Gloucestershire Care Services NHS

NHS Trust

Annual Report & Accounts

2015-16

Understanding You

Contents

PART 1
Performance Report

1.1 Overview

1.1.1 Statement from the Chair

In these ever-changing times for the NHS, I do find it hugely positive that throughout 2015-16, Gloucestershire Care Services NHS Trust (the Trust) continued to build upon our excellent relationships with partners and other stakeholders across the county. As we move towards a new landscape for health and social care, which I expect in 2016-17 will largely be dominated by ambitions to deliver against the countywide, cross-organisational Sustainability and Transformation Plan (in development at time of writing), it is more critical than ever that all local service providers and commissioners work together in order to reduce variation and duplication, identify system efficiencies, and ultimately, improve experiences and outcomes for service users, carers and families.

With partnership in mind, I would like highlight the following activities in 2015-16:

- throughout the year, Paul Jennings, Chief Executive and I continued to prioritise our attendance at the Gloucestershire Strategic Forum in order to actively engage with other local leaders of health and social care: I really feel that in 2015-16, this Forum made significant progress in developing plans for integrated services in Gloucestershire, and exploring the demand and workforce challenges which affect us all;
- Paul and I also regularly attended the Health and Care Overview and Scrutiny Committee to respond to appropriate challenge about our Trust's performance and contribution to the wider health and social care system;

- in February 2016, we held an extremely informative Board-to-Board with our main commissioners, the Gloucestershire Clinical Commissioning Group, which allowed both organisations an open platform to share opinions and reflect upon joint priorities;
- I and other Trust colleagues held regular meetings with Healthwatch Gloucestershire which acts as the champion of service users across the county. In particular this year, I was delighted that we were invited to act as guest speakers at a Healthwatch public engagement event at the Gloucester Guildhall, which was a fantastic opportunity to showcase the range of services provided by our Trust in the community, but also to hear directly from local people about their views and concerns;
- I met frequently with our Leagues of Friends, who all continued to contribute significantly to the Trust and local communities;
- I and our Community Partnerships Team continued to engage with a range of third sector organisations, who like us, support people in the community. These included the Voluntary Care Sector Alliance, Gloucestershire Voices, Gloucestershire Deaf Association, Carers Gloucestershire, GlosCats and Gloucestershire Older People's Association;
- and most importantly, throughout 2015-16, I and all Trust representatives met with service users, carers and families. Whether as part of small focus groups such as those looking at the development of complex leg wound care services in the community, or at our Your Care, Your Opinion public engagement events, or even as part of our on-going discussions with people in the Forest of Dean where we have been having dialogue ahead of formal consultation on the future of services later in 2016-17, these conversations remain absolutely essential to us being able to understand, and respond to, local people's needs.

Quality improvements

In June 2016, we will be publishing our third annual Quality Account. This year, we have identified six quality improvement priorities, informed by internal sources of assurance such as our audit processes, as well as external reviews such as the Care Quality Commission (CQC) Chief Inspector of Hospital's report of September 2015, and feedback from our service users, their families and carers.

As such, our priorities for 2016-17 encompass aspired improvement in the quality of services for people with learning disabilities, better involvement of service users with extra or different needs in service design projects, and adoption of a positive risk-taking approach in our Integrated Community Teams and community hospitals so that care is always solution-focused and service user-led. We have also included the introduction of continence services in the community, and in response to CQC recommendations, we are aiming to improve our clinical record-keeping standards, and enhancing end-of-life care practices.

Whilst these six priorities are of course important to us, we also continue to identify all opportunities to improve quality across the whole of the Trust, in order to deliver services that are caring, safe, responsive, effective and well-led

Board developments

This year has seen a number of changes at Board, which are detailed within this Annual Report and Accounts. However, in terms of our Executives, I was delighted to welcome Dr Mike Roberts to our Board table as our substantive Medical Director, following his previous 11 months' service as interim. Similarly, I would like to congratulate both Susan Field and Candace Plouffe, both of whom were successful internal appointments - Susan is now our Director of Nursing and

Candace, our Chief Operating Officer. We have also had to say some sad farewells over the year - specifically, to Dr Joanna Bayley our former Medical Director, Duncan Jordan who had been seconded from Gloucestershire County Council since 2014 to act as our Chief Operating Officer, Liz Fenton our former Director of Nursing, and Jason Brown, Director of Corporate Governance and Trust Secretary.

There were changes too this year, within our Non-Executive Directors - I was very happy to welcome Jan Marriott to the Trust, and similarly saddened that Ian Dreelan who joined us in 2015-16, also departed in year due to other work pressures. I wish Ian every success in his future.

Finally, may I take this opportunity to thank and commend all Trust colleagues on a successful 2015-16.

Ingrid Barker

Ingrid Barker, Chair

1.1.2 Statement from the Chief Executive

Looking back upon 2015-16, probably the most significant event for the Trust was the visit by the Care Quality Commission (CQC) as part of its on-going Chief Inspector of Hospital's national programme of assessments. The outcome of our inspection, delivered at a Quality Summit on 21 September 2015, was very much mixed. On one hand, I was incredibly proud that so many of our services were mentioned as providing outstanding aspects of care, with ten particular shining examples being highlighted. Similarly, it was very gratifying that two thirds of the areas in which we were evaluated, were deemed to be either "Good" or "Outstanding". In contrast however, the overall judgment of "Requires improvement" was disappointing.

TABLE 1
CARE QUALITY COMMISSION FINDINGS, SEPTEMBER 2015

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent & emergency services	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Community adults	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Community inpatients	Requires improvement	Good	Outstanding	Good	Good	Good
Children and young people	Good	Good	Good	Good	Good	Good
End-of-life care	Good	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Sexual health	Good	Good	Good	Requires improvement	Good	Good
Dentists	Good	Good	Good	Requires improvement	Good	Good
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

However, the legacy of the inspection was that it truly galvanised us, and gave us the added momentum to achieve quality improvement at pace. So whilst I think it is fair to say that we not unsurprised as to the recommendations of the inspection team - as our internal control processes including our risk management systems, as well as both internal audit and clinical audit reports, had already made us aware of the areas in which improvement was required - the CQC report did challenge us to effect change with an increased sense of urgency.

In responding to the CQC recommendations, we also benefitted greatly from our adoption of *Listening into Action*. This approach, to which we first committed in January 2014, is now proven for us as a fantastic way of inspiring, motivating and engaging colleagues to find ways to improve the ways in which they work, increasing efficiency and effectiveness, and impacting positively upon the quality of provided care, clinical outcomes, staff morale and organisational culture. Indeed, I remain so passionate about *Listening into Action*, that we have now launched a third wave of implementation.

In 2015-16, we also took the brave move - ahead of many other Trusts nationally - to create a role within the organisation which assumes the responsibilities of the Freedom to Speak Up Guardian, advised by Sir Robert Francis following the failings in Mid Staffordshire. So we now have an Ambassador for Cultural Change, who provides colleagues with an impartial route for enquiry, challenge or redress should they feel concerned about any aspect of the Trust's practice, or that their voice is otherwise not being heard. Significantly for us, the Ambassador for Cultural Change role also has lead responsibility for *Listening into Action*, thereby ensuring that any learning from future internal enquiries can be fed back into our quality improvement approach.

Operational performance

You will read about our operational performance elsewhere within this Annual Report and Accounts. However, in summary, I feel that it is important to note that in 2015-16:

- we were able to report 82.8% compliance with all prevailing national measures, despite increasing demand for services and financial constraint;
- we successfully achieved a number of targets which have previously eluded us - I would draw specific attention to our 95.3% harm-free care reported via the Safety Thermometer;
- we were recognised by our regulators, the NHS Trust Development Authority (TDA) henceforth known as NHS Improvement, as consistently rating "green" on quality throughout the whole of the year.

We acknowledged these successes - and the contributions of colleagues - at a number of internal events this year, including our Leadership Conference in June, and Nursing Celebration Day in November. Both occasions helped staff to reflect upon achievements, as well as share, and learn from, best practice to support further development.

We also continued this year to roll out our SystmOne electronic clinical information system across the Trust. Whilst this has not been without its challenges, especially when first introducing it into teams, I am pleased to say that colleagues have largely embraced the opportunities that the system affords, both in terms of ensuring a more robust recording and reporting system, but also as a means of appropriately sharing information with colleagues and other providers where appropriate in the local health and social care system. Particularly with reference to sharing, we also welcomed and supported in 2015-16, the start of the Joining Up Your Information project, which in the coming months, will begin to enable service user data to be accessible across a range of Gloucestershire services, making people's experiences of care smoother and more efficient. I look forward to reporting against the progress of this project in next year's Annual Report and Accounts.

Financial performance

I am exceptionally pleased to report that despite local and national pressures, including the challenge to achieve additional targets mid-year, in 2015-16 we delivered against all our financial goals and returned £2.5 million surplus. The details of our income (£114.9million) and expenditure (£112.4million) are shown in the charts below:

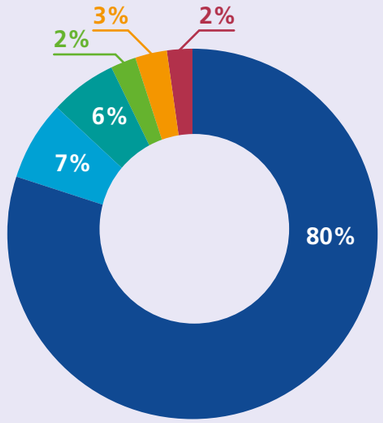


CHART 1
TRUST INCOME 2015-16

- Gloucestershire Clinical Commissioning Group (£91.6m)
- NHS England (£8.2m)
- Gloucestershire Hospitals NHS Foundation Trust (£6.3m)
- Gloucestershire County Council (£2.6m)
- Other NHS commissions (£4.1m)
- Other income (£2.1m)

Total £114.9million

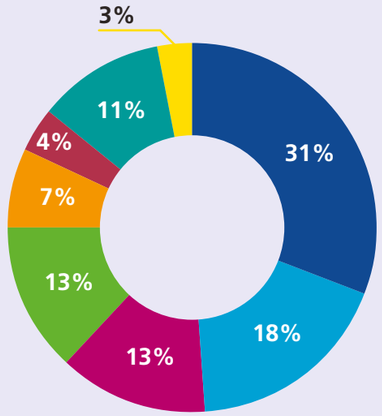


CHART 2
TRUST EXPENDITURE 2015-16

- Community hospitals (£35.1m)
- Integrated Community Teams (£20.2m)
- Countywide services (£14.8m)
- Children and young people's services (£14.1m)
- Sexual health (£7.6m)
- Unscheduled care (£4.8m)
- Support services (£12.6m)
- Clinical quality and development (£3.2m)

Total £112.4million

Going forward

In 2016-17, I very much anticipate us building upon the successes detailed above, whilst continuing to implement continuous quality improvement. I also look forward to working more closely with all our partner health and social care providers and commissioners in Gloucestershire, as we jointly develop a robust Sustainability and Transformation Plan, which will establish an ambitious countywide blueprint for addressing the challenges we face locally, regionally and nationally.

I look forward to reporting our progress in next year's report.

Paul Jennings

Paul Jennings, Chief Executive

1.1.3 Trust vision, values and strategic objectives

Vision

The Trust's vision, which defines its overarching ambition, is ***"To be the service people rely on to understand them and organise their care around their lives"***: therefore, that all health and care services provided by the Trust work together in a coordinated way in order to ensure that local people receive the right support, from the right staff, at the right time. This is further supported by the Trust's strapline ***"Understanding You"***.

Values

The Trust's CORE values remain to be **Caring**, **Open**, **Responsible** and **Effective**. In order to help colleagues to understand how best to represent these values in their daily interactions with others, in 2015-16, the Trust developed a Behaviours Framework. This highlighted the expectations on staff, linked to the CORE values: as such, the requisite behaviours were:

- **Caring:**
  - Respecting and valuing others
  - Acting in the best interests of service users
- **Open:**
  - Open in our communication
  - Connecting with others and working across boundaries
- **Responsible:**
  - Owning our actions
  - Professional in attitude
- **Effective:**
  - Ensuring the best outcomes
  - Realising your full potential

Strategic objectives

The Trust's strategic objectives describe the principal aims that the organisation aspires to achieve in all activities.

In 2015-16, these objectives were revisited and refined by the Trust Board, partially in response to organisational and environmental changes, but also to align them to the Care Quality Commission's five quality domains. The objectives are now:

- to achieve the best possible outcomes for our service users through high quality care;
- to understand the needs and views of service users, carers and families so that their opinions inform every aspect of our work;
- to actively engage in partnerships with other health and social care providers in order to deliver seamless services;
- to value colleagues, and support them to develop the skills, confidence and ambition to deliver our vision;
- to manage public resources wisely to ensure local services remain sustainable and accessible.

The risks to the Trust delivering against these strategic objectives are detailed in table 12 below: however, in summary, the three most significant strategic risks as identified by Board members are:

- inability of the Trust to recruit and retain staff with the right skills, which may have detrimental impact upon the quality of provided care;
- insufficient organisational preparedness and systemwide resilience in order to effectively manage winter pressures;
- inability to gain a "Good" or "Outstanding" rating following a CQC Chief Inspector of Hospital's assessment.

It is also noted that all strategic risks are routinely presented at the Trust Board, where Board members have opportunity to review and agree whether the noted mitigating actions are deemed sufficiently comprehensive as to reduce risk to achievement of the Trust's strategic objectives.

1.4 million
contacts with service users
were recorded by the Trust in 2015-16

service users surveyed
in 2015-16 said that they were likely or extremely likely to recommend the Trust to friends and family

38,846
individual people
were seen by an ICT in 2015-16

76.9 years
was the average age
of a person seen by an ICT

2,639
referrals were received
by the rapid response service, an increase of **91%** from 2014-15

referrers (including GPs)
reported that the rapid response service had avoided a hospital admission or attendance.
This was an increase of **15%** from 2014-15

1.1.4 Trust services

To support the people of Gloucestershire, the Trust employs more than 2,700 staff including nursing, medical and dental staff, allied healthcare professionals, as well as support service, administrative and clerical workers.

Services are delivered in a variety of settings including people's own homes, community clinics and community hospitals. The Trust also works alongside GPs and other primary care colleagues, and provides some services in the acute hospitals in Gloucester and Cheltenham, social care settings, as well as in nursing and residential homes.

Integrated Community Teams

The Trust's Integrated Community Teams (ICTs) bring social workers and reablement workers from Gloucestershire County Council together with the Trust's physiotherapists, community nurses and occupational therapists to make single teams.

These ICTs work closely with local GPs and provide care to service users at home or close to home. As such, they help people to be in control of their choices, and to maintain their independence safely and appropriately.

Teams are focused on:

- helping people manage their complex or long-term conditions at home;
- reducing unnecessary hospital admissions;
- providing high levels of support and monitoring during periods of recovery;
- enabling people to receive care at a time to suit them.

The ICTs also provide access to a rapid response service, which operates 24 hours a day, 7 days a week. This service offers assessment in the home for people who require urgent care within an hour, which avoids the need for hospitalisation.

Community hospitals

The Trust manages seven community hospitals across the county, namely:

- Cirencester and Fairford Hospital;
- North Cotswolds Hospital;
- Stroud General Hospital;
- Vale Community Hospital;
- Tewkesbury Community Hospital;
- Dilke Memorial Hospital;
- Lydney and District Hospital.

These community hospitals play a vital role in caring for service users of all ages, and provide high quality care that is centred on the needs of local people, delivered by skilled and dedicated staff.

Each community hospital provides the following services:

- community inpatient rehabilitation and semi-acute care beds;
- outpatient appointments including a varied range of nurse-led and therapy clinics, as well as consultant-led acute care services;
- X-ray facilities;
- Minor Injuries and Illness Units which can save people from unnecessarily attending the Emergency Departments in the Gloucester and Cheltenham acute hospitals, and which can treat a range of less serious conditions and ailments such as sprains, simple fractures that may need x-rays and plastering, wounds that may need stitches, minor burns etc.

A number of the community hospitals also provide access to day surgery / endoscopy services in partnership with other organisations.

71,482
community hospital inpatient bed days
were reported in 2015-16 meaning that 96.8% available beds were occupied every single day

20.9 days
was the average length of stay
for service users in a community hospital
This was an increase of **4 DAYS** from 2014-15 reflecting the increased acuity of inpatients

82 years
was the average age
of someone admitted to a community hospital

73,023
attendances were reported
at the Minor Injuries and Illness Units.
This was an increase of **7%** from 2014-15

with

people treated and discharged in **under 2 hours**

people treated and discharged in **under 4 hours**

10,182
people had
54,990
contacts
with the Trust's specialist nurses in 2015-16: this means that on average, each person had **5.4** contacts each, compared to **3.7** in 2014-15, showing the increased acuity of service users across the county

8,042
contacts
were reported with the heart failure team

8,285
contacts
were reported with the cardiac rehabilitation service

3,915
contacts
contacts were reported with the diabetes team

Adult countywide and specialist services

The Trust's specialist services provide care in community clinics and in people's own homes. They support service users who are living with long-term or complex conditions such as diabetes, enable people to be discharged from hospital with appropriate support, offer rehabilitation services, and provide palliative care to those managing life-limiting conditions. These teams also provide education and hands-on training to care homes.

A summary of the Trust's specialist services is provided below: however, for more comprehensive information, please visit the Trust website at www.glos-care.nhs.uk.

• Specialist Nursing Services

The Trust's specialist nursing teams provide expert care for people needing support with, for example, bone health, heart failure, respiratory conditions, tissue viability needs, Motor Neurone Disease, Parkinson's Disease and homeless healthcare.

• Therapy Services

The Trust's therapists provide physiotherapy, speech and language therapy, podiatry and occupational therapy, as well as MSKCAT (Musculoskeletal Clinical Assessment and Treatment) services which provide an alternative to surgery.

• Independent Living Services

These services help people be cared for in their own homes whilst providing vital links to community-based services such as GPs and hospitals. They offer advice on equipment to promote safety, and reduce risk if mobility is an issue. The team also provides telecare and wheelchair services.

• Sexual Health Services

This team provides free, confidential information to those looking for support and advice relating to sexual health. They can help with any issues regarding contraception and pregnancy, sexually transmitted infections, sexual assault, emergency contraception and routine testing such as chlamydia screening. Teams are also able to offer support and care to those either living with Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) or anyone caring for or supporting someone who is affected.

• Health Improvement Services

The Healthy Lifestyles Team provides countywide advice and treatment to help people stop smoking. In addition, the team offers targeted interventions to support individuals and groups to adopt healthy lifestyles.

• Community Dental Services

The Trust's dental service provides dentistry on referral for people with significant special needs including complex medical conditions, specific learning needs, and physical or mental health impairments. The service also provides urgent appointments for people who do not have a regular dentist, or who experience an out-of-hours dental emergency. Additionally, the Trust operates a standard NHS dental practice in Springbank, Cheltenham.

18,660
individual service users
were seen by the podiatry service

10,429
individual service users
were seen by the dental service

30,563
contacts
were reported with the sexual health service

11,170
chlamydia screens
were delivered to 15-24 year olds either through core services or via partner organisations including GPs and pharmacies

9,350
children and young people were seen
by the Trust's specialist therapy services

5,502
two year checks
were conducted by the Trust's Health Visitors

3,044
girls aged 12-13
received their first HPV immunisations during the 2015-16 academic year

6,583
reception school year children

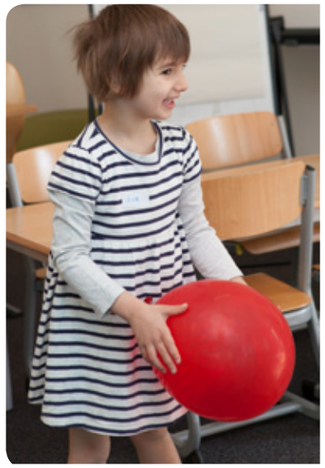
6,014
year 6 school year children

had their height and weight measured in the 2015-16 school year as part of the National Childhood Measurement Programme

Children and young people's services

The Trust also offers a range of services tailored to the needs of children and young people, and provides a coordinated approach to children's health. Teams include:

- health visitors who help families with children aged 0-5 years, to lead as healthy a life as possible, both physically and emotionally;
- children's physiotherapy, occupational therapy and speech and language therapy, which provide specialist assessment, advice and treatment planned around the individual needs of the child and their family;
- children's community nurses and children's complex care team who care for children with specific medical issues, including life-limiting conditions;
- school nurses who work with children and young people aged 5-19 years in the community, whether they attend school or not. These nurses play a vital role in children's development, carrying out immunisation and screening programmes, and acting as a point of contact for managing medical conditions such as allergies and anaphylaxis, asthma and epilepsy.



These clinical and care services are supported by a range of corporate functions such as human resources, finance, information and performance, IT, governance, estates, hotel services and risk management. Additionally, the service user experience team provides a key point of contact for service users, their families and carers.

1.1.5 Performance summary

- In 2015-16, the Trust's performance against both national and local indicators was as shown in table 2 below.

TABLE 2
TRUST PERFORMANCE AGAINST NATIONAL AND LOCAL INDICATORS 2015-16

	Number				Percentage		
	Red	Amber	Green	Total	Red	Amber	Green
National	3	2	24	29	10.3%	6.9%	82.8%
Local	10	5	19	34	29.4%	14.7%	55.9%

- In 2015-16, the Trust's performance against its own Quality Strategy measures was as shown in table 3 below.

TABLE 3
TRUST PERFORMANCE AGAINST QUALITY STRATEGY MEASURES 2015-16

Strategic objective	Quality metrics	Target*	2015-16 performance
To achieve the best possible outcomes for our service users through high quality care	Percentage of harm-free care in community hospitals and Integrated Community Teams	95%	**95.3%**
	Number of new harms to service users	Less than 267	**154**
	Reduction in incidents that result in severe harm to service users	Less than 12	**8**
	Not exceeding the agreed threshold of Clostridium difficile infections	Less than 18	**9**
	Achievement of agreed staffing levels in community hospitals	80-120%	**101.3%**
	Number of Never Events *(please refer to page 61 below)*	0	**1**

*All targets are the minimum required, unless stated otherwise

Strategic objective	Quality metrics	Target	2015-16 performance
To understand the needs and views of service users, carers and families so that their opinions inform every aspect of our work	Percentage of service users who would recommend the Trust as a place of care	90%	**95.2%**
	Number of service users who feel involved in their care and treatment	95%	**95.0%**
	Number of service users who feel treated with dignity and respect	98%	**98.3%**
	Response rates of service users completing the Friends and Family Test	4.6%	**5.4%**
	Number of public focus / discussion groups per quarter	8	**23**
To actively engage in partnerships with other health and social care providers in order to deliver seamless services	Percentage of CQUIN (Commissioning for Quality and Innovation) milestones achieved against agreed plan	100%	**96%**
	Percentage of QIPP (Quality, Innovation, Productivity and Prevention) milestones achieved against agreed plan	100%	**81.6%**
	Number of referrals accepted by the Rapid Response service	3,120	**2,642**
	Number of avoided admissions as a result of Rapid Response intervention	80%	**97.0%**
	Number of service users discharged by the Integrated Discharge Team from the acute Trust Emergency Department	280 per month	**114 average per month**
	Number of service users discharged by the Integrated Discharge Team from the acute Trust ACU (same day)	56 per month	**34 average per month**

Strategic objective	Quality metrics	Target	2015-16 performance
To value colleagues, and support them to develop the skills, confidence and ambition to deliver our vision	Percentage of staff who would recommend the Trust as a place to work	60%	**47%**
	Percentage of annual staff appraisals	95%	**77.3%**
	Completion of all mandatory training	100%	**81.1%**
To manage public resources wisely to ensure local services remain sustainable and accessible	Achievement of agreed Cost Improvement Programme (CIP) financial targets against plan	£3,150,000	**£3,324,000**
	Achievement of agreed CQUIN financial targets against plan	100%	**91.7%**
	Achievement of agreed QIPP financial targets against plan	100%	**96.2%**
	Financial sustainability risk rating	3	**3**

- In 2015-16, the Trust maintained a clear focus upon its corporate social responsibilities (CSR), which were delivered through an annual CSR action plan. This included contribution to environmental sustainability, by for example, reducing water usage, energy consumption and waste to landfill: this was exemplified by the Trust's 31% recycling rate and an overall estimated reduction in carbon emissions of 10% for 2015-16 (based on a 2007-08 baseline).

  The Trust also continued to be an active supporter of the NHS Forest, and sought to further reduce unnecessary travel by increasing the use of Webex technology to enable meetings to be held remotely via laptops and PCs, and encouraging mobile working to prevent community-based staff needing to return to office to access electronic records.

  Over the last year, the Trust also increased the number of volunteers by over 15% from 327 in 2014-15 to 379 in 2015-16.

