Great Western Hospitals NHS
NHS Foundation Trust

Great Western Hospitals NHS Foundation Trust
Annual Report and Accounts
2015/16

Great Western Hospitals NHS Foundation Trust
Annual Report and Accounts
2015/2016

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

Contents

CHAIR AND CHIEF EXECUTIVE'S STATEMENT

In April 2015, the Trust was at the start of our financial turnaround following a very difficult year. Each month we were spending far more than we were receiving and this caused us to end 2014/15 with a deficit of £8.7 million.

At that point, the Board was concerned that the deficit was expected to grow during 2015/16 with our plans showing we would end the year with a deficit of nearly £19 million. In response to these financial challenges, the Trust agreed enforcement undertakings with Monitor, the Foundation Trust regulator, to deliver savings and bring our finances under control.

During the year we delivered some significant savings notably £878k on medicines management; £578k on procurement and £982k on corporate costs.

As a result of this hard work colleagues across the Trust have saved over £16m this year meaning the Trust ended 2015/16 with a deficit of £9.744 million. The Board are fully aware that this is still a big deficit - although much smaller than we were originally forecasting. It still means we are spending more each month than we receive in income and in 2016/17 our financial turnaround will continue.

The Trust has had to deliver these savings against a backdrop of significant growth in patient demand. As we are all living longer with more complex health conditions, we are seeing more demand on our services. With more patients needing to be admitted, often requiring one to one nursing support, the winter period has been particularly tough in terms of these pressures and our staff have had to work incredibly hard to keep up with demand. Average daily attendances to the Emergency Department (ED) have grown by 20 per cent in the last five years and the Emergency Department is seeing an average of 30 extra patients every day.

Almost half of emergency admissions are over the age of 65 and a third over 75 highlighting the changing demographics. These pressures have meant that in some areas of our performance such as the four hour ED waiting time, we failed to meet the 95% standard. We ended the year with overall performance of 91.1%.

As a result, we are investing a significant amount of time and resource in implementing a remedial action plan to improve our ED performance. Whilst some of the actions required are internal to the Trust, others relate to actions across the rest of the health and social care system. The demand for services being experienced by colleagues in social care is having an impact on secondary care through high levels of delayed discharges. Over the winter period, on any given day, we have typically seen a ward's worth of capacity tied up with delayed discharges - sometimes much more. This has a knock on impact on the front door as patients cannot be admitted swiftly enough and is a priority for the whole system to improve.

During the year, we also received our first Care Quality Commission (CQC) inspection under the new-style inspection regime. Around 70 inspectors visited our services at GWH and in the community in Wiltshire talking to staff and patients and witnessing the care being provided.

The inspection offered a fresh perspective on the things we do well and the things we need to improve and gave our Trust an overall rating of 'Requires Improvement'. Whilst that was our overall rating, there were a number of services highlighted for high quality. The Children and Young People's Service in Wiltshire was rated as outstanding and we are particularly proud of this achievement ahead of the Children and Young People's Service transferring to a new provider on 31st March 2016.

Our Adult Community Services in the county were also rated as Good which sets an excellent foundation for a new approach to community services which will come into place in July 2016. During the year we worked with our partners in the Royal United Hospital Bath and in Salisbury Foundation Trust to submit a joint bid to provide adult community services and we were delighted that the partnership – Wiltshire Health and Care – was named as the preferred bidder by Wiltshire CCG following a competitive tender process. This new partnership goes live on 1st July 2016 offering greater opportunity to join up care between secondary, primary, community care and social care.

Within GWH our Maternity Service and End of Life Care services were also given a Good rating. The standard of care across all our acute services was given a Good rating which is a testament to the dedication

and professionalism of our staff that despite the pressures, patients still can expect to receive good care – something future improvements will be built upon.

There were some areas for improvement identified through a number of 'must do' actions which we are now in the process of implementing. Key amongst these were improvements in Emergency Care to improve quality and safety including investing in additional staffing levels, working with key partners to improve flow through the hospital to reduce delays and improving support for patients with mental health needs. The implementation of the actions identified in the CQC report are a top priority for the Board so that we can build on the good care identified by the CQC to deliver real and sustainable improvements to patient care.

This Trust relies on the dedication and motivation of our staff to provide good care to people in need 24 hours a day. Against a very challenging backdrop for the whole NHS, our staff should be proud of the job they do. This pressure is not without cost in human terms of the thousands of staff who go above and beyond to do their best for patients. Our staff survey results tell us that staff are highly motivated to work here and our job is to support them as much as possible to be the best they can be and it goes without saying that the whole Board are extremely proud of the individuals and teams who work and volunteer here and put on record our thanks to them.

Yours sincerely

Roger Hill
Chairman
23 May 2016

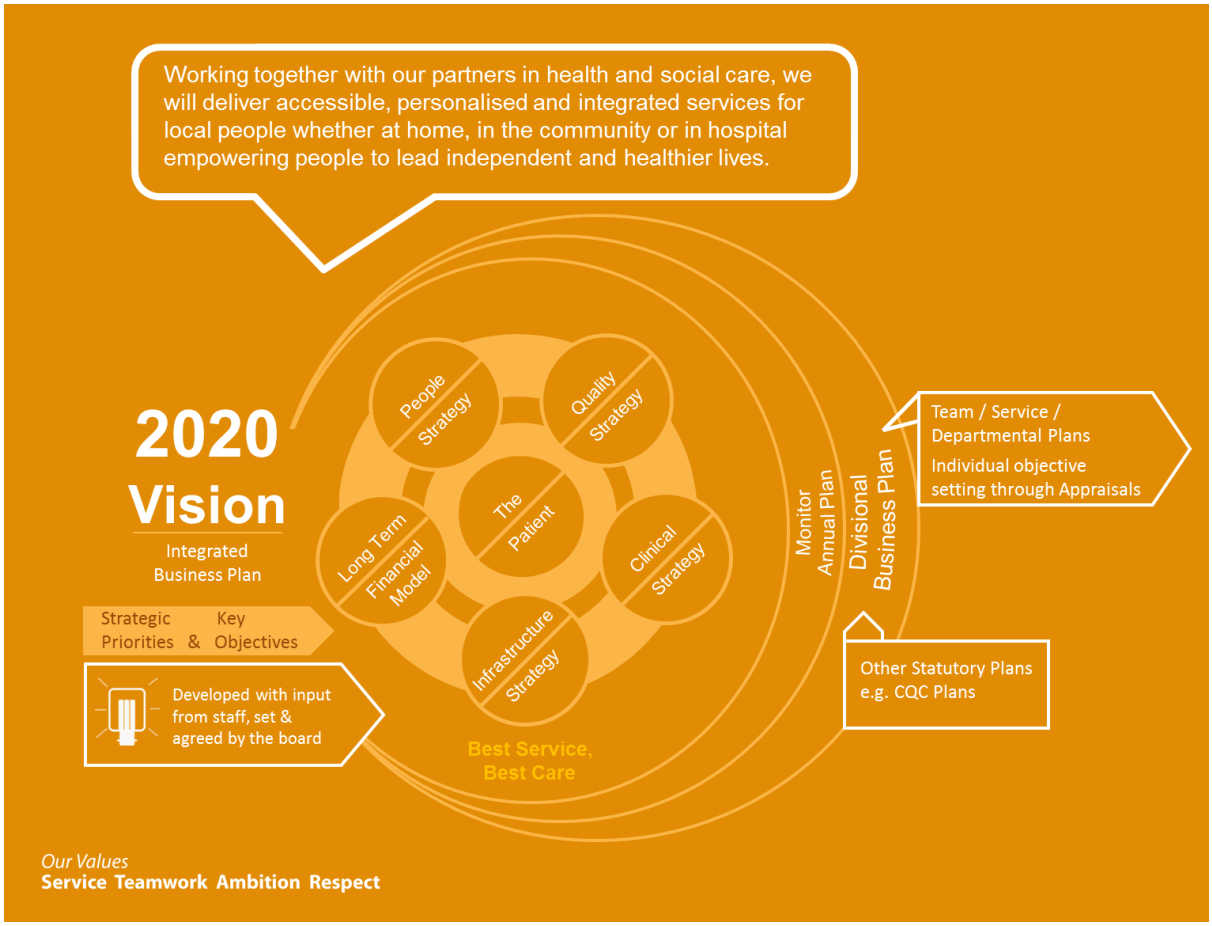
Nerissa Vaughan
Chief Executive
23 May 2016

PERFORMANCE REPORT

1 Overview of Performance

1.1 Trust Strategy

Our five year vision



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

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

1.2 Our priorities

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

We have set ourselves four strategic priorities that drive the broad outcomes we aim to achieve in the next five years. Over the next five years improvements will be delivered through progressive pieces of work with benefits being achieved at different times.

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

1.3 Our objectives

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

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

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

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

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

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

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

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

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

1.4 Business Model

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

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

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

Note - From 1 April 2016, NHS Improvement became responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. NHS Improvement offers the support these providers need to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. By holding providers to account and, where necessary, intervening, NHS Improvement help the NHS to meet its short-term challenges and secure its future.

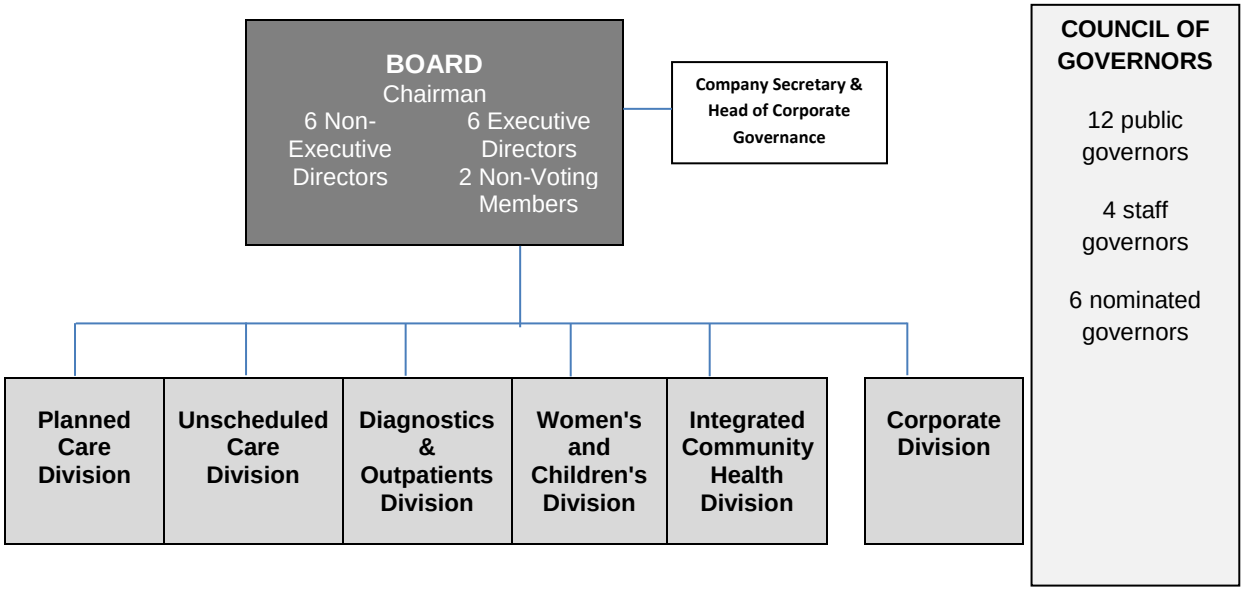
From 1 April 2016, NHS Improvement is the operational name for an organisation that brings together: -

- *Monitor*
- *NHS Trust Development Authority*
- *Patient Safety, including the National Reporting and Learning System*
- *Advancing Change Team*
- *Intensive Support Teams*

NHS Improvement builds on the best of what these organisations did, but with a change of emphasis. The priority is to offer support to providers and local health systems to help them improve.

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

1.5 Organisational structure 2015/16



1.6 Principal activities of the Trust

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

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

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

1.7 Location of services

Great Western Hospitals NHS Foundation Trust has its main headquarters at the Great Western Hospital (GWH) in Swindon, but provides a range of community health services across a wide geographical area covering Wiltshire, parts of Bath and North East Somerset, parts of Hampshire, Dorset, Oxfordshire, West Berkshire and Gloucestershire, covering a population of approximately 1,300,000 people.

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

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

Within the Community
The Trust provides a number of services closer to patients' homes in the local community. Some of our other sites include Chippenham, Trowbridge, Savernake, Warminster and Melksham Community Hospitals; Hillcote; Royal United Hospital Bath; Erlestoke Prison; Amesbury Health Clinic; Salisbury Central Health Clinic; Devizes Health Centre, West Swindon Health Centre, Malmesbury Primary Care Centre, Tidworth Clinic, Swindon Health Centre (Carfax Street) and various GP practices. Note that GWH's contract for adult community services comes to an end during 2016/17 but we will be part of the partnership – Wiltshire Health and Care – that will hold the contract from 1 July 2016.

1.8 History of the Trust

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

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

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

In the final quarter of 2015/16 the Trust has placed its expression of interest to Swindon Clinical Commissioning Group for the provision of Swindon Integrated Adult Community Services. This procurement activity is likely to take six months.

1.9 Principal risks and uncertainties facing the Trust

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

Examples of the principal risks and uncertainties facing the Trust during 2015/16 against our strategic objectives are set out below: -

Strategic Objective 1 -To deliver consistently high quality, safe services which deliver desired patient outcomes and we will perform in the top 25% (upper quartile) of comparable Trusts in delivering Hospital Standard Mortality Rate (HSMR), patient satisfaction and staff satisfaction.	*Increase in non-elective admissions and GP referrals resulting in failure to meet Key Performance Indicators (KPIs) - poor quality of care (e.g. Referral to Treatment (RTT) /cancer targets / Emergency Department 4 hour wait*
	Failure to reduce delayed transfers in care and delayed medically fit for discharge patients
Strategic objective 2 - To improve the patient and carer experience of every aspect of the service and care that we deliver. (patient experience)	*Failure to delivered personalised care planning*
	Failure to deliver National ED 4 hour targets
Strategic Objective 3 - To ensure that staff are proud to work for the Trust and would recommend the Trust as a place to work, and to receive treatment.	*Difficulty recruiting and retaining high quality staff particularly in some specialities*
	Insufficient provision of training, appraisals and development
Strategic objective 4 - To secure the long-term financial health of the Trust.	*Failure to deliver Cost Improvement Plans*
	Failure to ensure availability of sufficient cash to support the operational functioning of the organisation
Strategic objective 5 - To adopt new approaches and innovation to improve services as healthcare changes whilst continuing to become even more efficient.	*Failure to influence patient pathways*
Strategic objective 6 - To work in partnership with others so that we provide seamless care for patients.	*Failure to align annual and long term plans across an unsustainable health system*

1.10 Going concern

On 20 April 2015, following a review by Monitor, the Trust was found to be in breach of the following conditions of its licence: CoS3 (1)(a) and (b), FT4(2) and FT4 (5)(a), (d),(e), (f) and (g) relating to financial sustainability, performance and governance. Notwithstanding this breach, and a deficit for the year ending 31 March 2016 of £9.7m million, the Trust has a forecast surplus for the year ending 31 March 2017 of £0.6m. This includes the expected receipt of £8.9m Sustainability & Transformation Funding of £8.9m, which will also enable the Trust to maintain a minimum cash balance of £1.7m as shown in the Trust's Annual Plan.

- The Monitor NHS foundation trust annual reporting manual 2015/16 states that financial statements should be prepared on a going concern basis unless management either intends to apply to the Secretary of State for the dissolution of the NHS foundation trust without the transfer of the services to another entity, or has no realistic alternative but to do so.
- The Trust has prepared its annual plan, which includes a detailed cash flow forecast. The key assumptions within the plan are as follows: -
    - NHS Clinical Income includes assumptions on general population and demographic growth.
    - Delivery of Cost Improvement Plans (CIPs) of £14.3m.
      Receipt of £8.9m Sustainability & Transformation Funding

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

2 Performance Analysis

2.1 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 2015/16 which includes key developments, mapped against our priorities which guide the direction of the Trust.

We will make our patients the centre of everything we do
Our recent routine inspection by the Care Quality Commission (CQC) showed areas of strength and areas for improvement. Our kind and compassionate care was clear to the inspectors, who saw first-hand how we treat patients with dignity and respect. The quality of the Community Services demonstrates our track record of community services. Inspectors also observed many examples of high quality care and an organisation with solid foundations, a clear vision and established leadership. We knew many of the challenges highlighted and many improvements are already underway, but this inspection has given us a fresh perspective into where further progress can be made. Our culture of kindness and compassion, which is fundamental to safe and high quality care, gives us a strong foundation to build upon.

We will ensure that everything we do supports the long term viability of the Trust, working smarter not harder making the best use of limited resources
Ensuring the long term viability of the Trust is perhaps the biggest challenge we face. In 2015/16 the Trust has made good progress against a backdrop of starting the year by entering Monitor enforcement action. The Trust has now shifted focus from turnaround to transformation. Significant savings have been made in 2015/16 and a credible plan for achieving savings (that have largely already been identified) in 2016/17 has been set. 7 Transformation programmes will ensure that the Trust does not look at costs savings in isolation but also actively investigates pathway redesign and improved ways of working. This approach will complement the work the Trust has done building the Wiltshire community proposal, due to go live in 2016/17. The Business Improvement Group has been established as a Governance mechanism for the delivery of any Investment decision as part of the business planning process. All investment proposals must align with Trust priorities and must be within the investment envelope available. Appropriate proposals will go before the Executive Committee for formal approval.

We will innovate and identify new ways of working
<u>A Whole System Approach</u> We plan to remodel our secondary care services so that they are wrapped around community and social care, putting in place processes to support patients to live healthily at home for as long as possible, and when care is needed for it to be provided in the most suitable setting. Good progress has been made on this - during 2015 the Trust successfully bid for Adult Community Services in Wiltshire through a Joint Venture with Royal United Hospitals Bath NHS Foundation Trust and Salisbury NHS Foundation Trust. This service is currently mobilising and will go live in July 2016. Maintaining patient flow where patients are admitted to hospital is key to quality, performance and financial sustainability. This relies on a whole system approach to support people outside of hospital in the community. As a Trust, therefore, we need to focus on the things we are in control of whilst working with the system to address systemic constraints. Where patients are admitted to hospital, processes are being re-designed to improve flow through the Right Patient, Right Bed programme. We will develop integrated, planned, and prevention based pathways working with local partners, including the voluntary sector, commissioners and clinical networks to share best practice, learning, and resource to deliver more robust demand management as part of the mobilisation and integration of a new model for Swindon community services.

We will build capacity and capability by investing in our staff, infrastructure and partnerships
The Trust is currently working in collaboration with commissioners towards the Sustainability and Transformation Plan (STP). This is providing the Trust with a comprehensive understanding of the requirements for our services going forward. This information is being utilised by our divisional teams who have started to redesign and transform our existing services through the Strategic Service Review (SSR) process. The information provided within the Strategic Service Reviews has enabled us to proactively plan the workforce that we will require to deliver these services effectively in the future. These requirements, along with the workforce implications from the Trust's demand and capacity work, will be included in the divisional workforce plans. Over the past 12 months, the Trust has experienced an average staff turnover rate of 14%. A detailed analysis of turnover within the Trust has recently been undertaken with specific hot spots identified. Working in collaboration with the divisional teams, the HR department will identify ways of improving turnover and retention of both clinical and non-clinical staff, focusing on those areas of concern. The aim is to reduce Trust wide turnover to 13% by the end of the year by focusing on the hotspot areas. This will equate to a saving of approximately £175,000 across the Trust through a reduction in recruitment activity and temporary staffing cover whilst posts are vacant. The analysis identified that the highest level of turnover is for staff within the lower age groups; this generation has a different approach to work, whereby they move jobs more frequently, which may be a constraint to this project. In order to meet the employment expectations of the different generations the Trust will need to develop bespoke employment offers and a more flexible approach to employment in order to attract and retain staff. By improving retention, the Trust will be able to reduce vacancy levels, spend on bank and agency workers and also increase the level of experience held within the organisation. By addressing those concerns raised by employees who choose to leave the Trust, it will be possible to improve employee engagement resulting in a happier and more productive workforce. Over the next year, the Trust will explore opportunities for working in partnership with other organisations to provide corporate support services. This may involve the investment or disinvestment in some services or sharing resource across organisations in order to produce efficiencies across the whole system. The Trust will continue to invest in our infrastructure to meet our changing operational needs. The estate we utilise and the IT that supports it and the workforce will need to be flexible and accessible to add value and seamlessly integrate into our future provision. During 2015/16 the Trust has undertaken a review of its estate portfolio and has developed a strategy for its future utilisation. The Trust has also undertaken a review of its IT provision, network and support, including the future direction of how we are likely to work, operating on a more local and / or mobile basis, recognising advances in technology and the potential benefits. Such infrastructure changes will need to be carefully managed to ensure full benefit and output analysis is undertaken ensuring that investment is targeted in the best possible place to realise the best possible outcome, be that improvement in patient care or efficiency savings.

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

A detailed performance report is provided elsewhere in the Trust's Quality Report.

2.3 Research and development

We recruited 794 patients during 2015/16 to participate in research approved by a research ethics committee.

We currently have 73 actively recruiting Department of Health endorsed (portfolio) research projects. We also participate in a number of studies which are more difficult to recruit to given the complex nature of the inclusion and exclusion criteria. It is important to have these studies open in order to give our patients the opportunity of participating in such studies should they be eligible. Observational studies are run together with interventional studies. Our reputation in the commercial sector continues to grow and we are a top recruiter in the UK for one of our cardiology studies.

We continue with our efforts to ensure we recruit the agreed number of patients in the timescales given.

Progress continues to be made across the Trust to promote further research activity. We now have 4.8 wte Trust-Wide Research Nurses who oversee research in key areas such as Obstetrics and Gynaecology and Cardiology and work to actively engage new areas in research. We also have the equivalent of 3.8 whole time Research Nurses dedicated to Cancer Research.

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

2.4 Impact of the Trust's business on the environment

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

2.4.1 Environmental Matters

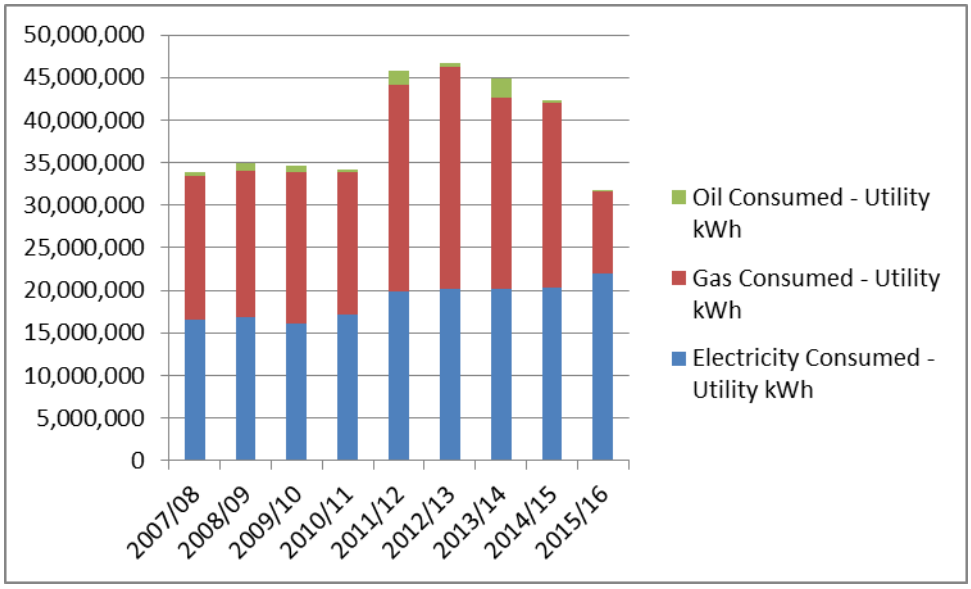
The Great Western Hospitals NHS Foundation Trust recognises that there are many benefits of having a strong focus on all aspects of sustainability, which means we continue to meet the needs of the present without compromising the needs of future generations. There are short, medium and long term advantages 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 the Trust's Sustainability Forum is currently reviewing the progress of the Sustainable Development Management Plan before resubmitting it to the Board. This plan will detail several commitments that future and on-going projects will help us achieve.

2.4.2 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). The Trust took over responsibility for several properties previously managed by WCHS. This correlates to the increase in consumption that is seen in this year and since. To help with energy conservation the Trust has become a Carbon & Energy Fund member and is currently working towards the installation of a Combined Heat and Power unit on site, along with a whole lighting refurbishment moving to LEDs.

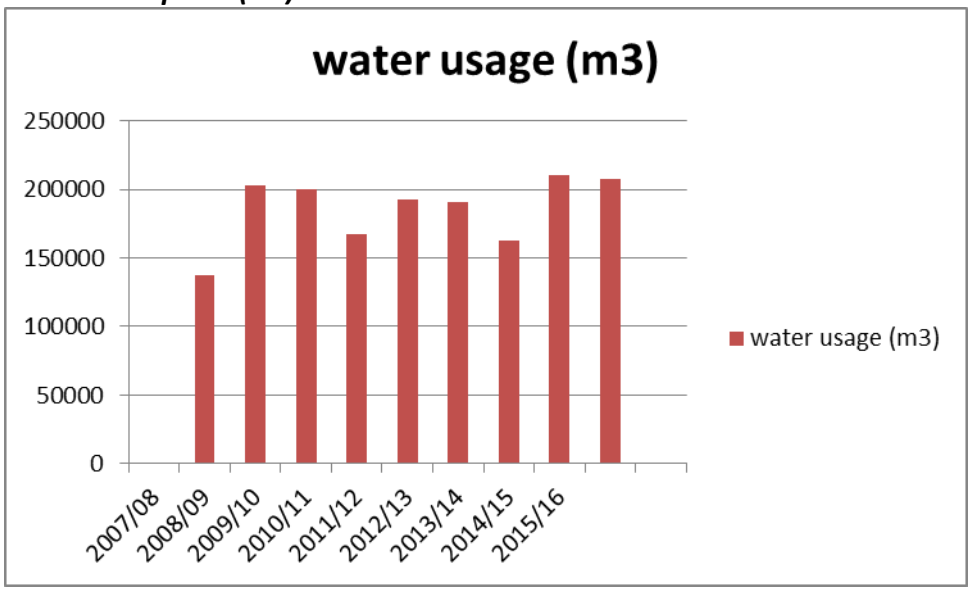
Graph 1 – Utility consumption (KwH)



2.4.3 Water

Water consumption has remained static in the past year. A number of mechanical plant replacement schemes by The Hospital Company should have led to water usage reductions, but several leaks in pipework have also been detected during the year.

Graph 2– Water consumption (m^3)

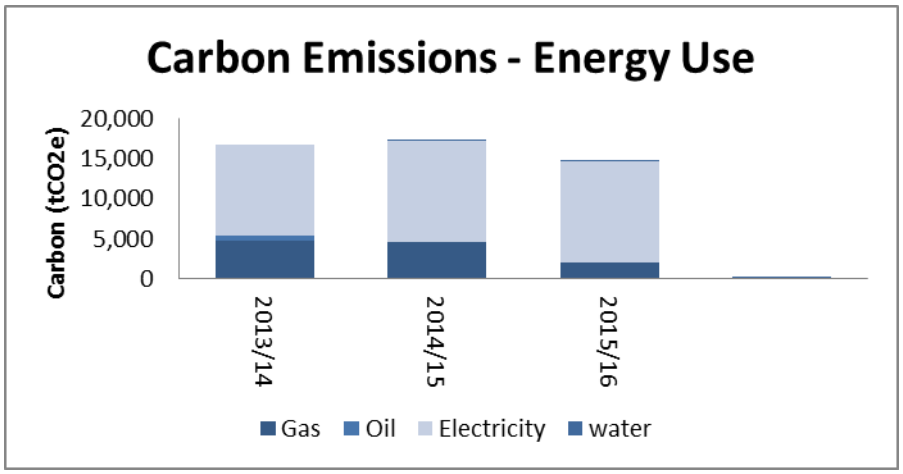


2.4.4 Carbon Reduction

Carbon reduction is one area where the Trust has legal targets. There is NHS Carbon Reduction Strategy which is underpinned by the Climate Change Act[2]. We are working towards achieving a percentage reduction in CO_2e emissions each year which will assist the NHS as a whole with reaching the overall target of reducing 80% CO_2e emissions by 2050. Graph 3 shows carbon emissions in tonnes from utility consumption for the Trust since the baseline year of 2007.

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

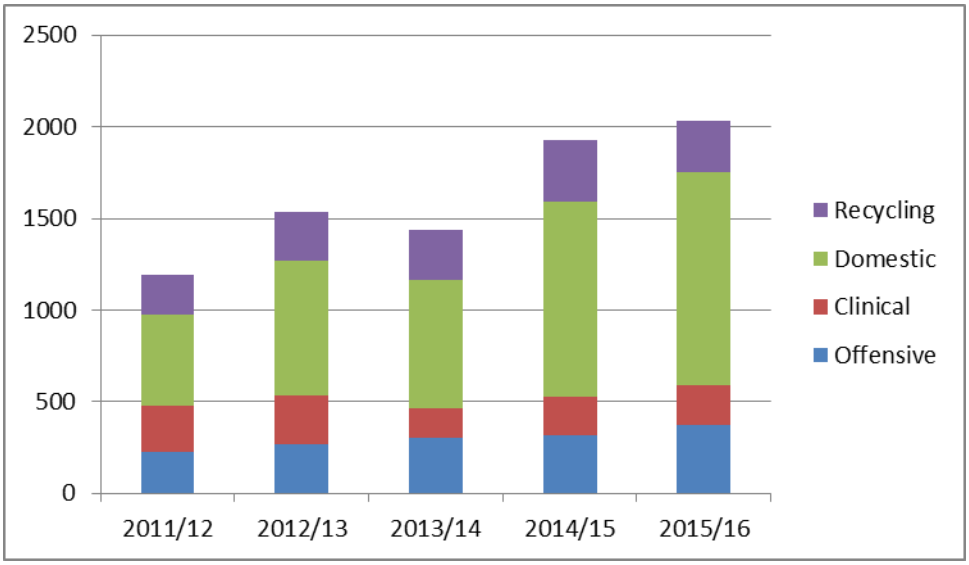
Graph 3– CO_2e emissions for utility consumption (tonnes)



2.4.5 Waste

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

Graph 4 – Waste produced (tonnes)



Note - The tables above show information at the time of printing the annual report. Final data for year end was still awaited.

2.5 Events since year end

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

2.6 Details of overseas operations

None during 2015/16.

2.7 Consultations

There were no formal public or stakeholder consultations during 2015/16.

2.8 Main trends, developments or matters likely to impact on the Trust business in 2016/17

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

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

We know that over the next five years our local population is expected to increase by 3.6% in Wiltshire and 6.9% in Swindon (based on Office of National Statistics (ONS) figures). People over 65 (retirement age population) currently make up 20% of the Wiltshire's population and 15% of Swindon's, and this group will see the largest growth of the next 20 years with the numbers of people over 75 and 85 years old growing fastest.

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

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

Our ageing population and the increased prevalence of chronic diseases such as hypertension, diabetes, coronary heart disease, COPD and respiratory conditions requires a reorientation away from an emphasis on acute care towards prevention, self-care and care that is integrated and provided in the community. This year we have seen an increase in people needing one-to-one nursing due to mental health issues or dementia which reflects the increasing acuity and frailty of the patients we are seeing. Nationally, the number of people expected to be living with dementia is expected to double over the next 40 years and this is reflected locally with the number of people over 65 years old with dementia projected to increase by 22% in Wiltshire and 24.8% in Swindon by 2020 (figures from Projecting Older People Population Information (POPPI) data).

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

As new technologies are introduced, patients expect care and treatment to be available seven days a week, and provided in the most convenient manner to suit their busy lifestyles. As we all become used to seven day services like online shopping and call centres, so too patients expect us to offer similar access and service. This becomes more challenging at a time when money is getting much tighter.

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

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

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

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

We also provide healthcare to people in the borders of the counties around Great Western Hospital (GWH) – Gloucestershire, Oxfordshire and West Berkshire. In general, the health of these areas is better than the England average, and over the last ten years early death rates from heart disease and stroke have fallen. In line with the national trend, the retirement age population is increasing in these areas with associated implications for the Trust as a provider of health care services. Priorities for commissioners in these counties include reducing early deaths from heart disease and stroke, supporting people with long term conditions and reducing childhood obesity. We have seen an increase in the number of GP referrals from West Berkshire (9.9%) and Oxfordshire (13.9%) since 2012/13 as changes in other trusts drive patient flow, and patient choice and traditional geographical boundaries become blurred.

The challenges we are facing at national and trust level are unprecedented, and we are taking a proactive approach to planning for the future to deliver transformational change across our services, which will enable us to deliver high standards of healthcare and positive patient experience.

2.9 Opportunities for the year ahead

The Annual Plan details the overall plan for the next two years. However, listed below are our key priorities for the year ahead:

- Living within agreed budgets and delivering the agreed savings in-line with our 7 transformation programmes
- Working safely and supporting our 500 extra lives initiative
- Delivering Emergency Department (ED), Referral to Treatment (RTT) and Cancer targets in a sustainable and affordable way
- Focus on integration, improve pathways across the system to help manage demand and maintain flow – Swindon & Wiltshire community focus
- Deliver the CQC Improvement Plan

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

Our financial position
If we continue delivering our services in the same way we do now, we are forecast to generate a further financial gap of £63.1m over the next five years. This is not operationally viable, and the Trust is acting on this to make appropriate and effective changes to the way we deliver our services to achieve a sustainable and stable organisation for now, and for the future. A number of transformational programmes are in place to streamline our processes, and our service reviews have highlighted areas to assess for financial stability with service line reporting. This challenge is a priority for the Trust to overcome as quickly and safely as possible, to continue to offer high quality, effective and efficient care to our patients in the longer term.

An ageing population
Many of the diseases that would have killed people 67 years ago - when the NHS was created - are now able to be treated or cured, which is fantastic news for everyone. As our ageing population increases, more people are living with one or more long term complex conditions such as diabetes or heart and kidney disease, which means they need on-going treatment and specialist care. By 2020, we expect our Retirement Age Population to increase to 18.5% in Swindon and 15.8% in Wiltshire with the largest growth in people over 85 years old. This means that as a trust, we are caring for increasing numbers of frail and acutely unwell people who have complex health and social needs.

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

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

Changing patient expectations and rising costs
Originally tackling disease was the main job of the NHS, but we now all expect so much more. From advice on health management through to mental and social care and fast, efficient customer service whether at home, in the community or a hospital environment. This means that limited resources are more stretched to provide the responsiveness and quality of service that patients expect. As new technologies are introduced, patients expect care and treatment to be available seven days a week and provided in the most convenient manner to suit their busy lifestyles. As we all become used to seven day services like online shopping and

call centres, so too patients expect us to offer similar access and service. This becomes more challenging at a time when money is getting much tighter.

Increasing demand
In general, we are experiencing an increase in demand for all our services but in particular more and more people are visiting our Emergency Department and Minor Injury Units as their first port of call. This is stretching the ability of these departments to respond, as well as creating pressure on other services within the Trust. Many people attend these departments because they are open 24/7 and they may be unclear about the most suitable place to access appropriate advice. Every winter sees an increase in the numbers visiting these departments and we need to support people to choose the most appropriate setting of care and understand where to access information and advice. Increased pressure in other sectors such as social services also has a negative impact on the Trust and affects our ability to support patients to return home as soon as possible. We cannot continue as we are with the massive increases in demand we have seen in recent years.

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

The main risks and uncertainties facing the Trust for 2015/16 are included in the Trust's Annual Plan, together with proposed actions to mitigate those risks. Examples are included in the Annual Governance Statement (Section 9 refers).

2.11 Position of the business at the year end

The financial figures reported in the accounts represent the consolidated accounts of the Trust and the NHS Charity in accordance with Foundation Trust Annual Reporting Manual.

The position of the business at the year-end was that the Trust and Charity reported a deficit of £9.7m which was £2.3m better than the Trust's planned deficit of £12m.

The following financial summary relates to the Trust only.

Income was £4.6m above plan. The main driver is outpatient acute activity. Outpatient attendances were 2,156 attendances above plan (primarily in A&E, Cardiology & Oral Surgery). Acute non-elective spells and A&E attendances increased by 5% compared to 2014/15 activity levels with an increase of 3,901 A&E attendance and 1,943 non-elective spells. The community contract also finished the year £1.3m over plan which was in large part due to contract variations not budgeted for at the start of the year.

Expenditure was £2.3m above plan. The main drivers for this were additional capacity and costs associated with additional activity. Drugs were overspent by £3.5m and clinical supplies £0.8m. Although pay expenditure was £4.9m below plan the Trust continued to incur agency and locum costs to fill vacancies and to ensure safe staffing levels.

Savings delivered totalled £16.6m against a target of £14.7m resulting in an overachievement of £1.9m. Of the savings delivered £10.8m were achieved recurrently and £5.8m were delivered non-recurrently. Non-recurrent savings have been carried forward and form part of the CIPS plans for 2016/17.

The cash balance at year end was £1.7m for the Trust which was in line with plan. This was after receipt of £4.9m borrowing from the Department of Health. This borrowing is called Distressed Funding as it is a loan to support a Trust in financial deficit and is not a "normal course of business loan".

2.12 Analysis using financial and key performance indicators

The earnings before interest, taxes, depreciation, and amortization (EBITDA) at year end was £11.668m which was £1.151m better than plan. The EBITDA income percentage was 3.77% against a plan of 3.45%. Creditors at year end amounted to £42m and were £3.7m higher than plan. Creditor days averaged 44.5. The Trust's Financial Sustainability Risk Rating (FSRR) at year end was 2 against a planned rating of 1. This is explained further in the Regulatory Ratings Report (Section 7 refers). Information about the Trust's performance is included in the Quality Report (Section 10 refers).

2.13 Additional activity creating pressure on finances

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

TABLE – GWH Acute Activity

Point of Delivery	2011/12	2012/13	2013/14	2014/15	2015/16	Variance from last year %
New Outpatients	137,504	148,766	160,295	149,247	158,170	***5.6%***
Follow Up Outpatients	263,066	274,326	291,214	299,806	308,468	***3.0%***
Day Cases	27,320	27,838	30,969	33,059	33,934	***2.8%***
Emergency Inpatients	35,804	38,192	39,178	43,055	45,341	***5.8%***
Elective Inpatients	6,723	6,343	6,247	5,936	5,863	***-1.2%***
Emergency Department Attendances	70,731	77,642	75,440	78,522	82,425	***5.1%***
Total	***541,148***	***573,107***	***603,343***	***609,655***	***634,201***	

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

TABLE – Community Activity

Point of Delivery	2011/12	2012/13	2013/14	2014/15	2015/16	Variance from last year %
Minor Injuries Unit	46,507	41,755	42,884	44,315	**47,277**	**6.68%**
Admitted Patients	7,445	8,498	7,998	2,311	**1,181**	**-48.90%**
Community contacts including outpatients	803,545	789,473	804,341	716,513	**633,423**	**-11.60%**
Total	***857,497***	***839,726***	***855,223***	***763,139***	***681,881***	**-10.65%**

Note –The inpatient admissions (community activity only) between 2014/15 and 2015/16 have decreased due to the reduction in beds. Contacts have decreased across the same period due to the implementation of SystemOne. Due to training of staff some data was not recorded

2.14 Contractual arrangements

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

2.15 Continued investment in improved services for patients

During 2015/16, the Trust agreed the following investments to improve services for patients:

- £1.145m Gastroenterology Business Case to enable Joint Advisory Group Intestinal Endoscopy (JAG) accreditation and ensure the ongoing viability for the Endoscopy Service (funding for consultants, nursing staff and equipment).

- £0.482m Urology Business Case to provide for further capacity and an additional Urologist to meet demand.

- £0.300m Orthodontics Business Case to ensure capacity available to meet demand.

- £0.120m Community Step Up/Step Down Beds for direct GP referrals to avoid acute admissions.

- £0.170m Safer 7 Day Working pilot within Unscheduled Care funded by Clinical Commissioning Group (CCG).

- £0.100m Therapies at the Front Door pilot within Diagnostics & Outpatients funded by the CCG to provide extended therapy services.

- £0.357m Ambulatory Care to provide additional staffing for the provision of the service.

- £0.150m funding to Divisions to support delivery of Commissioning for Quality and Innovation (CQUIN).

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

As at 31 March 2016 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 secured a £10million loan for healthcare provision in 2014/15 of which £5m was drawn down in 2015/16. Furthermore, the Trust received £2m working capital facility during the year which was repaid in year. Also the Trust received £4.9m distressed funding from the Department of Health.

2.17 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. There is no significant difference between market values and book values.

2.18 Donations

There are no political or charitable donations to disclose.

2.19 Future developments

During 2015/16 the Trust developed a 5 Year Integrated Business Plan, setting our strategy and areas of key focus for the future, our 2020 vision. Future developments are also detailed within the Trust's Annual Plan. These include:

1. **A Whole System Approach**

   We plan to remodel our secondary care services so that they are wrapped around community and social care, putting in place processes to support patients to live healthily at home for as long as possible, and when care is needed for it to be provided in the most suitable setting. Good progress has been made on this. During 2015 the Trust successfully bid for Adult Community Services in Wiltshire through a Joint Venture with Royal United Hospitals Bath NHS Foundation Trust and Salisbury NHS Foundation Trust. This service is currently mobilising and will go live in July 2016.

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

2. **Emergency Department (ED) & Non-Elective Demand**

   Over the past year, the Trust has seen an increase in emergency activity (quarters 1 to 3) compared to 2014/15 by 2.34%; this is lower than the planned activity increase for 2015/16. From a NEL (Non-Elective) perspective the Trust has continued to see growth, with a 3% increase in all non-elective admissions from 2014/15 to 2015/16.

   This level of sustained pressure on the Trust's bed capacity requires both the Trust and the Commissioners to consider system wide changes to pathways and increased use of non-acute models of care, if the local health systems are to remain financially viable and financial and access targets are to be achieved.

   This work is in progress and is being monitored system wide via the local Strategic Resilience Group. To support and oversee this work a Right Patient, Right Bed Steering Group has been established to oversee the Trust actions required to deliver this aspect of the system's 4 hour Remedial Action Plan (RAP). This includes assess to admit, discharge to assess, and length of stay initiatives.

   Delivery of the Great Western Hospital (GWH) 4 Hour Acute Service RAP incorporates the Care Quality Commission (CQC) recommendations, the SAFER bundle (described in the box below) and the Right Patient, Right Bed programme which is designed to improve quality and performance through effective flow management contributing to improved ED performance. It is underwritten by a performance trajectory that sees the 95% target achieved by July 2016, and sustained for the remainder of 2016/17. The RAP is a whole system plan and Commissioners and community health and social care provider partner organisations have committed, within the RAP, to reduce the current high levels of Delayed Transfers of Care (DTOC) and non-DTOC delays by 50% sustainably from quarter 2. The Trust achievement of the 95% target is dependent on partner organisations delivering on their commitment to reduce DTOC and non-DTOC patient delays by 50% sustainably from quarter 2 2016/17. This caveat has been fully acknowledged by commissioners.

   If the 50% reduction target in DTOCs and other delays is not achieved by quarter 2, the Trust would therefore seek to see a revision of the ED trajectory with commissioners.

   Over the longer term, as part of the Sustainability & Transformation Plan (S&TP), the system will need to ensure there is a credible solution to both out of hospital capacity and bed capacity in hospital as growth in Swindon continues with demographic and population changes. This is being

explored through an internal demand and capacity group to feed into the thinking around the emerging S&TP.

Note - The SAFER patient flow bundle is similar to a clinical care bundle.

S – Senior Review. All patients will have a senior review (preferably by a Consultant) before midday.

A – All patients will have an Expected Discharge Date (that patients are made aware of) based on the medically suitable for discharge status agreed by clinical teams. Patients and their loved ones need to know the answer to simple questions such as what is going to happen to me today, what is going to happen to me tomorrow and what do I need to do to leave hospital (in a patient's language).

F – Flow of patients will commence at the earlier opportunity (by 10am) from assessment units to inpatient wards. Wards (that routinely have patients transferred from assessment units) are expected to 'pull' the first (and correct) patient to their ward before 10am.

E – Early discharge, 33% of patients will be discharged from base inpatient wards before midday. TTO's (medication to take home) for planned discharges should be prescribed and with pharmacy by 3pm the day prior to discharge wherever possible to do so. If not they should be prepared in real time wherever possible to do so rather than leaving them to later in the day which results in unnecessary waiting for patients.

R – Review, a weekly systematic review of patients with extended lengths of stay (> 14 days) to identify the issues and actions required to facilitate discharge. This needs to be led by clinical leaders (with support from health and social care colleagues) supported by operational managers who will help remove constraints that lead to unnecessary patient delays.

3. Cancer

A key priority for the coming year is focussing on cancer capacity as demand has steadily increased. This follows on from a Feasibility Study carried out in 2014/15 looking at how the Trust can accommodate the expected increase in demand in the coming years. Whilst this is a long term piece of work, the immediate priority is to reconfigure services to manage the numbers of cancer patients currently being seen.

4. Referral to Treatment (RTT)

The delivery of RTT has relied on clearing the backlog partly through Waiting List Initiatives (WLIs), Virtual Activity and Outsourcing. Over the next year, to ensure financially sustainable delivery of the target, the Trust is focussed on demand and capacity modelling, together with a new approach to business planning and business cases to ensure a clear and transparent process for Divisions to seek funding for additional activity in a planned way.

5. Future Activity Planning

As part of the current business planning process the Trust is now undertaking a bottom up activity planning methodology to inform divisional business plans. This task is owned by the clinical delivery leads to ensure that there is full understanding of the data that is being used to develop the overall model. Each clinical division will build, develop and refine their activity data to better plan and inform decisions on future provision. This will form the basis of our activity planning for 2016/17 and 2017/18.

6. Quality & CQC Improvement

Our recent routine inspection by the Care Quality Commission (CQC) showed areas of strength and areas for improvement. Our kind and compassionate care was clear to the inspectors, who saw first-hand how we treat patients with dignity and respect. Inspectors observed many examples of high quality care and an organisation with solid foundations, a clear vision and established leadership. We knew many of the challenges highlighted and many improvements are already underway, but this inspection has given us a fresh perspective into where further progress can be made. Our culture of kindness and compassion, which is fundamental to safe and high quality care, gives us a strong foundation to build upon.

7. Transformation

The Trust achieved a total of £16.6m savings in 2015/16, including £5.8m non-recurrent savings. Our transformation/savings programme for 2016/17 is focused on recurrent cost reduction to achieve a year end surplus of £0.6m (including provision of STF funding).

As we look ahead to 2016/17, CIP delivery and cash flow represent the two most high profile financial risks to the Trust which emphasises the need for cost reduction as the primary focus of our transformation plans.

Traditional opportunities for CIP delivery will continue to be the focus of the savings plan for 2016/17. However as we look ahead, based on the Long Term Plan, the financial gap over the next five years stands at £62m, if there is no change in the way services are provided. The Trust therefore needs to ensure that 2016/17 is a transition year moving from turnaround and traditional CIP delivery to transformation as the route to long term sustainability.

The Trust has established 7 cross-cutting workstreams, each led by an accountable officer:

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

8. Long Term Financial Viability

2015/16 has been a challenging year for the Trust in terms of finances. It has meant we have had to deliver a step change in how we work as an organisation when it comes to issues of finance. We have seen good progress in developing a different financial culture, one which embraces and supports financial accountability, knowledge and success. Key support functions have been strengthened in order to better support the clinical divisions, notably Finance Team and the Programme Management Office (PMO). More recently changes are taking place within our Informatics function so that we are supporting the best clinical care with the right data for staff to make the right decisions in a timely manner.

Governance processes have been strengthened following an independent financial governance review and there is a clear, robust process to support executive leads and divisional directors through the Project Management Office (PMO) ensuring good solid governance and decision making is in place to protect patient safety and quality of care during a cost reduction programme.

During 2015/16 the Trust entered Monitor enforcement action. Since then the Trust has made substantial progress and has received positive feedback from Monitor. There is still work to be done but the Trust has emerged from turnaround and is now looking longer term and to transformation.

The Trust has achieved a strong CIP performance for 2015/16 and has a difficult but achievable CIP target for 2016/17 which will result in the Trust moving from a deficit position to a small surplus. To achieve long term viability the Trust cannot keep cost cutting without compromising patient quality and care, therefore the Trust's move from turnaround to transformation now focuses heavily not on cost saving but also service redesign and a more resilient and in-depth business planning approach which includes robust governance control.

One of the Trust's largest financial commitments is the PFI relating to Great Western Hospital. Over the coming year the Trust will be working closely with Monitor, the Department of Health and HM Treasury to look and consider all suitable options that may lower the financial burden to the Trust.

Our long term financial plan fully supports our whole system approach.

2.20 No Trust branches outside UK

The Trust does not have branches outside the UK.

2.21 Notes to the Accounts

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

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

2.22 Explanation of amounts included in the annual accounts

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

2.23 Preparation of the Accounts

The accounts for the period ended 31st March 2016 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 Preparation of the Annual Report and Accounts

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

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

Approved by the Board of Directors

Signed

Nerissa Vaughan, Chief Executive
Accounting Officer

23 May 2016

ACCOUNTABILITY REPORT

3 Directors' Report

General Companies Act Disclosures

3.1 Directors of Great Western Hospitals NHS Foundation Trust

Directors of Great Western Hospital NHS Foundation Trust during 2015/16: -

Roger Hill	Chairman
Nerissa Vaughan	Chief Executive
Roberts Burns	Non-Executive Director
Liam Coleman	Non-Executive Director Senior Independent Director
Oonagh Fitzgerald	Director of Human Resource
Angela Gillibrand	Non-Executive Director Deputy Chairman
Karen Johnson	Director of Finance (from 3 August 2015, acting Director of Finance from 28 February 2015)
Michelle Kemp	Chief Operating Officer (until 31 May 2015)
Jemima Milton	Non-Executive Director
Maria Moore	Deputy Chief Executive & Director of Finance and Performance (until 6 April 2015)
Steve Nowell	Non-Executive Director
Guy Rooney	Medical Director
Julie Soutter	Non-Executive Director
Hilary Walker	Chief Nurse

Non-Voting Board Members

Douglas Blair	Director of Community Services
Kevin McNamara	Director of Strategy

3.2 Board of Directors

The Board of Directors or Trust Board is comprised of Executive, Non-Executive Directors and Non-Voting Members and has overall responsibility for the performance of the Trust. The Board determines strategy and agrees the overall allocation of resources and ensures that adequate systems and processes are maintained to measure and monitor the Trust's effectiveness, efficiency and economy as well as the quality of its healthcare delivery. The Board takes decisions consistent with the approved strategy. The Executive Directors are responsible for operational management of the Trust. Non-voting Board Members do not have executive powers. Brief biographies for Board Members in 2015/16 are set out below.

3.3 Biography of individual Directors

Roger Hill, Chairman

	Roger was appointed to the Board in April 2008. Until 1999 he had been both the Chairman and Managing Director of the UK subsidiary of Intergraph Corporation, a large American computer company. Subsequently he was a Board Director of a number of IT services companies, both in the UK and Ireland. Until 2008 he was a Governor of Newbury College. Roger was re-appointed as a Non-Executive Director in January 2012 for a further term of three years ending 30 April 2015. Roger was appointed the Senior Independent Director of the Trust from 1 October 2012. In 2013/14 Roger was appointed Chairman of the Trust from 1 February 2014 for a three year term ending 31 January 2017 and therefore he ceased to be the Senior Independent Director. In 2015/16 Roger was an invitee of the Finance, Investment and Performance Committee. He was also a member of the Remuneration Committee and the Joint Nominations Committee.

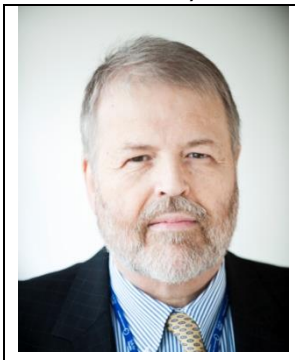
Nerissa Vaughan, Chief Executive

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

Douglas Blair, Director of Community Services

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

Robert Burns, Non-Executive Director



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

In 2015/16 Robert was Chair of the Audit, Risk and Assurance Committee up until 31 December 2015. Throughout the year he was also a member of the Mental Health Act/ Mental Capacity Act Committee and the Remuneration Committee. In addition Robert became a member of the Governance Committee on 1 January 2016.

Liam Coleman, Non-Executive Director and Senior Independent Director

Liam Coleman joined the Co-operative Bank in June 2013 as Treasurer, to deliver the Bank's recapitalisation and support its wider turnaround. On 1 September 2014, he assumed the role of Managing Director, Retail and Corporate Banking, reporting to Bank CEO Niall Booker. Based in split location between London and Manchester, he continues as a member of the Bank's Executive Team. Previous employers include Nationwide Building Society and RBS plc. He joined Nationwide in 1996, with his final position as Group Director (from 2009-11) and membership of their Executive Directors' Committee. His move to RBS in 2011 was as Deputy Group Treasurer, Head of Capital Management, responsible for four teams in Group Treasury.

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

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

In 2015/16 Liam was Chair of the Finance and Investment Committee and Chair of the Remuneration Committee. Liam was a member of the People Strategy Committee and the Joint Nominations Committee.

Oonagh Fitzgerald, Director of Human Resources

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

Angela Gillibrand, Non-Executive Director and Deputy Chair

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

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

In 2015/16 Angela was Chair of both the Governance Committee and the Mental Health Act/Mental Capacity Act Committee. Angela was a member of the Audit, Risk and Assurance Committee and the Remuneration Committee. She was a member of the Joint Nominations Committee up until 31 December 2015 and she became a member of the Finance and Investment Committee on 1 August 2015.

Karen Johnson, Acting Director of Finance *(from 3 August 2015, previous acting Director of Finance from 28 February 2015)*

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

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

Karen joined the NHS in January 2010 and is committed to ensuring the public sector provides good value for money whilst maintaining good quality services. Karen was appointed Acting Director of Finance on 28 February 2015 and was later appointed as the substantive Director of Finance on 3 August 2015.

Jemima Milton, Non-Executive Director

Jemima has been involved in Local Government for the last 15 years, first as a Councillor in Swindon holding a number of cabinet positions and then as a Councillor in Wiltshire where she took a key interest in Health and Social Care. Jemima was an active partner in the family farm with her late husband and during this time ran a catering company and then a Bed and Breakfast business.

In 2015/16 Jemima was Chair of the People Strategy Committee. .Jemima was also a member of member of the Audit, Risk and Assurance Committee, the Charitable Funds Committee, the Governance Committee and the Remuneration Committee.

