Gloucestershire Care Services
NHS Trust

ANNUAL REPORT & ACCOUNTS 2014-15

Understanding You

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1. Statement from the Chair

During 2014-15, our second year as a standalone NHS organisation, I believe that we at Gloucestershire Care Services NHS Trust made significant progress towards making a reality of our vision, namely "To be the service that people rely on to understand them and to organise their care around their lives".

This vision challenges us to always put the people and communities that we serve at the centre of our thinking. It's supported by our Trust strapline - Understanding You - which also charges us with aligning care to service users' own priorities and needs. I trust that this Annual Report and Accounts will ably demonstrate a number of tangible ways in which we have delivered upon these ambitions.

Understanding You

We are not undertaking this journey alone. During the last year, we worked closely with a wide range of partners and stakeholders locally, regionally and nationally. In doing so, we represented our CORE values, and as such were 'Open' and 'Responsible' in engaging with statutory agencies, elected representatives and third sector organisations: similarly, our work with the people who use our services sought to ensure that we deliver the most 'Caring' and 'Effective' community services possible.

This winter, with huge demands upon services, it was particularly evident that the whole health and social care system depends upon strong joint working and cooperation between all parts of our health and social care community.

With this in mind, I would like highlight the following activities in 2014-15:

- throughout the year, Paul Jennings, Chief Executive, and I prioritised our attendance at the Gloucestershire Strategic Forum, which provides an important opportunity to meet with leaders of health and social care organisations serving the county, and allows us to ensure alignment of our strategic plans with those of the wider health and social care community;
- we also regularly attended the Health and Care Overview and Scrutiny Committee (HCOSC) in order to be open to challenge about our Trust's performance and contribution to the wider health and social care system. I was also pleased to be able to work closely with other NHS Chairs and the Gloucestershire County Council Cabinet Lead for Adult Services to give the Committee assurance regarding our continued partnership working at times of pressure. Further, the Trust met informally with HCOSC members to keep them appraised of developments in our services;
- we maintained an open and positive relationship with Gloucestershire Clinical Commissioning Group (GCCG), our major commissioner. In addition to the many formal executive level meetings, the Chief Executive and I met regularly with the GCCG Chair and Chief Officer to assess progress on agreed joint priorities;
- within 2014-15, local NHS Boards, along with social care colleagues, gave time to learning and developing together through Board to Board seminars. This year, I organised one of these sessions on the theme of 'Integration' which was led by Professor Jon Glasby. Another was hosted by Professor Clair Chilvers when Chris Hopson, Chief Executive of NHS Providers led a session on national policy priorities and challenges;
- as an elected representative of Chairs of Community NHS Trusts, I was pleased to serve on the national board of NHS Providers. This gave me opportunity to influence the national agenda on key policy matters, and to ensure that the voice of community trusts generally, and providers in Gloucestershire specifically, was heard;
- Paul and I regularly attended national meetings of Chairs and Chief Executives, and I attended national and regional Chairs' meetings in order to keep abreast of relevant agendas.

Of course, we also work in partnership with a range of organisations and individuals who make significant contribution to local services, and we continue to be indebted to their energy and commitment. Examples of partnerships in 2014-15 included the following:

- we held regular meetings and dialogue with Healthwatch Gloucestershire which acts as the champion of people who use health and social care in the county, and provides them with a voice. In particular this year, I was pleased to share with Dr. Claire Feehily, Healthwatch Gloucestershire Chair, our Engagement Framework, which details our plans to ensure that the views and opinions of services users, their families and communities, inform every aspect of our work. I will continue to update Claire on our progress in implementing this framework;

- our community hospital Leagues of Friends and Friends of Lydney Hospital are a major part of our Trust's life, contributing as they do with volunteers, funds, helpful networks in the community and feedback on our services. Their input is enormous, and to name any one individual would be invidious, but they must know we owe them all a huge debt of gratitude. In 2014-15, I met Chairs of the Leagues, along with Paul, on a regular basis, and they are wonderful examples of 'critical friendship' at its best;

with us through regular meetings of the Your Care Your Opinion Programme Board, which gave us the opportunity to test our thinking and receive feedback from those who use our services;

- we were privileged throughout the year to hear from both frontline service providers and users about their experiences at our public Board meetings. This gave Board members a real insight into what matters to people using the services, and for us to learn more about how and where we can improve;

- throughout this year, Paul and I held a series of meetings with local District Council leaders in order to strengthen our mutual understanding and identify areas for greater joint working. Our schedule started with a visit to Gloucester City Council where we met with the lead for housing, health and leisure. Subsequently, we were welcomed in the Forest of Dean, Tewkesbury, Cheltenham and Stroud, enabling us to have open discussions about the future of services across the county. It also provided clear insight into how the Trust may be able to influence local strategic debates about economic development, employment and education, thereby helping us to play our part as good corporate citizens. We also held meetings during the year with local MPs;

- during the year, I continued to extend the network of third sector organisations to whom we relate. Amongst others, this included meetings with Gloucestershire Voices, Two Rivers Housing Association, Open Door, the Deaf Association, Physical Inclusion Network Gloucestershire (PING) and the Independence Trust. Our longstanding partners from the voluntary sector and self-advocacy groups also continued their relationship

- most importantly, throughout 2014-15, we met with local service users, carers and families. Whether in small focus groups, or as part of a quality improvement or service redesign project, or on a more consultative basis at our Your Care, Your Opinion events, we continued to work with Gloucestershire people to understand them and reflect their needs within our plans for care delivery.

Walkabouts

Another way in which I and my Board colleagues endeavour to engage with individuals is through our on-going programme of quality visits and walkabouts. These give us the chance to see colleagues in action, talk to them about how they are feeling, and speak to the people receiving care. Many of these walkabouts are conducted by the Non-Executive Directors who provide a balanced reflection on what they see on the frontline, and who have been able to identify some areas for quality improvement. In 2014-15, I was very pleased that these included visits to people's homes, which is where most of our services are delivered.

I would highlight the following three examples:

- following a superb presentation by Annie MacCallum, Head of Specialist Services, at one of our Board meetings, I was delighted to visit a clinic run by the Trust's heart failure service and listen to two individual consultations. Both service users provided extremely positive feedback about their care, and whilst I already knew that our work in this field was nationally recognised, it was nevertheless still an inspiration to hear this directly from the people who matter most;

- in the autumn, I shadowed a care support worker with the children's complex care team, and visited a family with a very disabled small child at home. The visit showed me how highly this service is valued, and the extent of the compassion and skilled care delivered by our colleagues;

- subsequently, I was invited by the Integrated Community Team in Cheltenham to attend two home visits with physiotherapists. Once again, it was very impressive to see colleagues at work, enabling older people to maximise their independence following severe health difficulties.

Quality improvements

Although the examples of care above are really inspiring and a clear testament to the staff involved, the Trust does recognise that quality improvements still need to be made. Thus, in June 2015, we will be publishing our second Quality Account as a standalone Trust. This will look back on the achievements of the last year - particularly against the priorities that we set ourselves in June 2014. It will also identify five areas where we believe we could still do better. Thus, our quality priorities for 2015-16 are:

- to ensure full understanding and learning from the experiences of service users who fall in our community hospitals or who acquire a pressure ulcer;
- to ensure that service users have appropriate access to the highest quality musculoskeletal care;
- to improve our 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;
- to further develop and enhance our Integrated Community Teams, with particular emphasis given to supporting people in the community with dementia;
- to ensure that we recruit and retain the right staff in the right place at the right time in order to provide the highest possible quality care across Gloucestershire.

Of course, these five priorities, whilst being exceptionally important to us, are not the limit of our ambition - we will also continue to identify and respond to all opportunities to improve our services across the whole of the Trust, in order to deliver services that are caring, safe, responsive, effective and well-led, and that allow us to ensure best possible outcomes for service users, carers and families across Gloucestershire.

Board developments

This year has also seen a number of changes at Board level, which are detailed within this Annual Report and Accounts. I was delighted in 2014-15 to welcome to the Board table, Duncan Jordan in the new post of Chief Operating Officer and Jason Brown as our Director of Corporate Governance and Public Affairs. I was also pleased to welcome Dr Mike Roberts who joined us as interim Medical Director when Dr Joanna Bayley was selected to take part in a major national development programme for clinical leaders.

There were also changes within the Non-Executive Directors - Richard Cryer joined our ranks, whilst in the latter part of the year, Chris Creswick sadly decided to take his retirement. His experience and wisdom are missed, and we wish him well.

Finally, may I take this opportunity to thank and commend all Trust colleagues on a successful 2014-15. A great deal has been achieved for the people we serve, and I look forward to working with you all to build on this in the coming year.

Ingrid Barker

Ingrid Barker
Chair

2. Chief Executive's Report

2014-15 has been a year of exceptional challenge for the NHS nationally. However, I'm extremely proud that within that period, Gloucestershire Care Services NHS Trust has continued to make significant advances in the quality of its care, and has largely delivered against national and local targets.

Moreover, we have achieved these successes whilst maintaining our financial viability, and reporting an end-of-year surplus in line with our original plan. In the current climate, I trust that you'll agree this is some achievement indeed!

In broad terms, our accomplishments in the last twelve months have included the following:

- we continued to develop, implement, embed and refine our portfolio of organisational strategies, which are intended to articulate and steer the Trust's ambitions and activities over the next five years: performance against each of the strategy's quality goals is now routinely monitored, challenged and evaluated at relevant Board sub-Committees;

- we maintained our high-performing, high-quality health and adult social care services despite financial pressures and operational challenges including recruitment: thus in 2014-15, the Trust achieved 85.3% and 74.1% against national and local targets respectively. Whilst it is recognised that this represents a slight decrease in performance compared to 2013-14, the Trust is mindful that there are a number of related metrics which are impacting heavily upon overall scores - in particular, the metrics relating to the MSKCAT wait times (see section 3.4.9 below);

- the Trust's Integrated Community Teams (ICTs) were strengthened further, with countywide roll-out of the rapid response service which supports local people in their own homes. The success of this initiative is evidenced by the fact that on average in 2014-15, referrers advised that 82% rapid response interventions prevented an acute admission;

- we undertook regular acuity audits within our community hospitals so as to ensure that staffing levels were appropriate to need. Equally, we sought to reaffirm the hospitals' unique place within their local communities - thus, for example, North Cotswolds Hospital recently launched a signposting service through a partnership with Cotswolds Volunteers North which enables people to access a wider network of services such as befriending and community transport. This supports our commissioner's objectives not only to ensure greater emphasis upon prevention and self-care, but also to better utilise the range of available community-based assets;

- we continued the rollout of the SystmOne clinical information system, which since April 2014, has been made available to a further 350 district nurses, 450 child health community workers and 230 occupational therapists and physiotherapists;

- we developed an Engagement Framework so as to ensure that the voice of local service users, carers and families is heard, especially when undertaking service redesign: this is best exemplified by the Trust's recent launch of focus groups initially exploring food and hydration practices. In line with commissioner intentions, this work seeks to both improve the experiences and outcomes for the population of Gloucestershire, but also represents best practice in service user engagement and involvement.

Milestones

Additional to the above, I would also like to reflect upon some of the key milestones of 2014-15 (NB our operational and financial performance in year are detailed in sections 3.4 and 3.5 below):

- I am pleased to report that in 2014-15, we did not have a single "Never Event", nor did we breach core quality standards relating to mixed sex accommodation or MRSA infection;

- throughout the year, we maintained clear oversight of our staffing capacity and capability in line with NHS England recommendations following the Mid Staffordshire Enquiry, and made this information widely available to the public so as to keep them best informed;

- on 22 April, the first group of colleagues to complete the Royal College of Nursing's Leading for Quality Care programme showcased their service improvement projects at a Trust event. Thereafter, throughout the rest of the year, regular cohorts of health and social care practitioners attended this programme which seeks to develop leadership and management skills to enable the improvements in safe, quality person-centred care, and then took learning back to their workplace. The culmination of this activity will be a Leadership Conference to be held in 2015-16;

- at a meeting with the NHS Trust Development Authority ("TDA") on 18 June, it was formally confirmed that the Trust's application to become a Foundation Trust had been approved, and that we were on the "pipeline" towards authorisation. Whilst Foundation Trust status continues to be a clear goal for the organisation, we are mindful that it is not a mission or preoccupation in its own right, but that instead, it will be achieved if we simply continue to focus upon delivering high quality, safe, sustainable health and social care services to the people of Gloucestershire;

- on 24 June, I received a letter signed by David Behan, Chief Executive of the Care Quality Commission, David Bennett, Chief Executive of Monitor, Catherine Dixon, Chief Executive of the NHS Litigation Authority, Simon Stevens, Chief Executive of NHS England, David Flory, Chief Executive of the NHS Trust Development Authority and David Dalton, Chief Executive of Salford Royal NHS Foundation Trust, inviting the Trust to join the Sign Up To Safety campaign, which aims to make the NHS the safest healthcare system in the world. Naturally, I was very happy to commit to this initiative, which continues to be implemented across the Trust;

- on 25 June, the Trust held its first Celebrating You staff awards, which recognised the skills, care and compassion of colleagues across the organisation;

- on 30 June, we seconded a Professional Team Lead for Community Nursing into our HR team, so as to lead a recruitment campaign for community nursing. To date, she has successfully recruited over 90 new nurses which has effectively reduced our reliance on bank and agency staff;

- during the summer, we successfully recruited to two new posts, namely the Head of Community Hospitals and the Head of Community Nursing. I believe that these posts, together with the strengthening of our Professional Team Leads across the Trust, will make a significant difference in providing expert clinical leadership to some of our core staff groups;

- on 14 October, we held our first Annual General Meeting (AGM) at Gloucester Rugby Club. This event included a range of interactive exhibitions and activities demonstrating our broad range of services, and was followed by a more formal session which outlined our achievements in our first year as a standalone NHS Trust. In total, over 200 people attended the AGM which proved to be a fantastic showcase for the Trust, as well as an important opportunity for us to engage with the local communities that we serve;

- on 24 November, we attended the local 7-Day Services Vision Workshop, which launched the countywide response to the national initiative to ensure increased service accessibility and improved weekend outcomes for service users: this work continues to be developed;

- in December and January, the health system in Gloucestershire was placed under significant pressure due to unprecedented levels of demand, especially upon the urgent care system. During this period, we responded in several ways including:

  - the opening of additional inpatient beds;

  - the introduction of new systems and processes to monitor activity on a daily basis and remain as proactive and responsive as possible;

  - making additional investment in our Integrated Discharge Team so as to move people from acute hospitals to community settings as soon as possible;

  - attending a number of cross-organisational meetings to address and resolve issues with partners in respect of best ways of working.

In particular, I would like to acknowledge the great efforts made by colleagues during this difficult time, to ensure that service users were effectively cared for at home, or were treated quickly and efficiently in a community hospital. Many staff worked additional hours and extra shifts, demonstrating both professionalism and pride in maintaining a focus on service user care and safety. I also wish to recognise that learning from last winter will now inform our planning for next year, and to ensure improves resilience and escalation processes;

- on 28 January, Her Royal Highness, The Princess Royal officially opened Tewkesbury Community Hospital, accompanied by Dame Janet Trotter, Lord Lieutenant of Gloucestershire. The Princess met colleagues and service users alike, and showed huge interest in the care that the hospital provides. This really was a special way to mark the formal opening of the hospital, and was an excellent opportunity to celebrate with colleagues, service users and local partners;

- starting in March, myself and the rest of the Executive Team, took turns to attend over 53 venues across the county in order to meet with colleagues, tell them about our future plans, and listen to their concerns and issues. I am determined that such widescale staff engagement events will become regular activity as we move forwards;

- on 26 March, we held a celebration event to thank colleagues for their work in delivering the Health Visitor Call to Action 2011-15 programme. This event recognised that in February, we had reached our annual target, with a workforce of 128.13 whole-time equivalent Health Visitors against the year-end target of 127.32 (we eventually achieved 131.19 by year end). The event also provided an opportunity to show the 15 service improvement programmes underway, demonstrating achievement not only in expanding the numbers of health visitors, but also in strengthening and modernising the delivery of health visiting services to help ensure that children and families have a positive start in life;

- in March 2015, we were pleased to report that we had achieved the required 95% standard for harm-free care, and that we had reported fewer cases of C. difficile infections across 2014-15 than the agreed threshold. This is a tremendous achievement by colleagues, and I would like to thank and commend everyone who contributed to both workstreams.

Organisational Development

Throughout 2014-15, we maintained a clear focus upon the continued implementation of our five year Organisational Development Strategy, in order to help create a sustainable Trust culture that can effectively support the delivery of high-quality, person-centred care across the whole of Gloucestershire.

To support this strategy, in January 2014, we launched the Listening into Action programme as a way of empowering staff to make changes and introduce innovations. The programme resulted in a wide range of quality improvement projects being run by colleagues across the year. Some of these sought to better the working life of staff, but the majority sought to improve the experiences of service users, carers and families.

I am glad to report that the programme was a resounding success, which was celebrated by a Pass It On event in November. More tangible, the Trust-wide survey that we undertook in December, when compared to the survey conducted at the programme start in January, showed that we had made improvement in all fifteen areas that were questioned. However, we do recognise that there is still significant work to do in order to engage and communicate well across the Trust, to support our colleagues in both their work and career development, and to recognise and respond where people are being prevented from working effectively.

For this reason, we are currently running a second year of Listening into Action in order to yield additional return. I am keen that at the end of the process, we will - like other Trusts - be able to demonstrate positive impact upon clinical outcomes, waiting times, mortality rates, staff morale, staff sickness levels, and leadership style and culture.

Looking to the future

In 2015-16, we will be seeking to build upon the successes and activities described above. In particular, we will be looking to:

- finalise our five year Integrated Business Plan and Long-Term Financial Model, ensuring that this is fully aligned with local commissioning intentions;

- achieve the best possible outcomes in the Chief Inspector of Hospitals assessment scheduled for June 2015, by demonstrating the excellent care that is provided by the Trust on a daily basis across the county;

- continue to extend Integrated Community Teams with workstreams dedicated to the introduction of mental health and well-being services, and adoption of a case management strategy;

- ensure a more integrated pathway approach to care delivery that transcends organisational boundaries, and represents true partnership working across all providers including the voluntary sector;

- continue to scope the most effective and efficient means to deliver relevant seven day services, focussing on the national clinical standards;

- explore innovative ways in which to recruit to newly redefined clinical positions which will best meet service user and business need, and thereafter offer the best possible professional development opportunities to colleagues so as to optimise appropriate retention.

I look forward to reporting progress against these priorities in next year's report.

Paul Jennings

Paul Jennings
Chief Executive

3. Strategic Report

3.1 Trust Establishment Order

The Trust is established under the Statutory Instrument (SI) 2013 No. 531 which came into effect at the time of the Trust's authorisation on 22 March 2013.

Subsequently, an Amendment Order was made, namely Statutory Instrument (SI) 2014 No. 358. This was issued on 17 February 2014 and came into force on 10 March 2014. It updated the original Establishment Order of 2013, by recognising that in addition to the Chair, the Trust then had four Executive Directors (voting) and six Non-Executive Directors (voting).

Both the Establishment Order and Amendment Order confirm that the accounting date of the Trust is 31 March.

3.2 Trust financial reporting standards

The accounting information within this Annual Report and Accounts has been prepared in line with the guidance contained in the Department of Health Group Manual for Accounts (MfA) 2014-15. The accounting policies of that Manual meet the Government Financial Reporting Manual (FReM) 2014-15 requirements, which in turn observe International Financial Reporting Standards (IFRS) and Companies Act mandates as appropriate.

The Trust is pleased to confirm that it has met all of its statutory financial duties for 2014-15, and that its financial performance is wholly in line with the plans and expectations approved by the Trust Board prior to the year start. The Trust believes that this demonstrates not only the financial strength of the Trust, but also the effectiveness and robustness of its financial planning, monitoring and control.

DID YOU KNOW THAT IN 2014-15…

…the Trust recorded 1,124,198 individual contacts with service users: this represents almost 2 contacts per person living Gloucestershire.

3.3 Overview of the Trust and its services

The Trust was established in March 2013, with the remit to provide high quality, accessible community and specialist NHS services across Gloucestershire. The Trust currently employs approximately 2,700 staff including nursing, medical and dental staff, allied healthcare professionals, as well as support service, administrative and clerical workers. During 2014-15, the Trust also managed approximately 800 social workers and reablement workers from Gloucestershire County Council which enables the delivery of integrated adult health and social care services across the county.

DID YOU KNOW THAT IN 2014-15…

…96.4% people said that they would be "likely" or "extremely likely" to recommend the Trust's services *(based on results of the Friends and Family Test which in 2014-15, surveyed 14,904 people across all of the Trust's settings and services).*

The Trust's portfolio of services is delivered in people's own homes, community hospitals, community clinics, outpatient departments, schools and GP practices. The Trust also provides in-reach services into acute hospitals, nursing and residential homes and social care settings.

The Trust's services are principally commissioned by the Gloucestershire Clinical Commissioning Group (CCG), although income is also received from a number of other sources including NHS England and the Local Authority.

3.3.1 Local environmental, social and community issues

Gloucestershire is a geographically diverse county, covering an area of about 1,045 square miles. The county includes the large urban communities of Gloucester and Cheltenham, with smaller market towns and villages making up the rest of this mostly rural area.

The county's population stands at approximately 605,000, two fifths of whom live in the city centres of Gloucester and Cheltenham. Moreover, the population is rapidly increasing, with Gloucester accounting for the greatest growth in population size in the county.

Like the national average, the population profile in Gloucestershire is increasingly ageing, with people aged 65+ representing the fastest growing demographic in the county: indeed, it is anticipated that by 2021, people aged 65+ will constitute more than 22% of the county's overall population (compared to 19% currently), and that there will be a significant increase in the number of people aged 85+.

An ageing population means that there will be an increasing number of people living in Gloucestershire with long-term health conditions such as heart disease, diabetes and dementia. This has significant implications for demand on health and social care services: for example, national statistics show that the care of people with long-term conditions accounts for 70% of the money spent on health and social care in England.

The ageing population is also likely to be a contributory factor in the increasing number of unpaid carers in the county. Census data from 2011 indicates that there are 62,600 informal carers in the county, equivalent to 10.5% of the population. Moreover, the number of carers has risen by 12.8% since 2001, and is projected to rise by a further 12% by 2017.

Overall, the health of the general population in Gloucestershire is good. Life expectancy is above the national average, and over the last ten years, mortality rates have fallen. However, there are significant variations in prosperity and health between different localities.

Thus, whilst Gloucestershire is a relatively prosperous county, there are distinct pockets of deprivation which are linked with poorer health outcomes and reduced life expectancy: this includes approximately 44,000 residents who live in areas that fall into the 20% most deprived in England (these are located mainly in Gloucester and Cheltenham). As a result, life expectancy is 7.9 years lower for men and 5.8 years lower for women in the most deprived areas of the county compared to the least deprived areas (data from 2010-12). Similarly, the three main causes of death locally - namely, circulatory diseases (heart disease and stroke), cancers and respiratory disease - are more prevalent in the deprived areas of Gloucestershire.

DID YOU KNOW...

The population of Gloucestershire includes:

- 51% women compared to 49% men, reflecting national averages;
- more people aged 65+ than the England average, particularly in the rural districts of the Cotswolds and Forest of Dean: this includes an estimated 8,667 people aged 65+ living with dementia;
- fewer people who are single or separated than the England average, but more who are married, divorced or widowed;
- a majority of new mothers aged 25-34, reflecting the national trend of later motherhood;
- nearly 92% people who classify themselves as White British, with the Black Minority Ethnic populations considerably smaller (under 5%) than the national average (14.6%). The travelling community represents 0.9% of the local population;
- a smaller proportion of disabled people than the England average (16.7% people with a long-term limiting illness or disability, compared with 17.6% in England: however, this rises to 19.6% in the Forest of Dean);
- 1 in 10 people who provide unpaid care to a friend or relative, which is equivalent to the England average;
- 7% of households which are deemed highly vulnerable to social isolation. These households tend to be associated with the main urban centres and the fringes of rural market towns, especially in the Forest of Dean and Cotswolds districts.

It is not just people living in areas of deprivation that are prone to poorer health outcomes. Certain individuals or groups of people also tend to be more vulnerable because of a combination of physical, mental and/or social factors. People with learning disabilities, for example, experience poorer health than the general population, but are less likely to seek or receive appropriate health care, and as a result, often die at a younger age. Other groups known to experience worse health outcomes, include the traveller community, offenders, people with mental health conditions and children in care.

Lifestyle factors also have a significant impact on the health and wellbeing of Gloucestershire's population. Overall, the county's levels of smoking, drinking, obesity and physical activity are similar or better than the national average: thus, 17.5% adults smoke in the county, 23.6% are drinking above the recommended levels, 24.7% are obese and 25.2% are classified as inactive. However as above, research suggests that there is a strong correlation between unhealthy lifestyle behaviours and deprivation, and so rates vary across localities and between groups of people i.e.:

- smoking rates rise to 28.2% in those working in routine and manual professions in the county, and are as high as 36.9% among routine and manual workers in Cheltenham;
- Gloucester and Cheltenham both have considerably higher rates of alcohol-related hospital admissions than the national average;
- In Tewkesbury, the percentage of adults classified as overweight or obese is well above the national average.

3.3.2 Integrated Community Teams

The 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, thereby avoiding the need for hospitalisation.

DID YOU KNOW THAT IN 2014-15...

- Within the Integrated Community Teams, community nurses alone cared for 20,996 individual service users.
- The average age of a service user seen by the Integrated Community Team's community nurses was 78.3 years: this is an increase on the average age in 2013-14 which was 77.5 years, demonstrating the ageing population of Gloucestershire.
- The rapid response service received 1,381 referrals.
- 82% referrers (including GPs) reported that a referral to the rapid response service had avoided a hospital admission or attendance.

3.3.3 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, Dursley;
- 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 the Trust's skilled and dedicated staff.

Each community hospital provides the following services:

- community inpatient rehabilitation and semi-acute care beds;
- outpatient services including a varied range of nurse led and therapy services and clinics;
- X-ray facilities;
- Minor Injuries and Illness Units which can save people from unnecessarily attending the Emergency Departments in Gloucester and Cheltenham, 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 hospitals also provide access to day surgery / endoscopy services in partnership with other provider organisations.

DID YOU KNOW THAT IN 2014-15…

- The Trust recorded 68,560 inpatient bed days. This means that 94.2% available beds in community hospitals were occupied every single day.
- The average length of stay for 95% service users in a community hospital was 14.8 days.
- The average age of people admitted to the Trust's community hospitals was 82.2 years.
- There were 68,374 attendances at the Trust's Minor Injuries and Illness Units with 95.3% service users seen, treated and discharged in under 2 hours, and 99.8% seen, treated and discharged in under 4 hours.
- The average time from a service user's arrival at a Minor Injuries and Illness Unit to their treatment was 24 minutes.

3.3.4 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's website at **www.glos-care.nhs.uk**.

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

- Therapy Services
  The Trust's specialist 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.

- Community Dental Services
  The dental service provides special care 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 pain appointments for people who do not have a regular dentist, or who experience an out-of-hours dental emergency. This is a nurse-led triaged service.

- Sexual Health Services
  The Trust's team provides free and confidential information to those looking for support and advice relating to sexual health. The highly trained and approachable team 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.

- 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, and also provide telecare and wheelchair services.

- 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, and enables access to the Expert Patients' Programme which is a self-management programme for people living with chronic long-term conditions.

DID YOU KNOW THAT IN 2014-15…

- Trust specialist nurses had 59,354 contacts with 15,897 service users: this represents a 358% increase in contacts compared to 2013-14, and a 208% increase in the number of service users seen.
- Specialist nurses contacts included 10,088 contacts by the heart failure team, 9,163 contacts by the cardiac rehabilitation service and 6,514 contacts by the diabetes team.
- The podiatry service treated 22,296 individual service users.
- The dentistry service treated 11,616 service users.
- The sexual health service had 29,750 contacts with service users, and delivered 18,484 chlamydia screens to 15-24 year olds either through core services or with partner organisations (including GP's and pharmacies).

3.3.5 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 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.

DID YOU KNOW THAT IN 2014-15…

- The Trust's specialist therapy services treated 8,974 children and young people.
- The Trust's Health Visitors conducted 8,181 two year checks.
- 2,952 girls aged 12-13 received their first HPV immunisations during the 2014-15 academic year (to the end of April 2015).
- 6,229 reception school year children (94.29%) and 5,521 year 6 school year children (87.63%) had their height and weight measured in the 2014-15 school year as part of the National Childhood Measurement Programme (to the end of April 2015).

3.3.6 Support services

The clinical and care services described in sections 3.3.2-3.3.5 above are supported by a range of corporate functions such as human resources, finance, performance, governance and risk management. Additionally, the service user experience team provides a key point of contact for service users, their families and carers.

3.3.7 Equal opportunities

The Trust is fully committed to ensuring equal opportunities, and this is reflected by both its accreditation by Investors in People and also its registration by Mindful Employer. It is also confirmed by the Trust's Equality and Human Rights Policy, which articulates that:

- all recruitment takes place in accordance with the organisation's Recruitment and Selection Policy and Procedure, which sets down how equal opportunities are implemented;
- advertising seeks to attract suitably qualified, skilled and experienced candidates from all sections of the community and the existing workforce;
- where there is an identified need, the Trust takes positive action to try and encourage a diverse range of applicants;
- everyone who applies for a job or 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;
- appropriate training is available to ensure that those responsible for making selection decisions do not discriminate, consciously or unconsciously, when making such decisions;
- all employees have access to regular supervision, an annual review of their performance, and a personal development plan which identifies their training needs;
- the reasons for choosing certain employees for training is clear and based on sound judgements;
- the Trust publishes equal opportunities monitoring information.

It is noted that as of 31 March 2015, the following gender distributions applied within the Trust:

- 53.3% Trust Directors (both Executive and Non-Executive) were female, and 46.7% were male;
- 82.1% senior managers (bands 8a to 8c) were female, and 17.9% were male;
- 91.1% Trust colleagues were female, and 8.9% were male.