1.2 Performance analysis

1.2.1 Operational performance against national indicators

Throughout 2015-16, the Trust continued to deliver a high quality of care, as demonstrated by its performance against national indicators as shown in table 4 below (NB explanation of instances where performance did not meet targets / thresholds is provided on page 23 below).

Trust performance is predominantly assessed by the analysis and interpretation of data held within the organisation's SystmOne electronic clinical information system (NB this differs for sexual health, dental, wheelchair and reablement services which use alternative and more service-specific electronic systems).

Performance scorecards highlighting targets and achievements by service are produced by the Performance and Information Team by the fifth working day of each month: these are then cascaded to service leads and operational managers for validation. Subsequently, updated performance scorecards are produced by the tenth working day. Board and Board subcommittee reports utilise this approved scorecard data so that only accurate, complete and verified information is available for scrutiny by members.

It is also noted that in 2015-16, the Trust began the development of a Business Intelligence Reporting Tool (BIRT) which aims to significantly increase the timeliness and availability of key data. The benefits and uptake of this tool will be reported in the 2016-17 Annual Report and Accounts.

TABLE 4
NATIONAL INDICATORS 2015-16

	National Indicator	Target / Threshold*	2015-16
Caring			
Mixed sex accommodation			
1	Number of non-exempt instances whereby a service user was not able to sleep in a same-sex ward or bay	0	**0**
Safe			
Infection control			
2	Number of cases of post 48 hour Clostridium difficile infection within community hospitals	Less than 18	**9**
3	Number of cases of MRSA bacteraemias infection	0	**0**
Venous thromboembolism (VTE)			
4	Percentage of relevant inpatients who were risk assessed for VTE	95%	**87.8%**
Safety Thermometer			
5	Percentage of service users reported via the Safety Thermometer census as receiving harm-free care	95%	**95.3%**
Minor Injuries and Illness Units (MIiU)			
6	Percentage of service users who were seen, treated and discharged within 4 hours by an MIiU	95%	**99.8%**
7	Number of service users who waited on a trolley in an MIiU for more than 12 hours	0	**0**
8	Average length of time spent by a service user in an MIiU from arrival to departure	Less than 4 hours	**2 hours 20 minutes**
9	Average time before the initial assessment for those service users arriving at an MIiU by ambulance	Less than 15 minutes	**Average 17 minutes**
10	Number of service users for whom the handover from an ambulance to an MIiU was longer than 15 minutes and who waited more than 30 minutes	0	**0**
11	Number of service users for whom the handover from an ambulance to an MIiU was longer than 15 minutes and who waited more than 60 minutes	0	**0**
12	Average time to treatment in an MIiU	Less than 60 minutes	**Average 21 minutes**
13	Percentage of service users who re-attended an MIiU within 7 days of discharge where the second visit was unplanned and for the same minor injury / illness as the original visit	Less than 5%	**4.4%**
14	Percentage of people who left an MIiU without being seen	Less than 5%	**0.7%**

*All targets / thresholds are the minimum required, unless stated otherwise

National Indicator		Target / Threshold	2015-16
Responsive			
HPV immunisations			
15	Percentage of 12-13 year old girls who were given the Human Papillomavirus (HPV) immunisation - first immunisation	75%	**88.7%**
16	Percentage of 12-13 year old girls who were given the Human Papillomavirus (HPV) immunisation - second immunisation	75%	**85.3%**
Childhood Measurement Programme			
17	Percentage of children in reception school year whose height and weight were recorded	95%	**99.6%**
18	Percentage of children in school year 6 whose height and weight were recorded	95%	**99.7%**
Newborn hearing screening			
19	Percentage of newborn children whose hearing was checked	95%	**100%**
20	Percentage of well newborn children whose hearing was checked within their first 5 weeks of life	95%	**99.4%**
Newborn bloodspot screening			
21	Percentage of newborn children whose blood was screened for rare but serious disease and whose details were recorded within the first 17 days of life	95%	**90.9%**
22	Percentage of newborn children who moved to the country from overseas whose blood was screened for rare but serious disease within the first 21 days of life	95%	**90.9%**
Quality			
23	Percentage of service users who waited less than 6 weeks from referral for a diagnostic test provided by the Trust	99%	**97.5%**
24	Number of urgent operations that were cancelled twice	0	**0**
25	Number of service users who had their operation cancelled for non-clinical reasons and who were not offered another binding date within 28 days	0	**0**
26	Percentage of records from Minor Injuries and Illness Units that had a valid NHS number recorded for the service user	95%	**98.4%**
27	Percentage of records from inpatient units that had a valid NHS number recorded for the service user	99%	**100%**
28	Percentage of records from outpatients that had a valid NHS number recorded for the service user	99%	**99.8%**
29	Percentage of social care data sets held by the Trust for which valid NHS numbers were recorded	80%	**83.7%**

For those service delivery areas where performance did not meet or exceed agreed targets / thresholds, explanation is given as below.

- **VTE risk assessments**
  (ref: indicator 4 in table 4 above)

  Upon admission to a community hospital, staff are required to completed an assessment in order to identify each new inpatient's risk of VTE i.e. a formation of blood clots in the vein which can result in deep vein thrombosis (DVT) or a pulmonary embolism. At present, the VTE risk assessment is recorded on the inpatient's drug chart and thereafter, confirmation should also be reported on the Trust's SystmOne electronic clinical information system. However, as SystmOne is relatively new to colleagues within community hospitals, having only been introduced to wards in 2015-16, there remains some unfamiliarity with due processes, including those relating to the reporting of VTE assessments. So whilst clinical audit and other on-going reviews have validated that inpatients are indeed being properly assessed for VTE, this activity is not being routinely verified on SystmOne, meaning that the Trust's reported performance is negatively affected.

  To ensure that this matter is addressed, additional support and training is being given to community hospital staff to remind them of the importance of accurate and complete information reporting on SystmOne.

- **Wait times for assessment in MIiUs for people arriving by ambulance**
  (ref: indicator 9 in table 4 above)

  In 2015-16, the Care Quality Commission advised that it was not deemed safe for a healthcare assistant to undertake an initial triage of people presenting at the Trust's Minor Injuries and Illness Units, ahead of their assessment by more qualified staff. Although the Trust responded to this recommendation with immediate effect, there has been a corresponding, albeit only slight, impact upon waiting times, as there has been insufficient capacity within the registered nursing workforce to manage all presentations within the required timescale. However, the Trust has now developed a revised staffing structure within the MIiUs, and is in discussions with the Gloucestershire Clinical Commissioning Group about the core operational model so as to ensure additional staffing cover and resilience.

- **Newborn bloodspot screening**
  (re: indicators 21 and 22 in table 4 above)

  In respect of newborn bloodspot screening, it is noted that the Trust manages the end of this process only. Thus, test samples are collected by colleagues employed by other Trusts which are then submitted for analysis, before the results are loaded onto the Child Health Information System (CHIS) by the Trust. In 2015-16, 22 sets of results were not uploaded within the first 17 days of the child's life. 15 of these cases were due to the need for repeat screening as insufficient samples had initially been taken by colleagues employed by other Trusts: in response, the Trust has been assured that additional training is being provided to all responsible clinicians, and that staff competencies will be reviewed. The remaining 7 cases were due to a combination of factors including delays over bank holiday periods. These delays have all been investigated, and remedial actions instigated.

  In respect of newborn children who had moved from overseas, the reported under-performance is not reflective of activity, and the Trust has therefore sought to understand why the CHIS was not always updated accordingly - thus, analysis of manual records shows that the true performance was 96.7%. The one baby for whom the screening was not completed in time, was impacted due to the parents wishing to validate what tests had been completed in India prior to potential duplication locally.

- **Waits for referral for diagnostic test**
  (ref: indicator 23 in table 4 above)

  In 2015-16, 16 service users had to wait more than 6 weeks for an echocardiogram i.e. an assessment for breathless service users who have a history suggestive of heart failure. This was caused by unplanned staff absence. As a result, the Trust took part in a pilot project to offer service users an enzyme to measure myocardial stretch, and reduce need for an echocardiogram by approximately 33%. In 2016-17, the Trust will be rolling out this project countywide. Simultaneously across this service and all other small services offered by the Trust, work is on-going to identify a suitable bank of locums so as to ensure suitable resilience.

1.2.2 Operational performance against local indicators

Throughout 2015-16, the Trust also monitored itself against a set of indicators established by local commissioners, namely the Gloucestershire Clinical Commissioning Group. Performance against these indicators is shown in table 5 below (NB explanation of instances where performance did not meet targets / thresholds is provided on pages 27-29 below).

TABLE 5
LOCAL INDICATORS 2015-16

	Local Indicator	Target / Threshold*	2015-16
Responsive			
Adult community and therapy services - referral to treatment times			
1	Percentage of service users seen and treated by the adult speech and language therapy service within 8 weeks of referral	95%	**95.1%**
2	Percentage of service users seen and treated by the adult podiatry service within 8 weeks of referral	95%	**98.3%**
3	Percentage of service users seen and treated by the adult occupational therapy services within 8 weeks of referral	95%	**87.0%**
4	Percentage of service users seen and treated by the adult physiotherapy service within 8 weeks of referral	95%	**92.9%**
5	Percentage of service users seen and treated by the adult occasional wheelchairs service within 8 weeks of referral	95%	**100%**
6	Percentage of service users seen and treated by the Parkinson's nursing service within 8 weeks of referral	95%	**100%**
7	Percentage of service users seen and treated by the adult diabetic nursing service within 8 weeks of referral	95%	**97.9%**
8	Percentage of service users seen and treated by the bone health service within 8 weeks of referral	95%	**99.8%**
9	Percentage of service users seen and treated by the adult musculoskeletal service within 8 weeks of referral	95%	**94.1%**
Unscheduled care			
10	Number of interventions by the Integrated Discharge Team which prevented an admission to a local acute hospital	3,660	**2,083**
11	Number of interventions by the Integrated Discharge Team which prevented an admission to Gloucester Royal Hospital	1,830	**1,004**
12	Number of interventions by the Integrated Discharge Team which prevented an admission to Cheltenham General Hospital	1,830	**1,079**
13	Number of referrals to the Rapid Response Service	3,120	**2,639**
Stop Smoking service			
14	Number of smokers who successfully quit, aided by third party providers for whom the Trust provides support	1,399	**926**
15	Number of smokers who successfully quit, supported directly by the Trust's Stop Smoking Service	933	**934**
Musculoskeletal Clinical Assessment and Treatment Service			
16	Percentage of service users seen and then referred onto secondary care	Less than 30%	**11.2%**
17	Percentage of service users who were referred onto secondary care within 2 days of the decision to refer	100%	**100%**
18	Percentage of urgent service users being referred and seen within 2 weeks of referral	95%	**97.1%**
Single Point of Clinical Access			
19	Percentage of abandoned calls	Less than 5%	**7.2%**
20	Percentage of calls resolved with an agreed onwards plan within 20 minutes	95%	**93.2%**

*All targets / thresholds are the minimum required, unless stated otherwise

	Local Indicator	Target / Threshold*	2015-16
Community hospitals			
21	Percentage occupancy of inpatient beds	90%	**96.6%**
22	Average number of patients per month delayed for onwards transfer to another care setting (including home)	10	**3**
23	Average number of discharges per day (weekends)	10	**4.4**
24	Average number of discharges per day (weekdays)	20	**11.3**
25	Percentage of new service users assessed by the Early Supported Discharge team within 2 days of notification	95%	**96.7%**
26	Percentage of service users discharged within 6 weeks	95%	**98.6%**
Sexual health services			
27	Number of young adults (15-24 year olds) who had a positive screening for chlamydia	1,169	**1,100**
28	Percentage of service users seen and treated by the contraception service within 8 weeks of referral	95%	**99.8%**
29	Percentage of service users seen and treated by the HIV service within 8 weeks of referral	95%	**97.7%**
30	Percentage of service users seen and treated by the psychosexual service within 8 weeks of referral	95%	**99.2%**
31	Percentage of terminations carried out within 9 weeks and 6 days of gestation	80%	**80.4%**
Children and young people's services			
32	Percentage of service users seen and treated by the children's speech and language therapy service within 8 weeks of referral	95%	**93.6%**
33	Percentage of service users seen and treated by the children's physiotherapy service within 8 weeks of referral	95%	**99.3%**
34	Percentage of service users seen and treated by the children's occupational therapy service within 8 weeks of referral	95%	**98.9%**

For those service delivery areas where performance did not meet or exceed agreed targets / thresholds, explanation is given as below.

- **Eight week wait for adult occupational therapy services *(ref: indicator 3 in table 5 above)***

  In 2015-16, the Trust experienced on-going difficulties in recruiting occupational therapists which did lead to increased waiting lists, and which potentially resulted in target breaches. However, at time of writing, the service is still undertaking an extensive data cleansing exercise, as there is evidence that a number of the reported breaches are attributable to inaccurate data entry, rather than under-performance.

  Whilst recruitment is an continual process - and one which is prioritised by the Trust at this time of national workforce shortages - the exact measures to mitigate against this breach re-occurring cannot be decided or articulated until the extent of the problem is known.

- **Eight week wait for adult physiotherapy services *(ref: indicator 4 in table 5 above)***

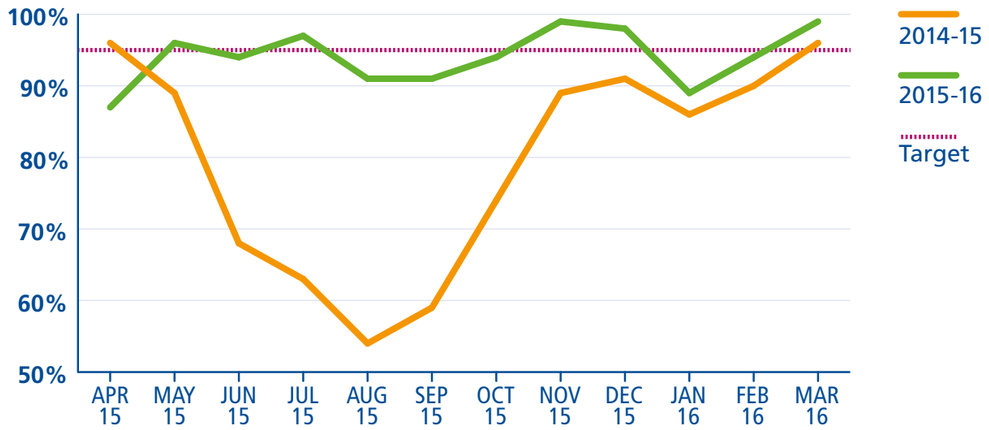
  As with occupational therapists above, waiting times to access adult physiotherapy services in 2015-16 were impacted by the national shortage of physiotherapists, with insufficient numbers of qualified staff progressing through graduate and post-graduate routes to support the growing demand across the system. To counter this, the Trust continues to strive to be recognised as a highly attractive employer, which values its staff and invests in them via on-going professional support and development.

  A secondary rationale for the extended waiting times is Patient Choice or Consultant Protocol, whereby service users may actively choose to defer their initial appointment, thereby creating delay for subsequent physiotherapy interventions which cannot commence before the appropriate juncture in post-operative rehabilitation.

- **Eight week wait for adult musculoskeletal services *(ref: indicator 9 in table 5 above)***

  Although wait times to access adult musculoskeletal services did not fully meet target in 2015-16, it is noted that performance was significantly improved since 2014-15 as noted in chart 3 below:

CHART 3
PERFORMANCE AGAINST THE 8 WEEK WAIT TARGET FOR ADULT MUSCULOSKELETAL SERVICES



Under-performance is attributed to increased demand across the county. However, as the service has now successfully recruited 7.76 whole-time equivalent (wte) Extended Scope Practitioners, compared to 4.5 wte in 2014-15, it is anticipated that targets will be met in 2016-17.

- **Integrated Discharge Team interventions** ***(ref: indicators 10, 11 and 12 in table 5 above)***

The Trust acknowledges that whilst the achievement of 10 hospital admission preventions or same-day discharges from the local acute hospitals to the community is an ambitious target, this is a challenge which will benefit both service users and other colleagues in the local health and social care system. However, vacancies within the Integrated Discharge Team in 2015-16 created a direct impact upon the Trust's ability to deliver all diversions. Substantial effort were therefore made to drive recruitment, and also to second colleagues from other areas of the Trust: this resulted in 6.8 whole-time equivalent (wte) vacancies being reduced to 2.2 wte.

Other issues which affected performance included the non-availability of community hospital inpatient beds later in the day into which to divert service users, and the lack of capacity in community-based services such as reablement and urgent temporary packages of care.

Despite these constraints, the number of admission preventions and same-day discharges has increased since 2014-15, and there is confidence that once the newly recruited staff have completed induction, performance will incrementally improve.

- **Referrals to rapid response** ***(ref: indicator 13 in table 5 above)***

In 2015-16, the number of referrals to the rapid response service achieved approximately 85% target, which represents a significant improvement from the 43% reported in 2014-15 (the service's first year of operation), and reflects the considerable work that was undertaken in order to design, develop and operationalise this relatively new service.

It is noted however, that achievement of the target is reliant upon referrals from a variety of sources, many of whom are external to the Trust and therefore not as familiar with the service's scope. Thus, service users who would normally have been admitted to an acute hospital, can now be managed safely at home, but this requires the GP and other medical and paramedic staff to appreciate the clinical capabilities of the team and be assured that the service user is safe. The Trust therefore continues to build the confidence and knowledge of its partner organisations.

- **Stop Smoking Service** ***(ref: indicator 14 in table 5 above)***

Although the data in table 5 above would suggest that the Trust has breached its target to support third party providers in assisting people to quit smoking, the reporting period for this indicator is not the same as the financial year, and therefore the service has a further three months to achieve the requisite number of quitters.

- **Single Point of Clinical Access** ***(ref: indicators 19 and 20 in table 5 above)***

This telephone-based facility supports healthcare professionals across Gloucestershire to ensure that service users are referred to the right place at the right time. Call numbers to the facility have significantly increased in 2015-16, with 31.2% uplift in activity compared to 2014-15: this equates to an additional 220-300 calls per week.

Whilst there was an above-target number of abandoned calls in 2015-16, in the final quarter of the year, the Trust upgraded its telephony platform to create a tiered system so that call handling can be better managed, and fewer priority calls missed in future.

In terms of resolving calls within the allocated 20 minutes, this is often not possible due to the acuity and complexity of service users' conditions, which therefore requires further time to negotiate and confirm. Nevertheless, the team continues to explore new ways to improve its service.

- **Occupancy of inpatient beds** ***(ref: indicator 21 in table 5 above)***

The high percentage of bed occupancy in the Trust's seven community hospitals is symptomatic of the demand and pressure across the whole of the local health and social care system. So whilst the Trust is looking to actively reduce length of stay wherever possible, this may not directly impact on bed occupancy rates as demand continues to outstrip availability. Countywide working towards development and implementation of the Sustainability and Transformation Plan in 2016-17 will seek to address this concern.

- **Average numbers of discharges from community hospitals, weekdays and weekends** ***(ref: indicators 23 and 24 in table 5 above)***

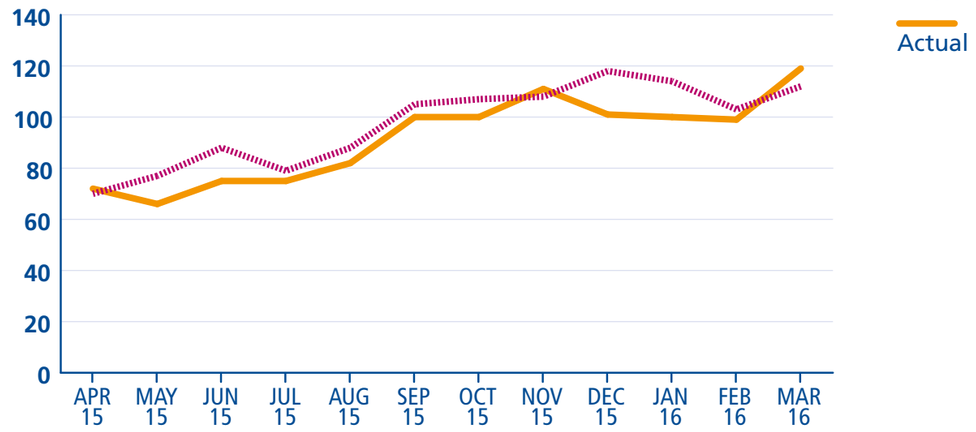
The Trust is currently discussing the viability of these targets with the Gloucestershire Clinical Commissioning Group, as in order to achieve them, an average length of stay of approximately 9 days would be required (currently around 21 days) - this seems unrealistic both in terms of local performance and national benchmarking. Additionally, the ability to safely discharge inpatients is constrained by the availability of other community-based services such as reablement, independent domiciliary care and/or nursing and residential care homes.

- **Number of positive chlamydia screens** ***(ref: indicator 27 in table 5 above)***

Although the target was missed in 2015-16, the sexual health service did achieve the highest number of positive screens for chlamydia since the screening programme first began, and demonstrated consistent improvement across the year as shown in chart 4 below. It is also noted that the service consistently achieved all other national and local targets, and received praise both from commissioners and in local Ofsted reports.

To ensure further improvement in 2016-17, the service has been working with the University of Gloucester on an age-relevant awareness communications campaign, which will be supported by increased social media activity. Marketing will also target audiences who traditionally do not engage with chlamydia testing including young men and certain ethnic populations.

CHART 4
POSITIVE CHLAMYDIA SCREENS AGAINST TARGET 2015-16



- **Eight week wait for children's speech and language therapy** ***(ref: indicator 32 in table 5 above)***

In 2015-16, the Trust incorrectly measured waiting times for children's speech and language therapy i.e. the Trust used the start time as being the date upon which the invitation letter was despatched, whereas it should have used the date upon which the parent booked their appointment with the service. This process has been revised for 2016-17, and as a result, it is expected that the target will be met.

1.2.3 Financial performance

Full details of the Trust's financial performance are provided in section three of this Annual Report and Accounts. However, a summary is provided below:

- the Trust exited 2015-16 with a £1.0million NHS-adjusted operational surplus as forecast. This was enhanced by an additional £1.5million from the Department of Health in respect of a capital-to-revenue transfer scheme, resulting in a total surplus of £2.5million;
- income at £114.9million was £8million higher than plan, and represented a £0.8million increase on 2015-16. In addition to the income for the capital-to-revenue scheme as noted above, this was as a result of new non-contracted activity, funding for the Trust's management of additional escalation inpatient beds to alleviate systemwide winter pressures, higher levels of MSKCAT activity, and a number of other smaller services which were requested and funded in-year by the Gloucestershire Clinical Commissioning Group;
- the Trust reported success in its Cost Improvement Programme (CIP) in 2015-16 which sought to identify and realise efficiencies within operational and support services. So within the year, the Trust achieved a total CIP of £3.3million which was £0.2 million higher than plan: this was achieved by a reduction of £1.6million in pay related costs and £1.7million in non-pay costs;
- at the end of the financial year, the Trust's cash balance was on plan at £6.1million;

- in 2015-16, the Trust's capital spend was fully in line with its initial plan at £4.4million: this included £0.8million to complete building projects such as the refurbishment of the Stratton Ward in Cirencester Hospital, and the development of the Trust's new premises in Milsom Street, Cheltenham;
- the impact of property revaluation in-year resulted in an impairment (below the line) of £7.4million, a reduction in annual depreciation charge of £1.6million and annual reduction of public dividend capital charge of £0.3million;
- between April and December 2015, the Trust identified approximately £0.5million reduction in agency costs, due to an increased focus upon workforce spend and the implementation of e-rostering across the Trust which has allowed for improved planning of staff rotas.

1.2.4 Performance against CQC recommendations

As already noted in this Annual Report and Accounts, the Care Quality Commission (CQC) undertook a Chief Inspector of Hospital's assessment of the Trust between June and August 2015, culminating in a Quality Summit held on 21 September.

As a result of the recommendations in the CQC report, the Trust produced a detailed Quality Improvement Plan (QIP): this captured the 101 actions necessary to address the "Must Do's" as well as the "Should Do's".

As at the end of March 2016, progress against the actions in the QIP was as follows:

TABLE 6
PROGRESS AGAINST THE CQC RECOMMENDATIONS

		Complete		Incomplete	
Action Type	**Total No.**	**Actions complete and validated**	**Actions completed but not validated**	**More work required**	**Not delivered**
'Must Do's'	19	5	6	8	0
'Should Do's'	82	9	31	39	3
Total	**101**	**14**	**37**	**47**	**3**

It is further noted that:

- the Trust anticipates all actions to be completed by June 2016, except for those that are dependent upon the introduction of new IT systems i.e. a new electronic clinical information system in sexual health services, and an electronic tracking system in estates to regulate compliance;
- in order to ensure more robust validation that actions which are thought to be completed by the Board, are equally recognised and known at all levels of the organisation, the Trust is adopting a Peer Review process led by the Heads of Service: thus, these supportive and constructive unannounced assessments are intended to encourage improved awareness and promote wider learning.

