensure the greatest benefit to our patients. Whilst Hips and Knee procedures are also above the national average within the Trust, we will again continue to monitor and improve these percentages throughout the coming year.

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 2013 to 22 May 2014;
    - Papers relating to Quality reported to the Board over the period April 2013 to 22 May 2014;
    - Feedback from the Swindon Clinical Commissioning Group dated 16 May 2014;
    - Feedback from the Wiltshire Clinical Commissioning Group dated 20 May 2014;
    - Feedback from Governors dated 19 May 2014;
    - Feedback from Swindon Healthwatch dated 16 May 2014;
    - Feedback from Wiltshire Healthwatch dated 15 May 2014;
    - Feedback from Bath & North East Somerset Healthwatch dated 20 May 2014;
    - Feedback from Swindon Overview & Scrutiny Committee dated 13 May 2014;
    - 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 2013 national patient survey dated February 2014;
    - The 2013 national staff survey dated 27 January 2014;
    - The Head of Internal Audit's annual opinion covering the 2013/2014 period;
    - Care Quality Commission Intelligent Monitoring tools from October 2013 and March 2014

- 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 28 May 2014

Chief Executive:  Date 28 May 2014

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 16 May 2014

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.

NHS Swindon Clinical Commissioning Group (CCG) has reviewed the information provided by Great Western Hospital NHS Foundation Trust in its 2013-2014 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 clearly presented in the format required by the Department of Health Toolkit and the information it contains accurately represents the Trust's quality profile.

In 2013/14 there have been a number of national seminal reports and recommendations that have influenced the quality and safety agenda, most notably the report of Robert Francis QC, the Government's response "Hard Truths Patients first and foremost" and the Berwick Review of patient safety: "A promise to learn – a commitment to act: Improving the safety of Patients in England". The Trust has demonstrated its commitment to continued improvement by embracing the recommendations of the Francis Report, from the implementation of the Friends and Family Test, improving its systems for the identification and monitoring of incident trends and improvements in its processes in managing and responding to complaints. The participation rate on the Friends and Family test across specific areas in the trust continues to be a challenge although we note the marked improvement at the end of year linked to the introduction of a new method of gathering information and engaging the Trust's customers. We will continue to monitor this throughout 2014/15.

A workforce with robust leadership is key to delivering services effectively. Therefore in 2014/15 greater emphasis will be placed on monitoring nursing and clinical skill mix and the impact that staff shortages have on patient experience and outcomes. We are pleased to note that in relation to the staff survey, staffing and teamwork are highlighted as key priorities for the year ahead.

We will continue to support Great Western Hospital to drive improvements in patient safety through areas such as the Pressure Ulcer Strategy with the Trust setting itself a challenging aim of zero healthcare acquired pressure ulcers by 2015.

We note that although the rates of healthcare associated infections are reducing year on year, they remain greater than expected and will continue to be a challenge in the coming year. We support the identified aim to continue to improve clinical practice and environmental cleanliness.

NHS Swindon CCG has a structured monthly quality review meeting with Great Western Hospital using a range of quality measures to help us to support and monitor improvements. We welcome the specific priorities for 2014/15 to improve on patient safety, patient experience and effectiveness which the Trust has highlighted in the Quality Account. All are appropriate areas to target for continued improvement, building on improvements already achieved in 2013/2014.

Gill May
Executive Nurse
NHS Swindon Clinical Commissioning Group

Statement from Wiltshire Clinical Commissioning Group dated 20 May 2014

NHS Wiltshire CCG have reviewed the information provided by Great Western Hospital NHS Foundation Trust in this report. In so far as we have been able to check the factual details, our view is that the report is materially accurate and is clearly presented in the format required by the Department of Health Toolkit and the information it contains accurately represents the Trust's quality profile. Our contract with Great Western Hospital Foundation Trust covers three key areas: Acute service, Community services in Wiltshire and Maternity services. The Quality report while providing data across the key areas predominantly focuses on the Inpatient services at Great Western Hospital.

Last year we commented on the arrangements for the involvement of service users in the development of their Quality accounts and evidence of this in the Quality report for GWHFT; this still needs to be addressed.

In 2013/14 there have been a number of national seminal reports and recommendations that have influenced the quality and safety agenda, most notably the report of Robert Francis QC, the Government's response "Hard Truths Patients first and foremost" and the Berwick Review of patient safety: "A promise to learn – a commitment to act: Improving the safety of Patients in England".

The Trust has embraced the recommendations of the Francis Report, from the implementation of the Friends and Family Test, the identification and monitoring of trends and early warning signs of changes and workforce review. The participation rate on the Friends and family test across specific areas in the Trust continues to be a challenge as the targets increase in 2014/15.

A workforce with robust clinical leadership is key to delivering services effectively therefore in 2014/15 greater emphasis will be placed on monitoring nursing and clinical skill mix and the impact that staff shortages have on patient experience and outcomes.

The Community Transformation Programme has been a significant local priority for Wiltshire in 2013/14 in terms of developing a model of care for community health services ensuring the right clinical balance of services between primary care, hospital care, community settings and patients' homes. Great Western Hospital foundation Trust has been pivotal in the development of Care Coordinators and the appointment of 23 new roles.

We will continue to support Great Western Hospital to drive improvements in patient safety through projects such as Pressure ulcer Reduction and Harm Free Care. We have a structured monthly quality review meeting with Great Western Hospital using a range of indicators and metrics from a number of sources.

NHS Wiltshire CCG welcomes the specific priorities for 2014/15 which the Trust has highlighted in this report all are appropriate areas to target for continued improvement and link with the Clinical Commissioning priorities

Name Deborah Fielding
Title Chief Officer
NHS Wiltshire Clinical Commissioning Group

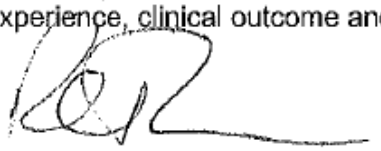
6.8.2 Statement from Governors dated 20 May 2014

The Council of Governors has been consulted on the Great Western Hospitals NHS Foundation Trust's Quality Account 2013-14 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 (94.1% achieved), but are satisfied with the efforts being undertaken towards addressing this, namely the engagement of the Emergency Care Intensive Support Team (ECIST), which has undertaken a whole system review and has made recommendations for improvement. The Governors have also noted that the Trust experienced an increase in attendance in A&E compared with last year and this undoubtedly impacted on the performance indicator.

Furthermore, the Governors noted that the Trust exceeded the maximum number of Clostridium Difficile cases, (23 cases against a maximum of 20). Governors are aware that each case is reviewed and any learning opportunities are considered and shared. Governors are satisfied with the actions being undertaken to reduce the number of cases, noting that a peer review has been undertaken and recommendations from that review are being progressed.

Despite a busy year, the Trust has made a number of achievements as set out in the Quality Account and in particular, Governors noted the improved performance around cancer waits in some areas and data completeness. 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

6.8.3 Statement from Local Healthwatch Organisations

Statement from Healthwatch Swindon dated 16 May 2014

Healthwatch Swindon is pleased to have worked with the Trust and welcomes the opportunity to comment on the Trust's Quality Account Report for 2013/14.

Healthwatch Swindon has been represented in a number of its forums during 2013/14, including the safeguarding forum, nutrition steering group and cancer users group.

We also established firm working arrangements with the PALS, customer service and communication teams in order to manage our new role as provider of independent complaints advocacy for NHS complaints and to pass on comments and feedback from local people.

We acknowledge the work undertaken by Trust staff to maintain and improve the quality of service provided in the acute hospital. However we have been concerned about a number of communication-related issues brought to our attention during the year.

Healthwatch Swindon will be monitoring progress on the Trust identified priorities for improvement during 2014/15 as well as drawing attention to other issues and comments brought to us.

We will be developing these relationships further during 2014/15 particularly with and through the Governors as elected representatives of local people in Trust membership.

Pete Rowe
Manager
Healthwatch Swindon

Statement from Healthwatch Wiltshire dated 15 May 2014

Healthwatch Wiltshire welcomes the opportunity to comment on Great Western Hospitals NHS Foundation Trust Quality Account for 2013/2014. During the period Healthwatch Wiltshire was established as a new organisation to promote the voice of patients and the wider public in respect to health and social care services. As such, Healthwatch Wiltshire has sought to develop a relationship with the Trust in order to understand its approach to patient and carer engagement and to satisfy itself that the Trust takes seriously all feedback from the people it serves.

The Quality Account references the unannounced inspection which was undertaken by the Care Quality Commission in November 2013. The Trust was found not to be fully meeting three of the standards in relation to cleanliness, staff numbers, and checks on quality (to assure health, welfare and safety of patients). Healthwatch Wiltshire notes that the Trust has worked hard to put in place an improvement plan and is currently implementing this (due for completion in May 2014) and is reporting regularly on progress. Healthwatch Wiltshire is pleased to support the Trust in its efforts to check the quality of the environment (particularly in respect to cleanliness) having been invited by the

Trust to nominate volunteers to take part in PLACE visits (PLACE stands for 'Patient Led Assessment of the Care Environment').

The Trust reports on four incidents which are called 'never events' on the basis that they should never occur. The first two (which occurred in April and August 2013) resulted in an investigation and a report with recommendations. It is rather troubling therefore that a further two 'never events' occurred in February 2014. All of the 'never events' happened in the maternity department. Following the events in February the Trust has commissioned an external investigator to look into what happened and a report will be published in May 2014. Healthwatch Wiltshire welcomes this approach because it is important that local people feel confident that the Trust is responding to such incidents in a robust manner. We also note and welcome the Trust's 'rolling audit' of previously closed serious incident investigations (including 'never events') in order to ensure that there is a change of practice following learning from such incidents.

The Trust describes its priority for improving patient experience and reducing complaints. In particular Healthwatch Wiltshire is pleased that the Trust has involved customers in the development of a new complaints system which will be put in place in early 2014/2015. There was a target for reducing the number of complaints and this has been achieved. Formal complaints are one way the Trust can find out about patient experience however there are other methods including the Friends and Family test. This is a valuable way to pick up positive and 'mediocre' experiences (i.e. experiences which may not result in a complaint but would nonetheless be of interest to the Trust). Healthwatch Wiltshire notes the 'good' score which the Trust is achieving on its Friends and Family test.

The Trust has set out a number of priorities for 2014/2015 and one of these is in respect to patient experience. Healthwatch Wiltshire will work closely with patients, carers, and the wider community to help support the Trust in meeting its targets against the priority areas. Furthermore, Healthwatch Wiltshire recognises that the wider health care community has a role to play in the Trust's performance and as such will take a particular interest in monitoring the partnership effort to provide patients with a seamless experience of acute and primary health services and social care services.

Patrick Wintour
Director
Healthwatch Wiltshire

Statement from Healthwatch Bath & North East Somerset dated 20 May 2014

Healthwatch Bath and North East Somerset are pleased to endorse the comments by Healthwatch Swindon and the opportunity to comment on the Trust's Quality Account Report for 2013/14.

Healthwatch has been represented in a number of its forums during 2013/14, including the safeguarding forum, nutrition steering group and cancer users group.

Healthwatch also established firm working arrangements with the PALS, customer service and communication teams in order to manage our new role as provider of independent complaints advocacy for NHS complaints and to pass on comments and feedback from local people.

