Gloucestershire Care Services

NHS Trust

ANNUAL REPORT & ACCOUNTS 2013-14

Understanding you

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1. Statement from the Chair

2013-14 has been a landmark year for us at Gloucestershire Care Services NHS Trust ("the Trust"). Indeed, this was the year that we first began operating as a standalone NHS provider organisation, having previously acted under the authority of NHS Gloucestershire (the former Primary Care Trust).

As such, we have been able in this year, to establish our own identity, and truly begin to consolidate some of our key principles and commitments, namely:

- finalising and promoting our vision and values that explain who we are and what we do, and that more importantly, describe both our aspirations, and the behaviours that service users across Gloucestershire can expect of our staff and services;

- extending the scope of our joined-up services with Gloucestershire County Council, which enable local people to access complete packages of integrated health and social care that treat them as individuals;

- developing our engagements across Gloucestershire, and in particular with our service users, their families and carers, so that we can truly understand and represent everyone's voice;

- focusing upon continuous quality improvement, that puts the needs of service users first and foremost, and that ensures that we provide the very highest quality of care in line not only with national requirements, but also with our own professional and ethical standards.

Each of these four fundamental tenets is summarised below, but is also, I hope, reflected throughout this document, our first official Annual Report and Accounts.

Vision and values

The Trust's vision was ratified at a meeting of the Trust Board on 10 December 2013, following several Board and Board Development sessions throughout the year, 19 consultation events with colleagues across the Trust, discussions with our key professional partners, and a number of engagements with service users and public interest groups via our Your Care, Your Opinion Programme Board.

The conclusion to this activity was the launch of our Trust vision, which is ***"To be the service people rely on to understand them and organise their care around their lives"***.

This is supported by a strapline, "Understanding You".

To fulfil this vision, we seek to deliver a wide range of high quality health and social care services for people of all ages - from health visiting to physiotherapy, podiatry to cardiac nursing, adult social care to telecare - as well as managing the county's seven community hospitals. Together, these services work hard to make sure that local service users receive the right support, from the right people, at the right time.

This year, we also agreed our CORE values, which apply to all colleagues within the Trust, whether they work in integrated health and social care, specialist services, children's services, health improvement teams or corporate services.

These values are to be **Caring, Open, Responsible** and **Effective.**

By now embedding these values within daily practice, we hope to instil a shared sense of consistency and accountability at all levels of the Trust. Specifically, we will be:

- ensuring that all senior staff lead by example in their demonstration of commitment to CORE values and the corresponding behaviours;
- using the CORE values throughout our recruitment processes as a basis for evaluating and selecting potential employees;
- clearly referencing our CORE values within all our training programmes, including induction;
- ensuring that appraisals include consideration of colleagues' adherence to values and behaviours.

Our Values

Caring: feeling and exhibiting compassion and empathy for others

Open: being honest, candid and frank, free from prejudice, limitations and boundaries

Responsible: making, and being accountable for, rational decisions based on sound judgement

Effective: having the intended or expected effect

Joined-Up Services

Integration of local community care with Gloucestershire County Council's adult social care services began in 2010, and is a philosophy that we as an organisation, continue to embrace whole-heartedly. The most visible example of this is our on-going development of Integrated Community Teams, as these really do represent multi-disciplinary professionals from different organisations working together in partnership in order to achieve shared goals and improve outcomes and experiences for service users, carers and families across Gloucestershire. This is described in more detail in section 3.2.1 below.

Equally, our school nurses work closely with the Gloucestershire Healthy Living and Learning team which is commissioned by Gloucestershire County Council, and which comprises a group of teachers who give up one day a week in order to provide dedicated support and advice.

The benefits of this joined-up approach to health and social care are now being recognised nationally, and described most eloquently by Sir Norman Lamb in November 2013, when he said **"If we want to deliver care which meets the needs of the patient, if we truly want person-centred care, if we truly want to protect our NHS for the future, new coordinated ways of working are the only answer. By that I mean health and care services joined together, providing support to people who need it the most. That could be helping an elderly person living independently at her family home through technology. Or it could be helping people who regularly turn to A&E services because of a long term condition to be more supported at home, to prevent them reaching crisis point."**

As a leader in integrated working, I believe that our service users are starting to benefit from the outcomes of joined-up care which are now extolled by the National Collaboration for Integrated Care and Support. These benefits include the following:

- service users will experience care support that is personalised, where they only have to tell their story once, and where they have a single point of contact;
- health and social care response will be coordinated between agencies, meaning that a person's health and social care needs will be assessed together, and that all professionals involved in that person's care will work as part of the same team, sharing knowledge and information;
- the needs of carers and families will be recognised, and they will be given the necessary support to be able to most effectively help the service user;
- people in need of care will be identified and treated at an earlier point in their care journey;
- the information about a service user's condition, care and treatment, will be given directly to the service user so that they can make decisions and choices about the care and support that they will receive.

However, integration with Gloucestershire County Council is just part of the story. In 2013-14, we have also broadened our working relationships with other professional partners and colleagues across Gloucestershire. These include the following:

- we continue to work closely with Gloucestershire Hospitals NHS Foundation Trust, with many of our services (including our sexual health and integrated discharge teams) operating from the acute sites in Gloucester and Cheltenham. This year also saw the launch of the Gloucestershire Respiratory Team, which combines specialists from both acute and community in order to create a single service which can best coordinate and deliver care for service users irrespective of setting;
- our specialist nursing services maintain excellent relationships with national organisations so as to provide outstanding care at a regional level: this includes our work with the British Lung Foundation, Diabetes UK and the British Heart Foundation;
- in 2013-14, we strengthened our partnership with 2gether NHS Foundation Trust, Gloucestershire's mental health service provider, via a number of integrated workstreams including the delivery of dementia services and learning disabilities training for colleagues;
- our health visitors are based at children's centres that are run by Barnardos and Gloucestershire County Council, demonstrating clear partnership working in action: similarly, our specialist health visitor for children and adult services works in association with both Turning Point and specialist midwives from Gloucestershire Hospitals NHS Foundation Trust in respect of parental substance misuse;
- the Trust is aided by eight League of Friends groups and a Friends of Lydney group. Through these groups, volunteers freely give their time and skills to support their local healthcare facility: this includes invaluable financial contribution that has significantly improved the quality and experience of care that the Trust is able to provide to local people.

Throughout the coming years, I anticipate that our commitment to such joint ventures will continue to flourish and grow, and would hope that our pathfinder work in this key area, is suitably recognised.

Public engagement

As Trust Chair, I am especially passionate about the Trust improving its involvement of service users, carers, families and the wider Gloucestershire public, so that we can absolutely reflect local people's needs in the design of our services. In 2013-14, the highlights of our public engagements were as follows:

- members of Gloucestershire Healthwatch, Carers Gloucestershire, the Gloucestershire Association for Voluntary and Community Action (GAVCA), local Leagues of Friends, the Deaf Association, local district and town councillors, and representatives from a range of other community and service user groups, all attended our Your Care, Your Opinion Programme Board, to offer their perspectives and to help us shape our strategies and services for the future;

- we routinely attended meetings of the local Health and Social Care Overview and Scrutiny Committee, keeping them informed about key developments within the Trust;

- colleagues from our Healthy Lifestyle Service made excellent progress in their work with a range of community groups - including the Hindu Elders, Age UK, the Gloucestershire Older Persons Association (GOPA), Active Gloucestershire, local Chinese community groups and the homeless amongst others - to promote health education and awareness across the county;

- the Roses Theatre commemorated more than 150 years of local hospital services in Tewkesbury, by working with the new Tewkesbury Community Hospital, as well as staff from Tewkesbury

Museum and young people from the Roses Youth Theatre, in order to create a modern museum piece and perform a play to celebrate the hospital's place in the local community;

- the walls of the Bowbridge reception and outpatients department at Stroud General Hospital are now lined with a rolling programme of artwork supplied by students from the renowned art department of South Gloucestershire and Stroud College (SGS). Moreover, thanks to work funded by Stroud Hospital's League of Friends, the hospital will continue to ensure a steady stream of images for both visitors and clinicians to enjoy;

- Cirencester Hospital celebrated NHS Sustainability Day (27 March 2014) by inviting local school children and members of the Green Gym (a partnership with UK-wide charity The Conservation Volunteers, Cirencester Town Council, Cotswold Volunteers, the League of Friends and Gardens for All) to plant wildflower meadows at the hospital and nearby Four Acre field.

Quality improvements

Ultimately the above activities, together with all the service developments that we have delivered in 2013-14 and those that we plan for 2014-15 and beyond which you will read about in this Annual Report and Accounts, seek to improve the lives and experiences of the most important group of people - our service users, their families and carers.

We are rightly proud of the advances that we have made in this last year, but equally, we recognise that there are areas in which we can improve, and it is for this reason that we have identified five key priorities for quality improvement in 2014-15. These are articulated in our latest Quality Account which is published on the Trust's website and are:

- to reduce the number of service users who fall in our community hospitals or who acquire a pressure ulcer;

- to improve the experiences of service users, carers and families within our community hospitals;

- to further develop and enhance our Integrated Community Teams;

- to improve our active two-way engagement with service users, carers and families;

- to ensure that we maintain staffing levels as appropriate to the needs of service users.

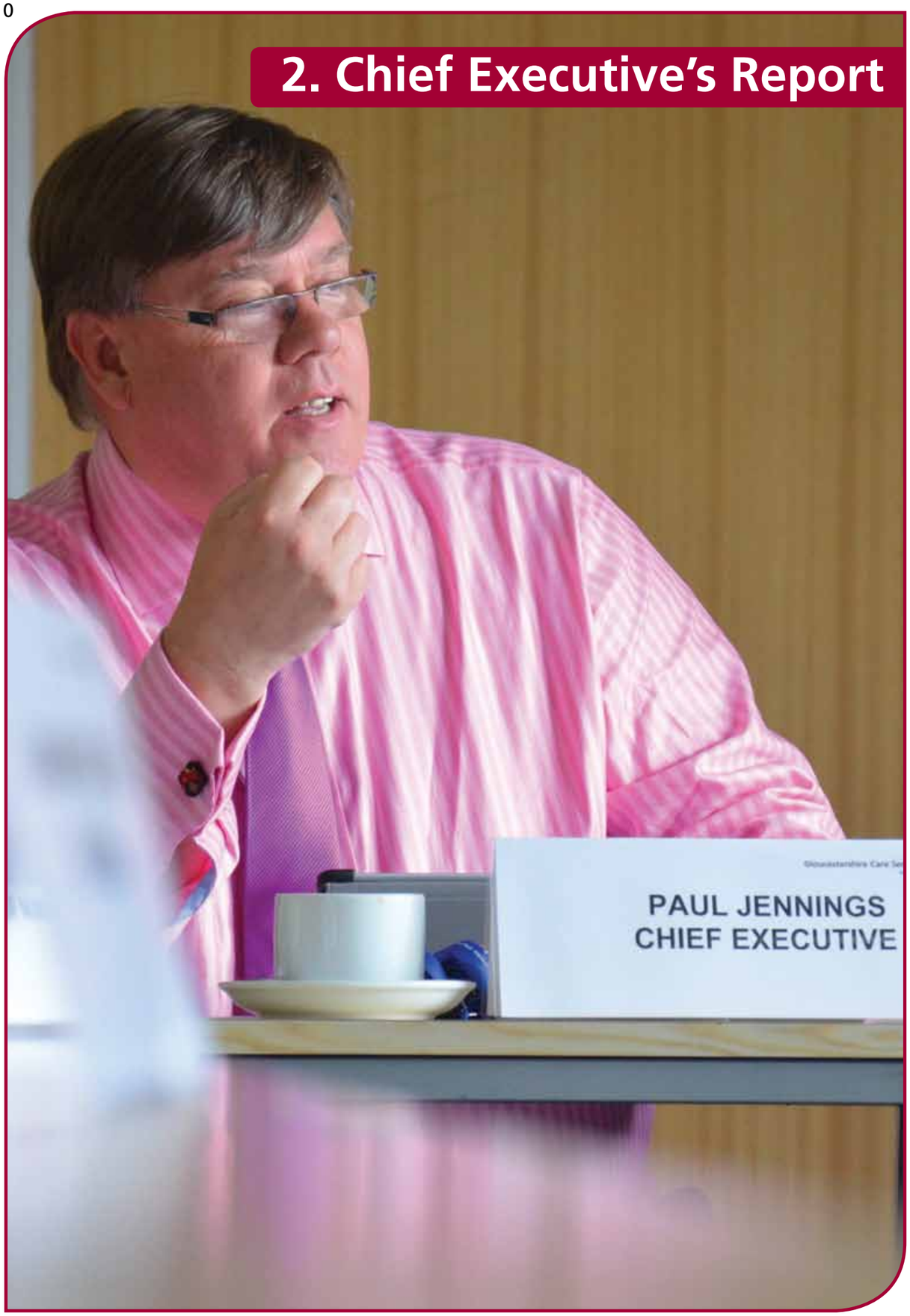
Of course, these five priorities, whilst being exceptionally important to us, are not the sole limit of our ambition. We will also continue to identify and respond to all opportunities to improve our services across the whole of the Trust, so as to be able to deliver well-led services that offer optimum safety, care, compassion, responsiveness and effectiveness, and that allow us to ensure quality outcomes to service users, carers and families across Gloucestershire.

Finally, may I take this opportunity to commend all colleagues on a successful 2013-14. I look forward to another exciting and challenging year ahead!

Ingrid Barker

Ingrid Barker
Chair

2. Chief Executive's Report



For any business or organisation to have made the great strides forward that we have in our first year of operation, would be an achievement. However, given that Gloucestershire Care Services NHS Trust launched at a time of unprecedented financial constraint within the public sector, I believe that the progress that we have made in 2013-14 is exemplary. It is a clear testament to both the commitment and dedication of our workforce, but also the support of service users, carers, families and the wider public across Gloucestershire.

Indeed, I note with satisfaction that we have achieved, if not exceeded, all of the goals that we set ourselves when we were first formed under the terms of the Gloucestershire Care Services National Health Service Trust (Establishment) Order 2013 No. 531. As such, in the past twelve months, we have:

- established the Trust and ensured safe transfer of more than £80million assets from NHS Gloucestershire, the former Primary Care Trust, thereby enabling us to provide consistent and coordinated management of the county's seven community hospitals and a wide range of community health and social care services;
- developed a clear set of strategic objectives, supported by a comprehensive range of Trust-wide strategies which have been ratified by the Trust Board following internal and external consultation;
- delivered against national and local priorities, most ably demonstrated by the Trust's operational performance which showed 93.8% achievement of national targets, and 86.1% achievement of local commissioner targets;
- simplified care pathways, with easy points of access for service users, clear referral routes, and shared assessment and management plans: this is exemplified by the further development of the Trust's Integrated Community Teams which have enabled the Trust to increase its operational flexibility by better integration of working practices, and maximisation of skills, knowledge and resources;
- maintained financial efficiency and sustainability, returning an operating surplus at year end of £2million in line with our plan;
- agreed a clear organisational development framework which aspires to deliver a consistent Trust culture.

Whilst most of these achievements are evident within this Annual Report and Accounts, I would wish to reflect on some of the key milestones of 2013-14 (NB our operational and financial performance in year are detailed at length in sections 3 and 4 below).

Strategic objectives

The Trust has now developed a clear set of strategic objectives, which we believe encapsulate our principles for the next five years. These objectives are to:

- achieve the best possible outcomes for our service users through high quality care;
- understand the needs and views of service users, carers and families so that their opinions inform every aspect of our work;
- provide innovative community services that deliver health and social care together;
- work as a valued partner in local communities and across health and social care;
- support individuals and teams to develop the skills, confidence and ambition to deliver our vision;
- manage public resources wisely to ensure local services remain sustainable and accessible.

To ensure that we remain focused upon these objectives at all times, each of the operating and enabling strategies that we have developed for the Trust contains a number of quality goals, measures and metrics which align to our strategic objectives, and thereby ensure that we will be able to monitor and evaluate our achievements in the coming years.

Key achievements in-year

Some of the highlights of our services in 2013-14 have been as follows:

- in April, we introduced a number of new or improved clinical services within our community hospitals, so as to ensure that they continue to play an invaluable role in their local area. Thus, for example, at Lydney and District Hospital, podiatric surgery was made available, and a new audiology booth was donated by the League of Friends to increase the number of audiology clinics offered to local people;

- in May, the refurbishment at Cirencester Minor Injuries Unit was completed. This included an extension in order to create new waiting rooms, treatment areas, an outside courtyard, a dedicated children's waiting room complete with mural painted by one of the doctors, and new equipment for the treatment areas;

- in August, Dr Peter Carter, the Chief Executive of the Royal College of Nursing visited both Vale Community Hospital and Stroud General Hospital as part of their development programme. Dr Carter's presentation underlined the commitment of all our staff to providing compassionate and high quality care for service users across our sites;

- in September, the Gloucestershire Respiratory Team (pictured below) was launched in partnership with Gloucestershire Hospitals NHS Foundation Trust. Together, we now provide service users with access to a single team that ensures a seamless service whether in hospital or at home, and which seeks to reduce the 1,000+ unplanned hospital admissions to Gloucestershire hospitals as a result of a collection of diseases including chronic bronchitis and emphysema;

- in September, and following a successful trial, we launched the Integrated Discharge Team. This team, based across Gloucestershire Royal Hospital and Cheltenham General Hospital, provides support for people who attend the Emergency Department and who may be more appropriately treated back in the community. The team therefore helps to prevent unnecessary hospital admissions, and ensures people receive the right level of care within their own homes;

- also in September, we opened the George Moore Community Clinic in Bourton-on-the-Water, supporting residents in the north Cotswolds by providing a range of consultant and other specialist-led outpatient clinics, together with therapy services which include podiatry, dental and physiotherapy;

- in October, we opened the new £10million Tewkesbury Community Hospital: facilities include 20 inpatient beds, x-ray, a Minor Injuries Unit, facilities for outpatients clinics, theatre with recovery suite for day case and minor surgical procedures, and an assessment and rehabilitation unit. The hospital continues to be supported by the Tewkesbury Hospital League of Friends, who make an invaluable contribution to the work of the hospital, its staff, volunteers, service users and visitors, by running a range of fund-raising activities and community events;

- in October, the Trust won three Community Hospital Association awards including the overall winner. These awards were made in respect of work to improve the identification and early reporting of pressure ulcers, ensure greater involvement of service users in their own care, and increase the availability of inpatient beds so that GPs can refer service users directly to community hospitals;

- in November, the first team went "live" on our new clinical software system which allows healthcare professionals to access secure, electronic information detailing a service user's contact with health services across a lifetime;

- in November and March, the Care Quality Commission visited first Stroud General Hospital and then Southgate Moorings Dental Clinic as part of their inspection processes: both inspections found nothing but good practice and high levels of care, of which staff should be rightly proud;

- in January, we launched the enhanced Integrated Community Team in Gloucester City. Thus, our regular team of community nurses, reablement workers, physiotherapists, social workers and occupational therapists, can now also offer urgent assessments within an hour, and high intensity care and support at home once an urgent situation has been stabilised;

- in March, staff were able to access the Leading for Quality Care leadership training programme in association with the Royal College of Nursing, that will allow colleagues to develop the skills and behaviours that are required of leaders and managers in health and social care, for now and for the future.

Organisational Development

In 2013-14, we developed 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.

As a key aspect of this strategy, in January 2014, we launched the Listening Into Action programme. This one year initiative is a new way of listening to the views of staff, and using what they say to make our Trust a better place for our service users, and a better place to work.

Examples of the measurable impact of Listening into Action from other Trusts include improved clinical outcomes, reduced waiting times for service users, improvements to the environment, reduced mortality rates, improvements in staff morale, reduced staff sickness levels, and a positive shift in leadership style and culture.

I await the outcomes of our experiences with Listening Into Action, with great interest.

Looking to the future

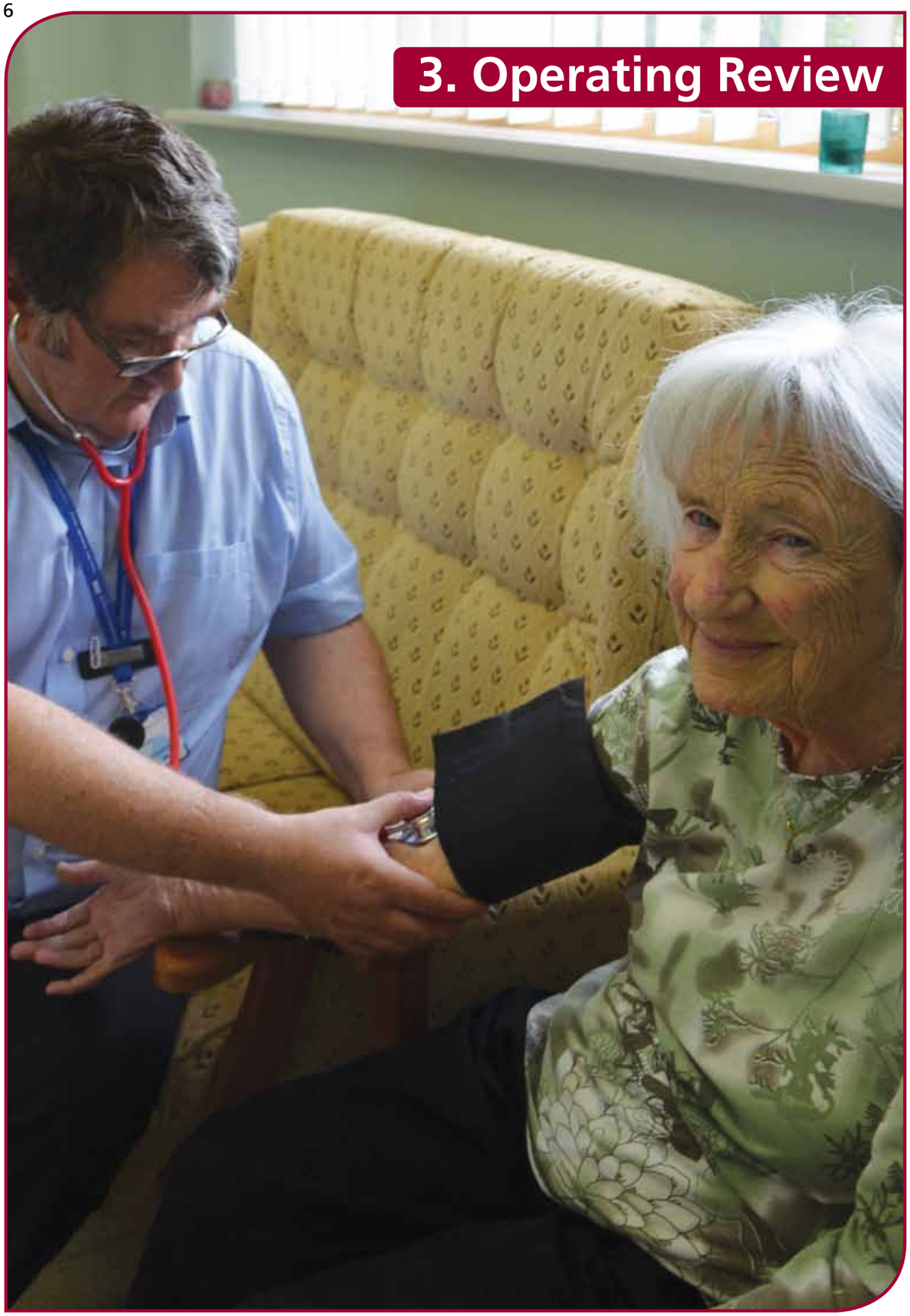
As we move into 2014-15 and beyond, we will be looking to further the reach, scope and quality of our services. You will be able to find details of our ambitions in our Integrated Business Plan which will be available during 2014-15: however, it is clear that our aspirations will include:

- moving towards Foundation Trust status, so that we can create a more responsive organisation that is accountable to local communities through membership;
- further extending the range of our Integrated Community Teams so as to best support service users at home and thereby help them avoid unnecessary hospitalisation: additionally, we will be looking to include mental health services within the Integrated Community Teams' portfolio, enabling resources to be best used to provide sustainable care for local people;
- routinely reviewing the cohort of service users in our community hospitals to ensure that the range of provided care services, and the corresponding staff skills and competencies, are wholly appropriate and safe: we will also explore the possibility of transforming our local hospitals into community health and social care hubs that offer access to a holistic range of health and social care services;
- continuing to work collaboratively with partner organisations across the local health and social care economy in order to deliver truly integrated services.

There are certainly challenging times ahead, but based on last year's experience, I have every confidence that our workforce will rise to the challenge.

Paul Jennings

Paul Jennings
Chief Executive



3. Operating Review

3.1 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.