I hereby confirm that the above Performance Report is a true and accurate representation of the described Trust activities in 2015-16.

Paul Jennings

Paul Jennings, Chief Executive
31 May 2016

PART 2
Accountability Report

2.1 Corporate Governance Report

2.1.1 The Directors' Report

The Trust Board

In 2015-16, seven public Trust Board meetings were convened, attendances at which are detailed in table 7 below. These meetings enabled the Board to fulfil its duties and obligations as prescribed within its Terms of Reference (summarised on page 38 below).

It is noted that at these meetings, Board members confirmed their commitment to abide by the Trust's Code of Conduct, which outlines their personal responsibilities to comply with all relevant best practice applicable to corporate governance in the health sector, including the Department of Health's Board Code of Conduct, the Monitor Code of Governance guidance, and the Nolan principles.

In addition to the Board meetings, there were also seven Board Development sessions held in 2015-16, at which Board members were able to explore, develop, shape and challenge new ideas prior to public scrutiny:

- four of these sessions welcomed internal and external representatives to explore key issues including:
  - Board evaluation and cohesiveness (two sessions led by representatives of Mitchell Damon);
  - the implications of The Care Act 2014 (presentation by DAC Beachcroft);
  - understanding and responsibilities of safeguarding practice (presentation by the Trust's Head of Adult Safeguarding);
  - reflections on the CQC inspection (presentation by the Trust's Head of Planning, Compliance and Partnerships);
- a further two sessions focused upon the Trust's strategic development, and therefore evaluated:
  - the continued application of the Five Year Forward View (NHS England 2014);
  - the Trust's SWOT (Strengths, Weaknesses, Opportunities and Threats) and PESTELI (Political, Environmental, Social, Technological, Economic, Legal and Industrial) analyses;
  - progress against the Quality Governance Assurance Framework;
- a two-day Board Summit held in December 2015 again invited contribution from Mitchell Damon, and confirmed strategic plans for 2016 and beyond.

In 2015-16, there were a number of changes in the Board composition, which are articulated on pages 39-40 below. However, as of 31 March 2016, the Trust Board comprised the Trust Chair (Ingrid Barker) and six voting Non-Executive Directors, representing a variety of professional backgrounds, including clinical, corporate finance, commercial and business management and consultancy. The Trust Board also included the Chief Executive (Paul Jennings), three additional voting Executive Directors, and two non-voting Executive Directors, all of whom bring a wide range of skills and experience in health and social care, business, finance and organisational development.

It is also noted that in 2015-16, the Trust Board served as the Corporate Trustee for the Trust's charitable funds for which a separate Annual Report and Accounts is available.

Directors' interests

The Register of Directors' Interests is available to view on the Trust's public website at http://www.glos-care.nhs.uk/about-us/publications

Statement as to disclosure to auditors

Each of the Trust's Directors has submitted that as far as they are aware, there is no relevant information relating to the Trust's operations or finances of which the organisation's auditors are unaware.

Each of the Trust's Directors has also confirmed that they have taken all necessary actions to make themselves aware of all relevant organisational information, and to establish that the auditors are equally aware of that information.

Audit and Assurance Committee members

It is noted that in 2015-16, the following Directors were members of the Audit and Assurance Committee:

- Richard Cryer, Non-Executive Director (Committee Chair)
- Rob Graves, Non-Executive Director / Trust Vice Chair
- Joanna Scott, Non-Executive Director
- Susan Mead, Non-Executive Director
- Nicola Strother Smith, Non-Executive Director
- Jan Marriott, Non-Executive Director
- Ian Dreelan, Non-Executive Director (designate)

The Trust's Director of Finance and the Trust Chair were not members of the Committee, but together with other relevant members of staff, were invited to attend all or part of any meeting as and when appropriate.

Details of the Committee's responsibilities are given on pages 48 and 49 below.

Confidentiality breaches

There was one breach of confidentiality reported to the Information Commissioner's Office in 2015-16 - details are given on page 75 below.

2.1.2 Statement of Accounting Officer's responsibilities

Under the National Health Service Act 2006, the Department of Health has directed Gloucestershire Care Services NHS Trust to prepare for each financial year, resource accounts detailing the resources acquired, held or disposed of during the year, and the use of resources by the Trust during the year.

The accounts are prepared on an accruals basis, and serve to offer a true and fair view of the state of affairs of the Trust and of its net resource outturn, application of resources, changes in taxpayers' equity and cash flows for the financial year.

The Department of Health has designated me, as Director of Finance, to serve as the Accounting Officer of Gloucestershire Care Services NHS Trust. The responsibilities of an Accounting Officer, including responsibility for the propriety and regularity of the public finances for which I as Accounting Officer am answerable, for keeping proper records and for safeguarding the Trust's assets, are set out in Managing Public Money published by the HM Treasury.

In preparing the accounts, I am also required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- observe the Accounts Direction issued by the Department of Health including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgments and estimates on a reasonable basis;
- ensure that applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and
- prepare the accounts on a "going concern" basis.

I also have explicit personal responsibility for ensuring that the Trust's Annual Report and Accounts as a whole is fair, balanced and understandable, and that the judgments required for determining that it is so, are also fair, balanced and understandable.

In undertaking the above, I can confirm that as far as I am aware, there is no relevant information relating to the organisation's operations or finances of which the Trust's auditors are unaware. Similarly, I can confirm that I have taken all necessary actions to make myself aware of all relevant Trust information, and to establish that the auditors are equally aware of that information.

Glyn Howells

Glyn Howells, Director of Finance and Deputy Chief Executive
31 May 2016

2.2 Annual Governance Statement

2.2.1 Scope of responsibility

As Chief Executive of Gloucestershire Care Services NHS Trust (the Trust), I hereby affirm my belief that this organisation ably demonstrates its absolute commitment to the principles and practices of corporate and clinical governance, and that this commitment is evident both in our outcomes and this Annual Governance Statement. I also assert that this Trust's activities in all aspects of governance are undertaken in accord with our organisational CORE values, namely to be Caring, Open, Responsible and Effective.

Additionally, I recognise that as Accountable Officer, I have ultimate responsibility for ensuring that this Trust maintains a robust system of internal control that facilitates achievement of our organisational vision and strategic objectives. As such, I would note the improvements which we have made in-year in order to further develop our risk management processes: whilst there are still additional opportunities for refinement, I am now confident that the concerns I noted in previous Annual Governance Statements about our risk practices and systems, have now largely been addressed.

I also acknowledge that I have personal responsibility for safeguarding public funds and optimising the use of organisational assets, and as ever, I remain committed to ensuring that this Trust is administered by the most economical and prudent means possible, and that all resources are applied with maximum efficiency. As best example of this practice, I would note that as at the end of the financial year 2015-16, the Trust remains financially sustainable, having returned an NHS-adjusted operational surplus of £2.5million in line with our plan, despite the financial challenges and constraints that are apparent across the national health and social care landscape.

I additionally recognise my personal responsibilities for overseeing the achievement of quality standards across this organisation. To this end, I have welcomed the feedback from the Care Quality Commission following the Chief Inspector of Hospital's assessment in 2015, and continue to monitor our implementation of actions in response to the report's findings.

Finally, I confirm my compliance with all obligations detailed within the Accountable Officer Memorandum, and reflected within the Trust's Standing Orders, Scheme of Reservation, Scheme of Delegation of Powers, and Standing Financial Instructions. These include accountability through the NHS Accounting Officer to Parliament for the stewardship of the Trust's resources. They also require me to ensure that all Trust managers have a clear view of their personal and team objectives, and that they are provided with the required resources to assess their performance against their responsibilities.

In summary therefore, I trust that this Annual Governance Statement shows the continued successes that the Trust has achieved in 2015-16, whilst also recognising the work necessary to deliver future quality improvement.

Paul Jennings

Paul Jennings, Chief Executive
31 May 2016

2.2.2 Board / corporate governance

Responsibilities of the Board

The Terms of Reference for the Trust Board made clear its responsibilities for 2015-16. These responsibilities encompassed:

- governing the organisation effectively, and maintaining public and stakeholder confidence in the Trust's continued quality and sustainability;
- managing, and continuously appraising, the strategic development, integrated governance and on-going financial and operational performance of the Trust in line with all prevailing mandatory and statutory guidelines;
- ensuring the delivery of safe, effective, high quality health and social care services that are wholly responsive and accessible to the public, and that have been shaped both directly and indirectly by service user experience and opinion;
- overseeing investment in appropriate resources that deliver optimum health and social care outcomes, and enable public money to be spent in a way that is both efficient and effective;
- upholding the values of the Trust and the NHS Constitution.

More specifically, the Terms of Reference charged the Trust Board with responsibility for:

- **providing leadership:** in particular, this included responsibility for formulating the overarching direction for the Trust, ratifying all documented strategies, and shaping a positive culture for the Board and Trust as a whole;
- **ensuring quality:** this required the Board to receive the Quality and Performance Report for assurance and/or direction, and validate via approval of the Trust's Quality and Equality Impact Assessments, that no programme of transformational change or other variation to process or activity, would result in negative impact upon the quality of provided care;
- **maintaining control:** this included responsibility for ensuring that financial probity and effective financial controls were in place, and scrutinising the Board Assurance Framework (BAF) to advise upon all strategic and operational risks;
- **introducing innovations:** as such, the Board was responsible for ratifying all business development opportunities recommended by its subcommittees, ensuring that these would minimise financial and clinical risk, and increase service effectiveness and efficiency: the Board was also responsible for approving the Trust's annual capital plan and any schemes in-year which fell outside that plan;
- **promoting integrity:** this required the Board members to set the standard for the Trust, act in accordance with the CORE values of the organisation, and observe the seven Nolan Principles, namely selflessness, integrity, objectivity, accountability, openness, honesty and leadership.

Discharge of statutory responsibilities

Prior to the start of 2015-16, the Trust updated its Standing Orders, Scheme of Reservation, Scheme of Delegation of Powers and Standing Financial Instructions. Together, these documents articulated how the Trust would seek to fulfil and discharge its statutory functions throughout the year, and how these functions would be directed and managed by the Trust Board.

All four documents were formally approved by the Trust's Audit and Assurance Committee, attended by both internal and external audit representatives, thereby ensuring independent scrutiny against any potential irregularities.

Board changes in 2015-16

The Trust experienced a number of significant changes at Board level in 2015-16 as detailed below. All changes were undertaken with the full oversight and support of the NHS Trust Development Authority (TDA) in its role as regulator.

Chief Operating Officer

The post of Chief Operating Officer within the Trust was created in April 2014, initially as an interim arrangement in order to evaluate the need for the role. At that time, Duncan Jordan was seconded from Gloucestershire County Council to fill the post for a twelve month period. However, in March 2015, it was announced that Mr Jordan's secondment was to be extended for a further twelve months until 31 March 2016.

It was subsequently reported in December 2015, that the Board had agreed for the role of Chief Operating Officer to be made substantive, given the critical need for the Trust to continue its absolute focus upon all aspects of operational development, and to maintain its excellent working relationships with all other local professional stakeholder organisations.

Thereafter, in March 2016, following a competitive recruitment process, Candace Plouffe, acting then as the Trust's Director for Service Delivery, was appointed as the organisation's new Chief Operating Officer, to begin work on 1 April 2016. It was also decided at that time, not to re-appoint to the Director for Service Delivery post, but instead, to recruit a Deputy Chief Operating Officer.

Medical Director

In April 2015, Dr Joanna Bayley returned to her post as Medical Director following a ten-month secondment to the NHS Leadership Academy. However, Dr Bayley subsequently made the decision to leave the Trust on 31 May 2015 in order to continue her dual work both as a local GP and also as National Medical Advisor specialising in urgent care for the Care Quality Commission.

Dr Mike Roberts was subsequently announced in May 2015 as the Trust's new Medical Director. Dr Roberts had already been acting as Interim Medical Director during the period of Dr Bayley's secondment, and thus had been a member of the Trust Board since July 2014. Dr Roberts' permanent appointment as Medical Director followed a robust and extensive recruitment exercise.

Director of Nursing

In June 2015, Director of Nursing and Quality, Elizabeth Fenton, left the Trust to join Health Education England as lead advisor on the Shape of Caring review. Initially intended as a secondment, in July 2015, it was announced that Mrs Fenton would not be returning to the Trust.

Following Mrs Fenton's departure, Susan Field, then Director of Service Transformation for the Trust, was requested to act as interim Director of Nursing commencing July 2015. This appointment was subsequently made permanent in September 2015, following a competitive recruitment and selection process which included advertising at national level. It was then also decided, not to re-appoint to the Director of Service Transformation post, but instead, to absorb additional responsibilities into the role of the Chief Operating Officer.

Director of Corporate Governance

In November 2015, Jason Brown, Director of Corporate Governance, chose to leave the Trust in order to pursue career opportunities elsewhere.

Following review of the role, the Trust Board agreed in December 2015, not to replace this Director post, but instead, to recruit to a lower band Trust Secretary, and assign other responsibilities of the previous role to colleagues elsewhere within the Trust.

Director of Human Resources

In March 2016, following an extensive organisational restructure, it was determined that the Director of Human Resources would report directly to the Chief Executive, rather than reporting via the Chief Operating Officer.

Non-Executive Directors

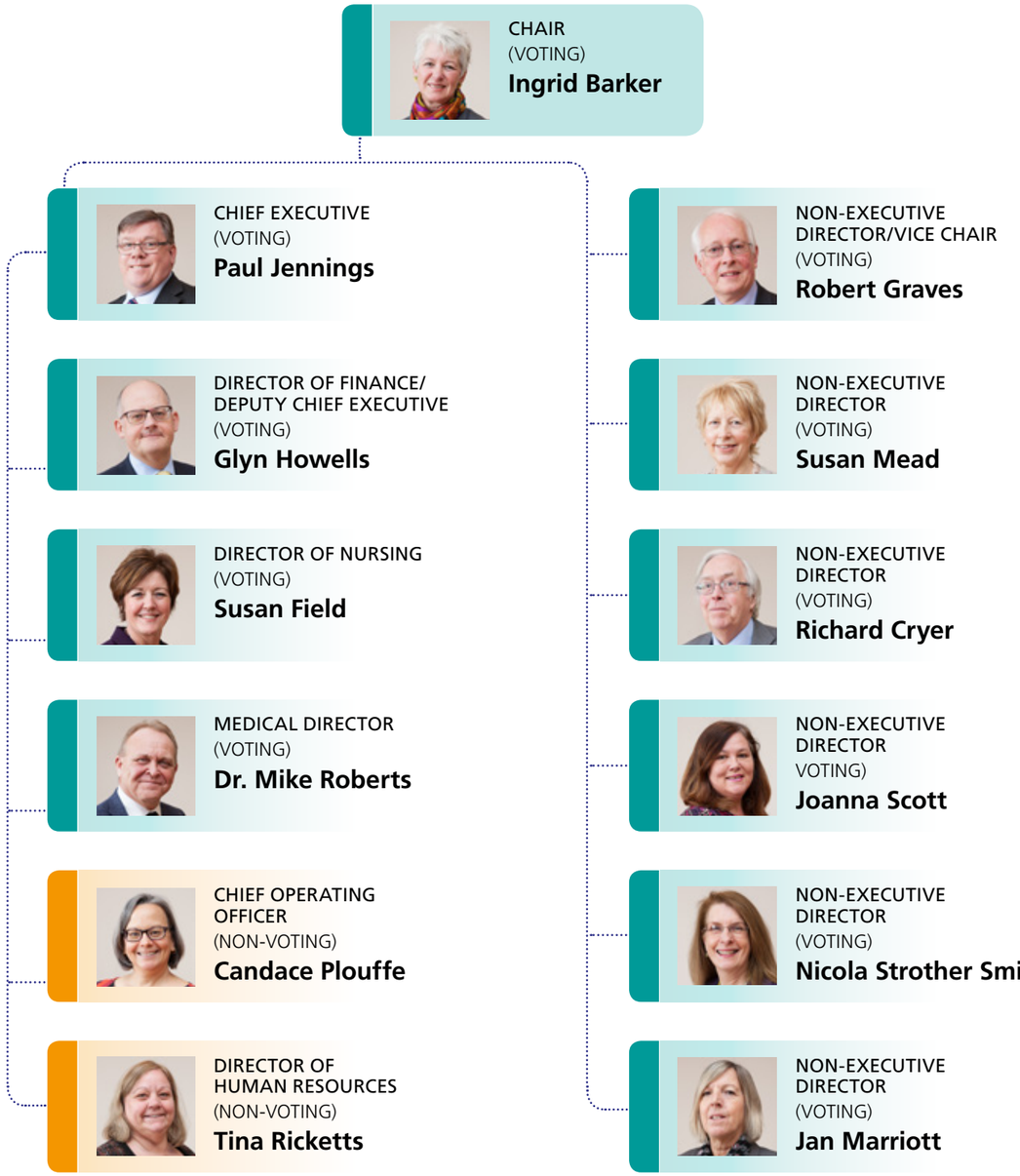
In May 2015, the Trust appointed two new designate Non-Executive Directors, namely:

- **Jan Marriott** who brought significant prior nursing and other senior healthcare experience, and who continued to serve as the Independent Chair of the Gloucestershire Mental Health and Wellbeing Partnership Board, as well as the Independent Co-Chair of Gloucestershire Learning Disability Partnership Board, and Vice Chair of the Community Hospitals Association;
- **Ian Dreelan** who acted as Human Rights Advisor for a global charity, and who was also a member of the Independent Agriculture Appeals Panel and Assistant Coroner for Birmingham and Solihull. Mr Dreelan had previously enjoyed a sixteen year career in the Army, where he attained the rank of Lieutenant Colonel.

Ms Marriott was subsequently made a voting member of the Trust Board in June 2015. Mr Dreelan retained his designate Non-Executive Director status until 22 March 2016, at which time, he tendered his resignation due to other work commitments.

As a result of the changes listed above, the composition of the Trust Board as at 1 April 2016, was as illustrated in chart 5 below:

CHART 5
BOARD COMPOSITION AT 1 APRIL 2016



Board attendance 2015-16

Table 7 below highlights Executive and Non-Executive Directors' attendance at the Trust Board in 2015-16. This shows that the total attendance of available members was 97% across the year, which represents a 3% increase on 2014-15. It is also noted that of the 3% absences, 2% related to the Trust's one designate Non-Executive Director who has since left the Trust due to other work commitments.

TABLE 7
BOARD ATTENDANCES 2015-16

	2015					2016		
	14 Apr	19 May	21 Jul	22 Sep	24 Nov	26 Jan	22 Mar	
Ingrid Barker Chair	✓	✓	✓	✓	✓	✓	✓	100%
Paul Jennings Chief Executive	✓	✓	✓	✓	✓	✓	✓	100%
Glyn Howells Director of Finance and Deputy Chief Executive	✓	✓	✓	✓	✓	✓	✓	100%
Robert Graves Non-Executive Director and Vice Chair	✓	✓	✓	✓	✓	✓	✓	100%
Richard Cryer Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	100%
Joanna Scott Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	100%
Susan Mead Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	100%
Nicola Strother Smith Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	100%
Jan Marriott Non-Executive Director		✓	✓	✓	✓	✓	✓	100%
Ian Dreelan Non-Executive Director (designate)		✓	✓	✓	✗	✗	✗	50%
Elizabeth Fenton Director of Nursing and Quality	✓	✓						100%
Susan Field Director of Service Transformation until July 2015, then Director of Nursing	✓	✓	✓	✓	✓	✓	✓	100%
Dr Joanna Bayley Medical Director	✓	✓						100%
Dr Michael Roberts Interim Medical Director until May 2015, then Medical Director	✓	✓	✓	✓	✓	✓	✓	100%
Duncan Jordan Chief Operating Officer	✓	✓	✓	✓	✓	✓	✓	100%
Tina Ricketts Director of Human Resources	✓	✓	✓	✓	✓	✗	✓	86%
Candace Plouffe Director of Service Delivery	✓	✓	✓	✓	✓	✓	✓	100%
Jason Brown Director of Corporate Governance	✓	✓	✓	✓				100%

Board effectiveness evaluation

At the end of each Trust Board, members discuss opportunities for improvement in future meetings. The Chair considers all comments received, and implements where appropriate. More formally, in March 2016, members confidentially reflected upon Board successes and achievements in 2015-16: the results of this evaluation are given in table 8 below:

TABLE 8
BOARD EFFECTIVENESS EVALUATION

	Strongly agree	Agree	Neither	Disagree	Strongly disagree
Experience					
As a Board member, I feel my skills and experience are well used	**60%**	40%	-	-	-
I feel my voice is heard and valued	40%	**60%**	-	-	-
I find the experience of being a Board member satisfying and rewarding	**50%**	**50%**	-	-	-

Comments

- Good to be part of a Board which is committed to quality care as reality rather than just rhetoric

	Strongly agree	Agree	Neither	Disagree	Strongly disagree
Communication and decision-making					
Board members support and encourage others to participate fully	20%	**80%**	-	-	-
Board members are comfortable raising and addressing issues where differences arise or conflict occurs	20%	**80%**	-	-	-
Board discussion is focused on major issues with fair, open, respectful and thorough deliberation	30%	**70%**	-	-	-
Decision-making processes are transparent	20%	**80%**	-	-	-
Board meetings are conducted efficiently and effectively	20%	**80%**	-	-	-

Comments

- Need to build upon the progress made in 2015-16 Board Development sessions to work more effectively as a united group
- Board papers are improved but further development is needed to ensure focus on issues of greatest significance
- Minutes need to be clearer so as to highlight when decisions have been made
- A summary of all Board decisions should be communicated to staff

	Strongly agree	Agree	Neither	Disagree	Strongly disagree
Board functioning					
Board members share a strong commitment to the Trust	**80%**	20%	-	-	-
Overall, the Board has been successful in accomplishing its goals and achieving results	10%	**90%**	-	-	-
The Board conducts itself in an ethical and professional manner	**70%**	30%	-	-	-
Board members have good working relationships	30%	**70%**	-	-	-
The Board celebrates its accomplishments and successes	10%	**70%**	10%	10%	-

Comments

- The strong values-base of Board members is clear
- Relationships have strengthened following Board Development work in 2015-16
- The Board is well-led with a shared commitment to improvement
- The revised agenda, which now schedules the private session before the public session, has vastly improved the Board functioning

Other Board members' comments

What are the Board's strengths?

- Good mix of skills, knowledge and experience
- Board members have a shared vision
- The Board is values driven, service user focused, self-reflective and willing to improve
- There is openness to consider all options
- The Board's attentions have rightly shifted to ensure greater focus on strategic rather than operational matters
- Members are appropriately focused upon the benefits to local people and communities

Thinking of the Board's accomplishments in 2015-16, what makes you most proud?

- The Board has overseen a financially balanced, well-performing, good quality Trust at time of great pressure nationally
- There is clear emphasis upon safety and quality
- Service user stories at Board have proved vital to remind members of focus
- There have been improved governance arrangements for subcommittees supporting the Board
- The Board has helped steer the whole system towards a more strategic approach to future sustainability

What impacts upon your ability to participate?

- Length of Board agendas
- Papers which do not present information succinctly with the necessary background in order to enable informed decision-making

What should occupy the Board in 2016-17?

- Delivery of the Sustainability and Transformation Plan
- Improvements in staff engagement and making cultural change
- Maintenance of good quality services
- Improving relationships with primary care
- Delivery of Trust strategies

UK Corporate Governance Code

The Trust is not explicitly required to comply with the UK Corporate Governance Code (Financial Reporting Council, September 2012). However, the organisation does regularly self-assess its alignment with the main principles of the Code as a means of internal assurance.

In the Annual Report and Accounts 2014-15, the Trust declared that it would be compliant with all relevant aspects of the Code if it applied, with the exception of some identified concerns regarding the robustness of its risk management processes. However, in the year 2015-16, the Trust has made significant advances in its escalation, understanding, reporting and mitigation of risks. Equally, the Trust has maintained its position against all other criteria enshrined within the Code, and thus would now deem itself fully compliant.