3.4 Operational Performance 2014-15

Throughout 2014-15, the Trust continued to deliver a high quality of care, exemplified by the data in the tables 1-3 below. These show the Trust's performance in year against a number of key criteria by which the organisation is measured and monitored both nationally and locally by its commissioners, Gloucestershire Clinical Commissioning Group. In summary, the Trust performance against targets in 2014-15 is as follows:

Table 1: Overall Trust performance 2014-15

Target	Red	Amber	Green	Total
National	3	2	29	34
Local	4	3	20	27
Total	**7**	**5**	**49**	**61**

Red	Amber	Green
8.8%	**5.9%**	**85.3%**
14.8%	**11.1%**	**74.1%**
11.5%	**8.2%**	**80.3%**

Specifically, these relate to the indicators below:

Table 2: Trust performance against national indicators 2014-15

National Indicator		Target	2014-15
CARING			
Friends and Family Test			
1	Percentage of people discharged from a Minor Injuries and Illness Unit who completed the Friends and Family Test (see section 3.4.1 below)	20%	**19%**
2	Percentage of people discharged from an inpatient unit who completed the Friends and Family Test	30%	**40%**
Mixed sex accommodation			
3	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			
4	Number of cases of post 48 hour Clostridium difficile infection within community hospitals	21	**17**
5	Number of cases of MRSA bacteraemias infection	0	**0**
Venous thromboembolism (VTE)			
6	Percentage of relevant inpatients risk assessed for VTE	95%	**98.2%**
Safety Thermometer			
7	Percentage of people reported via the Safety Thermometer census as receiving harm-free care (see section 3.4.2 below)	95%	**92.6%**
RESPONSIVE			
Primary Care Centres			
8	Percentage of service users who were assessed as an emergency and who received a face-to-face consultation in a Primary Care Centre within 1 hour	95%	**100%**
9	Percentage of service users who were assessed as urgent and who received a face-to-face consultation in a Primary Care Centre within 2 hours (see section 3.4.3 below)	95%	**93%**
10	Percentage of service users who were assessed as less urgent and who received a face-to-face consultation in a Primary Care Centre within 6 hours	95%	**98%**

National Indicator		Target	2014-15
RESPONSIVE			
Minor Injuries and Illness Units (MIIUs)			
11	Percentage of service users who were seen, treated and discharged within 4 hours by an MIIU	95%	**99.82%**
12	Number of people who waited on a trolley in an MIIU for more than 12 hours	0	**0**
13	Average time spent by a service user in an MIIU from arrival to departure	Less than 4 hours	**1 hour 58 minutes**
14	Average time before the initial assessment for those arriving at an MIIU by ambulance	Less than 15 minutes	**Average 11 minutes**
15	Number of people for whom the handover from an ambulance to an MIIU was longer than 15 minutes and who waited more than 30 minutes	0	**0**
16	Number of people for whom the handover from an ambulance to an MIIU was longer than 15 minutes and who waited more than 60 minutes	0	**0**
17	Average time to treatment in an MIIU	Less than 60 minutes	**Average 24 minutes**
18	Percentage of people 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 (see section 3.4.4 below)	Less than 5 %	**5.4%**
19	Percentage of people who left an MIIU without being seen	Less than 5%	**0.7%**
HPV immunisations			
20	Percentage of 12-13 year old girls who have been given the 3-dose Human Papillomavirus (HPV) immunisation (NB this is an on-going measure as it relates to the whole of the 2014-15 school year)	70% at the end of March 2014	**85.6%**
Childhood Measurement Programme			
21	Percentage of children in reception school year whose height and weight have been recorded (NB this is an on-going measure as it relates to the whole of the 2014-15 school year)	95% at the end of March 2014	**95.4%**
22	Percentage of children in school year 6 whose height and weight have been recorded (NB this is an on-going measure as it relates to the whole of the 2014-15 school year) (see section 3.4.5 below)	95% at the end of March 2014	**88.9%**
Newborn hearing screening			
23	Percentage of newborn children whose hearing was checked	95%	**100%**
24	The percentage of well newborn children whose hearing was checked within their first 5 weeks of life	More than 95%	**98.5%**
Newborn bloodspot screening			
25	Percentage of newborn children whose blood was screened for rare but serious disease	95%	**100%**
26	Percentage of newborn children whose blood screening results were available by the child's 17th day of life	95%	**95%**
Health visitors			
27	Number of full-time Health Visitors employed by the Trust	127.32	**131.19**

National Indicator		Target	2014-15
RESPONSIVE			
Diagnostic wait times			
28	Percentage of service users who waited less than 6 weeks from referral for a diagnostic test provided by the Trust	More than 99%	**100%**
Cancelled operations			
29	Number of urgent operations that were cancelled twice	0	**0**
30	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**
Data quality			
31	Percentage of records from Minor Injuries and Illness Units that had a valid NHS number recorded for the service user	99%	**99.6%**
32	Percentage of records from inpatient units that had a valid NHS number recorded for the service user	99%	**99.9%**
33	Percentage of records from outpatients that had a valid NHS number recorded for the service user	99%	**99.9%**
34	Percentage of social care data sets held by the Trust for which valid NHS numbers were recorded	80%	**81.4%**

Table 3: Trust performance against local indicators 2014-15

Local Indicator		Target	2014-15
RESPONSIVE			
Adult community and therapy services - referral to treatment times			
1	Percentage of service users seen and treated by the speech and language therapy service within 8 weeks of referral (see section 3.4.6 below)	95%	**92%**
2	Percentage of service users seen and treated by the podiatry service within 8 weeks of referral (see section 3.4.7 below)	95%	**90%**
3	Percentage of service users seen and treated by the occupational therapy services within 8 weeks of referral	95%	**99%**
4	Percentage of service users seen and treated by the adult physiotherapy service within 8 weeks of referral	95%	**97%**
5	Percentage of service users seen and treated by the 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%	**99%**
7	Percentage of service users seen and treated by the diabetic nursing service within 8 weeks of referral	95%	**98%**
8	Percentage of service users seen and treated by the bone health service within 8 weeks of referral (see section 3.4.8 below)	95%	**93%**
9	Percentage of service users seen and treated by the musculoskeletal service within 8 weeks of referral (see section 3.4.9 below)	95%	**80%**
Stop Smoking service			
10	Number of smokers who have successfully quit	1,632	**1,646**

Local Indicator		Target	2014-15
RESPONSIVE			
Musculoskeletal Clinical Assessment and Treatment Service			
11	Percentage of service users seen and then referred onto secondary care	Less than 30%	**4%**
12	Percentage of service users who were referred onto secondary care within 2 days of the decision to refer	100%	**100%**
13	Percentage of routine service users being referred and seen within 4 weeks of referral (see section 3.4.9 below)	95%	**41%**
14	Percentage of urgent service users being referred and seen within 2 weeks of referral (see section 3.4.9 below)	95%	**79%**
Single Point of Clinical Access			
15	Percentage of abandoned calls	Less than 5%	**4.3%**
16	Percentage of calls resolved with an agreed onwards plan within 20 minutes	95%	**95.5%**
Delayed transfers of care			
17	Average number of service users per month delayed for onwards transfer to another care setting (including home)	10	**2**
Early supported discharge			
18	Percentage of new service users assessed within 2 days of notification	95%	**98%**
19	Percentage of service users discharged within 6 weeks	95%	**99%**
Sexual health services			
20	Number of young adults (15-24 year olds) who had a positive screening for chlamydia (see section 3.4.10 below)	1,429	**1,014**
21	Percentage of service users seen and treated by the contraception service within 8 weeks of referral	95%	**99%**
22	Percentage of service users seen and treated by the HIV service within 8 weeks of referral	95%	**100%**
23	Percentage of service users seen and treated by the psychosexual service within 8 weeks of referral	95%	**98%**
24	Percentage of terminations carried out within 9 weeks and 6 days of gestation	80%	**84%**
Children and young people's services			
25	Percentage of service users seen and treated by the children's speech and language therapy service within 8 weeks of referral	95%	**98%**
26	Percentage of service users seen and treated by the children's physiotherapy service within 8 weeks of referral	95%	**98%**
27	Percentage of service users seen and treated by the children's occupational therapy service within 8 weeks of referral	95%	**99.4%**

Additionally, the Trust is required to report against the indicators of the Accountability Framework that is monitored by the NHS Trust Development Authority. Details of these indicators are given in section 5.7.2 below.

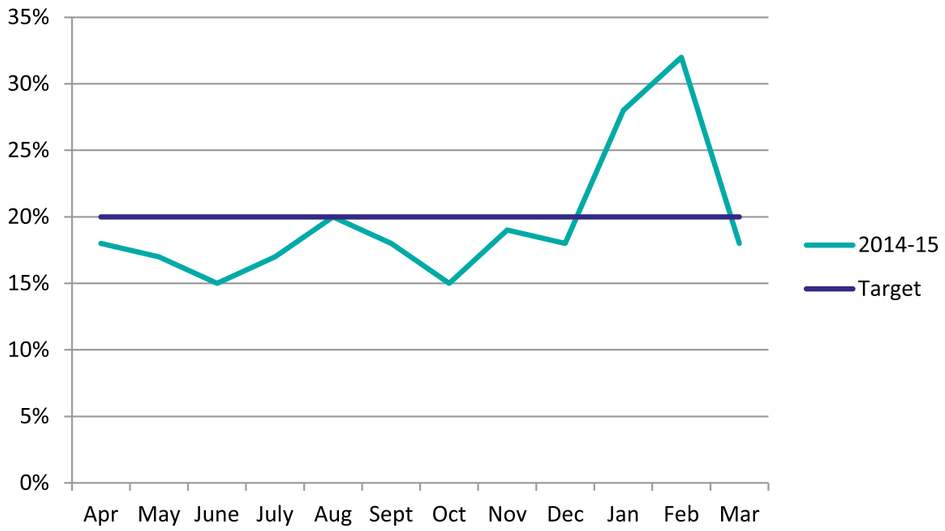
Given the above performance, there are a number of key areas which the Trust would wish to highlight, where it has achieved a result below its targeted level. Actions to improve performance in 2015-16 are therefore given in sections 3.4.1 - 3.4.10 below.

3.4.1 Friends and Family Test response rates

The Friends and Family Test is a survey that allows people to give feedback on the quality of care they have received. It is based on the use of one principal question: How likely are you to recommend our services to friends and family if they needed similar care or treatment?

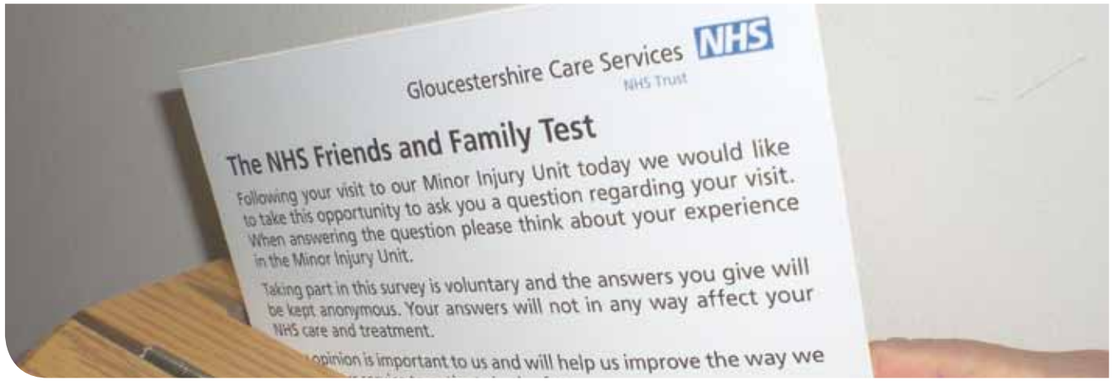
Throughout the whole of 2014-15, the Trust asked service users to complete the Friends and Family Test following their visit to a Minor Injuries and Illness Unit. Response rates are shown below:

Chart 1: Friends and Family Test: Minor Injuries and Illness Units response rates 2014-15 against target



This clearly shows that for the first 9 months of the year, the Trust under-performed against its target of 20% response rates. However, by working closer with relevant staff in the Minor Injuries and Illness Units, the Trust was able to encourage them to more effectively promote the Friends and Family Test to all service users. This yielded significant results in January and February where the target was exceeded - it was therefore especially disappointing that in March, performance again dropped under the threshold.

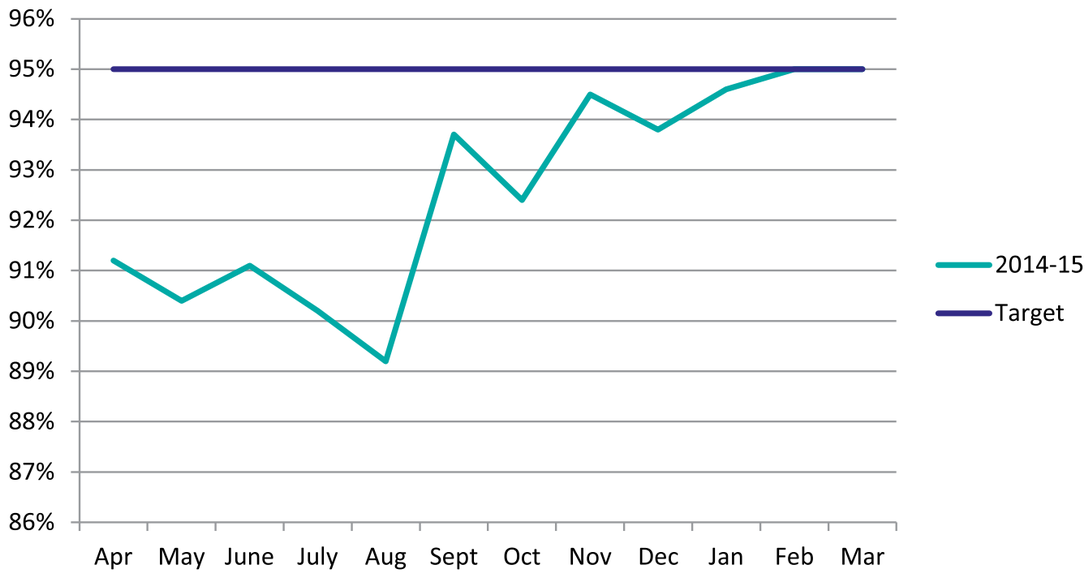
The Trust is now looking in more detail at those Minor Injuries and Illness Units whose performance does not compare against its peers (i.e. in March, Lydney Minor Injuries and Illness Unit only achieved 7% response rate compared to a 42% response rate in North Cotswolds). As a result, the Trust aims to provide increasingly targeted support to achieve sustainable improvement.



3.4.2 Safety Thermometer

The NHS Safety Thermometer is a national tool that provides a way to measure and compare performance in four key areas of service user safety, namely falls, pressure ulcers, venous thromboembolism and urinary tract infections in people with a catheter. The Trust's performance against the Safety Thermometer target in 2014-15 is shown below:

Chart 2: Safety Thermometer performance 2014-15 against target



Thus, although the average performance for the Trust in 2014-15 was only 92.6% compared to the target of 95%, the Trust did reach the 95% target in both February and March. This followed a period in which the Trust had given particular scrutiny to this key indicator (NB the resultant improvement is also evident when compared to the Trust's performance in 2013-14 of just 89.6%).

In order to maintain the 95% at minimum, and improve wherever possible, the Trust will be undertaking the following actions in 2015-16:

- reviewing and updating all relevant staff training, information and support in order to assist clinical teams in their understanding and application of Safety Thermometer harm-free standards;
- assessing Safety Thermometer data in relation to other organisational intelligence in order to identify themes and trends which will give better understanding about the overall quality of provided care;
- introducing 'safety huddles' at all community hospitals - these dedicated meetings will serve to review any safety incident, and ensure that resources are appropriately deployed to reduce risks;
- piloting the use of both alternative therapies and increased activities in community hospitals, so as to provide calm and occupation for agitated service users who are at increased risk of falls;
- ensuring that as SystmOne is rolled out into the community hospitals as the main electronic clinical system, it is able to automatically alert staff as to the requirement to complete the falls risk assessment upon the admission of inpatients;
- implementing the NICE Falls Care Pathway across all community hospitals. This will include the need to deliver improved information for service users and carers, and inform all other health and social care providers about the risk of falls when a service user is discharged;

- conducting environmental audits at all Trust sites in order to identify any changes which would reduce the risk of falls;
- classifying pressure ulcers that are deemed avoidable in the Trust's care as a "Never Event", signalling the significance that will be placed upon providing harm-free care;
- ensuring that the grading of pressure ulcers is increasingly consistent and accurate, and that all new national guidelines are observed.

3.4.3 Primary Care Centre wait times

During 2014-15, the Trust did not meet the target to provide 95% service users assessed as urgent with a face-to-face consultation in a Primary Care Centre within 2 hours: nevertheless, the Trust did meet the target to provide similar consultations for those assessed as an emergency (1 hour) and less urgent (6 hours). This was as a result of the following issues:

- the initial assessment as to whether emergency, urgent or less urgent response was required, was undertaken by NHS111, and did not always represent the actual level of a person's need upon their presentation at a Primary Care Centre;
- there were an increasing number of diverts from the Emergency Departments in the acute hospitals in Gloucester and Cheltenham to the community-based Primary Care Centres;
- across the community, there were a number of key GP retirements;
- there was uncertainty about the future of the out-of-hours service which was tendered by commissioners in 2014-15 and which therefore impacted upon GP commitment;
- the Trust experienced difficulty in filling shifts in the more rural Primary Care Centres such as that at the Dilke Memorial Hospital;
- national changes in GP pensions made it less attractive to work additional shifts in out-of-hours services.

It is noted however that despite periods of higher demand, the Trust continued to provide a consistent level of service at its Cheltenham, Gloucester, Stroud, Vale and North Cotswolds Primary Care Centres. Where services fell below target (namely, at Dilke, Tewkesbury, Cirencester and Lydney), the Trust maintained open dialogue with its commissioners. Moreover, service users who arrived at Primary Care Centres that were delayed, were seen by the Trust's Minor Injuries and Illness Unit where appropriate, or directed via NHS 111 to a telephone triage consultation and subsequent Primary Care Centre appointment if appropriate: alternatively, and depending upon service user need, a home visit was booked or a referral was made to the rapid response service.

It is also noted that throughout the period of delay, there was no corresponding increase in the number of service user complaints or incidents, suggesting that there was minimal impact upon people's experiences.

3.4.4 MIIU re-attendances

The data suggests that in 2014-15, the Trust experienced a higher percentage of people who re-attended a Minor Injuries and Illness Unit within 7 days of discharge where the second visit was unplanned and for the same minor injury / illness as the original visit. However, this data does not reflect that the majority of these re-attendances were for the routine practice of replacing dressings, which is activity that cannot be recorded as planned. Thus, the Trust does not believe that the reported rating reflects its performance, and so in 2015-16, will be looking to clarify this indicator, so that it is not similarly disadvantaged.

3.4.5 School measurement programme

The Trust is confident that it will meet the target to record the height and weight of year 6 school children by the end of the academic year (July 2015): the reported under-performance is due solely to the planned trajectory for delivery not aligning to the annual school schedule.

3.4.6 Speech and language therapy wait times

The speech and language therapy service first failed to meet its target to see 95% service users within 8 weeks of referral in November 2014. This was due to the resignation of several qualified staff, and the difficulty in recruiting specialist therapists who need to be dysphagia trained in order to aid the 70-80% service users on the caseload who require this particular support. The service was also heavily impacted by strong demand, especially in Stroud, Gloucester and Cheltenham.

Despite only a small dip in performance over the course of the year, a recovery plan was developed and shared with commissioners. Practical improvements were also made, including the recruitment of locum staff, with other members of the team providing cover wherever possible.

Additionally, the service is currently looking at more innovative ways of addressing the human resource issues including skill mixing of existing posts.

3.4.7 Podiatry wait times

In 2014-15, the podiatry service's performance was negatively impacted by three issues: these were:

- a consistent increase in demand estimated at 3% year-on-year, coupled with additional complexity of service users;
- the introduction of the SystmOne clinical system which commenced in March 2014, and which temporarily reduced the appointment capacity to 50% to allow training to take place, a position from which the service subsequently struggled to recover;
- significant turnover of staff, staff sickness absence and challenge in recruiting suitably qualified staff to vacancies.

As a result, the average percentage of service users waiting to be seen less than 8 weeks after referral across 2014-15, was only 90%: however, it is noted that intense work by the administrative team to reduce the waiting list and match the correct number of available new slots to the individual specialists' appointments, resulted in a position where by February, the service had recovered and was again reporting compliant wait times. In 2015-16, the service aims to maintain this position.

3.4.8 Bone health wait times

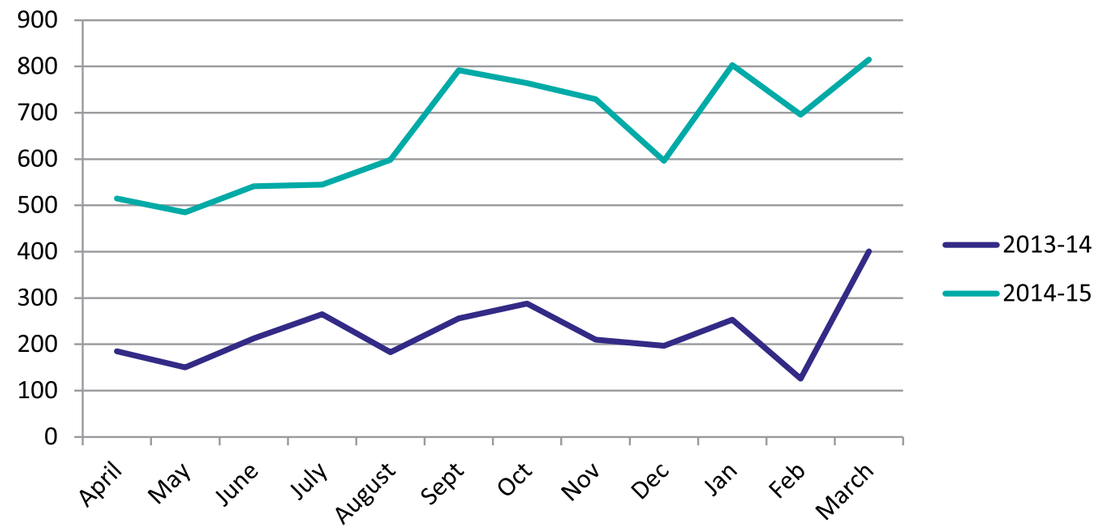
Although the bone health service only missed its target to see 95% service users within 8 weeks during the months of April - July, this did result in the service reporting overall under-performance for 2014-15. The failure was due partly to a change in data reporting regimes, and coincided with a key resignation and reduction in the workforce (NB the service is delivered by just two staff). However, since August, the service has been fully compliant with the requisite target.

3.4.9 MSKCAT service wait times

The MSKCAT (Musculoskeletal Clinical Assessment and Treatment) service which offers triage, review, diagnosis and treatment to service users with injuries and other conditions which affect their joints and bones, failed to achieve three of its targets in 2014-15.

However, it is noted that when it was first piloted, the MSKCAT service was only available to people in Gloucester and the Forest of Dean. However, when the service subsequently became available across the whole county from 1 April 2014 onwards, demand increased dramatically as demonstrated in chart 3.

Chart 3: MSKCAT activity 2013-14 compared to 2014-15



Although additional extended scope physiotherapists were recruited to address this increased demand, their long induction period meant that response could not be immediate. This therefore impacted upon the service's ability to:

- treat service users within 8 weeks of referral;
- see routine service users within 4 weeks of referral; and
- see urgent service users within 2 weeks of referral.

Moreover in 2014-15, the SystmOne clinical system was implemented across the service which resulted in a drop in clinical capacity to allow for training time. Also within the year, the Individual Funding Request Policy changed for bunions and lesser toe deformities which generated yet further demand. Nevertheless, due to the actions taken by the service:

- the 8 week target again achieved trajectory from March onwards;
- urgent cases only exceeded the target of 2 weeks in the period April-July, with the service being compliant from August onwards.

In order to maintain this position, and also ensure that routine service users are seen within four weeks, the service is now looking to:

- further develop the capacity of teams by engaging an increased number of Extended Scope Clinicians;
- work with commissioners to develop pathways around 7 MSK conditions in order to make the most appropriate use of countywide services, thereby ensuring that people are always seen by the right clinician at the right time and in the right place;
- realise the benefits of using the SystmOne electronic clinical system: this should reduce the administrative burden within the service, increase working efficiencies, and enable the service to share critical information with partners, including GPs, much more quickly;
- introduce additional services to the core MSKCAT portfolio, such as ultrasound scanning and orthotics, so that service users only need attend one clinic to address all their needs, rather than having to travel to numerous appointments across the county.

3.4.10 Chlamydia screening

In 2014-15, the Trust failed to meet its target to report positive screens for chlamydia. This was due to a combination of factors including:

- reduced health promotion activity within schools;
- reduced capacity within the Trust to deliver effective outreach services;
- decreased interaction by the target group (15-24 year old girls) with the sexual health service;
- ineffectual communications and limited social marketing, thereby not addressing the core audience in the language and form that they most recognise;
- limited engagement with young people so as to better understand how to involve them, and motivate them to be screened.

Recognising these shortfalls, the Trust is seeking to ensure improvement in 2015-16 by way of the following:

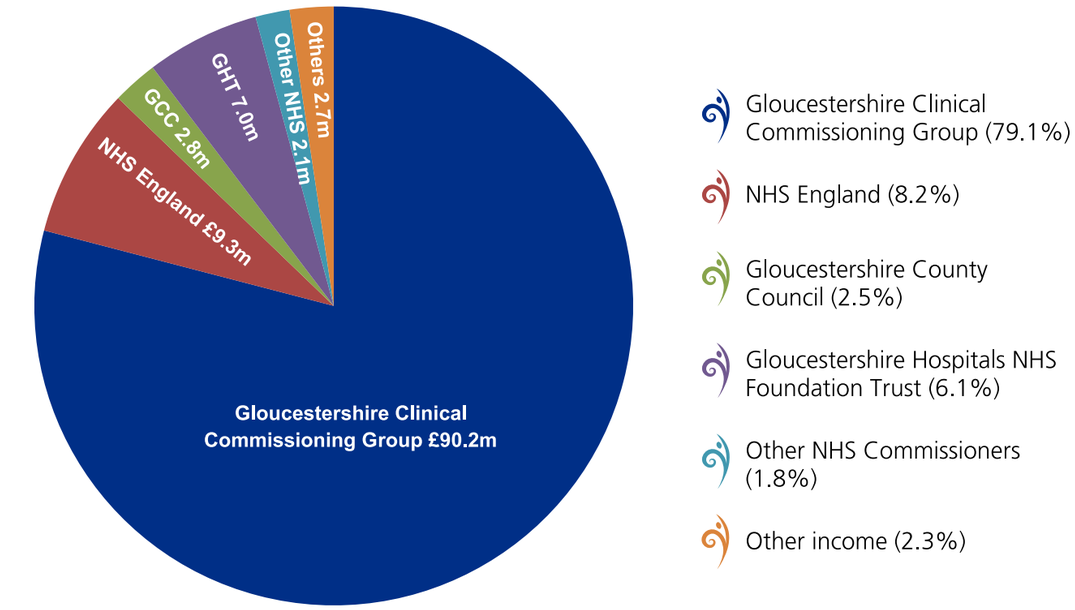
- operating a number of focus groups to gain improved insight from young people on how to raise greater awareness of chlamydia, and elicit support for co-producing a communications campaign that will engage them appropriately and effectively: this will include the development of a new website;
- increasing the monitoring of activity, improving the timeliness of data, and then cascading that information to colleagues efficiently so as to ensure that where necessary, they are focused upon offering chlamydia screening within clinics;
- undertaking partnership working with the chlamydia screening team in Public Health England so as to help develop a strategy for target achievement that includes a review of comparable areas of best practice;
- implementing the GP shared pathway in order to contact all partners of people who are screened as positive.

3.5 Financial Review

3.5.1 Summary of Trust income and expenditure

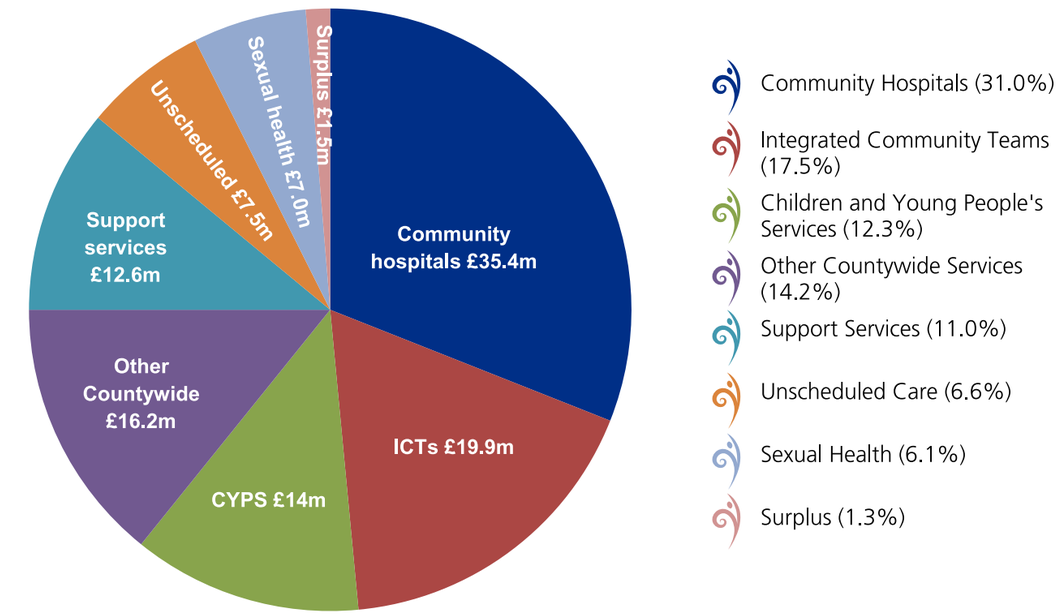
In 2014-15, the Trust received income totalling £114.1million. This was received from the following sources:

Chart 4: Trust income 2014-15



The total £114.1 million income was spent on services as per the below:

Chart 5: Trust expenditure 2014-15



3.5.2 Position of the business

In 2014-15, the Trust increased its income by £5.1 million compared to 2013-14, thereby receiving a total of £114.1 million.

Furthermore, the Trust achieved its planned surplus of £1.5 million.

At year-end, the Trust had a cash balance of £3.3 million after spending £3.7 million on capital items. This was below the planned cash balance due to some delays in billing and collection of cash relating to QIPP and CQUIN which was subsequently invoiced and received in full.

Within the capital spend of £3.7 million, the Trust completed the purchase and refit of a property in Cheltenham which will open early in 2015-16, and also refitted part of Cirencester Hospital to improve the rehabilitation and ambulatory care environments. The spend also enabled the continued rollout of SystmOne, the replacement electronic information system, which by year end, was available to over 1,500 colleagues across the Trust, allowing them to all use the same system to record their clinical activity: this implementation phase is set to continue into 2015-16 when the Trust's Community Hospitals will adopt the system.

3.5.3 Carry vs market value

The Trust's fixed assets were revalued at the end of 2013-14, which was the Trust's first year as a standalone NHS provider organisation. During 2015-16, the Trust is planning to carry out a further and more detailed revaluation in order to ensure that assets remain in the accounts at market value.

3.5.4 Cost Improvement Programme

The Trust's Cost Improvement Programme (CIP) comprises a series of long-term schemes to transform clinical and non-clinical services in order not only to achieve recurrent cost savings, but also to improve service user care, satisfaction and safety as well as working efficiencies.

All Trusts are required to deliver an effective CIP. In 2014-15, the Trust delivered £3.4million efficiency savings against a challenging target of £6.4million. The schemes that comprised the Trust's Cost Improvement Programme are shown below:

Table 4: Cost Improvement Programme 2014-15

CIP Scheme	Plan £000s	Actual £000s	Variance £000s
Mobile working	1,000	105	(895)
SystmOne	2,000	0	(2,000)
Operational efficiency	1,000	545	(455)
Centralised booking	500	0	(500)
Skill mixing	250	95	(155)
Estates	250	236	(14)
Support services	250	231	(19)
Procurement (incl. NHS recharges)	750	608	(142)
Others	400	1,607	1,207
Grand Total	**6,400**	**3,427**	**(2,973)**

The main reasons for non-delivery against these schemes are as follows:

- in order to realise the mobile working target, the Trust needed to have a robust baseline of activity against which to compare its 2014-15 performance. However, the introduction of SystmOne into community-based teams in year showed that previous understanding of colleagues' workload was under-estimated, making further efficiencies unattainable. This was further evidenced in 2014-15 by the publication of reference costs which unequivocally demonstrated that at 96.6% for peripatetic services, the Trust was already working with greater efficiency than other comparable community Trusts;
- the financial benefits associated with the introduction of SystmOne were synonymous with those for mobile working, and thus, the rationale for non-delivery against this scheme is also the same;
- to achieve the operational efficiency target, the Trust needed to significantly reduce the number of its district nurses: this was not a viable or sustainable option, and thus, the scheme was put on hold;
- the centralised booking project did not start in 2014-15, but is under review for implementation at a later date.