Gloucestershire's 600,000 people make this the second most populated county in the South West, after Devon. Conversely, the county has the seventh lowest population density in South West, despite the very busy city centres of Gloucester and Cheltenham.

Gloucestershire is widely recognised as one of the healthiest counties in England. Thus, life expectancy statistics (a common indicator of health status) show that the current average lifespan of a man in Gloucestershire is 79.7 years compared to 78.6 years nationally, whilst local women live 83.5 years on average, compared to 82.6 years nationally.

One significant impact of this comparative health in older people, is a corresponding shift in local demographics i.e. by 2035, it is anticipated that there will be a 70% increase in the number of local people aged 65+ which equates to an additional 78,000 individuals (NB the number of people aged 75+ will increase by 90%, and the number of people aged 85+ will increase by 150%).

This compares to only a small increase in the projected number of children and young people aged 0-19 years, and a decline in the number of working age adults.

In summary, by 2035, people aged 65+ will account for 28.4% of the local population, compared to 18.9% in 2010.

Did you know...

The population of Gloucestershire includes:

- 51% women compared to 49% men, reflecting national averages;
- 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 years, reflecting the national trend of later motherhood;
- nearly 92% people classified as White British, with the county's Black/ Ethnic Minority populations being considerably smaller (under 5%) than the national average (14.6%). The travelling community represents 0.9% of the local population;
- more older people than the England average, particularly in the rural districts of the Cotswolds and Forest of Dean;
- a smaller proportion of disabled people than the England average (thus, 16.7% people in Gloucestershire have 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 residents who provide unpaid care to a friend or relative, which is equivalent to the England average.

The significance of this becomes evident when recognising that as the age profile increases, so the number of people living with a long-term illness also grows. Already locally, people can expect to live the last 13-15 years of their lives in poorer health. However, in the next 20 years, these health burdens will increase further: for example, the number of people living with diabetes or stroke will increase by approximately 34%, whilst the number of people living with coronary heart disease, will increase by approximately 50%.

Currently, the three main causes of death locally are equivalent to those experienced nationally i.e. circulatory diseases (heart disease and stroke), cancers, and respiratory diseases. However, compared to national averages, Gloucestershire's incidences of these diseases are relatively low i.e.:

- heart disease and stroke account for 51 in every 100,000 deaths locally, compared to 40 (lowest county nationally) and 116 (highest county nationally);
- cancers account for 98 in every 100,000 deaths locally, compared to 83 (lowest county nationally) and 152 (highest county nationally);
- lung disease accounts for 17 in every 100,000 deaths locally, compared to 14 (lowest county nationally) and 62 (highest county nationally.

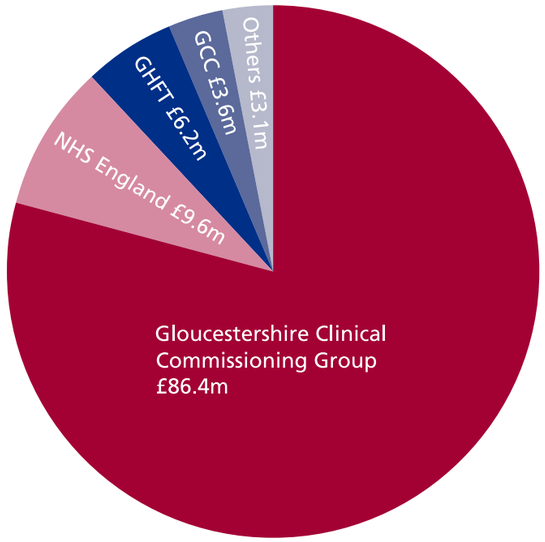
Whilst this data suggests that overall, Gloucestershire has a very healthy population, it is noted that across the county, there are vast differences between communities, and therefore significant local health inequalities. These inequalities result in men in Gloucestershire's most deprived areas living on average 5.3 years fewer than their counterparts in the most affluent areas: similarly, women in more deprived areas live 4.1 years fewer than women in the more affluent areas. In terms of specific disease types, early deaths from coronary heart disease and stroke in the most deprived areas of the county are more than double the rate of those across the whole of Gloucestershire. This is also true for respiratory disease and liver disease, whilst for diabetes, the death rate for people living in the more deprived areas is 150% more than that of the county (NB the Index of Multiple Deprivation shows that that in 2010, 7.4% local residents, or about 45,000 people, lived in neighbourhoods considered to be among the fifth most deprived in England. In contrast, 32.8% Gloucestershire residents lived in the fifth most affluent areas in England).

People's health in Gloucestershire is also affected by lifestyle choices, and to this end, it is noted that locally, 17.8% adults smoke, 23.6% adults drink alcohol at high risk levels, and 24.7% adults are obese, of which an estimated 86.4% are physically inactive.

3.2 Overview of the Trust and its services

As noted above, 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 2,600 people including nursing and allied health professionals, medical and dental colleagues, support services and administrative workers. In addition, the Trust is responsible for the management of 800 colleagues from Gloucestershire County Council, which enables the Trust to provide integrated adult health and social care across the county.

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. This is illustrated in the chart below:



Gloucestershire Clinical Commissioning Group (79.3%)

NHS England (8.8%)

Gloucestershire Hospitals NHS Foundation Trust (5.7%)

Gloucestershire County Council (3.3%)

Others (2.9%)

Total £108.9million (based on 2013-14 income)

The Trust's portfolio of services are 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.

These clinical and care services 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.

Did you know...

In 2013-14, the Trust recorded 1,173,142 individual contacts with service users: this represents almost 2 contacts per person living in Gloucestershire

3.2.1 Integrated Community Teams

The Trust's Integrated Community Teams bring together occupational therapists, social workers, physiotherapists, community nurses and reablement workers into single teams, who work closely with local GPs and provide care to service users at home or close to home. As such, these Integrated Community Teams help people to be in control of their choices, and to maintain their independence safely and appropriately. Teams are focused on:

- reducing unnecessary hospital admissions;
- caring for people where they recover best - at home, wherever possible;
- enabling people to receive care at a time to suit them.

Did you know...

When questioned, 97% 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 2013-14, surveyed 10,246 people on discharge from an inpatient ward or Minor Injuries Unit)

Did you know...

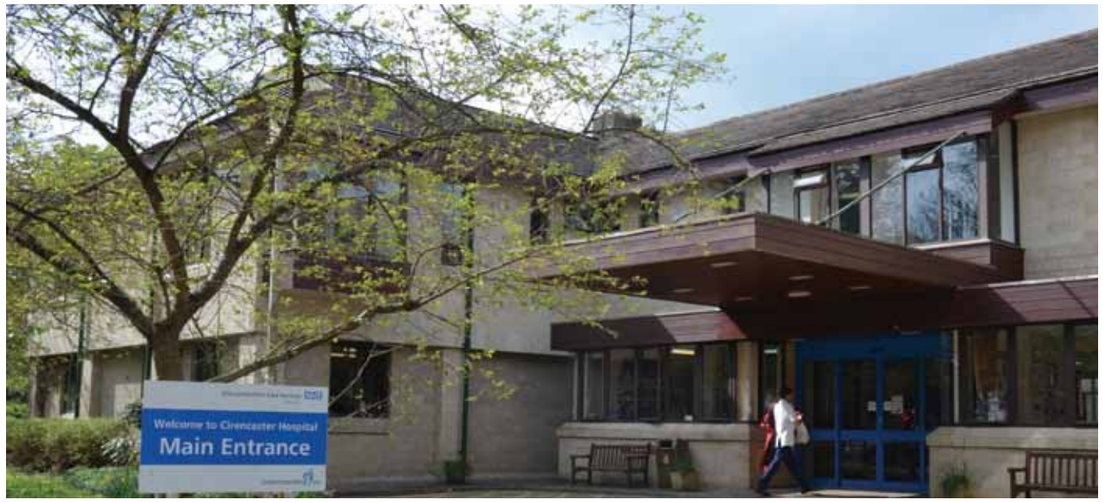
Within the Integrated Community Teams, community nurses alone cared for 26,405 individual service users in 2013-14

Did you know...

In 2013-14, the average age of a service user seen by the Integrated Community Team's community nurses was 77.5 years

A number of the Integrated Community Teams also provide access to:

- a rapid response service, which operates 24 hours a day, 7 days a week, in order to provide assessment in the home for people who require urgent care within an hour and therefore avoid the need for hospitalisation;
- a high intensity service which supports people who have been stabilised by the rapid response team, and which can then provide high levels of support and monitoring during a person's recovery.



3.2.2 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. The community hospitals provide the following services:

- community inpatient rehabilitation and palliative care beds;
- outpatient services including a varied range of nurse led and therapy services and clinics;
- Minor Injuries Units which can save people from unnecessarily attending the Emergency Department, and which can treat a range of less serious conditions and ailments such as sprains, simple fractures that may need x-rays and plastering, simple wounds that may need stitches, minor burns etc;
- Out of Hours GP services including Primary Care Centres;
- X-ray facility managed by Gloucestershire Hospitals NHS Foundation Trust.

Did you know...

- In 2013-14, the Trust recorded over 75,000 inpatient bed days. This means that 93% available beds in community hospitals were occupied every single day
- The average length of stay for 95% service users in a community hospital was 14.5 days in 2013-14
- The average age of people admitted to the Trust's community hospitals in 2013-14 was 83 years
- In 2013-14, the average time from a service user's arrival at a Minor Injuries Unit to their treatment was 23 minutes
- There were 65,620 attendances at the Trust's Minor Injuries Units in 2013-14 with 96.6% service users seen, treated and discharged in under 2 hours, and 99.9% seen, treated and discharged in under 4 hours

3.2.3 Specialist services

The Trust's specialist services provide care in community clinics and in people's own homes. They support service users who are managing 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. Teams also provide education and hands-on training to care homes.

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

- Specialist Nursing: the Trust's specialist nursing teams provide expert care for people needing support with, for example, heart failure, respiratory conditions, tissue viability, motor neurone disease, Parkinson's disease and homeless healthcare.
- Therapy Services: specialist therapists provide services such as podiatry, occupational therapy, physiotherapy services, and speech and language therapy.
- Community Dental Services: the dental service provides NHS dental care for people in Gloucestershire who are unable to access treatment from a general dental practitioner. The team provides routine dental healthcare check-ups, emergency appointments and out of hours emergency dental pain relief. Most of the dental clinics are accessible to all - however, the Trust also provides special care dentistry for those who are unable to access routine dental care due to mobility issues or specific learning needs.
- 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 staff can help with any issues regarding contraception and pregnancy, sexually transmitted infections, sexual assault, emergency contraception and routine testing such as chlamydia testing. 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.

Did you know...

- The Trust's specialist nurses had 16,583 contacts with 7,645 service users in 2013-14: this included 6,693 contacts by the heart failure team, 3,112 contacts by the cardiac rehabilitation team, and 2,061 contacts by the diabetes team
- The podiatry service treated 20,648 service users in 2013-14
- The dentistry service treated 13,495 service users in 2013-14
- In 2013-14, the sexual health service had 40,917 contacts with service users

3.2.4 Children and young people's services

The Trust offers a full range of NHS health services specifically tailored towards the needs of children and young people, and provides a coordinated approach for children's health. The Trust also delivers the universal services of health visiting, school nursing and the neonatal hearing screening service.

Wider services available include home safety checks, and children specific occupational therapy, physiotherapy and speech and language therapy. Children's health services are also available for children in care. The children's respite care team can additionally help children to be cared for in a familiar home environment where their illness is ongoing.

Did you know...

- In 2013-14, the Trust's specialist therapy services treated 9,484 children and young people
- In 2013-14, the Trust's Health Visitors conducted 4,687 two year checks
- 2,925 girls aged 12-13 received all three HPV immunisations during the 2012-13 academic year
- 6,185 reception school year children (93.9%) and 5,400 year 6 school year children (94.2%) had their height and weight measured in the 2012-13 school year as part of the National Childhood Measurement Programme

3.3 The Trust Board

The Trust's first official public Board meeting was held on 9 April 2013. Including this meeting, the Board was convened eight times in 2013-14, attendances at which are noted 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 the Trust Board also serves as the Corporate Trustee for the Trust's charitable funds for which a separate report and accounts is available on the Trust website.

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

In addition to the eight Board meetings, there were also nine Board Development sessions in 2013-14, at which Board members were able to explore issues salient to the organisation's growth in an appropriate and conducive environment. External attendees of these sessions included representatives from Manchester University Business School who delivered a number of coaching modules to Directors so as to facilitate their personal development, and the Chief Executive of the Good Governance Institute who helped the Board to evaluate the Trust's strategic objectives.

In 2013-14, there were a number of changes in the Board composition, which are articulated in section 5.2.2 below. However, as of 31 March 2014, the Trust Board comprised four voting Executive Directors and four 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.

At 31 March 2014, the Trust Board also comprised the Trust Chair and five Non-Executive Directors (one of whom was designate status and therefore non-voting), 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 3.4 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. Notwithstanding, it hereby noted that in 2013-14, membership of the Audit and Assurance Committee consisted of all the Trust's Non-Executive Directors, and was additionally attended as required by Trust colleagues including the Chief Executive, the Director of Finance and the Trust Chair.

It is also noted that in 2013-14, none of the Trust's Executive or Non-Executive Directors had any material interests in organisations that either directly or indirectly were likely to do business with the Trust. Furthermore, all of the Directors submitted that to the best of their knowledge, there was no relevant information relating to the organisation's operations or finances that was not shared with the Trust's auditors. The Directors also confirmed that they were familiar with all necessary organisational details, and had established that the auditors were similarly familiar with those details.

3.4 Board members

As of 31 March 2014, 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.

Ingrid serves 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 joined the Trust in summer 2013, initially as interim Chief Executive. His appointment was made substantive on 6 January 2014.

Previously, Paul had already worked in the NHS for over 30 years in a wide range of senior roles. Most recently, Paul was interim chief executive at Birmingham and Solihull Mental Health NHS Foundation Trust. He has a long history of managing community services, including learning disabilities and mental health.

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 that 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 also 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 is Non-Executive Chair of Welcome CIC, which focuses on addressing the health issues of Black and Minority communities and migrants.

Glyn Howells - Director of Finance (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. Glyn 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 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 three days a week. She is a member of the Gloucestershire Local Medical Committee and was the vice-chair of the Professional Executive Committee of NHS Gloucestershire before joining the Trust in 2012. She is also the Chief Executive of Gloucester GP Consortium.

Jo has a special interest in urgent and emergency care. She has an MA in medical law and ethics, and an interest in medico-legal issues and risk management.

Liz Fenton - Director of Nursing (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.

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.

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.

Rob serves as Chair of the Trust's Audit and Assurance Committee.

Christopher Creswick - Non-Executive Director (voting)

Christopher was formally a Non-Executive Director of Gloucestershire Ambulance Trust 1993-96, Chairman of Gloucestershire Health Authority 1996-2002, Acting Chair of North Somerset PCT 2005-06, and Chairman of Weston Area Health NHS Trust 2007-13. He is Trustee and Chairman of Crossroads Care, Forest of Dean and Herefordshire, and a Trustee of the Independence Trust.

Christopher joined the Trust in late November 2013. In 2014-15, he will chair the Trust's Human Resources and Organisational Development Committee.

Susan Mead - Non-Executive Director (voting)

Susan was formally 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.

Susan's appointment was announced on 8 November 2013. In 2014-15, she will chair the Trust's Quality and Clinical Governance Committee.

Joanna Scott - Non-Executive Director (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 Masters' 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 will chair the Trust's Communications and Public Affairs Steering Group.

Nicola Strother Smith - Non-Executive Director (designate, non-voting)

Nicola is Deputy Director of Transition and Delivery in the NHS Improving Quality Delivery Team. She was previously National Director for NHS Diabetes and Kidney Care, and Cancer Network Director for the 3 Counties Cancer Network. Nicola joined the Trust in late November 2013. In 2014-15, she will chair the Trust's Charitable Funds Committee.

Susan Field - Director of Adult Services (non-voting)

Susan holds both managerial and clinical (nursing and mental health) qualifications. Her role at the Trust includes leading and managing a range of services, for which she embraces partnership working with Gloucestershire County Council and others in providing community-focused care. Her responsibilites include the Trust's community hospitals, reablement, community nursing and therapy services, as well as a range of specialist services such as heart failure, telehealth, tuberculosis and palliative care.

Susan has considerable Board level experience, with the majority of this being in Bristol prior to her move to Gloucestershire.

Candace Plouffe - Director of Children and Young People's Services and Countywide Services (non-voting)

Candace qualified in 1986 as an occupational therapist, and has specialised in Children and Young People's services since graduation. Candace moved to Gloucestershire PCT in 2004 to be Head of Children's Occupational Therapy, and was appointed as General Manager of Children and Young People's services in March 2012.

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.

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

Tina Ricketts - Head of HR (non-voting)

Throughout her career, 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 Employee Excellence in 2011.

Tina has successfully 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 Local Delivery Partnership.

Simeon Foreman - Board Secretary (non-voting)

Simeon's NHS career began in 2000 following roles in the finance and education sectors. Since that time, he has worked for a range of different NHS organisations and the Department of Health on areas that include risk management, governance, research and development, project management, and emergency planning.

Simeon joined the Trust in June 2013 from NHS England, where he had worked on medical revalidation, GP appraisal and primary care performance management. Simeon had considerable knowledge of the health and care issues affecting Gloucestershire, having previously held the role of Company Secretary at Gloucestershire Primary Care Trust.

In attendance

In addition, Board meetings in 2013-14 were attended by Tony Hicks, Chairman of Gloucestershire County Council, and Duncan Jordan, Chief Operating Officer at Gloucestershire County Council.

3.5 Operational performance 2013-14

3.5.1 Performance against targets 2013-14

Throughout 2013-14, the Trust achieved an excellent quality of care delivery, exemplified by the activity illustrated in tables 1-3 below. This shows 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 2013-14 is as follows:

Table 1: Overall Trust performance 2013-14

Target	Red	Amber	Green	n/a*	Total
National	1	1	30	0	32
Local	3	1	31	1	36
Total	**4**	**2**	**61**	**1**	**68**

Red	Amber	Green	n/a*
3.1%	3.1%	93.8%	0%
8.3%	2.8%	86.1%	2.8%
5.9%	2.9%	89.7%	1.5%

* for further detail, please refer to section 3.5.2 below

Specifically, these relate to the indicators below:

Table 2: Trust performance against national indicators 2013-14

National Indicator		Target	2013-14
UNSCHEDULED CARE			
Primary Care Centres			
1	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%	**99%**
2	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	95%	**96%**
3	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%	**99%**
Minor Injuries Units			
4	Percentage of service users who were seen, treated and discharged within 4 hours by a Minor Injuries Unit	95%	**99.8%**
5	Average time spent by a service user in a Minor Injuries Unit from arrival to departure	Less than 4 hours	**Average 1 hour 49 minutes**
6	Time before initial assessment for those arriving at a Minor Injuries Unit by ambulance	Less than 15 minutes	**Average 10 minutes**
7	Average time to treatment in a Minor Injuries Unit	Less than 60 minutes	**Average 23 minutes**
8	Percentage of service users who re-attended a Minor Injuries Unit within 7 days of discharge where the second visit was unplanned and for the same minor injury / illness as the original visit	Less than 5%	**4%**
9	Percentage of service users who left a Minor Injuries Unit without being seen	Less than 5%	**0.6%**
SEXUAL HEALTH			
10	Number of young adults (15-24 year olds) who had a positive screening for chlamydia	831	**873**
CHILDREN'S SERVICES			
HPV Immunisations			
11	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 2013-14 school year)	3rd immunisation 40% (at the end of March 2014)	**41.4%**
		2nd immunisation 90%	**90.8%**
		1st immunisation 90%	**92.4%**
National Childhood Measurement Programme			
12	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 2013-14 school year)	85%	**98.6%**
13	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 2013-14 school year)	85%	**96.9%**

National Indicator		Target	2013-14
Newborn Hearing Screening			
14	Percentage of newborn children whose hearing was checked	95%	**100%**
15	Percentage of well newborn children whose hearing was checked within their first 5 weeks of life	More than 95%	**98.8%**
Newborn Bloodspot Screening			
16	Percentage of newborn children whose blood was screened for rare but serious disease	95%	**99.9%**
17	Percentage of newborn children whose blood screening results were available by the child's 17th day of life	95%	**96.8%**
Health Visitors			
18	Number of full-time Health Visitors employed by the Trust (for more information, see section 3.5.6 below)	106.00	**101.29**
QUALITY			
Friends and Family Test			
19	Number of service users who completed the Friends and Family Test on discharge from an inpatient ward or Minor Injuries Unit	15%	**15%**
20	Net Promoter Score which indicates the overall level of satisfaction with the service received at either an inpatient ward or Minor Injuries Unit	+75	**+83**
Infection Control			
21	Number of cases of post 48 hour Clostridium difficile infection that were acquired within community hospitals (for more information, see section 3.5.4 below)	18	**19**
22	Number of cases of MRSA infection	0	**0**
Diagnostic Test Waiting Times			
23	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			
24	Number of urgent operations that were cancelled twice	0	**0**
25	Number of service users who had their operation cancelled for non-clinical reasons and who were not offered another binding date within 28 days	0	**0**
Mixed Sex Accommodation			
26	Number of non-exempt instances whereby a service user was not able to sleep in a same sex ward or bay	0	**0**
Data Quality			
27	Percentage of inpatient records that had a valid ethnic code recorded for the service user	98.2%	**100%**
28	Percentage of inpatient records that had a valid NHS number recorded for the service user	99.1%	**99.9%**
29	Percentage of inpatient records that had a GP practice code recorded	99.9%	**100%**
30	Percentage of Minor Injuries Unit attendances that had a valid ethnic code recorded for the service user	87.6%	**97.2%**
31	Percentage of Minor Injuries Unit attendances that had a valid NHS number recorded for the service user	94.9%	**97.5%**
32	Percentage of Minor Injuries Unit attendances that had a GP practice code recorded	99.7%	**100%**

Table 3: Trust performance against local indicators 2013-14

	Local Indicator	Target	2013-14
REFERRAL TO TREATMENT			
Adult Community And Therapy Services			
1	Percentage of service users seen and treated by the speech and language therapy service within 8 weeks of referral	95%	**99%**
2	Percentage of service users seen and treated by the podiatry service within 8 weeks of referral	95%	**97%**
3	Percentage of service users seen and treated by the occupational therapy services within 8 weeks of referral	95%	**100%**
4	Percentage of service users seen and treated by the 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%**
Specialist Nurses			
6	Percentage of service users seen and treated by the Parkinson's nursing service within 8 weeks of referral	95%	**100%**
7	Percentage of service users seen and treated by the diabetic nursing service within 8 weeks of referral	95%	**99%**
8	Percentage of service users seen and treated by the bone health service within 8 weeks of referral	95%	**95%**
9	Percentage of service users seen and treated by the musculoskeletal service within 8 weeks of referral	95%	**98%**
Children's Services			
10	Percentage of service users seen and treated by the children's speech and language therapy service within 8 weeks of referral	95%	**99%**
11	Percentage of service users seen and treated by the children's physiotherapy service within 8 weeks of referral	95%	**98%**
12	Percentage of service users seen and treated by the children's occupational therapy service within 8 weeks of referral	95%	**99%**
Sexual Health			
13	Percentage of service users seen and treated by the contraception service within 8 weeks of referral	95%	**99%**
14	Percentage of service users seen and treated by the HIV service within 8 weeks of referral	95%	**100%**
15	Percentage of service users seen and treated by the psychosexual service within 8 weeks of referral (for more information, see section 3.5.7 below)	95%	**83%**
MUSCULOSKELETAL SERVICE			
16	Percentage of service users seen and then referred onto secondary care	Less than 30%	**5%**
17	Percentage of service users who were referred onto secondary care within 2 days of the decision to refer	100%	**100%**
18	Average time between routine service users being referred and seen	4 weeks	**3.2 weeks**
19	Average time between urgent service users being referred and seen	2 weeks	**1.6 weeks**

	Local Indicator	Target	2013-14
SINGLE POINT OF CLINICAL ACCESS (SPCA)			
20	Percentage of abandoned calls (for more information, see section 3.5.5 below)	Less than 5%	**5.2%**
21	Percentage of calls resolved with an agreed onwards plan within 20 minutes	95%	**96%**
COMMUNITY HOSPITALS			
22	Average length of stay in an inpatient ward (applies to 95% service users)	15.3 days	**14.5 days**
23	Percentage of direct admissions to community hospitals	50%	**50%**
24	Average number of discharges from a community hospital that were delayed even though the service user was medically fit	10	**5**
EARLY SUPPORTED DISCHARGE SERVICE			
25	Percentage of new service users assessed within 2 days of notification	95%	**100%**
26	Percentage of service users discharged within 6 weeks	95%	**100%**
SEXUAL HEALTH			
27	Percentage of terminations carried out within 10 weeks of gestation	70%	**83%**
CHILDREN'S SERVICES			
28	Percentage of children for whom breastfeeding status was recorded	95%	**97%**
29	Percentage of mothers breastfeeding at 2 weeks who continue onto 6-8 weeks	80%	**87%**
30	Implementation of UNICEF baby friendly initiative	Level 2	**Level 2**
QUALITY			
Pressure Ulcers			
31	Number of pressure ulcers acquired by service users whilst in the community and under the care of the Trust	32	**24**
32	Number of pressure ulcers acquired by service users whilst in a community hospital (for more information, see section 3.5.3 below)	108	**146**
33	Total number of acquired pressure ulcers (for more information, see section 3.5.3 below)	140	**170**
Falls			
34	Reduction in the total number of service user falls in community hospitals (for more information, see section 3.5.2 below)	1,020	**1,099**
35	Percentage of falls resulting in serious harm	Less than 1%	**0.0%**
Venous Thromboembolisms (VTEs)			
36	Percentage of relevant inpatients who received a risk assessment for venous thromboembolism	90%	**97.0%**

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.