Board subcommittee structure

In 2015-16, the Trust Board's subcommittee structure was as per the schematic in chart 6 below:

CHART 6
BOARD SUBCOMMITTEE STRUCTURE

The main subcommittees, and the primary focus of this Annual Governance Statement, are the six Statutory and Board Committees. To this end, it is noted that their key responsibilities in 2015-16 were as follows:

- the **Audit and Assurance Committee** was responsible for providing an independent and objective review of the Trust's financial systems, financial information, financial governance and compliance in accordance with all relevant laws, guidance and regulations governing the NHS. It was also delegated responsibility for overseeing the Trust's corporate governance functions, and thus assured the effectiveness of the organisation's system of governance, risk management and internal control;
- the **Remuneration and Terms of Service Committee** was responsible for overseeing the appointment, remuneration, allowances and other terms and conditions of office of the Trust's Very Senior Managers (VSMs);
- the **Charitable Funds Committee** was responsible for advising the Trust Board in its capacity as Corporate Trustee on all matters relating to charitable funds, which seek to provide benefit to local service users and Trust colleagues;
- the **Quality and Performance Committee** was responsible for providing clear assurance on all issues pertaining to clinical and professional care, clinical governance systems, clinical risk management, and all prevailing regulatory standards related to quality and safety. The Committee was also responsible for reviewing the Trust's service delivery activities, and agreeing and monitoring action plans where remedial steps were considered necessary to improve performance;
- the **Finance Committee** was responsible for providing detailed scrutiny of the Trust's financial matters, and agreeing and monitoring action plans where remedial steps were deemed necessary to improve financial performance. The Committee was also responsible for making recommendations to the Trust Board in respect of business development opportunities, and for overseeing capital expenditure against the Board-approved capital plan;
- the **Workforce and Organisational Development Committee** was responsible for providing clear assurance in respect of all aspects of workforce strategy, planning and organisational development, in order that the Trust could achieve exemplar clinical and professional outcomes and experiences for local service users and Trust colleagues. The Committee also had particular responsibility for making significant contribution towards the realisation of a supporting and learning organisational culture that promoted the Trust's CORE values of being Caring, Open, Responsible and Effective.

Each of these subcommittees reported directly to the Trust Board, and as such:

- monitored risks relating to their areas of responsibility, thereafter ensuring that the Trust Board had a clear and overarching understanding of such risks;
- provided regular summary reports to Board of the work undertaken by the subcommittee for assurance and performance monitoring purposes.

The other forum that supported the Trust Board in 2015-16 was the **Your Care, Your Opinion** group which provided opportunity for two-way communication with service users and local communities in order to create real public engagement, and enable planned service transformations to be informed by learning from people's experiences of care.

Annual subcommittee statements

As part of their delegated responsibility, Trust subcommittees were required to identify their key achievements in 2015-16, and provide sight of these to the Board. These statements also included a look towards planned actions in 2016-17: however, for the purposes of this Annual Governance Statement, it is deemed appropriate to include the past year's review only, namely:

TABLE 9
ANNUAL SUBCOMMITTEE STATEMENTS

Audit and Assurance Committee	Routinely reviewed financial reports and significant financial judgments including analysis of the service provided by SBS (Shared Business Services), standing orders and waivers, debtors and write-offs, special payments, Better Payment Practice performance and analysis of legal claims
	Reviewed the Trust's estate (both freehold and leasehold) in regard to compliance with building regulations and requirements
	Received reports from the Local Counter Fraud Team and reviewed activity including all cases under investigation: also received updates about incidence of whistleblowing, lessons learned and ensured all related actions were completed
	Approved the internal audit plan, ensuring that this was comprehensive: also, reviewed all issued reports, considered major findings, tracked closures, and requested supplementary work where appropriate
	Reviewed the external audit plan, and was assured that the necessary liaison between the finance team and internal / external audit was appropriate to ensure that statutory obligations were met
	Oversaw the process which led to significant improvements in the Trust's risk management processes and procedures

Quality and Performance Committee	Played a key role in the overseeing the Care Quality Commission inspection of the Trust in June 2015, and subsequently maintained a clear focus upon the remedial Quality Improvement Plan
	Strengthened the levels of challenge and assurance in relation to the delivery of safe care and reduction in harm, with a particular focus on community hospital staffing levels, Safety Thermometer activities, mortality reviews and Trust-wide capacity issues
	Ensured that incidents and complaints were robustly investigated and that learning was shared across the Trust: this included responsibility for setting up the Complaints Oversight Group (COG)
	Maximised opportunities to hear the voice of the service user, their families and carers - this was epitomised by the development of the Understanding You report, which analysed, triangulated and trended key information about service user experience and engagement
	Strengthened and refined reporting arrangements to support and challenge all aspects of care quality at Executive and committee level - this included the set-up of a clinically-led sub-group, namely the Clinical Reference Group, which was responsible in particular, for reviewing all Quality and Equality Impact Assessments
	Improved the breadth and depth of information available by which the committee was able to comprehensively evaluate and assess quality and risk - this included making effective use of the Trust's recently developed Corporate Risk Register

Finance Committee	Reviewed the financial performance of the Trust's services through summary reports, and also scheduled regular budget holder reviews
	Reviewed the performance and financial impacts of the Trust's Cost Improvement Programme (CIP), the Quality, Innovation, Productivity and Prevention (QIPP) programme and the Commissioning for Quality and Innovation (CQUIN) programme
	Reviewed progress against the External Care programme for adult social care managed by the Trust for Gloucestershire County Council, until this programme transferred back to the Council in August 2015
	Reviewed the Trust's financial performance including the capital programme and business development opportunities
	Oversaw the financial impact of the agency reduction work, ensuring compliance with developing agency spend reporting requirements
	Provided detailed scrutiny of the annual planning and budget setting processes for 2016-17
Charitable Funds Committee	Consolidated more than 80 small historic funds into 6 countywide funds and communicated the purpose of these Trust-wide, which successfully inspired and motivated colleagues to request available support
	Supported important work with local homeless communities in order to encourage them to access health and social care services
	Continued the development of plans with Great Western Hospital Charitable Funds to realise the benefits of a joint legacy of land
	Approved grants in order to make a real difference to local service users, carers and colleagues, including support for specialist clinical studies and research
	Continued the work to rebrand the Charitable Funds' identity and to reshape its proposition in association with the Charities Commission

Workforce & Organisational Development Committee	Oversaw continued implementation of the Organisational Development Strategy in order to perpetuate a supportive and learning culture across the Trust: this resulted in: • a measured improvement in staff job satisfaction (scored out of 5 as 3.57 in 2013, 3.64 in 2014 to 3.84 in 2015) • an increase in the number of colleagues recommending the Trust as a place to work or receive treatment (scored out of 5 as 3.61 in 2014 and 3.73 in 2015)
	Oversaw continued implementation of the Workforce Strategy in order to improve key workforce metrics: this resulted in a reduction in staff sickness absence (from an average 4.89% in 2014-15 to 4.71% in 2015-16) and improvements in appraisal and mandatory training compliance
	Requested and received assurance in respect of Year 3 of the *Listening into Action* programme
	Requested and received improved workforce information through updated dashboards and scorecards
	Oversaw the development and launch of the CORE Values behavioural framework which will henceforth be used to embed the values within the Trust's recruitment and appraisal processes
Remuneration and Terms of Office Committee	Agreed the overarching service contracts of the Trust's Very Senior Managers (VSMs) including appointments, salary range, provisions for other benefits, allowances and termination arrangements
	Liaised as appropriate with the NHS Trust Development Authority regarding VSM conditions of office
	Monitored the performance of the Trust's Chief Executive, evaluating his personal successes and outcomes against his objectives for 2015-16, and agreeing new objectives for 2016-17

2.2.3 Quality / clinical governance

Quality Governance Assurance Framework

In December 2014, the Trust Board undertook a rigorous evaluation of its performance against the ten requirements of the Quality Governance Assurance Framework (QGAF), scoring itself 17.5 against a required target of no more than 3.5. The results of this assessment helped focus the Board upon a clear series of remedial actions in 2015-16 including:

- development and implementation of improved risk management processes, thereby enabling risk to become significantly more visible at every level of the organisation;
- improvement in public engagement activity, evident by the formation of a dedicated Community Partnerships Team in February 2015: this team has since been responsible for working directly with all local people and populations to capture their views and opinions, and thereafter ensure that these are reflected in service design and delivery;
- increased encouragement of incident reporting, underpinning a quality-focused approach across the Trust;
- continued improvement in the quality of data reporting, with particular advancement in the Board's Quality and Performance Report which now provides clear qualitative and quantitative information aligned to the Trust's strategic objectives.

As a result of this and other associated actions, the Trust Board agreed in March 2016, that a QGAF score of 6 had been achieved - the Board also agreed further actions to achieve a score of 4 by December 2016.

Quality Account

In June 2015, the Trust published its second Quality Account. This public-facing document reviewed the organisation's successes in meeting its quality priorities for 2014-15, and looked forward to activities in the coming year which would seek to ensure continuous improvement, and achieve quality outcomes for local people.

The five quality priorities which were identified in this Quality Account for 2015-16 were to:

- ensure full understanding and learning from the experiences of service users who fall in the Trust's community hospitals or who acquire a pressure ulcer;
- ensure that service users have appropriate access to the highest quality musculoskeletal care;
- improve the Trust's active two-way engagement with service users, carers and families, as well as with GPs, and ensure that everyone knows how they may provide feedback;
- further develop and enhance the Trust's Integrated Community Teams, with particular emphasis given to supporting people in the community with dementia;
- ensure that the Trust recruits and retains the right staff in the right place at the right time, in order to provide the highest possible quality care across Gloucestershire.

Prior to publication, the Trust's Quality Account was reviewed and evaluated by some of the Trust's key stakeholders, with their feedback being included within the final draft. These stakeholders included the NHS Gloucestershire Clinical Commissioning Group, Healthwatch Gloucestershire, and the Health and Care Overview and Scrutiny Committee (HCOSC).

Thereafter, and as a means of assurance to Board, progress against the agreed quality priorities was continuously monitored throughout 2015-16 via a dedicated dashboard which was regularly presented at the Quality and Performance Committee.

The Trust's third Quality Account will be published in June 2016: this aims to build upon the previous year's document in order to further develop the delivery of safe, effective, caring, responsible and well-led services.

It is also noted that in order to help inform and shape this Quality Account, the Trust ran an engagement session with members of the local public as well as service users, carers and service user representatives, at a meeting of the Your Care, Your Opinion group on 1 March 2016: this session specifically sought to test whether the six quality priorities proposed for 2016-17 resonated with local people, and to gain public insight into areas where quality improvements could be made.

Clinical audit

In 2015-16, the Trust participated in all national audits relevant to the organisation. These were:

- the **National Audit of Intermediate Care**, for which a national benchmarking report was issued at the end of the year, now enabling the Trust to evaluate its own home-based rehabilitation and reablement services against equivalent care provided by other NHS organisations;
- the **National Chronic Obstructive Pulmonary Disease Audit**, whose findings were released late in 2015-16: these results will now be cascaded as appropriate across the Trust for information and learning purposes;
- the **National Parkinson's Audit**, for which the Trust is awaiting the release of the national report from Parkinson's UK;
- the **Sentinel Stroke National Audit Programme (SSNAP)** for which data collection is on-going;
- the **National Diabetes Foot Care Audit** for which data collection is also on-going.

Additionally at the start of 2015-16, a programme of clinical audit across all service areas was agreed by the Trust so as to be able to identify opportunities to increase service quality and effectiveness, reduce risks, and improve the experiences of service users, carers and families. A number of these audits were:

- **Deteriorating service users**

  As part of the 2015-16 Commissioning for Quality and Innovation (CQUIN) programme, the Trust's community hospitals carried out a monthly rolling audit on the use of the Modified Early Warning Score (MEWS), a tool which aids the recognition of, and timely response to, service users whose condition is deteriorating. As such, on one designated day per month, colleagues checked all inpatients in order to ascertain whether a MEWS had been undertaken within 12 hours of their admission. Audits proved that all Trust community hospitals were consistently exceeding the target of 90%, with between 98% and 100% inpatients having a MEWS recorded following their arrival at hospital.

- **Dental services**

  The Trust's dental teams are required to accurately record the type, amount and batch number of any local anaesthetic (LA) used, so that in the event of an adverse incident, the LA can be traced. Audit results showed that for Trust records, 99% recorded the type of LA, 93% recorded the amount of LA, and 94% recorded the LA batch number: this was a significant improvement from the previous audit in 2014. Notwithstanding, an action plan was developed in order to further improve recording, and a re-audit is planned for 2016-17.

• Minor Injuries and Illness Units

Partly in response to the Care Quality Commission Chief Inspector of Hospital's report, the Trust is currently seeking to increase audit activity within the Minor Injuries and Illness Units in order to demonstrate an improvement in compliance against NICE guidance. This will build upon the work already undertaken in 2015-16, which included re-audits of feverish illness in children aged under five, and head injuries response.

• Record-keeping

In 2015-16, all Trust services were required to complete an annual record-keeping audit. Whilst these demonstrated good compliance with requisite standards in some areas including specialist services, as well as children and young people's services, there were some clear concerns noted within the audit of the Integrated Community Teams (ICTs) - these included:

- only 7% ICT records showed that a two-stage mental capacity assessment had been completed where this was required;
- only 22% records identified a service user's next of kin;
- clinical observations by community nurses' were recorded in only 35% records, in addition to which, completion of assessment tools on nutrition and skin assessment scored only 22% and 60% respectively: additionally, there was insufficient recording of service users' current medication, medical history reviews and risk assessments;
- poor evidence of Occupational Performance Issues (OPIs) documentation (23%).

As a result, concerns have been added to the Corporate Risk Register (see page 67 below): moreover, Heads of Service are now working closely with Professional Leads, ensuring cascade of the audit's findings to every clinician, and re-iterating colleagues' personal responsibilities in respect of professional record-keeping practice and compliance.

Clinical governance

During 2015-16, the Trust made further progress in its clinical governance performance. Actions included:

- the clear identification of a number of new management roles to ensure clinical leadership: these included the introduction of a Head of Clinical Governance, the creation of two Clinical Pathways Leads to assume responsibility for end-of-life care and dementia respectively, and the redesign of the Specialist Nurse for Safeguarding post wherein increased focus was given to compliance with the learning disabilities agenda;
- the appointment of a Head of Professional Practice and Education, who reports jointly to the Director of Nursing and the Director of Human Resources, and who in 2015-16, focused upon the necessary update all of the Trust's mandatory and essential-to-role training;
- a renewed focus upon the Trust's response to the "Sign up to Safety" campaign, in order to help create a system devoted to continuous learning and improvement, with the aim of halving the number of avoidable harms;
- review of the Trust's safeguarding training policy, and further development of the Mental Capacity Act and Deprivation of Liberties training and implementation practice;
- preparation for the Joint Area Inspection on Child Sexual Exploitation and Missing Children which will take place within Gloucestershire between March and August 2016 in order to validate local multi-agency arrangements for organisational response to all forms of child abuse, neglect and exploitation;
- achievement of infection control targets with only nine cases of C. difficile recorded in-year against a threshold of 18, and zero incidence of MRSA bacteraemia infection;
- improved performance in harm-free care, measured by the use of the Safety Thermometer which details the incidence of pressure ulcers, falls, urinary tract infections (UTIs) and venous thromboembolism (VTEs): to this end, the Trust reported an average 95.3% harm-free care in 2015-16 against a target of 95% (NB in 2014-15, the Trust's average was 92.6%);
- significant increase in the number of incidents reported across the Trust, resulting in the Trust benchmarking more comparably with other NHS providers nationally;
- further development of the Trust's Incident Governance Policy, Complaints Policy and Duty of Candour Policy.

Serious Incidents / Never Events

In 2015-16, of the 1.4 million contacts that the Trust had with local service users, 22 events were classed as a Serious Incident Requiring Investigation (SIRI). These are as shown in table 10 below, together with details of the learning and actions that followed the Trust's investigations:

TABLE 10
SERIOUS INCIDENTS REQUIRING INVESTIGATION 2015-16

SIRI Type	No.	Learning / Actions
Pressure ulcers/wound management	6	Actions that arose from the investigations included: • encouraging staff to more routinely undertake proactive risk assessments using the SSKIN criteria (namely Surface, Skin inspection, Keep moving, Incontinence and Nutrition); • developing increased expertise in all community hospital wards so as to create a network of localised subject matter champions across the Trust; • enhancing essential-to-role education and learning opportunities; • establishing a dedicated working group to ensure improved learning Trust-wide from pressure ulcers.
Slips, trips and falls	4	Following investigations, the Trust is now seeking to ensure that the initial falls assessment, conducted in respect of all community hospital inpatients at time of their admission, is undertaken consistently and comprehensively across all sites. It has also been proposed that the Trust's post-falls assessment should be improved on the understanding that learning from less serious slips, trips and falls could lead to a reduction in more serious incidents - in particular, these assessments need to adopt a more holistic approach and therefore include, for example, consideration of an inpatient's psychological state as well as their medication regime, in order to fully understand their risk of falling.
Medication errors	2	Both SIRIs were deemed to be a result of human error in unique prevailing circumstances. Nevertheless, there was learning in respect of the need for improved handovers and better continuity of care. These SIRIs also led to a specific workstream undertaken with the Trust's Head of Medicines Management to review prescription charts and encourage improved recording thereon.
Safeguarding of vulnerable adults and children	2	Although the Trust is still awaiting the final reports into both these incidents, learning has already been highlighted which identifies the need for: • improved handovers and better continuity of care; • appropriate challenge to family members so as to gain direct access to a service user, especially when that service user is known to be vulnerable; • better understanding of how and when to escalate concerns through the Trust and other stakeholder organisations; • more robust observance of Trust policies in respect of safeguarding practice.
Delays in treatment	2	Learning from these incidents included the need to ensure that: • the responsible clinician always completes their own assessment documentation; • there are improved and standardised processes for interpreting and validating X-rays within the Minor Injuries and Illness Units.

SIRI Type	No.	Learning / Actions
Choking	1	Learning from this incident highlighted the need for interim bank and agency staff working within the Trust to have robust understanding of emergency procedures, as well as wider organisational policies and practices.
Scalding of a community hospital inpatient	1	Learning from this investigation included the following: • all community hospital inpatients to receive initial and on-going multi-disciplinary assessments regarding their ability to safely eat and drink; • a review of drinking vessels to be undertaken across all sites; • more robust handovers to be implemented; • near misses to be routinely reported; • assessment documentation to be improved
Incorrect management of VAC therapy	1	As a result of this incident, colleagues received further training in use of the VAC therapy equipment - additionally, the local VAC therapy representative provided increased support to colleagues in their care and treatment of complex wounds.
Infection control / potential contamination	1	This incident was attributed to human error. Nevertheless, the team recognised some opportunities for learning and as a result, introduced improved processes for pre-assessment.
Screening	1	In response to this SIRI, colleagues were reminded to be more vigilant in attending and responding to safety notices and alerts, and to improve record-keeping practices.
Incorrect extraction of tooth	1	At time of writing, this incident is still under investigation, but a full and detailed response will be developed.

It is noted that given the nature of the final SIRI listed in table 10 above, involving the incorrect extraction of a child's milk tooth, the Trust agreed to declare this as a Never Event and therefore applied additional scrutiny and rigour. This was the only such incident declared in 2015-16. No Never Events were reported in 2014-15.

It is also noted that in order to improve understanding in respect of all SIRIs, starting March 2016, the Trust Board will be receiving regular presentations about such incidents as part of its Service User Story. Such action not only enables increased discussion and learning opportunities, but it also epitomises the Trust's commitment to honesty and openness as enshrined within the Duty of Candour.

2.2.4 The internal control system

Purpose of the internal control system

The purpose of the Trust's internal control system is to ensure a formal and consistent basis for the identification, evaluation and prioritisation of all risks to the Trust's continued quality, effectiveness and sustainability, in order to gain assurance that these risks are properly controlled, managed and/or mitigated.

It is noted however that this internal control system is designed to manage risks to a reasonable level only: thus, the Trust recognises the impracticality of aiming to completely eliminate all risks to the organisation's capacity and/or capability to fulfil its vision, values and strategic objectives.

In summary, the Trust's internal control system is based on an on-going process that serves to:

- proactively identify all operational risks (both clinical and non-clinical) across the organisation;
- evaluate the likelihood and impact of those risks being realised;
- manage all identified operational risks efficiently, effectively and economically, and within agreed tolerances;
- ensure a measurable reduction in the detrimental impact of risk upon the quality of health and social care services provided across Gloucestershire, thereby improving service user safety and experience;
- enable decisions of the Trust to be taken with full consideration and awareness of the risk environment.

Moreover, the Trust ensures that via its Board Assurance Framework, all significant operational risks are clearly aligned to the Trust's strategic risks. Such an approach ensures both top-down and bottom-up management of risks, in that top-down strategic risks are determined by the Trust's Board members, whilst bottom-up operational risks are identified by staff at all levels across the organisation.

Leadership of the internal control system

The Trust recognises that clear leadership in the area of risk management is critical to the establishment and maintenance of a robust internal control system as articulated above. The Trust is therefore committed to ensuring that the organisation encompasses the necessary skills, expertise, controls and resources to provide this leadership.

The Trust's Risk Management Strategy (initially ratified by the Trust Board in March 2014, and scheduled for review in 2016) details the organisation's overall responsibility for ensuring the effective management of all risks that may otherwise impact detrimentally upon the quality of provided care across Gloucestershire. The Strategy also identifies that specific personal accountabilities are delegated on behalf of the Chief Executive as follows:

- the Trust's Executive and Non-Executive Directors maintain shared responsibility for the oversight of strategic risks, and for ensuring that adequate responses, actions and/or mitigations are in place and monitored via the Board Assurance Framework (NB management of the Board Assurance Framework which captures strategic risks is the responsibility of the Head of Planning, Compliance and Partnerships);
- the Head of Planning, Compliance and Partnerships maintains overarching responsibility for the oversight of all operational (non-clinical) risks, and for ensuring that suitable and effective corporate risk management processes are in place;
- the Director of Nursing maintains overarching responsibility for the oversight of all operational (clinical) risks, and for ensuring that suitable and effective clinical risk management processes are in place;
- the owner of each operational risk (clinical and non-clinical) is one of the Trust's Executive Directors, with assigned ownership relative to each Executive's individual areas of expertise;
- the lead for each operational (clinical and non-clinical) risk is a nominated colleague of suitable authority within the Trust who is responsible for practically managing the necessary actions that arise from each identified risk.

Leadership in respect of risk is also provided through the Trust's established governance structure, wherein all Board subcommittees are chaired by Non-Executive Directors and attended by appropriate Executive Directors and senior Trust managers. The Terms of Reference for each of these subcommittees makes clear its responsibility for identifying all operational risks as appropriate to the respective subcommittee's remit, enacting all mitigations as may be relevant, and/or making suitable recommendations to the Trust Board in respect of the management of risks that are outside the particular subcommittee's sphere of influence.

Strategic risk management

Responsibility for the oversight and management of strategic risks is allocated to the Trust's Executive Directors. This includes responsibility for identifying all strategic risks, evaluating these risks, and ensuring that adequate responses, actions and/or mitigations are in place and monitored.

The Trust classifies strategic risks as those risks which, as a result of inadequacies in the operation of controls or insufficient assurances, may threaten or impede achievement of the Trust's strategic objectives.

To support understanding and facilitate mitigation of these risks, the Trust is committed to the maintenance of an active Board Assurance Framework which documents all strategic risks. The Board Assurance Framework also provides confirmation as to how and where risks are being managed, and ensures that objectives are being delivered to time and budget. This allows the Trust Board to determine how to make the most efficient use of organisational resources, and address the associated issues in order to improve the quality and safety of provided care.

The Board Assurance Framework is evaluated by the Trust Board at each Board meeting, following update by the relevant Executive Directors and oversight by the Trust's newly-formed Risk Management Steering Group. The Board evaluation also serves to provide assurance of the effectiveness of the controls and actions that have been implemented in order to manage or mitigate the identified risks.

The Board Assurance Framework is also reviewed annually by the Audit and Assurance Committee in order to ensure its consistent use to inform risk-based Board decision-making.

