2gether NHS Foundation Trust
Annual Report and Accounts
2016/17

2gether
Making life better

2gether
NHS Foundation Trust
NHS

2gether NHS Foundation Trust

Annual Report and Accounts 2016/17

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

Contents

We're 2gether

Welcome to our Annual Report, where you will find information about who we are and what we have done throughout 2016/17.

2gether NHS Foundation Trust
A statement of our intent: 2015-2019

PURPOSE Why we exist	**Making Life Better**
VISION What we want to achieve	***To be the Provider and Employer of choice delivering sustainable high quality, cost effective, inclusive services.***
STRATEGIC PRIORITIES Headline targets we will focus on	• Continuous **Quality** Improvement • **Engagement** to support the delivery of a challenging agenda • Ensure **Sustainability** of services
VALUES How we do things	**S**eeing from a service user and carer perspective **E**xcelling and improving **R**esponsive **V**aluing and respectful **I**nclusive, open and honest **C**an do **E**fficient, effective, economic and equitable
PILLARS Enabling Strategies	• Organisational development • Practice development in professions e.g. nursing, AHP, medical, social care, psychological services • Service delivery • Technology • Finance • Engagement and communication • Research • Quality • Commerce • Corporate

Get involved

Find out more about our Trust at: **www.2gether.nhs.uk**

You can also keep in touch with us through our social media channels:

twitter.com/2getherTrust

facebook.com/2getherNHS

instagram.com/2getherNHS

linkedin.com/company/2gether-nhs-foundation-trust

Join us!

2gether operates within the NHS as a not-for-profit, public benefit corporation. As a member, you can help shape strategy and the way services are run. To become a member of the Trust, visit **2gether.nhs.uk/membership** or call **01452 894393**.

Our registered address is: 2gether NHS Foundation Trust, Rikenel, Montpellier, Gloucester, GL1 1LY. You can also contact us by telephone on 01452 894000.

Performance Report

An overview of our purpose, objectives, and performance during 2016/17

Chief Executive's Statement

Our Annual Report provides us with an opportunity to look back on what we have achieved during 2016/17.

It has been a challenging 12 months, but we have, as in previous years, made life better for many thousands of people. We can only continue to do so due to the significant contribution of our staff, as well as our Board, Governors, service users, carers, members, volunteers, commissioners, partners and communities. Despite the ever-increasing demand for our services and support, and the financial challenges facing the NHS as a whole, we remain a strong performing Trust, providing high quality services to some of the most vulnerable people in Gloucestershire and Herefordshire.

Not only have we maintained quality, we have also used our strong position as a Foundation Trust to further improve our services, through investment in our technology, buildings and people. We have also built strategic partnerships with organisations such as Swindon Mind and Cobalt, in order to broaden the support and innovation we can provide.

Despite the significant challenges we will undoubtedly face in 2017/18, we will continue to build still further on our legacy as a forward-thinking Trust to help more people and lead the way in mental health and learning disability service provision.

In our Quality Report you will read about all of our achievements in patient quality and care. Our performance against the NHS Improvement Single Oversight Framework is also contained within these pages, as is a full breakdown of our financial performance. Its highlights include the fact that we have delivered our planned financial position of £1.264m surplus as well as the efficiency savings required for the future ongoing financial stability of the organisation.

A more in depth explanation of how we have arrived at this figure can be found on page 55 of this report, where information on our Sustainability and Transformation Funding (STF) and Impairment Costs are explained. In 2017/18 we plan to deliver a surplus of £883,000, which includes STF of £642,000 and with the support and diligence of our staff I am confident we can do so.

We have much to look forward to in 2017/18. We will see the introduction of a new Perinatal Mental Health Service for Gloucestershire, along with the official openings of a new family room at Wotton Lawn Hospital, and the Alexandra Wellbeing House, in partnership with Swindon Mind. We also look forward to further roll-out of mobile working and digital dictation and transcription technology, in order to free up 'time to care' for our clinical colleagues.

Additionally, we will open our new Gloucester Hub and further embed the Mental Health Acute Response Service for Gloucestershire. We will also support more of our service users, carers and colleagues in improving their physical health by helping them to go Smokefree.

Much of our work this year will involve working in partnership with others, not least through our part in the Sustainability and Transformation Plans (STPs) for Gloucestershire, and Herefordshire and Worcestershire. The STPs set out how health and social care will evolve over the next five years. We are fully embedded in the processes and leading the way on enhancing service provision for people with mental ill health and learning disabilities.

Our Trust is full of enthusiastic and committed people, but we work with and for our communities. As Chief Executive I am proud of each and every one of my colleagues and look forward to leading and supporting them, as well as our communities, in everything we do during 2017/18. To play your part, why not sign up as a Trust member or volunteer?

Join us in Making Life Better.

Shaun Clee
Chief Executive **24 May 2017**

What we achieved in 2016/17

TOP 20

Service users rated the care we provide in the top 20% of Trusts nationally

We vaccinated **77%** of our frontline healthcare workers against the flu – **our highest ever figure**

86% We were above average or average in 86% of key findings from the national **NHS Staff Survey**, with a higher than above average rating for the number of colleagues who would recommend the Trust as a place to work or receive treatment

Between 89% and 94% of people who completed the Friends and Family Test said that they would recommend our services

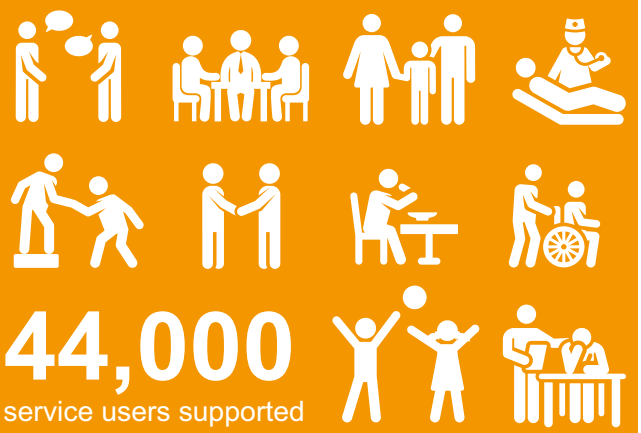
mind for better mental health

We worked with **Swindon Mind** and **Gloucestershire Commissioners** to open a Wellbeing House

We refurbished and re-opened our Forest of Dean and Stroud area community hubs

We opened our research centre and formed a new dementia research partnership with Cobalt

Cobalt
Diagnostic Imaging for Life



2,500 **dedicated** members of staff

46,000 referrals into our services

26,000 contacts per month

44,000 service users supported

7,443 members

310,000 contacts either face-to-face or by telephone

£113m income to deliver and enhance local service provision

About us

²gether NHS Foundation Trust (²gether) provides social and mental healthcare services across Gloucestershire and Herefordshire.

Our services are determined and paid for by NHS commissioning organisations. These are the organisations that manage local and specialist budgets.

In July 2007, we were one of the first 10 mental health trusts in England to be authorised as a foundation trust by Monitor, which was then the independent sector regulator for health services in England.

As a foundation trust, we are a not-for-profit, public benefit corporation. The applicant organisation, Gloucestershire Partnership NHS Trust, was established when we brought together specialist staff and services from four different organisations: Severn NHS Trust, East Gloucestershire NHS Trust, Gloucestershire County Council and Gloucestershire Health Authority.

We became ²gether in April 2008 as part of an initiative to strengthen our identity and pursue our purpose to help make life better. Our name is a statement of intent: 'together' we and our partners, communities, staff, service users, carers and families work to make life better for everyone who requires our services.

Since 2011, we have been commissioned by Herefordshire Clinical Commissioning Group (CCG) to provide mental health services. Herefordshire Local Authority commissions us to provide a learning disability health team. Social Care services in Herefordshire are provided directly by the local authority and services work closely together to deliver supportive integrated care pathways.

We employ more than 2,400 members of staff (including bank staff) and serve a combined population of more than 761,000, over nearly 1,900 square miles. Last year we delivered services to more than 40,000 individuals and offered education and support to their carers and families.

We also worked in partnership with a wide range of commissioners, collaborators and our colleagues across the health and social care community to enhance the support available for people with mental health conditions and learning disabilities, as well as tackle inequality and stigma.

As an NHS Foundation Trust, we are accountable to local people, who help ensure local ownership and control of their NHS. Nearly 7,500 members influence our activities, both directly by contacting the Trust and through locally elected representatives who sit on our Council of Governors.

Our services

Our services are provided according to core NHS principles - free care, based on need and not on someone's ability to pay.

The conditions we provide assessment, support and advice on include a wide range of mental health conditions, learning disabilities and long-term conditions, such as dementia.

Our services include Let's Talk, which is an Improving Access to Psychological Therapy (IAPT) service aimed at supporting people with common conditions such as depression and anxiety.

We also deliver community and inpatient NHS learning disability services; adult inpatient mental health care at Stonebow Unit (Hereford), Wotton Lawn Hospital (Gloucester) and Charlton Lane Hospital (Cheltenham); psychiatric intensive care at Greyfriars (Gloucester); assertive outreach and recovery services; children and young people emotional wellbeing services; eating disorder services; early intervention services; and a place of safety for those under Section 136 of the Mental Health Act at the Maxwell Centre Assessment Suite, in Gloucester. Our occupational health service provides services to public and private organisations through our Working Well identity.

Our Gloucestershire-based Better 2 Work services facilitate vocational opportunities and promote social inclusion for people recovering from mental ill health. We also provide, in partnership with other organisations, the Severn & Wye Recovery College, which delivers educational courses for people recovering from mental illness. This year we worked alongside our Gloucestershire Commissioners and Swindon Mind to open The Alexandra Wellbeing House, in Gloucester.

Strategic priorities

The NHS landscape is ever-changing, and increasing in complexity and challenge.

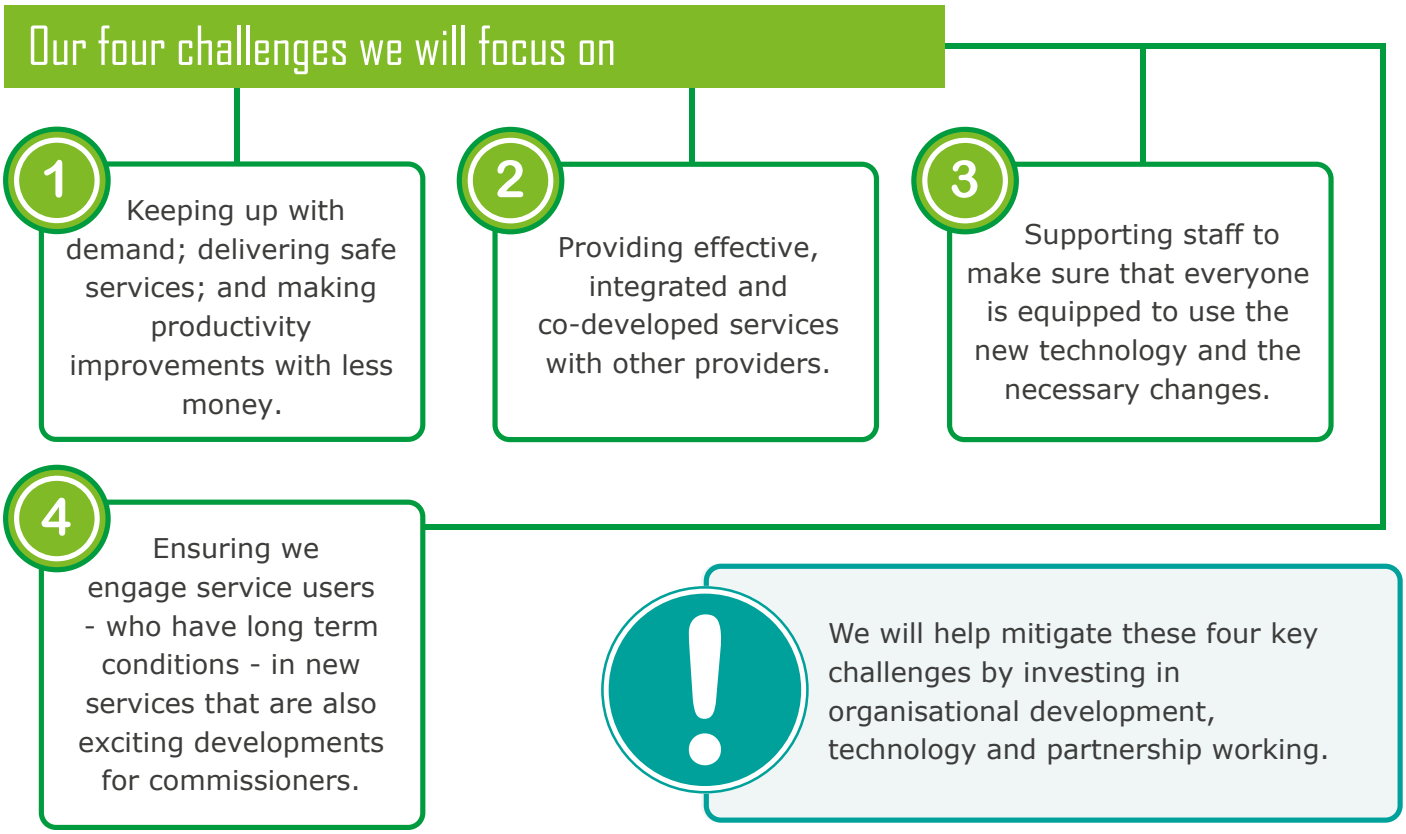
However, we remain focused on our three strategic priorities:

- Continually improving the quality of the services we provide
- Continually improving engagement with the Trust internally and externally to support the delivery of a challenging agenda which, to be successful, has to be delivered in partnership with others
- Ensuring the sustainability of services and the Trust as an effective partner, employer and advocate for services

Our five-year plan is structured around our three strategic priorities and provides the basis for our future investment. By 2019 we will have:

- Further empowered people to make informed choices to support their wellbeing
- Enabled rapid access to treatment and support which enables recovery from unavoidable acute episodes
- Helped people to spot and, wherever possible, avoid crisis

Our plan identifies four key challenges which we will help mitigate by investing in organisational development, technology and partnership working.



These significant changes are being driven by increasing demand, changing demography, a changing knowledge base and changing technology. In order to achieve our key priorities, we know that further transformational change is necessary – this will be asking a great deal from our colleagues who have already delivered significant changes and efficiency savings.

Sustainability and Transformation Plans (STPs)

We are working with our colleagues in the Gloucestershire Sustainability and Transformation Plan footprint, and the STP footprint for Herefordshire and Worcestershire, to develop an approach which will transform health and social care provision over the next five years.

The plans involve not only NHS Trusts and local authorities, but voluntary sector organisations, communities, staff, and the public. These plans will enable our Trust and our partners to meet the increasing demands placed upon us and provide a responsive, high quality and equitable service to our communities in the years to come.

You can view the STP for each area via the NHS England website: www.england.nhs.uk.

Above all, our desire to provide the best possible care is informed by the experiences that our service users, carers and our staff contribute to our ongoing process of community and internal engagement.

Going concern

After making enquiries, the directors have a reasonable expectation that ²gether NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Official opening of Colliers Court

Performance Report - Analysis

As an NHS Foundation Trust our performance is measured in a variety of ways, including the ratings we are given by our regulator, NHS Improvement.

As can be seen from our Regulatory Ratings on page 55, our 'score' against the single oversight framework at the end of 2016/17 was 2, where '1' reflects the strongest performance, and '4' reflects the lowest rating.

We are also regulated by the Care Quality Commission (CQC), which conducted a comprehensive inspection of our services in October 2015. We achieved an overall rating of 'good', with two of our core services achieving an 'outstanding' rating. Two of our services were rated as 'requires improvement'. We have developed and implemented a comprehensive action plan in response to the 15 'must do' recommendations and the 58 'should do' recommendations identified by the inspection.

A full copy of the CQC's inspection report can be seen on the CQC website.

The CQC did not take any enforcement action against the Trust in 2016/17.

We report on a number of local safety and quality standards agreed with Herefordshire and Gloucestershire commissioners through the Commissioning for Quality and Innovation (CQUIN) payment framework. You can read more about our CQUINs and our achievements against them in our Quality Report (page 87).

In addition to these operational performance measures, we also constantly undertake our own quality assurance reviews and audits across all services. We are also part of external inspections, such as those carried out by the Office for Standards in Education, Children's Services and Skills (OFSTED) with our local authority partners.

We constantly strive to improve and enhance our services, and during 2016/17 we have worked with our commissioners and partners to introduce a number of service delivery initiatives. These include:

- The refurbishment and opening of new 'hubs' for teams delivering services in the Forest of Dean, Herefordshire and Stroud areas
- The roll-out of mobile working devices alongside digital dictation and transcription, to reduce the administrative burden upon clinical colleagues
- The further development of the new Mental Health Acute Response Service (MHARS) for Gloucestershire, which includes the setting up of a new Urgent Response Team co-located with the emergency services in Gloucestershire
- The formation of a dementia research partnership with local charity Cobalt
- The opening of a new Research Centre and base for our Managing Memory ²gether service, at the Fritchie Centre, in Cheltenham
- The launch of a partnership with Big White Wall, to provide 24/7 support to veterans living in Herefordshire
- Work with our STP partners in Gloucestershire and Herefordshire to develop more joined-up services, reduce duplication, promote self-care and provide more sustainable services to meet the current and future needs of our communities
- Continued membership of the national Triangle of Care scheme, which brings carers, service users and professionals closer together to jointly promote the recovery of people with mental health conditions
- Work to make our Trust 'Smokefree', in line with National Institute for Clinical Excellence (NICE) PH48 guidance
- Our continued work as a partnership site for tackling mental health stigma as part of a national Time to Change initiative

Triangle of Care
MEMBER

Financial Performance

During 2016/17 our two main commissioners were Gloucestershire and Herefordshire Clinical Commissioning Groups (CCGs) with whom we agreed to provide clinical care and treatment through block contracts.

We also held contracts with commissioners in our surrounding region and a contract with NHS Specialist Commissioners for low secure mental health inpatient care.

Our 2016/17 Statement of Comprehensive income can be found on page 137. The table below details a financial performance summary for the past two years:

	2016/17 £m	2015/16 £m
Total income	112.813	105.709
Operating expenses	(112.373)	(103.979)
Underlying surplus	(2.745)	(2.445)
Deficit	(2.302)	(0.715)

As detailed above, operating expenses in 2016/17 totalled £112,373,000 which is an increase of 8.1% year-on-year. Staff costs accounted for £82m or 73% of our operating expenses.

NHS Improvement (NHSI), our regulator, set ²gether a Control Total of a surplus of £0.654m for 2016/17. Provided this control total was met NHSI would provide Sustainability and Transformation Funding (STF) of £0.650m.

We achieved a surplus of £0.677m and therefore met our control total and received the STF of £0.650m. However, as we over-achieved our control total, we were also eligible for both STF Incentive and STF Bonus monies. We received a further £0.056m Incentive STF and a further £0.531m Bonus STF monies.

This means that for 2016/17 ²gether NHS Foundation Trust has achieved a surplus of £1.264m for NHS segmentation purposes, and received £1.237m of STF.

To reconcile to our reported financial position of a deficit of £2.302m, impairment costs of £3.566m need to be deducted from the surplus of £1.264m. However, impairment costs are a technical non cash financial adjustment arising from a change in asset values and do not count against the achievement of our Control Total or our segmentation.

In 2017/18 we plan to deliver a surplus of £883,000 while we continue to deliver our existing capital programme, which includes further improvements to our community environments and our extensive improving care through technology programme.

Our full annual accounts can be found at page 135.

Efficiency savings

During 2016/17 we were expected to deliver £4.116m in efficiency savings in addition to the £4.01m we delivered in 2015/16. This comprised a 3.8% national efficiency requirement and additional savings to meet cost pressures and service developments.

Over the year, we delivered savings of £4.166m against a total income of £112.813m.

In a challenging and complex environment, we have delivered significant transformational change. We have managed our money cautiously and, by investing in our communities' mental health and enhancing the services we have been commissioned to deliver, we have retained our stable financial performance.

All efficiency schemes must be approved by our Medical Director, Director of Engagement and Integration, and Director of Quality at the planning and delivery stages. This helps us to ensure that an appropriate clinical risk assessment process informs our decisions.

Quality is uppermost in our mind and the Trust's Board receives regular updates on whether we are delivering our savings plans. They also provide challenge while seeking clear assurances on the impact that any schemes may have on our ability to deliver the best clinical care.

Cost allocation and charging requirements

The Directors confirm that 2gether NHS Foundation Trust complies with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance.

Public Sector Payment Policy

The Trust's performance against the policy has remained consistently high throughout 2016/17. The cumulative Public Sector Payment Policy (PSPP) performance for the Trust for the financial year 2016/17 was 86% of invoices paid within 10 days and 97% paid within 30 days.

The Trust paid no interest under the Late Payment of Commercial Debts (Interest) Act 1998.

Income disclosure

The Directors confirm that 2gether NHS Foundation Trust has met the requirement that income from the provision of goods and services for the purposes of the health service in England is greater than its income from the provision of goods and services for any other purposes.

Post balance sheet events

There are no material post balance sheet events to report.

Counter fraud

Our robust and effective Counter Fraud Service demonstrates our commitment to ensuring that public money is not defrauded; this helps make sure that NHS funds are used for patient care and services.

Over the year, Gloucestershire Local Counter Fraud Service (LCFS) has assisted us in reducing opportunities for the commission of fraud and corruption to an absolute minimum.

It has also helped to increase liaison with other government, public and private organisations, and the national and regional offices of NHS Protect to improve the impact of our counter fraud activity. We continue to encourage the honest majority of staff to report any concerns to the LCFS about potential fraud and corruption or areas of high fraud risk. The LCFS then takes appropriate action and pursues appropriate sanctions. The outcome of this activity is reported to act as a deterrent to others.

Future investment

The coming year is arguably likely to be the most challenging in the history of the NHS. Change in demographics, demand, awareness, national guidance and targets, the introduction of new technologies and our work with our STP partners, means we must remain flexible and adaptable.

Delivering against our financial plan while maintaining and enhancing the care we provide will be essential, yet demanding.

Our commitment to our service users, carers, staff, partners and communities remains at the forefront of everything we do. We will continue to invest in what we need to do and what is best for the people we serve, while ensuring that we are responsible and careful with our necessary spending.

Environmental sustainability

The Trust's estate strategy includes the following objective:

Strategic Objective Four – To develop the estate to reduce our carbon footprint year- on-year in line with national policy and guidance.

This Strategic Objective is underpinned by Key Performance Indicators which set specific greenhouse gas emissions (expressed in the following tables as CO2e), in line with the national targets. The next milestone target is a minimum of 34% by 2019/20 from the 2008/09 base year; having already exceeded our 2014/15 target.

Recognising that the Trust did not operate services in Herefordshire in 2008/09, our Key Performance Indicator for Herefordshire is to reduce greenhouse gas emissions (CO2e) by 2% year-on-year from our contract base year of 2011/12, making our 2015/16 target an 8% reduction.

We have achieved a 38% reduction in Gloucestershire from 2008/09 to 2015/16, exceeding our 2019/20 target of 34%.

Utilities carbon production in Gloucestershire

	Baseline 2008/09 Weight of CO_2e (tonnes)	2009/10 Weight of CO_2e (tonnes)	2010/11 Weight of CO_2e (tonnes)	2011/12 Weight of CO_2e (tonnes)	2012/13 Weight of CO_2e (tonnes)	2013/14 Weight of CO_2e (tonnes)	2014/15 Weight of CO_2e (tonnes)	2015/16 Weight of CO_2e (tonnes)	Percentage Change against 2008/09
Gas	1597	1279	1403	1109	1156	1182	999	938	**-41%**
Electricity	1633	1592	1638	1734	1437	1581	1151	1030	**-27%**
Heating Oil	69	57	64	69	82	83	52	63	**-9%**
Water	7	7	9	9	11	9	23	25.8	**+369%**
TOTAL	**3306**	**2935**	**3114**	**2921**	**2686**	**2855**	**2225**	**2057**	**-38%**

We have achieved a 16% reduction in Herefordshire from 2011/12 to 2015/16, exceeding our 8% target. We also achieved our 2019/20 target of 16% two years early, although as a Trust we have some concerns about the base data quality.

Utilities carbon production in Herefordshire

	2011/12 Weight of CO_2e (tonnes)	2012/13 Weight of CO_2e (tonnes)	2013/14 Weight of CO_2e (tonnes)	2014/15 Weight of CO_2e (tonnes)	2015/16 Weight of CO_2e (tonnes)	Percentage Change against 2011/12
Gas	82	86	71	87	75	**-9%**
Electricity	70	167	157	129	77	**+10%**
Heating Oil	237	282	221	240	174	**-27%**
Water	2	2	2	4.9	4.2	**+210%**
TOTAL	**391**	**537**	**451**	**461**	**330**	**-16%**

Gas

The Trust's primary heating source is gas, with the exception of the Stonebow Unit and Westridge, which have oil-fired boilers. Over the reporting period there has been a combined reduction in greenhouse emissions of 27% in Herefordshire and Gloucestershire. This is due to a programme of works installing, or improving roof insulation; the replacement of older inefficient boilers; improved plant controls; and solar water heating.

Electricity

There has been a 27% reduction in greenhouse emissions from electricity between 2008/09 and 2015/16, reversing recent trends. Electricity is generally used for lighting, Information Technology and to a smaller extent for air conditioning. The reduction in electrical consumption has been the consequence of installing higher performance lighting during refurbishment projects.

Water

Trust-measured water consumption has increased steadily and will continue to do so. This is the consequence of a trend towards the metering of water instead of water bills which are a product of rateable value.

We are also systematically flushing water outlets to combat the risk of microbiological population of our water systems and providing more en-suite facilities. However, the 429% increase in greenhouse gases from water are the consequence of a change in the calculation during 2014/15, which now includes waste water and sewerage, as well as water consumed. However, water only represents 0.2% of the greenhouse gases generated by our buildings.

Waste

Significant changes have occurred in the Treatment of the Trust's waste, resulting in large reductions in the greenhouse gases produced; and DEFRA has changed the metrics for the calculation of CO2e, compounding these changes.

During 2014/15, recycling was rolled out across Herefordshire and the Trust's domestic and recycling waste provider put all of our Gloucestershire waste through an Energy From Waste (EFW) Plant that sorts its black bag waste, diverting it from landfill to fuel.

This means that 1 tonne of black waste only produces 21kg of CO2e compared with 459kg when sent to landfill. This service was extended to Herefordshire from 1 April 2015.

In 2008/09 the Trust put approximately 233 tonnes of waste into landfill generating 96.4 tonnes of greenhouse gases. In 2015/16 the Trust only generated 9.71 tonnes of greenhouse gases from its waste.

Waste data for Gloucestershire

	Baseline 2008/09 Weight of CO_2e (tonnes)	**2009/10** Weight of CO_2e (tonnes)	**2010/11** Weight of CO_2e (tonnes)	**2011/12** Weight of CO_2e (tonnes)	**2012/13** Weight of CO_2e (tonnes)	**2013/14** Weight of CO_2e (tonnes)	**2014/15** Weight of CO_2e (tonnes)	**2015/16** Weight of CO_2e (tonnes)	**Percentage Change against 2008/09**
Landfill	88.0	80.3	66.3	69.1	66.0	61.7	0	0.62	-
Treated & Incinerated	8.4	0	0.8	0.5	0.5	0.4	0	0	-
Treated & energy from waste							4.34	4.04	-
Treated & Landfill	0	6.4	6.4	8.4	8.7	9.7	2.3	0	-
Mixed Recycling	0	2.3 = 0	20.1 = 0	25.2 = 0	58.3 = 0	34.02 = 0	3.0	3.36	-
TOTAL	**96.4**	**86.7**	**73.5**	**78.0**	**75.2**	**71.8**	**9.6**	**8.02**	**-92%**

Waste data for Herefordshire

	Baseline 2011/12 Weight of CO_2e (tonnes)	**2012/13** Weight of CO_2e (tonnes)	**2013/14** Weight of CO_2e (tonnes)	**2014/15** Weight of CO_2e (tonnes)	**2015/16** Weight of CO_2e (tonnes)	**Percentage Change against 2008/09**
Landfill	37.4	37.4	37.4	7.7	0.08	-
Treated & Incinerated	1.0	1.5	1.3	0.6	0	-
Treated & energy from waste					0.99	-
Treated & Landfill	0	0	0	0	0	-
Mixed Recycling	6.6 = 0	6.0 = 0	6.3 = 0	0.63	0.63	-
TOTAL	**38.4**	**38.9**	**38.7**	**8.3**	**1.69**	**-94%**

CO_2e is the universal unit of measurement to indicate the global warming potential (GWP) of Greenhouse Gases (GHGs), expressed in terms of the Global Warming Potential of one unit of carbon dioxide expressed in tonnes.

DEFRA is the Department of Environment, Food and Rural Affairs.

Public and patient involvement

We launched our Engagement and Communication Strategy in early 2016. Our collaborative approach is based on an engagement cycle using three fundamental principles: to **inform**, **involve** and **improve** services together.

Our engagement and communication vision is that people in our community will become champions of our services to make life better. This vision includes the involvement of our members and our volunteers. The contribution of volunteers has continued to be of significant value and has made a real difference to individuals and local communities.

In 2016/17, we have continued to modernise recruitment and support of our volunteers across Herefordshire and Gloucestershire in line with our Volunteering Strategy.

We also continue to grow our network of Experts by Experience, and involve them in many aspects of our work. Their invaluable contribution continues to ensure we consider the needs, preferences and suggestions of those people who have used or continue to use our services in developing and enhancing our services.

Social inclusion

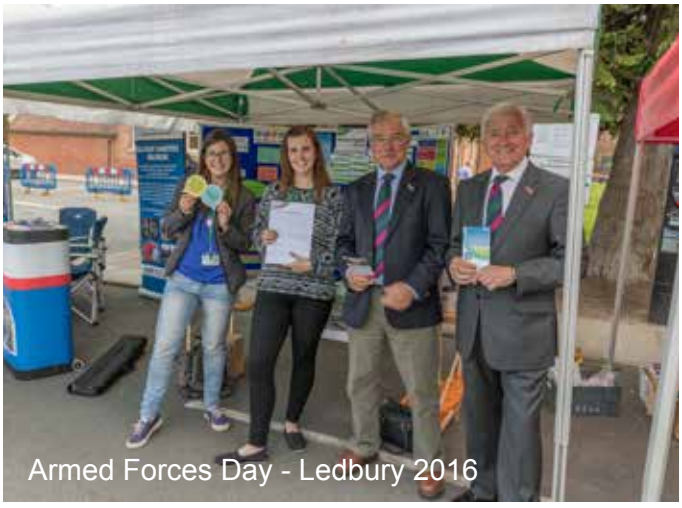
A core value of ²gether NHS Foundation Trust is to undertake socially inclusive practice. The Trust is fully committed to ensuring a socially inclusive, recovery-orientated approach to the delivery of care across all areas.

We have a strong emphasis on partnership working, with co-development and co-delivery of services in collaboration with service users and carers, local communities and care delivery partners. A network of positive relationships to ensure the inclusion of such valued perspectives is essential and so developing further opportunities for listening, inclusion and participation remains a key priority for us.

The Trust has played an active role across both counties in the strategic development and implementation of community-wide measures to support mental health and wellbeing. Activities have aimed to: promote easy access to services for all; invite feedback and involvement in planning and delivery of services; combat stigma and discrimination; and to further advance multiagency working.

Socially inclusive practice development has been evidenced across all Trust services during 2016/17. Corporate and clinical teams have been working to make progress in the following areas:

- Inclusion of people who use ²gether's services
- Carer inclusion
- Community involvement and development
- Tackling stigma and discrimination
- Volunteer activity
- Recovery-focused practice
- Employment championship
- Physical wellbeing for inclusion
- Engagement activities


Armed Forces Day - Ledbury 2016

In 2016/2017 we have continued to improve the experience of carers and families through the implementation of the Triangle of Care project across our services (including Young Carers). We currently have 53 Carers Champions across the localities and have delivered 40 Carer Aware training sessions to staff. The project is co-facilitated by local carers.

We have continued to work with internal and external stakeholders in order to tackle stigma and support social inclusion across our communities. Some of the events that we have attended and occasions we have marked include:

- Gloucestershire Pride
- Time to Talk day events
- Armed Forces day
- Mental Health Awareness week events
- Gloucestershire Police open day
- Fresher's Fairs
- Carers' Rights day
- Big Health Check day
- World Mental Health day
- Crucial Crew (for 1,600 young people in Herefordshire)
- Skillzone

Our dedicated Social Inclusion Team influences people to become champions by delivering our Expert by Experience Strategy. Our Experts by Experience are involved in range of activities, ranging from recruitment, sharing of experiences to inspire others, steering and reference groups, project work, and training. The range of activities and numbers of the Experts taking part has increased and we are looking to further develop our Expert by Experience programme in order to offer more opportunities for people to get involved and engaged.

Service Experience

Our overarching vision is that every service user will receive a flexible, compassionate, empathetic, respectful, inclusive and proactive response from our staff and volunteers. As we serve our patients and their carers we will go beyond what people expect of us to ensure that we earn their trust and confidence, and engender hope for the future. Our Service Experience Strategy was co-designed and co-produced with staff and other stakeholders.

This strategy continues to drive our vision for best service experience for patients and carers. The implementation of the work to deliver our service experience vision is monitored through the Trust's Service Experience Committee, which meets quarterly. Members of the committee include service users, carers, partner organisations and senior operational colleagues. Our quarterly Service Experience Reports are presented to and discussed at our public Trust Board meetings.

Learning from experiences

Listening to and learning from patient and carer stories forms part of every agenda at each Trust Board meeting. We routinely invite patients, carers and staff members to share their experiences directly with our Trust Board. This helps us to have a continued awareness of service user and carer feedback at the highest level of the organisation. Detailed information is also considered by our individual Locality Boards. We also ensure service users and carers are actively involved in advising on and appraising our services through a wide range of methods. Furthermore, our Trust Experts by Experience are involved in recruitment processes as well as consultation on policy and service developments. Staff training and development also involves Experts by Experience.

Partnerships

During 2015/16, we were selected to participate in a national pilot initiative led by campaigning organisation Time to Change to reduce stigma experienced by people using mental health services. Our involvement, which continued during 2016/17, has included a series of facilitated workshops with staff, as well as communication and awareness-raising activities. The pilot's success led to the wider rolling out of the programme to Trusts across the rest of the country. We were proud to be part of this ground-breaking project, which builds on our strong history of tackling mental health stigma.

We entered into partnerships with Swindon Mind and Cobalt during 2016/17. With Swindon Mind and our Gloucestershire Commissioners we have opened a Wellbeing House, and with Cobalt we have entered into a dementia research partnership.

The Alexandra Wellbeing House in Gloucester

Both partnerships form part of our ongoing aim to link with other agencies to further enhance service provision and support to our communities.

Future performance and risks

During 2017/18, we will face continued challenges, and perhaps more challenges than we have in previous years. Our Trust has proved itself to be innovative, flexible and willing to work alongside partners to ensure we continue to meet the demands now placed upon us and those challenges we will face in the future.

We wish to maintain our CQC rating of 'good', while building towards an 'outstanding' rating at our next inspection.

Our work with the STPs for both Herefordshire and Worcestershire and Gloucestershire will help to direct much of our work, but we will also remain focused on our own service users, carers, staff, partners and communities. Within the STPs we will continue to champion the rights and needs of people with mental health conditions and learning disabilities across our two counties.

Operationally we will focus on improving and enhancing the physical health and wellbeing of our service users, carers and staff; further developing the Mental Health Acute Response Service in Gloucestershire; meeting national targets set for Improving Access to Psychological Therapy (IAPT); and further development of the buildings and technology we need in order to support the delivery of clinical care.

During 2016/17 a successful bid was submitted to provide a Perinatal Mental Health Service for Gloucestershire. This service, which is being led by 2gether, will provide mental health assessments and treatment for pregnant women and women who have given birth within the last 12 months across Gloucestershire. This will also form a key part of our operational focus over the coming year.

These are just examples of the service developments we will introduce and focus on this year. We are aware that we face risks in achieving our aims. We will continue to monitor and assess those risks and include them in our Risk Register and Board Assurance Framework, which is reported and discussed regularly at our Trust Board.

This Performance Report has been approved by the directors of 2gether NHS Foundation Trust.

Shaun Clee
Chief Executive **24 May 2017**

Accountability Report

Directors' Report

As described in our Performance Report, NHS Improvement (NHSI), our regulator, set ²gether a control total of a surplus of £0.654m for 2016/17. Provided this control total was met NHSI would provide Sustainability and Transformation Funding (STF) of £0.650m.

We achieved a surplus of £0.677m and therefore met our control total and received the STF of £0.650m. However as we over-achieved our control total, we were also eligible for both STF Incentive and STF Bonus monies. We received a further £0.056m Incentive STF and a further £0.531m Bonus STF monies.

This means that for 2016/17 ²gether NHS Foundation Trust has achieved a surplus of £1.264m for NHS segmentation purposes, and received £1.237m of STF.

To reconcile to our reported financial position of a deficit of £2.302m, impairment costs of £3.566m need to be deducted from the surplus of £1.264m. However impairment costs are a technical non cash financial adjustment arising from a change in asset values and do not count against the achievement of our control total or our segmentation.

We have also achieved the savings efficiencies required for the future financial security of the organisation.

Our Annual Accounts can be found from page 135 onwards and the accounting policies under which our accounts were prepared and completed are detailed within the notes to the accounts, from page 141 onwards.

Charitable Funds

Charity Commission Registration Number: 1097529

For many people, recovery can be quick – perhaps a few months.

For others, the enduring struggle with their illness can lead to years of difficulties, with significant personal and family consequences.

The Trust's Charitable Funds enable people to have experiences which are not part of core NHS spending. They could not be offered without your generosity.

Find out more about our charitable funds committee and how you can support it via

www.2gether.nhs.uk/charitablefunds.

Directors' responsibilities

The Directors confirm that, so far as they are aware, there is no relevant audit information of which the Trust's auditor is unaware. The Directors have taken all the steps that they ought to have taken as Directors in order to make themselves aware of any relevant audit information and to establish that the auditor is aware of that information.

Accounting policies for pensions and other retirement benefits are set out in note 1.4 to the accounts, and details of senior employees' remuneration can be found in the Trust's Remuneration Report.

Income disclosures

As per Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012), we can confirm that the income from the provision of goods and services for the purposes of the health service in England is greater than its income from the provision of goods and services for any other purposes.

The impact of the provision of other income is not material on the provision of goods and services for the purposes of the health services in England.

Use of the Commissioning for Quality and Innovation (CQUIN) framework

The national contractual use of CQUINs is to support the essential focus upon quality improvement in the provision of services and incentivise through specific quality payments.

A proportion of ²gether NHS Foundation Trust's income in 2016/17 was conditional on achieving quality improvement and innovation goals agreed between ²gether NHS Foundation Trust and

Gloucestershire Clinical Commissioning Group, Herefordshire Clinical Commissioning Group and NHS South West Specialised Commissioning Group (for the provision of low secure mental health NHS services) 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.

The total potential value of the income conditional on reaching the targets within the CQUINs during 2016/17 was £2,219,300, of which £2,219,300 will be achieved.

Full details of our achievements against our CQUINS are contained within our Quality Report, which includes information about our agreed CQUINS for 2017/18.

Strategic partnerships

We have entered into a strategic partnership with Swindon Mind, through which we deliver the Alexandra Wellbeing House, in Gloucester. We also partner with Cobalt on a dementia research partnership. We will continue to explore other partnership opportunities throughout 2017/18.

Signing of our Cobalt partnership

Trust membership

As an NHS foundation trust, we help ensure local accountability, ownership and control of local services. We also seek to educate and inform people so that they in turn can become ambassadors for our Making Life Better Campaign to tackle the stigma that is so often experienced by people living with mental ill health and their families.

Membership constituencies and eligibility requirements

There are eight public membership constituencies and a staff constituency, which is divided into three classes.

Public constituencies

Members of our public constituency must live in England, be aged 11 or older and not eligible to become a member of our staff constituency. Six of our public constituencies are based in the city, borough and district councils of Gloucestershire. The seventh constituency is Greater England.

On 1 April 2014, our public constituencies were amended in our constitution. This amendment established Herefordshire as a separate eighth public membership constituency.

Staff constituency

Members of the staff constituency are individuals who are employed by the Trust under a contract of employment. Staff leaving Trust employment have the option to not transfer automatically to public membership.

The Trust provides automatic membership of the staff constituency and, when ineligible to remain a member of the staff constituency, we provide automatic membership of a public constituency. All eligible members of staff become a member of the organisation unless they elect otherwise.

On 1 April 2014, our staff constituency was amended in our constitution. There are now three classes:

- Medical and nursing staff
- Clinical and social work and support staff
- Management, administrative and other staff

Membership data

Constituency	As at 31 March 2017
Public	5,355
Staff	2,088
Average new members per month	24

Public membership by constituency

17%	Cheltenham
7%	Cotswolds
10%	Forest of Dean
26%	Gloucester
15%	Stroud
11%	Tewkesbury
7%	Herefordshire
7%	Greater England

Membership strategy

A new membership strategy was agreed in September 2016. It seeks to recruit more members, particularly among hard-to-reach groups, and enhance the involvement of and information provided to our existing members.

The actions presented within it also complement the Trust's Engagement and Communication Strategy 2016 -2020, which is structured to influence more people in our community to become champions of the services that we deliver to make life better. The strategy aims to:

- Promote and increase membership among groups who are currently under-represented
- Retain our current members
- Enhance membership engagement by building opportunities for members to communicate with their Governor and the Trust
- Encourage members to get involved in Governor elections
- Support the Trust's Social Inclusion strategy
- Raise public awareness of mental health issues

We continue to engage with members through our quarterly newsletter 'Up2Date'. We also send e-flyers and invite members to specific engagement events.

The vast majority of members who leave the Trust do so as a result of not providing new contact details. To help mitigate this, we continue to promote the benefit of electronic communication where it is appropriate for the member.

Become a member

If you are interested in helping to shape local NHS services or want to support our campaign to tackle the stigma that is so often associated with mental ill-health, join us:

- Telephone: 01452 894393
- Email: 2gnft.comms@nhs.net
- Web: www.2gether.nhs.uk/membership

Using our foundation trust status

Since achieving foundation trust status, we have been able to use our capital programme to reinvest in a number of areas.

During 2016/17, the investments we made to improve the care we provide included:

- The opening of new team bases in Stroud, the Forest of Dean and Hereford
- The purchase of a new building in central Gloucester, which will become our new Gloucester Hub
- The opening of a new clinical trials and research facility on our Charlton Lane site in Cheltenham – The Fritchie Centre
- Continued investments in clinical systems, mobile technology and digital transcription

Opening of The Fritchie Centre

Service experience

Our overarching vision is that every service user will receive a flexible, compassionate, empathetic, respectful, inclusive and proactive response from our staff and volunteers. As we serve our patients and their carers we will go beyond what people expect of us to ensure that we earn their trust, confidence and engender hope for the future.

[2]gether's Service Experience Strategy was co-designed and co-produced with staff and other stakeholders. This strategy continues to drive our vision for best service experience for patients and carers. The implementation of the work to deliver our service experience vision is monitored through the Trust's Service Experience Committee, which meets quarterly. Membership of the committee includes service users, carers, partner organisations and senior operational colleagues.

Our quarterly Service Experience Reports are presented to and discussed at our public Trust Board meetings.

Complaints and concerns

A total of 106 formal complaints were made to the Trust between April 2016 and March 2017. This is a decrease of 19% in formal complaints when compared with the number received in the same period last year.

Our quarterly Service Experience Reports are presented to and discussed at our public Trust Board meetings.

Complaints and concerns

A total of 106 formal complaints were made to the Trust between April 2016 and March 2017. This is a decrease of 19% in formal complaints when compared with the number received in the same period last year. Where possible and appropriate we aim to resolve concerns through the Patient Advice and Liaison Service (PALS) as this is a less formal process which enables a swifter response and resolution for complainants. A total of 195 concerns were reported this year to the Service Experience Department. This is a 24% increase from the previous year.

The reduction in the number of formal complaints and the increase in the number of concerns could suggest that the Service Experience Department along with operational colleagues are making every effort to effectively resolve issues locally in a timely manner.

The number of people making a complaint/raising a concern in relation to the number of people using our services has been reasonably consistent over a three-year period and is in line with national benchmark figures.

Our timely written acknowledgement of formal complaints continues with 99% (n=105) of complaints acknowledged within the three-day standard this year. We have continued to undertake awareness-raising activities with colleagues in clinical services to encourage the earliest possible response to complaints or concerns.

113 complaints (which include complaints that were open in the previous year) were closed between 1 April 2016 and 31 March 2017; on average 65.5% of complaints were closed within the required time frame. Action has been taken during the year to reduce the time taken to respond to complaints. At year-end, closure rates had improved to 78% for Quarter 4 and this resulted in a lower proportion of complaints remaining 'open' into the new financial year.

We continue to offer to meet with people who have complained with the aim of facilitating a local resolution. Seven people who complained chose to refer their concerns to the Parliamentary Health Services Ombudsman this year for further examination. The Ombudsman advised that five cases would be investigated further; we have not yet been advised of the outcome of these investigations.

Learning from individual complaints forms a key part of each response we make to people who complain. Even when complaints are not upheld, all learning from an individual's experience and feedback is reflected upon and appropriate action taken to embed this in practice.

Compliments

In addition to complaints and concerns, we also record the number of compliments we receive as a Trust. These compliments range from verbal messages to cards, emails and formal letters of thanks for support and treatment provided by individuals and teams across our services.

During 2016/17 we recorded a total of 2,209 compliments – more than 10 times the total number of complaints and concerns reported. Last year (2015/16) we recorded 2,822 compliments.

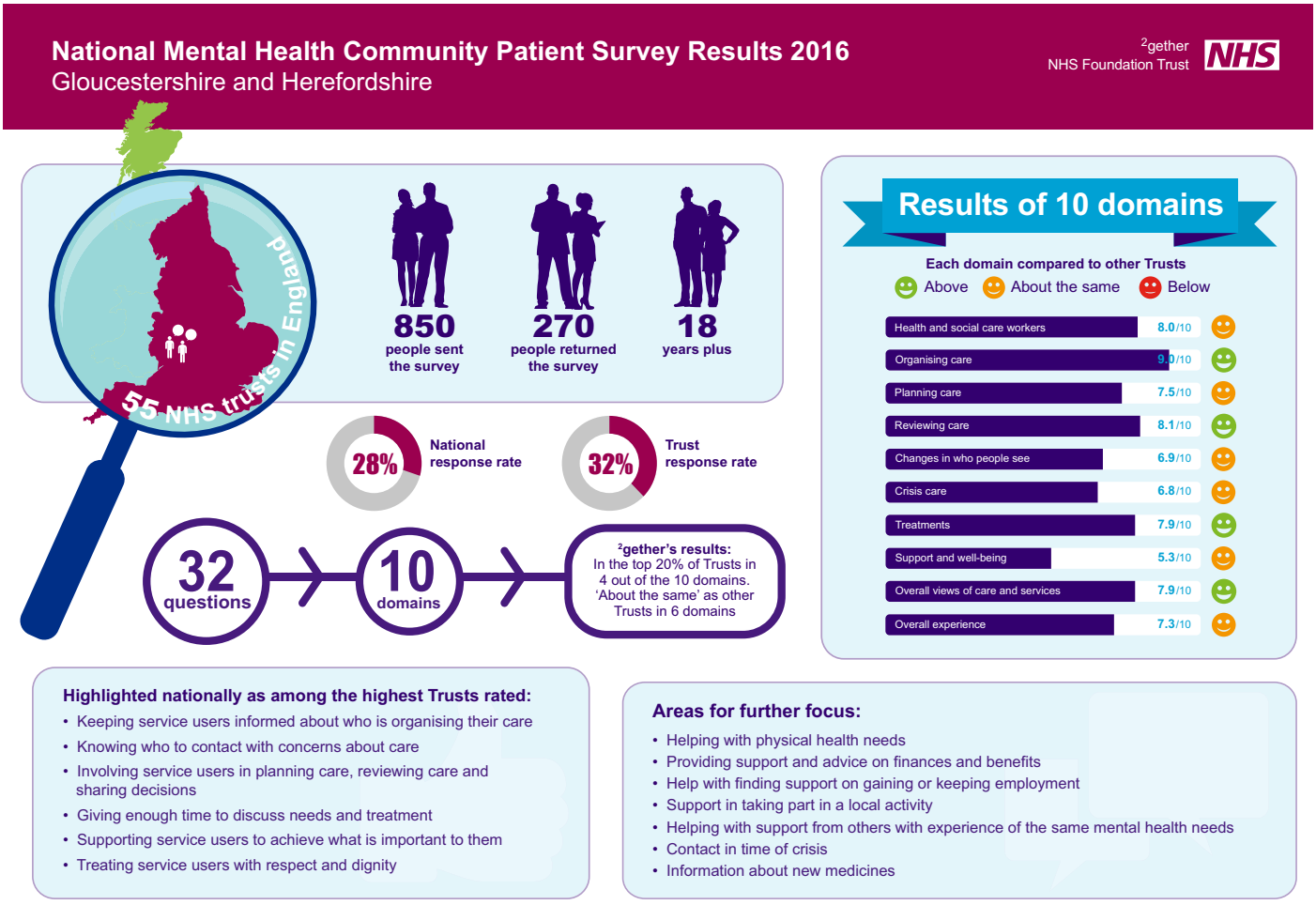
NHS Friends and Family Test

The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether people are happy with the service provided, or where improvements are needed. It is a quick and anonymous way to share views after receiving care or treatment across the NHS. We invite everyone who uses our services to respond to the FFT.

During 2016/17, the number of respondents who would recommend our services to their friends and family has ranged from 89% to 94%. This level of recommendation is on average higher than other mental health trusts in England.