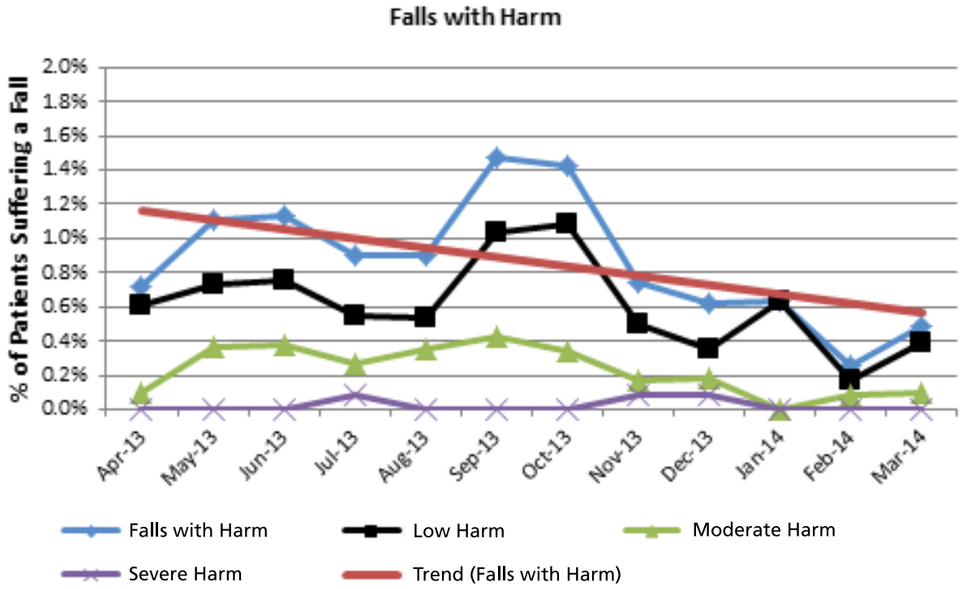
Given the above performance, there are a number of key areas which the Trust would wish to highlight, where it has achieved a result below its targeted level. Actions to improve performance in 2014-15 are given in sections 3.5.2 - 3.5.7 below.

3.5.2 Falls

Falls can be common for older people, and can often have significant consequences including longer stays in hospital, associated healthcare infections and complications, increased morbidity and, in extreme circumstances, increased risk of mortality.

To provide improved care in 2013-14, the Trust sought to ensure that 98% service users received a falls risk assessment and if indicated, a care plan, within 24 hours of their admission to a community hospital. Service users were also given use of appropriate equipment such as hi-low beds to help prevent falls. Staff explained the risks of falls to service users as well as to their family members and carers where possible, to enhance their understanding and enable them to support risk reduction activities.

As a result of the above, the Trust saw an 8% reduction in the number of falls in community hospitals in 2013-14, although it failed to reach its original target (NB the Trust's performance in 2013-14 as shown in table 3 above is not rated red, amber or green, given that the measure was adjusted in-year). Notwithstanding, the number of falls that resulted in harm decreased significantly over 2013-14, despite a temporary increase in the middle of the year as new processes were developed and implemented. This is illustrated in the chart below.

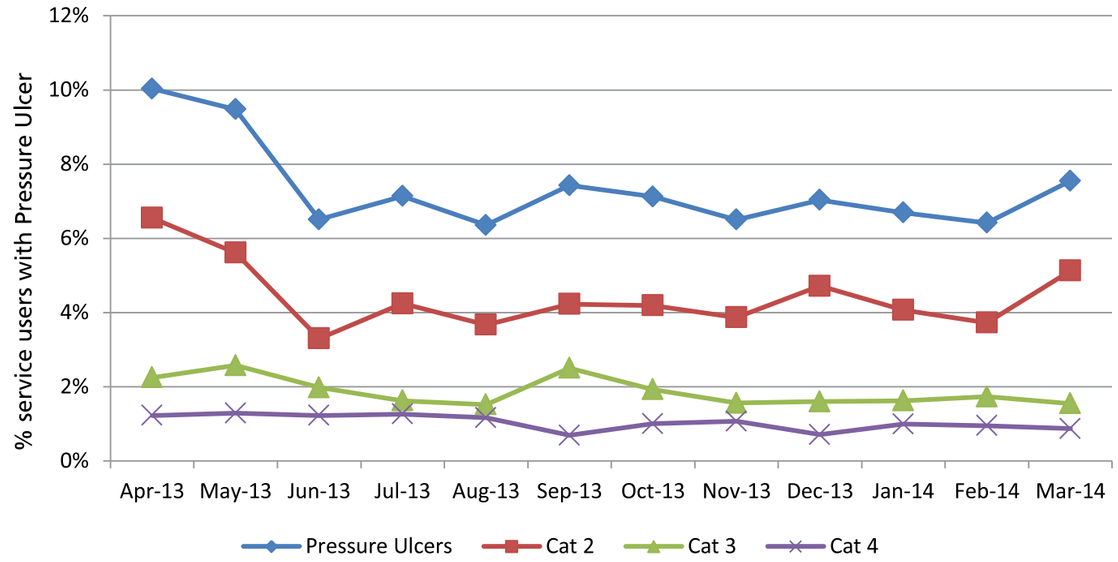


In 2014-15, the Trust will continue to embed these working practices, and will also ensure that by means of better training, all staff are working to the same standard across the organisation. Similarly, the Trust will audit the effectiveness of its nutrition and hydration programme in the support of service users who are at increased risk of a fall, given that persistent dehydration can lead to dizziness which may result in falling.

3.5.3 Pressure ulcers

The development of avoidable pressure ulcers is widely recognised as an indicator of poor care. Pressures ulcers can lead to considerable pain and distress for service users. More importantly, complications from the most serious pressure ulcers (grade 3 or 4) can occasionally be life-threatening.

In 2013-14, the Trust improved its pressure ulcer risk assessment processes, and sought to improve staff's knowledge and awareness of pressure damage so that concerns could be more readily identified and preventative actions taken. As a result, the Trust achieved a 17% reduction in acquired avoidable pressure ulcers. Additionally, the Trust significantly decreased the number of pressure ulcers with a high degree of harm (grade 3 and 4) compared to the previous year: thus, there were five (two grade 3 and three grade 4) pressure ulcers in 2013-14, compared to eight (seven grade 3 and one grade 4) pressure ulcers in 2012-13.



The Trust therefore legitimately believes that the red rating of its performance as given in table 3 above, is a result of inconsistencies in grading and reporting of pressure ulcers, rather than poor quality of care. Notwithstanding, in 2014-15, to further reduce the occurrence of pressure ulcers, the Trust will ensure that a specialist tissue viability nurse reviews and reports against all acquired grade 2, 3 or 4 pressure ulcers, and that any grade 3 or 4 pressure ulcer that is acquired within a community hospital is automatically classified as a serious incident which requires formal investigation. The Trust will additionally use a nationally approved tool so as to undertake more consistent risk assessment, interventions and evaluation of service users who are at risk. This approach has been validated by the Trust winning an award from the Community Hospitals Association for its innovative approach to identifying and managing risks of pressure ulcers.

3.5.4 Infection control

In 2013-14, the Trust breached its Clostridium difficile tolerance by one case, as there were 19 cases diagnosed in year. This represents an increase in the number of cases and rate per 1,000 occupied bed days in comparison to 2012-13 as shown in the table below:

Table 4: Incidence of C diff 2012-13 compared to 2013-14

Hospital	2012-13 number of cases	2012-13 rate per 1,000 bed days	2013-14 number of cases	2013-14 rate per 1,000 bed days
Dilke	2	0.22	5	0.54
Cirencester	2	0.10	4	0.20
Lydney and District	2	0.29	3	0.43
Stroud General	3	0.20	3	0.20
North Cotswolds	4	0.54	2	0.27
Tewkesbury	3	0.18	1	0.14
Vale	0	0.00	1	0.14
Total	**16**	**0.19**	**19**	**0.25**

To ensure that the Trust meets its C. diff target in 2014-15 (which is increased to 21 cases, based upon new national guidelines issued by the Department of Health), there will be clear adherence to a newly-developed action plan that seeks to raise staff awareness, and provide better education and understanding.

Did you know...

In respect of infection control, it is noted that the Trust reported no cases of either E. coli or MRSA bacteraemia in 2013-14

3.5.5 Single Point of Clinical Access

The Trust's Single Point of Clinical Access receives telephone calls from GPs across the county, and provides them with support, guidance, assistance and signposting to appropriate community services. In 2013-14, the service handled 28,283 calls, but reported a failure against target as 42 calls were handled outside of the agreed threshold. To ensure improvement, the service has already introduced a number of telephony system changes, and is pleased to report that performance has been to standard since these changes came into effect.

3.5.6 Call to Action (Health Visitors)

The Trust is required by the NHS England Area Team to increase the number of health visitors employed, and missed its target in 2013-14 by 4.71 whole-time equivalent posts. However, at time of writing, 42 new health visitors are undergoing training in order to meet the need for an additional 22 employees in 2014-15.

3.5.7 Psychosexual Medicine

In 2013-14, the Trust did not achieve the standard of 95% service users receiving treatment by the Psychosexual Medicine service within eight weeks of referral. To address this, updated processes for triage and administration have been implemented by the service, which have thus far, ensured that all referrals are seen and treated within the requisite timescales.

3.6 Workforce Review

3.6.1 Workforce composition

The Trust's workforce in 2013-14 comprised an average 2,004.20 whole time equivalent posts each month, with an average headcount of 2,623 workers excluding bank staff. Staff were allocated across the various professional disciplines as per the below:

Table 5: Workforce composition 2013-14

Staff Group	WTE	Headcount
Nursing, Midwifery & Health Visiting Staff	973.78	1,263
Allied Health Professional	451.88	582
Administration & Estates Staff	416.69	525
Ancillary Staff	101.20	157
Medical & Dental Staff	34.15	67
Nursing, Midwifery & Health Visiting Learners	26.50	28
Total	**2,004.20**	**2,622**

Further details relating to the composition of this workforce (based upon research conducted at 31 December 2013) identified that:

- 87% colleagues provide clinical care services, and 13% deliver corporate services which nevertheless includes a significant number of frontline colleagues such as Hotel Services staff;
- less than 1.5% are medical staff, although their combined salaries equate to £2.7million of pay costs;
- 42% colleagues are aged 50+, with only 10% aged under 30 years;
- 97% colleagues originate from a white, British background, with 3% from black and minority ethnic groups;
- 1% colleagues have declared that they have a disability, 45% have not declared and 54% have confirmed they are not disabled;
- 39% colleagues are employed full-time: moreover, of the 61% who are part-time, 55% work less than 24 hours per week;
- 57% colleagues are at the top of their Agenda for Change pay band and are therefore not eligible for any further pay increments.

3.6.2 Workforce performance 2013-14

The key indicators, targets and current performance relating to the Trust's workforce are summarised in the table below.

Table 6: Workforce performance

Indicator	Target	Performance
Sickness absence	3%	**4.28%**
Mandatory Training - Fire / Health & Safety	90%	**92.81%**
Mandatory Training - Equality & Diversity	90%	**74.47%**
Mandatory Training - Information Governance	90%	**67.69%**
Mandatory Training - Conflict Resolution	90%	**68.47%**
Appraisal completion	95%	**80.45%**
Turnover rate	**7-17%**	**11.71%**

Further details regarding these metrics are given in sections 3.6.3 - 3.6.5 below.

3.6.3 Sickness absence

In 2013-14, sickness absence levels have increased slightly to 4.28% from 4.22% in 2012-13. Although this is in excess of the Trust target of 3%, it does nevertheless compare favourably with other comparable community trusts, who have an average sickness absence rate of 4.83%.

It is noted that the top 2 causes of absence as recorded by the Trust in 2013-14 were anxiety / stress / depression / other psychiatric illness (25%) and back / musculoskeletal pain (9%).

The table below shows sickness absence by base of employment in 2013-14, and illustrates variance between areas. Relevant managers are working with HR and colleagues to address this performance.

Table 7: Sickness absence by profession and locality

	Locality									Average Sickness % Rate
	Corporate	Cheltenham and Cotswolds	Forest and Tewkesbury	Gloucester and Stroud	Management	Specialist Nursing	Unscheduled Care and Capacity	Children, Family and Young People	Countywide	
Average Sickness % Rate	**4.46**	**4.84**	**4.37**	**5.03**	**0.26**	**3.22**	**3.24**	**3.38**	**4.11**	**4.28**

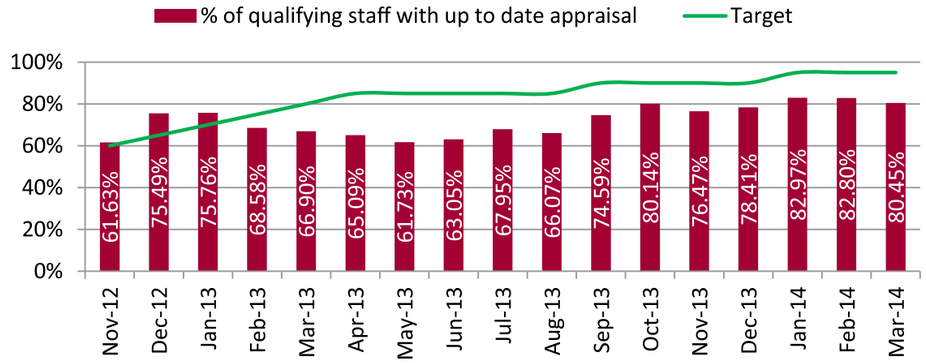
3.6.4 Staff training

The Trust has noted that all of its mandatory training programmes have failed to achieve target attendances in 2013-14, with the exception of the Fire and Health and Safety training. In 2014-15, the Trust will be reassessing how all training can be delivered in ways that are more efficient and appropriate to the workforce - this includes a greater emphasis on e-learning, given that the Trust's workforce is increasingly mobile.

3.6.5 Staff appraisals

Although the Trust's appraisal completion rates compare favourably with other comparable community Trusts (benchmark average of 76.39%, compared to the Trust's 80.45%), the Trust nevertheless did not achieve its target in 2013-14.

The chart below provides further insight into appraisal completions over the year:



To improve performance in 2014-15, work will continue with line managers whose team is below target. Additionally, the Human Resources and Training team will provide further support to managers by way of specific advice and guidance relating to conducting appraisals and managing the introduction of the Pay Progression Policy which requires staff to complete appraisals and remain up-to-date with all mandatory training in order to qualify for pay increments.

3.6.6 Employee engagement

The Trust operates 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 offers a forum for employee consultation. The Chief Executive, Director of Adult Services, Director of Children and Young People's Services and Countywide Services, and the Head 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 ensures continued staff engagement through its network of Staff Forums which are held in each locality. Thereafter, staff from each of the Forums are elected by their colleagues to sit on the Trust's Staff Council which is chaired by a Non-Executive Director. The terms of reference for both the Staff Forums and Staff Council have been determined by staff in order to encourage as much participation as possible.

3.6.7 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 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 is developing a full set of equalities objectives, which will be based on priorities identified in the Annual Equality Report and discussions with service users, local communities, and colleagues. These will be published in July 2014, and will thereafter be supported by a detailed action plan highlighting expected outcomes, metrics, responsibilities and milestones for implementation;

- as an integral part of Trust business planning and service redesign, equality impact assessments are completed 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;

- sound governance is maintained via the Equalities Steering Group which is attended by executive-level membership and a dedicated Non-Executive Director who has explicit responsibility for championing equality. This Group oversees the strategic management of equalities practice, and ensures that Trust policies, including the Equality and Human Rights Policy, are appropriately observed across the Trust;

- the Trust's recruitment and selection process is as fair as possible. This includes use of the NHS Jobs system for recruitment, which ensures that personal details are removed for the shortlisting stage: the Trust also operates a Guaranteed Interview Scheme, so that people with disabilities are assured of an interview as long as they meet the minimum criteria. In recognition of this work, the Trust holds Two Ticks and Mindful Employer status;

- all employees receive Equality, Diversity and Human Rights training as part of their induction, and equality training updates are mandatory every three years: however, the Trust acknowledges some weakness in this area, and will be seeking to strengthen this training in 2014-15, including making equality training updates mandatory on an annual basis;

- the Trust seeks to involve local communities in decisions which 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 (see section 1 above).

Specific equalities activities in respect of disabled employees and equal opportunities are detailed in sections 3.6.8 and 3.6.9 below. For further information, please also refer to section 5.6.2 below which forms part of the Annual Governance Statement.

3.6.8 Disabled employees

The Trust's Equality and Human Rights Policy, ratified in October 2013, 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 the situation where a provision, criterion or practice puts 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 8: Register of disabled people throughout the recruitment process

	Applied	Shortlisted	Appointed
Disability	4%	4%	4%
No disability	95%	95%	95%
Undisclosed	1%	1%	1%

The Trust currently reports that 1.28% of its workforce are people with a disability. However, the disability status for almost half of the Trust's staff is unknown, as many colleagues have chosen not to declare their status. This means that the Trust is currently unable to conduct detailed analysis of 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:

- 12% staff declared a disability in an anonymous 2011 staff survey (and only 6% declined to declare their disability status);

- 16.7% people in Gloucestershire have a limiting long-term illness or disability, which if extrapolated to the organisation's workforce, would suggest that over 430 people employed by the Trust have a disability.

3.6.9 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, ratified in October 2013, 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's Learning and Development teams ensure that equal opportunities monitoring information is published.

It is noted that as of 31 March 2014, the following gender distributions applied within the Trust:

- 64.3% Trust Directors (both Executive and Non-Executive) were female, and 35.7% were male;

- 83.3% senior managers (band 8a to 8c) were female, and 16.7% were male;

- 91.8% all Trust colleagues were female, and 8.2% were male.

3.7 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 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 by Sir David Nicholson in his letter to NHS Chief Executives and Finance Directors dated 20 May 2008 as illustrated by the table below:

Table 9: Classification of information breaches

0	1	2	3	4	5
No significant reflection on any individual or body. Media interest very unlikely	Damage to an individual's reputation. Possible media interest e.g. celebrity involved. Potentially serious breach. Less than 5 people affected or risk assessed as low e.g. files were encrypted	Damage to a team's reputation. Some local media interest that may not go public. Serious potential breach and risk assessed high e.g. encrypted clinical records lost. Up to 20 people affected	Damage to a service's reputation. Low-key local media coverage	Damage to an organisation's reputation. Local media coverage	Damage to NHS reputation. National media coverage
Minor breach of confidentiality. Only a single individual affected			Serious breach of confidentiality e.g. up to 100 people affected	Serious breach with either particularly sensitivity e.g. sexual health details, or up to 1,000 people affected	Serious breach with potential for ID theft or over 1,000 people affected

In 2013-14, the Trust recorded seven incidents that involved loss of data or breach of confidentiality, and that were classified as being within the range of categories 1-5 above. However, all seven incidents were confirmed as category 1 only, and thus represented the least severe form of incident. More specifically, these incidents are categorised as below:

Table 10: Summary of Category 1 data related incidents in 2013-14

Category 1 Subgroup	Nature of incident	Total
a	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	1
b	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	2
c	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	0
d	Unauthorised disclosure	4

It is noted that two of the "unauthorised disclosures" (category IV incidents) identified in the table above, resulted from IT system errors which were subsequently corrected so as to prevent such situations from reoccurring. The other two incidents were as a result of poor staff practice, and thus in response, refresher guidance was cascaded Trust-wide to reinforce adherence to exemplar governance standards.

For further information, please refer to section 5.5.6 below, which forms part of the Trust's Annual Governance Statement.

In terms of setting charges for information, it is noted that the Trust complied fully with HM Treasury's guidance in 2013-14. Thus, whilst 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 have exceeded the cost limit laid down in the Fees Regulations, in practice, none of the enquiries received by the Trust in 2013-14 were that substantial that a corresponding charge had to be levied. With regards to Subject Access Requests, the Trust's charges ranged from £10 - £50 for copies of records, with any such charge made clear to requesters in advance.

3.8 Emergency preparedness

At the time of its establishment, the Trust chose to adopt the existing Major Incident Plan that had previously been developed by NHS Gloucestershire, as it was agreed by the Trust Board that this would provide suitable guidance to staff until an updated plan could be scoped and developed.

In early 2014-15, the Trust will focus upon creating its own revised Major Incident Plan, which will govern the organisation's response to an event such as a sudden major transport or industrial accident, an outbreak of infection, or a terrorist incident, and which will act as tactical guidance if the Trust is required to provide support to the wider Gloucestershire health and social care community. This document will be supported by a number of associated plans regulating the Trust's actions given potential disruption to services or staff such as adverse weather, fuel shortage, pandemic flu etc. The Major Incident Plan will also be complemented by a central corporate Business Continuity Management Plan, and lower-level continuity plans relating to individual services.

In undertaking this work, the Trust will continue to co-operate and liaise closely with all its key partners in 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 Emergency Preparedness, Resilience and Response (EPRR) guidance.

3.9 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.

3.10 Risks

Operational risks are highlighted in table 24 in section 5.5.3 below.

3.11 Health and safety

In 2013-14, the Trust reported 1,757 health and safety incidents which are shown in table 11. 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 11: Health and safety incidents 2013-14

Incident by Type	Total 2013-14
Personal Accident (Service User/Staff)	1,469
Violence, Abuse, Harassment	189
Security Incident	76
Fire Incident	15
Estates, Staffing, Infrastructure	8
Total	1,757

These incidents may be further categorised as follows:

Table 12: Breakdown of personal accident health and safety incidents 2013-14

Incident by Type	Top 3 Categories	Total
Personal Accident	Hit by/against object	119
	Slip, Trip or Fall (Service User)	1,131
	Slip, Trip or Fall (Staff / visitor)	54

Slips, trips and falls represent the highest number of recorded incidents. As a result, the Trust is committed to ensuring quality improvements in its falls risk assessments and prevention work (see section 3.5.2 above).

The Trust notes that in 2013-14, 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 2013-14, there were 5 RIDDOR incidents (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) reported as a result of a work-related accident. 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.

3.12 Fraud management

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 services of a Local Counter Fraud Specialist to represent the organisation in all matters of fraud. This specialist 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 2013-14 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 Local Counter Fraud Specialist'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. Financial Review

The accounting information within this Annual Report and Accounts has been prepared in line with the guidance contained in the 2013-14 Manual for Accounts as issued by the Department of Health. The accounting policies of that Manual meet the Government Financial Reporting Manual (FReM) 2013-14 requirements, which in turn observes 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 2013-14, and that its financial performance is wholly in line with the plans and expectations approved by the Trust Board prior to the organisation's establishment. 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.

4.1 Position of the business

For its first year as a standalone NHS provider organisation, the Trust forecast that it would achieve an income of £103.3million, and return an operating surplus of £2million. By year-end, the Trust was able to demonstrate that it had:

- increased its revenue to £108.9million over the course of the year, the extra £5.6million resulting from the Trust being asked by its commissioners to cover extra non-recurrent costs principally relating to the purchase of high-cost drugs, and the provision of additional activity by the musculoskeletal service;

- achieved its projected £2million operating surplus*.

As this was the Trust's first year of operations, it was exempt from paying charges on the capital that funded its activities in 2013-14. Thus, the Trust benefitted from an additional £2.8million which was invested in a number of one-off purchases relating to the establishment of the Trust: it also allowed for the implementation of a new clinical audit system, the development of an integrated reporting system, and the preparation for a new Trust-wide clinical and child health IT system, all of which will ultimately have significant impact upon the quality and efficiency of care provided to service users across Gloucestershire.