Two of the strategic risks detailed in the Board Assurance Framework as at March 2016, had emerged during the course of 2015-16: these are described in greater detail in table 11 opposite:

TABLE 11
STRATEGIC RISKS WHICH EMERGED IN 2015-16

Risk description	Mitigating actions / internal controls
Insufficient organisational preparedness and system-wide resilience which may affect the Trust's ability to effectively manage winter pressures: this risk was identified in November 2015, and highlighted the continued challenge to maintain high-quality, high-performing community services during periods of excessive demand	The Trust's daily input into the Alamac system which enables the Trust and all other local providers to understand system-wide capacity and demand, and therefore ensure suitably measured and coordinated response The work of the Trust's Emergency Preparedness and Resilience Group which facilitates robust contingency planning
Inability to gain a "Good" or "Outstanding" rating following a Care Quality Commission (CQC) Chief Inspector of Hospital's assessment: this risk was identified in September 2015 following publication of the CQC report into the Trust operations	Development of an extensive and comprehensive Quality Improvement Plan (QIP) which monitors, measures and assures the actions taken by the Trust in order to mitigate against the risks raised by the CQC Establishment of a dedicated governance structure in order to oversee implementation of the actions raised within the Trust's QIP: this structure includes: • the CQC QIP Working Group i.e. a monthly forum, chaired by the Director of Nursing and comprising operational leads, whose purpose is to track the actions outlined in the QIP and ensure that they are being delivered to time; • the CQC Compliance Steering Group i.e. a bi-monthly forum, chaired by the Chief Executive and comprising the Executive Team together with the Trust's Non-Executive Director with responsibility for quality, whose purpose is to receive reports from the CQC QIP Working Group and validate that agreed tasks are on schedule: thereafter, this group provides suitable assurance to the Trust's Quality and Performance Committee and subsequently, the Trust Board; • the CQC QIP Oversight Group i.e. a bi-monthly forum, chaired by the NHS Trust Development Authority (TDA) and comprising both senior representatives from the Trust and also from Gloucestershire Clinical Commissioning Group, whose purpose is to ensure commissioner-provider agreement to the QIP, and maintain a shared understanding of the key issues, priorities, outcomes and progress in delivering to plan.

Of all the strategic risks detailed in the Board Assurance Framework as at March 2016, those deemed most significant at that time were the two risks described in table 11 above: additionally, the risk relating to the inability of the Trust to recruit and retain staff with the right skills. Mitigating actions against this risk in 2015-16 included:

- weekly submissions of nurse staffing numbers within community hospitals and ICTs so as to identify gaps and respond effectively;
- monthly recruitment drives / attendance at job fayres to attract new staff;
- the development and introduction of a revised establishment control process;
- the use of bank/agency workers so as to maintain safe staffing levels at all times: this however was monitored and regulated by the Trust's Agency Usage Group so as to ensure that the organisation's deployment of interim staff was appropriate and in line with national guidance;
- the implementation of e-rostering across the Trust so as to allow all Trust colleagues to see management information on shift patterns (including preferred shift patterns of individual colleagues), together with data relating to staff's annual leave, sickness absence and skill mix, thereby enabling line managers to quickly create bespoke rotas that could effectively fulfil service user demand;
- the review and analysis of exit interviews so as to be able to identify and address any trends or themes in staff's rationale for leaving the employment of the Trust.

Operational risk management

All Trust colleagues have explicit responsibility for identifying operational risks relevant to their service, team and/or working environment, and adding these onto their locally-held risk register. Risks may be identified as a result of colleagues' observations, or they may require the triangulation of information from a range of sources including all internal or external evaluations. Once recognised, risks are reviewed to assess their actual or potential impact upon:

- the safety of service users, colleagues or the public (including both physical and psychological harm);
- the quality of Trust services;
- human resources / organisational development (to include considerations of staffing levels and competencies);
- the Trust's statutory duty or the result of inspections;
- achievement of the Trust's development priorities or quality initiatives;
- the Trust's finances including claims;
- disruption or interruption to Trust services;
- the local environment.

A range of tools and resources are maintained to support colleagues in their identification, assessment and escalation of risks, including a comprehensive portfolio of fully documented risk management policies and other control documents that are readily available via the Trust intranet.

An essential element of the Trust's risk management process is the Corporate Risk Register. This systematically gathers together all local risk registers in order to describe the total extent of operational (clinical and non-clinical) risks across the Trust. Thereafter, the most salient risks (i.e. those that are scored as 12+ using the NHS National Patient Safety Agency mechanism which quantifies both the likelihood and consequence of risk) are both:

- forwarded for review and debate by the relevant Trust Board subcommittee, whether the Quality and Performance Committee, the Finance Committee, the Workforce and Organisational Development Committee or the Audit and Assurance Committee dependent upon the nature of the risk;
- included within the Board Assurance Framework which is routinely presented at Board, aligned to the Trust's strategic objectives.

Moreover, it is noted that:

- all risks irrespective of significance, are assigned a senior manager to lead, manage and mitigate where appropriate;
- all risks that are attributed a 4-10 risk rating are subject to regular review at local level via the relevant operational forum;
- all risks that are attributed a 12-14 risk rating have a formal action plan developed, and are routinely monitored and reviewed at a senior operational forum;
- any risks that are attributed a 15+ risk rating have actions identified which must be implemented within 3 months and are audited until under control;
- each month, the Trust's Risk Management Steering Group undertakes a review of all reported operational risks attributed 12+ in order to ensure consistency in reporting and to identify any themes or gaps.

In order to understand the extent of risk as at the end of March 2016, table 12 below illustrates the strategic risks identified at that time within the Board Assurance Framework, aligned to the most significant operational risks facing the Trust as described within the Corporate Risk Register:

TABLE 12
STRATEGIC AND OPERATIONAL RISKS AS AT MARCH 2016

Strategic objectives	Strategic risks	Significant operational risks	Operational risk mitigation
Achieve the best possible outcomes for service users through high quality care	Under-reporting of incidents may result in missed learning opportunities and increased safety risks	Colleagues do not feel confident and secure about raising concerns in respect of unsafe clinical practice which may impact directly upon service user safety	In addition to existing escalation routes, the Trust has introduced an Ambassador for Cultural Change role, which includes the Freedom to Speak Up Guardian responsibilities
	Continued increases in demand for services may restrict the Trust's flexibility and capacity to provide services in other settings, and in particular, may limit aspirations to deliver greater preventative interventions	No significant operational risk	
Understand the needs and view of our service users, carers and families so that their opinions inform every aspect of our work	Inconsistent engagement practices with service users, families and carers may result in the public's voice not being heard or used to inform Trust decision-making	No significant operational risk	
Actively engage in partnerships with other health and social care providers in order to deliver seamless services	The under-defined service delivery model for Integrated Community Teams may prevent the Trust from undertaking effective planning for one of its most critical services	No significant operational risk	
	Delay in commissioning decisions may impede the Trust from taking necessary remedial actions to ensure quality and safety	No significant operational risk	
	Lack of a countywide Sustainability and Transformation Plan may reduce the potential for effective system-wide planning	No significant operational risk	
	Insufficient organisational preparedness and system-wide resilience which may affect the Trust's ability to effectively manage winter pressures	Insufficient numbers of GPs providing medical cover to community hospital inpatient wards, may compromise service user safety	Locum cover is arranged where necessary whilst the Trust seeks a more permanent solution via Service Level Agreement

Strategic objectives	Strategic risks	Significant operational risks	Operational risk mitigation
Value colleagues, and support them to develop the skills, confidence and ambition to deliver our vision	Failure to develop a learning and supportive culture that engages, inspires and motivates colleagues, may impact upon the Trust's recruitment and retention, and its ability to deliver the highest standards of care quality	No significant operational risk	
	Lack of assurance that colleagues have the clinical skills and managerial competencies to create a workforce with the necessary knowledge and expertise to deliver best care	The Trust may be unable to evidence levels of staff's safeguarding training, leading to non-compliance with the Children Act 2004 and the Care Act 2014	The Trust has newly agreed a revised training matrix for roll-out in 2016-17. Systems are being developed to ensure the robust capture and reporting of training data
	Inability of the Trust to recruit and retain staff with the right skills may have detrimental impact upon the quality of provided care	There are a high number of nursing vacancies which may threaten service quality and safety	The Trust now has a dedicated post leading on nurse recruitment. Actions include the development of preceptorship and return to practice programmes, and attendance at nurse recruitment open days and recruitment fayres: additionally, exit interviews are analysed for trends

Strategic objectives	Strategic risks	Significant operational risks	Operational risk mitigation
Manage public resources wisely to ensure local services remain sustainable and accessible	Failure to deliver a successful CIP, CQUIN and QIPP programme	No significant operational risk	
	Inability to maintain independence as a NHS provider may threaten the future provision of community health and social services across Gloucestershire	No significant operational risk	
	A breakdown in internal control / governance systems may lead to reputational loss and long-term sustainability	Failure to comply with necessary standards means that the Trust is no longer level 2 compliant with the requirements of the Information Governance Toolkit	Dedicated resource to undertake the remedial work is being sought: in the interim, the Head of Planning, Compliance and Partnerships is managing workload
	Inability to gain a "Good" or "Outstanding" rating following a Care Quality Commission Chief Inspector of Hospital's assessment	Lack of a consistent staff model in the Trust's Minor Injuries and Illness Units, plus the inability to recruit and retain appropriate staff, and the lack of resilience in smaller units, may threaten service user safety	The issue has been escalated to the Trust Board for decision. Dialogue is on-going with the Gloucestershire Clinical Commissioning Group to resolve
		Poor record-keeping practices may impede the delivery of co-ordinated care and may result in unsafe and/or inappropriate care	The Trust's Heads of Professional Practice will seek to address non-compliance through education and supervision
		Gaps and inconsistencies in record-keeping mean that the Trust may not be able to comprehensively refute allegations of clinical negligence	Policies in respect of record-keeping and records management are being reviewed, and operational practice will be subject to review

Future risks

In April 2016, the Trust Board reviewed all of its strategic risks in order to ensure that they remained valid, and to be assured that the identified mitigations were still appropriate and sufficient. In doing so, Board members were also informed by both the Trust's operational plan for 2016-17, and national directives in respect of the Five Year Forward View, in order to determine whether any additional strategic risks needed to be included within the Board Assurance Framework.

Equally, operational (clinical and non-clinical) risks continue to be reviewed on a minimum monthly basis in order to ensure that these adequately capture the totality of threats to the Trust's quality and effectiveness. Particular scrutiny will be afforded to any future risks which may arise from the organisation's failure both to abide by robust record-keeping standards, and also to maintain suitably comprehensive information governance practices and processes as noted in table 12 above.

Training and learning

To support colleagues in their understanding of operational risk identification and management, the Trust is committed to delivering a range of training programmes. Thus currently, all colleagues joining the Trust receive training in risk management as part of their mandatory induction.

As additional support, colleagues are directed to the Trust's portfolio of risk management policies, including the Risk Assessment and Management Policy and the Incident Governance Policy.

Members from the Planning, Compliance and Partnerships team also regularly attend relevant operational forums as well as Board subcommittees in order to disseminate learning from risk experiences, including learning from how risks occurred, how they were identified, mitigated, and resolved or accepted within agreed tolerance levels.

Moreover, the Trust maintains a network of Risk Champions across all operational delivery areas and support services in order that colleagues within frontline and back office teams can help raise the profile and understanding of risk management across the Trust. In 2016-17, these Champions will benefit from quarterly dedicated meetings, actively supporting the Trust's risk management processes by ensuring that:

- where an identified risk is deemed to be pertinent or applicable to staff across the Trust, the Champions oversee the escalation of transferable learning to all relevant teams so as to prevent or reduce the likelihood of the same or similar risk occurring;
- all changes to practice that result from risk learning, are effectively communicated to the Trust's professional partners and other stakeholders in order to evidence the organisation's integrity and commitment to continuous quality improvement;
- formal analyses in respect of operational (clinical and non-clinical) risks are routinely shared with relevant forums in order to facilitate the identification of trends, and enable proactive measures to be taken to reduce the potential of repeated risks occurring in future.

Internal audit results

The Trust appropriately uses its internal audit resource to test those elements of its internal control system which the Trust believes requires additional scrutiny and/or assurance.

In 2015-16, nine internal audits were conducted and completed in respect of key aspects of the Trust's control system. These audits are summarised below:

TABLE 13
INTERNAL AUDITS 2015-16

Review	Report Classification	Number of findings			
		Critical	High	Medium	Low
Cost Improvement Programme (CIP)	High	-	2	1	1
Procurement	Medium	-	-	3	1
Care Quality Commission (CQC) preparation	Medium	-	-	4	-
Risk management	Medium	-	-	4	2
Business continuity strategy	Medium	-	-	4	1
System decommissioning	Medium	-	-	4	3
SystmOne benefits realisation	Medium	-	-	2	2
Shared Records review	Medium	-	-	2	4
Anonymisation and pseudonymisation	Low	-	-	-	2
Total		**0**	**2**	**24**	**16**

In addition to the nine audits identified above, one other audit is in development, reviewing SystmOne data quality / accuracy. The outcome of this audit will be described in the Annual Governance Statement for 2016-17.

Deterrents to fraud

In order to secure additional internal control, all organisations providing NHS services are explicitly required under the terms of the new NHS Standard Contract to maintain appropriate counter-fraud and security management arrangements. The Trust is fully compliant in this matter, and obtains its counter-fraud, bribery and corruption service from the Gloucestershire Local Counter-Fraud Service (GLCFS) which provided regular updates on activity to the Audit and Assurance Committee in 2015-16. Highlights of activity included:

- completion of an Organisational Crime Profile for which the Trust was allocated a Category 1, meaning that there were no specific high crime risks associated with the organisation;
- delivery of 20 induction sessions and 13 fraud awareness presentations, which were supported by the dissemination of documented materials and resources to inform all Trust colleagues;
- roll-out of three proactive exercises, two of which related to the charging of service users both specifically within the Trust's Pregnancy Advisory Service, and more generally via the European Health Insurance Card (EHIC) portal. The third exercise related to colleagues claiming time off in lieu;
- review of the four main areas of counter-fraud, namely (i) Strategic Governance, (ii) Inform and Involve, (iii) Prevent and Deter, and (iv) Hold to Account, which highlighted the Trust's full compliance in all areas;
- investigation of ten reports of suspected fraud or corruption, resulting in one criminal prosecution, one resignation and one dismissal, in addition to the recovery of £51,858.20 Trust funds;
- implementation of a comprehensive communications plan to publically demonstrate the Trust's commitment to fraud prosecutions, which has been proved nationally to act as a deterrent to other potential fraudsters;
- completion of the National Fraud Initiative (NFI) bi-annual exercise to identify fraud in payroll and creditors.

Information Governance breaches

The Trust maintains processes to identify all possible and actual risks to information governance, and thus, the occurrence of any incident which may threaten the safety, security, confidentiality, integrity, availability or accessibility of any person-identifiable or other confidential information held under the Trust's guardianship, whether such information relates to the Trust's service users, colleagues or business critical matters.

Throughout 2015-16, the Trust used the Datix system to report and monitor all such information governance incidents. In summary, these were as follows:

TABLE 14
SUMMARY OF INFORMATION BREACHES 2015-16

Breach Type	2014-15	2015-16
Corruption or inability to recover electronic data	1	2
Information disclosed in error	37	17
Information lost in transit	7	9
Lost or stolen hardware	2	2
Lost or stolen paperwork	23	1
Non-secure disposal of hardware	2	0
Non-secure disposal of paperwork	1	2
Information uploaded to website in error	0	0
Technical security failing	1	1
Unauthorised access/disclosure of information	36	22
Other	16	8
Total	126	**64**

All of the above 64 incidents received internal review, with only one being of such severity that it required escalation to the Information Commissioner's Office. This concerned the inappropriate disclosure by email of 3,542 staff payslips to one staff member who had requested copies of two of their own payslips from NHS Shared Business Services. As a result of this incident, a full investigation was undertaken.

This concluded that the Payroll and Pensions team of NHS Shared Business Services had failed to follow agreed best practice procedures relating to the provision of copy payslips to employees of the Trust. As a result, NHS Shared Business Services' policies were reviewed, and training was re-evaluated. It is also noted that all Trust staff were informed of the incident, and reported concerns were addressed.

2.2.5 Trust performance against TDA indicators

For 2015-16, the Trust's performance against the relevant indicators within the TDA Accountability Framework was as follows:

TABLE 15
TDA ACCOUNTABILITY FRAMEWORK INDICATORS 2015-16

Quality domain: Responsive Metric	Trust performance 2015-16	Target / tolerance* (if applicable)	RAG
Percentage of service users who waited more than 6 weeks from referral for a diagnostic test provided by the Trust *(see also page 23)*	2.5%	Less than 1%	
Percentage of service users who were treated and discharged from a Minor Injuries and Illness Unit within 4 hours	99.8%	95%	
Number of people who waited on a trolley in a Minor Injuries and Illness Unit for more than 12 hours	0	0	
Number of people for whom an urgent operation was cancelled for a second time	0	0	
Number of service users who had their operation cancelled for non-clinical reasons and who were not offered another binding date within 28 days	0	No more than 1	
Number of days lost due to a delayed discharge from hospital as a proportion of the total number of bed-days	0.98%	7.5%	

*All targets / tolerances are the minimum required, unless stated otherwise

Quality domain: Effective Metric	Trust performance 2015-16	Target / tolerance (if applicable)	RAG
Percentage of discharges from hospital where the service user was deceased	6.9%	Not available	
Percentage of emergency re-admissions to the Trust within 30 days following an elective or emergency spell at the Trust	14.6%	Not available	
Percentage of emergency re-admissions to the Trust within 7 days following an elective or emergency spell at the Trust	8.1%	Not available	
Percentage of emergency re-admissions to the Trust within 14 days following an elective or emergency spell at the Trust	10.9%	Not available	
Percentage of emergency re-admissions to the Trust within 28 days following an elective or emergency spell at the Trust	14.4%	Not available	

KEY

- Met or exceeded target / tolerance
- Near achievement of target / tolerance
- Failure to achieve target / tolerance
- No target / tolerance

Quality domain: Caring Metric	Trust performance 2015-16	Target / tolerance (if applicable)	RAG
Percentage of colleagues who would recommend the Trust as a place to receive care (Staff Friends and Family Test, quarter 2 2015-16)	81.24%	71.93%	
Percentage of colleagues who would not recommend the Trust as a place to receive care	3.9%	Not available	
Percentage of positive responses to the Friends and Family Test question from hospital inpatients (i.e. "Would you recommend this service")	95.6%	Not available	
Percentage of negative responses to the Friends and Family Test question from hospital inpatients	1.5%	Not available	
Percentage of positive responses to the Friends and Family Test question from service users leaving a Minor Injuries and Illness Unit	96.9%	Not available	
Percentage of negative responses to the Friends and Family Test question from service users leaving a Minor Injuries and Illness Unit	1.6%	Not available	
Percentage of positive responses to the Friends and Family Test question from service users who received community-based care (i.e. from Integrated Community Teams)	92.9%	90.78%	
Percentage of positive responses to the Friends and Family Test question from service users across all Trust services	95.2%	Not available	
Number of written complaints received per 1,000 bed-days *(this target is not wholly indicative of Trust activity, as the majority of the 1.4million contacts made by the organisation in 2015-16 were outside of a community hospital setting. As such, this target is more applicable to acute care services)*	1.23	0.768	
Number of non-exempt instances whereby a service user was not able to sleep in a same-sex ward or bay	0	0	

Quality domain: Safe Metric	Trust performance 2015-16	Target / tolerance (if applicable)	RAG
Number of instances of Clostridium Difficile infection measured against the agreed tolerance	9	18	
Number of instances of MRSA bactaraemias infection	0	0	
Number of Never Events *(see also page 61 below)*	1	0	
Proportion of Never Events per 1,000 people in the local community (incidence rate)	0	0.07	
Time since the last Never Event within the Trust	24 months	Not available	
Repeat of same-cause Never Event	0	0	
Proportion of Serious Incidents Requiring Investigation (SIRIs) per 1,000 people in the local population (incidence rate)	0.004	0 - 13.725	
Proportion of medication errors causing serious harm per 1,000 people in the local population (incidence rate)	0	4.375 - 34.872	
Proportion of service user incidents causing severe harm or death per 100 incidents (incidence rate)	0	0 - 3.076	
Percentage of staff who stated that the Trust's incident reporting procedure was fair and effective	3.57 (maximum 5)	Not available	
Number of Central Alerting System (CAS) alerts that are outstanding	0	0	
Time to close outstanding CAS alerts	0	0	
Percentage of relevant inpatients risk assessed for venous thromboembolism (VTE) *(see also page 23 above)*	87.8%	95%	
Percentage of people reported via the Safety Thermometer census as receiving harm-free care	95.3%	92.47%	
Percentage of new harms	1.2%	0.73%	
Admissions to adult facilities of service users who were under 16 years of age	0	0	

Quality domain: Well-led Metric	Trust performance 2015-16	Target / tolerance (if applicable)	RAG
Percentage of staff absent from work and reported as suffering sickness	4.71%	5.31%	
Percentage of staff turnover	15.16%	12.608 - 29.857%	
Percentage of colleagues who responded to the Staff Friends and Family Test question	16.60%	4.92%	
Percentage of hospital inpatients who responded to the Friends and Family Test question	41.7%	Not available	
Percentage of service users leaving a Minor Injuries and Illness Unit who responded to the Friends and Family Test question	22.9%	Not available	
Percentage of service users who received community-based care who responded to the Friends and Family Test question	2.6%	1.36%	
Percentage of all Trust service users who responded to the Friends and Family Test question	5.4%	Not available	
Percentage of colleagues who would recommend the Trust as a place to work (Staff Friends and Family Test, quarter 2 2015-16)	51.37%	43.65%	
Percentage of colleagues who would not recommend the Trust as a place to work	23.3%	Not available	
Overall safe staffing fill rate	101.0%	97.47%	
Safe staffing fill rate – wards with <80% fill rate	0	Not available	
Safe staffing fill rate – fill rate variance	90.8%-126.2%	Not available	

Quality domain: Finance Metric	Trust performance 2015-16 (£000's)	Target / tolerance (if applicable) (£000's)	RAG
Bottom line I&E (Income & Expenditure) position - Forecast compared to plan	2,501	1,000	
Bottom line I&E position - Year to date actual compared to plan	2,501	1,000	
Actual efficiency recurring/ non-recurring compared to plan - Year to date actual compared to plan	3,150	3,150	
Actual efficiency recurring/ non-recurring compared to plan - Forecast compared to plan	3,150	3,150	
Forecast underlying surplus/ deficit compared to plan	349	79	
Forecast year end charge to capital resource limit *(this underspend on capital was agreed with the NHS Trust Development Authority)*	3,750	4,350	
Is the Trust forecasting a funding requirement for liquidity purposes?	No	Not applicable	

In respect of the above, it is noted that the Trust regularly reviews the quality of its recorded data, specifically that which is provided to the national Secondary Uses Service. Such reviews consistently evidence the Trust's data quality to be approximately 99%. Additionally, as noted on page 73 above, the Trust has commissioned a review of its data quality by internal audit as additional assurance.

2.2.6 Review of effectiveness

As Accountable Officer, I have ultimate responsibility for reviewing the effectiveness of the Trust's Board / corporate governance, quality / clinical governance and internal control systems. My review of 2015-16 however is additionally informed by the contribution and perspective of the Trust's Executive and Non-Executive Directors, as well as senior managers, who each have individual responsibility for contributing to the maintenance and quality of these functions.

In developing this Annual Governance Statement, I have also drawn upon the wealth of information that has been reported to the Trust Board and/or its subcommittees over the past twelve months, together with self-assessments, peer and external reviews, including, but not limited to, the Care Quality Commission (CQC) Chief Inspector of Hospital's report published September 2015. Furthermore, my assessment is underpinned by the work of both the internal and external auditors in their various reports.

Finally, I have been advised on the implications of my review by the Trust Board and its appropriate subcommittees, and would note that a plan to address all identified weaknesses, and thereby ensure continuous quality improvement, is already in place. To this end, I would note that the following actions have been highlighted as requiring additional focus in 2016-17:

- continue to implement the actions identified in the Trust's Quality Improvement Plan, written in response to the CQC report;
- strengthen service user safety within Minor Injuries and Illness Units by means of the introduction of a more robust operational model;
- ensure particular focus is given to the Trust's record-keeping practices in light of clinical audit findings, operational risk concerns and CQC recommendations;
- address the downturn in colleagues' adherence to best practice information governance standards which has resulted in the Trust losing its level 2 compliance status;
- validate that the additional improvements made to the Trust's incident reporting processes in year are suitably encouraging colleagues to highlight areas of concern so that corresponding quality improvements can be made.

However, in light of the information within this Annual Governance Statement, I conclude that the Trust has a sound system of governance practice and internal control that with the above adjustments, will facilitate achievement of the organisation's vision, values and strategic objectives within the coming years.

Paul Jennings

Paul Jennings, Chief Executive
31 May 2016

2.3 Remuneration and staff report

2.3.1 Policy for the remuneration of Directors

The Trust's remuneration policy for Executive Directors observes the Department of Health's *Pay Framework for Very Senior Managers (VSMs) in Strategic and Special Health Authorities, Primary Care Trusts and Ambulance Trusts* (NB although this document dated July 2013 now references organisational forms and bodies no longer in existence, this is the latest available version of the guidance).

Accordingly, in 2015-16, the pay for the Trust's Chief Executive was in line with that proposed within the *Pay Framework* for Primary Care Trust (PCT) Chief Executives i.e. it was based on a local population of 0.5million to 1.0million people, weighted for age and deprivation. Additionally, a 10% Recruitment and Retention Premium was agreed at time of his appointment in 2014-15.