Learning from 2014-15 has informed the development of the Cost Improvement Programme for 2015-16, which is detailed below:

Table 5: Cost Improvement Programme 2015-16

CIP Scheme	Details	Plan £000s
System / process re-engineering	Creating efficiencies via increased automation and process improvement including the introduction / improvement of: • e-rostering to better plan staffing requirements, and report on hours, overtime, sickness and annual leave; • call systems to enable service users to self-check into community hospital-based clinics; • an automated self-service management information tool so that data is more accessible to staff to enable planning; • a digital dictation solution; • improved deployment of SystmOne; • strategies to reduce administration spend; • improved HR processes.	1,500
Contracts and procurement	Efficiency savings made through the re-procurement and re-negotiation of existing contracts	400
Infrastructure management	Continued efficiency savings resulting from implementation of the Trust's Estates and IT strategies	400
Smart working	Enhanced cost management processes and a new budgeting approach to increase accountability for expenditure and improve monitoring, review and challenge of spend	300
NHS contracts	Realignment of appropriate income and costs in line with agreed contracts	200
Asset management	Reviewing Trust assets to remove surplus and reduce depreciation and capital charges	650
Contingency		(300)
Total		**3,150**

3.5.5 Quality, Innovation, Productivity and Prevention (QIPP)

Each year, funds are withdrawn from the Trust's income by commissioners, which the Trust then effectively seeks to earn back by evidencing that it has successfully delivered quality, innovation, productivity or prevention improvements across a number of services. These are known as Quality, Innovation, Productivity and Prevention (QIPP) schemes. These QIPPs can be measured either in terms of milestones achieved in delivering a project, or by key performance indicators (KPIs). In 2014-15, the Trust's QIPP schemes were as follows:

Table 6: QIPP schemes 2014-15

QIPP schemes	Purpose
Integrated Community Teams (ICTs)	To develop and roll out ICTs across the county to include Rapid Response, and to reduce non-planned hospital admissions for service users with identified conditions
Integrated Discharge Team (IDT)	To bring together existing IDT teams to increase the number of service users being discharged to home, community hospitals or other community services
Community Hospital programme	To deliver seven projects to improve efficiencies in community hospitals including Minor Injuries and Illness Units
Use of Minor Injuries and Illness Units	To increase referrals to local Minor Injuries and Illness Units, including by the NHS 111 service
Musculoskeletal service	To develop clear, clinically agreed thresholds for musculoskeletal related procedures
Primary care in ED	To better understand changes in urgent care pathways
Physiotherapy and podiatry review	To review the service user pathway and improve outcomes
Other service changes	To (i) develop a leg ulcer service, (ii) undertake a rehabilitation service review, (iii) asses telehealth procurement, (iv) develop respiratory services outpatient pathways, (v) trial heart failure services

In 2015-16, the following QIPP schemes will apply:

Table 7: QIPP schemes 2015-16

QIPP schemes	Purpose
Integrated Community Teams (ICTs)	• To continue to roll-out the ICT model across the county • To reduce non-planned hospital admissions for service users with identified conditions • To implement the Community Nursing Action Plan • To meet the reablement outcomes as identified within the Better Care Fund
Integrated Discharge Team (IDT)	To continue with the existing IDT programme and increase the flow of service users being discharged from the acute hospital to their home, community hospital or into other community services
Community Hospital programme	To deliver seven projects to improve efficiencies in community hospitals including Minor Injuries and Illness Units
Musculoskeletal pathways	To be fully engaged and involved with further development of musculoskeletal pathways
Single Point of Clinical Access	To increase reductions in acute hospital admissions and increase the use of appropriate alternative community services by simplifying the process of accessing services and actively re-directing requests to the most appropriate setting including social care
Leg ulcer	To establish a complex wound service that will support primary care in the management of both simple and complex leg ulcers
Service reviews	To contribute to service reviews of physiotherapy, rehabilitation and podiatry services

3.5.6 Commissioning for Quality and Innovation (CQUIN)

Each year, in line with NHS standard contracting, the Trust receives 2.5% of the value of its recurrent funding as a non-recurrent payment for achieving agreed improvements in quality. These improvements are known as Commissioning for Quality and Innovation (CQUIN) schemes, and represent a combination of national targets and local priorities. For 2014-15, the Trust's CQUIN schemes were as follows:

Table 8: CQUIN schemes 2014-15

	Goal name	Purpose of goal	Plan £000	Actual £000	Variance £000
Gloucestershire Clinical Commissioning Group CQUINs					
1	NHS Safety Thermometer	To measure and reduce harm, and specifically to help understand the prevalence of pressure ulcers	91	91	0
2	Friends and Family Test	To make the Friends and Family Test available across all Trust settings	91	91	0
3	Person-centered coordinated care	To enable Integrated Community Teams to work closely with GPs to best identify and support people who are at risk of losing their independence	290	290	0
4	Trust development	To ensure that Integrated Community Teams see themselves as part of a wider community network, and know when to refer service users to other care providers	363	363	0
5	Service user discharge	To ensure that service users are appropriately supported upon discharge from hospital, enabling them to return home	291	291	0
6	Staff skills and competencies	To ensure that staff have the knowledge and capability to support service users with more acute healthcare needs	509	509	0
7	Service user records and documentation	To help improvements in record keeping practices	182	182	0
NHS England CQUINs					
8	Dental activity reporting	To ensure that there is detailed analysis and understanding of community dentistry activity	286	286	0
Total			**2,103**	**2,103**	**0**

For 2015-16, the following CQUIN schemes have been agreed:

Table 9: CQUIN schemes 2015-16

	Goal name	Purpose of goal	Plan £000
Gloucestershire Clinical Commissioning Group CQUINs			
1	Urgent Care	To improve the journey of inpatients through community hospitals, and prevent unnecessary waiting. This includes: • ensuring daily senior (GP) reviews of inpatients: also daily discharge coordinator reviews of long-stay inpatients; • assuring that all inpatients have an expected discharge date; • ensuring that 95% inpatients are admitted in line with clear admission criteria; • managing effective discharge of inpatients.	349
2	Delirium	To develop and use an effective screening and assessment tool for inpatients with delirium	174
3	Transition	To improve outcomes and experiences for young people transitioning into adult services	349
4	Integrated care pathway for frail older people	To ensure safe, compassionate care for frail older people using an integrated care pathway, including improved screening, assessment and care planning	349
5	Positive risk taking	To empower staff, service users and carers to better understand and manage risk and enable service users to live as independently as possible	349
6	Acute Kidney Injury	To use a Modified Early Warning Score (MEWS) tool to assess and manage Acute Kidney Injury in community hospitals	174
NHS England CQUINs			
7	Dental activity reporting	To continue with the reporting on dental activity	161
Total			**1,905**

3.6 Sustainability report

3.6.1 Trust commitment

All public organisations currently face challenging times. Pressures on services are increasing, yet income is decreasing. This creates the need to work smarter and achieve more with less. However, even if money were plentiful, there would still be a clear rationale for reducing the demands of healthcare services on the planet's finite resources, so as to ensure that enough remain to deliver care indefinitely.

To address this issue of sustainability, the Trust has developed a Corporate Social Responsibility (CSR) workstream, which involves both its workforce and the local community, and which is delivered through an annual CSR action plan.

3.6.2 Social values

Part of the CSR workstream in 2014-15 focused upon raising awareness and understanding about Social Values in line with the Public Services (Social Value) Act 2012. This Act aims to ensure that public sector organisations commission goods and services in a way which maximises the social benefit of the investment and delivery in the local area. The Act is now supported by additional guidance issued in January 2015 by Public Health England and NHS England which identifies the main benefits of social values to be:

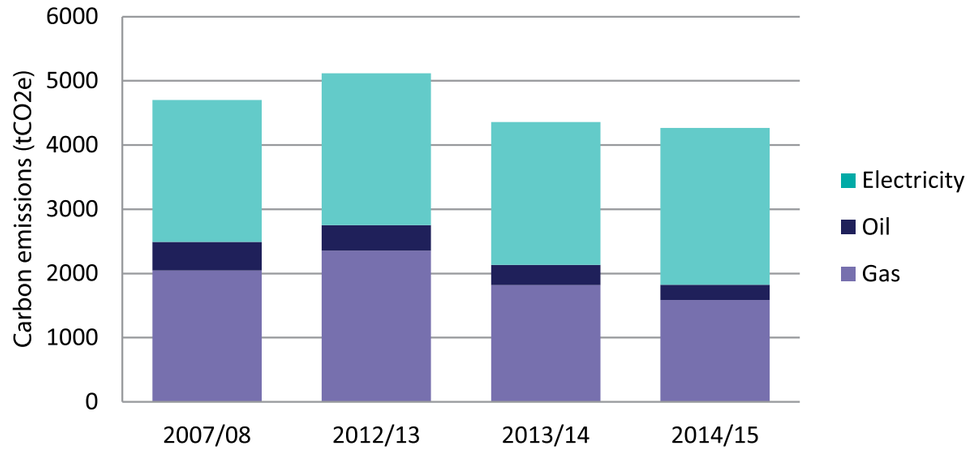
- economic value, through the generation of local economic activity and employment;
- social and cultural value, by contributing to social capital and community well-being for instance, by encouraging community cohesion and support, ensuring a living wage, encouraging apprenticeships, and tailoring services to local needs;
- political value, by encouraging community dialogue and active public participation and engagement. This means making sure that services are informed by public voice, and in particular groups with protected characteristics, through their design, delivery and evaluation;
- ecological value, by enhancing green spaces, local food production, reducing waste and protecting natural resources. This might also mean supporting energy efficient homes to improve health and reduce fuel poverty.

By embracing these values, the Trust seeks to ensure the sustainability not only of the organisation, but also of the wider community. As such, the Trust is now determining how quality goals identifying activities, achievements and successes in social values can be added to its range of strategies, so as to highlight need and measure performance across future years.

3.6.3 Carbon emissions

In 2014-15, the Trust achieved 2% reduction in its carbon footprint compared to 2013-14. This was the cumulative effective of the organisation's reduced use of gas, electricity and oil over the twelve month period. More significantly, this now means that the Trust has achieved a 9% reduction in its carbon footprint compared to its 2007-08 baseline, and therefore suggests that the 10% reduction due by the end of 2015-16, will be met.

Chart 6: Tonnes carbon dioxide equivalent from Trust buildings 2014-15



A number of the projects which have led to this reduction are described in section 5.6.4 below.

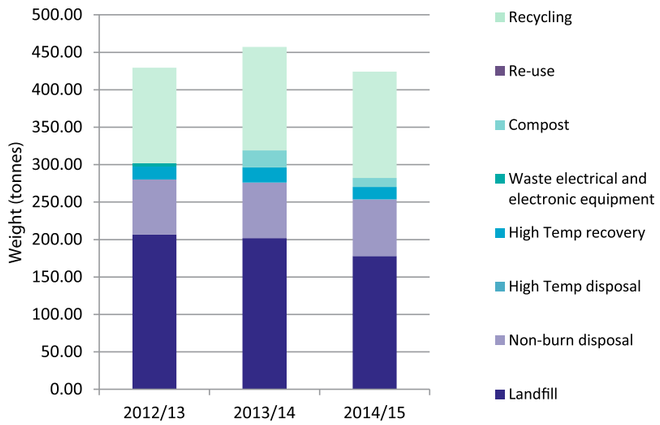
3.6.4 Water

The Trust's water consumption decreased by over 10% in 2014-15 after several previous years of increases (i.e. there was a 1.6% increase in 2013-14 compared to 2012-13). This is largely attributable to leak abatement, and the continued adoption of water saving technologies - such as modern-style taps, toilets and showers - during refurbishment works.

3.6.5 Waste

The total amount of waste produced by the Trust in 2014-15 decreased by approximately 7%, and recycling increased to 33% of the total waste produced which is above the target threshold of 25%. Both of these actions are contributing to reduced carbon emissions and costs from waste.

Chart 7: Waste tonnes by waste type 2014-15



3.6.6 Travel

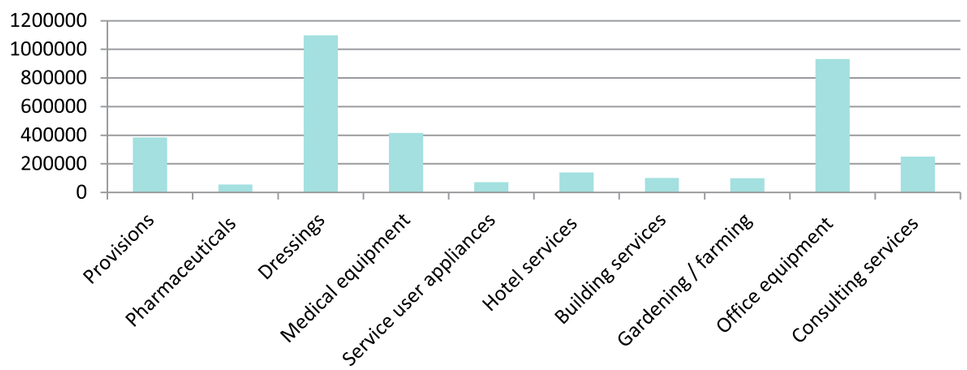
In 2014-15, the Trust accessed funding from the Local Sustainable Transport Fund to purchase 9 pool bikes for the use of staff at head office and in Gloucester City.

However, business mileage within the year increased by 3%. With the increasing use of Webex technology to enable meetings to be held remotely via laptops and PCs, and the continued rollout of mobile working and SystmOne which reduces the need for community-based staff to return to office to access electronic records, it is anticipated that this trend will be reversed in 2015-16.

3.6.7 Impact of procurement practices

In calculating the carbon footprint of the goods that were bought by the Trust in 2014-15, it is noted that dressings constituted the most significant impact. As a result, a stock control project will be instigated in 2015-16 in order to reduce waste and hence associated carbon emissions.

Chart 8: Procurement carbon footprint 2014-15 (carbon emissions in tonnes)



3.6.8 Green spaces and the community

The Trust is a keen supporter of the NHS Forest initiative and has already planted 1,500 trees, representing 45% of its target to plant a tree for every member of staff.

In 2014-15, the Trust won the national NHS Forest Award: Best Community Project for the work at Cirencester Hospital. The award recognised the diversity of people who have been involved in the Trust's Green Gym including representatives from local schools and colleges, universities, voluntary agencies and councils. Additionally, the award acknowledged the health and wellbeing benefits of the project which supports physical activity and reduces social isolation for people living locally in Gloucestershire. Indeed, some of the volunteers' lives have been transformed by attending the Green Gym and they now have employment employment in the horticultural sector.

The Trust was also highly commended for its the Most Pioneering Healthcare Professional Site, with the physiotherapy team recognised for its use of purpose built outdoor steps and exercise benches.

In 2014-15, volunteers continued to provide invaluable and much appreciated support throughout the Trust, whether helping in community hospitals or working across countywide services. Over the last year, the Trust was able to increase the range and variety of roles available to its volunteers, as a result of which, volunteer numbers rose by 17% compared to 2013-14.

New roles for volunteers in 2014-15 included:

- working within health records at Tewkesbury Hospital;
- assisting the social group on Coln Ward in Cirencester;
- helping with refreshment trollies;
- expanding the work of the Pets As Therapy (PAT) dog.

I hereby confirm that the above Strategic Report is a true and accurate representation of the described Trust activities in 2014-15.

Paul Jennings

Signed: Paul Jennings, Chief Executive
Date: 3 June 2015

4. Directors' Report

4.1 Board members

4.1.1 The Trust Board

In 2014-15, the Trust Board convened six public Board meetings, attendances at which are detailed in section 5.2.3 below. These meetings enabled the Board to fulfil its duties and obligations as prescribed within its Terms of Reference (summarised in section 5.2.1 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.

Additional to these public Board meetings, the Trust also called two extraordinary closed-session Board meetings in 2014-15, namely:

- 24 June, which followed the TDA's decision on 18 June to approve the Trust to work towards Foundation Trust status: thus, the extraordinary Board meeting focused upon a presentation by the Head of Corporate Planning in respect of strategic planning for future sustainability;

- 12 January, at which the Head of Corporate Planning presented the proposed submissions for the TDA Annual Planning Cycle for the approval of Board members.

In addition to the Board meetings, there were also seven Board Development sessions held in 2014-15, at which Board members were able to explore pertinent issues in an appropriate and conducive environment. Expert external attendees of these sessions included representatives from:

- the NHS South, Central and West Commissioning Support Unit, who provided information governance training in April;

- GE Healthcare Worldwide, who hosted a discussion based upon the Trust's SWOT (Strengths, Weaknesses, Opportunities and Threats) and PESTELI (Political, Environmental, Social, Technological, Economic, Legal and Industrial) analyses in August;

- Capsticks, who delivered insight into Board functions and roles in September; and

- DAC Beachcroft who updated the Board on the Duty of Candour in February.

In 2014-15, there were a number of changes in the Board composition, which are articulated in section 5.2.2 below. However, as of 31 March 2015, the Trust Board included the (voting) Chief Executive (Paul Jennings), three additional voting Executive Directors, and five non-voting Executive Directors, all of whom bring a wide range of skills in health and social care as well as significant business, financial and organisational development experience (NB a Board vote on 10 February approved the Chief Operating Officer to also be a voting member: this is currently awaiting Department of Health endorsement).

At 31 March 2015, the Trust Board also comprised the Trust Chair (Ingrid Barker) and five voting Non-Executive Directors, representing a variety of professional backgrounds, including corporate finance, commercial and business management and consultancy. Details of all Executive and Non-Executive Directors are given in section 4.1.2 below.

The Annual Governance Statement which is included within this Annual Report and Accounts (see section 5 below) contains information about the work of the Board's sub-committees.

It is also noted that in 2014-15, the Trust Board served as the Corporate Trustee for the Trust's charitable funds for which a separate report and accounts is available.

4.1.2 Board members' profiles

As of 31 March 2015, the following were members of the Trust Board:

Ingrid Barker - Chair (voting)

Since April 2011, Ingrid has been Chair of the entity known as Gloucestershire Care Services (part of NHS Gloucestershire until 22 March 2013), and was previously a Non-Executive Director on the NHS Gloucestershire Board for five years.

Ingrid has undertaken national policy and service development roles through King's College, London and Birmingham University. She was Deputy Chief Executive of an NHS Trust in Surrey, and led Croydon Mental Health Unit as Unit General Manager, transforming institutional services to community provision.

A qualified social worker, Ingrid established a service for young homeless people in Central London and was Regional Director of MIND. Ingrid led the creation of the first mental health patients' councils and advocacy projects in Britain. She has published on topics including user empowerment, mental health and multidisciplinary teamwork.

In 2014-15, Ingrid served as Chair of the Trust Board, as well as Chair of the Trust's Remuneration and Terms of Service Committee, the Your Care, Your Opinion Programme Board and the Foundation Trust Programme Board.

Paul Jennings - Chief Executive (voting)

Paul has worked in the NHS for 37 years in a wide range of senior roles. Prior to joining Gloucestershire Care Services NHS Trust in summer 2013, Paul was Interim Chief Executive at Birmingham and Solihull Mental Health NHS Foundation Trust. He has a long history of managing community services, including services for people with a learning disability and mental health services.

Paul has held the role of Chief Executive for three Primary Care Trusts (North Birmingham PCT, NHS Walsall and, NHS Warwickshire). He has a strong track record of building partnerships, and leading organisations to deliver changes that make a positive difference to the health and care services people receive in their local community. He has always made it top priority to work closely with clinicians and service users to gain support for what have, on occasions, been innovative and challenging schemes.

Paul has led a number of significant pieces of work to address issues of health inequality, particularly for older people and newborn infants, and was made a Fellow of the Faculty of Public Health, by distinction, in 2012. Paul is a trustee of The Extra Care Charitable Trust, which provides high quality supported living for older people, and non-executive chair of Welcome CIC, which focuses on addressing health issues from Black and Minority Communities and Migrants.

Glyn Howells - Director of Finance and Deputy Chief Executive (voting)

Glyn has a wealth of experience in both operational finance and project management, and has previously worked as Finance Director for several organisations. Glyn provides strong commercial finance support to the Trust, as well as guiding the development of its systems, processes and controls.

Glyn gained his Associate Chartered Management Accounting (ACMA) qualification whilst at Calor Gas where he worked in a series of accounting and systems roles before moving to ICL where he worked latterly as Financial Controller of the Desktop Services Division. He then moved to PricewaterhouseCoopers, where he worked as a consultant for 3 years before taking a Director level role in Medas, one of their joint ventures providing outsourced accounting services to the BBC. Subsequently, Glyn joined United Technologies Corporation working as Business Systems Director for Chubb Electronic Security, Director for Strategic Change for Chubb UK, Ireland and South Africa, Internal Audit Director for United Technologies Corporation in Europe, and Finance Director for Chubb Fire Ltd. Most recently, Glyn was Finance Director at the Richardson Group, where he worked alongside a new management team to integrate several businesses and provide improved management reporting and controls.

Dr Joanna Bayley - Medical Director (voting)*

**Jo is listed here as her place was on the Trust Board was substantive as at 31 March 2015: however at that time, she was on secondment as detailed below.*

Jo qualified as a doctor in 1997, and specialised in emergency medicine and intensive care before becoming a GP in 2005. She continues to work as a GP in central Gloucester. She is also the National Medical Advisor on Urgent Care to the Care Quality Commission, and the Chief Executive of Gloucester GP Consortium.

In June 2014, Jo temporarily left the Trust to take up a 10 month secondment to the Executive Fast-Track Programme set up by the Secretary of State for Health, which included study at the John F Kennedy School of Government at Harvard.

Dr Mike Roberts - Interim Medical Director (voting)

Mike joined the Trust in July 2014, deputising during Joanna Bayley's secondment.

Mike qualified as a Doctor in 1982 and worked in a number of hospital specialities before becoming a GP in 1989. He has worked as a GP in Gloucester (Rosebank Health) for 25 years.

Mike has extensive experience of health service management, having served as Professional Executive Chair for West Gloucestershire Primary Care Trust (PCT), Medical Professional Lead (and Responsible Officer) for Gloucestershire PCT and as a member of the Gloucestershire Local Medical Committee. Mike also has a particular interest in clinical governance and is a member of the Performance Advisory Group of NHS England, which deals with complaints and concerns about GP performance.

Mike has a special clinical interest in Sports Medicine, was Gloucester Rugby Club Doctor for 10 years, and continues as Stadium Doctor at Kingsholm.

Elizabeth Fenton - Director of Nursing and Quality (voting)

Liz qualified as a registered general nurse in 1981, starting her career working in a liver failure unit. Liz has worked in Gloucestershire since 1987, and has held various clinical and senior managerial posts in both community and secondary care settings. She moved to Gloucestershire Primary Care Trust in 2006 to be the Associate Director of Clinical Leadership. Liz was appointed as Head of Nursing in November 2011: this title subsequently changed to Director of Nursing and Quality in April 2014.

Liz has a special interest in the dissemination of best practice to develop the quality of clinical services, and acts as a specialist advisor to the Care Quality Commission. In addition, Liz participates in national and international peer accreditation programmes as a member of teams reviewing clinical services against best practice standards.

In her spare time, Liz is an elected member of the Community Hospital Association Committee, supporting innovation and sharing of learning.

Joanna Scott - Non-Executive Director and Vice Chair (voting)

Joanna joined the Trust in April 2013. An experienced communications professional with a strong private and public sector profile, Joanna had worked for leading national food trade bodies and multi-national food companies including, most recently, Kraft Foods based in Cheltenham.

Joanna graduated from the University of London with a Master's degree in Nutrition Science, and is a member of a number of professional bodies including the Chartered Institute of Public Relations.

In 2014-15, Joanna served as Chair of the Trust's Communications and Public Affairs Steering Group.

Robert Graves - Non-Executive Director (voting)

Rob has enjoyed an extensive career in the finance function of 3M Company (a component of the Dow Jones Industrial Average) including director level positions in the USA, Belgium and the United Kingdom. A qualified accountant, he has significant experience of leading large finance teams, serving complex business units that span operational accounting and business planning functions, and has been instrumental in establishing a European shared service operation.

Rob joined the board of NHS Gloucestershire in 2006 as a Non-Executive Director and Audit Chair where he took an energetic and proactive approach in ensuring excellent governance. Since 2011, Rob has acted for as Non-Executive Director for Gloucestershire Care Services.

In 2014-15, Rob served as Chair of the Trust's Audit and Assurance Committee

Susan Mead - Non-Executive Director (voting)

Susan was formerly a Board member and Chair of the Quality, Performance and Resources Committee for the West Mercia Cluster of PCTs (2012-13) and Non-Executive Director at Herefordshire PCT from 2004-12. Her background includes work at the Audit Commission, Assistant Director at Birmingham City Council, and work in the Lord Chancellor's Office.

At the Trust Board on 20 May 2014, Susan was formally appointed as the Trust's Senior Independent Director (SID).

In 2014-15, Susan served as Chair of the Trust's Quality and Clinical Governance Committee.

Nicola Strother Smith - Non-Executive Director (voting)

Nicola has 40 years' experience in the NHS, including clinical, operational management, improvement and strategic roles in local, regional and national organisations. As National Director of NHS Diabetes and Kidney Care, she was responsible for implementation of national strategy in diabetes, kidney and liver disease and led the implementation of the NHS Health Check programme with the Department of Health. Regionally, Nicola was Director of the 3 Counties Cancer Network, leading implementation of the Calman-Hine report: a policy framework for commissioning cancer services and the NHS Cancer Plan across Gloucestershire, Herefordshire and south Worcestershire. Other experiences include: director in NHS Improving Quality; primary care management; oncology centre management and radiotherapy department superintendent.

Nicola was awarded a Master's degree in Public Administration (MPA) with distinction from the University of Warwick Business School. She is also a qualified therapy radiographer.

In 2014-15, Nicola served as the Chair of the Trust's Charitable Funds Committee. In February 2015, Nicola also assumed the role of Chair for the Human Resources and Organisational Development Committee given the retirement of the former Chair, Christopher Creswick.

Richard Cryer - Non-Executive Director (voting)

Richard joined the Trust in April 2014. He was previously Director of Finance at the University of London between 2006 and his retirement at the end of 2012. He is currently Treasurer and a Trustee of Amnesty International UK, as well as of Hereford learning disabilities charity, Aspire Living. Additionally, Richard is a member of the finance committee of national learning disability charity Mencap and of the audit committee of the Institution of Civil Engineers.

In 2014-15, Richard served as the Chair of the Trust's Performance and Resources Committee.

Duncan Jordan - Chief Operating Officer (non-voting)

Duncan joined the Trust in April 2014 on secondment from Gloucestershire County Council, where he held the role of Group Director and Chief Operating Officer.

His role within the Trust gives him responsibility for all front-line services delivered by the Trust and leadership of an extensive programme of change, as health and social care services adapt to meet the challenges of a growing ageing population and increasing numbers of people with complex medical needs.

An engineering graduate and chartered civil engineer by training, Duncan began his career at East Sussex County Council in 1988, rising to the role of Deputy Director before joining Gloucestershire County Council in 2006 as Group Director for environment. His portfolio included economic development, planning, highways, transport and waste management, and Duncan was also appointed a director of the local enterprise partnership Gloucestershire First. In 2010, his portfolio was expanded to include the directorate for Children and Young People, where he led the successful turnaround of services.

Appointed to the Council's Chief Operating Officer in 2011, Duncan's portfolio expanded again to include Fire and Rescue as well as Adult Social Care Services. He also played a lead role in developing the organisation's strategy as a provider of services with a focus on outcomes for customers, and leading community focused programmes with key partners across the county.

Susan Field - Director of Service Transformation (non-voting)

Susan holds both managerial and clinical (nursing and mental health) qualifications, and has considerable Board level experience.

Her current role within the Trust includes leading transformational change and service improvement programmes of work across the Trust.

Additionally, Susan leads the delivery of high quality care within the Trust's seven Community Hospitals, as well as within the urgent care and capacity services.

Candace Plouffe - Director of Service Delivery (non-voting)

Candace qualified in 1986 as an occupational therapist, and specialised in Children and Young People's services, working in a variety of community settings in Canada and New Zealand. Candace moved to Gloucestershire in 2000, where she worked in Swindon Borough Council Child Health team until moving to Gloucestershire Primary Care Trust in 2004. She was appointed as General Manager of Children and Young People's services in September 2011, before her substantive appointment as Director of Service Delivery in April 2014.

Candace holds a Bachelor's of Medical Rehabilitation (Occupational Therapy) from the University of Manitoba, Canada, and a Master's of Science (Special Education) from Minot State University, USA. She was a recipient of the Florence Nightingale Leadership Scholarship in 2010, which provided her with the opportunity to complete a postgraduate Diploma in Organisational Leadership, at the Saïd Business School, Oxford University. She obtained an Executive coaching and mentoring qualification from Institute of Leadership & Management in 2013.

Candace has previously held a number of Board positions and currently is a Board member for Active Gloucestershire, a local organisation whose aim is to promote sport and physical activity within the county.

Tina Ricketts - Director of Human Resources (non-voting)

Tina has held various HR managerial posts in both the public and private sector, and became a member of the Chartered Institute of Personnel and Development (CIPD) in 1999. She first joined the NHS by way of appointment to West Gloucestershire Primary Care Trust in 2003, after which she was promoted to the position of Associate Director of HR for Gloucestershire Care Services in 2007, and subsequently, to the Head of HR in 2011 and Director of HR in 2014.

Tina has secured the Investors in People accreditation for her last three employers, and has won both regional and county awards for HR best practice.

Tina has a special interest in leadership development, and is an accredited assessor for the NHS Leadership Framework, Leadership Qualities Framework, and Pi Coaching for Behaviour and Results. Tina is a Board member of the Southwest Leadership Academy.

Jason Brown - Director of Corporate Governance and Public Affairs (non-voting)

Jason joined the Board in May 2014, having worked for the Trust since December 2012. In addition to his role responsibilities, Jason also assumed the statutory duties of Board Secretary in June 2014.

Previously, Jason had worked within the NHS for 22 years, providing corporate, strategic and operational management for a range of acute, community and mental health providers, as well as adult and children's social care in England. This included work as Associate Director with Central and North West London NHS Foundation Trust, as well as a long-term commission with County Durham and Darlington NHS Foundation Trust. Jason has also worked nationally on behalf of both the Department of Health supporting confidential enquiries, and the Health and Social Care Information Centre.

Jason is a member of the Chartered Institute of Secretaries and Administrators (ICSA).

Others

Within 2014-15, the following also served on the Trust Board: Simeon Foreman (Board Secretary) and Christopher Creswick (Non-Executive Director). Their departures are detailed in section 5.2.2 below.

In May 2015, Dr Jo Bayley resigned from the Trust, and Dr Mike Roberts was appointed as substantive Medical Director: more details will be available in the 2015-16 Annual Report and Accounts.

4.1.3 Directors' interests

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

4.1.4 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 organisation's operations or finances of which the Trust'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.

4.1.5 Audit and Assurance Committee

It is noted that in 2014-15, the following Board members were also members of the Trust's Audit and Assurance Committee:

- Rob Graves, Non-Executive Director (Committee Chair)
- Joanna Scott, Non-Executive Director
- Richard Cryer, Non-Executive Director
- Susan Mead, Non-Executive Director
- Nicola Strother Smith, Non-Executive Director
- Christopher Creswick, Non-Executive Director (until his retirement in January 2015)
- Glyn Howells, Director of Finance and Deputy Chief Executive
- Duncan Jordan, Chief Operating Officer
- Jason Brown, Director of Corporate Governance and Public Affairs

Additionally, the Committee was attended by Trust senior managers and external representatives as appropriate.

Details of the Committee's responsibilities are given in section 5.2.6 below.

4.2 Workforce

4.2.1 Workforce composition

The Trust's workforce at the end of 2014-15 comprised 2,132.59 whole time equivalent (WTE) posts, with a headcount of 2,706 workers excluding bank staff (NB there were 343 people on bank contracts as at 31 March 2015). Staff were allocated across the various professional disciplines as per the below:

Table 10: Workforce composition 2014-15

Staff Group	WTE	Headcount
Nursing	1,089.43	1,363
Allied healthcare professional	462.73	587
Administration	457.67	558
Ancillary staff	94.61	147
Medical and dental staff	28.15	51
Total	**2,132.59**	**2,706**

This represents a slight increase in staffing numbers compared to 31 March 2014 of 46.09 WTE posts and 7 headcount.

4.2.2 Staff turnover

The Trust's turnover of staff in 2014-15 is detailed below:

Table 11: Staff turnover 2014-15

Staff Group	Turnover
Nursing	13.66%
Allied healthcare professional	13.05%
Administration	17.41%
Ancillary staff	9.63%
Medical and dental staff	22.38%
Clinical support	16.55%
Total	**14.70%**

This represents a decrease in turnover from 15.76% in 2013-14 to 14.70% in 2014-15.

4.2.3 Staff training

Performance relating to the Trust's mandatory training as at 31 March 2015 is as below:

Table 12: Training rates 2014-15

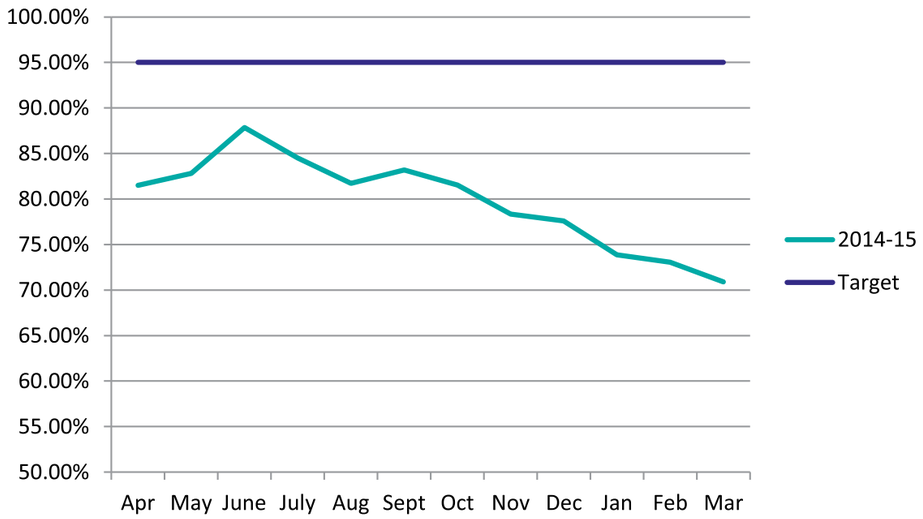
Programme	Target	Performance
Health, safety and welfare	95%	**79.83%**
Equality and diversity	95%	**72.93%**
Information governance	95%	**61.58%**
Conflict resolution	95%	**72.69%**
Induction for new starters	100%	**100%**

The above figures were largely impacted by significant under-performance in the latter half of the year: thus, it is acknowledged that winter pressures during this period prevented many colleagues from attending training. Nevertheless, the Trust is now exploring new ways to raise the profile of mandatory training so as to address this issue.