By year-end, the Trust originally planned to have a cash balance of £3.9million: however, the Trust achieved a balance of £6.7million as a result of the planned deferral of capital spend, and the effective management of working capital.

During the year, capital spending was £5.2million. This was in line with budget, and included £2.8million on completing the new community hospital in Tewkesbury, £1.6million on modernising and refurbishing other community hospitals to aspired clinical standards, £0.3million on replacing all syringe drivers that allow controlled rate injections to be managed safely, and £0.3million on information management improvements including the purchase of laptops to enable more efficient mobile working, the upgrading of desktop PCs, the replacement of fax machines with electronic mail solutions to secure information confidentiality, and the enhancement of technological facilities in meeting rooms.

4.2 Carry vs market value

During 2013-14, all property assets transferred to the Trust under a transfer order from NHS Gloucestershire, the former Primary Care Trust. Once complete, the Trust commissioned a full detailed revaluation of these assets from the District Valuer to ensure that they were shown at the correct level on the Trust's balance sheet. This revaluation resulted in an overall net increase in property assets, giving a closing asset base as follows:

Table 13: Closing asset base at 31 March 2014

Assets	Value (£'000)
Land	£13,340
Buildings	£55,875
Assets under Construction	£2,217
Plant and Machinery	£4,923
Transport and Equipment	£137
Information Management and Technology (IM&T)	£1,198
Fixtures and Fitting	£4,070
Total	**£81,760**

One of the assets that transferred to the Trust was the partly completed new community hospital in Tewkesbury. This was finished during the summer, and opened on 1 October 2013.

** Although this surplus was achieved, the Trust recorded a deficit of £3million in its statutory accounts due to an impairment of £5.8million assets that transferred to the Trust on the dissolution of NHS Gloucestershire. These impairments predominantly relate to accounting for the impact of the closure of the old Tewkesbury Hospital and the completion of the new hospital (see notes to the accounts section 8.2.10).*

4.3 Performance against financial targets

4.3.1 Cost Improvement Programme

Each year, in line with NHS standard contracting, the Trust receives 4% less funding than the previous year for delivering the same level of service. To remain a viable organisation, the Trust therefore seeks sustainable ways in which it can effectively reduce its costs year-on-year by 4%: this is known as its Cost Improvement Programme (CIP).

In 2013-14, the Trust delivered £3million efficiency savings against a challenging target of £4million. The schemes that comprised the Trust's Cost Improvement Programme are shown below:

Table 14: Cost Improvement Programme 2013-14

	Plan £000s	Actual £000s	Variance £000s
Mobile Working	885	1,184	299
Centralised Booking	150	0	-150
Procurement	338	108	-230
Medicines Management	358	157	-201
Outpatient Review	399	58	-341
Support Services Review	1,012	497	-515
Estates	434	198	-236
Community Developments	399	287	-112
Managed Vacancy Factor	0	511	511
Other	88	0	-88
Grand Total	**4,063**	**3,000**	**-1,063**

Learning from 2013-14 has informed the development of the Cost Improvement Programme for the next two years, which is detailed below:

Table 15: Cost Improvement Programme 2014-15 and 2015-16

Project / Activity	Description	CIP value 2014-15 £m	CIP value 2015-16 £m
Mobile Working	This project has already driven efficiencies across services, delivering savings of £1.2m during 2013-14. Moving into 2014-15, the project will focus on benefits realisation	1	-
SystmOne	The Trust's new community and child health IT system will support more efficient service user pathways and processes	2	1
Operational Efficiency	Revising pathways and processes will maximise use of clinical time spent with service users	1	1
Centralised Booking	By developing a single point of contact for service users, carers and health and social care professionals, each service will be able to provide a more efficient appointment booking process	0.5	-
Skill Mixing	This project will ensure that a cost-efficient skill mix is available to meet current demands on services	0.25	0.5
Estates	A review of the Trust's estate has identified opportunities for reducing rented, leased and underutilised properties	0.25	0.25
Support Services	A review of current support services has identified ways to control expenditure	0.25	0.5
Procurement	This project will focus upon the tightening control of purchasing, contracts management and retendering	0.5	0.375
Inter NHS Recharges	Evaluation of current inter-NHS contracts has identified activity where recharges for services may contain opportunities for reducing cost	0.25	0.25
Other	To be identified	0.4	0.275
Total		**6.4**	**4.15**

4.3.2 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 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 2013-14, the Trust's required QIPP schemes included the following:

- improving efficiencies in community hospitals by reducing the number of people who are ready to be discharged, and shortening people's length of stay;
- delivering a rapid response service as part of the Integrated Community Team in Gloucester City;
- increasing the number of people attending Minor Injuries Units having been directed there, rather than to the acute hospitals' Emergency Departments, by ambulance staff;
- improving the efficiency of Integrated Discharge Teams in supporting people to leave hospital with appropriate packages of care.

As the measures for a number of these QIPP schemes were negotiated late in year, the Gloucestershire Clinical Commissioning Group agreed a settlement figure with the Trust, representing £375,000 of the total £750,000 available funding.

For 2014-15, the following QIPP schemes will apply:

Table 16: QIPP schemes 2014-15

QIPP schemes	Purpose	Value (£000s)
Integrated Community Teams (ICTs)	• To develop and roll out ICTs across the county to include Rapid Response and High Intensity Service • To reduce non-planned hospital admissions for service users with identified conditions	1,660
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	265
Community Hospital Programme	To deliver seven projects that will improve efficiencies in community hospitals including Minor Injuries Units	975
Use of Minor Injuries Units	To increase referrals to the Gloucestershire Minor Injuries Units, including by the 111 service and South West Ambulance Service	125
Musculoskeletal Service	To build on the successes in 2013-14 and develop clear, clinically agreed thresholds for musculoskeletal related procedures	500
Paediatrics	To better understand changes in children's urgent care pathways	125
Physiotherapy and Podiatry Review	To review the service user pathway and improve outcomes	250
Grand Total		**3,900**

4.3.3 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 2013-14, the Trust's CQUIN schemes were:

Table 17: CQUIN schemes 2013-14

	CQUIN name	Purpose	RAG Rating	Value (£000s)	Value earned in 2013-14 (£000)
1	NHS Safety Thermometer	To ensure complete data collections		103.8	103.8
2	Dementia care	To ensure better identification and management of people with dementia		373.7	342.3
3	Service user experience	To increase focus on the views and opinions of service users		373.7	373.7
4	Falls	To reduce harm to service users		373.7	373.7
5	End of life care	To ensure that service users at the end of life will have care that is planned, implemented and evaluated to meet their needs		373.7	373.7
6	Pressure ulcers	To reduce acquired and inherited pressure ulcers		373.7	373.7
7	Learning disabilities	To ensure training to better support people with learning disabilities		103.8	103.8
Total				**2,076.4**	**2,045.0**

For 2014-15, the following CQUIN schemes have been agreed, with the combined value of £2.09million:

Table 18: CQUIN schemes 2014-15

	CQUIN name	Purpose
1	NHS Safety Thermometer	To measure and reduce harm, and specifically to help understand the prevalence of pressure ulcers
2	Friends and Family Test	To make the Friends and Family Test available across all Trust settings
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
4	Organisational 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
5	Service user discharge	To ensure that service users are appropriately supported upon discharge from hospital, enabling them to return home
6	Staff skills and competencies	To ensure that staff have the knowledge and capability to support service users with more acute healthcare needs
7	Service user records and documentation	To help improvements in record keeping practices

4.4 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 2014, the scheme was over funded by £32,000 which was adjusted out into retained reserves.

Further information is given in the notes to the accounts section 8.2.6.

4.5 Severance payments

In 2013-14, the Trust made 17 severance payments totalling £181k. See section 8.2.6.

4.6 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.

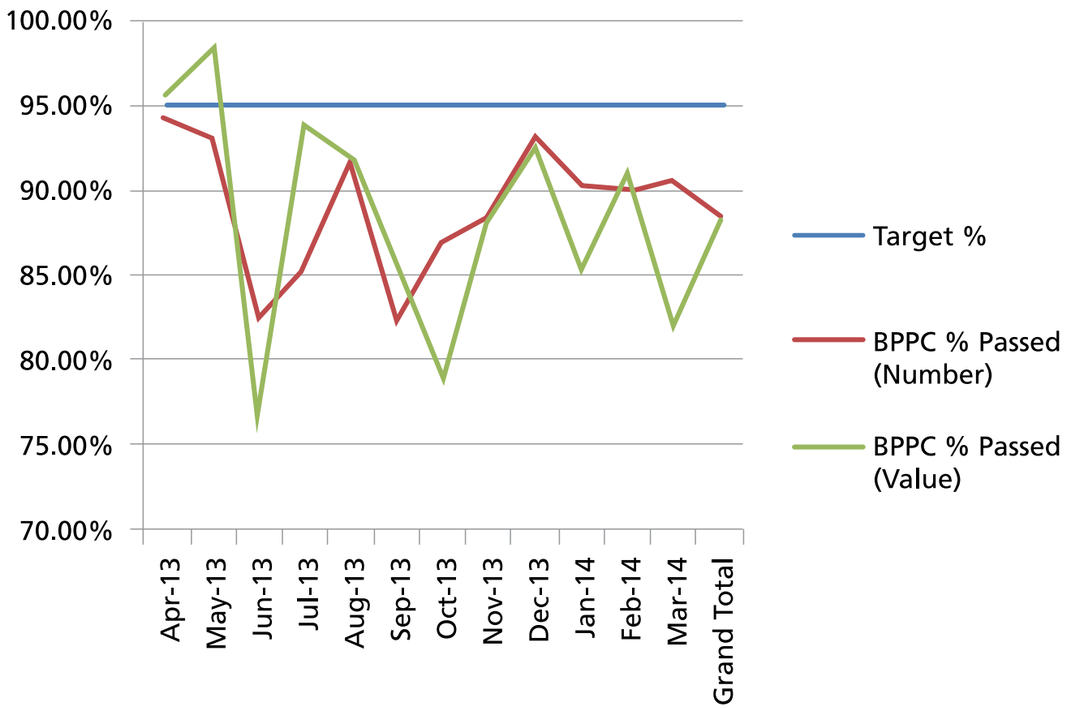
In practical terms, the Code requires organisations to pay 95% suppliers within 30 days of receiving a valid invoice.

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 2013-14, performance against the above requirements was not of the expected standard (see chart below).



In the early part of the year, this was due to a number of challenges including that:

- the Trust's Shared Business Service was unable to locate a number of scanned invoice images that took some time to retrieve;
- the transition to a new accounting system created a temporary delay due to the time required for initial set-up;
- a number of the Trust's suppliers continued to invoice the incorrect organisation, not recognising the change in the Trust's name and status.

Performance improved in the latter half of the year, enabling the number of invoices paid within agreed timescales to increase from 88% to 90%: however, the value of these invoices decreased from 90% to 86%. This was due to a number of larger invoices from partner agencies not providing the necessary support for costs to allow the Trust to make payment.

Further initiatives to enable improvement include ensuring that a higher number of invoices are processed against purchase orders. To this end, the Trust is confident of achieving its target of 95% for 2014-15.

Details of compliance with the code are given in note 8.2.7 to the accounts.

4.7 External audit

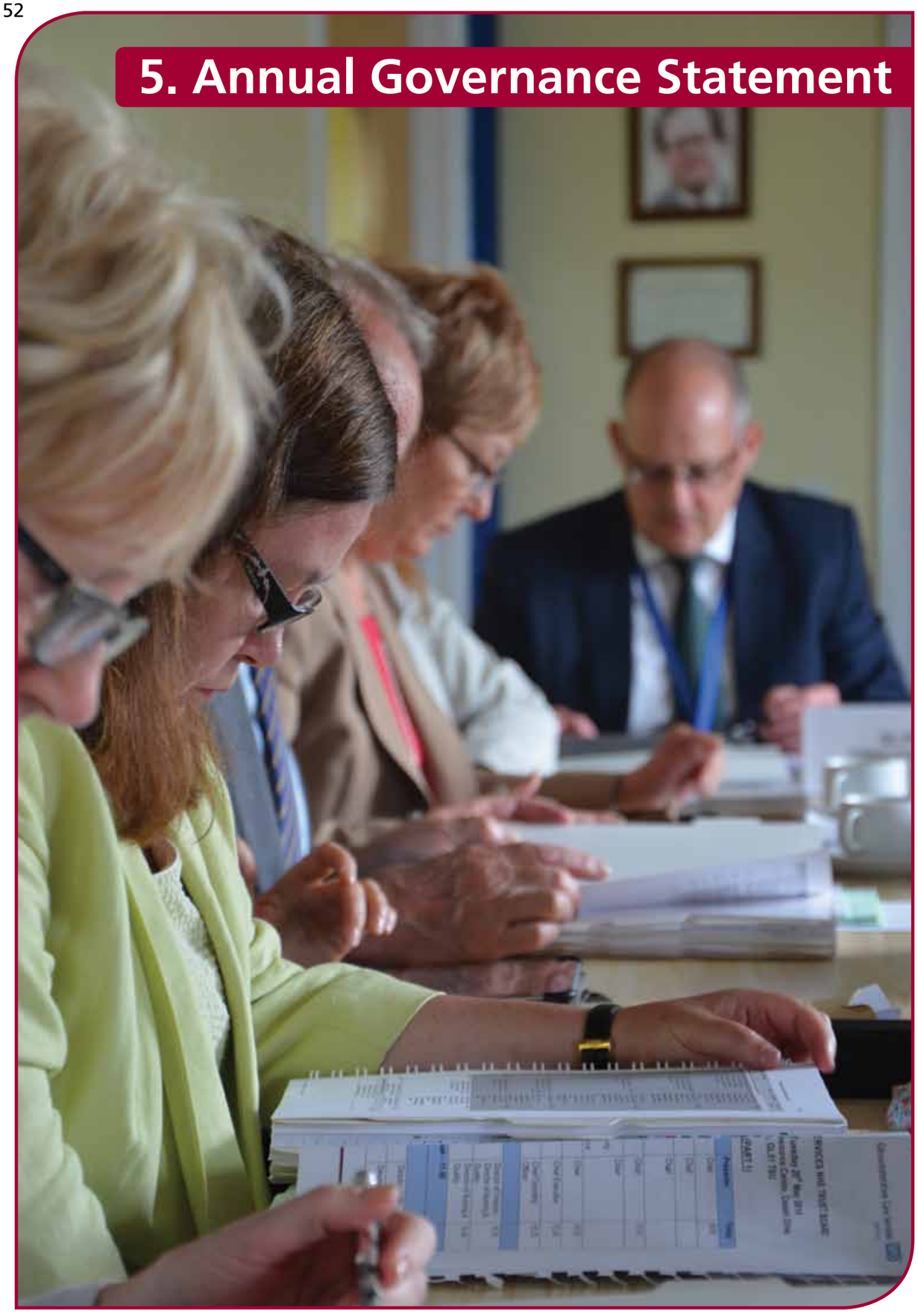
Through its Audit and Assurance Committee, and following instruction from the Audit Commission, the Trust appointed KPMG as its external auditors in 2013-14.

Throughout the year, KPMG and the Trust's finance team have been in regular communication regarding the establishment of the Trust and the transferring of assets in order to help inform the formal audit of the 2013-14 accounts, on which the audit opinion is attached at section 7.2 below.

The fee for this external audit activity, as dictated by the Audit Commission's Guidelines for the Trust in its first year, is £58,000.

KPMG also provided additional services to the Trust to the value of £23,000, the most significant of which was a review of the Trust's VAT accounting practices which cost circa £22,000.

5. Annual Governance Statement



5.1 Scope of Responsibility

As Accountable Officer and Chief Executive of Gloucestershire Care Services NHS Trust ("the Trust"), I have ultimate responsibility for ensuring that the organisation maintains a robust system of governance and internal control that will enable achievement of the organisation's vision, values and strategic objectives. I also 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. To this end, I would note that as of the end of the financial year 2013-14, the Trust remains financially sustainable, recording an operating surplus of £2million in line with our plan.

I additionally recognise my personal responsibility for overseeing the achievement of quality standards across the 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. In this, I believe that the Trust has been most successful in 2013-14, returning 93.8% delivery against national targets and 86.1% against local commissioner targets.

The above responsibilities were all discharged during a period of significant change: thus, it was only in 2013-14 that Gloucestershire Care Services NHS Trust was first authorised as a standalone NHS provider. Equally on a personal level, I joined the Trust in summer 2013, initially on an interim basis, which was subsequently made permanent in January 2014 following due process: this included interview by the Trust Chair, two Non-Executive Directors, the Chief Executive of Gloucestershire County Council, the Chief Executive of Avon and Wiltshire Mental Health Partnership NHS Trust, and the Director of Development and Delivery from the NHS Trust Development Authority ("TDA").

Now as the Trust's substantive Chief Executive, I naturally comply with all the requirements and obligations as determined within the Accountable Officer Memorandum, and reflected within the Trust's Standing Orders, Reservation and 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 overseeing robust corporate governance across the Trust, including responsibility to ensure that managers:

- have a clear view of their objectives and the means to assess their achievements in relation to those objectives;
- are assigned well defined responsibilities for making best use of resources;
- have the information, training and access to the expert advice they need to exercise their responsibilities effectively.

In summary, I believe that this Annual Governance Statement attests the significant successes that the Trust has achieved in its first year, whilst also recognising the work necessary to achieve continuous quality improvement.

Paul Jennings

Paul Jennings
Chief Executive Officer

Date: 6 June 2014

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 2013-14. Thus, the Board was charged with:

- establishing the Trust's vision, values and strategic objectives;
- ensuring robust management of the Trust's strategic development, governance and performance;
- assuring the delivery of safe, effective, high quality health and social care services at all times, and validating that no programme of transformational change or other variation to Trust process or activity, would result in negative impact upon the quality of provided care;
- verifying the efficient use of resources to ensure value for money, overseeing effective financial controls, and ensuring compliance with all prevailing legal obligations, requirements and regulations;
- ratifying all business development opportunities, ensuring the minimisation of financial and clinical risk, and increasing service effectiveness and efficiency;
- developing an effective organisational development strategy;
- assuring a framework of integrated governance that monitored compliance with all necessary risk management and quality standards;
- scrutinising and approving, where appropriate, all relevant recommendations and proposals made by the Board's Committees (see section 5.2.6 below), in order to ensure the sustainable delivery of quality care, quality governance, exemplar financial management and probity across the organisation;
- overseeing effective engagement with staff, service users, Commissioners and other professional partners in line with strategic objectives, and ensuring process to reflect stakeholders' views in organisational strategy.

Prior to the start of the financial year 2013-14, the Trust agreed a comprehensive set of Standing Orders, together with its Reservation and 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. The Standing Orders were subject to scrutiny by the Trust's Audit and Assurance Committee, and were validated on 25 March 2013, ensuring that they were free of irregularity, and were sufficiently robust so as to ensure the Trust's legal compliance.

5.2.2 Board changes in 2013-14

In the Trust's first year of operations, there were a number of changes at Board level as detailed below. These changes were undertaken with the full support of the TDA.

It is also noted that the additions to the Trust's complement of Non-Executive Directors necessitated formal change of the Trust's Establishment Order, and as such, were authorised by the Secretary of State for Health.

- **Penny Harris (Chief Executive)**
  Penny left the post of Chief Executive on 1 September 2013.
- **Paul Jennings (Chief Executive)**
  Paul joined the Trust in summer 2013, initially as interim Chief Executive. His appointment was made permanent on 6 January 2014. Paul's profile is given at section 3.4 above.
- **Susan Field (Director of Adult Services)**
  Susan's role was made substantive on 31 May 2013, having performed the same role on an interim basis since December 2012. Her profile is given at section 3.4 above.
- **Candace Plouffe (Director of Children and Young People's Services and Countywide Services)**
  Candace's role was made substantive on 31 May 2013, having performed the same role on an interim basis since September 2011. Her profile is given at section 3.4 above.
- **Andrew Hall (Director of Project Development and Strategy)**
  Andrew joined the Trust in April 2013, from NHS Nottingham City where he was Acting Director of Health and Wellbeing Transition. In this role, Andrew had worked closely with Nottingham City Council to manage the transition of community provider services, including integration with social care.

Andrew left his post on 27 March 2014, to take up a new role as Deputy Chief Operating Officer at Derby Hospitals NHS Foundation Trust.

- **Simeon Foreman (Board Secretary)**
  Simeon joined the Trust in June 2013 from NHS England. His profile is given in section 3.4 above.
- **Sally Sheen (Non-Executive Director)**
  In April 2013, it was announced that Sally would be stepping down from her position as Non-Executive Director of the Trust.
- **Anne Noble (Non-Executive Director)**
  Anne joined the Trust in April 2013. From her previous career as a social analyst, university lecturer, management consultant and Director of the Health Services Development and Evaluation Centre at Brunel University, Anne brought a proven track record of translating abstract ideas into clinical solutions through research, change management and formative evaluation. On 8 November 2013, it was announced that Anne had stood down from her position as Non-Executive Director and chair of the Trust's Integrated Governance and Quality Committee.
- **Joanna Scott (Non-Executive Director)**
  Joanna joined the Trust in April 2013. Her profile is given in section 3.4 above.
- **Christopher Creswick (Non-Executive Director)**
  Christopher joined the Trust in late November 2013. His profile is given in section 3.4 above.
- **Nicola Strother Smith (Designate Non-Executive Director)**
  Nicola joined the Trust in late November 2013. Her profile is given at section 3.4 above.
- **Susan Mead (Non-Executive Director)**
  Susan's appointment was announced on 8 November 2013. Her profile is given at section 3.4 above.
- **David Harwood (Non-Executive Director)**
  In March 2014, David stood down from his position as Non-Executive Director and chair of the Trust's Performance and Resources Committee, in order to dedicate time to his other business concerns.

5.2.3 Board attendance

The table below provides details of Executive and Non-Executive Directors' attendance at the Trust Board throughout 2013-14. This illustrates that the total attendance of available members was 88% across the year. It is also noted that of the 12% non-attendances, a minimum 33% were due to ill-health.