Kevin McNamara (Director of Strategy – Non Voting Board Member)

Kevin first joined the Trust is November 2009 as Head of Marketing and Communications and has worked in the NHS for over 10 years. Kevin previously worked at South Central Strategic Health Authority (SHA) leading on public campaigns, market research, stakeholder engagement and parliamentary business. Before that Kevin worked for Thames Valley SHA on media relations. In his previous role in the Trust, Kevin lead on all aspects of communications and reputation management including the Patient Advice and Liaison Service and the way the Trust investigates and responds to complaints and other customer feedback. In December 2013 Kevin was appointed as the interim Director of Strategy. He is the Board lead for developing and implementing a five-year plan for the Trust and for identifying new business opportunities through bids, tenders and fundraising.
Kevin was appointed to the substantive position of Director of Strategy on 10 April 2014.

Steve Nowell, Non-Executive Director

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

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

Steve became a Non-Executive Director on 1 June 2014. During 201516 he was Chair of the Charitable Funds Committee. Furthermore, he was a member of the Finance, Investment and Performance Committee, Governance Committee, People Strategy Committee and Remuneration Committee.

Guy Rooney, Medical Director *(from 1 April 2015)*

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

Julie Soutter, Non-Executive Director

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

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

Julie has held a number of non-executive roles in the NHS, public and charitable sectors. She has been a Non-Executive Director since 1 January 2015. During 2015/16 Julie was a Committee member of Audit, Risk and Assurance Committee becoming Chair of that Committee on 1 January 2016. Julie was also a member of the Mental Health Act / Mental Capacity Act Committee and the People Strategy Committee up until 31 July 2015 and was a member of the Governance Committee up until 31 December 2015. Julie became a member of the Finance Investment and Performance on 1 August 2016 and a member of the Joint Nomination Committee on 1 January 2016. Throughout 2015/16 Julie was a member of the Remuneration Committee.

Hilary Walker, Chief Nurse

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

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

Michelle was appointed to GWH as Chief Operating Officer in October 2014. Michelle left the Trust's employment on 31 May 2015.

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

Maria was appointed as Director of Finance and Performance in September 2008. Maria was appointed as Deputy Chief Executive from 1 April 2014. Maria left the Trust on 6 April 2015.

3.4 Length of appointments of Non-Executive Directors

Listed below are details of the length of appointments of those Non-Executive Directors who held office during 2015/16. Appointments are shown from 1 December 2008, being the date of Authorisation as a Foundation Trust.

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

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

No new Non-Executive Directors were appointed during 2015/16. *These Non-Executive Directors were re-appointed during 2015/16. The process involved assessment by the Joint Nominations Committee. The following considerations were taken into account and matched against a job description and person specification in respect of each re-appointment / appointment: -

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

The appointments were approved by the Council of Governors.

As recommended by the Local Counter Fraud Service (LCFS), the names of all Trust Directors (Executive and Non-Executive) are cross-referenced with the Disqualified Directors Register on the Companies House website on an annual basis. No Trust Directors appeared on the Disqualified Directors Register (as of 14 April 2016).

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

The Non-Executive Directors are all considered to be independent of the Foundation Trust and the Trust Board believes it has the correct balance, completeness and appropriateness in its composition to meet the requirements of an NHS Foundation Trust.

The Board is committed to reviewing its balance and composition in order to maintain its effectiveness. During 2015/16, the Trust again mapped the skills required from Directors on 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 2015/16 recruitment commenced for new Non-Executive Directors. On 30 March 2016 the Joint Nominations Committee recommended to the Council of Governors two candidates for appointment one with financial and accountancy experience and the other with extensive clinical expertise and knowledge. The Trust may appoint up to seven Non-Executive Directors in addition to the Chairman.

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

During 2015/16 there was change and refreshment of the Board, which is continuing. There were no new Non-Executive Directors but, as explained above, one Non-Executive Director was re-appointed and recruitment took place for new Non-Executive Directors, two of which are due to commence in post in July and August respectively. A new Director of Finance commenced on 3 August 2015 (previously interim appointment). The Chief Operating Officer position remains vacant following the resignation of the post holder. However, the post is covered by an interim appointment but not as an Executive Director.

The Board considered its effectiveness in terms of decision making, refreshing its reserved powers, the Scheme of Delegation and the Terms of Reference of the Board Committees.

For individual Non-Executive Directors, the Trust has in place a framework for their appraisal based on elements of the Hay Group work and best practice from other Foundation Trusts. In June 2014 a formal appraisal process for the Chairman and the Non-Executive Directors was undertaken by the Council of Governors. The evaluation of the Chair's performance was led by the Senior Independent Director with input from the Lead Governor and the Chief Executive on behalf of the Executive Directors and having regard to the views of the other Non-Executive Directors. The Chief Executive and Non-Executive Directors' performance was evaluated by the Chairman taking account of Governors' and other Directors' input. The Executive Directors' appraisals were led by the Chief Executive in March/April 2016, and will be reported through the Remuneration Committee in May 2016 following a formal appraisal process.

External evaluations of the Board and / or governance of the Trust commenced in February 2016 under Monitor's Well Led Governance Framework. This is being undertaken by Deloitte as an independent reviewer and a report is expected in May 2016.

3.7 Attendance at meetings of the Board of Directors during 2015/16

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

	30.04.15	11.05.15 (extraordinary meeting)	04.06.15	02.07.15	28.07.15	06.08.15	03.09.15	01.10.15	05.10.15 (extraordinary meeting)	27.10.15	05.11.15	12.11.15 (additional meeting)	03.12.15	07.01.16	25.01.16	04.02.16	22.02.16	03.03.16
Robert Burns	✓	✓	×	×	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Liam Coleman	✓	✓	×	✓	✓	×	✓	✓	×	×	✓	×	✓	✓	✓	✓	✓	✓
Oonagh Fitzgerald	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	✓	✓	✓	✓	✓	✓	✓	✓
Angela Gillibrand	✓	×	×	✓	✓	✓	✓	×	×	×	✓	✓	✓	✓	✓	✓	✓	✓
Roger Hill	×	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	✓	×
Karen Johnson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Michelle Kemp (until 31.05.15)	✓	✓	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Jemima Milton	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Maria Moore (until 06.04.15)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Steve Nowell	✓	✓	✓	✓	×	✓	✓	✓	×	✓	✓	✓	✓	✓	×	✓	✓	✓
Guy Rooney	✓	✓	✓	✓	✓	✓	×	✓	✓	✓	✓	×	✓	✓	✓	✓	✓	✓
Julie Soutter	✓	✓	✓	✓	✓	✓	✓	✓	×	✓	✓	✓	✓	✓	✓	×	✓	✓
Nerissa Vaughan	✓	✓	×	✓	✓	✓	×	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Hilary Walker	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Douglas Blair (non-voting member)	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	×	×	✓	✓	✓	✓	✓	✓
Kevin McNamara (non-voting member)	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	✓	✓	×	✓	✓	✓	✓	✓

There was a Joint Council of Governors and Board on 11 June 2015.

3.8 Decisions reserved for the Board of Directors

There are certain matters which are reserved for the Board of Directors to decide relating to regulation and control; appointments; strategic and business planning and policy determinations; direct operational decisions; financial and performance reporting arrangements; audit arrangements and investment policy.

The Reservation of Powers to the Board was refreshed in June 2015 and will be refreshed again during 2016. A full copy can be obtained from the Company Secretary.

3.9 Interests of Directors

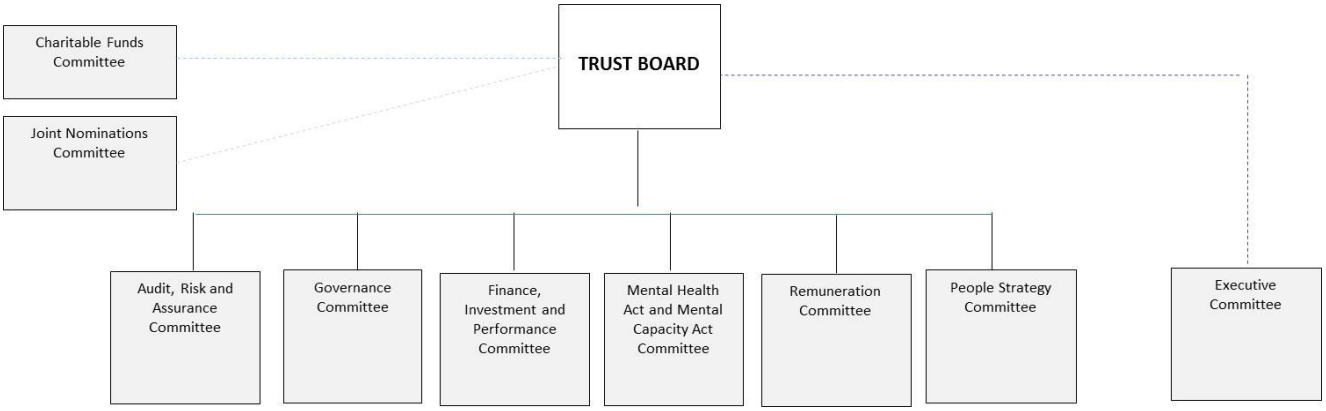
A Register of Interests of Directors is maintained, a copy of which can be obtained from the Company Secretary.

3.10 Significant commitments of the Chairman

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

3.11 Committee structure

The structure of the Board committees during 2015/16 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.

3.12 Key Committees

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

The Board has established the following committees: -

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

* Statutory Committees

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

3.13 Accounting policies for pensions and other retirement benefits

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

3.14 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.

3.15 Cost allocation and charging requirements

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

3.16 Political Donations

There were no political donations during 2015/16.

3.17 Better payment Practice Code

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

3.18 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.

3.19 Enhanced Quality Governance Reporting

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

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

Arrangements are in place to ensure quality governance and quality is discussed in more detail within the Annual Governance Statement (Section 9 refers).

3.20 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 10 refers) and in the Annual Governance Statement (Section 9 refers).

During 2015/16 the Trust had in place a number of plans and processes which contribute to ensuring Quality Governance. Examples of this include: -

- On-going development of the Trust's business strategy with particular emphasis on quality. In addition, sitting under the Trust Strategy, is a Quality Strategy specifically focussed on patient care, a good patient experience and good clinical outcomes.

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

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

- Ongoing refreshment of the Board to ensure that the Board has the necessary skills and qualities to manage the Trust and deliver the quality agenda.

- Promotion of a quality focused culture throughout the Trust evidenced by the role 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.

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

- 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 Quality Report, which includes metrics and analysis of essential quality indicators.

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

- During the year there was a Care Quality Commission (CQC) Inspection. During the course of the year there was a trust wide programme of learning and training to understand the CQC regulations and key lines of enquiry.

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

Patient Care

3.21 Development of services to improve patient care

We treat thousands of patients every year as outlined in the Performance Report (Section 2 refers). Service improvements are also included in the Performance Report (Section 2 refers).

3.22 Performance against key healthcare targets

Details of performance against key healthcare indicators is set out elsewhere in the Quality Report (Section 10 refers).

3.23 Arrangements for monitoring improvements in the quality of healthcare

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

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

3.24 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 is reported to Monitor quarterly.

Progress towards targets as agreed with local Commissioners, together with details of other key quality improvements, are included in the Quality Report (Section 10 refers).

3.25 New or significantly revised services

Details of services throughout the year are included in the Overview of Performance Report (Section 1 refers).

There were no new or significantly revised services during 2015/16 other than those detailed below.

The Trust did decide not to continue with Wiltshire Children & Young People's Services at the time that this service came to tender. As a result, this service transferred to Virgin Healthcare from 01/04/16. In addition, due to the bundling of locations, the Trust was unable to bid for health services delivered to HMP Erlestoke. As a result this service transferred to Bristol Community Health from 1 April 2016.

The business planning process has been updated during 2015/16. Part of this process included the development of a 5 Year Integrated Business Plan and Strategic Service Reviews (SSRs) for all operational and back office services. The outputs of these SSRs have formed part of our Annual Plan, will continue to inform our future development and will be reviewed and updated on a quarterly basis from 2016/17.

3.26 Improvement in patient / carer information

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

3.27 Focusing on the patient

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

3.28 Complaints Handling

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

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

3.29 Using patient experience to drive service improvements

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

Stakeholder Relations

3.30 Partnerships and alliances

During the course of the year we have continued to place significant emphasis in building strong relationships with local providers and commissioners. In respect of the Wiltshire health community, we have worked extensively with local GPs, voluntary sector organisations, the CCG and the public to develop our Joint Venture, Wiltshire Health & Care which is due to go live in June 2016. The establishment of the Joint Venture in itself is a leap forward in joint partnership working. For the first time we will be working (on an equal basis) with two other Trusts (Royal United Hospitals Bath NHS Foundation Trust and Salisbury NHS Foundation Trust) to deliver community services. This link-up will allow us to share knowledge and best practice, improve pathways and patient care and potentially identify ways of working smarter and more efficiently.

Looking forward, the Trust is actively working to develop partnerships and closer working relationships with a network of organisations across Swindon, which will place us well in our longer term ambition to become an Accountable Care Organisation.

Work has continued with our partners at the Oxford University Hospitals NHS Trust on plans to develop a local Radiotherapy Unit on the Great Western Hospital site in Swindon. Our Trust Board has made a clear commitment to support the development of this vital service, which will mean local people who require radiotherapy no longer need to travel to and from Oxford for treatment. The development was given the official go ahead in March 2016. A crucial element of the development of this service will be a multi-million fundraising appeal, which was launched in early 2015 by our Trust, and which as of April 2016 had already reached the £500,000 mark.

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

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

3.32 Health and Overview Scrutiny Committees (HOSCs)

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

3.33 Local Healthwatch organisations

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

3.34 Public and patient involvement activities

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

Additional disclosures

3.35 Statement as to disclosures to auditors

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

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

3.36 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.

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 Non-Voting Board Members and to develop, maintain and implement a remuneration policy that will enable the Trust to attract and retain the best candidates. The Committee reviews the structure, size and composition (including the skills, knowledge and experience) required of the Board and gives consideration to and is responsible for succession planning. The responsibility for carrying out these duties rests with the Remuneration Committee whilst the accountability for the actions of the Committee remains with the full Board.

Executive Directors and Non-Voting Board Members are in senior positions that influence the decisions of the Trust as a whole.

4.2 Membership of the Remuneration Committee

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

4.3 Membership and attendance at meetings of the Remuneration Committee during 2015/16

There were 2 meetings of the Remuneration Committee during 2015/16. Membership and attendance is set out below.

	Record of attendance at each meeting (✓ = attended × = did not attend n/a = was not a member)	
	14 May 2015	**12 November 2015**
Robert Burns	✓	✓
Liam Coleman (Chair)	✓	×
Angela Gillibrand	✓	✓
Roger Hill	✓	✓
Steve Nowell	✓	✓
Jemima Milton	✓	✓
Julie Soutter	✓	✓
Nerissa Vaughan	✓	✓

4.4 Policy and guidance

In exercising its responsibilities, the Committee: -

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

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

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

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

In May 2015 the Remuneration Committee undertook its annual review of remuneration, excluding the variable pay element. The Remuneration Committee wishes to ensure that Directors' remuneration reflects current market levels, thus enabling the Trust to continue to recruit and retain high calibre Directors. Benchmarking information relating to other Trusts was considered and basic pay was reviewed to reflect benchmarking rates.

The following steps were taken to ensure that the Committee satisfied itself that it was reasonable to pay one or more senior managers more than £142,500: -

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

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

The variable pay scheme (suspended throughout 2015/16) is as follows: -

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

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

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

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

The Director remuneration was considered in the context of senior manager's remuneration in that at the time of extending variable pay from the Chief Executive to the Executive Directors it was intended that a variable pay scheme would be replicated to the senior management via a phased approach. However, as the variable element of the scheme has been suspended the Remuneration Committee decided in November 2015 not to proceed with variable pay for senior manager below Board level.

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

4.6 Service contract obligations

There are no service contract obligations.

4.7 Performance of senior managers

The appraisal process for the Chief Executive and Executive and Non-Voting Directors involves an annual review of the objectives set and performance against those objectives. These are agreed by the Chairman and Chief Executive respectively and reported through the Remuneration Committee.

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

4.8 Board of Directors' employment / engagement terms

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

The Chief Executive and Executive Directors have a contract with no time limit and the contract can be terminated by either party with six months' notice as per NHS Employers standard Director contract. These contracts are subject to usual employment legislation. New Director contracts include claw back clauses for any variable payment and fit and proper person disqualification provisions, 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. The policy for loss of office payment is that the Trust would normally pay not more than contractual notice period. Any exceptions would be considered at the Remuneration Committee on a case by case basis.

4.9 Remuneration of Non-Executive Directors

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

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

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

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

This report contains a summary of the work of the Remuneration Committee during 2015/16. There were no major decisions on senior managers' remuneration during 2015/16 although there was uplift to basic salaries. The context in which this occurred was to bring senior manager salaries in line with market rates and was considered having regard to relativities of senior staff pay.

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

Michelle Kemp, the Chief Operating Officer left the Trust on 31 May 2015. The Chief Operating Officer post is currently vacant but the Trust has in post an interim Chief Operating Officer (Non-Board member appointment).

Disclosures required by Health and Social Care Act

4.11 Expenses of Directors and Governors

Expenses 2015-16 (unaudited)

Note - The total number of directors in office during 2015/16 was 16 (2014/15: 16) and the total number of Governors in office was 24 (2014/15: 22)

Name	Title	Expenses 2015-16 £
Robert Burns	Non-Executive Director	1547.72
Liam Coleman	Non-Executive Director	0
Angela Gillibrand	Non-Executive Director	74.48
Roger Hill	Chairman	1173.64
Jemima Milton	Non-Executive Director	0
Steve Nowell	Non-Executive Director	564.40
Julie Soutter	Non-Executive Director	148.70
Douglas Blair	Director of Community Services (non-voting)	1626.53
Oonagh Fitzgerald	Director of Workforce & Education	221.20
Karen Johnson	Director of Finance	0
Michelle Kemp	Chief Operating Officer (to May-15)	2920.20
Maria Moore	Deputy Chief Executive & Director of Finance (to Apr-15)	118.84
Kevin McNamara	Director of Strategy (non-voting)	1384.54
Guy Rooney	Medical Director	2514.73
Nerissa Vaughan	Chief Executive	554.40
Hilary Walker	Chief Nurse / Chief Nurse	678.82
Total		**13,528.20**

Name	Title	Expenses 2015/16 £
Shane Apperley	Staff Governor (to Jul-15)	0
David Barrand	Nominated Governor	0
Orli Berman (previously known as Elizabeth Garcia)	Public Governor	0
Roger Bullock	Public Governor (to Nov-15)	0
Lisa Campisano	Staff Governor	0
Anna Collings	Nominated Governor (from Nov-15)	0
Pauline Cooke	Public Governor (from Nov-15)	0
Mike Halliwell	Public Governor (to Nov-15)	0
Peter Hanson	Staff Governor	0
Louise Hill	Public Governor	508.92
Ian James	Nominated Governor	0
Janet Jarmin	Public Governor	943.60
Hayley Madden	Staff Governor (to Sep-16)	0
Brian Mattock	Nominated Governor	0
Phrynette Morrison	Nominated Governors (from Aug-15)	0
Sheila Parker	Nominated Governor	0
Kevin Parry	Public Governor	0
Peter Pettit	Public Governor	226.80
Martin Rawlinson	Public Governor (from Aug-15)	0
Saul Richardson	Staff Governor (from Nov-15)	0
Ros Thomson	Public Governor	0
Margaret White	Public Governor	678.16
Edward Wilson	Nominated Governor (to Sep-15)	0
Robert Wotton	Public Governor	0
Total		**2,357.48**

Expenses 2014/15

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

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

Note Michelle Kemp's expenses include a relocation sum

Information subject to audit

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

4.12 Pension Benefits and Remuneration

Pensions Benefits 2015-16

Name (alphabetical order)	**Title**	**Real Increase in Pension 2015-16 (Bands of £2500)**	**Real Increase in Lump Sum 2015-16 (Bands of £2500)**	**Total accrued pension at 31st March 2016 (Bands of £5000)**	**Total accrued related lump sum at 31st March 2016 (Bands of £5000)**	**Cash Equivalent Transfer Value at 31st March 2016**	**Cash Equivalent Transfer Value at 31st March 2015**	**Real Increase in Cash Equivalent Transfer Value**	***Employers Contribution to Stakeholder Pensions***
		£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	***£000***
Douglas Blair	Director of Community Services	0-2.5	2.5-5	20-25	60-65	288	274	14	0
Oonagh Fitzgerald	Director of Human Resources	0-2.5	2.5-5	20-25	60-65	319	300	19	0
Karen Johnson	Director of Finance	2.5-5	0-2.5	10-15	0-5	93	62	31	0
Michelle Kemp	Chief Operating Officer	(2.5)-(5)	(7.5)-(10)	10-15	40-45	256	289	(33)	0
Kevin McNamara	Director of Strategy (non-voting)	0-2.5	0.2.5	5-10	25-30	109	99	10	0
Maria Moore	Deputy Chief Executive & Director of Finance	0-2.5	0-2.5	25-30	85-90	451	443	8	0
Guy Rooney	Medical Director	2.5-5	10-12.5	55-60	165-170	1045	970	75	0
Nerissa Vaughan	Chief Executive	0-2.5	2.5-5	45-50	140-145	782	754	28	0
Hilary Walker	Chief Nurse	0-2.5	5-7.5	40-45	120-125	774	726	48	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 2015/16 is referred to elsewhere in the Directors Report (Section 3 refers)

Note - CETV values are not applicable over age 60.

Remuneration 2015-16

		2015-16							
Name	**Title**	**Salary (Bands of £5000)**	**Arrears for 2014-15 paid in 2015-16 (Bands of £5,000)**	**Benefits in Kind Rounded to the Nearest £100**	**Annual Performance Related Bonuses (Bands of £5,000)**	**Long Term Performance Related Bonuses (Bands of £5,000)**	**Other Remuneration (Bands of £5000)**	**Pension-Related Benefits (Bands of £2,500)**	**Total**
Robert Burns	NED	15-20	-	-	-	-	-	-	15-20
Liam Coleman	NED	10-15	-	-	-	-	-	-	10-15
Angela Gillibrand	NED	10-15	-	-	-	-	-	-	10-15
Roger Hill	Chairman	40 – 45	-	-	-	-	-	-	40-45
Steve Nowell	NED	10-15	-	-	-	-	-	-	10-15
Jemima Milton	NED	10-15	-	-	-	-	-	-	10-15
Julie Soutter	NED	10-15	-	-	-	-	-	-	10-15
Douglas Blair	Director of Community Services	100-105	-	-	-	-	-	2.5-5	105-110
Oonagh Fitzgerald	Director of Human Resources	105-110	-	-	-	-	-	5-7.5	110-115
Karen Johnson	Acting Director of Finance	115-120	-					47.5-50	160-165
Michelle Kemp	Chief Operating Officer	70-75	-					(65)-(62.5)	5-10
Kevin McNamara	Director of Strategy (non-voting)	95-100	-	-	-	-	-	2.5-5	100-105
Maria Moore	Deputy Chief Executive & Director of Finance	0-5	-	-	-	-	100-105	0-2.5	100-105
Guy Rooney	Medical Director	125-130		-	-	-	35-40	52.5-55	220-225
Nerissa Vaughan	Chief Executive	170-175	-	-	-	-	-	(7.5)-(5)	165-170
Hilary Walker	Chief Nurse	110-115	-	-	-	-	-	25-27.5	135-140

Note – In respect of Guy Rooney, other remuneration relates to his clinical role.
Note – In respect of Maria Moore, other remuneration relates to exit package paid in April 2015.
Note – The remuneration figures do not include any final bonus/performance related pay increases which are subject to agreement by the Remuneration Committee. None were approved for payment in 2015/16.
Note - Pension Related Benefits relate to the increase in employer contributions from prior year.
Note - Maria Moore left the Trust on 6 April 2015.
Note – Michelle Kemp left the Trust on 31 May 2015.

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

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

Notes to Pension, Remuneration and Expenses Tables

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

Cash Equivalent Transfer Value

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

A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme, or arrangements when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures show the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of the scheme at their own cost. CETV's are calculated within the guidelines and frameworks prescribed by the Institute and Faculty of Actuaries. The CETV is based on actual contributions to 31st March 2016.

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report.

Due to the lead in time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not be recalculated.

Real Increase in CETV

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

Additional disclosures

All NHS Foundation Trusts are required to disclose the relationship between the remuneration of the highest paid Director in their organisation and the median remuneration of the organisation's workforce. The median total remuneration above is the total remuneration of the staff member lying in the middle of the linear

distribution of staff employed in the Trust, excluding the highest paid Director. This is based on an annualised full time total staff equivalent remuneration as at the reporting period date. There are no Executive Directors who have been released, for example to serve as Non-Executive Directors elsewhere and, therefore, there are no remuneration disclosures on whether or not the Director will retain such earnings.

Executive Name and Title	**Total remuneration**	
	2015/16	**2014/15**
Nerissa Vaughan, Chief Executive	**£172,500**	**£177,500**

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	**2015/16**	**2014/15**	**% change**
Highest paid Directors' total remuneration	**£172,500**	**£177,500**	-2.8%
Median total remuneration	**£27,090**	**£26,043**	+3.8%
Ratio	**6.37**	**6.8**	-6.4%

Signed 

Nerissa Vaughan
Chief Executive 23 May 2016

5 Staff Report

5.1 Staff Numbers

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

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

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

At the end of March 2016 we had 5,411 staff in the organisation. The breakdown by professional group is listed below: -

	Headcount of Staff
Admin and Clerical	1133
Allied Health Professionals	522
Medical and Dental	555
Non-Clinical Support	154
Registered Nursing and Midwifery	1795
Scientific, Therapeutic & Technical	492
Unregistered Nursing and Midwifery	760
Grand Total	**5411**

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

5.2 Trust employees

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

	Male	Female	Total
Directors (senior managers)	1 Executive Director, 2 Non-Voting Board Directors & 4 Non-Executive Directors	3 Executive Directors & 3 Non-Executive Directors	**13**
Bank & Substantive Staff	49	736	**785**
Substantive Staff Only	738	3767	**4505**
Bank Staff only	158	885	**1043**
TOTAL	**952**	**5394**	**6346**

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

5.3 Sickness Absence

Staff Sickness Absence	**GWH Data**		**HSCIC Data**	
	2015/16	**2014/15**	**2015/16**	**2014/15**
Total Days Lost	68,411	71,979	33,812	35,913
Total Staff Years	6,379	6,406	4,364	4,340
Average Working Days Lost per whole time equivalent	11	11	8	8

5.4 Staffing related issues during the year

Junior doctor strike
Over the course of the year we have had a number of days of strike action by junior doctors following national dispute about the new junior doctor contracts. We have worked well with the junior doctors to agree how to manage the strike days to reduce the impact on patient care. Arrangements continue to be in place into 2016/17 to mitigate the impact of the ongoing industrial action.

International recruitment
Nurse staffing levels remain a concern so the Trust continued its international recruitment campaign during 2015/16 in addition to encouraging local people to return to a career in nursing or acute care.

Agency spend
Agency caps for nursing and medical staff and managers were introduced nationally in November 2015. The caps limit the rate of pay for those staff and this has impacted on the Trust's ability to fill some shifts. However, the Trust has broken the ceiling for agency caps to ensure patient safety.

National Pay Rise
For the year 2015/16 pay rises for staff were frozen (with the exception of lower band staff). During the year national negotiations took place resulting in a 1% pay rise for all staff groups covered under Agenda For Change (our national terms and conditions) effective from 1 April 2016.

Children and Young People Services
Following a formal service tender exercise, the Children and Young People Service was awarded to Virgin Health Limited from 1 April 2016 which resulted in the formal TUPE of 328 staff from the Trust to Virgin.

Prison Services
Following a formal service tender exercise, the Erlestoke Prison Service was awarded to Bristol Community Health from 1 April 2016 which resulted in the formal TUPE of 6 staff from the Trust to Bristol Community Health.

Apprentices
In line with the national agenda for the employment of apprenticeships, the Trust has employed approximately 30 apprentices in differing and varied roles to include the traditional junior administrator posts as well as the introduction of higher apprentices in healthcare settings.

5.5 Staff Policies and actions applied during the year

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

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

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

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

Actions taken in the financial year to consult employees or their representatives on a regular basis so that the views of employees can be taken into account in making decisions which are likely to affect their interests are included elsewhere in this report under the Staff Survey information below.

To enable consultation with employees, the Trust has in place an employee partnership agreement. There is an Employee Partnership Forum made up of representatives from 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 Report (Section 5 refers).

The Chief Executive leads Open Forums for staff during the year. 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.

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

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

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

5.7 Staff consultation and engagement / other consultations

The Trust has a strong relationship with its trade union colleagues and also the Employee Partnership Forum (EPF) which formally negotiates on changes to 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. EPF is formally recognised under a Trade Union Recognition Agreement.

In quarter 3 and 4, a large scale Non Ward Based Review of Nursing Staffing took place and continues into quarter 1 of 2016/17. The Deputy Chief Nurse leading the project worked closely with EPF members to agree an appropriate process for the review to follow and provided regular updates throughout the review to ensure that staff were kept updated and any concerns were addressed appropriately.

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

5.8 Communicating with staff

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

- 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 intranet also features a 'Hot News' section which allows important information to be shared with staff in a timely manner.

- A number of Chief Executive 'road shows' have been hosted 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 and continue to be very popular with staff.

- 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.

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

5.9 Workforce Key Performance Indicators (KPI's)

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

Sickness absence - Sickness absence levels were 3.46% for the period April 2015 - March 2016. This is a significant decrease on the same period for the previous year which was 3.74%. The Employee Relations team continue to work closely with managers to review all long and short term sickness absences within the Divisions and support the managers to reduce absence across the Trust by supporting their staff and addressing any issues which affect absence.

Turnover – Turnover as at March 2016 was 14.59%, of which voluntary turnover was 11.13%.

Vacancy levels – As at April 2016 there were 363.96 WTE vacancies Trust wide, which equates to 7.89% of our total staffing levels (numbers exclude central allocations).

Appraisal rates - The overall completion rate for the Trust is 81.73% as at 11 May 2016, (compared to 85.22% in May 2015). In 2016/17 the Trust will be focusing on improving the quality of the discussion and content of performance appraisals to ensure that staff feel that the appraisal was worthwhile and added value to them as an employee of the Trust.

Appraisal compliance rate is an area we are focusing on as a Trust. We have seen an increase in the quality of appraisals being completed but a drop in the number being completed. We believe this is partly due to the change in appraisal season and partly due to our current vacancy position across the Trust. Our aim is to increase this to at least 85%.

5.10 Workforce Development

The Trust is committed to supporting and motivating current staff, trainees and future workforce, including students, with on-going learning and development. Despite challenging service pressures across the Trust, the Academy has been proactive in delivering training and in supporting staff and managers to engage with mandatory elements of training. Mandatory training compliance now stands at 83% and 5 new subjects have been added to the mandatory training requirements over the past year. The subjects and areas with the lowest compliance rates are now highlighted in the monthly Board report and a separate action plan to deliver 95% child protection level 3 compliance is in place.

The Academy continues to deliver training and support in a number of locations across the Trust. Simulation activity has increased with multi professional simulation scenarios now applying a human factor approach to reducing risk and increasing competence and self-awareness. The Academy has aimed to support the Trust in a proactive way by conducting a skill assessment and seeking the views of staff and service leads around key areas for improvement. The aim has been to provide an education solution to support succession planning and retention as well as competency development and support for Advanced and specialist skills.

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

- Seeking academic accreditation for a range of 5 patient pathway education modules from Oxford Brookes University.
- As part of the Academy continuing professional development programmes (CPD) new courses have been created. These programmes focus on advance respiratory care, the fundamentals of acute stroke and its treatment, enhanced learning for excellence in chemotherapy, and include the patient pathway through different services in the acute and community settings. These programmes are multidisciplinary (for nursing/medics etc.) promoting a cross service approach to learning and service delivery.
- An increase in apprenticeships to support both existing staff and those new to the healthcare work force to develop and maximise their potential.
- Support of students to develop as caring, competent registrants and to successfully apply for positions within the Trust.
- Ensuring our Continuing Professional Development (CPD) spend continues to be firmly aligned to service requirements with a panel made of key managers from each Directorate determining it's spend.
- Delivery of the Resuscitation Treatment escalation plan project, where a common understanding and document has now been agreed between the CCGs and all health care providers in the region, aimed at preventing inappropriately hospital admission and treatment.
- Experiences are continually measured after an educational event and to identify the impact of education. This feedback is used to inform future educational approaches. This year this has revealed that over 92% feel the service has been very good or excellent.
- Support from the Academy for leadership development, with a new competency based leadership development programme, investment in workforce planning skills, and coaching and mentoring training to support the launch of a GWH coaching register.

Post Graduate Medical Education has started moving into a new phase with the changes to the way Junior Doctors are funded, and the updated 'Tomorrow's Doctors' from the GMC due out in 2016/17. Broadening Foundation has meant that we have had to strengthen our Community based provision for our Foundation Doctors.

Our library has continued to improve the quality of service offered with NHS Library Quality Assurance Framework (LQAF) peer review. The Trust received 100% compliance against the reviews criteria in 2016, which puts us ahead of other local trusts that have been accredited a 95% compliance score rate.

Research & Development continues to gain momentum across the Trust with increased activity in Cardiology and the Emergency Department, offsetting a reduction in recruitment from our Cancer studies. Therefore recruitment remains consistent with 7 new Commercial research projects being opened this year.

The increased investment in support for newly qualified and overseas staff has enable development of essential, high quality skills in a safe simulated environment to our patients and supported staff both pastorally and with their specific development needs within the clinical setting, enabling these staff to meet our standards in an efficient time frame.

5.11 Supporting our volunteers

We are extremely fortunate to have so many, more than 500, committed and enthusiastic volunteers who support delivery of services across our acute and community services. The volunteers provide an extremely valuable service to patients and provide support to staff. They form an essential part of the hospital team and are greatly appreciated.

For many, volunteering is a step on the ladder to employment; an opportunity to experience the hospital environment before going to university or to gain a familiarity with the NHS before applying for a role. Many of our volunteers stay with us for years, with many having achieved awards for five and ten years' service and some have accrued over 25 years' of voluntary service. Each volunteer has their own personal reasons for offering their time. We ask our volunteers to commit to a minimum of three hours per week for a minimum of six months. They come through a robust recruitment process, including referencing and criminal records checks. Our volunteers sit alongside new members of staff at the Trust induction and in any other relevant training they need before they start volunteering with us. Following induction, all volunteers attend at least one half day training session in each 12 month period.

Volunteers can be found across the Trust in a variety of roles, such as patient befriending and assisting patients at mealtimes on the wards, manning information points for patients in the Eye Clinic and Cancer Services, doing exercises with patients in Physiotherapy, assisting patients in Radiology, providing a way finding service, and even helping in the laboratories to archive specimen slides and records. Additionally, there is the opportunity to volunteer at the hospital via other organisations, such as British Red Cross, Changing Faces, Hospital Radio, Royal Voluntary Service and the Friends of Savernake Hospital & Community.

5.12 Occupational Health

Our approach to our staff's health and wellbeing is to ensure we are offering all staff the opportunity to speak to an Occupational Health (OH) specialist who can guide them in the right direction and signpost them to the most appropriate support agency in a timely manner, e.g. Staff Support Services.

The Occupational Health department continues to work closely with managers and HR to reduce time lost due to sickness absence. The two key areas that have been addressed are Musculoskeletal Disorder (MSD) issues and reducing stress related absence. The Occupational Health Team now has an advisor who is a Registered Mental Health Nurse. This nurse complements the Occupational Health Nurses already in post and can offer full mental health assessments on a one to one basis. Group sessions are offered to those employees on long-term sick or with ongoing mental health issues. The Nurse is also working alongside the Staff Support Service, which offer a range of counselling and support therapies.

The Physiotherapy Service has increased provision by taking on a new staff member, who is on rotation from the Main Physiotherapy Department, thus increasing our cooperative work practices. We continue to offer drop-in advice on MSD problems and physiotherapy assessment / treatment via management referrals.

The Musculoskeletal Disorder Team and the Occupational Health team including physiotherapy input have worked closely together to carry out workplace assessments along with early intervention treatment. Over the past 12 months there has been some correlation between the number of referrals received within Occupational Health from line managers and the number of staff off sick. We have seen an increase in referrals to Staff Support.

5.13 Health and Safety

The Trust Health and Safety (H&S) function has for the past 18 months incorporated Trust wide Fire and Security management responsibilities and has set out to drive forward a range of business plan improvements for the benefit of all Trust staff and other stake holders in accordance with the People Strategy Delivery plan 2014/19. There have been significant improvements made across the Trust's H&S, Fire and Security management systems throughout the year which are highlighted below.

The Trust has had no prosecutions or Improvement Notices from the HSE or Wiltshire Fire & Rescue Service during 2015/16 but has received a notice from the CQC related to the Ionising Radiations [Medical Exposure] Regulations 2000 concerning training competency assurance of Agency Radiography staff. An action plan is in place to deliver improvements. Specific targeted achievements this year have included:

- Only 12 RIDDOR reportable accidents were reported to the HSE during the last financial year and root cause analysis investigations have been completed. This level of RIDDOR rate has again benchmarked considerably lower than all other comparable Trusts in the South West Region.

- A comprehensive Health & Safety audit programme across all Departments within the Acute and Community sites has been completed which enables central appraisal of Departmental risk assessments and safe systems of work. From this, further analysis and feedback to Departments has been possible to achieve improvements.

- Significant Trust Security improvements have been achieved in several areas and include improved reporting of violence and aggression incidents by incorporating Carillion Security call outs onto the Trust Safeguard IR1 system for immediate Local Security Management Specialist [LSMS] notification & investigation. A new comprehensive Baby Tagging security system has been introduced into Hazel and Delivery wards and the Birthing Centre.

- A new Elpas security call alarm system has been purchased for the Emergency Department staff to enable immediate Security staff response.

- On-going promotional and publicity campaigns of the Trust Security capabilities have resulted in improved reporting by staff of violence experienced at work with the latest staff survey results achieving a 7% improvement with a 59% positive score to this question [NHS Acute/Community Trust average was 52%].

- Trust Fire Safety management improvements have been made in reducing Unwanted Fire Signals by 75% [false fire alarm activations resulting in Fire & Rescue Service attendance]. This has been achieved by introducing a 5 minute internal investigation period and confirming if Fire Service is necessary before a call sent. This has ensured that patient safety mobilisation risk is reduced with all GWH lifts returned to normal much quicker and also not calling Fire & Rescue Service for a wasted and risky journey to site.

5.14 Swine / seasonal flu vaccinations

The seasonal flu campaign had a 48% uptake across the Trust in 2015/16 which correlates to similar Trusts in the Southwest. The national picture is outlined as follows:-

14/15 uptake	54.9%
15/16 uptake	50.8%

There has been a decrease both nationally and across the South West. This may have been in part to the negative national coverage in relation to the flu strain and information communicated by Public Health England.

We have a revised plan for the 2016/17 campaign learning and sharing good practice from other NHS Trusts. A presentation to Infection Control and Health and Safety Committees will form part of the engagement process.

5.15 Off Payroll Engagements

TABLE 1: For all off-payroll engagements as of 31 March 2016, for more than £220 per day and that last longer than 6 months

	Number
No. of existing engagements as of 31 March 2016	18
Of which:	
No. that have existed for less than one year at time of reporting	17
No. that have existed for between one and two years at time of reporting	1
No. that have existed for between two and three years at time of reporting	
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 2015 and 31 March 2016, 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 2015 and 31 March 2016	22
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	19
No. for whom assurance has been requested	3
Of which:	
No. for whom assurance has been received	0
No. for whom assurance has not been received	3
No. that have been terminated as a result of assurance not being received	0

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

TABLE 3: For any off-payroll engagements of Board members, and/or senior officials with significant financial responsibility between 1 April 2015 and 31 March 2016

	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**

The consequence of assurance not being received referred to in table 2 above could result in tax liability.

Staff Survey Report 2015/16

At the Great Western Hospitals NHS Foundation Trust, we recognise that our staff are our greatest asset. Every single person who works for us plays an invaluable role in providing the high quality care and excellent service that we strive for. We know that when our staff have positive experiences at work, our patients also have positive experiences and, therefore, we are keen to hear from our staff about what it is like to work for us and what we can do to make things better.

The NHS Staff Survey is understood to be the largest workforce survey anywhere in the world and offers unparalleled insight into staff experiences. The survey involves 297 NHS organisations from across the country and achieves just fewer than 300,000 responses. As one of the 297 participating NHS organisations, in October 2015 we randomly selected 850 employees to complete the 2015/16 NHS Staff Survey. 367 of those employees selected returned a completed questionnaire giving the Trust a 43% response rate which is higher than most of our surrounding Trusts.

5.16 National and regional comparisons

Despite the numerous challenges currently facing the NHS and its workforce, this year's NHS Staff Survey results demonstrate a positive improvement in terms of staff experience and engagement. Nationally, staff engagement has improved continuously over the last five years and this year the NHS has also seen an increase in staff's willingness to recommend their organisations as places to work or receive treatment. The majority of staff (69%) either agreed or strongly agreed that they would be happy with the standard of care their organisation provided if a friend or relative needed treatment and most (80%) agreed that they feel able to do their job to a standard they are personally pleased with. However, in contrast to this, the survey also highlighted that staff are continuing to experience difficulties with some of the pressures facing them, including inadequate resources and staffing shortages.

When comparing our results with the National results, there are similar themes evident. The Trust's Staff Engagement score has also improved this year, from 3.68 in 2014 to 3.88 in 2015 which is above average when compared with similar Trusts. (Possible scores range from 1 to 5 with 1 indicating that staff are poorly engaged with their work, team and Trust and 5 indicating staff are highly engaged).

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

Comparison of 2014 and 2015 Results – Trust Wide

This year the Trust has seen improvements in a number of areas compared to 2014. A summary of those sections with significant changes can be found below.

Management

This year the Trust has made improvements in all of the questions within the Management section. The most noticeable improvement (+10%) has been in the effectiveness of communication between senior management and staff with only 27% of respondents providing a negative response. There have also been significant improvements in the number of staff who know who our senior managers are (+ 8%) and who feel involved in making important decisions (+4%).

Communication and visibility of senior management was one of the key priority areas that the Trust identified from last year's survey. In order to improve our staff's experience of this, we introduced a 'Message of Month' where each month one of our Executive Directors provide staff with an update on a 'hot topic' relating to the Trust. In addition to this, we have also continued the 'In Your Shoes' initiative, with a number of our senior managers working alongside our staff to learn about their jobs and to experience what it is like to work in different departments across the Trust.

Bullying, Harassment and Whistleblowing
The results within this section are varied. Although we have seen improvements in the questions relating to reporting incidents of physical violence or clinical practice concerns, the number of staff who experience harassment, bullying or abuse at work has increased with fewer people reporting it. More than half (55%) of those staff who responded stated that their last experience of harassment, bullying or abuse was not reported. We want to ensure our staff feel safe and supported at work and, therefore, we have identified this as a key priority for improvement over the next year.

Patient / Service User Care
Performance within this section has been strong this year, with more people (+5%) feeling that the care of patients is the organisation's top priority. More staff reported that patient / service user feedback is collected within their division or department and that they were provided with regular updates on this feedback. The Trust also saw an increase this year in the number of staff who feel that feedback from patients or service users is used effectively from 3.55 in 2014 to 3.71 in 2015. Our patients are at the centre of everything we do and, therefore, we want to continue this good work into the next year.

Appraisals and Your Job
There were small improvements made within all of the questions asked in this section apart from one where there was a significant decrease. Although the quality of our appraisals has improved, the number of staff reporting that they had received an appraisal within the last 12 months has decreased by 5% compared to last year to 86%.

We are committed to supporting our staff's development to help them to perform to the best of their ability in their roles. One of the ways in which we achieve this is through the Trust's appraisal process. Earlier this year we reviewed our appraisal processes in order to make sure that they were effective and easy to use. Part of this review included asking employees and managers for their feedback and suggestions on the process. This feedback was then used to inform the changes that we made to the policy and paperwork used. This year's Staff Survey results show that the changes we have made have improved the quality of our appraisals and that staff who received an appraisal do feel more valued by the organisation. This year we will work with managers across the Trust to ensure that all our staff receive an appraisal.

Team working and Involvement
This year more staff have reported that they are involved in deciding changes that affect their work (+3%) and feel that they are able to make improvements within their work area (+9%). This is following the introduction of an ideas generation initiative, where staff are encouraged to put forward any suggestions for improvement they have both within their own teams and across the Trust. Since introducing this process, more than 200 ideas have been submitted.
Staff are still, however, reporting challenges with the resources available to them at work, both in terms of the number of staff within the organisations and having adequate materials, supplies and equipment to enable them to do their work. The Trust continues its focus on recruitment, exploring and developing innovative ways of recruiting new staff to join our hard working teams. In addition to developing and maintaining positive relationships with local schools and universities, the Trust is also continuing its overseas search for nurses. The Trust has held a number of recruitment events over the year seeking to attract people from all professional groups to come and work with us and this will continue into 2016/17.

5.17 Summary of staff survey results

Table - Response Rate

2014		2015		Trust Improvement/ Deterioration
Trust	National Average	Trust	National Average	
55%	42%	43%	41%	12% deterioration

Table – Summary of Performance

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

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

	2015		2014	
Top Five Ranking Scores	**Trust**	**National**	**Trust**	**National**
Percentage of staff able to contribute towards improvements at work *(the higher the score the better)*	77%	71%	68%	68%
Staff confidence and security in reporting unsafe clinical practice *(the higher the score the better)*	3.79	3.64	68%*	67%*
Staff motivation at work *(the higher the score the better)*	4.09	3.92	3.88	3.86
Quality of non-mandatory training, learning or development *(the higher the score the better)*	4.13	4.04	Results from 2014 not comparable	
Fairness and effectiveness of procedures for reporting errors, near misses and incidents *(the higher the score the better)*	3.86	3.71	Results from 2014 not comparable	
* Converted from % result in 2014 to scale result in 2015				
Bottom Five Ranking Scores	**Trust**	**National**	**Trust**	**National**
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months *(the lower the score the better)*	35%	27%	29%	29%
Percentage of staff working extra hours *(the lower the score the better)*	79%	72%	74%	71%
Staff satisfaction with resourcing and support *(the higher the score the better)*	3.2	3.3	Results from 2014 not comparable	
Percentage of staff/colleagues reporting most recent experience of harassments, bullying or abuse *(the higher the score the better)*	34%	38%	Results from 2014 not comparable	
Percentage of staff experiencing physical violence from staff in last 12 months *(the lower the score the better)*	2%	2%	3%	3%

These results reflect the National results with more people (77%) feeling able to contribute towards improvements at work and feeling motivated at work (4.09). However higher levels of staff are working extra hours (79%) and staff are reporting concerns regarding their satisfaction with resourcing and support.

The Trust is ranked 10th when benchmarking performance against organisations from across the South West. When compared against local Trust's, the organisation is ranked 2nd.

Acute Trusts - * Denotes Combined Acute and Community	Response Rate	KF1	KF2	KF3	KF4	KF5	KF8	KF9	KF14	KF10	KF11	KF12	KF13	KF15	KF16	KF17	KF18	KF19	KF22	KF23	KF24	KF25	KF26	KF27	KF6	KF7	KF20	KF21	KF28	KF29	KF30	KF31	KF32	Total Score	Total Score %
Salisbury NHS Foundation Trust	31%	G	A	G	G	G	G	G	G	G	G	G	G	G	R	G	G	G	G	G	G	G	A	G	G	G	G	G	G	G	G	G	92	96%
Great Western Hospitals NHS Foundation Trust *	43%	A	A	G	G	A	G	G	R	G	A	A	G	A	R	A	G	A	A	R	G	R	A	R	A	G	A	G	G	A	G	G	A	72	75%
Oxford University Hospitals NHS Trust	30%	A	A	R	R	A	R	A	A	R	G	A	R	R	R	R	G	A	G	G	R	G	G	R	A	G	A	G	G	R	R	G	A	62	65%
Royal United Hospital Bath NHS Trust	48%	G	R	R	R	A	A	R	R	G	G	A	R	R	G	A	A	A	R	A	G	R	G	A	R	A	G	G	A	R	R	R	R	58	60%
Royal Berkshire NHS Foundation Trust	37%	A	A	A	A	R	R	R	A	A	A	A	R	A	A	A	G	R	A	A	R	R	A	R	R	R	R	R	G	R	R	R	G	52	54%
Gloucestershire Hospitals NHS Foundation Trust	51%	R	R	R	R	R	R	A	R	R	G	R	R	A	G	G	R	R	R	R	G	A	A	A	R	R	A	R	A	A	R	R	R	48	50%
University Hospitals Bristol NHS Foundation Trus	44%	A	R	R	R	R	R	R	R	R	R	R	R	R	A	A	R	A	G	R	A	A	A	A	R	A	R	A	R	A	A	R	R	46	48%
North Bristol NHS Trust *	30%	R	R	R	R	R	R	R	R	R	R	R	R	A	A	R	G	R	R	R	R	A	R	A	R	R	A	A	R	R	R	R	R	40	42%
Average	39%																																	59	61%
Mental Health and Learning Disabilities Trusts																																			
Avon and Wiltshire Mental Health Partnership NI	50%	R	R	R	A	A	R	A	A	R	G	R	R	A	A	R	A	R	G	A	A	R	R	R	R	A	A	A	A	G	A	R	A	53	55%
Average	50%																																	53	55%

5.18 Summary of Actions / Priorities for 2016/17

Based on the information provided in the responses to this year's survey, the Trust has agreed the following key priorities for 2016/17;

- Protecting our staff against harassment, bullying and abuse from patients and service users
- Continuing to address challenges with the resources available to our staff at work, both in terms of the number staff within the organisation and having adequate materials, supplies and equipment
- Supporting our staff's health and wellbeing and personal development

These priority areas will be used to identify a number of Trust wide schemes which will be developed and implemented to address the key areas for concern. Next year, the Staff Friends and Family Test will be used to continuously monitor the Trust's performance in these areas. Each quarter we will use the Staff Friends and Family Test to focus on a different key theme highlighted from the report, asking additional questions to gain a better understanding of the concerns raised and actions required to make improvement. Each division will also identify their own key priority areas for the next 12 months and will develop and implement actions to address key areas of concern.

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

6 NHS Foundation Trust Code of Governance

6.1 Council of Governors

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

- To appoint and remove the Chairman and Non-Executive Directors.
- 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 Auditor's opinion on them.

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

During 2015/16 the Council of Governors carried out or was involved in the following: -

- Appraisals of the Chairman and Non-Executive Directors.
- The re-appointment of two Non-Executive Director
- Holding the Non-Executive Directors to account on a number of issues such as nursing skills mix, Referral to Treatment (RTT) performance, agency worker payment caps, social media and the Trust's retention policy.

In 2015/16 the Council of Governors did not exercise its power to require one or more of the Directors to attend a Governors' meeting for the purpose of obtaining information about the Foundations Trust's performance of its function or the Directors' performance of their duties

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

6.2 Members of the Council of Governors, Constituencies and Elections

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

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

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

Governors are elected by members of those constituencies in accordance with the election rules stated in the Trust's Constitution using the "first past the post" voting system. Elections were carried out on behalf of the Trust in 2015/16 by the independent Electoral Reform Services Ltd. In the event of an elected Governor's seat falling vacant for any reason before the end of a term of office, it shall be filled by the second (or third) place candidate in the last held election for that seat provided they achieved at least five percent of the vote and they will be known as reserve Governors.

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

6.2.1 Elected Governors in 2015/16 – Public Constituencies

	Name	Constituency	Date first elected	Current Term of Office (date ending)	Attendance from 5 Council of Governor meetings
1	Ros Thomson	Swindon	Dec-08	3 years *(ending Nov-16)*	5/5
2	Kevin Parry	Swindon	Nov-11	3 years *(ending Nov-16)*	3/5
3	Louise Hill	Swindon	Nov-13	3 years *(ending Nov-16)*	5/5
4	Robert Wotton	Swindon	Nov-13	3 years *(ending Nov-16)*	1/5
5	Orli Berman (previously known as Elizabeth Garcia)	Swindon	Nov-13	3 years *(ending Nov-16)*	5/5
6	Michael Halliwell	Northern Wiltshire	Nov-12	3 years *(term ended Nov-15)*	3/4
7	Roger Bullock	Northern Wiltshire	Jun-13	Remainder of 3 years *(term ended Nov-15)*	0/4
8	Pauline Cooke	Northern Wiltshire	Nov-15	3 years *(from Nov-15 ending Nov-18)*	2/2
9	Margaret White	Central Wiltshire	Jun-11	3 years *(re-elected Nov-15 ending Nov-18)*	5/5
10	Janet Jarmin	Central Wiltshire	Dec-08	3 years *(re-elected Nov-15 ending Nov-18)*	5/5
11	Martin Rawlinson	Gloucestershire, Bath & North East Somerset	Nov-15	Remainder of 3 years *(ending Nov-17)*	2/2
12	Peter Pettit	West Berkshire & Oxfordshire	Apr-14	Remainder of 3 years *(ending Nov-17)*	5/5

In August 2015 a contested election was held for the Gloucestershire and Bath & North East Somerset Public Constituency for 1 seat to serve for the remainder of the term of office ending November 2017. There were two candidates and Martin Rawlinson was elected.

In September 2015 an uncontested election was held for the Central Wiltshire Public Constituency for 2 seats to serve for a three year term ending November 2018. Janet Jarmin and Margaret White were both re-elected.

In September 2015 an uncontested election was held for the Northern Wiltshire Public Constituency for 2 seats to serve for a three year term ending November 2018. Mike Halliwell and Roger Bullock did not stand for re-election. Pauline Cooke was elected. Only 1 candidate stood and therefore a vacancy remains in this constituency.

During 2015/16 there remained insufficient membership to trigger an election for the Wiltshire Southern Constituency.

6.2.2 Elected Governors in 2015/16 – Staff Constituency

	Name	Staff Constituency – sub class	Date first elected	Current Term of Office (date ending)	Attendance from 5 Council of Governor meetings
1	Lisa Campisano	Administrators, Maintenance, Auxiliary and Volunteers	Nov-12	3 years *(ending Nov-16)*	3/5
2	Hayley Madden	Community Nursing & Therapy Staff	Nov-14	3 years *(resigned Nov-15)*	1/4
3	Peter Hanson	Doctors & Dentists	Nov-10	3 years *(ending Nov-16)*	4/5
4	Shane Apperley	Hospital Nursing & Therapy Staff	Nov-13	3 years *(resigned Jul-15)*	2/2
5	Saul Richardson	Hospital Nursing & Therapy Staff	Nov-15	Remainder of 3 years *(ending Nov-16)*	1/2

There are 4 staff Governor seats split into sub-classes of which two became vacant during the year.