Healthwatch acknowledge the work undertaken by Trust staff to maintain and improve the quality of service provided in the acute hospital. However we have been concerned about a number of communication-related issues brought to our attention during the year.

Healthwatch Bath and North East Somerset will be monitoring progress on the Trust identified priorities for improvement during 2014/15 as well as drawing attention to other issues and comments brought to us.

Healthwatch Bath and North East Somerset hope to develop better relationships with the Trust during 2014/15 particularly with and through the Governors as elected representatives of local people in Trust membership.

P Afoster

General Manager
The Care Forum

6.8.4 Health Overview and Scrutiny Committee Statement

Statement from Swindon Health Overview & Scrutiny Committee dated 13 May 2014

The Swindon Health Overview & Scrutiny Committee is encouraged by the work that is already being undertaken to improve services for quality improvement.

The Health 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 2013/14.

The Committee welcomes attendance and regular reporting at its committee meetings and hopes that this will continue throughout 2014/15, albeit under a new Committee structure.

The Committee supports the areas for Quality Improvement and looks forward to continuing to work with the Great Western Hospital NHS Foundation Trust to provide improving health services for the residents of Swindon and the region.

S Smith

Sally Smith
Overview & Scrutiny Officer
Swindon Borough Council

6.9 Independent Auditors Report to the Council of Governors of Great Western Hospitals NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of Great Western Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Great Western Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2014 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2014 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Clostridium Difficile – all cases of Clostridium Difficile positive diarrhoea in patients aged two years or over that are attributed to the Trust; and
- 62 Day cancer waits – the percentage of patients treated within 62 days of referral from GP.

We refer to these national priority indicators collectively as the "indicators".

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by 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; and.*
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports.*

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 2013 to May 2014;
- Papers relating to Quality reported to the Board over the period April 2013 to May 2014;
- Feedback from the Commissioners dated May 2014;
- Feedback from local Healthwatch organisations dated May 2014;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, 2013/14;
- The 2013/14 national patient survey*;*
- The 2013/14 national staff survey*;*
- Care Quality Commission intelligent monitoring reports 2013/14; and
- The 2013/14 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 Great Western Hospitals NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2014, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Great Western Hospitals NHS Foundation Trust for our work or this report save 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.
- Reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact 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 thereof, 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 non-mandated indicators which have been 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 2014:

- 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 above; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual.*

KPMG LLP

KPMG LLP
Chartered Accountants
100 Temple Street
Bristol
BS1 6AG
28 May 2014

7 STAFF SURVEY REPORT

7.1 Our staff

We are very proud of our staff who work incredibly hard and are committed to providing the highest care possible to our patients and their carers. As a Trust we are committed to being an exemplar employer 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.

As an organisation that provides a public service, we have also focused on ensuring that our staff have the right knowledge and skills to provide high standards of care to our patients and their carers but also the right values so that they provide care in a compassionate way to local people.

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.

We have been trying to engage with our staff in a different way over the course of the year so that they are more involved in organisational change at an early stage and also so that we are actively getting staff ideas and suggestions on ways to deliver care differently.

At the end of February 2014 we had 5,241 staff in the organisation. The breakdown by professional group is listed below.

	Headcount of Staff
Admin & Clerical	1024
Allied Health Professionals	414
Medical and Dental	469
Midwives	362
Non-Clinical Support	162
Registered Nursing	1527
Scientific, Therapeutic & Technical	296
Senior Managers	92
Support Staff	189
Unregistered Nursing	718
Total Trust	**5241**

7.2 Staff satisfaction

We recognise that a more satisfied and motivated workforce provides better patient care. Therefore the Trust places a great deal of 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 2014 benchmarks the Trust as fifth across 23 Trusts in the South West of England, including Royal Berkshire, Oxford. Last year the Trust benchmarked in third position so this is a downward trend.

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 28 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 13 out of 28 indicators including staff motivation levels, training, appraisals and equal opportunities for promotion.

We are better than average for 4 out of 28 indicators including work related stress and agreeing that their role makes a difference to patients. We are average for 2 out of 28 indicators relating to effective team working and reporting good communication between senior management and staff. The Trust are worse than average in 9 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.

Following our year's staff survey results, the Executive Committee and Trust Board will receive a presentation in March so that we can determine which areas to focus on so that we could improve the experience of our staff. Each directorate will be provided with a staff survey information pack which sets out the key priorities for the Trust and directorate and how these are aligned to the People Strategy.

We recognise that we need to continue to focus on recruiting staff with the qualities we value – service, teamwork, ambition and respect. We are also focused on ensuring we do all we can to support the health and wellbeing of staff and making sure staff feel safe and supported to raise concerns .

Staffing
We are all extremely busy, so it is not surprising that the majority of staff (76%) said we need more pairs of hands. Our recruitment drive means we have almost 100 more nursing and midwifery staff than we did this time last year, however we still need more. Recruiting nurses in particular is a real challenge for the whole NHS due to a national shortage. However, we are doing all we can, even going as far afield as Spain, Portugal and Ireland and this effort will continue until we have the staff we need, in the places we need them.

Teamwork
There has been a slight reduction in teams having a shared set of objectives (76%) which is essential to ensure we are all working towards the same goal. Fewer staff also said that they had to communicate closely with other team members to achieve team objectives (76%).

Health and wellbeing of staff
We cannot deliver high quality care without healthy staff and therefore we need to focus on reducing any *work related stress.* As we are busier than ever, *we also need to ensure we give staff the time and support to care for themselves. Around six in every ten staff say their manager takes a positive interest in their health and wellbeing – we want all staff to feel this. The Trust has a range of free services including counselling sessions, physiotherapy treatment, health and wellbeing checks, free eye tests, gym discounts and flu jabs for staff.*

Raising concerns and feeling informed about errors, incidents and near misses
Only half of staff said they are informed when things go wrong (52%). On rare occasions errors can occur and it is important that we are open about these, by telling patients what has happened and explaining what action will be taken. It is only by being open and sharing mistakes that we learn and take action to prevent the same thing happening again.

Although nine out of every ten staff reported incidents which they thought could cause harm, some staff are still not speaking up. We therefore need to focus on encouraging staff that when they are concerned about something they need to say something at the earliest opportunity. Any concerns raised will be treated confidentially and with discretion. We are also committed to sharing any changes made as a result of your feedback.

7.3 Summary of staff survey results

Table - Response Rate

2012		2013		Trust Improvement/ Deterioration
Trust	National Average	Trust	National Average	
63%	50%	67%	49%	4% improvement

Table – Summary of Performance

	2012		2013		Trust Improvement/ Deterioration
Top 4 Ranking Scores	Trust	National Average	Trust	National Average	
Question: KF19. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months (the lower the score the better)	25%	24%	20%	24%	5% improvement
Question: KF7. Percentage of staff appraised in the last 12 months (the higher the score the better)	86%	78%	92%	84%	6% improvement
Question: KF9. Support from immediate managers (the higher the score the better)	3.63	3.61	3.75	3.64	0.12 improvement
Question: KF8. Percentage of staff having well structured appraisals in the last 12 months (the higher the score the better)	35%	36%	44%	38%	7% improvement

	2012		2013		Trust Improvement/ Deterioration
Bottom 4 Ranking Scores	Trust	National Average	Trust	National Average	
Question: KF18. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months (the lower the score the better)	28%	30%	32%	29%	4% deterioration
Question: KF3. Work pressure felt by staff (the lower the score the better)	3.03	3.08	3.16	3.06	0.13 deterioration
Question: KF14. Percentage of staff reporting errors, near misses or incidents witnessed in the last month (the higher the score the better)	92%	90%	88%	90%	4% deterioration
Question: KF6. Percentage of staff receiving job relevant training, learning or development in the last 12 months (the higher the score the better)	81%	81%	79%	81%	2% deterioration

7.4 Staff consultation and engagement / other consultations

The GWH 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 4, Oonagh Fitzgerald, Director of Workforce & Education facilitated a 'Managing Change Effectively' workshop with Employee Partnership Forum members, HR colleagues and senior managers from across the Trust.

Teresa Harding, General Manager for Women & Children attended the workshop and said:

"The workshop was a good opportunity to work with the Employee Partnership Forum colleagues and understand things from their perspective. EPF can help and support management teams with implementing changes. One of the main actions I've taken away from the workshop is to involve EPF colleagues earlier to ensure effective change management processes"

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.

Our Chief Executive, Nerissa Vaughan continues to hold Open Meetings with staff across the Trust sites which are appreciated by staff. Further a feedback process called 'Ask Nerissa' continues to enable staff to email her directly about their concerns and questions on issues affecting them.

We are committed to dealing responsibly, openly and professionally with any genuine concerns raised and want staff to feel empowered to raise concerns with earliest opportunity. With this in mind the Trust launched a '***See something, say something' campaign to all staff in September 2013. This campaign encourages staff to raise any concerns they may have at an early stage and confirms a number of ways in which they can do this.***

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 4.18% at the end of the year which is an increase from 4.06% for last year. Work continues to support staff who have musclo skeletal disorders and those who are experiencing stress at work or through personal problems through our Staff Counselling Service. .

Turnover - Voluntary turnover at the end of the year was 9.06%.

Vacancy levels - We ended the year with 285 vacancies which equates to 6.07% of our total staffing levels. This year we successfully conducted a large international recruitment campaign where we recruited over 70 qualified nurses and midwives from Ireland, Spain and Portugal to ensure we have enough staff to look after our patients. We continue to work with local Universities to ensure we have jobs for the best students.

Appraisal rates - The overall rate for the Trust is 74.24%. 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 continues to be committed to encouraging and supporting staff, students and trainees with ongoing learning and development.

The Academy has been successful in encouraging staff to engage with mandatory elements of training with mandatory training compliance now at its highest ever at 89%. Quality assurance and audit have revealed that retention of knowledge needed to be improved, therefore workshop scenario based sessions are now run for a number of modules. Changes in the training need analysis and monthly reports to managers have contributed to a higher than ever compliance rate.

The Academy continues to train in a number of locations across the county improving facilities in Warminster, Chippenham and Savernake Hospitals. Simulation activity has increased with investment in a state of the art simulation suite where staff and students can safely learn to perfect skills in a realistic environment, using the latest sim-man, sim-baby and maternity sim.

The aim of the Academy is to support the current and future workforce of all disciplines to gain knowledge, skills and understanding which will enable them to deliver empathetic care of the highest quality to our service users, now and in the future. The Academy listens to feedback from service users and inspectors and firmly links educational aims to service delivery, striving for excellence in both delivery of clinical care and overall patient experience.

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

- The Academy course portfolio has expanded to include PACE – Physical Assessment and Clinical Examination. To improve the skills of staffing quick and accurate decision making, when caring for our service users.
- A range of new regional study days have been developed and delivered to prepare our staff for new future challenges in healthcare including falls and communication difficult circumstances.
- The development of a band 1-4 course, including Academy clinical supervision of those new in these roles has allowed development of unregistered role models who can deliver a more responsive service.
- Support of those from overseas with a reactive overseas programme tailored to the needs of these staff and feedback from the service users. This includes communication and terminology elements as well as a programme of clinical supervision to allow individual support.
- Our Continuing Professional Development (CPD) spend is now firmly aligned to service requirement with a panel made of key managers from each Directorate determining it's spend.
- An increased investment into Resuscitation Officers has ensured that there will be improved clinical support as well as dedicated time for community projects such as the project to examine and change the way we make and review 'Do not resuscitate orders' to recognise the complexities of end of life care across the community
- Experiences are continually measured after an educational event and to identify the impact of any education once they have returned to a service area. This feedback and that of the service user is used to inform future educational approaches. This year this has revelled that over 90% feel the service has been very good or excellent.
- Support from the Academy for leadership develops with a new NHS Elect leadership development programme for emerging leaders. Project support and coaching for the 93 participating on the Transforming leadership, transforming care programme.