4.2.4 Staff appraisals

The Trust did not meet its appraisals target in 2014-15 as illustrated below:

Chart 9: Appraisal rates 2014-15



Thus, the appraisal completion rate at the end of March stood at 70.91%, which was 10% lower than the rate in 2013-14 (80.45%). It is however noted that last year's data did not include staff on long term sick or on maternity leave, or bank staff as now required.

Nevertheless, it is evident that appraisal compliance rates have steadily fallen across the year. As a result, all line managers are now provided with a monthly report highlighting colleagues whose appraisal is overdue, or due by the end of that month. This seeks to facilitate the scheduling of appraisals, and to highlight those colleagues that need to be addressed as a priority.

4.2.5 Staff sickness absence

Staff sickness absence in 2014-15 is detailed below:

Table 13: Sickness absence 2014-15

Staff Group	Percentage
Nursing	5.44%
Allied healthcare professional	3.75%
Administration	4.32%
Ancillary staff	6.32%
Medical and dental staff	4.57%
Total	**4.85%**

This represents an increase of 0.57% compared to 2013-14. Whilst there were a range of reasons for colleagues' sickness, it is noted that the highest percentage of calendar days lost due to sickness was attributed to "Anxiety / stress / depression / other psychiatric illnesses" which accounted for 28.4%, although only 8.74% total sickness episodes. The highest percentage of total sickness episodes was for "Cold / Cough / Influenza" which accounted for 23.39%, followed by "Gastrointestinal problems" at 22.40%.

Detailed reports are provided to managers to enable them to best support colleagues suffering sickness absence, and to enable on-going monitoring.

4.2.6 Employee consultation

The Trust continues to operate a Joint Negotiating and Consultative Forum (JNCF) that meets at least bi-monthly, where terms and conditions of employment and Human Resources policies are negotiated and discussed, and therefore that offers a forum for employee consultation. The Chief Executive, Director of Service Transformation, Director of Service Delivery, and the Director of Human Resources are all active members of the JNCF. The following trade unions are also represented: Unison, Unite, Chartered Society of Physiotherapy (CSP), Royal College of Nursing (RCN), British Dental Association (BDA), Society of Chiropodists and Podiatrists (SCP), and the British Medical Association (BMA).

Additionally, the Trust has a dedicated staff engagement programme, which seeks to ensure two-way dialogue with colleagues in order to motivate them to take ownership for activity within their respective spheres of influence, and inspire and empower them to deliver the highest quality of care. This includes specific actions to:

- raise understanding and awareness of the Trust's core values, and ensure that they are effectively used to inform and support the growth of Trust culture;
- support the growth of a learning and supportive culture, that emphasises the importance of team working to achieve common goals;
- contribute to a measurable increase in the capacity and capability of leadership across the Trust, supporting a more engaged workforce that feels valued;
- empower and motivate colleagues to make a positive contribution to Trust planning and decision-making, and instil a sense of purpose and ownership at all levels of the organisation.

These activities are also supported by an on-going programme of communications that includes global emails and newsletters.

4.2.7 Commitment to equalities

It is fundamental to the Trust's practice that equality of opportunity is advanced throughout its delivery of services and employment practices. This is evident by the following:

- information about equality amongst service users and Trust colleagues which is routinely gathered and shared, not least as part of the Annual Equality Report, a copy of which can be accessed via the Trust website;
- the Trust's equalities objectives, which were agreed in July, and based upon the priorities identified within the Annual Equality Report as well as upon discussions with service users, local communities, and colleagues;
- equality impact assessments which are completed for each service design or redesign, in order to give assurance that associated decisions relating to service delivery and employment, have full and appropriate regard for the Equalities Act, and that no development in service delivery will have a negative impact upon people of protected characteristics or people from seldom heard, seldom seen communities;
- work to implement the NHS Equality Delivery System (EDS2) and the Workforce Race Equality Standard, for which the Trust's Equalities Governance Group will oversee the strategic management;
- the Trust's recruitment and selection process, which seeks to be as fair as possible and therefore uses the NHS Jobs system for recruitment in order to ensure that personal details are removed for the shortlisting stage. The Trust also 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;
- the delivery of Equality, Diversity and Human Rights training as part of every new employee's induction, and equality updates which are mandatory every three years: however, the Trust acknowledges some weakness in this area, and will be seeking to strengthen this training in 2015-16, including making equality training updates mandatory on an annual basis;
- the involvement of local communities in decisions which may affect them. Indeed, the organisation is particularly mindful of people who might have extra or different needs. As such, the Trust holds regular events to inform and involve community representatives.

Specific equalities activities in respect of disabled employees and equal opportunities are detailed in sections 4.2.8 and 3.3.7 respectively. For further information, please also refer to section 5.6.2 below which forms part of the Annual Governance Statement.

4.2.8 Disabled employees

The Trust's Equality and Human Rights Policy confirms that the organisation fully embraces the philosophy and practice of making reasonable adjustments for people with disabilities. In particular, the Trust is committed to:

- taking positive steps to ensure that disabled people can access and progress in employment with the Trust;
- avoiding provisions, criteria or practices that put a disabled person at a substantial disadvantage, compared to those who are not disabled;
- removing or altering a physical feature, or providing a reasonable means of avoiding such a feature, where it puts a disabled person at a substantial disadvantage, compared to those who are not disabled;
- providing an auxiliary aid where a disabled person would otherwise be put at a substantial disadvantage, compared to those who are not disabled.

Specifically in terms of recruitment, the Trust can report the following in respect of responses to advertised posts:

Table 14: Register of disabled people throughout the recruitment process May 2014 - March 2015

	Applied	Shortlisted	Appointed
Disability	3.9%	3.5%	3.4%
No disability	94.5%	94.9%	95.2%
Undisclosed	1.5%	1.7%	1.4%

The Trust currently reports that 1.4% of its workforce are people with a disability. However, the disability status for 40% of the Trust's staff is unknown, as many of colleagues have chosen not to declare. This means that the Trust is currently unable to conduct detailed analysis on the effect of disability on employment activities such as training, promotion, sickness absence and performance management. However, by way of comparison, the Trust notes that:

- 13% staff declared a disability in an anonymous 2014 staff survey (and none declined to declare their disability status);
- 16.7% people in Gloucestershire have a limiting long-term illness or disability.

4.3 Financial matters

4.3.1 Pension contributions

Existing employees of the Trust are covered by the NHS Pension Scheme, whilst for those staff who are ineligible to join, the Trust has signed up to the government's National Employment Savings Trust (NEST).

In respect of new employees, the Trust complies with the mandatory requirement to automatically opt all new staff into the NHS Pension scheme.

The organisation also supports a small cohort of staff who transferred into the Trust from the Local Authority and who chose to remain in the Local Government Pension Scheme (LGPS). As this is a funded scheme, a valuation of assets and estimated values is required each year. This shows that as at 31 March 2015, the scheme was under-funded by £703,000 which was adjusted out into retained reserves. Further information is given in the notes to the accounts section 7.2.8.

4.3.2 Exit packages and severance payments

In 2014-15, eleven exit payments were paid totalling £176,434. For further details, please refer to section 7.2.8 below.

Table 15: Exit packages 2014-15

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
	Whole Numbers Only	£s	Whole Numbers Only	£s	Whole Num-bers Only	£s	Whole Numbers Only	£s
Less than £10,000	3	16,543	3	10,733	6	27,276	-	-
£10,000-£25,000	3	50,226	1	11,426	4	61,652	-	-
£25,001-£50,000	-	-	-	-	-	-	-	-
£50,001-£100,000	1	87,506	-	-	1	87,506	-	-
£100,001-£150,000	-	-	-	-	-	-	-	-
£150,001-£200,000	-	-	-	-	-	-	-	-
>£200,000	-	-	-	-	-	-	-	-
Totals	7	154,275	4	22,159	11	176,434	-	-

Redundancy and other departure costs were paid in accordance with the provisions of the Medical and Dental or Agenda for Change terms and conditions as appropriate.

Exit costs in this note are accounted for in full in the year of departure.

In 2014-15, 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.

The disclosure in table 16 below 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.

Table 16: Exit packages 2014-15

	Agreements Number	Total value of agreements £000s
Voluntary redundancies including early retirement contractual costs	None	0
Mutually agreed resignations (MARS) contractual costs	None	0
Early retirements in the efficiency of the service contractual costs	None	0
Contractual payments in lieu of notice*	4	22
Exit payments following Employment Tribunals or court orders	None	0
Non-contractual payments requiring HMT approval	None	0
Total	**4**	**22**

* *Any non-contractual payments in lieu of notice are disclosed under "Non-contractual payments requiring HMT approval".*

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

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

4.3.3 External audit

Through its Audit and Assurance Committee, and following instruction from the Audit Commission, the Trust appointed KPMG as its external auditors in 2013-14.

KPMG has continued to support the Trust in this capacity throughout 2014-15. The fee for this external audit activity in year was £57,800 + VAT. The majority of this work related to formal audit of the 2014-15 accounts, on which the audit opinion is attached at section 7.3 below.

In 2014-15, KPMG also provided audit of the Trust's charitable funds accounts for 2013-14 for which the charge was £4,000 + VAT.

4.3.4 Better Payment Practice Code / Prompt Payments Code

The Better Payment Practice Code was designed to promote an improved payment culture within the UK. Thus, the Code compels all organisations to adopt a responsible attitude and ensure that payments are made on time to all suppliers. The four fundamental principles of the Code are:

- to agree payment terms with suppliers at the outset of a transaction and stick to them;
- to explain payment procedures to suppliers;
- to pay bills in accordance with any contract agreed with the supplier or as required by law;
- to inform suppliers when an invoice is contested and settle disputes quickly.

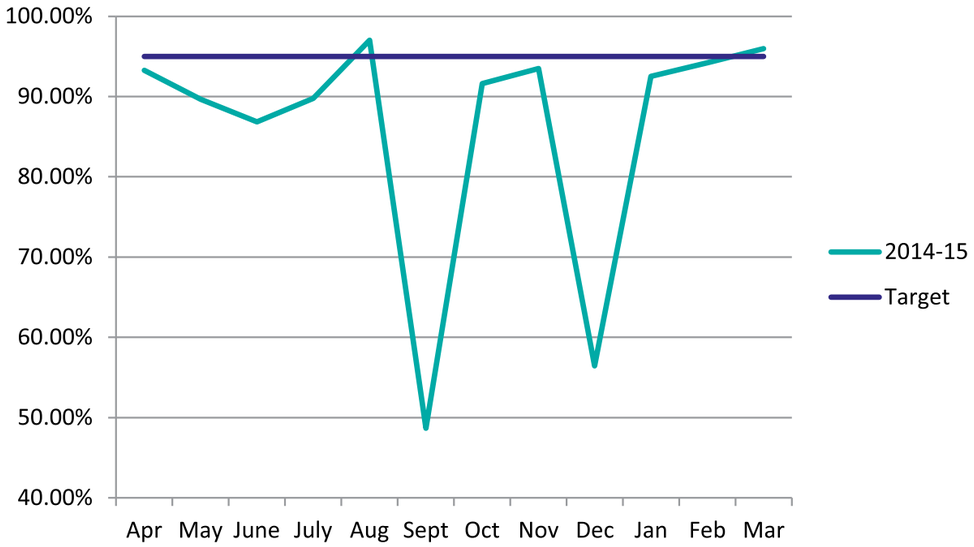
In practical terms, the Code requires organisations to pay 95% suppliers within 30 days of receiving a valid invoice.

The Prompt Payment Code, which is administered by the Institute of Credit Management on behalf of the Department for Business, Innovation and Skills, requires organisations to:

- pay suppliers on time within the terms agreed at the outset of the contract, without attempting to change payment terms retrospectively, and without changing practice on length of payment for smaller companies on unreasonable grounds;
- give clear guidance to suppliers in respect of payment procedures, ensuring there is a system for dealing with complaints and disputes which is communicated, and advising suppliers promptly if there is any reason why an invoice will not be paid to the agreed terms;
- encourage good practice by requesting that lead suppliers promote adoption of the code throughout their own supply chains.

The Trust is fully supportive of the Better Payment Practice Code and is also signed up to the Prompt Payment Code. However during 2014-15, performance against the above requirements was not of the expected standard, averaging 85.79% across the year as illustrated below:

Chart 10: Invoice payments with 30 days 2014-15



This was due to the following reasons:

- lost paperwork and delays in scanning invoices by SBS, the Trust's supplier of accounting services;
- low numbers of purchase orders which meant that a higher number of invoices required coding and approval following submission.

In 2015-16, initiatives to enable improvement will include:

- increasing colleagues' use of purchase orders;
- validating that the scanning issue is fully resolved;
- starting the process to identify a new supplier and move away from SBS.

4.3.5 Off-payroll engagements

In 2014-15, the Trust employed 9 people whose charges exceeded £220 per day and whose contract lasted longer than six months. All these engagements were suitably assessed to assure that the individuals concerned were paying the right amount of income tax and National Insurance.

These engagements are shown in the tables below:

Table 17: Off-payroll engagements as at 31 March 2015, for more than £220 per day and that last longer than six months

	Number
Number of existing engagements as of 31 March 2015	8
Of which, the number that have existed:	
for less than one year at the time of reporting	7
for between one and two years at the time of reporting	1
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
Confirmation that all existing off-payroll engagements have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought	YES

Table 18: Off-payroll engagements between 1 April 2014 and 31 March 2015, 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 2014 and 31 March 2015	9
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	9
Number for whom assurance has been requested	9
Of which:	
assurance has been received	9
assurance has not been received	0
engagements terminated as a result of assurance not being received	0

Board off-payroll engagements

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

4.4 Information governance

4.4.1 Charges for information

In 2014-15, the Trust complied fully with HM Treasury's guidance on setting charges for information. Thus, the Trust reserved the right to charge for disclosures under the terms of the Freedom of Information Act 2000 whereby work to fulfil that disclosure would exceed the cost limit laid down in the Fees Regulations: however, in practice, none of the enquiries received by the Trust in 2014-15 were that substantial that a corresponding charge had to be levied.

With regards to Subject Access Requests, the Trust's charges range from £10 - £50 for copies of records, but any such charge is made clear to requesters in advance.

4.4.2 Confidentiality breaches

All incidents that may, or do, result in loss of data or breach of confidentiality are taken extremely seriously by the Trust, irrespective of whether such loss or breach relates to either the person-identifiable information about a service user or member of staff, or whether it relates to sensitive or confidential information relating to the Trust's business or operations.

To this end, the Trust classifies all such incidents using the criteria recommended within the Checklist Guidance for Reporting, Managing and Investigating Information Governance Serious Incidents Requiring Investigation (IG SIRI) issued by the Health and Social Care Information Centre (HSCIC).

The results of this classification for confidentiality breaches in 2014-15 are as below:

Table 19: Classification of information breaches

Category	Breach Type	IG Scale Point	Scale Point Type	No	Mitigating Actions
A	Corruption or inability to recover electronic data	0	Limited clinical information corrupted within the clinical system	1	The responsible service identified the corrupted information and corrected the details from information held within the medical record
B	Information disclosed in error	0	Basic demographic information disclosed in error to third party	37	Colleagues referred to Information Governance refresher training
C	Information lost in transit	0	Limited clinical information plus basic demographic data lost in transit between organisations	6	Colleagues referred to Information Governance refresher training following a full investigation. Colleagues made aware of information security policy
		1	Detailed children's clinical information lost in transit between organisations	1	
D	Lost or stolen hardware	0	Lost mobile phone holding limited demographic data and no clinical information	2	Colleagues made aware of confidentiality code of practice and referred to Information Governance refresher training

Category	Breach Type	IG Scale Point	Scale Point Type	No	Mitigating Actions
E	Lost or stolen paperwork	0	Basic demographic information and limited clinical information lost	23	The responsible services reproduced the lost information in order to reduce the risk. Each team member was referred for Information Governance refresher training
F	Non-secure disposal of hardware	0	Basic demographic data at risk - information found on CD	1	Colleagues referred to Information Governance refresher training
		1	Unauthorised disposal of clinical system server containing limited clinical information	1	The Director of Finance held an emergency meeting with the countywide provider of IT support, and introduced measures to prevent this reoccurring
G	Non-secure disposal of paperwork	0	Limited clinical information at risk including basic demographic information	1	The manager was made aware of the situation and the team was referred to additional Information Governance refresher training. Additionally, the team was made aware of the Trust's information destruction rules
H	Information uploaded to website in error	N/A	N/A	0	None occurred
I	Technical security failing	1	Detailed clinical data lost including sensitive children information	1	Colleagues were required to re-enter the information from existing notes back onto the system. In cases of uncertainty, colleagues contacted the service users by telephone to clarify that the correct information was being recorded
J	Unauthorised access/ disclosure of information	0	No clinical data at risk. Limited demographic data disclosed.	36	Colleagues referred to Information Governance refresher training
K	Other	0	Incorrect data entered onto clinical system	16	The team manager was made aware of the situation and asked to correct the data entered onto the system
Total				**126**	

Thus, as shown above, in 2014-15, there were 126 breaches of data confidentiality, although none were of such significance that it needed to be reported to the Information Commissioner.

In order to deliver improvement in 2015-16, the Trust has developed a suite of information leaflets covering a variety of topics for colleagues' education. Additionally, detailed guidance will be available to colleagues via the Trust intranet, and there will be a strengthened process for receiving and resolving information governance queries.

For further information, please refer to section 5.5.6 below.

4.5 Health and safety

In 2014-15, the Trust reported 2,099 health and safety incidents which are shown in table 20 below. In this context, an incident is defined as any event which has given rise to actual harm or injury to an individual, or which has resulted in damage to, or loss of, property. This therefore includes service user or staff injury, assault and accident, as well as fire, theft and vandalism. It also includes harm from negligent acts, whether deliberate or unforeseen.

Table 20: Health and safety incidents 2014-15

Incident by type	Total
Personal accident (service user/staff)	1,307
Estates, staffing, infrastructure	375
Security incident	205
Violence, abuse or harassment	193
Fire incident	19
Total	**2,099**

The largest category of incidents, namely personal accidents, can be broken down further as below:

Table 21: Top 3 categories of personal accident 2014-15

Incident type	Top 3 categories	Total
Personal accident (service user/staff)	Slip, trip or fall (service user)	958
	Hit by/against object	97
	Slip, trip or fall (staff / visitor)	53

As shown above, slips, trips and falls represent the highest number of recorded accidents. As a result, the Trust is committed to ensuring quality improvements in its falls risk assessments and prevention work.

The Trust notes that in 2014-15, it did not receive any improvement notice from the Health and Safety Executive in respect of poor practice or reported concerns.

It is also noted that in 2014-15, there were 13 RIDDOR incidents (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) reported as a result of a work-related accident. 9 of these incidents affected staff, 2 affected service users and 2 affected members of the public. This is considerably fewer than other Trusts with whom comparisons are shared. Nevertheless, the Trust will continue to monitor any such incidents, and seek to take remedial actions where corresponding weaknesses in health and safety systems or processes are identified. Moreover in respect of the 13 RIDDOR incidents reported in 2014-15, the following actions have already been taken:

- the falls risk assessment process was reviewed and updated in light of a service user suffering a fracture as a result of a fall;
- procedures for the manual handling of service users were reviewed and updated;
- staff received retraining on door security procedures;
- llighting was repaired and improved in a clinical area after a fall;
- staff were reminded of the need to assess the working area before commencing treatment: equally, staff were reminded to be aware of trip hazards while they were working.

4.6 Fraud prevention

The Trust maintains a Counter Fraud and Corruption Policy and Response Plan which serves to regulate its activities in respect of fraud prevention and management.

The Trust also uses the Gloucestershire Local Counter Fraud Service to represent the organisation in all matters of fraud. This service undertakes work in relation to countering fraud and corruption across the eight areas of counter fraud activity, namely culture, deterrence, prevention, detection, investigation, sanction, redress and management / mandatory arrangements.

On behalf of the Trust Board, the Audit and Assurance Committee assumed corporate responsibility in 2014-15 for ensuring that the Trust maintained an appropriate fraud response, and more specifically:

- reviewed the policies and procedures for all work related to the detection of wrong-doing, fraud or corruption;
- evaluated the Trust's systems and controls for the prevention of bribery;
- assessed the arrangements in place for countering fraud; and
- considered and monitored the annual plan for the Gloucestershire Local Counter Fraud Service's work, validating the efficiency and effectiveness of this function.

For further information, please refer to section 5.5.5 below, which forms part of the Annual Governance Statement.

4.7 Emergency preparedness

During 2014-15, the Trust gave particular focus to ensuring the resilience of its services. This included the development of a Business Continuity Strategy. Additionally, the Trust Board tasked the Emergency Preparedness and Resilience Group with reviewing the organisation's existing business continuity plans, and raising awareness of Emergency Preparedness, Resilience and Response (EPRR) across the organisation. As a result, there were presentations and workshops at the Trust's Leadership Group, and active work with operational teams so as to ensure the implementation of an effective communications plan to support the Trust's continued working with key partners such as Gloucestershire County Council.

In 2015-16, the Trust will focus upon implementation of its Business Continuity Strategy, which will include enhancing service level business impact and continuity plans. It will also require the Trust to undertake training and exercising for potential disruptions to services such as a sudden major transport or industrial accident, an outbreak of infection, or a terrorist incident, in order to ensure that colleagues are clear on their roles and responsibilities should the Trust be required to provide support to the wider Gloucestershire health and social care community. This will also serve to embed the principles of EPRR, and will be supported by a number of associated internal plans regulating the Trust's actions given potential disruption to services or staff such as adverse weather, fuel shortage, pandemic flu etc.

In undertaking this work, the Trust will continue to co-operate, contribute and liaise closely with all its key partners in the Gloucestershire Local Health Resilience Partnership and the Gloucestershire Local Resilience Forum so as to ensure consistent and coordinated response countywide, and maintain compliance with the Civil Contingencies Act 2004 and key EPRR guidance. It will also ensure that the Trust maintains its EPRR alignment to the Gloucestershire System Resilience Group (SRG) activities.

4.8 Complaints management

The Trust is committed to providing remedies for any injustice or hardship which may result from maladministration or poor service. As such, the Trust observes the following processes in line with the Principles for Remedy advised by the Parliamentary and Health Service Ombudsman (2009):

- Getting it right

  The Trust is committed to acknowledging quickly any right case of maladministration or poor service, accepting responsibility where appropriate, and seeking to put matters right. Thus, an explanation and apology will always be offered where there is cause, an offer of further discussion will be made, and compensation will be considered if the Trust is unable to return a complainant to the position they were before the maladministration or poor service occurred.

- Being customer focused

  The Trust will undertake full, thorough and timely investigations in respect of any incident, and where investigations identify failures, the Trust will acknowledge these, apologise, accept responsibility, and provide a clear explanation of why the failure occurred. The Trust also recognises the importance of managing complainants' expectations so they understand clearly what the Trust is able to do in any situation.

  In respect of formal complaints, the apology and explanation will be sent from the Chief Executive. With concerns, response may come from the Head of Service, or in some cases where appropriate, a Senior Manager or Director may contact the complainant by telephone. Where complaints involve other local organisations, the Trust will work with its partners to agree who will lead on the complaint, and who will be the point of contact for the complainant.

  The Trust will carefully consider the wishes and needs of the complainant in deciding an appropriate remedy, evaluating all the circumstances to offer a solution that is fair, impartial, appropriate, professional and respectful to the complainant.

- Being open and accountable

  The Trust's complaints policy makes clear what remedies may be available in any given circumstance. The Trust will also discuss openly with complainants, any remedies that may be available to them. In offering a remedy, the Trust will explain to the complainant how any decision was reached, and will keep a record of the decision and reasons for it.

- Acting fairly and proportionately

  The Trust is committed to be fair, reasonable and proportionate to injustice or hardship suffered, and will consider the circumstances of each case on its own merits, assessing how a complainant may have been affected.

  Previous decisions relating to similar cases will be referenced when deciding a remedy in order to ensure consistency. The Trust is also mindful of the proper protection of funds, and will ensure that legal powers are not exceeded when deciding an appropriate solution.

- Putting things right

  Where possible, the Trust aims to return each complainant to the position they were before the maladministration or injustice took place. In cases where financial remedy is appropriate, this will include assessment of how much the complainant has lost by the incident, and the impact of the event upon the individuals concerned, such as any contribution to ill health or other inconvenience or distress.

  Incidents will also result in the Trust taking remedial action such as reviewing procedures, training or supervising staff, or reviewing or changing a decision on the service.

- Seeking continuous improvement

  The Trust is committed to learning, and will identify and inform complainants of the actions taken to prevent the reoccurrence of maladministration or poor service. The Trust also reports all incidents through its governance structures, so that information is learnt and suitably cascaded organisation-wide, so that ultimately, all Trust services can be improved.

Further to the above, it is recognised that in 2014-15, the Trust updated its complaints policy. This sought to strengthen processes to:

- ensure that the Trust's desire to listen to, and learn from, feedback is realised;
- implement a complaints management procedure that is easy to understand, accessible to everyone and simple to use;
- ensure that people are not treated differently as a result of making a complaint or raising a concern;
- provide robust assurance that complaints are effectively managed and lessons can be learnt so as to improve services;
- support colleagues to conduct investigations which are thorough, fair, responsive and open.

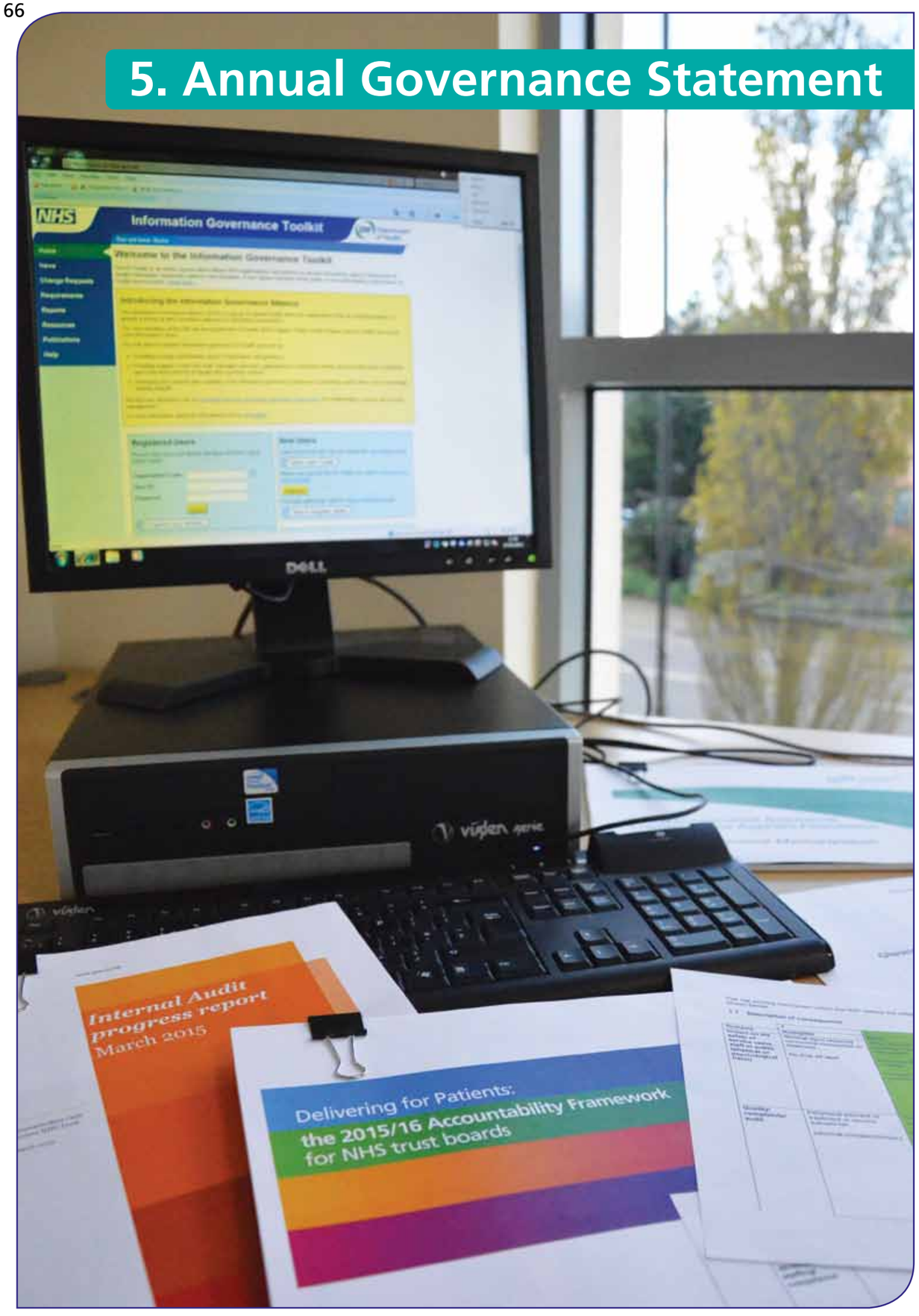
More specifically, the policy sought to ensure equity in the Trust's approach, giving particular consideration to people who may find it harder to engage with the complaints management process. These include: people with learning disabilities, hearing loss, sight loss, communication difficulties and other disabilities; people who do not speak and/or read English; people who are new to the NHS; people who are more likely to face, or fear, prejudice including transgender people, gypsies and travellers, lesbians, gay men and bisexual people, and people from black and minority ethnic communities.

I hereby confirm that the above Directors' Report is a true and accurate representation of the described Trust activities in 2014-15.

Paul Jennings

Signed: Paul Jennings, Chief Executive
Date: 3 June 2015

5. Annual Governance Statement



5.1 Scope of responsibility

As Chief Executive of Gloucestershire Care Services NHS Trust ("the Trust"), I hereby affirm my belief that this organisation ably and routinely demonstrates its clear commitment to the principles and practices of corporate 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 areas of governance, be it corporate governance, clinical governance, financial governance or information governance, are undertaken fully in accord with our organisational values of Caring, Open, Responsible and Effective.

Moreover, I recognise that as Accountable Officer, I have ultimate responsibility for ensuring that the Trust maintains a robust system of governance and internal control that facilitates achievement of our organisational vision and strategic objectives. I also acknowledge that I have personal responsibility for safeguarding public funds and optimising the use of organisational assets: thus, I am committed to ensuring that the 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 efficiency, I would note that as at the end of the financial year 2014-15, the Trust remains financially sustainable, returning a surplus of £1.5million 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, not only throughout all aspects of provided care, but also within the support functions that serve to enable the Trust's health and social care services. To this end, I would claim that overall, this Trust delivers excellent standards of care across the whole of Gloucestershire. This is demonstrated by, for example, our achievement of the Safety Thermometer standard for harm-free care in February and March 2015, and our consistently low rates of infections. I therefore welcome the opportunity to showcase this excellence as part of the assessment by the Chief Inspector of Hospitals that is scheduled for June 2015.

Finally, I confirm my compliance with all requirements and obligations as determined 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.

This includes being accountable through the NHS Accounting Officer to Parliament for the stewardship of the Trust's resources, and for ensuring that all Trust managers have a clear view of their personal and team objectives, and are duly provided with the means and information to assess their achievements in relation to those responsibilities.

In summary therefore, I trust that this Annual Governance Statement shows the significant successes that the Trust has achieved in 2014-15, whilst also recognising the work necessary to achieve future quality improvement.