Table 19: Board attendances 2013-14

	2013						2014		
	9 Apr	14 May	9 Jul	10 Sep	12 Nov	10 Dec	14 Jan	11 Mar	
Voting Members									
Ingrid Barker, Chair	✓	✓	✓	✓	x	✓	✓	✓	88%
Penny Harris, CEO	✓	x	x						33%
Paul Jennings, CEO			x	✓	✓	✓	✓	✓	83%
Robert Graves, NED	✓	✓	✓	✓	✓	✓	✓	✓	100%
Sally Sheen, NED	x								0%
Anne Noble, NED	x	✓	✓	x					50%
Joanna Scott, NED	x	✓	✓	✓	✓	✓	✓	✓	88%
David Harwood, NED	✓	✓	✓	x	✓	✓	✓	✓	88%
Susan Mead, NED					✓	✓	✓	✓	100%
Nicola Strother Smith, NED						✓	x	✓	67%
Chris Creswick, NED						✓	✓	✓	100%
Glyn Howells, Director of Finance	✓	✓	✓	✓	✓	✓	✓	✓	100%
Liz Fenton, Director of Nursing	✓	✓	✓	✓	✓	x	✓	✓	88%
Joanna Bayley, Clinical Director	✓	✓	x	✓	✓	✓	✓	✓	88%
Non-Voting Members									
Tony Hicks, GCC representative	✓	✓	✓	✓	✓	✓	✓	✓	100%
Duncan Jordan, GCC representative	✓	✓	✓	✓	✓	✓	✓	✓	100%
Susan Field, Director of Adult Services	✓	✓	✓	x	✓	✓	✓	x	75%
Tina Ricketts, Head of HR	✓	✓	✓	✓	✓	✓	✓	✓	100%
Candace Plouffe, Director of CYP and Countywide Services	✓	✓	✓	✓	✓	✓	✓	✓	100%
Andrew Hall, Director of Project Development and Strategy		✓	✓	✓	✓	✓	✓	✓	100%
Katie Norton, Interim Board Secretary	✓	✓							100%
Simeon Foreman, Board Secretary			✓	✓	✓	✓	x	x	67%
Jason Brown, Interim Board Secretary							✓	✓	100%

5.2.4 Board effectiveness and evaluation

As part of a Board Development session held on 8 April 2014, Board members took opportunity to reflect upon successes and achievements in respect of the Board responsibilities detailed in section 5.2.1 above. In summary, this Board Effectiveness Questionnaire concluded as follows:

Table 20: Board evaluation 2013-14

	Assessment of 2013-14	Development opportunities
How effective has the Trust Board been?	• A number of key personnel changes throughout the year has impacted on the Board's development and effectiveness • Honest and open engagement between Board members • Effective and constructive challenge between Board members • Clear focus on quality • Establishment of vision, values and strategic objectives to inform future strategic growth	• More systematic Board development • Further support the Trust's cultural change • Need to drive strategic change whilst meeting on-going operational demands • Increased visibility of emerging trends / benchmarking • Improve assessment of the impact and result of service changes
What were the Board's biggest achievements in 13/14? What could have been done better?	• Establishing the Trust in its first year, including the appointment of a new Chief Executive • Ensuring the delivery of excellent services within budget • Evaluating Board composition and making positive change • Improving governance arrangements and processes • Overseeing the development of the Trust's key enabling strategies as foundations for future development	• Review timescales to allow more time to embed ownership of the Trust's strategies • Better engagement with colleagues below Executive Director level • Routine appraisals of Board behaviours and systems • Availability of more informed information between the Trust and Gloucestershire County Council
Does the Trust have the right balance of skills around the Boardroom? Where are the gaps?	• Appropriate skills balance within the Executive Directors' team • Strong assembly of Non-Executive Directors, all with beneficial backgrounds • Recognition however, that many of the current Board members are new to the Trust	• Be better informed by the voice of the Trust's service users and their families • Better project management / commercial operational management which has been addressed via the appointment of the Chief Operating Officer in April 2014
What style of leadership does the Board use? How successful is the Board in promoting this style of leadership across the Trust?	• The Board promotes the principles of engagement, empowerment and involvement • The Board encourages a collegiate approach, which is increasingly modelled across the Trust • Challenge is largely constructive • Clear acceptance of accountability and responsibility as appropriate	• Be less reactive and more proactive, so as to facilitate sustainable change and long-term development • Develop a behaviours framework for all staff • Introduce a leadership development programme for all Band 7 and 8a staff • Develop succession planning and talent management programmes

	Assessment of 2013-14	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?	• Attendance at public Board meetings by stakeholders was very low, although these meetings were held in a range of localities and venues • Limited visibility and perceived relevance to most people • Staff have stated that they do not feel involved, and that the Board does not always listen to concerns • Stakeholders who attended Board in 2013-14 provided positive feedback, particularly upon the focus on quality and the level of debate	• Need greater attendance / involvement of stakeholders at public Boards • Service users and carers should present at Board • Information about decisions taken at Board should be made available in an easy-to-read format • Need to ensure that feedback from service users (including that from complaints) systematically informs service design
Does the Board agenda adequately reflect the things that the Trust needs to give attention to? Are there sufficient opportunities for Board members (and NEDs in particular) to influence the agenda?	• On the whole, Board agendas were balanced and mostly allowed for suitable reflection on key topics: however, there were concerns that on occasions, Board agendas were too busy and did not allow for necessary in-depth explorations or scrutiny • The Board Forward Plan was regularly reviewed by all Executive and Non-Executive Directors • Discussions at Board Committees and Board Developments were instrumental in shaping future Board discussions	• Need increased time to address those issues that the Board wants to consider: therefore greater prioritisation of salient issues is essential • NED meetings will be used to assess future Board agendas • Reporting from Committees to Board needs to be streamlined to ensure effective focus on key issues / exceptions only • Increased focus on risks to achievement of the Trust's strategic objectives
Are the Trust's governance structures effective? Do Committees and provide sufficient assurances to the Board? Should the Board be reviewing certain information that is currently delegated to its Committees?	• A number of the key Committees and forums are still evolving: therefore, the Committees should operate as per agreed Terms of Reference for a minimum of another year prior to assessment at the end of 2014-15	• Greater delegation to the Board Committees and other forums • Reduction in the amount of time that Committees provide updates to Board • Data and information reporting across the governance structure needs to be evaluated so as to ensure that there is neither duplication nor omission
Does the Trust know enough about the quality of care delivered to service users and their carers and relatives?	• Insufficient assurance is provided at present, although this is attributed more to systems of reporting being in development rather than lack of information • There is a robust system for providing Board with service user feedback through, for example, the Friends and Family Test results, complaints information and the Your Care, Your Opinion Programme Board: however, the actions to ensure a better quality service in response to complaints and other feedback are not always evidenced	• Focus needs to be given to the positive, not just the negative • Reporting needs to be evaluated so as to ensure that intelligent information (that includes triangulated data and remedial actions in response to identified weaknesses) is routinely provided to Board, enabling appropriate understanding and comment by all Board members

	Assessment of 2013-14	Development opportunities
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 Board has been assured that work on behalf of service users with dementia has made excellent progress in-year • The Board specifically requested regular updates on all activities designed to ensure appropriate care and support for Gloucestershire people with learning disabilities	• Greater emphasis needs to be given as to how to engage with seldom heard, seldom seen individuals and communities • A rolling programme of independent audits should be conducted to validate Trust effectiveness • Particularly highlighted groups with whom the Trust should ensure better engagement include people with learning disabilities and vulnerable children

5.2.5 Compliance with the UK Corporate Governance Code

In 2013, 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 21: Compliance with the UK Corporate Governance Code 2013-14

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		In 2013-14, the Trust developed a Board composition matrix by which it assessed members' skills, talent and capabilities so as to inform their annual objectives and personal development plans, and thereby ensure a high-performing Board. In 2013-14, the Board also agreed the Trust's vision, values and strategic objectives.
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 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. 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		During 2013-14, there were significant changes within the Non-Executive Director representation at Board. Notwithstanding, the Trust has ended the year with a full complement of qualified NEDs, and a nominated Senior Independent Director, all of whom have already made clear contribution to Trust strategy.

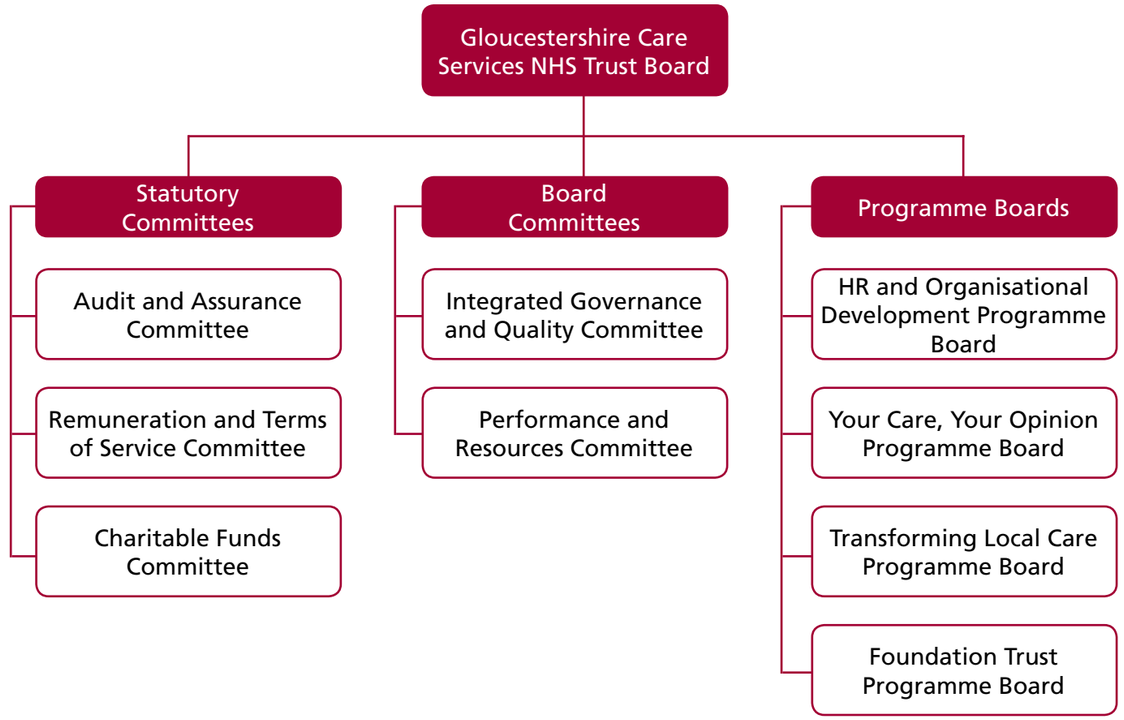
Code Requirement	RAG	Trust Response
Effectiveness		
The Board and its committees should have the appropriate balance of skills, experience, independence and knowledge to enable them to discharge their respective duties and responsibilities effectively		Throughout 2013-14, the Trust Board was actively 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. In particular, Non-Executive Directors represented a minimum 50% of all voting members at Board throughout the year.
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 Executives 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 2013-14, all individuals made contributions well in excess of these requirements, demonstrating their commitment to their respective 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 supported by an induction manual which provides a wealth of support 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 2013-14, the Trust appointed a Board Secretary (initially on an interim basis) with clear delegated responsibility for ensuring that through the Chair, all Executives and Non-Executive Directors received the full complement of information and reports appropriate to their individual roles and responsibilities.
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 2013-14, and also at the end of the financial year, the Board undertook assessment of its performance and that of its Committees (see also section 5.2.4 above).
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		As is evidenced by the Trust Directors' evaluation of Board meetings (see section 5.2.4 above), it is believed that in 2013-14, the majority of information that was presented was fair, balanced and understandable - however, it was felt by a number of the Trust's Directors that there were some gaps in information reporting, with a particular requirement identified for more detailed assurance that high quality services are being provided to all service users, carers and families including those who are most vulnerable.
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		The Trust determined in 2013-14, that significant progress needed to be made in respect of risk management: as a result, an updated Risk Management Strategy was developed and ratified by the Trust Board in March 2014. However, further work needs to be undertaken particularly in respect of developing and maintaining the Board Assurance Framework, and embedding suitable internal control processes into working practice across the organisation. For further information, refer to section 5.5 below.
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 2013-14, these arrangements and responsibilities were clearly delegated to the Trust's Audit and Assurance Committee, attended by all of the organisation's Non-Executive Directors. The key roles of this Committee are described in section 5.2.6 below. 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.
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 2013-14, scrutiny of remuneration for the Trust's Executive Directors was delegated to the Remuneration and Terms of Service Committee. Thus, this Committee agreed the individual remuneration arrangements for the Trust's Very Senior Managers including their salaries, benefits and allowances, giving due regard to the policies and recommendations of the Department of Health and the TDA, 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 involved with discussion regarding their own remuneration.

Code Requirement	RAG	Trust Response
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		In March 2014, the Board ratified the Trust's Communications and Engagement Strategy that sought to formalise the Trust's commitment to work closely with all professional and public stakeholders. Notwithstanding, throughout the previous year, the Trust had undertaken on-going dialogue with all stakeholders: thus, for example, the Trust met with its Commissioners formally on a regular basis as part of the Contract Monitoring Board, and held a Board-to-Board with its partner, Gloucestershire Hospitals NHS Trust. There were also regular meetings with local MPs, the Overview and Scrutiny Committee and local elected members. Service users and the 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 Annual General Meeting (AGM) to communicate with stakeholders and to encourage their participation	N/A	As the Trust only became a standalone NHS provider in 2013-14, it was not appropriate to hold an AGM during that financial year. However, it is noted that an AGM is now planned for October 2014.

5.2.6 Committee structure

In 2013-14, the Trust's Committee structure was as per the schematic below:



The main Committees, and those that are the primary focus of this Annual Governance Statement, are the five 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 the Trust Board with an independent and objective review of its financial systems, financial information and compliance with laws, guidance and regulations governing the NHS. It was also delegated responsibility for ensuring an effective system of risk management and internal control across the whole of the Trust's activities (both clinical and non-clinical);

- the Remuneration and Terms of Service Committee was responsible for determining the Trust's remuneration policy and performance management framework;

- 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;

- the Integrated Governance and Quality Committee was responsible for providing the Board with clear assurance on all issues pertaining to clinical care, governance systems, clinical, financial and corporate risk management, and regulatory standards of quality and safety;

- the Performance and Resources Committee was responsible for reviewing the fiscal and operational activities of the Trust, assessing business development opportunities, and approving capital investments.

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

5.2.7 Annual Committee Statements

As part of their delegated responsibility, all Board Committees were required to identify the key highlights of their performance in 2013-14, and provide these by means of a formalised statement to the Board. This statement also included a look forward to planning actions and developments in 2014-15: however, for the purposes of this Annual Governance Statement, it is deemed appropriate to include the past year's review only for certain statutory and Board committees, namely:

Table 22: Annual Committee Statements

Audit and Assurance	Regularly reviewed the Trust's financial reporting, including assessment of standing orders, budget holders' cost centre status, debtors and write-offs, special payments and "Better Payment Practice" performance.
	Oversaw the development and approval of the Trust's Risk Management Strategy, prior to its escalation to Board for ratification.
	Received reports from the Internal Auditors and the Local Counter Fraud Team, and requested supplementary investigation and analysis where appropriate.
	Considered all major findings of Trust audits (non-clinical), and oversaw the Trust's follow-up responses thereto.
	Liaised with the Trust's external auditor, and arranged an independent meeting with the Trust's Non-Executive Directors.
Charitable Funds	Received all Charitable Funds passed to the Trust by the former PCT, NHS Gloucestershire.
	Filed the Charitable Funds' annual return and accounts for 2012-13.
	Established administrative arrangements for charitable funds management including the implementation of a new IT system.
	Commissioned necessary legal work in order to establish the history of the Charitable Fund's ownership of donated land.
	Provided an overview of the Charitable Funds' purpose and operation to the new Corporate Trustees.
Integrated Governance and Quality Committee	Strengthened the Committee's sub-group structures in order to provide appropriate assurances regarding service quality at Executive, Committee and Board level.
	Ensured that all serious incidents were robustly investigated, and that learning was shared appropriately across the Trust.
	Undertook an on-going review of information reports in order to provide assurance of the quality and safety of the Trust's services.
	Maintained a clear focus on the quality of provided care on behalf of the Trust, during a period of organisational change.
	Successfully maintained the Committee's attendance and form despite a number of significant changes within the Committee itself, including the role of Chair.
Performance and Resources Committee	Reviewed the Quality and Performance Report on behalf of the Trust Board in months when the Board was not convened.
	Reviewed the Finance Report on behalf of the Trust Board in months when the Board was not convened: this included particular scrutiny of Cost Improvement Programme performance by scheme.
	Reviewed the processes and actions of the Capital Management Group in delivering the approved Capital Plan.
	Reviewed and approved business development opportunities on behalf of the Trust Board.
	Reviewed and approved the IT Strategy, the Estates Strategy and the CIP Strategy, prior to their escalation to the Trust Board for ratification.

5.2.8 Board Governance Assurance Framework

At the start of 2013-14 and again at its conclusion, the Trust undertook an assessment of its compliance with the Board Governance Assurance Framework.

This identified that in-year, significant progress had been made towards compliance: thus, of the 15 Framework criteria, the Trust had made tangible improvement in 6 areas, resulting in a final RAG rating of 3 green, 11 amber and 1 non-applicable indicators.

Much of this improvement is already evidenced by the detail provided in sections 5.2.1-5.2.7 of this Annual Governance Statement. It is also noted that a programme of work to develop this compliance further in 2014-15 is already in place.

5.3 Quality / Clinical Governance

5.3.1 Quality Governance Framework

At the start of 2013-14, the Trust undertook a self-assessment of its compliance with the ten requirements of the Quality Governance Framework (reported through the Trust's Foundation Trust Programme Board). This assessment yielded a score of sixteen against a target of no more than four (NB a position necessary for Foundation Trust authorisation). However, since that time, significant progress has been made to address a number of the key weaknesses identified by the initial review, resulting in a reassessment score of nine by year-end. Areas wherein there was particular improvement in 2013-14 included the following:

- quality is now fully embedded in the Trust's strategies: thus all key strategies that have been developed by the Trust in-year, including the Clinical and Professional Care Strategy, include a number of quality goals with corresponding actions and quality measures;
- the Board's dashboard that illustrates monthly progress against the Trust's most important quality metrics, continues to be refined and improved in line with both national and local priorities and emerging guidance.

Notwithstanding, the Trust recognises that there is still significant work to undertake in order to improve its rating against the Quality Governance Framework, and thus has formed a dedicated Quality Governance Working Group to maintain oversight of this key workstream. However, the evidence provided in section 5.3.2-5.3.4 below provides some indication of the improvements and activities within 2013-14.

5.3.2 Quality Account

As the Trust only commenced operations as a standalone NHS provider in 2013-14, it has not previously been required to publish a Quality Account i.e. a public facing document that summarises quality achievements in the previous twelve months, and looks forward to service delivery activities in the coming year that will ensure continuous quality improvements and achieve quality outcomes for local people. Thus, the Trust will be publishing its first Quality Account in June 2014. This Quality Account will include coverage of a series of tasks that aim to achieve the following quality goals:

- to deliver compassionate and considerate care which ensures that service users remain safe from avoidable harm;
- to determine that local health and social care services adopt a person-centred approach, and are wholly effective and efficient;
- to inform and involve service users, their carers and families so that they are confident and have the best possible experience during their care.

5.3.3 Clinical audit

At the beginning of the financial year, service and locality managers across the Trust were encouraged to review recent incidents, complaints and service user feedback in order to identify those practices which could benefit from investigation and further improvement via the use of audit. The result of this exercise was the development of a comprehensive audit programme that operated throughout 2013-14, and that sought to:

- improve the effectiveness of the service delivered across Gloucestershire;
- reduce risk to service users; and
- improve the quality of local service users' experiences.

This programme of clinical and care audits included the following:

- social care safeguarding: under the direction of the Trust's Head of Social Care and the three professional team leads, this audit sought to address staff skills, knowledge and confidence in safeguarding practice. The audit found that staff had a good understanding of their roles and responsibilities in regard to safeguarding concerns that are raised on a daily basis, and that they worked together well in order to keep Gloucestershire people safe. However, the audit also identified some lack of clarity regarding recording of information: this deficiency was addressed through the introduction of briefing sessions and the development of information packs to include the most relevant guidance and documentation. Moreover, additional training was provided for managers, senior practitioners and social workers who manage more complex safeguarding work;

- community hospitals admissions: this audit considered the role of the Medical Officer in admissions to one of the Trust's community hospitals. It concluded that almost all service users who presented within the community hospital, were seen within 24 hours of admission, and that a diagnosis and treatment plan was documented for the majority. However, the audit also found that documentation was far more limited in respect of resuscitation, and rarely captured service users' attitudes to transfer to an acute hospital. As a result of the audit, admitting GPs and hospitals were reminded to communicate each service user's resuscitation status, and the Medical Officer was instructed to record this information within 48 hours of admission. The Medical Officer was also advised to record the preferences of service users and/or carers with respect to possible transfer elsewhere;

- stroke rehabilitation: this audit by the adult physiotherapy service, identified that a number of service users had demonstrated needs which were not being met: these needs included access to an Early Supported Discharge service, specialist stroke input, intensive rehabilitation and vocational rehabilitation. The audit findings were fed back to local commissioners to inform future decision-making;

- speech and language therapy: an audit on the provision of speech and language therapy (SALT) to service users with oropharyngeal cancers, resulted in such service users always receiving a formal referral to the SALT service in order to ensure that potential issues with swallowing are managed, and that Percutaneous Endoscopic Gastrostomy be considered in agreement with the dietician. The audit also recommended that the speech and language therapy pathway be more clearly defined to validate that interventions are provided in a measured and timely manner, and that prophylactic exercises are reliably provided pre-treatment;

- children's physiotherapy: an audit on spasticity in children and young people by the physiotherapy service found good compliance with relevant NICE guidance. The service is now looking to increase its task-focused active therapy over short periods, and to provide more muscle strengthening therapy using repetitive exercise against resistance.

In addition to these locally-identified audits, the Trust also conducted a number of commissioner-led audits throughout its community hospitals and within all 60 community nursing teams as part of the Commissioning for Quality and Innovation (CQUIN) programme. This included monthly audits in respect of:

- end of life care: these audits showed clear evidence of good symptom management, but also highlighted that in some instances, nurses found it difficult to discuss spiritual needs. As a result, guidance was drafted and widely disseminated together with the care planning documentation which replaced the Liverpool Care Pathway;

- dementia: within dementia, the focus has been on prompt identification of memory loss, with referral for onward investigation. Over the year, the percentage of service users screened rose from 80% to 100% for community hospital admissions and from 27% to 91% for service users on the community nursing caseload. Appropriate care planning for those with diagnosed dementia or memory loss also showed a significant increase in attainment over the year with 83% and 85% of admissions and community caseload service users with evidence of a care plan at the end of the year.

These local audits were complemented in 2013-14 by contribution to national audit where appropriate. This included the Trust's participation in:

- the Sentinel Stroke National Audit Programme (SSNAP), a new programme of work which aims to include information from initial admission to six month follow-up through all subsequent care settings;

- the National Chronic Obstructive Pulmonary Disease (COPD) audit data collection, which commenced in February 2014, and which will continue into 2014-5.

Audit work in 2014-15 will be directed by the Trust's five year Audit and Effectiveness Strategy, which was ratified by the Board in December 2013.

5.3.4 Clinical governance

During 2013-14, the Trust made comprehensive progress in the development of its clinical governance function. This included:

- significant contribution to the Trust's Clinical and Professional Care Strategy including the identification of quality goals relating to (i) the development of a supportive and learning culture that is clinically-led, that will strengthen leadership across the Trust, and that will enable delivery of improved services and outcomes, (ii) the championing of an able, flexible workforce that can meet new challenges and opportunities, and that is supported by exemplar standards in education, training and research, and (iii) the achievement of excellence in integrated health and social care, and the development of appropriate strategic partnerships with local professional stakeholders;

- the introduction of a Clinical Senate reporting directly to the Integrated Governance and Quality Committee, in order to provide a forum wherein the Trust's collective knowledge relating to clinical and care matters, is shared, evaluated and the implications for the Trust are considered;

- the introduction of three Professional Cabinets reporting directly to the Clinical Senate, formed around the professional registration bodies of nursing, allied health and social care professionals, and medical and dental services;

- tangible improvements in quality reporting so as to enable appropriate information to be escalated as appropriate across the Trust;

- oversight of the 10 Serious Incidents Requiring Investigation (SIRIs) that occurred in 2013-14, one of which was also reported as a Never Event. In summary, the SIRIs were as follows:

Table 23: Serious Incidents Requiring Investigation 2013-14

SIRI Type	No	Remedial Actions
Pressure Ulcer	5	As part of the Trust's drive to ensure continuous quality improvement, all grade 3 and 4 pressure ulcers that are acquired by service users whilst under the care of the Trust (whether treatment is being provided in the service user's home or in an in-patient setting), are classified as a Serious Incident Requiring Investigation. Thus, all such incidents benefit from the development of care and treatment plans, the effectiveness of which are monitored through the CQUIN programme and quality indicator reporting.
Attempted service user suicide	1	Guidelines have been developed to support Trust colleagues in the identification of risk factors where there is a potential for self-harm.
Unexpected Death	1	As a result of an unexpected death, by which the Trust acknowledged that its response had been flawed and that not all clinicians involved had appropriately recognised and responded to a deteriorating service user, a policy was developed to regulate the use of a Modified Early Warning Score (MEWS). Training in the use of the MEWS has now been rolled out across the county, and equipment competencies have been reinforced amongst all community hospital clinical staff. A programme of audit is imminent and will aim to establish whether improvements have been made.
Missed diagnosis at a Minor Injuries Unit	1	Concerns were raised regarding the failure of a clinician to correctly assess and refer a service user who presented to a community Minor Injuries Unit following a road traffic accident. A root cause analysis and corresponding action plan will be completed shortly.
Staff Assault	1	Following this incident, safe havens and escape routes have been identified, and a more robust process has been established to further support Trust colleagues.

SIRI Type	No	Actions
Dentistry - wrong tooth removal	1	This event was classified as a 'Never Event' i.e. a serious, largely preventable service user safety incident that should not have occurred if the available preventative measures had been implemented by healthcare providers. In this case, the wrong tooth (also diseased) was incorrectly extracted. This investigation recognised that gaps in organisational guidance existed. A clinical protocol is now being developed to minimise the risk of wrong extraction, and will include pathways which will support the use of effective analgesia.