National Mental Health Community Patient Survey

The 2016 Community Mental Health Survey surveyed people who had been in contact with community mental health services in England between 1 September and 30 November 2015. The results of the survey for Gloucestershire and Herefordshire are depicted here:



Highlighted nationally as among the highest Trusts rated:

- Keeping service users informed about who is organising their care
- Knowing who to contact with concerns about care
- Involving service users in planning care, reviewing care and sharing decisions
- Giving enough time to discuss needs and treatment
- Supporting service users to achieve what is important to them
- Treating service users with respect and dignity

Areas for further focus:

- Helping with physical health needs
- Providing support and advice on finances and benefits
- Help with finding support on gaining or keeping employment
- Support in taking part in a local activity
- Helping with support from others with experience of the same mental health needs
- Contact in time of crisis
- Information about new medicines

Accountability

The NHS Foundation Trust Code of Governance

Governance is the system by which the Trust is directed and controlled to achieve its objectives and meet the necessary standards of accountability and probity. The Trust has adopted its own governance framework, which requires Governors, Directors and staff to have regard for recognised standards of conduct, including the overarching objectives and principles of the NHS, the seven Nolan Principles, the NHS Constitution and the NHS Foundation Trust Code of Governance.

Board of Directors

Our Board of Directors provides leadership and helps drive overall Trust performance, ensuring accountability to Governors and our members.

The Board is legally responsible for the strategic and day-to-day operational management of the Trust, our policies and our services. It maintains a scheme of delegation giving authority to Directors, and others within certain limits, to carry out actions required under financial procedures and the Mental Health Act.

Members of the Board

About our independent Non-Executive Directors

1. Ruth FitzJohn, DL – Chair

Ruth has been our Chair since 1 April 2013, and also chairs our Council of Governors and the Appointments & Terms of Service Committee. For the previous six years she was Chair of NHS Gloucestershire and during 2011, 2012 and 2013 was also Chair of NHS Swindon.

Ruth had a successful, international career in IT management and strategic planning before joining the NHS, where she has gained considerable experience as Vice Chair of the East Gloucestershire NHS Trust, then Chair of the '3 Star' Cheltenham and Tewkesbury Primary Care Trust.

Ruth was appointed a Deputy Lieutenant of Gloucestershire in September 2013 and was elected President of Midcounties Co-operative in November 2014. Ruth was reappointed as Trust Chair on 1 April 2016.

2. Maria Bond – Independent Non-Executive Director *(from 1 November 2016)*

Maria, who lives in Stroud, Gloucestershire, uses both her personal and professional experience to support the work of the Trust.

She has previous experience as a non-executive director for Gloucestershire Hospitals NHS Foundation Trust. This has given her a valuable understanding of how acute services works and the challenges they, and the wider NHS, face.

Her professional experience comes in the construction and commercial development sector, where she has worked for many years as a chartered quantity surveyor. She has particular experience in integrating small businesses and change management. Maria chairs the Trust's Delivery Committee.

3. Martin Freeman – Independent Non-Executive Director *(to 31 October 2016)*

Martin is a retired GP who joined the Trust as a Non-Executive Director on 1 April 2012 and was reappointed by the Council of Governors on 1 April 2015. He chairs the Trust's Governance Committee, and the Mental Health Legislation Scrutiny Committee. He has gained knowledge and understanding of service delivery and strategic planning in his role as GP Clinical Lead for Dementia and GP Regional Lead for Dementia.

Martin has a great interest in the provision of care for people with mental illness, learning disability and dementia. Previously Chair of Governors for a large comprehensive school, he has also been the lead clinical support in business planning and service redesign, involved in closing Berkeley Community Hospital and building the new Vale Community Hospital. Martin retired from the Trust on 31 October 2016.

4. Charlotte Hitchings – Deputy Chair; Senior Independent Non-Executive Director *(to 30 November 2016)*

Charlotte was appointed as a Non-Executive Director on 1 March 2011, and reappointed by the Council of Governors on 1 March 2014. She is the Trust's Deputy Chair and Senior Independent Director, and chairs the Trust's Delivery Committee.

During a 20-year management career in commercial organisations she has led teams in marketing, business development, product development and community investment. Prior to becoming a self-employed consultant and executive coach in 2004, Charlotte was Group Community Investment Manager with O2 PLC and a member of O2's Corporate Responsibility Advisory Council. For several years Charlotte served as Vice Chair of the Board of Governors and on the Budget Committee of King Edward VI Handsworth School. Charlotte resigned on 30 November 2016.

5. Nikki Richardson – Deputy Chair; Senior Independent Non-Executive Director *(from 1 November 2016)*

Nikki was appointed as Independent Non-Executive Director on 2 February 2015. She recently retired from an Executive role within the NHS, working for a Mental Health and Community Foundation NHS Trust. Initially qualified as a Speech and Language Therapist, her career has involved working across a wide range of clinical services including older people's mental health, learning disabilities, community nursing, paediatric services, and across therapy services. During this time she also held a national role within Speech and Language Therapy as the Vice Chair of the managers' association and as a consultant with the National Development Team, developing person-centred services for people with a learning disability. Her last role included Board level responsibility for Human Resources, Organisational Development, Training and Workforce Planning, Patient and Public Engagement, Information Technology and Communications.

Nikki has retained her original professional links and has been a Trustee for the Royal College of Speech and Language Therapists for the past four years, a role that will continue for a further two years. She now has her own consultancy company and has been providing project management support following the acquisition of NHS services. She is the Chair of the Trust's Governance Committee and lives in Cheltenham. Nikki took on the roles of Deputy Trust Chair and Senior Independent Director from 1 December 2016.

6. Marcia Gallagher - Independent Non-Executive Director

Marcia was appointed on 1 April 2016. She brings with her 40 years' NHS service and her experience both as a qualified accountant and the holder of a number of senior functioning roles in the NHS. Marcia chairs the Trust's Audit Committee.

Marcia, who lives in the Forest of Dean, worked in both commissioner and provider organisations in Gloucestershire, Herefordshire and the West Midlands. More recently, she worked for NHS England, before her retirement in January 2016.

She has had both a professional and personal involvement with mental health services, something that has helped drive her decision to become involved with ²gether.

7. Richard Szadziewski – Independent Non-Executive Director *(to 30 April 2016)*

Richard was appointed on 1 December 2015 on an interim basis while the Trust recruited to vacant Non-Executive Director roles. Richard was previously a Non-Executive Director with the Trust for three years from March 2011 to February 2014.

Richard is a qualified accountant with over 20 years' experience at Director level in a range of public sector organisations either in permanent or interim roles.

8. Duncan Sutherland – Independent Non-Executive Director

Duncan, who was appointed on 1 April 2016 and who lives just outside Hereford, brings with him years of experience as a Non-Executive Director of a number of public companies.

Duncan was non-executive director of the British Waterways Board for eight years before stepping down. He is currently a Non-Executive Director for High Speed 2, in a role focusing on economic growth, regeneration and property. His other Non-Executive Director post is with the South Bank Sinfonia, which works with music graduates.

He is also a director of Sigma, a specialist regeneration company, working with local authorities. Duncan chairs the Charitable Funds Committee and is Deputy Chair of the Development Committee.

9. Jonathan Vickers - Independent Non-Executive Director

Jonathan was appointed on 1 April 2013. He spent 25 years in the international oil and chemicals industries including board membership of Castrol and Burmah Chemicals.

Over the past decade, Jonathan has served as a Non-Executive Director on the boards of a range of public sector organisations including NHS South West Strategic Health Authority. He is an Independent Member of the Department of Energy and Climate Change (DECC) Investment Committee and a board member of British Rowing. Jonathan chairs the Trust's Development Committee and became Deputy Chair of the Audit Committee in May 2015. He was reappointed by the Council of Governors on 1 April 2016.

10. Quinton Quayle – Independent Non-Executive Director *(from 1 June 2016)*

During his diplomatic career, Quinton served as British Ambassador to Romania, Thailand and Laos, before retiring five years ago. Since then, he has taken on a number of board roles with a focus on regulation in the public interest, including serving as a lay member of the Nursing and Midwifery Council (NMC). He has also worked as an advisor to multinational companies, including Prudential and De La Rue.

Quinton, who lives in a small village in north Gloucestershire, is looking forward to using his experience in both the public and private sectors for the benefit of the Trust. He chairs the Trust's Mental Health Legislation Scrutiny Committee and is Deputy Chair of the Delivery Committee.

About our Executive Directors

11. Shaun Clee - Chief Executive

Shaun has over 36 years' experience in the NHS having trained as a Registered Mental Health Nurse before moving into management in 1990. He brings a passion for providing services that are responsive to service users and carers and has significant experience in both the commissioning and provision of mental health, learning disability and substance misuse services, having led mental health services in South Warwickshire for a number of years. He has also had executive board level responsibility for community hospitals, dentistry, sexual health, intermediate care teams, chiropody, physiotherapy, and occupational therapy as well as estates, information management and technology, and human resources and organisational development.

He has held national roles as the Chair of the NHS Confederation Mental Health Network, a Trustee and Board member of the NHS Confederation, a member of the NHS Confederation National Policy Forum, Chair of the NHS Confederation Audit Committee and as the Senior Independent Director for the NHS Confederation.

Shaun is currently Chair of the South of England Mental Health Safety Collaborative, Chair of the Herefordshire and Worcestershire Local Workforce Action Board, Chair of the South West Mental Health CEO Forum, Board member of Health Education England South West, Board member of South West Leadership Academy and Ambassador for NHS Benchmarking, and Chair of Kids Like Us.

12. Dr Chris Fear – Medical Director

Chris was appointed to the role of Medical Director in 2015 and combines this with his role as Caldicott Guardian and Consultant Psychiatrist in General Adult Psychiatry. He has recently worked, as Associate Medical Director, in both Gloucestershire and Herefordshire. Chris trained in North Wales and Birmingham, spending three years as a Research Fellow with the University of Wales, and was appointed as a consultant in Gloucester in 1996.

His clinical and research interests include delusional disorders, OCD, factitious illness and service models.

Chris is the Responsible Officer for doctors within our Trust, reporting to NHS England. He has recently chaired the South West Executive Committee for the Royal College of Psychiatrists and served nationally on its Council and Board of Trustees. He has been a Trustee for Gloucestershire Counselling Service and been Chair of the Board of Governors of a local state primary school.

13. Colin Merker - Director of Service Delivery

Colin has over 36 years' experience in the NHS. He is a professionally qualified Chartered Engineer. For the last 22 years he has held Board Level posts in a number of NHS organisations. He has experience of commissioning services at a PCT and regional level as well as operationally directing services at a provider level. He has experience of establishing and running a successful NHS Shared Service. He was Director of Mental Health Services in Coventry from 2002 and Chief Operating Officer of the Coventry & Warwickshire NHS Trust from 2006 until joining ²gether in 2009.

14 Carol Sparks - Director of Organisational Development *(to 27 November 2016)*

Carol has 20 years' experience in the NHS and is a Chartered Fellow of the Chartered Institute of Personnel and Development. She has responsibility for ensuring colleagues have the knowledge and skills to lead our services into the future, that our culture reflects Trust values and the NHS Constitution and, last but not least, that the health and wellbeing of staff is assured. Carol is particularly passionate about ensuring equality and diversity is integrated into how we work and deliver services. Carol resigned her position on the Board on 27 November, taking on a short-term role as Director of Special Projects for the Trust before retiring on 31 March 2017.

15. Neil Savage - Director of Organisational Development *(from 28 November 2016)*

Neil joined the Trust from his previous role as Director of HR Transformation, leading on the HR integration of Birmingham Children's and Birmingham Women's NHS Foundation Trusts. Prior to this, Neil worked at Birmingham Women's NHS Foundation Trust, most recently as Chief Operating Officer. In this role, he successfully delivered local and national performance and access targets, developed and implemented a number of service improvements and people strategies, as well as implementing Business Continuity Management and Emergency Planning systems. Before this, he was Executive Director of Workforce & Organisational Development. From 2004, Neil worked for Gloucestershire Hospitals NHS Foundation Trust as Assistant HR Director and Acting Director of HR & Organisational Development. Neil has previously also worked in other HR roles for NHS trusts covering acute, mental health, learning disabilities and community services.

A Chartered Fellow of the CIPD, Neil was the winner of the Health Education England West Midlands "Inspirational Leader of the Year" award in 2015 and was shortlisted as a national finalist in 2016.

16. Andrew Lee - Director of Finance and Commerce

Andrew has over 35 years of experience working in the NHS and is a Fellow of the Chartered Association of Certified Accountants (FCCA). More than 20 years previously he was either Finance Director or Deputy Director within the NHS, working in service provision including acute, mental health and community services, shared service provision, and service commissioning at Health Authority level and PCT level. Andrew also played a lead role in setting up a Clinical Commissioning Group and worked at the Welsh Assembly Government for two years as it became a devolved administration from the Welsh Office.

As well as operating as a Director of Finance at a number of different organisations, Andrew has also undertaken roles as Director of Quality & Performance and Director of Strategy.

17. Professor Jane Melton - Director of Engagement and Integration

Jane is a registered Allied Health Professional (Occupational Therapist) and has worked with people who have learning disabilities and people experiencing mental illness for the majority of her career. Her exceptional contribution to practice was acknowledged through a Fellowship of the College of Occupational Therapists in 2012.

Alongside her dedication to practice, Jane has achieved doctoral level qualifications and published collaborative, research and practice development activity.

Her academic connections are maintained through her honorary professorial role with Queen Margaret University, Edinburgh.

Jane brings a track record of service development that is shared with service users, their families, colleagues and local communities. She is passionate about the need to deliver the best experience of NHS care, is dedicated to the principles of recovery and underpins her approach to leadership with inclusion and engagement.

18. Marie Crofts – Director of Quality

Marie is a mental health nurse with over 30 years' experience. She has worked in adult and childrens' services across provider organisations as well as within specialised commissioning. The majority of her working life she has lived and worked in the West Midlands and had opportunities working in regional posts developing evidence-based practice, as well as service improvement work within the National Institute of Mental Health in England.

Marie has worked in Service Director roles managing large-scale Child and Adolescent Mental Health Services (CAMHS) and, more recently, been Deputy Director of Nursing and Operations within a community trust in Liverpool. She is committed to improving services through engagement with service users and their families, as well as active and effective engagement with all staff. She has a passion for involving families in services, as well as an interest in parental mental health and child welfare.

Attendance by Non-Executive Directors and Executive Directors

Terms of reference define membership for each committee. The Chair and Chief Executive by virtue of office may attend all meetings (except the Audit Committee).

The number of meetings and individual attendances at those meetings are detailed in the following table. Board members who are "members" of a particular committee or Board, as per the Terms of Reference, and therefore expected to attend are highlighted.

All Board members can attend any meeting and ad hoc attendance is also recorded.

Attendance at Trust Board and Board Committees by Non-Executive and Executive Members

Name and position	Council of Governors	Board	Development	Charitable Funds	Audit	Governance	Delivery	Mental Health Legislation Scrutiny
Ruth FitzJohn, DL, Trust Chair [1]	4	10	1		1			
Maria Bond, Non-Executive Director [2]	3	5	1	1	2	2	4	
Martin Freeman, Non-Executive Director [3]	2	6			3	7		4
Marcia Gallagher, Non-Executive Director	5	11		1	5			
Charlotte Hitchings, Deputy Trust Chair [4]	3	4	1		2		5	
Nikki Richardson, Non-Executive Director	5	11		2	5	10	8	5
Quinton Quayle, Non-Executive Director [5]	3	9		1	2		7	4
Duncan Sutherland, Non-Executive Director [6]	2	9	2	1	3			
Richard Szadziewski, Non-Executive Director [7]	1							
Jonathan Vickers, Non-Executive Director	2	11	9	1	4			
Shaun Clee, Chief Executive [1]	1	9			1			
Marie Crofts, Director of Quality	3	8				9		
Dr Chris Fear, Medical Director	1	9				9		
Andrew Lee, Director of Finance and Commerce	2	9	8		5			
Professor Jane Melton, Director of Engagement and Integration	3	10				8		
Colin Merker, Director of Service Delivery	3	10	2	1			11	6
Neil Savage, Director of Organisational Development [8]	1	4	1				2	
Carol Sparks, Director of Organisational Development [9]	4	6						

Member of a Committee/Board as stated in the terms of reference. Board members are welcome to attend all Committees and ad hoc attendance is also included in the table above.

[1] Ex officio (by virtue of office) member of all committees other than Audit
[2] Appointment commenced 1 November 2016
[3] Resigned 31 October 2016
[4] Resigned 30 November 2016
[5] Appointment commenced 1 June 2016
[6] Appointment commenced 1 April 2016
[7] Interim appointment ended 30 April 2016
[8] Appointment commenced 28 November 2016
[9] Resigned from the Board 27 November 2016

Board Committees

Audit Committee

All Non-Executive Directors, except the Trust Chair, are members of the Audit Committee. Marcia Gallagher chairs the Audit Committee. The role of the Audit Committee is to provide the Board of Directors with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities, both generally and in support of the Annual Governance Statement.

There were five meetings of the Audit Committee held in the reporting period. The Audit Committee's agenda is structured so as to enable consideration of significant issues throughout the year. Standing agenda items include:

Internal Audit: PwC is the Trust's Internal Audit provider. The Committee has commissioned from PwC a full audit programme based upon risk as identified by the Board Assurance Framework and received regular reports on the outcomes and actions completed. Where appropriate, the findings of these audits were also reported to other Committees in order for action plans to be developed and their timely implementation monitored. A number of these audits were specifically requested by the Committee in order to scrutinise known areas of risk.

External Audit: Each year the Committee approves an External Audit Plan setting out the timetable for the audit of the annual accounts and the Quality Report. The Committee also receives at each meeting a summary of any additional significant risks identified through the planned audit work, as well as a summary of significant risk, regulatory and health sector developments that are pertinent to the work of the Trust.

Deloitte was appointed as the Trust's External Auditor in 2012 for an initial period of three years, through a competitive tendering process overseen by the Council of Governors. The Council of Governors subsequently accepted a recommendation from the Audit Committee to extend Deloitte's appointment for a further two years, with effect from 1 April 2015.

Financial Reporting: The Committee receives a number of reports throughout the year on significant financial issues such as losses and special payments and valuation of intangible assets. In accordance with International Financial Reporting Standards the Committee also receives the 'Going Concern' report ,enabling the Trust to make and document a rigorous assessment of whether the Trust is a going concern when preparing its annual financial statements. In reviewing and approving the financial statements, the Committee also reviews any changes to accounting policies, and receives a report outlining factors which the Committee must take into account in order to satisfy itself that no material misstatements have been made in the accounts, and providing assurance that sufficient controls exist for the Committee to be assured that the Annual Accounts present an accurate assessment of the Trust's financial position, and the External Auditor can rely on the information contained within the Letter of Representation.

Counter Fraud Reporting: The Committee approves a Counter Fraud Plan each year, and receives reports on Counter Fraud activity at each meeting.

Appointment and Terms of Service Committee

The Appointment and Terms of Service Committee is chaired by the Trust Chair and has a membership of all Non-Executive Directors. In the absence of the Chair, the Deputy Chair of the Trust will lead the meeting. The Committee's role is to agree the arrangements for appointment to, and conditions of service for, the posts of Chief Executive and Executive Director. It also ensures there are appropriate arrangements for the consideration and management of succession planning.

During the year the committee met five times and considered:

- The performance of each Executive Director and the Chief Executive
- Executive Director and Chief Executive pay
- Succession arrangements
- The allocation of clinical excellence awards for consultants, discretionary points to associate specialists and optional points to staff grades in line with the Trust's policies and procedures and as necessary

Appointment

Appointment of new Non-Executive Directors is for an initial period of three years, subject to earlier termination or extension, and is governed by the terms of the Trust's Constitution and the Standing Orders for the Council of Governors and Board of Directors.

Appointment both of Executive and Non-Executive Directors is subject to candidates satisfying the requirements for Fit and Proper Persons; Directors, this is set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Directors must continue to satisfy these requirements during the term of their appointment.

Reappointments

Non-Executive Directors are eligible for reappointment at the end of their initial period of office in accordance with the Trust's Constitution, but they have no absolute right to be reappointed. Decisions about reappointments are made by the Council of Governors.

In reaching a decision, in addition to having regard for the appraised performance of the individual, the Council of Governors will consider the performance of the Trust, the make-up of the Board of Directors in terms of skills, diversity and geographical representation, the Board dynamics and the effectiveness of its team working.

The maximum term of office for a Non-Executive Director is six years.

Termination of appointment

Our Constitution sets out the following circumstances in which the appointment of a Non-Executive Director may be terminated by the Trust:

- Removal from the Board of Directors being approved by 75% of members of the Council of Governors at a general meeting of the Council of Governors
- The Non-Executive Director being adjudged bankrupt or their estate being sequestrated and (in either case) not being discharged
- The Non-Executive Director making a composition or arrangement with, or granting a trust deed for, their creditors and not having been discharged in respect of it
- Within the past five years, the Non-Executive Director having been convicted in the British Isles of any offence for which a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed
- The Non-Executive Director being a person whose tenure of office as a Chair or as a member or director of a health service body having been terminated on the grounds that the appointment is not in the interests of public service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest
- The Non-Executive Director having had his/her name removed from any relevant list of medical practitioners prepared pursuant to paragraph 10 of the National Health Service (Performers Lists) regulations 2004 or Section 151, of the 2006 Act (or similar provision elsewhere), and has not subsequently had his/her name included in such a list; or a person who has had their professional clinical registration revoked. This provision shall not apply where a person's registration lapses or their name has been removed at their own request, for example following retirement
- The Non-Executive Director having within the previous two years been dismissed, otherwise than by reason of redundancy or ill health, from any paid employment with a health service body
- The Non-Executive Director being subject to a director's disqualification order made under the Company Directors Disqualification Act 1986.
- The Non-Executive Director being a person who is a registered sex offender pursuant to the Sex Offenders Act 2003
- The Non-Executive Director ceasing to be a public member of the Trust
- The Non-Executive Director being or becoming a Governor of the Trust

If the Council of Governors is of the opinion that it is no longer in the interests of the National Health Service that a Non-Executive Director continue to hold office then, subject to the provisions of the Trust's Constitution, their appointment may be terminated.

The following list provides examples of matters which may indicate to the Council of Governors that it is no longer in the interests of the National Health Service that a Non-Executive Director continues in office:

- If an annual appraisal or sequence of appraisals is unsatisfactory
- If the Non-Executive Director loses the confidence of the public or local community in a substantial way
- If the Non-Executive Director fails to deliver work against agreed targets incorporated within their annual objectives
- If there is a terminal breakdown in essential relationships, for example between the Chair and Chief Executive, or between a Non-Executive Director and the other directors

The above list is not intended to be exhaustive or definitive. The Council of Governors will consider each case on its merits, taking all relevant factors into account.

Balance of the Board and appraisal

The Board reviews its effectiveness after each meeting, and through developmental workshops throughout the year. These build on similar performance evaluations carried out during previous years. Board Committees' objectives and Terms of Reference are reviewed annually, and Committee membership is regularly reviewed to take account of any new Non-Executive Directors joining the Board, and to ensure that Non-Executive Directors' skills and knowledge are being put to the best possible use.

It is the Trust Chair's responsibility to ensure Committee and Board membership is revitalised when appropriate. The balance of skills on the Board is considered when appointing replacements, thus ensuring that the Board's mix of skills, knowledge and experience remains appropriate for the current and future requirements of the Trust.

Except where people join the Board late in the financial year, all Board members have a performance appraisal during the year involving input from colleagues and, when appropriate, Governors and others in order to provide insight into effectiveness and to identify learning and development opportunities.

The results of the appraisals of the Executive Directors have been shared in summary with the Appointments and Terms of Service Committee of the Board of Directors. Similar arrangements have been followed for the summary of Non-Executive and Chair appraisals to be given to the Nomination and Remuneration Committee of the Council of Governors. Each Board member has individual development and performance targets for the coming year, and it is the responsibility of the Trust Chair to ensure that the results of Directors' performance appraisals are acted upon

Board remuneration

Accounting policies for pensions and other retirement benefits are set out in note 1.4 of the accounts.

Details of senior employees' remuneration can be found in page 40 of the Remuneration Report; and details of company directorships and other significant interests held by Directors or Governors which may conflict with their management responsibilities are set out in note 18 of the accounts.

Directors' Statement as to Disclosure to the Auditors

The Directors confirm that so far as they are aware, there is no relevant audit information of which the auditors are unaware. The Directors have taken all the steps that they ought to have taken as Directors in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

Accounting policies for pensions and other retirement benefits are set out in note 1.4 to the full statutory accounts and details of senior staff's remuneration can be found in the Remuneration Report later in this document.

Going Concern

After making enquiries, the Directors have a reasonable expectation that ²gether NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Council of Governors

Our Council of Governors consists of public, staff, and appointed Governors from the local authority and clinical commissioning groups. There is also a Governor appointed by the Gloucestershire Learning Disability Partnership Board.

Governors are an essential link between our membership and the Board of Directors. They help ensure that the Trust hears everyone's views.

Public and staff Governors are elected by members of their own constituency using the single transferable vote system.

The following elections took place during 2016/17 for public and staff governor positions.

Constituency	Vacant Posts	Candidates	Total Votes Cast	Turnout
June 2016				
Public: Forest of Dean	1	Hilary Bowen*	N/A	
Public: Greater England	1	N/A	N/A	
Public: Tewkesbury	1	Richard Butt-Evans*	N/A	
Public: Gloucester City	1	Said Hansdot* Nigel Hayward	Eligible voters: 1368 Valid votes cast: 133	9.7%
Public: Stroud	2	Mervyn Dawe* Ann Elias* John Gillett Brian Marsh	Eligible voters: 799 Valid votes cast: 123	15.4%
Public: Cotswolds	1	Dee Drinan*	N/A	
Staff: Clinical and Social Care and Support	2	Elaine Davies**	N/A	

* Elected ** Re-elected

The appointment term of all Governors is three years unless they are councillors representing first and second tier authorities. Local authority Governors may hold office for the period of their current term of office as a councillor.

Council of Governors by constituency and current vacancies

Category of Governor	Total number of Governors	Vacancies as of 31 March 2017
Public constituencies		
Cheltenham	2	0
Cotswolds	2	1
Forest	2	0
Gloucester	2	0
Stroud	2	0
Tewkesbury	2	0
Herefordshire	2	0
Greater England	1	1
Staff constituencies		
Medical and Nursing	3	0
Clinical and social care support staff class	2	1
Management, administrative and other staff class	2	0
Appointed Governors		
Gloucestershire Clinical Commissioning Group	1	0
Gloucestershire County Council	1	0
Herefordshire Clinical Commissioning Group	1	0
Herefordshire Council	1	0
Gloucestershire Learning Disabilities Partnership Board	1	1
Total	**27**	**7**

The Council of Governors has three primary roles:

- to hold the Non-Executive Directors individually and collectively to account for the performance of the Board; and
- to represent the interests of the Trust's stakeholders in the governance of the organisation; and
- to communicate the key messages of the Trust to the electorate and appointing bodies.

The Trust's Constitution was amended in July 2013 to fully implement the requirements of the Health and Social Care Act 2012, particularly in relation to the role of Governors, and was revised further in November 2015. The duties and powers of Governors are defined within the constitution and include:

- Reviewing and providing advice and comments to the Board of Directors on any strategic plans
- Developing and approving a membership strategy, including feeding information back to their constituencies and stakeholder organisations
- Appointing or removing the Chair and the Non-Executive Directors
- Deciding the remuneration and allowances of the Chair and Non-Executive Directors
- Appointing or removing the Trust's auditors
- Receiving and reviewing the annual accounts, any report of the auditor on the accounts and the Trust's annual report
- Holding the Non-Executive Directors to account for the performance of the Board
- Approving an appointment by the Non-Executive Directors of the Chief Executive
- Enforcing standards of conduct for Governors
- Such other responsibilities as the Board of Directors and Council of Governors may agree

In 2016/17, the Council of Governors has:

- Met six times in the reporting period
- Appointed two new Non-Executive Directors
- Re-appointed the Trust Deputy Chair
- Assisted in the development of strategic plans and provided comments on drafts
- Developed a work programme for the coming year
- Carried out a joint development programme with the Board of Directors to develop more effective ways of working
- Received presentations from services and the Chief Executive on various aspects of their work
- Received assurance from Non-Executive chairs of Board Committees as part of the process for holding the Non-Executive Directors to account for the performance of the Board
- Organised one local engagement event for members in 2016/17
- Reviewed the Trust's Quality priorities
- Selected local Quality Report indicators to be audited
- Re-appointed a Lead Governor (Rob Blagden, Staff Governor)
- Received the Annual Report and Accounts
- Held a joint Annual General Meeting with the Board of Directors
- Agreed the process of appraisal for the Chair and the Non-Executive Directors

The following table shows the composition of the Council of Governors during the reporting period, listing names, appointment dates and length of service.

Constituency	Constituency Governors	Name of Governor	Date of appointment/ Nomination (Date of reappointment) (*resignation date*)
Elected Public Governors			
Cheltenham Borough Council	2	Al Thomas	July 2014
		Vic Godding	July 2014
Cotswold District Council	2	Pat Ayres MBE	July 2011 (July 2014)
		Dee Drinan	July 2016 ***(Sept 2016)***
Forest District Council	2	Jennifer Thomson	August 2015
		Hilary Bowen	July 2016
Gloucester City Council	2	***Gillian Hayes***[1]	***June 2016***
		Said Hansdot	July 2016
		Paul Toleman	July 2014
Stroud District Council	2	Ann Elias	***July 2016***
		Mervyn Dawe	***July 2016***
Tewkesbury Borough Council	2	***Mandy Nelson***[1]	***June 2016***
		Richard Butt-Evans	July 2016
		Josephine Smith	July 2015
Herefordshire	2	Dawn Lewis	June 2014
		Cherry Newton	September 2015
Greater England	1	Vacant	
Elected Staff Governors			
Medical and Nursing	3	Dr Amjad Uppal	November 2011 (Nov 2014)
		Paul Grimer	December 2012 (Nov 2015)
		Dr Svetlin Vrabtchev	July 2015
Clinical and Social Care and Support Staff	2	Elaine Davies	July 2013 (July 2016)
		Vacant	
Management, Administrative and Other Staff	2	Rob Blagden	July 2014
		Katie Clark	December 2015
Governors nominated by partner organisations			
Gloucestershire Clinical Commissioning Group	1	***Dr Helen Miller***	July 2014 ***(March 2016)***
		Dr Tristan Lench	May 2016
Gloucestershire County Council	1	Cllr Roger Wilson	July 2014
Herefordshire Clinical Commissioning Group	1	Hazel Braund	November 2016
		Simon Hairsnape	***October 2016***
Herefordshire County Council	1	Cllr Jenny Bartlett	July 2015
Gloucestershire Learning Disabilities Partnership Board	1	Vacant	

Resignation Notes:

[1] End of term

[2] Deceased

[3] Removed by Council of Governors

[4] Personal reasons

How Governors work with Directors and Members

Meetings of the Council of Governors and Board of Directors are both presided over by the Chair of the Trust or, in her absence, the Deputy Chair of the Board of Directors.

It is the Chair's role to ensure there is a positive working relationship between the Council of Governors and the Board of Directors. The constitution provides for the sharing of responsibilities and this is supported by standing orders for each forum. The Trust has a formal process for the resolution of disputes between the two bodies if required but use of this process has not been necessary to date. Directors' duties are set out in a scheme of delegation.

Both Non-Executive and Executive Directors have attended Council of Governors meetings to present information and to seek Governors' views. The Council of Governors was consulted as part of the Trust's business planning and strategic planning processes. Individual Non-Executive Directors have provided assurance to the Council of Governors on areas relevant to their roles as Committee Chairs, as part of the Council of Governors' responsibility to hold the Non-Executive Directors to account for the performance of the Board.

Governors have been provided with summaries of feedback received by the Trust about its services. Actions taken in response to issues raised have also been reported. The Chair informs the Council of Governors of the work of the Board through regular correspondence to Governors and reports at meetings.

The Chief Executive has given several presentations to the Council on current and future developments for the Trust. Some Governors have attended Board of Directors' meetings and the Chair keeps the Board informed of the issues dealt with at the Council of Governors. The minutes of Council meetings are included on the agenda of the Board of Directors.

Members are informed of changes and proposals through a newsletter and invited to comment and make suggestions. Public and member events showcasing services or highlighting issues have been held at various venues, with Governors and Members attending.

The following shows the number of meetings of the Council of Governors attended by Governors during the reporting period. Attendance by Board members at Council of Governors' meetings is detailed elsewhere in this report.

Official opening of Weavers Croft

Attendance by Governors at Council of Governors' meetings

Constituency	Name of Governor	Possible Attendance
Elected Public Governors		
Cheltenham Borough Council	Al Thomas	6/6
	Vic Godding	6/6
Cotswold District Council	Pat Ayres MBE	5/6
	Dee Drinan	1/1
Forest District Council	Jennifer Thomson	4/6
	Hilary Bowen	4/5
Gloucester City Council	Said Hansdot	5/5
	Paul Toleman	5/6
	Gillian Hayes	***1/1***
Stroud District Council	Ann Elias	4/5
	Mervyn Dawe	2/5
Tewkesbury Borough Council	***Mandy Nelson***	***1/1***
	Richard Butt-Evans	5/5
	Josephine Smith	6/6
Herefordshire	Dawn Lewis	4/6
	Cherry Newton	5/5
Greater England	Vacant	
Elected Staff Governors		
Medical and Nursing	Dr Amjad Uppal	2/6
	Paul Grimer	4/6
	Dr Svetlin Vrabtchev	5/6
Clinical and Social Care and Support Staff	Elaine Davies	2/6
	Vacant	
Management, Administrative and Other Staff	Rob Blagden	6/6
	Katie Clark	3/6
Appointed Governors		
Gloucestershire Clinical Commissioning Group	Dr Tristan Lench	3/5
Gloucestershire County Council	Cllr Roger Wilson	1/6
Herefordshire Clinical Commissioning Group	Hazel Braund	2/3
	Simon Hairsnape	***0/3***
Herefordshire County Council	Cllr Jenny Bartlett	5/6
Gloucestershire Learning Disabilities Partnership Board	Vacant	

Nominations and Remuneration Committee

The Nomination and Remuneration Committee is a committee of the Council of Governors, which advises the Council on the appointment, dismissal, remuneration and terms of service of the Chair and Non-Executive Directors of the Board. The Committee is normally chaired by the Trust Chair, unless they must be excluded from the meeting due to the business being conducted. In this instance, the Deputy Chair of the Committee, a Governor, will oversee the meeting. The committee has delegated authority to manage and oversee the recruitment and appraisal processes for the Chair and Non-Executive Directors on behalf of the Council.

In 2016/17 the Committee oversaw the appointment of two new Non-Executive Directors. The Committee reviewed the process for future appointments and reappointments. The annual appraisals of the Non-Executive Directors and Trust Chair were discussed, and the process for future appraisals agreed.

The Nominations and Remuneration Committee met twice during the reporting period.

Name	24 May 2016	10 January 2017
Ruth FitzJohn	✓	✓
Charlotte Hitchings*	✓	N/A
Rob Blagden	✓	✓
Gillian Hayes	✓	N/A
Mervyn Dawe		✓
Vic Godding		✓
Al Thomas	✓	
Amjad Uppal		N/A

* Charlotte Hitchings, Deputy Trust Chair and Senior Independent Director was in attendance at this meetings as the business being conducted related to the Trust Chair

Governor expenses

Governors do not receive remuneration but are paid reasonable expenses in order to perform their role. During the reporting period, eight Governors received expenses payments. The aggregate sum of expenses paid to Governors during the reporting period is £1706.

Register of Governors' and Directors' interests

Our hospitality register and register of Governors' and Directors' interests, including that of our Trust Chair, is available from the Trust Secretary, who may be contacted on **01452 894000** or by emailing **anna.hilditch@nhs.net**.

Shaun Clee, Chief Executive **Date: 24 May 2017**

Remuneration Report

Annual Statement on Remuneration

Our Appointments and Terms of Service Committee has delegated responsibility from the Board of Directors to review and set the remuneration and terms of service of the Chief Executive and the Executive Directors.

All other senior managers are covered by Agenda for Change, or, in the case of medical managers, Consultant terms and conditions of service. The intention is to continue to review the definition of senior manager, although the policy has been for all staff who are not board members to be employed on national terms and conditions of employment. The Appointment and Terms of Service Committee is chaired by the Trust Chair and has a membership of all Non-Executive Directors. In the absence of the Chair, the Deputy Chair of the Trust leads the meeting.

The Committee has adopted a policy of developing a simple reward package. Salary ranges for Executive Directors have been agreed through an established job evaluation process. Appointments are made through a spot salary within one of 4 salary ranges. The remuneration package does not include a Performance Related Pay scheme and has no additional other pay or non-pay benefits which are outside standard terms and conditions that apply to the majority of staff employed within the trust e.g. annual leave, sick pay etc.

Decisions which the Committee takes on the salary and terms of conditions of service of its Chief Executive and Executive Directors will be informed by reviews that take into account the wider labour market, the scope of responsibilities, performance, best practice, NHS Executive remuneration benchmarking and, where appropriate, national guidance. The Committee also takes into account the awards for other staff groups through, for example, the Pay Review Body.

For all other senior managers, performance is managed in accordance with our appraisal and pay progression policies, both of which are consistent with national terms and conditions of service and agreed locally with our Staff Side representatives.

The appraisal process for Executive Directors and senior managers employed on Agenda for Change terms ensures that objectives for each individual are aligned to the Trust strategy and business needs.

For senior managers on Agenda for Change terms and conditions under the Trust's Pay Progression Policy, one increment may be withheld if levels of performance are not maintained.

The Committee receives an annual report on the performance of the Chief Executive and Executive Directors from the Chair and Chief Executive respectively. This follows the assessment of the appraisal objectives for each member of the Board that are agreed for each financial year.

The Chief Executive and Executive Directors are employed on substantive contracts of employment. The current Chief Executive's contract is subject to six months' written notice from either party. The exception to this is in the case of incapacity and for reasons of qualification, conduct or capability. In these cases, the contract is subject to three months' notice of termination. Executive Director contracts are subject to a notice period of six months to minimise the risk from loss of management capacity at this level, while recruitment processes take place. None of the contracts for the Chief Executive or Board Directors contains clauses specifying termination payments which are in excess of contractual obligations. Contractual redundancy terms are as per Section 16 of the Agenda for Change NHS Terms and Conditions of Service Handbook.

Senior managers on Agenda for Change terms and conditions are employed on substantive contracts subject to three months' written notice by the individual and statutory notice by the Trust. No contract contains clauses specifying termination payments which are in excess of contractual obligations.

For those senior managers who are also designated as Directors but are not Executive Directors, their remuneration is as determined under national terms and conditions and therefore applicable to the majority of staff employed by the Trust.

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 the direction of the Secretary of State. As a consequence, it is not possible for the NHS Trust to identify its share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as a defined contribution scheme and the cost of the scheme is equal to the contributions payable to the scheme for the accounting period. Further details can be found in note 1.4 of our annual accounts.

Salary and pension entitlement of senior managers: Remuneration

Name	Year	a Salary and fees bands of £5000 £0	b Taxable benefits Rounded to nearest £100 £0	c Annual performance related bonuses bands of £5000 £0	d Long-term performance related bonuses bands of £5000 £0	e Pension related benefits bands of £2500 £0	Total bands of £5000 £0
Non-Executive Directors							
Ruth FitzJohn - Chair	2016/17	40-45	0	0	0	0	40-45
	2015/16	40-45	0	0	0	0	40-45
Charlotte Hitchings	2016/17	10-15	0	0	0	0	10-15
left (30/11/16)	2015/16	15-20	0	0	0	0	15-20
Martin Freeman	2016/17	05-10	0	0	0	0	05-10
(left 31/10/16)	2015/16	15-20	0	0	0	0	15-20
Jonathan Vickers	2016/17	10-15	0	0	0	0	10-15
	2015/16	10-15	0	0	0	0	10-15
Nikki Richardson	2016/17	15-20	0	0	0	0	15-20
	2015/16	10-15	0	0	0	0	10-15
Richard Szadziewski	2016/17	00-05	0	0	0	0	00-05
(left 30/04/16)	2015/16	00-05	0	0	0	0	00-05
Marcia Gallagher	2016/17	10-15	0	0	0	0	10-15
started (01/04/16)	2015/16	0	0	0	0	0	0
Duncan Sutherland	2016/17	10-15	0	0	0	0	10-15
started (01/04/16)	2015/16	0	0	0	0	0	0
Quinton Quayle	2016/17	10-15	0	0	0	0	10-15
started (01/06/16)	2015/16	0	0	0	0	0	0
Maria Bond	2016/17	05-10	0	0	0	0	05-10
started (01/11/16)	2015/16	0	0	0	0	0	0
Executive Directors							
Shaun Clee	2016/17	165-70	0	0	0	0	165-170
Chief Executive	2015/16	165-70	0	0	0	0	165-170
Andrew Lee	2016/17	125-130	0	0	0	0	125-130
Director of Finance and Commerce	2015/16	120-125	0	0	0	0	120-125
Carol Sparks	2016/17	90-95	0	0	0	20-22.5	110-115
Director of Organisational Development	2015/16	90-95	0	0	0	12.5-15	105-110
(Director of Special Projects 28/11/16 - 31/03/17)			0	0	0		
Neil Savage	2016/17	35-40	0	0	0	n/a	35-40
Director of Organisational Development	2015/16	0	0	0	0	0	0
started (28/11/16)			0	0	0		
Marie Crofts	2016/17	95-100	0	0	0	130-132.5	230-235
Director of Quality	2015/16	85-90	0	0	0	115-117.5	200-205
Colin Merker	2016/17	115-120	0	0	0	27.5-30	145-150
Director of Service Delivery	2015/16	115-120	0	0	0	15-17.5	135-140
Jane Melton	2016/17	90-95	0	0	0	42.5-45	130-135
Director of Engagement and Integration	2015/16	80-85	0	0	0	157.5-160	240-245
Christopher Fear	2016/17	225-230	0	0	0	775-777.5	1000-1005
Medical Director[1]	2015/16	0	0	0	0	0	0
started on (01/04/16)							
Frances Martin	2016/17	50-55	0	0	0	n/a	50-55
Director of Transformation	2015/16	0	0	0	0	0	0
started (25/07/16)							

Salary and pension entitlement of senior managers: Remuneration (continued)

Name	Year	a Salary and fees bands of £5000 £0	b Taxable benefits Rounded to nearest £100 £0	c Annual performance related bonuses bands of £5000 £0	d Long-term performance related bonuses bands of £5000 £0	e Pension related benefits bands of £2500 £0	Total bands of £5000 £0
Locality/Service Directors							
Les Trewin	2016/17	65-70	0	0	0	0-2.5	70-75
Locality Director	2015/16	70-75	0	0	0	-27.5 - -25	40-45
Jan Furniaux	2016/17	65-70	0	0	0	72.5-75	140-145
Locality Director	2015/16	60-65	0	0	0	22.5-25	85-90
Mark Hemming	2016/17	70-75	0	0	0	10-12.5	80-85
Locality Director	2015/16	70-75	0	0	0	22.5-25	80-85
Sarah Batten	2016/17	55-60	0	0	0	12.5-15	70-75
Service Director	2015/16	55-60	0	0	0	10-12.5	80-85
Alison James	2016/17	50-55	0	0	0	17.5-20	65-70
Service Director	2015/16	45-50	0	0	0	40-42.5	85-90

(1) The post of Medical Director is a part-time role. Dr Fear received remuneration of £92,417 for his Medical Director role, and remuneration of £133,062 for his clinical work.

Salary and pension entitlement of senior managers: pension benefits

Pension Entitlement of Senior Managers - Pension Benefits

Name and title	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2017	Lump sum at pension age related to accrued pension at 31 March 2017	Cash Equivalent Transfer Value at 1 April 2016	Cash Equivalent Transfer Value at 31 March 2017	Real Increase in Cash Equivalent Transfer Value	Employers Contribution to Stakeholder Pension
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	£'000	£'000	£'000	£'000
Shaun Clee - Chief Executive	0	0	0	0	0	0	0	0
Andrew Lee - Dir of Finance	0	0	0	0	0	0	0	0
Christopher Fear – Medical Director	35-37.5	105-107.5	95-100	290-295	1,203	1987	783	0
Carol Sparks - Dir Spec Ops	0-2.5	2.5-5	30-35	90-95	670	-	-	0
Neil Savage – Dir of OD	0-2.5	0	30-35	90-95	517	548	31	0
Marie Crofts - Dir of Quality	5-7.5	12.5-15	40-45	120-125	665	789	124	0
Colin Merker - Dir of Internal Customer Svcs	0-2.5	5-7.5	55-60	170-175	1170	1249	79	0
Jane Melton - Director of E&I	0-2.5	5-7.5	30-35	100-105	554	614	60	0
Frances Martin – Dir of Transformation	2.5-5	12.5-15	25-30	75-80	411	504	92	0

Pension Entitlement of Senior Managers - Pension Benefits (continued)

Name and title	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2017	Lump sum at pension age related to accrued pension at 31 March 2017	Cash Equivalent Transfer Value at 1 April 2016	Cash Equivalent Transfer Value at 31 March 2017	Real Increase in Cash Equivalent Transfer Value	Employers Contribution to Stakeholder Pension
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	£'000	£'000	£'000	£'000
Les Trewin - Service Director	0-2.5	0-2.5	20-25	70-75	447	482	35	0
Jan Furniaux - Locality Director	2.5-5	10-12.5	30-35	100-105	551	654	102	0
Mark Hemming – Locality Dir	0-2.5	2.5-5	15-20	50-55	349	379	30	0
Sarah Batten – Service Dir	0-2.5	2.5-5	5-10	20-25	120	140	20	0
Alison James – Service Dir	0-2.5	0	5-10	0	78	95	17	0

As Non-Executive members do not receive pensionable remuneration, there are no entries in respect of pensions for Non-Executive Directors.

Median pay

Reporting bodies 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 banded remuneration of the highest-paid director in ²gether NHS Foundation Trust in the financial year 2016/17 was £225,000-£230,000 (2015/16, £195,000-£200,000). This was 8.3 times (2015/16, 7.0) the median remuneration of the workforce, which was £27,328 (2015/16, £28,280).

In 2016/17, 0 (2015/16, 3) employees received remuneration in excess of the highest-paid director.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The calculation is based on the full-time, annualised equivalent of every member of staff in post at 31 March 2017, including bank staff and medical locums.

The disclosure of the median remuneration of the Trust's workforce and the ratio between this and the mid-point of the banded remuneration of the highest paid director has been audited.

Governor expenses

Governors do not receive remuneration but are paid reasonable expenses in order to perform their role. During the reporting period, eight Governors received expense payments. The aggregate sum of expenses paid to Governors during the reporting period is £1706.

Directors

In 2016/17, 19 Directors were in office during the period, including starters and leavers. During the reporting period all but one director claimed expenses to a total of £26,769.30.

The above information has been audited.

Shaun Clee, Chief Executive

24 May 2017

Staff Report

Everyone who works for ²gether is helping to Make Life Better for the people we serve.

On March 31 2017, we employed 2,472 people across a variety of professions, including doctors, nurses, Allied Health Professionals, social workers and support staff.

Our staff are categorised as follows:

Permanent employees	1983
Bank staff	389
Others	100

The following table provides a breakdown of the number and percentage of **female and male members of staff:**

Board Members	Employees	Percentage
Female	6	43%
Male	8	57%

Total staff * (up to Band 8b)	Employees	Percentage
Female	1502	80%
Male	380	20%

* Permanent staff only

Senior Clinicians/ Managers (Band 8c and above)	Employees	Percentage
Female	40	43%
Male	54	57%

* Excludes executives, bank staff, temporary staff and locums)

Staff costs

Our staffing costs for 2016/17 and a comparison with the previous financial year are detailed here:

	12 Months to 31 March 2017 (£000)	12 Months to 31 March 2016 (£000)
Salaries and wages	£63,187	£61,303
Social security costs	£6,091	£4,712
Pension costs – defined contribution plans (employers' contributions to NHS Pension Scheme)	£7,711	£7,510
Pension cost – other contributions	£0	£0
Other post employment benefits	£0	£0
Other employment benefits	£0	£0
Termination benefits	£0	£0
Agency/contract staff	£5,492	£5,497
Total staff costs	**£82,481**	**£79,022**

Sickness absence data

Our staff sickness absence figures are reported, as per national guidance, on a calendar year basis using data from NHS Digital. The table here shows the number of staff days lost to sickness for the period January to December 2016.

Figures Converted by Department of Health to Best Estimates of Required Data Items			Statistics Published by NHS Digital from ESR Data Warehouse	
Average FTE 2016	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Days per FTE	FTE-Days Available	FTE-Days recorded Sickness Absence
1,736	19,458	11.2	633,727	31,566

Explanatory note: The information above is supplied by NHS Digital, using data from the national NHS Electronic Staff Record (ESR) system. ESR does not hold details of the normal number of days worked by each employee. Data on days available and days recorded sick are based on a 365-day year.

The number of Full Time Equivalent (FTE) days available has been taken directly from ESR. This has been converted to FTE years in the first column by dividing by 365 (with a further adjustment where the figures are based on less than 12 months' data).

The number of FTE-days lost to sickness absence has been taken directly from ESR. The adjusted FTE-days lost has been calculated by multiplying by 225/365 to give the Cabinet Office measure (with a further adjustment where the figures are based on less than 12 months' data).

Average Annual Sick Days per FTE has been estimated by dividing the estimated number of FTE-days sick by the average FTE, and multiplying by 225 (the typical number of working days per year).

The Trust has a comprehensive Sickness Absence Policy, which includes provision of support to staff who become disabled during their employment, and encourages redeployment to alternative roles wherever this is possible.

Equal opportunities

We continue to meet all of our responsibilities as part of the Public Sector Equality Duty Sector Equality (PSED), outlined in the Equality Act 2010. We are committed to ensuring equality of opportunity both in the provision of our services and with how we support our staff.
Equality and Diversity is represented at Board level by our Director of Organisational Development. Working within the parameters of the NHS Equality Delivery System known as EDS2, we recognise the diversity of the community we serve and of our workforce, always seeking to ensure inclusivity of access to services and delivering the best possible care. We have implemented the Workforce Race Equality Standard (WRES), which comprises nine indicators that compare the work experience of Black and Minority Ethnic (BME) colleagues with that of white colleagues working in the NHS. Issues arising from the WRES, Staff Survey and Staff Friends and Family Test have contributed to the development of initiatives that include the revision of our Managing Dignity at Work policy, expanding our network of Dignity at Work Officers and the roll-out of Values Based Recruitment training.

We remain a signatory to the Mindful Employer Charter, promoting the health and wellbeing of all our staff.

We are proud to be a Disability Confident Employer, the standard that is the successor to 'Positive about Disabled People' known as '2 ticks'.

We offer an interview to any applicants who declare themselves to have a disability, provided they meet the minimum criteria of the post for which they are applying. We also endeavour to make any reasonable adjustments to the work environment to support colleagues with a disability to assist them to remain in employment. We will be working towards becoming a Disability Confident Leader over the coming weeks and months.