Other Trust VSM Executive Directors whose salaries reflected some variation from the *Pay Framework* were:

- the Director of Finance who received a 10% uplift above that recommended within the *Pay Framework*. This was as a result of salary being agreed with the former Gloucestershire PCT prior to the formation of Gloucestershire Care Services NHS Trust in March 2013. This has subsequently been confirmed by both the Trust's Remuneration and Terms of Service Committee and the TDA's Remuneration Committee;
- the Director of Nursing who upon appointment in September 2015, received a 5% Recruitment and Retention Premium on VSM salary: again, this was formally approved by the relevant committees of both the Trust and the TDA.

Other Executive Directors in post as of 31 March 2016 (namely the Medical Director, the Director of Service Delivery and the Director of Human Resources) were paid in line with either VSM or Agenda for Change recommendations (NB it is noted that the Chief Operating Officer whose secondment ended on 31 March 2016 was paid via separate arrangements with his former employer, Gloucestershire County Council). It is also noted that given the fewer numbers of Executive Directors as of 1 April 2016 compared to 1 April 2015, it has been agreed that all Executive Directors will receive VSM salary in 2016-17.

In terms of performance pay awards, the Trust again abides by the *Pay Framework* which recommends that annually, Executive Directors are placed into one of four categories, dependent upon their achievements and successes in-year, with relevant bonus payments applied. However in 2015-16, despite a number of the Trust's Executive Directors being recognised for high performance, the corresponding pay awards were not made for reasons of financial stringency.

In 2015-16, all Non-Executive Director payments were made in line with Department of Health guidelines.

2.3.2 Salary and pension entitlements of Directors 2015-16

The total remuneration of the Trust's Executive Directors and Non-Executive Directors in 2015-16 is given in table 16 below, and for comparison purposes, remuneration from 2014-15 is provided in table 17 below. Both tables show all costs incurred by the Trust relating to pay, bonuses, benefits in kind (including relocation) or other remuneration relating to Directors.

TABLE 16
DIRECTORS' REMUNERATION 2015-16

	Salary (bands of £5,000) £000	Expense payments (taxable) total to nearest £1,000 £000	Performance pay and bonuses (bands of £5,000) £000	Long term performance pay and bonuses (bands of £5,000) £000	All pension-related benefits (bands of £2,500) £000	TOTAL (bands of £5.000) £000
Ingrid Barker, Chair	20-25	3	-	-	-	25-30
Paul Jennings, Chief Executive	150-155	5	-	-	-	155-160
Glyn Howells, Director of Finance / Deputy Chief Executive	115-120	1	-	-	25-27.5	140-145
Dr Joanna Bayley, Medical Director	5-10	0	-	-	-	5-10
Dr Michael Roberts, Interim Medical Director / Medical Director	45-50	0	-	-	2.5-5	50-55
Duncan Jordan, Chief Operating Officer (*)	135-140	1	-	-	-	135-140
Elizabeth Fenton, Director of Nursing and Quality	15-20	1	-	-	15-17.5	35-40
Susan Field, Director of Service Transformation / Director of Nursing	95-100	2	-	-	37.5-40	135-140
Candace Plouffe, Director of Service Delivery	85-90	1	-	-	32.5-35	120-125
Tina Ricketts, Director of Human Resources	70-75	0	-	-	32.5-35	105-110
Jason Brown, Director of Corporate Governance	55-60	1	-	-	-	55-60
Robert Graves, Non-Executive Director	5-10	2	-	-	-	5-10
Richard Cryer, Non-Executive Director	5-10	2	-	-	-	10-15
Joanna Scott, Non-Executive Director	5-10	1	-	-	-	5-10
Susan Mead, Non-Executive Director	5-10	2	-	-	-	5-10
Nicola Strother Smith, Non-Executive Director	5-10	1	-	-	-	5-10
Jan Marriott, Non-Executive Director	5-10	1	-	-	-	5-10
Ian Dreelan, Non-Executive Director	5-10	1	-	-	-	5-10

(*) On secondment from Gloucestershire County Council

TABLE 17
DIRECTORS' REMUNERATION 2014-15

	Salary (bands of £5,000) £000	Expense payments (taxable) total to nearest £1,000 £000	Performance pay and bonuses (bands of £5,000) £000	Long term performance pay and bonuses (bands of £5,000) £000	All pension-related benefits (bands of £2,500) £000	TOTAL (bands of £5.000) £000
Ingrid Barker, Chair	20-25	4	-	-	-	25-30
Paul Jennings, Chief Executive	150-155	6	-	-	-	160-165
Glyn Howells, Director of Finance / Deputy Chief Executive	110-115	2	-	-	20-22.5	135-140
Dr Joanna Bayley, Medical Director	5-10	1	-	-	-	5-10
Dr Michael Roberts, Interim Medical Director	25-30	0	-	-	-	25-30
Duncan Jordan, Chief Operating Officer (*)	130-135	1	-	-	-	130-135
Elizabeth Fenton, Director of Nursing and Quality	75-80	4	-	-	7.5-10	90-95
Susan Field, Director of Service Transformation	90-95	2	-	-	12.5-15	110-115
Candace Plouffe, Director of Service Delivery	75-80	1	-	-	32.5-35	115-120
Tina Ricketts, Director of Human Resources	70-75	1	-	-	10-12.5	85-90
Jason Brown, Director of Corporate Governance	65-70	5	-	-	-	70-75
Robert Graves, Non-Executive Director	5-10	2	-	-	-	5-10
Richard Cryer, Non-Executive Director	5-10	3	-	-	-	5-10
Joanna Scott, Non-Executive Director	5-10	0	-	-	-	5-10
Susan Mead, Non-Executive Director	5-10	1	-	-	-	5-10
Nicola Strother Smith, Non-Executive Director	5-10	2	-	-	-	5-10
Jan Marriott, Non-Executive Director (**)	-	-	-	-	-	-
Ian Dreelan, Non-Executive Director (**)	-	-	-	-	-	-

Further to the above declarations, there were no other payments made to past Directors in 2015-16.

(*) On secondment from Gloucestershire County Council

(**) Appointed May 2015

Table 18 below shows the pension contributions for Executive Directors in 2015-16. As Non-Executive Directors do not receive pensionable remuneration, there are no corresponding entries for these individuals.

It is also noted that neither the Trust's Chief Executive nor the Director of Corporate Governance participated in a pension scheme in 2015-16.

TABLE 18
PENSION CONTRIBUTIONS 2015-16

	Real increase in pension at pension age (Bands of £2,500)	Real increase in pension lump sum at pension age (Bands of £2,500)	Total accrued pension at pension age at 31 March 2016 (Bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2016 (Bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2015 £000	Cash Equivalent Transfer Value at 31 March 2016 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension £000
Paul Jennings, Chief Executive	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Glyn Howells, Director of Finance / Deputy Chief Executive	0-2.5	0-2.5	5-10	0-5	78	102	23	16
Dr Joanna Bayley, Medical Director	0-2.5	0-2.5	5-10	25-30	143	145	0	1
Dr Michael Roberts, Interim Medical Director / Medical Director	0-2.5	0-2.5	5-10	25-30	186	198	10	7
Duncan Jordan, Chief Operating Officer (*)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Elizabeth Fenton, Director of Nursing and Quality	0-2.5	2.5-5	20-25	65-70	448	481	7	3
Susan Field, Director of Service Transformation / Director of Nursing	0-2.5	5-7.5	20-25	70-75	386	435	45	14
Candace Plouffe, Director of Service Delivery	0-2.5	5-7.5	10-15	35-40	192	234	39	12
Tina Ricketts, Director of Human Resources	0-2.5	0-2.5	10-15	35-40	197	227	28	11
Jason Brown, Director of Corporate Governance	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

(*) Mr Jordan received a pension contribution of £35,000-£40,000 which was paid into a fully-funded scheme.

The definition of terms used in table 18 includes:

- **Cash Equivalent Transfer Values:** a Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

  The pension figures shown in table 18 above relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries;

- **Real Increase CETV:** this reflects the increase in CETV effectively funded by the Trust. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

2.3.3 Pay multiples

The Trust is required to disclose the relationship between the remuneration of its highest-paid Director and the median (average) remuneration of the organisation's workforce.

The midpoint of the banded remuneration of the highest paid Director in the Trust in the financial year 2015-16 was £152,500 (2014-15, £152,500). This was 5.8 times (2014-15,5.9 times) the median remuneration of the workforce, which was £26,472 (2014-15, £25,970).

In 2015-16, no employees (2014-15, also no employees) received remuneration in excess of the highest-paid Director. Remuneration ranged from £15,100 to £153,961 (2014-15, £15,100 to £153,953).

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

In respect of the above, it is noted that there were no significant changes to the remuneration of the workforce in 2015-16. In general, staff salaries were increased by 1% in April 2015 in line with government policy. Senior managers and Executive Directors however were excluded from these arrangements, so did not receive any corresponding increase during the year.

2.3.4 Staff report

Senior managers' analysis

The details of staff within the Trust at Agenda for Change Band 8A and upwards (excluding Executive Directors) as at 31 March 2016 are shown in table 19 below:

TABLE 19
NUMBERS OF SENIOR MANAGERS AS AT 31 MARCH 2016

Banding	Whole-Time Equivalent (WTE)	Headcount
Band 8A	53.7	59
Band 8B	17.4	18
Band 8C	9	9
Band 8D	1	1
Total	**81.1**	**87**

Staff numbers

The numbers of staff employed by the Trust in 2015-16 analysed by professional discipline (excluding staff on outward secondment) are as shown in table 20 below:

TABLE 20
STAFF NUMBERS 2015-16

Occupation	WTE	Headcount
Administration and estates staff	412.5	496
Allied health professionals	457.1	583
Ancillary staff	87.4	135
Medical and dental staff	28.6	47
Nursing, midwifery and health visiting staff	1,124.8	1,408
Grand Total	**2,110.4**	**2,669**

This represents a slight decrease in WTE posts (-22.2) compared to 31 March 2015, and a reduction in headcount of 37.

Staff composition

The gender composition of the Trust is as follows:

TABLE 21
TRUST COMPOSITION AS AT 31 MARCH 2016

Role	Male		Female	
	Number	Percent	Number	Percent
Board members	5	38%	8	62%
Senior managers	17	20%	70	80%
All other staff	216	8%	2,393	92%

This represents:

- an increase in female representation at Board from 53% in 2014-15 to 62% in 2015-16;
- a slight decrease in female representation at senior management level from 82% in 2014-15 to 80% in 2015-16;
- a slight increase in female representation across the Trust from 91% in 2014-15 to 92% in 2015-16.

Sickness absence

Sickness absence in 2015-16 is detailed below:

TABLE 22
TRUST SICKNESS ABSENCE 2015-16

Occupation	Percentage
Administration and estates staff	4.2
Allied health professionals	3.7
Ancillary staff	6.0
Medical and dental staff	6.0
Nursing, midwifery and health visiting staff	5.1
Grand Total	**4.7**

Overall, this represents a reduction in sickness absence from 4.9% in 2014-15 to 4.7% in 2015-16. In terms of specific professions, sickness absence fell in all categories in-year except for medical and dental staff who experienced an increase of 1.4% from 2014-15.

Staff policies on disabled employees

The Trust is fully committed to ensuring equal opportunities, and this is reflected by its accreditation by Investors in People. It is also evidenced by the Trust's continued application of its Equality and Human Rights Policy, as well as its Recruitment and Selection Policy and Procedure, which together demonstrate that the Trust gives full and fair consideration for applications for employment by disabled persons, namely:

- all recruitment uses the NHS Jobs system in order to ensure that personal details are removed for the shortlisting stage;
- advertising seeks to attract suitably qualified, skilled and experienced candidates from all sections of the community and the existing workforce;
- the Trust operates a Guaranteed Interview Scheme, so that people with disabilities are guaranteed an interview as long as they meet the minimum criteria: in recognition of this work, the Trust holds Two Ticks and Mindful Employer status;
- appropriate training is available to ensure that those responsible for making selection decisions do not discriminate, consciously or unconsciously, when making such decisions;
- where there is an identified need, the Trust takes positive action to try and encourage a diverse range of applicants.

Equally, all people are treated fairly when in employment with the Trust i.e.

- the Trust actively avoids practices that would put a disabled person at a disadvantage, compared to those who are not disabled;
- the Trust makes reasonable adjustments at work, such as removing or altering a physical feature, or providing a reasonable means of avoiding such a feature, where it would put a disabled person at a substantial disadvantage, compared to those who are not disabled;
- the Trust provides auxiliary aids where a disabled person would otherwise be put at a substantial disadvantage, compared to those who are not disabled;
- all employees, irrespective of disability status, have access to regular supervision, an annual review of their performance, and a personal development plan which identifies their training needs: moreover, the reasons for choosing certain employees for training is clear and based on sound judgments.

In terms of career progression, everyone who applies for a promotion within the Trust receives fair treatment and is considered solely on their ability to do the job. Furthermore, no applicant is placed at a disadvantage by requirements or conditions that are not essential for the performance of the job.

Equality Delivery System

In order to assure appropriate equity across its workforce, the Trust continued in 2015-16 to review its progress against the relevant components of the updated NHS Equality Delivery System (EDS2). In doing so, the Trust was encouraged to evaluate the impact of the nine criteria shown in table 23 below, upon groups of staff representing the nine protected characteristics outlined in the Equality Act 2010, namely age, sex, disability, sexual orientation, gender reassignment, marriage or civil partnership, pregnancy and maternity, race / ethnicity, or religion / belief.

TABLE 23
WORKFORCE CRITERIA, NHS EDS2

A representative and supported workforce	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels
	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations
	Training and development opportunities are taken up and positively evaluated by all staff
	When at work, staff are free from abuse, harassment, bullying and violence from any source
	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives
	Staff report positive experiences of their membership of the workforce
Inclusive leadership	Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations
	Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed
	Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination

However, with the exception of race / ethnicity which is described under the Workforce Race Equality Standard (WRES) below, the majority of Trust workforce information in 2015-16 was analysed at a more generalised level, and therefore did not specifically assess outcomes upon people representing the nine protected characteristics. This was, in part, due to the fact that significant numbers of staff did not wish to disclose details of, for example, their disabilities, sexual orientation or religion, meaning that baseline data was not indicative of the workforce as a whole.

As a result, in 2016-17, the Trust will be seeking to elicit improved data reporting in order to quantify its progress against the EDS2 standards. An update will be available in next year's Annual Report and Accounts.

Workforce Race Equality Standard (WRES)

Compliance with WRES was introduced in the NHS Standard Contract 2015-16, in response to clear evidence of race inequality in the NHS, and a strong correlation between race equality amongst staff and the quality and safety of care.

WRES requires NHS organisations to report annually against nine indicators. In 2015-16, the Trust's initial submission was as follows:

TABLE 24
WORKFORCE RACE EQUALITY STANDARD RESULTS 2015-16

Indicator	Trust data	
	White colleagues	BME colleagues
Percentage of white and black and minority ethnic (BME) staff in Bands 8-9 or VSM compared to the overall workforce	3.2% at senior level	0.9% at senior level
Relative likelihood of BME staff being appointed from shortlisting compared to that of white staff across all posts	1.31 times more likely to be appointed from shortlisting	
Relative likelihood of BME staff entering the formal disciplinary process, compared to that of white staff, as measured by entry into a formal disciplinary investigation	1.06 times more likely to enter the formal disciplinary process	
Relative likelihood of BME staff accessing non-mandatory training and Continuing Professional Development (CPD) as compared to white staff	1.03 times more likely to access non-mandatory training and CPD	
Percentage of staff experiencing harassment, bullying or abuse from service users, relatives or the public in last 12 months	30%	38%
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	18%	31%
Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion	93%	N/A
In 2015-16, the number of staff who personally experienced discrimination at work from a manager/team leader or other colleague	3.7%	16.7%
Boards are expected to be broadly representative of the population they serve	4.0% of Gloucestershire population is BME; none of the Trust's Board members is BME	

The significant findings from the above were as follows:

- although the Trust's workforce is not wholly representative of the local population on the basis of race (i.e. 94% Trust colleagues are white British, compared with 91.9% of the county as a whole), there does appear to be a slight upward trend in the proportion of BME colleagues since October 2013. Nevertheless, job applicants from white people are still 1.31 times more likely to be appointed from shortlisting than BME job applicants;
- none of the Trust's Board members comes from a BME background: furthermore, 3.2% white colleagues hold senior positions, compared with only 0.9% BME colleagues;
- based on the Trust's 2014 staff survey, BME colleagues are more likely to experience bullying, harassment and discrimination - both from services users and colleagues - than their white counterparts.

Early analysis from the 2015 staff survey, which will impact upon the Trust's 2016-17 WRES submission, indicates quite clearly that the gap is closing between the experiences of white and BME colleagues in respect of bullying and harassment both from service users and colleagues - however, discrimination remains significantly higher for BME colleagues than the rest of the workforce.

To understand the issues behind this data, the Trust is planning a number of WRES specific focus groups in 2016-17, to be chaired by the Trust's Deputy Medical Director, Dr. San Sumathipala. Progress will be reported in next year's Annual Report and Accounts.

Expenditure on consultancy

In 2015-16, the Trust spent £50,000 on consultancy services. This enlisted the support of 4 external consultancy companies who provided specialist expert input into specific HR, IT and clinical governance issues, where such expertise did not exist within the Trust workforce at the time.

Off payroll engagements

As at 31 March 2016, the Trust employed no people whose charges exceeded £220 per day and whose contract had lasted longer than six months.

TABLE 25
OFF-PAYROLL ENGAGEMENTS AS AT 31 MARCH 2016, FOR MORE THAN £220 PER DAY AND THAT HAD LASTED LONGER THAN SIX MONTHS

	Number
Number of existing engagements as of 31 March 2016	0
Of which, the number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

Equally, the Trust employed no contractors at over £220 per day for a six month or longer period within the whole of 2015-16.

TABLE 26
ALL NEW OFF-PAYROLL ENGAGEMENTS BETWEEN 1 APRIL 2015 AND 31 MARCH 2016, FOR MORE THAN £220 PER DAY AND THAT LAST LONGER THAN SIX MONTHS

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016	0
Number of new engagements which include contractual clauses giving the Trust the right to request assurance in relation to income tax and National Insurance obligations	0
Number for whom assurance has been requested	0
Of which:	
assurance has been received	0
assurance has not been received	0
engagements terminated as a result of assurance not being received	0

In 2015-16, no Board members or senior officials of the Trust were paid off-payroll (although it is noted that Duncan Jordan, Chief Operating Officer was paid on secondment from Gloucestershire County Council between April 2014 and March 2016).

TABLE 27
OFF-PAYROLL ENGAGEMENTS OF BOARD MEMBERS AND/OR SENIOR OFFICIALS WITH SIGNIFICANT FINANCIAL RESPONSIBILITY BETWEEN 1 APRIL 2015 AND 31 MARCH 2016

	Number
Number of off-payroll engagements of Board members and/or senior officers with significant financial responsibility, during the year	0
Number of individuals that have been deemed "Board members and/or senior officers with significant financial responsibility" during the financial year. This figure includes both off-payroll and on-payroll engagements	18

Exit packages

In 2015-16, 41 exit payments were paid totalling £435,128 as shown below.

TABLE 28
EXIT PACKAGES 2015-16

Exit package cost band (including any special payment element)	*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
	Number	£s	Number	£s	Number	£s	Number	£s
Less than £10,000	2	7,927	25	143,193	27	151,120	-	-
£10,000-£25,000	2	37,866	9	132,739	11	170,605	-	-
£25,001-£50,000	2	84,868	1	28,535	3	113,403	-	-
£50,001-£100,000	-	-	-	-			-	-
£100,001-£150,000	-	-	-	-	-	-	-	-
£150,001- £200,000	-	-	-	-	-	-	-	-
>£200,000	-	-	-	-	-	-	-	-
Totals	**6**	**130,661**	**35**	**304,467**	**41**	**435,128**	**-**	**-**

Redundancy and other departure costs were paid in accordance with the provisions of the Medical and Dental or Agenda for Change Schemes as appropriate. Exit costs are accounted for in full in the year of departure. In 2015-16, the Trust did not agree any early retirements, so there are no additional costs to be met. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

It is also noted that 27 of the 35 other departures listed in table 27 above, related to mutually-agreed resignation costs.

The disclosure in table 29 below reports the number and value of exit packages agreed in the year. Note: the expenses associated with these departures may have been recognised in part or in full in a previous period.

TABLE 29
EXIT PACKAGES 2015-16

	Agreements Number	Total value of agreements £000s
Voluntary redundancies including early retirement contractual costs	None	0
Mutually agreed resignations (MARS) contractual costs	27	273
Early retirements in the efficiency of the service contractual costs	None	0
Contractual payments in lieu of notice	8	31
Exit payments following Employment Tribunals or court orders	None	0
Non-contractual payments requiring HMT approval	None	0
Total	**35**	**304**

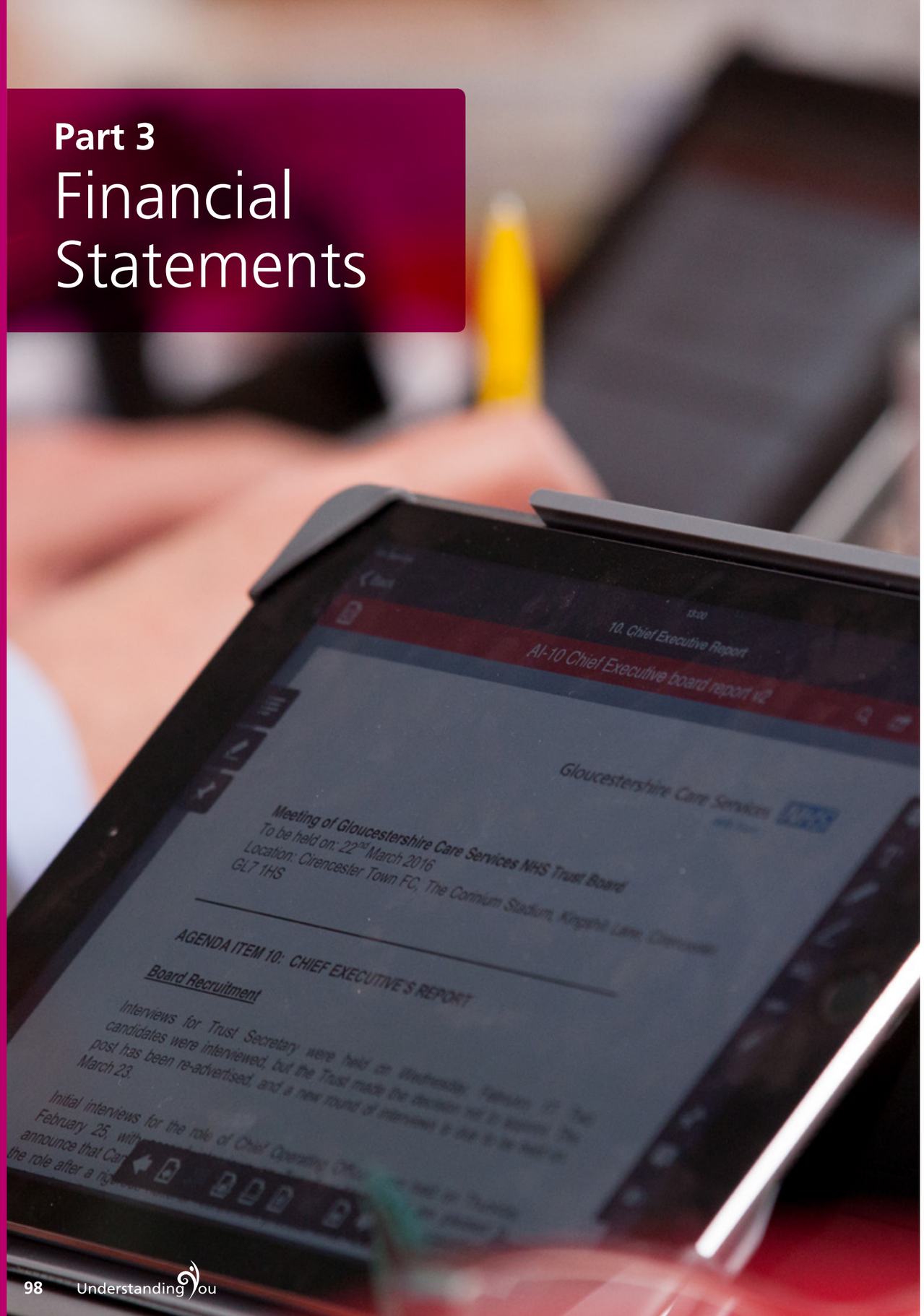
No non-contractual payments in lieu of notice were paid. No non-contractual severance payments were made following judicial mediation, and therefore none related to non-contractual payments in lieu of notice.