Work continues to strengthen the education of junior doctors with the Postgraduate team securing agreement with the Deanery to provide and run additional Leadership courses as well as the new course for Doctors from overseas.

Our library has continued to improve the quality of service offered with NHS Library Quality Assurance Framework (LQAF) peer review demonstrating compliance of 98% against a mean percentage compliance by our South West NHS library services of 95.5%.

Research and Development throughout the Trust has developed well this year with increased recruitment into more complex studies with commercial research projects increasing by 2 to 10 with a further 6 currently closed but the activity following up participants.

Generation of income from education clinical skills and resuscitation courses that can be reinvested within the Trust will be in excess of £80k this year.

A new and successful course (return to acute care) has been run this year to re-skill nurses who have been out of acute care for a number of years to re-enter the acute hospital workforce. This has been very successful with 13 out of the 18 initial participant gaining employment in the Trust and replication of the project by other Trusts in the region.

Undergraduate medical training provision has expanded this year to include 2nd year students from Bristol University. The faculty has expanded to support this with additional clinical fellow posts and a simulation post to deliver the expanding requirements of undergraduate curriculum, ensuring the quality of our future workforce. Feedback from Bristol University has been excellent; they feel that the Trust has a strong education culture in the organisation.

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 enormous 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 having the courage to leave their current employment to follow a long held dream of working in the NHS. Of course, many of our volunteers stay with us for years with some having 5, 10, 15, 20 and even 25 years or more voluntary service and each volunteer has their own personal reason for offering their time.

There remains a constant interest in volunteering within the Great Western Hospitals NHS Foundation Trust, and we interview, on average, between 40 – 50 people each month. Volunteers come through the same recruitment process as a member of staff.

In addition, 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.

A quarterly “Voluntary Service Matters” newsletter is sent to all volunteers and we hold an annual “Volunteer Social Events” (including Long Service Awards) to ensure that the volunteers are well communicated with and have an opportunity to share their ideas with us too.

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 to the most appropriate support agency in a timely manner, for example the smoking cessation team at SEQOL.

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 nurses already in post and can offer full mental health assessments on a 1 to 1 basis and also group work to support our staff. She is also working alongside the Staff Support Service, which offer the full range of counselling and support therapies.

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 a very clear 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 referrals and support offered to staff in community services.

7.10 Swine / Seasonal Flu Vaccinations

The seasonal flu campaign obtained a 58% uptake across the Trust in 2013/14 which is an increase from last year when we achieved 46%.

7.11 Health and Safety

Last year we continued to drive improvements across the Trust's Health and Safety (H&S) management system. The implementation of the same Incident Management system across all community sites and the introduction of the Safeguard electronic incident reporting process has significantly sped up and improved the quality of reports and investigations.

Further major targeted achievements this year have included:

- Implementation of a 'Smart Survey' based H&S self-audit system within GWH Acute Hospital and 50% of Community based departments. This has enabled departmental H&S evidence to be posted and verified and Quality based against NHSLA requirements whilst remainder continued with face to face process.

- Sustained fire safety management improvements in maintaining a reduction in unwanted fire signals at GWH to only 33 Fire Service call-outs which was the same as last year and is an extremely low number for an acute hospital of this size and was achieved in partnership with Carillion. The comprehensive fire safety warden training programme has also continued across the Trust.

- Significant reduction in serious RIDDOR reportable accidents for the Trust from 9 last year to only 5 for this year. The community contribution to this total RIDDOR accident number also fell significantly from 7 last year to only 1 this year.

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.

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 replaces 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.
Monitoring Quarterly and annually where available/necessary (e.g. for staff/patient surveys)	

8.8 Risk Ratings 2013/14

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 2012/13	Q1 2012-13	Q2 2012-13	Q3 2012-13	Q4 2012-13
Under the Compliance Framework					
Financial Risk Rating	**3**	3	3	3	3
Governance Risk rating	**Green**	Green	Amber/Green	Green	Amber/red

	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

8.8.1 Explanation for differences in actual performance versus expected performance at the time of the annual risk assessment

Quarter 1

In Quarter 1 the Board anticipated that the Trust would continue to maintain a financial risk rating of at least 3 over the next 12 months based on the current 2013/14 compliance Framework.

The Board confirmed that there were no matters arising in the quarter requiring an exception report to Monitor (per the compliance framework) which had not already been reported.

The Board was not satisfied that plans in place were sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set in the Risk Assessment Framework and a commitment to comply with all known targets going forward. This was in view of the failure to achieve the A & E 4 hour wait target in Q1. Actual performance was 94.1% against a target of 95%. A plan was put in place in March 2013 to ensure that all patients were seen within 4 hours by the end of May. In addition, the Trust had reported 5 cases of clostridium difficile against a trajectory of 5 for Quarter 1. The Trust initiated an external Infection Prevention and Control peer review in December 2012. This review was completed and further work continued within the annual IP&C work plan to support the Trust in maintaining its 2013/14 Clostridium difficile target. Furthermore, following an unannounced CQC visit during December 2012 to inspect Maternity Services, the Trust was deemed not fully compliant with two outcomes. An action plan was developed and progress made toward assuring full compliance with these two outcomes.

Quarter 2

In Quarter 2 the Board was unable to confirm that it anticipated that the Trust would continue to maintain a continuity of service risk rating of at least 3 over the next 12 months. ***As a PFI hospital the Trust can only achieve a rating of 2 and therefore will not be able to confirm the finance declaration rating of 3. In year the Trust was expecting to be recognised as a 2* which means the level of risk is material, but the Trust is stable.***

The Board confirmed that there were no matters arising in the quarter requiring an exception report to Monitor which had not already been reported.

The Board was satisfied that plans in place were sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set in the Risk Assessment Framework and a commitment to comply with all known targets going forwards.

Quarter 3

In Quarter 3 the Board was unable to confirm that it anticipated that the Trust would continue to maintain a continuity of service risk rating of at least 3 over the next 12 months.
The Board confirmed that there were no matters arising in the quarter requiring an exception report to Monitor which had not already been reported.
The Governance Committee had discussed the plans that were in place regarding targets and on its recommendation, the Board confirmed that taking into consideration the performance on C.diff and A&E 4 hour target 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 the Risk Assessment Framework and a commitment to comply with all known targets going forwards.

Quarter 4

In Quarter 4 the Board was unable to confirm that it anticipated that the Trust would continue to maintain a continuity of service risk rating of at least 3 over the next 12 months.
The Board confirmed that there were no matters arising in the quarter requiring an exception report to Monitor (per the Risk Assessment Framework) which had not already been reported.
The Board discussed the performance against C.diff and A&E 4 hour target and the actions being taken to recover the position and thereafter agreed 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 Risk Assessment Framework and a commitment to comply with all known targets going forwards.

8.8.2 Details and actions from any formal interventions.

The Trust had no formal interventions during 2013/14.

8.9 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.

8.9.1 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 1st 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 previous years is therefore to be treated with considerable care.

Each IG SIRI is graded as either:

(a) Lower severity Level 1 – to be reported statistically in the Annual Report, or

(b) Higher severity Level 2 – to be reported to the Information Commissioner's Office and detailed individually in the Annual Report.

During 2013/14 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 2013/14 there were a total of 83 such incidents.

Summary of other personal data related incidents in 2013/14 (severity Level 1)		
Category	**Nature of incident**	**Total**
A	Corruption or inability to recover electronic data	0
B	Disclosed in error	42
C	Lost in transit	3
D	Lost or stolen hardware	0
E	Lost or stolen paperwork	28
F	Non-secure disposal – hardware	0
G	Non-secure disposal – paperwork	3
H	Uploaded to website in error	0
I	Technical security failing (including hacking)	4
J	Unauthorised access/disclosure	2
K	Other	1

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. There were no incidents of paperwork being stolen.

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.

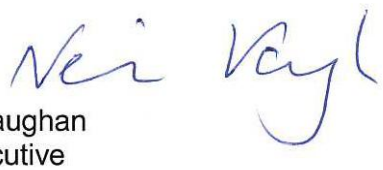
Under the NHS Act 2006, Monitor has directed Great Western Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the 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

28 May 2014

12 AUDITOR'S OPINION AND CERTIFICATE

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

We have audited the financial statements of Great Western Hospitals NHS Foundation Trust for the year ended 31 March 2014 on pages 213 to 250. These financial statements have been prepared under applicable law and the NHS Foundation Trust Annual Reporting Manual 2013/14.

This report is made solely to the Council of Governors of Great Western Hospitals NHS Foundation Trust 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.

Respective responsibilities of the accounting officer and the auditor

As described more fully in the Statement of Accounting Officer's Responsibilities on page 191 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 Auditing Practice's Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed, the reasonableness of significant accounting estimates made by the accounting officer and the overall presentation of the financial statements.

In addition we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

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 2014 and of the Group's and the Trust's income and expenditure for the year then ended; and
- have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2013/14.

Opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts

In our opinion 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.

Matters on which we are required to report by exception

We have nothing to report where 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 2013/14, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

We are not required to assess, nor have we assessed, whether all risks and controls have been addressed by the Annual Governance Statement or that risks are satisfactorily addressed by internal controls.

Certificate

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.

Jonathan Brown for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
100 Temple Street
Bristol
BS1 5SW

28 May 2014

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.

Staff education and training on risk management is carried out commensurate with their 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. In addition during 2013/14, further training on risk management was provided to staff across directorates with over 120 staff receiving refresher training on risk management. In addition an easy "How to manage risk" guide was published to help staff identify, manage and record risks. The electronic system for compiling and managing risk continues to be rolled out. Particular emphasis is being given to the identification and management of risk at a local level. Members of the Corporate Governance Team

13.4 The risk and control framework

13.4.1 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

13.4.2 Risk assessment

All trust staff are responsible for identifying and managing risk. In addition there is a robust Incident Management Policy in place and at corporate induction staff are actively encouraged to utilise our web-based incident reporting system. A healthy incident reporting culture has been maintained for a number of years providing assurance that staff feel able to report incidents and risks. A Being Open Policy, based on National Patient Safety Agency guidance, is in place and regularly reviewed. 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.

In addition, as part of the refresher training in 2013/14, there was a strong focus on thinking differently around risk identification and assessment with teams being asked to consider what might be preventing them doing their jobs effectively and discussions on risks verses business as usual. New risks were identified for management.

13.4.3 Risk Register

The Trust has agreed that the most significant risks to the Trust, being those which score 15 and above 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 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 in the Board Assurance Framework (top down) and risks identified from within the directorates (bottom up).

In addition, in 2013/14 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 directorate meetings and there is a strong focus on managing all risks is in place, although recording action needs to be kept up to date

13.4.4 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 January 2014 granted the Trust substantial (green) assurance on the design and implementation of the board assurance framework. 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.