Occupational health

Working Well is our occupational health service. The service promotes and helps improve the health and wellbeing of people in work – both within our Trust and for external public and private sector organisations.

The service offers independent advice both to managers and employees, which includes staff counselling; appropriate return to work guidance; the working environment; and assessment of health risks associated with the workplace. In addition, appropriate training is provided to support the health and safety of staff, with training provided to all new staff in their first week of employment, and comprehensive managers' health and safety training.

Engagement

All staff have access to information through a number of different communication mechanisms. Our weekly staff e-bulletin is called ByteSize, and we deliver monthly Team Talk sessions to managers, which enables them to cascade key information to their teams. We also publish comprehensive news updates, policies and other information of relevance and interest to staff on [2]getherNet.

There are a number of other Trust-wide gatherings, such as our Senior Leadership and Leadership Forums, which act as an opportunity for leaders to be consulted on policy and performance issues. We also run regular 'focus groups' for staff across the Trust to enable colleagues to raise issues, concerns, and develop solutions. This ensures engagement with staff at all levels.

We work in partnership with Staff Side colleagues through the formal Joint Negotiation and Consultative Committee, which meets bi-monthly. In addition, we encourage participation from Staff Side representatives, and staff at all levels from across the Trust, to take a role within our Workforce and Organisational Development Committee and its underpinning work streams of Training, Workforce Planning, Engagement, and Culture. These mechanisms are used to consult with staff, share Trust performance, seek feedback and develop staff-related initiatives.

Staff Side representatives, including Safety Representatives, meet bi-monthly with managers to discuss and share a range of information on health and safety; health and wellbeing; and other related staff and workplace health issues.

We also work closely with our local Counter Fraud Service to ensure policies and procedures are 'fraud proofed'. The service provides regular briefings and updates to staff to maintain fraud awareness.

Last year we introduced 'SpeakInConfidence', which enables staff to access a web-based system to have an anonymous and confidential dialogue with a manager of their choice about issues they may be concerned about.

SpeakInConfidence has been introduced primarily to support staff who are subjected to inappropriate behaviour but who do not feel able to raise the issue through existing channels.

SpeakInConfidence is an additional support mechanism, and our existing network of Dignity at Work officers has been expanded this year. We continue to encourage colleagues to speak to Dignity at Work officers if they are experiencing bullying, harassment or other forms of inappropriate conduct.

This year has also seen the introduction of the Freedom to Speak Up Guardian. Our Freedom to Speak Up Guardian – Rob Newman – has the role of supporting and encouraging colleagues to 'speak up' if they have concerns about safety, quality and issues that have a Trustwide impact and may jeopardise patient or staff safety.

Reward and recognition

Our annual Recognising Outstanding Service and Contribution Awards (ROSCAs) are now in their 10th year. More than 275 nominations were received in 2016, across ten award categories, and the winners were announced during an award ceremony held in March 2017.

Our monthly Best Supporting Colleague Award is now in its fourth year and enables staff to nominate colleagues who have made a significant difference to their working life. The award helps to make sure that staff who perform above and beyond are recognised throughout the year.

Staff survey

Each year we participate in the annual NHS Staff Survey. For 2016, the Trust decided to run a census of all staff (in post on 1 September 2016) rather than the random sample of 750 staff that formed the basis of the survey in previous years. Staff were invited to take part in the confidential survey by our independent provider. The survey was carried out entirely online.

The overall response rate was 40%, slightly below the national average for Mental Health and Learning Disability Trusts. But in actual numbers, 777 colleagues took part in the survey - a significant improvement on 298 in the previous year. The larger response has provided us with the most accurate picture so far, of the Trust as seen by our staff as an employer and provider of care. The data has been compared with the previous year and with other like/type Trusts.

The answers given by staff have been compiled into a series of 32 Key Findings (KF) arranged in the following groups:

- Appraisals and support for development
- Equality and diversity
- Errors and incidents
- Health and wellbeing
- Job satisfaction
- Managers
- Patient care and experience
- Violence, harassment and bullying
- Working patterns

Colleagues told us that the Trust was better than average in 18 Key Findings, average in 10 Key Findings and worse than average in four Key Findings. This represents a favourable comparison with the previous year when the Trust was seen as better than average in 18 Key Findings, average in 13 and worse than average in one.

Although there were no statistically significant changes between the Key Findings of 2016 and 2015, 19 of the Key Findings showed some improvement.

Staff engagement increased again in 2016, showing a score of 3.89 out of a possible 5 and is higher than the national average score of 3.77. Staff engagement is measured against the responses to three Key Findings:

- KF1 - Staff recommendation of the Trust as a place to work or receive treatment
- KF4 - Staff motivation at work
- KF7 - Staff ability to contribute towards improvements at work

Staff recommendation of the Trust as a place to receive care or treatment improved again with a score of 3.84 out of 5, higher than the previous year and above the national average of 3.62.

To complement the survey, we also run the Staff Friends and Family Test each quarter. This is a pulse survey that asks two questions. The first being 'would you recommend the Trust to friends and family as a place to receive care or treatment.' During 2016, an average of 80% of staff said they would be likely or extremely likely to do so. The other question asks if you would recommend the Trust to friends and family as a place to work, to which an average of 70% of staff said that they would be likely or extremely likely to do so.

Following careful analysis of the survey results, a number of key priorities for the wider Trust have been identified. These are:

- To focus actions on encouraging colleagues to report bullying, harassment, abuse and physical violence
- To make more effective use of patient feedback
- To improve the health and wellbeing of our staff

In addition, our various localities and services will be using the results of the Staff Survey to identify three key priorities upon which they will focus during the coming year, ensuring that the outcome of the 2016 survey has local ownership.

Throughout the year we will of course continue to seek the opinions of our staff through a range of survey and focus groups. Feedback will be given through the various communications media such as Team Talk, Bytesize (our weekly newsletter) and through the 'you said, we did' format on the intranet. We also engage through Leadership Forums, Senior Leadership Forums, staff focus groups and online discussion forums on the Trust intranet. Engagement will be reported on through regular updates via our Trust Development Committee during 2016/17.

Here we provide more detail on our 2016 Staff Survey results, and comparisons to the previous year:

	2015		2016		
Response rate	**Trust**	**National Average***	**Trust**	**National Average***	**Trust Improvement/Deterioration**
	40%	41%	40%	45%	Percentage response remains the same but number of responses up from 298 to 777 following census of all staff.

	2015		2016		
Top 5 ranking scores	**Trust**	**National Average***	**Trust**	**National Average***	**Trust Improvement/Deterioration**
KF29 – Percentage of staff reporting errors, near misses or incidents in the last month.	95%	91%	97%	92%	2% improvement (Higher score better)
KF7 - Percentage of staff able to contribute towards improvements at work	80%	73%	78%	73%	Deterioration of 2% (Higher score better)
KF20 – Percentage of staff experiencing discrimination at work in the last 12 months	10%	14%	8%	14%	Improvement of 2% (Lower score better)
KF28 – Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month	20%	26%	18%	27%	Improvement of 2% (Lower score better)
KF23 – Percentage of staff experiencing physical violence from staff in the last 12 months	0%	2%	0%	3%	No change

Bottom 5 ranking scores	2015 Trust	2015 National Average*	2016 Trust	2016 National Average*	Trust Improvement/Deterioration
KF27 – Percentage of staff/ colleagues reporting most recent experience of harassment, bullying or abuse	50%	49%	54%	60%	Improvement of 4% (Higher score better)
KF24 – Percentage of staff/ colleagues reporting most recent experience of violence	94%	84%	91%	93%	Deterioration of 3% (Higher score better)
KF26 – Percentage of staff experiencing harassment, bullying or abuse in the last 12 months	22%	22%	26%	22%	Deterioration of 4% (Lower score better)
KF32 – Effective use of patient/service user feedback	3.64	3.68	3.59	3.70	Deterioration of 0.5 (from a possible score of 5, higher score better)
KF16 – Percentage of staff working extra hours	73%	74%	74%	72%	Deterioration of 1% (Lower score better)

*National Average for Mental Health/Learning Disability Trusts

Expenditure on consultancy

During 2016/17 our consultancy costs totalled £91,000. During 2015/16 our consultancy costs totalled £148,000.

Off-payroll engagements/arrangements

We are required to declare highly paid and/or senior off-payroll engagements. The off-payroll engagements for more than £220 per day and that last for longer than six months are as follows:

Number of existing engagements as of 31 March 2017	5

Of which:

Number that have existed for less than one year at the time of reporting	2
Number that have existed for between one and two years at the time of reporting	1
Number that have existed for between two and three years at the time of reporting	2
Number that have existed for between three and four years at the time of reporting	0
Number that have existed for four or more years at the time of reporting	0

We confirm that all existing off-payroll engagements, outlined above, have at some point been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

The following table details all new off-payroll engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017, for more than £220 per day and that last longer than six months.

Number of new engagements, or those that reached six months in duration between 1 Apr 2016 and 31 Mar 2017	2
Number of the above which include contractual clauses giving the Trust the right to request assurance in relation to income tax and national insurance obligations	2
Number for whom assurance has been requested	2

Of which:

Number for whom assurance has been received	0
Number for whom assurance has not been received	2
Number that have been terminated as a result of assurance not being received	0

The following table details the off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2016 and 31 March 2017.

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals who have been deemed "board members and/or senior officials with significant financial responsibility". This figure should include both off payroll and on payroll engagements.	19

Exit packages

We are required to publish information on our use of exit packages during the year, with comparative tables for the previous year.

This table details the number of exit packages used during 2016/17 and the table below gives a comparative for 2015/16.

Exit packages 2016/17

	Number of Compulsory Redundancies	Cost of Compulsory Redundancies	Number of Other Departures Agreed	Cost of Other Departures Agreed	Total Number of Exit Packages	Total Cost of Exit Packages	Number of Departures where Special Payments have been made	Cost of Special Payment Element included in Exit Packages
Exit package cost cost band (including any special payment element)	**Number**	**£000s**	**Number**	**£000s**	**Number**	**£000s**	**Number**	**£000s**
< £10,001	1	9	25	93	26	102	0	0
£10,001 - £25,000	4	60	2	31	6	91	0	0
£25,001 - £50,000	0	0	0	0	0	0	0	0
£50,001 - £100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
> £200,000	0	0	0	0	0	0	0	0
Total	**5**	**69**	**27**	**124**	**32**	**193**	**0**	**0**

Exit packages 2015/16

	Number of Compulsory Redundancies	Cost of Compulsory Redundancies	Number of Other Departures Agreed	Cost of Other Departures Agreed	Total Number of Exit Packages	Total Cost of Exit Packages	Number of Departures where Special Payments have been made	Cost of Special Payment Element included in Exit Packages
Exit package cost cost band (including any special payment element)	**Number**	**£000s**	**Number**	**£000s**	**Number**	**£000s**	**Number**	**£000s**
< £10,001	0	0	12	60	12	60	0	0
£10,001 - £25,000	0	0	0	0	0	0	0	0
£25,001 - £50,000	0	0	2	51	2	51	0	0
£50,001 - £100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
> £200,000	0	0	0	0	0	0	0	0
Total	**0**	**0**	**14**	**111**	**14**	**111**	**0**	**0**

This table details the other (non-compulsory) departure payments used during the year, with comparison figures for the previous year:

	2016/17 Payments Agreed Number	2016/17 Total value of Agreements £000s	2015/16 Payments Agreed Number	2015/16 Total value of Agreements £000s
Voluntary redundancies including early retirement contractual costs	**0**	**0**	0	0
Mutually agreed resignations (MARS) contractual costs	**0**	**0**	0	0
Early retirements in the efficiency of the service contractual costs	**0**	**0**	0	0
Contractual payments in lieu of notice	**26**	**112**	14	111
Exit payments following Employment Tribunals or court orders	**1**	**12**	0	0
Non-contractual payments requiring HMT approval	**0**	**0**	0	0
Total	**27**	**124**	14	111

This table details the number and value of early retirements on the grounds of ill-health:

	2016/17	2015/16
No. of early retirements on grounds of ill health	**3**	4
Cost of early retirements on grounds of ill health (£000)	**165**	149

Compliance with the NHS Foundation Trust Code of Governance

The purpose of the Foundation Trust Code of Governance is to assist Foundation Trust Boards in improving their governance practices by bringing together the best practice of public and private sector corporate governance.

The Foundation Trust Code of Governance can be found on the NHS Improvement website, at:

www.gov.uk/government/publications/nhs-foundation-trusts-code-of-governance

The Code requires Foundation Trusts to:

- Make certain information publicly available, either on the Foundation Trust's website or on request. The Trust provides such information both through its website, and via its Freedom of Information Act Publication Scheme. The Trust is therefore fully compliant with these requirements of the Code.
- Confirm to Governors that where a Non-Executive Director seeks reappointment, his/her performance continues to be effective. The Trust provides Governors with annual summary appraisal information in respect of each Non-Executive Director, including the Chair, and this information is reprised in reports to the Council of Governors accompanying a resolution to reappoint the Non-Executive Director.
- Provide biographical and other relevant information to members to enable them to make an informed decision about any Governor seeking election or re-election. The Trust uses an external organisation to manage Governor elections and is fully compliant with this provision of the Code.
- Make clear within their annual reports where compliance with the Code has not been achieved.

The Code of Governance also requires Foundation Trusts to provide some supporting explanation within the annual report to demonstrate compliance with certain provisions of the Code, and these are set out below. To avoid duplication, where the information required by the Code is already provided elsewhere in the annual report, a reference to its location is given to avoid unnecessary duplication.

Reference	Code of Governance requirement	Trust response
A.1.1	The schedule of matters reserved for the Board of Directors should include a clear statement detailing the roles and responsibilities of the Council of Governors. This statement should also describe how any disagreements between the Council of Governors and the Board of Directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the Board of Directors and the Council of Governors operate, including a summary of the types of decisions to be taken by the Board and the Council of Governors and which are delegated to the executive management of the Board of Directors.	The Trust's Scheme of Delegation sets out the roles and responsibilities of the Board of Directors, its Committees, the Council of Governors and executive management. Any disputes between the Board and the Council are resolved in accordance with the procedure set out in the Trust's constitution, whereby the Trust Chair will seek to resolve the matter in the first instance. Where this cannot be achieved, the matter may be escalated to a special joint committee of Governors and Directors, or as a final step, referred to an external mediator. Details of how the Board and the Council of Governors operate are given on pages 36-38 of this Annual Report.
A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the Appointments and Terms of Service, and Audit committees. It should also set out the number of meetings of the Board and those committees and individual attendance by directors.	This information can be found on page 25 of the Annual Report.

Reference	Code of Governance requirement	Trust response
A.5.3	The annual report should identify the members of the Council of Governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	This information is set out in page 33 of the Annual Report.
FT ARM	The annual report should include a statement about the number of meetings of the Council of Governors and individual attendance by Governors and Directors.	This information is set out in pages 30-38 of the Annual Report.
B.1.1	The Board of Directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary.	This information is set out in pages 25-27 of the Annual Report.
B.1.4	The Board of Directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the Board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.	This information is set out in pages 25-27 of the Annual Report.
FT ARM	The annual report should include a brief description of the length of appointments of the non-executive directors, and how they may be terminated.	This information is set out on page 31 of the Annual Report.
B.2.10	A separate section of the annual report should describe the work of the Appointments & Terms of Service Committee, and the Governors' Nomination & Remuneration Committee, including the process each has used in relation to Board appointments.	This information is set out in pages 31-38 of the Annual Report.
FT ARM	The disclosure in the annual report on the work of the Appointments & Terms of Service Committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director.	This information is set out in pages 31-33 of the Annual Report.
B.3.1	A chairperson's other significant commitments should be disclosed to the Council of Governors before appointment and included in the annual report. Changes to such commitments should be reported to the Council of Governors as they arise, and included in the next annual report.	This information is set out on page 25 of the Annual Report. Interests are disclosed to the Council of Governors as part of the appointments process for Non-Executives, and the declaration of interests is a standing agenda item at Council of Governors' meetings.
B.5.6	Governors should canvass the opinion of the Trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the Board of Directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	The Council of Governors received a presentation on the forward plan and feedback was taken into account when compiling the final version. This built on a number of Governor-led engagement events that have taken place during the year, enabling Governors to seek feedback from members and the public.
FT ARM	If during the financial year the Council of Governors has exercised its power under Paragraph 10C of Schedule 7 of the NHS Act 2006 (to require a director to attend a meeting of the Council of Governors) then information on this must be included in the annual report.	Not relevant. This power has not been exercised.

Reference	Code of Governance requirement	Trust response
B.6.1	The Board of Directors should state in the annual report how performance evaluation of the Board, its committees, and its directors, including the chairperson, has been conducted.	The Board evaluates its own performance after each meeting, and has conducted a self-assessment during the year in accordance with Monitor's Well-Led Framework for Governance. Committees each produce an annual report for the Board, setting out how they have performed against their terms of reference. Committee remits have been reviewed through the year to ensure appropriate focus and reduce potential duplication of effort. Directors are subject to annual performance appraisals; for Non-Executive Directors, Governors are invited to contribute through a 360 degree feedback process. Non-Executive Director appraisals are presented in summary form to the Nomination & Remuneration Committee.
B.6.2	Where there has been external evaluation of the Board and/or governance of the Trust, the external facilitator should be identified and a statement made as to whether they have any other connection with the Trust.	Not relevant. No external evaluation has taken place during the year.
C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. There should be a statement by the external auditor about their reporting responsibilities. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report).	This information is set out in pages 58-176 of the Annual Report.
C.2.1	The annual report should contain a statement that the Board has conducted a review of the effectiveness of its system of internal controls.	This information is set out on page 58 of the Annual Report.
C.2.2	A trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	This information is set out on page 61 of the Annual Report.
C.3.5	If the Council of Governors does not accept the Audit Committee's recommendation on the appointment, reappointment or removal of an external auditor, the Board of Directors should include in the annual report a statement from the Audit Committee explaining the recommendation and should set out reasons why the Council of Governors has taken a different position.	Not relevant. The Audit Committee's recommendation for the appointment of the external auditor during the financial year was accepted by the Council of Governors.

Reference	Code of Governance requirement	Trust response
C.3.9	A separate section of the annual report should describe the work of the Audit Committee in discharging its responsibilities. The report should include: • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment • or reappointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	This information is set out in pages 29-30 of the Annual Report.
D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	This information is set out in pages 20-38 of the Annual Report.
E.1.5	The Board of Directors should state in the annual report the steps they have taken to ensure that the members of the Board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the Council of Governors, direct face-to-face contact, surveys of members' opinions and consultations.	This information is set out on page 37 of the Annual Report.
E.1.6	The Board of Directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	This information is set out in pages 21-22 of the Annual Report.
FT ARM	The annual report should include: • a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; • information on the number of members and the number of members in each constituency; and • a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership [see also E.1.6 above], including progress towards any recruitment targets for members.	This information is set out in pages 21-22 of the Annual Report.
FT ARM and FReM	The annual report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS foundation trust. As each NHS foundation trust must have registers of governors' and directors' interests which are available to the public, an alternative disclosure is for the annual report to simply state how members of the public can gain access to the registers instead of listing all the interests in the annual report.	This information is set out on page 38 of the Annual Report.

[2]gether NHS 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.

Shaun Clee
Chief Executive

Date: 24 May 2017

NHS Improvement's Single Oversight Framework

The Single Oversight Framework provides the basis for overseeing NHS providers and identifying potential support needs. It has five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are given a segmentation or grading from 1 to 4. A '4' reflects providers who receive the most support, and a '1' reflects providers who have the most independence. A Foundation Trust will only be graded '3' or '4' if it has been found to be in breach or suspected of breaching its licence.

The Single Oversight Framework was introduced in Quarter 3 of 2016/17. Prior to this, Monitor's Risk Assessment Framework (RAF) was in place. Information for the prior year and the first two quarters relating to RAF has not been included in this report, as the basis or accountability was different. This is in line with NHS Improvement's guidance for annual reports.

[2]gether's Segmentation

As of 7 April 2017, we are currently in segment '2'. More up-to-date segmentation information for our Trust can be found on the NHS Improvement website.

Our segmentation reflects the position in relation to our waiting times for our Let's Talk service (Improving Access to Psychological Therapy or IAPT), where we have not been meeting our targets. We have a recovery plan in place for this service and waiting times are improving. Our recovery plan has been agreed in conjunction with NHS Improvement, NHS England and our commissioners.

Finance and Use of Resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4' where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the Trust disclosed above might not be the same as the overall financial score here.

Area	Metric	2016/17 Q3 score	2016/17 Q4 score
Financial sustainability	Capital service capacity	2	2
As above	Liquidity	1	1
Financial efficiency	I&E margin	2	1
Financial controls	Distance from financial plan	1	1
As above	Agency spend	4	4
		Overall score: 3	**Overall Score: 3**

Renowned singer songwriter Emily Maguire performed for our inpatients at Stonebow Unit and Wotton Lawn in September 2016

Statement of Chief Executive's Responsibilities as the Accounting NHS Officer of 2gether Foundation Trust

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust.

The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require 2gether NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of 2gether NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; and
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

Shaun Clee
Chief Executive

Date: 24 May 2017

Annual Governance Statement

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.

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 ²gether 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 ²gether NHS Foundation Trust for the year ended 31 March 2017 and up to the date of approval of the Annual Report and accounts.

3. Capacity to handle risk

To support the Trust's Board and me as Accounting Officer, the Board has in place:

- A Governance Committee, of Executive and Non-Executive Directors, supported by Clinical Directors and Heads of Profession which receives assurance on all aspects of information governance, clinical governance and quality management.
- An Audit Committee, comprising only Non-Executive Directors, to review the adequacy of arrangements for risk management and internal control.
- A Delivery Committee that receives assurance on operational performance management including economy, efficiency and effectiveness on behalf of the Board.
- A Mental Health Legislation Scrutiny Committee that receives assurance on the measures in place to ensure the Trust's continued compliance with the Mental Health Act, Mental Capacity Act, Human Rights Act and associated codes of practice.
- A Development Committee that receives assurance on business development matters, and works with other Committees to ensure ongoing monitoring of business plan implementation and performance, and ongoing management of business case risks.
- A Charitable Funds Committee that oversees the management, in accordance with Charity Commission requirements, of funds held on trust by the Board of Trustees.

These committees, chaired by Non-Executive Directors, are directly accountable to the Board and report to it. Committees are subject to regular review of membership and objectives to ensure that they remain sufficiently focussed on relevant quality, performance and financial risks, and to further improve coordination between Committees in their support of the Board. In addition to the Committees outlined above, an Executive Committee comprising Executive Directors is the executive decision-making body of the Trust and is accountable to the Trust Board for enacting the Trust's strategic priorities.

Lead Executive Directors have been identified for Clinical Governance and Patient Safety, Finance, Risk Management, Mental Health Act and Mental Capacity Act compliance, Infection Prevention and Control, Safeguarding Children and Vulnerable Adults, Security, Service User Experience, Engagement and Integration, Health and Safety, Workforce and Organisational Development. They provide leadership for the management of the risks presented.

The Trust has in place a number of policies and procedures designed to ensure the safety of its staff. These policies are supported by a suite of statutory and mandatory training which includes training to enable good quality care to be delivered in our inpatient units and community services while ensuring that both staff and service users are able to remain safe.

Delivery of statutory and mandatory training is monitored by the Delivery Committee, and incidents involving injury to or aggression towards staff are recorded and scrutinised on a quarterly basis by the

Governance Committee to identify areas for procedural or policy improvement and ensure that learning is disseminated throughout the organisation.

To help minimise the number of incidents and ensure risks are appropriately controlled, all new staff are required to attend corporate induction training prior to commencing employment with the Trust, and to undertake a local induction during their first week in the work place. For all staff, annual appraisals include a review of training including attendance at mandatory risk management courses appropriate to their authority and duties. Monitoring, benchmarking and other means are used to identify examples of good practice that can be introduced into services and systems as appropriate.

The Trust takes steps to seek out and learn from good practice in terms of the management of risk. This includes compliance with guidance issued by the Department of Health, NHS Improvement, the Care Quality Commission and other regulatory bodies. The Trust's active leadership and participation in the South of England Safety Improvement in Mental Health Programme enables the Trust to share and learn from good practice in terms of clinical risk management. The Trust receives regular bulletins from its legal advisers outlining sector developments and good practice, including in terms of risk management. The Trust receives sector development reports from its External Auditor which also highlight relevant guidance in terms of risk management. The Trust also agrees and implements actions arising from Internal Audit reports, and reviews incidents to ensure that lessons are captured and implemented in the organisation.

As a matter of good practice, the Trust commissioned an external review of governance during the year. This review, conducted by Deloitte LLP, highlighted a number of areas of good practice with regard to risk management, and made recommendations to enable the Trust to strengthen still further its internal control and management of risk. An action plan was developed and implemented to address each of the review's recommendations. The findings of the external review were used by the Care Quality Commission to inform its formal inspection of the Trust in October 2015.

4. The risk and control framework

The CQC undertook a formal inspection of the Trust in October 2015 and its report, delivered early in 2016, confirmed that the Trust has developed a detailed governance system to support the achievement of its vision of making life better. The CQC found that the process for monitoring risk is robust and the Board is sighted on both the corporate and operational risks facing the organisation. The CQC agreed that the structure of committees and meetings which provide the Board with assurance is well established and effective, and agreed that the Non-Executive Director oversight on Board committees ensures objectivity and appropriate challenge. In reaching this conclusion the CQC drew on the findings of an external Well Led Review of Governance, undertaken by Deloitte in 2015.

Through meetings, reports and correspondence, the Chair, Directors and I have regularly exchanged information about risks with NHS Improvement, the Care Quality Commission and our partners including Clinical Commissioning Groups, Gloucestershire County Council, and Herefordshire Council. Whenever possible and appropriate the Trust works jointly with these partners to manage risks. Representatives of Gloucestershire and Herefordshire Clinical Commissioning Groups attend the Governance Committee as observers, enabling them to contribute to and take assurance from the Trust's approach to the management of clinical and quality risks.

Risk management principles and practical risk management arrangements, including the duties of relevant committees, directors, managers, clinicians, specialist advisers and individual employees, are set out in the Trust's Risk Management framework. The framework was reviewed and updated by the Board during the year, and is underpinned by policies, procedures and guidance documentation that contribute to the management and control of risk. The framework and supporting information has been brought to the attention of all managers and is widely available in all work areas through the Trust intranet. All managers are required to draw the attention of employees to their duties and responsibilities in relation to the identification and control of risks. The Board promotes a culture of openness in reporting without fear of unwarranted repercussions. This is reinforced in the advice and training given to staff.

The Risk Management framework sets out a process for the assessment and prioritisation of risks and describes the level at which risks may simply be monitored, those that must be treated and the level at which the Board must be informed of a risk and ensure that mitigating actions are in place and working.

The following are identified as particularly important tools supporting the Trust's Risk Management framework:

• An Assurance Framework - The framework approved by the Board has evolved during the year and following a recommendation from the Trust's Internal Auditor, now uses an assurance mapping approach to identify and monitor high-scoring risks to the Trust's principal objectives, and assess the sources and levels of assurance in respect of each risk.

The assurance map comprises all high-scoring risks in the corporate risk register, and includes the Board's 'Top 5' risks regardless of their current risk score. Based around the '3 lines of defence' model of risk management which is considered best practice, the assurance map highlights both sources of and gaps in assurance, and thus allows the Board and the Audit Committee to identify risk areas which may benefit from further examination and assurance. Taken together with regular reviews of the corporate risk register by the Board and its Committees, the assurance map provides a comprehensive picture of the risks to the Trust's strategic priorities, and the mitigation in place to address those risks. The Audit Committee reviews the information provided by the assurance map on a quarterly basis on behalf of the Board, which itself reviews the assurance map twice each year. Further quarterly scrutiny of the assurance map is provided by me as the Accounting Officer and by the Trust's Executive Committee.

• Risk Management - The Board determines the Trust's appetite for risk as part of the process for setting and regularly reviewing the Trust's strategy in the light of the prevailing economic outlook. This approach ensures that corporate and operational risks are mitigated as fully as possible through regular reviews of the risk register and assurance map, while indicating how much, or little, the Trust wishes to commit in terms of risk when reviewing service changes or investment.

A Board review of risk management in April 2016 has further increased understanding of the Trust's risk profile by identifying and clarifying the Board's 'Top 5' strategic risks which may hinder the achievement of the Trust's objectives. This review of risk management and oversight included a review of the Trust's risk appetite, the provision of appropriate challenge at Locality Governance committees in respect of risks graded just below the threshold for inclusion in the Board's assurance map, and embedding the 'Three Lines of Defence' model of risk management within an updated risk management framework.

Each strategic and corporate risk identified by the Trust is assigned to an appropriate Committee of the Board for oversight and assurance that risks are being robustly managed. This means, for example, that the Board's Development Committee provides oversight of business and commercial risks by ensuring that these risks are properly identified, assessed and mitigated; the Delivery Committee provides similar oversight in relation to performance risks, with the Governance Committee addressing clinical and quality risks. The Audit Committee receives aggregated assurance on all corporate and strategic risks on a quarterly basis, enabling the Committee to provide robust challenge in respect of mitigation in place, and assurance to the Board.

The Trust uses a number of methods to identify potential risks and learning opportunities affecting external stakeholders. These include the Trust's procedures for raising Complaints, Comments and Concerns, the national Patient Survey, local Friends and Family Test processes. The Trust also participates in multi-agency safeguarding procedures to ensure that safeguarding risks are appropriately and promptly managed. Governors have access to the risk register and may raise concerns with the Board on behalf of their stakeholders and communities.

A Local Security Management Specialist has been appointed by the Trust to ensure the safety and security of the Trust's property and assets. In accordance with guidance from the Secretary of State, the Trust has maintained a Counter Fraud Service during the year. Mitigating actions are in place for those areas where the Trust relies on single points of expertise.

A template for Board and Committee reports is in place to standardise the format of reports and ensure that both assurance and risks are highlighted within the executive summary. A common definition of each level of assurance has also been provided in guidance to report authors to ensure consistency. Committee summary reports to the Board include a structured reporting framework that provides the Board either with assurance that mitigation is in place or highlights areas where there may be a lack of assurance and in this case, lists the proposed actions to address this. Committee agendas include a standing item to identify any matter requiring inclusion in the Trust's corporate risk register.

This has assisted in the identification of a number of risks throughout the year, for which mitigating actions have been put in place.

• **Risk Register** - The risk register is a log of risks of all kinds that threaten success in achieving the Trust's aims and objectives. It provides a structure for collating information about risks that helps both in the analysis of risks and in decisions about whether or how those risks should be treated. Locality risk registers are reviewed by Locality Boards each quarter, and the corporate risk register is reviewed quarterly by the Audit Committee, which reviews management responses to risks and decisions relating to the Trust's risk appetite. The Board also reviews the corporate risk register every 6 months. Committees receive updates every quarter in respect of specific risks assigned to them. Risk registers are also in place to enable the capture and review of risks at a more granular level, for example by wards and teams.

• **Risk Dashboard** - This document is produced by the Risk Manager each quarter for the Executive Committee. The purpose of the Dashboard is to provide the committee with a view of the Trust's risk management performance in respect a range of activities by using KRIs (Key Risk Indicators), and determine the level of assurance relating to each risk and the mitigating actions.

• **Risk Rating/Grading System** – This assists the Board, managers and staff in deciding priorities and highlighting areas which need particular attention. The use of a 5x5 impact/likelihood matrix enables risks to be graded consistently.

• **Authority to treat risks** – This is delegated to the lowest competent level to ensure prompt and effective action is taken without bureaucratic delays.

• **Incident Reporting** - The Trust expects all incidents to be reported via the Trust's web-based incident and risk reporting system, Datix. All staff have been trained in how to report incidents and this forms part of the Trust's corporate induction programme for new staff. Incidents are analysed on a quarterly basis and reported to the relevant committees within the Trust with patterns and trends identified to inform future actions.

Work has continued during the year to upgrade Datix, and so improve the use and management of incident and risk data. The Datix upgrade programme is overseen by the Executive Committee which receives regular progress reports. Progress reports are also received regularly by the Governance Committee and a Datix User Group has been established. A Datix Manager and Administrator are in place, and a number of new Datix modules including Incidents, Risk, Claims, Service Experience and Safety Alerts are now online and provide greater flexibility in terms of the collection of risk data and how information is presented, and also allow risks to be directly reported throughout the Trust. A further internal audit review of incident reporting during the year received a medium risk classification and demonstrates the improvements made by the Trust in its incident reporting processes. This review will be repeated during 2017/18 to provide assurance that improvements made to incident reporting procedures are embedded as part of normal business.

• **Whistle-blowing Policy** – A policy is in place to enable staff to report any suspected malpractice, danger or wrongdoing without fear of unwarranted repercussions. To complement the Whistle-blowing Policy, the Trust has introduced 'Speak in Confidence', a web-based system enabling staff to have an anonymous and confidential dialogue about issues that they may be concerned about, with a manager of their choice. The Trust will continue to review the national guidance and consider the impact of this on our local processes. A Freedom to Speak Up Guardian has also been appointed and is now working alongside our designated dignity at work officers and trust leadership teams to support the organisation in becoming a more open and transparent place to work, where all staff are actively encouraged and enabled to speak up safely.

• **Performance Management** – The Trust has robust processes in place to ensure that it is able to manage performance at team, locality and corporate level, and report accurately to the Trust Board and to the Trust's commissioners. Operational performance is managed 'on the ground' by Service Directors in Localities who meet regularly with their respective teams to discuss performance. Localities' services are supported by a corporate Information Department which provides near real-time performance information that teams are able to use to identify risks to the achievement of performance targets.

The Delivery Committee and the Board both receive detailed performance reports on a monthly basis which set out performance against local and national operational and contractual targets. These performance reports are subject to robust challenge, and are augmented by exception reports from Service Directors which flag any performance

areas which are at risk of going off trajectory, and thus enable early remedial action to be taken.

In addition to these operational performance measures, the Trust undertakes its own quality assurance reviews and audits on a frequent basis across all services. The Trust also seeks to accredit its services against national standards such as the Accreditation for Inpatient Mental Health Services (AIMS) scheme. Many of the Trust's services are AIMS accredited.

The Trust takes advantage of a number of benchmarking opportunities which allows measurement of Trust service performance against local and regional comparators.

Financial performance is closely monitored by the Trust Board at each meeting to ensure that financial plans are realistic and achievable, and that savings and expenditure plans are realised in accordance with the Trust's agreed financial strategy and its external financial obligations.

• **Emergency Preparedness** – The Trust has systems in place to ensure that services can continue to be provided in an emergency situation. The Trust is required to demonstrate its ability to adapt to variations in demand throughout the year, with particular emphasis placed on risks to service continuity in the local health system in the winter period between November and March. Those risks include staffing availability, severe weather, service pressures, increased demand on services, and bed availability. The Trust's Operational Resilience and Capacity Plan and Pandemic Flu Action Plan represent two core aspects of the assurance process for emergency preparedness. Before being submitted to Gloucestershire and Herefordshire Clinical Commissioning Groups annually as part of the health system assurance process, both plans are subject to scrutiny both by the Executive Committee and by the Board's Delivery Committee to ensure not only that the Trust's own services are prepared, but that the Mental Health Liaison Service in particular is able to support the local health economy in maintaining patient flows within acute hospitals.

In addition to routine winter planning, the Trust's systems are subject to regular major incident testing, to ensure that the Trust has adequate capacity, systems and expertise to respond to a major incident in the area. Plans for and outcomes of these tests are reported to the Delivery Committee. Risks to business continuity, particularly in respect of clinical and other IT systems, are also captured in the Trust's annual Information Governance Toolkit return, and on Information Asset Registers which are completed by each team and service on an annual basis, with assurance on the completeness of those registers being provided to the Information Governance and Health Records Committee.

• **Clinical Audit and Assurance Processes** – The Trust regards clinical audit and clinical assurance processes as important tools in promoting the adoption of clinically effective practice and is committed to maintaining an effective programme of review which includes participating in national audits.

• **Internal Audit** – The integrity of the Trust's arrangements for both general and financial management and control is a fundamental requirement of sound risk management. The Trust actively commissions a comprehensive programme of internal audit designed to provide assurance on the main risks of the Trust, and responds positively to the auditor's findings and recommendations.

A full programme of internal audit reviews was completed for the year ended 31 March 2017, with findings graded as high, medium or low risk as appropriate. No critical risks were reported. One high risk review was received regarding procurement processes. The review made a number of recommendations to improve the robustness of procurement processes delivered through Financial Shared Services, and the Trust has agreed a comprehensive action plan and training programme with Financial Shared Services to ensure these recommendations are addressed. The Trust's Audit Committee will monitor progress, and a further Internal Audit review will be carried out during the second quarter of 2017/18 to provide independent assurance that improvements are being made and embedded.

The Trust reviewed and updated its Risk Management Framework during the year, and a subsequent Internal Audit review of corporate governance and risk management produced a classification of 'low risk'.

• **Health and Safety** – Compliance with health and safety legislation and internal policies is central to the welfare of staff and service users. There is an annual health and safety programme and risk assessments are carried out based on priority. A programme of training and audits to assess compliance with health and safety regulations, codes of practice and procedures is maintained and monitored by the Delivery and Governance Committees, each of which report to the Board

on a monthly basis. The Governance Committee has paid particular attention during the year to fire compliance training, which remains subject to ongoing monitoring in the form of quarterly fire safety reports to the Committee.

Following a serious tragic incident in 2014 in which a member of staff lost her life, the Trust conducted its own internal investigation and co-operated fully with an investigation by the Police and subsequently the Health and Safety Executive, to ensure that any lessons which could be learnt from this tragic event were quickly identified and learning was promptly disseminated across the Trust. A letter of contravention was issued by the HSE, informing the Trust formally that in the opinion of the Health and Safety Executive the Trust was in contravention of the Health and Safety at Work Act in relation to this incident. The Trust has implemented a comprehensive action plan to address all issues identified from our internal review and raised by the HSE. During 2016/17 the Trust was informed formally by the HSE that no further action will be taken in terms of enforcement or prosecution.

• **Training** – Training is an essential prerequisite of safe working. The Trust aims to ensure it assesses the risk management training needs of all staff and that staff receive adequate training and professional education to enable them to carry out their duties safely. The Trust has a Key Performance Indicator for statutory and mandatory training in order to monitor compliance. A training strategy and a workforce strategy were approved by the Board during the year. These strategies are aimed at developing our workforce and ensuring we have in place well trained and well led staff, in the right place, at the right time and in the right numbers, to deliver the Trust's strategic priorities. An Allied Health and Psychological Professions strategy, approved by the Board during the year, seeks to apply the principles of these more generic strategies in order to achieve an outstanding Allied Health and Psychological professions service delivered by skilled, energised, and compassionate people.

• **Quality Governance** – The Trust has robust arrangements in place to monitor and improve the safety, experience and effectiveness of care provided to those who use our services, to support delivery of NHS Improvement's Quality Governance Framework, and to provide the Board with evidence which in turn enables the Board to make an informed declaration of compliance to NHS Improvement as and when required.

Quality is a central element of the Trust's vision and values, organisational strategy, and annual business plan. Together with the Quality Report, these mechanisms enable the Board to take assurance that quality governance is embedded into the organisation. The Board is supported in identifying risks to quality through the work of its committees, notably the Governance Committee which reviews quality matters on a monthly basis, is constantly challenging of what we can do to continuously improve, and reports to the Board on these issues. The Audit Committee also considers quality and the governance processes associated with it, and is supported by a programme of internal audits. Aspects of quality which are considered to be higher risk are included in the clinical audit and assurance programme, with action plans arising from these audits being monitored by the appropriate committee to ensure implementation and delivery of the intended outcome. Care Quality Commission outcome standards are allocated to specific directors, and both the Board and the Governance Committee receive regular reports on CQC Compliance. The Trust is fully compliant with the registration requirements of the Care Quality Commission.

Board agendas include a number of standing items relating to quality, including reports on Patient Safety and Serious Incidents, Quality Report monitoring, Service Delivery and Service Experience reports. The Board uses checklists based on the Burdett Trust's report 'Sustaining Quality during Turbulent Times' to ensure that all relevant quality issues have been identified and adequately reviewed. A comprehensive monthly performance dashboard provides timely monitoring information on all quality targets, and data assurance processes are in place to ensure that quality information presented to the Board is robust.

Following the publication of the Mid Staffordshire NHS Foundation Trust Public Inquiry (the Francis report), and the subsequent report by Professor Don Berwick 'A promise to learn – a commitment to act: Improving the safety of patients in England' the Trust instigated a comprehensive and ongoing programme of engagement in order to identify and embed learning. Monitoring of the resulting detailed action plans takes place through an Organisational Development and Workforce Committee structure with four work streams led by Trust staff covering Staff Engagement, Culture, Workforce Planning, and Training and Development. Progress is monitored by the Executive and Delivery Committees, with the Governance Committee receiving regular updates on progress against an overall high-level action plan.

The Governance Committee receives regular updates on safe staffing levels in inpatient wards.

During the year the Board and Council of Governors concluded a joint development programme designed to improve quality by enabling both bodies to work more effectively together. The programme produced a number of outputs comprising a team charter, a revised role description which clarified the Governors' role, a revised process for Governor induction, and a template for evaluating each Council of Governor meeting. These outputs are now part of normal business for the Council of Governors and the Board, and will be reviewed during 2017/18 by means of a further joint development session.

The Medical Director and Director of Quality take the executive lead for quality, working closely with the Chief Executive and other Directors, and for (together with the Director of Engagement and Integration and the Director of Finance and Commerce) assessing Quality Impact Assessments in respect of every cost improvement programme to ensure that adverse safety impacts are avoided and adverse quality impacts other than safety are mitigated. The Director of Engagement and Integration is the lead Executive for service experience and complaints. The Board takes an active leadership role in quality in order to promote a quality-focused culture throughout the Trust, and Board members participate in a regular programme of service visits and patient safety walkabouts. The organisation is structured to enable quality accountability in appointed Clinical Directors, Heads of Profession, and Lead Nurses. A Quality Management Team provides support in embedding this quality culture and ensuring that learning is captured from complaints, incidents and other initiatives.

The Trust was inspected formally by the Care Quality Commission during October 2015 and assigned the Trust an overall rating of Good. Two of the Trust's core services (Crisis and Health-based Place of Safety, and Acute Inpatient Services and Psychiatric Intensive Care Unit) were rated as Outstanding and the CQC reported that both of these services were able to demonstrate excellent practice and innovation which went above the standards expected. A further seven core services were rated as Good. The Learning Disability Service and Community Older People's Service were rated as Requires Improvement, and an action plan was developed with the Trust's Leadership Forum, agreed with the CQC, and has been monitored throughout the year by the Trust's Governance Committee. The majority of actions have been completed, and those actions outstanding have been allocated to individual action owners and continue to be progressed until completion.

The Trust actively engages with patients, staff and other key stakeholders on quality; the Quality Report and public Board papers are published, and quarterly updates on the Quality Report are shared with stakeholders such as Clinical Commissioning Groups, Healthwatch, and Health & Social Care Overview and Scrutiny Committees, and feedback is encouraged. The Board receives a 'patient story' presentation at each meeting in public, providing an opportunity for the Board to hear first-hand service users' experience of the Trust's services. The Council of Governors' agenda also includes a standing item on service and quality issues, and there is active development of patient and carer experience through the Director of Engagement and Integration. Regular surveys of service users inform the quality debate and help to ensure quality of service.

• **Review and Assurance** – Each level of management, including the Board, frequently reviews the risks and controls for which it is responsible. These reviews are monitored by and reported to the next level of management and the results recorded on the risk register. Any need to change priorities or controls is either actioned or reported to those with authority to take action. Lessons that can be learned, from both successes and failures, are identified and disseminated to those who can gain from them by the Assistant Director of Governance & Compliance or the Risk Manager. The Board ensures an appropriate level of independent assurance is provided on the whole process of risk identification, evaluation and control.

• **Information Governance** – The Trust maintains a number of systems and processes to ensure that all information, but particularly person-identifiable information, is kept safe, accurate and only shared with appropriate authority.

The Trust has appointed, at Board level, a Caldicott Guardian and a Senior Information Risk Officer to oversee this area of risk. The Trust self-assessed at Level 2 in NHS Digital's Information Governance Toolkit, and is committed to maintaining full compliance with the Information Governance Toolkit standards by tracking information flows, auditing compliance with relevant policies and procedures, raising the awareness of staff, training, and improving the Trust's information technology infrastructure.

The Trust has implemented a range of solutions to ensure information is managed securely and to prevent the theft or accidental loss of information, including secure port control so that data can only be downloaded to approved encrypted media. All laptops and other portable IT equipment are fully encrypted before they are distributed and all staff have access to network shared drives to remove the need to store information locally on a PC. Information governance training is given to all new staff at corporate induction. Information governance refresher training forms part of the Trust's suite of mandatory training, and must be completed by all staff on an annual basis. Training has also been provided to Information Asset Owners throughout the Trust to enable the completion of revised Information Asset Registers which capture the flows of patient-identifiable information through the Trust and provide assurance that, where appropriate, information sharing agreements are in place and regularly monitored so as to provide a legal basis for the sharing of such information.

The Trust has signed up as an early adopter of NHS Digital's CareCERT programme which provides access to tools and resources to strengthen data security. The Trust also receives regular CareCERT Cyber Security Bulletins from NHS Digital which identify the latest cyber security threats, and ensures, through its membership of the cross-organisational IT Security Panel, that mitigating actions in respect of these threats are put in place by Countywide IT Services who provide IT network services to 2gether and other trusts. The Trust is also an active member of Information Governance groups in Gloucestershire and Herefordshire, comprising health economy and local authority partners, which aim to promote information security and the lawful sharing of information where appropriate.

The Trust is a partner in Gloucestershire's Joining Up Your Information (JUYI) initiative, which seeks to enable shared access to relevant patient information held on clinical systems across partner organisations in order to support the delivery of safe, effective and collaborative care. The Trust is an active partner on cross-organisational information governance groups which ensure that information sharing takes place lawfully, and that robust information security procedures and policies are in place to ensure the security of and appropriate access to this sensitive personal information.

The Trust actively encourages the reporting of information governance incidents and near misses. These are investigated internally where it is appropriate to do so, and incident trends and themes are reported to and reviewed by the Information Governance and Health Records Committee (a sub-committee of the Board's Governance Committee comprising Information Asset Owners from across the Trust) to ensure that learning is appropriately cascaded throughout the organisation. The Trust has had no incidents categorised as level 2 on the Information Governance Incident Reporting Tool during the year.

• **Involvement** – The Trust aims to involve service users, carers, members, the local community and its own staff in matters that affect them and to ensure the manner of their participation will enhance their own confidence that the Trust and its employees will always act professionally, and listen to and take account of their views. The Trust has established a membership and created a Council of Governors which represents the interests of constituents and members of the public, and holds the Trust's Non-Executive Directors to account for the performance of the Board. The Trust has developed an Engagement and Communication strategy which will improve still further its communication and engagement with stakeholders. The Trust is also a member of the new Gloucestershire Social Partnership Forum, which provides an established route for local health and social care employers to engage with and involve local and regional trades unions.

The Duty of Candour is considered in all the Trust's serious incident investigations, and we include service users and their families and carers in this process to ensure that their perspective is taken into account. We provide feedback to service users, families and carers on conclusion of each investigation. The Trust is a participant in the Triangle of Care programme, a national scheme bringing carers, service users and professionals together to offer support to adult and young carers.

• **Human Rights** – Fundamental to the work of the Trust is the protection and promotion of the human rights of its service users and others in contact with the organisation. The Trust ensures that its responsibilities are carried out through a programme of staff training, policy review, audit and inspection of services. The Board's Mental Health Legislation Scrutiny Committee ensures the rights of detained patients are properly safeguarded. The Director of Organisational Development is the Trust's lead for human rights.

• **Equality and Diversity** - Supporting its work on human rights the Trust utilises the NHS Equality Delivery System as the basis for ensuring it meets its legal obligations under the Equality Act 2010. Feedback obtained from service users, carers, volunteers, staff, partner agencies, volunteers and others enables the Trust to reduce health inequalities based on a protected characteristic, reduce stigma and discrimination and improve our working environment and employment practices. The Trust requires equality impact assessments to be undertaken on all policies, practices, activities and services. These are then reviewed by trained nominated individuals in the Trust prior to being published on the Trust's intranet and internet sites. Through the use of equality impact assessments the Trust makes reasonable adjustments to ensure people with protected characteristics have their rights secured and are provided with fair and appropriate access to high quality care.

The Trust published an annual Equality Statement as required by the Equality Act 2010, made its annual submission of data to the Workforce Race Equality Standard, and has continued to develop its commitment to equality this year by implementing changes to its service planning process and embedding the use of the Equality Delivery System into service delivery. The Trust encourages applications from under-represented groups for election as a Governor or appointment as a Non-Executive Director. The Trust was the first mental health NHS trust in the country to sign the Armed Forces Corporate Covenant, and in doing so has committed to the Covenant's two core principles:

- no member of the armed forces community should face disadvantage in the provision of public and commercial services compared to any other citizen; and
- in some circumstances special treatment may be appropriate, especially for the injured or bereaved.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. Human Rights control measures are monitored by the Mental Health Legislation Scrutiny Committee through scrutiny of Key Performance Indicators regarding the Mental Health Act, Deprivation of Liberty Safeguards and Mental Capacity Act, and by scrutinising audits of compliance with requirements to ensure patients and their carers are informed and aware of their rights. The Delivery Committee receives an annual assurance statement outlining measures taken to meet the Trust's Public Sector Equalities duty in accordance with the Equalities Act 2010.

In addition to supporting the Trust's Risk Management Strategy, the structures, policies and procedures set out in this Annual Governance Statement also allow the Trust to address risks to compliance with the terms of its licence. One such risk is that the Trust's governance structures and reporting lines may not be sufficiently focused to enable an appropriate level of oversight of the Trust's operations, management and control.