There was an uncontested election for the Community Nursing and Therapy Staff Sub Class, Staff Constituency in November 2015 with Saul Richardson elected. This seat had been vacant following the resignation of Shane Apperley on 8 July 2015. However Saul Richardson died on 15 March 2016.

Hayley Madden, the Staff Governor for the Community Nursing and Therapy Sub Class resigned on 6 November 2015.

With the transfer of community services to Wiltshire Community Health in 2016, the Trust will review the staff constituency sub-classes to ensure that they remain representative of the Trust's staffing mix.

6.2.3 Nominated Governors in 2015/16

	Name	Nominating Partner Organisation	Date first nominated	Current Term of Office (ending date)	Attendance from 5 Council of Governor meetings
1	Ian James	Swindon Clinical Commissioning Group	Aug-13	3 years *(ending Aug-16)*	4/5
2	Edward Wilson	Wiltshire Clinical Commissioning Group	Aug-13	3 years *(resigned Aug-15)*	2/4
3	Anna Collings	Wiltshire Clinical Commissioning Group	Nov-15	3 years *(ending Nov-18)*	1/2
4	Brian Mattock	Local Authority – Swindon Borough Council	Nov-11	3 years *(ending Nov-17)*	2/5
5	Sheila Parker	Local Authority – Wiltshire Council	Nov-14	3 years *(ending Nov-17)*	4/5
6	David Barrand	Other Partnerships – Prospect Hospice	Feb-15	Remainder of 3 years *(ending Nov-17)*	1/5
7	Phrynette Morrison	Other Partnerships – Swindon and North Wiltshire Health and Social Care Academy	Aug-15	Remainder of 3 years *(ending Nov-17)*	2/2

There are 6 appointed Governor seats. During the year, Phrynette Morrison was nominated as the Governor representing Swindon & North Wiltshire Health and Social Care Academy for the remainder of the term ending in November 2017. This seat had been vacant since November 2014.

Also during the year Ted Wilson resigned on 1 September 2015 as the Governor representing Wiltshire Clinical Commissioning Group. A replacement nomination was sought to fill the vacancy for the remainder of the term of office with Anna Collings nominated in November 2015 to serve for a three year term.

6.3 Attendance at meetings of the Council of Governors during 2015/16

There were 5 meetings of the Council of Governors in 2015/16. The table below shows Governor attendance at those meetings: -

	Attendee(✓ = attended X = did not attend)	16-Apr-15	11-Jun-15	17-Aug-15	12-Nov-15	11-Feb-16
	Governors					
1	Shane Apperley	✓	✓	n/a	n/a	n/a
2	David Barrand	×	✓	×	×	×
3	Orli Berman *(previously known as Elizabeth Garcia)*	×	✓	×	×	×
4	Roger Bullock	×	×	×	×	n/a
5	Lisa Campisano	✓	×	✓	×	✓
6	Anna Collings	n/a	n/a	n/a	×	✓
7	Pauline Cooke	n/a	n/a	n/a	✓	✓
8	Michael Halliwell	×	✓	✓	✓	n/a
9	Peter Hanson	✓	✓	✓	×	✓
10	Louise Hill	✓	✓	✓	✓	✓
11	Ian James	✓	×	✓	✓	✓
12	Janet Jarmin	✓	✓	✓	✓	✓
13	Hayley Madden	✓	×	×	×	n/a
14	Brian Mattock	×	✓	×	×	✓
15	Phrynette Morrison	n/a	n/a	n/a	✓	✓
16	Sheila Parker	✓	×	✓	✓	✓
17	Kevin Parry	✓	✓	✓	×	×
18	Peter Pettit	✓	✓	✓	✓	✓
19	Martin Rawlinson	n/a	n/a	n/a	✓	×
20	Saul Richardson	n/a	n/a	n/a	✓	✓
21	Ros Thomson	✓	✓	✓	✓	✓
22	Edward Wilson	✓	✓	×	×	n/a
23	Margaret White	✓	✓	✓	✓	✓
24	Robert Wotton	×	×	✓	×	×
	Directors					
1	Robert Burns	✓	×	✓	✓	×
2	Liam Coleman (Senior Independent Director)	✓	×	✓	×	✓
3	Oonagh Fitzgerald	×	✓	✓	✓	✓
4	Angela Gillibrand (Deputy Chair)	✓	✓	✓	×	×
5	Roger Hill (Chair)	✓	✓	✓	✓	✓
6	Karen Johnson	✓	✓	✓	✓	✓
7	Michelle Kemp (until 31.05.15)	×	n/a	n/a	n/a	n/a
8	Jemima Milton	✓	✓	✓	×	×
9	Maria Moore (until 06.04.15)	n/a	n/a	n/a	n/a	n/a
10	Steve Nowell	✓	×	✓	×	×
11	Guy Rooney	×	✓	✓	×	✓
12	Julie Soutter	×	×	✓	×	×
13	Nerissa Vaughan	✓	✓	✓	✓	×

	Attendee(✓ = attended X = did not attend)	16-Apr-15	11-Jun-15	17-Aug-15	12-Nov-15	11-Feb-16
14	Hilary Walker	✓	✓	✓	×	×
15	Douglas Blair (non-voting member)	×	✓	×	×	×
16	Kevin McNamara (non-voting member)	×	✓	✓	✓	✓

6.4 Lead and Deputy Lead Governors

Ros Thomson and Mike Halliwell were Lead and Deputy Lead Governors respectively up until the meeting of the Council of Governors in November 2015, when Margaret White was nominated as Lead Governor and Peter Pettit 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.

6.5 Council of Governors meetings structure

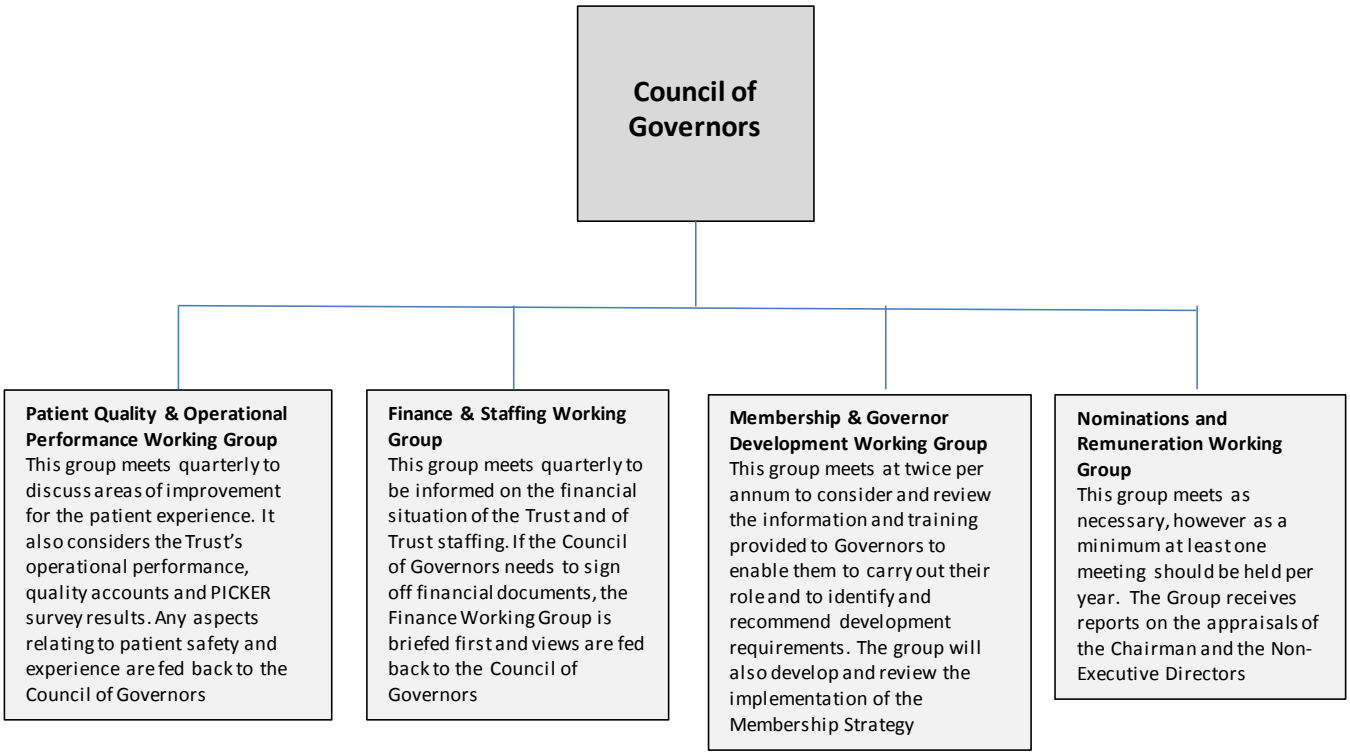
The Council of Governors has established a number of working groups which each have focussed attention for specific areas of work. During 2015/16 these were expanded and strengthened with the following working groups established: -

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

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

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

STRUCTURE – Council of Governors Meeting structure



6.6 Biography of individual Governors

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

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

The overall responsibility for running the Trust lies with the Board of Directors 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 3 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 Provider Licence. The Council of Governors also works with the Board of Directors to shape the future strategy of the organisation.

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

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

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

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

Non-Executive Director attendance at Council of Governors meetings – During 2015/16 Non-Executive Directors attended Council of Governor meetings which enabled them to listen to Governors' concerns and to respond to any questions raised.

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

Joint Board of Directors and Council of Governors training – A programme to provide joint training for Non-Executive Directors and Governors (with Executive Directors invited) on the role and work of individual directorates within the Trust continued to be rolled out in 2015/16. Two sessions were held whereby divisions explained the services they provide. The joint training provides an opportunity for the Non-Executive Directors to engage with the Governors and to better understand their views and concerns.

Public health lectures – To provide forums for members to meet Governors, public health lectures were introduced in 2012/13 and have continued ever since. Members and the public are invited to attend a public lecture on a specific health topic and thereafter meet Governors and share thoughts and views on healthcare. In 2015/16 five public health lectures were held as follows: -

- Antibiotic Resistance (Apr-15)
- Breast Cancer & Reconstructive Surgery (Jun-15)
- Pain Management (Oct-15)
- Migraines (Dec-15)
- Seizures, Blackouts and Epilepsy (Feb-16)

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

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

Council of Governors effectiveness review – An effectiveness review of the Council of Governors was held in December 2015, led by the Chairman and Governance Officer. The outcome was a refreshed work plan, with agreement reached on a planned approach to hold Non-Executive Directors to account for the performance of the Board on priority areas linked to complaints, Governors concerns and areas where further assurance is needed.

Governor Working Groups / Non-Executive Directors aligned – As referred to elsewhere in this section, there are a number of working groups of the Council of Governors, the work of which is supported by staff and directors. The joint working results in effective communication between the staff, Directors and Governors. Governors have an opportunity to input directly into the workings of the Trust. On request, Non-Executive Directors may attend meetings of working groups to provide information and receive feedback from Governors directly. Since 2013/14 Non-Executive Directors have been aligned to Working Groups providing a clear link for Governors to hold Non-Executive Directors to account individually for the performance of the Board in specific areas that those working groups consider.

Additional briefing sessions – The Chief Executive has held separate sessions with Governors to discuss specific topics of interest, with other members of the Board present. In addition there have been additional briefing sessions and training including Directorate Briefings; Finance & Effectiveness Training in February 2016 and a Care Quality Commission new Inspection style awareness presentation in September 2015.

Annual Members Meeting – In September 2015 an Annual Members Meeting was held in Swindon. The annual report and accounts were presented and a briefing given on the overall performance of the Trust in the previous year. This meeting allowed an opportunity for Governors to address members, seek questions on Trust business and provide feedback to the Board of Directors.

Chairman – The Chairman of the Trust meets monthly with the Lead and Deputy Lead Governors to discuss their views on any matters currently being considered. The Lead and Deputy Lead Governors are representatives of the Council of Governors. Their advice and input is incorporated into the decision making process via the Chairman.

Southwest Governor Exchange Network - In 2015/16 Governor representatives attended the Southwest Governor Exchange Network events. These provide useful information to Governors and enable them to network with Governors from other trusts.

Governor involvement in events / activities – Governors are invited to attend a number of events throughout the year which allows them to be directly involved in the work of the Trust and to influence the decisions being made. A few examples in 2015/16 were: -

- Governor representatives on the End of Life Committee Group.
- Joint workshops and training events with the Trust Board
- Governor involved in determining staff awards
- Patient Quality & Operational Performance Working Groups
- Membership & Governor Training Working Groups
- Finance & Staffing Workings Groups
- Nominations and Remuneration Working Groups
- Governor representative on the Improvement Committee

6.9 Non-Executive Director Allowances and Appraisals - 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 (two elected, two nominated and one staff). The Chairman is appointed by the Chairman of the Council of Governors who attends as appropriate with the Senior Independent Director attending as requested.

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

The Working Group met once in 2015/16, to undertake the annual Chairman and Non-Executive Directors' appraisals. The pay arrangements for Non-Executive Directors was originally fixed at Authorisation in December 2008 to reflect foundation trust responsibilities. A remuneration increase was awarded during 2014 to reflect rates elsewhere but has not been increase since. Further information about the remuneration of the Non-Executive Directors can be found in this report (section 4 refers).

6.10 Interests of Governors

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

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

6.11 Non-Executive Director Appointments - 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.

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

In 2015/16 the Committee met during the year to consider existing Non-Executive Director re-appointments and new Non-Executive Director appointments and thereafter to consider feedback from interviews and recommend candidates for appointment to the Council of Governors.

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

The Joint Nominations Committee 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

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

6.13 Attendance at the Joint Nominations Committee Meetings during 2015/16

Joint Nominations Committee Members	Record of attendance at each meeting ✓ = Attended × = Did not attend n/a = not applicable as not member at that time	
	7 April 2015	31 March 2016
Liam Coleman – Non-Executive Director	× (Jemima Milton substitute)	×
Angela Gillibrand – Non-Executive Director (member until 31-Dec-15)	✓	n/a
Roger Hill – Chairman	✓	✓
Julie Soutter – Non-Executive Director (member from 31-Dec-15)	n/a	×
Lisa Campisano– Governor	✓	✓
Pauline Cooke – Governor (member from Nov-15)	n/a	✓
Orli Berman (previously known as Elizabeth Garcia) – Governor (member until Nov-15)	✓	n/a
Ted Wilson – Governor (member until Aug-15)	✓	n/a
Peter Pettit	✓	✓
Margaret White – Governor (member from Nov-15)	✓	✓

Note: Liam Coleman, Angela Gillibrand, Roger Hill and Julie Soutter are Non-Executive Directors appointed by the Chairman / Board and Lisa Campisano, Pauline Cooke, Orli Berman, Ted Wilson, Peter Pettit and Margaret White are Governors appointed by the Council of Governors.

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

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

6.14 Membership

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

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

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

6.15 Public Members

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

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

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

6.16 Staff Members

Staff members include Trust employees, Carillion Health employees and volunteers. The Trust has strong links with the local community, with over 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 in a variety of professions, split into the following sub classes to reflect occupational areas: -

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

This will be reviewed again in 2016/17 to reflect the transfer of community services to Wiltshire Health and Care. Whilst the Trust will employ staff working for WCHS, thought will be given as to whether the community nursing and therapy sub-class within the staff constituency should remain.

6.17 Membership analysis

During the year, the Trust again sought to increase membership numbers. As at 31 March 2016, the membership of the Great Western NHS Foundation Trust was as follows: -

Total Number of Members across all Constituencies	2014/15	2015/16
Swindon	2854	2981
North Wiltshire	1054	1196
Central Wiltshire	398	466
Southern Wiltshire	42	109
West Berkshire and Oxfordshire	304	323
Gloucestershire and Bath and North East Somerset	235	296
Staff	6213	6386
TOTAL	**11,100**	**11,757**

This shows an increase in overall membership of 657 (5.9% increase)

Public Constituency	2014/15	2015/16	2016/17 *(estimate based on 2015/16 levels)*
At year start (1 April)	4751	4887	5371
New Members	396	624	685
Members leaving	260	140	153
At year end (31 March)	**4887**	**5371**	**5903**

This shows an increase in public members of 484 (10.9% increase)

Staff Constituency	2014/15	2015/16	2016/17 *(estimate based on 2015/16 levels)*
At year start (1 April)	6,353	6213	6386
New Members	1190	986	1012
Members leaving	1130	813	835
At year end (31 March)	**6213**	**6386**	**6563**

This shows an increase in staff members of 173 (2.8% increase)

The estimates for 2016/17 public members are based on a prediction having regard to membership recruitment drives planned to take place in 2016/17 and an initiative to retain former staff as members, provided they meet the eligibility criteria.

The estimates for 2016/17 staff members are based on expected staff levels and turnover.

6.18 Numbers of members by age ethnicity and gender

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

Age	2014/15	2015/16
0-16	13	12
17-21	190	184
22+	4632	5118
Unknown	52	57
Total	**4887**	**5371**

Ethnicity	2014/15	2015/16
White	3705	3726
Mixed	26	26
Asian or Asian British	146	150
Black or Black British	53	53
Other	27	27
Unknown	930	1389
Total	**4887**	**5371**

Gender	2014/15	2015/16
Male	2062	2127
Female	2813	3109
Unspecified	12	135
Total	**4887**	**5371**

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

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

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

The Trust fulfils this aim by communicating and engaging with members via the Trust's newsletter, News in Brief, and hosting members' briefings and events such as Public Lectures. The Trust's website provides regular updates and information on meetings and events. 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 2015/16 included: -

- Public lectures
- Governor article in local newspaper
- Governors talking to members and the public at local community events
- Public and member attendance at Council of Governor Meetings
- 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. Their views were communicated to the Board via a meeting of the Council of Governors held in February 2016, where an open discussion on proposals took place and Governors' comments were incorporated.

Mailings to members have been sent out regarding Undergraduate Pharmacy courses, newsletters to support the Brighter Future charity appeals, CQC Inspection Feedback and advertising Non-Executive Director vacancies.

6.20 Membership Strategy

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

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

6.21 Membership development in 2015/16

In order to build a representative membership during 2015/16 the Trust undertook the following: -

- The Governance Officer hosted monthly recruitment drives in the hospital atrium
- The Governance Officer attended various Wiltshire Council public health events
- An Annual Members Meetings was held in September 2015
- The Governance Officer attended the Swindon Indian Association's Holi Milan event.
- The Governance Officer attended various school and college careers events within the area
- A partnership was formed with a number of sports teams in Wiltshire who are promoting Trust membership in their sports programmes and on their websites.
- Monthly health messages were sent to various companies and councils to be distributed to their employees.

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

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

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

6.22 Membership recruitment proposed for 2016/17

1. **Engagement with existing forums**
   The Governance Officer will continue to engage with existing forums, such as Patient Participation Groups, parish and town councils, sports teams, carers groups etc. by attending meetings and presenting to them information about membership and encouraging new members.

2. **Youth Membership Drive**
   The Governance Officer is continuing to develop and work with contacts within youth groups who are likely to be interested in the future of the hospital and is planning to engage with GCSE and A Level students, working alongside the Trust's Academy.
   The Governance Officer will attend careers events along with the NHS Careers team to better engage and recruit members. Students will receive a presentation on the structure of foundation trusts, tied in with the politics and funding of healthcare. This will be an opportunity to increase our membership of younger people.

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

4. **Public Lectures**
   A series of public lectures on a variety of topics from Cancer to Obesity are planned, with the Governance Officer in attendance to recruit new members.

5. **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.

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

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

6.23 Contacting the Governors and Directors

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

Company Secretary, the Great Western Hospital, FREEPOST (RRKZ-KAYR-YRRU), Swindon, SN3 6BB.

6.24 Code of Governance Disclosure Statement

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

The Great Western Hospitals Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

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

B.2.2.2 Directors on the Board of Directors and Governors on the Council of Governors should meet the "fit and proper" persons test described in the provider licence. For the purpose of the licence and application criteria, "fit and proper" persons are defined as those without certain recent criminal convictions and director disqualifications, and those who are not bankrupt (undischarged). In exceptional circumstances and at Monitor's discretion an exemption to this may be granted. Trusts should also abide by the updated guidance by the Care Quality Commission (CQC) regarding appointments to senior positions in organisations subject to CQC regulations. In September 2015 the Trust was inspected by the CQC which found that the current arrangements for the Fit and Proper persons test did not constitute a clear and transparent process. This needs to be addressed and the Director of Human Resources will establish a clear and transparent process which meets the requirements of the regulation for the Fit and proper person test.

D.2.3 The Code states that the Council of Governors should consult external professional advisers to market-test the remuneration levels of the chairperson and other non-executives at least once every three years and when they intend to make a material change to the remuneration of a non-executive. However, in view of the costs associated with this, the Council of Governors resolved that instead the Director of Human Resource should undertake a benchmarking exercise. This was completed in Spring 2014. There was no review of remuneration levels of the chairperson and other non-executives during 2015/16.

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

Other disclosures required under the Code of Governance are included in the Directors Report and the Remuneration report.

6.25 Audit Committee Annual Report 2015/16

6.25.1 Introduction

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. It comprises three Non-Executive Directors, has met six times during the period and has reported to the Board and Council of Governors on its activities. The Committee also provides assurance in relation to the Annual Governance Statement made by the Trust's Chief Executive (CE) as Accountable Officer (AO) in respect of Great Western Hospitals NHS Foundation Trust for year ended 31 March 2016. This report covers activities and accounts during the period 1 April 2015 to 31 March 2016.

6.25.2 Terms of Reference

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 4 June 2015. 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.

6.25.3 Committee membership and attendance

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

Robert Burns	In 2015/16 Robert was Chair of the Audit, Risk and Assurance Committee up until 31 December 2015. Throughout the year he was also a member of the Mental Health Act/ Mental Capacity Act Committee and the Remuneration Committee. In addition Robert became a member of the Governance Committee on 1 January 2016.
Angela Gillibrand	In 2015/16 Angela was Chair of both the Governance Committee and the Mental Health Act/Mental Capacity Act Committee. Angela was a member of the Audit, Risk and Assurance Committee and the Remuneration Committee. She was a member of the Joint Nominations Committee up until 31 December 2015 and she became a member of the Finance and Investment Committee on 1 August 2015.
Jemima Milton	In 2015/16 Jemima was Chair of the People Strategy Committee. Jemima was also a member of the Audit, Risk and Assurance Committee, the Charitable Funds Committee, the Governance Committee and the Remuneration Committee.
Julie Soutter	During 2015/16 Julie was a member of Audit, Risk and Assurance Committee, becoming Chair of that Committee on 1 January 2016. Julie was also a member of the Mental Health Act / Mental Capacity Act Committee and the People Strategy Committee up until 31 July 2015 and was a member of the Governance Committee up until 31 December 2015. Julie became a member of the Finance Investment and Performance on 1 August 2015 and a member of the Joint Nomination Committee on 1 January 2016. Throughout 2015/16 Julie was a member of the Remuneration Committee.

Attendances **Non-Exec Members**	**22 May 2015**	**13 July 2015**	**7 September 2015**	**9 November 2015**	**14 January 2016**	**17 March 2016**
Robert Burns *(Chair until 31-Dec-15)*	✓	✓	✓	✓	n/a	n/a
Angela Gillibrand	×	×	✓	✓	✓	×
Jemima Milton	✓	✓	✓	✓	✓	✓
Julie Soutter *(Chair from 1-Jan-15)*	✓	✓	✓	✓	✓	✓

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

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

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

6.25.4 Audit Committee purpose and activity in discharging its responsibilities

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

Operational oversight and scrutiny, in particular relating to service quality and patient care performance, is also provided through the Governance Committee. There is a direct link between the Governance Committee and ARAC through committee membership and exception reporting. The Finance Investment and Performance 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 of corporate governance and compliance and the performance and outcomes of Internal Audit, (including Counter Fraud services) and of External Audit. The Committee seeks to ensure that the relationship between Internal and External Audit is robust and effective and that all parties receive and provide adequate support to and from Trust management as required. Time is set aside for private discussion with Internal Audit, External Audit and Trust Finance Management, should it be required, at the end of all committee meetings.

6.25.5 Risk and Governance Activity

The Committee met in May, July, September and November 2015, and also in January and March 2016. For the current financial year a minimum of six meetings is scheduled, commencing in May 2016 with the review and approval of the 2015/16 year-end Annual Report and Accounts. The major review areas addressed in the meetings in 2015/16 can be summarised as follows:

- At least on a quarterly basis the Trust's Assurance Framework and higher risk 15+ Risk Register, as presented by the FD and 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 appropriate. Suggestions have been made, discussed and actioned to ensure Risk Management and the Assurance Framework remain "fit for purpose", reflect risks that impact on strategic objectives and the assurance and mitigation provided, or, if none exist, prompt a suitable course of action to minimise the impact therefrom. This included a review of the presentation of the Assurance Framework to ensure any gaps in assurance are more clearly identified and action taken, and the development of a Statement of Risk Tolerance to provide guidance to managers.

- The Committee has during the period reviewed Trust policies including Fraud and Corruption, Whistleblowing and the Standing Financial Instructions.

- The Committee also reviewed reports relating to Legal Services, including claims management, and Information Governance. This included discussion on progress made and mitigating actions to control any future risks.

- The Committee has reviewed and approved, at least quarterly, reports of any single tender actions, contract extensions and reports of losses, including patient property, 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. The Chair of the Committee has also given verbal updates on the work of the Committee and any current concerns to the Board as required.

- During the reporting period the Committee received verbal updates on any issues of concern to Governance Committee, and any significant financial management issues including updates on forecast year-end performance against plan, the borrowing facility application, and Monitor's investigation into the Trust's performance deficit and likely future course of action.

- As indicated above, in May 2016 the Trust's Financial Accounts for 2015/16 and Annual Report, including the Quality Report, were reviewed and approved by the Committee for endorsement by the Board.

6.25.6 Internal Audit and Counter Fraud

The Committee reviewed and approved TIAA's internal audit and counter-fraud plans for 2016-17 to ensure the provision of support to the assurance framework and adequate review of internal control and known areas of risk or concern. This included a review of planned chargeable days and proposed audit programme, following outcomes from the CQC inspection and operational performance for the year. The Committee ensured that audit planning also took account of areas identified by the Governance and Finance Investment and Performance Committees as worthy of an audit review if not already so identified by Trust management.

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 updates at meetings that confirm progress against the plan, areas of concern and the progress on resolving audit recommendations.

The Audit Committee has considered and endorsed the Head of Internal Audit's 2015-16 Annual Report that assessed the Trust's internal controls as reasonable and that they provided overall Reasonable Assurance.

Two reviews were conducted in the 2014/15 period but reported to the Committee in 2015/16. These were an assurance review of PFI Contract management and Governance, and a compliance review of Estates Compliance. Both reports provided limited assurance only and the recommended actions to address weaknesses were monitored by the Committee. It should be noted that each year there are areas of the internal audit plan work that are reported to the ARAC in the following financial year. Progress on implementing recommended actions was also reviewed for reports undertaken in 2014/15, including management of Private Patient Income.

During the year the Committee reviewed two reports which reported only limited assurance overall. The first related to a compliance review of Medicines Management, looking at the robustness of cost improvement plans and the charging and receipting of high cost drugs (where the majority of costs are passed through). The second concerned a compliance review of Infrastructure Security Arrangements looking at policy and procedures, network security and disaster recovery. Actions were monitored by the Committee and additional reports presented during the year.

All other internal audit reports provided reasonable or substantial assurance. These included employment and staffing, clinical audit, income, debtors and financial accounting and payroll. All reports have agreed action plans and were subject to detailed review by the Committee.

The Data Quality (RTT Follow Up) audit planned for 2015/2016 is to be carried over to 2016/17 following significant ongoing work by the Trust in this area during the year following the identification of data quality and data integrity issues. The RTT audit was replaced by an assurance review of Equality & Diversity.

The Committee also reviewed the work of Counter Fraud during the year. In addition to regular reports, it received the Fraud Risk Assessment 2015 report and the final report from NHS Protect on the focused quality assessment of compliance against NHS Protect standards for providers (Fraud, Bribery and Corruption). Overall the Trust received a 'green' rating for the Prevent and Deter and 'amber' for the Inform and Involve areas of strategic governance. Actions arising from this report are being reported through the Committee. The Committee also approved the Counter Fraud Work Plan 2015-16.

6.25.7 External Audit

KPMG were represented at all meetings of the Committee and submitted reports as needed, including their 2015-16 **Unqualified audit opinion on the Trust's Financial Accounts** and their Annual ISA260 report, to those charged with Governance regarding the audit findings.

In April 2015 Monitor reported that the Trust was failing to comply with a number of the provider licence conditions, in particular, those relating to financial reporting and financial governance, due to a failure to comply with its general duty to exercise its functions effectively, efficiently and economically. During 2015/16 the enforcement undertakings remained and therefore as a result, the external auditors **qualified the Use of Resources certificate for 2015/16**.

Furthermore, the external auditors have completed a review of the Trust's Quality Accounts and have given a **clean limited assurance on the content of the Quality Report**. Two indicators were tested namely 'percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period (RTT)' and percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge (A&E).

As a result of the testing performed, a **clean limited assurance opinion on the presentation and recording of the four hour A&E** wait was given. However, the auditors were **unable to provide a clean opinion on the RTT indicator** due to the lack of availability of patient level data from 1 April 2015 to 30 September 2015.

The external auditors reported that their work on the local indicator on 30 day emergency re-admissions as selected by Governors had indicated that if required to provide a limited assurance opinion, this would be clean.

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

The 2015/16 year-end audit plan has been reviewed and agreed and will be monitored by the Committee. All significant points raised by the KPMG as a result of their audit work, including any issues carried forward and their Use of Resources assessment, have been discussed with the Committee, were considered by management and, if needed, appropriate responses have been made and control processes are to be strengthened. The Committee also reviews the fees charged by KPMG and the scope of work undertaken.

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

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

6.25.8 Review of Effectiveness

The Committee undertook its annual formal self-assessment and reviewed any outstanding prior year actions. An action plan was prepared and approved to address all weaknesses where identified. Although no major weaknesses were identified, the Committee will seek to improve its effectiveness through reviewing induction and development needs and conduct of business, including use of meeting time, forward planning and presentation of agenda items. A review will also be undertaken in 2016/17.

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

So far as the Directors are aware, there is no relevant material audit information of which the Auditor is unaware. The Directors have ensured that any such information has been brought to the Auditor's attention.
The Directors are aware of their responsibilities for preparing the accounts and are satisfied that they meet NHS FT reporting requirements 2015-16 and the requirements reflected in the Accounting Officer's (AO) Statement of Internal Control made by the Chief Executive Officer (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.

6.25.10 Audit Committee Assurance

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

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

In 2016-17 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, sound systems of internal control and quality control, monitor actions planned to implement audit recommendations or strengthen controls in areas of concern.

6.25.11 Acknowledgements

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 co-operate 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.

Julie Soutter

Chair
Audit Risk and Assurance Committee
May 2016

7 Regulatory ratings

7.1 Monitor the Independent Regulator / NHS Improvement

As a Foundation Trust, up until 31 March 2016, we were regulated by Monitor, the sector regulator of health services in England. Monitor's role was 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.

Enforcement Undertakings – April 2015

In April 2015, Monitor had reasonable grounds to suspect that the Trust has provided and is providing health care services for the purposes of the NHS in breach of the following conditions of its licence: CoS3(1)(a) and (b), FT4(2) and FT4(5)(a),(d), (e), (f) and (g). Monitor has agreed to accept and the Trust as Licensee has agreed to give undertakings, pursuant to section 106 of the Health and Social Care Act 2012, in relation to financial sustainability, financial governance, distressed funding, reporting and general matters. Details of the enforcement undertakings are available on Monitor's website and also set out below (Section 7 refers).

Investigation – January 2016

In January 2016, the Trust received notification from Monitor of a formal investigation into the Trust's compliance with its licence in response to findings in the CQC Inspection Report and the related Warning Notice (received December 2015) in respect of A&E and aspects of planned care.

Monitor's investigation is continuing with the following being considered:

- the adequacy and breadth of the Trust's response and governance to oversee CQC action plan delivery;
- progress by the Trust in delivering key actions to address the concerns in CQC's December 2015 warning notice;
- whether the issues resulting in the December 2015 warning notice and the associated 'must do' actions in the CQC Report were identified by the Trust pre-inspection and the Trust could demonstrate it had taken sufficient actions to mitigate key safety risks;
- Trust engagement of system partners in the development and delivery of its CQC action plan;
- adequacy of the Trust Board's response to related safety risks in A&E more generally (including oversight of SIs, complaints and other key metrics); and
- Progress against its A&E improvement plan to recover 4-hour A&E performance. (Section 7 refers.

NHS Improvement

From 1 April 2016, Monitor became part of NHS Improvement. NHS Improvement is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. NHS Improvement offer the support these providers need to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. By holding providers to account and, where necessary, intervening, NHS Improvement helps the NHS to meet its short-term challenges and secure its future.

From 1 April 2016, NHS Improvement is the operational name for an organisation that brings together:

- Monitor
- NHS Trust Development Authority
- Patient Safety, including National Reporting and Learning System
- Advancing Change Team
- Intensive Support Teams

7.2 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 (now NHS Improvement) 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 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.
As referred to elsewhere in this report (Section 7 refers) during 2015/16 the Trust entered into enforcement undertaking relating to breach of licence conditions and is currently being investigated for breach of licence.

7.3 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 the Trust's compliance.

The Compliance Framework 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 Compliance Framework indicates that the Trust is breaching, or potentially breaching, its 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 on NHS Improvement's website.

7.4 Foundation trust planning and reporting

Monitor requires that the Board submits an operation 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 licence conditions.

7.5 Financial and governance ratings

There are two ratings provided by Monitor under a Compliance Framework as follows: -

1. **A Financial Sustainability Risk Rating** describes the risk of the Trust ceasing to be a going concern and its overall financial efficiency.
2. **A Governance Rating** indicated Monitor's degree of concern about the governance of the Trust, any steps Monitor is taking to investigate this and/or any actions Monitor is taking.

Set out below is a table explaining in summary how the former Continuity of Services Risk Rating (CoSRR) and the Financial Sustainability Risk Rating (FSRR) are calculated. In addition a further table is provided explaining the Governance Rating. Full information can been found in the Compliance Framework available on NHS Improvement's website.

<table>
<tr><th>Financial Sustainability Risk Rating
(from August 2015)</th><th>Continuity of Services risk rating</th></tr>
<tr><td><u>Continuity of services</u>
Two financial criteria:
1. Balance sheet sustainability
2. Liquidity

Two metrics:
1. Liquidity (days)
2. Capital Capacity (times)</td><td rowspan="2">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></tr>
<tr><td><u>Financial efficiency</u>
Two financial criteria:
1. Underlying performance
2. Variance from Plan

Two metrics:
1. I&E margin (%)
2. Variance in I&E margin as a % of income</td></tr>
<tr><td></td><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></tr>
<tr><td rowspan="2"><u>Assessment</u> is via
- Annual Plan submission
- Quarterly and monthly financial information
- Material financial events</td><td><u>Monitoring</u> is via a Forward plan:
- submission of forward-looking financial information
- calculation & publication of risk rating</td></tr>
<tr><td>In-year monitoring:
- quarterly
- year-to-date risk rating published</td></tr>
</table>

Financial Sustainability Risk Rating *(from August 2015)*	**Continuity of Services risk rating**
	Monitor may request a reforecast/'re-plan' and adjust the risk rating accordingly – depending on the revised rating further action may be taken
4 (5)-point scale Risk Rating 4: no evident concerns (quarterly monitoring) 3: emerging or minor concerns (potential enhanced monitoring) 2*: level of risk is material but sustainable (potential enhanced monitoring) 2: material risk (potential investigation) 1: significant risk (likely investigation / potential appointment of contingency planning team)	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 Continuity of Service (CoS) and other regulatory powers may be likely; higher monitoring frequency)

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, 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
Monitoring Quarterly and annually where available/necessary (e.g. for staff/patient surveys)
3 Categories Green – no evident grounds for concern or Monitor is not undertaking a formal investigation Under review – concerns identified but action not yet taken by Monitor. Red – enforcement action

7.6 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.

Note that from 1 April 2016, Monitor became part of NHS Improvement.

7.7 Risk Ratings 2015/16

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 2015/16	**Q1 2015-16**	**Q2 2015-16**	**Q3 2015-16**	**Q4 2015-16**
Under the Risk Assessment Framework only					
Continuity of Service Risk Rating	1	1	1	1	1
Financial Sustainability Risk Rating	n/a	n/a	2	2	2
Governance Risk rating	Plans are sufficient	Plans are sufficient	Plans are not sufficient	Plans are sufficient	Plans are not sufficient
Governance risk score	1	1	2	2	2

	Annual Plan 2014/15	**Q1 2014-15**	**Q2 2014-15**	**Q3 2014-15**	**Q4 2014-15**
Under the Risk Assessment Framework only					
Continuity of Service Risk Rating	2	1	1	1	1
Governance Risk rating	Plans are sufficient	Plans are sufficient	Plans are sufficient	Plans are sufficient	Plans are sufficient

7.8 Explanation for differences in actual performance versus expected performance at the time of the annual risk assessment

7.8.1 Quarter 1

In quarter 1 the Board confirmed a Continuity of Service Risk Rating (CoSRR) of 1 which the Trust expected to sustain moving forward. The Trust's financial position at the end of quarter 1 was a deficit of expenditure over income of £3.823m. Overall operating income was £0.521m below plan.

There was a scoring of 2 against governance for quarter 1. The Trust did not achieve performance of all three Referral to Treatment (RTT) targets.

Referral to Treatment (RTT)
Performance against each of the targets was reported as follows: -

- Admitted 87.3% against a target of 90%
- Non-Admitted 90.2% against a target of 95%
- Incomplete 88.4% against a target of 92%

Although the Admitted target was met in April and June it was not achieved in May and, therefore, was reported as a fail for the quarter. The Non-Admitted and Incomplete targets were not met in April, May and June.

Non-achievement of the target was due to the Trust concentrating on reducing backlogs and achieving a sustainable position with support from the Elective Care Intensive Support Team. The Trust, along with local commissioners, was engaged in an RTT Improvement Programme. This included a fortnightly system-wide monitoring meeting which included Monitor. The trajectory in quarter 1 for recovery was, by the end of quarter 3 2015/16, dependent on the agreement of the financial envelope to undertake the additional work required.

C. difficile
Also in quarter 1 the Trust reported 10 cases of C. difficile. Of these, 6 had been deemed unavoidable by Commissioners responsible for the patients and 3 were still under review by the appropriate Commissioner. There was 1 case that was found to be avoidable and, therefore, considered as due to a lapse in care. This was below the de minimus of 5 and, therefore, did not affect the Trust's rating.

Access to Healthcare for people with a Learning Disability
Access to Healthcare for people with a Learning Disability was introduced as a new target in 2014/15 and was mandated for compliance from quarter 3. The target relates to six indicators and criteria for meeting the needs of people with a learning disability, based on recommendations set out in 'Healthcare for all' (DH, 2008). The Trust was compliant with all six targets at quarter 1.

Never Events
There were no Never Events during quarter 1

Declaration
There were no exceptional matters that occurred in quarter 1 that required reporting to Monitor as part of the quarterly submission which had not already been reported. In quarter 1 the Board confirmed that it was satisfied that plans in place were sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework and a commitment to comply with all known targets going forward.

7.8.2 Quarter 2

In quarter 2 the Board confirmed a Financial Sustainability Risk Rating (FSRR) of 2 which the Trust expected to sustain moving forward. The Trust's financial position at the end of quarter 2 was a deficit of expenditure over income of £5.147m. Overall operating income was £2.182m below plan.

There was a scoring of 2 against governance for quarter 2. These related to A & E Performance and RTT.

A & E 4 hour wait target

The Trust did not achieve the A & E 4 hour wait target in quarter 2 with actual achievement of 94.3% against a target of 95%. The Trust was investigating whether SEQOL (Social Enterprise Quality of Life - an NHS organisation) attendances could be included as part of this data. This has been approved by NHS England. However, the Trust was looking at how this data was produced to ensure that the data was not double counted when reported nationally. The inclusion of this data would mean that the Trust had achieved the target in quarter 2.

Referral to Treatment (RTT)

The Trust is only monitored against the Incomplete Pathway target. Performance against this target in quarter 2 was as follows:

- Incomplete 88.3% against a target of 92%

The rationale for non-achievement of the target was the same in quarter 2 as in quarter 1 above.

C. difficile

The Trust reported 6 cases of *C. difficile* in quarter 2. The 6 cases had not been reviewed and assigned with commissioners at the time of reporting, although it was noted that there was likely to be at least 1 case that would be deemed avoidable and considered as a lapse in care. This was below the de minimus of 5 and, therefore, did not affect the Trust's rating.

Access to Healthcare for people with a Learning Disability

The target relates to six indicators and criteria for meeting the needs of people with a learning disability, based on recommendations set out in 'Healthcare for all' (DH, 2008).
The Trust was compliant with all six targets.

Never Event

There was one Never Event reported during quarter 2 relating to Wrong Site Surgery.

Care Quality Commission (CQC) Inspection

Commencing on 29 September 2015 and continuing into early October, the CQC inspected the Trust as part of its planned programme of inspections of healthcare providers. The final report on the Inspection was expected in the New Year.

Declaration

There were no exceptional matters that occurred in quarter 2 that required reporting to Monitor as part of the quarterly submission which had not already been reported. In quarter 2 the Board confirmed that it was satisfied that plans in place were not sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework and a commitment to comply with all known targets going forward.

7.8.3 Quarter 3

In quarter 3 the Board confirmed a Financial Sustainability Risk Rating (FSRR) of 2 which the Trust expected to sustain moving forward. The Trust's financial position at the end of quarter 3 was a deficit of expenditure over income of £6.494m. Overall operating income was £0.147m below plan.

There was a scoring of 2 against governance for quarter 3. This related to A & E Performance and Referral to Treatment.

A & E Performance

The Trust did not achieve the A & E 4 hour wait target in quarter 3 with actual achievement of 90.9% against a target of 95%. The Trust was including SEQOL as part of this data which has been approved by NHS England.

Referral to Treatment (RTT)

The Trust is only monitored against the Incomplete Pathway target. Performance against this target in quarter 3 was as follows:

- October – 88.7%
- November – 86.9%
- December – 90%

There was a Remedial Action Plan in place that had been agreed with the Clinical Commissioning Groups which predicted delivery of the 92% target by the end of March 2016. The quality of data reporting within the Trust had required significant improvement during quarter 3, involving migration to a new database and reporting suite and the full impact of this change on performance was to be understood by the end of January.

In quarter 3 an additional activity plan was in place at specialty level, the Trust was over-delivering against the non-admitted activity plan but around 40% behind plan on the admitted activity plan. Winter pressures combined with industrial action had contributed to the under-performance against plan. This was being addressed through further admitted activity within the organisation and at local private providers. Fortnightly RTT Steering Groups with external partners, chaired by the Interim Chief Operating Officer, continued to monitor progress against all work-streams. Fortnightly tripartite calls with Monitor and NHS England were also in place. On-going support was being received from the Elective Care Intensive Support Team.

C. difficile

The Trust reported 10 cases of *C. difficile* in quarter 3. There were 18 cases to be reviewed and assigned with commissioners. Swindon Clinical Commissioning Group had arranged to complete 7 reviews for quarter 2 and quarter 3 later in January 2016. Wiltshire Clinical Commissioning Group needed to convene a panel to review their assigned 11 cases for quarters 1, 2 and 3.

Access to Healthcare for people with a Learning Disability

The target relates to six indicators and criteria for meeting the needs of people with a learning disability, based on recommendations set out in 'Healthcare for all' (DH, 2008). The Trust was compliant with all six targets.

Never Event

There were no Never Events during quarter 3

Exceptional Items to Report - Care Quality Commission (CQC) Inspection

Commencing on 29 September 2015 and continuing into October, the CQC inspected the Trust as part of its planned programme of inspections of healthcare providers. The final report on the Inspection was issued to the Trust in January 2016 and the overall rating was "requires improvement".

Declaration

In quarter 3 the Board confirmed that it was satisfied that plans in place were sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework and a commitment to comply with all known targets going forward.

7.8.4 Quarter 4

In quarter 4 the Board confirmed a Financial Sustainability Risk Rating (FSRR) of 2 which the Trust expected to sustain moving forward. The Trust's financial position at the end of quarter 4 was a deficit of expenditure over income of £9.744m. Overall operating income was £4.601m below plan.

There was a scoring of 2 against governance for quarter 4. These relates to A & E Performance and Referral to Treatment.

A & E Performance

The Trust did not achieve the A & E 4 hour wait target in Q4 with actual achievement of 81.4% against a target of 95% and full year performance is 91.1%. The Trust is now including SEQOL as part of this data which has been approved by NHS England.

Referral to Treatment (RTT)

The Trust is only monitored against the Incomplete Pathway target. Performance against this target in quarter 3 was as follows:

January – 89.1%
February – 89.0%
March – 91.18%

Achievement at year end was 91.18% which was in line with Trust expectations. Although every effort is being made to maximise incomplete performance, 92% on 31st March was not achievable, given the lost capacity and activity in March for reasons beyond the Trust's immediate control. We are continuing the running of both additional outpatient clinics as well as inpatient operating lists alongside on-going outsourcing of operations to our local private provider. The impact of 4 days of industrial action is likely to be significant in April and therefore the Trust is predicting performance will vary within the month in particular during the weeks where industrial action occurs with the end of April position being around 90%. Steady improvement throughout May is anticipated to achievement of 92% at aggregate level by the end of May. This is assuming that there are no further Junior Doctor strikes after those taking place in April.

C. difficile

The Trust has reported 4 cases of *C. difficile* in quarter 4. There have been 30 cases reported for the whole year, 18 of these have been deemed 'unavoidable', 3 have been assigned as 'avoidable' and the remaining 9 cases are still under review and awaiting assignment by the Commissioners.

Access to Healthcare for people with a Learning Disability

The target relates to six indicators and criteria for meeting the needs of people with a learning disability, based on recommendations set out in 'Healthcare for all' (DH, 2008).
The Trust was compliant with all six targets.

Never Event

There were two Never Events during quarter 4 - 1 Retained Foreign Body and 1 Wrong Implant/ Prosthesis.

Exceptional Items to Report - Care Quality Commission (CQC) Inspection

In January 2016 the Trust received a report from the CQC following its inspection of Trust services during September and October 2015, which was part of the CQC's planned programme of inspections of healthcare providers. The overall rating was "requires improvement". The Trust had established an action plan to drive improvements which was submitted to the CQC and Monitor in February 2016. Progress was being monitored through a newly established Improvement Committee and through existing Committee meetings with regular reporting to the CQC and Monitor on milestone actions and sustainability of improvement.

In the quarter, the Trust received notification from Monitor of a formal investigation into the Trust's compliance with its licence in response to findings in the CQC Inspection Report and the related Warning Notice (received December 2015) in respect of A&E and aspects of planned care.

Monitor's investigation was continuing with the following being considered:

- the adequacy and breadth of the Trust's response and governance to oversee CQC action plan delivery;
- progress by the Trust in delivering key actions to address the concerns in CQC's December 2015 warning notice;
- whether the issues resulting in the December 2015 warning notice and the associated 'must do' actions in the CQC Report were identified by the Trust pre-inspection and the Trust can demonstrate it had taken sufficient actions to mitigate key safety risks;
- Trust engagement of system partners in the development and delivery of its CQC action plan;
- adequacy of the Trust Board's response to related safety risks in A&E more generally (including oversight of SIs, complaints and other key metrics); and
- Trust progress against its A&E improvement plan to recover 4-hour A&E performance.

During the quarter on 11 January 2016, the Trust had received a letter from the Assistant Coroner for Wiltshire and Swindon under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 regarding concerns relating to the lack of a system on the paper drug chart or the electronic prescribing system for alerting medical staff to patients being on long term steroids. The Trust responded to the Coroner within 56 days as required.

During the quarter on 23 February 2016, the Trust had received an Improvement Notice from the Care Quality Commission issued under the Health and Safety at Work etc. Act 1974 and the Ionising Radiation (Medical Exposure) Regulations 2000 reporting that the Trust was in Breach of Regulation 5(3) relating to Duties of the Practitioner, Operator and Referrer and Regulation 11(1) relating to Training. The Trust was required to remedy the contraventions by 10 May 2016 and action was underway to address this.

It was noted that in the quarter the practice of anaesthetising children below 24 months of age for elective or non-life/limb threatening surgery had ceased.

Declaration

In quarter 4 the Board confirmed that it was not satisfied that plans in place were sufficient to ensure ongoing compliance with all existing targets.

7.9 Details and actions from any formal interventions

7.9.1 Monitor Investigation and Enforcement undertakings April 2015

The Trust was subject to a Monitor investigation during 2014/15 which carried over into 2015/16. This was because the Trust's Continuity of Risk Rating was a 1, flagging high risk.

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

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

1. Financial sustainability

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

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

1.3. The Licensee will develop and agree with Monitor a realistic and robust long-term strategy for financial sustainability (the "Strategy") along with a realistic and robust supporting long-term financial recovery plan to address the five years following submission of the Short-Term Recovery Plan, or such other

period as may be agreed with Monitor (the "Long-Term Recovery Plan"). The Licensee will submit the final Strategy and the final Long-Term Recovery Plan to Monitor by 1 October 2015 or such later date as may be agreed with Monitor. The Long-Term Recovery Plan should be aligned with commissioners' intentions and wider strategic developments impacting on the local health economy insofar as practicable.

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

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

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

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

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

2. Financial governance

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

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

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

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

3. Distressed funding

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

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

4. Reporting

4.1. The Licensee will provide regular reports to Monitor on its progress in meeting the undertakings set out above, including reporting against the KPIs agreed pursuant to paragraph 1.5 and will attend meetings or, if Monitor stipulates, conference calls, to discuss its progress in meeting those undertakings. These meetings shall take place once a month unless Monitor otherwise stipulates, at a time and place to be specified by Monitor and with attendees specified by Monitor.

5. General

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

5.1.1. The Short-Term Recovery Plan;

5.1.2. The Long-Term Recovery Plan; and

5.1.3. The Financial Governance Plan.

Summary of Action taken to address the Enforcement Undertakings

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

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

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

7.9.2 Care Quality Commission – Breach of The Health and Social Care Act 2008 (regulated Activities) Regulations, Section 29A Warning Notice - December 2015

The Care Quality Commission (CQC) undertook a routine inspection of Trust services commencing in September 2015. Subsequent to this the CQC served a Section 29A Warning Notice on the Trust notifying that the CQC had formed the view that the quality of health care provided by the Trust for the treatment of disease, disorder or injury required significant improvement at the Great Western Hospital, Swindon. The reasons for this view were as follows: -

Systems or processes have not been established and operated to ensure

(a) The assessment, monitoring and improvement of quality and safety of the services provided;

(b) The assessment, monitoring and mitigations of risk relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of regulated activity;

(c) That accurate, complete and contemporaneous records are maintained in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

and treatments are not being provided in a safe way for service users.

The Warning Notice required the Trust to make significant improvement relating to the following: -

A. The location, design and layout of the emergency department observation unit at the Great Western Hospital, combined with inadequate staffing levels and staff training, presents risk to patients and staff.
B. Systems to ensure accurate records were maintained in respects of patient' care and treatment were not effective. The CQC could not be assured appropriate care and treatment takes place in a timely manner.
C. There was a lack of assurance that nurse staffing levels had been appropriately established or that planned levels of staffing were consistently achieved to ensure that patients attending the emergency debarment received timely, safe and effective care and treatment.
D. There were insufficient numbers of staff employed in the children's emergency department who had received appropriate training to equip them to care for children. Planned staffing levels were not consistently maintained. This, combined with the design and layout of the department, presented unacceptable risks to patients. These risks were not addressed and steps to mitigate risks were not adequate or effective to ensure safe care and treatment.
E. There were inadequate oversight and monitoring of staff training to ensure that staff had the right qualifications, skills, knowledge and experience to provide appropriate care and treatment in a safe way.
F. The governance systems and processes in place within the Trust, were not effectively operated and as such were not able to demonstrate effective clinical governance, continuous learning, improvement and changes to practice from reviews of incidents, complaints, mortality and morbidity reviews. This was particularly evident within the Unscheduled Care Division and Planned Care Division.

<u>Summary of Action taken to address the Warning Notice</u>

The Trust took a number of actions to address the Warning Notice which included the following: -

- Establishment of an action plan with milestone actions
- The establishment of workstreams covering the following each with actions in the short and longer term: -
    - Paediatric ED
    - Mental Health
    - Nursing Practice
    - Education
    - Staffing
    - Emergency Department Capacity and Resilience
- The establishment of a Steering Group which met weekly to oversee the roll out of actions and to test and challenge sustainability
- New clinical leadership
- Additional nursing leadership

7.9.3 Monitor Investigation into the Trust's compliance with its provider licence - January 2016

On 25 January 2016, the Trust received notification from Monitor of a formal investigation into the Trust's compliance with its licence in response to findings in the CQC Inspection Report and the related Warning Notice in respect of A&E and aspects of planned care.

Monitor's investigation is to consider the following:

1. the adequacy and breadth of the Trust's response and governance to oversee CQC action plan delivery;
2. progress by the Trust in delivering key actions to address the concerns in CQC's December 2015 warning notice;
3. whether the issues resulting in the December 2015 warning notice and the associated 'must do' actions in the CQC Report were identified by the Trust pre-inspection and the Trust can demonstrate it had taken sufficient actions to mitigate key safety risks;
4. Trust engagement of system partners in the development and delivery of its CQC action plan;
5. adequacy of the Trust board's response to related safety risks in A&E more generally (including oversight of SIs, complaints and other key metrics); and
6. Trust progress against its A&E improvement plan to recover 4-hour A&E performance.

Summary of Action taken to date

The findings of the investigation have yet to be received from the Trust. Notwithstanding this, the Trust has commissioned two well led governance reviews looking at Board governance and Divisional Board governance, the outcome of which will inform an action plan of improvements. In the meantime, actions have taken place to strengthen Divisional governance arrangements, including a focus on improved risk management, reporting and escalation.

7.10 The Care Quality Commission

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

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

Care Quality Commission (CQC) Inspection – September 2015

In January 2016 the Trust received a report from the CQC following its inspection of Trust services during September and October 2015 which was part of the CQC's planned programme of inspections of healthcare providers. The overall rating was "requires improvement". The Trust has established an action plan to drive improvements which was submitted to the CQC and Monitor in February 2016. Progress is being monitored through a newly established Improvement Committee and through existing Committee meetings with regular reporting to the CQC and Monitor on milestone actions and sustainability of improvement.