13.4.5 Significant Risks

There are a number of risks identified on the board assurance framework and risk register. Examples of significant risks identified during 2013/14, together with the actions that have been taken to mitigate them are summarised as follows: -

Risk	How risk was mitigated
Failure to have effective risk management processes	• Update made to Board Assurance Framework • Refresher training on how to managing risk rolled out across directorate • How to Manage Risk easy guide produced and circulated • Safeguard risk management system reconfigured to include additional fields and mandated fields • 12+ risk register reviewed by Executive and Audit, Risk and Assurance Committees
Lack of capacity to meet demand in Ophthalmology Services	• Royal College Review of Ophthalmology Services • Modelling of capacity verses demand / future sustainability considered • Workforce and accommodation planning • Engagement with staff groups • Establishment of overarching steering group, with sub groups for specific areas • Discussions with Clinical Commissioning Groups about future services
Failure to develop talent and experience within the Trust will jeopardise our ability to deliver in a changing market	• Implemented leadership programme and talent management / succession planning for senior managers • Brought in external support to assess middle management against management standards • Introduction of tailored development programme
Failure to meet 95% ED 4 hour wait target	• Review systems and processes in minors to improve care flow and instances of breaches in minors • ECIST invited in to undertake review and recommend areas for improvement • Monthly reporting to Executive Committee and Trust Board

Assurances and gaps in those assurances have been identified during 2013/14. Assurances and gaps are sought from a variety of sources including audits, external reviews or peer challenge. As at the end of March 2014, there were 36 gaps in assurances identified. This compared with 17 gaps at the end of 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 2014/15 have been identified through the annual plan process and will be added to the Assurance Framework. Major future risks, including significant clinical risks for 2014/15 include the following: -

TABLE – Examples of Future risks

Risk	Actions to manage and mitigate, including how outcomes will be assessed
Risk of change fatigue responding to both national and local drivers	• Consolidating and embedding the change already in place, delivering the benefits of recent initiatives before taking a more considered approach to prioritising new initiatives to reduce any detrimental impact too much change can have on staff. • Development and roll out of strategies to meet future challenges (People Strategy; Quality Strategy; Clinical Strategy; Infrastructure Strategy (IT, Estates, Business Intelligence); Medium Term Viability (finance, performance and commercial approach) • Each strategy feeds into an overarching Integrated Business Plan which is being developed. • Strategic plans and projects will add support.
Risk of continued high agency staff costs to cover vacancies and activity pressures	• An international clinical recruitment to include overseas recruitment will be rolled out • New E-Rostering system to be rolled out.
Risk of not being able to balance demand and capacity challenges	• Seek to increase the use of alternative services to reduce the need for admission in the first instance. • Look to expand the number of ambulatory care conditions which can be seen, treated and discharged from this service by 10-15% which would release the equivalent capacity of 76 beds. • 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 not achieving key quality indicators (quality and performance levels)	• Learn from the NHS Emergency Care Intensive Support Team (ECIST) which is working with us delivering an improved position measured against the four hour access target, the aim being to focus on improving performance, quality assurance and programme enhancement. • To deliver the recommendations which come out of the ECIST Review to place us and the system in a stronger position ahead of next winter.
Risk that some specialities are not sustainable	• Use advice from the independent review by KPMG of what specialities are particularly vulnerable and therefore a sustainability risk to shape future plans and inform decision making about new opportunities to support our focus on sustainability.
Risk of the unrelenting focus on poor quality in the NHS in the media seriously impacting on staff morale and the ability for the Trust to recruit, retain and motivate staff	• Staff engagement • See Something, Say Something Campaign • Action plan to address staff survey results • STAR values / STAR awards and staff recognition

13.4.6 Organisation Culture

The Trust promotes a culture of putting the patient at the forefront of everything we do. 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. In 2014/15 the Family and Friends Test will be rolled out to staff and additional questions will be included focussing on making improvements.

The Trust has mechanisms in place to promote a culture in which staff 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 staff to come forward with concerns. Action continued in 2013/14 to further embed an openness culture. A "See Something, Say Something Campaign" was launched to encourage staff to come forward with any concerns. In addition there was a focus around "nipping problems in the bud" instead of using formal HR policies, such as grievance and capability to solve issues.

The Trust takes part in an annual staff survey (*Section 7 – Staff Survey Report refers*). For 2013/14 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 2013/14 the People Strategy was developed and this will be rolled out over the coming years.

The Trust has an Incident Management Policy whereby staff are required to report incidents and near misses. This helps the Trust to learn and make improvements when things go wrong. The levels of reporting of incidents and near misses at our Trust is comparable with similar trusts.

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 2.11.3 – Social and community rights issues refers*).

During 2013/14 the Trust rolled out a programme of training and workshops to further embed a risk management culture throughout the organisation.

13.4.7 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 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.

13.4.8 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 2013/14, the Council of Governors agreed priority areas for focus and a series of presentations about how the Board manages these is planned over the next two years.

The governors contributed to the development of the Trust's strategy via a joint workshop with the Trust Board, through informal discussions with the Chairman and via a formal Council of Governors meeting 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.

In 2013/14 a joint seminar was held with Swindon Clinical Commissioning Group, Wiltshire Clinical Commissioning Group and our Trust to share thoughts on strategy development and visions to ensure joined up thinking in approach and priorities. A further joint event is planned for June 2014.

13.4.9 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.

In September 2011, the Trust introduced revised arrangements 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.

In 2012/13 the Trust commissioned an independent assessment of compliance with Monitor's Quality Framework. The assessment was satisfactory, however a number of areas for improvement were

identified and during 2013/14 action has been underway to address these. Shortly after this review, in April 2013, Monitor published guidance on questions the Trust should ask itself to gain assurance that the Trust is a quality focused organisation.

The Trust uses its Board Assurance Framework and Risk Register as tools to ensure risks are managed, including risks to quality. However, during 2013/14 the Trust has worked to develop 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 the independent assessment, 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.

13.4.10 Internal CQC Compliance Assessment arrangements

Internal processes for assessing compliance against the CQC and Health and Social care Act 2008 (Regulated Activities 2010) are led by the Regulatory Compliance Group (RCG) which meets on a monthly basis. The Trusts internal compliance judgement is informed by a range of information, including the CQC's Intelligence Monitoring Tool (which has replaced the Quality and Risk Profile), and many other accessible sources of intelligence including internal and external inspections.

Internal judgement of compliance is being restructured to reflect the CQC's 'New Wave' inspection framework. The Intelligence Monitoring Tool is now actively used to sign post for specific improvements made and further investigations and subsequent actions required. These improvement plans are monitored centrally by the Quality Team. Gaps in compliance identified either internally or externally inform the Patient Safety Committee, Governance Committee and Trust Board. Action plans are developed and monitored to ensure improvements are progressed. Risks identified from the internal compliance assessment process and risks arising from within the directorates, inform the relevant risk registers and are linked to the CQC outcomes where appropriate.

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

13.4.11 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.

Condition requirement	Controls	Risk
Good systems of governance	The Trust has a Board of Director comprised of (7) Non-Executive and (5) Executive 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.	
Establishment and implementation of: - (a) effective Board and committee structures; (b) clear responsibilities for the Board, for committees and for staff reporting to the Board and those committees; (c) clear reporting lines and accountabilities throughout the organisation	(a) The Board has agreed a schedule of powers it reserves for itself *"Powers Reserved to the Board"* and this is refreshed annually. (b) Sitting under the Board are a number of committees, each with areas of responsibility. These committees are 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 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. An exercise was undertaken in 2013/14 to map these 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	During the year as part of its inspection, the Care Quality Commission raised concerns regarding arrangement to enable reporting from ward to board in relation to patient quality and safety including medicines management, incidents and infection control. As part of the action plan, the Terms of Reference of the Patient Safety Committee, the Patient Experience Committee, the Medicines Management Group and the Infection Prevention and Control Committee were reviewed to ensure their effectiveness and reporting arrangements. A further review of reporting structures is planned during 2014/15 to develop the decision making framework and to reflect again that all areas of Trust business have a mechanism whereby issues can be escalated to the Board and messages from the

Condition requirement	Controls	Risk
	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 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.	Board can be disseminated. An issue identified at year end 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. Therefore a training programme will be rolled out in 2014/15 to improve understanding. In 2013/14 a risk was identified around the need to ensure clinical guideline are accessible and kept up to date. An exercise was undertaken whereby a doctor working group was established to co-ordinate and review clinical guidelines which are now stored in alphabetical order on the Trust's intranet. There is further work to do during 2014/15 to review and update nursing clinical guidelines. In 2013/14 it was identified that a potential risk was lack of Non-Executive Director oversight of achievement of outcomes and delivery of performance objectives. Therefore, the Terms of Reference of the Finance and Investment Committee were expanded to include performance to plug this gap, with a particular focus on finance. In 2014/15, this will be

Condition requirement	Controls	Risk
		reviewed again to change the emphasis to overseeing the management of performance and formalised processes for board assurance that business plans are delivered will be established.
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 directorates to prepare a business plan 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. In developing the overall Trust Strategy numerous workshops and meetings are held to build on ideas, specifically considering what is right for our local community. These sessions involve governors, managers and Board members. In 2013/14 the Trust engaged a consultant who worked with the Board to develop the Trust Vision and 5 year plan. In the latter part of the year, the Trust appointed a Director of Strategy as a dedicated resource to lead on the development, roll out and implementation of the Trust Strategy and to oversee that business plans are delivered. 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.	In 2013/14, it was considered that timely information at ward level is needed, presented in an understandable and usable form to assist managers in the management of their wards. During the year a *"Nursing Dashboard"* has been developed. There is further work to do to improve the accessibility of the dashboard and surveys of data dissemination and usefulness are currently underway to better understand what is needed. In addition, the Board has identified the need for a comprehensive performance report each month. The Trust has considered possible options and this will be rolled out in 2014/15.
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	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	

Condition requirement	Controls	Risk
and there is accountability for quality of care.	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.	

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 (two year plan in 2014/15) 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 directorate business plans which detail specific objectives and milestones to deliver actions. To ensure delivery of the planned action, there is continual review of progress against directorate business plans within directorates and cost savings plans are scrutinised by the Finance and Investment Committee to ensure achievement (whilst maintaining and improving quality and safety). In 2014/15 the remit of the Finance and Investment Committee has been expanded to formally include performance monitoring to ensure there is high level overview of performance management. 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;
- 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 and Investment 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 and Investment 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.

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 Medical Director is the Executive lead for the Quality Account with designated personal leadership for patient safety and quality on behalf of the Trust Board. In 2013/14 the Trust approved a refreshed Quality Improvement Strategy which provides details on roles and responsibilities for quality and safety and defines the key focus for the Annual Quality Accounts.

- The Annual Quality Account Report 2013/14 provides a narrative of progress toward achieving the quality improvement indicators agreed by the Executive Committee, the Patient Safety Committee and the Trust Board.

- The Trust has a robust process for scrutinising and revising local policies and monitoring compliance with NICE and other best practice guidelines. Annual audit programmes include the assessment of compliance with best practice guidance at both local and national level. This provides assurances to the Board that the quality of clinical care provided is based on the best clinical practice recognised nationally and that policies are up to date, appropriate and meet our legislative obligations.