The Trust takes a number of actions to mitigate this risk: The Trust's governance structures are subject to regular review to ensure that they remain fit for purpose and to maintain compliance with relevant legislation, licence conditions and good practice; Committee membership and responsibilities are regularly reviewed and revised where necessary in the light of Non-Executive Director changes to ensure continued oversight of performance standards; the remits of the Governance and Development Committees were reviewed in 2016/17 and changes agreed to their respective terms of reference in order to align these Committees' responsibilities more closely to the Trust's refreshed strategic priorities; the Governance Committee has also established a sub-Committee which will focus on reviewing quality and clinical risk, thus providing additional assurance on these matters to the Governance Committee and thence on to the Board; and the Executive Team has taken steps to add capacity in order to develop and deliver Sustainability and Transformation Plans and the Trust's internal transformation agenda, enabling Executive Directors to oversee the Trust's operations and exercise effective management and control, including managing risks to compliance with the conditions of the Trust's licence.

Alignment of Board and Committee dates where possible ensures that Committees provide appropriate challenge to management and onward assurance to the Board based on the latest available information. Committee administration processes support prompt and efficient referral of issues between Committees, and from Committees to the Board, Council of Governors and Locality Boards.

The Trust's Corporate Governance Statement also provides assurance to the Board that risks to compliance with the terms of its licence are being appropriately addressed. Before signing off its Corporate Governance Statement, the Board receives and reviews a detailed report summarising the evidence upon which the Board might rely in making each individual declaration within the Corporate Governance Statement.

The Board also considers reports it has received through the year and takes account of the work undertaken through the year by its Committees in assessing the Trust's performance, overseeing compliance with relevant legislation, and ensuring the efficient, effective and economic operation of the Trust. The Council of Governors reviews and comments on the Corporate Governance Statement, enabling the Board to take account of Governors' views when considering and approving the statement.

The Council of Governors provides a further layer of governance. As part of its joint development work with the Board, the Council of Governors has developed and implemented a revised process by which Governors are able to hold Non-Executive Directors individually and collectively to account for the performance of the Board, in accordance with its duty under the Health and Social Care Act 2012. This holding to account process provides a valuable additional layer of assurance to the Council of Governors, and to the Trust's members and the public about the performance of the Non-Executive Directors and the Board in general. The Council of Governors has exercised its statutory duty during the year by appointing two new Non-Executive Directors, and by appointing a new external auditor.

Key Risks

The Executive Committee has identified five overarching organisational risks which the Trust faced during the year and beyond. These 'Top 5' risks, which have been agreed by the Board, comprise a number of individual risks which are each included in the corporate risk register, but which when taken together represent a significant risk to the achievement of the Trust's objectives during the reporting year and beyond. The Trust has mitigating actions in place for each of these risks, which are summarised as follows:

That a serious incident occurs that is judged to have been preventable for which the organisation is negligent and catastrophically destabilises clinical and/or financial governance: The Trust joined the Sign Up To Safety (SUP2S) campaign from its outset. SUP2S is a national initiative which has set out a three-year shared objective to save 6,000 lives and halve avoidable harm as part of the journey towards ensuring patients get harm free care every time, everywhere. The Trust has made five pledges as part of this campaign: Put Safety First; Continually Learn; Honesty; Collaborate; Support. The Trust implements these pledges through a number of practical actions such as:

- Executive Directors carrying out monthly patient safety visits to wards and teams to have conversations about patient safety directly with clinical staff. Any actions are then actively followed up
- Seeking and acting on feedback about services from service users, carers, families and staff
- Collaborating with families and carers about service users' care
- Building a culture that supports staff to do the right thing, every time and to speak up when it may not be possible

A Safety Improvement Plan has been developed, submitted and approved to support delivery of the SUP2S programme. Monitoring of progress as a whole is undertaken by the Governance Committee, with each discrete work stream having its own regular forum and reporting mechanism. Within the Trust SUP2S is used as an umbrella for a number of patient safety initiatives such as South of England Improving Patient Safety and Quality in Mental Health; NHS Safety Thermometer; Safety Interventions; and the Reducing Physical Interventions project.

The Trust maintains a robust approach on the reporting and investigation of Serious Incidents which includes the active promotion of incident reporting using Datix, and a comprehensive training and induction programme in incident reporting. The Trust's patient safety agenda is a top priority for the Board, which receives monthly patient safety reports and quarterly reports detailing compliance against the CQC's Essential Regulations. The Board's oversight of patient safety issues is supported by the work of its Committees. The Governance Committee reviews quality, and the associated risks on a monthly basis, which are then reported to the Board. Ownership of quality is clear, with clinical leads for specific areas.

The Governance Committee also ensures that learning points from incidents, complaints and claims are captured, reviewed and disseminated throughout the organisation. An ongoing engagement and learning process, supported by a Workforce and Organisational Development Committee structure and monitored regularly by the Governance Committee, ensures that lessons from the Francis and Berwick reports are captured and embedded within the Trust in order to improve patient safety and the quality of service. The Audit Committee also considers quality and the governance processes associated with it, through a programme of internal audits.

The corporate risk register collates all risks and monitors progress on mitigation, including those impacting on quality. Aspects of quality which are considered to be higher risk are included in the annual clinical audit programme. Quality targets are monitored each month by the Trust Board and the Delivery Committee through the Trust's performance dashboard.

The Trust places particular importance on the safety of its staff, and through the Delivery Committee monitors compliance with training for staff in the management of violence and aggression. Such training is mandatory for those staff in relevant frontline inpatient roles, and helps to ensure the safety of staff providing high quality compassionate care to patients.

That if the Trust's Improving Access to Psychological Therapies services in Gloucestershire and Herefordshire fail to meet national performance standards and/or commissioners fail to agree the necessary investments in our IAPT services then patients will not have access to appropriate services. Improving Access to Psychological Therapies (IAPT) is a free NHS service for people in Gloucestershire and Herefordshire experiencing common mental health issues associated with anxiety and/or depression. The service was introduced to provide treatment for people who otherwise may not have received a service and/or would have been supported by their GP. The service offers guidance, courses and talking therapies to support people with skills and techniques to manage their conditions better and improve their overall wellbeing.

IAPT services are currently expected to support circa 2,178 people a year in Herefordshire and 10,298 people a year in Gloucestershire. This is a high volume service accounting for 20-25% of the people that the Trust sees each year. The IAPT service has a high profile nationally and there is a real drive to expand access and deliver good outcomes, and the Trust is measured against key performance indicators including a recovery rate (50% target) and access rate (15% target).

The Trust invited NHS England's Intensive Support Team (IST) to review the way the Trust delivers its Improving Access to Psychological Therapies (IAPT) Services in the light of recovery rates which were lower than expected. The IST was also invited to review how the Trust calculates its performance in terms of access and recovery rates, following the discovery of a misalignment between our locally and nationally reported IAPT data.

The IST visited the Trust early in 2016 and the final review outcomes and recommendations were reported back to the Trust in April 2016. The IST report highlighted a number of areas of good practice particularly in respect of the Gloucestershire service, but identified a number of areas for improvement, some of which were common to both services, and some which were specific to one service or the other.

To address the IST's recommendations, service improvement plans were agreed with commissioners. Improvement actions included:

- The redesign of the overall care pathway in line with IST recommendations
- Establishment of governance arrangements to oversee the improvement process. A Project Board has been established with Commissioner representatives, detailed monthly reporting takes place to the Trust's Delivery Committee, and meetings have taken place with NHS England and NHS Improvement
- Production of new patient tracking lists and waiting list information reports
- Development and implementation of backlog waiting list clearance plans
- Agreement by commissioners to increase funding for both services in order to increase capacity
- Recruitment and training of staff
- Improvements in staff productivity
- Development of trajectories and revised reporting methodologies for all performance measures

The Trust has worked well with the IST to resolve the data and reporting issues. The IST has signed off the Trust's work and both organisations now have a high confidence in our local and national data reporting. Service improvements have been achieved in line with the recovery plan, relating in particular to the delivery of a new clinical pathway and compliance with 18-week waiting time targets. The Delivery Committee will continue to monitor IAPT service development plans throughout 2017/18 to ensure that the remaining improvement actions are implemented in a timely fashion and performance improves according to the agreed trajectory. That we fail to secure the workforce and evolve the organisational culture necessary to deliver our strategic objectives: To achieve the required transformation of services that will both support financially constrained local health partners, and provide better, more accessible services to patients, the Trust has to achieve a shift in culture to enable new models of service delivery to be developed and implemented.

Alongside the financial investment outlined above, the Trust is therefore making a significant investment in organisational development and engagement with staff in order to develop change jointly wherever we can, and to do so in a transparent, open and honest way. A Leadership Forum has been established to provide a setting in which the wider Leadership Team can actively contribute to the Trust's purpose and help in identifying and achieving its key strategic objectives. A three-year organisational development programme is in place alongside an organisational committee structure which enables the Trust to manage internal engagement; both are subject to regular review. Service plans have been aligned to the Trust's strategic priorities. A technology and mobile working project board, including clinical representation, has been set up to identify and implement suitable enabling technologies in support of the Trust's Technology Strategy.

The Trust continues to review local terms and conditions to ensure these support a flexible and agile workforce and that supporting policies and procedures provide the framework for recruitment and retention. The Trust also has in place a comprehensive package of training and leadership development to ensure our leaders understand the challenges and can support and manage their own teams to deliver sustainable services.

The Trust has collaborative, open and honest relationships with Staff Side representatives so that we can co-produce new ways of working, enhance our respective understanding of the challenges we collectively face and adopt an approach that enables us to deliver our strategic objectives.

That uncertain commissioning arrangements with regard to the procurement of secure services and Tier 4 Children and Young People's Services may result in children and young people being admitted to the Trust's inpatient unit without the necessary safeguards being put in place: Admissions of children and young adults under the age of 18 to an adult inpatient ward are significant events monitored by the Department of Health. However, a national shortage of inpatient beds for children and young people means that there are occasions where the Trust admits a person under the age of 18 to its adult inpatient wards. This happens only where no safer and more clinically appropriate alternative is available. Such admissions are carefully considered, fully risk assessed and consulted on with the patient and their family. A bespoke and exclusive package of care is put in place to ensure the safety and dignity of the young person for the period that they are in our care as an inpatient.

The Trust has audited the compliance with its own policies for ensuring the quality of care provided for children and young people admitted to adult wards. That audit provided significant assurance that the Trust's policies reflect the latest national guidance, that there is a good level of compliance with those policies, and thus that children and young people who are admitted to our adult inpatient wards are kept safe and are transferred to age-appropriate accommodation at the earliest opportunity.

During the year the Trust was successful in being awarded capital funding to support the development of a Children and Young Persons Community-Based Intensive Support Service for Gloucestershire. This development should provide an alternative location to Wotton Lawn for children and young people who require some form of supported care, pending their possible transfer to an age-appropriate inpatient service and/or a return home with an appropriate community package of care. This innovative service development will span input from across all of Gloucestershire's children's services, the Voluntary Sector and the Trust's own services.

That if the Trust continues to spend at its current rate on agency staff it will breach the agency staff control total set by NHS Improvement and this will impact on services: Nationally there is a drive to obtain better value for money for the NHS in terms of agency staffing. As a result, NHS Improvement has introduced controls to reduce agency spend across the NHS. As part of these controls Trusts are required to utilise agency staff only from organisations that have been selected as part of a nationally agreed procurement framework agreement, and financial control totals have been introduced to limit the amount spent by each Trust on agency staff.

The Trust has set up a Temporary Staffing Project Board, led by the Director of Quality and the Director of Finance, to examine all aspects of temporary staff usage in order to assist the Trust in meeting its agency control total. Four work streams report in to the project board and are tasked with implementing a number of actions to better understand the reasons why agency staff are used, reduce the Trust's use of off-framework agencies, increase the use of the staff bank as an alternative to agency staff, improve the Trust's recruitment processes, and thus reduce the overall spend on agency staff. The Executive Committee oversees the agency staffing project as a whole, and reports regularly to the Trust Board on progress.

A number of specific measures have been taken during the year, including:

- A review of all agency spend, by staff group and service, including a detailed analysis of the reasons why nursing bank and agency shifts have been booked in order to find the best ways to control agency usage
- The introduction of an e-rostering system for staff working shifts to increase efficient deployment
- An upgrade to our staff bank software to enable our bank workers to book bank shifts via mobile devices
- The establishment of a staff bank co-ordinator in Herefordshire to complement the existing arrangements in Gloucestershire and support the increase in bank workers in this locality
- A prominent campaign to increase the number of staff on the Trust staff bank to reduce the demand for agency staff
- The alignment of pay increments for substantive staff who also have bank worker contracts to ensure they are paid the same in equivalent roles
- A change to the line management arrangements of the staff bank office to bring it under the responsibility of the Director of Organisational Development
- Attendance at national and regional recruitment fairs to help fill vacancies, and streamlining Trust recruitment processes to speed up recruitment
- Working with universities to offer new intake student nurses and Allied Health Professionals the opportunity to work bank shifts and receive a fixed rate monthly payment with a contractual arrangement to work during their holiday periods
- Providing weekly detailed agency and bank usage information to all ward managers
- Developing principles for and recruiting to a peripatetic team in Herefordshire to provide a first line response to fill last-minute shift gaps to avoid use of agency staff

These measures have enabled the Trust to analyse, better manage, create wider understanding and ownership and reduce its agency expenditure in 2016/17. The Trust expects to be in line with the run rate needed to meet its agency control total for 2017/18 and onwards.

Focus will continue to be applied to the reduction of agency staffing costs until the Board can be confident not only that regulatory control totals have been achieved, but that measures taken to achieve this are fully bedded in and part of “business as usual”.

NHS Pension Scheme

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 Regulations 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.

Carbon Reduction

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 the UKCIP 2009 weather projects, to ensure that this organisation’s obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

5. Review of economy, efficiency and effectiveness of the use of resources

The Trust has a number of key processes designed to ensure the economy, efficiency and effectiveness of the use of resources. These include:

- Monthly monitoring by the Board of Trust performance in relation to contracts, services, financial performance and associated risk ratios, training and attendance targets, resource usage and the delivery of national and local target trajectories
- The use of reference cost benchmarks for service review and economic improvement
- The development of Service Line Costing to enable the Trust to understand better its cost structure, improve the potential for benchmarking, and inform future cost improvement programmes
- The use of internal audit to review the efficiency and effectiveness of corporate business processes
- Active management of NICE Technical Appraisals and Guidelines implementation including planned audits
- Service and pathway redesign within the Trust’s services

The Executive Committee has responsibility for overseeing the day-to-day operations of the Trust and for ensuring that resources are used efficiently, effectively and economically.

At a strategic level, the Delivery Committee receives assurance on the efficient, economic and effective use of resources and provides onward assurance on these matters to the Board through its monthly summary report. The Board itself reviews the Trust's financial position on a monthly basis. In its report on the Trust's formal inspection carried out in October 2015, the CQC found that the Trust has effective systems in place for financial reporting and that these, along with key performance indicators for all teams, ensure that the Trust's management team is aware of the organisation's performance throughout the year.

Internal Audit conducts a review of the Trust's internal control systems and processes as part of an annually agreed audit plan. This review encompasses the flow through the organisation of information pertaining to risk and assurance. It ensures that systems are in place, are appropriate, and can be evidenced by a range of documents available within the organisation. Internal audits have reviewed the governance arrangements within the organisation over a range of financial and other functions to ensure that there is an appropriate and robust approach to the use of resources.

The Trust knows that staff are its biggest resource and account for its highest expenditure. The Trust is committed to minimising its expenditure on agency staff and has set up a Temporary Staffing Project Board led by our Director of Quality and Director of Finance, and supported by the Director of Special Projects. This will ensure the Trust has a comprehensive approach in aligning quality of service delivery with efficient use of resources.

6. Annual Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The Trust has put a number of processes 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. The Trust has a Data Quality policy which is reviewed annually, and which places ultimate responsibility for data quality with the Chief Executive. Operationally, the Director of Quality oversees the production of the Quality Report, while the Director of Service Delivery has responsibility for data quality. Data quality is also overseen by an Information Governance and Health Records Committee which reports to the Trust Board's Governance Committee. Corporate data quality objectives have been agreed by the Executive Committee. Clinicians are involved in the production of the Quality Report through approval of the constituent data and involvement in the development of the Quality Report objectives. Minutes of the Board's Delivery and Governance Committees demonstrate the involvement of clinicians in the operational aspects of data quality.

The Trust has processes in place to ensure that data are used to inform reporting and decision making and are subject to a system of internal control and validation. Internal and external reporting requirements have been critically assessed and data provision is reviewed regularly. Data are used to populate a Performance Dashboard which is reviewed by the Executive Committee, Delivery Committee, Service Directorates and the Trust Board, subjected to appropriate levels of challenge, and used to inform strategic and operational decision making and monitor performance. The Performance Dashboard contains information about performance in relation to national and local targets and contractual obligations including waiting times, quality targets, internal 'stretch' performance targets and other internal performance measures regarding finance and human resources.

A Data Quality Assurance Group is in place and comprises senior operational managers from each Service Directorate in the Trust who each have lead responsibility for clinical data quality in their respective services. The Group is chaired by the Trust's Deputy Head of Information, and provides a forum for dissemination of policy and process changes as well as the opportunity to address data quality issues in a consistent manner across all services. Financial and performance data are subject to scrutiny and challenge by the Delivery Committee, Audit Committee and Development Committee, in order to provide assurance to the Board. Non-Executive Directors chairing these Committees will request further clarification and assurance in the event that information initially presented is unclear. Data are benchmarked where appropriate against national and regional data sets to ensure consistency and identify improvement opportunities.

A RiO System User Group, established as part of the local implementation of the RiO Electronic Patient Record System across the Trust, provides a forum to ensure that data quality issues arising from the use of the Electronic Patient Record System can be tackled consistently across all Trust services.

Real time automated data quality reports derived from RiO are available in a secure manner to operational managers, team managers and individual clinicians throughout the Trust. Each clinician can view a report of each patient on their caseload which highlights missing key data items on that person's record. These are refreshed on a 24-hour basis and enable managers to monitor data quality performance and clinicians to identify and fix specific data quality issues.

A number of mechanisms exist to ensure that staff have the knowledge, competencies and capacity for their roles in relation to data quality. Managers monitor staff competencies and development needs through the annual appraisal process, and ensure that staff have access to appropriate training opportunities. The Trust has put training programmes in place to ensure staff have the capacity and skills for effective collection, recording and analysis of data. RiO training is provided to all appropriate staff, and RiO support materials are available on a dedicated intranet page. Individual members of staff have their own training records and are responsible for identifying their own individual skill requirements in relation to data quality. Training provision is regularly reviewed by the Strategic Training Group, and training provision is periodically evaluated by clinical managers.

The Trust has a comprehensive suite of Care Practice policies in place to ensure the quality of care provided to service users. Care Practice policies are subject to a regular programme of consultation, review and update to incorporate emerging good practice and inform existing training and awareness programmes. An annual programme of local audits measures compliance against these policies, and results are reported to the Governance Committee or Mental Health Legislation Scrutiny Committee as appropriate.

In the development of the annual Quality Report, the trust draws on several sources of information and data to develop a holistic analysis of its performance against nationally and locally defined quality measures. These have included internal data and information such as clinical audit findings, patient care performance data and NICE compliance. The Trust has also drawn on information from independent studies such as the patient survey, staff survey, NHSLA accreditation and achievement of CQUINs, as well as external bodies such as the Care Quality Commission assessment of compliance. This triangulated approach provides assurance that the information provided to the Trust Board on its Quality Reports is both measured and objective.

We have involved stakeholders including Governors, Healthwatch, Overview and Scrutiny Committees and commissioners, in the development of our Quality Report objectives and have taken that opportunity to include many of their very useful comments and suggestions. The comments received indicate an agreement that the Quality Report is representative and that there are no significant omissions of concern. Our commissioners have confirmed that the accuracy of the data presented in the Quality Report accords with the data and information they have available and that there are robust arrangements in place to monitor and review the quality of services. Quality Reports are produced on a quarterly basis and shared with commissioners and stakeholders to enable continuous feedback to be collected.

7. 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 and clinical leads 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 auditor in its 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, the audit committee and governance committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

I have taken account of the findings of an external Well-Led Framework for Governance review undertaken in 2015 on behalf of the Board by Deloitte, and which identified the Trust as a strategically focused organisation with a strong focus and commitment to continuous learning, and a commitment to engaging with service users and carers to improve the quality of care.

I have also taken account of the report issued by the Care Quality Commission following its inspection of the Trust in October 2015, and which assigned an overall classification of 'Good' to the Trust.

The assurance framework provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

In maintaining and reviewing the effectiveness of the system of internal control:

- The Board has reviewed and updated its risk management framework, and reviewed its assurance framework.
- The Board or its committees have considered all major assurance reports received by the Trust and ensured action plans were developed to address any weaknesses.
- The Board has received reports on the revalidation of medical staff.
- The Governance Committee has received regular reports on revalidation of nursing staff, and on professional regulation for Health and Social Care staff.
- The Audit Committee has reviewed all internal and external audit reports and ensured action is taken to address the recommendations, and has provided an annual report to the Board setting out the Committee's work during the year.
- The Audit Committee and the Executive Committee have each reviewed the assurance map four times during the year.
- The Audit Committee has received reports on various aspects of internal control, including losses and special payments, and has received regular reports from the Local Counter Fraud Specialist.
- The Audit Committee has reviewed the register of Directors' interests and declarations of gifts and hospitality.
- The Audit Committee has considered the risks of material mis-statements in the preparation of the annual accounts.
- The Governance Committee has also considered the results of the monitoring of incidents and complaints to ensure any lessons were carefully reviewed and acted upon.
- The Board and Governance Committee have closely monitored arrangements for the prevention and control of infection. They have also monitored all service areas and continued the implementation of a substantial clinical governance development plan.
- The Governance Committee has received regular clinical audit reports in order to take assurance regarding compliance with national and local policies and processes, and has requested and received assurance on actions taken to address any identified areas of improvement
- The Risk Manager has reported on the management of the risk register and supporting processes.
- Non-executive and Executive Directors, the Chair and I have visited services and met staff, service users, carers, members and governors as part of an informal programme of review.
- The Board has approved changes to the roles of its Committees in order to strengthen the focus on quality and clinical risk, and to further align Committees' remits to the Trust's strategic priorities.

8. Conclusion

The Trust firmly believes that it has comprehensive and robust governance processes in place. No significant internal control issues have been identified.

Shaun Clee
Chief Executive **Date: 24 May 2017**

Quality Report 2016/17

Contents

Part 1: Statement on Quality from the Chief Executive

Introduction

"To improve engagement with service users and carers, we will continue to build upon our commitment to the 'Triangle of Care' programme. We are also introducing a new method of gathering service user and carer feedback."

Our Trust has a clear focus on three strategic priorities. The first and most important to my colleagues and I is 'Continuous Quality Improvement'.

Quality and the pursuit of providing high quality services runs throughout everything we do on a daily basis, for every team, department and service. It is only by focussing on quality that we can achieve our overall purpose of Making Life Better for our communities, service users and carers.

This report outlines the quality standards either set nationally or that we have set for ourselves, how we monitor performance against those standards, our main quality achievements during 2016/17 and the priorities we will focus upon in the coming 12 months.

In summary, our main quality initiatives this year included:

- measures focussed on improving the physical health of our service users;
- improving care planning, discharge and transition processes;
- enhancing the perinatal mental health care pathway;
- risk reduction (in the form of improving transitions from children's' to adult services, reducing opportunity for detained patients to be absent without leave, suicide prevention activities and improved inpatient discharge planning); and
- including and involving service users and carers.

Whilst we have continued to make strong progress, we have not achieved every target we set out to and the reasons for that are many, varied and complex. These priorities will continue to be the focus of our attention in 2017/18, as we recognise their importance for the health and wellbeing of our communities.

One of our main initiatives for 2017/18 is our move to becoming 'Smokefree'. This will go a long way towards helping service users, carers and staff to quit smoking and improve their physical health. We also hope to build on our most successful flu vaccination programme, in which 77 per cent of staff and service users were vaccinated for the 2016/17 flu season.

To improve engagement with service users and carers, we will continue to build upon our commitment to the 'Triangle of Care' programme. We are also introducing a new method of gathering service user and carer feedback.

For safety, we have a number of initiatives planned for the coming year. These include the continued embedding of our new Mental Health Acute Response Service, work with the media to encourage responsible reporting of suicides or suspected suicides and awareness raising of a new 'app' to help people at risk of suicide.

Our comprehensive CQC inspection in October 2015 continues to inform many of our quality initiatives. Our overall outcome was 'good', however we are ambitious and there were some areas for

further development. While the vast majority of these areas have been fully addressed, there are still some issues we continue to work on, with the aim of improving still further.

The content of this report has been reviewed by the people who pay for our services (our commissioners), the Health and Care Scrutiny Committees of our local authorities and Healthwatch. Their views on this report are included on page 56. The report is also subject to review by our external auditor.

In preparing our Quality Report, we have used 'best endeavours' to ensure that the information presented is accurate and provides a fair reflection of our performance during the year. The Trust is not responsible, and does not have direct control for all of the systems from which the information is derived and collated. The provision of information by third parties introduces the possibility that there is some degree of error in our performance, although we have taken all reasonable steps to verify and validate such information.

As Chief Executive, I confirm that to the best of my knowledge the information within this document is accurate.

On behalf of our Trust, I am privileged to present this Quality Report, containing many significant achievements and an outline of our areas of focus for the coming year. I will work with my colleagues, Board, Governors, communities and partner organisations to strive for continued quality improvements during 2017/18.

Shaun Clee
Chief Executive
[2]gether NHS Foundation Trust

Date: 24 May 2017

Part 2.1: Looking ahead to 2017/18

Quality Priorities for Improvement 2017/18

This section of the report looks ahead to our priorities for quality improvement in 2017/18.

We have developed our quality priorities under the three key dimensions of **effectiveness, user experience** and safety and these have been approved by the Trust Board following discussions with our key stakeholders.

Following feedback from service users, carers and staff, our Governors and commissioners as well as Herefordshire and Gloucestershire Healthwatch, we have identified 7 goals and 10 associated targets for 2017/18. These targets will be measured and monitored through reporting to the Trust Governance Committee with the period of time varying from monthly, quarterly or annually dependent upon what we measure, and the frequency of data collection.

How we prioritised our quality improvement initiatives

The quality improvements in each area were chosen by considering the requirements and recommendations from the following sources:

Documents and organisations:

- Our 2017/18 Business Plan;
- The 2017/18 NHS England Mandate;
- NHS England: Five Year Forward View;
- NHS England: Next Steps on the NHS Five Year Forward View. March 2017;
- Care Quality Commission (via CQC Comprehensive Inspection at our sites in October 2015);
- NHS Outcomes Framework 2016-17;
- Department of Health, with specific reference to 'No health, without mental health' (2011) and 'Mental health: priorities for change (January 2014);
- Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing. Department of Health 2015;
- NHS England: Commissioning for Quality & Innovation (CQUIN) Guidance for 2017-2019. November 2016;
- NHS Improvement;
- National Institute for Health & Care Excellence publications including their quality standards;
- Preventing suicide in England: Third annual report on the cross-government outcomes strategy to save lives. Department of Health 2016;

- National Confidential Inquiry into Suicide & Homicide by People with Mental Illness: Making Mental Health Care Safer, Annual Report and 20-year Review October 2016;
- Gloucestershire Sustainability Transformation Plan (STP); and
- Herefordshire & Worcestershire STP.

The feedback and contributions have come from:

- Healthwatch Gloucestershire;
- Healthwatch Herefordshire;
- Gloucestershire Health and Care Overview and Scrutiny Committee (HCOSC) and Council colleagues;
- Herefordshire Overview and Scrutiny Committee and Council colleagues;
- Gloucestershire Clinical Commissioning Group;
- Herefordshire Clinical Commissioning Group;
- Internal assurance and Internal Audit reports;
- NHS South of England Mental Health Patient Safety Improvement Programme;
- Trust Governors; and
- Trust clinicians and managers.

Effectiveness

Goal	Target	Drivers
Improving the physical health care for people with serious mental illness.	1.1 To improve the physical health of patients with a serious mental illness on CPA by a positive cardio metabolic health resource (Lester Tool). This will be used on all patients who meet the criteria within the inpatient setting and all community mental health teams. In accordance with national CQUIN targets we aim to achieve 90% compliance for inpatients and early intervention teams and 65% compliance for all other community mental health teams.	To support NHS England's commitment to reduce the 15-20 year premature mortality in people with psychosis and improve their safety through improved assessment, treatment and communication between clinicians. We wish to continue to improve the physical health for those people in contact with our services. There is historical data available for year on year comparison.
Ensure that people are discharged from hospital with personalised care plans.	1.2 To further improve personalised discharge care planning in adult and older peoples wards, including the provision of discharge information to primary care services within 24hrs of discharge .	To ensure effective discharge from our inpatient services and enhance communication with both service users and primary care services. There is historical data available for year on year comparison.
Improve transition processes for child and young people who move into adult mental health services.	1.3 To ensure that joint Care Programme Approach reviews occur for all service users who make the transition from children's to adult services.	As we did not achieve this in 2016/17 we wish to continue to support this as a key quality priority during 2017/18 to further improve our transition processes.

User Experience

Goal	Target	Drivers
Improving the experience of service user in key areas. This will be measured though defined survey questions for both people in the community and inpatients	2.1 Were you involved as much as you wanted to be in agreeing the care you receive? > 92% **Target :** To achieve a response 'Yes' for more than **92%** of the people surveyed.	Questions 2.2 – 2.4 are areas relating to patient experience where we wish to improve following the 2016 Care Quality Commission (CQC) national community mental health survey results.
	2.2 Have you had help and advice to find support to meet your physical health needs if you have needed it? > 76% **Target :** To achieve a response 'Yes' for more than **76%** of the people surveyed.	
	2.3 Do you know who to contact out of office hours if you have a crisis? >74% **Target :** To achieve a response of 'Yes' for more than **74%** of the people surveyed.	
	2.4 Has someone given you advice about taking part in activities that are important to you? > 69% **Target :** To achieve a response of 'Yes' for more than **69**% of the people surveyed.	

Goal	Target	Drivers
Minimise the risk of suicide of people who use our services.	3.1 Reduce the proportion of patients in touch with services who die by suspected suicide when compared with data from previous years. This will be expressed as a rate per 1000 service users on the Trust's caseload.	Gloucestershire Suicide Prevention Strategy and Action Plan. Preventing suicide in England: Third annual report on the cross-government outcomes strategy to save lives. We have historical data available for year on year comparison. This is a variation on our previous suicide reduction indicator.
Ensure the safety of people detained under the Mental Health Act.	3.2 Detained service users who are absent without leave (AWOL) will not come to serious harm or death. We will report against 3 categories of AWOL as follows; harm as a consequence of: 1. Absconded from escort 2. Failure to return from leave 3. Left the hospital (escaped)	NHS South of England Patient Safety Improvement Programme. It is a high risk area with historical data available for year on year comparison. We have historical data available for year on year comparison. This is a variation on our previous AWOL indicator.
Minimise the risk of harm to service users within our inpatient services when we need to use physical interventions	3.3 To reduce the number of prone restraints by 5% year on year (on all adult wards & PICU) based on 2016/17 data. During 2016/17 we reported **211** such incidents.	Positive and safe: reducing the need for restrictive interventions. April 2014 As we did not achieve this in 2016/17 we wish to continue to support this as a key quality priority during 2017/18 to promote restraint reduction. There is historical data available for year on year comparison.

Part 2.2: Statements relating to the Quality of NHS Services Provided

Review of services

The purpose of this section of the report is to ensure we have considered the quality of care across all our services which we undertake through comprehensive reports on all services to the Governance Committee (a sub-committee of the Board).

During 2016/2017, the ²gether NHS Foundation Trust provided and/or sub-contracted the following NHS services:

Gloucestershire

Our services are delivered through multidisciplinary and specialist teams. They are:

- One stop teams providing care to adults with mental health problems and those with a learning disability;
- Intermediate Care Mental Health Services (Primary Mental Health Services & Improving Access to Psychological Therapies);
- Specialist services including Early Intervention, Crisis Resolution and Home Treatment, Assertive Outreach, Managing Memory, Children and Young People Services; Eating Disorders, Intensive Health Outcome Team and the Learning Disability Intensive Support Service;
- Inpatient care.

Herefordshire

We provide a comprehensive range of integrated mental health and social care services across the county.

Our services include:

- Providing care to adults with mental health problems in Primary Care Mental Health Teams, Recovery Teams and Older People's Teams;
- Children and Adolescent Mental Health care;
- Specialist services including Early Intervention, Assertive Outreach and Crisis Resolution and Home Treatment;
- Inpatient care;
- Community Learning Disability Services;
- Improving Access to Psychological Therapies.

²gether NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these NHS services through a systematic plan of quality reporting and assurance that is considered by the Trust's Governance Committee and the Board.

The income generated by the NHS services reviewed in 2016/17 represents 93.3% of the total income generated from the provision of NHS services by the ²gether NHS Foundation Trust for 2016/17.

Participation in Clinical Audits and National Confidential Enquiries

During 2016/17 two national clinical audits and three national confidential enquiries covered NHS services that ²gether NHS Foundation Trust provides.

During that period, ²gether NHS Foundation Trust participated in 50% national clinical audits and 100% of confidential enquiries of the national clinical audits and national confidential enquiries which we were eligible to participate in.

The national clinical audits and national confidential enquiries that ²gether NHS Foundation Trust was eligible and participated in during 2016/17 are as follows:

National Clinical Audits

Clinical Audits	Participated - Yes/No	Reason for no participation
Prescribing Observatory for Mental Health	No	The Trust is not a member of the Observatory.
Early Intervention in Psychosis audit	Yes	N/A

National Confidential Enquiries

National Confidential Enquiries	Participated - Yes/No	Reason for no participation
Confidential Enquiry into Maternal and Child Health	Yes	N/A
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness	Yes	N/A
Sudden Unexplained Death Study	Yes	N/A

The national clinical audits and national confidential enquiries that ²gether NHS Foundation Trust participated in, and for which data collection was completed during 2016/2017 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.

Topic	Trust Participation		National Participation	
	Teams	Submissions	Teams	Submissions
Early Intervention in Psychosis	Early Intervention Service	Information not available*	Information not available*	Information not available*

*This information has not been provided by the Royal College of Psychiatrists

The report of 1 national clinical audit was reviewed in 2016/17 and ²gether NHS Foundation Trust intends to take the following action to improve the quality of healthcare provided.

- Continued focus on the physical health of people diagnosed with schizophrenia via Target 1.1 2016/17 - to increase the number of service users with a LESTER tool alongside increased access to physical health treatment.

Participation in National Confidential Enquiries

	% cases submitted	
Confidential Enquiries	²gether	National Average
Confidential Enquiry into Maternal and Child Health	Information not published	Information Unavailable
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness	99%	98%
Sudden Unexplained Death Study	Information unavailable	Information unavailable

Local Clinical Audit Activity

Within our services there is a high level of clinical participation in local clinical audits, demonstrating our commitment to quality across the organisation. All clinically led local audits are reported to the Quality & Clinical Risk Committee in summary form to ensure that actions are taken forward and learning is shared widely. The table below shows the status of the audit plan at the end of the year. During this process we internally identified a significant number of recommendations to further improve our practice as part of our commitment to continuous improvement.

Clinical Audits	2015/16 audit programme	2016/17 audit programme
Total number of audits on the audit programme	168	168
Audits completed (at year end)	75	95
Audits that are progressing and will carry forward	49	31
Audits taken off the programme for specific reasons4	4	42

The reports of **95** local clinical audits were reviewed by the provider in 2016/17 and [2]gether NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- Building on the review of key clinical policies **Assessment and Care Management CPA** and **Assessing and Managing Clinical Risk and Safety** undertaken in 2016, the Trust has continued to implement and embed these principles into policies and practice. There have been a number of audits carried out throughout the year to provide assurance and actions plan were developed to support improvements in compliance throughout the year. This action continues from last year;
- The Trust has continued to review and develop its training programme to all staff (clinical and non-clinical) in line with the learning that is established from the clinical audit programme. This has, and will continue, to drive the constant review and evaluation of training modules and their contents. This action also continues from last year.

Specific examples of change in practice that have resulted from clinical audits are:

- [2]gether no longer considers the use of 'PO/IM' (Oral/Intramuscular) prescriptions, in which the professional dispensing or administering a drug is given discretion about which route to use from a single prescription, acceptable. This is due to the risk of mishaps, and as such, this prescription should no longer be accepted. In February 2016 an audit was carried out looking specifically at the prescription of PRN sedative medication. The key finding of the initial audit was that 39% of prescriptions for PRN sedative medication took the form of 'PO/IM', giving a compliance of only 61% prescribed in line with new expectations. A re-audit was then carried out in May 2016, again making a cross-sectional analysis of prescription charts in Wotton Lawn and Charlton Lane Hospitals, with the audit criterion being that no prescription for PRN sedative medication should be prescribed as 'PO/IM'. The key finding of the re-audit was that only 10% of prescriptions for PRN sedative medication now take the form of 'PO/IM', giving a much improved compliance of 90% prescribed in line with new expectations.
- CG43 Obesity: Guidance on the prevention, identification, assessment and management of overweight and obesity in adults re audit. This re-audit was conducted as part of the Trusts rolling programme of Quality Assurance 2015 – 2016 in order to assess how the organisation is performing against the NICE guidance CG43. Data collection took place during April to June 2016 and was carried out by a health and exercise practitioner across inpatient services in the Trust. A total of 203 patients were included in the audit. The compliance increased from 74% to 85% since the previous audit carried out in 2015 and provided assurance that:
  - Patients had undergone a physical examination
  - That an Essence of Care screening tool had been used
  - A MUST screening Tool assessment had been completed
  - Service users with a BMI greater than 30 had received a health and exercise or physiotherapy intervention.

A re-audit will occur in July 2017 to monitor ongoing compliance with this guidance.

Participation in Clinical Research

Research Activity in [2]gether in 2016-17

The number of patients receiving relevant health services provided or subcontracted by [2]gether NHS Foundation Trust in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee 308.

This participation was from across 23 different studies. This level of recruitment is slightly less than the previous year's total of 354 participants, and reflects a drop in the number of research studies that have been registered and opened to recruit participants in Trust services.

In 2016/17, the Trust registered and approved 27 studies. Of these studies, 19 were based in mental health services and 1 in dementia services. The remaining studies were made up from 5 "generic and cross-cutting themes" studies (often academic studies involving staff participants) and 2 neurological studies. This also included 8 National Institute for Health Research (NIHR) portfolio studies and 5 of the studies were service evaluations.

Growing 2gether Research

Our research team has performed well in a national key performance indicator of recruiting to time and target for open research studies, as well as supporting a number of activities that help to grow research across the counties of Gloucestershire and Herefordshire. We continue to seek new ways to expand our service, and have recently received funding from the Clinical Research Network West Midlands to fund a full-time Research Nurse post for Herefordshire in 2017/18, and plan to expand our activity across this region.

In August 2016 we held an official opening for the Fritchie Centre; a new development for the organisation to expand our research activity to include commercial and academic research for clinical trials involving medicines. The Research Centre is a team base for both the Research Team and the Managing Memory Service, and we are working towards an integrated service where researchers work collaboratively with clinicians, offering research opportunities to service users and carers.

Alongside our research centre, a new partnership has been formed to carry out research into Alzheimer's disease and dementia. The pioneering programme, between our Trust and the Cheltenham-based charity Cobalt Health, will ensure that research into the illness is undertaken in Gloucestershire and Herefordshire. The research results will contribute towards improving standards of care and treatment locally, and also to the wider research environment nationally and internationally. Cobalt has also undertaken to fund Research Nurse posts at the centre to exclusively support the development and opening of clinical trials for dementia.

We have had additional funding from the Clinical Research Network West of England for a Research Nurse to deliver a development project to integrate the secondary care and primary care interface for research studies. We are working closely with three GP surgeries as part of a pilot to increase opportunities for patients to take part in dementia research and the Join Dementia Research database, a national register for people wanting to be part of ementia research.

Seeking new research opportunities

The availability of research through the National Institute of Health Research (NIHR) and local portfolios fluctuated throughout 2016/17. We are pleased to report a partnership with Queen Mary University, London, who have now received a 5 year NIHR programme grant for a research study aiming to help people with chronic depression. We continue to work collaboratively with partners through the Clinical Research Network West of England to support programme grant applications in other areas of interest.

Currently we have 23 approved NIHR studies recruiting or active in Gloucestershire and Herefordshire, an increase on the 2 open at this time last year. We continue to develop a rolling programme of studies open across the range of our services, as new studies come on to the NIHR portfolio.

Research 2gether strategy

Our Research 2gether Strategy 2016 - 2020 enters its second year and continues to work towards our vision to be a world class centre of practice-based research and development to help make life better. One development from this strategy will be the adoption and roll out of an 'opt-out' research programme that will enable us to offer research opportunities to more people using our services so that they are routinely offered information about research studies.

Research Studies

Examples of the portfolio of activity for 2016/17 are listed below.

Mental Health

- SCIMITAR - Smoking Cessation Intervention for Severe Mental Ill Health Trial: a definitive randomised evaluation of a bespoke smoking cessation service;
- The MILESTONE Study: Improving Transition from Child to Adult Mental Health Care;
- PPiP – Prevalence of neuronal cell surface antibodies in patients with psychotic illness;
- DPIM Polymorphisms in Mental Illness: investigating genetic factors involved in schizophrenia, bipolar disorder, alcoholism and autism and exploring possible treatment options;

[1] Data reported by the West of England Comprehensive Research Network, WoE CRN, from 1 April 2016 to 27 March 2017)

[2] The Viewpoint survey was about national attitudes to mental illness and accounted for nearly 60% of the total research recruitment for 2014/15).

- Molecular Genetics – Bipolar Disorder Research Network;
- REACT – An online randomised controlled trial to evaluate the clinical and cost effectiveness of a peer supported self-management intervention for relatives of people with psychosis or bipolar disorder: Relatives Education And Coping Toolkit (REACT);
- Autism Cohort - Learning about the lives of adults on the autism spectrum;
- ESMI - The Effectiveness and cost-effectiveness of Mother and Baby Units versus general psychiatric Inpatient wards and Crisis Resolution Team services (ESMI).

Dementias and Neurodegenerative Disease

- DAPA – Dementia and Physical Activity research programme;
- VALID - Valuing Active Life in Dementia: a randomised controlled trial of Community Occupational Therapy in Dementia (COTiD-UK);
- IDEAL: Improving the experience of dementia and enhancing active life; the IDEAL longitudinal research study;
- MADE: Minocycline in Alzheimer's Disease Efficacy, a clinical trial;
- MAS: Using Patient Reported Outcome Measures (PROMs) to Improve Dementia Services: Evaluation of Memory Assessment Services;
- MS PAIPMS – Primary progressive multiple sclerosis survey;
- Caregiving HOPE: How obligations, preparedness and eagerness influence wellbeing.

Use of the Commissioning for Quality & Innovation (CQUIN) framework

A proportion of 2gether NHS Foundation Trust's income in 2016/17 was conditional on achieving quality improvement and innovation goals agreed between 2gether NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2016/17 and for the following 12 month period are available electronically at:

www.2gether.nhs.uk/cquin

2016/17 CQUIN Goals

Gloucestershire

Gloucestershire Goal Name	Description	Goal weighting	Expected value	Quality Domain
Young Peoples Transitions	This CQUIN will improve outcomes in young people transitioning from [2]gether Young People's Services to Adult Mental Health Services.	.80	£564256	Effectiveness
Perinatal Mental Health	This CQUIN will focus on quality improvement across the perinatal mental health pathway to promote integration, knowledge and skills of staff and improve outcomes for women and families.	1.7	£1199044	Effectiveness

2016/17 CQUIN Goals

Herefordshire

Herefordshire Goal Name	Description	Goal weighting	Expected value	Quality Domain
1a (b) National CQUIN – Staff health and wellbeing	The introduction of health and wellbeing initiatives covering physical activity, mental health and improving access to physiotherapy for people with MSK issues	.25	£41100	Effectiveness
1b National CQUIN – Staff health and wellbeing	Healthy food for NHS staff, visitors and patients	.25	£41100	Effectiveness
1c National CQUIN - Staff health and wellbeing -	Improving the uptake of flu vaccinations for front line staff	.25	£41100	Safety
3 National CQUIN Improving Physical Healthcare	- To reduce premature mortality - Improved communication with GPs	.25	£41100	Effectiveness
Local CQUIN1 personalised relapse prevention plans for adults	Personalised relapse prevention plans for adults accessing services, specifically Assertive Outreach Team and Early Intervention Service	0.52	£85488	Safety
Local CQUIN2 personalised relapse prevention plans for Children and Young People	Personalised relapse prevention plans for young people accessing services, specifically children and young people accessing and using CAMHS services	0.52	£85488	Safety
Local CQUIN 3 Frequent attenders	Care and management for frequent attenders to WVT Accident and Emergency	0.46	£75624	Safety

2016/17 CQUIN Goals

Low Secure

Low Secure Goal Name	Description	Goal weighting	Expected value	Quality Domain
Reduction in length of stay	Aim to reduce lengths of stay of inpatient episodes and to optimise the care pathway. Providers to plan for discharge at the point of admission and to ensure mechanisms are in place to oversee the care pathway against estimated discharge dates.	2.5	£45000	Effectiveness

The total potential value of the income conditional on reaching the targets within the CQUINs during 2016/17 is £2,219,300 of which we anticipate £2,219,300 will be achieved.

In 2015/16, the total potential value of the income conditional on reaching the targets within the CQUINs was £2,107,995 of which £2,107,153 was achieved.

2017/18 CQUIN Goals

CQUIN goals for 2017/18 reflect the nationally agreed two year scheme and are intended to deliver clinical quality improvements and drive transformational change in line with the Five Year Forward View and NHS Mandate. These include:

National CQUINs applicable to Gloucestershire and Herefordshire mental health services

- CQUIN 1 – NHS Staff Health and Wellbeing;
- CQUIN 2 - Improving physical healthcare to reduce premature mortality in people with serious mental illness (PSMI);
- CQUIN 3 – Improving Services for people with mental health needs who present to A & E;
- CQUIN 4 – Transitions out of Children and Young People's Mental Health Services;
- CQUIN 5 – Preventing ill health by risky behaviors – alcohol and tobacco.

Low Secure Services

- Reduction in length of stay.

Statements from the Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and adult social care services in England. From April 2010, all NHS trusts have been legally required to register with the CQC. Registration is the licence to operate and to be registered, providers must, by law, demonstrate compliance with the requirements of the CQC (Registration) Regulations 2009.

[2]gether NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is to provide the following regulated activities:

- Assessment or medical treatment to persons detained under the Mental Health act 1983;
- Diagnostic and screening procedures;
- Treatment of disease, disorder or injury.

[2]gether NHS Foundation Trust has no conditions on its registration.

The CQC has not taken enforcement action against [2]gether NHS Foundation during 2016/17 or the previous year 2015/16.

CQC inspections of our services

[2]gether NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

The CQC last undertook a planned comprehensive inspection of the Trust week commencing 26 October 2015 and published its findings on 28 January 2016. The CQC rated our services as GOOD, rating 2 of the 10 core services as "outstanding" overall and 6 "good" overall.

Overall rating	Inadequate	Requires improvement	Good	Outstanding

Are services

Safe?	Requires improvement	
Effective?		Good
Caring?		Good
Responsive?		Good
Well led?		Good

The inspection found that there were some aspects of care and treatment in some services that needed improvements to be made to ensure patients were kept safe. However, the vast majority of services were delivering effective care and treatment.

The Trust developed an action plan in response to the 15 “must do” recommendations, and the 58 “should do” recommendations identified by the inspection and is managing the actions through to their completion.

	Safe	Effective	Caring	Responsive	Well led	Overall
Community-based mental health services for older people	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement
Long stay/rehabilitation mental health wards for working age adults	Requires improvement	Good	Good	Good	Good	Good
Wards for older people with mental health problems	Requires improvement	Good	Good	Good	Good	Good
Community-based mental health services for adults of working age	Requires improvement	Good	Good	Good	Good	Good
Specialist community mental health services for children and young people	Good	Good	Good	Good	Good	Good
Acute wards for adults of working age and psychiatric intensive care units	Outstanding ☆	Good	Good	Good	Outstanding ☆	Outstanding ☆
Wards for people with learning disabilities or autism	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Mental health crisis services and health-based places of safety	Good	Good	Outstanding ☆	Outstanding ☆	Good	Outstanding ☆
Forensic inpatient/secure wards	Good	Good	Good	Good	Good	Good
Community mental health services for people with learning disabilities or autism	Good	Good	Good	Good	Requires improvement	Good

A full copy of the Comprehensive Inspection Report can be seen at:

www.cqc.org.uk/provider/RTQ

Changes in service registration with Care Quality Commission for 2016/17

There have been no requests to change our registration with the CQC this year.

Quality of Data

Statement on relevance of Data Quality and actions to improve Data Quality

Good quality data underpins the effective provision of care and treatment and is essential to enabling improvements in care. 2gether NHS Foundation Trust submitted records during 2016/17 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data (Month 11 data is reported below, as this was the only available information at the date of publication).

- The patient's valid NHS number was: 99.7% for admitted patient care (99.3% national); and 99.9% for outpatient care (99.5% national);

- The patient's valid General Practitioner Registration Code was: 100% for admitted patient care (99.9% national); and 100% for outpatient care (99.8% national).

2gether NHS Foundation Trust has taken the following action to improve data quality building on its existing clinical data quality arrangements:

- During 2016/17 the Trust has continued to progress data quality improvement. Based on the work undertaken in previous years to provide automated reports, we have continued the early warning report for Senior Managers so they are alerted to any identified gaps;

- "Masterclasses" have continued to take place across all areas of the Trust. These have focused on educating staff how to use the new Assessment and Care Management clinical audit dashboard which ensures the right data is entered, at the right time. This method enables effective management of data quality through awareness, training and support and moves away from the labor intensive data quality management through list generation;

- As a result of the Masterclass series and the successful pilot of more intuitive "Team Sites" a platform that brings many data sources together into one place, teams can manage their individual and team data quality more effectively. The Trust is continuing to roll this out across all areas with full implementation completed by June 2017;

- Once the rollout has completed a series of 'deep dives' throughout 2017/18 and the following years will be completed, reviewing all aspects of service performance and data quality focusing on Service Specific Reporting" and "Demand and Capacity".

Information Governance Toolkit

Ensuring that patient data is held securely is essential, as such the Trust complies with the NHS requirements on Information Governance and assesses itself annually against the national standards set out in the Information Governance Toolkit which is available on the Health & Social Care Information Centre website:

http://systems.hscic.gov.uk/infogov

2gether NHS Foundation Trust Information Governance Assessment Report overall score for 2016/17 was 85% and was graded green. The Trust scored 84% in 2015/16.