5.4 Financial Governance

In 2013-14, the Trust opted to undertake a self-assessment of its compliance with the Financial Governance component of the Board Governance Assurance Framework. This assessment - together with the financial systems audit which is detailed in section 5.7.1 below - subsequently provided steer on the Trust's in-year priorities in respect of financial management. Thus, the principle control mechanisms that were introduced or enhanced in 2013-14 were as follows:

- the Trust's Long Term Financial Model, which identified the need to achieve substantial cost savings to ensure the Trust remains financially sustainable;
- the Trust's Cost Improvement Programme (CIP) schedule, which identified and regulated the specific transformational changes that were designed to release cost-efficiencies in-year, and which utilised both Equality Impact Assessments and Quality Impact Assessments to ensure no detrimental impact upon service provisions or service users. Although this programme under-achieved in its target of £4million efficiency savings in 2013-14 by only reaching a total of £3million, this shortfall has been added to the 2014-15 target (set at £6.4million). Moreover, robust project plans are now fully in place to evidence how the increased savings will practically be realised within the forthcoming financial year;
- the Standing Financial Instructions, which provided details on how the resources of the Trust 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 the Board to discharge its 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 (see section 5.7.1);
- the Audit and Assurance Committee, which in 2013-14, provided scrutiny of all financial reporting and financial controls (see sections 5.2.6 and 5.2.7).

In summary, weaknesses that were identified by the above processes as being within the Trust's financial management systems related principally to deficiencies in working practices between the Trust and the Shared Business Support service which undertakes much of the Trust's financial administration practices. Thus, it is noted that no significant inadequacies were identified in the Trust's internal 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.

Moreover, the internal control system is designed to manage all prevailing risks to a reasonable level: this includes both operational risks (both clinical and non-clinical) as well as strategic risks. Thus, the Trust's internal control system recognises the inherent impracticality of aiming to eliminate all risks to the organisation's capacity and/or capability to fulfil its vision, values and strategic objectives. As such, the Trust can only provide reasonable, practical, and not absolute, assurance of effectiveness.

Thus, 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.

Moreover, this system of internal control is embedded within an integrated governance framework, whereby salient risks are aligned to the key domains of corporate governance, clinical governance, quality governance, information governance, financial governance and research governance. By contextualising risks via this approach, the Trust not only ensures that its systems work together holistically, but it also gives increased focus to ensuring that the Trust's services continue to be safe, clinically effective and centred upon service user needs, preferences and outcomes.

This system of internal control was used consistently by the Trust throughout the year 2013-14. However, as is noted below, there were some weaknesses within the processes that supported and facilitated internal control during this period: these weaknesses have now been identified, and there are clear remedial plans in place so as to ensure use of a more comprehensive system in 2014-15.

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 (ratified by 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 Board Secretary maintains overarching responsibility for the oversight of all operational (non-clinical) risks, and for ensuring that suitable and effective corporate risk management processes are in place;
- the Director of Nursing maintains overarching responsibility for the oversight of all operational (clinical) risks, and for ensuring that suitable and effective clinical risk management processes are in place;
- the 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;
- 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 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 Board Secretary).

Leadership in respect of risk is also provided through the Trust's governance 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 clinical, corporate and commercial risks as appropriate and relevant 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

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 and escalation of risks, including a comprehensive portfolio of fully documented risk management policies and other control documents that are readily available via the Trust intranet. During 2013-14, it was identified that a number of these documents required review and update, a process which commenced with the refresh of the Trust's Risk Management Strategy, which was ratified by the Trust Board in March 2014.

An essential element of the risk management process employed by the Trust is the Corporate Risk Register. This seeks to systematically gather all local departmental, 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 at every appropriate level of the organisation, and is subject to regular review and monitoring as part of the Trust's performance management and governance arrangements.

Previously, the Corporate Risk Register was compiled from individual risk registers held by teams, directors, project managers etc: however, in 2014-15, the Trust will be moving to an electronic system to manage its Corporate Risk Register: this will be available to all Trust staff early within the new financial year.

Thereafter, the Trust maintains a standardised process by which all operational risks can be 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. To this end, the Trust will ensure throughout 2014-15 that the scores that are assigned to each risk, are applied in a consistent and uniform manner, irrespective of the source or originator of the risk: equally, the Trust will ensure that:

- risks that are attributed a 4-10 risk rating will be subject to regular review at local level via the relevant Trust forum;
- risks that are attributed a 12-14 risk rating will require the development of a formal action plan with timescales, and will be monitored and reviewed every 6 months;
- risks that are attributed a 15+ risk rating will require actions to be implemented within a minimum of 3 months and audited until in control.

As a result of Trust processes to date, the following were identified as the most significant operational issues at the end of 2013-14. These will continue to be managed in line with the proposed mitigations throughout 2014-15:

Table 24: Operational risks

Domain	Issue	Mitigations
Workforce	Failure to manage staffing resources effectively and efficiently, which may result in reduced levels of service provision and dissatisfied colleagues and service users	The Trust will be undertaking a programme of work in 2014-15 to assess staffing levels against the National Quality Board standards
	Failure to ensure an engaged, empowered and healthy workforce whereby (i) colleagues do not raise concerns about practice, (ii) status quo is accepted and colleagues are unable to propose change, (iii) colleagues' absence rates have impact on the delivery of care	An organisational change programme is underway in line with the Trust's Organisational Development Strategy and delivered by the Listening Into Action initiative
	Failure to establish and communicate clear workforce plans, objectives and performance monitoring, which may lead to poor prioritisation, unclear direction, service disruption and reduced service levels	Workforce planning is being addressed both as a top-down process, and also as a bottom-up approach utilising the framework of the Service Development Plans to which each team across the Trust is making active contribution
Quality	Failure to close complaints within agreed timescales, and maintain robust systems to ensure timely learning from all incidents and service user / public feedback	Responsibility for complaints management has now reverted to the Trust's Quality and Nursing Directorate, and revised processes are currently being explored to identify and address any prevailing weakness
	Failure to evidence that Trust practices are fully compliant with (i) national standards and best practice guidelines, (ii) regulatory authorities i.e. CQC outcomes, and (iii) recommendations of external enquiries e.g. Francis, Winterbourne	The Trust is currently reviewing all of its clinical policies so as to ensure that they adequately reflect all appropriate requirements
	Failure to identify, monitor and mitigate the impact on clinical quality as a result of the Cost Improvement Programme	Robust Quality Impact Assessments linked to CIP project plans are signed off at each project's start, and routinely reviewed thereafter
Finance	Failure to provide quality integrated care as a result of financial constraint due to deficit in the External Care budget	Operational, HR and finance teams are working together to evaluate the impact of budgetary reductions
	Failure to ensure that procurement processes provide best value, which may result in reduced levels of service provision and increased costs	The Trust is looking to ensure compliance with the standards proposed by the Better Procurement, Better Value, Better Care development programme
	Failure to ensure that expenditure is contained within budget, and is properly accounted for, which may otherwise result in overspend	The Trust will be ensuring more robust financial monitoring / scrutiny, to be validated by the Audit and Assurance Committee
Reputation	Failure to comply with key legislation or legal requirements (particularly in respect of Information Governance) resulting in external censure, financial loss, and damage to reputation	The Trust has appointed a Director of Corporate Governance and Public Affairs in April 2014, partly in order to ensure corporate compliances in all relevant areas, and provide particular scrutiny of the Trust's internal control systems

Domain	Issue	Mitigations
Reputation	Failure to maintain a secure information management system, creating risk that the confidentiality, integrity and availability of Trust information may be comprised due to unauthorised access or disclosure	The Trust is exploring the option to undertake ISO27001 assessment, and thereby improve its information management practices in line with accredited information security standards
	Failure to evidence that in comparison to other community providers, the Trust is ensuring adequate harm-free care, and is therefore protecting service users against (i) community hospital acquired infections, (ii) falls within community hospitals, (iii) pressure ulcers	Although the TDA's Winter Report suggests that the Trust remains at level 2 for compliance, its relative status compared to other benchmarked Trusts has slipped - the Trust is therefore reviewing its reporting practices so as to ensure that it is not over-reporting against key metrics, and thus inadvertently impacting upon its reputation both locally and nationally

Strategic risks

Responsibility for the oversight and management of strategic risks is allocated to the Trust's Executive and Non-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;
- delivery of the Trust's core strategies, based upon the six identified strategy domains, namely (i) quality, (ii) culture and environment, (iii) care delivery, (iv) compliance, (v) finance and resources, and (vi) communications and engagement.

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 as defined above. Additionally, the Board Assurance Framework identifies the most significant operational risks that require the input and direction of the Board (these risks are detailed in table 24 above).

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 six 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 2013-14, the Trust Board sought to identify the principal themes of its strategic risks, focusing initially upon those risks which may impact upon achievement of the Trust's strategic objectives (NB, the risks against delivery of the Trust's core strategies will be extrapolated in 2014-15). Thus, the principle strategic risks, which are recorded in detail in the Board Assurance Framework, are summarised in table 25 below.

Table 25: Risks to delivery of strategic objectives

Strategic Objectives	Strategic Risks
Achieve the best possible outcomes for our service users through high quality care	• Lack of high quality management information may impede the Trust's ability to agree baselines with commissioners, and support future planning and benchmarking • Increasing demand, especially for urgent care, may lead to inability to maintain service delivery and quality standards
Understand the needs and views of service users, carers and families so that their opinions inform every aspect of our work	• Failure to involve service users, and reflect their experiences within service design
Provide innovative community services that deliver health and social care together	• Failure to maintain focus upon the integration agenda with Gloucestershire County Council • Failure to ensure delivery of sustainable and financially viable change and transformation programmes
Work as a valued partner in local communities and across health and social care	• Failure to maintain a robust working relationship with local Commissioners • Failure to exploit local opportunities for shared services and joint ventures
Support individuals and teams to develop the skills, confidence and ambition to deliver our vision	• Inability to recruit, develop or retain a suitably diverse, skilled and competent workforce • Failure to create a culture where there is a shared sense of purpose, and clarity about values and behaviours • Failure to maintain the management capacity necessary to deliver on ambitious strategic plans, due to current and future planned reductions in resources
Manage public resources wisely to ensure local services remain sustainable and accessible	• Serious financial difficulties elsewhere in the health and social care environment may lead to an adverse impact on the Trust • Failure of the Trust to develop and deliver effective saving schemes • Growing demand upon services due to increasing elderly population and needs acuity • Immature systems and governance processes may impede delivery of key objectives

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.

Moreover, in 2013-14, the Nursing and Quality Directorate provided a significant level of both formal and informal training, in order to inform colleagues about the use of the risk scoring matrix, incident reporting and investigation, and general risk management principles in respect of operational (clinical) risks. In 2014-15, this will be supported by wider risk training which will be delivered across the organisation in a range of settings and using a variety of methodologies, albeit with clear focus upon self-service training which will enable colleagues to access the information and support that they need, where and when is most convenient and appropriate to them.

During 2013-14, and as a direct result of increased awareness of reporting processes, the Trust experienced a rise in no- or low-harm incident reports as demonstrated in the most recent feedback from the National Patient Safety Agency's (NPSA) National Reporting and Learning System.

Equally, the Trust saw a reduction in serious harm incidents. Improvements were also made in the quality of reporting, and in the analysis of themes and trends in incidents, complaints and claims. These improvements have resulted in more robust assurances, particularly in respect of better identification of risks, enabling more targeted local actions to be taken in order to address concerns.

In 2014-15, the Trust will seek to further 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. To this end, the Trust will seek to ensure that:

- where an identified risk is deemed to be pertinent or applicable to staff across the Trust, the risk lead 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;

- via its routine engagement, the Trust will seek to ensure that 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 shared with relevant Committees bi-annually 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 by the Board in 2013-14 in order to validate the effectiveness of the Trust's internal controls, are derived from a range of internal and external sources i.e.:

Internal assurance - these include, but are not limited to:

- internal audit reports and Head of Internal Audit opinion;
- local performance scorecards;
- the Quality and Performance Report;
- benchmarking reports;
- 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;
- Early Warning Trigger Tool;
- Report on Controlled Drug Incidents;
- health and safety reviews;
- sickness absence / mandatory training rates / appraisals completion.

External assurance - these include, but are not limited to:

- 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;
- Health and Safety Executive reviews;
- National Confidential Enquiries into Patient Outcome and Death (NCEPOD);
- 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.

A clear example of external assurance was the routine, unannounced inspection of Stroud General Hospital by the Care Quality Commission (CQC) that took place on 27-28 November 2013. The focus of this inspection was in respect of the following care standards:

- the care and welfare of people who use Trust services;
- meeting nutritional needs;
- cleanliness and infection control;
- staffing;
- assessing and monitoring the quality of service provision.

Detailed verbal feedback was provided immediately after the visit, wherein the CQC inspectors were very complimentary about the reception that they had received, and more importantly, the very positive experience of care that was reported by all service users who were interviewed. The final report was shared with the Trust on 23 December 2013 and subsequently published on the CQC website.

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 2013-14:

- 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;

- as a new Trust, and in order to understand its current status, the organisation undertook a fraud risk assessment in April 2013 using the Self Review Tool provided by NHS Protect;

- as a result of the Self-Review, the Trust developed a counter fraud, bribery and corruption policy and comprehensive action plan, comprising a full range of activity covering four areas: (i) Strategic Governance, (ii) Inform and Involve, (iii) Prevent and Deter, and (iv) Hold to Account;

- the LCFS 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 applied, including prosecution, internal and professional disciplinary action, and financial recovery.

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 service users or carers, employees or business critical matters.

Throughout 2013-14, the Trust used the Datix risk management system to report and monitor all such information governance incidents, the majority of which were deemed low risk and classified as category 0 as per the guidance given in table 9 above. Nevertheless, it is noted that the main themes of these reported incidents involved:

- data quality matters such as necessary information being missing or incorrect from service user or staff records;

- health records not being delivered in a timely manner, thereby compromising the ability of clinicians to be fully informed;

- confidential data being left unguarded on staff's desks, and not being labelled correctly either manually or electronically.

Team managers were routinely informed about these incidents and trends, in order to ensure improvements from lessons learned for the coming year.

However, it is noted that in 2013-14, there were no serious information governance breaches. The most critical incident occurred in February 2014, when a district nurse's car was broken into, and a laptop, professional diary and prescription pad were stolen. In response, a full root cause analysis was undertaken, and the Trust followed the Health and Social Care Information Centre's guidance on the categorisation of SIRIs, which established that the incident was a level 1 and therefore did not need reporting via the IG Toolkit or to the Information Commissioner's Office (NB this was due to the encryption of the laptop, the later discovery of the diary which was unreadable due to weather damage, and the fact that the prescription pads were confirmed to be for dressings only, and not medication).

The principle success of the year in terms of the Caldicott Guardian's office was the signing of the Gloucestershire Information Sharing Partnership Agreement (V6) which is hosted by Avon IM&T Consortium, and which enables informed information sharing to be undertaken across local partner organisations including the Gloucestershire Constabulary, Gloucestershire County Council and all Gloucestershire NHS organisations.

5.5.7 Future risks

Given the above detail in sections 5.5.1-5.5.6, the Trust has identified the following areas which it believes could become future risks:

- potential disinvestment by Commissioners, which if too significant, would undermine the Trust's continued financial sustainability;
- increased competition from existing acute and mental health providers in Gloucestershire, as well as public and private providers from outside local boundaries;
- loss of qualified nursing staff due to a recruitment drive by the acute sector in light of the National Quality Board's safer staffing initiative;
- pressures on service due to national and local requirements for increased 24/7, 7 day working practices without corresponding financial investment;
- increasing health inequalities between the least and most affluent sectors of local society, especially once the medium- to long-term impact of the financial downturn becomes apparent.

The Trust will continue to monitor all these possible eventualities as part of its routine evaluation of the Board Assurance Framework.

5.6 Other Controls

5.6.1 Public and stakeholder involvement

The Trust is committed to close partnership working with all local professional stakeholders including the Gloucestershire Clinical Commissioning Group, Gloucestershire County Council, Gloucestershire Hospitals NHS Foundation Trust and 2gether NHS Foundation Trust.

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. Other relationships of note in 2013-14 have included:

- increased engagement with Carers Gloucestershire, specifically to help shape and develop a carers' survey and carers' focus groups;
- dialogue with service users and stakeholders as part of a Your Care, Your Opinion Involvement Event, in which the public contributed to the development of the Trust's Clinical and Professional Care Strategy, and the Communications and Engagement Strategy: additionally, the public were invited to comment on the Trust's emerging vision, values and strategic objectives;
- discussion with the Health and Social Care Overview and Scrutiny Committee (HSCOSC) in respect of the Trust's strategic objectives for 2014-19;
- engagement with local MPs and Councillors in respect of the Trust's performance and strategic ambitions.

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 Equalities Annual Report in January 2014 in order to verify how the Trust meets the Public Sector Equality Duties under the Equality Act 2010;
- the development of equalities objectives that address the priorities identified both within the Equalities Annual Report and as evidenced by the Trust's communities and colleagues;
- the use of detailed Equality Impact Assessments (EIAs) to support all policy creation and revision, and to complement the Quality Impact Assessments (QIA) which underpin all service change initiatives;
- an Equality and Human Rights Policy which sets out the responsibilities of all Trust colleagues, and which is readily available on the Trust's internet and intranet sites;
- an Equalities Steering Group which comprises senior managers, and which reports to the Integrated Governance and Quality 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 process 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 organisation 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 and controls in 2013-14, have included the following:

- reduction in business fuel mileage, estimated at 8%, by means of mobile working and the use of communications technology to replace the need for face-to-face meetings;
- production of public travel guides for three Trust hospital sites;
- a rolling programme of energy improvements including the installation of a large PV (solar panel) array, improvements to building management systems, and the second phase of LED external lighting;
- increase in the provision of recycling facilities in Trust sites, creating a 8% increase in waste recycled;
- expansion of the Trust's network of community volunteers;
- fundraising for the Charity of the Year.

Refer also to section 7 below.

5.7 Trust performance

5.7.1 Internal audit results 2013-14

In 2013-14, six new internal audits and one follow-up audit were conducted in respect of key aspects of the Trust's internal control system (i.e. corporate governance, risk management, corporate record-keeping, procurement, core financial systems, information governance and clinical record-keeping). The risks that these audits highlighted are shown below, together with details of mitigating actions. The table also notes the good practice identified by audits.

Table 26: Risks highlighted by internal audits 2013-14

Subject of audit	Level of risk	Identified risks	Trust mitigation	Current level of risk
Corporate governance (Sept 2013)	Medium	While the Trust has a business plan for 2013-14 that includes strategic objectives, the Trust's 5 year Integrated Business Plan (IBP) will not be completed until March 2014	The Trust has now refreshed its strategic objectives: these are articulated in the Trust's portfolio of strategies and the 2-year business plan, and will also be reflected in the pending IBP	Low
		Only 9/16 Board and lay members have completed a declaration of interest form	By January 2014, all Board members had completed the requisite declaration of interest form: these forms will be revisited early in 2014-15	Good practice
		Only 2/13 Board members have signed to agree to abide by the Board Code of Conduct	All Board members have received the Code of Conduct: it is scheduled to be re-signed early in 2014-15	Low
	Low	There is no formal mechanism in meetings to report issues to the Board and Sub-Committees	The Trust is currently refreshing its reporting of issues/risks through the Corporate Risk Register	Low
	Advisory	The Integrated Governance and Quality Committee has a large standard agenda, resulting in long meetings which do not always cover all areas of the agenda in sufficient detail	The Chair and Lead Executive for the Committee have since reviewed responsibilities and membership, and routinely review the Forward Plan so as to ensure sufficient time for discussion and debate	Good practice
	Good practice	There is an established structure of the Board and Sub-Committees, which is of size and composition able to support the Trust		
		The key policies of the organisation support corporate governance arrangements		
		The Trust has a 'Whistleblowing' policy which has been communicated to staff across the organisation		
		There are financial governance arrangements in place		

Subject of audit	Level of risk	Identified risks	Trust mitigation	Current level of risk
Risk management (Sept 2013)	Medium	The process for the identification of project risks and the link to the risk register is not clearly defined in the risk management policy	The Trust's Risk Management Strategy was significantly updated and ratified by Board in March 2014. The corresponding policies are now being refreshed in line with strategy	Medium
		The risks in respect of the Trust's application for Foundation Trust status have not been included on the Board Assurance Framework	Appropriate strategic risks from the Foundation Trust Programme Board's Risk Register have been incorporated within the Board Assurance Framework (March 2014)	Good practice
		The corporate risk register has not been updated for progress made on 11 of the recorded risks. Also, 2 risks do not state the controls that are in place to mitigate these risks	The risk management process is currently being updated, in order to record all risks electronically. As part of this process, all existing risks are being reviewed	Medium
		Risk appetite has not yet been discussed or agreed by the Trust	Risk appetite is articulated in the refreshed Risk Management Strategy	Good practice
	Low	The frequency of reporting the BAF to the Board and Integrated Governance and Quality Committee is not clearly defined in the Risk Management Strategy and policy	The frequency of reporting the BAF to Board and Audit and Assurance Committee is articulated in the refreshed Risk Management Strategy	Good practice
	Advisory	Although risk management is considered as part of staff induction and ongoing mandatory training, there are no planned training sessions for Executive Directors and Senior Managers	Risk management education is included with the Board Development Programme	Good practice
	Good practice	The Risk Management Strategy has been produced and reviewed by the Board in July 2013 (since updated)		
		The Risk Assessment and Management Policy has been produced and reviewed by the Integrated Governance and Quality Committee in May 2013		
		Risk registers are reviewed regularly by the Board and the Integrated Governance and Quality Committee		
		Responsibility for risk management is outlined in the Risk Assessment and Management Policy		

Subject of audit	Level of risk	Identified risks	Trust mitigation	Current level of risk
Corporate record keeping (December 2013)	High	Formal processes are not in place for the disposal of corporate records across all areas	The Trust is currently updating its Corporate Records Management Policy to govern this requirement	Medium
	Medium	There is no mandatory training for staff around corporate record keeping	A corporate records management training programme is in development	Medium
		DoH guidance on protective marking of corporate records is not applied consistently across all areas	The Trust is currently updating its Corporate Records Management Policy to encompass appropriate classification requirements	Medium
	Low	Corporate record keeping policies are out-of-date, and ownership of the policies lies with an individual that no longer works for the Trust	The Trust is currently updating its Corporate Records Management Policy	Low
		Version control is not consistently applied across areas of the Trust that hold corporate records	The Trust is currently updating its Corporate Records Management Policy and will ensure that it is implemented consistently	Low
		There is no periodic review system in place for the finance contract master file to ensure that details match the contracts, and to ensure that staff have entered contract change requests appropriately in the query log	Contract management processes are currently under review	Low
	Good practice	Corporate record keeping policies are in place within the Trust, and a formal project is underway to tailor the policies to the specifics of the entity		
		Within the Children and Young People and Countrywide Services area, there are formal processes for the storage and disposal of records, which are documented and communicated		
		The process by which Subject Access Requests are handled, and the training that is provided to staff, is well documented and ownership is clear		
		Record dates are detailed on corporate records to confirm that the record is still in use		
		There is mandatory training for staff around Information Governance and Information Security		

Subject of audit	Level of risk	Identified risks	Trust mitigation	Current level of risk
Procurement (January 2014)	High	No effective use of the purchase ordering system	The Trust has reviewed its processes in this respect, and is now seeking to enforce routine use of the purchase ordering system	Medium
		The Standing Financial Instructions provide high level guidance on non-pay expenditure. However, there is no clear procurement policy to ensure that both the Trust and service provider organisations follow a standard process	A revised Procurement Policy is in development: once ratified, this policy will be implemented and measured across all relevant areas of the Trust	Medium
	Medium	There is no formal process for monitoring the performance of suppliers, which is the responsibility of the contract owner in the Trust	The Trust is currently reviewing how it will ensure formal and routine monitoring of suppliers' performance	Medium
		Shared Business Services (SBS) reports on 13 key performance indicators. However, as the Trust does not have a procurement policy, the monitoring of performance of SBS operations in relation to the Trust's expected procurement process has not been developed	A revised Procurement Policy is in development: once ratified, the Trust will have a formal process by which it can assess and evaluate the performance of SBS	Medium
	Low	Not all KPIs that should be reported to the Trust in accordance with the Shared Service SLA are reported	The Trust is working with SBS to address this failure to report all necessary KPIs	Low
		During sample testing of waivers, one instance was noted where the waiver had not been approved by the Chief Executive	The quoted instance was an isolated anomaly: processes in this respect have now been strengthened so as to prevent reoccurrence	Good practice
	Good practice	Training had been provided to staff in the use of the iProcurement system and uptake of this training is being monitored		
		Management have appointed a procurement officer tasked with streamlining and improving the procurement practices at the Trust		
		Contract expiry dates are being monitored		