- The Quality Account is compiled by a Clinical Governance Administrator 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. Once compiled the Quality Account Report is scrutinised by the Associated Director of Quality and Patient Safety for challenging the veracity of data. The Medical Director 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 a Patient Safety 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 Patient Safety 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.

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.
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	- On 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.
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 March 2014 provided substantial assurance 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.

Self-assessment declaration against CQC standards	-	The Trust has self-assessed compliance with the CQC regulations. There have moderate concerns with compliance with the CQC regulations for which is it registered, but action plans are in place to address moderate and minor concerns. External NHSLA Risk Management Standards (Acute) – level 2 (November 2012) External CNST Risk Management Standards (Maternity) – level 2
Quarterly reporting to Monitor	-	Declarations are considered by the Executive Committee and Finance and Investment Committee and thereafter approved by the Board on a quarterly basis prior to submission 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

28 May 2014

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 2014

These accounts for the period ended 31 March 2014 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.

Great Western Hospitals NHS Foundation Trust
Accounts for the year ended 31 March 2014

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2014

		Group		Trust	
		Year Ended 31 March 2014	Year end 31 March 2013	**Year Ended 31 March 2014**	Year end 31 March 2013
	Notes	**£000**	£000	**£000**	£000
Operating Incomes from continued operations	3 - 4	**308,102**	303,429	**307,799**	302,962
Operating Expenses of continued operations	5	**(309,167)**	(275,776)	**(308,699)**	(275,766)
Operating surplus/(deficit)		**(1,065)**	27,653	**(900)**	27,196
Finance Costs					
Finance income	10	**280**	313	**280**	313
Finance expense - financial liabilities	11	**(15,471)**	(15,088)	**(15,471)**	(15,088)
Finance expense - unwinding of discount on provisions		**(38)**	(40)	**(38)**	(40)
Public Dividend Capital Dividends payable		**(1,094)**	(1,415)	**(1,094)**	(1,415)
Net finance costs		**(16,323)**	(16,230)	**(16,323)**	(16,230)
Movement in fair value of investments	33	**22**	74		
SURPLUS/(DEFICIT) FOR THE YEAR		**(17,366)**	11,497	**(17,223)**	10,966
Other comprehensive income					
Items that are not subsequently reclassified to income and expenditure					
Gain from transfer by absorption from demising bodies	25	**34,848**	0	**34,848**	0
Revaluation	13.3	**(3,164)**	1,933	**(3,164)**	1,933
Total comprehensive income for the year		**14,318**	13,430	**14,461**	12,899
Note:					
Surplus/(deficit) for the year as shown above		**(17,366)**	11,497	**(17,223)**	10,966
Less net impairment gain charged to Operating Income	13.3	**17,463**	(7,294)	**17,463**	(7,294)
Adjust for (surplus)/deficit on Charitable Funds consolidation		**143**	(531)		
Surplus before impairments and consolidation of Charity		**240**	3,672	**240**	3,672

All income and expenditure is derived from continuing operations.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2014

	Notes	Group 31 March 2014 £000	31 March 2013 £000	1 April 2012 £000	Trust 31 March 2014 £000	31 March 2013 £000
Non-Current Assets						
Intangible assets	12	**1,094**	1,347	1,162	**1,094**	1,347
Property, Plant and Equipment	13	**205,333**	185,952	179,122	**205,333**	185,952
Other investments	15	**820**	738	664	**0**	0
Total non-current assets		**207,247**	188,037	180,948	**206,427**	187,299
Current Assets						
Inventories	16	**5,779**	5,362	4,839	**5,779**	5,362
Trade and other receivables	17	**20,969**	17,127	13,577	**21,098**	17,277
Cash and cash equivalents	19	**4,891**	11,447	14,636	**4,438**	10,718
Total current assets		**31,639**	33,936	33,052	**31,315**	33,357
Current Liabilities						
Trade and Other Payables	20	**(28,627)**	(26,007)	(24,855)	**(28,623)**	(25,942)
Borrowings	23	**(1,989)**	(5,001)	(4,533)	**(1,989)**	(5,001)
Provisions	24	**(153)**	(565)	(565)	**(153)**	(565)
Tax Payable	22	**(1,649)**	(1,672)	0	**(1,649)**	(1,672)
Other liabilities	21	**(545)**	(1,248)	(1,425)	**(545)**	(1,248)
Total current liabilities		**(32,963)**	(34,493)	(31,378)	**(32,959)**	(34,428)
Total assets less current liabilities		**205,923**	187,480	182,622	**204,783**	186,228
Non-Current Liabilities						
Trade and Other Payables	20	**0**	0	(412)	**0**	0
Borrowings	23	**(125,895)**	(123,101)	(128,133)	**(125,895)**	(123,101)
Provisions	24	**(1,733)**	(1,672)	(4,686)	**(1,733)**	(1,672)
Other Liabilities	21	**(1,588)**	(1,702)	(1,816)	**(1,588)**	(1,702)
Total non-current liabilities		**(129,217)**	(126,475)	(135,047)	**(129,217)**	(126,475)
Total assets employed		**76,707**	61,005	47,575	**75,566**	59,753
Financed by Taxpayers' Equity						
Public dividend capital		**28,895**	27,511	27,111	**28,895**	27,511
Revaluation reserve		**29,828**	20,462	18,529	**29,828**	20,462
Income and expenditure reserve		**16,779**	11,631	1,214	**16,844**	11,780
Charitable fund reserves		**1,205**	1,401	721	**0**	0
Total taxpayers' equity		**76,707**	61,005	47,575	**75,567**	59,753

Signed..... Date....
Nerissa Vaughan
Chief Executive

The notes on pages 218-250 form part of the financial statements

Great Western Hospitals NHS Foundation Trust
Accounts for the year ended 31 March 2014

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 2012 - as previously stated	**0**	**27,111**	**18,529**	**1,214**	**46,854**
Adjustment for Charitable Funds consolidation	721	0	0	0	721
Taxpayers' Equity at 1 April 2012 - restated	**721**	**27,111**	**18,529**	**1,214**	**47,575**
Surplus/(deficit) for the year	531	0	0	10,966	11,497
Transfers between reserves	0	400	0	(400)	0
Revaluation gains/(losses) and impairment losses property, plant and equipment	0	0	1,933	0	1,933
Other reserve movements - charitable funds consolidation adjustment	149	0	0	(149)	0
Taxpayers' Equity at 31 March 2013	**1,401**	**27,511**	**20,462**	**11,631**	**61,005**
Surplus/(deficit) for the year	(143)	0	0	(17,223)	(17,366)
Revaluation gains/(losses) and impairment losses property, plant and equipment	0	0	(3,164)	0	(3,164)
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)	0
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**	**76,707**

NHS Charity is separately identifiable above.

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2014

	Notes	Group Year Ended 31 March 2014 £000	Year Ended 31 March 2013 £000	Trust Year Ended 31 March 2014 £000	Year Ended 31 March 2013 £000
Cash flows from operating activities					
Operating surplus/(deficit) from continuing operations		**(1,065)**	27,653	**(900)**	27,196
Depreciation and amortisation		**8,646**	7,780	**8,646**	7,780
Reversals of impairments		**0**	(7,294)	**0**	(7,294)
Impairments		**17,463**	0	**17,463**	0
Gain on disposal		**0**	(330)	**0**	(330)
Dividends accrued and not received or paid		**0**	267	**0**	267
Increase in inventories		**(417)**	(523)	**(417)**	(523)
Increase in trade and other receivables		**(3,125)**	(3,700)	**(3,104)**	(3,700)
Increase in trade and other payables		**2,006**	2,444	**2,068**	2,444
Decrease in other liabilities		**(817)**	(177)	**(817)**	(177)
Decrease in provisions		**(389)**	(3,014)	**(389)**	(3,014)
NET CASH GENERATED FROM OPERATIONS		**22,302**	23,106	**22,550**	22,649
Cash flows from investing activities					
Interest received		**280**	313	**280**	313
Purchase of Intangible assets		**(209)**	0	**(209)**	0
Purchase of Property, Plant and Equipment		**(7,702)**	(6,870)	**(7,702)**	(6,870)
Sales of Property Plant and Equipment		**0**	330	**0**	330
Cash from acquisitions (not absorption transfers)		**0**	118	**0**	0
NHS Charitable funds - Net cash flows from investing activities		**0**	0	**0**	0
Net cash used in investing activities		**(7,631)**	(6,109)	**(7,631)**	(6,227)
Cash flows from financing activities					
Public Dividend Capital received		**884**	0	**884**	0
Public dividend capital received (PDC adjustment for modified absorption transfers of payables/receivables)		**500**	0	**500**	0
Capital element of Private Finance Initiative Obligations		**(4,983)**	(4,064)	**(4,983)**	(4,064)
Interest paid		**(50)**	(58)	**(50)**	(58)
Interest element of Finance Leases		**(31)**	(37)	**(31)**	(37)
Interest element of Private Finance Initiative Obligations		**(15,390)**	(14,993)	**(15,390)**	(14,993)
PDC dividends paid		**(2,027)**	(1,034)	**(2,027)**	(1,034)
Cash flows from other financing activities		**(130)**	0	**(102)**	0
Net cash used in financing activities		**(21,227)**	(20,186)	**(21,199)**	(20,186)
Decrease in cash and cash equivalents		**(6,556)**	(3,189)	**(6,280)**	(3,764)
Cash and cash equivalents at 1 April 2013		**11,447**	14,636	**10,718**	14,482
Cash and cash equivalents at 31 March 2014	19	**4,891**	11,447	**4,438**	10,718

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 2013/14 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.

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 fund. From 2013/14, the Foundation Trust has consolidated the charitable fund and has applied this as a change in accounting policy.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Generally Accepted Accounting Principles (UK GAAP). On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

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

The key accounting policy for the Charity is in relation to investments. The Corporate Trustee has determined the investment policy to, in so far is reasonable, avoid undue risk to the real value of the capital and income of the portfolio, after allowing for inflation. 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 occurs, and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services.

Income relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

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'.

.

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
Medical equipment and engineering plant and equipment	5 to 15
Furniture	10
Information technology equipment	5
Transport	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 Revenue Grants and other Grants

Government grants are grants from Government Bodies other than income from Clinical Commissioning Groups or NHS Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

1.10 Inventories

Inventories are valued at the lower of cost and net realisable value. Pharmacy stocks are valued at average cost, other inventories are valued on a first-in first-out basis. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks. Work-in-progress comprises goods and services in intermediate stages of production.

ACCOUNTING POLICIES (continued)

1.11 Financial instruments and financial liabilities

1.11.1 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.

1.11.2 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.

1.11.3 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.

1.11.4 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.

1.11.5 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.

1.11.6 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)

1.11.7 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.

1.11.8 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.

1.12 Trade receivables

Trade receivables are recognised and carried at original invoice amount less provision for impairment. A provision for impairment of trade receivables is established when there is objective evidence that the Trust will not be able to collect all amounts due according to the original terms of receivables. The amount of the provision is recognised in the Statement of Comprehensive Income.

1.13 Deferred income

Deferred income represents grant monies and other income received where the expenditure has not occurred in the current financial year. The deferred income is included in current liabilities unless the expenditure, in the opinion of management, will take place more than 12 months after the reporting date, which are classified in non-current liabilities.