The Toolkit has been the focus of regular review throughout the year by the Information Governance and Health Records Committee, and the Information Governance Advisory Committee. In this year's assessment of 45 key indicators:

- 25 key indicators were at level 3;
- 19 key indicators were at level 2;
- 1 key indicator was deemed not relevant.

The Toolkit has been the subject of an audit by the Trust's Internal Auditor, which produced a classification of low risk.

The Trust's efforts will remain focussed on maintaining the current level of compliance during 2017/18 and ensuring that the relevant evidence is up to date and reflective of best practice as currently understood, and that good information governance is promoted and embedded in the Trust through the work of the Information Governance and Health Records Committee, the IG Advisory Committee and Trust managers and staff.

Clinical Coding Error Rate

2gether NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2016/2017 by the Audit Commission.

Part 2.3: Mandated Core Indicators 2016/17

There are a number of mandated Quality Indicators which organisations providing mental health services are required to report on, and these are detailed below. The comparisons with the national average and both the lowest and highest performing trusts are benchmarked against other mental health service providers.

1. Percentage of patients on CPA who were followed up within 7 days after discharge from psychiatric inpatient care

	Quarter 3 2015-16	Quarter 4 2015-16	Quarter 1* 2016-17	Quarter 2* 2016-17	Quarter 3* 2016-17
[2]gether NHS Foundation Trust	97.2%	98.10%	97.1% 9	7.2% 9	8.3%
National Average	96.9%	97.2%	96.2%	96.8%	96.7%
Lowest Trust	50%	80%	28.6%	76.9%	73.3%
Highest Trust	100%	100%	100%	100%	100%

[2]gether NHS Foundation Trust considers that this data is as described for the following reasons:

- During 2015/16 we reviewed our practices and policies associated with both our 7 day and 48 hour follow up of patients discharged from our inpatient services, the changes were introduced in 2016/17. This has strengthened the patient safety aspects of our follow up contacts.

[2]gether NHS Foundation Trust has taken the following action to improve this percentage, and so the quality of its services, by:

- Clearly documenting follow up arrangements from Day 1 post discharge in RiO;
- Continuing to ensure that service users are followed up within 48 hours of discharge from an inpatient unit whenever possible.

2. Proportion of admissions to psychiatric inpatient care that were gate kept by Crisis Teams

	Quarter 3 2015-16	Quarter 4 2015-16	Quarter 1* 2016-17	Quarter 2* 2016-17	Quarter 3* 2016-17
[2]gether NHS Foundation Trust	100%	98.4%	98.9%	98.9%	99.4%
National Average	97.5%	98.2%	98.1%	98.4%	98.7%
Lowest Trust	61.9%	84.3%	78.9%	76%	88.3%
Highest Trust	100%	100%	100%	100%	100%

[2]gether NHS Foundation Trust considers that this data is as described for the following reasons:

- Staff respond to individual service user need and help to support them at home wherever possible unless admission is clearly indicated;

[2]gether NHS Foundation Trust has taken the following action to improve this percentage, and so the quality of its services, by:

- Continuing to remind clinicians who input information into the clinical system (RiO) to both complete the 'Method of Admission' field with the appropriate option when admissions are made via the Crisis Team and ensure that all clinical interventions are recorded appropriately in RiO within the client diary.

* Activity published on NHS England website via the NHS IC Portal is revised throughout the year following data quality checks. Activity shown for Quarters 1, 2 & 3 2016/17 has not yet been revised and may change. Quarter 4 data has not been published.

3. The percentage of patients aged 0-15 & 16 and over, readmitted to hospital, which forms part of the Trust, within 28 days of being discharged from a hospital which forms part of the trust, during the reporting period

	Quarter 4 2015-16	Quarter 1 2016-17	Quarter 2 2016-17	Quarter 3 2016-17	Quarter 4 2016-17
[2]gether NHS Foundation Trust 0-15	0%	0%	0%	0%	0%
[2]gether NHS Foundation Trust 16+	6%	7%	5%	8%	6%
National Average	Not available	Not available	Not available	Not available	Not available
Lowest Trust	Not available	Not available	Not available	Not available	Not available
Highest Trust	Not available	Not available	Not available	Not available	Not available

[2]gether NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust does not have child and adolescent inpatient beds;
- Service users with serious mental illness are readmitted hospital to maximize their safety and promote recovery;
- Service users on Community Treatment Orders (CTOs) can recalled to hospital if there is deterioration in their presentation.

[2]gether NHS Foundation Trust has taken the following action to improve this percentage, and so the quality of its services, by:

- Continuing to promote a recovery model for people in contact with services;
- Supporting people at home wherever possible by the Crisis Resolution and Home Treatment Teams.

4. The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends

	NHS Staff Survey 2013	NHS Staff Survey 2014	NHS Staff Survey 2015	NHS Staff Survey 2016
[2]gether NHS Foundation Trust Score	3.46	3.61	3.75	3.84
National Median Score	3.55	3.57	3.63	3.62
Lowest Trust Score	3.01	3.01	3.11	3.20
Highest Trust Score	4.04	4.15	4.04	3.96

[2]gether NHS Foundation Trust considers that this data is as described for the following reasons:

- For the first time, all staff in post on 1 September 2016 were invited to take part in the survey, confidentially online. Previously the survey had only been sent to a random sample of 750 staff. The overall response rate was 40%, equal to the previous year but 777 staff took the time to respond and give their views, a significant increase on the 298 responses in the previous year. The 2016 survey has provided the most accurate picture of the Trust obtained to-date.
- Staff have reported an increase in the level of motivation at work. Whilst the improved level of staff satisfaction is encouraging, the trust is very careful to also take note of feedback from colleagues who are less satisfied and where possible to address these concerns.

²gether NHS Foundation Trust considers that this data is as described for the following reasons:

- For the first time, all staff in post on 1 September 2016 were invited to take part in the survey, confidentially online. Previously the survey had only been sent to a random sample of 750 staff. The overall response rate was 40%, equal to the previous year but 777 staff took the time to respond and give their views, a significant increase on the 298 responses in the previous year. The 2016 survey has provided the most accurate picture of the Trust obtained to-date.
- Staff have reported an increase in the level of motivation at work. Whilst the improved level of staff satisfaction is encouraging, the trust is very careful to also take note of feedback from colleagues who are less satisfied and where possible to address these concerns.

²gether NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services, by:

- Encouraging staff to report any incidents which affect patient and staff safety or morale in the workplace;
- Acting to make the best use of service user feedback and highlighting how this feedback is used;
- Promoting the health and wellbeing of Trust staff.

5."Patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.

	NHS Community Mental Health Survey 2013	NHS Community Mental Health Survey 2014	NHS Community Mental Health Survey 2015	NHS Community Mental Health Survey 2016
²gether NHS Foundation Trust Score	8.7	8.2	7.9	8.0
National Average Score	Not available	Not available	Not available	Not available
Lowest Score	8.0	7.3	6.8	6.9
Highest Score	9.0	8.4	8.2	8.1

²gether NHS Foundation Trust considers that this data is as described for the following reasons:

- Across six of the ten domains in the survey our scores were reported as 'About the Same' as other trusts. In the other four domains people scored ²gether's service as 'Better than Others', which is in the top 20% of similar organisations.

²gether NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services, by:

- Helping people with a focus on their physical health needs;
- Providing people with signposting, support and advice on finances and benefits;
- Help people with finding support for gaining or keeping employment;
- Signposting and supporting people to take part in activities of interest;
- Helping people to access peer support from others with experience of the same mental health needs;
- Ensure knowledge of contacts in time of crisis;
- Provision of information about new medicines.

6. The number and rate* of patient safety incidents reported within the Trust during the reporting period and the number and percentage of such patient safety incidents that resulted in severe harm or death.

	1 October 2015 –31 March 2016				1 April 2016 – 30 September 2016			
	Number	Rate*	Severe	Death	Number	Rate*	Severe	Death
[2]gether NHS Foundation Trust	1,371	39.01	1	5	1,900	54.85	4	30
National	146,325	-	501	1167		-	562	1240
Lowest Trust	25	14.01	0	0	40	10.28	0	0
Highest Trust	5,572	85.06	51	91	6,349	88.97	50	84

* Rate is the number of incidents reported per 1000 bed days.

[2]gether NHS Foundation Trust considers that this data is as described for the following reasons:

- NRLS data is published 6 months in arrears; therefore data for severe harm and death will not correspond with the serious incident information shown in the Quality Report.

[2]gether NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services, by:

- Re-auditing its Incident Reporting Systems (DATIX) to improve the processes in place for the timely review, approval of, and response to reported patient safety incidents;
- Creating an additional part time DATIX Administrator post to enhance data quality checks and further promote timeliness of reporting. This post will commence in 2017/18.

Part 3: Looking Back: A Review of Quality during 2016/17

Introduction

The 2016/17 quality priorities were agreed in May 2016.

The quality priorities were grouped under the three areas of Effectiveness, User Experience and Safety.

The table below provides a summary of our progress against these individual priorities. Each are subsequently explained in more detail throughout Part 3.

Summary Report on Quality Measures for 2016/2017

		2015 - 2016	2016 - 2017
Effectiveness			
1.1	To increase the number of service users (all inpatients and all SMI/CPA service users in the community, inclusive of Early Intervention Service, Assertive Outreach and Recovery) with a LESTER tool intervention (a specialist cardio metabolic assessment tool) alongside increased access to physical health treatment.	Achieved	Achieved
1.2	To improve personalised discharge care planning in: a) Adult inpatient wards and; b) Older people's wards.	Achieved	Achieved
1.3	To ensure that joint Care Programme Approach reviews occur for **all** service users who make the transition from children's to adult services.	-	Not achieved
User Experience			
2.1	Were you involved as much as you wanted to be in agreeing what care you will receive? **> 78%**	78%	83%
2.2	Were you involved as much as you wanted to be in decisions about which medicines to take? **> 73%**	73%	77%
2.3	Do you know who to contact out of office hours if you have a crisis? **>71%**	71%	81%
2.4	Has someone given you advice about taking part in activities that are important to you? **> 48%**	48%	83%
Safety			
3.1	Reduce the numbers of deaths by suspected suicide (pending inquest) of people in contact with services when comparing data from previous years.	24	26
3.2	Reduce the number of detained patients who are absent without leave (AWOL) when comparing data from previous years. Reported against 3 categories of AWOL as follows:		
	1. Absconded from an escort	13	23
	2. Did not return from leave	23	53
	3. Absconded from a ward	78	135
		114 total	211 total
3.3	To reduce the number of prone restraints by 5% year on year (on all adult wards & PICU) based on 2015/16 data.	121	211
3.4	**95%** of adults will be followed up by our services within 48 hours of discharge from psychiatric inpatient care.	90%	95%

Quality Report 	This report looks at the quality of [2]gether's services. We agreed with our Commissioners the areas that would be looked at.	
Physical health 	We increased physical health tests and treatment for people using our services. We met the target.	
Discharge Care Plans 	More people had a discharge care plan at the end of the year than previously. We met the target.	
Care (CPA) Review 	Not everyone moving from children's to adult services had a care review. We have not met the target. We are working on this and are getting better.	
Care Plans 	83% of people said they felt involved in their care plan. This is more than last time (78%). We met the target.	
Medicines 	77% of people said they felt involved in choosing their medications. This is more than last time (73%). We met the target.	
Crisis 	81% of people said they know who to contact if they have a crisis. This is more than last time (71%). We met the target.	
Activity 	83% of people said they had advice about taking part in activities. This is more than last time (48%). We met the target.	
Suicide 	Sadly there have not been less suicides compared to this time last year. We have not met the target. We are working hard to keep people safe.	

AWOL 	The number of inpatients who were absent without leave has increased. We have not met the target. We are doing lots of work to get better at this.	↓
Face down restraint 	We have not reduced the number of face-down restraints this year. We have not met the target. We are doing lots of work to get better at this.	↓
Follow up 	We saw 95% of people within 48 hours of discharge from hospital. This is more than last time (90%).	↑

	Key		
↑	Increased performance/activity		Full assurance
↔	Performance/activity remains similar		Significant assurance
↓	Reduced performance/activity		Limited assurance
			Negative assurance

Effectiveness

In 2016/17 we remained committed to ensure that our services are as effective as possible for the people that we support. We set ourselves 3 targets against the goals of:

- Improving the physical health care for people with schizophrenia and other serious mental illnesses;
- Ensuring that people are discharged from hospital with personalised care plans;
- Improving transition processes for child and young people who move into adult mental health services.

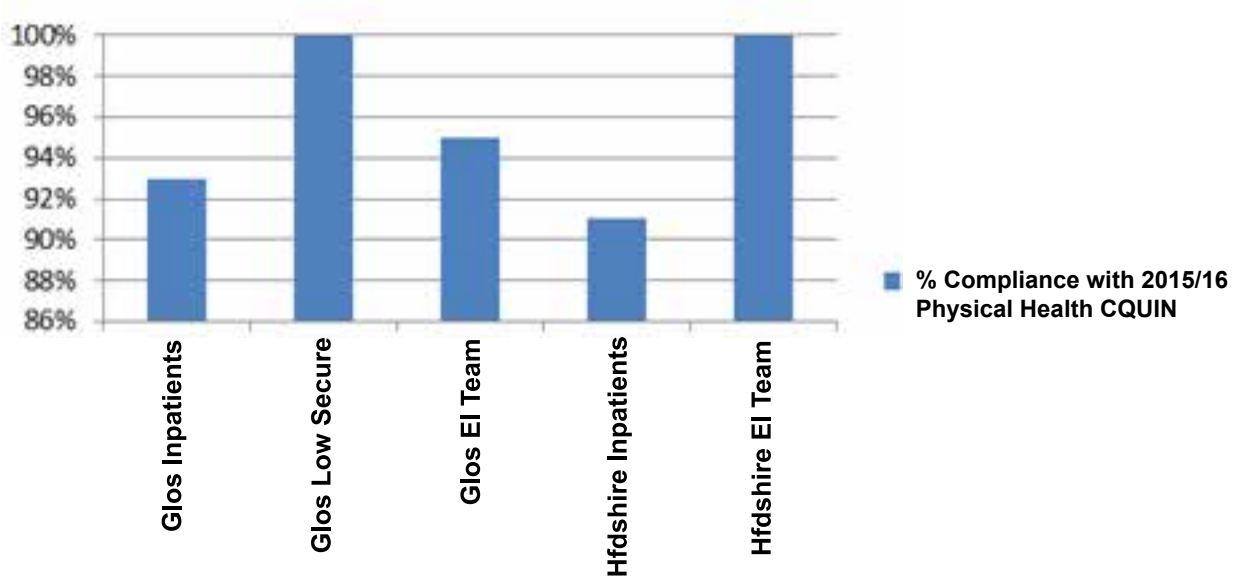
Target 1.1 - To increase the number of service users (all inpatients and all SMI/CPA service users in the community, inclusive of Early Intervention Service, Assertive Outreach and Recovery) with a LESTER tool intervention (a specialist cardio metabolic assessment tool) alongside increased access to physical health treatment

There is a long established association between physical comorbidity (the presence of multiple illnesses) and mental ill health. People with severe and enduring mental health conditions experience reduced life expectancy compared to the general population. People with Schizophrenia and Bipolar disorder die on average, 20 to 25 years earlier than the general population, largely because of physical health problems. These include coronary heart disease, diabetes, respiratory disease, greater levels of obesity and metabolic syndrome.

In 2014/15 the Trust introduced the LESTER screening tool within the inpatient services as part of the National Physical Health Commissioning for Quality and Innovation (CQUIN) payment framework. The LESTER tool is a way of identifying service users at risk of cardiovascular disease and implementing interventions to reduce any risk factors identified. Specific areas covered in the tool are, diabetes, high cholesterol, high blood pressure, increased body mass index, smoking, diet and exercise levels, and substance and alcohol misuse.

In 2015/16 the National Physical Health CQUIN was repeated within the inpatient services and was extended to include the Early Intervention teams within Herefordshire and Gloucestershire. We successfully achieved full compliance with this CQUIN and using the same methodology for both the inpatients and community teams, the Trust achieved overall 93% compliance (see Figure 1).

Figure 1 - % Compliance with 2015/16 Physical Health CQUIN



This year 2016/17 the Physical Health CQUIN has been adapted slightly to continue to build on the good work already in place. The sample group has now been extended to include both inpatients and patients from all community mental health teams who have a diagnosis of psychosis and are on CPA. (This year the CQUIN only relates to Herefordshire, however internal audits continue within Gloucestershire to ensure standards are maintained trust wide).

In order to support this work a substantial Lester Tool training programme for both inpatient areas and community mental health teams has been undertaken by the Physical Health Facilitator. The training department have also facilitated a one day Physical Health Awareness course, designed to complement the Lester tool training and increase staff awareness of coronary heart disease, chronic obstructive pulmonary disease and diabetes. All teams currently working with the Lester tool have an allocated 'lead' professional who receives regular feedback regarding progress in implementing and completing the Lester tool.

Within quarter three, the Trust ensured that the clinical training plan was fully rolled out to all necessary medical, inpatient and community teams. The medical doctor's induction programme also included a section on the Lester tool. The roll out of the screening programme within the community teams highlighted the need for a standardisation of physical health equipment needed as a minimum to undertake the screening.

A "Physical Health Clinic" has been established at the community base in Hereford to enable staff to complete the Lester tool in a suitable environment; however staff are also able to screen patients at home if they are unable to attend the clinic. Documentation has been highlighted as an issue nationwide, in that physical health information (screening details and interventions offered) are currently documented in multiple locations within the Electronic Patient Record RiO. The Trust received access to 'open RiO' in May 2015 which enabled us to make changes to the Electronic Patient Record. Work has taken place to streamline where Physical Health information is recorded within the RiO system. This will improve the way in which information can be audited and fed back to the clinicians. This system has now gone live and staff are now familiar with the new pages within RiO. Feedback from staff, so far, has been positive and appears to reduce the need for duplication of data.

We are currently awaiting the results of the National audit of inpatients, early intervention and community mental health teams. These results are due to be published later this month; however we are confident that we will have met the threshold needed for 100% payment for this CQUIN.

Work continues to revise and update the Physical Health information pages within the Trust intranet. It is hoped to be a central point for obtaining information regarding the Lester tool, along with general physical health information, updates, audits and quality improvement projects.

A Physical Health Awareness Day was held for both patients and staff in February 2017. This was considered to be a huge success with over a hundred people attending and leaving positive feedback. Plans are being made to combine this event next year with a similar event held in Gloucester for people with learning difficulties.

To support the improvement in service user's physical health, the Trust will become "Smoke Free" in April 2017, and plans are in place to ensure this transition takes place smoothly, enabling service users to both quit and abstain from smoking across all Trust sites. The annual Flu vaccination programme was successfully rolled out across the Trust, with the Trust obtaining 77% of staff and patients immunised this year. A ten month secondment for one of our Physical Health Facilitators to provide support for staff and patients at Wotton lawn hospital has been approved. It is hoped this will improve standards of care with regards to wound care, diabetes and health screening.

This target has been met.

Target 1.2 - To improve personalised discharge care planning in: a) Adult inpatient wards and; b) Older people's wards.

Discharge from inpatient units to the community can pose a time of increased risk to service users. During 2015/16 we focused on making improvements to discharge care planning to ensure that service users are actively involved in shared decision making for their discharge and the self-management care planning process.

There were different criteria in use across Gloucestershire and Herefordshire at this time due to audit criteria being influenced by the West Midlands Quality Review which resulted in a differing set of standards within Herefordshire.

This year identical criteria are being used in the services across both counties as follows:

1. Has a Risk Summary been completed?
2. Has the Clustering Assessment and Allocation been completed?
3. Has the Pre-Discharge Planning Form been completed?
4. Have the inpatient care plans been closed within 7 days of discharge?
5. Has the patient been discharged from the bed?
6. Has the Nursing Discharge Summary Letter to Client/GP been sent within 24 hours of discharge?
7. Has the 48 hour follow up been completed?

We are also including discharge care planning information from within our Recovery Units, as they too discharge people back into the community.

Results from the quarterly audit against these standards are seen below.

Gloucestershire Services

Criterion	Year End Compliance (2015/16)	Year End Compliance (2016/17)
Overall Average Compliance	**69%**	**72%**
Chestnut Ward	84%	85%
Mulberry Ward	75%	79%
Willow Ward	59%	71%
Abbey Ward	72%	75%
Dean Ward	79%	73%

* Data for Honeybourne and Laurel House (Recovery Units) was not collected in 2015/16 – only hospital wards were audited to reflect comparable data across both Gloucestershire and Herefordshire.

Overall average compliance in Gloucester for these standards during this year is 72% which is a 3% improvement from last year.

Herefordshire Services

Criterion	Year End compliance (2015/16)	Compliance Quarter 1 (2016/17)	Year End compliance (2016/17)
Overall Average Compliance	**N/A**	**70%**	**74%**
Cantilupe Ward	**N/A**	77%	85%
Jenny Lind Ward	**N/A**	65%	71%
Mortimer Ward	**N/A**	72%	69%
Oak House	**N/A**	67%	70%

There is no 2015/16 data for Herefordshire. This is due to the audit criteria changing from the original set of questions which were influenced by the West Midlands Quality Review. As the audit widened to the whole Trust across two counties, the criteria within the audit changed to reflect the standards outlined within the clinical system in relation to discharge care planning. Quarter 1 data therefore provided the baseline information and it is seen that year end average compliance increased from 70% to 74%.

Of the seven individual criteria assessed, overall compliance has improved in both counties in all areas except in the following:

1. Has the Pre-Discharge Planning Form been completed?
2. Have the inpatient care plans been closed within 7 days of discharge?

Services will, therefore, be focusing on these elements to promote improvement next year.

This target has been met.

Target 1.3 - To ensure that joint Care Programme Approach reviews occur for all service users who make the transition from children's to adult services.

The period of transition from children and young people's services (CYPS) to adult mental health services is often daunting for both the young person involved and their family or carers. We want to ensure that this experience is as positive as it can be by undertaking joint Care Programme Approach (CPA) reviews between children's and adult services.

Gloucestershire Services

During Quarter 1, there were 7 young people who transitioned into adult services, of these 7, 6 (86%) had a joint CPA review.

All young people received input from the relevant services but this is not clearly documented within RiO.

Compliance improved in Quarter 2, 5 young people were transitioned from CYPS to adult services. All of these (100%) had a joint CPA review with CYPS and adult services staff present.

In Quarter 3, there were 4 young people who transitioned from children's to adult services. All of these (100%) had a joint CPA review with CYPS and adult staff present. This was the second successive quarter with 100% compliance which needs to be maintained.

During Quarter 4 there were no transitions of young people into adult services.

Criterion	Compliance Quarter 1 (2016/17)	Compliance Quarter 2 (2016/17)	Compliance Quarter 3 (2016/17)	Compliance Quarter 4 (2016/17)
Joint CPA Review	86%	100%	100%	N/A

Herefordshire Services

During Quarter 1, there were 3 young people who transitioned into adult services, of these 3, 1 (33%) had a joint CPA review. All young people received input from the relevant services but this is not clearly documented within RiO.

In Quarter 2, there were 2 young people who transitioned into adult services, of these 1 (50%) had a joint CPA review. The one young person who did not receive a joint CPA review was having their care coordinated by a new member of staff who was unfamiliar with process.

In Quarter 3, there were 2 young people who transitioned from children's to adult services. All of these (100%) had a joint CPA review with CYPS and adult staff present. This was the first quarter with 100% compliance which now needs to be maintained.

During Quarter 4 there were 4 transitions of young people into adult services, all of these had a joint CPA review.

Criterion	Compliance Quarter 1 (2016/17)	Compliance Quarter 2 (2016/17)	Compliance Quarter 3 (2016/17)	Compliance Quarter 4 (2016/17)
Joint CPA Review	33%	50%	100%	100%

To improve our practice and documentation in relation to this target a number of measures have been developed as follows:

- Transition to adult services for any young person will be included as a standard agenda item for teams, to provide the opportunity to discuss transition cases;
- Transition will be included as a standard agenda item in caseload management to identify emerging cases;
- Teams are encouraged to contact adult mental health services to discuss potential referrals;
- There is a data base which identifies cases for transition;
- SharePoint report identifies those young people who are 17.5 years open to CYPS. Team Managers will monitor those who are coming up to transition and discuss in supervision.

As the target was not met, this will continue as a quality priority during 2017/18.

We have not met this target.

User Experience

In this domain, we have set ourselves 1 goal of improving service user experience and carer experience with 4 associated targets.

- Improving the experience of service users in key areas. This was measured though defined survey questions for both people in community and inpatient settings.

The Quality Survey provides people with an opportunity to comment on key aspects of the quality of their treatment. It is available as a paper questionnaire and an online survey. In order to encourage more feedback and increase response rates our Trust is launching a new survey for 2017/18 known as "How did we do?" The Quality survey and Friends and Family Test will be combined in this survey to streamline feedback.

The responses for the Quality Survey and Friends and Family Test will continued to be reported separately.

A combined total percentage for both counties is provided for these questions to mirror the methodology used by the CQC Community Mental Health Survey, as this does not differentiate by county.

Cumulative data for Quality survey 2016/17 results:

Target 2.1 - Were you involved as much as you wanted to be in agreeing what care you will receive? > 78%

Questions	Treatment Setting	Sample Size Glos	Number 'yes' Glos	Sample size Hereford	Number 'yes' Hereford	Total % giving 'yes' answer
Question 1 Were you involved as much as you wanted to be in agreeing what care you will receive? > 78%	Inpatient	32	25	17	13	
	Community	118	95	45	43	83%
	Total Responses	150	120	62	56	

This target has been met.

Target 2.2 - Were you involved as much as you wanted to be in decisions about which medicines to take? > 73%

Questions	Treatment Setting	Sample Size Glos	Number 'yes' Glos	Sample size Hereford	Number 'yes' Hereford	Total % giving 'yes' answer
Question 2 Were you involved as much as you wanted to be in decisions about which medicines to take? > 73%	Inpatient	32	23	17	13	
	Community	96	73	41	34	77%
	Total Responses	128	96	58	47	

This target has been met.

Target 2.3 - Do you know who to contact out of office hours if you have a crisis? >71%

Questions	Treatment Setting	Sample Size Glos	Number 'yes' Glos	Sample size Hereford	Number 'yes' Hereford	Total % giving 'yes' answer
Question 3 Do you know who to contact out of office hours if you have a crisis? > 71%	Inpatient	24	19	16	11	
	Community	110	86	44	42	81%
	Total Responses	134	105	60	53	

This target has been met.

Target 2.4 - Has someone given you advice about taking part in activities that are important to you? > 48%

Questions	Treatment Setting	Sample Size Glos	Number 'yes' Glos	Sample size Hereford	Number 'yes' Hereford	Total % giving 'yes' answer
Question 3 Has someone given you advice about taking part in activities that are important to you? > 48%	Inpatient	31	25	17	17	
	Community	77	59	42	37	**83%**
	Total Responses	108	84	59	54	

This target has been met.

Friends and Family Test (FFT)

FFT responses and scores for Quarter 4

Service users are asked "How likely are you to recommend our service to your friends and family if they needed similar care or treatment?", and have six options from which to choose:

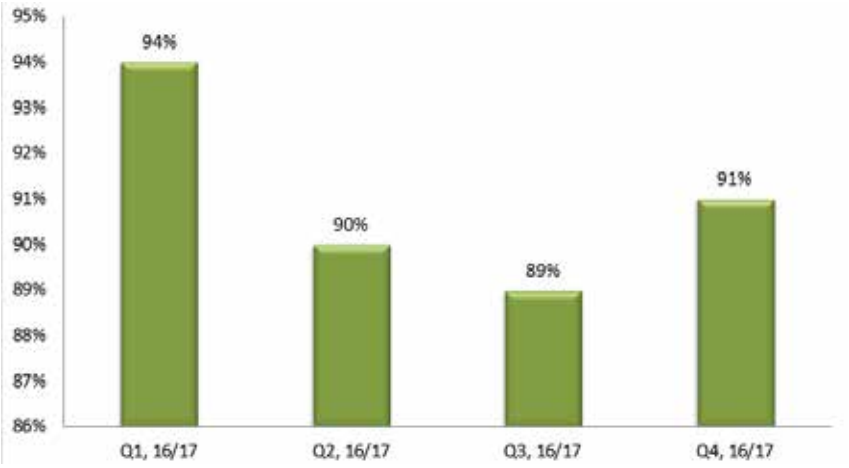
1. Extremely likely
2. Likely
3. Neither likely nor unlikely
4. Unlikely
5. Extremely unlikely
6. Don't know

The table below details the number of responses received each month; the FFT score is the percentage of people who chose either option 1 or 2 - they would be extremely likely/likely to recommend our services.

	Number of responses	FFT Score (%)
January 2017	312	90%
February 2017	228	90%
March 2017	200	95%
Total	**740 (Q3 = 1,100)**	**91% (Q3 = 89%)**

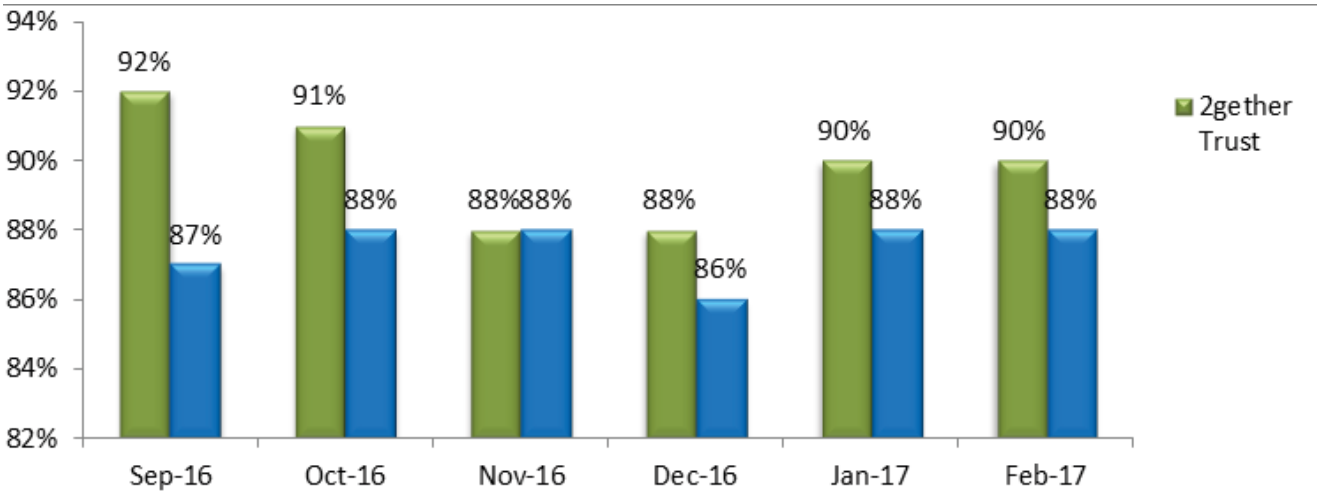
Friends and Family Test Scores for ²gether for the past year

The following graph shows the FFT Scores for the past rolling year, including this quarter. The Trust receives consistently positive feedback.



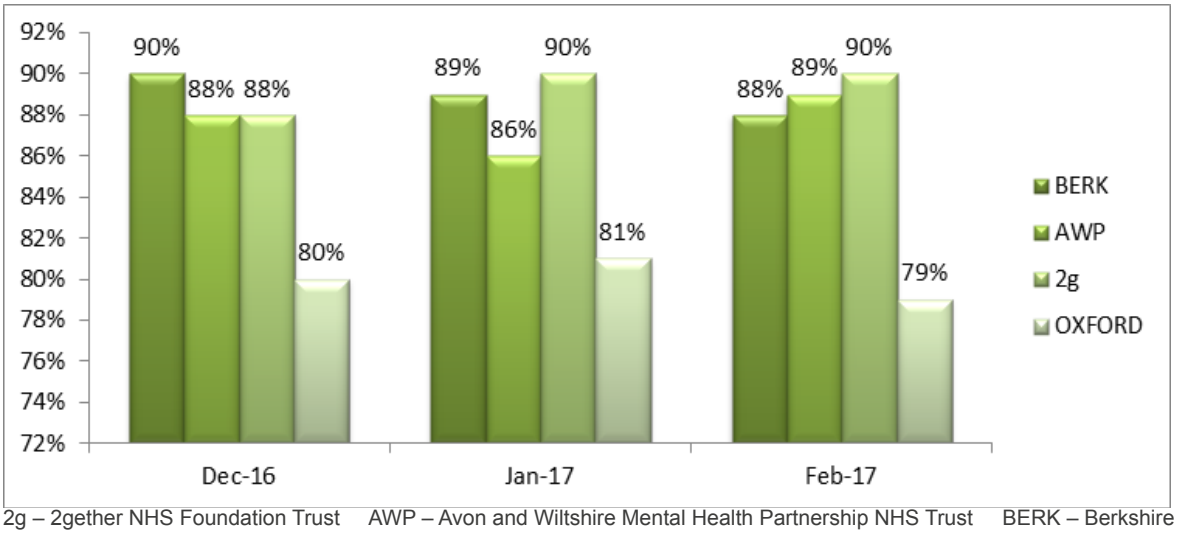
Friends and Family Test Scores – comparison between ²gether and other Mental Health Trusts across England

Figure 3 shows the FFT Scores for the past six months, including this quarter. The Trust receives a consistently high percentage of recommendation scores (March 2017 data for England is not yet available).



Friends and Family Test Scores – comparison between ²gether and other Mental Health Trusts in the NHSE South Central Region

The following graph shows the FFT Scores for December 2016, January and February 2017 (the most recent data available). The Trust receives a consistently high percentage of feedback. (March 2017 data for the region is not yet available).

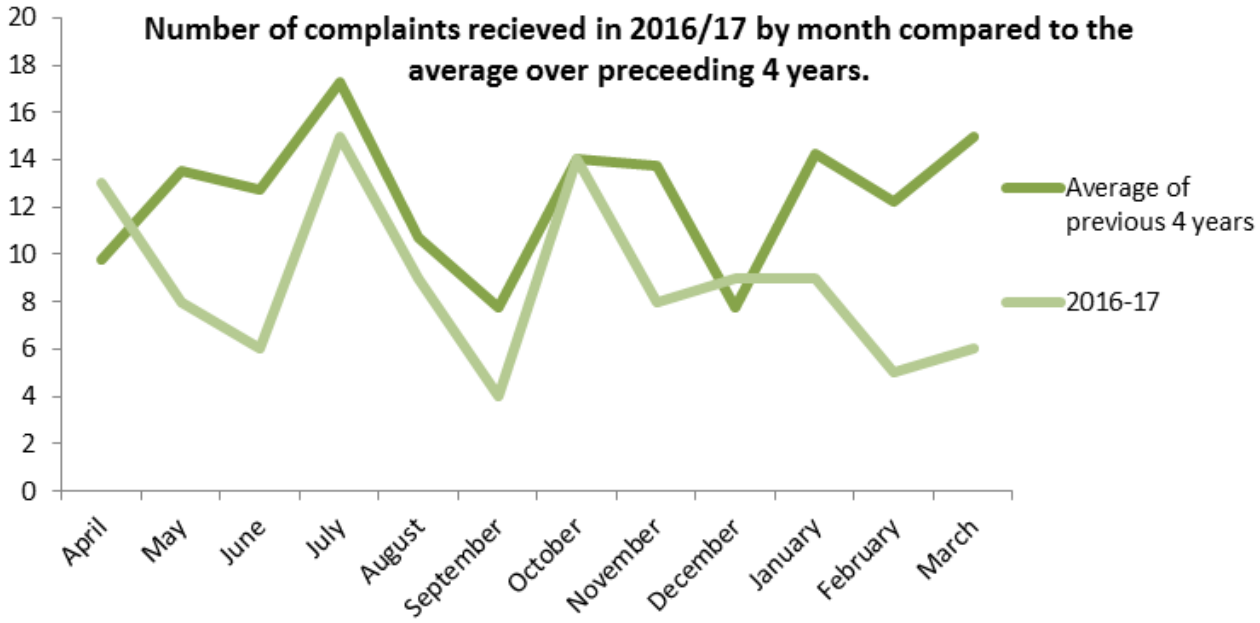


2g – 2gether NHS Foundation Trust AWP – Avon and Wiltshire Mental Health Partnership NHS Trust BERK – Berkshire Healthcare NHS Foundation Trust OXFORD – Oxford Health NHS Foundation Trust

Complaints

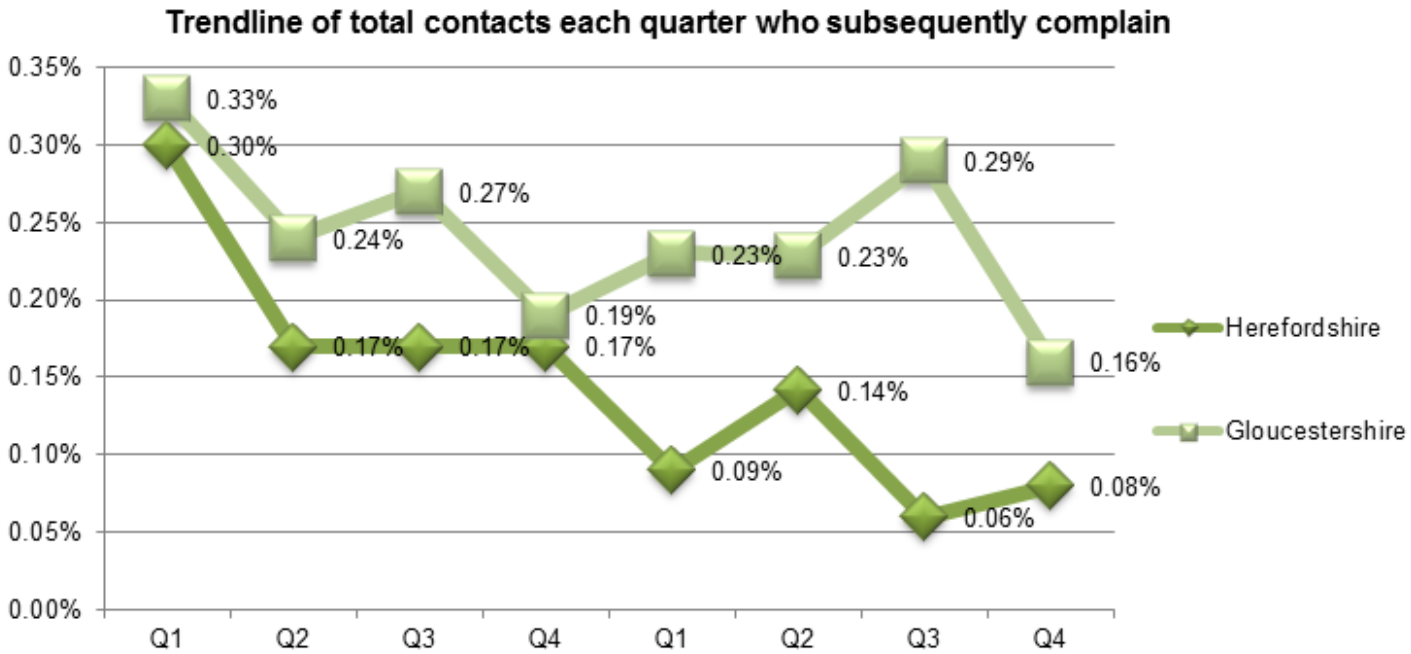
Between 1 April 2016 and 31 March 2017 the Trust received 106 formal complaints, a reduction in actual number from the previous year. However, Figure 5 below (The numbers of complaints received by ²gether in 2016/17 by month compared to the average over preceding 4 years) provides a trend line suggesting that the numbers of complaints received has been relatively consistent in relation to the number of people seen over a period of three years.

Figure 5



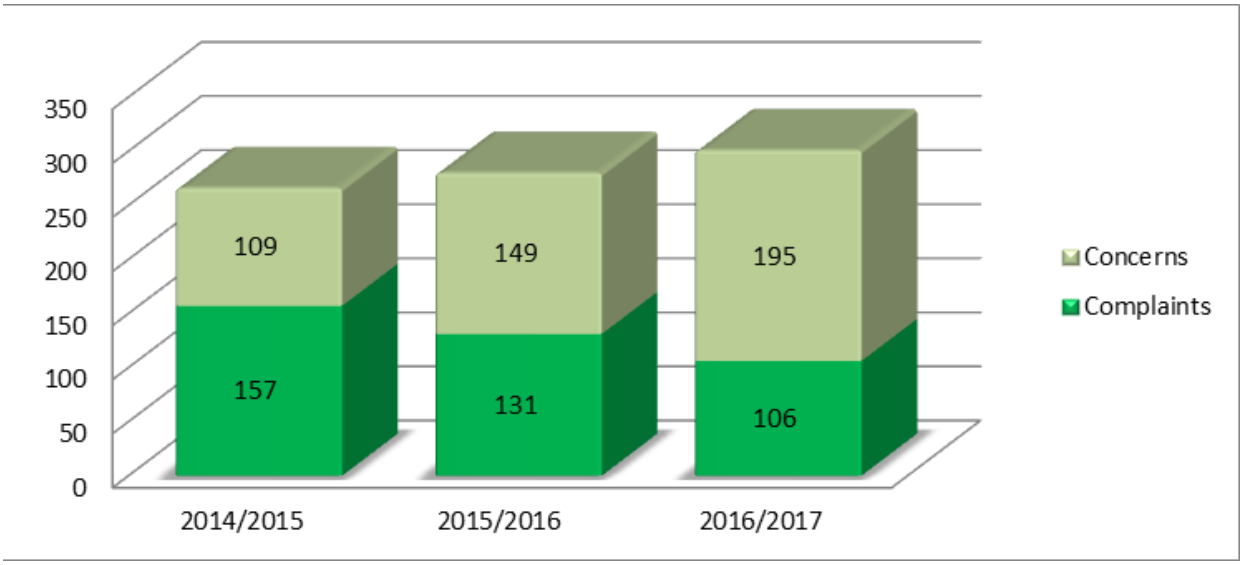
When the numbers of complaints are measured against the number of individual contacts within our services the percentage of complaints is very low (trend line shown for 2015/16 and 2016/17 in Figure 6).

Figure 6



People who raise concerns or complain about ²gether NHS Foundation Trust are contacted by our Service Experience Department. The aim of this is to clarify issues with people and to identify the outcomes being sought from the complaint. The complaint process is explained and the opportunities for informal resolution are also explored. This year increasing numbers of concerns were dealt with by local resolution in a timely manner reducing the need for the formal complaints process.

Comparison of formal complaints and concerns 2015/16 and 2016/17



A continuous year on year improvement in written acknowledgement of complaints within the expected three day timeframe has been demonstrated. 99% (105) of complaints were acknowledged within the three day time standard this year.

People are encouraged to seek an independent investigation of their complaint via the Parliamentary Health Services Ombudsman (PHSO) if they are not satisfied with the outcome of 2gether's investigation or if they feel that their concern remains unresolved. On average the PHSO uphold a third of cases referred from organisations across the country.

This year the PHSO requested information about 7 complaints, a reduction from the 11 requested the previous year. The Ombudsman took 5 of these cases forward for review and investigation. This is fewer than last year, although it represents 5% of complaints received during 2016/17, which is the same percentage as last year. Five cases remain open with the PHSO (one from 2014/15) and four have been closed. Of the latter, one related to a complaint received in 2013/14 and this was partially upheld by the PHSO. An action plan was created by our Trust to address the areas of the complaint that were upheld. The action plan was implemented and completed in November 2016, the complaint was then closed.

Building on developments from 2015/16, the Service Experience Department have continued to focus on and progress complaint resolution this year in the following areas:

- Review and triage of the complaint at point of contact from complainants to attempt to resolve concerns in a timely and responsive way;
- Tailored training sessions lead by our Complaints Manager to support our staff to carry out quality, impartial and transparent complaint investigations;
- Sustained embedding and adjustment to the Datix information system used to record all Complaint data and activity. This ensures that all relevant service experience information and data is captured allowing themes and trends to be monitored;
- Review of the standards for quarterly audit of complaints from our Trusts Non- Executive Directors (NEDS) to ensure impartial review of best practice used;
- Continued review, development and implementation of the processes to resolve complaints;
- Development work with directorate leads to assure that learning from complaints and concerns is shared and embedded in practice.

The quarterly Service Experience Report to the Trust Board outlines in detail the themes of complaints, the learning and the actions that have been taken. Learning from complaints, concerns, compliments and comments is essential to the continuous improvement of our services.

Safety

Protecting service users from further harm whilst they are in our care is a fundamental requirement. We seek to ensure that we assess the safety of those who use our services as well as providing a safe environment for service users, staff and everyone else that comes into contact with us. In this domain, we have set ourselves 4 goals to:

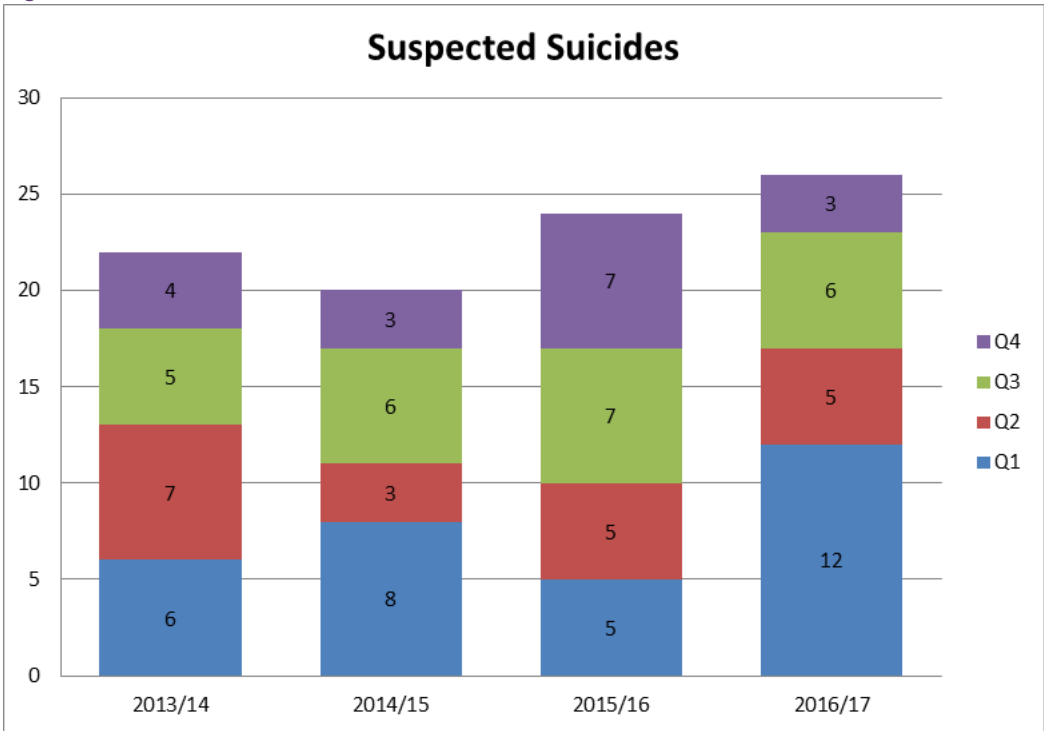
- Minimise the risk of suicide of people who use our services;
- Ensure the safety of people detained under the Mental Health Act;
- Reduce the number of prone restraints used in our adult inpatient services:
- Ensure we follow people up when they leave our inpatient units within 48 hours to reduce risk of harm.

There are 4 associated targets.

Target 3.1- Reduce the numbers of deaths relating to identified risk factors of people in contact with services when compared data from previous years.

We aim to minimise the risk of suicide amongst those with mental disorders through systematic implementation of sound risk management principles. In 2013/14 we set ourselves a specific quality target for there to be fewer deaths by suicide of patients in contact with teams and we have continued with this important target each year. Last year we reported 24 suspected suicides, this year has seen a further rise in these tragic incidents and at the end of the year we reported 26 suspected suicides. It is not clear why higher numbers of suspected suicides were reported in Quarter 1.

Figure 8



This information is provided below in Figures 9 & 10 for both Gloucestershire and Herefordshire services separately. It is seen that greater numbers of suspected suicides are reported in Gloucestershire services. There is no clear indication of why the difference between the two counties is so marked, but it is noted that the population of people in contact with mental health services in Gloucestershire is greater, and the overall population of Gloucestershire is a little over three times that of Herefordshire (based on mid -2015 population estimates).

Figure 9

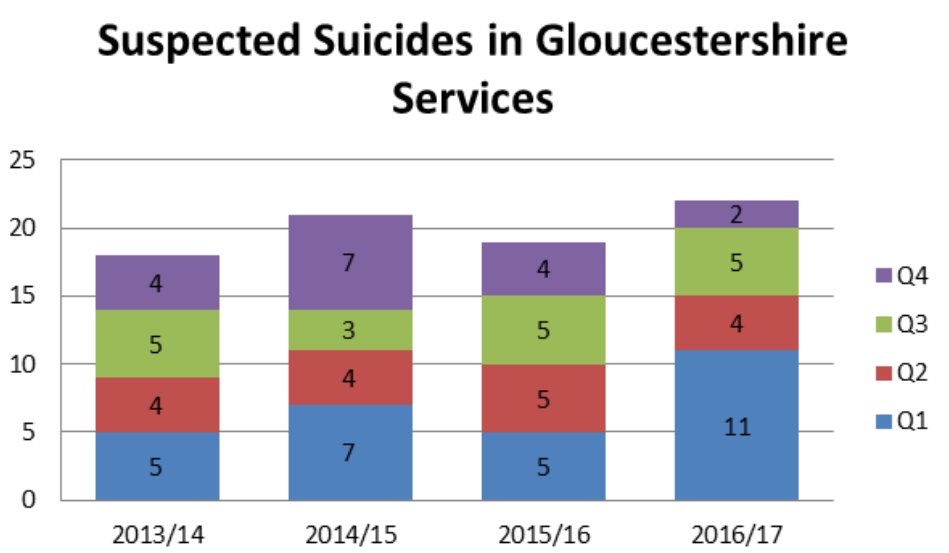
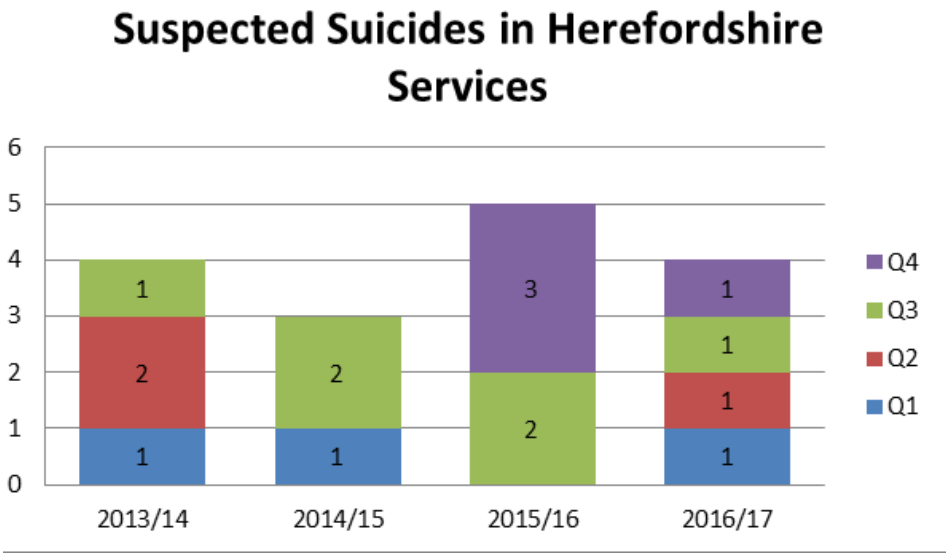


Figure 10



Whilst we report all deaths which appear to be as a consequence of self-harm as suspected suicide, ultimately it is the coroner who determines how a person came by their death. Figure 11 provides the number of suicide, open and narrative conclusions following an inquest being heard for the same cohort of service users. The outcome of inquests for each county is subsequently provided in Figures 12 & 13.