Paul Jennings

Paul Jennings, Chief Executive

Date: 3 June 2015

5.2 Board / corporate governance

5.2.1 Responsibilities of the Board

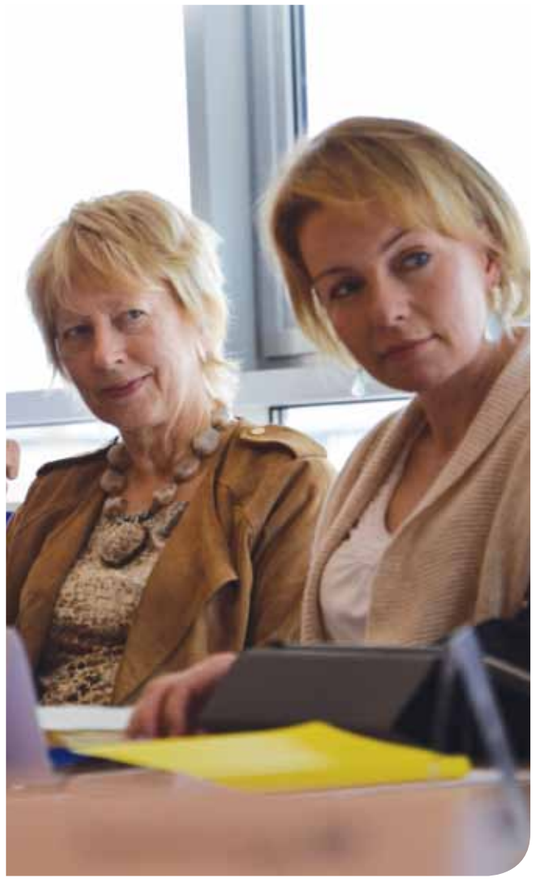
The Terms of Reference for the Trust Board made clear its responsibilities for 2014-15. These responsibilities encompassed:

- 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 at all times, 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 optimal 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 comment and/or direction, and validate 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 the Performance and Resources Committee, and approving all business cases that required capital investment, ensuring that these would minimise financial and clinical risk, and increase service effectiveness and efficiency;
- 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.

Prior to the start of the financial year 2014-15, 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.



5.2.2 Board changes

In 2014-15, there were a number of changes at Board level as detailed below. These changes were undertaken with the full support of the NHS Trust Development Authority ("TDA").

- Duncan Jordan, Chief Operating Officer
  Duncan joined the Trust in April 2014 on secondment from Gloucestershire County Council, where he previously held the role of Group Director and Chief Operating Officer. Duncan's role within the Trust gives him responsibility for all front-line services delivered by the organisation, and leadership of an extensive programme of change.

  Duncan's appointment prompted additional changes in the titles and portfolios of two other Trust Directors, namely:

  - Candace Plouffe, previously Director of Operations - Countywide, Children's and Young People's Services, became Director of Service Delivery with responsibility for the management of all scheduled care activity i.e. that supported by the Trust's Integrated Community Teams, Countywide and Specialist Services as well as Children and Young People's Services;
  - Susan Field, previously Director of Operations - Adult Services, became Director of Service Transformation with responsibility for the management of all unscheduled care activity i.e. that supported by the Trust's community hospitals and urgent care services: Susan is also responsible for managing the Transformation and Change Team;

- Elizabeth Fenton, Director of Nursing and Quality
  In April 2014, Elizabeth's job title changed from Director of Nursing to Director of Nursing and Quality.

- Tina Ricketts, Director of Human Resources
  In April 2014, Tina's job title changed from Head of HR to Director of HR.

- Richard Cryer, Non-Executive Director
  Richard joined the Board in April 2014, having previously served as Director of Finance at the University of London between 2006 and his retirement at the end of 2012.

- Dr Joanna Bayley, Medical Director
  In June 2014, Jo took up a ten-month secondment with the NHS Leadership Academy as one of just 35 clinicians from across the UK who was selected to join the NHS Fast Track Executive Programme.

- Dr Mike Roberts, Interim Medical Director
  In Dr Jo Bayley's absence, Mike joined the Board in July 2014. Mike has worked as a GP in Gloucestershire for 25 years, and has also held a number of leadership positions across the county, including Clinical Lead, Interim Medical Director, Chair of the Gloucester City Executive, and representative for the Gloucestershire LMC.

- Simeon Foreman, Board Secretary
  In June 2014, Simeon stood down as Board Secretary to pursue new opportunities elsewhere: upon his departure, the statutory responsibilities of Board Secretary passed to Jason Brown.

- Jason Brown, Director of Corporate Governance and Public Affairs
  Jason joined the Board in May 2014, having previously worked within the NHS for the past 22 years, providing corporate, strategic and operational management for a range of acute, community and mental health providers, as well as adult and children's social care in England. Jason had also worked nationally on behalf of both the Department of Health supporting confidential enquiries, and the Health and Social Care Information Centre.

- Nicola Strother Smith, Non-Executive Director
  In July 2014, Nicola's status changed from designate (non-voting) Non-Executive Director to Non-Executive Director (voting).

- Christopher Creswick, Non-Executive Director
  Christopher retired from his post in January 2015.

Please note: in 2013-14, Councillor Tony Hicks and Duncan Jordan (then at Gloucestershire County Council) attended Trust Board meetings in a non-voting capacity, given that the Trust manages some of the Council's budgets under joint management arrangements. This oversight is now obtained through joint contracting arrangements with Gloucestershire Clinical Commissioning Group under a Collaborative Commissioning Arrangement, and as a result, Gloucestershire County Council representatives no longer attend Trust Boards.

5.2.3 Board attendance

The table below provides details of Executive and Non-Executive Directors' attendance at the Trust Board throughout 2014-15. This illustrates that the total attendance of available members was 94% across the year: this represents a 6% increase in attendance compared to 2013-14. It is also noted that the majority of Board absences were due to Board members being elsewhere on critical Trust business.

Table 22: Board attendances 2014-15

	2014				2015		
	20 May	15 July	16 Sep	25 Nov	20 Jan	17 Mar	
Voting Members							
Ingrid Barker, Chair	✓	✓	✓	✓	✓	✓	100%
Paul Jennings, Chief Executive	✓	✓	✓	✓	✓	✓	100%
Robert Graves, Non-Executive Director	x	✓	✓	✓	✓	✓	83%
Richard Cryer, Non-Executive Director	✓	✓	✓	✓	✓	✓	100%
Joanna Scott, Non-Executive Director and Vice Chair	✓	✓	✓	✓	✓	✓	100%
Susan Mead, Non-Executive Director	✓	✓	✓	✓	✓	✓	100%
Nicola Strother Smith, Non-Executive Director	✓	✓	✓	✓	✓	✓	100%
Christopher Creswick, Non-Executive Director	✓	✓	✓	✓	✓		100%
Glyn Howells, Director of Finance and Deputy Chief Executive	✓	✓	✓	✓	✓	✓	100%
Elizabeth Fenton, Director of Nursing & Quality	✓	✓	✓	x	x	✓	66%
Dr Joanna Bayley, Medical Director	✓						100%
Dr Michael Roberts, Interim Medical Director			✓	✓	✓	✓	100%
Non-Voting Members							
Duncan Jordan, Chief Operating Officer	✓	✓	✓	✓	✓	✓	100%
Susan Field, Director of Service Transformation	x	✓	✓	✓	✓	✓	83%
Tina Ricketts, Director of HR	✓	✓	✓	✓	✓	✓	100%
Candace Plouffe, Director of Service Delivery	✓	✓	x	✓	✓	✓	83%
Simeon Foreman, Board Secretary	x						0%
Jason Brown, Director of Corporate Governance and Public Affairs	✓	✓	✓	✓	✓	✓	100%
Total							**94%**

5.2.4 Board effectiveness and evaluation

Following the Trust Board meeting in March 2015, Board members took opportunity to reflect upon successes and achievements, measured against the Board responsibilities as detailed in section 5.2.1 above. In summary, this Board effectiveness evaluation concluded as follows:

Table 23: Board evaluation 2014-15

	Evaluation	Development opportunities
How effectively has the Trust Board fulfilled its responsibilities as prescribed in its terms of reference?	• There was clear development and greater stability of the Board in 2014-15 • The Board faced up to a number of considerable challenges to the Trust, and addressed these effectively • There was good scrutiny and improved reporting of key issues with a firm focus on performance, quality and safety • Governance structures supporting the Trust Board were suitably strengthened	• Increase visibility of service user experience / opinion • Ensure more alignment to risk, and make risks the impetus for papers / agenda • Undertake full appraisal of new initiatives or service transformations • Increase debate on key clinical issues • Reflect on assessments from the NHS Trust Development Authority and other external agencies
What were the Board's biggest achievements in 2014-15? What could have been done better?	• There were a number of detailed and productive discussions regarding the Trust's strategic direction • Some critical service user safety issues saw performance improvement as a consequence of Board focus • Similarly, there were improvements in staff engagement, satisfaction and motivation as directed by Board • The Board saw improved service user / service delivery stories at beginning of sessions	• Further enhance the Board Development programme • Ensure better focus upon the Cost Improvement Programme (CIP) • Understand challenges in achieving key national performance targets • Increase scrutiny of HR hotspots • Build better relationships with local commissioners • Ensure that the Duty of Candour is suitably embedded across the Trust
Does the Trust have the right balance of skills around the Boardroom? Where are the gaps?	• There was an appropriate skills balance within the Executive Directors' team: in particular, this was strengthened by the appointment of the Chief Operating Officer • Strong assembly of Non-Executive Directors, all with relevant, rounded backgrounds	• Additional clinical Non-Executive Director input would be beneficial • Due to the recent retirement of one of the Non-Executive Directors, additional NED expertise is needed in respect of the HR/OD agenda
What style of leadership does the Board use? How successful is the Board in promoting this style of leadership across the Trust?	• The Board adopted a democratic, collaborative and inclusive approach, championed by the Chair • Board members committed to leading by example, and aimed to build a Trust culture of open engagement, empowerment and involvement • There was clear acceptance of accountability and responsibility as appropriate	• Less focus on reassurance, and increased emphasis upon assurance at Board • Opportunity for a more outward-facing approach so as to ensure wider horizon scanning, leading to clear direction setting for the Trust • Greater visibility of Executives around the Trust so that all staff have opportunity to interact

	Evaluation	Development opportunities
How do colleagues, service users, the public and other stakeholders perceive the Board? Is the Trust doing enough to listen to their views? Is the Trust doing enough to inform others about its work?	• In 2014-15, the Board updated the way it heard service user / service delivery stories, and this will evolve further in 2015-16 • Service user experience was included in the Board Quality and Performance Report albeit not comprehensively • The Trust developed an Engagement Framework with the support of stakeholders, to stimulate improved dialogue • Attendance at Board by the public was very limited: equally, few staff attend • The Annual General Meeting was well attended and received by public and partners • Much work was undertaken in 2014-15 to raise the Trust profile with partner agencies	• Extend coverage of service user experience within Board reporting • Provide clear evidence to the Board and other stakeholders of examples of where service change has been informed by service user feedback • Promote Board meetings more widely so as to encourage increased attendance by a range of stakeholders • Improve communications and engagement with key stakeholders, in particular, local GPs
Does the Board agenda adequately reflect the things that the Trust needs to give attention to? Are there sufficient opportunities for Board members to influence the agenda?	• In 2014-15, the Board discussed the Forward Plan at each meeting giving opportunity for all members to contribute • Non-Executive Directors also had opportunity via the NED meetings and one-to-one discussions with the Chair to influence future agendas • The new Board format whereby NEDs presented summaries of sub-committees brought better balance to the Boardroom	• Increase the level of discussion held at public Board rather than in private • Increase the level of discussion in respect of risk and risk mitigations • Enact the agreed plan to hold regular Board planning meetings between the Chair, Chief Executive and Director of Corporate Governance and Public Affairs
Are the Trust's governance structures effective? Do Committees provide sufficient assurances to the Board? Should the Board be reviewing certain information that is currently delegated to its Committees?	• At the end of 2013-14, it was agreed that Board sub-committees which were established in April 2013, should operate for a further year prior to assessment: this time has now passed and analysis has been undertaken, resulting in a revised governance structure for 2015-16 • The introduction of Committee reviews of progress against strategy and operational risk registers were welcome • The revised format of the Board, whereby summaries of subcommittees were presented, provided suitable assurances	• Embed the revised Board sub-committee governance structure, ensuring that there is absolute clarity of remit, role and responsibilities so as to avoid any potential duplications or omissions: equally, ensure that membership of these subcommittees is appropriate so as not to overburden Executive and Non-Executive Directors

	Evaluation	Development opportunities
Does the Trust know enough about the quality of care delivered to service users and their carers and relatives?	• Compared to concerns raised in 2013-14, the Trust Board felt more assured that it understood where quality care was being delivered in Gloucestershire, and equally where there were opportunities for improvement: in particular, the Quality and Performance Report significantly improved • Benchmarking data was increasingly available to compare Trust performance against other similar Trusts	• Increase the number of quality visits by Executive and Non-Executive Directors to places of care, including service users' homes • Build upon recent improvements in Friends and Family Test response rates • Continue to increase the triangulation of information in Board reporting • Routinely receive and act upon Healthwatch feedback
Does the Trust meet the needs of its most vulnerable service users, and does the Board have sufficient assurances that they are safe from harm and receiving high-quality care?	• The Trust continued to monitor how best to meet the needs of all people for whom it cares and mitigate against any unforeseen consequences of change (thus, for example, the increase in single inpatient rooms has led to higher numbers of falls in community hospitals) • The Trust Board was assured of significant improvements in work with people with dementia	• Greater support is needed for people with learning disabilities as insufficient progress was made in 2014-15 by the Learning Disabilities Steering Group • The eQuality Impact Assessment tool needs further strengthening so as to provide appropriate assurance in respect of service developments

5.2.5 Compliance with the UK Corporate Governance Code

In March 2015, the Trust undertook self-assessment against the main principles of The UK Corporate Governance Code (Financial Reporting Council, September 2012). A summary of this assessment is as follows:

Table 24: Compliance with the UK Corporate Governance Code

Code Requirement	RAG	Trust Response
Leadership		
Every Trust should be headed by an effective Board which is collectively responsible for the long-term success of the organisation		The Trust Board has very clear Terms of Reference which establish its remit, duties and responsibilities (see summary at section 5.2.1 above). Moreover, these responsibilities are reiterated within the organisation's Standing Orders. Throughout 2014-15, the Trust continued to update and maintain its Board composition matrix which it routinely used to assess members' skills, talent and capabilities so as to inform their annual objectives and personal development plans, and thereby ensure a high-performing Board. In 2014-15, the Trust also assessed and ensured its absolute compliance with the requirements of the Fit and Proper Persons Test (Regulation 5 of the Health and Social Care Act 2008 (Regulation of Regulated Activities) (Amendment) Regulations 2014).

Code Requirement	RAG	Trust Response
Leadership		
There should be a clear division of responsibilities at the head of the Trust between the running of the Board and the executive responsibility for the running of the Trust's business. No one individual should have unfettered powers of decision		There is clear demarcation between the responsibilities of the Chair and the Chief Executive, which is articulated in their respective job descriptions and enforced within the Trust's Standing Orders. Thus, the Chair is pivotal in creating the conditions for Board and for ensuring the effective contribution of all individuals, whilst the Chief Executive is responsible for leading and managing the Executive Directors.
The Chair is responsible for leadership of the Board and ensuring its effectiveness on all aspects of its role		The Chair is paramount in setting the tone, style and agenda for the Board, taking into account, the concerns of the Executive and Non-Executive Directors. Supported by the Director of Corporate Governance and Public Affairs, the Chair also ensures that the Board receives accurate, timely and clear information on all relevant issues, enabling Board members to make sound judgements and decisions, and monitor the Trust's performance. Additionally, the Chair encourages active engagement and constructive challenge by all Board members.
As part of their role as members of a unitary Board, Non-Executive Directors should constructively challenge and help develop proposals on strategy		Throughout 2014-15, the Trust's Non-Executive Directors made crucial contribution to the development of Trust strategy and policy. This was directed through Trust Board, Board Development sessions, Board sub-committees, and where appropriate, one-to-one engagement with Executive Directors and other senior Trust colleagues. The Chair meets formally on a monthly basis with the Non-Executive Directors, independent of the Trust's Executive Directors, to debate pertinent issues. In September 2014, led by the Senior Independent Director, the Non-Executive Directors undertook a detailed appraisal of the Trust Chair.
Effectiveness		
The Board and its committees should have the appropriate balance of skills, experience, independence and knowledge to enable them to discharge their respective duties and responsibilities effectively		Throughout 2014-15, the Trust Board was actively supported by a number of Committees and other key forums as illustrated in section 5.2.6 below. The Terms of Reference for these groups sought to ensure an appropriate balance of attending Executive and Non-Executive Directors supported by other Trust colleagues. At the start of each Board meeting, the Chair ascertains whether there are any changes to the Declarations of Interest already formally lodged by each Executive and Non-Executive Director. Any such change would be formally recorded by the Director of Corporate Governance and Public Affairs, and used to determine the independence of the associated individual. Throughout 2014-15, Non-Executive Directors represented over 50% voting members of the Board.

Code Requirement	RAG	Trust Response
Effectiveness		
There should be a formal, rigorous and transparent procedure for the appointment of new directors to the Board		The Trust observes a formal process for the appointment of Board members which explores each prospective candidate's competencies, attributes, knowledge and experience linked to the corresponding role. Moreover, the TDA's input on key positions has always been sought, and TDA representatives have participated in relevant recruitment exercises. Overall, the recruitment process for Board Directors is overseen by the Remuneration and Terms of Service Committee so as to ensure transparency, openness and accountability.
All directors should be able to allocate sufficient time to the Trust to discharge their responsibilities effectively		The Chair and all Non-Executive Directors are made formally aware at appointment, the time commitment expected of them. In 2014-15, all individuals made contributions well in excess of these requirements, demonstrating their commitment to their roles.
All directors should receive induction on joining the Board and should regularly update and refresh their skills and knowledge		The Trust maintains a clear induction programme so as to provide appropriate support to new Executive and Non-Executive Directors. This is complemented by an induction manual which provides a wealth of information materials. The Directors' personal development plans identify how they are expected to update and refresh their skills: moreover, all Directors are actively encouraged to attend both local and national conferences.
The Board should be supplied in a timely manner with information in a form and of a quality appropriate to enable it to discharge its duties		In 2014-15, the Trust's Director of Corporate Governance and Public Affairs ensured that through the Chair, all Executives and Non-Executive Directors received the necessary information and reports appropriate to their individual roles and responsibilities. The Director of Corporate Governance and Public Affairs was also responsible for advising the Trust Board, via the Chair, of all relevant governance matters.
The Board should undertake a formal and rigorous annual evaluation of its performance and that of its committees and individual directors		Both at the start of 2014-15, and also at the end of the financial year, the Board undertook formal assessment of its performance and that of its Committees (see also sections 5.2.4 above and 5.2.7 below). The results of the 2013-14 Board self-assessment were included within the Trust's 2013-14 Annual Report and Accounts. Throughout 2014-15, both the Trust Board as a whole, and also the Board's Executive Directors, have benefited from external assessment of their individual and collective skills and performance.
All directors should be submitted for re-election at regular intervals, subject to continued satisfactory performance	N/A	This principle is not relevant to NHS Trusts.

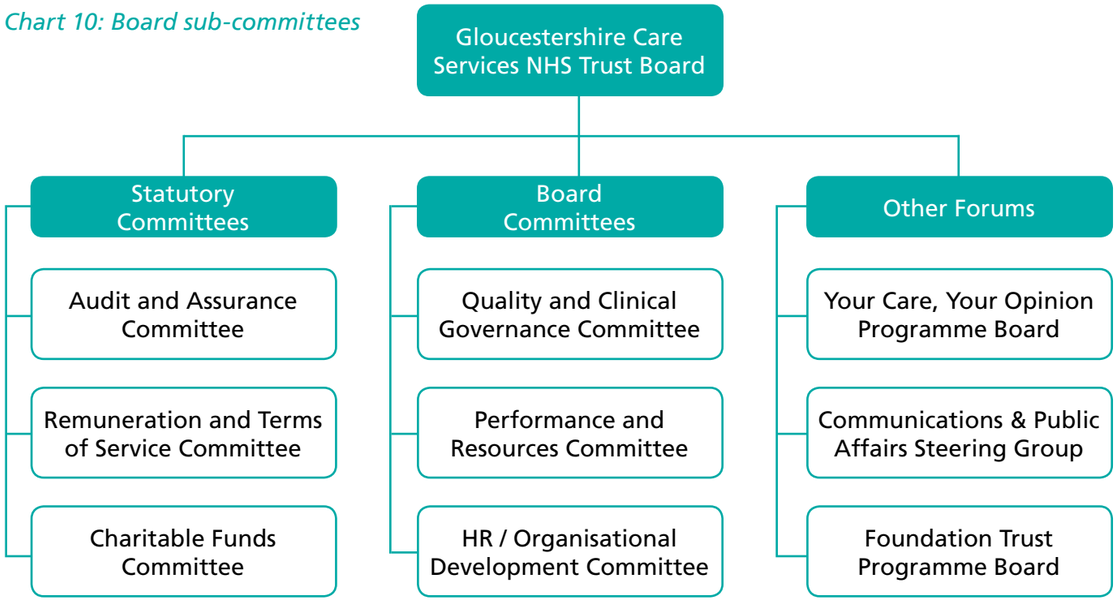
Code Requirement	RAG	Trust Response
Accountability		
The Board should present a fair, balanced and understandable assessment of the Trust's position and prospects		Via the Annual Report and Accounts which was issued in June 2014, the Trust made clear its position and prospects. This document was approved as a true reflection of the Trust's financial status by the Chief Executive as Accountable Officer and the Director of Finance, and was additionally validated and endorsed by the organisation's External Auditors. Moreover, at each Board, a Finance Report is presented that identifies the Trust's most up-to-date position.
The Board is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives. The Board should maintain sound risk management and internal control systems		In March 2015, the Trust Board received and debated the Board Assurance Framework, which identified the most salient strategic risks aligned to the organisation's strategic objectives as proposed by the Executive and Non-Executive Directors. As a result of this first draft, Executive Directors were charged with refining the document further, and bringing it to the Board Development session in April 2015 for final ratification. Thereafter, the Board Assurance Framework will become a living document to be routinely reviewed and revised by both the Audit and Assurance Committee and the Trust Board. This is part of a systematic ongoing process of improvement in the Trust's risk management procedures.
The Board should establish formal and transparent arrangements for considering how it should apply the corporate reporting, risk management and internal control principles and for maintaining an appropriate relationship with the company's auditors		In 2014-15, these arrangements and responsibilities were clearly and formally delegated to the Trust's Audit and Assurance Committee, which is open to all of the organisation's Non-Executive Directors. The key roles of this Committee are described in section 5.2.6 below. It is noted in particular however, that in June 2014, the Audit and Assurance Committee was responsible for approving the organisation's draft Annual Report and Accounts on behalf of the Trust Board. Additionally, the Audit and Assurance Committee maintained overview of the Trust's whistleblowing policy and activity throughout 2014-15. Moreover, the Audit and Assurance Committee was responsible for overseeing the work of both internal and external audit: this included responsibility for considering the major findings of all internal and external audit work (and management response), and ensuring suitable coordination between the auditors to optimise audit response.

Code Requirement	RAG	Trust Response
Remuneration		
Levels of remuneration should be sufficient to attract, retain and motivate directors of the quality required to run the Trust successfully, but no more than is necessary for this purpose. A significant proportion of executive directors' remuneration should be structured so as to link rewards to corporate and individual performance		In 2014-15, scrutiny of remuneration for the Trust's Very Senior Managers was delegated to the Remuneration and Terms of Service Committee. Thus, this Committee agreed individual Directors' remuneration arrangements including their salaries, benefits and allowances, giving due regard to the policies and recommendations of the Department of Health and the NHS Trust Development Authority, and adhering to all relevant laws, codes and regulations.
There should be a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration packages of individual directors. No director should be involved in deciding his or her own remuneration		In determining the remuneration, allowances and other terms and conditions of office for the organisation's Very Senior Managers, the Trust's Remuneration and Terms of Service Committee acted wholly in accord with the requirements of the NHS Codes of Conduct and Accountability, the Higgs report, and the Trust's Standing Financial Instructions. It is noted that the Committee's membership comprised the Trust's Non-Executive Directors only, thereby ensuring that no Director was directly involved with discussion regarding their own remuneration.
Relationships with Stakeholders		
There should be a dialogue with stakeholders based on the mutual understanding of objectives. The Board as a whole has responsibility for ensuring that a satisfactory dialogue with stakeholders takes place		Throughout 2014-15, the Trust held regular on-going dialogue with all professional stakeholders: thus, for example, the Trust met with its Commissioners formally on a regular basis as part of the Contract Monitoring Board, and was an active participant in all relevant cross-organisational committees including the Gloucestershire Strategic Forum (attended by senior Trust representatives including the Chair and Chief Executive), and the Joining Up Your Care Group which sought to identify ways in which provider and commissioner organisations could jointly fulfil the vision of the Gloucestershire Strategic Forum. Additionally, there were regular meetings with local MPs, the Health and Care Overview and Scrutiny Committee and local elected members. Service users, carers, families, community representative groups and the local Gloucestershire public were consulted as part of a number of events, including the Your Care, Your Opinion Programme Board, and its larger consultative sub-group.
The Board should use the AGM to communicate with stakeholders and to encourage their participation		In October 2014, the Trust hosted its inaugural Annual General Meeting. The event was attended by over 200 staff and external stakeholders including the public and representatives from provider and commissioner organisations. Presentations were given by a number of the Board members, and questions were received from those in attendance. The AGM was well received, and plans are already underway to stage a similar event in October 2015.

5.2.6 Board sub-committee structure

In 2014-15, the Trust Board's sub-committee structure was as per the schematic below:

Chart 10: Board sub-committees



The main sub-committees, 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 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 an effective system of governance, risk management and internal control, which covered the whole of the Trust's activities, and supported achievement of the Trust's strategic objectives;

- 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 Corporate Trustee on all matters relating to charitable funds, and for decision-making on fund allocations in order to provide appropriate benefit to Gloucestershire service users and Trust colleagues;

- the Quality and Clinical Governance 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 Performance and Resources Committee was responsible for reviewing the fiscal and service delivery activities of the Trust, agreeing and monitoring action plans where remedial steps were necessary to improve performance. The Committee was additionally responsible for making recommendations in respect of business development opportunities and business cases that required capital investment;

- the Human Resources / Organisational Development (HR/OD) Committee was responsible for overseeing workforce strategy, planning and organisational development, in order that the Trust could achieve exemplar clinical and professional outcomes and best experiences for local service users and Trust colleagues.

Each of these Committees reported directly to the Trust Board, provided a mechanism for escalation of risks and other issues, and ensured that the Trust Board had a clear and overarching role in assurance and performance monitoring.

In summary, the other three forums that supported the Trust Board in 2014-15 were:

- the Your Care, Your Opinion Programme Board which provided opportunity for two-way communication with representatives of service users and local communities in order to create real engagement, and enable planned service transformations to be informed by learning from service user experience;

- the Communications and Public Affairs Steering Group which assured the Trust's effective communications with the organisation's colleagues, service users, carers, families and the wider Gloucestershire public, as well as with all of the Trust's professional stakeholders;

- the Foundation Trust Programme Board which oversaw the management and delivery of all work necessary to enable the Trust to progress its Foundation Trust application, subject to agreement with the Trust Development Authority and Monitor as appropriate.

5.2.7 Annual committee statements

As part of their delegated responsibility, relevant Board Committees were required to identify the key highlights of their performance in 2014-15, and provide these by means of a formalised statement to the Board. These statements also included a look forward to planning actions and developments in 2015-16: however, for the purposes of this Annual Governance Statement, it is deemed appropriate to include the past year's review only, namely:

Table 25: Annual committee statements

Audit and Assurance	Routinely reviewed financial reports including analysis of the service provided by SBS (the Shared Business Support service), standing orders and waivers, budget holders' cost centre status, debtors and write-offs, special payments and "Better Payment Practice" performance
	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
	Approved the internal audit plan, reviewed all issued reports, considered all major findings 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 in place in order to ensure that statutory obligations were met
Charitable Funds	Supported people from across the county at their time of need, crisis or illness, aided by the generous donations and legacies of local people
	Provided food hampers for vulnerable service users in the community and commenced planning with local food bank organisations in respect of emergency food parcel distribution
	Clarified ownership of historic sizeable legacy and commenced development of plans to realise the benefits
	Approved grants in order to make a real difference to service users, carers and staff, particularly in respect of support of specialist clinical studies and research
	Commenced work to rebrand the Charitable Funds' identity and to reshape its proposition in association with the Charities Commission

Quality and Clinical Governance Committee	Strengthened the levels of challenge and assurance in relation to the delivery of safe care and reduction in harm, with a particular focus upon Harm Free Care (Safety Thermometer) as well as safe and suitable staffing across hospital and community nursing services
	Provided assurance to the Trust Board that incidents were robustly investigated and that learning was shared across the organisation
	Maximised opportunities to hear the voice of the service user, their families and carers
	Strengthened and refined reporting structures to support challenge in relation to all aspects of care quality at Executive and Committee level
	Improved the breadth and depth of information available by which to judge quality, ensuring appropriate triangulation of information on costs, activity, outcomes and service user views, and improved use of benchmarking and trend analysis
Performance and Resources Committee	Reviewed the performance of the Trust's health and social care services
	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 on behalf of Gloucestershire County Council
	Reviewed the Trust's financial performance including the capital programme and business development opportunities
	Provided initial scrutiny of the budget for 2015-16
HR/OD Committee	Oversaw continued implementation of the Organisational Development Strategy in order to perpetuate a supportive and learning culture across the Trust: this resulted in improvement in all areas of the NHS Staff Survey compared to 2013-14
	Requested and received assurance in respect of plans for staff engagement, in addition to plans for Year 2 of the Listening into Action programme
	Oversaw continued implementation of the Workforce Strategy in order to improve workforce planning and processes
	Requested and received improved workforce information through updated dashboards and scorecards
	Received, approved and monitored remedial action plans in respect of deterioration in workforce metrics (i.e. sickness absence, turnover, mandatory training rates)

5.2.8 Board Governance Assurance Framework

Throughout 2014-15, the Trust continued to monitor its on-going compliance with all requirements of the Board Governance Assurance Framework. This resulted in a programme of work which saw significant improvements in the Trust's performance against the Framework's criteria, specifically in respect of:

- Board evaluation, development and learning, given the Trust's commitment to increased internal and external assessment of Executive and Non-Executive Directors' strengths and capabilities;

- Board insight and foresight, which has improved, in part due to improved information reporting as evidenced by Board members' responses to the Board evaluation detailed in section 5.2.4 above.

Notwithstanding, the Trust aims to achieve further improvement to its compliance with the Board Governance Assurance Framework in 2015-16.

5.3 Quality / clinical governance

5.3.1 Quality Governance Assurance Framework

Throughout 2014-15, the Trust regularly re-assessed its position against the ten criteria of the Quality Governance Assurance Framework. Initially, these reviews suggested a continued and positive decrease in overall scores, moving the Trust towards the required target of 4. However, a more formalised reappraisal in December 2014, informed by external authorities including representatives of the NHS Trust Development Authority and Monitor who identified the need for greater triangulation in Trust responses, suggested to the Trust Board that a more cautious and conservative stance should be taken. Although this yielded a higher score, implying a worsening position, this reflection did enable the Trust to more clearly identify areas in which quality improvements were required, and to attribute corresponding remedial plans.

As a result, and since the time of the reassessment, work has been targeted at key areas, namely:

- ratification of the overarching Quality Strategy by Board in January 2015, and on-going monitoring of performance against identified goals, aligned to the organisation's strategic objectives and Quality Account priorities;
- implementation of improved risk management processes resulting in the presentation of a full Board Assurance Framework in March 2015, now designed as a live document to be updated and reviewed at every subsequent Board meeting;
- development of a Core Values Framework so that colleagues across the Trust can easily recognise their personal responsibilities for adhering to the Trust values and associated behaviours;
- agreement to a Team Performance Framework which sets the standard for performance management within each operational service delivery team across the Trust;
- publication of the Trust's Engagement Framework which details a variety of methodologies and approaches by which the organisation will realise its commitment to improved two-way dialogue with local service users, carers and families, as well as the wider Gloucestershire community;
- development of an Internal Engagement Implementation Plan which specifies the activities to be undertaken in 2015-16 in order to improve communications with colleagues, and thus ensure their active involvement in Trust decision-making.