1.14 Leases

1.14.1 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.

1.14.2 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.

1.14.3 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)

1.15 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.

1.15.1 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.

1.15.2 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.

1.16 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.

1.17 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)

1.18 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.

1.19 Corporation Tax

The Trust does not have a corporation tax liability for the year 2013/14. 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.

1.20 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.

1.21 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.

1.22 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.

1.23 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 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)

1.24 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 £182m, 2011-12 (£166m): 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 2013/14 financial year end, the estimated value of partially completed spells is £1,420k (2012-13 £1,370k)

Untaken annual leave: salary costs include an estimate for the annual leave earned but not taken by employees at 31 March 2014, to the extent that staff are permitted to carry up to 5 days leave forward to the next financial year. For 2013-14 this was £558k (2012-13 £534k).

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 2015	**Effective Date**	
IFRS 13 Fair Value Measurement	2013/14	not yet adopted by HM Treasury
IFRS 10 Consolidated Financial Statements	2014/15	
IFRS 11 Joint Arrangements	2014/15	
IFRS 12 Disclosure of Interests in Other Entities	2014/15	
IAS 27 Separate Financial Statements	2014/15	
IAS 28 Associates and Joint Ventures	2014/15	
IAS 32 Financial Instruments Presentation -amendment	2014/15	
IFRS 9 Financial Instruments	Uncertain	

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
2013-14

Operating Income	**GWH £'000**	**WCHS £'000**	**Charity £'000**	**Total £'000**
NHS Clinical Income	204,424	73,155		277,579
Private Patients	2,869	0		2,869
Other Non Mandatory/Non Protected Revenue	2,597	84		2,681
Research & Development Income	737	0		737
Education and Training Income	8,413	48		8,461
Misc Other Operating Income	9,852	5,620	303	15,775
Total Income	**228,892**	**78,907**	**303**	**308,102**

2012-13

Operating Income	**GWH £'000**	**WCHS £'000**	**Charity £'000**	**Total £'000**
NHS Clinical Income	193,523	72,924		266,447
Private Patients	2,871	0		2,871
Other Non Mandatory/Non Protected Revenue	3,341	323		3,664
Research & Development Income	713	0		713
Education and Training Income	7,046	35		7,081
Misc Other Operating Income	11,074	3,817		14,891
Non Operating Income	7,295	0	467	7,762
Total Income	**225,863**	**77,100**	**467**	**303,429**

NHS Charity is separately identifiable above.

3. Income
Group and Trust

3.1 Income from Activities (by Type)

	Year Ended 31 March 2014 £000	Year Ended 31 March 2013 £000
NHS Foundation Trusts	**237**	316
NHS Trusts	**94**	386
Primary Care Trusts	**0**	264,351
CCGs and NHS England	**273,360**	0
Local Authorities	**3,888**	1,394
Private Patients	**2,869**	2,804
Non-NHS: Overseas patients (non-reciprocal)	**61**	206
NHS Injury Cost Recovery scheme	**992**	993
	281,501	270,450

NHS Injury Cost Recovery scheme income is shown gross and is subject to a provision for doubtful debts of 15.8% (2012/13 12.6%) to reflect expected rates of collection.

3.2 Income from Activities (by Class)

	Year Ended 31 March 2014 £000	Year Ended 31 March 2013 £000
Elective income	**38,592**	37,027
Non elective income	**72,660**	74,768
Outpatient income	**44,770**	40,414
A & E income	**7,617**	7,495
Other NHS clinical income	**50,174**	45,207
Community contract income	**64,819**	62,735
Private patient income	**2,869**	2,804
	281,501	270,450

The increase on Other NHS Clinical income relates to funding for Winter Pressures (£2,400k) and Transformational Change funding (£800k)

3.3 Commissioner Requested Services

The table below shows the split of Commissioner Requested Services (CRS).

	Year Ended 31 March 2014 £000	Year Ended 31 March 2013 £000
Elective income	**38,592**	37,027
Non elective income	**72,660**	74,768
Outpatient income	**44,770**	40,414
A & E income	**7,617**	7,495
Community contract income	**64,819**	62,735
Other NHS clinical income	**49,121**	44,008
Total CRS	**277,579**	266,447
Non Commissioner Requested Service		
Private Patients	**2,869**	2,804
Non-NHS: Overseas patients (non-reciprocal)	**61**	206
NHS Injury Cost Recovery scheme	**992**	993
Total Non CRS	**3,922**	4,003
Total Income from Activities	**281,501**	270,450

4. Other Operating Income **Group**	**Year ended 31 March 2014** **£000**	Year ended 31 March 2013 £000
Research and Development	**737**	713
Education and Training	**8,461**	7,080
Charitable and other contributions to expenditure	**1,072**	1,088
Non-patient care services to other bodies	**2,268**	2,385
Staff recharges	**1,613**	1,871
Other Income	**12,147**	11,751
Profit on disposal of land and buildings	**0**	330
Reversal of impairments on land and buildings	**0**	7,294
NHS Charitable Funds: Incoming resources excluding investment income	**303**	467
	26,601	32,979

4.1 Other Income includes		
Car Parking (Staff & Patients)	1,452	1,282
Estates recharges	2,371	1,974
IT recharges	48	16
Pharmacy sales	30	5
Clinical Excellence Awards	267	177
Catering	123	134
Property Rentals	1,859	2,611
Payroll & Procurement Services	195	326
Occupational Health Service	262	131
Dietetics	27	35
Ultrasound Photo Sales	62	14
Heart Improvement Programme	1,065	1,076
Transport services	254	287
Staff accommodation	126	131
Domestic services	124	117
Maternity improvement funding	494	0
Pathology	147	176
Other	3,241	3,259
Total	12,147	11,751

NHS Charity is separately identifiable above.

5. Operating Expenses **Group**	**Year Ended** **31 March** **2014** **£000**	Year ended 31 March 2013 £000
Services from Foundation Trusts	**976**	937
Services from other NHS Trusts	**9,085**	10,002
Services from PCTs	**0**	873
Services from other NHS bodies	**0**	0
Purchase of healthcare from non NHS bodies	**240**	801
Employee Expenses - Executive Directors	**1,047**	798
Employee Expenses - Non-Executive Directors	**118**	124
Employee Expenses - Staff	**187,614**	173,880
Drug Costs	**19,927**	17,853
Supplies and services - clinical	**25,985**	24,808
Supplies and services - general	**2,794**	2,477
Consultancy services	**393**	341
Establishment	**5,132**	4,203
Research and development	**737**	713
Transport	**251**	179
Premises	**8,860**	7,544
Increase / (decrease) in bad debt provision	**(495)**	301
Rentals Under operating Leases	**389**	2,821
Depreciation on property, plant and equipment	**8,184**	7,453
Impairments of property, plant and equipment	**17,463**	0
Amortisation on intangible assets	**462**	327
Loss on disposal of property, plant and equipment	**0**	0
Audit services (Statutory audit)	**73**	73
Audit services (Other Assurance Services)	**57**	65
Clinical negligence	**4,407**	5,492
Patient travel	**1,185**	1,580
Car parking and security	**78**	116
Insurance	**243**	158
Hospitality	**39**	71
Legal Fees	**292**	516
Training courses and conferences	**629**	811
Other Services	**12,524**	10,474
Losses, ex gratia & special payments	**14**	(21)
NHS Charitable Funds - other resources expended	**464**	6
	309,167	275,776

Expenditure on NHS Charity is separately identifiable above.

Staff Exit Packages
The Trust has not agreed any staff exit packages in 2013/14 (31 March 2013: £nil).

Limitation on auditor's liability
The limitation on the auditor's liability is £1,000,000

Services Provided by NHS Trusts

The decrease in Services provided by NHS Trust's relates to a reduction in CNST charge from Royal United Hospital Bath NHS Trust.

Purchase of Healthcare from Non NHS Bodies

The decrease in Healthcare purchased from NHS Bodies relates to services provided by SEQOL relating to Therapies that transferred to GWH in 2013.

Services Provided by PCTs

The decrease in Services provided by PCTs relates to Community Assets transferred to GWH and NHS Property Services from 1/4/13.

Employee Expenses - Staff

Employee Costs have increased as a result of the costs of treating additional patients over the year and due to the premium cost of agency staff used to fill vacancies.

Drug Costs

Drug Costs have increase in 2013/14 reflecting additional patient activity. In particular additional expenditure has been incurred on exception and NICE drugs.

Establishment
The increase in Establishment costs relates to the costs of Overseas Nurse Recruitment, travel expenses and telephony charges.

Impairments of property, plant and equipment
This increase in cost relates to the impairment on buildings and dwellings as a result of revaluation at 1/4/13.

Premises, Rentals under Operating Leases and Depreciation
The reduction in Rentals under Operating Leases and increase in premises and depreciation costs relates to the transfer of Wiltshire Community Assets to GWH and NHS Property Services.

Other Services

Other Services - includes cleaning, catering, portering, housekeeping and estates services.
The increase in Other services compared to 2012/13 relates to the release of Section 106 Provision of £2.9m in 2012/13 which reduced Other Services expenditure in that year.

6. Operating leases - as Lessee

Group and Trust	**Year Ended 31 March 2014 £000**	Year ended 31 March 2013 £000
Minimum lease payments	**389**	2,821
	389	2,821

Total future minimum lease payments	**Year Ended 31 March 2014**	Year Ended 31 March 2013
Payable:	**£000**	£000
Not later than one year	**379**	653
Between one and five years	**648**	1,129
After 5 years	**241**	244
Total	**1,268**	2,026

The reduction in Operating Lease Rentals relates to the transfer of Wiltshire Community Assets in 2013-14.

7. Employee costs and numbers

Group and Trust

7.1 Employee Expenses

	Year Ended 31 March 2014			Year Ended 31 March 2013		
	Total	**Permanently Employed**	**Other incl agency**	Total	Permanently Employed	Other incl agency
	£000	**£000**	**£000**	£000	£000	£000
Salaries and wages	**146,867**	**145,457**	**1,410**	140,866	139,765	1,101
Social security costs	**11,408**	**11,408**	**0**	10,991	10,991	0
Pension costs - defined contribution plans Employers contributions to NHS pensions	**18,124**	**18,124**	**0**	16,993	16,993	0
Agency and contract staff	**12,262**	**0**	**12,262**	5,828	0	5,828
	188,661	**174,989**	**13,672**	174,678	167,749	6,929

7.2 Average number of employees

	Year Ended 31 March 2014			Year Ended 31 March 2013		
	Total	**Permanently Employed**	**Other incl agency**	Total	Permanently Employed	Other incl agency
	Number	**Number**	**Number**	Number	Number	Number
Medical and dental	**499**	**473**	**26**	487	471	16
Administration and estates	**1,353**	**1,257**	**96**	1,210	1,193	17
Healthcare assistants and other support staff	**915**	**915**	**0**	896	895	1
Nursing, midwifery and health visiting staff	**1,928**	**1,846**	**82**	1,878	1,788	90
Nursing, midwifery and health visiting learners	**10**	**10**	**0**	7	7	0
Scientific, therapeutic and technical staff	**733**	**697**	**36**	703	698	5
	5,438	**5,198**	**240**	5,181	5,052	129

7.3 Key Management Compensation

	Year Ended 31 March 2014	Year Ended 31 March 2013
	£000	£000
Salaries and short term benefits	**840**	696
Social Security Costs	**103**	79
Employer contributions to NHSPA	**104**	79
	1,047	854

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**	
	2013/14	**2012/13**
Dr A F Troughton, Medical Director	£187,500	£182,500

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

	2013/14	**2012/13**	**% change**
Highest paid director's total remuneration	£187,500	£182,500	2.7%
Median total remuneration	£27,759	£27,625	0.5%
Ratio	6.75	6.61	2.2%

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 small movement in the above ratio of 2.2% reflects impact of pay award in 2013/14 which has resulted in a change in banding of the highest paid director.