Figure 11

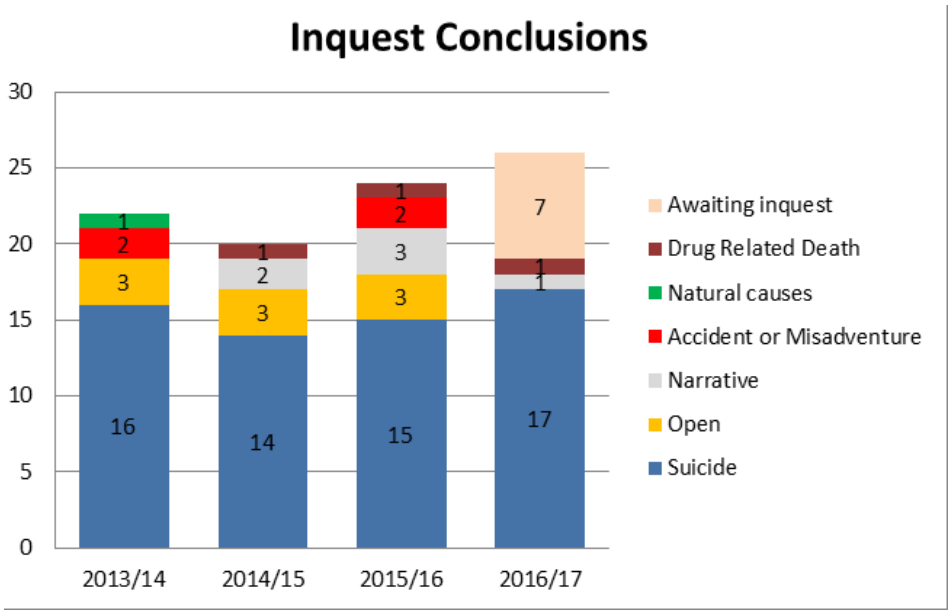


Figure 12

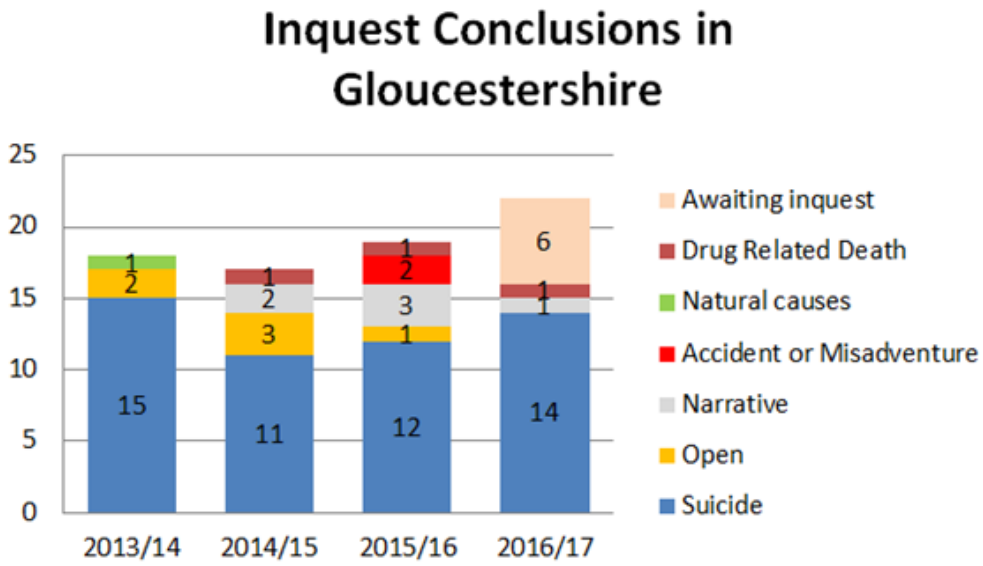
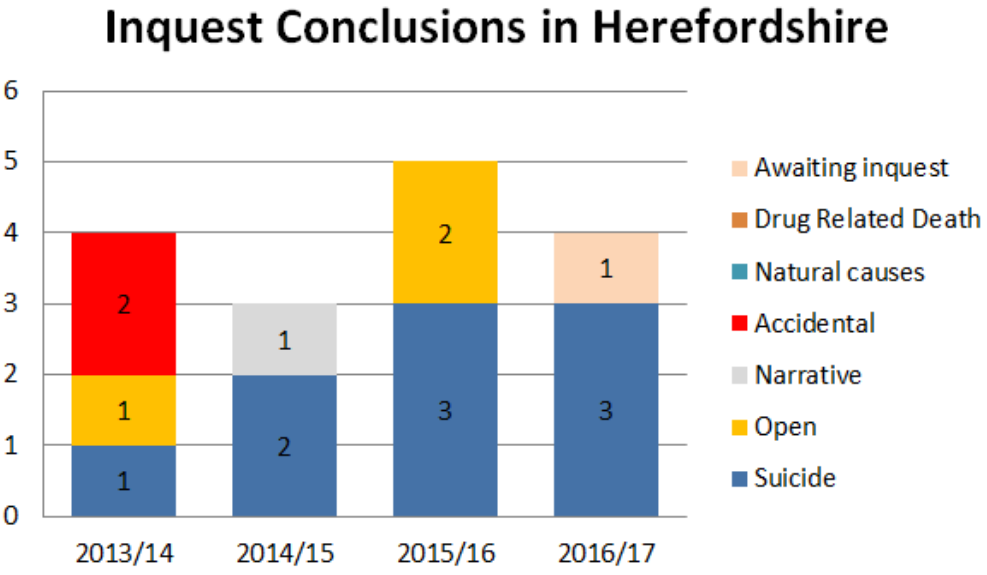


Figure 13



As well as clinical risk assessment training for frontline staff, the Trust also implements the nationally developed Suicide Prevention Toolkit on a monthly basis within all its inpatient units and within the community teams which report the most suspected suicides, these being Recovery and Crisis Teams. There were 2 consecutive months when the North Recovery Team did not complete the toolkit due to staffing issues; all other areas undertook the exercise.

Additionally, inpatient units undertake annual ligature audits to identify and remove, where possible, potential ligature points. This occurred on each inpatient unit except Hollybrook who did not undertake the audit due to the building work occurring on the site throughout the year. Hollybrook will be renamed Berkeley House from April 2017 and a ligature audit will be undertaken during 2017/18.

The Trust has active input into the Gloucestershire Suicide Prevention Partnership Forum, which works to improve the lives of people and carers in Gloucestershire, by focussing action on suicide and self-harm prevention. The Gloucestershire Suicide Prevention Strategy can be accessed at:

www.gloucestershire.gov.uk/suicide-prevention

A number of “Task and Finish” groups are operational, these consider:

- Suicide Hotspots;
- Self-Harm;
- Media reporting;
- Suicide and self-harm in children and young people.

Whilst there is currently no similar forum in Herefordshire, Herefordshire CCG are in discussion with Herefordshire Public Health regarding the need to

formalise countywide arrangements for a suicide prevention strategy.

This year has seen the continuation of number of interagency activities including the following:

- Joint annual [2]gether/SOBS Conference in June 2016, this year focusing on children and young people's mental health issues;
- Continued joint working between [2]gether and Gloucester Constabulary in supporting people in the aftermath of being bereaved by suicide, this model is being adopted by an increased number of trusts and constabularies nationally. [2]gether and Gloucestershire Constabulary presented the model at the Zero Suicide Collaborative annual conference;
- ASIST training for both statutory and voluntary sector organisations being funded via Public Health Gloucestershire;
- Continued delivery of Mental Health First Aid Training;
- Continued multi-agency working regarding frequent attenders (self-harm) at Emergency Departments in both Herefordshire & Gloucestershire;
- Continuation of the Gloucestershire Rethink Mental Illness Self harm helpline to 7 evenings per week from 5-10pm and launch of the associated website in September 2016;
- Implementation of the Mental Health Acute Response Service;
- 48 Hour follow up from an inpatient unit remains a key quality target;
- Leadership of Gloucestershire wide, multi-agency forum to tackle stigma;
- Research poster developed and presented at a Royal College of Psychiatrists event in response to the local hypothesis that the suicide rate reduced during the Olympics;
- An initial comparison of both local and [2]gether suicide data against the National Confidential Inquiry 20 Year Review. This will inform further suicide prevention work in the Trust during 2017/18;
- Development and launch in January 2017 of the "Stay Alive" app (Gloucestershire & Herefordshire) for iPhone & Android smartphones. This will be trialed by small number of services initially using small "tests of change" in line with improvement methodology. As further improvements are made these can be added to the app on a quarterly basis. General awareness raising of the app will be scheduled for April 2017 following local trials;
- An additional "task & finish" group of the Gloucestershire Suicide Prevention Partnership Forum was set up in January 2017 to progress establishing a Suspected Suicide Early Alert System similar to that developed in County Durham. This group consists of representatives from Public Health Gloucester, Gloucestershire Constabulary, [2]gether, HM Coroner for Gloucester and Gloucestershire SOBS.

We have not met this target.

Target 3.2 - Reduce the number of people who are absent without leave from inpatient units who are formally detained.

Much work has been done to understand the context in which detained service users are absent without leave (AWOL) via the NHS South of England Patient Safety and Quality Improvement Mental Health Collaborative. AWOL reporting includes those service users who:

1. Abscond from a ward,
2. Do not return from a period of agreed leave,
3. Abscond from an escort.

During 2015/16 114 episodes of AWOL were reported with the overall target being met, but there was an increase of 9 incidents where service users absconded from a ward. Therefore, we want to continue with this indicator as a quality priority during 2016/17. A breakdown of the 3 categories of AWOL for each county showing the year-end figures for 2015/16 and the quarterly figures for 2016/17 are seen over the page.

Herefordshire

	Total 2015/16	Quarter 1 2016/17	Quarter 2 2016/17	Quarter 3 2016/17	Quarter 4 2016/17
Absconded from a ward	23	15	9	7	9
Did not return from leave	4	2	1	1	0
Absconded from an escort	4	2	0	2	1
Totals for year	**31**			**49**	

Gloucestershire

	Total 2015/16	Quarter 1 2016/17	Quarter 2 2016/17	Quarter 3 2016/17	Quarter 4 2016/17
Absconded from a ward	55	20	36	24	15
Did not return from leave	19	9	16	14	10
Absconded from an escort	9	3	9	3	3
Totals for year	**83**			**162**	

A total of **211** episodes of AWOL were reported during 2016/17.

The increase in reported AWOL incidents has prompted a local review to better understand the context and detail about this increase. Several sources of data have been requested and explored and the findings are summarised below:

- Revisions to the Trust's incident reporting system (Datix) were implemented from 1 April 2016 meaning that the reporting of AWOL is quicker and easier than previously, and this may have impacted as "better reporting". Data quality has also improved as a result.

- The number of people who are formally detained in inpatient units has increased slightly by 3% overall across the Trust this year. Whilst this is not significant, it is noteworthy.

- There are no significant changes reported as modes of absconding. Leaving a hospital is reported more than other categories. The detail of absences from the Wotton Lawn Hospital has been reviewed closely by the Hospital Matron during Quarter 4 and it has been identified that Priory Ward which hosts local people from Gloucester city, reports higher levels of absconding around meal times and bed times implying that people who are much nearer their home leave the hospital around their customary daily habits. Increased vigilance has been implemented on this ward around these times.

- Throughout the year, no reported AWOLS have resulted in severe harm, or death.

- As part of the NHS South of England Patient Safety and Quality Improvement Mental Health Collaborative, it was reported that one other Trust had identified that reduced length of stay correlates with reduced reported AWOLS. This has been explored using data from our information team and although some minor changes in length of stay were noted, overall this is largely unchanged.

We will continue to promote the use of "leave cards". These are cards given to patients, along with a conversation on what the expectations of returning from leave are as agreed. For example, planned leave arrangements can be documented on the back of the credit card sized "leave card", explicitly showing the time due to return and a prompt to contact the ward team if unable to return by the agreed time. The hospital/ward contact numbers are provided on the other side of the cards also.

There has been increased receptionist cover at the Stonebow Unit since September 2016 to include week day evenings and weekend/bank holiday cover in addition to office hours. Staff report this as being helpful. A time delay on reception doors is also being considered.

There will be a continued focus on positive engagement within our inpatient services to reduce the number of occasions where detained patients abscond from the ward environment. We will use coproduction to understand in more detail why patients abscond from the ward and what we can put in place to support them.

We have not met this target.

Target 3.3 - To reduce the number of prone restraints by 5% year on year (on all adult wards & PICU)

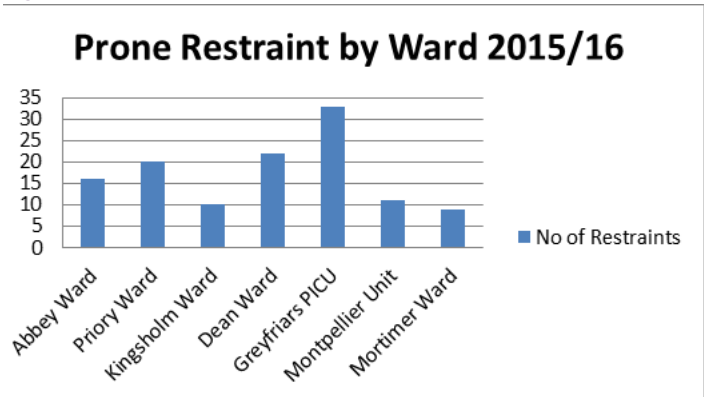
This is a new target for 2016/17. During 2015/16, the Trust developed an action plan to reduce the use of restrictive interventions, in line with the 2 year strategy – Positive & Safe: developed from the guidance Positive and Proactive Care: reducing the need for restrictive interventions. This strategy offered clarity on what models and practice need to be undertaken to support sustainable reduction in harm and restrictive approaches, with guidance and leadership by the Trust Board and a nominated lead.

The Trust developed its own Positive & Safe Sub-Committee during 2015/16 which is a sub-committee of the Governance Committee. The role of this body is to:

- Support the reduction of all forms of restrictive practice;
- Promote an organisational culture that is committed to developing therapeutic environments where physical interventions are a last resort;
- Ensure organisational compliance with the revised Mental Health Act 1983 Code of Practice (2015) and NICE Guidance for Violence and Aggression;
- Oversee and assure a robust training programme and assurance system for both Prevention & Management of Violence & Aggression (PMVA) and Positive Behaviour Management (PBM);
- Develop and inform incident reporting systems to improve data quality and reliability;
- Improve transparency of reporting, management and governance;
- Lead on the development and introduction of a Trust wide RiO Physical Intervention Care Plan/ Positive Behavioural Support.

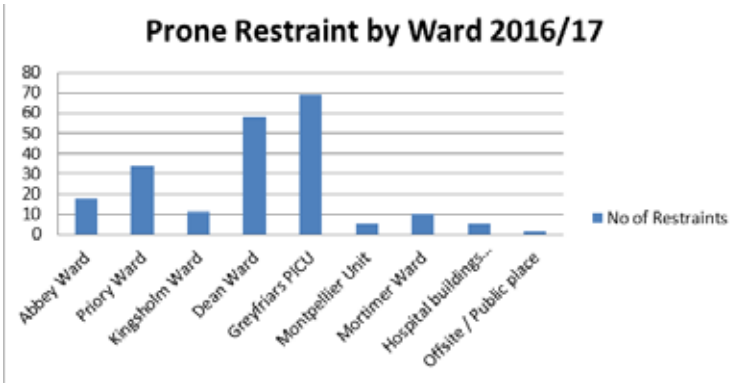
As use of prone restraint (face down) is sometimes necessary to manage and contain escalating violent behaviour, it is also the response most likely to cause harm to an individual. Therefore, we want to minimise the use of this wherever possible through effective engagement and occupation in the inpatient environment. All instances of prone restraint are recorded and this information was used to establish a baseline in 2015/16. Overall, there were 121 occasions when prone restraint was used in our acute adult wards and PICU and the breakdown of this information by month is shown in Figure 14.

Figure 14



At the end of 2016/17, 211 instances of prone restraint were used as seen in Figure 15 which is an overall increase this year.

Figure 15

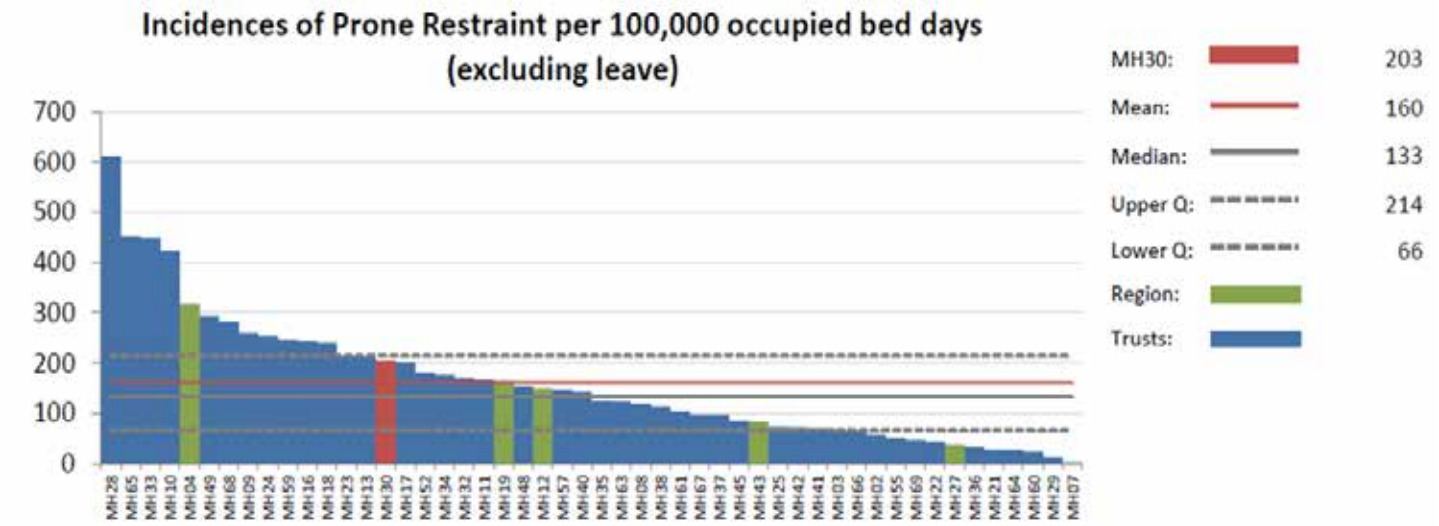


Analysis of the data during April – September 2016 identified that not all of these incidents are, in fact, episodes of prone restraint, rather the application of precautionary holds for individuals who place themselves face down whilst holding items being used for the purpose of self-harm. These precautionary holds are fleeting and the person is released as soon as the item has been safely removed. A new category of “Precautionary/Non-Standard Hold” was, therefore, added to DATIX for more accurate reporting.

In terms of further developments to minimise the use of prone restraint, injection sites for the purpose of rapid tranquillisation have been reviewed. Historically staff have been trained to provide rapid tranquillisation intramuscularly via the gluteal muscles, this necessitates the patient being placed into the prone restraint position if they are resistant to the intervention. New training is in the process of being rolled out to all inpatient nursing and medical staff to be able to inject via the quadriceps muscles. This requires the patient to be placed in the supine position which poses less risk. These important changes will be implemented during 2017/18 and it is anticipated that we will see a corresponding reduction in the use of prone restraint.

Each year, the Trust engages in the NHS Mental Health Benchmarking exercise, which all English NHS Trusts who are providers of secondary mental health services participate in. This enables individual organisations to compare trends and benchmark themselves against the national data. Figure 16 below shows that the Trust reports incidences of prone restraint slightly above the national average.

Figure 16



We have not met this target.

Target 3.4 - 95% of adults will be followed up by our services within 48 hours of discharge from psychiatric inpatient care

This is a local target and one which we first introduced in 2012/13. The national target is that 95% of CPA service users receive follow up within 7 days[2].

Discharge from inpatient units to community settings can pose a time of increased risk of self-harm for service users. The National Confidential Inquiry into Suicides and Homicides[3] recommended that 'All discharged service users who have severe mental illness or a recent (less than three months) history of self-harm should be followed up within one week'

One of the particular requirements for preventing suicide among people suffering severe mental illness is to ensure that follow up of those discharged from inpatient care is treated as a priority and that care plans include follow up on discharge. Although the national target for following up service users on CPA is within 7 days, in recognition that people may be at their most vulnerable within the first 48 hours, we aim to follow up 95% of people within these 2 days. This has been an organisational target for many years, and the cumulative figures for each year end are seen in the table below.

During 2015/16 we took the opportunity to review our practices and policies associated with both our 7 day and 48 hour follow up of patients discharged from our inpatient services. Whilst the adjustments we have undertaken have strengthened the patient safety aspects of our follow up contacts, introducing these changes have led to an impact on our in year performance, in comparison to our previous year's performance against these performance standards. In the case of our 48 hour local stretch target, our 2015/16 organisational performance fell to 90% (Herefordshire services followed up 91% (25 breaches) of people discharged from inpatient care and Gloucestershire services have followed up 90% (83 breaches) which is below our stretch target.

We are confident that the practice changes we introduced have strengthened the patient safety aspects of this measure and that our performance in both our 7 day and 48 hour follow ups will ultimately return to being well above the national performance requirement and our local stretch target.

At the end of 2016/17, Herefordshire services followed up 96% (11 breaches) of people discharged from inpatient care and Gloucestershire services followed up 95% (39 breaches). This gives an overall organisational compliance of 95%. Each of these breaches were reviewed to establish if there were any themes and trends, and the learning from this review will be used to promote practice.

[2] Detailed requirements for quality reports 2014/15: Monitor, February 2015

[3] Five year report of National Confidential Inquiry into Suicide and Homicide by people with mental illness Department of Health – 2001

	Target	2012-13	2013-14	2014-15	2015-16	2016-17
Gloucestershire Services	>95%	89%	95%	95%	90%	95%
Herefordshire Services	>95%	70%	95%	92%	91%	96%

This target has been met.

Serious Incidents reported during 2016/17

By the end of 2016/17, 43 serious incidents were reported by the Trust, 1 of which was subsequently declassified; the types of these incidents reported are seen below in Figure 17.

Figure 17

Serious incidents by type 2016/17

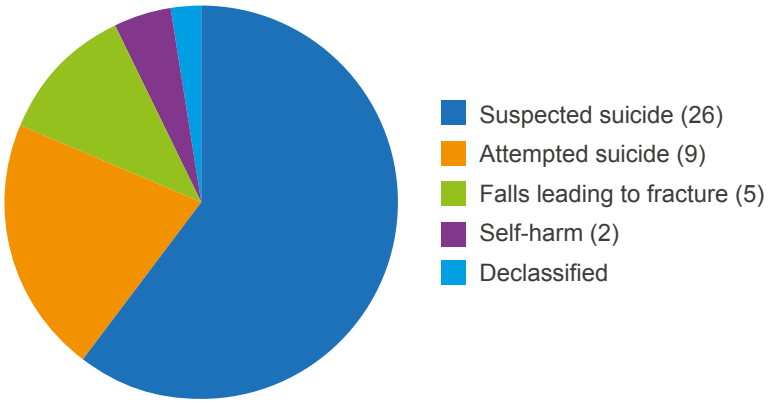
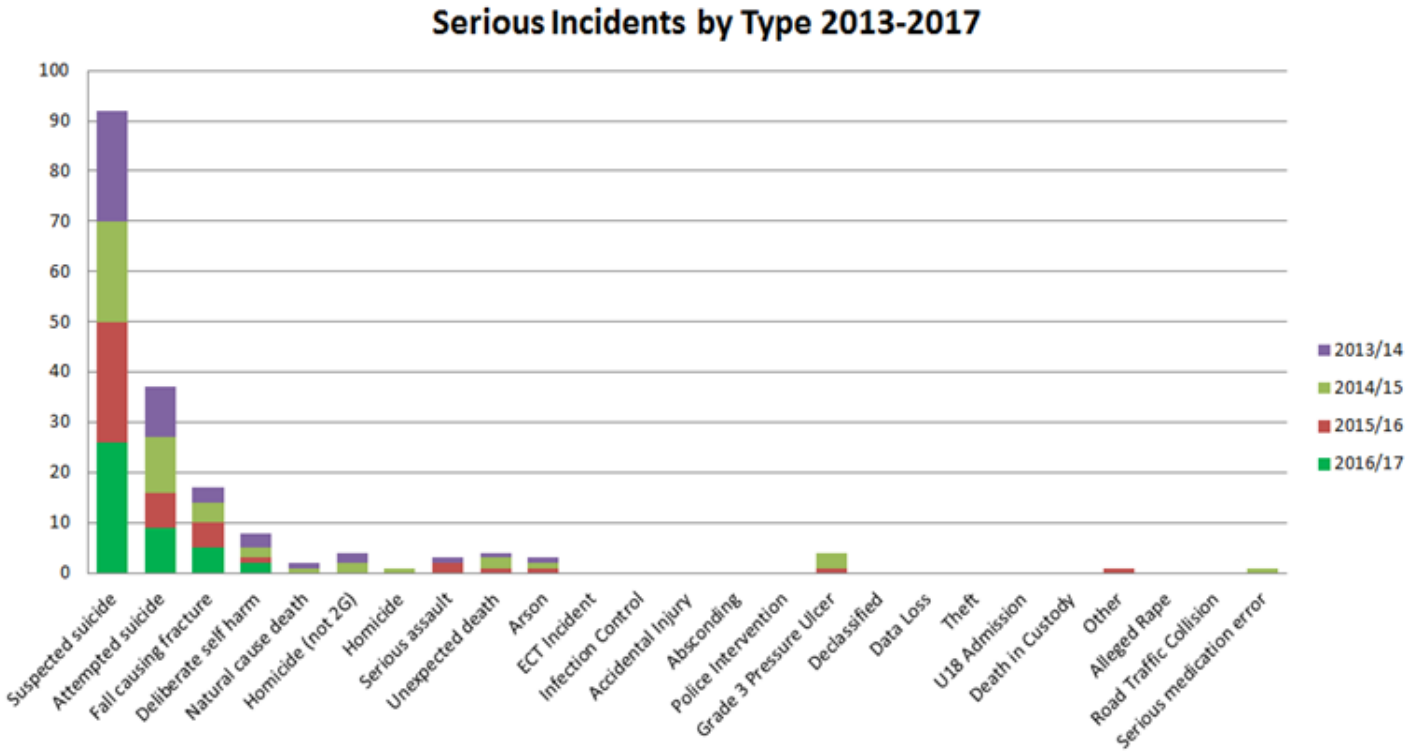


Figure 18 shows a 4 year comparison of reported serious incidents. The most frequently reported serious incidents are “suspected suicide” and attempted suicide which is why we continue to focus on suicide prevention activities in partnership with stakeholders. All serious incidents were investigated by senior members of staff, all of whom have been trained in root cause analysis techniques. To further improve consistency of our serious incident investigations we have seconded a whole time equivalent Lead Investigator for 12 months who will commence this important work in May 2017, and we are in the process of appointing further dedicated Investigating Officers via the Trust’s Staff Bank. This arrangement will be reviewed during Quarter 4 2017/18.

Figure 18



Wherever possible, we include service users and their families/carers to ensure that their views are central to the investigation, we then provide feedback to them on conclusion. During 2016/17 we engaged the Hundred Families organisation to deliver 'Making Families Count' training to 51 staff to improve our involvement of families and this will be explored further next year. In 2017/18 we will also be developing processes to provide improved support to people bereaved by suicide. The Trust shares copies of our investigation reports regarding "suspected suicides" with the Coroners in both Herefordshire and Gloucestershire to assist with the Coronial investigations.

There have been no Department of Health defined "Never Events" within the Trust during 2016/17. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Duty of Candour

The Duty of Candour is a statutory regulation to ensure that providers of healthcare are open and honest with services users when things go wrong with their care and treatment. The Duty of Candour was one of the recommendations made by Robert Francis to help ensure that NHS organisations report and investigate incidents (that have led to moderate harm or death) properly and ensure that service users are told about this.

The Duty of Candour is considered in all our serious incident investigations, and as indicated in our section above regarding serious incidents, we include service users and their families/carers in this process to ensure their perspective is taken into account, and we provide feedback to them on conclusion of an investigation. Additionally, we review all reported incidents in our Datix System (incident reporting system) to ensure that any incidents of moderate harm or death are identified and appropriately investigated.

To support staff in understanding the Duty of Candour, we have historically provided training sessions through our Quality Forums and given all staff leaflets regarding this. There is also a poster regarding this on every staff notice board.

During the CQC comprehensive inspection of our services, they reviewed how the Duty of Candour was being implemented across the Trust and provided the following comments in their report dated 27 January 2016.

"Staff across the trust understood the importance of being candid when things went wrong including the need to explain errors, apologise to patients and to keep patients informed."

"We saw how duty of candour considerations had been incorporated into relevant processes such as the serious investigation framework and complaints procedures. Staff across the trust were aware of the duty of candour requirements in relation to their role."

Our upgraded Incident Reporting System (Datix) has been configured to ensure that any incidents graded moderate or above are flagged to the relevant senior manager/clinician, who in turn can investigate the incident and identify if the Duty of Candour has been triggered. Only the designated senior manager/clinician can "sign off" these incidents.

Mortality Reviews

From 1 April 2016 the Trust has collected detailed information regarding the deaths of patients open to our services, and deaths within 6 months of their discharge from services in preparation for the "Single Framework for Reviewing Deaths in the NHS" requirement which was published in March 2017. To date, there is limited assurance that the data collected is of good quality. However, several improvements have been made to both Datix and the technology available for collecting information relating to patient deaths.

An administrator has been employed in a full-time capacity from October 2016 to begin to complete initial screening of the reported patient death information and the categorisation of patient deaths within the Mazars categories of Expected Natural 1, Expected Natural 2, Expected Unnatural, Unexpected Natural 1, Unexpected Natural 2, and Unexpected Unnatural. The pro-forma review tool based on the Learning Disabilities Mortality Review Programme (LeDer) format will be utilised within the Datix system to assist with desktop reviews of healthcare records, and red flag indicators are being developed by the Clinical Directors involved with the mortality work to identify deaths which

should be more closely investigated. An unused Datix module is being developed to contain this work.

The 'active' review of patient deaths will commence from 1 April 2017 and it is anticipated that we will be reporting to Board within the requirements of the "National Guidance on Learning from Deaths", with policy development and publication by Quarter 2 2017/18 and data publication by Quarter 3 2017/18.

Sign up to Safety Campaign - Listen, Learn and Act (SUP2S)

[2]gether NHS Foundation Trust signed up to this campaign from the outset and was one of the first 12 organisations to do so.

Within the Trust the campaign is being used as an umbrella under which to sit all patient safety initiatives such as the NHS South of England Patient Safety and Quality Improvement Mental Health Collaborative, the NHS Safety Thermometer, Safewards interventions and the Reducing Physical Interventions project. Participation in SUP2S webinars has occurred, and webinar recordings are shared with colleagues.

A Safety Improvement Plan has been developed, submitted and approved. Monitoring of progress as a whole is completed every 6 months via the Trust Governance Committee, but each work stream has its own regular forum and reporting mechanisms.

Indicators & Thresholds for 2016/2017

The following table shows the metrics that were monitored by the Trust during 2016/17. These are the indicators and thresholds from NHS Improvement.

		2014-2015 Actual	2015-2016 Actual	National Threshold	2016-2017 Actual
1	Clostridium Difficile objective	3	0	0	**3**
2	MRSA bacteraemia objective	0	0	0	**0**
3	7 day CPA follow-up after discharge	97.73%	95.63%	95%	**98%**
4	CPA formal review within 12 months	97.1%	99.35%	95%	**99%**
5	Delayed transfer of care	0.06%	1.02%	≤7.5%	**1.7%**
6	Admissions gate kept by Crisis resolution/home treatment services	99.57%	99.74%	95%	**99%**
7	Serving new psychosis cases by early intervention teams	100%	63.56%		**71%**
8	MHMDS data completeness: identifiers	99.71%	99.57%	97%	**99.9%**
9	MHMDS data completeness: CPA outcomes	97.06%	97.42%	50%	**94.7%**
10	Learning Disability – six criteria	6	6	6	**6**
11	EIP: Receipt of NICE approved care within 2 weeks	-	-	50%	**71.3%**
12	Improving access to psychological therapies - treated within 6 weeks of referral - treated within 18 weeks of referral			75% 95%	**37.8%** **86.1%**

Commissioner Agreed Developments

There have been a number of innovative developments during the year which now form part of our commissioned services, these include:

- **Gloucestershire Mental Health Acute Response Service (MHARS).** The Urgent Response Team is located with, and works alongside the emergency services to advise on and respond to incidents taking place anywhere in the county, where it is suspected that mental health has played a part. The intention is to provide a quicker service for people experiencing mental health crisis or distress so they can get the right response at the right time in the right place.

- **Wellbeing House**. Alexandra Wellbeing House opened in spring 2017. This is a partnership venture between 2gether, Swindon MIND and Gloucestershire CCG, and provides an alternative to an inpatient admission for when a person is feeling overwhelmed and needs somewhere peaceful and away from everyday life to recover from an episode of distress.

- **Gloucestershire Perinatal Service**. The team is in the process of being formed following a successful bid for £1.5million of Government funding during 2016/17. This will see improved care and outcomes for women with mental health problems during pregnancy and in the postnatal period.

- **Community Dementia Nurse Pilot**. We are working collaboratively with primary care and Gloucestershire Care Services colleagues to enable one of our Community Dementia Nurses to create better working relationships throughout the healthcare system and achieve better outcomes for people with dementia. This forms part of the work being carried out through the Sustainability and Transformation Plan agenda.

- **Gloucester City Primary Mental Health (PMH) Specialist Nurse Pilot.** We are working with Gloucester City GPs to pilot two specialist PMH nurse posts to work alongside GPs in practices. This is a developmental role exploring the opportunities and benefits that can be offered from a Mental Health Nurse working at a GP Practice level.

Community Survey 2016

The CQC published results of an independent survey taken in 2016 that tested the experience of service users who use Trust community services. The published results compare ratings about 2gether NHS Foundation Trust's services with the results of other mental health trusts.

2gether NHS Foundation Trust received a relatively high percentage response rate (compared with others in the country) to the questionnaire at 33% returned. Full details of this survey questions and results can be found on the CQC website:

www.cqc.org.uk/provider/RTQ/survey/6

No significant differences were noted between the results for Herefordshire and Gloucestershire. Across six of the ten domains in the survey our scores were reported as 'About the Same' as other trusts. In the other four domains people scored Trust's service as 'Better than Others' which is in the top 20% of similar organisations. The results are tabulated below together with the scores out of 10 for 2gether NHS Foundation Trust calculated by the CQC.

2gether's scores compared with scores of other trusts

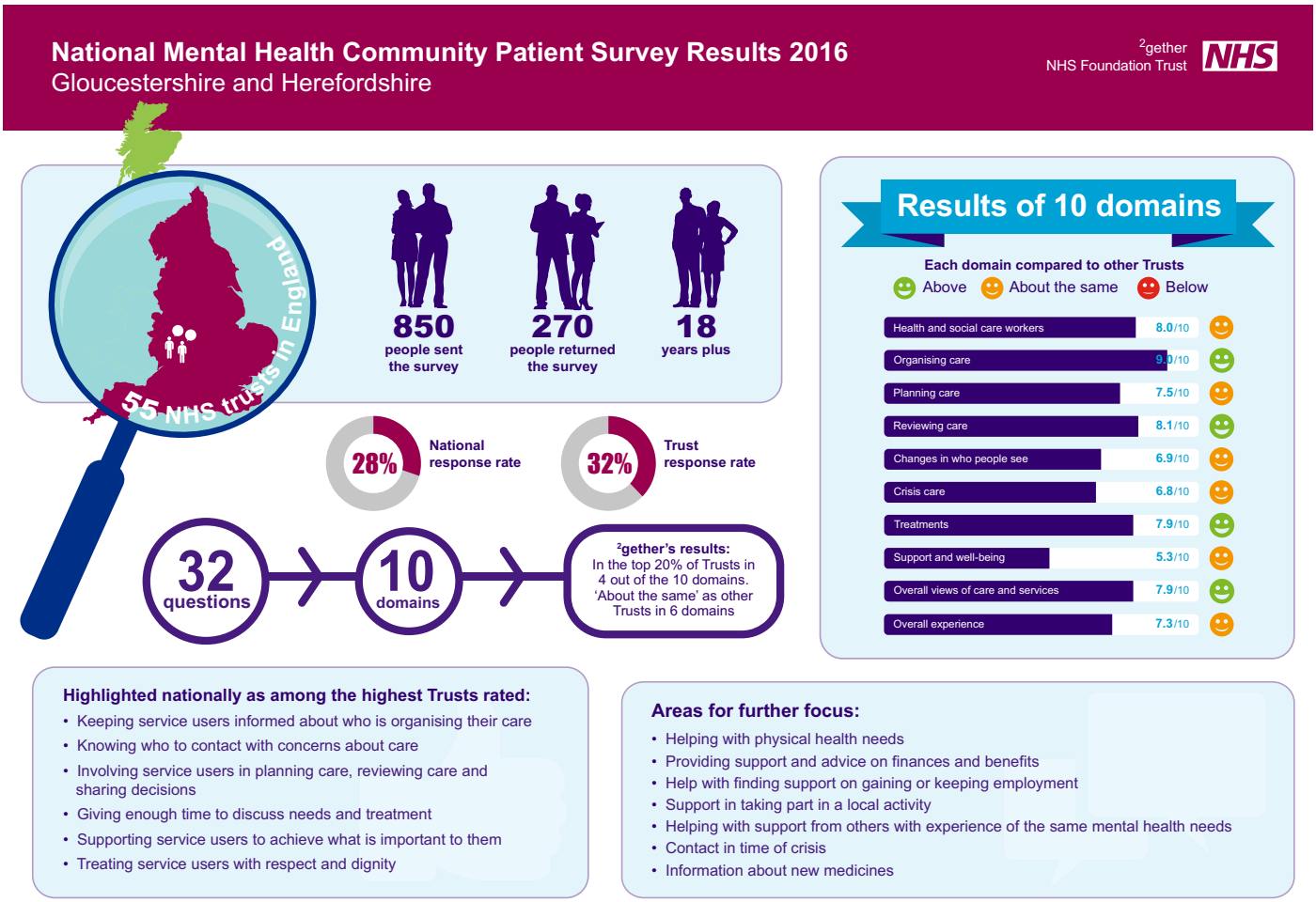
Score (out of 10)	Domain of questions	How the score relates to other trusts
8.0	Health and Social Care workers	Same as others
9.0	Organising Care	Better than others
7.5	Planning care	Same as others
8.1	Reviewing Care	Better than others
6.9	Changes in who people see	Same as others
6.8	Crisis care	Same as others
7.9	Treatment	Better than others
5.3	Support and Wellbeing	Same as others
7.9	Overall view of care and services	Better than others
7.3	Overall	Same as others

In 12 out of the 32 evaluative questions, 2gether NHS Foundation Trust received particularly favourable results compared with other Trusts rated in the CQC Survey. These questions are illustrated in the infographic.

The results have been considered further for areas where improvements will be sought. These include:

- Helping people with a focus on their physical health needs
- Providing people with signposting, support and advice on finances and benefits
- Help people with finding support for gaining or keeping employment
- Signposting and supporting people to take part in activities of interest
- Helping people to access peer support from others with experience of the same mental health needs
- Ensure knowledge of contacts in time of crisis
- Provision of information about new medicines

The Trust has also produced an infographic summarising the key messages from the CQC Survey and this can be seen below.



Staff Survey 2016

High levels of staff engagement and satisfaction are priorities for 2gether NHS Foundation Trust.

As part of this, each year the Trust is able to use information from the annual NHS Staff Survey to improve this. Although staff have a variety of ways to feedback on their experiences at work, the NHS Staff Survey provides the most in-depth analysis of how our staff view the Trust as an employer and as a provider of mental health and learning disability services. The responses to each of the questions asked are grouped into 32 Key findings, progress against which can be measured year on year.

For the first time, all staff in post on 1 September 2016 were invited to take part in the survey, confidentially online. Previously the survey had only been sent to a random sample of 750 staff. The overall response rate was 40%, equal to the previous year but 777 staff took the time to respond and give their views, a significant increase on the 298 responses in the previous year. The 2016 survey has provided the most accurate picture of the Trust obtained to-date.

Overall staff engagement has again increased with the result being derived from three Key Findings:

KF1 – Staff recommendation of the Trust as a place to work or receive treatment
KF4 – Staff motivation at work
KF7 – Staff ability to contribute towards improvements at work.

The Trust score was 3.89 (from a possible 5) and was higher than the national average for Mental Health/Learning Disability Trusts.

The results of the 2016 Survey showed the Trust to be better than average in 18 Key Findings, average in 10 Key Findings and worse than average in 4 Key Findings when compared with the national average. This represents a favourable comparison with the previous year when the Trust was reported to be better than average in 18, Key Findings, average in 13 and worse than average in one Key Finding.

There were no statistically significant changes to any of the Key Findings but there were improvements show in 19 of them, 12 worsened slightly and one Key finding showed no change.

It has been encouraging to note that the number of staff recommending the organisation as a place to work or receive treatment had increased and was higher than the national average. Staff motivation at work also remains above the national average. After a disappointing score last year, the percentage of staff reporting good communication between senior managers and staff had improved although remains slightly below the national average. It has however been disappointing to see that whilst the reporting of near misses and incidents have been diligently reported, colleagues have been less likely to report incidences of bullying and harassment.

The Staff Survey results are also used to inform progress against the Workforce Race Equality Standard (WRES), introduced in 2014. Four of the nine WRES indicators are taken from the survey. An average of 88% of staff reported that there were equal opportunities for career progression and promotion, slightly above the national average.

It is not possible to compare responses from Black and Minority Ethnic (BME) staff with last year's results as the response rate from BME colleagues last year was too low to include. However for 2016, the results from BME and White staff were broadly similar. 30% of white and 30% of BME staff reported experiencing harassment from patients and members of the public, both below the national average but still of concern. 25% of white staff experienced harassment from other staff while 21% of BME staff reported the same.

Nationally, levels of bullying and harassment remain unacceptably high but as a Trust we continue to work to eliminate this kind of behaviour. Over the last 12 months we have increased the number of Dignity at Work Officers and we continue to promote our confidential online dialogue system known as Speak in Confidence as part of the range of measures introduced to offer support to staff.

Following analysis and discussion of the survey outcomes, the Trust's resultant action plan will be focussing on encouraging staff to report such incidences as these are unacceptable and against our values. Emphasis will also be put on making the best use of service user feedback and highlighting how such feedback is used. The third element of the action plan will focus on promoting the health and wellbeing of our staff. To complement the Trust actions, our service localities will utilise the survey to define priorities that will be addressed locally.

PLACE Assessment 2016

In April 2013, Patient Led Assessments of the Care Environment (PLACE) were introduced in England.

PLACE are self-assessments carried out voluntarily that involve local people who go into hospitals as part of teams to assess how the environment supports patient's privacy and dignity, food, cleanliness, general building maintenance, Dementia friendly environments and for the first time this year a disability domain has been added. PLACE focuses entirely on the care environment and does not cover clinical care provision or how well staff are doing their job. It is only concerned about the non-clinical activities.

PLACE is now in its fourth year and the 2016 assessments took place between February and June 2016 with the results being seen in the tables below.

Domain:	1		2		3	4	5	6
Site Name	**Cleanliness**	**Food Overall**	Organisational Food	Ward Food	**Privacy, Dignity and Wellbeing**	**Condition Appearance and Maintenance**	**Dementia**	**Disability** new domain for 2016
Overall 2gether Trust Score:	**99.54%**	**90.85%**	90.34%	90.65%	**95.63%**	**97.62%**	**95.43%**	**91.04%**
HOLLYBROOK	**100.00%**	**95.11%**	92.13%	100.00%	**100.00%**	**99.58%**	**N/A**	**100.00%**
WESTRIDGE	**100.00%**	**82.73%**	91.53%	55.56%	**94.12%**	**100.00%**	**N/A**	**93.65%**
CHARLTON LANE	**99.72%**	**93.16%**	93.37%	92.88%	**93.15%**	**99.28%**	**98.07%**	**93.92%**
WOTTON LAWN	**100.00%**	**94.14%**	89.18%	99.49%	**96.91%**	**98.17%**	**N/A**	**87.23%**
HONEYBOURNE	**99.21%**	**91.58%**	94.31%	88.28%	**96.55%**	**99.58%**	**N/A**	**100.00%**
LAUREL HOUSE	**100.00%**	**95.17%**	91.53%	100.00%	**100.00%**	**100.00%**	**N/A**	**100.00%**
STONEBOW UNIT	**99.89%**	**79.76%**	87.21%	70.72%	**95.89%**	**93.82%**	**92.17%**	**90.10%**
OAK HOUSE	**92.26%**	**N/A**	N/A	N/A	**86.49%**	**91.12%**	**N/A**	**84.62%**
National Average MH/LD	97.80%	89.70%	86.60%	91.90%	89.70%	94.50%	82.90%	84.50%

At or above MH/LD national average Below England MH/LD average

The Trust has achieved very positive results placing us above the national average for Mental Health and Learning Disability settings in all six domains. This demonstrates how we are improving the quality of the non-clinical services to our patients.

A Disability domain has been added for the first time this year, with the Trust scoring above the upper interquartile (top 25%) compared with other UK Healthcare establishments.

Cleanliness has improved to 99.54% this year which places us above the UK national average for all healthcare establishments.

As a result of the PLACE outcomes and scores, the Trust has developed a comprehensive action plan for each unit, highlighting areas for improvement and resolution; owned by the unit managers under the Matrons. Progress against these action plans is monitored by the Patient Environment Action Groups (PEAG) and supported by the Estates and Facilities Department.

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Annex 1: Statements from our partners on the Quality Report

Gloucestershire Health and Care Overview and Scrutiny Committee

On behalf of the Health and Care Overview and Scrutiny Committee I welcome the opportunity to comment on the ²gether NHS Foundation Trust Quality Account 2016/17.

Members from the HCOSC and the Children and Families Overview and Scrutiny Committee (CFOSC) share concerns with regard to the provision of mental health services to children and young people in the county. Members believe that early intervention is important, and can better support health and wellbeing outcomes. Members therefore welcome the willingness of the Trust to engage with and support the scrutiny workshops on this matter. Elected members have found these sessions to be very beneficial and will be following up on this work in the new council.

The committee notes that the Trust has still not met the targets relating to the numbers of deaths by suspected suicide (pending inquest) of people in contact with services when comparing data from previous years. Elected members are aware that the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness is investigating suicide by children and young people in England. This work is being undertaken in two phases. The second phase of this work is due to be published in 2017, and will include recommendations for services. The county council's Student Mental Health Task Group has asked the Gloucestershire Suicide Prevention Partnership Forum (GSPPF) to consider the recommendations from this report and inform the HCOSC and CFOSC of their findings. I anticipate that these committees will wish to discuss this work with the Trust as part of the work to review the Gloucestershire Suicide Prevention Strategy.

The committee congratulates the 2gether NHS Foundation Trust on being rated as one of the top two mental health trusts in the country, based on service user's ratings in the National Community Mental Health Patient Survey (Adults) 2016. Members welcome the opening of the Wellbeing House and look forward to hearing, in due course, if this facility is making a difference.

Members particularly welcome the productive partnership working with the Emergency Services on the delivery of the Mental Health Acute Response Service (MHARS); and the successful bid for funding to provide a perinatal service in Gloucestershire.

I would like to thank the Trust for its continued willingness to work with and inform committee members, in particular, Jane Melton, Ruth FitzJohn and Shaun Clee.

Iain Dobie, Chairman
Gloucestershire Health Overview and Scrutiny Committee

Healthwatch Herefordshire Response to 2gether NHS Foundation Trust Annual Quality Accounts 2016-17

Healthwatch Herefordshire is pleased to have been a partner of 2gether over the past year. We still strongly support the Triangle of Care initiative and with our partner organisation HCS continue working with 2gether to ensure that this is implemented throughout the Herefordshire services as soon as possible. Regular board reports tracking this progress would be helpful.

Another initiative we strongly support is the need to tackle higher than expected suicide rates in the county, we look forward to plans being rapidly developed and implemented in Herefordshire.

Disappointing progress with access to and the effectiveness of IAPT is an area which needs serious and urgent attention. Early intervention services are strongly supported and we look forward to improvement in this.

Once again Healthwatch Herefordshire thanks 2gether Trust for its open and supportive culture and its continued collaboration with Healthwatch in working towards delivering excellent mental health services for the people of Herefordshire.