The Trust is now confident that it can more reliably undertake renewed assessment of compliance, and that the results will evidence the significant progress made.

5.3.2 Quality Account

In June 2014, the Trust published its first Quality Account as a standalone NHS provider. This public-facing document summarised the organisation's quality achievements in 2013-14, and looked forward to activities in the coming year which would ensure continuous improvement and achieve quality outcomes for local people. Thus, the quality goals which were identified for 2014-15 were:

- to reduce the number of service users who fall in community hospitals or who acquire a pressure ulcer;
- to improve the experiences of service users, carers and families within community hospitals;
- to further develop and enhance Integrated Community Teams;
- to improve active two-way engagement with service users, carers and families;
- to ensure that staffing levels are maintained as appropriate to the needs of service users.

Progress against these goals has been continuously monitored throughout the year via a dedicated dashboard which has been regularly presented at the Quality and Clinical Governance Committee.

The Trust's second Quality Account will be published in June 2015: this aims to build upon the successes of the previous year in order to further develop the delivery of safe, effective, caring, responsible and well-led care services.

5.3.3 Clinical audit

At the beginning of 2014-15, service managers and commissioners agreed a programme of clinical audit to enable them to identify opportunities to increase service effectiveness, reduce risks, and improve the experiences of service users, carers and families. A number of these audits are described below:

- children's speech and language therapy: this audit identified that one in six service referrals did not actually require therapy and were discharged after initial assessment. As a result, the Trust introduced a telephone triage service which has subsequently ensured appropriate service referrals only. This has been supported by the publication of additional referral advice for parents, health visitors and schools on the Trust's website;

- children's occupational therapy: sling clinics were introduced to special schools in 2013 in order to provide guidance in respect of the moving and handling of children who need hoisting. This audit demonstrated the benefit for parents of regular contact with therapists, and the need to make slings more readily available by holding them as stock items;
- podiatry: in response to an increasing number of referrals for domiciliary podiatry, an audit was undertaken to review whether all staff were assessing service users against the same criteria, thereby ensuring equity of provision. The audit identified disparity of assessment, and has since led to the establishment of a telephone triage service for all new referrals;
- integrated discharge team: the IDT supports service users in the local acute hospitals who require healing time, but who cannot return home due to physical or environmental issues. An audit looked at the opportunities for securing placements to Non Weight Bearing Beds (NWBB) in care homes, and concluded that NWBBs were both a cost-effective and safe alternative to people remaining in hospital. As a result, a revised management process enabled more prompt discharge of service users;
- diabetes: an audit of Diabetes, Food and You, a new programme designed to provide dietary education to people with type 2 diabetes, showed a significant improvement in attendance rates compared to the previous education programme, and an improvement in diabetes control for the majority of those who attended;
- pulmonary rehabilitation: an audit of outcomes achieved by people attending the pulmonary rehabilitation programme was undertaken in 2014, so as to better support service users in future;
- dementia: a monthly audit of dementia case finding and care planning was undertaken in 2014-15 throughout all community hospitals and community nursing teams in order to ensure continued prompt identification of memory loss, and onwards referral for investigation and appropriate care planning;
- record-keeping: a programme of record-keeping audits in 2014-15 enabled the Trust to address areas of weaker performance, especially important in the move from paper documentation to electronic data capture.

Additionally during 2014-15, the Trust participated in all four national clinical audits relevant to the services provided by the organisation. These were:

- the Sentinel Stroke National Audit Programme (SSNAP), which aims to review information from a service user's initial admission to six month follow-up through all subsequent care settings;
- the National Audit of Intermediate Care, which allows the Trust to benchmark its home-based rehabilitation and reablement services with equivalent services delivered by other providers;
- the National Chronic Obstructive Pulmonary Disease audit, which will continue into 2015-16;
- the National Diabetes Foot Care audit, for which data collection also continues into 2015-16.

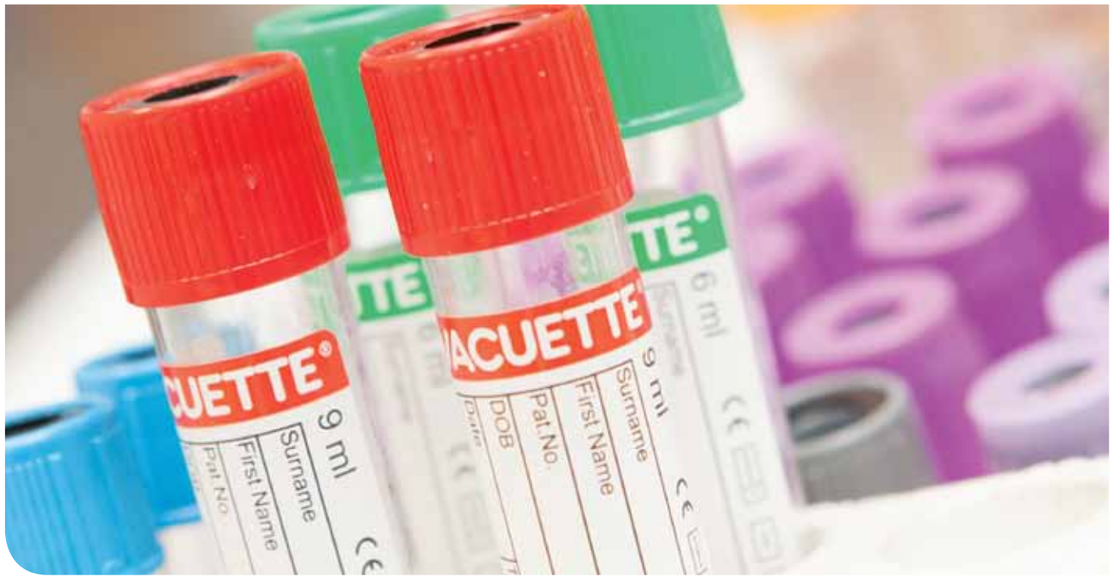
5.3.4 Clinical governance

During 2014-15, the Trust made significant progress in its clinical governance performance. This included:

- greater focus on the need to provide harm-free care and optimum service user safety. Success in this initiative was measured by the use of the Safety Thermometer, which detailed the incidence of pressure ulcers, falls, urinary tract infections (UTIs) and venous thromboembolism (VTEs). This showed that in both February and March 2015, the Trust achieved the 95% target for harm-free care as required nationally. Notwithstanding, the Trust is not complacent in this matter, and will undertake further work in 2015-16 so as to ensure no harm to any of its service users;
- revision of incident management processes, given that barriers to incident reporting were identified by the Trust. Moreover, additional support and training was provided to frontline clinical teams in order that they could fully understand the need for, and benefit of, robust reporting to enable continuous quality improvement;
- fewer cases of Clostridium difficile than the agreed threshold, in that only 17 cases of infection were recorded in year against a threshold of 21;
- launch of the "Hello, my name is" campaign within the Trust, based on the national initiative to ensure that staff always introduce themselves to service users, carers and families, and thus improve care experiences;
- update of the Trust's Complaints Policy and process, supported by education and training so that it is easier for service users, carers and families to lodge a complaint should they wish to do so;
- initiation of bi-annual service user dependency audits as a tool by which to review staffing levels across the Trust;
- implementation of the Friends and Family Test across all Trust services and locations;
- management of response to the 27 Serious Incidents Requiring Investigation (SIRIs) that occurred in 2014-15, which were as follows:

Table 26: Serious Incidents Requiring Investigation 2014-15

SIRI Type	No	Remedial Actions
Pressure Ulcer	13*	Learning from the investigations included improvements in the use of wound care charts; better assessment, planning, implementation and evaluation of care; earlier identification of service users at higher risk with clear plans of management; and timely reporting of incidents in order to foster continual improvement. ** As at the end of October 2014, 8 of these pressure ulcers were found to be unavoidable following independent review*
Hip fracture following fall	9	An action plan developed from the recommendations of all falls investigations is currently being implemented by the Head of Community Hospitals. This includes the roll-out of a new falls risk assessment which includes the NICE Falls Pathway and introduces "safety huddles" at all community hospitals
Potentially incorrect management of VAC therapy leading to harm to a service user	2	Two similar incidents have been declared as separate SIRIs: however, one investigation is considering both cases. The resulting report will be reviewed by a panel independent to the service in order to consider the findings and recommendations. The service users are being kept informed, and apologies have been made both verbally and in writing
Possible delay in transfer to acute Trust	1	The service user was prescribed IV antibiotics which were not stock items, leading to a delay in administering the drugs. Initially, the service user declined transfer to the local acute hospital; however, as vital signs began to deteriorate, the service user was transferred. The investigation recommended ensuring the availability of drugs that are recommended for use at ward level; standard operating procedure for handover to ensure ward responsibilities can be managed safely and communication is effective; review of deteriorating patient pathway as a multi-disciplinary team
Mistaken reuse of a needle during a Human papilloma virus immunisation clinic	1	At the time of writing, this investigation is ongoing. Immediate actions include close working with the young people and families involved in order to offer support and apologies



5.4 Financial governance

Throughout 2014-15, the Trust continued to monitor its on-going compliance with the Financial Governance component of the Board Governance Assurance Framework. The actions resulting from this review provided direction on the Trust's in-year priorities in respect of financial management, supported by the recommendations of the financial systems audit (see section 5.7.1 below) and the priority goals identified in the Trust's Financial Management Strategy which was ratified by the Board in January 2015. Thus, the principle control mechanisms that were introduced or enhanced in 2014-15 were as follows:

- the Trust's emerging Long Term Financial Model, which built upon projections made at the time of the Trust's authorisation in 2013, and which will be finalised in 2015-16;

- the Trust's Financial Management Strategy which sought to further develop financial management systems, and thereby enable the organisation to maintain financial sustainability whilst continuing to deliver high quality care. To this end, the Strategy identified a number of priority goals to:
  - ensure that relevant financial management activities demonstrate clear engagement with commissioners, colleagues and other stakeholders as appropriate, so as to increase understanding of, contribution to, and recognition for, financial decision-making. This includes requirement for the Trust to promote an environment in which queries relating to finance can be discussed openly and honestly;
  - maintain stringent financial planning processes, regulated by strong governance and accountability arrangements, in order to ensure appropriate scrutiny in advance of all spending. This requires the production of clear, credible and realistic financial plans which are thoroughly evaluated via the Trust's established committee structure;
  - implement effective financial controls across all relevant parts of the organisation. This includes responsibility for developing robust mechanisms and systems to ensure efficient cash management and capital spend processes, and safeguard against fraud and corruption;
  - maintain effective purchasing practices in order to reduce expenditure, facilitate the delivery of high quality care, provide support to budget holders, and enable the Trust to benefit from best value. This requires the Trust to develop a more consistent and systematic procurement service, and create closer working with service budget holders and clinical staff;
  - ensure that the Trust's responsibilities and obligations under all forms of enforceable agreement, are appropriately recognised, documented and managed;
  - scrutinise and challenge all proposed business developments so as to validate that they are financially robust and sustainable, ethically sound, and represent appropriate use of financial resource;
  - ensure that all Trust financial modelling and performance analysis is based upon the most accurate, timely, relevant and complete information and intelligence;

- the Trust's Cost Improvement Programme (CIP), which regulated the specific transformational changes designed to release cost-efficiencies in-year, and which utilised eQuality Impact Assessments to ensure no detrimental impact upon service provisions or service users.

  Although this programme under-achieved in its target of £6.4million efficiency savings in 2014-15 by only reaching a total of £3.4million, this was countered by the publication of reference costs which unequivocally demonstrated that at 96.6% for peripatetic services, the Trust was already working at greater efficiency than other comparable community Trusts;

- plans for the Trust to comply fully with the recommendations of the Better Procurement, Better Value, Better Care programme, and in particular, the requirement to ensure the implementation of GS1 coding where appropriate;

- the Trust's Standing Financial Instructions, which provided details on how the resources of the organisation were to be managed within an agreed governance framework. These included an emphasis on budgetary management, and ensured that service developments were implemented with appropriate financial controls. Financial governance arrangements were further supported by both internal and external audit, in order to secure the economic, efficient and effective use of all resources that were at the Trust's disposal;

- the Finance Report, which was presented at each Trust Board in order to provide relevant financial information to allow Board members to discharge their duties effectively (NB it is noted that in months when the Trust Board did not convene, the Finance Report was presented at the Performance and Resources Committee for information and guidance);

- the internal and external audit reviews and reports;

- the Audit and Assurance Committee, which in 2014-15, provided scrutiny of financial reporting and financial controls (see sections 5.2.6 and 5.2.7 above).

In summary, weaknesses that were identified by the above processes related mainly to deficiencies in working practices between the Trust and the Shared Business Support service which undertakes much of the Trust's financial administration. Thus, there were no significant inadequacies in the Trust's own internal financial management practices, nor in its use of public resources.

5.5 The internal control system

5.5.1 Purpose of the internal control system

The role of the Trust's internal control system is to provide a formal and consistent basis for the identification, evaluation and prioritisation of all risks to the Trust's quality, operations, effectiveness and sustainability, in order to gain assurance that these are properly controlled, managed and/or mitigated, and thereby ensure safe and effective care. This includes both operational risks (both clinical and non-clinical) as well as strategic risks.

It is noted however that the internal control system is designed to manage all prevailing 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:

- identify and prioritise all operational and strategic risks;
- evaluate the likelihood and impact of those risks being realised;
- manage all identified 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.

This system of internal control is designed to sit within an integrated governance framework, whereby salient risks are aligned to the key domains of corporate governance, clinical and quality governance, information governance, financial governance and research governance. By contextualising risks via this approach, the Trust not only enables its systems to work together holistically, but it also helps ensure that the Trust's services continue to be safe, caring, responsive, effective and well-led.

In the 2013-14 Annual Governance Statement, the Trust recognised that it needed to commit further time and focus towards ensuring that this internal control system became fully embedded across the organisation, so as to move from a strategic and aspirational model to daily practice. In 2014-15, this ambition has been realised, although the Trust would concede that significant progress was made in the latter half of the year only. Notwithstanding, there are now clear risk reporting and governance structures in place, which will be improved further in the coming year.

5.5.2 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) 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. Furthermore, the Strategy 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 (see section 5.5.3 below), 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 Director of Corporate Governance and Public Affairs);

- the Director of Corporate Governance and Public Affairs 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 and Quality 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 Board Committee structure, wherein all Board Committees are chaired by Non-Executive Directors and attended by appropriate Executive Directors and senior Trust managers (see also section 5.2.6 above). Thus, the Terms of Reference for each of these Committees makes clear its responsibility for identifying all operational risks as appropriate to the respective Committee'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 Committee's sphere of influence.

5.5.3 Risk prevention and management

Strategic risks

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. Additionally, the Board Assurance Framework identifies the most significant operational risks that require the input and direction of the Board (these risks are detailed below).

The Board Assurance Framework also provides structured assurances about where risks are being managed, and ensures that objectives are being delivered to time and budget. This allows the Board to determine how to make the most efficient use of 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 every two months. This includes review, assessment and update of the Board Assurance Framework's content as appropriate. The 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 strategic and high-level operational risks. The Board Assurance Framework is also evaluated annually by the Audit and Assurance Committee in order to ensure its consistent use to inform risk-based Board decision-making.

At the end of March 2015, the principle strategic risks recorded in the Board Assurance Framework, were as follows:

Table 27: Strategic risks as at 31 March 2015

Strategic Objectives	Strategic Risks
Achieve the best possible outcomes for our service users through high quality care	• Under-reporting of incidents may compromise service user safety • Lack of robust risk management processes may restrict the Trust's ability to respond quickly and effectively to concerns about care quality • 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
Understand the needs and views of 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
Provide innovative community services that deliver health and social care together	• The under-defined service delivery model for Integrated Community Teams (ICTs) may prevent the Trust from undertaking effective planning for one of its most critical services • Threats to the delivery of integrated services with Gloucestershire County Council may prevent an effective joined-up approach to health and social care
Work as a valued partner in local communities and across health and social care	• A developing relationship with the Gloucestershire Clinical Commissioning Group which needs to increase its focus on long-term strategic planning • Unclear relationships with local partner organisations may reduce the potential for effective system-wide planning and service delivery
Support individuals and teams 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 • 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 • Inability of the Trust to recruit and retain staff with the right skills may be detrimental impact upon the quality of provided care • The lack of robust formalised succession planning may lead to Board instability should senior staff leave or become unavailable for any extended period • The Trust's financial management processes and structures do not consistently provide budget managers and senior management with the financial information needed to address all relevant issues
Manage public resources wisely to ensure local services remain sustainable and accessible	• Failure to deliver a successful CIP, CQUIN and QIPP programme • Ability to operate against a small planned surplus • Inability to maintain independence as a NHS provider may threaten the future provision of community health and social services across Gloucestershire • A breakdown in internal control / governance systems may lead to reputational loss and long-term sustainability

Operational risks

All Trust colleagues have explicit responsibility for identifying operational risks relevant to their service, team and/or working environment. These risks may be apparent 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 (see section 5.5.4 below).

A range of tools and resources are maintained to support colleagues in the identification, assessment and escalation of these 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 risk management process employed by the Trust is the Corporate Risk Register. This systematically gathers together all service delivery, team and project risk registers in order to portray the total extent of operational (clinical and non-clinical) risks across the Trust. The Corporate Risk Register is then used to inform operational management, and is subject to regular review and monitoring as part of the Trust's governance arrangements, in particular via the Scheduled Care Governance Forum and the Community Hospitals, Urgent Care and Capacity Group, which in 2014-15, both reported to the Quality and Clinical Governance Committee.

It is also noted that the Trust maintains a standardised process by which all operational risks are effectively analysed, evaluated, managed and mitigated. This process includes the nomination of a relevant lead and Executive owner for each risk as described in section 5.5.2 above. It also enables each identified risk to be evaluated so as to determine the risk score, based upon the comparative likelihood and consequence of that risk's occurrence. Thereafter, the Trust ensures that:

- risks that are attributed a 4-10 risk rating are subject to regular review at local level via the relevant Trust forum;
- risks that are attributed a 12-14 risk rating have a formal action plan developed, and are monitored and reviewed every 6 months at either the Scheduled Care Governance Forum or the Community Hospitals, Urgent Care and Capacity Group as appropriate;
- risks that are attributed a 15+ risk rating have actions identified which must be implemented within 3 months and audited until under control.

As a result of Trust processes, the following significant operational risks were identified as at the end of March 2015:

Table 28: Significant operational risks as at 31 March 2015

Domain	Issue	Mitigations
Scheduled care to include integrated community teams, countywide / specialist services and children's and young people's services	The Homeless Healthcare team may no longer have a base of operation as the charity hosting the service is having to respond to financial pressures by selling its building for redevelopment	Working to source an alternative inner city location. Potential has already been identified to rent additional space from a building already used in part by the Trust
	County Council commissioners have tendered the Health Improvement Service and there is risk that this business may therefore be lost	The Trust is working towards its response to the tender application
	There is unclear governance, accountability and reporting for Medical Devices into the Quality and Performance Committee. There is no recognised Medical Devices Lead with clear role and responsibilities	This issue has been raised at the Clinical Senate. There is on-going discussion between the Director of Nursing and Quality and the Director of Service Delivery in order to resolve
	The Trust requires a recognised Decontamination Lead (as per Medicines and Healthcare Products Regulatory Agency (MRHA) guidelines) with appropriate qualifications and experience	Discussions are on-going to agree a Decontamination Lead. Dental services and Endoscopy are currently challenged to demonstrate full compliance with standards although both services have an agreed action plan
	There are a number of vacancies in senior management posts within Sexual Health services, including the service manager. This has led to senior colleagues taking on additional management duties, which has made it difficult for them to complete their usual clinic based work	Interviews are being held at the end of March 2015, although as any new member of staff will take time until settled in post, continued support from colleagues will be needed
Unscheduled care to include community hospitals and urgent care services	Staffing shortfalls in inpatient units are exacerbated by the escalation beds that remain open. There are insufficient numbers of bank nurses to fill the gaps leading to increased use of agency nurses which increases cost, decreases quality and continuity of care, and puts extra pressure on substantive staff	Substantive staff are currently covering clinical shifts, although this is not sustainable. The introduction of rotational posts linked to the preceptorship programme and competency frameworks, will alleviate. There is also a centralised recruitment campaign, headed by a dedicated lead on nurse recruitment
	The removal of the integrated Patient Administration System by Gloucestershire Hospitals NHS Foundation Trust will commence in May 2015, resulting in information not necessarily being available electronically to Trust colleagues	A working group has been set up in collaboration with the local acute Trust, and a robust deployment plan is in place
Corporate governance	There are some gaps and inconsistencies in record-keeping, meaning that the Trust is not always providing care based on the most up-to-date information: additionally, the Trust may then not be able to refute allegations of clinical negligence	Work is on-going to update all clinical and clinical governance policies. A training programme will be carried out to confirm that colleagues have read and understood amendments to the processes
Transformation and change	Non-delivery of the External Care programme may result in continued overspend by the County Council and loss of confidence in the Trust to maintain responsibility for this area of work	All performance in relation to External Care for 2014-15 is showing trends which would indicate achievement of the savings plan albeit in contrast to the County Council's current view
Foundation Trust programme	There is risk that the Trust's Integrated Business Plan and Long-Term Financial Model will not be able to identify required cost savings across a five year period	The Trust's current and projected financial position suggests that costs savings are not being achieved, which may lead to financial instability

In determining the above operational risks, the Trust utilises the scoring mechanism (based upon a calculation of likelihood versus consequence), as well as the corresponding definitions, provided by the NHS National Patient Safety Agency. As such, all operational risks are reviewed in terms of their actual or potential impact upon:

- the safety of service users, staff or the public (including both physical and psychological harm);
- the quality of Trust services (which may be measured by complaints or audit);
- human resources / organisational development (to include considerations of staffing levels and competencies);
- the Trust's statutory duty or the result of inspections;
- business objectives or projects;
- the Trust's finances including claims;
- disruption or interruption to Trust services;
- the local environment.

Training and learning

To support staff 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, the Incident Reporting and Management Policy and the Serious Incident Management Policy.

In 2015-16, the Trust will continue to disseminate learning from its risk experiences, including learning from how risks occurred, how they were identified, mitigated, and resolved or accepted within agreed tolerance levels.

Moreover, it is noted that the Trust has recently identified 24 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. This network will now support the Trust's risk management processes which seek to ensure that:

- where an identified risk is deemed to be pertinent or applicable to staff across the Trust, the Champions will oversee the escalation of all 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 will be routinely shared with relevant Committees 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.

5.5.4 Internal and external sources of assurance

The assurances used in 2014-15 in order to validate the effectiveness of the Trust's internal controls, were derived from a range of internal and external sources as shown below (NB these lists are indicative only and not exhaustive):

- Internal assurance, including:
  - internal audit reports and Head of Internal Audit opinion;
  - local performance scorecards;
  - the Quality and Performance Report (includes benchmarking);
  - Quality Visits by the Executive and Non-Executive Directors;
  - Matron-led peer reviews
  - the Finance Report;
  - local counter fraud reviews;
  - clinical and care audit reports;
  - Friends and Family Test;
  - local service user satisfaction surveys / site specific surveys;
  - Serious Incident Requiring Investigation (SIRI) reviews;
  - incident reviews;
  - the Quality Account;
  - Annual Report of the Director of Infection Control;
  - Cost Improvement Programmes reviews;
  - the Safety Thermometer;
  - Mortality Tool;
  - Report on Controlled Drug Incidents;
  - health and safety reviews;
  - sickness absence / mandatory training rates / appraisals completion.
- External assurance, including:
  - Care Quality Commission reports;
  - Audit Commission reports;
  - NICE guidance;
  - compliments and complaints;
  - safeguarding reviews (adults or children's) that are initiated by Gloucestershire County Council;
  - external audit and annual letter;
  - private meetings between Chair of the Audit and Assurance Committee and NED colleagues with the Heads of Internal and External Audit;
  - Health and Safety Executive reviews;
  - National Confidential Enquiries into Patient Outcome and Death;
  - Rule 43 Reports;
  - national audits;
  - peer reviews;
  - Information Governance Toolkit submissions;
  - NHS Protect reports;
  - Patient-Led Assessment of the Care Environment (PLACE) inspections;
  - national staff surveys;
  - NHS Trust Development Authority returns;
  - Department of Health returns;
  - Information Centre for Health and Social Care returns;
  - Secondary Uses Service (SUS) submissions.

An example of external assurance was the Review of Health Services for Children Looked After and Safeguarding in Gloucestershire published by the Care Quality Commission in July 2014. This multi-agency assessment provided five clear recommendations, of which the following were pertinent to the Trust:

- ensure that appropriately trained individuals undertake health assessments and implement a robust monitoring system to ensure consistently good quality of health assessments for looked after children and young people who are living in placements either in or out of county;
- ensure that care leavers receive good quality health information, advice and guidance, and are provided with a full summary of their healthcare history in a format suitable to their needs;
- develop and implement robust monitoring systems for the safeguarding responsibilities of all independent contractors.

To address these recommendations, a detailed action implementation plan was developed for monitoring by appropriate committees within the Trust, and to provide assurance to the Board.

5.5.5 Deterrents to fraud

The Trust is committed to observing General Condition 6 of the NHS Standard Contract which sets out the clauses relating to counter fraud. Of particular note in 2014-15:

- the Trust obtained 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;
- the organisation undertook a fraud risk assessment in April 2014 using the Self-Review Tool provided by NHS Protect;
- as a result of the Self-Review, the Trust drew up a comprehensive action plan, comprising a full range of activity to follow on from that undertaken in 2013-14 covering four areas, namely (i) Strategic Governance, (ii) Inform and Involve, (iii) Prevent and Deter, and (iv) Hold to Account;
- the Trust reviewed its counter fraud, bribery and corruption policy to ensure compliance with legislation;
- in August 2014, the Trust was visited by the Quality and Assurance Team from NHS Protect who undertook an assessment of the Trust's counter fraud arrangements and activities relating to the Prevent and Deter standards. As a result of the progress the Trust had already made to strengthen procedures which had previously rated "red" in the 2013-14 Self-Review Tool and "amber" in 2014-15, the assessors uplifted both ratings to "green", giving the Trust an overall "green" rating for Prevent and Deter;
- the GLCFS delivered fraud awareness presentations as part of induction and at departmental meetings, and used newspaper articles of successful prosecutions as a deterrent to would-be fraudsters;
- the Trust adopted a robust response to anyone found to have committed fraud and ensured all appropriate sanctions were considered, including prosecution, internal and professional disciplinary action, and financial recovery. Outcomes from investigations included two criminal prosecutions (one guilty plea with a sentence of 120 hours community service; one case withdrawn as the subject had left the country), in addition to three resignations and one written warning following internal disciplinary action. £13,169.89 was recovered.

5.5.6 Information Governance breaches

The Trust maintains robust processes to identify all possible and actual risks to robust 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, employees or business critical matters.

Throughout 2014-15, the Trust used the Datix system to report and monitor all such information governance incidents. In summary, these were as follows:

Table 29: Summary of information breaches 2014-15

Breach Type	Number of incidents
Corruption or inability to recover electronic data	1
Information disclosed in error	37
Information lost in transit	7
Lost or stolen hardware	2
Lost or stolen paperwork	23
Non-secure disposal of hardware	2
Non-secure disposal of paperwork	1
Information uploaded to website in error	0
Technical security failing	1
Unauthorised access/disclosure of information	36
Other	16
TOTAL	126

All of the above 126 incidents received internal investigation: however, none were of such severity that they required escalation to the Information Commissioner.

The principal success of 2014-15 in terms of information governance was the achievement of Level 2 compliance with the requirements of the Information Governance Toolkit. The Trust now plans to aim for Level 3 compliance in those areas where this is practical and achievable.

5.5.7 Future risks

Whilst the individual risk registers in operation across the Trust already anticipate some future risks, additional potential concerns are held within the organisation's SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis, which is routinely reviewed at Board. These additional risks / threats include:

- potential disinvestment from Commissioners which, if too significant, could undermine the Trust's continued financial sustainability;
- increased competition from other providers both from within Gloucestershire and outside;
- an ageing clinical workforce profile which could, in the medium- to long-term, impact upon staffing numbers and therefore the ability to deliver commissioned care;
- pressures on services due to national and local requirements for increased 7 day working practices without corresponding financial investment;
- increasing health inequalities between the least and most disadvantaged in Gloucestershire society.

The Trust will continue to monitor all these possible eventualities as part of its routine evaluation of its SWOT, and transfer to the Board Assurance Framework as risks when appropriate.

5.6 Other controls

5.6.1 Public and stakeholder involvement

The Trust is committed to partnership working with all local professional stakeholders including the Gloucestershire Clinical Commissioning Group, Gloucestershire County Council, Gloucestershire Hospitals NHS Foundation Trust, 2gether NHS Foundation Trust and South Western Ambulance Service NHS Foundation Trust. Equally, the Trust works closely with a range of organisations from the voluntary sector including Sue Ryder, Carers Gloucestershire, the Gloucestershire Deaf Association etc.

Moreover, the Trust actively seeks service user involvement and feedback, not only through formal surveys and consultations, but also proactively through the established Your Care, Your Opinion Programme Board which is attended by a range of public and service user representatives including Healthwatch Gloucestershire and the Learning Disability Partnership Board.

The most visible public event in 2014-15 was the Trust's first Annual General Meeting (AGM) which was held in October 2014. This welcomed over 200 members of the public, professional partners and staff, and celebrated the work of the Trust with a large-scale interactive exhibition.

5.6.2 Equality, diversity and human rights

The Trust maintains dedicated processes and controls so as to gain assurance that the organisation complies appropriately with all relevant equalities and human rights legislation and regulations. These controls include:

- the publication of an Equality Annual Report in January 2015 to demonstrate how the Trust meets the Public Sector Equality Duties under the Equality Act 2010;
- equalities objectives and detailed implementation plans to address priorities identified both within the Equality Annual Report and as evidenced by the Trust's communities and colleagues;
- the use of detailed eQuality Impact Assessments (eQIAs) to support policy creation and revision, and all service change initiatives;
- an Equality and Human Rights Policy which sets out the responsibilities of all colleagues, and which is available on the Trust's internet and intranet;
- a reporting line into the Quality and Clinical Governance Committee in order to provide assurance that equality and human rights considerations are embedded throughout the Trust;
- mandatory Equality, Diversity and Human Rights training that is made available for all Trust colleagues.

5.6.3 NHS pension scheme

As an employer whose workforce is entitled to membership of the NHS Pension Scheme, the Trust maintains necessary control measures to ensure that all obligations contained within the Scheme's regulations, are fully embedded in policy and procedure. These control measures include formal processes to verify that deductions from salary, as well as employer's contributions and payments into the Scheme, are made in accordance with the Scheme's rules, and that members' records are updated accurately in accordance with the timescales detailed within the regulations and associated guidance.

The Trust also offers the NEST pension scheme to staff who do not qualify for the NHS pension scheme.

5.6.4 Corporate social responsibility

As part of its Corporate Social Responsibility (CSR) policy, which recognises that the Trust has an explicit responsibility to act as a Good Corporate Citizen, the Trust is wholly committed to reducing its environmental impact whilst contributing positively to local communities. Key achievements in 2014-15 have included the following:

- reduction of carbon footprint from building energy use by 2%;
- reduction of water consumption across Trust sites by 5%;
- refurbishment of the Thames Ward, Cirencester Hospital, and addition of LED lighting;
- installation of smart LED lighting at the Trust's head office;
- implementation of an inverter project to reduce the energy consumption of air handling at Cirencester Hospital by 50%;
- promotion of active healthy lifestyles with a cycling event and the provision of 9 pool bikes for use by school nurses for appointments, and office staff for meetings;
- increase in the use of Webex for meetings across the Trust to reduce unnecessary travel across the county;
- encouragement of volunteers to plant an additional 500 trees across Trust sites in order to increase physical activity and reduce carbon emissions;
- refresh and re-launch of the Trust's Charitable Funds so as to increase the awareness and understanding of ways in which the Trust can help some of the most vulnerable service users in Gloucestershire.

5.7 Trust performance

5.7.1 Internal audit results

In 2014-15, seven internal audits were conducted in respect of key aspects of the Trust's control system i.e. performance reporting, clinical systems, payroll, staffing escalation, staff overpayment, core financial systems and corporate governance (NB an additional audit on External Care spend commenced in March 2015, but will not report until later in the year). The risks and issues highlighted by these audits are shown below, together with details of the Trust's mitigating actions.