8. Retirements due to ill-health
Group and Trust

During the year to 31 March 2014 there were 2 early retirements from the Trust agreed on the grounds of ill-health (31 March 2013 - 8 early retirements). The estimated additional pension liabilities of these ill-health retirements will be £225,590 (31 March 2013 - £453,923). 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 2014		Year ended 31 March 2013	
	Number	**£000**	Number	£000
Total trade bills paid in the year	**61,486**	**114,606**	54,747	126,652
Total trade bills paid within target	**26,923**	**74,157**	40,109	106,760
Percentage of trade bills paid within target	**43.79%**	**64.71%**	73.26%	84.29%
Total NHS bills paid in the year	**2,415**	**29,168**	2,837	33,841
Total NHS bills paid within target	**1,241**	**14,844**	2,371	28,710
Percentage of NHS bills paid within target	**51.39%**	**50.89%**	83.57%	84.84%

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.

9.2 The Late Payment of Commercial Debts (Interest) Act 1998

The Trust was charged £7,845 in the year for late payment of commercial debts (31 March 2013 £253).

10. Finance Income
Group and Trust

	Year Ended 31 March 2014	Year Ended 31 March 2013
	£000	£000
Interest on bank accounts	**280**	313
	280	313

11. Finance Expense
Group and Trust

	Year Ended 31 March 2014	Year Ended 31 March 2013
	£000	£000
Working Capital Facility Fee	42	58
Interest on late payment of commercial debt	8	0
Interest on obligations under Finance leases	31	37
Interest on obligations under PFI	15,390	14,993
	15,471	15,088

12. Intangible Assets
Group and Trust
12.1 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**

12.2 2012/13:

	Computer software - purchased	Licences and trademarks	Intangible assets under construction	Total
	£000	£000	£000	£000
Gross cost at 1 April 2012	1,140	1,329	0	2,469
Additions purchased	512	0	0	512
Gross cost at 31 March 2013	**1,652**	**1,329**	**0**	**2,981**
Amortisation at 1 April 2012	213	1,094	0	1,307
Provided during the year	216	111	0	327
Amortisation at 31 March 2013	**429**	**1,205**	**0**	**1,634**
Net book value				
Purchased	1,223	124	0	1,347
Total at 31 March 2013	**1,223**	**124**	**0**	**1,347**

Reclassification relates to transfer of assets from tangible assets.

13. Property, plant and equipment

Group and Trust

13.1 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	2,348	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**	**163,623**	**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	1,169	351	8,184
Depreciation at 31 March 2014	**0**	**22,327**	**733**	**0**	**26,730**	**58**	**10,597**	**2,618**	**63,063**
Net book value									
- Purchased at 31 March 2014	35,962	141,296	4,759	6,782	9,218	0	6,538	652	205,207
- Donated at 31 March 2014	0	0	0	0	126	0	0	0	126
Total at 31 March 2014	**35,962**	**141,296**	**4,759**	**6,782**	**9,344**	**0**	**6,538**	**652**	**205,333**
Asset Financing									
Net book value									
- Owned	35,962	21,145	93	6,782	9,344	0	6,538	652	80,516
- Finance Leased	0	120,151	4,666	0	0	0	0	0	124,817
Total at 31 March 2014	**35,962**	**141,296**	**4,759**	**6,782**	**9,344**	**0**	**6,538**	**652**	**205,333**

13. Property, plant and equipment

Group and Trust

13.2 Prior year 2012/13:	**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 2012	21,049	154,004	5,206	6,704	31,882	58	11,939	3,000	233,842
Additions Purchased	0	588	0	1,341	1,110	0	1,996	21	5,056
Reversal of Impairments	(249)	2,182	0	0	0	0	0	0	1,933
Reclassifications	0	1,711	0	(2,944)	1,191	0	34	8	0
Gross cost at 31 March 2013	**20,800**	**158,485**	**5,206**	**5,101**	**34,183**	**58**	**13,969**	**3,029**	**240,831**
Depreciation at 1 April 2012	0	21,077	443	0	22,568	58	8,601	1,973	54,720
Provided during the year	0	4,139	135	0	2,058	0	827	294	7,453
Reversal of Impairments	0	(7,294)	0	0	0	0	0	0	(7,294)
Depreciation at 31 March 2013	**0**	**17,922**	**578**	**0**	**24,626**	**58**	**9,428**	**2,267**	**54,879**
Net book value									
- Purchased at 31 March 2013	20,800	140,563	4,628	5,101	9,394	0	4,541	762	185,789
- Donated at 31 March 2013	0	0	0	0	163	0	0	0	163
Total at 31 March 2013	**20,800**	**140,563**	**4,628**	**5,101**	**9,557**	**0**	**4,541**	**762**	**185,952**
Asset Financing									
Net book value									
- Owned	20,800	1,756	0	5,101	9,557	0	4,541	762	42,517
- Finance Leased	0	138,807	4,628	0	0	0	0	0	143,435
Total at 31 March 2013	**20,800**	**140,563**	**4,628**	**5,101**	**9,557**	**0**	**4,541**	**762**	**185,952**

Reclassification Relates to Capitalisation of Assets under Construction

13. Property, plant and equipment (cont.)

13.3 Revaluation

The Trust has revalued land, buildings and dwellings as at 1st April 2013 in accordance with Note 1.5.2. This has resulted in a decrease in the value of buildings and dwellings and a small increase in land value. The overall impact is an decrease in land, buildings and dwellings of £20,627k which is 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 2013: £nil).

14. Capital commitments

There are no commitments under capital expenditure contracts at the end of the period (31st March 2013: £nil), not otherwise included in these financial statements.

15. Investments

	Group		**Trust**	
	Year Ended 31 March 2014 £000	Year end 31 March 2013 £000	**Year Ended 31 March 2014 £000**	Year end 31 March 2013 £000
Financial Assets designated as fair value through profit & loss	**820**	738	**0**	0
	820	**738**	**0**	**0**

All Investments are non-current.

16. Inventories

Group and Trust

	31 March 2014 £000	31 March 2013 £000
Materials	**5,779**	5,362
	5,779	5,362

Inventories carried at fair value less costs to sell where such value is lower than cost are nil (31 March 2013 - £nil).

17. Trade and other receivables

Group
(All Receivables are Current)

	31 March 2014 £000	31 March 2013 £000
NHS receivables	6,573	5,321
Other receivables with related parties	2,004	2,501
Provision for impaired receivables	(1,080)	(1,241)
Prepayments	3,407	2,414
Lifecycle prepayment	3,008	3,086
Accrued Income	2,867	2,979
Other receivables	3,653	2,217
NHS Charitable Funds: Other receivables	(129)	(150)
PDC receivable	666	0
	20,969	17,127

NHS Charity is separately identifiable above.

18.1 Provision for impairment of receivables

Group and Trust

	31 March 2014 £000	31 March 2013 £000
Balance at 1 April	**1,241**	940
Increase in provision	**(545)**	301
Amounts utilised	**334**	0
Unused amounts reversed	**50**	0
Balance at 31 March	**1,080**	1,241

18.2 Analysis of Impaired Receivables

	31 March 2014 £'000	31 March 2013 £'000
Ageing of impaired receivables		
0-30 days	**25**	32
30-60 days	**13**	12
60-90 days	**15**	12
90-180 days	**250**	192
over 180 days	**777**	993
	1,080	1,241

	31 March 2014 £'000	31 March 2013 £'000
Ageing of non-impaired receivables past their due date		
0-30 days	**2,058**	1,639
30-60 days	**2,758**	1,468
60-90 days	**302**	204
90-180 days	**278**	301
over 180 days	**3,764**	2,218
	9,160	5,830

19. Cash and cash equivalents	**Group**		**Trust**	
	31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	£000	£000	**£000**	£000
Balance at 1 April	**11,447**	14,636	**10,718**	14,482
Net change in year	**(6,556)**	(3,189)	**(6,280)**	(3,764)
Balance at 31 March	**4,891**	11,447	**4,438**	10,718
Made up of				
Cash with Government Banking Service	**4,883**	11,439	**4,430**	10,710
Commercial banks and cash in hand	**8**	8	**8**	8
Cash and cash equivalents as in statement of financial position	**4,891**	11,447	**4,438**	10,718
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	**4,891**	11,447	**4,438**	10,718

20. Trade and other payables

Group	**Current**	
	31 March 2014	31 March 2013
	£000	£000
NHS payables	**2,525**	3,498
Trade payables - capital	**2,469**	2,101
Other trade payables	**12,929**	7,374
Other payables	**4,733**	6,411
Accruals	**5,967**	6,558
Receipts in advance	**0**	0
NHS Charitable Funds: Trade and other payables	**4**	65
	28,627	26,007

Other payables include outstanding pension contributions of £2,518,546. (31 March 2013: £2,241,362).

The decrease in NHS Payables as at 31 March 2014 relates to the reduction in amount outstanding with RUH Bath at year end (31/3/14 £856k, 31/3/13 £1,882k)

The increase in other trade payables relates to a higher level of spend not paid at year end.

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	**545**	1,248	**1,588**	1,702
	545	1,248	**1,588**	1,702

All deferred income relates to the Trust there are no other liabilities relating to Charitable Funds.

22. Tax Payable

Tax payable of £1,649,737 (31 March 2013: £1,672,068) 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 2014**	31 March 2013
	£000	£000
Gross PFI liabilities	245,655	247,480
Of which liabilities are due		
Within one year	12,744	15,672
Between one and five years	57,785	52,197
After five years	175,126	179,611
Less future finance charges	(118,160)	(119,875)
	127,495	127,605
Net PFI liabilities		
Of which liabilities are due		
Within one year	1,876	4,893
Between one and five years	16,965	11,689
After five years	108,654	111,023
	127,495	127,605
Included in:		
Current borrowings	1,876	4,893
Non-current borrowings	125,619	122,712
	127,495	127,605

23.2 Finance lease obligations

Amounts payable under Finance lease obligations:	**31 March 2014**	31 March 2013
	£000	£000
Gross Finance lease liabilities	456	595
Of which liabilities are due		
Within one year	139	139
Between one and five years	317	456
After five years	0	0
Less future finance charges	(67)	(98)
	389	497
Net Finance lease liabilities		
Of which liabilities are due		
Within one year	113	108
Between one and five years	276	389
After five years	0	0
	389	497
Included in:		
Current borrowings	113	108
Non-current borrowings	276	389
	389	497

23.3 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 £11,891k (£11,265k 2012/13)

The Trust is committed to the following annual charges

	31 March 2014	31 March 2013
PFI commitments in respect of service element:	**£000**	£000
Not later than one year	**11,623**	11,874
Later than one year, not later than five years	**49,473**	48,494
Later than five years	**158,425**	172,162
Total	**219,521**	232,530
PFI commitments present value in respect of service element:		
Not later than one year	**11,230**	11,472
Later than one year, not later than five years	**43,847**	42,979
Later than five years	**108,362**	115,741
Sub total	**163,439**	170,192

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 2014**	31 March 2013	**31 March 2014**	31 March 2013
	£000	£000	**£000**	£000
Pensions relating to other staff	**125**	124	**1,053**	1,191
Legal claims	**0**	277	**84**	0
Other	**28**	164	**596**	481
	153	565	**1,733**	1,672

	Pensions relating to other staff	**Legal claims**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**
At 1 April 2013	1,315	277	645	2,237
Arising during the year	0	0	0	**0**
Used during the year	(167)	(193)	(29)	**(389)**
Reversed unused	0	0	0	**0**
Unwinding of discount	30	0	8	**38**
At 31 March 2014	**1,178**	**84**	**624**	**1,886**
Expected timing of cash flows:				
Within one year	125	0	28	**153**
Between one and five years	521	84	250	**855**
After five years	532	0	346	**878**
	1,178	84	624	**1,886**

The provision under 'legal claims' relates to outstanding Employment Tribunal Claims £84,000 (31 March 2013: £277,000). The provisions under 'other' includes Injury Benefit Provision £494,000 (31 March 2013:£515,000).