Ian Stead
Board Member - Healthwatch Herefordshire

Healthwatch Gloucestershire comments on the 2gether Foundation Trust's Quality Statement 2016/17

Healthwatch Gloucestershire welcomes the opportunity to comment on 2gether NHS Foundation Trust's quality account for 2016/17. Healthwatch Gloucestershire exists to promote the voice of patients and the wider public with respect to health and social care services. As of April 1st 2017 Healthwatch Gloucestershire came under a new provider and we are therefore unable to comment on the previous year's activity as it relates to work carried out under the previous Healthwatch Gloucestershire contract. However, we look forward to developing relationships with the Trust over the coming year and working with them to ensure the patient voice is heard.

It is good to see that the Trust has a clear focus on continuous quality improvement with a view to making life better for communities, service users and unpaid carers. In addition, the input of service user experience into the priorities for the coming year is welcomed and ensures that the Trust remain user-focused.

We are pleased to see the ongoing commitment of the Trust to improve the physical health of patients under their care and note that a health awareness event for patients and staff is to be held in Gloucestershire in the coming year.

Last year The Trust set a target to improve the process for children and young people who transition from child to adult mental health services. In particular, they aimed to ensure that joint care programme approach reviews were carried out for all of those who were transitioning. The Trust did not achieve this aim so we are pleased to see that this remains a priority and we will be monitoring progress over the coming year.

We welcome the prioritisation of user experience by the Trust and note the positive results achieved by the Trust on the CQC national community mental health survey and the proposed introduction of the 'How did we do?' survey. Healthwatch Gloucestershire would be happy to work with the Trust over the coming year to ensure that the voice of service users continues to be used to improve services provided by the Trust.

We are concerned to see that a greater number of suspected suicides are reported within Gloucestershire compared with Herefordshire. We acknowledge however that the population of people in contact with services is higher in Gloucestershire and that the service is configured differently to reflect commissioning requirements. We also note the work being carried out by the Trust to improve outcomes for patients including their continued partnerships working with external agencies.

The Trust's target to reduce prone restraints by 5% year on year was not met; in fact, there was a significant increase in reported incidents. The Trust established a baseline for its target based on the number of instances of prone restraint it had recorded in 2015/16 We note that analysis of the data for 2016/17 identified that a proportion of the incidents recorded as prone restraint were in fact the application of fleeting, precautionary holds for individuals who hold themselves face down, and that consequently a new category of "precautionary non-standard hold" has been added to the incident reporting system. We note the work being carried out by the Trust to reduce the instances of prone restraint and would like to see a reduction in recorded incidents (from baseline) during 2017/18.

Work by the Healthwatch network has shown that people often find the complaints process stressful we are therefore pleased to see that an increasing number of concerns raised by patients are dealt with by local resolution without need for a formal complaints process. We acknowledge also the work being carried out to improve the consistency of serious incident investigations. We welcome the involvement of service users in these investigations and welcome the plans to provide improved support for those bereaved by suicide.

Healthwatch Gloucestershire look forward to developing the relationship with The Trust over the coming year and working with them to ensure that the experiences of patients, their families and unpaid carers are heard and taken seriously.

Dr. Sara Nelson
Healthwatch Gloucestershire

NHS
Herefordshire
Clinical Commissioning Group

Herefordshire CCG response to 2gether NHS Foundation Trust Quality Accounts

Herefordshire Clinical Commissioning Group (CCG) welcomes the opportunity to provide comments on the Quality Report prepared by 2gether NHS Foundation Trust (2gNHSFT) for 2016/17. The report is easy to read and understandable given that it has to be considered by a range of stakeholders.

Within the past year Herefordshire Health and Social Care partnerships have faced varied challenges, 2gNHSFT has worked together with partnership organisations, including the CCG to face the challenges whilst striving to deliver improved quality of care and outcomes for the residents of Herefordshire.

The 2016/17 Quality Report demonstrates some of the challenges, concerns and opportunities that the Trust has faced. Herefordshire CCG continues to regularly attend the Trust Quality Committee meetings and contribute constructively at the Contract Quality Review Forum.

The CCG acknowledge 2gNHSFT's continuing focus on patient and carer experience and the delivery of high quality of care, which underpins all clinical work delivered by the Trust, the results of this focus is demonstrated in the outcomes from the Friends and Family test with over 90% of respondents reporting they would recommend 2gNHSFT and the increasing number of staff who would do the same. The links between poor mental health and poor physical health have been long established.

The work 2gNHSFT has undertaken to improve the physical health of their patients is to be commended and also contributes to improving the patient's experience of services provided by the Trust.

The CCG notes that the Trust did not reach its targets of:

- Ensuring that all services users making the transition from childhood to adulthood had joint Care Programme Approach reviews.
- Reducing the number of patients who were Absent without Leave (AWOL)
- Reducing the number of prone restraints

The CCG will monitor these aspects of care to ensure that the practice changes undertaken by the Trust support improved outcomes.

We were pleased to note there continues to be a high level of 2gNHSFT engagement in both national and local clinical audits and research as well as participation in national confidential enquiries.

The CCG reviews 2gNHSFT's incident responses on a regular basis and find robust systems and processes in place with evidence of duty of candour has been undertaken in each report and evidence that learning is embedded within the wider Trust workforce.

We are aware that 2gNHSFT are actively engaged in partnership working with the Local Authority, other statutory partners and voluntary sector bodies in Herefordshire through many fora. We are confident that this engagement will continue throughout 2017/18.

The CCG endorses all 2gNHSFT's priorities for improvement as contained in this report in the expectation that they will lead to improved delivery against effectiveness, service user experience and safety, supporting improved outcomes for service users.

Following a review of the information presented within this report, coupled with commissioner led reviews of quality across all providers, the CCG is satisfied with the accuracy of the report. This recognises the Trust commitment to quality and demonstrates transparency, honest assessment and further development which mirror the aspirations of commissioners.

Lynne Renton, Deputy Chief Nurse
Herefordshire CCG

NHS
Gloucestershire
Clinical Commissioning Group

NHS Gloucestershire CCG Comments in Response to 2gether NHS Foundation Trust Quality Report 2016/17

NHS Gloucestershire Clinical Commissioning Group (CCG) welcomes the opportunity to provide comments on the Quality Report prepared by 2gether NHS Foundation Trust (2gNHSFT) for 2016/17 in line with NHS Improvement guidance 'Detailed requirements for quality reports for foundation trusts 2016/17' published February 2017.

The past year has continued to present major challenges across both Health and Social care in Gloucestershire and we are pleased that 2gNHSFT have worked jointly with partnership organisations, including the CCG during 2016/17 to deliver a system wide approach to maintain, further develop and improve the quality of commissioned services and outcomes for service users and carers. We wish to acknowledge the Trust's contribution and commitment to the development of the Sustainability and Transformation Plan for Gloucestershire (STP).

Following the comprehensive CQC inspection during October 2015, where the overall outcome was rated as 'good', the CCG has continued to work with the Trust to monitor the implementation of the CQC action plan developed to address areas identified for further improvement. We were pleased to note the good progress in closing down these actions and recognise the focus and commitment of management and staff in addressing the necessary quality improvements. However we note there remain some areas for further development and improvement, and the CCG will continue to work with the Trust to address these in 2017/18.

The 2016/17 Quality Report is easy to read and understandable given that it has to be considered by a range of stakeholders with varying levels of understanding. The report clearly identifies how the Trust performed against the agreed quality priorities for improvement for 2016/17 and also outlines their priorities for improvement in 2017/18.

The CCG endorses the quality priorities included in the report whilst acknowledging the very difficult financial and partnership challenges 2gNHSFT have to address in the future, particularly in the implementation and delivery of the Gloucestershire STP. We are pleased to note progress and achievement against these quality priorities, and will continue to work with the Trust where targets have not been met.

We commend the Trust for good progress and achievement against the mandated core indicators 2016/17. The CCG were pleased to note the continued improvement of physical healthcare for people with schizophrenia and other serious mental illnesses in 2016/17, whilst recognising the commitment of staff to further improve the physical health and wellbeing outcomes for patients in 2017/18. We recognise the challenges for the Trust in becoming "Smoke Free" in April 2017, and also the extensive work undertaken to successfully roll out the annual Flu vaccination programme across the Trust whilst achieving 77% of staff and patients immunised.

Given the local CQUIN in relation to Young Peoples Transitions 2016/17, we were disappointed that the target to ensure that joint Care Programme Approach reviews occur for all service users who make the transition from children's to adult services was not met and will continue to work with the Trust on this quality priority for 2017/18. We acknowledge the extensive work undertaken by the Trust and progress to date against the Gloucestershire Improving Access to Psychological Therapies (IAPT) recovery plans. This remains a high priority for the CCG, and we will continue to work with 2gNHSFT in 2017/18 to improving access to IAPT services to meet national targets.

2gNHSFT did not achieve the target for reducing the number of deaths relating to identified risk factors of people in contact with services in 2016/17 when compared to data from previous years. We recognise that the number of suicides reported was in line with national reporting trends and that minimising the risk of suicide continues to be a priority for the Trust in 2017/18. The CCG note the Trust continues to be an active member of the Gloucestershire Suicide Prevention Partnership

Forum (GSPPF) and is working in partnership with other key stakeholders in Gloucestershire to reducing stigma around suicide and self-harm.

The Trust also failed to meet the target to reduce the number of people who are absent without leave (AWOL) from inpatient units who are formally detained. However the CCG recognise that the Trust has undertaken a great deal of work to understand the context in which detained service users are AWOL via the NHS South of England Patient Safety & Quality Improvement Mental Health Collaborative. We welcome that the Trust will have a continued focus in 2017/18 on positive engagement within their inpatient services to try and reduce the number of occasions where detained patients abscond from the ward environment.

The Trust has demonstrated continued improvement in service user and carer experience of mental health services provided, and we welcome the focus on improvement of the experience of service users in transition from children and young people's mental health service to adults. We also note a reduction in the actual number of complaints from the previous year. However the Trust has demonstrated that the numbers of complaints received has been relatively consistent in relation to the numbers of people seen over a period of three years, and report a continuous year on year improvement in written acknowledgement of complaints within the expected three day timeframe.

The CCG are pleased to note the Trust's focus on continuing improvement in identified priorities for effectiveness, service user experience and safety in 2017/18. We note achievement of targets in 2016/17, and whilst there are a number of areas where targets were partially or not achieved, the CCG are content that the Quality Report provides a balanced view.

The CCG also acknowledge the Trust's commitment to the 'Sign up to Safety Campaign' and all the patient safety initiatives such as the continued involvement in the NHS South of England Improving Patient Safety and Quality in Mental Health Collaborative, the NHS Safety Thermometer, Safewards interventions and Reducing Physical Interventions project to focus improvement on ways of working, and thereby improving the patient's experience of services provided by the Trust. We welcome the development of the Trust's Safety Improvement Plan and will continue to work with the Trust to improve the safety of patients.

The CCG acknowledge [2]g's continued strong focus on service user and carer experience and quality of caring, which demonstrates a joint commitment to delivering high quality, compassionate care, and also dignity and respect with which service users are treated. This is demonstrated in the results of the CQC Community Survey 2016 where [2]gNHSFT received particularly favourable results compared with other Trusts rated in the CQC Survey. We are pleased to note that the Trust are continuing to improve engagement with service users and carers and will continue to build upon their commitment to the 'Triangle of Care' programme.

The CCG also wish to acknowledge the Trust has achieved very positive results in the Patient Led Assessments of the Care Environment (PLACE) 2016 and were placed above the national average for Mental Health and Learning Disability settings in all six domains.

We recognise that the Trust's response rate to the Staff Survey 2016 saw an increase from 298 responses in 2015 to 777 staff responses in 2016, and overall staff engagement has again increased. We note the Trust score was higher than the nation average when compared to other Mental Health and Learning Disabilities Trusts.

We were pleased to note there continues to be a high level of clinical participation in local clinical audits, and also a positive increase in activity in relation to Clinical Research.

The CCG note that from 1 April 2016 the Trust was required to collect detailed information regarding the deaths of patients open to their services, and deaths within six months of their discharge from services in preparation for the 'Single Framework for Reviewing Deaths in the NHS' requirement published.

March 2017. However there is limited assurance in relation to data quality and we note several improvements have been made in both Datix and available technology for collecting information relating to patient deaths. The CCG will work with the Trust to monitor progress against these requirements in 2017/18.

[2]gNHSFT need to be in a strong position to manage both present and future challenges. The CCG will continue to work with the trust to deliver mental health and learning disabilities services that provide best value with a clear focus on providing high quality, safe and effective care for the people of Gloucestershire.

Gloucestershire CCG wish to confirm that to the best of our knowledge we consider that the 2016/17 Quality Report contains accurate information in relation to the quality of services provided by [2]gNHSFT.

During 2017/18 the CCG wish to work with [2]gNHSFT, all stakeholders and the people of Gloucestershire to further develop ways of receiving the most comprehensive reassurance we can regarding the quality of the mental health and learning disability services provided to the residents of Gloucestershire and beyond.

Dr Marion Andrews-Evans
Executive Nurse & Quality Lead
NHS Gloucestershire CCG

Herefordshire Health and Care Overview and Scrutiny Committee

I have noted the report and commend you for the successes over the past year.

The report raises a number of points that I would welcome further information on in relation to Herefordshire and to see improvements on meeting targets in the next quality report as described below:

- You'll be aware that the Herefordshire HSCOSC recently heard the outcomes of a task and finish review of mental health services for children and young people. One of the points that came up was regarding the transition from children's to adult services and in particular a recommendation that the upper age limit for children' services to be 25. I also note that targets for transition described on pages 30 and 31 have not been met. I would like to know more about developments to ease the transition and to align age groups with other services for children and young people.

- Page 7, point 2.2 refers to help and advice around physical health. How does this relate to age groups?

- Initiatives to support smoking cessation are commendable in terms of over-all physical health of services users and health outcomes, but it should be recognised within this that smoking can be a source of comfort or a handrail for some people with emotional difficulties during recover and to attempt smoking cessation during this time may be a big ask.

- Page 23 points 1.3, 2.4, where there are under achievements, why are they so, and how are they being addressed. How does quality compare between Herefordshire and Gloucestershire?

- Regarding complaints – I would like to see more information about the nature of complaints and comparisons between Herefordshire and Gloucestershire. I am not convinced by the friends and family test as there is one provider and therefore no choice!

- Regarding safety (Page 38) goals could also include a longer period of support beyond 48 hours, and as well as follow-ups, include a goal about ensuring people know who to contact if they feel they need support when they leave inpatient services. Page 46 gives a target of 95% follow-ups within 48 hours and I'd like to see this set at 100%. I'd like to understand why it wasn't clear why there were high numbers of suspected suicides in quarter 1.

- I'd welcome development of a suicide prevention forum for Herefordshire, and to see an update on the trial of the "stay alive" app

- P49 indicators regarding IAPT show an improvement is required, and shown separately for both counties, although this is a good example of how the split data is helpful to see

- P49 references to service developments and pilots for Gloucestershire would be welcomed as equivalents in Herefordshire if they prove successful in Gloucestershire

As services within Herefordshire develop and become more embedded I would welcome more detail in relation to Herefordshire services and for some of the statistics to be more defined for Herefordshire for the next quality report.

I would like to take this opportunity to thank you and your colleagues for your engagement with the health and social care overview and scrutiny committee. The council adopts constitutional arrangements this month which will include a change to the scrutiny arrangements to better align to our service structure and forward plan. I hope that we will see your continued contact with the two new scrutiny committees for adults and children's services in the coming year.

Cllr PA Andrews
Chair, Herefordshire Health and Care Overview and Scrutiny Committee

The Royal College of Psychiatrists

Statement of Participation in National Quality Improvement Projects managed by The Royal College of Psychiatrists' Centre for Quality Improvement

2gether NHS Foundation Trust

Programmes	Participating services in the Trust	Accreditation Status	Number of Services Participating Nationally
MSNAP: Memory Services National Accreditation Project	Gloucester Memory Service	Accredited	107
PLAN: Psychiatric Liaison Accreditation Network	None	N/A	74
QNCC ED: Quality Network for Community CAMHS (Child and Adolescent Community Mental Health Services) Eating Disorders	Eating Disorder Service	Participating but not yet undergoing accreditation	18
QNLD: Quality Network for Learning Disability Wards	None	N/A	40
QNOAMHS: Quality Network Older Adults Mental Health Services	Chestnut Ward Willow Ward Cantilupe Ward Jenny Lind Ward Mulberry Ward	Accreditation deferred Accreditation deferred Accredited Accredited as excellent Participating but not yet undergoing accreditation	67
AIMS-WA: Working Age Adult Wards	Mortimer Ward, Stonebow Unit Hospital Dean Ward, Wotton Lawn Hospital Kingsholm Ward, Wotton Lawn Hospital Priory Ward, Wotton Lawn Hospital	Accreditation suspended for this service Accredited Accredited as excellent Accredited as excellent Accredited as excellent	136
ECTAS: Electro Convulsive Therapy Accreditation Service	Stonebow (Hereford) Wotton Lawn (Gloucester)	Accredited Accredited as excellent	101
EIP Self-Assessment (English Teams only): EIP GRIP (Gloucestershire) N/A Self-Assessment (English Teams only)	GRIP (Gloucestershire) Herefordshire Early Intervention Service	N/A N/A	153
Perinatal: Perinatal In-Patient & Community Settings	None	N/A	43

The Royal College of Psychiatrists (continued)

Programmes	Participating services in the Trust	Accreditation Status	Number of Services Participating Nationally
QNCC: Quality Network for Community CAMHS (Child and Adolescent Community Mental Health Services)	None	N/A	32
QNFMHS: Quality Network for Forensic Mental Health Services	The Montpellier Unit (LSU)	Accreditation not offered by this network	125
QNIC: Quality Network for Inpatient CAMHS (Child and Adolescent Community Mental Health Services)	None	N/A	127
QNPMHS (Prison): Quality Network for Prison Mental Health Services	None	N/A	40
AIMS PICU: Psychiatric Intensive Care Units	Greyfriars PICU	Accredited as excellent	38
AIMS Rehab: Rehabilitation Wards	Honeybourne Recovery Unit	Accredited as excellent	65
	Laurel House	Accredited as excellent	
HTAS: Home Treatment Accreditation Service	Cheltenham Crisis Resolution and Home Treatment Team	Accredited	49
	Gloucester Crisis Resolution and Home Treatment Team	Accredited	
	Stroud and Cirencester Crisis Resolution and Home Treatment Team	Accredited	
QED: Quality Network for Eating Disorder Services	None	N/A	32
APPTS: Accreditation Project for Psychological Therapy Services	None	N/A	22
CofC: Community of Communities	None	N/A	8
MS-AT: Assessment Triage	None	N/A	5
EIPN: Early Intervention in Psychosis Network	None	N/A	5
QNLD : Quality Network for Learning Disability Wards	None	N/A	1
ACOMHS: Accreditation for Community Mental Health Services	None	N/A	12

Annex 2: Statement of Directors' Responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

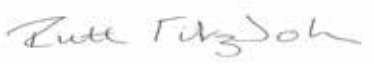
In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2016/17 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 2016 to April 2017
  - papers relating to Quality reported to the Board over the period April 2016 to April 2017
  - feedback from Gloucestershire commissioners dated 15 May 2017
  - feedback from Herefordshire commissioners dated 15 May 2017
  - feedback Governors dated 17 January 2017
  - feedback from Herefordshire Healthwatch dated 2 May 2017
  - feedback from Gloucestershire Healthwatch dated 15 May 2017
  - feedback from Gloucestershire Overview and Scrutiny Committee dated 28 April 2017
  - feedback from Herefordshire Overview and Scrutiny Committee dated 15 May 2017
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2017
  - the 2016 national patient survey
  - the 2016 national staff survey
  - the Head of Internal Audit's annual opinion over the trust's control environment dated 17 April 2017
  - CQC inspection report dated 28 January 2016
- 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 MHs Improvement's annual reporting 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.

Signed:



Chair **Date: 24 May 2017**

Signed:

Chief Executive **Date: 24 May 2017**

Annex 3: Glossary

ADHD	Attention Deficit Hyperactivity Disorder
BMI	Body Mass Index
CAMHS	Child & Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CHD	Coronary Heart Disease
CPA	Care Programme Approach: a system of delivering community service to those with mental illness
CQC	Care Quality Commission – the Government body that regulates the quality of services from all providers of NHS care.
CQUIN	Commissioning for Quality & Innovation: this is a way of incentivising NHS organisations by making part of their payments dependent on achieving specific quality goals and targets
CYPS	Children and Young Peoples Service
DATIX	This is the risk management software the Trust uses to report and analyse incidents, complaints and claims as well as documenting the risk register.
GRiP	Gloucestershire Recovery in Psychosis (GriP) is 2gether's specialist early intervention team working with people aged 14-35 who have first episode psychosis.
HoNOS	Health of the Nation Outcome Scales – this is the most widely used routine Measure of clinical outcome used by English mental health services.
IAPT	Improving Access to Psychological Therapies
Information Governance (IG) Toolkit	The IG Toolkit is an online system that allows NHS organisations and partners to assess themselves against a list of 45 Department of Health Information Governance policies and standards.
MCA	Mental Capacity Act
MHMDS	The Mental Health Minimum Data Set is a series of key personal information that should be recorded on the records of every service user
Monitor	Monitor is the independent regulator of NHS foundation trusts. They are independent of central government and directly accountable to Parliament.
MRSA	Methicillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans. It is also called multidrug-resistant.

MUST	The Malnutrition Universal Screening Tool is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan.
NHS	The National Health Service refers to one or more of the four publicly funded healthcare systems within the United Kingdom. The systems are primarily funded through general taxation rather than requiring private insurance payments. The services provide a comprehensive range of health services, the vast majority of which are free at the point of use for residents of the United Kingdom.
NICE	The National Institute for Health and Care Excellence (previously National Institute for Health and Clinical Excellence) is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.
NIHR	The National Institute for Health Research supports a health research system in which the NHS supports outstanding individuals, working in world class facilities, conducting leading edge research focused on the needs of patients and the public.
NPSA	The National Patient Safety Agency is a body that leads and contributes to improved, safe patient care by informing, supporting and influencing the health sector.
PHSO	Parliamentary Health Service Ombudsman
PICU	Psychiatric Intensive Care Unit
PLACE	Patient-Led Assessments of the Care Environment
PROM	Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient perspective.
QRP	The Quality and Risk Profile is a monthly compilation by the CQC of all the evidence about a trust they have in order to judge the level of risk that the trust carries to fulfil its obligations of care
RiO	This is the name of the electronic system for recording service user care notes and related information within 2gether NHS Foundation Trust.
ROMs	Routine Outcome Monitoring (ROMs)
SIRI	Serious Incident Requiring Investigation, previously known as a “Serious Untoward Incident”. A serious incident is essentially an incident that occurred resulting in serious harm, avoidable death, abuse or serious damage to the reputation of the trust or NHS. In the context of the Quality Report, we use the standard definition of a Serious Incident given by the NPSA
SMI	Serious mental illness
VTE	Venous thromboembolism is a potentially fatal condition caused when a blood clot (thrombus) forms in a vein. In certain circumstances it is known as Deep Vein Thrombosis.

Annex 4: How to Contact Us

About this report

If you have any questions or comments concerning the contents of this report or have any other questions about the Trust and how it operates, please write to:

Mr Shaun Clee
Chief Executive Officer
²gether NHS Foundation Trust
Rikenel
Montpellier
Gloucester
GL1 1LY

Or email him at: **shaun.clee@nhs.net**

Alternatively, you may telephone on **01452 894000** or fax on **01452 894001.**

Other Comments, Concerns, Complaints and Compliments

Your views and suggestions are important us. They help us to improve the services we provide.

You can give us feedback about our services by:

- Speaking to a member of staff directly
- Telephoning us on **01452 894673**
- Completing our Online Feedback Form at **www.2gether.nhs.uk**
- Completing our Comment, Concern, Complaint, Compliment Leaflet, available from any of our Trust sites or from our website **www.2gether.nhs.uk**
- Using one of the feedback screens at selected Trust sites
- Contacting the Patient Advice and Liaison Service (PALS) Advisor on **01452 894072**
- Writing to the appropriate service manager or the Trust's Chief Executive

Alternative Formats

If you would like a copy of this report in large print, Braille, audio cassette tape or another language, please telephone us on **01452 894000** or fax on **01452 894001**.

Annual Accounts

Foreword to the Financial Statements

These financial statements for the period ended 31 March 2017 have been prepared by 2gether NHS Foundation Trust under Paragraphs 24 & 25 of schedule 7 to the National Health Service Act 2006.

2gether NHS Foundation Trust provides mental health services to the populations of Gloucestershire and Herefordshire.

NHS Improvement (NHSI), our Regulator, set 2gether NHS Foundation Trust a Control Total of a surplus of £0.654m for 2016/17. Provided this Control Total was met NHSI would provide Sustainability and Transformation Funding (STF) of £0.650m.

2gether NHS Foundation Trust achieved a surplus of £0.677m and therefore met its Control Total and received the STF of £0.650m. However as we over-achieved our Control Total, 2gether NHS Foundation Trust was also eligible for both STF Incentive and STF Bonus monies. We received a further £0.056m Incentive STF and a further £0.531m Bonus STF monies.

This means that for 2016/17 2gether NHS Foundation Trust has achieved a surplus of £1,264m for NHS segmentation purposes, and received £1.237m of STF.

To reconcile to our reported financial position of a deficit of £2.302m, impairment costs of £3.566m needs to be deducted from the surplus of £1.264m. However impairment costs are a technical non cash financial adjustment arising from a change in asset values and do not count against the achievement of our Control Total or our segmentation.

NHSI segments all NHS Trusts on a scale of 1 to 4 with 1 being the best achievable; 2gether NHS Foundation Trust has a segmentation of 2.

Signed

Shaun Clee, Chief Executive
Date: 24 May 2017

STATEMENT OF COMPREHENSIVE INCOME - for the period ended 31 March 2017

	NOTE	12 Months to 31 March 2017 £000	12 Months to 31 March 2017 £000	12 Months to 31 March 2016 £000	12 Months to 31 March 2016 £000
Operating income from continuing operations	6		**112,813**		105,709
Remuneration		**(81,746)**		(77,646)	
Drugs		**(1,277)**		(1,289)	
Clinical supplies & services		**(922)**		(904)	
Non clinical supplies & services		**(1,320)**		(956)	
Miscellaneous other operating expenses		**(27,180)**		(23,184)	
Operating expenses of continuing operations	7		**(112,373)**		(103,979)
OPERATING SURPLUS / (DEFICIT)			**440**		1,730
Finance costs					
Finance income - interest receivable	9		**57**		91
Finance expense - financial liabilities	9		**(19)**		(21)
PDC dividends payable			**(2,783)**		(2,477)
Net finance costs			**(2,745)**		(2,407)
Gains/(losses) on disposal of assets			**3**		(2)
Surplus/(deficit) from continuing operations			**(2,302)**		(679)
Surplus/(deficit) of discontinued operations and gain/loss on disposal of discontinued operations	3		**0**		(36)
SURPLUS/(DEFICIT) FOR THE YEAR			**(2,302)**		(715)
Other comprehensive income **Will not be reclassified to income and expenditure:**			**0**		0
Impairments			**(2,103)**		(1,221)
Revaluations			**1,170**		4,146
Total other comprehensive income (expense) for the year			**(933)**		2,925
TOTAL COMPREHENSIVE INCOME/(EXPENSE) FOR THE YEAR			**(3,235)**		2,210

The notes on pages 141 to 176 form part of these financial statements.

All transactions within the Statement of Comprehensive Income are attributable to the beneficiaries of the Trust (taxpayers).

STATEMENT OF FINANCIAL POSITION - for the period ended 31 March 2017

	NOTE	At 31 March 2017 £000	At 31 March 2016 £000
NON-CURRENT ASSETS			
Intangible assets	10.3	**2,621**	1,794
Property, plant and equipment	10.5	**85,867**	84,240
Trade and other receivables	11	**475**	479
TOTAL NON-CURRENT ASSETS		**88,963**	85,513
CURRENT ASSETS			
Trade and other receivables	11	**6,608**	4,115
Non-current assets for sale and assets in disposal groups	10.2	**430**	430
Cash and cash equivalents	15	**11,034**	20,617
TOTAL CURRENT ASSETS		**18,072**	25,162
TOTAL ASSETS		**107,035**	111,675
CURRENT LIABILITIES			
Trade and other payables	13.1	**(10,156)**	(10,283)
Borrowings	13.3	**(43)**	(40)
Provisions	14	**(475)**	(1,781)
Other liabilities	13.2	**(117)**	(100)
TOTAL CURRENT LIABILITIES		**(10,791)**	(12,204)
TOTAL ASSETS LESS CURRENT LIABILITIES		**96,244**	99,471
NON-CURRENT LIABLILITIES			
Trade and other payables	13.1	**0**	0
Borrowings	13.3	**(275)**	(318)
Provisions	14	**(67)**	(46)
Other liabilities	13.2	**0**	0
TOTAL NON-CURRENT LIABILITIES		**(342)**	(364)
TOTAL ASSETS EMPLOYED		**95,902**	99,107
FINANCED BY TAXPAYERS' EQUITY:			
Public Dividend Capital		**46,153**	46,123
Revaluation reserve		**24,828**	25,761
Other reserves		**1,157**	1,157
Income and expenditure reserve		**23,764**	26,066
TOTAL TAXPAYERS' EQUITY		**95,902**	99,107

The financial statements on pages 137 to 140 were approved and authorised for issue by the Audit Committee on 24 May 2017 and signed on its behalf by:

Shaun Clee, Chief Executive
Date: 24 May 2017

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY For the Period 1 April 2016 to 31 March 2017

	Total	Public Dividend Capital	Revaluation Reserve	* Other Reserves	Income & Expenditure Reserve
	£000	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2016	**99,107**	**46,123**	**25,761**	**1,157**	**26,066**
Surplus/(deficit) for the year	**(2,302)**	**0**	**0**	**0**	**(2,302)**
Transfers by normal absorption: transfers between reserves	**0**	**0**	**0**	**0**	**0**
Impairments	**(2,103)**	**0**	**(2,103)**	**0**	**0**
Revaluations - property, plant and equipment	**1,170**	**0**	**1,170**	**0**	**0**
Transfer to retained earnings on disposal of assets	**0**	**0**	**0**	**0**	**0**
Other recognised gains and losses	**0**	**0**	**0**	**0**	**0**
Actuarial gains/(losses) on defined benefit pension schemes	**0**	**0**	**0**	**0**	**0**
Public Dividend Capital received	**30**	**30**	**0**	**0**	**0**
Taxpayers Equity at 31 March 2017	**95,902**	**46,153**	**24,828**	**1,157**	**23,762**

** Other Reserves. When the Trust was originally established the Statutory Instrument that confirmed the Public Dividend Capital was incorrect. As advised by the Department of Health, the element which had been missed off was classified as 'other reserves'.*

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY For the Period 1 April 2015 to March 2016

	Total	Public Dividend Capital	Revaluation Reserve	* Other Reserves	Income & Expenditure Reserve
	£000	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2015	**96,897**	**46,123**	**23,415**	**1,157**	**26,202**
Surplus/(deficit) for the year	**(715)**	**0**	**0**	**0**	**(2,302)**
Impairments	**(1,221)**	**0**	**(2,103)**	**0**	**0**
Revaluations - property, plant and equipment	**4,146**	**0**	**4,146**	**0**	**0**
Transfer to retained earnings on disposal of assets	**0**	**0**	**(579)**	**0**	**579**
Other recognised gains and losses	**0**	**0**	**0**	**0**	**0**
Actuarial gains/(losses) on defined benefit pension schemes	**0**	**0**	**0**	**0**	**0**
Public Dividend Capital received	**0**	**0**	**0**	**0**	**0**
Public Dividend Capital adjustment for cash impact of payables/receivables transferred from legacy teams	**0**	**0**	**0**	**0**	**0**
Taxpayers Equity at 31 March 2016	**99,107**	**46,123**	**25,761**	**1,157**	**26,066**

** Other Reserves. When the Trust was originally established the Statutory Instrument that confirmed the Public Dividend Capital was incorrect. As advised by the Department of Health, the element which had been missed off was classified as 'other reserves'.*

STATEMENT OF CASH FLOWS - for the period ended 31 March 2017

	NOTE	12 Months to 31 March 2017 £000	12 Months to 31 March 2016 £000
OPERATING ACTIVITIES			
Operating surplus/(deficit) from continuing operations		**440**	1,730
Operating surplus/(deficit) from discontinued operations		**0**	(36)
OPERATING SURPLUS/DEFICIT		**440**	1,694
NON CASH INCOME AND EXPENSE:			
Depreciation and amortisation	3.1	**2,741**	2,371
Net Impairments	3.1	**3,566**	199
Income recognised in respect of capital donations (cash and non-		**0**	(226)
(Increase)/decrease in trade and other receivables		**(1,995)**	8
Increase/(decrease) in trade and other payables		**(451)**	(137)
Increase/(decrease) in other liabilities		**17**	24
Increase/(decrease) in provisions		**(1,285)**	(751)
NET CASH GENERATED FROM/(USED IN) OPERATIONS		**3,033**	3,182
CASHFLOWS FROM INVESTING ACTIVITIES			
Interest received		**61**	90
Purchases of financial assets		**(22,000)**	(85,000)
Sales of financial assets		**22,000**	85,000
Purchases of intangible assets		**(1,046)**	(1,623)
Purchases of property, plant and equipment		**(8,734)**	(6,579)
Sales of property, plant and equipment		**3**	573
Receipt of cash donations to purchase capital assets		**0**	118
Net cash generated from/(used in) investing activities		**(9,716)**	(7,421)
CASHFLOWS FROM FINANCING ACTIVITIES			
Public dividend capital received		**30**	0
Capital element of finance lease rental payments		**(40)**	(38)
Other capital receipts		**0**	0
		0	0
Interest element of finance lease		**(19)**	(22)
PDC dividend paid		**(2,871)**	(2,452)
Net cash generated from/(used in) financing activities		**(2,900)**	(2,512)
Increase/(decrease) in cash and cash equivalents	15	**(9,583)**	(6,751)
Cash and cash equivalents at 1 April		**20,617**	27,368
Cash and cash equivalents at 31 March		**11,034**	20,617

Notes to the Financial Statements

1. Accounting Policies

NHS Improvement, in exercising the statutory functions conferred on Monitor, is responsible for issuing an accounts direction to NHS foundation trusts under the NHS Act 2006. NHS Improvement has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Department of Health Group Accounting Manual (DH GAM) which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the DH GAM 2016/17 issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual (FReM) to the extent that they are meaningful and appropriate to the NHS. The accounting policies have been applied consistently in dealing with items considered material in relation to the financial statements in the current and prior year.

1.1 Accounting convention

These financial statements have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities. Note 2 states why the Trust continues to adopt the going concern basis in preparing the financial statements.

1.2 Subsidiary undertakings

Following Treasury's agreement to apply IAS 27 to NHS Charities from 1 April 2013, the Trust has established that as the Trust is the corporate trustee of the linked NHS Charities ²gether NHS Foundation Trust Charitable Fund and 'New Highway Charity', it effectively has the power to exercise control so as to obtain economic benefits. However the transactions are immaterial in the context of the group and transactions have not been consolidated. Details of the transactions with the charities are included in the related parties' notes.

1.3 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.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.4 Expenditure on Employee Benefits

Short Term Employee Benefits

Salaries, wages and employment related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service;

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation";

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI); Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

1.5 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.

1.6 Property, Plant and Equipment

1.6.1 Recogition

Property, plant and equipment is capitalised where:

- It is held for use in delivering services or for administration 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; and

- the cost of the item can be measured reliably.

and where they:

a.Individually have a cost of at least £5,000; or

b. Form a group of assets which collectively have a cost of at least £5,000 and individually have a cost of more than £250, 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

c. 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; or

d. Form part of an IT network which collectively has a cost more than £5,000 and individually have a cost more than £250. However, small individual purchases are expensed.

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and

depreciated over their own useful economic lives.

1.6.2 Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by the management.

All assets are measured subsequently at valuation. An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5

Asset	Treatment
Asset held for its service potential: *in use*	Current value in existing use: For non-specialised assets this means Existing Use Value (EUV) For specialised assets this usually means depreciated replacement cost on a modern equivalent asset basis.
Asset held for its service potential: *surplus but restrictions on its sale*	Current value in existing use
Asset held for its service potential: *surplus and no restrictions on its sale*	Fair value (highest and best use) (IFRS 13)
Assets not held for their service potential: *Investment property*	Fair value (highest and best use) (IAS 40 / IFRS 13)
Assets not held for their service potential: *Held for Sale*	Lower of carrying amount and fair value less costs to sell (IFRS 5)
Assets not held for their service potential: *Surplus*	Fair value (highest and best use) (IFRS 13)

Assets in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Costs includes professional fees but not borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

The carrying values of property, plant and equipment are reviewed for impairment if events or changes in circumstances indicate the carrying value may not be recoverable.

All land and buildings are revalued using professional valuations every five years. A three yearly interim valuation is also carried out. Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual.

In March 2014 all land and buildings were revalued by the District Valuer and this was accounted for on 31 March 2014. In March 2015, March 2016 and March 2017 the Trust undertook annual impairment reviews and commissioned the District Valuer to revalue all land and buildings in a desktop exercise.

Subsequent Expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as "Held for Sale" ceases to be depreciated upon reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

Property, plant and equipment assets are depreciated at rates calculated to write them down to estimated residual value on a straight-line basis over their estimated useful lives.

Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as assessed by the NHS Foundation Trust's professional valuers. Leaseholds are depreciated over the primary lease term, or useful expected life if shorter.

Equipment is depreciated on current cost evenly over the estimated life of the asset using the following lives:

	Years
Engineering plant and equipment	5-15
Furniture and fittings	5-10
Information Technology	3-8
Set-up costs in new buildings	5-10
Transport equipment	7

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the FT ARM, impairments that arise from a clear consumption of economic benefits 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 charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefits or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss are 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.

1.6.3 De-recognition

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

- The asset is available for immediate sale in its present condition subject 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 within twelve 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 and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. 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.

1.6.4 Donated 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 items of property, plant and equipment.

1.7 Private Finance Initiative

The Trust does not have any Private Finance Initiative transactions.

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. They must have a useful life of more than one year and a cost of at least £5,000.

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 e.g. the presence of a market for its output, or where it is to be used for internal use, the usefulness of the asset;

adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and

the Trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware 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 hardware e.g. application software, is capitalised as an intangible asset.

1.8.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of being operated in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.9 Government Grants

Government grants are grants from Government bodies other than income from commissioners or NHS Trusts for the provision of services. Where the Government grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. The Trust has not received any Government grants during the current or prior year.

1.10 Inventories

Inventories are measured at the lower of cost and net realisable value. The cost of inventories is measured using the First In First Out (FIFO) method or the weighted average cost method. However, the Trust does not recognise inventories as the value is immaterial.

1.11 Leases

Finance leases

Where substantially all the risks and rewards of ownership of an asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

"The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for 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.

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 are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

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 the discount rates published and mandated by HM Treasury.

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust 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 at note 14 but it is not recognised in the NHS Foundation Trust's financial statements.

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 17 where an inflow of economic benefits is probable."

Contingent liabilities are not recognised, but are disclosed in note 17 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 (PDC)

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,
(ii) average daily cash balances held with the Government Banking Services and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short- term working capital facility
(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 annual accounts."

1.15 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in eneral, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.16 Corporation Tax

"The Trust is a Health Service Body within the meaning of s519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for the Treasury to dis-apply the exemption in relation to specified activities of a Foundation Trust (s519A (3) to (8) ICTA 1988). Accordingly, the Trust is potentially within the scope of corporation tax in respect of activities which are not related to, or ancillary to, the provision of healthcare, and where the profits there from exceed £50,000 per annum."

The Trust has determined that it has no corporation tax liability as it does not carry out any applicable commercial activities.

1.17 Foreign Exchange

The functional and presentational currency of the Trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

The Trust has no assets or liabilities denominated in a foreign currency at the Statement of Financial Position date.

1.18 Cash and Cash Equivalents

Cash is cash in hand and deposits

with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in three months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

1.19 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the financial statements since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the financial statements in accordance with the requirements of the HM Treasury Financial Reporting Manual.

1.20 Financial Instruments and Liabilities

The Trust may hold any of the following financial instruments and liabilities:

Financial assets
- Investments
- Long-term trade receivables
- Short-term trade receivables
- Cash at bank and in hand

Financial liabilities
- Loans and overdrafts
- Long-term trade payables
- Finance lease obligations
- Short-term trade payables
- Provisions arising from contractual arrangements

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.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described in note 1.11.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement

Financial assets are categorised as loans and receivables. Financial liabilities are classified as other financial liabilities.

Loans and Receivables

Loans and receivables are non-derivative 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: cash and cash equivalents, NHS receivables, accrued income and other trade receivables.

Loans and receivables are recognised initially at fair value, net of transaction costs, and are measured subsequently at amortised cost, using the effective interest rate method. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest rate method and credited to the Statement of Comprehensive Income.

Other financial liabilities

All 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 exactly discounts 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 the income and expenditure account.

Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from quoted market values.

Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly.

1.21 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds

for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in the income and expenditure account on an accruals basis, including losses which would have been made good through insurance cover had NHS Foundation Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However note 21, the losses and special payments note, is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.22 Reserves

Other reserves reflect differences between the value of fixed assets taken over by the Trust at inception and the corresponding figure in its originating debt.

1.23 Gifts

Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.24 Transfers of Functions to/from other NHS bodies/local government bodies

For functions that have been transferred to the Trust from another NHS / local government 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/loss corresponding to the net assets/liabilities transferred is recognised within income/expenditure 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 financial statements are preserved on recognition in the Trust's financial statements. 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 financial statements.

For functions that the Trust has transferred to another NHS/local government body, the assets and liabilities transferred are de-recognised from the financial statements as at the date of transfer. The net loss/gain corresponding to the net assets/liabilities transferred is recognised within expenses/income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve.

1.25 Accounting Standards issued but not yet adopted

The DH GAM does not require the following Standards and Interpretations to be applied in 2016/17. These standards are still subject to HM Treasury FReM adoption, with IFRS 9 and IFRS 15 being for implementation in 2018/19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

IFRS 9 Financial Instruments - Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted

IFRS 15 Revenue from Contracts with Customers - Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted

IFRS 16 Leases - Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRIC 22 Foreign Currency Transactions and Advance Consideration – Application required for accounting periods beginning on or after 1 January 2018.

1.26 Prior Period Adjustments

There were no prior period adjustments.

2. Going Concern and Liquidity Risk

The Trust's business activities, together with the factors likely to affect its future development, performance and position are set out in the Strategic Report. In addition, notes 1 to 22 to the financial statements include the Trust's policies and processes for managing its capital; its financial risk management objectives; details of its financial instruments; and its exposures to credit risk and liquidity risk.

At the Audit Committee in February 2017 the Committee received the annual assessment of the Trust's Going Concern status. The Committee concluded that the Trust has sufficient resources to continue to provide services for the foreseeable future. The Trust has signed two year contracts with its leading commissioners indicating the Trust has resources secured to provide clinical services for a period of greater than 12 months. The Trust's plans and future financial projections indicate the Trust should generate surpluses and achieve NHS Improvement's Use of Resources financial risk rating of 2 over the next three financial years. As a consequence, the Audit Committee believe that the Trust is well placed to manage its business risks successfully despite the current financial pressures in the NHS.

The Audit Committee is confident that the Trust has adequate resources to continue in operational existence for the foreseeable future. Thus they continue to adopt the going concern basis of accounting in preparing the annual financial statements.

3 Discontinued Operations

	12 Months to 31 March 2017 £000	12 Months to 31 March 2016 £000
Operating income of discontinued operations	**0**	1,232
Operating expenses of discontinued operations	**0**	(1,268)
Gain on disposal of discontinued operations	**0**	0
(Loss) on disposal of discontinued operations	**0**	0
Total	**0**	(36)

On 30 November 2015, the Trust stopped providing the Drug and Alcohol Services Herefordshire (DASH). The full year contract was £1.635m and involved 31 whole time equivalents.

4 Business combinations involving the trust and another entity within the Whole of Government Accounts (WGA) boundary

There were no Business combinations involving the trust and another entity within the Whole of Government Accounts (WGA) boundary in 2016/17 or 2015/16.

5 Critical Accounting Judgements and Key Sources of Estimation Uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

The Trust believes the use of the Modern Equivalent Asset (MEA) basis to value land and buildings to fair value is the methodology with least risk of material uncertainty.

The Trust must ensure that the fixed asset register holds each asset separately and by components. The Trust believes that a threshold of £800,000 is reasonable, above which owned property assets will be accounted for as structures, engineering and external works components.

Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment within the next financial year.

With regard to valuing provisions the methodology to determine best estimate differs according to the class of provision.

An accrual for annual leave was estimated by requesting from all budget holders a list of staff with leave outstanding at the end of 31 March 2017. The remaining leave was valued at the appropriate pay band for each member of staff. Annual leave outstanding for medical staff was calculated differently as their annual leave year does not run from 1 April to 31 March but annually from their start date.

The actual date of the individual's leave year has been factored into the calculation for determining the outstanding leave and applied to their actual pay.

6 Operating Income

6.1 Income from activities

	12 Months to 31 March 2017	12 Months to 31 March 2016
	£000	£000
Cost and volume contract income	**1,354**	1,132
Block contract income	**98,482**	95,520
Clinical partnerships providing mandatory services (including S75 agreements)	**981**	1,049
Clinical income for the secondary commissioning of mandatory services	**0**	0
Other clinical income from mandatory services	**4,466**	3,465
Additional income for delivery of healthcare services	**0**	0
	105,283	101,166

6.2 Other Operating Income

	12 Months to 31 March 2017 £000	12 Months to 31 March 2016 £000
Research and development	**82**	232
Education and training	**2,395**	2,067
Received from NHS charities: Cash donations/grants for the purchase of capital assets	**0**	141
Received from NHS charities: Other charitable and other contributions to expenditure	**7**	0
Received from other bodies: Donation of physical assets (non-cash)	**0**	108
Received from other bodies: Other charitable and other contributions for the purchase of capital assets	**0**	8
Received from other bodies: Other charitable and other contributions to expenditure	**0**	0
Non-patient care services to other bodies	**731**	710
Sustainability and Transformation Fund income*	**1,237**	0
Other **	**2,223**	2,017
Rental revenue from operating leases	**0**	0
Income in respect of staff costs where accounted on gross basis	**855**	492
	7,530	5,775
Total Operating Income	**112,813**	106,941
Of which:		
Related to continuing operations	**112,813**	105,709
Related to discontinued operations	**0**	1,232

For details of discontinued operations, see note 3

* NHS Improvement (NHSI), our Regulator, set ²gether NHS Foundation Trust a Control Total of a surplus of £0.654m for 2016/17. Provided this Control Total was met NHSI would provide Sustainability and Transformation Funding (STF) of £0.650m. ²gether NHS Foundation Trust achieved a surplus of £0.677m and therefore met its Control Total and received the STF of £0.650m. However as we over-achieved our Control Total, ²gether NHS Foundation Trust was also eligible for both STF Incentive and STF Bonus monies. We received a further £0.056m Incentive STF and a further £0.531m Bonus STF monies. This means that for 2016/17 ²gether NHS Foundation Trust has achieved a surplus of £1.264m for NHS segmentation purposes, and received £1,237m of STF.

** 'Other' includes supporting people services of £1,112,657 (£1,147,814 in 2015/16), sale of goods and services £31,797 (£32,397 in 2015/16), rental income £78,567 (£86,849 in 2015/16), improving patient safety programme monies £290,000 (£143,163 in 2015/16), staff contributions to employee benefit schemes £182,326 (£218,000 in 2015/16), catering income £22,565 (£13,018 in 2015/16) and £20,000 of QSIR funding (£0 in 2015/16).

6.3 Income from Activities (By Commissioner)

	12 Months to 31 March 2017 £000	12 Months to 31 March 2016 £000
NHS Foundation Trusts	**1,652**	1,666
NHS Trusts	**49**	51
CCGs and NHS England	**100,970**	95,828
Local Authorities	**2,152**	3,143
Department of Health - other	**0**	0
NHS other	**445**	464
Non NHS: private patients	**0**	0
Non-NHS: overseas patients (non-reciprocal)	**0**	0
NHS injury scheme	**0**	0
Non NHS: other	**15**	14
Additional income for delivery of healthcare services	**0**	0
	105,283	101,166

The Trust does not generate private patient income.

6.4 Overseas Visitors

Overseas visitors relates to patients charged directly by the foundation trust. The Trust does not generate income from overseas visitors income.

6.5 Operating Lease Income

The Trust does not generate operating lease income.

6.6 Commissioner Requested Income

	12 Months to 31 March 2017 £000	12 Months to 31 March 2016 £000
Commissioner Requested services	**106,078**	99,555
Non-Commissioner Requested services	**6,735**	6,154
Total operating income from continuing operations	**112,813**	105,709

7 Operating Expenses

7.1 Operating expenses comprise:

	12 Months to 31 March 2017 £000	12 Months to 31 March 2016 £000
Services from NHS Foundation Trusts	**1,440**	2,093
Services from NHS Trusts	**90**	113
Services from CCGs and NHS England	**(48)**	48
Services from other NHS bodies	**0**	1
Purchase of healthcare from non NHS bodies	**6,080**	5,655
Purchase of social care	**4,806**	4,672
Executive directors' costs	**962**	931
Non-executive directors' costs	**149**	135
Staff costs	**80,548**	77,350
Supplies and services - clinical (excluding drug costs)	**922**	982
Supplies and services - general	**1,320**	961
Establishment	**1,254**	966
Research and development (Pay)	**222**	189
Research and development (Other)	**26**	8
Transport	**1,289**	1,129
Premises	**5,294**	4,695
Increase / (decrease) in bad debt provision (for impairment of receivables)	**(543)**	(179)
Increase in other provisions	**(1,260)**	(693)
Drug costs	**1,277**	1,510
Other impairment of financial assets	**0**	0
Rentals under operating leases	**534**	483
Depreciation on property, plant and equipment	**2,563**	2,233
Amortisation on intangible assets	**178**	138
Impairments of property, plant and equipment	**3,566**	199
Impairments of intangible assets	**0**	0
Impairments of financial assets	**0**	0
Impairments of assets held for sale	**0**	0
Audit fees - statutory reporting	**56**	54
Other auditors remuneration * Further assurance services	**0**	62
Clinical negligence	**124**	106
Legal fees	**213**	195
Consultancy costs	**91**	148
Internal Audit	**69**	68
Training, courses and conferences	**587**	549
Patient travel	**2**	6
Car parking & security	**50**	55
Redundancy (Pay)	**14**	0
Redundancy (Other)	**56**	0
Early retirements	**0**	0
Hospitality	**6**	3
Publishing	**0**	0
Insurance	**113**	115
Losses, ex gratia & special payments	**6**	3
Other	**317**	264
	112,373	105,247
Of which:		
Related to continuing operations	**112,373**	103,979
Related to discontinued operations	**0**	1,268

For details of discontinued operations see note 3

The Trust has contributed £81k to pension schemes in respect of directors in 2016/17 (£63k in 2015/16). None of the directors have benefits accruing under money purchase schemes or non NHS pension schemes. No advances or credits have been made to directors by the Trust, nor have any guarantees been entered into on their behalf.