No non-contractual payments were made to individuals where the payment value was more than 12 months' of their annual salary.

I hereby confirm that the above Accountability Report is a true and accurate representation of the described Trust activities in 2015-16.

Paul Jennings

Paul Jennings, Chief Executive
31 May 2016



3.1 Primary Financial Statements

3.1.1 Statement of Comprehensive Income (SoCI) for year ended 31 March 2016

	NOTE	**2015-16 £000s**	2014-15 £000s
Gross employee benefits	3.2.8	**(79,268)**	(82,023)
Other operating costs	3.2.6	**(29,849)**	(28,056)
Revenue from care activities	3.2.3	**112,941**	112,427
Other operating revenue	3.2.4	**964**	1,684
Operating surplus/(deficit)		**4,788**	4,032
Investment revenue	3.2.14	**19**	19
Finance costs	3.2.15	**(4)**	(15)
Surplus/(deficit) for the financial year		**4,803**	4,036
Public dividend capital dividends payable		**(2,637)**	(2,650)
Retained surplus/(deficit) for the year		**2,166**	1,386
Other Comprehensive Income			
Impairments and reversals taken to the revaluation reserve (***)		**(6,854)**	0
Net gain/(loss) on revaluation of property, plant & equipment		**0**	0
Net gain/(loss) on revaluation of intangibles		**0**	0
Net gain/(loss) on revaluation of financial assets		**0**	0
Other gain /(loss) (*)		**0**	55
Net gain/(loss) on revaluation of available for sale financial assets		**0**	0
Net actuarial gain/(loss) on pension schemes (**)		**703**	(329)
Other pension remeasurements		**0**	0
Reclassification adjustments			
On disposal of available for sale financial assets		**0**	0
Total Other Comprehensive Income		**(6,151)**	(274)
Total comprehensive income for the year		**(3,985)**	1,112
Financial performance for the year			
Retained surplus/(deficit) for the year		**2,166**	1,386
Impairments (excluding IFRIC 12 impairments) (***)		**397**	0
Adjustments in respect of donated government grant asset reserve elimination (****)		**(62)**	122
Adjusted retained surplus/(deficit)		**2,501**	1,508

(*) In 2014-15, this is where the value of assets donated to the Trust in year was shown: see (****) for 2015-16 information

(**) This movement is based on a reduction in expected benefits relating to colleagues who have part or all of their pension benefits in the Local Government Pension Scheme

(***) During 2015-16, the carrying value of property assets was reviewed by external assessors and revalued based upon the Depreciated Replacement Cost Method of Valuation

(****) Adjustments in respect of donated assets in 2015-16

The notes on pages 104 to 138 form part of this account.

3.1.2 Statement of Financial Position as at 31 March 2016

	NOTE	31 March 2016 £000s	31 March 2015 £000s
Non-current assets			
Property, plant and equipment	3.2.16	**75,761**	81,691
Intangible assets	3.2.17	**1,256**	0
Total non-current assets		**77,017**	81,691
Current assets			
Inventories	3.2.20	**225**	225
Trade and other receivables	3.2.21	**12,833**	10,384
Other financial assets		**0**	0
Other current assets		**0**	0
Cash and cash equivalents	3.2.22	**6,112**	3,328
Sub-total current assets		**19,170**	13,937
Non-current assets held for sale	3.2.23	**0**	600
Total current assets		**(1,334)**	14,537
Total assets		**96,187**	96,228
Current liabilities			
Trade and other payables	3.2.24	**(17,460)**	(11,320)
Other liabilities		**0**	0
Provisions	3.2.26	**(23)**	(16)
Borrowings		**0**	0
Other financial liabilities		**0**	0
DH revenue support loan		**0**	0
DH capital loan		**0**	0
Total current liabilities		**(17,483)**	(11,336)
Net current assets/(liabilities)		**1,687**	3,201
Total assets less current liabilities		**78,704**	84,892
Non-current liabilities			
Trade and other payables	3.2.24	**0**	(703)
Total non-current liabilities		**0**	(703)
Total assets employed:		**78,704**	84,189
Financed by			
Public Dividend Capital		**79,982**	81,482
Retained earnings		**(1,334)**	(3,531)
Revaluation reserve		**2,454**	9,339
Charitable Funds Reserve			
Other reserves		**(2,398)**	(3,101)
Total Taxpayers' Equity		**78,704**	84,189

The notes on pages 104 to 138 form part of this account.

The financial statements on pages 99 to 102 were approved by the Board on 31 May 2016 and signed on its behalf by

Chief Executive:

Paul Jennings

Date: 31 May 2016

3.1.3 Statement of Changes in Taxpayers' Equity for the year ending 31 March 2016

	Public Dividend capital £000s	Retained earnings £000s	Revaluation reserve £000s	Other reserves £000s	Total reserves £000s
Balance at 1 April 2015	**81,482**	**(3,531)**	**9,339**	**(3,101)**	**84,189**
Changes in taxpayers' equity for 2015-16					
Retained surplus/(deficit) for the year		2,166			**2,166**
Impairments and reversals (*)			(6,854)		**(6,854)**
Transfers between reserves		31	(31)		**0**
Reclassification Adjustments					
Permanent PDC repaid in year (**)	(1,500)				**(1,500)**
Net actuarial gain/(loss) on pension (***)				703	**703**
Net recognised revenue/(expense) for the year	**(1,500)**	**2,197**	**(6,885)**	**703**	**(5,485)**
Balance at 31 March 2016	**79,982**	**(1,334)**	**2,454**	**(2,398)**	**78,704**
Balance at 1 April 2014	**81,482**	**(3,024)**	**7,446**	**(2,801)**	**83,103**
Changes in taxpayers' equity for the year ended 31 March 2015					
Retained surplus/(deficit) for the year		1,386			1,386
Other gains / (loss) (****)				55	55
Reclassification Adjustments					
Other movements (*****)	0	(1,893)	1,893	(26)	(26)
Net actuarial gain/(loss) on pension				(329)	(329)
Net recognised revenue/(expense) for the year	**0**	**(507)**	**1,893**	**(300)**	**1,086**
Balance at 31 March 2015	**81,482**	**(3,531)**	**9,339**	**(3,101)**	**84,189**

(*) During 2015-16, the carrying value of property assets was reviewed by external assessors and revalued based upon the Depreciated Replacement Cost Method of Valuation

(**) £1,500,000 was repaid to the Department of Health as part of the capital to revenue transfer

(***) This movement is based on a reduction in expected liabilities relating to colleagues who have part or all of their pension benefits in the Local Government Pension Scheme

(****) Value of assets donated in year

(*****) This includes the transfer of prior year £2,177,000 write-off of PCT revaluation reserve to retained earnings, as the PCT revaluation reserve was not transferred to the Trust in 2013-14 as had been previously reported. The remainder of the reserve movement relates to transferring depreciation on revalued assets that has been charged to earnings in year in 2014-15.

3.1.4 Statement of Cash Flows for the Year ended 31 March 2016

	NOTE	2015-16 £000s	2014-15 £000s
Cash Flows from Operating Activities			
Operating surplus/(deficit)		**4,788**	4,032
Depreciation and amortisation		**1,912**	3,203
Impairments and reversals		**397**	0
Donated Assets received credited to revenue but non-cash		**(139)**	0
PDC Dividend (paid)/refunded		**(2,724)**	(2,688)
(Increase)/Decrease in Inventories		**0**	(225)
(Increase)/Decrease in Trade and Other Receivables		**(2,449)**	(2,150)
Increase/(Decrease) in Trade and Other Payables		**8,869**	(2,610)
Provisions utilised		**(10)**	(339)
Increase/(Decrease) in movement in non cash provisions		**17**	0
NHS Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows			
Net Cash Inflow/(Outflow) from Operating Activities		**10,661**	(777)
Cash Flows from Investing Activities			
Interest Received		**0**	19
(Payments) for Property, Plant and Equipment		**(6,043)**	(2,669)
(Payments) for Intangible Assets		**(934)**	0
Proceeds of disposal of assets held for sale (PPE) (*)		**600**	0
Rental Revenue		**0**	38
NHS Charitable Funds - net cash flows relating to investing activities			
Net Cash Inflow/(Outflow) from Investing Activities		**(6,377)**	(2,612)
Net Cash Inform / (outflow) before Financing		**4,284**	(3,389)
Cash Flows from Financing Activities			
Gross Temporary (2014/15 only) and Permanent PDC Repaid (**)		**(1,500)**	0
Net Cash Inflow/(Outflow) from Financing Activities		**(1,500)**	0
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**2,784**	(3,389)
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**3,328**	6,717
Effect of exchange rate changes in the balance of cash held in foreign currencies		**0**	0
Cash and Cash Equivalents (and Bank Overdraft) at year end	3.2.22	**6,112**	3,328

(*) The £600,000 was received for the sale of surplus land at Tewkesbury to local GPs for them to build a practice on site adjacent to the new Community Hospital

(**) £1,500,000 was repaid to the Department of Health as part of the capital to revenue transfer

Notes

3.2 Note to the Accounts

3.2.1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS Trusts shall meet the accounting requirements of the Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2015-16 issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

i) Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

ii) Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

iii) Movement of assets within the DH Group

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Treasury FReM. The FReM does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the SOCI, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

iv) Charitable Funds

Under the provisions of IAS 27 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies can be consolidated within the entity's financial statements. In accordance with IAS 1 Presentation of Financial Statements, restated prior period accounts are presented where the adoption of the new policy has a material impact. The Trust has agreed with its auditors not to consolidate its charitable funds as they are considered immaterial. The Charitable Fund "Gloucestershire Care Services NHS Trust Charitable Fund", charity number 1096480 reports its accounts annually to the Charities Commission.

v) Pooled Budgets

The Trust receives funds from a pooled budget between Gloucestershire Clinical Commissioning Group and Gloucestershire County Council. Under the arrangement, funds are pooled under S75 of the NHS Act 2006 for community activities. The pool is hosted by Gloucestershire County Council. Payment for services provided by the Trust are accounted for as income from Gloucestershire County Council.

vi) 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.

Critical 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.

Going Concern - after making enquiries, the directors have a reasonable expectation that the 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 these financial statements.

Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the Statement of Financial Position date, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

The critical estimates and judgements made in applying the Trust's accounting policies are detailed in the notes to the annual financial statements as listed below:

- Asset Valuations and Lives: see note 3.2.16c)
- Impairments of Receivables: see note 3.2.21c)
- Provisions; see note 3.2.26
- Accruals

vii) Revenue

Revenue 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 revenue for the Trust is from commissioners for healthcare services.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

viii) 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 leave 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.

Retirement benefit costs

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, in England and Wales. The scheme is 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, the scheme is accounted for as if it were a defined contribution scheme: the cost to the Trust of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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 expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

Some employees are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme. The scheme's assets and liabilities attributable to those employees can be identified and are recognised in the Trust's accounts. The assets are measured at a fair value, and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within operational expenses. Actuarial gains and losses during the year are recognised in the General Fund and reported on the Statement of Changes in Taxpayer's Equity.

The Trust also offers a National Employment Savings Trust (NEST) pension scheme for employees who do not or cannot access the NHS pension scheme. The scheme is provided by NEST Corporation (www.nestpensions.org.uk) and the Trust contributes 1% of relevant salaries. The scheme is a defined contribution scheme.

ix) Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

x) Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- collectively, a number of items have a cost of at least £5,000 and individually have 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
- items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values for land and buildings are determined using the depreciated replacement cost method.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

All buildings were revalued during 2015-16 and all specialised buildings revalued at depreciated replacement cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

xi) Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset.

Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

xii) Depreciation, amortisation and impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

xiii) Donated assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

xiv) Government grants

Government grant funded assets are capitalised at their fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

xv) Non-current assets held for sale

The Trust has no non-current assets held for sale.

xvi) Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the Trust's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

The Trust as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

xvii) Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

xviii) Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management.

xix) Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

xx) Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. 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 3.2.26.

xxi) 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 as and when they become due.

xxii) Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

xxiii) Financial assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

xxiv) Financial liabilities

Financial liabilities are recognised on the statement of financial position when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

xxv) Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

xxvi) Foreign currencies

The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Trust's surplus/deficit in the period in which they arise.

xxvii) Third party assets

Assets belonging to third parties (such as money held on behalf of service users) are not recognised in the accounts since the Trust has no beneficial interest in them.

xxviii) Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the Trust. At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets and cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

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 the audit of the annual accounts.

xxix) Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature, they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

xxx) Subsidiaries

Material entities over which the Trust has the power to exercise control are classified as subsidiaries and are consolidated. The Trust has control when it is exposed to or has rights to variable returns through its power over another entity. The income and expenses; gains and losses; assets, liabilities and reserves; and cash flows of the subsidiary are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Trust or where the subsidiary's accounting date is not co-terminus.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

xxxi) Research and Development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SOCI on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

xxxii) Accounting Standards that have been issued but have not yet been adopted

The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2015-16. These standards are still subject to HM Treasury FReM interpretation, 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 for Contracts with Customers** - Application required for accounting periods beginning on or after 1 January 2017, 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.

3.2.2 Operating segments

The vast majority of the Trust's income comes under a block arrangements from one collaborative commissioning contract with the Gloucestershire Clinical Commissioning Group and so segmental analysis is not reported.

3.2.3 Revenue from care activities

	2015-16 £000s	2014-15 £000s
NHS Trusts	**44**	84
NHS England	**7,719**	9,272
Clinical Commissioning Groups	**92,479**	90,881
Foundation Trusts	**5,809**	7,041
Department of Health	**0**	0
NHS Other (including Public Health England and Prop Co)	**241**	1,098
Additional income for delivery of healthcare services	**1,500**	0
Non-NHS		
Local Authorities	**2,786**	2,712
Private patients	**2**	3
Overseas patients (non-reciprocal)	**1**	0
Injury costs recovery	**482**	280
Other	**1,878**	1,056
Total Revenue from care activities	**112,941**	112,427

Other revenue includes contract income for; staff provided to other NHS bodies; provision of care through out of area treatments via the Welsh Aneurin Bevan Health Board; non NHS Dental income; and provision of occupational therapy to other bodies.

3.2.4. Other operating revenue

Education, training and research	**616**	1,541
Charitable and other contributions to revenue expenditure - non-NHS	**10**	0
Receipt of donations for capital acquisitions - Charity	**139**	0
Income generation (other fees and charges)	**116**	0
Rental revenue from operating leases	**83**	141
Other revenue	**0**	2
Total Other Operating Revenue	**964**	1,684
Total operating revenue	**113,905**	114,111

3.2.5. Overseas Visitors' Disclosure

Income recognised during 2015-16 (invoiced amounts and accruals)	**1**	0
Cash payments received in-year (iro invoices issued 2014-15)	**1**	0

3.2.6 Operating Expenses

	2015-16 £000s	2014-15 £000s
Services from other NHS Trusts	**80**	214
Services from CCGs/NHS England	**0**	11
Services from other NHS bodies	**12**	804
Services from NHS Foundation Trusts	**5,381**	5,415
Total Services from NHS bodies*	**5,473**	6,444
*Services from NHS bodies do not include expenditure which falls into a category that is analysed separately		
Purchase of healthcare from non-NHS bodies	**430**	399
Purchase of Social Care	**154**	
Trust Chair and Non-executive Directors	**64**	61
Supplies and services - clinical	**7,683**	3,702
Supplies and services - general	**1,193**	3,075
Consultancy services	**50**	772
Establishment	**3,454**	2,652
Transport	**176**	201
Business rates paid to local authorities	**0**	831
Premises	**6,435**	5,578
Hospitality	**24**	5
Insurance	**126**	149
Legal Fees	**25**	118
Impairments and Reversals of Receivables	**196**	(254)
Depreciation	**1,874**	3,203
Amortisation	**38**	0
Impairments and reversals of property, plant and equipment	**397**	0
Audit fees	**107**	81
Other auditor's remuneration	**122**	0
Clinical negligence	**237**	280
Education and Training	**760**	750
Other	**831**	9
Total Operating expenses (excluding employee benefits)	**29,849**	28,056
Employee Benefits		
Employee benefits excluding Board members	**78,145**	81,025
Board members	**1,123**	998
Total Employee Benefits	**79,268**	82,023
Total Operating Expenses	**109,117**	110,079

3.2.7 Operating Leases

Gloucestershire Care Services as lessee

	Land £000s	Buildings £000s	Other £000s	2015-16 £000s	2014-15 £000s
Payments recognised as an expense					
Minimum lease payments				**412**	556
Contingent rents				**977**	0
Sub-lease payments				**0**	0
Total				**1,389**	**556**
Payable					
No later than one year	62	527	145	**734**	694
Between one and five years	192	1,782	803	**2,777**	1,974
After five years	562	4,206	401	**5,169**	5,357
Total	**816**	**6,515**	**1,349**	**8,680**	8,025
Total future sublease payments expected to be received:				0	0

Gloucestershire Care Services as lessor

	2015-16 £000s	2014-15 £000s
Recognised as revenue		
Rental revenue	**0**	0
Contingent rents	**83**	141
Total	**83**	141
Receivable		
No later than one year	**270**	141
Between one and five years	**122**	0
After five years	**0**	0
Total	**392**	141

3.2.8 Employee benefits

Employee Benefits - Gross Expenditure 2015-16	Total £000s	Permanently employed £000s	Other £000s
Salaries and wages	**67,062**	63,345	3,717
Social security costs	**4,043**	4,043	0
Employer Contributions to NHS BSA - Pensions Division	**8,163**	8,163	0
Other pension costs	**0**	0	0
Termination benefits	**0**	0	0
Total employee benefits	**79,268**	**75,551**	**3,717**
Employee costs capitalised	**0**	**0**	**0**
Gross Employee Benefits excluding capitalised costs	**79,268**	**75,551**	**3,717**
Employee Benefits - Gross Expenditure 2014-15			
Salaries and wages	**70,976**	67,522	3,454
Social security costs	**3,728**	3,728	0
Employer Contributions to NHS BSA - Pensions Division	**7,074**	7,074	0
Other pension costs	**159**	159	0
Termination benefits	**86**	86	0
TOTAL - including capitalised costs	**82,023**	**78,569**	**3,454**
Employee costs capitalised	**0**	**0**	**0**
Gross Employee Benefits excluding capitalised costs	**82,023**	**78,569**	**3,454**

3.2.9 Staff Numbers

Average Staff Numbers	2015-16 Total Number	Permanently employed Number	Other Number	2014-15 Total Number
Medical and dental	**28**	28	0	32
Administration and estates	**430**	395	35	444
Healthcare assistants and other support staff	**91**	90	1	97
Nursing, midwifery and health visiting staff	**1,088**	1,071	17	1,081
Nursing, midwifery and health visiting learners	**10**	4	6	36
Scientific, therapeutic and technical staff	**460**	448	12	469
Other	**4**	4	0	5
TOTAL	**2,112**	**2,040**	**73**	2,164
Of the above - staff engaged on capital projects	**0**	0	0	0

Staff sickness absence and ill health retirements	2015-16	2014-15
Total Days Lost	**35,211**	36,143
Total Staff Years	**752,265**	744,854
Average working Days Lost	**0.05**	0.05
Number of persons retired early on ill health grounds	**11**	4
	£000s	**£000s**
Number of persons retired early on ill health grounds	**0**	0

3.2.10 Exit packages agreed in 2015-16

Exit package cost band (including any special payment element)	*Number of compulsory redundancies Number	Cost of compulsory redundancies £s	Number of other departures agreed Number	Total number of exit packages Number	Total cost of exit packages £s	Number of Departures where special payments have been made Number	Cost of special payment element included in exit packages £
Less than £10,000	2	7,927	25	27	151,120	0	0
£10,000-£25,000	2	37,866	9	11	170,605	0	0
£25,001-£50,000	2	84,868	1	3	113,403	0	0
£50,001-£100,000	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0
Total	**6**	**130,661**	**35**	**41**	**435,128**	**0**	**0**
2014-15							
Less than £10,000	3	16,543	3	6	27,276	0	0
£10,000-£25,000	3	50,226	1	4	61,652	0	0
£25,001-£50,000	0	0	0	0	0	0	0
£50,001-£100,000	1	87,506	0	1	87,506	0	0
£100,001 - £150,000	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0
Total	**7**	**154,275**	**4**	**11**	**176,434**	**0**	**0**

Redundancy and other departure costs have been paid in accordance with the provisions of Agenda for Change or National Medical and Dental Terms and Conditions. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are not included in the table.

(*) Any non-contractual payments in lieu of notice are disclosed under "non-contractual payments requiring HMT approval" below

This disclosure reports the number and value of exit packages agreed in the year. Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

3.2.11 Exit packages - Other departures analysis

	2015-16		2014-15	
	Agreements Number	Total value of agreements £000s	Agreements Number	Total value of agreements £000s
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	27	273	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	8	31	4	22
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval*	0	0	0	0
Total	**35**	**304**	**4**	**22**
Non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary	0	0	0	**0**

As a single exit packages can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 3.2.10 which will be the number of individuals.

*Includes any non-contractual severance payment made following judicial mediation or non-contractual payments in lieu of notice.

The Remuneration Report includes disclosure of exit payments payable to individuals named in that report.

3.2.12 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 Trust of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years".

An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and 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.

Local Government Pension Scheme (LGPS)

As part of the S75 Integrated Services arrangements, the Trust employs staff who were TUPEd from Gloucestershire County Council. As part of the TUPE transfer, former local authority staff could elect to remain in the LGPS. The LGPS is a defined benefit statutory scheme administered by the County Council in accordance with the LGPS (Benefits, Membership and Contributions) Regulations 2007; the LGPS (Administration) Regulations 2008 and the LGPS (Transitional Provisions) Regulations 2008. It is contracted out of the State Second Pension.

During the financial period 1 April 2015 to 31 March 2016, the Trust's pension contributions totalled £133k and employees' contributions totalled £26k.

Period end	31 March 2016 %	31 March 2015 %
Pension Increase Rate	2.2%	2.4%
Salary Increase Rate	3.7%	3.8%
Discount Rate	3.9%	3.2%

The fair value of employer assets of the whole fund as at 31 March 2016 is as shown below:

Assets	31 March 2016 £000s	%	31 March 2015 £000s	%
Equity Securities	1,256	19%	1,200	18%
Debt Securities	1,050	16%	1,078	16%
Private Equity	19	0%	19	0%
Real Estate	519	8%	469	8%
Investment Funds & Unit Trusts	3,622	55%	3,663	57%
Derivatives	-1	0%	0	0%
Cash and Cash Equivalents	72	1%	99	2%
Total	**6,537**	**100%**	**6,528**	**100%**

The details of the Trust's share of assets and the net position as included in the accounts are as follows:

	Assets £000s	Obligations £000s	Net Liability £000s
Fair Value of employer assets	6,528		6,528
Present value of funded liabilities		-7,231	-7,231
Opening position at 31 March 2015	**6,528**	**-7,231**	**-703**
Current service cost		-181	-181
Net interest			
Interest on plan assets	209		209
Interest cost on defined benefit obligation		-233	-233
Total net interest	209	-233	-24
Total defined benefit cost recognised in Profit or Loss	209	-414	-205
Cashflow			
Participants contributions	26	-26	0
Employer contributions	133		133
Benefits paid	-129	129	0
Expected closing position	**6,767**	**-7,542**	**-775**
Remeasurements			
Change in financial assumptions	0	1,172	1,172
Other experience		40	40
Returns on assets excluding amounts included in net interest	-230		-230
Total remeasurements recognised in other comprehensive income	-230	1,212	982
Fair value of employer assets	6,537		6,537
Present Value of funded liabilities		-6,330	-6,330
Closing position at 31 March 2016	**6,537**	**-6,330**	**207**
In Year Movement	**9**	**901**	**910**

The in year reduction in net liability has been credited to reserves. The Trust has elected not to create an asset on its balance sheet as there is no scenario where any surplus assets will become the property of the Trust.