7.10.4 Full Inspection Outcomes

The ratings for both Acute and Community locations are summarised as follows: -

Our ratings for The Great Western Hospitals Foundation NHS Trust

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

Our ratings for Community health services

Core Service	Safe	Effective	Caring	Responsive	Well-led		Overall
Community health services for children, young people and families	Good	Good	Outstanding	Outstanding	Good		Outstanding
Community health services for adults	Good	Good	Good	Good	Good		Good
Community health inpatient services	Good	Good	Good	Good	Good		Good
End of life care	Good	Good	Good	Good	Good		Good
Overall	Good	Good	Good	Good	Good		Good

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

The CQC raised concerns that the location, design and layout of the emergency department and the observation unit, combined with inadequate staffing levels and staff training, presented risks to patients and staff in the Emergency Department (ED). The CQC issued a Warning Notice to the Trust on 1st December 2015 and rated this service as "requires improvement" within the full Inspection report received in January 2016. In addition 6 Compliance Actions were made, as follows;

Type	Date	Health and Social Care Act 2008 Regulation
Compliance Action	19/01/2016	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care
Compliance Action	19/01/2016	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect
Compliance Action	19/01/2016	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
Compliance Action	19/01/2016	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment
Compliance Action	19/01/2016	Regulation 17 HSCA (RA) Regulations 2014 Good Governance
Compliance Action	19/01/2016	Regulation 18 HSCA (RA) Regulations 2014 Staffing

7.10.5 Care Quality Commission Warning Notice - December 2015

The Care Quality Commission (CQC) undertook a routine inspection of Trust services commencing in September 2015. Subsequent to this the CQC served a Section 29A Warning Notice on the Trust notifying that the CQC had formed the view that the quality of health care provided by the Trust for the treatment of disease, disorder or injury required significant improvement at the Great Western Hospital, Swindon. The Warning Notice required the Trust to make significant improvement

7.10.6 Care Quality Commission (CQC) registration

Any person (individual, partnership or organisation) who provides regulated activity in England must be registered with the CQC. To be registered, an application must be made to the CQC, providing details about the applicant, the regulated activities applied for, and the places at which, or from which, it will be provided (known as 'locations').

The CQC assess the applicant and, to grant registration, the CQC must be satisfied about their fitness and compliance with the requirements of the relevant regulations and enactments. The term 'fitness', the regulated activities and the wider registration requirements are set out in the Health and Social Care Act 2008 (the 'Act') and its associated regulations.

When the CQC registers a person, they may do so with conditions (about, for example, the locations at which regulated activity may be provided). If, subsequently, the provider wishes to vary or remove any of these conditions, to apply for another regulated activity or to cancel their registration, they must make a further application to the CQC. Some providers must have a registered manager as a condition of their registration. Appointed managers must also apply and satisfy the CQC about their fitness and meet with the other requirements of the relevant regulations and enactments.

Through this system of registration, the CQC ensures that only those people who are judged to be fit, and are likely to provide and manage good quality care that meets the needs of people, are authorised to do so.

The Trust is registered with the CQC without additional conditions attached to the registration.

Statement of Accounting Officer's responsibilities

7.11 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.

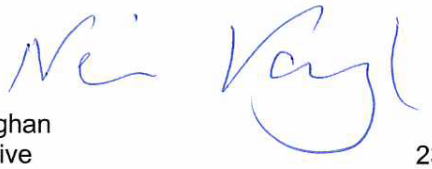
Under the NHS Act 2006, Monitor has directed Great Western Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the 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 23 May 2016

8 Auditor's opinion and certificate

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

Opinions and conclusions arising from our audit

1. *Our opinion on the financial statements is unmodified*

We have audited the financial statements of Great Western Hospitals NHS Foundation Trust for the year ended 31 March 2016 set out on pages 208 to 248 of the Accounts. In our opinion:

- the financial statements give a true and fair view of the state of the Trust's affairs as at 31 March 2016 and of the Trust's income and expenditure for the year then ended; and
- the financial statements have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2015/16.

2. *Our assessment of risks of material misstatement*

In arriving at our audit opinion above on the financial statements the risks of material misstatement that had the greatest effect on our audit were as follows:

Valuation of land and buildings including dwellings - Land £36.0 million (2014/15: £36.0 million) and Buildings (including dwellings) £170.0 million (2014/15: £171.9 million) *risk level is → (consistent) year on year*

Refer to pages 9 (Audit Committee Report), page 6 to 10 (accounting policies) and page 24 to 25 (financial disclosures).

The risk: Land and buildings are initially recognised at cost, but subsequently are recognised at current value in existing use (EUV). For non-specialised property assets in operational use, and, for specialised assets where no market value is readily ascertainable, they are recognised at the depreciated replacement cost (DRC) of a modern equivalent asset that has the same service potential as the existing property. A review is carried out each year to test assets for potential impairment and a full valuation is carried out every five years.

There is significant judgment involved in determining the appropriate basis (EUV or DRC) for each asset according to its degree of specialisation, as well as over the assumptions made in arriving at the valuation of the asset. In particular the DRC basis of valuation requires an assumption as to whether the replacement asset would be situated on the existing site or, if more appropriate, on an alternative site.

An interim desk-top revaluation of all the land and buildings, which did not involve physical inspection of the assets, was undertaken by management using building price and cost indices as at 31 March 2016 provided by the Royal Institute of Chartered Surveyors. There is a high degree of judgement required in undertaking a desk-top revaluation, in particular relating to the indices applied to the assets in order to assess potential increases or decreases in the valuation. Management use this exercise to assess whether there has been a material change in the valuation that needs to be recognised in years in between their full revaluation cycle of five years.

Our response: In this area our audit procedures included:

- Critically assessing the appropriateness of the indices used within the interim desk-top valuation produced by management;
- Considering those assets acquired or constructed during the year which were not subject to a desk-top valuation and challenging the judgement of management that the fair value of these assets was not significantly different from their initial cost;
- Challenging the bases and assumptions applied to individual assets by reference to property records held by the Trust, including the reconciliation of details provided for revalued assets to the fixed asset register and the benchmarking of indices applied to the revaluation with reference to third party data; and

We also considered the adequacy of the Trust's disclosures in respect of land and buildings.

Recognition of NHS and non-NHS income – Income from activities £281.7.4 million (2014/15: £273.8 million) and other operating income £28.7 million (2014/15: £27.0 million) *risk level is → (consistent) year on year*

Refer to pages 10 (Audit Committee Report), page 5 (accounting policies) and page 17 (financial disclosures).

The risk: The main source of income for the Trust is the provision of healthcare services to the public under contracts with NHS commissioners, which make up 87% of income. The Trust participates in the Agreement of Balances (AoB) exercise which is mandated by the Department of Health (the Department), covering the English NHS only, for the purpose of ensuring that intra-NHS balances are eliminated when the consolidation exercise takes place to report the Department's Consolidated Resource Account. The AoB exercise identifies mismatches between income, expenditure, receivable and payable balances recognised by the Trust and its counter-parties at 31 March 2016.

Mis-matches can occur for a number of reasons, but the most significant arise where the Trust and commissioners have not concluded the reconciliations of healthcare spells completed within the last quarter of the financial year, which have not yet been invoiced, or there is no final agreement over proposed contract penalties as activity data for the period has not been validated.

In addition to this patient care income the Trust reported total income of £28.7 million (2014/15: £27.0 million) from other activities, principally education and training and research and development. Much of this income is generated by contracts with other NHS and non-NHS bodies which are based on varied payment terms, including payment on delivery, milestone payments and periodic payments. Therefore there is a greater risk that income will be recognised on a cash rather than an accruals basis. In addition some sources of income require independent grant confirmations which can impact the amount of the income the Trust will actually receive.

We do not consider NHS income and income from other activities to be at high risk of significant misstatement, or to be subject to a significant level of judgement. However, due to their materiality in the context of the financial statements as a whole NHS income and income from other activities are is considered to be two of the areas which had the greatest effect on our overall audit strategy and allocation of resources in planning and completing our audit.

Our response: In this area our audit procedures included:

- We agreed commissioner income to the signed contracts and selected a sample of the largest balances (comprising 98% of income from patient care activities) to agree in more detail to supporting evidence.
- We reviewed third party confirmations from your commissioners as part of the AoB exercise and compared the values they are disclosing within their financial statements to the value of income captured in your financial statements. We sought explanations for any variances over £0.25m, and all balances in dispute.
- We reviewed the approach to providing for bad debt and confirmed that they were in line with the Trust's accounting policies, and the judgement for the level of provision was appropriate.
- We reviewed the judgement made in accounting for incomplete spells to determine whether income had been recognised in the appropriate period.
- We carried out testing of other income by analysing the movement in key balances and obtaining explanations for significant variances.
- We carried out testing of other income by analysing the movement in key balances and obtaining explanations for significant variances.

We also considered the adequacy of the Trust's disclosures in respect of income, particularly in relation to any key judgments made and estimates used in recognising income.

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

The materiality for the financial statements (excluding non-current assets) was set at £6.2 million (2014/15: £5.8 million), determined with reference to a benchmark of income from operations (of which it represents 2%, 2014/15: 2%). We consider income from operations to be more stable than a surplus related benchmark.

For non-current assets, we set materiality at £20.2 million, determined with reference to the underlying carrying value of fixed assets (of which it represents 10%).

We report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £0.3 million (2014/15: £0.25 million), in addition to other identified misstatements that warrant reporting on qualitative grounds.

4 Our opinion on other matters prescribed by the Code of Audit Practice is unmodified

In our opinion:

- the parts of the Remuneration Report and Staff Reports to be audited have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2015/16; and
- the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

5 We have nothing to report in respect of the matters on which we are required to report by exception

Under ISAs (UK and Ireland) we are required to report to you if, based on the knowledge we acquired during our audit, we have identified other information in the Annual Report that contains a material inconsistency with either that knowledge or the financial statements, a material misstatement of fact, or that is otherwise misleading.

In particular, we are required to report to you if:

- we have identified material inconsistencies between the knowledge we acquired during our audit and the directors' statement that they consider that the Annual Report and Accounts taken as a whole is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy; or
- the Audit Committee Report (within the Annual Report) does not appropriately address matters communicated by us to the Audit Committee.

Under the Code of Audit Practice 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 2015/16, 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.
- the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in its use of resources.

In addition we are required to report to you if:

- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.
- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in respect of the above responsibilities.

6 Other matters on which we report by exception - adequacy of arrangements to secure value for money

Under the Code of Audit Practice we are required to report by exception if we conclude that we are not satisfied that the Trust has put in place proper arrangements to secure value for money in the use of resources for the relevant period.

Monitor considers that the Trust has contravened and is failing to comply with the provider licence condition CoS3: Standards of corporate governance and financial management paragraphs (1)a and FT4: NHS foundation trust governance arrangements paragraphs 2 and 5(a), (c), (d), (f) and (h) relating to using its resources "effectively, efficiently and economically" and that these contravention and failures are significant.

As a result of these matters, we are unable to satisfy ourselves that the Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

Certificate of audit completion

We certify that we have completed the audit of the accounts of Great Western Hospitals NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

Respective responsibilities of the accounting officer and auditor

As described more fully in the Statement of Accounting Officer's Responsibilities on page 108 the accounting officer is responsible for the preparation of financial statements which give a true and fair view. Our

responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the UK Ethical Standards for Auditors.

Scope of an audit of financial statements performed in accordance with ISAs (UK and Ireland)

A description of the scope of an audit of financial statements is provided on our website at www.kpmg.com/uk/auditscopeother2014. This report is made subject to important explanations regarding our responsibilities, as published on that website, which are incorporated into this report as if set out in full and should be read to provide an understanding of the purpose of this report, the work we have undertaken and the basis of our opinions.

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

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General (C&AG), as to whether the Trust has proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The C&AG determined this criterion as necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

The purpose of our audit work and to whom we owe our responsibilities

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

Jonathan Brown

Jonathan Brown
for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
100 Temple Street
Bristol
BS1 6AG

26 May 2016

9 Annual Governance Statement

9.1 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.

9.2 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 2016 and up to the date of approval of the annual report and accounts.

9.3 Capacity to handle risk

Leadership is given to the risk management process by the Executive Directors. 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.

On a monthly basis the Executive Directors through the Executive Committee review the 15+ risks register to ensure risks are being managed and that the top risks for the Trust are reflected. Monthly all Directors receive oversight of 15+ risks at the Board meeting.

Risk Management is introduced into employee culture immediately upon employment. Employee education and training on risk management is carried out commensurate with employee roles. All new employees receive corporate induction, which includes risk management and incident reporting, alongside health and safety, manual handling and infection control training appropriate to their duties. Employees with applicable roles are provided with a one to one hour training session on how to use the risk register and manage risks before access to the electronic register is provided. Refresher training if required is offered on the same one to one basis to existing employees, or group drop in clinics if preferred.

Divisions are provided with a monthly risk register report detailing comparison and movement to the previous month. This has been in place since 2014/15 as additional support in management of risks for managers. Particular emphasis is given to the identification and management of risk at a local level. Discussions at Divisional meetings are encouraged as part of the culture to agree upon the identified score of the risk, the appropriate mitigating actions and whether the risk is valid, or "accepted/tolerated "as business as usual (risks scoring 15 plus are to be accepted by the Board only) or can be closed as appropriate. Discussions at this level and frequency reduce the duplication of risks, encourage active discussion on what are tangible risks, what can be tolerated at a local level and that the description of the risk demonstrates the consequences should the risk materialise.

Furthermore, on a weekly basis a whole risk register is circulated to risk owners, handlers and managers and in addition numerous supporting guides are available, which were refreshed during 2015/16.

9.4 The risk and control framework

9.4.1 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

In 2015/16 the Board introduced a risk tolerance statement aimed at supporting managers in decision making. The statement sets out the Trust's appetite for risk.

9.4.2 Risk assessment

All Trust employees are responsible for identifying and managing risk. The Trust uses the National Patient Safety Agency (NPSA) Risk Matrix for Risk Managers to ensure risks are collectively scored objectively against the likelihood and the consequence of the risk materialising.

In addition there is a robust Incident Management Policy in place and at corporate induction employees are actively encouraged to utilise the web-based incident reporting system. A healthy incident reporting culture has been maintained for a number of years providing assurance that employees feel able to report incidents and risks.

9.4.3 Risk register

The risk register is a risk management tool whereby identified risks are described, scored, controls identified, mitigating actions planned and a narrative review is recorded. Data in the risk register is extractable into report format to provide an overall picture of risks to the Trust as well as thematic overviews.

The Trust has agreed that the most significant risks to the Trust, being those that score 15 and above (15+), should be reviewed monthly at the Executive Committee. A register containing 15 plus risks is scrutinised and challenged by the Executive Committee (to ensure risks are being managed) and three times a year at the Audit, Risk and Assurance Committee (to ensure processes in place to manage risk are effective). This high-level register is informed both by those risks which score 15 and above in the Board Assurance Framework (top down) and risks identified from within the Divisions (bottom up).

In 2015/16 the Audit, Risk and Assurance Committee overviewed the 15+ risk register and considered that whilst processes were in place for managing risks, there were concerns regarding consistency within Divisions. As a result a number of actions were taken during 2015/16 to provide further support to Divisional Managers in their management of risks as follows: -

- Weekly risk register training sessions scheduled
- Individual training sessions provided as well as group sessions
- Guides widely circulated
- Monthly reporting of Divisional Risks Registers to Divisional Managers
- Weekly report on whole risk register circulated to risk owners, leads and managers
- 15+ risk summary report to Board monthly (via Board circular and latterly as Board agenda item)
- Divisional governance arrangements for risk management refreshed and mapped
- Divisional risk leads identified

- Focussed meeting with Divisional and Departmental managers to scrutinise and challenge risks, controls, actions and reviews
- Electronic risk system reconfigured to include mandatory fields around funding or risks
- Electronic system reconfigured to continually remind handlers of risk actions
- Committee reports refreshed to include movement of risks / grouping risks into types
- Workshop with governance facilitators held to understand barriers to effective risk management and to share best practice – action plan being rolled out

Risks are scrutinised locally at Divisional meetings and there is a strong emphasis from Executive Directors that managing all risks at Divisional level using the risk management system is essential. The housekeeping of the risk register and use of the system as a management tool requires further improvement. Therefore, work will continue to support the Division in ensuring that the risk register is well managed and updated frequently, so that reports received by the Committees are well informed and up to date. A workshop is plan for May 2016 when the Executive Committee will focus on how to embed and sustain use of the risk register as a risk management tool.

In January 2016 the internal auditors undertook an audit of the Board Assurance Framework which included risk management processes and a "reasonable" assurance opinion was given. The audit found that risk management processes were operating across the Trust although improvements were needed around timeliness of review of overdue risks and associated actions at Divisional level.

9.4.4 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.

In January 2016 the internal auditors undertook an audit of the Board Assurance Framework and risk management processes and a "reasonable" assurance opinion was given in relation to Divisional risk management (see above). The audit found that the 2015/16 Board Assurance Framework (BAF) was embedded in the governance structure of the Trust and is maintained as a "live" document. Streamlining of the BAF content and layout during 2015/16 had made the BAF a more user friendly document.

During 2015/16 a refreshed approach was taken to the Board Assurance Framework as follows: -

- Refreshed risks, controls and assurances
- Improved reporting with a focus on what the BAF is telling us
- Additional assurance reviews undertaken (internally meeting with leads)
- Additional assurance reviews identified for inclusion in the Annual Audit Plan

9.4.5 Risk appetite

During 2015/16 the Board introduced a risk tolerance statement aimed at supporting managers in decision making. The statement dated Dec-15 sets out the Trust's appetite for risk.

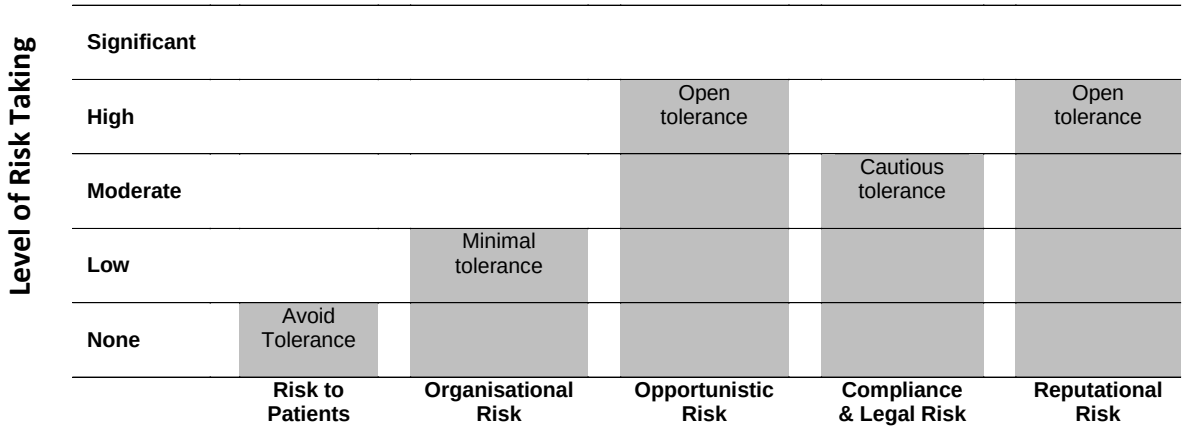
"The Trust recognises that its long term sustainability depends upon the delivery of its strategic objectives and its relationships with its patients, the public and strategic partners. The Trust will not accept risks that impact on patient safety and wishes to avoid risks which adversely impact on the financial position. However, the Trust has a greater appetite to take considered risks in terms of pursuing innovation and challenge current working practices where positive gains can be anticipated within the constraints of the regulatory and legal environment. The Trust has a higher tolerance for reputational impact, although this should be carefully considered. This is depicted in the chart below.

However, any consideration of risk needs to be in a broad context. Risk taking and decision making based on risk should not be considered in isolation or in "silos". There is often the potential for a greater impact of risks with wider organisational context or in relation to other decisions made.

To assist managers and staff in decisions that may involve or facilitate exposure to risk, the Trust Board has set out below its current attitude to risk.

This may change over time as internal and external circumstances change, but it provides an approved approach to support decision making by managers and staff. Decisions taken which would be contrary to this statement must be referred to the Executive Directors before implementation."

Risk Appetite by Area



9.4.6 Significant Risks

There are a number of risks identified on the board assurance framework and risk register. Examples of significant risks identified during 2015/16, together with the actions that have been taken to mitigate them are summarised as follows: -

Risks	Actions to manage and mitigate, including how outcomes will be assessed
Quality and Safety	
Adverse impact on quality and safety due to financial constraints.	Safety Improvement Plan was developed and approved setting out clear and measurable safety priorities together with clear principles underpinning our approach. Quality Impact Assessments before and during a change continued which were essential to monitor the impact with sign off at Executive level from both the Chief Nurse and Medical Director before a change was made. Additional transformation support was secured to support the Trust in equipping divisions with the skills and ideas to help identify opportunities to deliver savings as well as drive quality. Our process for Strategic Service Reviews helped identify different ways of working and areas for disinvestment without a material impact on quality and safety. Senior Quality representation was involved in reviewing the Divisional outputs. A Communications Plan for 2015/16 was delivered to ensure the focus for staff remained on quality and safety and that whilst the drive to deliver savings was a key priority, it must not impact on the quality and safety of patient care. Visible leadership and strong visibility on issues of quality and safety throughout the year were key to reinforcing the culture we aimed for.
Demand in some of the smaller specialties outstrips capacity resulting in longer waits.	Strategic Service Reviews were completed. These help identify significant 'pinch points' in services and opportunities to resolve them including new ways of working, partnership opportunities and informing commissioners of changing demand profiles or service arrangements.
Workforce	
Agency spend continues at the same or higher level due to inability to recruit substantive staff in significant numbers.	A Recruitment and Retention Plan was implemented detailing an 18 month trajectory which was closely monitored. Strengthened management controls remained in place and spend against pay bill was closely scrutinised at Divisional Performance Review meetings, Optimising Nursing and Midwifery Programme Board and the Senior Clinical Staffing Group. This allowed the opportunity to identify deviation and reasons early enough to take action.
Early indicators from staff survey highlighting concerns around communications and engagement which continue to deteriorate impacting on morale and ultimately quality of care.	Following the staff survey results for 2014, staff engagement and communication was a key priority for the Trust with the aim of improving the communication score between senior management and staff to at least better than average. A communications plan for 2015/16 was rolled out which included a range of activity to strengthen communications so staff could understand the future direction and the part they could play in helping us get there. The Trust continued to invest time and resource into staff engagement to build on

Risks	Actions to manage and mitigate, including how outcomes will be assessed
	the mechanisms in place including: • Team Development and listening projects • Ward and department based deep dive listening projects • The ongoing development of See Something, Say Something – and the 'Nipping Things In The Bud' programme so that staff and leaders could feel free to express and have difficult conversations • Team or Department based confidential surveys • Ensuring all projects and change management had engagement at the core • Ensuring a strong, visible leadership within the Trust.
System	
Some gaps in alignment between Trust plans and commissioners resulting in risk in relation to demand management and capacity plans.	Significant work took place in 2014/15 to develop a plan to bridge the gaps in alignment and during 2015/16 progress continued in rolling out actions. The Trust mitigated this risk by revisiting the capacity plan to provide resilience within the Trust to cope with demand. The Trust actively sought to influence Clinical Commissioning Group (CCG) decision making through a System Resilience Group and Strategy Group and supported the CCG in a long term aim to transform the health economy in Swindon.
Financial	
CIP plans do not materialise and are not sustainable on a recurrent basis.	The Trust actively worked towards a fully identified and costed plan which was rolled out during 2015/16.
Cash position – ability to pay our suppliers and workforce.	This formed part of a recovery plan and was closely monitored through the Finance, Investment and Performance Committee.

Assurances and gaps in those assurances have been identified during 2015/16. Assurances and gaps are sought from a variety of sources including audits, external reviews or peer challenge. Whilst there are gaps in assurances, there are action plans in place to address them or seek additional assurances. 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 2016/17 have been identified through the operational planning process. Future risks include the following: -

TABLE – Examples of Future risks

Risks	Actions to manage and mitigate, including how outcomes will be assessed
Financial Risk	
Ability to Manage Sufficient Capital Investment	Additional leases funded via depreciation reduction
Non-Financial Risks	
Continued failure to meet the 4 hour ED standard	Right Patient Right Bed programme in place to support flow. Remedial action plan in place to improve performance including protection of Ambulatory care to increase the medical activity. Plan to include the addition of medical 'hot clinics' to support take. Plans include full protection of Surgical Assessment Unit (SAU) and a goal for 50% reduction in the number of medically fit patients through a system-wide focus on improving discharges. Planned move towards seven day working over the longer term for consultant and clinical support staff.
Failure to maintain progress made against RTT trajectory	Positive progress made against the incomplete trajectory to end of March 2016. However some impact experienced due to Junior Doctor strike, and peak escalation in March resulting in cancelled operations. Demand and capacity modelling developed through a bottom up approach to identify capacity available to the Trust to meet demand to reduce the risk of backlogs building up. This work is informing the contractual discussions for 16/17 and a new quarterly process to agree requests for additional investment to support growth issues has been agreed internally. RTT validation and skill set enhanced within the Trust to reduce the risk of recurrence.
Failure to deliver improvements arising from the CQC inspection consistently and at pace with a specific focus on ED (particularly during times of high escalation).	Establishment of an Improvement Board under Executive leadership to oversee and drive improvements, provide assurance to the Board and check consistency of delivery. Well-led Governance Review currently underway, the findings of which will be used to strengthen governance within the Trust. Learning gained from other organisations who have successfully responded to issues identified through the CQC both in terms of governance and organisational development (OD). Strengthened clinical leadership within ED, supported by team development. Nurse staffing model agreed for ED and new Midwife investment agreed. Specific actions being taken on improving resilience in mental health nursing in ED and protection of the Paeds ED together with alignment of ED capacity and escalation planning with that of the rest of the hospital.
System-wide pressures continue to increase activity to unsustainable levels impacting on quality and safety.	Development of the Full Hospital Protocol in 2015/16 sets out the process for expanding capacity within the hospital at peak times. Embedding all of the Right Patient Right Bed standards and protection of Ambulatory Care and Surgical Assessment Unit (SAU) to protect flow together with a continued focus on reducing length of stay to improve capacity. In addition, a continued drive to influence and improve out of hospital escalation through partners.
Failure to recruit to substantive posts impacting on safer staffing levels and increasing agency use.	Overseas recruitment expanded for 2016/17 with a pipeline identified for India. Development of the Band 4 role to support nursing and expanding through 16/17. Continued focus on domestic recruitment with a focus on working with local education providers to encourage training at GWH so qualified nurses stay here. Exploring opportunities for an innovative approach to attracting nursing staff following the decision to remove the bursaries. Proposals to incentivise use of staff bank to support better use of nursing staff familiar with the Trust together with continued delivery of Return to Practice courses

9.5 Organisation culture

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

The Trust promotes a culture of putting the patient at the forefront of everything it does. Listening to patients is important and patient comments and complaints are considered and investigated to ensure the Trust learns from the feedback received. The Trust also learns from the Family and Friends Test, comment cards and social media.

In 2015/16 the Family and Friends Test continued to be rolled out to employees. Results are published in the NHS Choices webpage.

The Trust has mechanisms in place to promote a culture in which employees are supported to be open with patients when things go wrong. The Trust has a recently reviewed Whistle Blowing Policy which encourages employees to come forward with concerns. This Policy has been based on support from National Guidance and feedback from both staff and patients.

9.5.7 If you see something, say something

We are committed to dealing responsibly, openly and professionally with any genuine concerns raised and want staff to feel empowered to raise concerns at the earliest opportunity.

If you see something, please say something!

The Trust takes part in an annual staff survey (Section 5 refers). For 2015/16 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. The People Strategy was approved by the Board in February 2014 and this continues to be refined annually with updates on milestone actions reported to the Board.

The Trust has an Incident Management Policy whereby employees are required to report incidents and near misses. This helps the Trust to learn and form plans for improvements when things go wrong.

Reports to the Board and its Committees include a quality impact assessment for all papers, with any areas of concern highlighted and addressed. Quality as well as equality impact assessments have also been introduced for policies and Trust wide procedural documents, thus ensuring that equality and quality considerations are core to the Trust’s overall policy framework and business. In addition, the Board has agreed refreshed milestone actions for objectives around equality and diversity to ensure everyone is treated fairly and equally.

During 2014/15 risk register reporting was formalised and reactive to the Division’s needs outside of the reports to the Board and Executive Committee, providing weekly, monthly, comparison, for Divisional meetings, Divisional Directors of Nursing, or based upon themes, such as falls, pressure ulcers etc. This continued into 2015/16.

9.6 Information risk

Risks to information, including data confidentiality, integrity and availability, are being managed and controlled. A system of monitoring and reporting on data security risks is established under delegated authority of the Trust Board through the Information Governance Steering Group, which reports into the Board's Audit, Risk and Assurance Committee. The Trust has appointed a senior manager who is the Chair of the Information Governance Steering Group as the Senior Information Risk Owner (SIRO) with responsibility and accountability to the Board for information risk policy.

The Information Risk Policy defines an overall structured approach to the management of information risk, in line with the Risk Management Strategy. A register of Information Assets is maintained. The business ownership of those assets is the responsibility of senior managers within the Trust, supported by staff with responsibility for operational management of the assets. These 'owners' and 'administrators' ensure that the principal risks are identified, assessed and regularly reviewed, and that annual assurance reports are provided on the satisfactory operation and security of the key information assets.

Where assessed as appropriate, risk treatment plans are actioned, additional controls are implemented, and prioritised risks are escalated to the appropriate Risk Register. As Accounting Officer I am committed to ensuring that immediate actions are taken where significant risks have been highlighted.

A range of measures is used to manage and mitigate information risks, including: staff training, privacy impact assessments, physical security, data encryption, access controls, penetration testing, audit trail monitoring, departmental checklists and spot checks. In addition, a comprehensive assessment of information security is undertaken annually as part of the Information Governance Toolkit and further assurance is provided from Internal Audit and other reviews.

The effectiveness of these measures is reported to the Information Governance Steering Group. This includes details of any Information Governance Serious Incidents Requiring Investigation (IG SIRIs), the Trust's annual Information Governance Toolkit score (a score on how we can be trusted to handle public data), and reports of other information governance incidents, audit reviews and spot checks.

During 2015-16 there has been one significant control issue resulting in a Level 2 (higher severity) IG SIRI. This has resulted in a comprehensive review being undertaken of internal/external flows of patient data. In addition, recommendations have been made for improving checks on regular reports prior to them being released by the Trust.

9.7 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 6 refers). During 2015/16, the Council of Governors again agreed priority areas for focus and a series of presentations about how the Board manages these is being rolled out. The Non-Executive Directors are engaged in this process.
The Governors contributed to the development of the Trust's strategy via a Governor working group in May 2015, through informal discussions with the Chairman and through formal Council of Governors meetings where quality was discussed in particular.

The Trust welcomes the input of wider stakeholders in the development of its Business Strategy. The Chief Executive and the Chairman represent the Trust at a number of stakeholder forums. There is ongoing dialogue with Clinical Commissioning Groups, GPs, local authorities and other trusts, which has included shared thinking on future services focussing on quality of care to patients. To ensure Trust services match the needs and wishes of the local community, there has been shared information and learning with the Clinical Commissioning Groups via workshops. This has developed further over the past year and will become more important as a system wide approach begins to form the basis of our Sustainability & Transformation Plan (STP). This will be completed by June 2016 across Swindon, Wiltshire and Bath & North East Somerset.

9.8 Quality governance arrangements

In November 2012, the Trust was assessed as compliant with Level 2 National Health Service Litigation Authority (NHSLA) Risk Management Standards for Acute Trusts. In addition, the Trust was assessed as compliant with level 2 for Clinical Negligence Scheme for Trusts (CNST) Risk Management Standards for maternity in May 2013.

Since 2011, the Trust has had robust arrangements in place to ensure that there is a corporate governance overview of trust wide policies and procedural documents. As part of the revised requirements, authors must carry out an equality impact assessment and a quality impact assessment of the reviewed document to ensure that any issues of concern relating to equality and quality are highlighted and addressed.

The Trust uses its Board Assurance Framework and Risk Register as tools to ensure risks are managed, including risks to quality. However, the Trust has developed a Quality Governance Assurance Framework specifically to assist the Trust in ensuring that there is continual focus on Monitor's domains of quality. Using Monitor's Quality Governance Framework and advice from a previous independent assessment of quality, the Trust has considered in detail the controls it has in place to ensure that required standards are achieved; there is investigation and action taken in respect of sub-standard 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 on 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.

9.9 Internal CQC Compliance Assessment arrangements

During 2015/16 the Trust's internal compliance assessment was informed by a range of information, including staff feedback sessions, mini inspections, service review and self-assessments. In addition the Internal Auditors undertook a service review of End of Life Care to provide additional assurance of compliance with the CQC regulations.

Mini visits are spot checks of compliance against the CQC Regulations and Key Lines of Enquiry. The purpose of these is to provide "fresh eyes" on service delivery, to assist service leads in ensuring compliance and to ensure awareness of any improvement requirements.

The mini visits showed that there were areas for improvement across the Trust and led to action to address these. The visit enables any issues to be raised with the appropriate managers ensuring that all risk assessments, patient safety and care quality assurances were in place. Improvements were identified and actions put in place.

The Trust underwent a planned inspection by the Care Quality Commission (CQC) in September and October 2015. The final report was published in January 2016. The report identified 28 actions that the Trust must do and 43 actions that the Trust should do. Additionally, the report identified other areas for improvement that the organisation would like to address. The overall rating was "requires improvement". This is referred to in the Rating Report (Section 7 refers).

Action plans have been developed for monitoring compliance against milestone actions to deliver improvement. Monthly exception and escalation reports are produced to monitor key deliverables. This includes the scrutiny of evidence of progress against the action plans to identify and review key issues and risks that may prevent or delay the achievement of the improvement.

9.10 CQC registration

During 2014/15, the Trust undertook a fundamental review of its registration with the CQC to ensure compliance. This work continued into 2015/16 with updates to registration made. Processes are in place to ensure ongoing refresh and a better understanding of registration requirements have been gained.

The Trust is fully compliant with the registration requirements of the Care Quality Commission.

9.11 Other control measures

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

9.12 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.

The Trust has processes in place to record and monitor compliance with Monitor's Provider Licence conditions. In April 2015, the Trust was reported as in breach of licence conditions CoS3 (1) (a) and (b) (standards of corporate governance and financial management), FT4 (2) and FT4 (5) (a), (d), (e), (f) and (g) (relating to Foundation Trust governance). Throughout 2015/16 the Trust remained in breach of licence conditions. During 2015/16 the Trust worked closely with Monitor, the regulator of NHS Trusts who maintained oversight of actions associated with the enforcement undertakings. This support continues.

Condition requirement	Controls	Risk
To have regard to guidance issued by Monitor	The Trust has in place system to ensure it meets the requirement of licence condition G5 (1) in that a register of guidance is maintained with dedicated leads for each and assurance sought that regard is had to the guidance. On the Monitor website there is a dedicated section where all the mandatory guidance for Foundation Trust is published. The Trust uses this as the basis on its register. The Trust maps this information to its own Register of Guidance on a regular basis (at least annually). The register was last updated in February 2016. Leads have been identified for each and assurance is sought that there has been regard to the guidance.	In February 2016 the Trust's Register of Guidance was updated and new guidance added. Currently the Trust is mapping assurance that it has regard to the new guidance and as such is not yet assured. This will be completed by the end of May-16. Action is underway to cascade the Register of Guidance to the appropriate leads in order to obtain assurance that this licence condition is complied with. Should the Trust not have regard to any guidance, this would be reported to Monitor in accordance with licence condition G5 (2) in the quarterly exception report to Monitor.
Procedures in place to comply with the licence	The Trust has a schedule which documents each of the licence conditions, the controls in place, the assurances that the controls are robust and if there are any gaps or risks to being able to meet the conditions of the Licence. Where appropriate risks of being able to comply with the Licence are managed via the Risk Register. An audit in 2014/15 gave a substantial assurance opinion around the processes in place for monitoring compliance. Exceptions are reported to the Governance Committee awareness and guidance. During 2015/16 the Trust worked to deliver the recommendations of a financial governance review undertaken by Deloitte to deliver improvements in governance and financial sustainability. During 2015/16 the Trust worked closely with Monitor and significant improvements have been made with the Trust's financial position exceeding year end outturn predictions.	During 2015/16 the Trust remained in breach of licence conditions CoS3 (1) (a) and (b) (standards of corporate governance and financial management), FT4 (2) and FT4 (5) (a), (d), (e), (f) and (g) (relating to Foundation Trust governance). Risks remain around ability to meet the requirements of these licence conditions and Monitor has not lifted its enforcement undertakings with the Trust. Furthermore, the Trust is currently being investigated by NHS Improvement (Monitor) in relation to its governance arrangements following the issue of a warning notice from the Care Quality Commission (CQC) and an inspection report. In addition the Trust is at risk of being in breach of FT4 (7) relating to the ability to ensure the existence and effective operation of systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of the licence. This is because the Trust is currently carrying a number of vacancies and there is a national shortage of nursing staff.
Set out, apply and publish	The Trust complies with the Prior Approval Policies (only treat	None - The Trust has regular contract meetings with the

Condition requirement	Controls	Risk
a transparent eligibility and selection criteria	patients if prior approval is received) and the Criteria Based Policies (only treat patients who meet the criteria) established by Wiltshire and Swindon Clinical Commissioning Groups	commissioner to ensure that the Trust is adhering to their requirements.
At the point where a patient has a choice of providers, the patient should be notified of this and told where information can be found about the options	The Trust will refer a patient back to the care of the GP for onward referral to a different speciality. At this point the patient will have a choice of provider from Choose and Book.	The Trust lacks assurance about how patients are offered choice of providers where a referral back to the GP is not appropriate i.e. for internal referrals or referrals to a tertiary centre.
Shall not cease to provide or materially alter the specification or provision of any Commissioner Requested Service	All services provided are Commissioner Requested Services. Controls to ensure compliance include an Interim Chief Operating Officer and Divisional Management Teams who oversee operational performance. Regular contract meetings are held with Clinical Commissioning Groups to discuss performance with areas of concern highlighted and discussed.	There is a risk that the Trust could breach licence conditions CoS1 (1) (3) and (4) in terms of following correct processes and formal notifications within 28 days of any material change in contract. To address this, the Company Secretary is working with the Interim Chief Operating Officer to map a formal process to ensure that correct procedures are following in all cases.
Good systems of governance	During 2015/16 the Trust had in place a Board of Directors comprised of (7) Non-Executive (including the Chairman) and (5) Executive Directors, plus 2 Non-Voting Directors. The Chief Executive leads on executive arrangements and the Chairman leads the Non-Executive Directors in holding the Executive Directors to account for their performance. The Trust has in place a Council of Governors with 22 Governor positions who hold the Non-Executive Directors to account for the performance of the Trust. A programme of areas for focus by the Governors has been developed having regard to key risk, performance areas and finance. The Trust has an internal audit function and an external audit function that both provide assurance to the Trust on an on-going	In March 2015 the Trust entered into enforcement undertakings with Monitor for breach of the governance conditions. In September 2015 the Trust underwent a Care Quality Commission (CQC) inspection which resulted in the issue of a Warning Notice for breach of regulation. Thereafter the report of the Inspection was published in January 2016 following which Monitor initiated a further investigation of the governance processes and systems in place in the Trust in the light of the CQC warning notice and findings. The outcome of this investigation is expected in May 2016. In addition the Trust has commissioned independent Well Led Governance reviews. These findings are also due in May 2016.

Condition requirement	Controls	Risk
	basis about the systems of internal control. An Internal Audit Programme is agreed each year having regard to the Trust's Board Assurance Framework and advice from Executive Directors on areas for focus.	
Shall at all times act in a manner calculated to secure that is or has access to the Required Resource.	During 2015/16 the Trust implemented recommendations from an independent financial governance review to improve financial governance arrangements and improve financial sustainability. In addition, throughout the year, Trust worked with Monitor to implement improvements. The Trust has the opportunity to receive additional income from the Sustainability Transformational Fund. Attached to the offer are numerous conditions which the Trust is working towards. One condition is that financial recovery must be seen. The Trust has in place a Finance Team which has been restructured during 2015/16 with refreshed monitoring and reporting processes. In addition, the Trust has been supported by interim appointments that have focused on specific areas of work to drive improvement, notably the Cost Improvement Programme. Processes are now embedded and continue. The Trust has in place a Finance, Investment and Performance Committee which meets monthly to scrutinise and challenge financial governance and sustainability with monthly reporting to the Board.	There is a risk to compliance with this licence condition even though the Trust is making progress to financial recovery. This is because Monitor has not yet lifted the enforcement undertakings and a further investigation is underway. There is a risk around ability to deliver further Cost Improvement Programmes going forward noting that many in 2015/16 were non-recurring. Furthermore there are risks to achieving the conditions attached to the Sustainability Transformational Funding offer which are being reported through the Trust's Finance Investment and Performance Committee.
Establishment and implementation of: - (a) effective Board and committee structures;	(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	A risk exists relating to gaps in divisional governance. Currently the Divisions are working to improve Divisional committee and meeting structures. This also encompasses standardisation of committee documentation. This piece of work is being implemented in one division with the view that this will be rolled out to all divisions.

Condition requirement	Controls	Risk
(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	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 Investment and Performance Committee 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 most senior managers in the organisation in attendance. Key operational management decisions are made and there is oversight of directorate issues through receipt of Directorate Board minutes. The minutes of the Board Committees are submitted to the Board at each meeting and the Chairs of those committees draw to the attention of the Board any issue of concern. In addition the Chairs of the Finance, Investment and Performance Committee and the Governance Committee submit separate reports to the Board in public, highlighting significant points. The Terms of Reference of the Board Committees are refreshed annually to ensure they are fit for purpose and that all areas of Trust business are reflected. (c) Sitting under the Board Committees are a number of sub-committees and working groups. These have been mapped to ensure reporting lines and accountabilities are in place and that there are mechanisms to ensure issues are escalated to the Board. Minutes / reports of these meetings are presented to the respective Board Committees and any areas of concern are highlighted for discussion.	

Condition requirement	Controls	Risk
	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 most senior 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. In 2015/16 standardised documentation for departmental governance meetings was introduced to ensure that necessary	

Condition requirement	Controls	Risk
	governance conversations and actions/responses are taking place. Discussion of quality and safety at Divisional Boards takes place including best patient care and need for improvements. There is a Well Led Governance review underway looking at both Board and Divisional Governance and it is expected that the outcome will be reported on in May 2016.	
Systems must ensure a capable Board; decision making which takes account of quality of care; there is up to date data on quality of care; the Board considers data on quality of care and there is accountability for quality of care.	The Trust has a capable Board. The Non-Executive Directors are appointed by the Council of Governors and they are accountable to Governors on the performance of the Board. When a vacancy arises consideration is given to the skills needed and also to the balance and composition on the Board in terms of knowledge and experience. The composition is mapped to ensure there is a sufficient spread of expertise to cover all Board areas of responsibility. In 2015/16 reporting to the Board was amended with an updated financial report and quality report. In addition there was an introduction of an operational report and an Integrated Performance Report. Furthermore the Chairs of the Finance, Investment and Performance Committee and the Governance Committee submit reports to the Board in public on the issues to highlight from a Non-Executive Director perspective. Each month the Board considers up to date information and data about the quality of care in the form of performance indicators and achievement against targets. In 2015/16 there was a due diligence exercise to look at the quality of data the Board was receiving. As a result of this, improvements have been made and a there has been implementation of a divisional dashboard, a patient tracking list (PTL) and referral to treatment (RTT) data. 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	-

Condition requirement	Controls	Risk
	quality of care but to ensure that the Board is assured that quality care is delivered. The Governance Committee obtains assurance on behalf of the Board that the necessary governance structures and processes (relating to quality not internal control) are in place for the effective direction and control of the organisation so that it can meet all its objectives including specifically the provision of safe high quality patient care and comply with all relevant legislation, regulations and guidance that may from time to time be in place. Sitting under the Governance Committee is a Patient Quality Committee (PQC) (in 2015/16 the PQC was established and this replaced the Patient Experience Committee and Patient Safety Committee).	
Systems must ensure a capable Board; decision making which takes account of quality of care; there is up to date data on quality of care; the Board considers data on quality of care and there is accountability for quality of care.	The Trust has a capable Board. The Non-Executive Directors are appointed by the Council of Governors and they are accountable to Governors on the performance of the Board. When a vacancy arises consideration is given to the skills needed and also to the balance and composition on the Board in terms of knowledge and experience. The composition is mapped to ensure there is a sufficient spread of expertise to cover all Board areas of responsibility. In 2015/16 reporting to the Board was amended with an updated financial report and quality report. In addition there was an introduction of an operational report and an Integrated Performance Report. Furthermore the Chairs of the Finance, Investment and Performance Committee and the Governance committee submit reports to the Board in public on the issues to highlight from a Non-Executive Director perspective. Each month the Board considers up to date information and data about the quality of care in the form of performance indicators and achievement against targets. In 2015/16 there was a due diligence exercise to look at the quality of data the Board was receiving. As a result of this, improvements have been made and a there has been implementation of a divisional dashboard, a patient tracking list (PTL) and referral to treatment (RTT) data.	-

Condition requirement	Controls	Risk
	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. 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 is a Patient Quality Committee (PQC) (in 2015/16 the PQC was established and this replaced the Patient Experience Committee and Patient Safety Committee).	
Must ensure that there are enough sufficient qualified people to comply with this licence	The Trust has a capable Board. Please see above. There are difficulties in sustaining sufficient numbers of trained clinical staff. The Trust has a number of controls in place including recruitment plans, training, retention measures and staff support. In 2015/16 a nursing skills mix review was undertaken to identify where the significant gaps in workforce are. Leadership programmes were held to assist in closing the gap in shortage of senior staff. Plans have been made to recruit internationally in 2016.	There is a risk that the Trust may not meet the requirements of this condition. The Trust has a number of nursing and doctor vacancies and is unable to recruit to the desired levels. This shortage is national. The Trust are looking to recruit internationally to help full some of the vacancies.
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	-

Condition requirement	Controls	Risk
	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 going forward, specifying any risks to compliance and any action proposed to take to manage risks as part of Monitor's annual governance submissions.	

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

In April 2015 Monitor reported that the Trust was failing to comply with a number of the provider licence conditions, in particular, those relating to financial reporting and financial governance, due to a failure to comply with its general duty to exercise its functions effectively, efficiently and economically. As a result, the external auditors qualified the Use of Resources certificate.

The Trust Board responded to this in a pro-active and positive manner, putting in place clear governance and accountability frameworks by adopting a structured approach to enable the right level of assurance to be provided for Trust Board, focusing on the use of resources and the importance of the scale of medium-term cost savings required in the current economic and operating environment.

The processes outlined below are well established and ensure the effectiveness of the systems of internal control through:

- Board of Directors review of the Board Assurance Framework, including the risk register and Internal Audit reports on its effectiveness;
- Audit Risk and Assurance Committee and Governance Committee review of the effectiveness of the Trust's systems and processes
- Review of serious incidents and learning by the Governance Committee and Internal Audit report on its effectiveness May-15;
- Review of progress in meeting the Care Quality Commission's essential standards by the Governance Committee informed by the CQC Inspections Report Jan-16;
- Clinical Audits;
- National Patient and Staff Surveys;
- Internal audits of effectiveness of systems of internal control;
- Business Investment Group – Check and challenge panel to understand the implications of any investment from a financial, use of resources and impact on patient experience/safety prior to submission to Executive Committee;
- Transformation Board – review the CIPs and the Quality Impact Assessments;
- Regular reporting to the Board on key performance indicators including finance, activity, patient safety and human resources targets;
- Monthly review of financial and operational targets by the Finance, Investment and Performance Committee;
- Monthly reporting to the Executive Committee on directorate and Trust performance;
- Monthly monitoring and reporting within Directorates which feeds into the Executive Committee and up to the Board; and
- Monthly reporting to Monitor, via the Finance, Investment and Performance Committee

Sitting below the Annual Plan are divisional plans and capacity plans which detail specific objectives and milestones to deliver actions. All Divisional plans are reviewed at Divisional Performance Meetings and any deviation to plan will be reported to Finance, Investment and Performance Committee.

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.

The Trust's reference cost index score for 2014/15 was 93, before Market Forces Factor (MFF) adjustment, which indicated that the cost of the Trust providing healthcare was 7% below the national average.

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.

9.14 Serious incidents involving data loss or confidentiality breach

The Health and Social Care Information Centre (HSCIC) has published assessment criteria and reporting guidelines for incidents involving data loss or confidentiality breach. Such events are termed Information Governance Serious Incidents Requiring Investigation (IG SIRIs). The criteria have been revised from time to time, such that more incidents of a minor nature are now reportable. Any comparison with figures published in earlier years is, therefore, to be treated with considerable care.

Each IG SIRI is graded as either:

(a) Lower severity Level 1 – to be reported statistically in the Annual Report, or

(b) Higher severity Level 2 – to be reported to the Information Commissioner's Office and detailed individually in the Annual Report.

During 2015/16 there was one IG SIRI at the higher severity Level 2 which was reported to the Information Commissioner's Office (ICO).

Summary of serious incident requiring investigation involving personal data, as reported to the Information Commissioner's Office in 2015-16 (severity Level 2)				
Date of incident (month)	**Nature of incident**	**Nature of data involved**	**Number of data subjects potentially affected**	**Notification steps**
January 2016	Disclosed in error. A patient treatment list was sent securely to NHS staff at two NHS Clinical Commissioning Groups before the patient identifiers had been removed from the document.	Patient name; age; NHS no; hospital no; medical specialty and procedure.	19,933	Individuals not notified.
Further action on information risk	The error was detected immediately, the document was deleted, and a revised document was re-issued. The patient data had not been placed in the public domain, and the recipients were all NHS staff under a duty of confidentiality. A comprehensive review of internal/external flows of patient data is being undertaken. Recommendations have been made for improving checks on regular reports prior to being released by the Trust. The member of staff responsible for this incident had completed all the required training; disciplinary proceedings are now under consideration. The ICO has considered the incident and decided that there is no need to take any regulatory action against the Trust.			

IG SIRIs classified at the lower severity Level 1 are aggregated and reported below in the specified format. During 2015/16 there were a total of 74 such incidents.

Summary of other personal data related incidents in 2015-16 (severity Level 1)		
Category	**Breach type**	**Total**
A	Corruption or inability to recover electronic data	0
B	Disclosed in error	35
C	Lost in transit	7
D	Lost or stolen hardware	0
E	Lost or stolen paperwork	27
F	Non-secure disposal – hardware	0
G	Non-secure disposal – paperwork	0
H	Uploaded to website in error	0
I	Technical security failing (including hacking)	0
J	Unauthorised access/disclosure	4
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.

9.15 Annual Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation Trust Boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

Steps which have been put in place to assure the Board that the Quality Report presents a balanced view and that there are appropriate controls in place to ensure the accuracy of data include the following: -

- The Chief Nurse is the Executive lead for the Quality Account with designated personal leadership for patient safety and quality on behalf of the Trust Board. The Trust approved a refreshed Quality Improvement Strategy in 2013/14 which provides details on roles and responsibilities for quality and safety and defines the key focus for the Annual Quality Accounts. The Board considers progress in delivering the Quality Strategy at least twice a year.

- The Annual Quality Account Report 2015/16 provides a narrative of progress toward achieving the quality improvement indicators agreed by the Executive Committee, the Patient Safety Committee and the Trust Board.

- The Trust has a robust process for scrutinising and revising local policies and monitoring compliance with NICE and other best practice guidelines. Annual audit programmes include the assessment of compliance with best practice guidance at both local and national level. This provides assurances to the Board that the quality of clinical care provided is based on the best clinical practice recognised nationally and that policies are up to date, appropriate and meet our legislative obligations. During 2014/15 there was a fundamental review of the clinical audit programme to ensure a greater focus on priority audits with meaningful outcomes. This review has provided greater clarity for priority audits into 2015/16.

- The Quality Account is compiled following both internal and external consultation to inform the improvement indicators. Data is provided by nominated leads in the Trust. These leads are responsible for scrutinising the data they provide to ensure accuracy. The Chief Nurse is ultimately accountable to Trust Board and its committees for the accuracy of the Quality Account Report.

- The Quality Account is subject to robust challenge at the Governance Committee on both substantive issues and also on data quality. Where variance against targets is identified the leads for individual metrics are held to account by the Governance Committee. Following scrutiny at that committee, the Quality Account is reported to Trust Board which is required to both attest to the accuracy of the data and also ensure that improvements against the targets are maintained.

- Directors' responsibilities for the Quality Account Report are outlined separately in this report.

- The Quality Account Report has been prepared in accordance with Monitor's annual reporting guidance as well as the standards to support data quality for the preparation of the Quality Report. No material weaknesses in the control framework associated with Quality Accounts have been identified.

- The Trust has a Data Quality Group responsible for reviewing the way data is captured and recorded to ensure its accuracy and robustness. Internal and external data audits are undertaken focusing on data quality and associated process and procedures and the Data Quality Group reviews internal and external data quality dashboards. This Group feeds into an Information Governance Group which overviews information governance across the Trust.

- During the year the Trust had concerns around the accuracy of data of the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of reporting period (RTT). To address this work carried out around RTT has changed and overall the Board is confident in the RTT data for patients on an incomplete pathway. We have established a RTT Data Quality and Training Group to address issues and practice together with the establishment of a RTT Steering Group with the Clinical Commissioning Group. In addition, the Intensive Support Team (IST) has been part of the process to review and advise around what we have been doing to improve RTT.

9.16 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 June 2015 the Board refreshed again the Terms of Reference for Board Committees to ensure that the Trust's system of internal control reflects the current needs of the organisation and to ensure that appropriate reporting and decision making mechanisms are in place. There will be a further refresh in 2016. In addition in March 2015 the Trust commissioned a well led governance review with a focus on divisional governance and how issues are fed to and from the Board within the organisation.
Audit, Risk and Assurance Committee	-	The Committee provides scrutiny of internal controls, including the review and challenge of the Board Assurance Framework and Risk (Section 6 refers).
Internal audits	-	Internal audits are carried out which look at the effectiveness of systems of internal control. Audit findings are presented to the Audit, Risk and Assurance Committee and the Board through the Audit, Risk and Assurance Committee minutes. A programme of internal audits is agreed each year having regard to the key risks to achieving the Trust's strategic objectives. The Board Assurance Framework informs the Audit Plan.
Clinical audits	-	Clinical Audit is a key component of clinical governance and it aims to promote patient safety, patient experience and to improve effectiveness of care provided to patients. The Trust is compliant with the Trust Clinical Audit plan. The NICE lead is responsible for actively disseminating and monitoring NICE compliance.
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. During 2015/16 additional reports from the Chair of the Finance, Investment and Performance Committee and latterly the Chair of the Governance Committee were introduced. These are reported to the Board each month on the public part of the agenda and provide a Non-Executive Director perspective of the issues discussed, including key areas for focus, challenges and risks. These reports are in addition to any other reports which would normally be reported to the Board (such as the Finance Report or the Quality Report) and in addition to the minutes of the Committee meetings. During 2015/16 there was a more robust approach to reviewing the Committee effectiveness for the Finance, Investment and Performance Committee and this will be

rolled out to other Committees for next year having regard to any recommendations from the well led governance review and preferences of Chairs of Committees.