7.2 Operating leases

7.2.1 Operating expenses include

	12 Months to 31 March 2017	12 Months to 31 March 2016
	£000	£000
Minimum lease payments Buildings	**187**	116
Minimum lease payments Lease Cars	**347**	367
	534	483

7.2.2 Annual commitments containing operation leases are:

On buildings leases expiring: Future minimum lease payment due	12 Months to 31 March 2017	12 Months to 31 March 2016
Within 1 year	184	48
Between 2 and 5 years	0	0
After 5 years	0	0
	184	48

On other leases (Lease Cars) expiring: Future minimum lease payment due	12 Months to 31 March 2017	12 Months to 31 March 2016
Within 1 year	247	278
Between 2 and 5 years	169	243
After 5 years	0	0
	416	521

7.3 Limitation on auditor's liability

	12 Months to 31 March 2017	12 Months to 31 March 2016
	£000	£000
Limitation on auditor's liability	**1,000**	1,000

7.4 The late payment of commercial debts (interest) Act 1998

	12 Months to 31 March 2017	12 Months to 31 March 2016
	£000	£000
Amounts included within other interest payable arising from claims made under this legislation	**0**	0
Compensation paid to cover debt recovery costs under this legislation	**0**	0

8 Staff costs and numbers

Details of staff costs and numbers are now shown in the Annual Report.

9. Finance income and finance expenses

9.1 Finance income - interest receivable

	12 Months to 31 March 2017 £000	12 Months to 31 March 2016 £000
Interest on bank accounts	40	88
Interest on loans and receivables	17	3
Interest receivable	57	91

9.1 Finance income - interest receivable

	12 Months to 31 March 2017 £000	12 Months to 31 March 2016 £000
Finance leases	19	21

10. Intangible and tangible non-current assets

10.1 Impairment of non-current Assets (Property, Plant and Equipment and non-current assets for sale Assets):

	2016/17			2015/16		
	Net impairments £000	Impairments £000	Reversals £000	Net impairments £000	Impairments £000	Reversals £000
Impairments charged to operating surplus / deficit:						
Loss or damage from normal operations	0	0	0	0	0	0
Over specification of assets	0	0	0	0	0	0
Abandonment of assets in course of construction	2,571	2,571	0	0	0	0
Unforeseen obsolescence	0	0	0	0	0	0
Loss as a result of catastrophe	0	0	0	0	0	0
Other	0	0	0	0	0	0
Changes in market price	995	1,073	(78)	199	310	(111)
Total Impairments charged to operating surplus / deficit	3,566	3,644	(78)	199	310	(111)
Impairments charged to the revaluation reserve	2,103	2,103	0	1,221	1,221	0
Total Impairments	5,669	5,747	(78)	1,420	1,531	(111)

10.2 Non-current assets for sale and assets in disposal groups

	2016/17 £000	2015/16 £000
NBV of non-current assets for sale and assets in disposal groups at 1 April	430	570
Transfers by absorption	0	0
Plus assets classified as available for sale in the year	460	430
Less assets sold in year	(460)	(575)
Less Impairment of assets held for sale	0	0
Plus reversal of impairment of assets held for sale	0	0
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0
NBV of non-current assets for sale and assets in disposal groups at 31 March	430	430

10.3 Intangible assets

	2016/17			
	Total	Software Licences (Purchased)	Information Technology (Internally Generated)	Assets Under Construction
	£000	£000	£000	£000
Gross cost at 1 April	**2,752**	**749**	**1,131**	**872**
Impairments	0	0	0	0
Reversal of impairments	0	0	0	0
Reclassifications	0	33	0	(33)
Revaluation surpluses	0	0	0	0
Additions - purchased	1,005	142	(1)	864
Additions - purchased from donations/grants	0	0	0	0
Additions - donated assets	0	0	0	0
Transferred to disposal group as asset held for sale	0	0	0	0
Disposals	0	0	0	0
Gross cost at 31 March	3,757	924	1,130	1,703
Amortisation at 1 April	958	97	861	0
Provided during the year	178	132	46	0
Impairments recognised in the income and expenditure account	0	0	0	0
Reversal of impairments recognised in the income and expenditure account	0	0	0	0
Reclassifications	0	0	0	0
Revaluation surpluses	0	0	0	0
Transferred to disposal group as asset held for sale	0	0	0	0
Disposals	0	0	0	0
Amortisation at 31 March	1,136	229	907	0
Net book value				
Purchased at 1 April	1,690	548	270	872
Donated at 1 April	104	104	0	0
Total as at 1 April	1,794	652	270	872
Net book value				
Purchased at 31 March	2,532	606	223	1,703
Donated at 31 March	89	89	0	0
Total as at 31 March	2,621	695	223	1,703

	2015/16			
	Total	Software Licences (Purchased)	Information Technology (Internally Generated)	Assets Under Construction
	£000	£000	£000	£000
Gross cost at 1 April	**1,800**	**80**	**900**	**820**
Impairments	0	0	0	0
Reversal of impairments	0	0	0	0
Reclassifications	0	9	0	(9)
Revaluation surpluses	0	0	0	0
Additions - purchased	844	552	231	61
Additions - purchased from donations/grants	0	0	0	0
Additions - donated assets	108	108	0	0
Transferred to disposal group as asset held for sale	0	0	0	0
Disposals	0	0	0	0
Gross cost at 31 March	2,752	749	1,131	872
Amortisation at 1 April	820	50	770	0
Provided during the year	138	47	91	0
Impairments recognised in the income and expenditure account	0	0	0	0
Reversal of impairments recognised in the income and expenditure account	0	0	0	0
Reclassifications	0	0	0	0
Revaluation surpluses	0	0	0	0
Transferred to disposal group as asset held for sale	0	0	0	0
Disposals	0	0	0	0
Amortisation at 31 March	958	97	861	0
Net book value				
Purchased at 1 April	980	30	130	820
Donated at 1 April	0	0	0	0
Total as at 1 April	980	30	130	820
Net book value				
Purchased at 31 March	1,690	548	270	872
Donated at 31 March	104	104	0	0
Total as at 31 March	1,794	652	270	872

In 2015/16 the Trust received £108,500 RIO software licence transfers as a donated addition from the Department of Health.

The Trust has no commitments to purchase intangible assets.

Intangible Valuations	Software Licences (Purchased)	Information Technology (Internally Generated)	Assets Under Construction
Method of determining fair value	**Management Review**	**Management Review**	**Held at Cost**
Year of revaluation	**2015/16**	**2016/17**	**N/A**
Carrying amount revalued assets at 31 March 2017 (£000)	**695**	**223**	**1,703**

The Trust's Software Licences have a market value and an established economic life and are required in connection with the main clinical and financial systems. Since there is not an active market value for the internally generated IT intangible assets each year the Trust's Audit Committee review them to confirm they are a fair value, and to agree the remaining life over which the assets will be amortised is reasonable.

10.4 Economic life of intangible assets

10.4.1 Intangible assets - internally generated

	Min Life Years	Max Life Years
Information technology	5	7
Development expenditure	0	0
Other	0	0

10.4.2 Intangible assets - purchased

	Min Life Years	Max Life Years
Software	5	7
Licences and trademarks	5	7
Patents	0	0
Other	0	0
Goodwill	0	0

10.5 Tangible Property, Plant and Equipment

Tangible property, plant and equipment at the balance sheet date comprise the following elements:

	2016/17							
	Total	Land	Buildings	Assets Under Construction	Plant and Machinery	Transport Equipment	Information Technology	Furniture & Fittings
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2016	85,898	19,428	59,927	2,644	1,499	0	2,390	10
Transfer by absorption Normal	0	0	0	0	0	0	0	0
Additions purchased / internally generated	9,149	0	664	7,326	112	0	1,047	0
Additions grants/donations of cash to purchase assets	0	0	0	0	0	0	0	0
Impairments charged to operating expenses	0	0	0	0	0	0	0	0
Impairments charged to revaluation reserve	0	0	0	0	0	0	0	0
Reversal of impairments credited to operating income	0	0	0	0	0	0	0	0
Reversal of impairments credited to the revaluation reserve	0	0	0	0	0	0	0	0
Reclassifications	(7,690)	(70)	(4,059)	(3,967)	15	0	391	0
Revaluations	1,170	0	1,170	0	0	0	0	0
Transferred to disposal group as asset held for sale	(460)	(460)	0	0	0	0	0	0
Disposals	0	0	0	0	0	0	0	0
Cost or valuation at 31 March 2017	88,067	18,898	57,702	6,003	1,626	0	3,828	10
Accumulated depreciation at 1 April 2016	1,658	0	310	0	656	0	687	5
Transfer by absorption Normal	0	0	0	0	0	0	0	0
Provided during the year	2,563	0	1,997	0	187	0	377	2
Impairments charged to operating expenses	3,644	253	820	2,571	0	0	0	0
Impairments charged to revaluation reserve	2,103	160	1,943	0	0	0	0	0
Reversal of impairments credited to operating income reserve	(78)	0	(78)	0	0	0	0	0
Reversal of impairments credited to operating income reserve	0	0	0	0	0	0	0	0
Reclassifications	(7,690)	(413)	(4,706)	(2,571)	0	0	0	0
Revaluation surpluses	0	0	0	0	0	0	0	0
Transfer to disposal group as asset held for sale	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	0	0	0	0
Accumulated depreciation at 31 March 2017	2,200	0	286	0	843	0	1,064	7
Net book value								
Purchased at 31 March	85,867	18,898	56,682	6,003	783	0	2,764	3
Finance lease at 31 March	254	0	254	0	0	0	0	0
Donated at 31 March	480	0	480	0	0	0	0	0
Total as at 31 March	85,867	18,898	57,416	6,003	783	0	7,764	3

During 2016/17 a property was revalued to Market Value as it was to be marketed for sale and transferred to non-current assets for sale. The resulting impairment was £1,471k of which £746k was credited against revaluation reserve and an impairment of £725k was charged to operating expenses.

During 2016/17 a property was revalued for unforeseen obsolescence .The resulting impairment was £2,571k which was charged to operating expenses.

As a result of the annual desktop review of land and buildings by the District Valuation Office, the Trust's overall land and buildings value decreased by £457k;

Some properties incurred an impairment totalling £1,705k of which £1,357k was credited against revaluation reserve and an impairment of £348k was charged to operating expenses.

Other properties experienced an increase in value totalling £1,248k of which £1,170k was debited to revaluation reserves and £78k was credited to the operating income as a reversal of previous years impairments against operating expenses.

	2015/16							
	Total	Land	Buildings	Assets Under Construction	Plant and Machinery	Transport Equipment	Information Technology	Furniture & Fittings
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2015	79,032	19,175	54,940	2,510	1,113	35	1,249	10
Additions purchased	6,323	0	3,014	2,281	386	0	642	0
Additions grants/donations of cash to purchase assets	118	0	8	110	0	0	0	0
Impairments charged to operating expenses	0	0	0	0	0	0	0	0
Impairments charged to revaluation reserve	0	0	0	0	0	0	0	0
Reversal of impairments credited to operating income	0	0	0	0	0	0	0	0
Reversal of impairments credited to the revaluation reserve	0	0	0	0	0	0	0	0
Reclassifications	0	275	(1,483)	(2,257)	107	0	499	0
Revaluations	890	408	482	0	0	0	0	0
Transferred to disposal group as asset held for sale	(430)	(430)	0	0	0	0	0	0
Disposals	(35)	0	0	0	0	(35)	0	0
Cost or valuation at 31 March 2016	85,898	19,428	59,927	2,644	1,499	0	2,390	10
Accumulated depreciation at 1 April 2015	1,297	0	274	0	491	35	494	3
Provided during the year	2,233	0	1,872	0	165	1	193	2
Impairments charged to operating expenses	310	0	310	0	0	0	0	0
Impairments charged to revaluation reserve	1,221	0	1,221	0	0	0	0	0
Reversal of impairments credited to operating income	(111)	0	(111)	0	0	0	0	0
Reversal of impairments credited to revaluation reserve	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0
Revaluation surpluses	(3,256)	0	(3,256)	0	0	0	0	0
Transfer to disposal group as asset held for sale	0	0	0	0	0	0	0	0
Disposals	(36)	0	0	0	0	(36)	0	0
Accumulated depreciation at 31 March 2016	1,658	0	310	0	656	0	687	5
Net book value								
Purchased at 31 March	83,560	19,428	58,937	2,644	843	0	1,703	5
Finance lease at 31 March	290	0	290	0	0	0	0	0
Donated at 31 March	390	0	390	0	0	0	0	0
Total as at 31 March	84,240	19,428	59,617	2,644	843	0	1,703	5

In 2015/16 the Trust conducted an exercise to review all equipment asset values and remaining lives.

As a result of the annual desktop review of land and buildings by the District Valuation Office, the Trust's overall land and buildings value increased by £2,726k;

Some properties incurred an impairment totalling £1,531k of which £1,221k was credited against revaluation reserve and an impairment of £310k was charged to operating expenses.

Other properties experienced an increase in value totalling £4,257k of which £4,146k was debited to revaluation reserves and £111k was credited to the operating income as a reversal of previous years impairments against operating expenses.

10.6 Economic life of property, plant and equipment

	Min Life Years	Max Life Years
Land	99	99
Buildings excluding dwellings	15	69
Plant & machinery	5	15
Transport equipment	0	0
Information technology	3	7
Furniture & fittings	5	8

11 Trade Receivables and Other Receivables

	31 March 2017 £000	31 March 2016 £000
Current:		
NHS receivables - revenue	3,703	3,073
NHS receivables - capital	0	0
Other receivables with related parties - revenue	1,501	1,298
Other receivables with related parties - capital	0	0
Provision for impaired receivables	(382)	(925)
Deposits and advances	0	0
Prepayments (non-PFI)	191	92
Accrued income	0	0
Interest receivable	0	4
Corporation tax receivable	0	0
Finance lease receivables	0	0
Operating lease receivables	0	0
PDC dividend receivable	38	0
VAT receivable	242	300
Other receivables - revenue	855	273
Other receivables - capital	460	0
Total current trade and other receivables	6,608	4,115
Non Current:		
Prepayments (non-PFI)	154	141
Other receivables - revenue	321	338
Total non current trade and other receivables	475	479
Total trade and other receivables	**7,083**	**4,594**

The non current 'Other receivables - revenue' relates to a payment arrangement with a purchaser of a trust property, the term of which is 15 years from January 2016.

11.1 Provisons for impairment of trade receivables

	31 March 2017 £000	31 March 2016 £000
As at 1 April	**925**	1,171
Increase in provisions	**0**	75
Amounts utilised	**0**	(67)
Unused amounts reversed	**(543)**	(254)
As at 31 March	**382**	**925**

11.2 Analysis of impaired receivables

	31 March 2017 Trade Receivables £000	31 March 2017 Other Receivables £000	31 March 2016 Trade Receivables £000	31 March 2016 Other Receivables £000
Ageing of impaired receivables				
0 - 30 days	**0**	**0**	0	0
30 - 60 days	**0**	**0**	0	0
60 - 90 days	**0**	**0**	0	0
90 - 180 days (was “In three to six months”)	**0**	**0**	75	0
180 - 360 days (was “over six months”)	**382**	**0**	850	0
Total	**382**	**0**	925	0
Ageing of non-impaired receivables past their due date				
0 - 30 days	**4,514**	**0**	3,513	0
30 - 60 days	**446**	**0**	211	0
60 - 90 days	**96**	**0**	135	0
90 - 180 days (was “In three to six months”)	**434**	**0**	503	0
180 - 360 days (was “over six months”)	**866**	**0**	(693)	0
Total	**6,356**	**0**	3,669	0

No collateral is held as security against any impaired receivables. There are also no credit enhancements or changes in the fair value of any impaired receivables.

11.3 Finance lease receivables

The Trust is not a lessor on finance leases.

12 Current Asset Investments

	31 March 2017 £000	31 March 2016 £000
Cost or valuation at 1 April	**0**	0
Additions	**22,000**	85,000
Disposals	**(22,000)**	(85,000)
Revaluations	**0**	0
Cost or valuation at 31 March	**0**	0

The Trust used the Bank of England for short term investments which were no greater than 3 months in duration.

13 Trade and Other Payables

13.1 Trade and other payables at the balance sheetb date are made up of:

	31 March 2017 £000	31 March 2016 £000
Current		
Receipts in advance	**0**	**0**
NHS payables - capital	**415**	**1**
NHS payables - revenue	**1,070**	**563**
NHS Payables - early retirement costs payable within one year	**0**	**0**
Amounts due to other related parties - capital	**0**	**0**
Amounts due to other related parties - revenue	**1,511**	**2,566**
Other trade payables - capital	**595**	**635**
Other trade payables - revenue	**1,777**	**1,673**
Social Security costs	**1,552**	**1,352**
Other taxes payable	**24**	**13**
Other payables	**652**	**539**
Accruals	**2,560**	**2,891**
PDC dividend payable	**0**	**50**
Total current trade and other payables	**10,156**	**10,283**
Non-current		
Receipts in advance	0	0
Other trade payables - capital	0	0
Other trade payables - revenue	0	0
Other payables	0	0
Total non-current trade and other payables	0	0

13.2 Other liabilities

	31 March 2017 £000	31 March 2016 £000
Current		
Deferred income goods & services	117	100
Deferred income rent of land	0	0
Other deferred income	0	0
Total other current liabilities	**117**	100
Non-current		
Deferred income goods & services	0	0
Deferred income rent of land	0	0
Other deferred income	0	0
Total other non current liabilities	**0**	0

13.3 Borrowings

	31 March 2017 £000	31 March 2016 £000
Current		
Bank overdrafts - Government Banking Service	0	0
Other Loans	0	0
Obligations under finance leases	43	40
Total current borrowings	**43**	40
Non-current		
Obligations under finance leases	275	318
Total other non current liabilities	**275**	318

13.4 Finance lease obligations

	31 March 2017 £000	31 March 2016 £000
Gross buildings lease liabilities	**59**	59
- not later than one year;	**236**	236
- later than one year and not later than five years;	**82**	140
- later than five years.	**377**	435
Gross buildings lease liabilities	**(59)**	(77)
Less finance charges allocated to future periods	**318**	358
Net buildings lease liabilities		
Net lease liabilities payable:	**43**	40
- not later than one year;	**199**	189
- later than one year and not later than five years;	**76**	129
- later than five years.	**318**	358

The Trust has one finance lease arrangement, Avon House. The term of the lease is for 20 years and 6 months calculated from 24 November 2003. Any discussions on the remainder of the lease/option to buy can commence at the tenth or fifteenth anniversary of the date from which the term is calculated.

14 Provisons

	31 March 2017 Other legal claims £000	31 March 2016 Other legal claims £000
As at 1 April	**1,827**	2,578
Arising during the period	**144**	255
Utilised during the period - Accurals	**0**	0
Utilised during the period - Cash	**(25)**	(58)
Reclassified to liabilities held in disposal groups in year	**0**	0
Reversed unused	**(1,404)**	(948)
At 31 March	**542**	**1,827**
Expected timing of cash flow:		
- not later than one year;	**475**	**1,781**
- later than one year and not later than five years;	**38**	**13**
- later than five years.	**29**	**33**
At 31 March	**542**	**1,827**

The provision for other legal claims is stated subject to uncertainty about the outcome of legal proceedings.

The Trust has made provisions for some employment and supplier issues in accordance with International Accounting Standard 37. No individual provision is over £800,000. (Nil in 2015/16)

The NHS Litigation Authority held provisions of £20,491,254 at 31 March 2017 in respect of clinical negligence liabilities of the NHS Foundation Trust (£1,431,423 in 2015/16).

Since the effect of the time value of money is not significant, since April 2013 cash flows are not discounted.

15 Cash and cash equivalents

	31 March 2017 £000	31 March 2016 £000
At 1 April	26,617	27,368
Net change in year	(9,583)	(6,751)
At 31 March	**11,034**	20,617
Broken down into:		
Cash at commercial banks and in hand	38	35
Cash with the Government Banking Service	10,996	8,582
Deposits with the National Loan Fund	0	12,000
Other current investments	0	0
Cash and cash equivalents as in SoFP	**11,034**	20,617
Bank overdraft - GBS & commercial	0	0
Cash and cash equivalents as in SoCF	**11,034**	20,617

15.1 Third Party Assets

	31 March 2017 £000	31 March 2016 £000
Third party assets held by the Trust	**102**	94

16 Commitments

16.1 Capital Commitments

Commitments under capital expenditure contracts at 31 March were as follows:

	31 March 2017 £000	31 March 2016 £000
Property, plant and equipment	**2,453**	958
Intangible assets	**0**	0
	2,453	958

16.2 Other Financial Commitments

The Trust is not committed to any non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangements) with any related party or other organisation at 31 March 2016.

17 Contingencies

	31 March 2017 £000	31 March 2016 £000
Gross value of contingent liabilities	**(244)**	(149)
Amounts recoverable against contingent liabilities	**0**	0
Net value of contingent liabilities	**(244)**	(149)
Net value of contingent assets	**13**	21

Net contingent assets and liabilities relate to personal injury claims (NHS Litigation Authority Scheme) and permanent injury benefit claims (NHS Pensions scheme).
Contingent liabilities relate to obligations arising from past events such as legal claims. They are not recognised as provisions either:
- because it is not probable that any expenditure will be incurred, or
- because the expenditure cannot be measured reliably

18 Related Party Transactions

²gether NHS Foundation Trust is a corporate body established by order of the Secretary of State for Health.

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 Trust.

The Chief Executive, Shaun Clee, is the Chair of the NHS Confederation Mental Health Network and a Trustee and Board member of the NHS Confederation. Shaun is Chair of the South West SHA Clinical Faculty for Improving Safety in Mental Health. Shaun is currently Chair of 'Kids Like Us', a registered charity for children, young people and families with juvenile arthritis.

The Chief Executive's wife, Sarah Clee, runs a marketing consultancy company called CleeCo Ltd which bids for work amongst a wide client base across the private, public and third sector. CleeCo Ltd has not undertaken any work for ²gether NHS Fondation Trust. However, CleeCo Ltd successfully bid for work for the South of England Patient Safety Collaborative which is hosted by ²gether NHS Foundation Trust. Neither ²gether NHS Foundation Trust or Shaun played any role in any procurement decision making processes directly or indirectly in relation to the contract CleeCo Ltd won. Full disclosure was made to the Chair and Director of Finance of ²gether NHS Foundation Trust as well as to the Academic Health Science Network who supported the collaborative.

The Director of Quality, Marie Crofts, is a Trustee of Papyrus, a charity which works towards the prevention of young suicides.

The Trust Chair, Ruth FitzJohn, is President of the Midcounties Cooperative (from November 2014), Director of the Midcounties Cooperative Society, a Trustee of the Gloucestershire GP Educational Trust and a Trustee of the Catholic Diocese of Clifton.

A Non Executive Director, Marcia Gallagher, has a business, MMG Services Ltd which carries out work for Herefordshire CCG.

A Non Executive Director, Martin Freeman, is a Director and Trustee of Carers Gloucestershire. This role has not involved any negotiations or transactions related to the Trust.

A Non Executive Director, Charlotte Hitchings, is a self employed executive coach/consultant trading as C-Change, and was Chair of Health Education England's Local Training and Education Board (LETB) West Midlands.

A public governor, Paul Toleman, is a Gloucester City Councillor.

The Board of Governors has five nominated roles (one of which is vacant at 31 March 2017):

Roger Wilson is a Gloucestershire County Councillor and Vice-Chair of the Health and Care Overview and Scrutiny Committee.

Jenny Bartlett is a Herefordshire County Councillor.

Dr Tristan Lench is a senior partner at a Gloucestershire GP Practice, and the Clinical Commissioning Lead for the Forest of Dean.

Hazel Braund is the Director of Operations at Herefordshire CCG.

The Department of Health and Monitor (the independent regulator of NHS Foundation Trusts) are regarded as related parties. During the period the Trust has had a significant number of material transactions with the Department, and with other entities for which these bodies are regarded as the parent departments. In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Those entities with transactions or balances totalling more than £500,000 are listed below:

Total as at 31 March 2017	Income	Expenditure	Receivables	Payables
Entity	£'000	£'000	£'000	£'000
Berkshire Healthcare NHS Foundation Trust	741			
Gloucestershire Hospitals NHS Foundation Trust	1,306	3,798	513	1,278
Wye Valley NHS Trust		772		
NHS Gloucestershire CCG	79,056			
NHS Herefordshire CCG	19,120		501	
Department of Health		2,821		
Health Education England	2,398			
NHS England	3,602		833	
Gloucestershire County Council	2,507	4,991	1,310	1,273
Herefordshire Council	1,001			
NHS Pension Scheme		7,711		1,090
HM Revenue and Customs		6,136		1,576
Aneurin Bevan Local Health Board			563	

Total as at 31 March 2016 Entity	Income £'000	Expenditure £'000	Receivables £'000	Payables £'000
Berkshire Healthcare NHS Foundation Trust	733			
Gloucestershire Hospitals NHS Foundation Trust	1,334	3,815	884	
Wye Valley NHS Trust		783		
NHS Gloucestershire CCG	76,044			
NHS Herefordshire CCG	17,171			
Department of Health		2,477		
Health Education England	2,022			
NHS England	2,040			
Gloucestershire County Council	2,508	4,524	1,124	2,167
Herefordshire Council	2,069			
NHS Pension Scheme		7,537		1,063
HM Revenue and Customs		4,741		1,365

²gether NHS Foundation Trust is the corporate trustee of the ²gether NHS Foundation Trust Charitable Fund, registered with the Charity Commission, registration number 1097529. (Further details in note 19.1).

Trustees, officers and key management staff of ²gether NHS Foundation Trust Charitable Fund are members of the Board of ²gether NHS Foundation Trust or its employees. During 2016/17 (and 2015/16) none of the trustees or members of key management staff or parties related to them undertook any material transactions with the ²gether NHS Foundation Trust Charitable Fund. The executive and non executive Directors of the Trust Board share the responsibility for ensuring that the NHS body fulfils its duties as a corporate trustee in managing the charitable funds.

Since 11 December 2013 ²gether NHS Foundation Trust became the corporate trustee of the New Highway Charity, registered with the Charity Commission, registration number 1063888. (Further details in note 19.2).

During 2016/17 (and 2015/16) none of the trustees or members of key management staff of New Highway Charity or parties related to them undertook any material transactions with ²gether NHS Foundation Trust or ²gether NHS Foundation Trust Charitable Fund. During the year, the New Highway Charity did not use any resources to benefit the Trust.

19 Charitable funds where ²gether NHS Foundation Trust is the corporate trustee

The Treasury agreed to apply IAS 27 to NHS organisations from 1 April 2013 therefore from 2013/14, foundation trusts must consolidate any charitable funds where it is the corporate trustee and effectively has the power to exercise control unless the impact on the accounts would not be material.

²gether NHS Foundation Trust is the corporate trustee of the ²gether NHS Foundation Trust Charitable Fund, registered with the Charity Commission, registration number 1097529.

Since 11 December 2013 ²gether NHS Foundation Trust has been the corporate trustee of the New Highway Charity, registered with the Charity Commission, registration number 1063888.

The Trust has assessed the transactions and balances of its linked charities '²gether NHS Foundation Trust Charitable Funds' and 'New Highway' Charity and has decided that these are not material, in the context of the NHS Trust accounts, and they do not require consolidation.

The Trust will produce Annual Accounts and Trustee Reports for both charities in accordance with the Charity Commission Requirements. Further details of the charities are given in section 19.1 and 19.2.

19.1 ²gether NHS Foundation Trust Charitable Fund

The funds are held on trust under paragraph 16c of schedule 2 of the NHS and Community Care Act 1990.

At 31March 2017 the funds held by the charity were £140,000. In 2016/17 £15,000 was spent on patient welfare, £7,000 spent on Staff Welfare and £3,000 on Management and Administration.

19.1.1 From Charity's Statement of Financial Activities

Total Incoming Resources	31 March 2017 £000	31 March 2016 £000
Resources Expended with this NHS body	21	21
Resources Expended with other NHS foundation trusts	(1)	(111)
Resources Expended with NHS Trusts	(2)	(2)
Resources Expended with NHS England & CCGs	0	0
Resources Expended with bodies outside the NHS	0	0
Total Resources Expended	(23)	(7)
	(26)	(120)
Net (outgoing) / incoming resources before transfers	(5)	(96)
(Losses) / gains on revaluation and disposal	0	0
Other fund movements	0	0
Net movement in funds	(5)	(96)

19.1.2 From Charity's Balance Sheet

	31 March 2017 £000	31 March 2016 £000
Investments	0	0
Other fixed assets	0	0
Total fixed assets	0	0
Cash	140	145
Other Current Assets	0	0
Current Liabilities	0	0
Creditors due after one year	0	0
Net assets / liabilities	140	145
Restricted / Endowment funds	4	7
Unrestricted funds	136	138
Total Charitable Funds	140	145

19.1.3 Restricted/Non-Restricted Analysis

	12 Months to 31 March 2017 Total charitable funds £000	12 Months to 31 March 2017 Restricted / Endowment £000	12 Months to 31 March 2017 Non-restricted £000
Opening Balance	145	7	138
Net (outgoing) / incoming resources	(5)	(3)	(2)
(Losses)/gains on revaluation and disposal	0	0	0
Transfers to FT charities (where parent trust is Authorised)	0	0	0
Transfers to/from other bodies	0	0	0
Other movements	0	0	0
Closing Balance	140	4	136

19.2 New Highway Charity

The Trust became the corporate trustee of the New Highway Charity on 11 December 2013 and has no responsibility for transactions earlier than this.

In 2016/17 (and 2015/16) the Trust did not utilise the Charity's funds as no suitable opportunities arose that could make appropriate use of the Charity structure and the available funds.

19.2.1 From Charity's Statement of Financial Activities

Total Incoming Resources	31 March 2017 £000	31 March 2016 £000
Resources Expended with this NHS body	**0**	0
Resources Expended with other NHS foundation trusts	**0**	0
Resources Expended with NHS Trusts	**0**	0
Resources Expended with NHS England & CCGs	**0**	0
Resources Expended with bodies outside the NHS	**0**	0
Total Resources Expended	**0**	0
Net (outgoing) / incoming resources before transfers	**0**	0
(Losses) / gains on revaluation and disposal	**0**	0
Other fund movements	**0**	0
Net movement in funds	**0**	0

19.2.2 From Charity's Balance Sheet

	31 March 2017 £000	31 March 2016 £000
Investments	**0**	0
Other fixed assets	**0**	0
Total fixed assets	**0**	0
Cash	**93**	**93**
Other Current Assets	**0**	**0**
Current Liabilities	**0**	**0**
Creditors due after one year	**0**	**0**
Net assets / liabilities	**93**	**93**
Restricted / Endowment funds	**0**	**0**
Unrestricted funds	**93**	**93**
Total Charitable Funds	**93**	**93**

19.2.3 Restricted/Non-Restricted Analysis

	12 Months to 31 March 2017 Total charitable funds £000	12 Months to 31 March 2017 Restricted / Endowment £000	12 Months to 31 March 2017 Non-restricted £000
Opening Balance	93	0	93
Net (outgoing) / incoming resources	0	0	0
(Losses)/gains on revaluation and disposal	0	0	0
Transfers to FT charities (where parent trust is Authorised)	0	0	0
Transfers to/from other bodies	0	0	0
Other movements	0	0	0
Closing Balance	93	0	93

20 Financial Instruments

Financial Reporting Standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with local Primary Care Trusts and the way those Primary Care Trusts are financed, the NHS Foundation Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies, to which the reporting standards mainly apply.

The Trust's treasury management operations are carried out by the Finance Department, within parameters formally defined within the Trust's Standing Financial Instructions and policies agreed by a committee of the Board. Trust treasury activity is subject to review by the Trust's internal auditor.

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 fluctuations.

Interest rate risk

The Trust invests in fixed term money market deposits with the National Loans Fund and a small number of banks and building societies with a maximum period of three months.
The Trust limits its investment in any one organisation, limits the time of the investment and regularly monitors interest rates in the market. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

The majority of the Trust's income comes from contracts with other public sector bodies. The Trust has low exposure to credit risk. The maximum exposures as at 31 March are in receivables from customers, as disclosed in the trade and other receivables note.

The Trust invests in fixed term money market deposits with a small number of banks and building societies. The Trust manages counterparty credit risks by monitoring credit ratings from three agencies and by only investing in organisations with a very strong credit rating and by investing for short periods only.

Liquidity risk

The Trust's operating costs are incurred under contracts with Primary Care Trusts, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from retained surpluses and capital disposals. The Trust is not, therefore, exposed to significant liquidity risks. The Trust keeps £8 million in cash and short term deposits to ensure the liquidity position.

20.1 Financial assets by category

	Loans and Receivables	Assets at Fair Value through the I&E	Held to Maturity	Available for Sale	Total
	£000	£000	£000	£000	£000
Financial Assets as per Statement of Financial Position:					
At 31 March 2017					
Trade and other receivables excluding non financial assets	**6,475**	**0**	**0**	**0**	**6,475**
Other investments	**0**	**0**	**0**	**0**	**0**
Other financial assets	**0**	**0**	**0**	**0**	**0**
Non current assets held for sale and assets held in disposal group excluding non financial assets	**0**	**0**	**0**	**0**	**0**
Cash and cash equivalents at bank and in hand	**11,034**	**0**	**0**	**0**	**11,034**
Total as at 31 March 2017	**17,509**	**0**	**0**	**0**	**17,509**
At 31 March 2016					
Trade and other receivables excluding non financial assets	3,861	0	0	0	3,861
Other investments	0	0	0	0	0
Other financial assets	0	0	0	0	0
Non current assets held for sale and assets held in disposal group excluding non financial assets	0	0	0	0	0
Cash and cash equivalents at bank and in hand	20,617	0	0	0	20,617
Total as at 31 March 2016	24,478	0	0	0	24,478

For all categories of the Trust's financial assets the book values are equal to the fair values.

20.2 Financial Liabilities by category

	Other Financial Liabilities	Liabilities at Fair Value through the I&E	Total
	£000	£000	£000
Liabilities as per Statement of Financial Position:			
At 31 March 2017			
Borrowings excluding finance lease and PFI liabilities	**0**	**0**	**0**
Obligations under finance leases	**318**	**0**	**318**
Obligations under PFI contracts	**0**	**0**	**0**
Trade and other payables excluding non financial assets	**8,604**	**0**	**8,604**
Other financial liabilities	**0**	**0**	**0**
Provisions under contract	**0**	**0**	**0**
NHS charitable funds: financial assets (at 31 March)	**0**	**0**	**0**
Total as at March 2017	**8,922**	**0**	**8,922**
At 31 March 2016			
Borrowings excluding finance lease and PFI liabilities	0	0	0
Obligations under finance leases	358	0	358
Obligations under PFI contracts	0	0	0
Trade and other payables excluding non-financial assets	8,948	0	8,948
Other financial liabilities	0	0	0
Provisions under contract	0	0	0
NHS charitable funds: financial assets (at 31 March)	0	0	0
Total as at March 2016	**9,306**	**0**	**9,306**

21 Losses and Special Payments

	2016/17		2015/16	
	Numbers	Value	Numbers	Value
Losses:				
1. Losses of cash due to:				
a. theft, fraud etc.	**1**	**0**	0	0
b. overpayment of salaries etc.	**3**	**0**	4	13
c. other causes	**0**	**0**	0	0
2. Fruitless payments and constructive losses	**0**	**0**	0	0
3. Bad debts and claims abandoned in relation to:				
a. private patients	**0**	**0**	0	0
b. overseas visitors	**0**	**0**	0	0
c. other	**0**	**0**	1	3
4. Damage to buildings, property etc. due to:				
a. theft, fraud etc.	**0**	**0**	1	0
b. stores losses	**0**	**0**	0	0
c. other	**0**	**0**	1	1
Total losses	**4**	**0**	7	14
Special payments:				
5. Compensation under legal obligation	**0**	**0**	0	0
6. Extra contractual to contractors	**0**	**0**	0	0
7. Ex gratia payments in respect of:				
a. loss of personal effects	**6**	**3**	10	3
b. clinical negligence with advice	**0**	**0**	0	0
c. personal injury with advice	**2**	**8**	1	0
d. other negligence and injury	**0**	**0**	0	0
e. Other employment payments	**0**	**0**	0	0
f. Patient referrals outside the UK and EEA guidelines	**0**	**0**	0	0
g. other	**0**	**0**	0	0
h. maladministration, no financial loss	**2**	**1**	0	0
8. Special Severance payments	**0**	**0**	0	0
9. Extra statutory and regulatory	**0**	**0**	0	0
Total special payments	**10**	**12**	11	3
Total losses and special payments	**14**	**12**	18	17

These amounts are reported on an accruals basis but excluding provisions for future losses.

22 Post Balance Sheet Events

There are no Events after the Balance Sheet Date that need reporting.

Independent Auditor's Report to the Council of Governors and Board of Directors of 2gether NHS Foundation Trust

Opinion on financial statements of 2gether NHS Foundation Trust

In our opinion the financial statements:
- **give a true and fair view of the state of the Trust's affairs as at 31 March 2017 and of its income and expenditure for the year then ended;**
- **have been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and**
- **have been prepared in accordance with the requirements of the National Health Service Act 2006.**

The financial statements that we have audited comprise:
- the Statement of Comprehensive Income;
- the Statement of Financial Position;
- the Statement of Cash Flows;
- the Statement of Changes in Taxpayers' Equity;
- the Accounting Policies; and
- the related notes 1 to 22.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts.

Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Summary of our audit approach

Key risks	The key risks that we identified in the current year were: • Recognition of NHS revenue; and • Property valuations.
Materiality	The materiality that we used in the current year was £2.3m which was determined on the basis of 2% of revenue.
Scoping	Our audit was scoped by obtaining an understanding of the Trust and its environment, including Trust-wide controls, and assessing the risks of material misstatement. Audit work was performed at the Trust's offices in Gloucester directly by the audit engagement team, led by the audit partner.
Significant changes in our approach	There has been no significant change in our approach from the prior year.

Going concern

We have reviewed the Accounting Officer's statement contained within the Annual Report that the Trust is a going concern.

We confirm that:
- **we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and**
- **we have not identified any material uncertainties that may cast significant doubt on the Trust's ability to continue as a going concern.**

However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the Trust's ability to continue as a going concern.

Independence

We are required to comply with the Code of Audit Practice and Financial Reporting Council's Ethical Standards for Auditors, and confirm that we are independent of the Trust and we have fulfilled our other ethical responsibilities in accordance with those standards.

We confirm that we are independent of the Trust and we have fulfilled our other ethical responsibilities in accordance with those standards. We also confirm we have not provided any of the prohibited non-audit services referred to in those standards.

Our assessment of risks of material misstatement

The assessed risks of material misstatement described below are those that had the greatest effect on our audit strategy, the allocation of resources in the audit and directing the efforts of the engagement team.

Recognition of NHS revenue

Risk description

There are significant judgements in recognition of revenue from care of NHS service users and in provisioning for disputes with commissioners due to:

- the judgements taken in evaluating volume-related and Commissioning for Quality and Innovation ("CQUIN") income; and
- the judgemental nature of provisions for disputes and bad debts.

Details of the Trust's income, including £105.2m of Commissioner Requested Services, are shown in note 6.3 to the financial statements. NHS debtors are shown in note 11 to the financial statements and consideration of the Trust's financial performance have been included in the Annual Performance Report section of the Annual Report.

How the scope of our audit responded to the risk

We evaluated the design and implementation of controls over recognition revenue.

We tested the recognition of income through the year, including year-end cut-off, and evaluated the results of the agreement of balances exercise. We assessed the assumptions made in respect of achievement of CQUIN targets.

We challenged key judgements around specific areas of dispute and actual or potential challenge from commissioners and the rationale for the accounting treatments adopted. In doing so, we considered the historical accuracy of provisions for disputes and reviewed correspondence with commissioners.

Key observations

Based on the audit evidence obtained, we conclude that NHS revenue is appropriately recognised and that debtors have been appropriately valued, with management's judgement in relation to bad debts being optimistic but acceptable.

Property valuations	
Risk description	The Trust holds property assets within Property, Plant and Equipment at a modern equivalent use valuation of £86m at 31 March 2017. The valuations are by nature significant estimates which are based on specialist and management assumptions (including the floor areas for a Modern Equivalent Asset, the basis for calculating build costs, the level of allowances for professional fees and contingency, and the remaining life of the assets) and which can be subject to material changes in value. At 31 March 2017 the Trust recognised a decrease in land and building values of £0.4m and £1.5m respectively following a revaluation exercise performed by an external valuer. In addition, there is a risk that data provided to the valuer is not complete or accurate.
How the scope of our audit responded to the risk	We evaluated the design and implementation of controls over property valuations, and tested the accuracy and completeness of data provided by the Trust to the valuer. We evaluated the design and implementation of controls over property valuations.

These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Our application of materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality both in planning the scope of our audit work and in evaluating the results of our work.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

Trust materiality	£2.3m (2016: £2.1m).
Basis for determining materiality	2% of revenue (2016: 2% of revenue).
Rationale for the benchmark applied	Revenue was chosen as a benchmark as the Trust is a non-profit organisation, and revenue is a key measure of financial performance for users of the financial statements.

We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £0.114m (2016: £0.107m), as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds. We also report to the Audit Committee on disclosure matters that we identified when assessing the overall presentation of the financial statements.

An overview of the scope of our audit

Our audit was scoped by obtaining an understanding of the Trust and its environment, including internal control, and assessing the risks of material misstatement.

Audit work was performed at the Trust's offices in Gloucester directly by the audit engagement team, led by the audit partner.

The Trust utilises the services of Gloucester Shared Services to provide day to day accounting services to the Trust.

As part of the audit process we visited the shared service provider to access the audit documentation that provided the necessary audit evidence.

Opinion on other matters prescribed by the National Health Service Act 2006

In our opinion:
- the parts of the Directors' Remuneration Report and Staff Report to be audited have been properly prepared in accordance with the National Health Service Act 2006; and
- the information given in the Performance Report and the Accountability Report to be audited for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Annual Governance Statement, use of resources, and compilation of financial statements.

We have nothing to report in respect of these matters.

Under the Code of Audit Practice, we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit;
- the NHS Foundation Trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources; or
- proper practices have not been observed in the compilation of the financial statements.

We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

Reports in the public interest or to the regulator

We have nothing to report in respect of these matters.

Under the Code of Audit Practice, we are also required to report to you if:

- 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; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

Our duty to read other information in the Annual Report

We confirm that we have not identified any such inconsistencies or misleading statements.

Under International Standards on Auditing (UK and Ireland), we are required to report to you if, in our opinion, information in the annual report is:

- materially inconsistent with the information in the audited financial statements; or
- apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Trust acquired in the course of performing our audit; or
- otherwise misleading.

Respective responsibilities of Accounting Officer and auditor

As explained more fully in the Accounting Officer's Responsibilities Statement, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Code of Audit Practice and International Standards on Auditing (UK and Ireland). We also comply with International Standard on Quality Control 1 (UK and Ireland). Our audit methodology and tools aim to ensure that our quality control procedures are effective, understood and applied. Our quality controls and systems include our dedicated professional standards review team.

This report is made solely to the Council of Governors and Board of Directors ("the Boards") of ²gether NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards 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 Trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accounting Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Ian Howse (Senior statutory auditor)
for and on behalf of Deloitte LLP
Chartered Accountants and Statutory Auditor
Cardiff, United Kingdom
24 May 2017

Independent auditor's report to the council of governors of 2gether NHS Foundation Trust on the quality report

We have been engaged by the Council of Governors of 2gether NHS Foundation Trust to perform an independent assurance engagement in respect of 2gether NHS Foundation Trust's quality report for the year ended 31 March 2017 (the 'Quality Report') and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the Council of Governors of 2gether NHS Foundation Trust as a body, to assist the Council of Governors in reporting 2gether 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 2017, to enable the Council of Governors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and 2gether NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- Access to Crisis Resolution / Home Treatment Team (Crisis Gatekeeping)

- Delayed Transfers of Care (DTOC)

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified below:

  o board minutes for the period April 2016 to March 2017;
  o papers relating to quality reported to the board over the period April 2016 to March 2017;
  o feedback from Gloucestershire commissioners dated 15 May 2017
  o feedback from Herefordshire commissioners dated 15 May 2017
  o feedback from Governors dated 17 January 2017
  o feedback from Herefordshire Healthwatch dated 2 May 2017
  o feedback from Gloucestershire Healthwatch dated 15 May 2017
  o feedback from Gloucestershire Overview and Scrutiny Committee dated 28 April 2017
  o feedback from Herefordshire Overview and Scrutiny Committee dated 15 May 2017
  o the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2017
  o the 2016 national patient survey
  o the 2016 national staff survey
  o the Head of Internal Audit's annual opinion over the trust's control environment dated May 2017
  o CQC inspection report dated 28 January 2016; and
  o any other information included in our review.

- 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 'Detailed guidance for external assurance on quality reports'.

We read the quality report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual' and 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 documents listed above and specified in the detailed guidance for external assurance on Quality Reports (collectively the 'documents').

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with 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.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – ' Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- Making enquiries of management;
- Testing key management controls;
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- Comparing the content requirements of the 'NHS foundation trust annual reporting manual' and supporting guidance to the categories reported in the quality report; and
- Reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

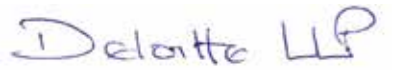
The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance.

The scope of our assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by ²gether NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

- 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 2.1 of the NHS Improvement 2016/17 detailed guidance for external assurance on quality reports for foundation trusts; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and supporting guidance.



Deloitte LLP
Chartered Accountants
Cardiff
United Kingdom
24 May 2017

Contact us

If you would like to contact the Trust you can:

Write to: Trust Secretary, Rikenel, Montpellier, Gloucester GL1 1LY
Email: j.mcilveen@nhs.net
Telephone: 01452 894000

Communicating with Governors

Members of the Trust may contact Governors via:

Email: anna.hilditch@nhs.net

Writing to: Freepost RLYA-XAKR-HABZ, [2]gether NHS Foundation Trust, Rikenel, Montpellier, Gloucester GL1 1LY

Telephone: the Assistant Trust Secretary on 01452 894165

There is also a feedback form on the Trust website at www.2gether.nhs.uk.

Information in other languages/formats

The [2]gether NHS Foundation Trust Annual Report and Accounts 2016/17 describe the activities of the Trust during the 2016/17 financial year.

If you would like the Annual Report in large print, Braille, audio cassette tape or another language please telephone 01452 894000 or email us at 2gnft.comms@nhs.net

Chinese

2gether 國家健康服務信託社的週年報告和 2015-16 年度的帳目說明信託社在該財政年度的事務。如果你希望得到週年報告的大型字體版本、凸字本、音帶或其他語言的譯本，請致電01452 894007 或者電郵 2gnft.comms@nhs.net

Polish

Roczny Raport i Rachunkowość Funduszu Powierniczego Narodowej Służby Zdrowia [2]gether na rok 2015 - 16 opisuje działalność funduszu w czasie roku finansowego 2015 - 16 . Po kopię Raportu Rocznego w dużym druku, w języku Braille's, na kasecie audio lub w innym języku proszę dzwonić pod numer **01452 894007** lub email: 2gnft.comms@nhs.net

Czech

Výročni zpráva a účetni knihy 2015 - 16 nadace 2gether svěřenecké společnosti NHS popisují činnosti společnosti během finančního roku 2015 - 16. Pokud budete chtít výročni zprávu ve velkém tisku, Braillovu písmu, na audio kazete nebo v jiném jazyce, volejte prosím na **01452 894007** nebo napište na email: 2gnft.comms@nhs.net

Gujarati

ટુગેધર એનએચએસ ફાઉન્ડેશન ટ્રસ્ટનો 2015-16 વાર્ષિક અહેવાલ અને હિસાબ ટ્રસ્ટની ૨૦૦૮ - ૦૯નાં વર્ષ દરમ્યાનની કામગીરીઓ બતાવે છે. તમોને જો એ અહેવાલ મોટા અક્ષરોમાં, બ્રેઈલ (અંધલિપિ), ઓડિઓ કસેટ કે બીજી કોઈ ભાષામાં જોઈતો હોય તો, મહેરબાની કરીને ૦૧૪૫૨ ૮૯૧૧૬૫ નંબર પર ફોન કરશો અથવા આ જગ્યા પર ઈમેઈલ કરશો : 2gnft.comms@nhs.net

Bengali

টুগেদার এন্এইচ্এস্ ফাউন্ডেশন ট্রাস্টের ([2]gether NHS Foundation Trust) 2015-16 সালের বাৎসরিক রিপোর্ট ও এ্যাকাউন্টে, ২০০৮-২০০৯ আর্থিক বছরে এই ট্রাস্টের কাজকর্মের কথা বলা হয়েছে। আপনি যদি এই রিপোর্টটি বড় ছাপায়, ব্রেইল-এ, কানে শোনার ক্যাসেট টেপ-এ বা অন্য কোন ভাষায় চান, তাহলে দয়া করে **০১৪৫২ ৮৯১১৬৫** নম্বরে টেলিফোন করবেন অথবা 2gnft.comms@nhs.net ঠিকানায় ইমেইল করবেন।

Urdu

ٹو گیدر این ایچ ایس فاؤنڈیشن ٹرسٹ کی سالانہ رپورٹ اورسن 2015-16 کے اکاؤنٹس میں ٹرسٹ کی اُن سرگرمیوں کا ذکر کیا گیا ہے جو مالی سال 2015-16 کے دوران انجام دی گئیں ۔ سالانہ رپورٹ اگر آپ کو بڑے حروف کی چھپائی، آڈیو کسٹ یا کسی دیگر زبان میں درکار ہو تو برائے مہربانی نمبر **01452** پر فون کریں یا اس پتے پر ای میل بھیجیں : 2gnft.comms@nhs.net **894007**