Table 30: Internal audits 2014-15

Subject of audit	Level of risk	Identified risks	Trust mitigation	Current level of risk
Performance Reporting System (quarter 1)	Medium	There is no defined control framework for managing and controlling changes to system configurations	A process is currently being embedded to ensure a control framework is introduced. To date, the evolution of Essbase (the Trust's reporting tool) has been developmental; however the need for this framework is crucial as this continues	Low
		There is currently no requirement for teams performing data validation to confirm the number of records corrected, the root causes of the data problems, or retain any evidence of their activity	A process has now been established to ensure validation of load data. This formalises the checks that currently take place and establishes a documented procedure to provide an audit trail and ensure consistency	Low
	Low	There is not a consistent process of access authorisation to ensure that user access is reviewed on a periodic basis and therefore that access remains commensurate with job roles and responsibilities	An authorisation process has been fully established and embedded	Good practice
		Formal training is not regularly provided to users who require technical skills and knowledge as part of their job role	This will be embedded into the Essbase System Manager role. The need for more complex, technical training for key individuals will also be reviewed. Moreover, all users of the Trust's new business intelligence reporting tool (OBIF) will have full system training	Low

Subject of audit	Level of risk	Identified risks	Trust mitigation	Current level of risk
Clinical System Project Management (quarter 1)	High	There is no clear documentation which outlines how non-financial benefits will be measured	The Trust is currently developing a document to outline non-financial benefits and how they will be measured. The Trust will also be implementing a mechanism for monitoring and reporting	Medium
	Medium	The Trust would benefit from a review of the project scope against deliverables to ensure that the project is still in alignment and 'scope creep' has not occurred	The Trust continues to review the project scope to ensure that it is still in alignment with the needs of the Trust	Good practice
	Low	The project organisational structure chart is out of date	The Trust has updated the organisational, reporting and governance structure, so that the project configuration is appropriate	Good practice
		Stakeholders were originally defined within the Project Initiation Document: however, there is no clear stakeholder engagement strategy, plan or responsible role. As such, their expectations and needs may not be met	The Trust has mapped all stakeholders, and has clear processes and governance arrangements to ensure that all relevant internal and external parties are involved and engaged via participation in forums, routine communications etc	Low
		There may be an opportunity for key members of the project team, such as the Senior Project Manager, to undertake formal project management training	The Senior Project Manager is suitably qualified and has clear documented objectives	Good practice
	Opport-unities for further review	Risk and opportunities management could be reviewed to provide assurance of the quality and effectiveness of the risk processes	Risk management processes have been significantly improved with reporting and review through established governance arrangements, and robust escalation procedures to alert senior colleagues of any salient concerns	
		A more detailed audit may enhance project outcomes and provide control operating effectiveness assurance to the Project Board	This opportunity will be reviewed as the project continues	

Subject of audit	Level of risk	Identified risks	Trust mitigation	Current level of risk
Payroll Review (quarter 2)	High	Employees are able to submit duplicate or inaccurate timesheets which could result in an overpayment to the employee	Staff will receive training on fraud awareness, and will be reminded of the importance of diligently reviewing time sheets. Analysis is already being undertaken of payroll each month to highlight the largest variances for further review. It is noted that the introduction of e-rostering will eliminate the potential for duplication	Medium
	Medium	There is no list of authorised signatories to determine whether or not an authorisation is appropriate and legitimate	The Trust will maintain a list of authorised signatories. All amendment forms will be agreed by an authorised signatory before processing	Medium
		In respect of starters, leavers and amendments, forms are not always provided in good time to the Workforce team or are appropriately dated	All starters, leavers and amendment forms will be authorised and dated in good time. Line managers will be held to account where this process is not followed	Medium
	Low	The Trust's leavers' process has existed since January 2012, and as such, may not meet the needs of the Trust	The Trust has reviewed and updated its procedures, and ratified these through agreed governance structures	Good practice
		It is possible for members of the Trust's Workforce team to amend their own payroll details within the payroll system	To reduce risk, the payroll team sends records to SBS for authorisation: once completed, analysis is forwarded to the Director of Finance highlighting variances from the previous month to enable further validation	Low
		The log which records and tracks errors made by SBS is not reviewed or approved by senior members of Trust staff	The query log will be periodically reviewed by the ESR Systems Manager, who will escalate necessary issues to senior management	Low
		The Trust does not review final payment calculations to ensure that these have been made correctly	The Workforce team will check the accuracy and completeness of a sample of pay information each month	Low
	Advisory	There are no KPIs for processing new joiners or leavers	Reporting, KPIs and metrics are now included in workforce reports	Good practice

Subject of audit	Level of risk	Identified risks	Trust mitigation	Current level of risk
Staffing Escalation (quarter 2)	Medium	There is limited sharing of information between central support service teams, with budget holders regularly receiving duplicate requests for information from teams	A formal feedback loop will be established to ensure relevant central functions receive appropriate information from monthly finance and performance review meetings with service managers: this will form part of the new formalised finance governance guidelines	Medium
		Cost Improvement Plans (CIPs) should include guidance and support on implementation to enable budget holders to get a better understanding of how they can achieve savings within their teams	CIP training (together with CQUINs and QUIPPs) will be provided where a need is identified	Medium
		Quality and equality impact assessments are not completed by budget holders before any changes are made to establishment	The Trust will ensure that each operational plan is supported by a workforce plan and subject to an eQuality Impact Assessment	Medium
		Budget holders do not always ensure that the HR team is provided with timely leaver information to ensure that final payroll calculations can be met and overpayments avoided	All leavers information will be authorised and dated in good time. Line managers will be held to account where this process is not followed	Medium
		Workforce planning changes are not clearly communicated to teams and there is not sufficient collaboration with budget holders during development	When relevant, workshops for service leads will be held to provide guidance and instruction on the development of workforce plans in line with both operational and strategic organisational goals	Medium
		There appears to be a lack of clarity around the need to either hold open or recruit staff to vacant posts	The quality of feedback provided for rejected requests has been enhanced with more detailed explanations provided	Good practice
		Budget holders should raise concerns regarding staffing levels into Datix and to line managers on a daily basis if required	There is greater understanding and escalation of staffing risks: this needs to be an on-going focus to reinforce its importance	Low

Subject of audit	Finding (NB not risk rated)	Trust actions
Staff Overpayment (quarter 2)	The Trust's leavers' process has existed since January 2012, and as such, may not meet the needs of the Trust	The Trust has reviewed and updated its procedures, and ratified these through agreed governance structures
	Upon someone leaving the employ of the Trust, it is the line manager's responsibility to email the workforce team. The Workforce team should then check that this person has been removed from the payroll system	All starters, leavers and amendment forms will be authorised and dated in good time. Line managers will be held to account where this process is not followed
	Budget holders' review of monthly budget reports should identify if costs in relation to a leaver, are still being processed inappropriately	Budget holders are reminded of the need to fully interrogate their budgets to ensure that all pay and non-pay costs incurred within their budgeted responsibility, are appropriate
	Payslips are distributed to employees at their work address. If more than one month's payslip is sent to a directorate, the budget holder should become aware that an overpayment may have been made to an ex-employee	Budget holders are reminded to check payslips upon receipt. Moreover, staff should be reminded not to send payslips to employee's home addresses unless given appropriate authorisation to do so
	Should an overpayment occur, there should be a process to systematically communicate this back to the budget holder	The Workforce team will liaise with budget holders in the event of an overpayment to ensure that all relevant parties are aware of the issue
	There is evidence that the Trust has previously advised SBS that a member of staff was being paid through the incorrect annual fee rate, but that the responsible officer in SBS was unavailable, so a colleague acted on their behalf but missed the Trust instruction	The Trust will seek assurance from SBS that should responsible officers within SBS be unable to fully undertake their duties, an appropriate officer will be assigned
	SBS send follow up letters to client employees if overpayments are made. However, it is not standard practice for SBS to inform clients, such as the Trust, if an overpayment is made to a client's employee	The Trust should liaise with SBS to agree monetary amount above which all correspondences related to overpayment are discussed with the Trust before issue. This recommendation could be expanded to include all staff members on the red list

Subject of audit	Level of risk	Identified risks	Trust mitigation	Current level of risk
Core Financial Systems (quarter 3)	Medium	There is currently no control in place to confirm the completeness of the list of journals which have been printed and stored in paper files for review	The Trust has implemented a formal monthly review to reconcile the list of journals posted into the ledger with those in the paper files. This review will be retained in case any further investigation is required	Good practice
		The procurement process requires multiple quotes to be obtained for certain purchases. These are not retained on a shared drive leaving management unable to establish when a Procurement Waiver Form should be signed by the Director of Finance	Quotes obtained for purchases will be retained on a shared drive. These will be reviewed centrally to identify cases where a Procurement Waiver is required	Medium
	Low	The Trust does not maintain a Signatory List of the finance staff who review documents and journals	The Trust will maintain a signatory list of all members of staff who may authorise journals or review information received by SBS. This list will be used to confirm that authorising signatories are appropriate	Low
	Advisory	There are no reports provided and no monitoring of the performance SBS against contract KPI's	Monitoring of SBS against contract KPIs is undertaken on a weekly basis	Good practice

Subject of audit	Level of risk	Identified risks	Trust mitigation	Current level of risk
Corporate Governance (quarter 4)	Medium	The Information Governance team structure and cost is not in line with other Trusts who scored highly on the Toolkit	The Trust is currently reviewing structures for Information Governance support, with a view to delivering the most efficient and cost-effective service	Medium
	Low	The job descriptions for Information Governance roles require review, ensuring that there are no duplicate tasks, and there is clear definition of the responsibilities for each role	Job descriptions have now been reviewed supported by the HR team in order to ensure that there is clarity of purpose, role, remit and responsibility	Good practice

5.7.2 TDA Accountability Framework indicators 2014-15

For 2014-15, the Trust's performance against the relevant indicators within the NHS Trust Development Authority (TDA) Accountability Framework was as follows:

Table 31: TDA Accountability Framework performance 2014-15

Metric		Trust Performance 2014-15	Target (where applicable)	RAG
Caring	Inpatient scores from Friends and Family Test *	+69 (April-December)	+60	
	A&E scores from Friends and Family Test *	+80 (April-December)	+46	
	Complaints	63	n/a	n/a
	Inpatient Survey: Q68 Overall I had a very poor/good experience?	83%	n/a	n/a
	Mixed sex accommodation breaches	0	0	
Well-Led	Inpatients response rate from Friends and Family Test	40%	30%	
	A&E response rate from Friends and Family Test	19%	20%	
	Data quality of Trust returns to the HSCIC	99.2%	96%	
	NHS Staff Survey: Percentage of staff who would recommend the Trust as a place of work	52%	61%	
	NHS Staff Survey: Percentage of staff who would recommend the Trust as a place to receive treatment	68%	67%	
	Trust turnover rate	14.70%	n/a	n/a
	Trust level total sickness rate	4.89%	n/a	n/a
	Total Trust vacancy rate	5.5%	n/a	n/a
	Temporary costs and overtime as % total paybill	7.9%	n/a	n/a
	Percentage of staff with annual appraisal	70.91%	n/a	n/a
Effective	Emergency re-admissions within 30 days	10.7%	n/a	n/a
Safe	C. diff (variance from plan)	17	<21	
	MRSA	0	0	
	Never Event incidence	0	0	
	Medication errors causing serious harm	1	0	
	Harm Free Care **	92.6%	95%	
	Proportion of patients risk assessed for VTE	98.2%	95%	
	Serious Incidents	27	0	
	Patient safety events that are harmful	14	0	
	Overdue CAS alerts	2	0	
Responsive	Number of diagnostic tests waiting longer than 6 weeks	0%	1%	
	A&E 4 hour waiting time (all types)	99.82%	95%	
	A&E 12 hour trolley waits	0	0	
	Urgent ops cancelled for second time	0%	0%	
	Proportion of patients not treated within 28 days of last minute cancellation	0%	0%	
	Delayed transfers of care	1.0%	7.5%	

*These two measures ceased nationally in December 2014, to be replaced by a calculation of the percentage of people reporting that they were either "Likely" or "Extremely Likely" to recommend the Trust to friends and family: Trust results against this revised metric for the three months to March 2015 showed 91% recommendations in respect of inpatient units and 97.9% recommendations in respect of A&E (i.e. Minor Injuries and Illnesses Units).

**Performance against this target increased throughout the course of the year, with the Trust achieving the requisite 95% in both February and March 2015.

5.8 Review of effectiveness

As Accountable Officer, I have ultimate responsibility for reviewing the effectiveness of the Trust's Board/corporate governance, quality/clinical governance, financial governance and internal control systems. My review of 2014-15 however is 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 Committees over the past twelve months, together with self-assessments, peer and external reviews. Additionally, 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 Committees, 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 2015-16:

- reflect upon the feedback received by the NHS Trust Development Authority as well as other independent assessors, in order to strengthen Board and subcommittee practices;
- validate that the implemented improvements to incident reporting processes are successfully encouraging colleagues to highlight areas of concern so that corresponding quality improvements can be made;
- maintain the momentum in building improved risk management processes and practices that have already resulted in the development of a detailed Board Assurance Framework;
- ensure consistent use of a more robust eQuality Impact Assessment tool so as to understand the potential consequence of service change upon all stakeholders and populations, especially those who are most seldom seen and seldom heard.

Notwithstanding, 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

Chief Executive
Date: 3 June 2015

6. Remuneration Report

6.1 Remuneration and Terms of Service Committee

Throughout 2014-15, the Trust maintained a Remuneration and Terms of Service Committee, which was designated responsibility by the Trust Board for determining the organisation's broad remuneration policy, giving due regard to the recommendations of the Department of Health and the Trust Development Authority, and adhering to all relevant laws, codes and regulations.

More specifically, the Committee was responsible for deciding the remuneration, allowances and other terms and conditions of office - including benefits, allowances and termination arrangements - for the organisation's Very Senior Managers, in line with the requirements of the NHS Codes of Conduct and Accountability, the Higgs report, and the Trust's Standing Financial Instructions (NB the definition of "Very Senior Managers" is based upon the Department of Health's Very Senior Managers Pay Framework, and therefore refers to the Trust's Chief Executive and the Executive Directors, except those who are eligible to be on the Consultant Contract by virtue of their qualification and the requirements of their post).

Additionally, the Committee had explicit duty to monitor and evaluate the performance of the Trust's Chief Executive and Very Senior Managers against their personal objectives for the previous year and note forward objectives.

The Committee was chaired by the Trust Chair and attended by all of the Non-Executive Directors. Additionally, the Chief Executive, the Director of HR and the Director of Corporate Governance and Public Affairs were regularly in attendance, except when issues regarding their own positions were discussed. Other directors were invited to attend by the Chair as required.

6.2 Salary and pension entitlements of Directors 2014-15

The total remuneration of the Trust's Executive Directors and Non-Executive Directors in 2014-15 is given in table 32.

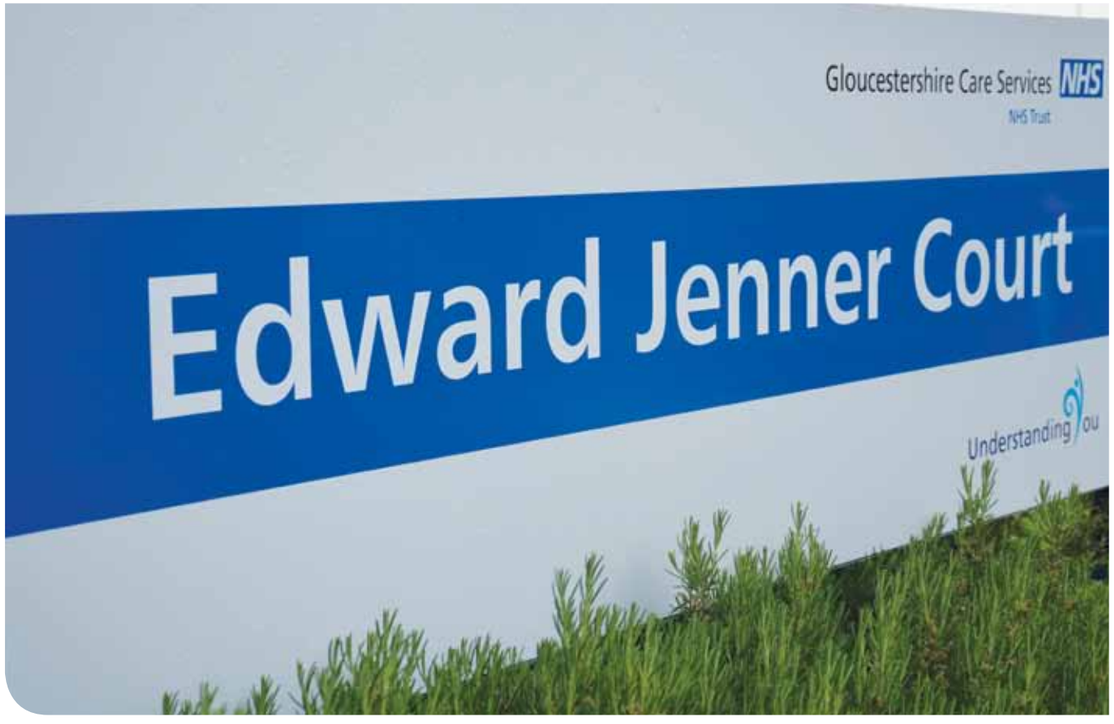


Table 32: Directors' salary entitlements 2014-15

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 and Deputy Chief Executive	110-115	2	-	-	-	115-120
Elizabeth Fenton, Director of Nursing and Quality	75-80	4	-	-	-	80-85
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
Susan Field, Director of Service Transformation	90-95	2	-	-	-	90-95
Candace Plouffe, Director of Service Delivery	75-80	1	-	-	-	75-80
Tina Ricketts, Director of HR	70-75	1	-	-		70-75
Simeon Foreman, Board Secretary	10-15	0	-	-	-	10-15
Jason Brown, Director of Corporate Governance and Public Affairs	65-70	5	-	-		70-75
Robert Graves, NED	5-10	2	-	-	-	5-10
Richard Cryer, NED	5-10	3	-	-	-	5-10
Joanna Scott, NED and Vice Chair	5-10	0	-	-	-	5-10
Susan Mead, NED	5-10	1	-	-	-	5-10
Nicola Strother Smith, NED	5-10	2	-	-	-	5-10
Christopher Creswick, NED	5-10	2	-	-	-	5-10

2013-14

Ingrid Barker, Chair	20-25	4	-	-	-	20-25
Paul Jennings, Chief Executive	35-40	0	-	-	-	35-40
Glyn Howells, Director of Finance and Deputy Chief Executive	110-115	3	25-30	-	-	140-145
Elizabeth Fenton, Director of Nursing and Quality	75-80	2	-	-	-	80-85
Dr Joanna Bayley, Medical Director	40-45	2	-	-	-	40-45
Dr Michael Roberts, Interim Medical Director	-	-	-	-	-	-
Duncan Jordan, Chief Operating Officer	-	-	-	-	-	-
Susan Field, Director of Service Transformation	85-90	2	-	-	-	85-90
Candace Plouffe, Director of Service Delivery	65-70	1	-	-	-	65-70
Tina Ricketts, Director of HR	65-70	1	-	-	-	65-70
Simeon Foreman, Board Secretary	50-55	1	-	-	-	50-55
Jason Brown, Director of Corporate Governance and Public Affairs	-	-	-	-	-	-
Robert Graves, NED	5-10	2	-	-	-	15-20
Richard Cryer, NED	-	-	-	-	-	-
Joanna Scott, NED and Vice Chair	5-10	1	-	-	-	5-10
Susan Mead, NED	0-5	0	-	-	-	0-5
Nicola Strother Smith, NED	0-5	0	-	-	-	0-5
Christopher Creswick, NED	0-5	0	-	-	-	0-5

Table 32 includes all costs incurred by the Trust relating to pay, bonuses, benefits in kind (including relocation) or other remuneration relating to Directors. Furthermore, it is noted that where Directors' salaries increased in year, this was due to incremental rises in basic pay scales awarded under the national Agenda For Change framework which is equally applicable to all colleagues across the Trust.

Table 33 shows the pension contributions for Executive Directors in 2014-15. 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 and Public Affairs is participating in a pension scheme at present.

Table 33: Pension contributions 2014-15

	Real increase in pension at age 60 (Bands of £2,500)	Real increase in pension lump sum at aged 60 (Bands of £2,500)	Total accrued pension at age 60 at 31 March 2015 (Bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2015 (Bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2014 £000	Cash Equivalent Transfer Value at 31 March 2015 £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 and Deputy Chief Executive	0 - 2.5	5 - 7.5	5 - 10	-	55	78	22	16
Elizabeth Fenton, Director of Nursing and Quality	0 - 2.5	0 - 2.5	20 - 25	60 - 65	407	448	30	11
Dr Joanna Bayley, Medical Director	0 - 2.5	0 - 2.5	5 - 10	25 - 30	131	143	7	11
Dr Michael Roberts, Interim Medical Director	2.5 - 5	12.5 - 15	5 - 10	25 - 30	52	186	88	9
Duncan Jordan, Chief Operating Officer *	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Susan Field, Director of Service Transformation	0 - 2.5	2.5 - 5	20 - 25	60 - 65	345	386	32	13
Candace Plouffe, Director of Service Delivery	0 - 2.5	5 - 7.5	10 - 15	30 - 35	148	192	41	11
Tina Ricketts, Director of HR	0 - 2.5	2.5 - 5	10 - 15	30 - 35	173	197	20	10
Simeon Foreman, Board Secretary	(0 - 2.5)	(0 - 2.5)	10 - 15	35 - 40	161	171	1	2
Jason Brown, Director of Corporate Governance and Public Affairs	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

* Duncan received a pension contribution banded £30,000-35,000 which was paid into a fully-funded scheme.

The definition of terms used in table 33 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 33 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 employer. 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.

6.3 Pay multiples

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation, and the median (average) remuneration of the organisation's workforce.

In accordance with the guidance published within HM Treasury's Financial Reporting Manual (FReM), this calculation is based upon the cost of the most highly-paid individual in post at the end of the period, scaled up to show the amount that would have been paid by the Trust had that individual been in post for the whole financial year.

The mid-point of the banded remuneration of the highest paid director of the Trust in the financial year 2014-15 was £152,500 (2013-14, £142,500). This was 5.9 times (2013-14, 5.6 times) the median remuneration of the workforce which was £25,970 (2013-14, £25,783).

In 2014-15, no employees (2013-14, also no employees) received remuneration in excess of the highest paid director. Employee remuneration ranged from £15,100 to £153,953 (2013-14, £14,294 to £142,500).

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

In respect of the above, it is noted that there have been no significant changes to the overall workforce this year. In general, staff salaries were increased by 1% in April 2014 in line with government policy. Senior managers and Executive Directors were excluded from these arrangements, so did not receive any increase during the year with the exception of incremental pay increases due under the Agenda For Change Framework as detailed in section 6.2 above.

6.4 Terms of service

The agreed terms of service for the Trust's Executive and Non-Executive Directors who were in post as of 31 March 2015 are as below:

Table 34: Directors' terms of service

Name and title	Terms of service and/or notice period
Chair	
Ingrid Barker	Until 31 March 2017
Non-Executive Directors	
Robert Graves	Until 19 June 2016
Joanna Scott (Vice Chair)	Until 26 April 2017
Nicola Strother Smith	Until 30 June 2016
Susan Mead	Until 10 November 2017
Richard Cryer	Until 31 March 2017
Executive Directors	
Paul Jennings, Chief Executive	6 months
Glyn Howells, Director of Finance and Deputy Chief Executive	6 months
Duncan Jordan, Chief Operating Officer	3 months
Elizabeth Fenton, Director of Nursing and Quality	6 months
Dr Joanna Bayley, Medical Director	3 months
Dr Michael Roberts, Interim Medical Director	Until 31 July 2015
Susan Field, Director of Service Transformation	3 months
Candace Plouffe, Director of Service Delivery	3 months
Tina Ricketts, Director of HR	3 months
Jason Brown, Director of Corporate Governance and Public Affairs	3 months

I hereby confirm that the above Remuneration Report is a true and accurate representation of the described Trust activities in 2014-15.

Paul Jennings

Signed: Paul Jennings, Chief Executive

Date: 3 June 2015

7. Primary Financial Statements

7.1 Primary Financial Statements

7.1.1 Statement of Comprehensive Income (SoCI) for year ended 31 March 2015

Income and Expenditure

	NOTE	2014-15 £000s	2013-14 £000s
Gross employee benefits	7.2.8	**(82,023)**	(77,614)
Other operating costs	7.2.6	**(28,056)**	(35,058)
Revenue from service user care activities	7.2.3	**112,427**	107,367
Other operating revenue	7.2.4	**1,684**	1,613
Operating surplus/(deficit)		**4,032**	**(3,693)**
Investment revenue	7.2.10	**19**	19
Finance costs	7.2.12	**(15)**	0
Surplus/(deficit) for the financial year		**4,036**	**(3,674)**
Public dividend capital dividends payable (*)		**(2,650)**	0
Transfers by absorption - gains		**0**	903
Transfers by absorption - (losses)		**0**	(253)
Net Gain/(loss) on transfers by absorption		**0**	**650**
Retained surplus/(deficit) for the year		**1,386**	**(3,024)**

Other Comprehensive Income

	2014-15 £000s	2013-14 £000s
Impairments and reversals taken to the revaluation reserve	**0**	(2,177)
Net gain/(loss) on revaluation of property, plant & equipment	**0**	9,623
Other gain/loss) (**)	**55**	0
Net actuarial gain/(loss) on pension schemes	**(329)**	32
Total comprehensive income for the year	**1,112**	**4,454**

Financial performance for the year

Retained surplus/(deficit) for the year	**1,386**	(3,024)
Impairments (excluding IFRIC 12 impairments)	**0**	5,845
Adjustments in respect of donated gov't grant asset reserve elimination	**122**	(165)
Adjustment re absorption accounting	**0**	(650)
Adjusted retained surplus/(deficit)	**1,508**	**2,006**

(*) Public dividend capital dividends were payable in 2014-15 for the first time following a holiday in the Trust's first year of operation 2013-14 as is standard practice.

(**) Value of assets donated to the Trust in year.

The notes in section 7.2 below form part of this account.

7.1.2 Statement of Financial Position (SoFP) as at 31 March 2015

	NOTE	31 March 2015 £000s	31 March 2014 £000s
Non-current assets:			
Property, plant and equipment	7.2.13	**81,691**	81,760
Total non-current assets		**81,691**	**81,760**
Current assets:			
Inventories	7.2.16	**225**	0
Trade and other receivables	7.2.16	**10,384**	8,235
Cash and cash equivalents	7.2.17	**3,328**	6,717
Sub-total current assets		**13,937**	**14,952**
Non-current assets held for sale	7.2.18	**600**	0
Total current assets		**14,537**	**14,952**
Total assets		**96,228**	**96,712**
Current liabilities			
Trade and other payables	7.2.22	**(11,320)**	(13,276)
Provisions	7.2.21	**(16)**	(16)
Total current liabilities		**(11,336)**	**(13,292)**
Net current assets/(liabilities)		**3,201**	**1,660**
Total assets less current liablilities		**84,892**	**83,420**
Non-current liabilities			
Liabilities > 1 year	7.2.19	**(703)**	(317)
Total non-current liabilities		**(703)**	**(317)**
Total assets employed:		**84,189**	**83,103**
FINANCED BY:			
Public Dividend Capital	7.1.3	**81,482**	81,482
Retained earnings		**(3,531)**	(3,024)
Revaluation reserve		**9,339**	7,445
Other reserves		**(3,101)**	(2,800)
Total Taxpayers' Equity:		**84,189**	**83,103**

The notes in section 7.2 below form part of this account.

The financial statements in section 7.1 were approved on behalf of the Board on 3 June 2015 and signed on its behalf by

Chief Executive: Paul Jennings **Date: 3 June 2015**

7.1.3 Statement of Changes in Taxpayers' Equity for the year ended 31 March 2015

	Public dividend capital £000s	Retained earnings £000s	Revalu-ation reserve £000s	Other reserves £000s	Total reserves £000s
Balance at 1 April 2014	**81,482**	**(3,024)**	**7,446**	**(2,801)**	**83,103**
Changes in taxpayers' equity for 2014-15					
Retained surplus/(deficit) for the year		1,386			**1,386**
Impairments and reversals					**0**
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**
Balance at 1 April 2013	**0**	**0**	**0**	**0**	**0**
Changes in taxpayers' equity for the year ended 31 March 2014					
Retained surplus/(deficit) for the year		(3,024)			**(3,024)**
Net gain / (loss) on revaluation of property, plant, equipment			9,623		**9,623**
Impairments and reversals			(2,177)		**(2,177)**
Reclassification Adjustments					
Originating capital for Trust established in year	72,544				**72,544**
New temporary and permanent PDC received - cash	1,691				**1,691**
New PDC received/(repaid) - PCTs and SHAs legacy items paid for by DH	7,247				**7,247**
Other movements	0			(2,833)	**(2,833)**
Net actuarial gain/(loss) on pension				32	**32**
Balance at 31 March 2014	**81,482**	**(3,024)**	**7,446**	**(2,801)**	**83,103**

(*) The £55,000 adjustment to other reserves reflects the value of assets donated to the Trust in the year.

(**) Other movements includes the transfer of prior year £2,177,000 writeoff 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.

7.1.4 Statement of Cash Flows for the year ended 31 March 2015

	2014-15 £000s	2013-14 £000s
Cash Flows from Operating Activities		
Operating surplus/deficit	**4,032**	(3,693)
Depreciation and amortisation	**3,203**	2,546
Impairments and reversals	**0**	5,845
Interest paid	**0**	(45)
Dividend paid	**(2,688)**	0
Increase in Inventories	**(225)**	0
Increase in Trade and Other Receivables	**(2,150)**	(3,136)
Increase in Trade and Other Payables	**(2,610)**	(1,994)
Provisions utilised	**(339)**	(51)
Increase in movement in non cash provisions	**0**	362
Net Cash Inflow/(Outflow) from Operating Activities	**(777)**	**(163)**
Cash Flows from Investing Activities		
Interest Received	**19**	19
(Payments) for Property, Plant and Equipment	**(2,669)**	(2,077)
Rental Revenue	**38**	0
Net Cash Inflow/(Outflow) from Investing Activities	**(2,612)**	**(2,058)**
Net Cash Inflow/(Outflow) before Financing	**(3,389)**	**(2,221)**
Cash Flows from Financing Activities		
Gross Temporary and Permanent PDC Received	**0**	14,037
Gross Temporary and Permanent PDC Repaid	**0**	(5,099)
Net Cash Inflow/(Outflow) from Financing Activities	**0**	**8,938**
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS	**(3,389)**	**6,717**
Cash and Cash Equivalents at Beginning of the Period	**6,717**	0
Cash and Cash Equivalents at year end	**3,328**	**6,717**

7.2 Notes to the Accounts

7.2.1 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 2014-15 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 Department of Health 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 IAS20 and similarly give rise to income and expenditure entries.

For transfers of assets and liabilities from those NHS bodies that closed on 1 April 2013, Treasury agreed that a modified absorption approach should be applied. For these transactions and only in the prior-period, gains and losses are recognised in reserves rather than the SoCI.

iv) Charitable Funds

Under the provisions of IAS27 *Consolidated and Separate Financial Statements*, those Charitable Funds that fall under common control with NHS bodies are recommended to be consolidated within the entity's financial statements. In accordance with IAS1 *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. Payments 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 7.2.13
- Impairments of Receivables: See note 7.2.16
- Provisions: See note 7.2.21
- 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) 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 NHS body 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 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.

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) Tangible assets

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, 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.

The District Valuer undertook a revaluation exercise as at 1 March 2013. The Valuer is RICS (Royal Institute of Chartered Surveyors) qualified and used the Modern Equivalent Asset Valuation (MEAV) technique. It is planned to repeat this exercise in 2015-16.

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 are determined as follows:

- Land and non-specialised buildings - market value for existing use
- Specialised buildings - depreciated replacement cost

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.

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 IAS23 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 (SoCI).

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

The Trust has no intangible assets.

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.

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME). This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set.

AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

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

The value of assets received by means of a government grant are credited directly 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

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

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 7.2.6.

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.

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.

xxii) 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.

xxiii) 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.

xxiv) 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.

xxv) 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.

xxvi) 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.

xxvii) 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.

xxviii) 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 the Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

xxix) 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'.
From 2013-14, the Trust could consolidate the results of the Gloucestershire Care Services NHS Trust Charitable Funds over which it considers it has the power to exercise control in accordance with IFRS10 requirements. However the value of the Funds is considered immaterial and it has therefore been agreed with the Trust's auditors and the Trust Development Authority not to consolidate its accounts in 2014-15.