Board Assurance Framework / Risk Management - The Board Assurance Framework provides a structure and process that enables the Trust to focus on those risk which may compromise the achievement of its annual objectives and to identify and record the controls in place to achieve those objectives and confirm that the Board has received sufficient assurance about the effectiveness of controls.

In January 2016 an internal audit review of the Board Assurance Framework and risk management processes provided "reasonable" assurance with one recommendation. The audit found that the 2015/16 Board Assurance Framework (BAF) was embedded in the governance structure of the Trust and is maintained as a "live" document. Streamlining of the BAF content and layout during 2015/16 had made the BAF a more user friendly document. The auditors found that risk management processes were operating across the Trust although improvements were needed around timeliness of review of overdue risks and associated actions.

Care Quality Commission (CQC) standards / CQC Inspection Report - The Trust monitors compliance with CQC standards through mini visits across the Trust. Areas for improvement are identified and led by the areas inspected. The Trust's CQC Compliance Manager works with leads to help them better understand the requirements of the Regulations and the key lines of enquiry which form part of the CQC new style inspection. The CQC undertook a formal inspection in September 2015 with a report received in January 2016. The outcome was that the Trust is required to make improvements in a number of areas. An action plan has been developed to address the areas for attention identified through the report and progress of delivering milestone actions and sustaining improvement is being monitored through an Improvement Committee and the Governance Committee which meets monthly. Monthly reports are being made to the Board

Reporting to Monitor - Declarations are considered by the Executive Committee and the Finance, Investment and Performance Committee and thereafter approved by the Board on a quarterly basis prior to submission to Monitor.

In addition during 2015/16, the Trust made monthly reports to Monitor.

In addition the Trust has had performance review meetings each month with Monitor, primarily focused on delivering improvements to financial governance but latterly to also discuss roll out of improvement to address the findings in the Care Quality Commission Inspection Report dated Jan-16.

Well Led Governance Review

During 2015/16 the Trust commissioned two independent well led governance reviews (Board level and Divisional Board level) which will focus on the following: -

1. **Strategy and planning** – how well is the Board setting direction for the organisation?
2. **Capability and culture** – is the Board taking steps to ensure it has the appropriate experience and ability, now and into the future, and can it positively shape the organisation's culture to deliver care in a safe and sustainable way?
3. **Process and structures** – do reporting lines and accountabilities support the effective oversight of the organisation?
4. **Measurement** – does the Board receive appropriate, robust and timely information and does this support the leadership of the trust?

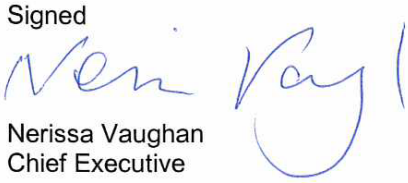
The findings from the reviews are expected in May-16 and action plans will be rolled out to address any findings.

The Trust will continue to review all risks and where necessary will take appropriate actions to either reduce or eliminate these. Actions taken will be monitored through the appropriate Committees of the Board, and where necessary the Chair of the Committee will escalate concerns to Board.

9.17 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

23 May 2016

10 Quality Report

Our Commitment to Quality

I am pleased to present our Quality Account for 2015/16. This document provides a clear account of our work to improve the quality of care our patients have experienced over the last year and our priorities for the year ahead.

There is no getting away from the fact it has been an incredibly tough year, with operational pressures, recruitment challenges and financial constraints. However we have ended the year stronger and our priorities have not changed. Providing safe, high quality and effective care, is what we are here to do.

Our focus on quality is now more important than ever before. This is because efficiency and quality go hand in hand. You cannot have one without the other. Over the past 12 months, we have been changing how we do things, adopting international best practice and being smarter with our resources. This has helped us to achieve better value for local taxpayers, while treating more patients and saving more lives than ever before.

I see lives saved every day and our mortality rates continue to reduce. This means that more patients are now surviving their illness than would be expected according to national averages.
This is particularly evident in our survival rates for patients with sepsis, with 120 lives saved last year alone. I am pleased that we have been recognised nationally for leading the way in this area with nominations for prestigious BMJ and Health Business awards.

Building on this life saving work, we have set ourselves an ambitious goal to save an extra 500 lives, over and above what would be expected, over the next five years.
Our focus will therefore remain on our Sign up to Safety Priorities, which alongside sepsis, include deteriorating patients, acute kidney injury, and falls and pressure ulcer prevention. You can read about our progress in these areas in this Quality Account.

I acknowledge that the data quality of the 18 weeks referral to treatment pathway has been identified as needing improvement and I'm confident that in the last six months we have made significant improvements and investment in this area.

With a growing and ageing population the NHS is facing fresh challenges, but it is still important to recognise the fantastic work which is taking place in our local hospitals, communities and in people's own homes.

I am particularly proud of how we are bringing cancer treatment closer to home for hundreds of people across Wiltshire, pioneering mobile chemotherapy with national charity Hope for Tomorrow and working with Oxford University Hospitals NHS Foundation Trust to bring radiotherapy to Swindon. This is just one area where we are making a big difference to people's lives and I'm pleased to able to share many more examples in our Quality Account.

I hope your enjoy reading about our work over the last year and our plans to further improve the quality of care for all of our patients.

Signed 

Nerissa Vaughan
Chief Executive

23 May 2016

Priorities for improvement and statements of assurance

10.1 Review of Quality Performance 2015/16

This section reflects on the priorities we set for 2015/16 and whether we have achieved our goals. Where performance was below what we expected we explain what we are doing to improve in 2016/17.

10.2 Sign Up To Safety

The Trust committed to a safety improvement plan: Sign Up To Safety. This covered the following key areas of focus:

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

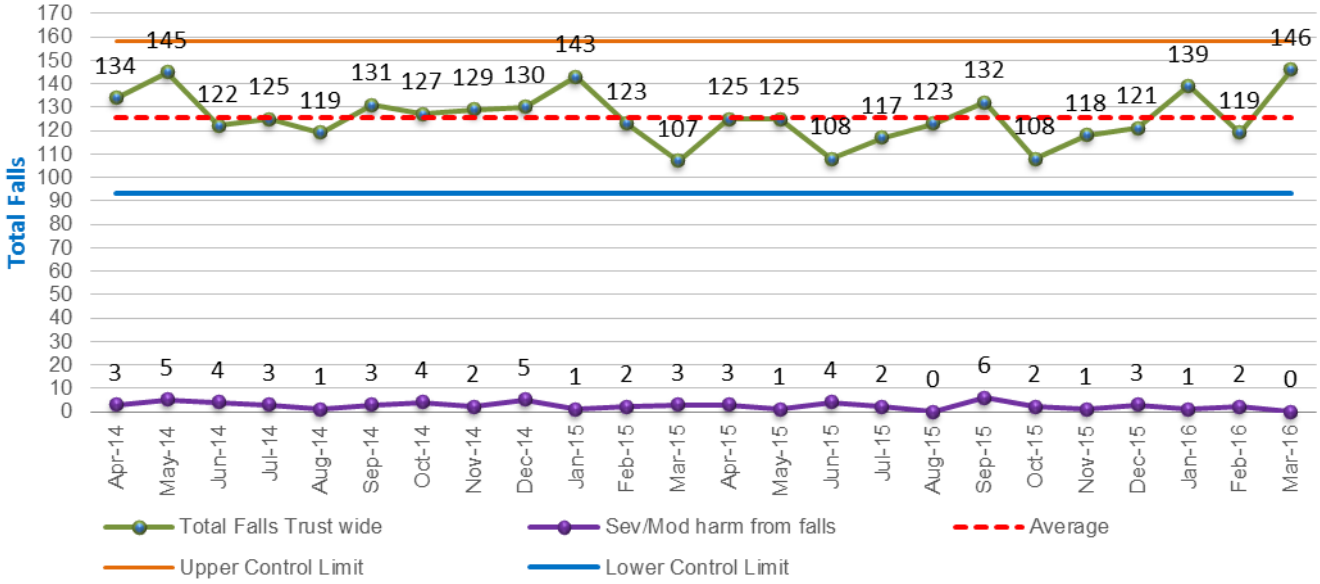
10.2.1 Reducing falls

Falls are one of the leading causes of harm in hospitals. They can lead to injury, loss of confidence, independence, and prolonged hospital stays.

Across the Trust, over the last year, we have seen a 30% reduction in harm from falls even though we have only had a slight reduction in the number of falls

In 2014/15 we were reporting an average of 3 moderate, severe harm or death from falls a month. In 2015/16 this has reduced to an average of 2 moderate, severe harm or death a month.

Total falls across the Trust



The chart above shows the total number of falls reported by month trust wide and the number of moderate, severe or death harm from falls.

What improvements have we achieved?

In 2015/16 we have reported a 30% reduction in harm from falls with. 13 falls were reported as severe harm with the remaining 12 as moderate harm. In total we reported 25 falls experiencing moderate or severe harm against 36 falls suffering moderate or severe harm that were reported in 2014/15.

Drivers for improvement

- We launched our 'Falls Collaboratives' for hotspot wards, bringing together multi-disciplinary teams to identify change ideas and test them in clinical areas.
- Our hotspot wards tested change ideas to reduce falls in clinical areas using PDSA (Plan, Do, Study, Act) methodology: Bedside Handover, Safety Briefs and Board Rounds.
- Trialing post incident safety huddles (SWARM) for early identification of learning after a fall.
- Training on quality improvement methodology for Ward Managers.

Further Improvements identified and our priorities for 2016/17:

- All Ward Managers sharing learning through the monthly Falls Operational Group to share ideas that have worked well on their areas.

- We will work closely with social services to fast track the discharge of our patients who are at greatest risk of a fall who are medically fit for discharge.

10.2.2 Reducing avoidable pressure ulcers

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

The development of a pressure ulcer can have a negative impact on our patient's quality of life by causing pain, emotional distress and loss of independence. They also increase the risk of infection and prolong hospital stays. In the most serious of cases pressure ulcers increase a patient's risk of death.

Most pressure ulcers can be prevented through effective risk assessment and care planning for our patients, and ensuring our patients are kept mobile, changing positions wherever possible

Acute Hospital Performance

Reduce avoidable pressure ulcers

Quality Focus

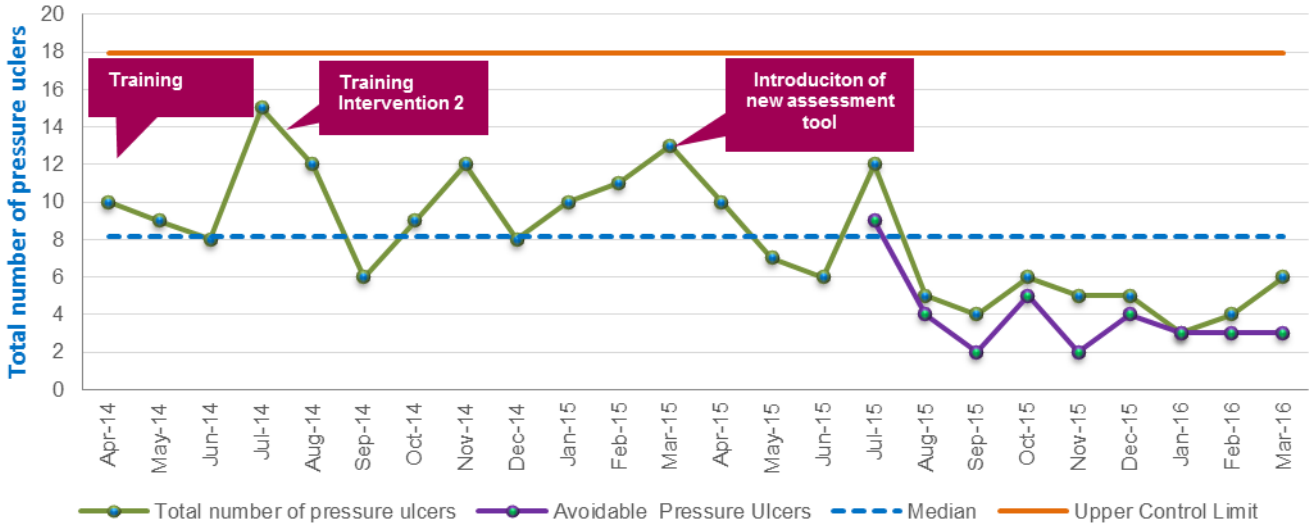
We have reduced the number of avoidable pressure ulcers (category II, III & IV) across the acute hospital from nine to four per month.

Target: **<5 per month** sustained to April 2018.

Improved risk assessment, care of patients at risk & effective care planning.

On Target

Total number of pressure ulcers (category II, III, IV for all acute inpatients)



The chart above shows the total number of category II, III and IV Pressure Ulcers reported and unavoidable pressure ulcers reported for all our acute in-patients.

During the reporting period of 2015/16, our acute hospital achieved a reduction in the percentage of patients who developed a health care acquired pressure ulcer from the previous year from 0.84% to 0.5%.

This incidence was significantly lower than the estimated national average of 3-7% (*The cost of Pressure Ulcers in the UK, Oxfordjournals.org).*

Community Hospitals and Integrated Community Health Teams

Reduce avoidable pressure ulcers

Quality Focus

We have reduced the number of avoidable pressure ulcers (category II, III & IV) across the Wiltshire community to an average of twelve per month.

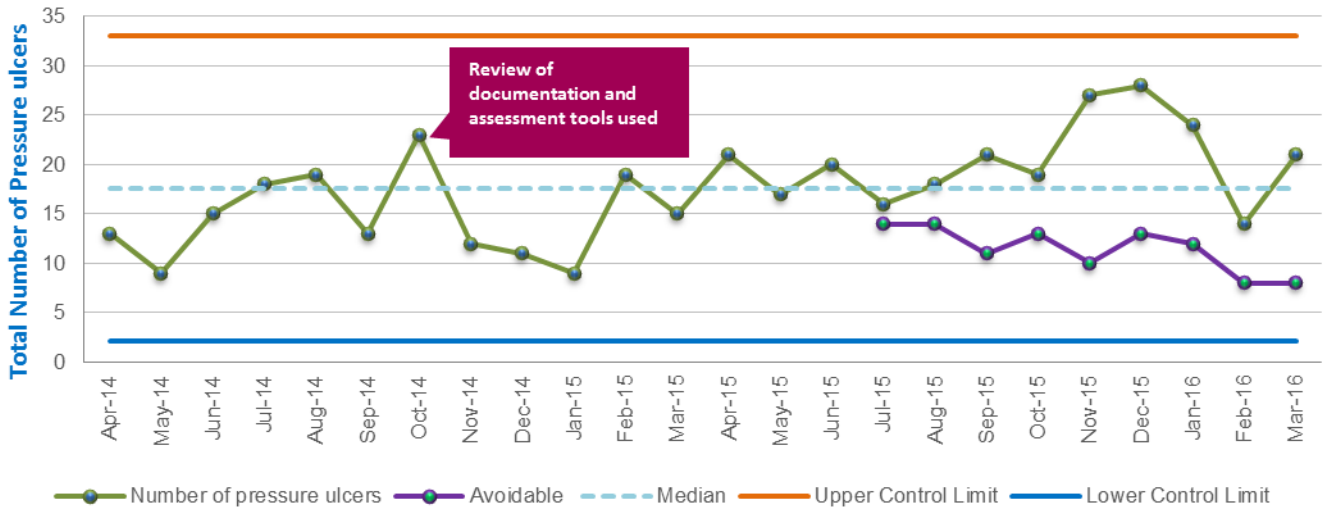
Target: **<14 per month** sustained to April 2018.

Improved risk assessment, care of patients at risk & effective care planning.

On Target

There has been a reduction in the incidence of patients cared for by our community teams who developed an avoidable health care acquired pressure ulcer from 1.25% to 0.57%. This incidence was lower than the estimated national average of 3-7%. *(the cost of Pressure Ulcers in the UK. Oxford journals.org.)*

Total number of pressure ulcers (category II, III, IV for all community patients)



The chart above shows the number of pressure ulcers reported for all community patients 2015/16.

What improvements have we achieved?

We have reduced the number of avoidable pressure ulcers across the Wiltshire community to an average of 12 per month which is below the target we set to achieve by 2018. Since July 2015 we have taken measures to differentiate between avoidable and unavoidable pressure ulcers that we report. This has enabled us to identify that 58% of these pressure ulcers were unavoidable.

Drivers for improvement

- Revised and implemented the Pressure Ulcer Risk Assessment Tool across the acute hospital to ensure timely identification of patients at risk of developing a pressure ulcer.
- Implemented the Wound Assessment and Management Care Plan to ensure patients who develop a pressure ulcer have an effective plan to manage their condition.
- Undertook an assessment of patients receiving pressure relieving air mattresses on our acute wards within two hours of the request.
- Distributed protective heel pads to hot spot wards with training for ward staff.
- Carried out process mapping with wards and community teams where pressure ulcers had been a problem to identify areas for improvement and deliver training to staff.

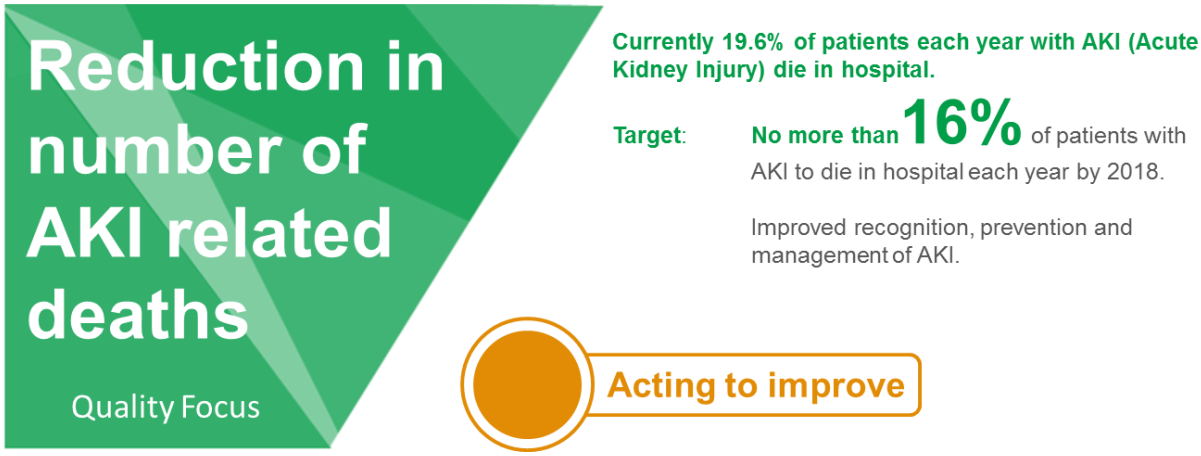
Further improvements identified and priorities for 2016/17

- For every pressure ulcer that develops, our Tissue Viability team will work with the Ward Manager or Community Team Leader to review the patient's care.
- We will continue to deliver training on pressure ulcer prevention and effective care management for our multi-disciplinary teams

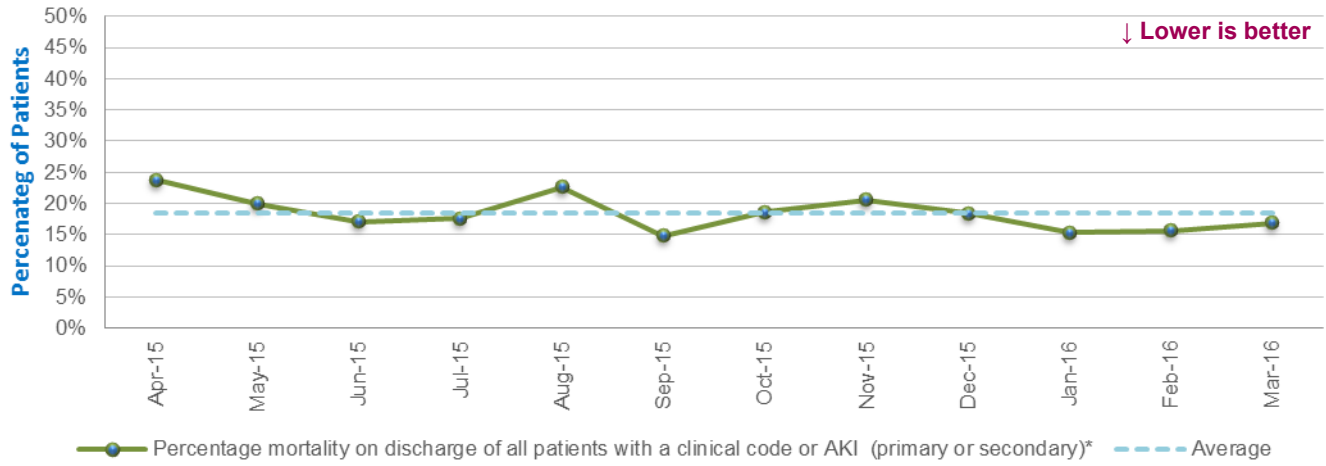
10.2.3 Acute Kidney Injury (AKI)

Acute Kidney Injury (AKI) is a sudden deterioration in kidney function that affects up to 20% of patients (1 in 5) admitted to hospital. It can range from minor loss of kidney function to complete kidney failure, and in the most serious cases can lead to death.

With early detection and the right care at the right time, both the risk of death and long term damage to the kidneys is greatly reduced. As a common and potentially life threatening condition, we are passionate about proactively improving care and saving lives.



Crude mortality on discharge: patients with a clinical code of AKI (primary or secondary)



The chart above shows the crude mortality on discharge with patients who have a clinical code of AKI (Primary or secondary). Since January 2016 we have reported an average of 15.9% in crude mortality on discharge that have a clinical code of AKI. This is below the 16% per annum we are striving to achieve.

What improvements have we achieved?

- Developed online AKI training modules for nursing and medical teams to equip clinical staff with the knowledge and skills to improve recognition and treatment of AKI.
- Introduced an electronic flagging system that detects patients who have AKI from blood test results. The flag alerts the doctor that their patient has AKI and its severity.
- Implemented the AKI Kidney 5 Care Bundle, Sepsis, Hypovolaemia, Obstruction, Urine Analysis, Toxins (SHOUT). Patients flagged with AKI receive five standard elements of care proven to be effective in managing AKI.
- Ward pharmacists carry our medicine reviews of all patients flagged with AKI to determine the most appropriate medication to manage their AKI and aid recovery.
- Formed an AKI quality improvement project group of nurses, doctors, pharmacists, clinical coders and data analysts to work collaboratively to improve AKI care processes.

Further improvements identified and priorities for 2016/17

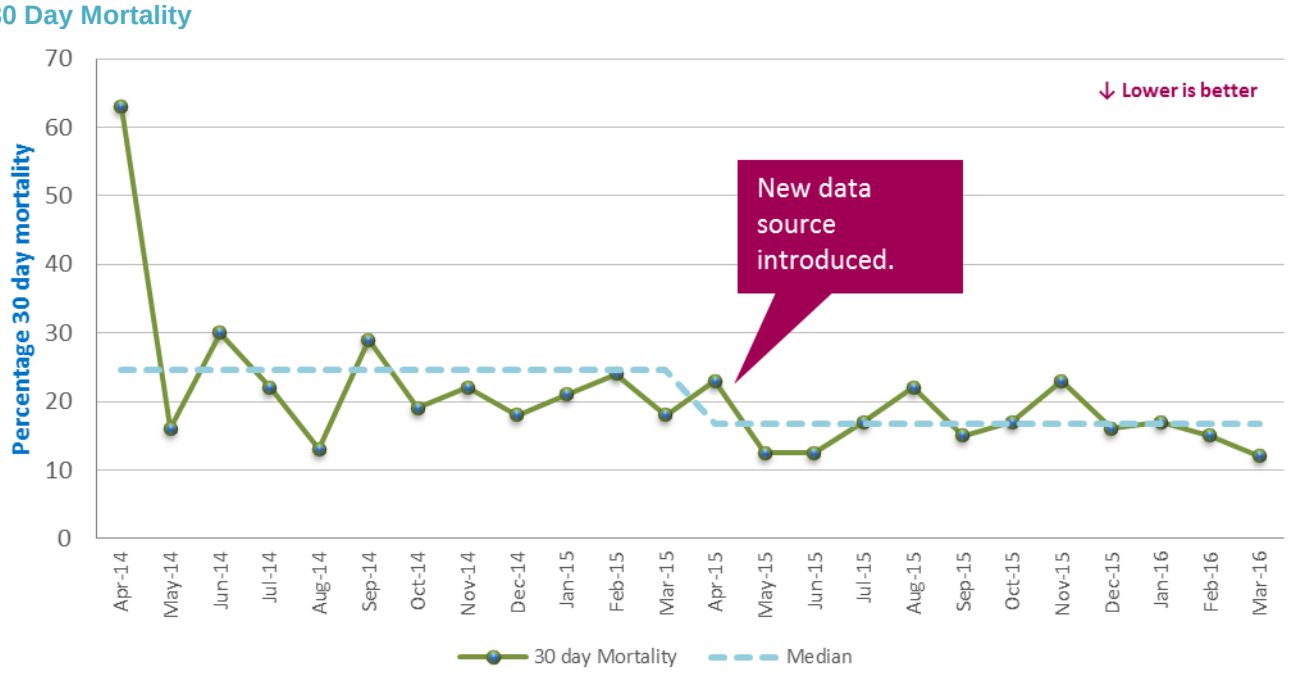
- We will launch an electronic AKI Care Bundle and integrate our IT systems to enable an AKI flag to be transferred across all relevant information systems to aid recognition, early treatment and coding of our patients with AKI.
- We will develop care pathways with GPs and community healthcare providers to improve prevention of AKI of our patients before coming into hospital and support appropriate care to aid their recovery once home.

10.2.4 Sepsis

Sepsis is a common and life threatening condition caused by the body's own response to infection. Sepsis occurs when severe infection in the body triggers widespread inflammation, swelling and organ failure.

Each year in the UK, it is estimated that more than 100,000 people are admitted to hospital with sepsis and around 44,000 people will die as a result of the condition.
Effective delivery of the Sepsis Care Bundle (Sepsis 6 UK Sepsis Trust) increases patients' chance of survival by up to 30%. Overall national mortality rate for patients admitted with severe sepsis is 35%. (UK Sepsis Trust 2014)

In 2014/2015 we reported an average of 25% patients admitted with severe sepsis that die within 30 days of discharge. We used this first year of data collection to set our annual mortality target to less than 23% sustained mortality from severe sepsis until 2018. However in In 2015/2016 we have achieved an average of 17% crude mortality from severe sepsis which is exceeding our current aim of below 23% mortality. Our challenge for 2016/2017 is sustaining this reduction in mortality each month.



The chart above shows 30 day crude mortality from severe sepsis and the improvements achieved since April 2015

What improvements have we achieved?

- Our sepsis campaign has had significant success in the early identification and response to this life threatening condition. This has brought both local and national recognition with our Sepsis Team winning a national Patient Safety Award in December 2015.

- We have continued to monitor and improve usage of our standardised Sepsis screening tool and Sepsis 6 Care Bundle for all emergency admissions to the acute hospital.

- We have rolled out a Sepsis education programme to all new junior doctors.

- Audit of all patients in our Surgical Assessment Unit (SAU) receiving Sepsis Screening.

- We have extended sepsis screening to surgical patients having an emergency laparotomy.

Further improvements identified and priorities for 2016/17

- Our sepsis screening and improvement work will expand to include all inpatient areas of the acute hospital in addition to the existing emergency admission areas.

- We will increase compliance with the Sepsis 6 Care Bundle to continue to improve early recognition and management of severe sepsis and septic shock.

- We will develop care pathways with GPs and community healthcare providers to improve prevention of sepsis of patients before coming into hospital and appropriate care to aid recovery once home.

10.2.5 Recognition and rescue of the deteriorating patient

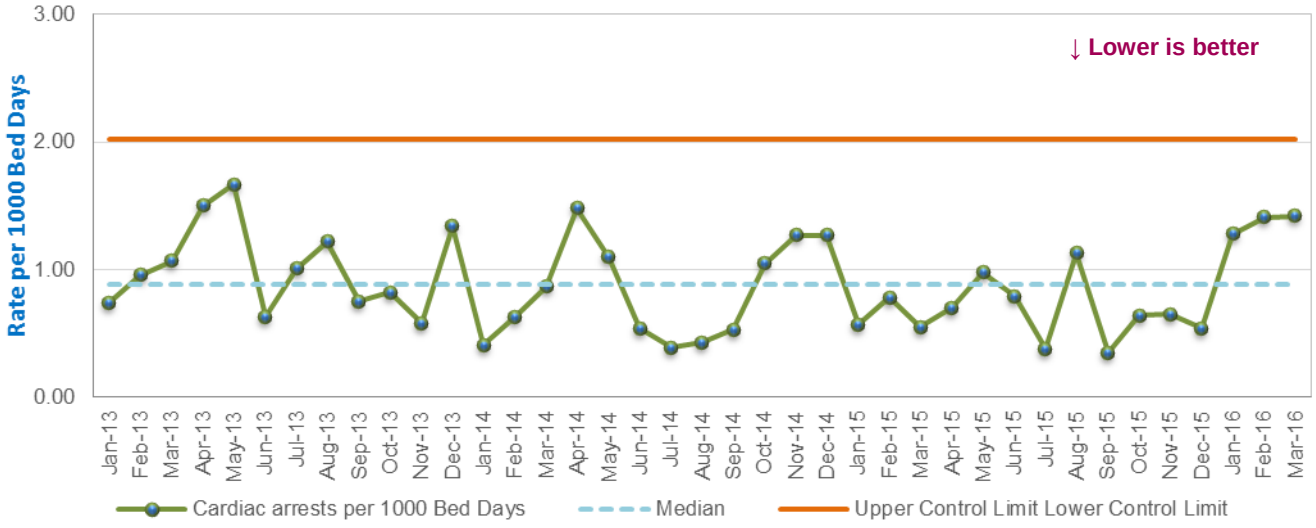
Recognition and appropriate timely management of the deteriorating patient has been recognised nationally as an area of concern. Numerous reports since the 1990s have identified patients are physiologically deteriorating, however that deterioration is not recognised appropriately or acted on as required, resulting in potential harm to the patient. In the worst case scenario this can result in the patient having an avoidable cardiac arrest.

Our improvement work aims to identify the range of contributory factors underpinning this aspect of patient care and implement changes in practice to improve patient outcomes.

What improvements have we achieved?

- Implemented the standardised National Early Warning Score (NEWS) tracker and trigger tool across our acute inpatient, Day Case and Emergency Department areas to help determine and prioritise patients' level of illness.
- Developed and tested a NEWS education programme with two wards to improve recognition, accuracy of assessment and escalation of unwell patients by nursing teams.
- Recording the NEWS score on above-bed boards in acute admission areas to support prioritisation and identification of unwell patients.
- Launched Treatment Escalation Plans (TEP) in August 2015.
- Revised the Deteriorating Patient Policy in November 2015 and Observation Policy under development

Cardiac Arrests per 1000 Bed days



The chart above shows our cardiac arrests per 1000 bed days. In 2015/2016 we reported an average of 0.86 cardiac arrests per 1000 bed days. Although we have not reached our aim of a 10% reduction in cardiac arrests per 1000 bed days each year we have identified 3 key areas to focus our improvements efforts.

Further improvements identified and priorities for 2016/17

- We will rollout NEWS and simulation training across all wards at our acute hospital.
- Additional training will be rolled out to our ward staff in the use of communication tools (e.g. Situation, Background, Assessment, Recommendation SBAR) to improve timely escalation and review of the deteriorating patient.
- We will work with medical teams to ensure prompt and appropriate care planning for acutely unwell patients.

10.3 Other Quality Performance

10.3.1 Continue to reduce our numbers of healthcare associated infections

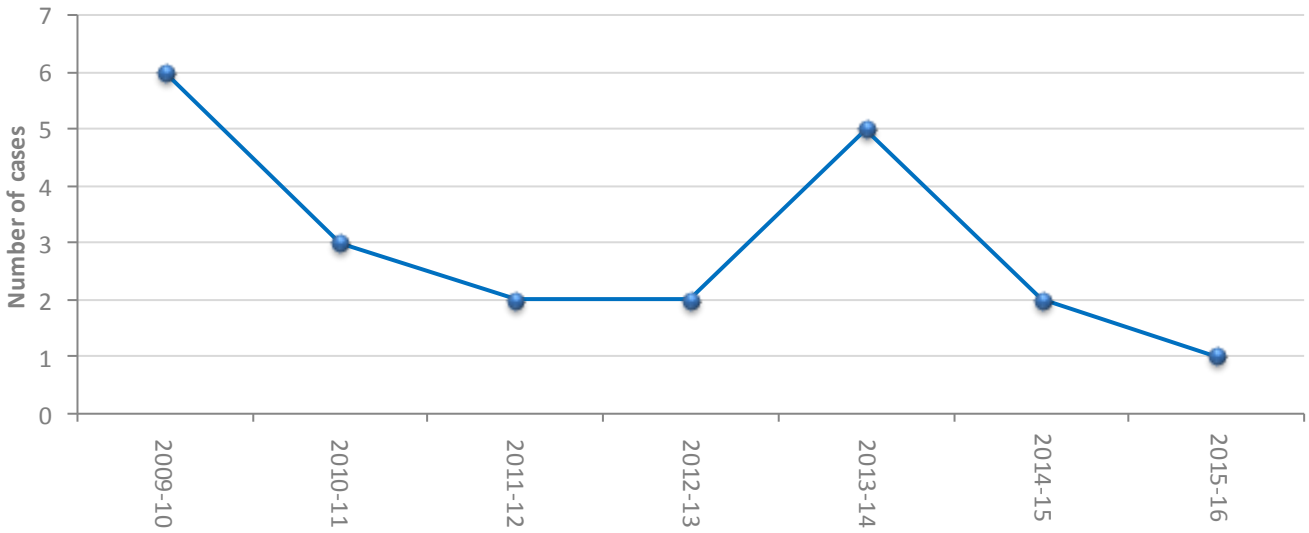
Meticillin Resistant Staphylococcus Aureus (MRSA)

During 2015/2016 we reported one case in total (acute site attributable) against a national target of zero cases. This was a contaminated sample obtained by a Locum Doctor in the Emergency Department rather than a healthcare associated infection.

In addition to expected practice of screening all emergency and categories of elective patients for MRSA, isolating and decolonising patient with positive results, the Great Western Hospitals NHS Foundation Trust has taken the following actions to improve patient safety, and so the quality of its services, by implementing the following initiatives:

- Blood culture contamination rates are reviewed monthly and staff practice reassessed when appropriate and practice with a valid competency to undertake the procedure.
- Management plans for patients with a new positive MRSA result or a history of MRSA.
- Clear focus on being vigilant for and preventing any cross contamination between patients and families and investigating cases where necessary.
- Working with our Occupational Health and Wellbeing team to support staff working in high risk areas
- The Sepsis Six programme continues to provide early diagnosis and management of patients suffering from blood stream infections.

Acute Cases of Trust Apportioned MRSA Bacteraemia



The graph above shows the number of cases of trust apportioned MRSA bacteraemia to Great Western Hospitals NHS Foundation Trust up until 2015/2016.

Clostridium Difficile

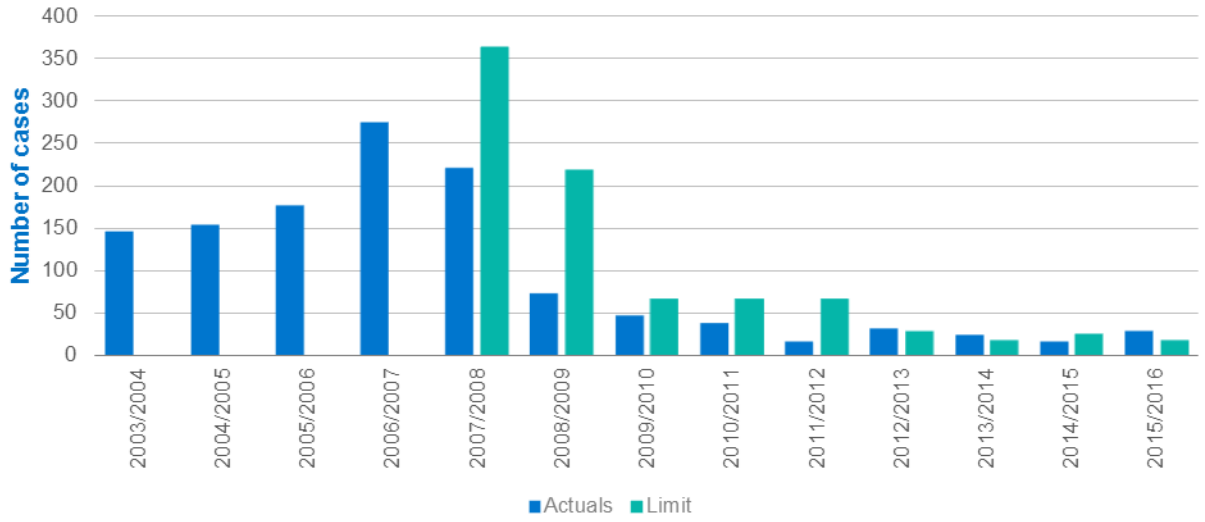
The Great Western Hospitals NHS Foundation Trust considers that this data is as described because as with MRSA above, in England it's mandatory for Trusts to report all cases of *Clostridium difficile (C.diff)* to Public Health England.

The nationally mandated goal for 2015/2016 was to report no more than twenty cases of *C.diff*. We have reported thirty cases in total which exceeds this goal; twenty five *C.diff* infections were attributed to the Acute Hospital and five cases to the Community Hospitals.
In conjunction with our Commissioners 3 of the 30 cases we reported were declared avoidable with care improvements recommended.

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

- Conducting a root cause analysis on each case to identify any areas of improvement
- Sharing the lessons learnt with staff concerned.
- Working with 'front door' services for prompt actions when patients attend with unexplained diarrhoea on admission.
- Ensuring our patients were 'isolated' within 2 hours of unexplained diarrhoea being reported
- We strive to improve antibiotic prescribing audit scores, which included adherence to antibiotic guidelines, recording the duration of the course and indication for their use; the introduction of electronic prescribing allows ease of audit, allowing a focus for improvement to be monitored. Electronic prescribing also allows the IP&C team to monitor antibiotic prescribing.
- We have fully implemented our cleaning strategy and the environmental cleaning standards group triangulates housekeeping audits, matron inspections and ward audits, friends and family feedback and managerial audits. This ensures consistency of cleanliness throughout the Trust.
- The assurance framework for cleaning to meet National requirements established with our business partner, Carillion, has ensured that cleaning is delivered at the correct frequency and level for each area. Audit scores are discussed at the environmental cleaning standards group.
- The importance of standard infection control precautions has been reinforced through link worker meetings and IP&C nurse feedback whilst in clinical areas.

Number of clostridium difficile cases 2015/16



The graph above shows the number of reported clostridium difficile cases in 2015/16. Our goal for 2015/2016 was to achieve no more than 20 cases. We reported 30 cases in total, 10 cases over our goal which equates to 50% above goal, 3 of the 30 cases we reported were declared avoidable with care improvements recommended.

Our priorities for 2016/17

The focus for the coming year will be on reducing the numbers of avoidable clostridium difficile. This includes promoting antibiotic stewardship, rapid isolation and sampling needs to continue with ward/department ownership of local cleaning standards, including patient care equipment all of which is specifically aimed at preventing avoidable cases of cclostridium difficile.

To evaluate the effectiveness of a multidisciplinary approach using Plan, Do, Study, Act (PDSA) in reviewing each case of clostridium difficile infection within 24 hours of reporting with departments involved.

10.4 Patient Safety

10.4.1 Never Events

Never Events are serious incidents that are wholly preventable. There is guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death does not have to be the outcome for an incident to be categorised as a Never Event.

We reported a total of three never events between April 2015 to March 2016, a decrease of one never event reported during the same period in 2014/15. They were:

- Wrong site surgery – reported in August 2015
- Retained foreign body – reported in February 2016
- Wrong implant / prosthesis – reported in March 2016

The incidents have been reported and investigated, with March 2016 still under investigation, and managed through the Trust Incident Management and Clinical Governance structures. Action plans have been developed, with implementation closely monitored by our Patient Quality Committee.
Final reports for the incidents are also shared with our Commissioners, the CQC and Monitor.

Key learning points to take forward in 2016/17

- We have reviewed the consent process across the organisation, to ensure identification and patient safety is robust.
- The consent form for patients who do not have capacity now includes the best interests' checklist for clinicians to refer to when consenting.
- Revision of the procurement policies and procedures for surgical consumables and equipment within theatres.
- Improving the process to ensure the selection of the correct Lens during cataract surgery operations is closely linked and embedded within the WHO check list process.

10.4.2 Reduce Incidents and Associated Harm

Serious incident reporting

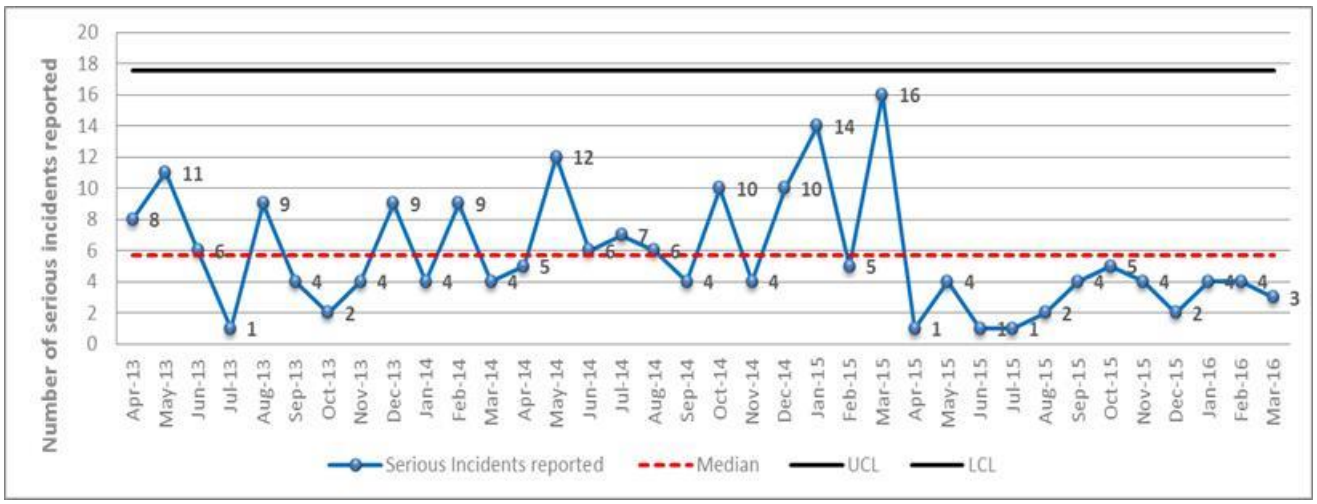
A total number of 35 serious incidents were reported and investigated during the period April 2015 to March 2016.

- All patient safety incidents that were reported within the Trust were submitted to the National Reporting and Learning System. Our reporting performance is evaluated against other medium acute trusts within the cluster group biannually following the publication of the NRLS Organisational reports.

- All Serious Incidents were reported to our Clinical Commissioning Groups and to the Strategic Executive Information System (STEIS) system.

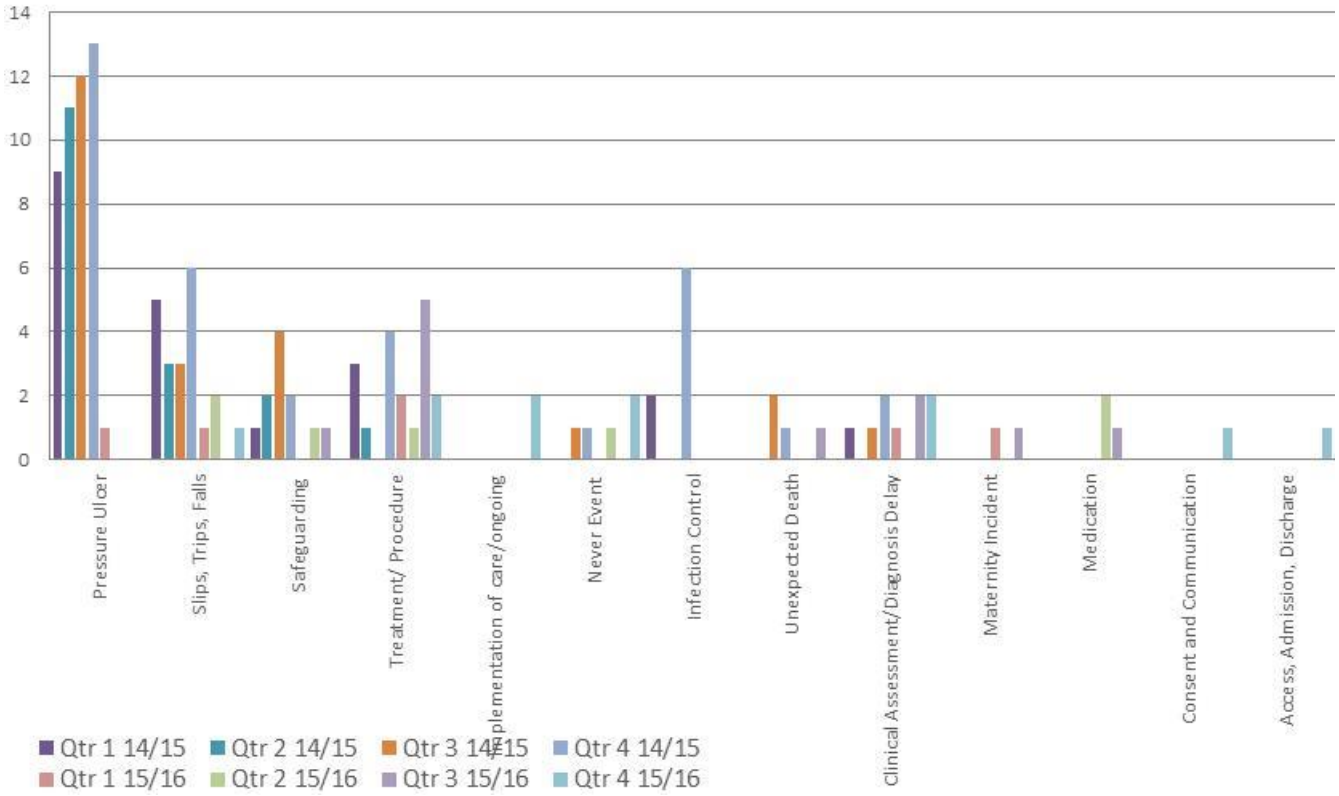
In March 2015 a revised serious incident framework was released by NHS England. The reduction in blanket reporting of pressure ulcers and falls on STEIS reflects this revised Serious Incident Framework allowing us to focus on the most significant risks and opportunity for learning.

Serious incidents reported 2015/16



The graph above shows the number of serious incidents reported in 2015/16. From April 2015 the number of serious incidents reported has remained below the median line.

Serious incidents reported by type per quarter 2015/16



The graph above shows the Trust's serious incidents reported by quarter in 2015/16 compared to 2014/2015 broken down by category. In 2015/2016 we reported a reduction in pressure ulcer and falls serious incidents. This was in line with the revised national Serious Incident Framework which came into force in April 2015 this saw nationally a decrease in 'blanket reporting' to allow trusts to focus attention on the identification and implementation of quality improvments that will prevent recurrance of serious incidents, rather than simply the completion of a series of tasks.

The most frequently reported types of serious incident are:-

- Pressure ulcers
- Patient falls
- Treatment/Procedure failure, including monitoring rescue of the deteriorating patient
- Problems with clinical assessment, delays in diagnosis, interpretation and response to diagnostic procedures and tests

Incident reporting and benchmarking

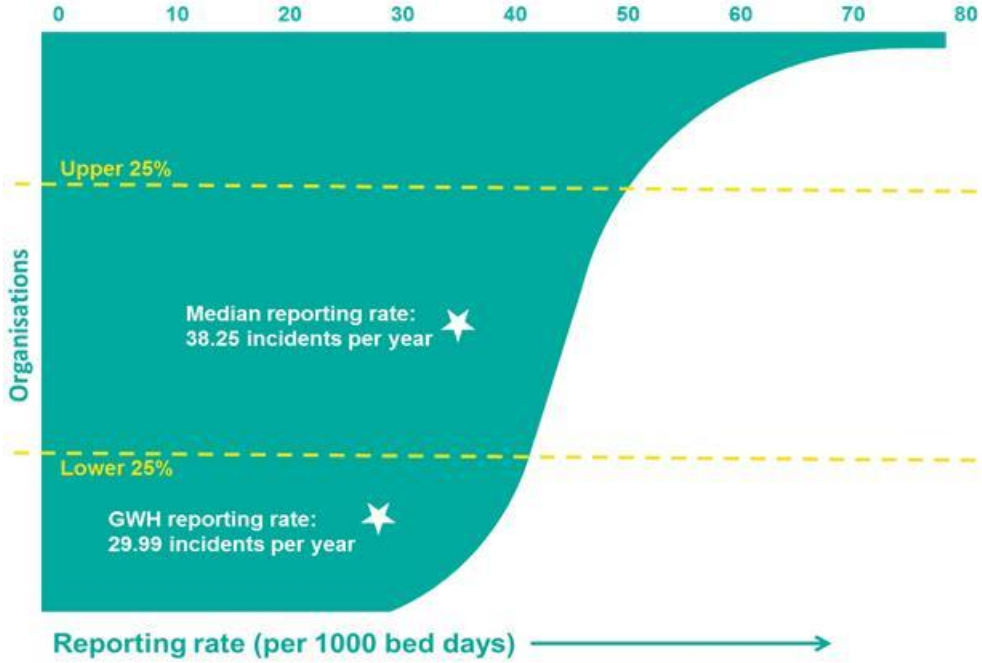
The Trust uploads all reported patient safety incident forms to the National Reporting and Learning System (NRLS) on a daily basis. The number of incidents we have reported in the last 5 years is as follows:

Reporting Year	Non-clinical incidents / Health and Safety	Patient Safety Incidents reported to NRLS	Total
2011/2012	2493	6513	9006
2012/2013	2405	6928	9333
2013/2014	3596	6967	10563
2014/2015	4164	6678	10842
2015/2016	4796	6169	10965

How do we compare with other organisations?

NHS England National Reporting and Learning System (NRLS) release an Organisational Patient Safety Incident report twice a year providing organisational and comparative incident data. The next report from NRLS containing incident data from 1st April 2015 to 30th Sept 2015 is due to be published on 31st March 2016.

Comparative reporting rate per 1000 bed days for 137 acute (non-specialist) organisations 1st April 2015 – 30th September 2015



The Trust reported 3055 incidents between 1st April 2015 to 30th September 2015 with a rate of 29.99 per 1000 bed days. The median reporting rate for this cluster is 38.25 incidents per 1000 bed days. The Trust is at the lower end of the scale, falling within the bottom 25%.

The Trust's reporting rate has decreased from the previous reporting period 1st October 2014 to 30th March 2015 when 31.5 incidents per 1000 bed days were reported.

Priorities for 2016/17

The Trust is in the lower 25% of reporters, with a reporting rate that has decreased from to 31.5 incidents 29.99% per 1000 bed days. During 2016/17 focussed activity on improving reporting culture will include:

- Rebranding of incident reporting from 'IR1' to 'Safety Incident Forms'
- Review of feedback mechanisms to ensure learning is shared with individual reporters, teams and Trust wide
- Safety videos
- GWH Patient Safety Conference in September 2016

Contributory factors from incidents involving recognition and management of the deteriorating patient will be aggregated to identify commonalities; these priority areas will directly inform the Deteriorating Patient Quality Improvement project.

Learning from incidents involving clinical assessment, diagnosis, and treatment to all speciality groups will be disseminated directly to Clinical Governance Leads who should assess relevance of recommendations from incidents occurring elsewhere and ensure appropriate actions are taken to review and improve similar processes in their own departments.

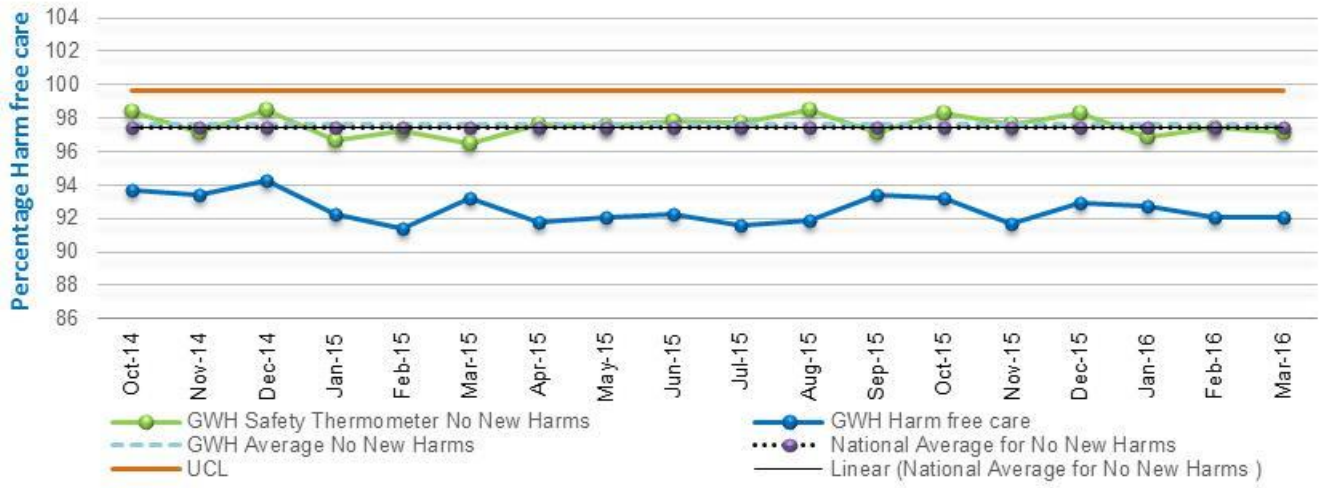
Build Quality Improvement (QI) capability across the organisation to move from an action planning, to a quality improvement approach when implementing change as a result of audit, incident management and risk management activities. Encourage and support Quality Improvement projects as the 'follow on' process from audit and incident management to achieve sustainable improvement;

- Deliver a programme of QI training to provide the skills for frontline teams
- Develop and make available QI resources and tools
- Accessible QI coaching and project troubleshooting
- Build a network of QI coaches within the organisation, with first cohort attending AHSN training in March 2015.