Provisions within the annual accounts of the NHS Litigation Authority at 31 March 2014 include £40,117,222 in respect of clinical negligence liabilities of the Trust (31 March 2013 - £32,843,481).

The Trust has not made a provision under the Carbon Emissions Scheme as the Trust is not required to be registered in 2013/14 as the properties managed by the Trust are below the threshold. This is not anticipated to change in 2014/15.

25. Transfer of Functions from another NHS Body

Group and Trust

From 1st April 2013 the Trust acquired the Wiltshire Community Assets that were owned by Wiltshire PCT and for which the Trust is the majority user.

The Assets acquired were as follows	Net Book Value at 1/4/13	Revaluation Reserve at 1/4/13
Category	£'000	£'000
Land	15,032	4,348
Buildings (incl dwellings)	23,833	8,172
Furniture & Fittings	193	7
IT	608	0
Plant & Machinery	456	3
Total	40,122	12,530

Transfer was prior to revaluation adjustment in note 13.3

In addition £51k of trade receivables and £551k of trade payables were identified as part of the transfer.

Effect on Financial Statements	**£'000**
Statement of Financial Position	
Non Current Assets	40,122
Trade & Other Receivable	51
Trade & Other Payables	(551)
Current Lease Liability	(112)
Non Current Lease Liability	(4,662)
Increase in Total Assets Employed	34,848
Revaluation Reserve	12,530
Income & Expenditure Reserve	22,318
Increase in Total Taxpayers Equity	34,848

In accordance with the 2013/14 FT ARM the transaction has been accounted for using absorption accounting

26. Contingencies

Group and Trust

There are no contingent assets and liabilities for the period ended 31 March 2014

27. 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 2013/14 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	1,516	51	33,685	222
Swindon CCG	1,980	0	108,534	0
Wiltshire CCG	945	0	106,235	0
BANES CCG	0	111	7,188	0
Newbury and District CCG	497	0	4,678	0
Bristol CCG	23	0	128	0
Gloucestershire CCG	179	0	6,211	0
Royal United Hospital Bath NHS Trust	155	856	1,232	8,818
Oxfordshire CCG	61	0	2,605	0
Somerset CCG	0	208	2,600	0
Health Education	16	0	7,968	0
NHS Litigation Authority	0	1	0	4,407
NHS Pension Scheme	0	2,519	0	18,124
Total	5,372	3,746	281,064	31,571

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.

28. Private Finance Initiative contracts

Group and Trust

28.1 PFI schemes on-Statement of Financial Position

The Trust has 4 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 (treated as one agreement), Downsview Residences 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 is dated 27 May 2002 with an effective date of 13 November 2001. The contract is for 12 years and is 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.

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.

29 Financial instruments and related disclosures

Group and Trust

The key risks that the Trust has identified relating to its financial instruments are as follows:-

29.1 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.

29.2 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.

29.3 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 2014	31 March 2013
	£000	£000
By up to three months	**1,080**	2,835
By three to six months	**2,058**	237
By more than six months	**2,758**	2,417
	5,896	5,489

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.

29.4 Liquidity risk

The NHS Trust's net operating costs are incurred under annual service agreements with local PCTs, 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 a Working Capital Facility of £18 million available within its terms of authorisation as an NHS Foundation Trust which reduces its liquidity risk still further.

29.5 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 2014 and 31 March 2013.

	Carrying Value 31 March 2014 £000	**Fair Value 31 March 2014 £000**	Carrying Value 31 March 2013 £000	Fair Value 31 March 2013 £000
Current financial assets				
Cash and cash equivalents	**4,438**	**4,438**	10,718	10,718
NHS Charitable funds: financial assets	**820**	**820**	738	738
Loans and receivables:				
Trade and receivables	**18,915**	**18,915**	11,777	11,777
	24,173	**24,173**	23,233	23,233
Non-current financial assets				
Loans and receivables:				
Trade and receivables	**0**	**0**	0	0
Total financial assets	**24,173**	**24,173**	23,233	23,233
Current financial liabilities				
Financial liabilities measured at amortised cost:				
Obligations under PFI	**1,876**	**1,876**	4,893	4,893
Obligations under Finance Leases	**113**	**113**	108	108
Trade and other payables	**26,863**	**26,863**	22,006	22,006
	28,852	**28,852**	27,007	27,007
Non-current financial liabilities				
Financial liabilities measured at amortised cost:				
Obligations under PFI	**125,619**	**125,619**	122,712	122,712
Obligations under Finance Leases	**276**	**276**	389	389
	125,895	**125,895**	123,101	123,101
Total financial liabilities	**154,747**	**154,747**	150,108	150,108
Net financial assets	**(130,574)**	**(130,574)**	(126,875)	(126,875)

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 2014 £000	31 March 2013 £000	**31 March 2014 £000**	31 March 2013 £000
Trade and other receivables:	**0**	1,474	**0**	0
Non-financial assets	**0**	114	**0**	0
Prepayments	**6,415**	4,450	**0**	0
	6,415	6,038	**0**	0
Trade and other payables:				
Taxes payable	**4,168**	3,430	**0**	0
Non-financial liabilities	**0**	0	**0**	0
	4,168	3,430	**0**	0
Provisions:				
Financial liabilities	**0**	206	**0**	0
Provisions under legislation	**153**	144	**1,670**	1,783
	153	350	**1,670**	1,783

The provisions under legislation are for personal injury pensions £494,286 (31 March 2013: £515,218) and early retirement pensions £1,139,355 (31 March 2013: £1,308,137). These liabilities are not contracted, but are defined by legislation and are owed to the NHS Pensions Agency.

30. Third Party Assets

Group and Trust

The Trust held £8,335 cash at bank and in hand at 31 March 2014 (31 March 2013: £8,399) 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.

31. Losses and Special Payments

Group and Trust

	31 March 2014		31 March 2013	
	No.	**£000**	**No.**	**£000**
Losses				
Cash losses	**6**	**1**	8	3
Bad debts and claims abandoned	**60**	**21**	127	32
Total Losses	**66**	**22**	135	35
Special Payments				
Compensation payments	**23**	**47**	5	24
Ex gratia payments	**23**	**9**	4	0.5
Total Special Payments	**46**	**56**	9	25
Total Losses and Special Payments	**112**	**77**	144	59

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. (2012/13 - 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.

32. Pooled Budget - Integrated Community Equipment Service

Group and Trust

	31 March 2014	31 March 2013
Income:	**£000**	**£000**
Swindon Borough Council	502	540
Paediatrics	38	38
NHS Swindon	244	244
Great Western Hospitals NHS Foundation Trust	153	153
Total Income	**937**	**975**
Expenditure	1,009	975
Total Surplus/(Deficit)	**(73)**	**0**

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	(41)	0
Swindon CCG	(24)	0
Great Western Hospitals NHS Foundation Trust	(7)	0
Total Surplus/(Deficit)	**(73)**	0

33. NHS Charity Prior Period Adjustment

In 2013/14 the Great Western Hospitals NHS Foundation Trust Charity has been consolidated in to the Trust's accounts in accordance with IAS 27. Until April2013, the Treasury had directed that IAS 27 should not be applied to NHS charities. That direction has now been removed and IAS 27 requires that consolidated accounts are prepared. This is because the Trust is the corporate trustee of Great Western Hospitals NHS Charity and the charity's objectives are for the benefit of the Trust.

33.1 Effect of the prior period adjustment

33.1.1 Statement of Comprehensive Income	Year end 31 March 2013 £000	Adjustment £000	Restated Year end 31 March 2013 £000
Operating Income from continuing operations	302,962	467	303,429
Operating Expenditure from continuing operations	(275,766)	(10)	(275,776)
Operating Surplus	27,196	457	27,653
Investment Revenue			
Finance Costs	(14,815)	0	(14,815)
PDC Payable	(1,415)	0	(1,415)
Net Non Operating Costs	(16,230)	0	(16,230)
Movement in fair value of Investments		74	74
Surplus for the Year	10,966	531	11,497
Other comprehensive income			
Revaluation	1,933	0	1,933
Total comprehensive income for the year	12,899	531	13,430
Note:			
Surplus for the year	10,966	531	11,497
Less net impairment gain charged to Operating Income	(7,294)	0	(7,294)
Surplus prior to impairment gain	3,672	531	4,203

Great Western Hospitals NHS Foundation Trust
Accounts for the year ended 31 March 2014

33.1.2 Statement of Financial Position	Year end 31 March 2013 £000	Adjustment £000	Restated Year end 31 March 2013 £000
Non-Current Assets			
Intangible assets	1,347	0	1,347
Property, Plant and Equipment	185,952	0	185,952
Other investments	0	738	738
Total non-current assets	187,299	738	188,037
Current Assets			
Inventories	5,362	0	5,362
Trade and other receivables	17,277	(150)	17,127
Cash and cash equivalents	10,718	729	11,447
Total current assets	33,357	579	33,936
Current Liabilities			
Trade and Other Payables	(25,942)	(65)	(26,007)
Borrowings	(5,001)	0	(5,001)
Provisions	(565)	0	(565)
Tax Payable	(1,672)	0	(1,672)
Other liabilities	(1,248)	0	(1,248)
Total current liabilities	(34,428)	(65)	(34,493)
Total assets less current liabilities	186,228	1,252	187,480
Non-Current Liabilities			
Trade and Other Payables	0	0	0
Borrowings	(123,101)	0	(123,101)
Provisions	(1,672)	0	(1,672)
Other Liabilities	(1,702)	0	(1,702)
Total non-current liabilities	(126,475)	0	(126,475)
Total assets employed	59,753	1,252	61,005
Financed by Taxpayers' Equity			
Public dividend capital	27,511	0	27,511
Revaluation reserve	20,462	0	20,462
Income and expenditure reserve	11,780	(149)	11,631
Charitable fund reserves	0	1,401	1,401
Total taxpayers' equity	59,753	1,252	61,005

Great Western Hospitals NHS
NHS Foundation Trust

Annual Report and Accounts 2013/14