7.2.2 Operating segments

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

7.2.3 Revenue from service user care activities

	2014-15 £000s	2013-14 £000s
NHS Trusts	**84**	116
NHS England	**9,272**	9,637
Clinical Commissioning Groups	**90,881**	86,385
Foundation Trusts	**7,041**	6,199
NHS Other (including Public Health England and Prop Co)	**1,098**	112
Non-NHS:		
Local Authorities	**2,712**	3,591
Private service users	**3**	2
Overseas service users (non-reciprocal)	**0**	1
Injury costs recovery	**280**	196
Other	**1,056**	1,129
Total Revenue from service user care activities	**112,427**	**107,367**

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

7.2.4 Other operating revenue

	2014-15 £000s	2013-14 £000
Education, training and research	**1,541**	1,113
Receipt of donations for capital acquisitions - Charity	**0**	319
Rental revenue from operating leases	**141**	141
Other revenue	**2**	40
Total Other Operating Revenue	**1,684**	**1,613**
Total Operating Revenue	**114,111**	**108,980**

7.2.5 Overseas Visitors Disclosure

	2014-15 £000s	2013-14 £000
Income recognised during 2014-15 (invoiced amounts and accruals)	**0**	1
Cash payments received in-year (re: receivables at 31 March 2014)	**0**	0
Cash payments received in-year (re: invoices issued 2014-15)	**0**	0
Amounts added to provision for impairment of receivables (re: receivables at 31 March 2014)	**0**	0
Amounts added to provision for impairment of receivables (re: invoices issued 2014-15)	**0**	0
Amounts written off in-year (irrespective of year of recognition)	**0**	0

7.2.6 Operating expenses

	2014-15 £000s	2013-14 £000s
Services from other NHS Trusts	**214**	12
Services from CCGs/NHS England	**11**	5
Services from other NHS bodies	**804**	210
Services from NHS Foundation Trusts	**5,415**	8,494
Total Services from NHS bodies*	**6,444**	8,720
Purchase of healthcare from non-NHS bodies	**399**	352
Trust Chair and Non-executive Directors	**61**	65
Supplies and services - clinical	**3,702**	5,784
Supplies and services - general	**3,075**	429
Consultancy services	**772**	961
Establishment	**2,652**	1,905
Transport	**201**	429
Business rates paid to local authorities	**831**	775
Premises	**5,578**	5428
Hospitality	**5**	5
Insurance	**149**	145
Legal Fees	**118**	130
Impairments and Reversals of Receivables	**(254)**	538
Depreciation	**3,203**	2,546
Impairments and reversals of property, plant and equipment	**0**	5,845
Audit fees	**81**	106
Other auditor's remuneration	**0**	23
Clinical negligence	**280**	336
Education and Training	**750**	525
Other	**9**	9
Total Operating Expenses (excluding employee benefits)	**28,056**	**35,058**
Employee Benefits		
Employee benefits excluding Board members	**81,025**	76,600
Board members	**998**	1,014
Total Employee Benefits	**82,023**	**77,614**
Total Operating Expenses	**110,079**	**112,672**

*Services from NHS bodies does not include expenditure which falls into a category below.

7.2.7 Operating Leases

The Trust as lessee

	Land £000s	Build-ings £000s	2014-15 Other £000s	2014-15 Total £000s	2013-14 Total £000s
Payments recognised as an expense					
Minimum lease payments				**556**	719
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total				**556**	**719**
Payable:					
No later than one year	62	527	105	**694**	614
Between one and five years	192	1,782	0	**1,974**	1,975
After five years	624	4,733	0	**5,357**	5,835
Total	**878**	**7,042**	**105**	**8,025**	**8,424**

Prior year has been restated on a consistent basis.

The Trust as lessor

The Trust has an operating lease with Care UK for the use of operating theatre and ward space at Cirencester Hospital.

	2014-15 £000s	2013-14 £000
Recognised as revenue		
Rental revenue	141	141
Total	**141**	**141**
Receivable:		
No later than one year	141	141
Total	**141**	**141**

7.2.8 Employee benefits and staff numbers

Employee benefits

2014-15	Total £000s	Permanently Employed £000s	Other £000
Employee Benefits - Gross Expenditure			
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 employee benefits	**82,023**	**78,569**	**3,454**
Employee costs capitalised	**0**	**0**	**0**
Gross Employee Benefits excluding capitalised costs	**82,023**	**78,569**	**3,454**

2013-14	Total £000s	Permanently Employed £000s	Other £000
Employee Benefits - Gross Expenditure			
Salaries and wages	**66,413**	61,746	4,667
Social security costs	**4,129**	4,129	0
Employer Contributions to NHS BSA (Business Services Authority) - Pensions Division	**6,878**	6,878	0
Other pension costs	**126**	126	0
Termination benefits	**68**	68	0
Total employee benefits	**77,614**	**72,947**	**4,667**
Employee costs capitalised	**0**	**0**	**0**
Gross Employee Benefits excluding capitalised costs	**77,614**	**72,947**	**4,667**

Staff numbers

	2014-15 Total Number	2014-15 Permanently Employed Number	2014-15 Other Number	2013-14 Total Number
Average Staff Numbers (WTE)				
Medical and dental	**32**	32	0	34
Ambulance staff	**0**	0	0	0
Administration and estates	**444**	444	0	440
Healthcare assistants and other support staff	**97**	97	0	101
Nursing, midwifery and health visiting staff	**1,081**	1,011	70	1,079
Nursing, midwifery and health visiting learners	**36**	36	0	27
Scientific, therapeutic and technical staff	**469**	469	0	452
Social Care Staff	**0**	0	0	0
Other	**5**	5	0	5
Total	**2,164**	**2,094**	**70**	**2,138**
Of the above - staff engaged on capital projects	**0**	0	0	0

Staff sickness absence and ill health retirements

	2014-15 Number	2013-14 Number
Total Days Lost	**36,143**	30,674
Total Staff Days	**744,854**	716,455
Average Working Days Lost (%)	**4.85%**	**4.28%**
Number of persons retired early on ill health grounds	**4**	**3**

	2014-15 £000s	2013-14 £000s
Total additional pensions liabilities accrued in the year	**0**	**0**

Exit packages agreed in 2014-15

	2014-15			2013-14		
Exit package cost band (including any special payment element)	***Number of compulsory redundancies Number**	***Number of other departures Number**	**Total number of exit packages Number**	*Number of compulsory redundancies Number	*Number of other departures Number	Total number of exit packages Number
Less than £10,000	3	3	6	0	16	16
£10,000-£25,000	3	1	4	0	0	0
£25,001-£50,000	0	0	0	0	0	0
£50,001-£100,000	1	0	1	0	0	0
£100,001 - £150,000	0	0	0	0	1	1
£150,001 - £200,000	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0
Total number of exit packages by type (total cost)	**7**	**4**	**11**	**0**	**17**	**17**
Total resource cost (£s)	**154,275**	**22,159**	**176,434**	**0**	**181,030**	**181,030**

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 met by the NHS pensions scheme and 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.

Exit packages - Other departures analysis

	2014-15		2013-14	
	Agree-ments Number	**Total value of agreements £000s**	**Agree-ments Number**	**Total value of agreements £000s**
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	4	22	17	114
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval	0	0	1	68
Total	**4**	**22**	**18**	**181**
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 the table above which will be the number of individuals.

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

Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at **www.nhsbsa.nhs.uk/pensions**. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP 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 NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, this Valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point, the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2011, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2011 with summary global member and accounting data.

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) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008, members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year.

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable

For early retirements other than those due to ill health, the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the Statement of Comprehensive Income at the time the Trust commits itself to the retirement, regardless of the method of payment.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

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 2014 to 31 March 2015, the Trust's contributions totalled £148k and employee's contributions totalled £50k.

Period Ended	**31-Mar-14**	**31-Mar-13**
	% p.a.	% p.a.
Pension Increase Rate	2.4%	2.8%
Salary Increase Rate	3.8%	4.1%
Discount Rate	3.2%	4.3%

The fair value of employer assets of the whole fund as at 31 March 2015 is as shown below:

Assets (whole Fund)	**31-Mar-15 Assets (£000s)**	**%**	**31-Mar-14 Assets (£000s)**	**%**
Equity Securities	1,200	18%	1,228	21%
Debt Securities	1,078	16%	848	15%
Private Equity	19	0%	19	0%
Real estate	469	8%	340	6%
Investment funds & Unit Trusts	3,663	57%	3,200	56%
Derivatives	0	0%	1	0%
Cash and Cash equivalents	99	2%	97	2%
Total	**6,528**	**100%**	**5,733**	**100%**

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

Period ended 31 March 2015	Assets £000s	Obligations £000s	Net (Liability) / Asset £000
Fair Value of employer assets	5,733		5,773
Present value of funded liabilities		(6,072)	(6,072)
Opening position at 31 March 2014	**5,733**	**(6,072)**	**(339)**
Current service cost	0	(168)	(168)
Net interest			
Interest on plan assets	245		245
Interest cost on defined benefit obligation		(260)	(260)
Total net interest	**245**	**(260)**	**(15)**
Total defined benefit cost recognised in Profit or Loss	**245**	**(428)**	**(183)**
Cashflow			
Participants contributions	50	(50)	0
Employer contributions	148		148
Benefits paid	(242)	(242)	0
Expected closing position	**5,934**	**(6,308)**	**(374)**
Remeasurements			
Change in financial assumptions		(948)	(948)
Other experience		25	25
Returns on assets excluding amounts included in net interest	594		594
Total remeasurements recognised in Other Comprehensive Income	**594**	**(923)**	**(329)**
Fair value of employer assets	6,528		6,528
Present Value of funded liabilities		(7,231)	(7,231)
Closing Position 31 March 2015	**6,528**	**(7,231)**	**(703)**
In Year Movement	**795**	**(1,159)**	**(364)**

The in year increase in net liability of £364k has been funded from reserves.

7.2.9 Better Payment Practice Code

Measure of compliance

	2014-15 Number	2014-15 £000s	2013-14 Number	2013-14 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**29,772**	**27,479**	22,989	21,547
Total Non-NHS Trade Invoices Paid Within Target	**27,447**	**25,200**	20,430	18,602
Percentage of NHS Trade Invoices Paid Within Target	**92.19%**	**91.71%**	88.87%	86.34%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**658**	**12,956**	277	9,848
Total NHS Trade Invoices Paid Within Target	**458**	**9,233**	186	8,627
Percentage of NHS Trade Invoices Paid Within Target	**69.60%**	**71.26%**	67.15%	87.61%

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

	2014-15 £000s	2013-14 £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**

7.2.10 Investment revenue

	2014-15 £000s	2013-14 £000s
Rental revenue	**0**	0
Subtotal	**0**	**0**
Interest revenue		
Bank interest	**19**	19
Subtotal	**19**	**19**
Total investment revenue	**19**	**19**

7.2.11 Other Gains and Losses

	2014-15 £000s	2013-14 £000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	**0**	0
Gain/(Loss) on disposal of assets other than by sale (intangibles)	**0**	0
Gain/(Loss) on disposal of Financial Assets other then held for sale	**0**	0
Gain (Loss) on disposal of assets held for sale	**0**	0
Gain/(loss) on foreign exchange	**0**	0
Change in fair value of financial assets carried at fair value through the SoCI	**0**	0
Change in fair value of financial liabilities carried at fair value through the SoCI	**0**	0
Change in fair value of investment property	**0**	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	**0**	0
Total	**0**	**0**

7.2.12 Finance Costs

	2014-15 £000s	2013-14 £000s
Interest		
Interest on loans and overdrafts	**0**	0
Interest on obligations under finance leases	**0**	0
Interest on obligations under PFI contracts:		
- main finance cost	**0**	0
- contingent finance cost	**0**	0
Interest on obligations under LIFT contracts:		
- main finance cost	**0**	0
- contingent finance cost	**0**	0
Interest on late payment of commercial debt	**0**	0
Total interest expense	**0**	0
Other finance costs	**15**	0
Provisions - unwinding of discount	**0**	0
Total	**15**	**0**

7.2.13 Property, plant and equipment

	Land £000s	**Buildings £000s**	**Dwellings £000s**	**Assets under construction & payment on account £000s**	**Plant & machinery £000s**	**Transport equipment £000s**	**Information technology £000s**	**Furniture & fittings £000s**	**Total £000s**
2014-15									
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 Purchased	0	0	0	0	0	0	0	0	**0**
Additions - Non Cash Donations (i.e. physical assets)	0	0	0	0	0	0	0	0	**0**
Additions - Purchases from Cash Donations & Government Grants	0	0	0	0	55	0	0	0	**55**
Additions Leased	0	0	0	0	0	0	0	0	**0**
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)**
Disposals other than for sale	0	0	0	0	0	0	0	0	**0**
Upward revaluation/positive indexation	0	0	0	0	0	0	0	0	**0**
Impairments/negative indexation	0	0	0	0	0	0	0	0	**0**
Reversal of Impairments	0	0	0	0	0	0	0	0	**0**
Transfers to NHS Foundation Trust	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**
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**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Reclassifications as Held for Sale and reversals	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	0	0	0	0	0	0	0	**0**
Upward revaluation/positive indexation	0	0	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	0	0	**0**
Reversal of Impairments	0	0	0	0	0	0	0	0	**0**
Charged During the Year	0	2,040	0	0	672	23	287	181	**3,203**
Transfers to NHS Foundation Trust	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**
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**

2014-15	Land £000s	Buildings £000s	Dwellings £000s	Assets under construction & payment on account £000s	Plant & machinery £000s	Transport equipment £000s	Information technology £000s	Furniture & fittings £000s	Total £000s
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**
Owned - Government Granted	0	0	0	0	0	0	0	0	**0**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	**0**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2015	**11,360**	**57,828**	**0**	**3,672**	**5,521**	**114**	**1,790**	**1,406**	**81,691**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land £000s	Buildings £000s	Dwellings £000s	Assets under construction & payment on account £000s	Plant & machinery £000s	Transport equipment £000s	Information technology £000s	Furniture & fittings £000s	Total £000
At 1 April 2014	315	7,130	0	0	0	0	0	0	**7,445**
Movements (specify)	0	0	0	0	0	0	0	0	**0**
At 31 March 2015	**315**	**7,130**	**0**	**0**	**0**	**0**	**0**	**0**	**7,445**

Additions to Assets Under Construction in 2014-15

	£000's
Land	0
Buildings excl Dwellings	3,679
Dwellings	0
Plant & Machinery	0
Balance as at YTD	**3,679**

Property, plant and equipment prior year

2013-14	Land £000s	Buildings £000s	Dwellings £000s	Assets under construction & payment on account £000s	Plant & machinery £000s	Transport equipment £000s	Information technology £000s	Furniture & fittings £000s	Total £000s
Cost or valuation:									
At 1 April 2013	0	0	0	0	0	0	0	0	**0**
Transfers under Modified Absorption Accounting - PCTs & SHAs	13,964	44,526	0	12,168	4,056	160	360	2,474	**77,708**
Transfers under Modified Absorption Accounting - Other Bodies	0	0	0	0	0	0	0	0	**0**
Additions of Assets Under Construction				378					**378**
Additions Purchased	0	2,594	0		506	0	273	1,253	**4,626**
Additions - Non Cash Donations (i.e. Physical Assets)	0	0	0	0	0	0	0	0	**0**
Additions - Purchases from Cash Donations & Government Grants	0	0	0	0	0	0	0	0	**0**
Additions Leased	0	0	0		0	0	0	0	**0**
Reclassifications	(939)	8,927	0	(10,329)	1,100	0	714	528	**(0)**
Reclassifications as Held for Sale and Reversals	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	0	0	0	(6)	0	0	0	**(6)**
Revaluation	315	9,308	0	0	0	0	0	0	**9,623**
Impairments/negative indexation charged to reserves	0	(2,177)	0	0	0	0	0	0	**(2,177)**
Reversal of Impairments charged to reserves	0	0	0	0	0	0	0	0	**0**
Transfers to Foundation Trust	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**
At 31 March 2014	**13,340**	**63,178**	**0**	**2,217**	**5,656**	**160**	**1,347**	**4,254**	**90,152**
Depreciation									
At 1 April 2013	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Reclassifications as Held for Sale and Reversals	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	0	0	0	0	0	0	0	**0**
Revaluation	0	0	0	0	0	0	0	0	**0**
Impairments/negative indexation charged to operating expenses	0	5,760	0	0	84	0	1	0	**5,845**
Reversal of Impairments charged to operating expenses	0	0	0	0	0	0	0	0	**0**
Charged During the Year	0	1,542	0	0	649	23	148	185	**2,546**
Transfers to Foundation Trust	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**
At 31 March 2014	**0**	**7,303**	**0**	**0**	**733**	**23**	**149**	**185**	**8,391**
Net Book Value at 31 March 2014	13,340	55,875	0	2,217	4,923	137	1,198	4,070	**81,760**

2013-14	Land	Buildings	Dwellings	Assets under construction & payment on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Asset financing:									
Owned - Purchased	13,340	54,720	0	2,217	4,645	137	1,198	4,070	**80,327**
Owned - Donated	0	1,155	0	0	278	0	0	0	**1,433**
Owned - Government Granted	0	0	0	0	0	0	0	0	**0**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	**0**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2014	**13,340**	**55,875**	**0**	**2,217**	**4,923**	**137**	**1,198**	**4,070**	**81,760**

Other

In 2014-15, Cirencester League of Friends donated medical equipment for use in the hospital to the value of £55k.

Asset Valuation

The District Valuer undertook a revaluation exercise as at 1 March 2013. The Valuer is RICS (Royal Institute of Chartered Surveyors) qualified and used the Modern Equivalent Asset Valuation (MEAV) technique. It is planned to repeat this exercise in 2015-16.

Asset Lives per Asset Class

Land - Not depreciated
Buildings - between 30-60 years
Plant and Machinery - Between 5 and 15 years
Fixtures and Fittings - Between 5 and 10 years
Transport Equipment - 7 years

As part of the Valuation exercise carried out as at 1 March 2013, the Valuer has made changes to the asset lives of certain buildings in the light of their assessment of remaining useful life of the buildings.

7.2.14 Analysis of impairments and reversals recognised in 2014-15

	2014-15 £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	0
Total charged to Annually Managed Expenditure	**0**
Total Impairments of Property, Plant and Equipment changed to SoCI	**0**
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	**0**
Overall Total Impairments	**0**
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

7.2.15 Intra-Government and other balances

	2014-15		2013-14	
	Current receivables £000s	**Non-Current receivables £000s**	Current payables £000s	Non-Current payables £000s
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**
Prior period:				
Balances with Other Central Government Bodies	4,671	0	3,178	0
Balances with Local Authorities	1,540	0	368	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS Trusts and FTs	1,155	0	2,253	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with Bodies External to Government	0	0	0	0
At 31 March 2014	**7,366**	**0**	**5,798**	**0**

7.2.16 Inventories

	Drugs £000s	**Consum-ables £000s**	**Work in Progress £000s**	**Energy £000s**	**Loan equipment £000s**	**Other £000s**	**Total £000s**
Balance at 1 April 2014	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Additions	0	225	0	0	0	0	**225**
Inventories recognised as an expense in the period	0	0	0	0	0	0	**0**
Write-down of inventories (including losses)	0	0	0	0	0	0	**0**
Reversal of write-down previously taken to SOCI	0	0	0	0	0	0	**0**
Transfers (to) Foundation Trusts	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	**0**
Balance at 31 March 2015	**0**	**225**	**0**	**0**	**0**	**0**	**225**

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 2015-16, a stock control system will be implemented to ensure that control and reporting in this area is improved.

Trade and other receivables

	Current		Non-Current	
	31 Mar 15	31 Mar 14	**31 Mar 15**	31 Mar 14
	£000s	£000s	**£000s**	£000s
NHS receivables - revenue	**6,008**	3,634	**0**	0
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**52**	2,416	**0**	0
Non-NHS receivables - revenue	**4,597**	2,073	**0**	0
Non-NHS receivables - capital	**0**	0	**0**	0
Non-NHS prepayments and accrued income	**11**	552	**0**	0
PDC Dividend prepaid to DH	**0**			
Provision for the impairment of receivables	**(284)**	(538)	**0**	0
VAT	**0**	97	**0**	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income	**0**	0	**0**	0
Interest receivables	**0**	0	**0**	0
Finance lease receivables	**0**	0	**0**	0
Operating lease receivables	**0**	0	**0**	0
Other receivables	**0**	0	**0**	0
Total	**10,384**	**8,234**	**0**	**0**
Total current and non current	**10,384**	**8,234**		
Included in NHS receivables are prepaid pension contributions:	**0**			

The great majority of trade is with Gloucestershire Clinical Commissioning Group. As all CCGs are funded by Government to buy NHS service user care services, no credit scoring of them is considered necessary.

Receivables past their due date but not impaired

	31 Mar 2015	31 Mar 2014
	£000s	£000s
By up to three months	**4.160**	3,419
By three to six months	**686**	114
By more than six months	**644**	317
Total	**5,490**	**3,850**

Provision for impairment of receivables

	2014-15	2013-14
	£000s	£000s
Balance at 1 April 2014	**(538)**	0
Transfers under Modified Absorption Accounting - PCTs & SHAs		0
Transfers under Modified Absorption Accounting - Other Bodies		0
Amount written off during the year	**0**	0
Amount recovered during the year	**0**	0
(Increase)/decrease in receivables impaired	**254**	(538)
Transfer to NHS Foundation Trust	**0**	
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	**0**	0
Balance at 31 March 2015	**(284)**	**(538)**

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

7.2.17 Cash and Cash Equivalents

	31 Mar 2015	31 Mar 2014
	£000s	£000s
Opening balance	**6,717**	0
Net change in year	**(3,389)**	6,717
Closing balance	**3,328**	**6,717**
Made up of		
Cash with Government Banking Service	**3,328**	6,716
Commercial banks	**0**	0
Cash in hand	**0**	1
Liquid deposits with NLF	**0**	0
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**3,328**	**6,717**
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**3,328**	**6,717**
Service users' money held by the Trust, not included above	**0**	**0**

7.2.18 Non-current assets held for sale

	Land	Buildings excluding Dwellings	Dwellings	Assets under construction & payment on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Intangible Assets	Financial Assets	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
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 Foundation Trust	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**
Balance at 1 April 2013	0	0	0	0	0	0	0	0	0	0	**0**
Transfers under Modified Absorption Accounting - PCTs & SHAs	0	0			0				0		**0**
Transfers under Modified Absorption Accounting - Other Bodies	0	0	0	0	0	0	0	0	0	0	**0**
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	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 Foundation Trust	0	0	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from other public sector bodies	0	0	0	0	0	0	0	0	0	0	**0**
Balance at 31 March 2014	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2014	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

The asset being held for sale is land that has been freed up in Tewkesbury following the demolition of the old Hospital. Part of this land was subject to a Heads of Terms passing from the PCT to the Trust as part of its creation. This Heads of Terms lays out the details of the land that is to be sold to local GPs who are consolidating several GP practices onto one campus alongside the new hospital. The land is being sold at the value that it was revalued at by the District Valuer as at 1 March 2013 and so no gain or loss will be made on this transaction.

7.2.19 Trade and other payables

	Current		Non-Current	
	31 Mar 15	31 Mar 14	31 Mar 15	31 Mar 14
	£000s	£000s	£000s	£000s
NHS payables - revenue	**1,151**	2,343	**0**	0
NHS payables - capital	**0**	0	**0**	0
NHS accruals and deferred income	**0**	0	**0**	0
Non-NHS payables - revenue	**3,745**	5,535	**0**	0
Non-NHS payables - capital	**3,937**	2,927	**0**	0
Non-NHS accruals and deferred income	**0**	0	**0**	0
Social security costs	**1,854**	1,767		
PDC Dividend payable to DH	**47**	0		
VAT	**34**	5	**0**	0
Tax	**552**	582		
Payments received on account	**0**	37	**0**	0
Other	**0**	80	**703**	0
Total	**11,320**	**13,276**	**703**	**0**
Total payables (current and non-current)	**12,023**	**13,276**		

Included above:
Other includes the Local Government Pension Liability based on actuarial calculations as at 31 March 2015 which was previously accounted for as a long term provision.

7.2.20 Deferred revenue

	Current		Non-Current	
	31 Mar 15	31 Mar 14	31 Mar 15	31 Mar 14
	£000s	£000s	£000s	£000s
Opening balance at 1 April 2014	**220**	0	**0**	0
Deferred revenue addition	**0**	220	**0**	0
Transfer of deferred revenue	**0**	0	**0**	0
Current deferred income at 31 March 2015	**220**	**220**	**0**	**0**
Total deferred income (current and non-current)	**220**	**220**		

7.2.21 Provisions

	Total	Early Departure Costs	Legal Claims
	£000s	£000s	£000s
Balance at 1 April 2014	**16**	0	16
Arising during the year	**0**	0	0
Utilised during the year	**0**	0	0
Reversed unused	**0**	0	0
Unwinding of discount	**0**	0	0
Change in discount rate	**0**	0	0
Transfers to NHS Foundation Trusts (for Trusts becoming FTs only)	**0**	0	0
Transfers (to)/from other public sector bodies under absorption accounting	**0**	0	0
Balance at 31 March 2015	**16**	**0**	**16**
Expected Timing of Cash Flows:			
No Later than One Year	**16**	0	16

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

As at 31 March 2015	**0**
As at 31 March 2014	**0**

Early departure costs relating to the Local Government Pension Fund liability for staff that TUPEd to the Trust from Gloucestershire County Council are now reported under liabilities greater than 1 year.

7.2.22 Financial Instruments

Financial Risk Management

Financial reporting standard IFRS7 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 (GCCG) and the way that the GCCG 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 board of directors. 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 has no overseas operations. 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 31 March 2015 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 commissioning organisations, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds generated from its operation which generates a small surplus and is not, therefore, exposed to significant liquidity risks.

Financial Assets

	At 'fair value through profit and loss'	Loans and Receivables	Available for Sale	Total
	£000s	£000s	£000s	£000s
Embedded derivatives	0	0	0	**0**
Receivables - NHS	0	6,060	0	**6,060**
Receivables - non-NHS	0	4,608	0	**4,608**
Cash at bank and in hand	0	3,328	0	**3,328**
Other financial assets	0	0	0	**0**
Total at 31 March 2015	**0**	**13,996**	**0**	**13,996**
Embedded derivatives	0	0	0	0
Receivables - NHS	0	3,634	0	3,634
Receivables - non-NHS	0	2,170	0	2,170
Cash at bank and in hand	0	6,717	0	6,717
Other financial assets	0	0	0	0
Total at 31 March 2014	**0**	**12,521**	**0**	**12,521**

Financial Liabilities

	At 'fair value through profit and loss' £000s	Loans and Receivables £000s	Total £000s
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**
Embedded derivatives	0		**0**
NHS payables		2,343	**2,343**
Non-NHS payables		10,816	**10,816**
Other borrowings		0	**0**
PFI & finance lease obligations		0	**0**
Other financial liabilities	0	120	**120**
Total at 31 March 2014	**0**	**13,279**	**13,279**

7.2.23 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.

7.2.24 Losses and Special Payments

The total number of losses cases in 2014-15 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	319	3
Special payments	7,772	7
Total losses and special payments	**8,091**	**10**

The total number of losses cases in 2013-14 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	1,498	5
Special payments	7,765	9
Total losses and special payments	**9,263**	**14**

7.2.25 Financial Performance Targets

Breakeven Performance

	2013-14 £000s	2014-15 £000s
Turnover	108,980	**114,111**
Retained surplus/(deficit) for the year	(3,024)	**1,386**
Adjustment for:		
Timing/non-cash impacting distortions:		
Pre FDL(97)24 agreements	0	**0**
2006/07 PPA (relating to 1997/98 to 2005/06)		
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**
Adjustments for impact of policy change re donated/government grants assets	(165)	**122**
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12	0	**0**
Absorption accounting adjustment	(650)	**0**
Other agreed adjustments	0	**0**
Break-even in-year position	**2,006**	**1,508**
Break-even cumulative position	**2,006**	**3,514**

	2013-14 %	2014-15 %
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**
Break-even cumulative position as a percentage of turnover	1.84	**3.08**

Capital cost absorption rate

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

External financing

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

	2014-15 £000s	2013-14 £000s
External financing limit (EFL)	**3,905**	**3,112**
Cash flow financing	3,389	2,221
Unwinding of Discount Adjustment	0	0
Finance leases taken out in the year	0	0
Other capital receipts	0	0
External financing requirement	**3,389**	**2,221**
Under/(over) spend against EFL	**516**	**891**

Capital resource limit

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

	2014-15 £000s	2013-14 £000s
Gross capital expenditure	3,679	5,007
Less: book value of assets disposed of	0	(193)
Less: capital grants	0	0
Less: donations towards the acquisition of non-current assets	0	(319)
Charge against the capital resource limit	**3,679**	**4,495**
Capital resource limit	4,495	4,495
(Over)/underspend against the capital resource limit	**816**	**0**

7.2.26 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.

	31 March 2015 £000s	31 March 2014 £000s
Third party assets held by the Trust	**1**	**1**

7.3 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 2015 on pages 109 to 146. 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 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 II of the Audit Commission Act 1998. 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 and auditor

As explained more fully in the Statement of Directors' Responsibilities set out on page 153, 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.

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 to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies, we consider the implications for our report.

Opinion on financial statements

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2015 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 prescribed by the Code of Audit Practice 2010 for local NHS bodies

In our opinion:

- the part of the Remuneration Report subject to audit has 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 information given in the Strategic Report and Director's Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Code of Audit Practice 2010 for local NHS bodies requires us to report to you if:

- in our opinion, the Governance Statement does not reflect compliance with the NHS Trust Development Authority guidance;

- any referrals to the Secretary of State have been made under section 19 of the Audit Commission Act 1998; or

- any matters have been reported in the public interest under the Audit Commission Act 1998 in the course of, or at the end of the audit.

Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Respective responsibilities of the Trust and auditor

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

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission requires us to report to you our conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission.

We report if significant matters have come to our attention which prevent us from concluding that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

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

We have undertaken our work in accordance with the Code of Audit Practice 2010 for local NHS bodies, having regard to the guidance on the specified criteria, published by the Audit Commission in October 2014, as to whether the Trust has proper arrangements for:

- securing financial resilience; and

- challenging how it secures economy, efficiency and effectiveness.

The Audit Commission has determined these two criteria as those necessary for us to consider under the Code of Audit Practice 2010 for local NHS bodies 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 2015.

We planned and performed our work in accordance with the Code of Audit Practice 2010 for local NHS bodies. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all material respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Conclusion

On the basis of our work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2014, we are satisfied that, in all material respects, Gloucestershire Care Services NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2015.

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 Audit Commission Act 1998 and the Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission.

Jonathan Brown

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

Chartered Accountants
100 Temple Street
Bristol
BS1 6AG

4 June 2015

8. Trust Statements

Paul Jennings, Chief Executive

Glyn Howells, Director of Finance and Deputy Chief Executive

8.1 Statement of the 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 must give a true and fair view of the state of affairs of Gloucestershire Care Services NHS Trust and of its net resource outturn, application of resources, changes in taxpayers' equity and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is 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 judgements and estimates on a reasonable basis;
- state whether 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.

The Department of Health has designated the Director of Finance as 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 the Accounting Officer is answerable, for keeping proper records and for safeguarding Gloucestershire Care Services HST Trust's assets, are set out in Managing Public Money published by the HM Treasury.

Glyn Howells

Signed: Glyn Howells, Director of Finance and Deputy Chief Executive

Date: 3 June 2015

8.2 Statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust

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 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.

Paul Jennings

Signed: Paul Jennings, Chief Executive

Date: 3 June 2015

8.3 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

Signed: Paul Jennings, Chief Executive

Date: 3 June 2015

Glyn Howells

Signed: Glyn Howells, Director of Finance and Deputy Chief Executive

Date: 3 June 2015

Notes

Notes

Gloucestershire Care Services NHS Trust
Edward Jenner Court
1010 Pioneer Avenue
Gloucester Business Park
Brockworth
Gloucester
Gloucestershire
GL3 4AW

Call: **0300 421 8100**

Email: **contactus@glos-care.nhs.uk**

Visit: **www.glos-care.nhs.uk**

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