10.4.3 The NHS Safety Thermometer

This is a national initiative that records the presence of four harms on all patients on one day every month. The rationale for focusing on the four harms is because they are common and because clinical consensus is that they are largely preventable through appropriate patient care.

Safety Thermometer performance 2015/16



The graph above shows our Safety Thermometer new harm free care (new harms are those which are evident after admission to hospital). Our average new harm free care for 2015/16 was 97.6%. This is an increase of 0.02% on the previous reporting year 2014/2015.

10.4.4 Duty of Candour

Duty of Candour is a legal duty which came into force in April 2015. As a trust we are legally obliged to inform and apologise to our patients if there have been mistakes in their care that have led to significant harm. Duty of Candour aims to help our patients receive accurate, truthful information and providing reasonable support and an apology when things go wrong. Errors can occur at the best hospitals and clinics - despite the best efforts of talented and dedicated professionals.

Duty of candour means 'being open' as soon as possible after an incident:

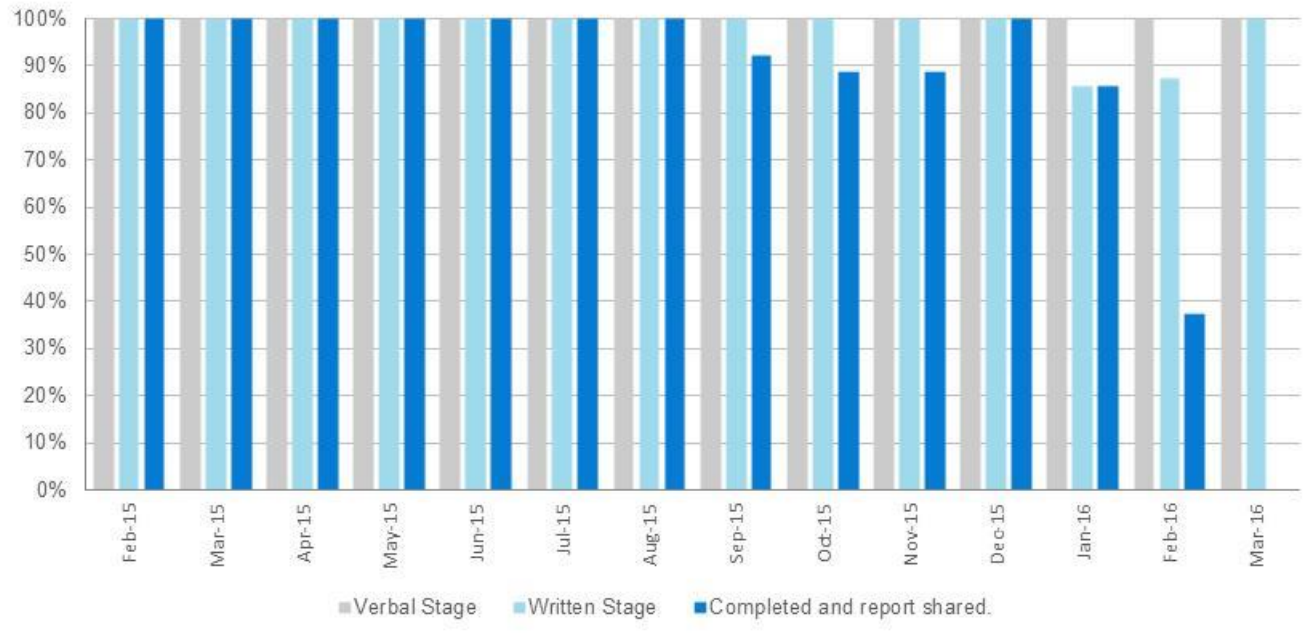
- Informing the patient or their family that an incident has occurred
- Acknowledging, apologising and explaining the incident – and confirming this in writing
- Providing information
- Providing reasonable support
- Inform the patient in writing of the original notification and the results of any further enquiries.
- Saying sorry is not an admission of liability and is the right thing to do.

How are we implementing Duty of Candour?

We revised our Duty of Candour (Being Open policy) along with implementing education and training which is provided to all clinical staff at our Trust induction with additional e-learning released in August 2015. Duty of Candour compliance is monitored at divisional level and within the Patient Safety and Clinical Risk Team with any exceptions reported to divisional boards and our Patient Quality Committee. The Trust's incident reporting system allows us to record Duty of Candour to document the three stages in communication to our patients or other relevant persons. We have also embedded template letters into the incident reporting system to support managers

We have a data extraction facility within the Trust's incident reporting system, which enables us to record and monitor compliance with all significant harm cases and is monitored at divisional level.

Compliance with each stage of Duty of Candour



The graph shows our current full compliance with each stage of Duty of Candour. We have 60 working days to conduct a Root Cause Analysis (RCA) investigation and write a report. This completed report is then shared with the patient/patients representative. The grey bar shows full compliance of verbal stage completed as soon as possible following an incident. The light blue and deeper blue bars representing the written and report stages show a slight lag to completion due to the 60 day full reporting and investigation process.

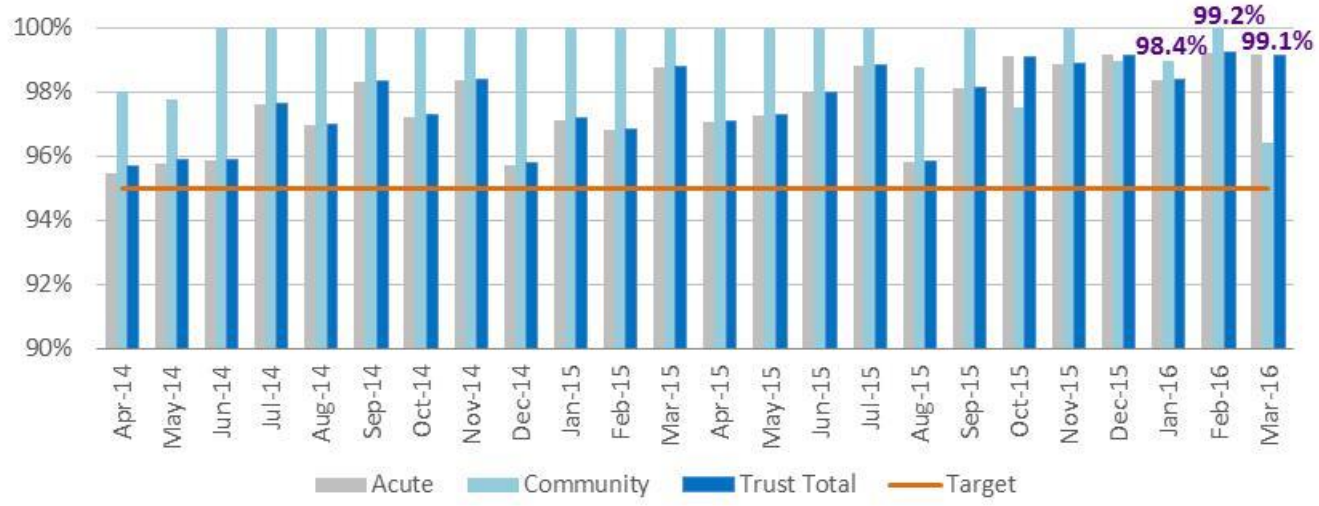
10.4.5 Venous Thromboembolism (VTE) risk assessment and hospital acquired thrombosis events

The Great Western Hospitals NHS Foundation Trust considers that this data is as described because data is collated in a variety of ways including the electronic prescribing system and compared to the total number of admissions during any given month. For clinical areas that do not use the electronic system, manual collation is used and validated by the lead for VTE and the informatics team. This validation is undertaken weekly and information disseminated to all clinical areas so that any under performance is highlighted and able to be rectified.
All adult patients who are admitted to GWH should undergo a risk assessment to determine their risk of developing a VTE related episode. (For example a blood clot such as deep vein thrombosis (DVT) or pulmonary embolus (PE)).

The national target is set at 95%, which means that 95% of patients admitted to hospital should be risk assessed on admission. Across both the acute hospital and the inpatient wards in our community hospitals, we have worked hard to achieve and sustain this target. Data is collected in a variety of ways and we work with individual departments to ensure that the appropriate method is suitable for their needs.

Since the implementation of a weekly email to enable wards to have more up-to-date information we are able to look closely at the performance of individual areas and support them in achieving the target. We can now easily access data via our electronic prescribing system which is in place on the majority of the wards at our acute site, which allows us to produce reports that can identify which patients have had a risk assessment and what time this was undertaken.

VTE risk assessment performance April 2014 – March 2016



The graph above shows the Trust's VTE Risk Assessment. The Trust's average for quarter 4 was 99% which is 4% above the target of 95%.

Appropriate prevention and hospital acquired thrombosis events

Once patients have had a risk assessment we want to ensure that they receive the appropriate preventative treatment. We monitor this using a national audit tool called the "safety thermometer". This looks at all patients in the hospital on one day each month and checks for a number of patients on each ward that have a VTE risk assessment and how many patients receive the appropriate preventative treatment. We currently give appropriate preventative treatment to 90-95% of patients.

For all hospital acquired thrombosis events we check first to make sure that a risk assessment has been carried out and also if the patient received the treatment they should have. If part or either of these points have not been done then a root cause analysis is carried out to determine why and to make sure that we learn from the findings to help prevent the same thing happening again.

The Great Western Hospitals NHS Foundation Trust intends to take the following actions to continue to improve this score, and the quality of its services, following recommendations from the "all parliamentary thrombosis group" we are looking at all cases of hospital acquired thrombosis to determine if there are certain specialities where we need to look at providing more preventative treatment for longer.

We will continue to ensure that the processes in place that help us to achieve our target are maintained and provide high quality care for our patients in preventing blood clots whilst they are hospitalised.

10.5 Effective Care

10.5.1 Preventing premature death

Hospital Standardised Mortality Rate (HSMR)

The Hospital Standardised Mortality Rate (HSMR) is an external validated method of calculating and comparing mortality rates. This information is analysed and presented to all trusts through Dr Foster; an independent benchmarking organisation specialising in healthcare analysis including mortality rates. HSMR is measured by a Relative Risk (RR) score, which is a ratio derived from the number of deaths in specific groups of patients divided by the risk-adjusted expected number of deaths and then multiplied by 100.
A local RR figure of 100 indicates that the mortality rate is exactly as expected; whilst a local figure of less than 100 indicates a mortality rate lower (better) than expected. The Care Quality Commission (CQC) uses HSMR values to monitor performance of hospitals and identify areas of practice where improvements in care may be needed.

In 2014 the Trust set a target to reduce our mortality rates measured by HSMR (Hospital Standardised Mortality ratio) and to be one of the trusts with the lowest HSMR value. We remain on our schedule to deliver this improvement. Our work has resulted in a lower number of deaths and we have one of the lowest HSMR values in Southern England.

The Trust considers that this data is as described for the following reasons:

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

Trust HSMR Trend 2009 – Dec 2015

The graph above shows the year on year HSMR following rebasing. This shows a general improvement over time.

Mortality Alerts

In 2015/16, there were no mortality alerts identified by the CQC. Red bell alerts identified by the Dr Foster monitoring process were investigated using a standard process. As a result of these investigations there were no alerts where the number of deaths identified any particular themes. No avoidable deaths were identified.

The Trust received an alert via the national hip fracture database of an excess of deaths in these patients. This was not identified by the CQC or the Dr Foster data collection process. A review of these cases was undertaken. This identified that patients had not always been admitted to the trauma unit and suggested that use of sepsis tools could be improved. Sepsis tools have now been added to the documentation for these patients. An external review of the service by the British Orthopaedic Association has been requested and it is anticipated that following this review a quality improvement project will be established in any areas identified as needing improvement. Mortality rates in this patient group have already improved.

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

Priorities for 2016/17

- The Trust Mortality Group will continue to review a range of Dr Foster mortality indicators each month and investigate Dr Foster mortality alerts as well as agreeing any other investigations or initiatives prompted by the data and trends
- The Terms of Reference for the Mortality Group and its membership will be revised this year to improve sharing of lessons learned from mortality reviews across the system.
- The Trust will be participating in a project with the West of England Academic Health Science Network to standardise mortality reviews and to learn from other organisations. This is part of a project across the whole of the NHS in England, led by the Royal College of Physicians. Local hospitals have agreed to act as early adopters of this programme of work
- We estimate that up to 80 lives have been saved each quarter by our work on sepsis. We aim to build on this by delivering a similar programme of work for patients with acute kidney injury which has the potential to save more lives. This is likely to result in further improvements in HSMR and SHMI values to help deliver our ambition to save an additional 500 lives by 2019.

10.5.2 Patient Reported Outcome Measures (PROMS)

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

Our provisional PROMS report shows that there has been an overall improvement on the scores for 2015/16 in particular Varicose Vein Surgery and hip replacement surgery. The Great Western Hospitals NHS Foundation Trust will take the following actions to continue to improve. We will continue to review our services, patient pathways and our own patient experience data to understand what further investigation is required, in order to fully understand this drop in standards.

10.5.3 Continue to Enhance the Quality of Life for Patients with Dementia

Our Dementia Strategy focuses on six key priorities as shown below. Delivery of these key objectives is overseen by the Dementia Strategy Group. The Dementia Strategy Group has a lead person for each of the six key priorities. In 2016 these work stream leads will form the basis of the Dementia Operational Group who will be overseeing improvements in dementia care at a ward based level. Much progress has been made with regards to our dementia priorities in 2015.

1. **Raising Awareness**

   A new lead has been created for the Trust's Dementia Champions, who has re-invigorated the role and activity of the Dementia Champions. A forum for Dementia Champions has been created and the Champions now meet every 2 months to discuss dementia care in their clinical areas and departments, share best practise and novel approaches with each other and get involved in new dementia projects and initiatives around the Trust. Informed and motivated Champions help to raise awareness of dementia among staff within their respective work areas and are also well informed to help patients and relatives they come into contact with.

   During National Dementia Awareness Week the Trust hosted a week of events to raise awareness of issues important to people with dementia. This included educational stalls and stands around the Great Western Hospital on the importance of personalised dementia care; delirium and dementia; supporting carers and dying with dementia. These stalls were aimed at educating both staff and public.

   There is much on-going work to ensure dementia care is individualised as much as possible throughout the Trust including the use of 'reasonable adjustment' flags on our computer systems; the use of electronic Forget-Me-Not flowers on our new electronic ward boards and improved accessibility of 'This is Me' documents throughout clinical areas. An annual audit is now conducted into the use of these tools which facilitate our delivery of personalised care.

2. **Education & Training**

   We provide basic dementia training to all hospital staff in accordance with Health Education England's requirements. We also provide a range of advanced dementia training courses for various staff. The Trust Lead for dementia training co-ordinates and regularly updates our dementia training programme.

3. **Dementia Friendly Environments**

   GWH opened the first dementia friendly ward in November 2014 after a £98,000 refurbishment project, which was funded by a grant from the Brighter Futures Charity. A review of the impact of this first dementia friendly ward was carried out in 2015 and revealed a reduction in falls on the ward; a small reduction in length of stay; reduced use of sedating medications; reduced use of close support (one to one supervision of patients) and improved patient experience with fewer complaints. A programme of meaningful activities has also been introduced on the dementia friendly ward including the use of memory boxes which to facilitate reminiscence therapy, regular music therapy and the introduction of sensory bands for distraction in individuals with agitation or anxiety.

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

4. **Dementia Care Pathway**

   During 2015 a new Dementia Care Pathway has been developed in conjunction with multiple specialties and departments throughout the hospital. The aim of this pathway is to ensure that excellent personalised dementia care is delivered throughout the Trust and throughout the patient journey from admission to discharge. It is anticipated that this pathway will be approved and introduced into clinical areas during 2016. In 2015 we have also developed guidelines for the management of pain in dementia as well as guidance on the use of specialist medications in delirium and dementia.

5. **Valuing Carers**

   The GWH Dementia Strategy Group continues to work in close collaboration with the Trust's Carers Committee to improve support for carers of people with dementia. In 2015 we developed and introduced a new carer feedback survey. This has allowed us to collect valuable feedback from over 100 carers using either an online or telephone survey after discharge. Carer feedback is now reviewed every 6 months and recommendations and actions are taken forward in a 'You Said, We Did' spirit.

We have also conducted a Trust wide review of current support and provisions for carers in line with John's Campaign, a National Campaign highlighting how carers can be supported when their loved one is in hospital. Recommendations for improvements following this review are underway.

6. Benchmarking Services

GWH continues to ensure that all our dementia services and work adhere to national and regional standards and recommendations. We are due to participate in the National Dementia Audit in 2016, which will allow us to see how our dementia services compare with other dementia services on a regional and national basis.

10.5.4 Referral to Treatment 18 weeks (RTT)

During 2015/16 the Trust's performance on waiting times for planned surgery has been a focus for improvement. The Referral to Treatment national standard for patients waiting for treatment is that at least 92% of patients should have been waiting for 18 weeks or less from referral to definitive treatment; this takes into account that some patients will have complex treatments or choose to wait longer.

At the beginning of the year around 88% of patients were waiting less than 18 weeks. Throughout the year there has been a sustained effort on improving this position. This has included undertaken increased clinic and operating activity in a range of specialties where waiting times were longer than expected. This activity has included some patients being treated at other providers. Waiting time for initial outpatient appointments have reduced as has the waiting time for routine day case and inpatient operations. We have also looked at our processes to ensure that patients are always booked according to clinical priority and then in order of waiting time. The programme has also included improving the quality of data recording and improving training for staff managing the patient journey.

Performance of 91.2% in March 2016 shows significant improvement and this is planned to continue into 2016/17. We feel this improvement is due to the introduction of the revised programme improving the quality of data recorded and focusing on training for staff in order to effectively manage the patient journey.

The Trust is anticipating that it will be back to sustainable achievement of the 92% standard from the end of May 2016.

RTT Performance waiting time for patients still waiting (incomplete pathways)

A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge

For the period 2015/16, the Trust achieved only 90.3% of patients having a maximum of 4 hours wait in A&E. Taking into account SEQOL data, where our patients can attend the urgent care centre this takes our actual to 91.1%. Delivery of the GWH 4 Hour Acute Service Remedial Action Plan (RAP) incorporates the CQC recommendations.

The SAFER bundle and the Right Patient, Right Bed programme, which is designed to improve quality and performance through effective flow management contributing to improved ED performance. It is underwritten by a performance trajectory that sees the 95% target achieved by July 2016, and sustained for the remainder of 2016/17.

The RAP is a whole system plan and Commissioners and community health and social care provider partner organisations have committed, within the RAP, to reduce the current high levels of DTOC and non-DTOC delays by 50% sustainably from Q2. The Trust achievement of the 95% target in Q4 will be achieved only if partner organisations deliver on their commitment to reduce DTOC and non-DTOC patient delays by 50% sustainably from Q2. This caveat has been fully acknowledged by commissioners.

If the 50% reduction target in DTOCs and other delays is not achieved by Q2, the Trust would therefore seek to see a revision of the ED trajectory, with commissioners, as follows:

- July – November 95%
- December 90%
- January 90%
- February 90%
- March 92%

10.5.5 Review of patients readmitted to hospital within 30 days of discharge

We carry out audits on patient readmissions within 30 days (28 days in 2014/15 as per commissioner request) of being discharged to find out if there was anything that we could have done to better prevent patients being re-admitted, especially if their readmission is related to their previous condition.

The Great Western Hospitals NHS Foundation Trust considers that this data is as described as we have undertaken a review of all patients (144 in total) over the age of 18 who had an emergency admission with a discharge date during two specific time periods in the year and who subsequently had an emergency readmission within 30 days.

The 2014/15 readmission review included 74 patients' case notes; this has increased to 144 in 2015/16 due to including all direct emergency readmission routes (our Surgical Assessment Unit & Linnet Acute Medical Unit) and revising the inclusion criteria from emergency readmission within 28 days of discharge to within 30. A 95% confidence level has been achieved during this review.

In order to allow us to complete a comprehensive comparison with previous readmission audits we reviewed patients over the age of 18 years who had an emergency admission with a discharge date between the 21st and the 27th of September or the 23rd and 29th of November 2015 who subsequently had an emergency readmission within 30 days. 144 patients were highlighted as meeting these criteria by the Trust's Informatics Department.

- The majority were readmitted having self-presented to our Emergency Department (92/144) from their own home (120/144) and in 38% the readmitting diagnosis was the same as that for the original admission.

- In only 2 cases was the readmission attributed to failure of planned community health services.

- In 2 cases it was felt that closer mental health and alcohol support in the community may have prevented the readmission. In 2 cases there was felt to have been inadequate resource for pain management in the community.

- 28 readmissions were identified as potentially being avoidable (19%). The most common intervention which might have prevented a readmission was the provision of mental health services.

- Community acquired pneumonia was highlighted as the most common initial diagnosis in 2014 but in this review, poisoning was highlighted as the most common initial diagnoses. In 2014 86% of patients had multiple comorbidities. In 2015 44% had multiple co-morbidities.

- Mental health support in the community may have prevented 9 readmissions. Mental health support in the emergency department may have prevented 4 readmissions.

- In 4 cases it was felt that better management of the first admission by secondary care would have prevented readmission.

- In 4 cases the readmission was precipitated by the patient's lack of compliance with treatment.

- In 3 cases it was felt that the patient could have been managed in primary care.
- In 2 cases it was felt that the patient could have been better managed by the community hospital.

- In 1 case it was felt that the patient could have received IV antibiotics in the community preventing readmission.

- In 1 patient there was a failure of communication between primary and secondary care.

- In 1 case it was felt that the decision to readmit from ED by secondary care was incorrect.

In summary, 13 readmissions might have been prevented by better mental health support, 4 by better management in secondary care, 3 by primary care and 2 by community care. The provision of IV antibiotics in a Nursing Home resident might have prevented one admission, better communication between primary and secondary care could have prevented another and better decision making in ED might have prevented one more. Four readmissions were related to patient compliance.

19% of the readmissions were felt to be avoidable. Of these, only 7 could have been prevented by improved management of their first admission by secondary care. Although the overall number of readmissions has risen compared to last year (144 vs. 74) this is against a background of increasing admissions overall and a change from 28 to 30 days as a criteria for readmission plus the inclusion of surgical readmissions. The percentage classified as avoidable has decreased from 37% to 19% suggesting that overall management has improved.

Areas for development

The overall findings are similar to those of a previous readmission audit, but the number being readmitted because of lack of community mental health support has risen significantly.

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

Monthly 28 day readmission by age group

Month of Original Discharge	Total Spells			Readmission Within 28 Days			Readmissions Percentage Within 28 Days		
	0-15yrs	16yrs+	Total	0-15yrs	16yrs+	Total	0-15yrs	16yrs+	Total
Apr 14	917	5365	6282	82	403	485	8.9%	7.5%	7.7%
May 14	1018	5707	6725	79	445	524	7.8%	7.8%	7.8%
Jun 14	939	5627	6566	89	489	578	9.5%	8.7%	8.8%
Jul 14	938	6138	7076	75	545	620	8.0%	8.9%	8.8%
Aug 14	820	5557	6377	63	510	573	7.7%	9.2%	9.0%
Sep 14	995	5911	6906	93	555	648	9.3%	9.4%	9.4%
Oct 14	978	6024	7002	96	529	625	9.8%	8.8%	8.9%
Nov 14	961	5417	6378	90	435	525	9.4%	8.0%	8.2%
Dec 14	1081	5429	6510	93	449	542	8.6%	8.3%	8.3%
Jan 15	908	5448	6356	100	423	523	11.0%	7.8%	8.2%
Feb 15	863	4911	5774	99	414	513	11.5%	8.4%	8.9%
Mar 15	943	5677	6620	95	534	629	10.1%	9.4%	9.5%
2014/15	**11361**	**67211**	**78572**	**1054**	**5731**	**6785**	**9.3%**	**8.5%**	**8.6%**
Apr 15	812	5581	6393	91	533	624	11.2%	9.6%	9.8%
May 15	910	5631	6541	94	501	595	10.3%	8.9%	9.1%
Jun 15	891	5924	6815	67	571	638	7.5%	9.6%	9.4%
Jul 15	893	6000	6893	73	536	609	8.2%	8.9%	8.8%
Aug 15	795	5441	6236	84	539	623	10.6%	9.9%	10.0%
Sep 15	927	5902	6829	92	609	701	9.9%	10.3%	10.3%
Oct 15	966	5947	6913	96	560	656	9.9%	9.4%	9.5%
Nov 15	996	5690	6686	110	552	662	11.0%	9.7%	9.9%
Dec 15	1053	5750	6803	100	540	640	9.5%	9.4%	9.4%
Jan 16	941	5375	6316	86	515	601	9.1%	9.6%	9.5%
Feb 16	911	5323	6234	99	499	598	10.9%	9.4%	9.6%
Mar 16	1022	6002	7024			0	0.0%	0.0%	0.0%
2015/16	**11117**	**68566**	**79683**	**992**	**5955**	**6947**	**8.9%**	**8.7%**	**8.7%**

Monthly 30 day readmission by age group

Month of Original Discharge	Total Spells			Readmission Within 30 Days			Readmissions Percentage Within 30 Days		
	0-15yrs	16yrs+	Total	0-15yrs	16yrs+	Total	0-15yrs	16yrs+	Total
Apr 14	917	5365	6282	84	410	494	9.2%	7.6%	7.9%
May 14	1018	5707	6725	80	458	538	7.9%	8.0%	8.0%
Jun 14	939	5627	6566	91	508	599	9.7%	9.0%	9.1%
Jul 14	938	6138	7076	76	560	636	8.1%	9.1%	9.0%
Aug 14	820	5557	6377	63	517	580	7.7%	9.3%	9.1%
Sep 14	995	5911	6906	94	563	657	9.4%	9.5%	9.5%
Oct 14	978	6024	7002	98	541	639	10.0%	9.0%	9.1%
Nov 14	961	5417	6378	90	442	532	9.4%	8.2%	8.3%
Dec 14	1081	5429	6510	93	456	549	8.6%	8.4%	8.4%
Jan 15	908	5448	6356	103	438	541	11.3%	8.0%	8.5%
Feb 15	863	4911	5774	101	419	520	11.7%	8.5%	9.0%
Mar 15	943	5677	6620	97	552	649	10.3%	9.7%	9.8%
2014/15	**11361**	**67211**	**78572**	**1070**	**5864**	**6934**	**9.4%**	**8.7%**	**8.8%**
Apr 15	812	5581	6393	93	539	632	11.5%	9.7%	9.9%
May 15	910	5631	6541	94	510	604	10.3%	9.1%	9.2%
Jun 15	891	5924	6815	68	581	649	7.6%	9.8%	9.5%
Jul 15	893	6000	6893	75	543	618	8.4%	9.1%	9.0%
Aug 15	795	5441	6236	84	547	631	10.6%	10.1%	10.1%
Sep 15	927	5902	6829	96	619	715	10.4%	10.5%	10.5%
Oct 15	966	5947	6913	97	568	665	10.0%	9.6%	9.6%
Nov 15	996	5690	6686	111	564	675	11.1%	9.9%	10.1%
Dec 15	1053	5750	6803	103	551	654	9.8%	9.6%	9.6%
Jan 16	941	5375	6316	89	529	618	9.5%	9.8%	9.8%
Feb 16	911	5323	6234	100	509	609	11.0%	9.6%	9.8%
Mar 16	1022	6002	7024			0	0.0%	0.0%	0.0%
2015/16	**11117**	**68566**	**79683**	**1010**	**6060**	**7070**	**9.1%**	**8.8%**	**8.9%**

10.5.6 Continue to Monitor and Maintain NICE Compliance

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

Every month, NICE publish their guidelines for healthcare organisation to assess and/or put into place. Since 1 April 2015, we have received 168 published NICE guidelines. Of the responses received from clinical divisions to date, 19 out of the 168 (11%) guidelines have been deemed not applicable to the organisation, and full compliance has been confirmed with at least 18 (11%) guidelines. Of the publications, a response is awaited for 125 (74%) guidelines, of these at least 30 guidelines were recently published in February 2016. There are action plans being implemented or are in the process of being formulated for the remaining 6 (4%) guidelines.

The Trust has maintained a compliance rate of 98%, and this is based on the initial assessment of all relevant guidelines.

10.6 Patient Experience

10.6.1 Friends and Family Test

The Friends and Family Test is commissioned nationally by NHS England. All providers of NHS-funded services are required to offer the Friends and Family Test (FFT) to all eligible patients at the point of discharge from hospital.

Throughout 2015/16 we have maintained a consistent 4.7 stars out of a possible 5 stars awarded by patients for the care they have received. Changes were made nationally to the reporting process; in line with these changes the Trust has also remained consistent with 90%-95% of patients likely to recommend our services to Friends and Family if they needed similar care or treatment.

FFT feedback from patients has allowed us to implement changes to be made to improve our services and this information is displayed on our ward/service area's noticeboards in the form of **"you said, we did"**.

To ensure that feedback is available to all eligible patients, Friends and Family cards have been produced in Large Print, Child & Young People friendly and Easy Read formats.

During 2015/2016 the Trust collected a total of 16,471 completed Friends and Family cards against a total of 140,166 total discharges throughout 2015/2016. We intend to take the following actions to improve this percentage and the quality of its services, as follows:

- We will continue to display "you said; we did" feedback in all of our areas throughout our hospital and community sites.
- We will continue to promote the Friends and Family Champions on each ward providing them with information and guidance on any changes and provide feedback to them to be shared with staff in their specific areas.
- We will introduce other methods of collection of Friends and Family comments for all areas in the form of real time data collection.

10.6.2 Improving patient experience & reducing complaints

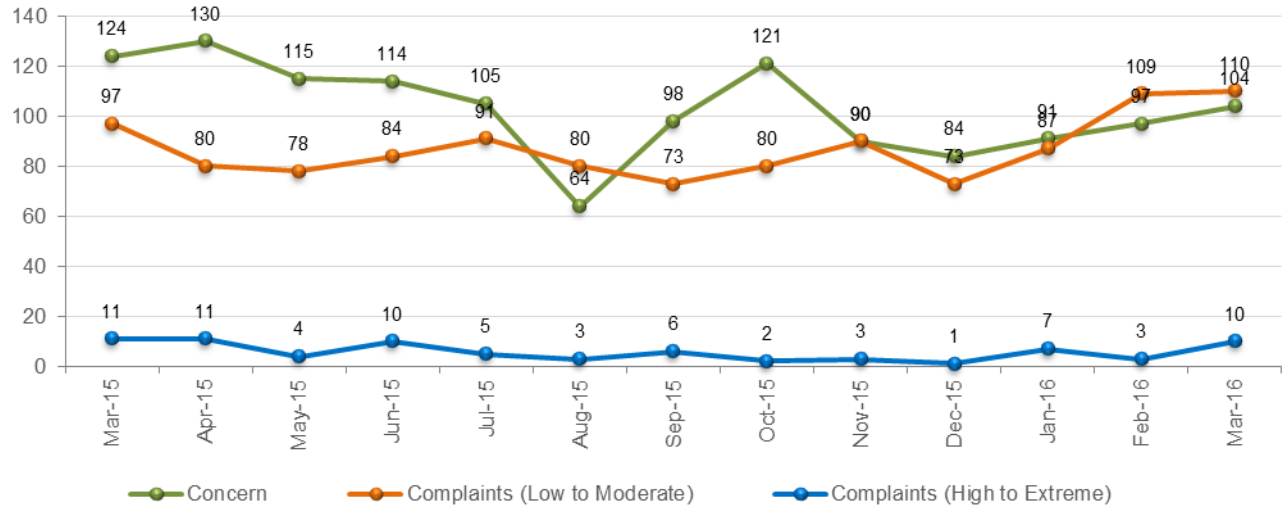
Listening to patients is important to us as it allows us to make changes to the care provided and the services we deliver. Throughout 2015/16 we have worked closely with Healthwatch Swindon and Healthwatch Wiltshire as part of their Engagement Plan to gain valuable feedback from inpatients about their overall patient experience, specifically related to inpatient stay, discharge and after care in the community.

Throughout 2015/16 Patient Experience films have been made to share patient's feedback on their overall patient journey. These short films have been made to share with the general public and trust wide staff. We intend to continue with filming these small films of patient stories throughout 2016/17. We will also continue to receive and use audio clips in the form of "Voicebook" for learning and improvement.

How we communicate with our patients is important to us and we are passionate about ensuring that our patients have detailed patient information in a plain English format to provide details or follow up information about the care patients have received or are about to receive. We are reviewing all of our Patient Information Leaflets and engaging with a "Lay Readership" panel to ensure that the information provided is relevant, helpful and in a format which is easy to understand. We have also made some of our Patient Information leaflets available in other languages and will continue to increase leaflets available in the top five requested languages to ensure that Patient Information is available to all.

We aim to respond to concerns within 24/48 working hours to avoid escalation through the complaints process; this allows for answers to be provided promptly and dealt with effectively. This ensures that the Trusts complaints procedure is accessible to all and easy and clear to follow.

Complaints received in 2015/16



The graph above gives a comparison on concerns/complaints received over a 12 month period towards the end of 2014//2015 and 2015/2016.

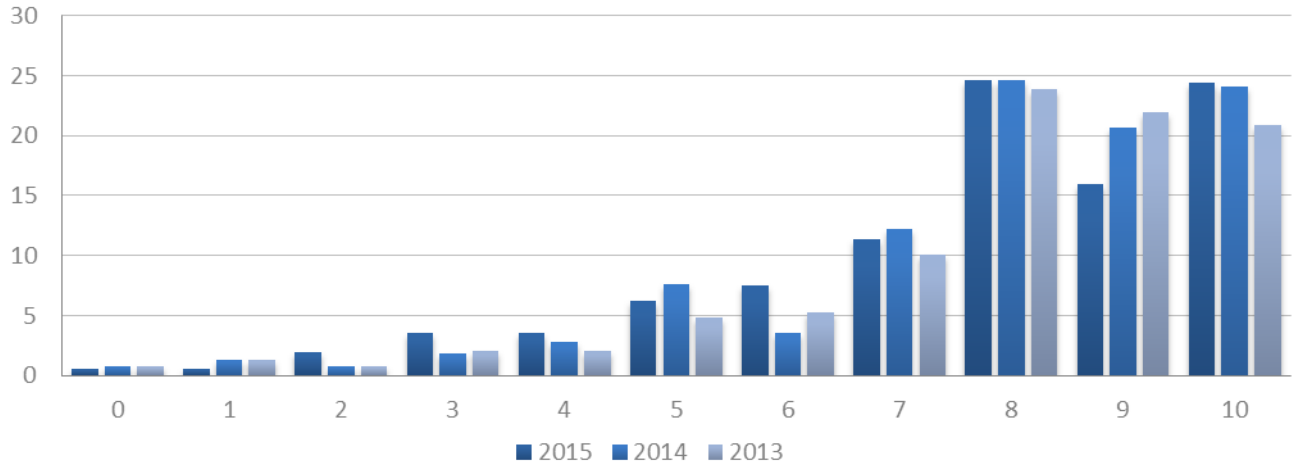
Further changes will include:

- Reducing response times to complaints.
- Ensuring that learning takes place and changes are made as an overall outcome to complaints raised.
- A service available to offer support, advice and guidance to patients, families and carers with an aim to resolve concerns, complaints effectively with an aim to avoid further escalation.

10.6.3 National Inpatient Survey

The National Inpatient Survey was carried out in quarter three of 2015 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.

Trust performance in patient experience rating



The chart above shows responses to a question about their experience of care; a score of 0 was aligned to the statement “I had a very poor experience” scaling up to a score of 10 – “I had a very good experience”. The graph shows that overall, patients have continued to rate their experiences highly with scores between 8 and 10 being the most common.

Implement plans to improve results of the National Inpatient Survey

Following the results received from the 2014 picker survey, areas were identified for improvements to be made during 2014/15:

Bothered by noise at night from staff

- To review times of bin and water changes
- To review times of the drink service
- To work with Carillion to address noisy doors
- To implement Matrons' night ward rounds

Could not always find staff member to discuss concerns with

- Re-launched supervisory role of Senior Sister
- To improve call bell response times
- Continuance of six monthly skill mix review

Food was fair or poor

- Trial of menu system took place
- Patient feedback took place Carillion

Not always enough emotional support from hospital staff

- To agree actions at team meetings

Did not always get clear answers to questions

- Addition of 'Has patient understood plan?' to ward round check-list
- Details Included in junior doctor induction

Did not receive any information explaining how to complain

- To ensure posters and leaflets are in clinical areas
- To ensure patient "welcome packs" are used

During 2016/17 we will:

- Analyse the National Inpatient Survey report 2015 to identify further areas for improvement, create a robust Trust wide action plan with close monitoring of progress.

10.6.4 Staff Survey 2015/16

At the Trust, we recognise that our staff are our greatest asset. Every single person who works for us plays an invaluable role in providing the high quality care and excellent service that we strive for. We know that when our staff have positive experiences at work, our patients also have positive experiences and therefore we are keen to hear from our staff about what it is like to work for us and what we can do to make things better.

The NHS Staff Survey is understood to be the largest workforce survey anywhere in the world and offers unparalleled insight into staff experiences. The survey involves 297 NHS organisations from across the country and achieves just under 300,000 responses. As one of the 297 participating NHS organisations, in October 2015 we randomly selected 850 employees to complete the 2015/16 NHS Staff Survey. Of those, 367 returned a completed questionnaire giving the Trust a 43% response rate which is higher than most of our surrounding trusts.

National and regional comparisons

Despite the numerous challenges currently facing the NHS and its workforce, this year's NHS Staff Survey results demonstrate a positive improvement in terms of staff experience and engagement. Nationally, staff engagement has improved continuously over the last five years and this year the NHS has also seen an increase in staff's willingness to recommend their organisations as places to work or receive treatment. The majority of staff (69%) either agreed or strongly agreed that they would be happy with the standard of care their organisation provided if a friend or relative needed treatment and most (80%) agreed that they feel able to do their job to a standard they are personally pleased with. However, in contrast to this, the survey also highlighted that staff are continuing to experience difficulties with some of the pressures facing them, including inadequate resources and staffing shortages.

When comparing our results with the national results, there are similar themes evident. Our Staff Engagement score has also improved this year, from 3.68 in 2014 to 3.88 in 2015 which is above average when compared with similar trusts (possible scores range from 1 to 5 with 1 indicating that staff are poorly engaged with their work, team and trust, and 5 indicating staff are highly engaged).

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

Top Five Ranking Scores	Trust Score	National Score
Percentage of staff able to contribute towards improvements at work *(the higher the score the better)*	77%	71%
Staff confidence and security in reporting unsafe clinical practice *(the higher the score the better)*	3.79	3.64
Staff motivation at work *(the higher the score the better)*	4.09	3.92
Quality of non-mandatory training, learning or development *(the higher the score the better)*	4.13	4.04
Fairness and effectiveness of procedures for reporting errors, near misses and incidents *(the higher the score the better)*	3.86	3.71

Bottom Five Ranking Scores	Trust Score	National Score
Percentage of staff experiencing harrassment, bullying or abuse from patients, relatives or the public in the last 12 months *(the lower the score the better)*	35%	27%
Percentage of staff working extra hours *(the lower the score the better)*	79%	72%
Staff satisfaction with resourcing and support *(the higher the score the better)*	3.2	3.3
Percentage of staff/colleagues reporting most recent experience of harrassments, bullying or abuse *(the higher the score the better)*	34%	38%
Percentage of staff experiencing physical violence from staff in last 12 months *(the lower the score the better)*	2%	2%

These results simulate the national results with more people (77%) feeling able to contribute towards improvements at work and feeling motivated at work (4.09), however higher levels of staff are working extra hours (79%) and staff are reporting concerns regarding their satisfaction with resourcing and support.

Comparison of 2014 and 2015 results

This year the Trust has seen improvements in a number of areas compared to 2014; a summary of those sections with significant changes can be found below.

Management

This year the Trust has made improvements in all of the questions within the Management section. The most noticeable improvement (+10%) has been in the effectiveness of communication between senior management and staff with only 27% of respondents providing a negative response. There have also been significant improvements in the amount of staff who know who our senior managers are (+ 8%) and who feel involved in making important decisions (+4%).

Communication and visibility of senior management was one of the key priority areas that the Trust identified from last year's survey. In order to improve our staff's experience of this, we introduced a 'Message of Month' where each month one of our Executive Director's provide staff with an update on a 'hot topic' relating to the Trust. In addition to this, we have also continued the 'In Your Shoes' initiative, with a number of our senior managers working alongside our staff to learn about their jobs and to experience what it is like to work in different departments across the Trust.

Bullying, Harassment and Whistleblowing

The results within this section are varied. Although we have seen improvements in the questions relating to reporting incidents of physical violence or clinical practice concerns, the amount of staff who experience harassment, bullying or abuse at work has increased with less people reporting it. More than half (55%) of those staff who responded stated that their last experience of harassment, bullying or abuse was not reported. We want to ensure our staff feel safe and supported at work and therefore we have identified this as a key priority for improvement over the next year.

Patient / Service User Care

Performance within this section has been strong this year, with more people (+5%) feeling that the care of patients is the organisations top priority. More staff reported that patient / service user feedback is collected within their division or department and that they were provided with regular updates on this feedback. The Trust also saw an increase this year in the amount of staff who feel that feedback from patients or service users is used effectively from 3.55 in 2014 to 3.71 in 2015. Our patients are at the centre of everything we do and therefore we want to continue this good work into the next year.

Appraisals and Your Job

There were small improvements made within all of the questions asked in this section apart from one where there was a significant decrease. Although the quality of our appraisals has improved, the number of staff reporting that they had received an appraisal within the last 12 months has decreased by 5% compared to last year to 86%.

We are committed to supporting our staff's development to help them to perform to the best of their ability in their roles. One of the ways in which we achieve this, is through the Trust's Appraisal process. Earlier this year we reviewed our appraisal processes in order to make sure that they were effective and easy to use. Part of this review included asking employees and managers for their feedback and suggestions on the process, this feedback was then used to inform the changes that we made to the policy and paperwork used. This year's Staff Survey results show that the changes we have made, have improved the quality of our appraisals and that staff who received an appraisal do feel more valued by the organisation. This year, we will work with managers across the Trust to ensure that all our staff receive an appraisal.

Team working and Involvement

This year more staff have reported that they are involved in deciding changes that affect their work (+3%) and feel that they are able to make improvements within their work area (+9%). This is following the introduction of an ideas generation initiative, where staff are encouraged to put forward any suggestions for improvement they have both within their own teams and across the Trust. Since introducing this process, more than 200 ideas have been submitted.

Staff are still however, reporting challenges with the resources available to them at work, both in terms of the number of staff within the organisations and having adequate materials, supplies and equipment to enable them to do their work. The Trust continues its focus on recruitment, exploring and developing innovative ways of recruiting new staff to join our hard working teams. In addition to developing and maintaining positive relationships with local schools and universities, the Trust is also continuing its overseas search for nurses. The Trust has held a number of recruitment events over the year seeking to attract people from all professional groups to come and work with us and this will continue into 2016/17.

Our priorities for 2016/17

Based on the information provided in the responses to this year's survey, the Trust has agreed the following key priorities for 2016/17:

- Protecting our staff against harassment, bullying and abuse from patients and service users
- Continuing to address challenges with the resources available to our staff at work, both in terms of the number staff within the organisation and having adequate materials, supplies and equipment
- Supporting our staff's health and wellbeing and personal development

These priority areas will be used to identify a number of Trust wide schemes which will be developed and implemented to address the key areas for concern.

Next year, the Staff Friends and Family Test will be used to continuously monitor the Trust's performance in these areas. Each quarter we will use the Staff Friends and Family Test to focus on a different key theme highlighted from the report, asking additional questions to gain a better understanding of the concerns raised and actions required to make improvement. Each division will also identify their own key priority areas for the next 12 months and will develop and implement actions to address key areas of concern.

10.6.5 Equality & Diversity within the organisation

Our vision for 2014-2017 is for: "Services and opportunities to be as accessible as possible, to as many people as possible, at the first attempt"
Our trust objectives ensure that in attending to aspects of Equality and Diversity, the results will be: better health outcomes for all; improved patient access and experience; comprehensively empowered and engaged workforce; effective and inclusive leadership at all levels:

The outcomes of our Equality Strategy will support us in the obligation we have to fulfil the Public Sector Equality Duty through; the elimination of discrimination, harassment and victimisation and any other conduct that is prohibited by or under the 2010 Act; advance equality of opportunity for all people; foster good relations between people, no matter how diverse they are from each other.

The Trust has an Equality and Diversity (E&D) Working Group with Health Care representatives from across the Trust's organisation. The purpose of the group is to develop awareness of Equality & Diversity impacts, with an end to support the delivery of the outcomes stated above. To support this we have developed a series of actions to deliver specific objectives over the next 12 months, which are all incorporated into an action plan and monitored and tracked accordingly.

The Trust recognises where we need to achieve excellence through the Equality agenda and, for 2016 – 2017, take into account the need to recognise the changes in legislation, the implementation of the refreshed Equality Delivery System (EDS2) and the new NHS Workforce Race Equality Standard (WRES) and to commit to taking the necessary steps to deliver this beyond our basic statutory duties.

10.7 Our Priorities for 2016/17

Our Trust's commitment to quality continues through a number of priorities that we set in 2015/16 which are informed by both national and local priorities, like our Sign up to Safety Campaign, and as such are aligned with our 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.

We have embraced the five Sign up to Safety pledges that we signed up to in 2015/16. These were a combination of national aspirations and our own specific improvement areas:

1. Put safety first

We will continue to commit to reduce avoidable harm in the NHS by half and make public our goals and plans developed locally. We will:

- Provide leadership for quality and safety, our Trust leaders will be highly visible role models/coach's championing quality improvement, empowering staff to continuously improve their services
- Continue to foster a safety culture that is open and fair across the whole organisation
- Aim to be within the 10% of NHS organisations with the lowest risk adjusted mortality
- Save 500 more lives over five years as a direct result of the efforts to improve quality and safety, particularly in relation to the key causes of mortality.
- Identify standards of care and safety measures which are monitored and understood from ward to board.
- Continue to implement the sepsis six care bundle
- Develop care bundles to ensure consistent care is delivered to patients with a high risk of death including those with acute kidney injury and following emergency laparotomy
- Reduce the incidence of pressure ulcers and patient falls by implementing improvements in care identified through incident investigation

2. Continually learn

We will make our organisation more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe our services are. We will:

- Continually learn and share safety lessons from incidents, complaints and claims
- Celebrate best practice and achievements of individuals and teams
- Develop and improve the learning from the Mortality case note review process
- Develop the use of data for improvement, increasing the knowledge base of our staff about measurement of safety

- Develop quality improvement plans to deliver safer care for patients
- Develop an internal and external network to ensure learning from best practice is implemented across the trust
- Actively seek the views of patients and relatives about areas of care that we can improve

3. Honesty

We will be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong. We will:

- Implement the statutory Duty of Candour, supporting staff to build skills in being open with patients when things go wrong
- Engage with service users, their carers and relatives and use their feedback to help us improve quality.
- Continue holding 'spotlight' listening events and turning public feedback into service improvements.
- Reviewing all 'VoiceBook' comments and using the Friends and Family test to inform us of what patients think about our services
- Listen to staff and provide ways for staff to have their say, for example the Staff Friends and Family Test and the ' See Something, Say Something' campaign
- Share progress of projects to improve patient safety with our patients, staff and Trust Board
- Engage with the national safer staffing agenda, displaying staffing levels clearly on our wards and publishing on NHS Choices.

4. Collaborate

Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use. We will:

- Actively participate in local and regional patient safety networks, including the NHS England Patient Safety Collaborative, as an opportunity to share best practice and to develop quality improvement expertise.
- Work with local partner organisations to improve patient pathways across NHS organisations.
- Continue to establish and progress the work of Trust quality improvement groups, developing expertise within these teams. Our key safety priorities as we 'Sign up to Safety' will be:

    - Acute Kidney Injury
    - Falls prevention
    - Pressure ulcer prevention
    - Rescue of deteriorating patients
    - Sepsis

5. Support

We will help people understand why things go wrong and how to put them right. We will give staff the time and support to improve and celebrate the progress. We will:

- Ensure that support is available for staff who have been involved in incidents, complaints and claims, both individually and as teams
- Provide staff with training in quality and safety methodology, and the tools to deliver improvements
- Provide staff with practical quality improvement tools and guidance
- Encourage ownership of safety and quality improvement by all staff , at all levels of the organisation
- Continue to develop the Executive Patient Safety Visits, ensuring these visits meet the needs of the executive and frontline teams.
- Develop clinical leadership and quality expertise within the Trust to champion quality and safety from ward to board.

We will be developing a Patient Experience Strategy, which will set out how the Trust intends to build on and improve how we work with people who access our services, and how we will work in partnership with patients, carers, families, patient groups and forums, CCGs, and professionals. We will strengthen the PALS service in

terms of the experience of those accessing it, and the support provided to internal stakeholders. The Trusts patient experience processes and systems, will be reviewed and strengthened in order to support operational divisions to be responsive to our patients, family and carer feedback. A work plan will be developed out of the strategy, with clear actions and timelines.

We are aiming for quality improvement methodology to be used for both Sign up to Safety and all Trust wide safety projects. Build organisational Quality Improvement (QI) capability and deliver a programme of QI coaching and training to provide the skills for frontline teams to apply the theory of QI practice when making changes at departmental level, to lead change from our frontline.

To ensure that all tools and resources are accessible and meet the needs of clinicians undertaking service improvement within their own practice. We will work collaboratively with Universities and the Deanery to support health professionals in training to complete service improvement projects whilst on placement within the organisation. We will implement a coordinated process with the university to ensure that whilst students achieve their objective the organisation benefits from the projects completed. Capturing the change ideas and not losing improvements that can be taken forward. The Trust will develop quality improvement systems, processes and tools to enable a culture of innovation and improvement and will widen our Trust's organisational network and engagement of staff in quality improvement and the Sign up to Safety programme at all levels.

10.8 Statements of Assurance

This section provides nationally requested content to provide information to our public which will be common across all Quality Accounts

10.8.1 Information on the Review of Services

During the reporting period of 2015/2016 the Trust provided and / or sub-contracted 8 relevant health services.

The Trust has reviewed all the data available on the quality of care in 100% of these relevant health services.

The income generated by the relevant health services reviewed in 2015/16 represents 100% of the total income generated from the provision of relevant health services by the Great Western Hospital NHS Foundation Trust for 2015/2016.

10.8.2 Participation in Clinical Audits

During 2015/2016, 35 National Clinical Audits and 4 National Confidential Enquiries covered relevant health services that Great Western Hospitals NHS Foundation Trust provides.

During that period Great Western Hospitals NHS Foundation Trust, participated in 34/35 (97%) national clinical audits and 4/4 (100%) of 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 enquires that Great Western Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2015/2016, 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		Participated	% Data Submission	Actions taken
1	Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	100%	
2	Adult Asthma	No	No National Audit this year	
3	Bowel cancer (NBOCAP)	Yes	100%	
4	Cardiac Rhythm Management (CRM)	Yes	100%	
5	Case Mix Programme (CMP)	Yes	100%	
6	Chronic Kidney Disease in primary care	NA	NA	
7	Congenital Heart Disease (Paediatric cardiac surgery) (CHD)	NA	NA	
8	Coronary Angioplasty/National Audit of PCI	Yes	100%	
9	Diabetes (Adult) Inpatient	Yes	100%	
10	Diabetes (Adult) Foot care	Yes	100%	
11	Diabetes (Adult) Pregnancy	Yes	100%	
12	Diabetes (Adult)	No	0%	
13	Diabetes (Paediatric) (NPDA)	Yes	100%	
14	Elective surgery (National PROMs Programme)	Yes	100%	
15	Emergency Use of Oxygen	NA	NA	
16	Falls and Fragility Fractures Audit Programme (FFFAP)	Yes	100%	
17	Inflammatory Bowel Disease	Yes	100%	

	(IBD) programme			
18	Lung cancer (NLCA)	Yes	100%	
19	Major Trauma: The Trauma Audit & Research Network (TARN)	Yes	100%	
20	National Adult Cardiac Surgery Audit	NA	NA	
21	National Audit of Intermediate Care	Yes	100%	
22	National Cardiac Arrest Audit (NCAA)	Yes	100%	As part of the "sign up to safety" campaign, the Resus team will be monitoring the number of cardiac arrests by working with the lead team for "the deteriorating patient" to jointly identify areas of development. There are trust wide plans for the introduction of a new Treatment Escalation Plan (TEP) to identify patients who are not for cardio-pulmonary resuscitation and to implement the National Early Warning Score (NEWS) to identify deteriorating patients to reduce numbers of unexpected cardiac arrests.
23	National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme: Community Services	Yes	100%	
24	National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme: Acute Services	NA	NA	
25	National Comparative Audit of Blood Transfusion programme	Yes	100%	
26	National Complicated Diverticulitis Audit (CAD)	Yes	100%	
27	National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)	NA	NA	
28	National Emergency Laparotomy Audit (NELA)	Yes	100%	Whilst the organisation has achieved good results in the National Emergency Laparotomy Audit, there remains a few small areas for improvement; GWH showed less than 50% for a consultant review within 12 hours of emergency admission and an assessment by a Medical Crisis in Older People specialist (MCOP) in patients >70yrs age.
29	National Heart Failure Audit	Yes	100%	
30	National Joint Registry (NJR)	Yes	100%	
31	National Ophthalmology Audit	Yes	100%	
32	National Prostate Cancer Audit	Yes	100%	
33	National Vascular Registry	NA	NA	
34	Neonatal Intensive and Special Care (NNAP)	Yes	100%	Neonatal Intensive & Special Care services are to improve the timeliness of retinopathy screening. All patients are to have a senior review within 24hrs of admission and a developmental assessment of all infants born at gestational age of <30weeks.
35	Non-Invasive Ventilation - adults	No	No National Audit this year	

36	Oesophago-gastric cancer (NAOGC)	Yes	100%	
37	Paediatric Asthma	Yes	100%	
38	Paediatric Intensive Care Audit Network (PICA Net)	NA	NA	
39	Paediatric Pneumonia	No	No National Audit this year	
40	Prescribing Observatory for Mental Health (POMH)	NA	NA	
41	Prescribing Observatory for Mental Health (POMH)	NA	NA	
42	Prescribing Observatory for Mental Health (POMH)	NA	NA	
43	Renal replacement therapy (Renal Registry)	NA	NA	
44	Procedural Sedation in Adults (care in emergency departments)	Yes	100%	
45	Pulmonary Hypertension (Pulmonary Hypertension Audit)	NA	NA	
46	Rheumatoid and Early Inflammatory Arthritis	Yes	100%	
47	Sentinel Stroke National Audit Programme (SSNAP): Community Services	Yes	100%	
48	Sentinel Stroke National Audit Programme (SSNAP): Acute Services	Yes	100%	
49	UK Cystic Fibrosis Registry	NA	NA	
50	UK Parkinson's Audit (previously known as National Parkinson's Audit)	Yes	100%	
51	Vital signs in Children (care in emergency departments)	Yes	100%	The Emergency Department, are planning to develop a simple proforma for recording information about seizures, and a patient information leaflets for febrile seizures and 'first fit'; this will ensure patients/carers of all children who present with seizures receive written advice. Further training and education around the management of hypoglycaemia and advanced paediatric life support (APLS/EPLS) will also be provided.
52	VTE risk in lower limb immobilisation (care in emergency departments)	Yes	100%	

Confidential enquiries			
1	Medical and surgical clinical outcome review programme: National confidential enquiry into patient outcome and death : Mental Health Patients in Acute Hospitals	Yes	100%
2	Medical and surgical clinical outcome review programme: National confidential enquiry into patient outcome and death : Child Health Programme (Chronic Neurodisability, focusing on cerebral palsy)	Yes	100%
3	Medical and surgical clinical outcome review programme: National confidential enquiry into patient outcome and death : Child Health Programme (Adolescent Mental Health, focusing on self-harm)	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	Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	100%

The reports of 32 national clinical audits were reviewed by the provider in 2015/2016 and Great Western Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- To improve care in the Emergency Department for older patients, there will be an introduction of a new Risk assessment for all older adults; this will incorporate cognitive impairment, dementia assessment, falls risk, safeguarding and NEWS scoring. Consideration is being given to also incorporate a specific box for recording Early Warning Score (EWS) on Emergency Department (ED) notes. Automatic documentation of cognitive assessment will be provided as a letter to the GP.