Subject of audit	Level of risk	Identified risks	Trust mitigation	Current level of risk
Core Financial Systems (March 2014)	Critical	Shared Business Services (SBS) is able to effect changes without Trust involvement, heightening the risk of fraudulent or incorrect payments	The Trust has requested notice of any pending changes. Also, it is clear contractually that any financial risk lies with SBS and not the Trust	High
	High	A number of suppliers have more than one active bank account (responsibility of SBS to manage)	The Trust has requested that SBS validates all held information to ensure that it is fully accurate, up-to-date and complete	High
	Medium	Only 18% of iProc (the procurement system) users have received training on the system	The Trust is currently considering making iProc training mandatory prior to initial user log-in	Medium
		The Trust does not have a medium-term cash flow forecast	A medium-term cash flow will be completed as part of the long-term financial model This information is now also requested as standard	Low
		The Trust is not always requesting or maintaining robust company and bank information for its suppliers	This information is now also requested as standard	Good practice
	Low	Some registered users of the iProc and Oracle systems are not current Trust employees	There is now a monthly update of system users, based on the Trust's leavers report	Good practice
		Some payments to GPs for Out of Hours services take too long to process	This was an isolated anomaly: processes have now been strengthened so as to prevent reoccurrence	Good practice
		Manual journals are not always authorised	Reminders are now sent regularly, enforcing practice	Good practice
		Not all control account reconciliations show the date when prepared or reviewed	Validated improvements have been made in this respect, ensuring 100% completeness	Good practice
	Good practice	There is clear segregation of duties between requestors and processors, good timeliness of invoice processing, and high accuracy of information input onto Oracle		
		The Trust has policies and procedures across the finance function, which are approved at an appropriate level in the current financial year		
		The budget setting process involves the right people, uses robust data from the financial system, and contains detailed checks to ensure the budgets are accurate and complete		

Subject of audit	Level of risk	Identified risks	Trust mitigation	Current level of risk
Information Governance (March 2014)	Medium	The Trust requires further development in respect of (i) Confidentiality and Data Protection Assurance, and (ii) Information Security Assurance	The Trust has a clear action improvement plan for 2014-15 that includes production of robust information governance policies	Medium
	Low	The following areas require less development: (i) Information Governance Management, (ii) Clinical Information Assurance, (iii) Secondary Use Assurance, and (iv) Corporate Information Assurance	The Trust has a clear action improvement plan for 2014-15	Low
	Good practice	The Trust has sufficient evidence to achieve a Level 3 in requirement 11-210. If current processes are continued for the rest of the year, a Level 3 is likely to be achieved		
		The governance processes relating to the toolkit are robust. There is a good level of interaction between the Information Governance and Risk Manager and those responsible for supplying information for the toolkit		
		There is a comprehensive Detailed Improvement Plan which has identified the actions to achieve a Level 2 in all requirements. There is a good awareness of where evidence is lacking and all requirements have an appropriate responsible owner		
		The evidence collated for the toolkit is well organised and assists the review of requirements		
Clinical record keeping follow up review (March 2014)	Medium	There is not absolute compliance with the clinical records keeping policy	Through the Clinical Governance function, the Trust seeks improvement in 2014-15	Medium
		Although each of the Trust's services should develop a record keeping action plan and monitor progress against it, there are instances where action plans are not prepared. Also, action plans for one year had not been completed by the time the second year's audit has been started.	Through the Clinical Governance function, the Trust seeks improvement in 2014-15. The Trust will also be reviewing the impact of its new Community and Child Health IT system on record-keeping practices and standards.	Medium

5.7.2 TDA Accountability Framework indicators 2013-14

For 2013-14, the Trust's performance against the indicators required by the TDA Accountability Framework was as follows:

Table 27: TDA Accountability Framework performance 2013-14

Metric		Trust Performance 2013-14	Target (where applicable)	RAG
CQC concerns	Warning notice	None	n/a	n/a
	Civil and/or criminal action	None	n/a	n/a
Access metrics	Referral to treatment within 18 weeks	n/a	n/a	n/a
	Delayed transfers of care	5 (average weekly census per month)	10 (average weekly census per month)	
Outcome metrics	Incidence of MRSA	0	0	
	Incidence of C. Difficile	19	18	
	E Coli and MSSA cases	1	n/a	n/a
	Harm free care (pressure sores, falls, C-UTI and VTE)	89.6% (Safety Thermometer): this figure rose throughout the year and was 91.2% for quarter 4	92% (TDA threshold in the absence of any national target)	
	Serious incidents	10 (including the 1 Never Event below)	n/a	n/a
	Never events	1	n/a	n/a
	VTE risk assessments	97%	90%	
Third party reports	Any relevant report including safeguarding alerts, serious case reviews, ad-hoc reports from MPs, GMC, Ombudsman, Commissioners, litigation etc	None	n/a	n/a
Quality governance	Patient satisfaction	83 (Friends and Family Test net promoter score)	No national target	n/a
	Mixed sex accommodation breaches	0	0	
	Board turnover	See section 5.2.2	n/a	
	Sickness/absence rate	4.28%	3%	
	Proportion temporary staff (clinical and non-clinical)	1 temporary to 19 permanent	n/a	n/a
	Staff turnover	11.71%	n/a	n/a
	Nurse to bed ratio	1 nurse to 8 beds on day duty and 1 nurse to 10/11 beds at night	n/a	n/a
	% nurses registered nurses	1 qualified nurse to 1 unqualified nurse (based on community hospital inpatient wards only)	n/a	n/a

Metric		Trust Performance 2013-14	Target (where applicable)	RAG
Quality governance	Complaints	78	n/a	n/a
	% staff appraised	80.45%	95%	
	Patient and carer voice	15% (Friends and Family Test response rate)	15%	

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 2013-14 is however, informed by the work 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 content of monthly and quarterly produced information that has been reported to the Trust Board and/or its Committees, 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. In particular, I would note that the key improvements marked for 2014-15 are as follows:

- produce improved quality reporting at Board so as to ensure that all Executive and Non-Executive Directors are fully informed of Trust activity, strengths and opportunities;
- deliver a measured and sustainable improvement in quality governance practices;
- improve internal controls, and in particular, ensure a more systematic and embedded process for risk identification and management across the organisation, supported by improved training;
- address the salient risks identified by internal audit.

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 will facilitate achievement of the organisation's vision, values and strategic objectives within the coming years.

Moreover, as the Trust moves into 2014-15 and progresses its Foundation Trust application, I am assured that colleagues are continuing to enhance our systems of corporate, quality and financial management.

Paul Jennings

Date: 6 June 2014

6. Remuneration Review

6.1 Remuneration and Terms of Service Committee

Throughout 2013-14, 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 and the Head of HR 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 2013-14

The total remuneration of the Trust's Executive Directors and Non-Executive Directors in 2013-14 is given in table 28 below.

Table 28: Directors' salary entitlements 2013-14

	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
Penny Harris, Chief Executive	65-70	1	-	-	-	65-70
Paul Jennings, Chief Executive	35-40	0	-	-	-	35-40
Ingrid Barker, Chair	20-25	4	-	-	-	20-25
Glyn Howells, Director of Finance and Deputy Chief Executive	110-115	3	25-30	-	-	140-145
Elizabeth Fenton, Director of Nursing	75-80	2	-	-	-	80-85
Dr Joanna Bayley, Medical Director	40-45	2	-	-	-	40-45
Susan Field, Director of Adult Services	85-90	2	-	-	-	85-90
Candace Plouffe, Director of CYP and Countywide Services	65-70	1	-	-	-	65-70
Andrew Hall, Director of Project Development and Strategy	75-80	2	-	-	-	80-85
Tina Ricketts, Head of HR	65-70	1	-	-	-	65-70
Simeon Foreman, Board Secretary	50-55	1	-	-	-	50-55
Joanna Scott, NED	5-10	1	-	-	-	5-10
Sally Sheen, NED	0-5	1	-	-	-	0-5
Nicola Strother Smith, NED	0-5	0	-	-	-	0-5
Chris Creswick, NED	0-5	0	-	-	-	0-5
Susan Mead, NED	0-5	0	-	-	-	0-5
David Harwood, NED	5-10	1	-	-	-	5-10
Ann Noble, NED	0-5	0	-	-	-	0-5
Robert Graves, NED	5-10	2	-	-	-	15-20

The above table includes all costs incurred by the Trust relating to pay, bonuses, benefits in kind or other remuneration relating to Directors.

Table 29 shows the pension contributions for Executive Directors in 2013-14 compared to payments made in 2012-13. Furthermore, as Non-Executive Directors do not receive pensionable remuneration, there are no corresponding entries for these individuals. It is also noted that the Trust's current Chief Executive, Paul Jennings, is not participating in a pension scheme at present.

Table 29: Pension contributions 2013-14

	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 2014 (Bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2014 (Bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2013 £000	Cash Equivalent Transfer Value at 31 March 2014 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension £000
Penny Harris, Chief Executive	0-2.5	0-2.5	45-50	140-145	829	853	2	18
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	2.5-5	5-7.5	0-5	0	32	55	21	16
Dr Joanna Bayley, Medical Director	0-2.5	0-2.5	5-10	25-30	126	131	3	6
Elizabeth Fenton, Director of Nursing	2.5-5	10-12.5	20-25	60-65	318	407	82	11
Candace Plouffe, Director of CYP and Countywide Services	0-2.5	2.5-5	5-10	20-25	125	148	20	9
Susan Field, Director of Adult Services	0-2.5	5-7.5	15-20	55-60	289	345	50	12
Andrew Hall, Director of Project Development and Strategy	0-2.5	n/a	0-5	0	n/a	11	10	11
Simeon Foreman, Board Secretary	0-2.5	2.5-5	10-15	35-40	137	161	16	7
Tina Ricketts, Head of HR	0-2.5	0-2.5	10-15	30-35	152	173	18	8

Given that this is the Trust's first year of operation, the comparable data relates to pension accrued with NHS Gloucestershire.

The definition of terms used in table 29 above 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 29 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 banded remuneration of the highest paid director of the Trust in the financial year 2013-14 was £142,500. This was 5.6 times the median remuneration of the workforce which was £25,783.

In 2013-14, no employees received remuneration in excess of the highest paid director. Employee remuneration ranged from £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 2013 in line with government policy. Executive Directors were excluded from these arrangements, so did not receive any increase during the year.

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 2014 are as below:

Table 30: Directors' terms of service

Name and Title	Terms of service for Non-Executive Directors and notice period for Executive Directors
Chair	
Ingrid Barker	Until 31 March 2015
Non-Executive Directors	
Robert Graves	Until 19 June 2014
Joanna Scott	Until 26 April 2017
Christopher Creswick	Until 31 March 2016
Nicola Strother Smith	Until 30 June 2016
Susan Mead	Until 10 November 2017
Executive Directors	
Paul Jennings, Chief Executive	6 months
Glyn Howells, Director of Finance and Deputy Chief Executive	6 months
Dr Joanna Bayley, Medical Director	3 months
Elizabeth Fenton, Director of Nursing	6 months
Sue Field, Director of Adult Services	3 months
Candace Plouffe, Director of CYP and Countywide Services	3 months
Tina Ricketts, Head of HR	3 months
Simeon Foreman, Board Secretary	3 months

6.5 Off payroll engagements

In 2013-14, the Trust employed 14 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 31: Off-payroll engagements as at 31 March 2014, for more than £220 per day and that last longer than six months

	Number
Number of existing engagements as of 31 March 2014	14
Of which, the number that have existed:	
for less than one year at the time of reporting	14
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0
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 32: Off-payroll engagements between 1 April 2013 and 31 March 2014, 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 2013 and 31 March 2014	14
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	14
Number for whom assurance has been requested	14
Of which:	
assurance has been received	14
assurance has not been received	0
engagements terminated as a result of assurance not being received	0
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	19

7. Sustainability Report

7.1 Trust approach to sustainability

All public organisations currently face challenging times. Pressures on services are increasing, yet income is decreasing. This begets 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. This programme acknowledges the national guidance contained within the ***Sustainable, Resilient, Healthy People and Places*** strategy which was published by NHS England and Public Health England in January 2014, and which is summarised by the diagram below:

7.2 Sustainability performance

One way in which the Trust measures its impact on corporate social responsibility is by the use of the Good Corporate Citizenship tool. Self-assessment against this tool undertaken in September 2013, yielded a score of 37% which is aligned to the recommended standard, and which suggests that the Trust is more advanced in its CSR programme than comparable community trusts.

More specifically, the Trust's performance against resource management targets in 2013-14 is as follows:

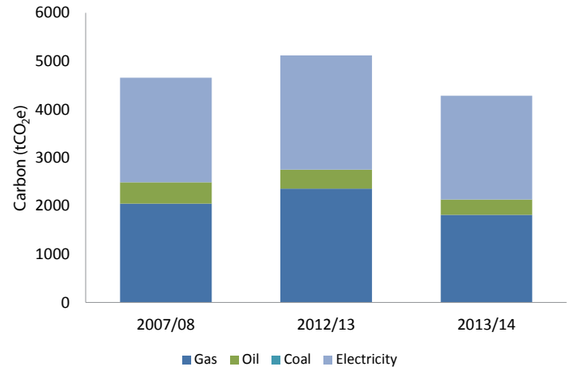
7.2.1 Carbon emissions

The Trust has adopted the national target of a 10% reduction in carbon emissions by 2015-16 compared to 2007-08 levels. Whilst the Trust did not exist as a unique entity in 2007-08, many of its buildings were already in existence at that time, and thus the organisation's baseline has been able to be calculated using the method proposed by the Department for Environment, Food and Rural Affairs (DEFRA).

It is also noted that the Trust's estates portfolio has changed significantly in 2013-14, particularly given the build of the new Tewkesbury Community Hospital.

The chart below indicates the Trust's 2013-14 carbon emissions compared to the 2007-08 baseline, and indicates that the Trust should meet its target next year.

Carbon Emissions - Energy Use



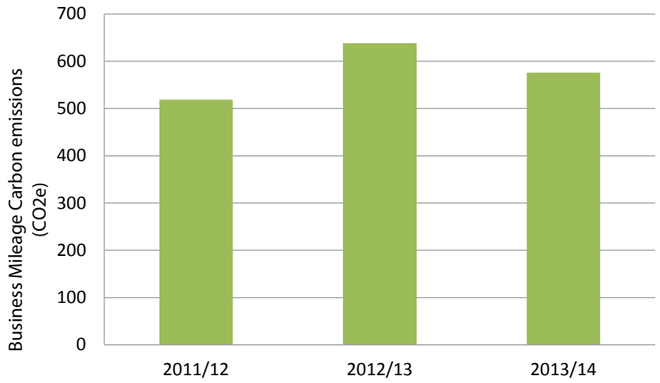
7.2.2 Business mileage

Sustainability and healthy lifestyles go hand-in-hand, as positive behaviours such as regular exercise can not only help to reduce carbon emissions, but can also enhance people's health and wellbeing. To this end, the Trust undertook a number of activities in 2013-14 to encourage healthier and greener lifestyles. For example, a number of Trust sites developed bespoke travel guides to provide staff and visitors with information on nearby cycling and walking routes. Equally, during Workout at Work Week, health walks took place at several community hospital sites.

Another event saw bus "taster" tickets being given out to staff to stimulate increased use of public transport - following this event, over half the attendees were reported to have continued using the bus rather than their cars.

In 2013-14, the Trust also increased the availability of laptops for use by colleagues who undertake home visits, in order to reduce the number of unnecessary journeys that they may otherwise take to their base of employment in order to enter service user data onto the Trust's clinical system. This has saved an estimated 15 miles per day per whole time equivalent post. Moreover, this initiative, together with the others itemised above, has helped reduce overall business mileage carbon emissions in year, as illustrated on the right.

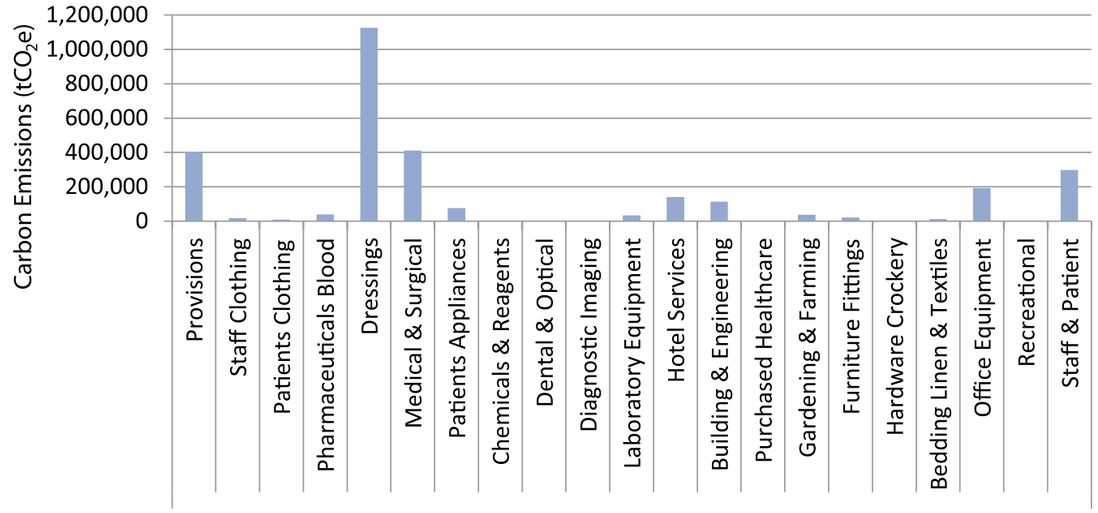
Carbon Emissions - Business Miles



7.2.3 Impact of procurement practices

The impact of purchasing goods (which includes all issues relating to their manufacture and supply) accounts for over two thirds of the NHS carbon footprint, significantly more than the carbon emissions of buildings and travel. For the Trust, the impact of purchasing dressings and medical / surgical equipment accounts for the largest proportion of its carbon emissions, and thus in 2014-15, the organisation will be looking to improve its procurement practices so that this may be reduced.

Procurement Carbon Footprint 2013-14



7.2.4 Energy costs

In 2013-14, the Trust spent £827,027 on energy, which is a 28% decrease on spend from the previous year (for equivalent buildings). This is partially in response to the success of the following projects:

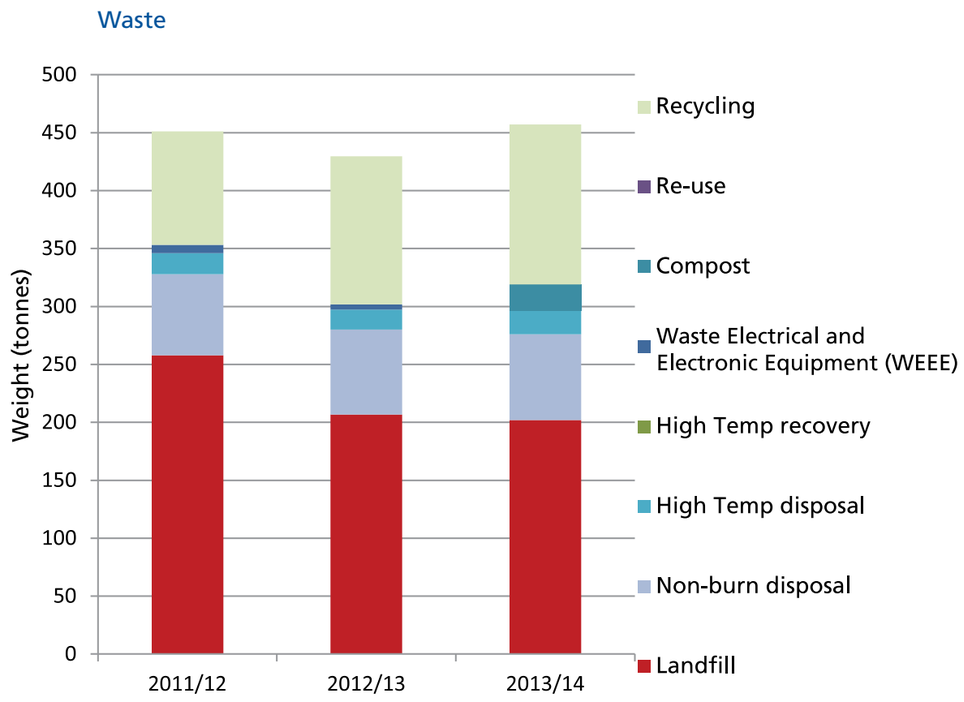
- to reduce heating costs in Stroud General Hospital, old boilers were replaced with high efficiency gas boilers and plate heat exchangers: this now means that all 7 of the Trust's community hospitals have boilers that are a maximum of 4 years old;
- Solar panels were installed at Lydney and District Hospital and Cirencester Hospital to generate electricity;
- low energy (LED) external lights were introduced at several of community hospital sites;
- windows were replaced at Stroud General Hospital to aid draught proofing;
- the new community hospital in Tewkesbury was designed to feature an extensive array of solar panels to generate electricity along with solar thermal panels to generate hot water, and a combined heat and power unit (CHP) for the generation of onsite electricity.

7.2.5 Waste

Throughout the year, the Trust has worked closely with its waste contractor to increase the proportion of waste that is recycled. Moreover, tendering of clinical, domestic and recycling waste contracts started in autumn 2013, and included more stringent environmental performance criteria to ensure that contractors support waste minimisation.

The Trust has also increased the composting of food and organics at 3 of its community hospitals. Additionally, staff appreciation and understanding of the need for recycling has been increased through an on-going awareness campaign. As a result, the Trust's recycling increased by 8% in 2013-14.

The Trust's successes in waste management are illustrated in the chart below:



7.2.6 Water

The table below illustrates that the Trust's use of, and spend on, water has increased by 1.6% in 2013-14. As a result, plans will be put in place to address this in the coming year.

Table 33: Water use / spend in 2013-14

Water		2012-13	2013-14
Mains	m^3	45,933	46,678
	tCO_2e	16	16
Water & Sewage Spend		£125,661	£129,147

7.3 Green spaces and the community

In 2013-14, the Trust continued to enhance its green spaces, recognising their importance to service user recovery, and the role of trees in absorbing carbon emissions.

One example of this work is the Green Gym at Cirencester which was launched in 2010 and which is run by The Conservation Volunteers. Its aim is to combine healthy physical activity – through tree-planting and landscaping – with the social benefits of volunteering, using a large area of green space on the hospital site. Spending time in nature has a host of health and well-being benefits – indeed, it is proven to reduce stress, anxiety and mild depression, and provides the physical activity necessary to raise the volunteers' heart rates! In partnership with Cirencester Town Council and the Cotswold Volunteers, the number of volunteers accessing the Green Gym continues to grow, with over 60 adult volunteers already signed up.

The Trust has also made significant contribution to the NHS Forest, and has planted over 600 trees at Cirencester: additionally, North Cotswolds Hospital incorporated over 200 trees when it was constructed. As part of NHS Sustainability Day, the Trust started another NHS Forest site, planting 12 fruit trees and blackcurrant bushes on the Stroud General Hospital campus.

Local schools have been involved in Apple Days, which have been a huge success. Children come to celebrate the apple harvests, and take part in activities including creating bee houses to explain the importance of pollination, collecting and pressing apples to make apple juice, and working with Play Gloucestershire's Play Rangers to make smoothies using energy powered by a 'smoothie bike'. These events have also promoted healthy eating and the 'five-a-day' message.

The Apple Days have been supported by The Royal Agricultural University, whose students have helped with the activities.

Circencester Green Gym

"I have been going to the Green Gym for almost a year now, and it's because of this that I have managed to turn my life around. I lost my job a few years ago due to depression, and I gradually withdrew from everything and found it difficult to even leave the house. I felt like there weren't many options left for me until Cotswold Volunteers mentioned a Green Gym.

I have never had any experience with conservation work, so I was a little cautious, but with their help, I made it along to a session, and since then, I have been going every week. As well as getting me out the house and keeping me fit, it has helped me make new friends, learn something new, and most importantly build my confidence. I have now started my Level 2 diploma in Work-based Environmental Conservation, and hope that one day, I can find work using everything I have learnt through the Green Gym!"