3.2.13 Better Payment Practice Code

Measure of compliance

	2015-16 Number	2015-16 £000s	2014-15 Number	2014-15 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**28,330**	**29,213**	29,772	27,479
Total Non-NHS Trade Invoices Paid Within Target	**26,005**	**26,344**	27,447	25,200
Percentage of NHS Trade Invoices Paid Within Target	**91.8%**	**90.2%**	92.2%	91.7%
NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**380**	**5,265**	658	12,956
Total Non-NHS Trade Invoices Paid Within Target	**191**	**4,816**	458	9,233
Percentage of NHS Trade Invoices Paid Within Target	**50.3%**	**91.5%**	69.6%	71.3%

The Better Payment Practice Code requires the Trust to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

The Late Payment of Commercial Debts (Interest) Act 1998

	2015-16 £000s	2014-15 £000s
Amounts included in finance costs from claims made under this legislation	**0**	0
Compensation paid to cover debt recovery costs under this legislation	**0**	0
Total	**0**	0

3.2.14 Investment Revenue

	2015-16 £000s	2014-15 £000s
Rental revenue		
PFI finance lease revenue (planned)	**0**	0
PFI finance lease revenue (contingent)	**0**	0
Other finance lease revenue	**0**	0
Subtotal	**0**	0
Interest revenue		
LIFT: equity dividends receivable	**0**	0
LIFT: loan interest receivable	**0**	0
Bank interest	**19**	19
Other loans and receivables	**0**	0
Impaired financial assets	**0**	0
Other financial assets	**0**	0
Subtotal	**19**	19
Total investment revenue	**19**	19

3.2.15 Finance Costs

	2015-16 £000s	2014-15 £000s
Interest on obligations under LIFT contracts		
Total interest expense	**0**	0
Other finance costs	**4**	15
Total	**4**	15

3.2.16 Property, plant and equipment

3.2.16a) Property, plant and equipment 2015-16

Cost or valuation	Land £000's	Buildings excluding dwellings £000's	Dwellings £000's	Assets under construction & payments on account £000's	Plant & machinery £000's	Transport equipment £000's	Information technology £000's	Furniture & fittings £000's	Total £000's
At 1 April 2015	11,360	67,170	0	3,672	6,926	160	2,226	1,772	**93,286**
Additions of Assets Under Construction				1,984					**1,984**
Additions Purchased	600	705	0		13	0	101	13	**1,432**
Additions - Non Cash Donations (i.e. physical assets)	0	0	0	0	139	0	0	0	**139**
Reclassifications	250	1,633	0	(3,363)	489	0	455	176	**(360)**
Impairment/reversals charged to operating expenses	0	(397)	0	0	0	0	0	0	**(397)**
Impairments/reversals charged to reserves	(411)	(3,378)	0	0	(2,458)	0	274	(881)	**(6,854)**
At 31 March 2016	**11,799**	**65,733**	**0**	**2,293**	**5,109**	**160**	**3,056**	**1,080**	**89,230**
Depreciation									
At 1 April 2015	0	9,342	0		1,405	46	436	366	11,595
Charged During the Year	0	906	0		489	23	377	79	1,874
At 31 March 2016	**0**	**10,248**	**0**	**0**	**1,894**	**69**	**813**	**445**	**13,469**
Net Book Value at 31 March 2016	**11,799**	**55,485**	**0**	**2,293**	**3,215**	**91**	**2,243**	**635**	**75,761**
Asset financing									
Owned - Purchased	11,799	55,485	0	2,293	3,021	91	2,243	635	75,567
Owned - Donated	0	0	0	0	194	0	0	0	194
Total at 31 March 2016	**11,799**	**55,485**	**0**	**2,293**	**3,215**	**91**	**2,243**	**635**	**75,761**

Revaluation Reserve Balance for Property, Plant & Equipment	Land £000's	Buildings excluding dwellings £000's	Dwellings £000's	Assets under construction & payments on account £000's	Plant & machinery £000's	Transport equipment £000's	Information technology £000's	Furniture & fittings £000's	Total £000's
At 1 April 2015	250	9,089	0	0	0	0	0	0	9,339
Movement	(250)	(6,635)	0	0	0	0	0	0	(6,885)
At 31 March 2016	**0**	**2,454**	**0**	**0**	**0**	**0**	**0**	**0**	**2,454**
Additions to Assets Under Construction in 2014-15									
Buildings excl Dwellings				1,044					
Plant & Machinery				940					
Balance as at YTD				**1,984**					

3.2.16b) Property, plant and equipment prior-year (2014-15)

	Land £000's	Buildings excluding dwellings £000's	Dwellings £000's	Assets under construction & payments on account £000's	Plant & machinery £000's	Transport equipment £000's	Information technology £000's	Furniture & fittings £000's	Total £000's
Cost or valuation									
At 1 April 2014	13,340	63,178	0	2,217	5,656	160	1,347	4,254	90,152
Additions of Assets Under Construction				3,679					3,679
Additions - Purchases from Cash	0	0	0	0	55	0	0	0	55
Donations & Government Grants									
Reclassifications	(1,380)	3,992	0	(2,224)	1,215	0	879	(2,482)	0
Reclassifications as Held for Sale and Reversals	(600)	0	0	0	0	0	0	0	(600)
At 31 March 2015	**11,360**	**67,170**	**0**	**3,672**	**6,926**	**160**	**2,226**	**1,772**	**93,286**
Depreciation									
At 1 April 2014	0	7,302	0	0	733	23	149	185	8,392
Charged During the Year	0	2,040	0		672	23	287	181	3,203
At 31 March 2015	**0**	**9,342**	**0**	**0**	**1,405**	**46**	**436**	**366**	**11,595**
Net Book Value at 31 March 2015	**11,360**	**57,828**	**0**	**3,672**	**5,521**	**114**	**1,790**	**1,406**	**81,691**
Asset financing									
Owned - Purchased	11,360	57,828	0	3,672	5,466	114	1,790	1,406	81,636
Owned - Donated	0	0	0	0	55	0	0	0	55
Total at 31 March 2015	**11,360**	**57,828**	**0**	**3,672**	**5,521**	**114**	**1,790**	**1,406**	**81,691**

3.2.16c) Asset Valuation

For assets held at revalued amounts:

Land and buildings were revalued as at 1st April 2015 by Cushman and Wakefield RICS (Royal Institution of Chartered Surveyors). The valuations were carried out using the Depreciated Replacement Cost method (DRC) and assumed the replacement would be a Modern Equivalent Asset located somewhere where services could be provided which is not neccessarily on the same site as the current asset.

This revaluation had the impact of reducing the carrying value of assets by £7,215k.

Asset Lives per Asset Class
Land - Not depreciated
Buildings - between 5 and 87 years
Plant and Machinery - between 5 and 15 years
Fixtures and fittings - between 5 and 10 years
Transport equipment - 7 years

3.2.17 Intangible non-current assets

3.2.17a) Intangible non-current assets 2015-16

	IT - in-house & 3rd party software £000s	Computer Licenses £000s	Licenses and Trademarks £000s	Patents £000s	Development Expenditure - Internally Generated £000s	Total £000s
At 1 April 2015	0	0	0	0	0	**0**
Additions Purchased	934	0	0	0	0	**934**
Reclassifications	360	0	0	0	0	**360**
At 31 March 2016	**1,294**	**0**	**0**	**0**	**0**	**1,294**
Amortisation	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
At 1 April 2015	0	0	0	0	0	**0**
Charged During the Year	38	0	0	0	0	**38**
At 31 March 2016	**38**	**0**	**0**	**0**	**0**	**38**
Net Book Value at 31 March 2016	1,256	0	0	0	0	**1,256**
Asset Financing: Net book value at 31 March 2016 comprises						
Purchased	1,256	0	0	0	0	**1,256**
Total at 31 March 2016	**1,256**	**0**	**0**	**0**	**0**	**1,256**

3.2.17b) Intangible non-current assets prior year (2014-15)

The Trust had no intangible assets prior to April 2015.

3.2.17c) Intangible non-current assets

The only intangible assets that the Trust recognises are costs of significant third party software. The gross value is taken as the purchase price and the economic life is 5 years.

3.2.18 Analysis of impairments and reversals recognised in 2015-16

	2015-16 Total £000s
Property, Plant and Equipment impairments and reversals taken to SoCI	
Loss or damage resulting from normal operations	0
Over-specification of assets	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	**0**
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	397
Total charged to Annually Managed Expenditure	**397**
Total Impairments of Property, Plant and Equipment changed to SoCI	**397**
Intangible assets impairments and reversals charged to SoCI	
Loss or damage resulting from normal operations	0
Over-specification of assets	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	**0**
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	0
Total charged to Annually Managed Expenditure	**0**
Total Impairments of Intangibles charged to SoCI	**0**
Financial Assets charged to SoCI	
Loss or damage resulting from normal operations	0
Total charged to Departmental Expenditure Limit	0
Loss as a result of catastrophe	0
Other	0
Total charged to Annually Managed Expenditure	**0**
Total Impairments of Financial Assets charged to SoCI	**0**
Non-current assets held for sale - impairments and reversals charged to SoCI	
Loss or damage resulting from normal operations	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	**0**
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	0
Total charged to Annually Managed Expenditure	**0**
Total impairments of non-current assets held for sale charged to SoCI	**0**
Total Impairments charged to SoCI - DEL	**0**
Total Impairments charged to SoCI - AME	**397**
Overall Total Impairments	**397**
Donated and Gov Granted Assets, included above	
PPE - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	0
Intangibles - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	0

	Property Plant and Equipment £000s	Intangible Assets £000s	Financial Assets £000s	Non-Current Assets Held for Sale £000s	Total £000s
Impairments and reversals taken to SoCI	0	0	0	0	
Loss or damage resulting from normal operations	0	0	0	0	**0**
Over-specification of assets	0	0	0	0	**0**
Abandonment of assets in the course of construction	0	0	0	0	**0**
Total charged to Departmental Expenditure Limit	**0**	**0**	**0**	**0**	**0**
	0	0	0	0	
Unforeseen obsolescence	0	0	0	0	**0**
Loss as a result of catastrophe	0	0	0	0	**0**
Other	0	0	0	0	**0**
Changes in market price	397	0	0	0	**397**
Total charged to Annually Managed Expenditure	**397**	**0**	**0**	**0**	**397**
Total Impairments of Property, Plant and Equipment changed to SoCI	**397**	**0**	**0**	**0**	**397**

Donated and Gov Granted Assets, included above	£000s
PPE - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	**0**
Intangibles - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	**0**

3.2.19 Intra-Government and other balances

	Current receivables	Non-current receivables	Current payables	Non-current payables
	£000s	£000s	£000s	£000s
Balances with Other Central Government Bodies	0	0	2,089	0
Balances with Local Authorities	1,177	0	0	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS bodies inside the Departmental Group	8,171	0	5,482	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with Bodies External to Government	3,485	0	9,889	0
At 31 March 2016	**12,883**	**0**	**17,460**	**0**
Prior period				
Balances with Other Central Government Bodies	0	0	2,440	0
Balances with Local Authorities	0	0	0	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS bodies inside the Departmental Group	6,060	0	1,198	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with Bodies External to Government	4,324	0	7,682	703
At 31 March 2015	**10,384**	**0**	**11,320**	**703**

3.2.20 Inventories

	Drugs	Consumables	Work in Progress	Energy	Loan Equipment	Other	Total	Of which held at NRV
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2015	**0**	**225**	**0**	**0**	**0**	**0**	**225**	**0**
Additions	0	1,493	0	0	0	0	**1,493**	0
Inventories recognised as an expense in the period	0	(1,493)	0	0	0	0	**(1,493)**	0
Balance at 31 March 2016	**0**	**225**	**0**	**0**	**0**	**0**	**225**	**0**

The Trust has identified levels of inventory at its seven community hospitals that require classification on the balance sheet. These have been estimated at £225,000. During 2016-17, a stock control system will be implemented to ensure control and reporting in this area is improved.

3.2.21 Current Assets

3.2.21a) Trade and other receivables

	31 March 2016	31 March 2015	31 March 2016	31 March 2015
	£000s	£000s	£000s	£000s
NHS receivables - revenue	5,992	6,008	**0**	0
NHS prepayments and accrued income	2,140	52	**0**	0
Non-NHS receivables - revenue	3,320	4,597	**0**	0
Non-NHS prepayments and accrued income	1,821	11	**0**	0
PDC Dividend prepaid to DH	40	0		
Provision for the impairment of receivables	(480)	(284)	**0**	0
Total	**12,833**	10,384	**0**	**0**
Total current and non current	**12,833**	10,384		
Included in NHS receivables are prepaid pension contributions:	**0**			

The great majority of transactions are with Gloucestershire Clinical Commissioning Group and NHS England. As NHS bodies are funded by Government to buy NHS care services, no credit scoring of them is considered necessary.

3.2.21b) Receivables past their due date but not impaired

	31 March 2016	31 March 2015
	£000s	£000s
By up to three months	**2,485**	4,160
By three to six months	**1,959**	686
By more than six months	**2,480**	644
Total	**6,924**	**5,490**

3.2.21c) Provision for impairment of receivables

	2015-16	2014-15
	£000s	£000s
Balance at 1 April 2015	**(284)**	(538)
Amount written off during the year	**0**	0
Amount recovered during the year	**284**	0
(Increase)/decrease in receivables impaired	**(480)**	254
Transfers to NHS Foundation Trust on authorisation as FT	**0**	
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	**0**	0
Balance at 31 March 2016	**(480)**	**(284)**

The only significant debt being provided for is against Gloucestershire County Council.

3.2.22 Cash and Cash Equivalents

	31 March 2016	31 March 2015
	£000s	£000s
Opening balance	**3,328**	6,717
Net change in year	**2,784**	3,389
Closing balance	**6,112**	**3,328**
Made up of		
Cash with Government Banking Service	**6,111**	3,328
Commercial banks	**0**	0
Cash in hand	**1**	0
Liquid deposits with NLF	**0**	0
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**6,112**	3,328
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**6,112**	**3,328**
Third Party Assets - Bank balance (not included above)	0	0
Third Party Assets - Monies on deposit	0	0

3.2.23 Non-current assets held for sale

	Land	Buildings, excl. dwellings	Dwellings	Asset Under Construction and Payments on Account	Plant and Machinery	Transport and Equipment	Information Technology	Furniture and Fittings	Intangible Assets	Financial Assets	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Balance at 1 April 2015	600	0	0	0	0	0	0	0	0	0	600
Plus assets classified as held for sale in the year	0	0	0	0	0	0	0	0	0	0	0
Less assets sold in the year	(600)	0	0	0	0	0	0	0	0	0	(600)
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	0
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	0
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	0	0
Transfers to Foundation Trust on authorisation as FT	0	0	0	0	0	0	0	0	0	0	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2016	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2016	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Balance at 1 April 2014	0	0	0	0	0	0	0	0	0	0	0
Plus assets classified as held for sale in the year	**600**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**600**
Less assets sold in the year	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	0
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	0
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	0	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Balance at 31 March 2015	**600**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**600**
Liabilities associated with assets held for sale at 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

The asset sold during the year was a piece of land at Tewkesbury that was surplus to Trust requirements following the demolition of the old Tewkesbury Hospital. It was revalued at the point of transfer to the Trust and was sold for the same value leaving no profit or loss on disposal of the asset. The land was sold to GPs in line with the requirements of a Heads of Terms that passed to the Trust from the predecessor Primary Care Trust upon its demise.

3.2.24 Trade and other payables

	Current		Non-current	
	31 March 2016	31 March 2015	31 March 2016	31 March 2015
	£000s	£000s	£000s	£000s
NHS payables - revenue	**5,694**	1,151	**0**	0
NHS payables - capital	**0**	0	**0**	0
NHS accruals and deferred income	**(482)**	0	**0**	0
Non-NHS payables - revenue	**4,065**	2,739	**0**	0
Non-NHS payables - capital	**1,511**	4,943	**0**	0
Non-NHS accruals and deferred income	**4,312**	0	**0**	0
Social security costs	**1,650**	1,854		
PDC Dividend payable to DH	**0**	47		
Accrued Interest on DH Loans	**0**			
VAT	**(53)**	34	**0**	0
Tax	**492**	552		
Payments received on account	**1**	0	**0**	0
Other	**0**	0	**0**	703
Total	**17,460**	11,320	**0**	**703**
Total payables (current and non-current)	**17,460**	12,023		
Included above:				
Outstanding Pension Contributions at the year end	**980**	0		

3.2.25 Deferred income

	Current		Non-current	
	31 March 2016	31 March 2015	31 March 2016	31 March 2015
	£000s	£000s	£000s	£000s
Opening balance at 1 April 2015	**220**	220	**0**	0
Deferred revenue addition	**0**	0	**0**	0
Transfer of deferred revenue	**0**	0	**0**	0
Current deferred Income at 31 March 2016	**220**	220	**0**	**0**
Total deferred income (current and non-current)	**220**	220		

3.2.26 Provisions

	Total	Early Departure Costs	Legal Claims	Restructuring	Continuing Care	Equal Pay (inc. Agenda for Change	Other	Redundancy
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2015	**16**	0	16	0	0	0	0	0
Arising during the year	**23**	0	23	0	0	0	0	0
Utilised during the year	**(10)**	0	(10)	0	0	0	0	0
Reversed unused	**(6)**	0	(6)	0	0	0	0	0
Balance at 31 March 2016	**23**	**0**	**23**	**0**	**0**	**0**	**0**	**0**
Expected Timing of Cash Flows:								
No Later than One Year	**23**	0	23	0	0	0	0	0
Later than One Year and not later than Five Years	**0**	0	0	0	0	0	0	0
Later than Five Years	**0**	0	0	0	0	0	0	0

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:

As at 31 March 2016	**228**
As at 31 March 2015	**705**

3.2.27 Contingencies

	31 March 2016	31 March 2015
	£000s	£000s
Contingent liabilities		
NHS Litigation Authority legal claims	**10**	0
Net value of contingent liabilities	**10**	**0**

3.2.28 Financial Instruments

3.2.28a) Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with Gloucestershire Clinical Commissioning Group and the way it is financed, the 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 listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds, and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Trust Board. The Trust's treasury activity is subject to review by the Trust's internal auditors.

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 therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust has no loans and therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31st March 2016 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups, which are financed through NHS England from resources voted annually by Parliament. The Trust funds its capital expenditure from its operation which generates a small surplus and is not therefore exposed to significant liquidity risks.

3.2.28b) Financial Assets

	At 'fair value through profit and loss'	Loans and receivables	Available for sale	Total
	£000s	£000s	£000s	£000s
Embedded derivatives	0			0
Receivables - NHS		0		0
Receivables - non-NHS		0		0
Cash at bank and in hand		6,112		6,112
Other financial assets	0	0	0	0
Total at 31 March 2016	**0**	**6,112**	**0**	**6,112**
Embedded derivatives	0			0
Receivables - NHS		6,060		6,060
Receivables - non-NHS		4,608		4,608
Cash at bank and in hand		3,328		3,328
Other financial assets	0	0	0	0
Total at 31 March 2015	**0**	**13,996**	**0**	**13,996**

3.2.28c) Financial Liabilities

	At 'fair value through profit and loss'	other	Total
	£000s	£000s	£000s
Embedded derivatives	0		0
NHS payables		500	500
Non-NHS payables		8,100	8,100
Other borrowings		0	0
PFI & finance lease obligations	0	0	0
Other financial liabilities	**0**	**0**	**0**
Total at 31 March 2016	0	8,600	8,600
Embedded derivatives	0		0
NHS payables		1,151	1,151
Non-NHS payables		10,169	10,169
Other borrowings		0	0
PFI & finance lease obligations		0	0
Other financial liabilities	0	0	0
Total at 31 March 2015	**0**	**11,320**	**11,320**

3.2.29 Events after the end of the reporting period

The Trust had no significant events after the end of the reporting period.

3.2.30 Related party transactions

During the year, none of the Department of Health Ministers, Trust Board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the Trust.

The Department of Health is regarded as a related party. During the year, the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. For example:

- CCGs
- NHS Foundation Trusts
- NHS Trusts
- NHS Litigation Authority
- NHS Business Services Authority

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Gloucestershire County Council in respect of joint commissioning of services. The Trust has also received revenue and capital payments from a number of charitable funds, certain of the trustees for which are also members of the Trust Board.

3.2.31 Losses and special payments

The total number of losses cases in 2015-16 and their total value was as follows:	Total Value of Cases	Total Number of Cases
	£s	
Losses	0	0
Special payments	14,265	11
Total losses and special payments	**14,265**	**11**

The total number of losses cases in 2014-15 and their total value was as follows:	Total Value of Cases	Total Number of Cases
	£s	
Losses	319	3
Special payments	7772	7
Total losses and special payments	**8,091**	**10**

3.2.32 Financial performance targets

3.2.32a) Breakeven performance

	2013-14	2014-15	2015-16
	£000s	£000s	£000s
Turnover	108,980	114,111	**114,873**
Retained surplus/(deficit) for the year	(3,024)	1,386	**(4,688)**
Adjustment for:			
Timing/non-cash impacting distortions:			
Pre FDL(97)24 agreements	0	0	**0**
2007/08 PPA (relating to 1997/98 to 2006/07)			
2008/09 PPA (relating to 1997/98 to 2007/08)			
Adjustments for impairments	5,845	0	**7,251**
Adjustments for impact of policy change re donated/government grants assets	(165)	122	**(62)**
Absorption accounting adjustment	(650)	0	**0**
Break-even in-year position	**2,006**	**1,508**	**2,501**
Break-even cumulative position	**2,006**	**3,514**	**6,015**

Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, the Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

	2013-14	2014-15	2015-16
	%	%	%
Materiality test (i.e. is it equal to or less than 0.5%)			
Break-even in-year position as a percentage of turnover	1.84	1.32	**2.20**
Break-even cumulative position as a percentage of turnover	1.84	3.08	**5.28**

3.2.32b) Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets based on the pre audited accounts and therefore the actual capital cost absorption rate is automatically 3.5%.

3.2.32c) External financing

The Trust is given an external financing limit which it is permitted to undershoot.

	2015-16 £000s	2014-15 £000s
External financing limit (EFL)	**(4,173)**	3,905
Cash flow financing	**(4,485)**	3,389
Finance leases taken out in the year	**0**	0
Other capital receipts	**0**	0
External financing requirement	**(4,485)**	3,389
Under/(over) spend against EFL	**312**	516

3.2.32d) Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2015-16 £000s	2014-15 £000s
Gross capital expenditure	**4,489**	3,679
Less: book value of assets disposed of	**(600)**	0
Less: capital grants	**0**	0
Less: donations towards the acquisition of non-current assets	**(139)**	0
Charge against the capital resource limit	**3,750**	3,679
Capital resource limit	**4,350**	4,000
(Over)/underspend against the capital resource limit	**600**	321

3.2.32e) Third party assets

The Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of service users or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	2015-16 £000s	2014-15 £000s
Third party assets held by the Trust	**1**	1

I hereby confirm that the above Financial Statements are a true and accurate representation of the described Trust activities in 2015-16.

Paul Jennings

Paul Jennings, Chief Executive
31 May 2016

3.3 Independent Auditor's Report to The Board of Directors of Gloucestershire Care Services NHS Trust

We have audited the financial statements of Gloucestershire Care Services NHS Trust for the year ended 31 March 2016 on pages 99 to 103 under the Local Audit and Accountability Act 2014. These financial statements have been prepared under applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to NHS Trusts in England. We have also audited the information in the Remuneration and Staff Report that is subject to audit.

This report is made solely to the Board of Directors of Gloucestershire Care Services NHS Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Board of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of Directors, the Accountable Officer and auditor

As explained more fully in the Statement of Directors' Responsibilities set out on page 143, the Directors are responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

As explained in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources. We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Scope of the 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 Directors; and the overall presentation of the financial statements.

In addition we read all the financial and non-financial information in the annual report and accounts 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.

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2015, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2016 and of the Trust's expenditure and income for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to NHS Trusts in England.

Opinion on other matters

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to NHS Trusts in England; and
- the other information published together with the audited financial statements in the Annual Report and Accounts is consistent with the financial statements.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the governance statement does not comply with the NHS Trust Development Authority's guidance; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014; or
- we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

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

Certificate

We certify that we have completed the audit of the accounts of Gloucestershire Care Services NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Jonathan Brown

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

Chartered Accountants
100 Temple Street
Bristol
BS1 6AG

PART 4
Trust Statements

4.1 Statement of the Chief Executive's responsibilities as Accountable Officer

The Chief Executive of the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer to the Trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers' Memorandum issued by the Chief Executive of the NHS Trust Development Authority. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets, and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the Trust;
- the expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the regulations set by the authorities which govern them;
- effective and sound financial management systems are in place; and
- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

I confirm that, as far as I am aware, there is no relevant audit information of which the Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information, and to establish that the Trust's auditors are aware of that information.

I confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the Annual Report and Accounts and the judgments required for determining that it is fair, balanced and understandable.

Paul Jennings

Paul Jennings, Chief Executive
31 May 2016

4.2 Statement of Directors' responsibilities in respect of the accounts

The Directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, Directors are required to:

- apply on a consistent basis, accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The Directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time, the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the Trust, and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

By order of the Board

Paul Jennings

Paul Jennings, Chief Executive
31 May 2016

Glyn Howells

Glyn Howells, Director of Finance
31 May 2016

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