- The blood transfusion service will be looking to improve their prescription chart by redesigning and incorporating the name of the person taking consent to encourage ownership of the process; ensure that training for medical staff on blood transfusion consent and documentation is given alongside general consent training; ensure that training on the appropriate use of blood, prescribing and documentation is carried out in a robust format to all medical staff.

- In Maternity services, perinatal mortality remains below the UK national average, and stillbirth rate at GWH was 3.87 per 1,000 births compared to UK national average of 4.64. Although neonatal death rate at 1.49 per 1,000 births compared to UK national average of 2.68 per 1,000 births remains low, regional benchmarking adjusted neonatal death rate shows GWH to be one of the highest. As a result of this, the Maternity Services, are organising a local review into neonatal mortality to examine where any quality improvements could be made, aiming at reducing the overall mortality rate.

The reports of 190 local clinical audits were reviewed by the provider in 2015/16 and Great Western Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Local Audit	Actions Taken
Mortality Reviews Q4 - 2014/15	Disseminate report to Senior Sisters, for discussion at local team meetings and presented at Harm Free Care Focus Group to identify key learning and examine the barriers to good practice
Diabetes Mortality and Morbidity (M&M) A root cause analysis approach 2014/15	Hold regular mortality and morbidity meetings for diabetes
Epidural Audit in Maternity 2015	Results of this audit presented and at relevant maternity forum. Consideration of integrating audit criteria to any relevant care pathway audits or changes to audit tool to improve condition for data collection.
WHO Checklist - Q1, Q2, Q3, Q4 2015/16	results disseminated to relevant staff within Maternity Services. Continuation with weekly spot checks and compliance trend monitoring presently. Staff to be further reminded via SMART News and Delivery Suite morning meeting of need to complete of all sections of the form especially date and signature.
Annual Sharps Reporting Audit 2015	Continue education with particular emphasis on the assembly of sharp bin containers Continue Education with emphasis on correct labelling of sharps bin containers Promotion and education of the use of temporary closures use on sharps bins Reinforce through education safe sharps practice highlighting the dangers of overfilling and protruding sharps Promote use of brackets or mobile units and ANTT trays when using sharps bins

Resuscitation Trolleys, Grab Bags and Resuscitaires Audit (inc Maternity) 2014	Resuscitation Officers to conduct monthly spot checks of resuscitation equipment in all areas of the Trust that are currently on red status. Areas on amber status will receive quarterly checks. Spot checks will continue until 100% compliance (green status) is achieved. The Resuscitation Department to review the equipment lists of community grab bags/AEDs to bring them into line with current recommendations from the Resuscitation Council UK. Alongside this will be the development of new check record documentation to enable accurate record keeping and appropriate medicines management in accordance with the Trust Medicines in Wiltshire Community Healthcare Unit – Safe and Secure Handling Policy. The Resuscitation Department to work with the Ward Manager on SCBU to identify appropriate equipment and stock levels for the Neonatal Emergency trolleys and facilitate the necessary changes.
Annual Hand Hygiene Audit Q4 2014-15	Clinical/Service Leads have shared audit results with their teams and use as an opportunity to promote and maintain best practice in hand hygiene. The Divisional Quality Governance Facilitator will request electronic evidence to support completion of actions i.e. team minutes where the results were discussed, emails to demonstrate you have achieved your action. Clinical/Service Leads to ensure that Occupational Health Referrals are made for those staff with existing skin problems.
Annual Health Records Audit Q3 2014-15	Acute: Gynaecology 1. Present the results at an educational half day to remind all staff about importance of record keeping Paediatrics 1. To remind all staff to document the date, time, signature, designation and printed name on all written entries. 2. To remind all staff about countersigning any deletions or alterations they make. Community: Speech and Language Therapy 1. To ensure the team are aware that the following need to be completed on the records: • The patient's ethnicity been documented within the notes? • The patient's religion been documented within notes? • The patient's first name, last name and DOB is recorded on each page • The patient's NHS number is recorded on each page Hillcote 2. To ensure the team are aware of the need to complete the following in health records on each occasion; • Legible printed name and designation on each entry • No spaces in between entries • To record time as well as date on each entry 3. To ensure an information sheet is present in each folder 4. To have ethnicity and religion sections added to general information sheet. Learning Disabilities 5. To disseminate the results to all team members 6. To ensure all written records meet audit standards
NHSBT - National Comparative Audit of: Use Anti D Audit (Local Re-Audit)	Audit report to be disseminated and any learning shared with relevant staff. Audit findings to be discussed at relevant forum meetings. Use of blood product in anti-D and the need for clear documentation of informed consent to be further highlighted to staff via SMART News feature. Draft anti-D care pathway proforma which integrates all elements of the care pathway and simplifies approach to be developed potentially in association with SHOT who will offer support. Use of Fetal DNA sampling to determine fetal Rh(D) to be further explored.

Blood Observation Local Audit 2014/15	1.1 Audit findings and key points for learning to be emailed out to all clinical area ward managers and Transfusion Champions for dissemination to clinical staff and display on transfusion notice boards. "Stop time documented" 79% compliance. 2.1 During transfusion training sessions to remind staff of the importance of documented stop time, as legal evidence that the transfusion has been administered over the appropriate time. 2.2 Audit summary and recommendations/ actions to be presented at Transfusion champion meeting "Documentation of informed consent" 70% Compliance 4.1 Key learning points education sheet to be sent out trust wide and displayed on Transfusion notice boards "Leaflet given" 57% compliance 5.1 Remind nursing and medical staff that patients receiving a blood transfusion must receive a patient information leaflet. Trust wide education for all staff on induction, referencing recent audit results and findings.
NICE CG160 - Feverish illness in children (Re-Audit)	Feverish child guideline protocol summary poster in visible place in PAU. Regular education of medical team – Summary of feverish illness guidelines in SHO induction pack. Collect urine (clean catch if possible) in all children under 5 years with fever without obvious source. Urine samples in children under 3 years should be sent for urgent microscopy and culture rather than just dipping
NICE CG149 - Diagnosis and Management of Neonatal Sepsis (Re-Audit)	Educational bundle to increase awareness Doctors at induction Message on the hand over sheet Spot checking "Sepsis Champion" ?Sepsis pack/stickers/printed cards Discharge leaflets made available on PNW as part of discharge check Consultant Board rounds on Hazel Reiterate and check on each baby
Therapeutic cooling for babies with Hypoxic-ischemic encephalopathy (HIE) (Re-Audit)	Ongoing teaching sessions for doctors and nurses to be arranged and cerebral function monitoring training to ensure the areas for improvement are addressed First page of therapeutic hypothermia guidelines to be printed for each baby considered for cooling to be available at the cot side for reference to ensure appropriate group assignment and subsequent management.
Transition of Children from Health Visiting to School Nursing Service (Re-Audit)	Results to be disseminated to Team Leaders and Teams. Health Visitors need to be reminded of the need to enter a high quality, robust record of all children who require handover and ensure this is entered on to Epex. The audit needs to be repeated in this year's 2014/15 format next year
NICE CG154 - Management of ectopic pregnancy (Re-Audit)	Ensure discussions with regard to future fertility take place and are documented at the time of intervention. Appropriate operation can then be arranged if required. Ensure that following 2 Bhcgs and progesterone estimation, the case is discussed with the consultant lead for EPU/EGU or his deputy to ensure management plan in place and documented. To ensure the Unit is compliant with regard to follow up pregnancy tests after slapingectomy and salpingostomy.
NICE CG154 - Management of women diagnosed as having a missed miscarriage (Re-Audit)	All staff should document everything with date, time, clear name. Confirmation whether patients are offered TVS or not and if yes whether declined or not. Confirmation of failed pregnancy to be documented on scan report with 2nd person identified by name even if the patient had previous scan showing viable pregnancy. To record` in the beginning of the history whether the patient was seen by other HCP or self-referred.

NICE CG98 Neonatal Jaundice (Maternity) (Re-Audit)	Audit report to be disseminated and shared with relevant staff. Audit findings to be discussed at PAG meeting to ensure reviewed by both Maternity and Paediatric Teams. Care pathways associated with referral and treatment of inpatients on the Postnatal Ward with Neonatal Jaundice to be discussed at PAG to identify where quality improvements can be made. Reaudit selection to more selective to ensure minimum of three babies at <36 weeks gestation included in order to examine compliance with different care pathways.
Supervisors Maternal Health Records (Oct14-Mar15)	Cascade results of this audit New approach to 'Supervisee Health Records Audit' to be trialled which will act as a complete audit including a scoring system and recommendations for the individual on how to improve their practice based on their score.
Maternity Swab Count Audit (Q4 2014/15)	Disseminate results to relevant staff within Maternity Services. Continue with weekly spot checks and compliance trend monitoring presently reporting any non-compliance identified to the department manager so a 1:1 discussion can be arranged to review case with staff involved.
Maternity Swab Count Audit - Q1 2015/16	Disseminate results to relevant staff within Maternity Services. Continue with weekly spot checks and compliance trend monitoring presently reporting any non-compliance identified to the department manager so a 1:1 discussion can be arranged to review case with staff involved.
Maternity Swab Count Audit - Q2 2015/16	Disseminate results to relevant staff within Maternity Services. Continue with weekly spot checks and compliance trend monitoring presently reporting any non-compliance identified to the department manager so a 1:1 discussion can be arranged to review case with staff involved. Develop paperwork for reporting non-compliance to department manager formally so evidence of actions taken against any non-compliance available.
Maternity Swab Count Audit - Q3 2015/16	Disseminate results to relevant staff within Maternity Services. Continue with weekly spot checks and compliance trend monitoring presently reporting any non-compliance identified to the department manager so a 1:1 discussion can be arranged to review case with staff involved.
Neonatal Readmissions Q1 2015/16	Cascade results of this audit to Midwifery and Paediatric Team. Explore need to admit short stay babies onto system causing potential inaccuracy on HES data.
Maternity NICE Smoking Re-Audit	Report to be disseminated as appropriate and staff informed of the key assurances and areas for development via e-mail. Smoking Cessation Midwife to record any care interventions including discussion related to risks and benefits of Nicotine Replacement therapy on Maternity Medway to ensure improved communication and a more seamless care pathway for the woman. Community Midwifery Team to be reminded of the importance of continuing Carbon Monoxide breath testing at each antenatal visit regardless of specialist service intervention and to record any discussion related to smoking in woman's notes.
Maternity Hypertension Pathway Audit	Cascade results of this audit Audit to be presented to appropriate forums to ensure multidisciplinary review of findings. Develop Postnatal Medical Review Proforma for High Risk women to be completed by the reviewing and/or discharging medic.
Maternity Multiple Pregnancy Pathway Audit	Cascade results of this audit Audit to be presented to appropriate forums to ensure multidisciplinary review of findings. Consider changing data collection tool to reduce the difficulty in data collection in future re-audit. Same criteria to be measured but tool to be developed as 'care pathway audit' and other related GWH policy specific criteria could be added and more examination of patient experience may be possible.
DNA-CPR: Decision making and patient discussion	Raise awareness amongst clinical leads and Resuscitation Officers regarding deficiencies in the involvement of patients, their families and carers in DNA-CPR decision making

Stem Cell Transplant Clinical Coding Audit (JACIE)	The issue of recording stem cell transplant dates on the discharge summary to be communicated at the next JACIE meeting (8th April 2015) and cascaded down to all relevant doctors by Ranjeet Babbra. Verification of secondary codes to be requested from the Clinical Coding Manager (E-mail sent on 24th March 2015).
Nutritional Screening (MUST) Compliance for Inpatients	Incorporate MUST into the new dietetic referral pathway Disseminate findings to department Disseminate findings to nutrition steering group and discuss improvement plan Consider adjusting current training
NICE QS44 Atopic Eczema in Children	Consideration of use of the Children's Dermatology Life Quality Index (CDLQI) for children seen with atopic eczema in paediatric dermatology clinics.
Breakthrough's Service Pledge for Breast Cancer	Re-word the Improvement Goals so they outline a clear, strong commitment that the hospital is going to make to patients.
Conversation Project Pre-audit Teal	Education of Teal Ward staff about 'The Conversation Project' including the rationale, objectives and support available. Present this base-line audit data to help identify areas for improvement. Implement the Conversation Project pilot on Teal Ward. To include the package of interventions that has been established on Jupiter Ward. Re-audit patient records on Teal Ward once the project has been introduced.
Conversation Project Teal (Re-audit)	Please note I have met with Dr Arunalantham to discuss the audit findings and to identify ways in which we can facilitate improvement in terms of patient inclusion, conversation topics discussed and communication with Primary Care. Dr Arunalantham felt that over the coming weeks there are a number of expected changes to staffing within the medical team which will impact on continuity, understanding of project objectives and team capacity. He felt that we should take a step back from work on Teal and consider broadening participation through involvement of other wards. In discussions with other Project team members we have decided to maintain a presence on Teal ward to attempt to sustain the improvements achieved thus far while these changes to staffing occur. Once some stability occurs we will then become more proactive in terms of addressing the areas identified for improvement and working with the ward team to improve the numbers of patients included, the scope of conversations and communication with Primary Care
PACE Patient Questionnaire 2014/15	1. To ensure all patients are able to access a PACE programme within 18 weeks of assessment. 2. To ensure all patients who have been offered a place on the programme are motivated to attend sessions in order to increase completion rates. 3. To ensure all patients have a short term (during programme) and long term (reviewed at follow up sessions) goal. 4. Formalise friends and family feedback via the PALS team. 5. To ensure that patients have a bridging exercise programme to carry out between assessment and programme.
Tissue Viability Pathway Audit 2015	1. The dietician will be asked to improve the compliance with nutritional assessment within the next six months. 2. Each team will be asked to improve the numbers of wounds that are measured or photographed 3. Each team will be asked to improve the use of the core care plan for patients reluctant to accept prescribed care / equipment

Fordingbridge Malnutrition Universal Screening Tool (MUST)	1. The MUST resource pack to be put in all patient notes. 2. A stadiometer should be used to measure height for all patients, and use alternative measurements (e.g. ulna, knee height, demi-span) as required and as per BAPEN recommendations. 3. Leaflets to support patients with diet and particular medical issues to be put into a resource folder for staff to have access to. 4. Nursing staff to receive update MUST training (which is logged) to ensure nutrition screening is carried out correctly. 5. Nursing staff should be informed how to use alternative height measures and mid-upper arm circumference during the training session.
Fordingbridge Malnutrition Universal Screening Tool (MUST) Re-Audit	1. To ensure a full, laminated copy of the MUST resource is in all patient notes. 2. To document whether food records are adequate and whether dietetic referral is needed.
Effectiveness of 1st and 2nd Line Dietary Treatment of IBS (Re-Audit)	1. To continue to monitor patient symptoms and PROM to help guide appropriate and tailored advice for the individual 2. To continue to deliver group education sessions, and evaluating and amending these as necessary based on patient experience, reflection and current recommendations 3. To start developing sessions and resource tools for other patient groups
Sepsis Audit Q4	Ongoing education and training, Meet with neighbouring trusts and Development of a sepsis screening tool for Primary Care Liaise with GP, DN, PN + community staff Reciprocal training and experience between GWH and Paramedic trainees.
2015-16 CQUIN Indicator 2a (sepsis screening) audit report	Agree improvement target with Wiltshire and Swindon CCGs Plan 2015/16 education programme
2015-16 CQUIN Indicator 2a (sepsis screening) audit report	Agree improvement target with Wiltshire and Swindon CCGs Plan 2015/16 education programme
Winter mortality Review 2014/15	DNAR decision making – education of doctors on this via a Grand Round Session Community planning for EOL care – to be raised with EOL group (chaired by Guy Rooney) and with Lorrain Austen to stimulate discussion and debate on improvements to EOL planning in community setting
Postoperative Epidural Analgesia Audit NPSA 2014	There are fewer patients receiving postoperative epidural analgesia therefore nursing staff may struggle to remain competent. This is an important priority for the Pain Specialist nurses who need to identify when additional support is required. The on-call anaesthetist should be aware of patients with epidural infusions on the wards out of hours and at weekends. Investigate why patients are in pain for more than 1 hour and target any common themes
Audiology Patient Satisfaction Survey Q4	To ensure that all staff who send out adult 'first assessment' appointment letters are aware that they must include the information sheet that has been written by the department. Survey questionnaire sheet to be amended to reflect recent changes to service provision.
Audiology Patient Satisfaction Survey May 15	To make staff aware of the new leaflet that has been produced. This should ensure that if patients do not received the initial Choose & Book information sheet they do have this further information. To remind staff at the July staff meeting as to how to advise patients should they wish to make a complaint.
Audiology Patient Satisfaction Survey Nov 15	There appears to be several areas where the department has slipped down by 2%. With a relatively small survey group this could be due to a single patient feeling that the service was not attaining the standard they expected.
Surgical Assessment Unit Pathway Audit	Discussion, Recommendations and actions agreed at the time of reviewing the results: 1. The SAU proforma has since been revised ensuring it is fit for purpose and there is confidence that areas of poor compliance in the clerking section will be improved, for example - a. Removing observations/assessments sections as this is recorded elsewhere b. Removing P-Possum score and include in the EPOCH boarding card – KJ to check c. Replacing sections with more appropriate elements i.e. Sepsis 6 d. Improved clarity around remaining sections i.e. eat/drink/Nil by Mouth (NBM) 2. The introduction of the SAU 'Pack' as previously recommended is considered no longer required as this has been replaced with the revised SAU proforma

	3. Affixing Patient identifiers on forms was highlighted at the time of review and this was an immediate action undertaken by the SAU Lead nurse. There is confidence that this should no longer remain a concern. 4. It was agreed that improvements are required around the property checklist and the clarity around the process. It was agreed that this needs to be taken forward to the next Matron's meeting for discussion. 5. It was discussed and agreed that not all Nursing assessments are required to be undertaken again upon arrival to the ward and this may account for the poor level of compliance identified in the results. 6. It was agreed that timely Consultant review remains an area of improvement. What are the actions around this one?? There was discussion around having a local arrangement in place i.e. for a reg to see a patient and liaise with the cons via phone and document accordingly in the notes – I can't remember what the final outcome of the discussion was. 7. Patient discharge at 12noon (SAFER Bundle standard) is not possible due to the way the wards operate; the tasks that are required before discharge and the time given to complete them. A 2pm discharge is more achievable. – was this going to be set as a standard for Meldon? 8. Feedback from patients was reviewed and discussion; waiting times in SAU and patient expectations remains an issue. It was agreed that notices are to be displayed in SAU to explain clearly to patients that whilst it is endeavoured to see patients as quickly as possible, delays/long wait may be possible. 9. From reviewing the patient experience were there any further actions to implement around privacy, involving patients in decision making and improved discharge planning???

10.8.3 Research & Development (R&D)

The number of patients receiving relevant health services provided or sub-contracted by Great Western Hospitals NHS Foundation Trust in 2015/2016, that were recruited during that period to participate in research approved by a research ethics committee was 794 to end March 2016.

At this point in time, we currently have 73 actively recruiting Department of Health endorsed (portfolio) research projects. We also participate in a number of studies which are more difficult to recruit to given the complex nature of the inclusion and exclusion criteria. We believe it is important to have these studies open in order to give our patients the opportunity of participating in such studies should they be eligible. We run observational studies together with interventional studies. Our reputation in the Commercial sector continues to grow and we are a top recruiter in the UK for one of our cardiology studies.

We continue with our efforts to ensure we recruit the agreed number of patients in the timescales given.

Progress continues to be made across the Trust to promote further research activity. We now have 4.8 Trust-Wide Research Nurses who oversee research in key areas such as Obstetrics and Gynaecology and Cardiology and work to actively engage new areas in research. We also have the equivalent of 3.8 whole time Research Nurses dedicated to Cancer Research.

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

10.8.4 Goals agreed with commissioners

Use of the CQUIN payment framework

A proportion of Trust income in 2015/16 was conditional on achieving quality improvement and innovation goals agreed between the Trust, Swindon Clinical Commissioning Group and Wiltshire Clinical Commissioning Group and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2015/2016 and for the following 12 month period is available electronically are available electronically by request

Financial Summary of CQUIN (£m)									
	Plan	Actual	%	Plan	Actual	%	Plan	Actual	%
	2013-2014			2014-2015			2015-2016		
Total CQUIN	£5.366	£4.353	81%	£5.722	£4.505	78.72%	£6.007	£4.507	75%

10.8.5 Care Quality Commission Registration

A quarterly review of our CQC registration is undertaken across the acute and community sites to ensure that our CQC registration is adequate for the regulated activities undertaken across the sites.

The Great Western Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is “registered” without conditions.

The Care Quality Commission has taken enforcement action against The Great Western Hospital NHS Foundation Trust during 2015/2016. A warning notice was issued in respect of some aspects of regulated activity requiring significant improvement within a defined timeframe Periodic/Special Reviews 2015/2016.

The Trust underwent a planned inspection by the Care Quality Commission (CQC) in September and October 2015. The final report was published in January 2016. The report identifies 28 actions that the Trust must do (including those associated with the warning notice) and 43 that the Trust should do. Additionally, the report identifies areas for improvement that the organisation and local teams would like to address.

10.8.6 Periodic/Special Reviews 2014/15

The Trust has not taken part in any special reviews or investigations by the CQC under section 48 of the Health and Social Care Act 2008 during the reporting period.

By law all trusts must be registered with the CQC under section 10 of the Health and Social Care Act 2008 - to show they are meeting essential quality standards. NHS Trusts have to be registered for each of the regulated activities they provide at each location from which they provide them. The Trust is registered for all of its regulated activities, without conditions. Without this registration, we would not be allowed to see and treat patients.

10.8.7 Full Inspection Outcomes

The Care Quality Commission (CQC) inspected The Great Western Hospitals Foundation Trust as part of its routine inspection programme. The inspection was carried out between 29 September - 2 October 2015 and the final report was published on the 19 January 2016.

Trust staff were described by the CQC as being “committed and passionate”. The ratings for both the acute and community aspects are summarised as follows:

Our Ratings for the Great Western Hospital

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

Our Ratings for Community Health Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for children, young people and families	Good	Good	Outstanding	Outstanding	Good	Outstanding
Community health services for adults	Good	Good	Good	Good	Good	Good
Community health inpatient services	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

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

The CQC did raise concerns about the location, design and layout of the Emergency Department Observation Unit, combined with inadequate staffing levels and staff training, presents risks to patients and staff in the Emergency Department (ED) and issued a Warning Notice on 1st December 2015 This service was rated as "requires improvement" within the full inspection report received in January 2016.

In addition 6 Compliance Actions were made, as follows;

Type	Date	Health and Social Care Act 2008 Regulation
Compliance Action	19/01/2016	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care
Compliance Action	19/01/2016	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect
Compliance Action	19/01/2016	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
Compliance Action	19/01/2016	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment
Compliance Action	19/01/2016	Regulation 17 HSCA (RA) Regulations 2014 Good Governance
Compliance Action	19/01/2016	Regulation 18 HSCA (RA) Regulations 2014 Staffing

10.8.8 Data Quality

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

Great Western NHS Foundation Trust submitted records during April 2015 to February 2016 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number was:

- 99.7% for admitted patient care
- 99.9 for outpatient care and
- 89% for accident and emergency care.

Which included the patient's valid General Medical Practice Code was:

- 100%for admitted patient care;
- 100% for outpatient care; and
- 99.5% for accident and emergency care.

Great Western NHS Foundation Trust will be taking the following actions to improve data quality
A role with in the informatics team has responsibilities to monitor these quality items.

We are currently developing a Data Quality dashboard which will allow us to monitor these areas prior to submission to allow corrective action before submissions

10.8.9 Information Governance Tool Kit Attainment Levels

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

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. These assessments and the information governance measures themselves are regularly validated through independent internal audit. The main Toolkit headings are:

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

The Trust's Information Governance Assessment Report overall score for 2015/2016 was 77% and was graded 'Not Satisfactory' ('red'). The 'Not Satisfactory' rating was solely due to a failure to reach the required level in respect of one new requirement, i.e. the requirement for at least 95% of all employees and volunteers to have completed their Information Governance 'annual refresh' training within the 2015/2016 year (the actual training figure being 88%). It should be noted that the Trust has produced an Improvement Plan to rectify this deficiency during 2016/2017, and that 100% of new staff receive the appropriate Information Governance training when they join the Trust.

Clinical Coding Error Rate

10.9 Explanatory Note of 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 were selected. The samples are therefore small and the results of the audit should not be extrapolated further than the actual sample audited.

The Trust was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.
However an Information Governance coding audit was undertaken, the error rates reported in this latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

Auditor	Primary Diagnosis	Secondary Diagnosis	Primary Procedure	Secondary Procedure
Information Governance	95.0%	87.9%	95.6%	91.3%

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

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

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

- General Medicine
- General Surgery
- Obstetrics
- Paediatrics
- Trauma & Orthopaedics

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

Reporting against Core Indicators

		2010/ 2011	2011/ 2012 Data includes Community	2012/ 2013	2013/ 2014	2014/ 2015	2015/ 2016	National Average	What does this mean	Trusts with the highest and lowest score	Source of measure	Definition
1 - Reducing Healthcare Associated Infections	**MRSA Bed Days as well** *provisional as at 02/05/14	3	2	2	5	2	2	0.96*	Zero is aspirational	Low- 0; High- 11	IP&C	National definition
	C.diff	40	17	33	23	19* *combined previously acute/ community split	30 Trust-wide	N/A	Zero is aspirational	Low-0; High- 121	IP&C	National definition
	C.diff 100,000 bed days*	20.1*	7.3*	13.4*	12.5*	9.60	14.7	15.01	Lower is better	Regionally Low:8.71 High: 28.02	PHE	National Definition
2 - Patient Falls in Hospital resulting in severe harm		15	17	16	23	16	13	Not available	Lower is better	--	IR1's	NPSA
3 – Reducing Healthcare Acquired Pressure Ulcers		40	31	28	28 Category III & Category IV	51 Category III & Category IV	8 Category III 6 Category IV	4% incidence	Lower is better	--	IR1's	National Definition (from Hospital database)
4 – Percentage of VTE Risk Assessments completed		85.1%	92.7%	95.3%	95.5%	97.1%	98.3	90%	Higher number better	Low - 91.3; High - 100	Crescendo nursing care plan and manual data collection from LAMU, Day Surgery, and ICU	National Definition (from Hospital database)
5 – Percentage of patients who receive appropriate VTE Prophylaxis		90% (No aud for Surgical actioned in Q2 & Q3 therefore YTD based o Medical only)	94.5%	93.9% (Apr-Oct)	95%	91.6%	95.2	N/A	Higher number better	--	One day each month whole ward audit for one surgical ward and one medical ward	National Definition (from Hospital database)

		2010/ 2011	2011/ 2012 Data includes Community	2012/ 2013	2013/ 2014	2014/ 2015	2015/ 2016	National Average	What does this mean	Trusts with the highest and lowest score	Source of measure	Definition
6 – Never Events that occurred in the Trust		0	3	3	4	2	3	NHS England 2014-15 Average	Zero tolerance	Highest - 9 Low - 0	IR1's	NPSA

								2.16				
7 – Mortality Rate (HSMR)	**HSMR**	97.9	106.2	91.8	97.3	90.3	89.0	100	Lower than 100 is good	Low -74.2; High -128.8	Dr Foster	National NHS Information Centre
8 – Early Management of deteriorating patients - % compliance with Early Warning Score	**Early Warning Score (Adults)**	93% GWH only	96% GWH only	91%	95% April – Dec 9 months	90%	85% April – Dec 9 months	Not available	Higher number is better	--	Audit	Audit criteria (50 patients per month)
	Paediatric Early Warning Score (Children)	--	--	74.2%	87.75%	92.25% Average yearly compliance	85% April - Sept 6 months	N/A	Higher number is better	--	Audit	Audit criteria (5 patients per month)
10 – Percentage of Nutritional Risk Assessments	**Using MUST**	70% Acute only	87.8% Combined	84%	82%	81%	Currently not available	Not available	Higher % is better	--	No longer Crescendo	National definition
11 – Were you involved as much as you wanted to be in decisions about your care and treatment?		48.1%	46.9%	51%	53.2%	51.4%	51.8%	54.8%	Higher is better	Low: 6.1 High: 9.2 GWH: 7.1	Picker Survey	National definition
12 – Did you find someone on the hospital staff to talk to about your worries and fears?		23%	22.5%	37%	37.1%	28.6%	33.0%	38.4%	Higher is better	Low: 4.3 High: 8.2 GWH: 4.9	Picker Survey	National definition
13 – Were you given enough privacy when discussing your conditions or treatment?		68.5%	66.8%	73%	70.8%	74.2%	72.6%	72.7%	Higher is better	Low: 7.5 High: 9.4 GWH: 8.5	Picker Survey	National definition
14 – Did a member of staff tell you about medication side effects to watch for when you went home?		22.9%	24.3%	30%	33.7%	32.1%	29.8%	40%	Higher is better	Low: 3.7 High: 7.6 GWH: 4.3	Picker Survey	National definition
15 – Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?		65.6%	66.6%	67%	67.2%	66.2%	68.0%	69.8%	Higher is better	Low: 6.4 High: 9.7 GWH: 7.6	Picker Survey	National definition
16 – Patient Reported Outcome Measures (Average Health Gain [score])	**Varicose Vein surgery**	--	--	100%	100%	90.9%	100% HSCIC Provisional data	80%	Higher is better	Not available (more than one Contractor for this service)	DoH/ HSCIC	National Definition
	Groin Hernia surgery	--	--	96.9%	100%	57.6%	42.9% HSCIC Provisional data	80%	Higher is better		DoH/ HSCIC	National Definition
	Hip Replacement surgery (Oxford Hip Score)	--	--	96%	98.5%	61.5%	93.9% HSCIC Provisional data	80%	Higher is better		DoH/ HSCIC	National Definition
	Knee Replacement Surgery (Oxford Knee Score)	--	--	95.6%	97%	94.4%	97% HSCIC Provisional data	80%	Higher is better		DoH/ HSCIC	National Definition

		2010/11	2011/12 Data includes Community	2012 / 13	2013/14	2014/15	2015/16	National Average	What does this mean	Trusts with the highest and lowest score	Source of measure	Definition
17 – Readmissions – 30 days		n/a	7.4%	8.1%	7.9%	9.4%	9.7	Local target (7.1%)	Lower is better	--		National Definition
18 – Readmissions – 28 days		6.9%	7.3%	7.9%	7.7%	9.2%	9.6	SW Region 6.9%	Lower is better	Low: 5.12; High:10.91	Dr Foster	Dr Foster
18 – Re-admissions 28 days **Ages 0-15** **Ages 16+**					9% 7.5%	8.5% 9.2%	9.02 10.02	Dr Foster	Lower is better	0-15 yrs: Low: 0.8; High: 15.8 16+ yrs: Low: 5.0; High: 11.1	Dr Foster	Dr Foster
19 - SHMI – The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the trust for the reporting period		22.5 %	20.6 %	18.4 %	26.0 %	26.5 %	31.7 % Oct 14-Sept 15 Most recent data available	25.3%		Low:0; High: 49.4	HSCIC	National Definition
20 - The number and where available, rate of patient safety incidents and the number and percentage of such patient safety incidents that resulted in severe harm or death	**Number of Incidents per 100 Bed Days**	3.32	4.05	4.22	4.55	4.98	4.9	--	Lower is better	--	Informatics & Clinical Risk	
	Number of Patient Safety Incidents per 100 Bed Days	2.45	2.93	3.13	3.00	3.07	2.8	--	Lower is better	--	Informatics & Clinical Risk	
	Number of Incidents resulting in Severe Harm or Death per 100 Bed Days	0.03	0.04	0.04	0.03	0.04	0.01	--	Lower is better	--	Informatics & Clinical Risk	
	Percentage of Combined Severe Harm and Death	0.93 %	1.08 %	0.85 %	0.56 %	0.80 %	0.55%	--	Lower is better	--	Informatics & Clinical Risk	

*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.

Other Information

This section provides information about other services we provide, through a range of selected quality measures. These measures have been selected to reflect the organisation and shows data relevant to specific services as well as what our patients and public tell us matters most to them.

10.10 Performance against key national priorities

An overview of performance in 2015/16 against the key national priorities from the Department of Health's Operating Framework is set out below. Performance against the relevant indicators and performance thresholds are provided.

Indicator	2010/ 2011 GWH	2011/ 2012 Trust	2012/ 2013 Trust	2013/ 2014 Trust	2014/ 2015 Trust	2014/ 2015 Target	2015/ 2016 Trust	2015/2016 Target	Achieved/ Not Met
Clostridium Difficile - meeting the *Clostridium Difficile* objective	40	19	33	23	17 Acute 19 All	28 or less (Acute)	25 Acute 30 All	20 or less (All)	Not Achieved
MRSA - meeting the MRSA objective	3	2	2	5	2	0 or less Contract Monitor de minimis 6	1	0 or less Contract Monitor de minimis 6	Monitor de minimis achieved
Cancer 31 day wait for second or subsequent treatment – surgery - 94%	98.5%	98.4%	98.4%	98.4%	99.0	94.0%	99.30%	94.00%	Achieved
Cancer 31 day wait for second or subsequent treatment - anti cancer drug treatments – 98%	100%	100%	100%	100%	99.7	98.0%	99.70%	98.00%	Achieved
Cancer 62 Day Waits for first treatment from urgent GP referral for suspected cancer – 85%	92.4%	89.3%	90.0%	89.0%	88.4	85.0%	87.70%	85.00%	Achieved
Cancer 62 Day Waits for first treatment from NHS cancer screening service referral - 90%	100%	98.4%	96.2%	98.9%	98.4	90.0%	98.10%	90.00%	Achieved
Cancer 31 day wait from diagnosis to first treatment	99.0%	98.7%	98.1%	98.8%	98.6	96.0%	98.00%	96.00%	Achieved
Cancer 2 week wait from referral to date first seen, all urgent referrals (cancer suspected) – 93%	97.0%	97.1%	95.3%	94.7%	94.0	93.0%	94.30%	93.00%	Achieved

Indicator	2010/ 2011 GWH	2011/ 2012 Trust	2012/ 2013 Trust	2013/ 2014 Trust	2014/ 2015 Trust	2014/ 2015 Target	2015/ 2016 Trust	2015/2016 Target	Achieved/ Not Met
Cancer 2 week wait from referral to date first seen, symptomatic breast patients (cancer not initially suspected) – 93%	97.2%	97.1%	96.0%	95.6%	96.8	93.0%	95.50%	93.00%	Achieved
Maximum time of 18 weeks from point of referral to treatment in aggregate, admitted patients	95.1%	96.1%	95.3%	94.9%	88.6%	90.0%	82.5%	90%	Not Met
Maximum time of 18 weeks from point of referral to treatment in aggregate, non-admitted patients	97.9%	98.2%	98.3%	96.3%	95.6%	95.0%	89.2%	95%	Not Met
Maximum time of 18 weeks from point of referral to treatment in aggregate, patients on incomplete pathways	--	--	96.1%	94.8%	90.5%	92.0%	88.9%	92.0%	Not Met
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge - 95%	97.4%	97.0%	95.6%	94.1%	91.9%	95.0%	91.1%	95.0%	Not Achieved
Data completeness community services: referral to treatment information	--	--	80.0%	88.2%	88.5%	50.0%	98%	50.0%	Achieved
Data Completeness community service information: referral information	--	--	80.0%	81.5%	81.0%	50.0%	96%	50.0%	Achieved
Data completeness community services information: treatment activity information	--	--	85.0%	96.0%	98.2%	50.0%	100%	50.0%	Achieved

10.11 Statements

10.11.1 Statement from the Council of Governors dated 17 May 2016

The Governors are of the opinion that the Quality Account is a reasonable representation of the Trust's performance as presented to the governors over the past year. The Governors have acknowledged that unfortunately the Trust did not achieve some targets, notably 90.3% of persons attending A & E were seen within 4 hours against the target of 95%. This is a further decrease against the 91.9% attained in the previous year however Governors consider these figures to be consistent with those of the majority of other Trusts and are reflective of the pressures brought about by increased attendance. The Governors are aware that the Trust is continuing to take action to address this issue and the consequential effects on other performance indicators nonetheless we are also aware that several proposed actions are dependent on partner organisations delivering on their commitments. Within the Quality Report the Trust has reported a number of achievements such as the reduction in the occurrence of avoidable pressure ulcers within acute care, a reduction in Sepsis related deaths and a below average mortality rate. These achievements combine to help achieve an improving experience for our service users and are noted by the Governors.

Margaret White
Lead Governor on behalf of the Council of Governors

10.11.2 Statement from Swindon Clinical Commission Group dated 13 May 2016

NHS Swindon Clinical Commissioning Group (CCG) has reviewed the information provided by Great Western Hospital NHS Foundation Trust in its 2015-2016 Quality Account. In so far as we have been able to check the factual details, our view is that the Quality Account is materially accurate and is presented in the format required by the NHS England 2015/2016 presentation guidance.
The Quality Account provides information across a wide range of quality measures which are monitored through regular Clinical Quality Review Meetings and gives a comprehensive view of the quality of care provided by the Trust, as set out within the three quality domains of safe care, effective care and patient experience.

Safe Care
Swindon CCG fully supports the Trust's commitment to ensuring quality and safety of care is at the heart of everything it does. During 2015/16 a number of quality improvement initiatives aimed at preventing avoidable harm have been successfully implemented through the Sign up to Safety scheme. The Trust has evidenced key achievements such as the reduction of pressure ulcers, harm from falls and mortality. NHS Swindon CCG will continue to work collaboratively with the Trust to deliver quality improvement initiatives such as the Swindon Wide Falls and Bone Health Collaborative and the national Sepsis Commissioning for Quality and Innovation (CQUIN) scheme during 2016/17 in order to improve patient care and ensure better outcomes.

During 2016/17, NHS Swindon CCG will continue to support the Trust to learn from and deliver improvements in response to clinical incidents, including serious incidents and Never Events. It is recognised that the Trust had 3 Never Events during 2015/16 and related action plans are being closely scrutinised to prevent recurrence of these patient safety incidents which should not happen. The CCG support the Trust's approach in building quality improvement capability across the Trust to move towards a more proactive process to achieve sustainable improvement.
NHS Swindon CCG acknowledges the findings of the CQC inspection completed during 2015/16. It was pleasing to see that staff were found to be "committed and passionate" and providing good end of life care and maternity services. The improvements that the Trust must deliver, particularly related to the warning notice issued for ED will be closely monitored through the Trust's CQC action plan and through the three quality improvement work streams that have been established related to mental health, effective pathways of care and learning and quality improvement.

Effective Care
A skilled workforce with robust leadership is key to delivering services safely and effectively. NHS Swindon CCG notes the continued challenges in relation to availability of staff and the continued need to focus on recruitment and retention of staff. NHS Swindon CCG will continue to monitor medical, nursing, midwifery and other clinical skill mixes during 2016/17 in light of the impact that staff shortages have on patient experience, safety and outcomes. A national CQUIN to support the Health and Wellbeing of staff will be implemented during 2016/17.
NHS Swindon CCG recognises the challenges in demand faced by the trust during 2015/16, particularly relating to waiting times in A&E and the 18 week referral to Treatment (RTT). NHS Swindon CCG will continue to work

together with the Trust to deliver improvements in compliance to the national targets through the monitoring and delivery of remedial action plans. During 2016/17 the CCG will focus quality visits in these specific areas to ensure patient safety and experience is maintained.

Patient Experience
The Trust has set out a number of feedback mechanisms aimed at collating patient experience feedback.
During 2015/16, the response rate for the Friends and Family Test has fallen significantly. NHS Swindon CCG will continue to monitor the response rate during 2016/17 to ensure this is improved to capture vital patient comments and appropriately acted upon to improve patient experience.
When comparing year on year data, the number of formal complaints received by the Trust during 2015/16 has remained constant. NHS Swindon CCG recognises the challenges faced by the Trust in meeting complaint response times and implementing the actions that arise as a result of complaints. This will be closely monitored through CQRM's in 2016/17, with a continued focus on trends and themes.

NHS Swindon CCG fully support the Trust's plan to develop a Patient Experience Strategy to improve how they work will work in partnership with patients, carers and their family and deliver improvements to patient experience and would encourage the Trust to ensure that FFT response rates and complaint response times are addressed as part of the work plan.
Swindon CCG is committed to ensuring continued collaborative working with Great Western Hospitals NHS Foundation Trust in order to achieve these goals and support the provision of high quality care across the whole health and social care economy.

Gill May, Executive Nurse
NHS Swindon CCG

10.11.3 Statement from Healthwatch, Swindon and Healthwatch Wiltshire dated 10 May 2016.

This statement is provided on behalf of Healthwatch Wiltshire and Healthwatch Swindon. The role of Healthwatch is to promote the voice of patients and the wider public in respect to health and social care services and we welcome the opportunity to comment.

Local Healthwatch have worked closely with the Trust over the previous year as part of their on-going engagement work and look forward to continuing this work going forward. We welcome the proposed development of a patient experience strategy and would welcome the opportunity to be involved.

We are concerned that the total number of falls has not reduced over the past year. However, we note that the harm caused by falls has reduced. We welcome the introduction of a number of initiatives that aim to reduce the number and severity of falls and to promote learning across the trust. We hope to see progress made towards meeting the proposed target of a 20% reduction in the rate of falls and avoidable harm by 2018.

We welcome the reported reduction in the number of avoidable pressure ulcers across acute and community settings. We would like to see the maintenance of this downward trajectory over the coming year.

We are concerned to see that the Trust has exceeded the National mandated level of cases of *C. Difficile*. However, we note the introduction of a number of initiatives that seek to improve learning and reduce the numbers of infections over the coming year.

We are pleased that the work carried out by the Trust to reduce mortality rates, has been successful and that the Trust now has one of the lowest hospital standardised mortality ratio rates in Southern England. We were concerned however that the Trust received an alert for the number of deaths of those with hip fracture. However, we are reassured that following swift actions including improved measures to recognise and treat sepsis, the mortality rate in these patients is already improving.

We welcome the work that the Trust has done to improve the care and experience of those with dementia, their families and unpaid carers. In particular, the creation of dementia friendly environments and the introduction of a new carer feedback survey. We also welcome the proposed introduction of a dementia care pathway and will be monitoring the outcomes of this in relation to patient/relative experience. We would like to see the commitment to dementia continue and also the increased involvement of patients, their relatives and unpaid carers in the development of any new initiatives.

We are concerned to see that the Trust achieved only 90.3% of patients having a maximum of 4 hours wait in the emergency department (ED). We are very concerned about the increase in12 hour breaches in March 2016 and the potential impact on patient safety. However, we note the measures being put in place to achieve an improvement in these times. As ED was an area of particular concern in the recent Care Quality Commission Inspection, we will continue to monitor progress with these targets over the coming year and review impact on other services within the Trust.

We are pleased that 90-95% of patients say that they would be likely to recommend the services of the Trust to their friends and family. In addition, we see that feedback from patients has been used to drive service improvements. However, the completion rate of the Friends and Family Test is low (11%). We note that the Trust has plans in place to achieve a higher completion rate that includes the introduction of real-time feedback mechanisms. We will continue monitor the situation over the coming year.

As Local Healthwatch we know that finding easily accessible, good quality information is a major issue for local people. Therefore, we are pleased that the Trust is reviewing all of their patient information with the help of lay readership panels. We would be happy to assist with this review process.

We note improvements in the handling of issues and concerns at an early stage to avoid escalation through the formal complaints process. Healthwatch Wiltshire welcomes the participation of the Trust's PALS team in our new complaints Liaison group that seeks to bring together managers from all local trusts, Wiltshire CCG and advocacy services with the aim of sharing good practice.

According to the National Inpatient Survey, only 33% of patients said that they found someone to talk about their worries and fears and only 29.8% stated that a member of staff had informed them of possible medication side effects. This raises concerns for patient wellbeing and we would like to see more done improve on these scores. We would also like to see an increase in the patients who reported feeling involved in care and treatment decisions (currently 51.8%).

The staff survey shows that 69% of staff agreed/strongly agreed that they would be happy with the standard of care their organisation provided if a friend/relative needed treatment. However, 79% of staff reported working extra hours.

Access for traffic to the hospital remains a perennial problem and we are hopeful that the ongoing work to promote alternatives to visiting ED and the development of an additional 400 spaces will go some way to alleviate this.

We recognise that the Trust has had a challenging couple of years both financially and as a result of the required actions put in place by the Care Quality Commission and Monitor following the CQC's inspection of the Trust in September/October 2015. We very much hope that the work being done impacts positively to reduce the pressures on staff and hence improve the experience of care for patients. We will be closely monitoring the progress of the Trust and will continue to raise concerns should we feel that the quality of care is being compromised.

Dr. Sara Nelson
Information and Communication Manager

10.11.4 Statement from Swindon Health Overview & Scrutiny Committee dated 17 May 2016

At the time of submission of the Great Western Hospital's NHS Foundation Trust Annual Quality Account Report, Swindon Health Overview & Scrutiny Committee was appointing a new Chair of their committee. Due to this key vacancy Swindon Health Overview & Scrutiny Committee informed the Trust that they have been unable to provide a statement of Assurance on Great Western Hospitals NHS Foundation Trust Quality Account Report for 2015/16.

10.11.5 Statement from Wiltshire Health Overview & Scrutiny Committee dated 17 May 2016

The Health Select Committee has been given the opportunity to review the draft Quality Account for Great Western Hospital Trust 2015/16.

The Committee has not undertaken any detailed work on the Trust this year. However, we have scheduled an item for its meeting on 27th September to consider:

- The CQC inspection report of the Trust, following the inspection undertaken in September 2015, the result of which was a grading of 'Requires Improvement'

- The Trust's improvement plan for addressing issues identified by the CQC.

Cllr Chuck Berry, Chairman
Wiltshire Health Select Committee

10.11.6 Statement from Wiltshire Clinical Commissioning Group

Wiltshire Clinical Commissioning Group (CCG) has reviewed the Great Western Hospital (GWH) Quality Accounts for 2015/2016. In so doing, the CCG reviewed the Account in light of key intelligence indicators and the assurances sought and given in the monthly Clinical Outcomes and Quality Assurance (CQRM) meetings attended by the GWH and Commissioners. This evidence is triangulated with information from Quality Assurance Visits to GWH which encompass clinician to clinician feedback and reviews. Wiltshire CCG therefore confirms that the Quality Account appears to be accurate and fairly interpreted.

It is the view of Wiltshire CCG that the 2015/16 Quality Account reflects the ongoing commitment of GWH to quality improvement by tackling key risks and areas of development in a focused and collaborative way. The Account summarises the achievements against quality priorities throughout the year and the CCG acknowledges the progress made by the Trust in these areas. Linked to the 15/16 Quality Priorities, the Trusts 'Sign Up to Safety' improvement plan is on target. The CCG commends the Trust's significant progress in reducing sepsis related deaths which was supported by a 'Sepsis CQUIN' in 2015/16, and congratulates the GWH sepsis team on their National Patient Safety Award in Dec 2015.

The Trust has rightly identified their continued 'better than expected' Hospital Standardised Mortality Ratio (HSMR) as an area of strong performance. As a Trust with one of the lowest HSMR scores in Southern England, the CCG will work with the Trust and the National Mortality Review to identify and share more widely the Trust's good practice in this area.

The CCG recognises the ongoing work by the Trust to monitor and improve patient experience and key to good patient experience are satisfied and engaged staff. The Trust has rightly identified some significant areas of improvement over the year and other areas for further action; this is inclusive of bullying, harassment and whistleblowing. Of note is the reported improvement in management communication.

The final report of the Trust's CQC inspection was published in January. The CCG will work with the Trust and co-commissioners to review and monitor progress against the areas identified within the Trust's formal action plan. The CCG is assured that the Quality Priorities set by the Trust for 16/17 align both to the areas we would wish to see addressed and to the key findings within the CQC report.

The CCG confirms that we believe the accounts are accurate in regard to the service provided to Wiltshire patients and will support the Trust in 2016/17 to embed learning and achieve the identified Quality Priorities. The CCG would be keen to see the GWH further develop its Quality Account into 2016/17 to include more information on work to ensure patient safety during periods of high demand and challenge, collaborative working with community and primary health providers, actions to specifically address patient and staff feedback, and how improvement work is linked to the NHS Outcomes Framework.

Yours sincerely

Deborah Fielding
Accountable officer, Wiltshire Clinical Commissioning Group

10.12 2015/16 Statement of Directors' Responsibilities in Respect on the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

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 NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
- Board minutes and papers for the period April 2015 to 23 May 2016
- Papers relating to Quality reported to the board over the period April 2015 to 23 May 2016
- Feedback from Swindon commissioners dated 13/05/2016
- Feedback from Wiltshire Commissioners dated 20/05/16
- feedback from governors dated 17/05/2016
- Feedback from local Healthwatch organisations dated 10/05/2016
- feedback from Overview and Scrutiny Committee dated 17/05/2016
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, reported to Board monthly.
- The [latest] national patient survey 07/10/2015
- the [latest] national staff survey 09/10/2015
- The Head of Internal Audit's annual opinion over the trust's control environment dated12/05/16

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 manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

23 May 2016 Date.....Chairman

23 May 2016 Date.....Chief Executive

11 Independent Auditor's Report to the Council of Governors of Great Western Hospitals NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of Great Western Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Great Western Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2016 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2016 subject to limited assurance consist of the following two national priority indicators (the indicators):

- A&E: maximum waiting time of four hours from arrival to admission / transfer / discharge; and
- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period.

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 and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed Guidance for External Assurance on Quality Reports 2015/16 ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance and the six dimensions of data quality set out in the Guidance.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and supporting guidance 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 the FT ARM 2015/16 and other documents, listed below:

- board minutes and papers for the period April 2015 to May 2016;
- papers relating to quality reported to the board over the period April 2015 to May 2016;
- feedback from commissioners;
- feedback from governors;
- feedback from local Healthwatch organisations;
- feedback from Overview and Scrutiny Committee;
- the Group's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the 2015 national patient survey, received February 2016;
- the 2015 national staff survey, received March 2016;
- the 2015/16 Head of Internal Audit's annual opinion over the Group's control environment;
- the CQC Report, released in January 2016: and
- the latest CQC Intelligent Monitoring Report.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Great Western Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2016, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Great Western Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

1. We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Great Western Hospitals NHS Foundation Trust.

Basis for qualified conclusion

As set out in the Statement on Quality from the Chief Executive of the Foundation Trust on page 140 of the Group's Quality Report, the Group currently has concerns with the accuracy of data of the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period (RTT) indicator.

The Group has reported data for the period ending 31 March 2016 for the RTT indicator in line with the national guidance. However, the Group were unable to provide detailed data from April 2015 to October 2015 to allow for sample testing over the whole period. As a consequence we are unable to conclude on the completeness, reliability, validity and accuracy of the RTT indicator included in the published Quality

Report. As a result of the issues described above we are unable to conclude that nothing has come to our attention that causes us to believe that the RTT indicator for the year ended 31 March 2016 has been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance and the six dimensions of data quality set out in the Guidance.

Qualified conclusion

Based on the results of our procedures, except for the effects of the matters described in the 'Basis for qualified conclusion' section above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the remaining indicator in the Quality Report subject to limited assurance (A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge) has not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance and the six dimensions of data quality set out in the Guidance.

Jonathan Brown
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
KPMG
100 Temple Street
Bristol
BS1 6AG

26 May 2016

12 Glossary of Terms

Abbreviation	Definition
A&E	Accident & Emergency
AHSN	Academic Health Science Network
AKI	Acute Kidney Injury
ANTT	Aseptic non-touch technique
AO	Accounting Officer
BARS	Blood Audit and Release System
C.diff	Clostridium Difficile - Bacteria naturally present in the gut
Carillion	The company that owns and runs the fabric of the site
CAUTIs	Catheter Associated Urinary Tract Infections
CCG	Clinical Commissioning Groups
CETV	Cash Equivalent Transfer Value
CLRN	Comprehensive Local Research Network
CNST	Clinical Negligence Scheme for Trusts
CO^2e	Carbon Dioxide Equivalent (standard unit for measuring carbon footprint)
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation Payment
Crescendo	An NHS IT system
CUSUM	Cumulative Sum Control Chart
D&O	Diagnostics & Outpatients
DNA – CPR	Do Not Attempt – Cardiopulmonary Resuscitation
DNAR	Do Not Attempt Resuscitation
DTOC	Delayed Transfer of Care
DOC	Duty of Candour
DVT	Deep Vein Thrombosis
E&D	Equality & Diversity
ED	Emergency Department
EDD	Estimated Date of Discharge
EDS	Equality Delivery System
EPF	Employee Partnership Forum
EPMA	Electronic Prescribing and Medicines Administration
FFT	Friends and Family Test
GWH	Great Western Hospitals NHS Foundation Trust
HAT	Hospital Acquired Thrombosis
HCAI	Healthcare Associated Infections
HDU	High Dependency Unit

Abbreviation	Definition
HMIP	Her Majesty's Inspector of Prisons
HPA	Health Protection Agency – now NHS England
HSCA	Health & Social Care Act
HSCIC	Health & Social Care Information Centre
HSMR	Hospital Standardised Mortality Rates
ICHD	Integrated Community Health Division
IP&C	Infection, Prevention & Control
JACIE	Joint Accreditation Committee
KLOE	Key Lines of Enquiry
LAMU	Linnet Acute Medical Unit
LCRN	Local Clinical Research Network
LQAF	Library Quality Assurance Framework
LSCB	Local Safeguarding Children's Board
MCQOC	Matrons Care Quality Operational Group
MFF	Market Factor Forces
MHRA	Medicines and Healthcare products Regulatory Agency (MHRA)
MIU	Minor Injuries Unit
Monitor	The NHS Foundations Trust's Regulator now part of NHS Improvement
MRSA or MRSAB	Methicillin-Resistant Staphylococcus Aureus Bacteraemia - a common skin bacterium that is resistant to a range of antibiotics
MUST	Malnutrition Universal Screening Tool
NEWS	National Early Warning System
NHS	National Health Service
NPSA	National Patient Safety Agency
NBM	Nil by mouth
NED	Non-Executive Director
NEWS	National Early Warning System
NHS	National Health Service
NHSG	Nutrition & Hydration Steering Group
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	Polymerase chain reaction (a method of analysing a short sequence of DNA or RNA)
PDSA	Plan, Do, Study, Act
PE	Pulmonary Embolism

Abbreviation	Definition
PEAT	Patient Environment Action Teams
PLACE	Patient Led Assessment of the Care Environment
POPPI	Projecting Older People Population Information
PROMS	Patient Recorded Outcome Measures
PSQC/PSC	Patient Safety & Quality Committee – now the Patient Safety Committee
PUs	Pressure Ulcers
PURAT	Pressure Ulcer Risk Assessment Tool
QI	Quality Improvement
RAP	Remedial Action Plan
R&D	Research & Development
RCA	Root Cause Analysis
RCM	Regulatory Control Manager
RCOG	Royal College of Gynaecologists
REACT	Rapid Effective Assistance for Children
RR	Relative Risk
RTT	Referral to Treatment
SAFE	Stratification and Avoidance of Falls in the Environment
SAFER	Patient Flow Bundle
SBAR	Situation, Background, Assessment, Recommendation
SEQOL	Social Enterprise Quality of Life (an NHS organisation)
SHMI	Summary Hospital Level Mortality Indicator
SHOUT	Sepsis, Hypovolemia, Obstruction, Urine Analysis, Toxins
SMART	Smart, Measureable, Attainable,, Realistic, Timely
SOPs	Standard Operating Procedures
SOS	Swindon Outreach Scoring System
SSKIN	Surface Skin Keep Moving Incontinence Nutrition
SSNAP	Sentinel Stroke National Audit Programme
STEIS	Strategic Executive Information System
SWICC	South West Intermediate Care Centre
S&TP	Sustainability & Transformation Plan
TEP	Treatment Escalation Plan
TV	Tissue Viability
TVNC	Tissue Viability Nurse Consultant
TVSNs	Tissue Viability Specialist Nurses
UTI	Urinary Tract Infection
VAP	Ventilated Acquired Pneumonia
VTE	Venous Thromboembolism
WCH	Wiltshire Community Health (New joint venture 2016 to provide community services)
WCHS	Wiltshire Community Health Service

Abbreviation	Definition
WHO	World Health Authority
WRES	Workforce Race Equality Standard

13 Foreword to the accounts

13.1 Foreword to the accounts for the year ending 31 March 2016

These accounts for the period ended 31 March 2016 have been prepared by Great Western Hospitals NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 of the National Service Act 2006 in the form than Monitor, the Independent Regulator of NHS Foundation Trusts, with the approval of the Treasury, has directed.

Signed

Nerissa Vaughan
Chief Executive

23 May 2016

Great Western Hospitals NHS Foundation Trust
Accounts for the year ended 31 March 2016

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2016

		Group		Trust	
		Year Ended	Year end	**Year Ended**	Year end
		31 March	31 March	**31 March**	31 March
		2016	2015	**2016**	2015
	Notes	**£000**	£000	**£000**	£000
Operating Income from continued operations	3 - 4	**310,382**	300,764	**309,706**	300,396
Operating Expenses of continued operations	5	**(306,410)**	(294,438)	**(306,117)**	(293,889)
Operating surplus/(deficit) from continued operations		**3,972**	6,326	**3,589**	6,507
Finance Costs					
Finance income	10	**75**	28	**32**	28
Finance expense - financial liabilities	11	**(12,701)**	(14,164)	**(12,701)**	(14,164)
Finance expense - unwinding of discount on provisions		**(20)**	(36)	**(20)**	(36)
Public Dividend Capital Dividends payable		**(644)**	(979)	**(644)**	(979)
Net finance costs		**(13,290)**	(15,151)	**(13,333)**	(15,151)
Movement in fair value of investments		**(39)**	54	**0**	0
SURPLUS/(DEFICIT) FOR THE YEAR		**(9,357)**	(8,771)	**(9,744)**	(8,644)
Total comprehensive income for the year		**(9,357)**	(8,771)	**(9,744)**	(8,644)
Note:					
(Deficit) for the year as shown above		**(9,357)**	(8,771)	**(9,744)**	(8,644)
Adjust for (surplus)/deficit on Charitable Funds consolidation		**(387)**	127		
(Deficit) before impairments and consolidation of Charity		**(9,744)**	(8,644)	**(9,744)**	(8,644)

All income and expenditure is derived from continuing operations.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2016

	Notes	Group 31 March 2016 £000	31 March 2015 £000	Trust 31 March 2016 £000	31 March 2015 £000
Non-Current Assets					
Intangible assets	12	**2,033**	2,389	**2,033**	2,389
Property, Plant and Equipment	13	**201,857**	204,040	**201,857**	204,040
Other investments	15	**822**	861	**0**	0
Total non-current assets		**204,712**	207,290	**203,890**	206,429
Current Assets					
Inventories	16	**5,779**	6,316	**5,779**	6,316
Trade and other receivables	17	**39,392**	28,469	**39,411**	28,526
Cash and cash equivalents	19	**2,300**	2,261	**1,715**	2,064
Total current assets		**47,471**	37,046	**46,905**	36,906
Current Liabilities					
Trade and Other Payables	20	**(42,004)**	(35,133)	**(42,000)**	(35,129)
Borrowings	23	**(6,448)**	(4,318)	**(6,448)**	(4,318)
Provisions	24	**(153)**	(153)	**(153)**	(153)
Tax Payable	22	**(1,596)**	(1,613)	**(1,596)**	(1,613)
Other liabilities	21	**(1,953)**	(2,302)	**(1,953)**	(2,302)
Total current liabilities		**(52,154)**	(43,519)	**(52,150)**	(43,515)
Total assets less current liabilities		**200,029**	200,817	**198,645**	199,820
Non-Current Liabilities					
Borrowings	23	**(136,544)**	(128,430)	**(136,544)**	(128,430)
Provisions	24	**(1,546)**	(1,486)	**(1,546)**	(1,486)
Other Liabilities	21	**(1,360)**	(1,474)	**(1,360)**	(1,474)
Total non-current liabilities		**(139,450)**	(131,390)	**(139,450)**	(131,390)
Total assets employed		**60,579**	69,427	**59,195**	68,430
Financed by Taxpayers' Equity					
Public dividend capital		**30,895**	30,386	**30,895**	30,386
Revaluation reserve		**29,828**	29,828	**29,828**	29,828
Income and expenditure reserve		**(1,528)**	8,216	**(1,528)**	8,216
Charitable fund reserves		**1,384**	997	**0**	0
Total taxpayers' equity		**60,579**	69,427	**59,195**	68,430

Signed

Date 23 May 2016

Nerissa Vaughan
Chief Executive

The noted on pages 213 – 243 form part of the financial statements.

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

Group and Trust	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 2014	**1,205**	**28,895**	**29,828**	**16,779**	**76,707**
(Deficit) for the year	(127)	0	0	(8,644)	(8,771)
Public Dividend Capital received	0	1,491	0	0	1,491
Other reserve movements - charitable funds consolidation adjustment	(81)	0	0	81	0
Taxpayers' Equity at 31 March 2015	**997**	**30,386**	**29,828**	**8,216**	**69,427**
Surplus/(deficit) for the year	563	0	0	(9,920)	(9,357)
Public Dividend Capital received	0	509	0	0	509
Other reserve movements - charitable funds consolidation adjustment	(176)	0	0	176	0
Taxpayers' Equity at 31 March 2016	**1,384**	**30,895**	**29,828**	**(1,528)**	**60,579**

NHS Charity is separately identifiable above.

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2016

	Notes	Group Year Ended 31 March 2016 £000	Year Ended 31 March 2015 £000	Trust Year Ended 31 March 2016 £000	Year Ended 31 March 2015 £000
Cash flows from operating activities					
Operating surplus from continuing operations		**3,972**	6,326	**3,589**	6,507
Depreciation and amortisation		**8,082**	8,671	**8,082**	8,671
Impairments		**0**	0	**0**	0
Loss on disposal		**2**	0	**2**	0
Increase in inventories		**537**	(537)	**537**	(537)
Increase in trade and other receivables		**(11,034)**	(7,945)	**(11,034)**	(7,776)
Increase in trade and other payables		**6,384**	6,910	**6,384**	6,910
Increase/(Decrease) in other liabilities		**(463)**	1,643	**(463)**	1,643
NHS charitable funds - net adjustments for working capital movement		**(36)**	94	**(36)**	0
Increase/(Decrease) in provisions		**40**	(283)	**40**	(283)
Net Cash Generated from Operations		**7,484**	14,879	**7,100**	15,135
Cash flows from investing activities					
Interest received		**75**	28	**32**	28
Purchase of Intangible assets		**(183)**	(351)	**(183)**	(351)
Purchase of Property, Plant and Equipment		**(4,891)**	(7,455)	**(4,891)**	(7,455)
Net cash used in investing activities		**(4,999)**	(7,778)	**(5,042)**	(7,778)
Cash flows from financing activities					
Public Dividend Capital received		**509**	1,491	**509**	1,491
Public dividend capital received (PDC adjustment for modified absorption transfers of payables/receivables)		**0**	0	**0**	0
Loans received from the Department of Health		**11,900**	5,466	**11,900**	5,466
Loans repaid to Department of Health		**(2,055)**	0	**(2,055)**	0
Capital element of Private Finance Initiative Obligations		**875**	(1,864)	**875**	(1,864)
Interest paid		**(138)**	(45)	**(138)**	(45)
Interest element of Finance Leases		**(20)**	(26)	**(20)**	(26)
Interest element of Private Finance Initiative Obligations		**(12,543)**	(14,093)	**(12,543)**	(14,093)
PDC dividends paid		**(522)**	(526)	**(522)**	(526)
Cash flows from other financing activities		**(451)**	(196)	**(423)**	(196)
Cash and cash equivalents transferred by normal absorption		**0**	63	**0**	63
Net cash used in financing activities		**(2,445)**	(9,730)	**(2,417)**	(9,730)
Decrease in cash and cash equivalents		**39**	(2,630)	**(359)**	(2,374)
Cash and cash equivalents at 1 April 2015		**2,261**	4,891	**2,064**	4,438
Cash and cash equivalents at 31 March 2016	19	**2,300**	2,261	**1,705**	2,064

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 2015/16 issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered in relation to the accounts.

On 20 April 2015, folowing a review by Monitor, the Trust was found to be in breach of the following conditions of its licence: CoS3(1)(a) and (b), FT4(2) and FT4 (5)(a), (d), (e), (f) and (g) relating to the financial sustainability, performance and governance of the Trust. Notwithstanding this breach and reporting a deficit for the year ending 31st March 2016 of £9.7m, the accounts have been prepared on a going concern basis. The Trust's Annual Plan forecasts a surplus of £0.6m for the year ending 31 March 2017 following receipt of £8.9m from Sustainability and Transformation Fund. This will enable the Trust to maintain a minimum monthly cash balance of at leat £1.7m and this is also set out in the Trust's 2016/17 Annual Plan.

The Monitor NHS Foundation Trust Annual Reporting Manual 2015/16 states that financial statements should be prepared on a going concern basis unless management either intends to apply to the Secretary of State for the dissolution of the NHS FT without the transfer of the services to another entity, or has no realistic alternative but to do so.

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

1.1 Accounting Convention

These accounts have been prepared under the historical cost convention, on a going concern basis modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.1.1 Consolidation

Great Western Hospitals NHS Foundation Trust Charitable Fund

The NHS Foundation Trust is the corporate trustee to Great Western Hospitals NHS Foundation Trust Charitable Fund. The Foundation Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Foundation Trust has the power to govern the financial and operating policies of the charitable fund so as to obtain benefit from its activities for itself, its patients or its staff.

Prior to 2013/14 the FT ARM permitted the NHS Foundation Trust not to consolidate the charitable 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 so the investments are held at fair value. The investment policy, also requires that all monies not required to fund working capital should be invested to maximise income and growth.

1.1.2 Subsidiaries

Subsidiary entities are those over which the Trust has the power to exercise control or a dominant influence so as to gain economic or other benefits. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

Until 31st March 2013, NHS Charitable Funds considered to be subsidiaries were excluded from consolidation in accordance with the accounting direction issued by Monitor.

1.2 Income

Income in respect of services provided is recognised when, and to the extent that, performance 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
Plant and Machinery	5 to 15
Furniture and Fittings	5 to 10
Information Technology	5
Transport Equipment	6

ACCOUNTING POLICIES (continued)

Revaluation Gains and Losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has been previously recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the FT ARM, impairments that are due to a loss of economic benefit or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charges to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'Held for Sale' once all the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales
- the sale must be highly probable i.e.

  management are committed to a plan to sell the asset;

  an active programme has begun to find a buyer and complete the sale;
  the asset is being actively marketed at a reasonable price;
  the sale is expected to be completed in within 12 months of the date of classification as 'Held for Sale' and
  the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

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

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the assets economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

ACCOUNTING POLICIES (continued)

1.6 Donated, government grant and other grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor imposes a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.
The donated and grant funded assets are subsequently accounted for in the same manner as other property, plant and equipment.

1.7 Private Finance Initiative (PFI) Transactions

PFI Transactions that meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with IAS17, the underlying assets are recognised as property, plant and equipment at their fair value together with an equivalent financial liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contractual payments are apportioned between the repayment of the liability, a finance cost and the charges for services.

The service charge is recognised in operating expenses and the finance cost is charged to the Statement of Comprehensive Income.

1.7.1 Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

1.8 Intangible assets

1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the Trust intends to complete the asset and sell or use it
- the Trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset and
- the Trust can measure reliably the expenses attributable to the asset during development.

ACCOUNTING POLICIES (continued)

1.8.2 Software

Software which is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of the hardware e.g. application software is capitalised as an intangible asset.

1.8.3 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at fair value. Revaluation gains and losses and impairments are treated in the same manner as for Property, Plant and Equipment.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.8.4 Valuation and economic useful lives

The valuation basis is described in note 1.5 to the accounts. There is no active market for the Trust's intangible assets and there is no revaluation reserve.

PFI Intangible Assets are depreciated over the life of the PFI Contract.
Economic useful lives of intangible assets are finite and amortisation is charged on a straight line basis:

	Minimum useful life Years	Maximum useful life Years
Software	5	5
Licences and trademarks	5	12

1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. Pharmacy stocks are valued at average cost, other inventories are valued on a first-in first-out basis. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks. Work-in-progress comprises goods and services in intermediate stages of production.

ACCOUNTING POLICIES (continued)

1.10 Financial instruments and financial liabilities

1.10.1 Recognition

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

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition

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

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

1.10.2 Classification

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

1.10.3 Financial assets and financial liabilities at 'fair value through the income and expenditure'

Financial assets and financial liabilities at 'fair value through the income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short term. Derivatives are also categorised as held for trading unless they are designated as hedges. Assets and liabilities in this category are classified as current assets and current liabilities.

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

1.10.4 Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets. The Trust's loans and receivables comprise current investments, cash and cash equivalents, NHS debtors, accrued income and other debtors.

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

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

1.10.5 Other financial liabilities

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

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

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

1.10.6 Determination of Fair Value

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

ACCOUNTING POLICIES (continued)

1.10.7 Impairment of financial assets

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

1.10.8 Accounting for derivative financial instruments

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through income and expenditure. They are held at fair value, with any subsequent movement recognised as gains or losses in the Statement of Comprehensive Income.

1.11 Leases

1.11.1 Finance Leases

Where substantially all of the risks and rewards of ownership of a lease asset are borne by the Trust the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present minimum value of the lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property, plant and equipment.

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

1.11.2 Operating Leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

1.11.3 Lease of Land and Buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

ACCOUNTING POLICIES (continued)

1.12 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using discount rates published and mandated by HM Treasury.

1.12.1 Clinical Negligence Costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed in note 24 on page 30 but is not recognised in the Trust's accounts.

1.12.2 Non-Clinical Risk Pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.13 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 26 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 26, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.14 Public Dividend Capital

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), and (ii) average daily cash balances with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding any cash balances held in GBS accounts that relates to a short term working capital facility and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the accounts.

ACCOUNTING POLICIES (continued)

1.15 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.16 Corporation Tax

The Trust does not have a corporation tax liability for the year 2015/16. Tax may be payable on activities as described below:

- the activity is not related to the provision of core healthcare as defined under Section 14(1) of the HSCA. Private healthcare falls under this legislation and is therefore not taxable.
- the activity is commercial in nature and competes with the private sector. In house trading activities are normally ancillary to the core healthcare objectives and are therefore not subject to tax.
- the activity must have annual profits of over £50,000.

1.17 Foreign exchange

The functional and presentational currencies of the Trust is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the date of the transaction. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Statement of Comprehensive Income in the period in which they arise.

1.18 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

1.19 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However, the note on losses and special payments is compiled directly from the losses and compensations register which reports amounts on an accruals basis with the exception of provisions for future losses.

1.20 Transfers of functions from other NHS bodies

For functions that have been transferred to the Trust from another NHS body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain corresponding to the net assets transferred is recognised within income, but not within operating activities.

For property plant and equipment assets and intangible assets, the Cost and Accumulated Depreciation / Amortisation balances from the transferring entity's accounts are preserved on recognition in the trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

ACCOUNTING POLICIES (continued)

1.21 Critical Accounting Estimates and Judgements

International accounting standard IAS1 requires estimates, assumptions and judgements to be continually evaluated and to be based on historical experience and other factors including expectation of future events that are believed to be reasonable under the circumstances. Actual results may differ from these estimates. The purpose of the evaluation is to consider whether there may be a significant risk of causing a material adjustment to the carrying value of assets and liabilities within the next financial year, compared to the carrying value in these accounts. The following significant assumptions and areas of estimation and judgement have been considered in preparing these financial statements. Value of land, buildings and dwellings £175m, 2014-15 (£178m): 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 2015/16 financial year end, the estimated value of partially completed spells is £1,338k (2014-15 £1,327k). An estimate relating to maternity pathway income has also been included within deferred income in 2015/16. The value of this estimate is £1,337k (2014-15 £1,376k).

Untaken annual leave: salary costs include an estimate for the annual leave earned but not taken by employees at 31 March 2016, to the extent that staff are permitted to carry up to 5 days leave forward to the next financial year. For 2015-16 this was £464k (2014-15 £561k).

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 2017	**Effective Date**	
IFRS 11 (amendment) - acquisition of an interest in a joint operation	2016/17	Not yet EU adopted
IAS 16 (amendment) and IAS 38 (amendment) - depreciation and amortisation	2016/17	Not yet EU adopted
IAS 16 (amendment) and IAS 41 (amendment) - bearer plans	2016/17	Not yet EU adopted
IAS 27 (amendment) - equity method in separate financial statements	2016/17	Not yet EU adopted
IFRS 10 (amendment) and IAS 28 (amendment) - sale or contribution of assets	2016/17	Not yet EU adopted
IFRS 10 (amendment) and IAS 28 (amendment) - investment entities applying the consolidation exception	2016/17	Not yet EU adopted
IAS 1 (amendment) - disclosure initiative	2016/17	Not yet EU adopted
Effective in future years		
IFRS 15 Revenue from contracts with customers	2017/18	Not yet EU adopted
Annual improvements to IFRS: 2012-15 cycle	2017/18	Not yet EU adopted
IFRS 9 Financial instruments	2018/19	Not yet EU adopted

The Trust has considered the above new standards, interpretations and amendments to published standards that are not yet effective and concluded that they are either not relevant to the Trust or that they would not have a significant impact on the Trust's financial statements, apart from some additional disclosures.

The Trust has not early adopted any new accounting standards, amendments or interpretations.

2. Segmental Analysis
Group

The Trust's Board has determined that the Trust operates in three material segments which is Great Western Hospitals (GWH), Wiltshire Community Health Services (WCHS) and the NHS Charity.

2015-16

	GWH	WCHS	Charity	Total
Operating Income	**£'000**	**£'000**	**£'000**	**£'000**
NHS Clinical Income	223,254	54,857	0	278,111
Private Patients	2,496	0	0	2,496
Other Non Mandatory/Non Protected Revenue	3,307	88	0	3,395
Research & Development Income	844	0	0	844
Education and Training Income	9,878	81	0	9,959
Misc Other Operating Income	8,019	6,707	852	15,578
Total Income	**247,798**	**61,733**	**852**	**310,383**

2014-15

	GWH	WCHS	Charity	Total
Operating Income	**£'000**	**£'000**	**£'000**	**£'000**
NHS Clinical Income	211,976	56,203	0	268,179
Private Patients	2,907	0	0	2,907
Other Non Mandatory/Non Protected Revenue	3,057	24	0	3,081
Research & Development Income	822	0	0	822
Education and Training Income	9,424	39	0	9,463
Misc Other Operating Income	9,452	6,492	368	16,312
Total Income	**237,638**	**62,758**	**368**	**300,764**

NHS Charity is separately identifiable above.

3. Income
Group and Trust

3.1 Income from Activities (by Type)

	Year Ended 31 March 2016 £000	Year Ended 31 March 2015 £000
NHS Foundation Trusts	**281**	1,585
NHS Trusts	**71**	889
CCGs and NHS England	**271,427**	261,071
Local Authorities	**6,509**	6,311
Private Patients	**2,495**	2,896
Non-NHS: Overseas patients (non-reciprocal)	**116**	201
NHS Injury Cost Recovery scheme	**740**	807
	281,639	273,760

NHS Injury Cost Recovery scheme income is shown gross and is subject to a provision for doubtful debts of 21.99% (2014/15 18.9%) to reflect expected rates of collection.

3.2 Income from Activities (by Class)

	Year Ended 31 March 2016 £000	Year Ended 31 March 2015 £000
Elective income	**39,519**	40,092
Non elective income	**73,659**	71,541
Outpatient income	**45,478**	45,591
A & E income	**9,928**	8,245
Other NHS clinical income	**56,735**	51,099
Community contract income	**53,825**	54,296
Private patient income	**2,495**	2,896
	281,639	273,760

3.3 Commissioner Requested Services

The table below shows the split of Commissioner Requested Services (CRS).

	Year Ended 31 March 2016 £000	Year Ended 31 March 2015 £000
Total CRS	**278,288**	269,856
Total Non CRS	**3,351**	3,904
Total Income from Activities	**281,639**	273,760

4. Other Operating Income **Group**	**Year ended 31 March 2016** **£000**	Year ended 31 March 2015 £000
Research and Development	**844**	822
Education and Training	**9,960**	9,463
Charitable and other contributions to expenditure	**53**	495
Non-patient care services to other bodies	**180**	1,680
Staff recharges	**738**	1,409
Other Income	**16,117**	12,768
NHS Charitable Funds: Incoming resources excluding investment income	**852**	368
	28,743	27,005

4.1 Other Income includes		
Car Parking (Staff & Patients)	**1,744**	1,554
Estates recharges	**1,563**	2,359
IT recharges	**70**	14
Pharmacy sales	**290**	82
Clinical Excellence Awards	**313**	175
Catering	**90**	118
Property Rentals	**1,126**	1,752
Payroll & Procurement Services	**55**	71
Occupational Health Service	**193**	312
Dietetics	**60**	7
Ultrasound Photo Sales	**63**	62
Transport services	**309**	264
Staff accommodation	**128**	130
Domestic services	**123**	116
Pathology	**93**	168
Cancer Drug Fund	**1,817**	1,411
Other	**8,080**	4,173
Total	**16,117**	12,768

NHS Charity Income is separately identifiable above.

4.2 Overseas visitors (relating to patients charged directly by the NHS foundation trust)

	2015/16 **£000**	**2014/15** **£000**
Income recognised this year	**116**	201
Cash payments received in-year	**61**	139
Amounts added to provision for impairment of receivables	**71**	13
Amounts written off in-year	**5**	24

5. Operating Expenses	**Year Ended**	Year ended
Group	**31 March**	31 March
	2016	2015
	£000	£000
Services from Foundation Trusts	**1,165**	2,583
Services from other NHS Trusts	**161**	1,197
Purchase of healthcare from non NHS bodies	**1,199**	1,015
Employee Expenses - Executive Directors	**1,063**	1,054
Employee Expenses - Non-Executive Directors	**136**	123
Employee Expenses - Staff	**191,915**	188,151
Drug Costs	**26,009**	22,510
Supplies and services - clinical	**29,742**	27,897
Supplies and services - general	**2,754**	3,575
Consultancy services	**409**	432
Establishment	**4,661**	4,970
Research and development	**700**	666
Transport	**333**	362
Premises - business rates payable to local authorities	**1,831**	1,960
Premises - other	**8,720**	7,801
Increase / (decrease) in bad debt provision	**767**	156
Increase in other provisions	**234**	0
Rentals Under operating Leases	**329**	341
Depreciation on property, plant and equipment	**7,543**	8,247
Amortisation on intangible assets	**539**	424
Loss on sale of asset	**2**	0
Audit services (Statutory audit)	**71**	73
Audit services (Other Assurance Services)	**3**	89
Internal audit services	**90**	99
Clinical negligence	**4,116**	4,457
Patient travel	**310**	277
Car parking and security	**55**	87
Insurance	**261**	237
Hospitality	**19**	37
Legal Fees	**480**	280
Training courses and conferences	**804**	937
Other Services	**19,679**	13,839
Losses, ex gratia & special payments	**20**	18
NHS Charitable Funds - other resources expended	**290**	545
	306,410	294,439

Expenditure on NHS Charity is separately identifiable above.

Staff Exit Packages

The Trust has agreed 1 staff exit package of £99k in 2015/16 (31 March 2015: £nil).

Supplies and Services

Supplies and Services Costs have increased in 2015/16 reflecting additional patient activity.

Drug Costs

Drug Costs have increased in 2015/16 reflecting additional patient activity. In particular additional expenditure has been incurred on high cost and NICE drugs.

Other Services

Other Services - includes cleaning, catering, portering, housekeeping and estates services.

6. Operating leases - as Lessee

Group and Trust	**Year Ended 31 March 2016 £000**	Year ended 31 March 2015 £000
Minimum lease payments	**329**	341
	329	341

Total future minimum lease payments	**Year Ended 31 March 2015 £000**	Year Ended 31 March 2014 £000
Payable:		
Not later than one year	**212**	328
Between one and five years	**418**	504
After 5 years	**0**	91
Total	**630**	923

7. Employee costs and numbers

Group and Trust

7.1 Employee Expenses

	Year Ended 31 March 2016			Year Ended 31 March 2015		
	Total	**Permanently Employed**	**Other incl agency**	Total	Permanently Employed	Other incl agency
	£000	**£000**	**£000**	£000	£000	£000
Salaries and wages	**152,661**	**149,908**	**2,753**	147,626	146,125	1,501
Social security costs	**11,573**	**11,573**	**0**	11,337	11,337	0
Pension costs - defined contribution plans Employers contributions to NHS pensions	**18,798**	**18,798**	**0**	18,090	18,090	0
Agency and contract staff	**10,646**		**10,646**	12,772	0	12,772
	193,678	**180,279**	**13,399**	189,825	175,552	14,273

7.2 Average number of employees (WTE)

	Year Ended 31 March 2016			Year Ended 31 March 2015		
	Total	**Permanently Employed**	**Other incl agency**	Total	Permanently Employed	Other incl agency
	Number	**Number**	**Number**	Number	Number	Number
Medical and dental	**515**	**491**	**24**	502	469	33
Administration and estates	**1,127**	**1,075**	**52**	1,105	1,064	41
Healthcare assistants and other support staff	**808**	**789**	**19**	845	750	95
Nursing, midwifery and health visiting staff	**1,625**	**1,475**	**150**	1,582	1,468	114
Nursing, midwifery and health visiting learners	**16**	**16**	**0**	16	16	0
Scientific, therapeutic and technical staff	**578**	**578**	**0**	568	555	13
	4,669	**4,424**	**245**	4,618	4,322	296

7.3 Key Management Compensation

	Year Ended 31 March 2016	Year Ended 31 March 2015
	£000	£000
Salaries and short term benefits	**841**	840
Social Security Costs	**100**	100
Employer contributions to NHSPA	**122**	115
	1,063	1,055

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 (2015 : 5) to whom pension benefits are accruing under defined benefit schemes.

7.4 Highest Paid Director

Executive Name & Title Salary	**Total remuneration**	
	2015/16	**2014/15**
Mrs N Vaughan, Chief Executive	**£172,500**	£177,500

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

	2015/16	**2014/15**	**% change**
Highest paid director's total remuneration	**£172,500**	£177,500	-2.8%
Median total remuneration	**£27,090**	£26,093	3.8%
Ratio	**6.37**	6.80	-6.4%

All NHS Foundation Trusts are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisations workforce. The median total remuneration above is the total remuneration of the staff member lying in the middle of the linear distribution of staff employed in the Trust, excluding the highest paid director. This is based on an annualised full time total staff equivalent remuneration as at the reporting period date. The median pay has increased from 2014/15 due to pay award and incremental costs.

8. Retirements due to ill-health
Group and Trust

During the year to 31 March 2016 there were 6 early retirements from the Trust agreed on the grounds of ill-health (31 March 2015 - 6 early retirements). The estimated additional pension liabilities of these ill-health retirements will be £181,437 (31 March 2015 - £337,739). 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 2016		Year ended 31 March 2015	
	Number	**£000**	Number	£000
Total trade bills paid in the year	**59,971**	**143,838**	63,547	137,998
Total trade bills paid within target	**17,542**	**79,308**	15,977	70,103
Percentage of trade bills paid within target	**29.25%**	**55.14%**	25.14%	50.80%
Total NHS bills paid in the year	**2,072**	**15,394**	2,072	12,784
Total NHS bills paid within target	**820**	**3,825**	424	1,291
Percentage of NHS bills paid within target	**39.58%**	**24.85%**	20.46%	10.10%

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

The deterioration of the Better Payment Practice Code measures is as a result of an increase in creditors due for payment as a result of in year cash management.

9.2 The Late Payment of Commercial Debts (Interest) Act 1998

The Trust was charged £5,330 in the year for late payment of commercial debts (31 March 2015 £45,331).

10. Finance Income

Group and Trust	**Year Ended 31 March 2016**	Year Ended 31 March 2015
	£000	£000
Interest on bank accounts	**32**	28
NHS Charitable Funds: Investment Income	**43**	0
	75	28

11. Finance Expense

Group and Trust	**Year Ended 31 March 2016**	Year Ended 31 March 2015
	£000	£000
Working Capital Facility Fee	**22**	0
Interest on loans from DoH	**148**	0
Interest on late payment of commercial debt	**5**	45
Interest on obligations under Finance leases	**20**	26
Interest on obligations under PFI	**12,506**	14,093
	12,701	14,164

12. Intangible Assets
Group and Trust
12.1 2015/16:

	Computer software - purchased	Licences and trademarks	Intangible assets under construction	Total
	£000	£000	£000	£000
Gross cost at 1 April 2015	2,091	1,450	1,368	4,909
Additions purchased	183	0	0	183
Reclassifications	0	1,368	(1,368)	0
Gross cost at 31 March 2016	**2,274**	**2,818**	**0**	**5,092**
Amortisation at 1 April 2015	1,165	1,355	0	2,520
Provided during the year	320	219	0	539
Amortisation at 31 March 2016	**1,485**	**1,574**	**0**	**3,059**
Net book value				
Purchased	789	1,244	0	2,033
Total at 31 March 2016	**789**	**1,244**	**0**	**2,033**

12.2 2014/15:

	Computer software - purchased	Licences and trademarks	Intangible assets under construction	Total
	£000	£000	£000	£000
Gross cost at 1 April 2014	1,740	1,329	121	3,190
Additions purchased	351	0	1,368	1,719
Reclassifications	0	121	(121)	0
Gross cost at 31 March 2015	**2,091**	**1,450**	**1,368**	**4,909**
Amortisation at 1 April 2014	780	1,316	0	2,096
Provided during the year	385	39	0	424
Amortisation at 31 March 2015	**1,165**	**1,355**	**0**	**2,520**
Net book value				
Purchased	926	95	1,368	2,389
Total at 31 March 2015	**926**	**95**	**1,368**	**2,389**

13. Property, plant and equipment

Group and Trust

13.1 2015/16:	**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 2015	35,962	164,116	5,492	8,418	36,897	58	21,031	3,301	275,275
Additions Purchased	0	2,292	0	(531)	2,753	0	833	15	5,362
Reclassification		(130)	130						0
Disposals/derecognition					(13)				(13)
Gross cost at 31 March 2016	**35,962**	**166,278**	**5,622**	**7,887**	**39,637**	**58**	**21,864**	**3,316**	**280,624**
Depreciation at 1 April 2015	0	26,914	856	0	28,660	58	11,774	2,974	71,236
Provided during the year	0	4,637	123	0	1,741	0	906	135	7,542
Disposals/derecognition					(11)				(11)
Depreciation at 31 March 2016	**0**	**31,551**	**979**	**0**	**30,390**	**58**	**12,680**	**3,109**	**78,767**
Net book value									
- Purchased at 31 March 2016	35,962	134,727	4,643	7,887	9,247	0	9,184	207	201,857
- Donated at 31 March 2016	0	0	0	0	0	0	0	0	0
Total at 31 March 2016	**35,962**	**134,727**	**4,643**	**7,887**	**9,247**	**0**	**9,184**	**207**	**201,857**
Asset Financing									
Net book value									
- Owned	35,962	21,377	130	7,887	9,247	0	9,184	207	83,994
- Finance Leased	0	113,350	4,513	0	0	0	0	0	117,863
Total at 31 March 2016	**35,962**	**134,727**	**4,643**	**7,887**	**9,247**	**0**	**9,184**	**207**	**201,857**

13. Property, plant and equipment

Group and Trust

13.2 Prior year 2014/15:	**Land**	**Buildings excluding dwellings**	**Dwellings**	**Assets under construction**	**Plant and Machinery**	**Transport Equipment**	**Information Technology**	**Furniture & fittings**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Gross cost at 1 April 2014	35,962	163,622	5,492	6,782	36,074	58	17,135	3,270	268,395
Transfers by absorption - Normal	0	0	0	0	(136)	0	0	0	(136)
Additions Purchased	0	494	0	1,636	959	0	3,896	31	7,016
Gross cost at 31 March 2015	**35,962**	**164,116**	**5,492**	**8,418**	**36,897**	**58**	**21,031**	**3,301**	**275,275**
Depreciation at 1 April 2014	0	22,327	733	0	26,730	58	10,596	2,618	63,062
Transfers by absorption - Normal	0	0	0	0	(73)	0	0	0	(73)
Provided during the year	0	4,587	123	0	2,003	0	1,178	356	8,247
Depreciation at 31 March 2015	**0**	**26,914**	**856**	**0**	**28,660**	**58**	**11,774**	**2,974**	**71,236**
Net book value									
- Purchased at 31 March 2015	35,962	137,203	4,636	8,418	8,237	0	9,257	327	204,040
- Donated at 31 March 2015	0	0	0	0	0	0	0	0	0
Total at 31 March 2015	**35,962**	**137,203**	**4,636**	**8,418**	**8,237**	**0**	**9,257**	**327**	**204,040**
Asset Financing									
Net book value									
- Owned	35,962	21,537	53	8,418	8,237	0	9,257	327	83,791
- Finance Leased	0	115,666	4,583	0	0	0	0	0	120,249
Total at 31 March 2015	**35,962**	**137,203**	**4,636**	**8,418**	**8,237**	**0**	**9,257**	**327**	**204,040**

Transfer by absorption adjustment relates to assets transferred on divestment of Maternity Services to RUH on 01.06.14

13. Property, plant and equipment (cont.)

13.3 Revaluation

The Trust has not revalued land, buildings and dwellings in 2015/16 as there has not been any significant changes to asset base and a standard valuation will be carried out next year as part of the Trust's rolling programme of asset valuations.

13.4. Non-current assets held for sale

The Trust has no non-current assets held for sale (31 March 2015: £nil).

14. Capital commitments

There are no commitments under capital expenditure contracts at the end of the period (31 March 2015: £nil), not otherwise included in these financial statements.

15. Investments

	Group		Trust	
	Year Ended 31 March 2016 £000	Year end 31 March 2015 £000	**Year Ended 31 March 2016 £000**	Year end 31 March 2015 £000
Financial Assets designated as fair value through profit & loss	**822**	861	**0**	0
	822	861	**0**	0

All Investments are non-current.

16. Inventories

Group and Trust

	31 March 2016 £000	31 March 2015 £000
Materials	**5,779**	6,316
	5,779	6,316

Inventories carried at fair value less costs to sell where such value is lower than cost are nil (31 March 2015 - £nil).

	31 March 2016 £000	31 March 2015 £000
Inventories consumed (recognised in expenses)	**(58,661)**	(53,082)
	(58,661)	(53,082)

17. Trade and other receivables

Group

(All Receivables are Current)

	31 March 2016 £000	31 March 2015 £000
NHS receivables	**9,501**	7,288
Other receivables with related parties	**3,465**	3,399
Provision for impaired receivables	**(2,003)**	(1,236)
Prepayments	**3,572**	3,443
Lifecycle prepayment	**16,419**	7,464
Accrued Income	**2,611**	2,780
Other receivables	**5,717**	5,110
NHS Charitable Funds: Other receivables	**19**	8
PDC receivable	**91**	213
	39,392	28,469

NHS Charity is separately identifiable above.

18.1 Provision for impairment of receivables

Group and Trust

	31 March 2016 £000	31 March 2015 £000
Balance at 1 April	**1,236**	1,080
Increase in provision	**767**	156
Amounts utilised	**0**	0
Unused amounts reversed	**0**	0
Balance at 31 March	**2,003**	1,236

18.2 Analysis of Impaired Receivables

	31 March 2016 £'000	31 March 2015 £'000
Ageing of impaired receivables		
0-30 days	**12**	28
30-60 days	**21**	35
60-90 days	**15**	17
90-180 days	**308**	204
over 180 days	**1647**	952
	2,003	1,236

	31 March 2016 £'000	31 March 2015 £'000
Ageing of non-impaired receivables past their due date		
0-30 days	**1,943**	1,631
30-60 days	**1,822**	1,280
60-90 days	**419**	546
90-180 days	**996**	1,034
over 180 days	**4,902**	3,755
	10,082	8,246

	Group		Trust	
19. Cash and cash equivalents	**31 March 2016**	31 March 2015	**31 March 2016**	31 March 2015
	£000	£000	**£000**	£000
Balance at 1 April	**2,261**	4,891	**2,064**	4,438
Transfers by absorption - NORMAL	**0**	63	**0**	63
Net change in year	**39**	(2,693)	**(349)**	(2,437)
Balance at 31 March	**2,300**	2,261	**1,715**	2,064
Made up of				
Cash with Government Banking Service	**2,290**	2,251	**1,705**	2,054
Commercial banks and cash in hand	**10**	10	**10**	10
Cash and cash equivalents as in statement of financial position	**2,300**	2,261	**1,715**	2,064
Cash and cash equivalents as in statement of cash flows	**2,300**	2,261	**1,715**	2,064

20. Trade and other payables

Group	**Current**	
	31 March 2015	31 March 2014
	£000	£000
NHS payables	**1,531**	3,880
Trade payables - capital	**2,500**	2,029
Other trade payables	**23,263**	18,180
Other payables	**4,439**	4,909
Accruals	**10,268**	6,131
NHS Charitable Funds: Trade and other payables	**4**	4
	42,005	35,133

Other payables include outstanding pension contributions of £2,555,025. (31 March 2015: £2,495,727).

NHS Charity is separately identifiable

21. Other liabilities

Group and Trust	**Current**		**Non-current**	
	31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	£000	£000	**£000**	£000
Deferred income	**1,953**	2,302	**1,360**	1,474
	1,953	2,302	**1,360**	1,474

22. Tax Payable

Tax payable of £1,595,703 (31 March 2015: £1,612,857) consists of employment taxation only (Pay As You Earn), owed to Her Majesty's Revenue and Customs at the period end.

23. Borrowings

Group

23.1 PFI lease obligations

Amounts payable under PFI on SoFP obligations:	**31 March 2016**	31 March 2015
	£000	£000
Gross PFI liabilities	**224,003**	235,383
Of which liabilities are due		
Within one year	**16,421**	9,608
Between one and five years	**58,372**	63,638
After five years	**149,210**	162,137
Less future finance charges	**(96,014)**	(108,377)
	127,989	127,006
Net PFI liabilities		
Of which liabilities are due		
Within one year	**5,739**	4,116
Between one and five years	**20,708**	22,343
After five years	**101,542**	100,547
	127,989	127,006
Included in:		
Current borrowings	**5,739**	4,116
Non-current borrowings	**122,250**	122,890
	127,989	127,006

23.2 Finance lease obligations

Amounts payable under Finance lease obligations:	**31 March 2016**	31 March 2015
	£000	£000
Gross Finance lease liabilities	**178**	317
Of which liabilities are due		
Within one year	**89**	139
Between one and five years	**89**	178
After five years	**0**	0
Less future finance charges	**(20)**	(41)
	158	276
Net Finance lease liabilities		
Of which liabilities are due		
Within one year	**76**	119
Between one and five years	**82**	157
After five years	**0**	0
	158	276
Included in:		
Current borrowings	**76**	119
Non-current borrowings	**82**	157
	158	276

23.3 Loan obligations

Amounts payable under Loan obligations

Net Loan liabilities	**31 March 2016**	31 March 2015
Of which liabilities are due	**£000**	£000
Within one year	**633**	83
Between one and five years	**9,527**	2,633
After five years	**4,685**	2,750
	14,845	5,466

Loan type	Date loan drawn down	Borrowed £'000	Repaid £'000	Outstanding £'000	Interest rates %	Repayable over Years
Working Capital loan	19/01/2015	5,000		5,000	1.53	10
	18/05/2015	2,500		2,500		
	20/07/2015	1,400		1,400		
		8,900	**0**	**8,900**		
Capital loan	18/05/2015	500	(55)	445	1.53	10
	20/07/2015	600		600		
		1,100	**(55)**	**1,045**		
Working Capital Facility	12/10/2015	2,000		**2,000**		
	01/01/2016		(2,000)	(2,000)		
		2,000	**(2,000)**	**0**		
Distressed funding	11/01/2016	3,900		3,900	1.50	2
	14/03/2016	1,000		1,000		
		4,900	**0**	**4,900**		

23.4 Charges to expenditure

The total charged in the year to expenditure in respect of the service element of On-Statement of Financial Position PFI contracts was £12,147,000 (£11,747,000 2014/15)

The Trust is committed to the following annual charges

	31 March 2016	31 March 2015
PFI commitments in respect of service element:	**£000**	£000
Not later than one year	**12,224**	11,611
Later than one year, not later than five years	**52,028**	50,604
Later than five years	**149,480**	145,794
Total	**213,732**	208,009
PFI commitments present value in respect of service element:		
Not later than one year	**34,707**	11,218
Later than one year, not later than five years	**147,726**	44,849
Later than five years	**368,250**	101,490
Total	**550,683**	157,557

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 2016**	31 March 2015	**31 March 2016**	31 March 2015
	£000	£000	**£000**	£000
Pensions relating to other staff	**125**	125	**801**	950
Legal claims	**0**	0	**273**	73
Other	**28**	28	**472**	463
	153	153	**1,546**	1,486

	Pensions relating to other staff	**Legal claims**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**
At 1 April 2015	1,075	73	491	**1,639**
Arising during the year	0	200	34	**234**
Used during the year	(162)	0	(32)	**(194)**
Unwinding of discount	13	0	7	**20**
At 31 March 2016	**926**	**273**	**500**	**1,699**
Expected timing of cash flows:				
Within one year	125	0	28	**153**
Between one and five years	521	273	250	**1,044**
After five years	280	0	222	**502**
	926	273	500	**1,699**

The provision under 'legal claims' relates to outstanding Employment Tribunal Claims £273,000 (31 March 2015: £73,000). The provisions under 'other' includes Injury Benefit Provision £462,000 (31 March 2015: £473,000).

Provisions within the annual accounts of the NHS Litigation Authority at 31 March 2015 include £114,936,532 in respect of clinical negligence liabilities of the Trust (31 March 2015 - £59,824,439).

The Trust has not made a provision under the Carbon Emissions Scheme as the Trust is not required to be registered in 2015/16 as the properties managed by the Trust are below the threshold. This is not anticipated to change in 2016/17.

25. Events after the reporting period

Following a tender exercise Wiltshire Adult Community services contract will be held by a Joint Venture LLP Wiltshire Health & Care (WH&C). The Joint Venture is a partnership between Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust and Salisbury District Hospital NHS Foundation Trust. WH&C wil contract with GWH for the provison of these services.

The expected impact on GWH Income and Expenditure in 2016/17 is set out below.

Wiltshire Health & Care (WHC&C)	Annual Values as at 1/4/16 £'000	With GWH 1/4/16 to 30/6/16 £'000	WH&C from 1/7/16 £'000
Contract Income	40,184	(10,046)	0
Other Income	2,573	(643)	(31,882)
Total Income	**42,757**	**(10,689)**	**(31,882)**
Pay	(30,999)	7,761	23,238
Non Pay	(6,488)	1,660	4,828
Overheads	(5,570)	1,463	4,107
Total Expenditure	**(43,057)**	**10,884**	**32,173**
Net	**(300)**	**195**	**291**

There will be no asset transfer to the LLP.

26. Contingencies

Group and Trust

There are no contingent assets and liabilities for the period ended 31 March 2016

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 2015/16 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 £000	Payables £000	Revenue £000	Expenditure £000
NHS England	1,292	101	34,402	409
Swindon CCG	2,490	1,215	120,131	0
Wiltshire CCG	261	17	99,891	17
BANES CCG	0	0	380	0
Newbury and District CCG	356	0	6,337	0
Bristol CCG	20	0	119	0
Gloucestershire CCG	0	59	8,224	0
Royal United Hospital Bath NHS Trust	382	185	2,261	694
Oxfordshire CCG	260	0	3,362	0
Health Education	38	0	9,659	40
NHS Litigation Authority	0	2	0	4,312
NHS Pension Scheme	0	2,555	0	18,799
Total	**5,099**	**4,134**	**284,766**	**24,271**

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 3 PFI schemes which are deemed to be on-Statement of Financial Position at the period end. These are the Main Hospital and Brunel Treatment Centre and Downsview Residences (treated as one agreement), Savernake Hospital and the agreement in place with Systems C.

Great Western Hospital

The contract commenced on 5 October 1999 for a period of 30 years until 4 October 2029. In terms of the contract the operator company was obliged to build the Great Western Hospital, which was completed in November 2002, for subsequent occupation and use by the Trust. The Trust pays the operator company a quarterly availability fee for the occupation of the hospital and a quarterly service fee for the services provided by the operator such as portering and catering. In October 2003 the Trust entered into a variation of the original agreement for the construction of the Brunel Treatment Centre which is an extension to the original hospital. The construction of the Treatment Centre has resulted in increased availability and service charges, however, the main terms of the contract including the termination date remain unchanged. Subsequently, in September 2006, the Trust entered into a refinancing agreement which resulted in a reduction in the annual availability payment again with no change to the contract term. The amount of the availability payment is determined annually and increased based on a combination of the annual increase in the Retail Price Index (RPI) and a fixed percentage increase of 2.5%. The operator is obliged to maintain the buildings and replace lifecycle elements of the buildings where necessary. At the end of the contract term the hospital buildings revert back to the Trust for Nil consideration. The nature of the contract meets the criteria for treatment as a service concession under IFRIC 12. Accordingly the hospital buildings are treated as an asset under property, plant and equipment with the resultant liability being treated as a finance lease under IAS 17.

Downsview Residences

The contract commenced on 5 October 1999 for a period of 30 years until 4 October 2029. In terms of the contract the operator company was obliged to build the Downsview staff residences on the Hospital site for the provision of housing to hospital staff. At commencement of the contract the Trust made a capital contribution of £649k towards the construction cost of the building. The residences are managed by the operator company who rent the accommodation units to, primarily, Trust staff. The Trust does not pay the operator company an availability fee, however, a monthly service fee is paid for the servicing of the units which is based on usage. The operator is responsible for maintaining the buildings over the contract term. At the end of the contract term the accommodation buildings revert back to the Trust for Nil consideration. The nature of the contract meets the criteria for treatment as a service concession under IFRIC 12. Accordingly the residences are recognised as an asset under property, plant and equipment. The cost of the building less the capital contribution has been accounted for as deferred income and is released to income equally over the entire contract term.

System C

The Trust has a PFI contract in respect of the Integrated Clinical Information System which meets the criteria for recognition as a service concession agreement as envisaged under IFRIC 12 and has, accordingly, been treated as on statement of financial position. The contract was dated 27 May 2002 with an effective date of 13 November 2001. The contract was for 12 years and was due to expire on 12 November 2013. The contract has been extended to November 2020 and has been varied to include a system refresh and removal of network and telephony elements. The contract is for the supply of computer hardware and software together with the provision of ongoing support and system management services. The revised contract commenced in May 2014.

Savernake Hospital

Savernake Hospital was transferred to the Trust form 1st April 2013 as part of the transfer of Community assets following the closure of PCT's. As part of the transfer the Trust took over the PFI contract that was entered into by Wiltshire PCT. The contract commenced on 21 November 2003 for a period of 30 years until 2034. The Trust pays the operator company a monthly fee that covers both the availability for the occupation of the hospital and a service fee that covers the services provided by the operator such as portering and catering.

The operator is responsible for maintaining the buildings over the contract term. At the end of the contract term the accommodation buildings revert back to the Trust for Nil consideration. The nature of the contract meets the criteria for treatment as a service concession under IFRIC 12. Accordingly the residences are recognised as an asset under property, plant and equipment. The cost of the building less the capital contribution has been accounted for as deferred income and is released to income equally over the entire contract term.

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 2016 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 2016	31 March 2015
	£000	£000
By up to three months	**417**	1,826
By three to six months	**1,022**	1,035
By more than six months	**4,897**	3,754
	6,336	6,615

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 CCG's, which are financed from resources voted annually by Parliament. The Trust also largely finances its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

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 2016 and 31 March 2015.

	Carrying Value 31 March 2016 £000	**Fair Value 31 March 2016 £000**	Carrying Value 31 March 2015 £000	Fair Value 31 March 2015 £000
Current financial assets				
Cash and cash equivalents	**1,715**	**1,715**	2,064	2,064
NHS Charitable funds: financial assets	**0**	**0**	861	861
Loans and receivables:				
Trade and receivables	**14,987**	**14,987**	24,159	24,159
	16,702	**16,702**	27,084	27,084
Non-current financial assets				
Loans and receivables:				
Total financial assets	**16,702**	**16,702**	27,084	27,084
Current financial liabilities				
Financial liabilities measured at amortised cost:				
Obligations under PFI	**5,739**	**5,739**	4,116	4,116
Obligations under Finance Leases	**76**	**76**	119	119
Trade and other payables	**40,205**	**40,205**	33,494	33,494
	46,020	**46,020**	37,729	37,729
Non-current financial liabilities				
Financial liabilities measured at amortised cost:				
Obligations under PFI	**122,250**	**122,250**	122,890	122,890
Obligations under Finance Leases	**82**	**82**	157	157
	122,332	**122,332**	123,047	123,047
Total financial liabilities	**168,352**	**168,352**	160,776	160,776
Net financial assets	**(151,650)**	**(151,650)**	(133,692)	(133,692)

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 2016 £000	31 March 2015 £000	**31 March 2016 £000**	31 March 2015 £000
Trade and other receivables:	**1,822**	0	**0**	0
Prepayments	**19,991**	6,415	**0**	0
	21,813	6,415	**0**	0
Trade and other payables:				
Taxes payable	**3,337**	4,168	**0**	0
	3,337	4,168	**0**	0
Provisions:				
Provisions under legislation	**153**	153	**1,363**	1,670
	153	153	**1,363**	1,670

The provisions under legislation are for personal injury pensions £479,493 (31 March 2015: £494,286) and early retirement pensions £1,037,240 (31 March 2015: £1,139,355). 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 £0 cash at bank and in hand at 31 March 2016 (31 March 2015: £3,223) 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 2016		31 March 2015	
	No.	**£000**	No.	£000
Losses				
Cash losses	**5**	**3**	6	2
Bad debts and claims abandoned	**60**	**23**	50	48
Total Losses	**65**	**26**	56	50
Special Payments				
Compensation payments	**6**	**3**	24	13
Ex gratia payments	**14**	**9**	11	9
Total Special Payments	**20**	**12**	35	22
Total Losses and Special Payments	**85**	**38**	91	72

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. (2014/15 - 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

Great Western Hospitals NHS Foundation Trust and NHS Swindon have entered into a pooled budget arrangement, hosted by Swindon Borough Council. Payments are made to the Council by the Swindon Community Equipment Service.

Group and Trust

	31 March 2016	31 March 2015
Income:	**£000**	£000
Swindon Borough Council	463	490
Paediatrics	38	5
NHS Swindon	305	333
Great Western Hospitals NHS Foundation Trust	92	146
Total Income	**898**	974
Expenditure	1,076	961
Total Surplus/(Deficit)	**(178)**	13

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	(101)	7
Swindon CCG	(57)	4
Great Western Hospitals NHS Foundation Trust	(20)	2
Total Surplus/(Deficit)	**(178)**	13

33. Charitable fund balances

	31 March 2016
	£000
Restricted funds	**1,143**
Unrestricted funds	**241**
	1,384

Restricted funds are funds that are to be used in accordance with specific restrictions imposed by the

Unrestricted income funds comprise those funds that the Trustee is free to use for any purpose in furtherance of the charitable objects. Unrestricted funds include general funds, where the donor has not specified or restricted the use the Charity may make of their donation. General funds additionally generate income from Gift Aid, investment income, interest and donations given specifically to cover running costs.

Great Western Hospitals NHS
NHS Foundation Trust

Annual Report and Accounts 2015/16