Volunteer, Cirencester Green Gym

8. Primary Financial Statements

8.1 Primary Financial Statements

8.1.1 Statement of Comprehensive Net Income (SOCNI) and Statement of Comprehensive Net Expenditure (SOCNE) for year ended 31 March 2014

Income and Expenditure

	NOTE	2013-14 £000s	2012-13 £000s
Gross employee benefits	8.2.6	**(77,614)**	0
Other operating costs	8.2.4	**(35,058)**	0
Revenue from service user care activities	8.2.2	**107,367**	0
Other operating revenue	8.2.3	**1,612**	0
Operating surplus/(deficit)		**(3,693)**	**0**
Investment revenue	8.2.8	**19**	0
Surplus/(deficit) for the financial year		**(3,674)**	**0**
Public dividend capital dividends payable		**0**	0
Transfers by absorption - gains		**903**	0
Transfers by absorption - (losses)		**(253)**	0
Net Gain/(loss) on transfers by absorption		**650**	**0**
Retained surplus/(deficit) for the year *		**(3,024)**	**0**

Other Comprehensive Income

		2013-14 £000s	2012-13 £000s
Impairments and reversals taken to the Revaluation Reserve		**(2,177)**	0
Net gain/(loss) on revaluation of property, plant & equipment		**9,623**	0
Net actuarial gain/(loss) on pension schemes	8.2.6	**32**	0
Total Comprehensive Income for the year		**4,454**	**0**

Financial performance for the year

Retained surplus/(deficit) for the year		**(3,024)**	0
Impairments (excluding IFRIC12 impairments)	8.2.10	**5,845**	0
Adjustments in respect of donated / gov't grant asset reserve elimination		**(165)**	0
Adjustment re Absorption accounting		**(650)**	0
**Adjusted retained surplus/(deficit) ** **		**2,006**	**0**

* The Trust recorded a deficit of £3,024k in its statutory accounts due to impairments of £5,845k of assets that transferred to the Trust upon the abolition of NHS Gloucestershire. These impairments predominantly related to accounting for the impact of the closure of the old Tewkesbury Hospital and the completion of the new Hospital. See detailed note 8.2.10.

** The Trust finished its first year by delivering its required operating surplus of £2m in line with plan.

There were also adjustments for net benefits due to creditors of £650k that transferred but did not materialise, and to add back depreciation expenses incurred on donated assets.

The notes in section 8.2 below form part of this account.

8.1.2 Statement of Financial Position as at 31 March 2014

	NOTE	31 March 2014 £000s	31 March 2013 £000s
Non-current assets			
Property, plant and equipment	8.2.9	**81,760**	0
Total non-current assets		**81,760**	**0**
Current assets			
Trade and other receivables	8.2.12	**8,235**	0
Cash and cash equivalents	8.2.13	**6,717**	0
Total current assets		**14,952**	**0**
Non-current assets held for sale		**0**	0
Total current assets		**14,952**	**0**
Total assets		**96,712**	**0**
Current liabilities			
Trade and other payables		**(13,279)**	0
Provisions	8.2.15	**(13)**	0
Total current liabilities		**(13,292)**	**0**
Net current assets/(liabilities)		**1,660**	**0**
Non-current assets plus/less net current assets/liabilities		**83,420**	**0**
Non-current liabilities			
Provisions	8.2.15	**(317)**	0
Total non-current liabilities		**(317)**	**0**
Total Assets Employed:		**83,103**	**0**
FINANCED BY:			
TAXPAYERS' EQUITY			
Public Dividend Capital		**81,482**	0
Retained earnings		**(3,024)**	0
Revaluation reserve		**7,445**	0
Other reserves		**(2,800)**	0
Total Taxpayers' Equity:		**83,103**	**0**

The notes in section 8.2 below form part of this account.

The financial statements in section 8.1 of this document were approved by the Board on 20 May 2014 and signed on its behalf by

Chief Executive: Paul Jennings **Date: 6 June 2014**

8.1.3 Statement of Changes in Taxpayers' Equity for the year ended 31 March 2014

	Public Divident capital £000s	Retained earnings £000s	Revalu-ation reserve £000s	Other reserves £000s	Total reserves £000s
Balance at 1 April 2013	**0**	**0**	**0**	**0**	**0**
Changes in taxpayers' equity for 2013-14					
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 PDC Received - Cash	1,691				**1,691**
New PDC Received/(Repaid) - PCTs Legacy items paid for by Department of Health	7,247				**7,247**
Other movements including PCT Modified Absorption	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**
Balance at 1 April 2012	**0**	**0**	**0**	**0**	**0**

There are no comparable figures for 2012-13.

8.1.4 Statement Of Cash Flows For The Year Ended 31 March 2014

	2013-14 £000s	2012-13 £000s
Cash Flows from Operating Activities		
Operating Surplus/(Deficit)	**(3,693)**	0
Depreciation and Amortisation	**2,546**	0
Impairments and Reversals	**5,845**	0
(Increase)/Decrease in Trade and Other Receivables	**(3,180)**	0
Increase/(Decrease) in Trade and Other Payables	**(1,994)**	0
Provisions Utilised	**(51)**	0
Increase/(Decrease) in Provisions	**362**	0
Net Cash Inflow/(Outflow) from Operating Activities	**(165)**	**0**
Cash Flows from Investing Activities		
Interest Received	**19**	0
(Payments) for Property, Plant and Equipment	**(2,075)**	0
Net Cash Inflow/(Outflow) from Investing Activities	**(2,056)**	**0**
Net Cash Inflow/(Outflow) Before Financing	**(2,221)**	**0**
Cash Flows from Financing Activities		
Public Dividend Capital Received	**14,037**	0
Public Dividend Capital Repaid	**(5,099)**	0
Net Cash Inflow/(Outflow) from Financing Activities	**8,938**	**0**
Net Increase/(Decrease) In Cash And Cash Equivalents	**6,717**	**0**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	**0**	0
Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign Currencies	**0**	0
Cash and Cash Equivalents (and Bank Overdraft) at year end	**6,717**	**0**

8.2 Notes to the Accounts

8.2.1 Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS Trusts must meet the accounting requirements of the Department of Health's Manual for Accounts, which observes the Government Financial Reporting Manual (FReM) 2013-14 requirements. Moreover, 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 between Department of Health organisations

Transfers as part of reorganisation are 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 SOCNE/SOCNI, and is disclosed separately from operating costs.

Other transfers of assets and liabilities between Department of Health organisations 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 has agreed that a modified absorption approach should be applied. For these transactions only, gains and losses are recognised in reserves rather than the SOCNE/SOCNI.

iv) Charitable Funds

For 2013-14, the divergence from the FReM that NHS Charitable Funds are not consolidated with an NHS Trust's own returns, is removed. Under the provisions of IAS27 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are 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 decided not to consolidate its charitable funds, as they are considered immaterial. The Charitable Fund "Gloucestershire Care Services NHS Trust Charitable Funds", charity number 1096480 reports its accounts annually to the Charities Commission.

v) Pooled Budget

The Trust receives funds from a pooled budget between Gloucestershire Clinical Commissioning Group and Gloucestershire County Council. Under the arrangement, funds are pooled under Section 75 (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 Valuation and Lives: See note 8.2.9
- Impairments of Receivables: See note 8.2.12
- Provisions: See note 8.2.15
- 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 Trust of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

Some employees are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme. The scheme assets and liabilities attributable to those employees can be identified and are recognised in the Trust's accounts. The assets are measured at 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. Actuarial gains and losses during the year are recognised in the General Fund and reported on the Statement of Changes in Taxpayers' 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

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

Valuation

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

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

The District Valuer has undertaken a revaluation exercise as at 1st March 2013. The Valuer is RICS (Royal Institution of Chartered Surveyors) qualified and has performed valuations using the Modern Equivalent Asset Valuation (MEAV) technique.

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 are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

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

xi) Intangible assets

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.

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) 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.

xviii) 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.

xix) 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 8.2.15.

xx) 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.

xxi) 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.

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. At the end of the reporting period, the Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset. Financial assets are initially recognised at fair value.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset. For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Net Expenditure and the carrying amount of the asset is reduced directly, or through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

xxii) 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 reversed when the liability has been discharged, that is, the liability has been paid or has expired.

xxiii) 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.

xxiv) 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.

xxv) 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. Details of third party assets are given in note 8.2.20 to the accounts.

xxvi) Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the NHS 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, net assets transferred from NHS bodies dissolved on 1 April 2013 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.

The Trust paid no PDC in 2013-14, as absorption accounting assets were excluded from the calculation for the first year of its operations.

xxvii) 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 its own risks (with insurance premiums then being included as normal revenue expenditure).

xxviii) Subsidiaries

Material entities over which the Trust has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows 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.

From 2013-14, the Trust could consolidate the Gloucestershire Care Services NHS Trust Charitable Funds, over which it considers it has the power to exercise control in accordance with IAS27 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 Agency not to consolidate its accounts in 2013-14.

xxix) Joint operations

Joint operations are activities undertaken by the Trust in conjunction with one or more other parties but which are not performed through a separate entity. The Trust records its share of the income and expenditure; gains and losses; assets and liabilities; and cashflows.

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

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2013-14. The application of the Standards as revised would not have a material impact on the accounts for 2013-14, were they applied in that year:

IAS27 Separate Financial Statements - subject to consultation
IAS28 Investments in Associates and Joint Ventures - subject to consultation
IFRS9 Financial Instruments - subject to consultation
IFRS10 Consolidated Financial Statements - subject to consultation
IFRS11 Joint Arrangements - subject to consultation
IFRS12 Disclosure of Interests in Other Entities - subject to consultation
IFRS13 Fair Value Measurement - subject to consultation
IPSAS32 - Service Concession Arrangement - subject to consultation

8.2.2 Revenue from service user care activities

	2013-14 £000s	2012-13 £000s
NHS Trusts	**116**	0
NHS England	**9,637**	0
Clinical Commissioning Groups	**86,385**	0
NHS Foundation Trusts	**6,199**	0
Department of Health	**0**	0
NHS Other (including Public Health England and Prop Co)	**112**	0
Non-NHS:		
Local Authorities	**3,591**	0
Private service users	**2**	0
Overseas service users (non-reciprocal)	**1**	0
Injury costs recovery	**195**	0
Other *	**1,129**	0
Total revenue from service user care activities	**107,367**	**0**

8.2.3 Other operating revenue

	2013-14 £000s	2012-13 £000
Recoveries in respect of employee benefits	**0**	0
Education, training and research	**1,112**	0
Receipt of donations for capital acquisitions - NHS Charity	**319**	0
Rental revenue from operating leases	**141**	0
Other revenue **	**40**	0
Total other operating revenue	**1,612**	**0**
Total operating revenue	**108,979**	**0**

Revenue is almost totally from the supply of services. Revenue from the sale of goods is immaterial.

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

** Other operating revenue relates to staff accommodation income, and the dividends paid out by NHS Shared Business Services to its clients.

8.2.4 Operating expenses

	2013-14 £000s	2012-13 £000s
Services from other NHS Trusts	12	0
Services from CCGs/NHS England	5	
Services from other NHS bodies	210	0
Services from NHS Foundation Trusts	8,494	0
Total services from NHS bodies*	**8,721**	**0**
Purchase of healthcare from non-NHS bodies	352	0
Trust Chair and Non-executive Directors	65	0
Supplies and services - clinical	5,784	0
Supplies and services - general	429	0
Consultancy services **	961	0
Establishment	2,680	0
Transport	429	0
Premises	5,428	0
Hospitality	5	
Insurance	145	
Legal Fees	130	
Impairments and Reversals of Receivables	538	0
Depreciation	2,546	0
Impairments and reversals of property, plant and equipment	5,845	0
Audit fees (internal and external audit)	106	0
Other auditor's remuneration ***	23	0
Clinical negligence - CNST contributions	336	0
Research and development (excluding staff costs)	0	0
Education and Training	526	0
Losses and Special payments	9	0
Total Operating expenses (excluding employee benefits)	**35,058**	**0**
Employee Benefits		
Employee benefits excluding Board members	76,600	0
Board members	1,014	0
Total Employee Benefits	**77,614**	**0**
Total Operating Expenses	**112,671**	**0**

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

** Consultancy services relate to specific projects, namely: Stroud Hospitals review; NHSLA Compliance; GSS Telecare; CHS Implementation; Essbase development; FT Programme; Procurement Savings Review; Mobile Working; Communications Support; Adult Operations Management and Project Management

*** Other auditor's remuneration relates to advice, predominantly relating to a VAT review and training

8.2.5 Operating Leases

The following summarises the Trust's operating leases:

Description	End Date	Annual Charge (£'000)
Buildings / Land	2015-2033	536
Equipment	2016	25

The Trust as lessee

	Land £000s	Build-ings £000s	Other £000s	2013-14 Total £000s	Total £000s
Payments recognised as an expense					
Minimum lease payments				**719**	0
Total				**719**	**0**
Payable:					
No later than one year	62	527	25	**614**	0
Between one and five years	240	2,189	25	**2,454**	0
After five years	3,121	21,616	0	**24,737**	0
Total	**3,423**	**24,332**	**50**	**27,805**	**0**

The Trust as lessor

The Trust has an operating lease with Care UK for use of a ward space at Cirencester Hospital

	2013-14 £000s	2012-13 £000
Recognised as revenue		
Rental revenue	141	0
Contingent rents	0	0
Total	**141**	**0**
Receivable:		
No later than one year	0	0
Between one and five years	0	0
After five years	0	0
Total	**0**	**0**

8.2.6 Employee benefits and staff numbers

Employee benefits

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**

There is no comparable data for 2012-13.

The highest paid Director in the year was in the salary band £140-145k and the Trust's median pay level was £25.783k. This gives a pay multiple of 5.6.

Staff numbers

	2013-14 Total Number	Permanently Employed Number	Other Number
Average Staff Numbers			
Nursing, midwifery and health visiting staff	**1,079**	974	105
Scientific, therapeutic and technical staff	**452**	452	0
Administration and estates	**441**	412	29
Healthcare assistants and other support staff	**101**	101	0
Medical and dental	**34**	34	0
Nursing, midwifery and health visiting learners	**27**	27	0
Other	**5**	5	0
Total	**2,139**	**2,005**	**134**
Of the above - staff engaged on capital projects	0	0	0

Staff sickness absence and ill health retirements

	2013-14 Number	2012-13 Number
Total Days Lost	**30,674**	0
Total Staff Days	**716,455**	0
Average Working Days Lost (%)	**4.28%**	**0.00**

	2013-14 Number	2012-13 Number
Number of persons retired early on ill health grounds	**3**	0

Exit packages agreed in 2013-14

	2013-14			2012-13		
	***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	0	16	16	0	0	0
£10,000-£25,000	0	0	0	0	0	0
£25,001-£50,000	0	0	0	0	0	0
£50,001-£100,000	0	0	0	0	0	0
£100,001-£150,000	0	1	1	0	0	0
£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)	**0**	**17**	**17**	0	0	0
Total resource cost (£000s)	**0**	**181**	**181**	0	0	0

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.

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

	2013-14		2012-13	
	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		
Mutually agreed resignations (MARS) contractual costs	0	0		
Early retirements in the efficiency of the service contractual costs	0	0		
Contractual payments in lieu of notice	17	113		
Exit payments following Employment Tribunals or court orders	0	0		
Non-contractual payments requiring HMT approval	1	68		
Total	**18**	**181**	**0**	**0**

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.

As a single exit package 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 previous note which will be the number of individuals.

Off-Payroll Engagements

All off-payroll engagements as at 31 March 2014, costing more than £220 per day and lasting longer than six months:

	Number
Number of existing engagements as of 31 March 2014	14
Of which, the number that have existed:	
for less than one year at the time of reporting	14
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

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

All new off-payroll engagements between 1 April 2013 and 31 March 2014, costing more than £220 per day and lasting longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2013 and 31 March 2014	14
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	14
Number for whom assurance has been requested	14
Of which:	
assurance has been received	14
assurance has not been received	0
engagements terminated as a result of assurance not being received	0

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	19 *

* Per Remuneration 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 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, his 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 13.3% 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.

d) Local Government Pension Fund (LGPS)

As part of the S75 Integrated Sevices arrangements, the Trust employs staff who were TUPE'd from Gloucestershire County Council. As part of the TUPE transfer, former local authority staff could elect to remain in the Local Government Pension Scheme (LGPS). The LGPS is a defined benefit statutory scheme administered by the County Council, in accordance with the Local Government Pension Scheme (Benefits, Membership and Contributions) Regulations 2007, the Local Government Pension Scheme(administration) Regulations 2008 and the Local Government Pension Scheme (Transitional Provisions) Regulations 2008. It is contracted out of the State Second Pension. The latest formal valuation of the Fund for the purpose of setting employer's actual contributions was as at 31 March 2010.

During the financial period 1/04/2013 to 31/03/2014, the Trust's contributions totalled £125k and employees' contributions totalled £42k

Period Ended	**31-Mar-14**	**31-Mar-13**
	% p.a.	% p.a.
Pension Increase Rate	2.8%	2.8%
Salary Increase Rate	4.1%	4.6%*
Discount Rate	4.3%	4.5%

* Salary increases are assumed to be 1% p.a. until 31 March 2015 reverting to the long term assumption shown thereafter.

The fair value of employer assets of the whole fund as at 31 March 2014 is as shown in the table below

Assets (whole Fund)	**31-Mar-14 Assets (£000s)**	**%**	**31-Mar-13 Assets (£000s)**	**%**
Equity Securities	1,228	21%	1,080	21%
Debt Securities	848	15%	860	16%
Private Equity	19	0%	17	0%
Real Estate	340	6%	298	6%
Investment Funds and Unit Trusts	3,200	56%	2,917	55%
Derivatives	1	0%	-	0%
Cash and cash equivalents	97	2%	98	2%
Total	**5,733**	**100%**	**5,270**	**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 2014	**Assets £000s**	**Obligations £000s**	**Net (Liability) / Asset £000**
Fair value of employer assets	5,270		5,270
Present value of funded liabilities		(5,641)	(5,641)
Opening position as at 31 March 2013	**5,270**	**(5,641)**	**(371)**
Service cost - Current service cost *	**0**	**(158)**	**(158)**
Net interest			
Interest income on plan assets	239		239
Interest cost on defined benefit obligation		(256)	(256)
Total net interest	**239**	**(256)**	**(17)**
Total defined benefit cost recognised in Profit or (Loss)	**239**	**(414)**	**(175)**
Cashflows			
Plan participants' contributions	42	(42)	0
Employer contributions	124		124
Benefits paid	(87)	87	0
Expected closing position	**5,588**	**(6,010)**	**(422)**
Remeasurements			
Changes in demographic assumptions		(147)	(147)
Changes in financial assumptions		(150)	(150)
Other experience		235	235
Return on assets excluding amounts included in net interest	145		145
Total remeasurements recognised in Other Comprehensive Income	**145**	**(62)**	**83**
Fair value of employer assets	5,733		5,733
Present value of funded liabilities		(6,072)	(6,072)
In Year Movement	463	(431)	32
Closing position as at 31 March 2014	**5,733**	**(6,072)**	**(339)**

* The service cost figures include an allowance for administration expenses of 0.6% payroll.

The in-year reduction in net liability of £32k has been moved to reserves, in order to offset any future increases in liability due to market fluctuations.

8.2.7 Better Payment Practice Code

Measure of compliance

	2013-14 Number	2013-14 £000s	2012-13 Number	2012-13 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**22,989**	**21,547**	0	0
Total Non-NHS Trade Invoices Paid Within Target	**20,430**	**18,602**	0	0
Percentage of Non-NHS Trade Invoices Paid Within Target	**88.87%**	**86.33%**	**0.00%**	**0.00%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**277**	**9,848**	0	0
Total NHS Trade Invoices Paid Within Target	**186**	**8,627**	0	0
Percentage of NHS Trade Invoices Paid Within Target	**67.15%**	**87.60%**	**0.00%**	**0.00%**

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

	2013-14 £000s	2012-13 £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**

8.2.8 Investment revenue

	2013-14 £000s	2012-13 £000s
Interest revenue		
Bank interest	**19**	0
Other loans and receivables	**0**	0
Subtotal	**19**	**0**
Total investment revenue	**19**	**0**

8.2.9 Property, plant and equipment

Property, plant and equipment

2013-14	Land £000s	Buildings £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**
Transfers under Modified Absorption Accounting - PCTs & SHAs	**13,964**	**44,526**	**12,168**	**4,056**	**160**	**360**	**2,474**	**77,708**
Additions of Assets Under Construction	0	0	378	0	0	0	0	**378**
Additions Purchased	0	2,594	0	506	0	273	1,253	**4,626**
Reclassifications	(939)	8,927	(10,329)	1,099	0	714	527	**(1)**
Disposals other than for sale	0	0	0	(6)	0	0	0	**(6)**
Upward revaluation/positive indexation	315	9,307	0	0	0	0	0	**9,622**
Impairments/negative indexation	0	(2,177)	0	0	0	0	0	**(2,177)**
At 31 March 2014	**13,340**	**63,177**	**2,217**	**5,655**	**160**	**1,347**	**4,254**	**90,151**
Depreciation								
At 1 April 2013	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Impairments	0	5,760	0	84	0	1	0	**5,845**
Charged During the Year	0	1,542		649	23	148	184	**2,546**
At 31 March 2014	**0**	**7,302**	**0**	**733**	**23**	**149**	**184**	**8,391**
Net Book Value at 31 March 2014	**13,340**	**55,874**	**2,217**	**4,923**	**137**	**1,198**	**4,069**	**81,760**
Asset financing:								
Owned - Purchased	13,340	54,720	2,217	4,645	137	1,198	4,070	**80,327**
Owned - Donated	0	1,155	0	278	0	0	0	**1,433**
Total at 31 March 2014	**13,340**	**55,875**	**2,217**	**4,923**	**137**	**1,198**	**4,070**	**81,760**

Revaluation Reserve Balance for Property, Plant & Equipment

At 1 April 2013								
Transfer of Revaluation Reserve from NHS Gloucestershire	0	7,333	0	0	0	0	0	**7,333**
Assets Revalued as at 31 March 2014	315	7,130	0	0	0	0	0	**7,445**
At 31 March 2014	**315**	**14,463**	**0**	**0**	**0**	**0**	**0**	**14,778**

Property, plant and equipment prior-year

The Trust first began operations in 2013-14 so this section is not applicable.

Other

Donations in year

A £319k donation was received in 2013-14 from the Tewkesbury League of Friends for equipment for the new Tewkesbury Community Hospital.

All assets were subject to an independent onsite valuation by the District Valuer in March 2014.

The valuations have been undertaken in accordance with IFRSs as interpreted and applied by the Department of Health Manual for Accounts, which is compliant with HM Treasury Financial Reporting Manual guidance for the United Kingdom public sector.

The valuations also accord with the requirements of the RICS Valuation - Professional Standards 2014 UK edition, including the International Valuation Standards, in so far as these are consistent with IFRS and the above mentioned guidance; RICS UKVS 1.15 refers.

The basis of valuation has been fair value, which is taken to be Existing Use Value (EUV), with an estimate of the remaining Economic Useful Life of each asset provided.

Asset Lives per Asset Class

Land - Not depreciated
Buildings - Between 30 and 60 years
Plant and machinery - Between 5 and 15 years
Fixtures and fittings - Between 5 and 10 years
Transport equipment - 7 years

The district valuation has made changes to the asset lives of certain buildings as per the end of March, but the impact on depreciation for the year 2013-14 is minimal.

There has been no compensation from third parties for the impairment of assets.

Write-down of new-build Tewkesbury Community Hospital

The Trust was expecting to receive a completed, fully operational hospital from NHS Gloucestershire. Instead, an asset under construction was transferred in April 2013. As anticipated with hospital facilities, the cost of the building including VAT, was higher than market value assessment. Upon completion, the hospital had to be impaired in 2013-14. See note 8.2.10 for details.

Temporary idle assets

The old Tewkesbury hospital is revalued to zero awaiting demolition.

8.2.10 Analysis of impairments and reversals recognised in 2013-14

	2013-14 £000s
Property, Plant and Equipment impairments and reversals taken to SoCI	
Loss or damage resulting from normal operations	**0**
Over-specification of assets	**5,635**
Abandonment of assets in the course of construction	**0**
Total charged to Departmental Expenditure Limit (DEL)	**5,635**
Unforeseen obsolescence	**0**
Loss as a result of catastrophe	**0**
Other	**0**
Changes in market price	**210**
Total charged to Annually Managed Expenditure (AME)	**210**
Total Impairments of Property, Plant and Equipment changed to SoCI	**5,845**
Total Impairments charged to SoCI - DEL	**5,635**
Total Impairments charged to SoCI - AME	**210**
Overall Total Impairments	**5,845**

Detailed analysis

Impairments & reversals taken to SoCI	
Over specification of assets:	**£000s**
Quedgeley clinic impairment of land	**34**
Hope House impairment of land	**13**
New Moreton hospital impairment of buildings	**163**
	210
Changes in market price:	
Tewkesbury old hospital site impaired for demolition	**3,209**
Tewkesbury Community Hospital new build where the cost of building work carried out was far higher than the market value (beyond revaluation balance for Tewkesbury)	**2,425**
	5,845

There are no intangible assets owned by the Trust.

8.2.11 Intra-Government and other balances

	Current receivables £000s	Non-Current receivables £000s	Current payables £000s	Non-Current payables £000s
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 Foundation Trusts	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**	**5,799**	**0**
Prior period:				
Balances with other Central Government Bodies	0	0	0	0
Balances with Local Authorities	0	0	0	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	0	0	0	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 2013	**0**	**0**	**0**	**0**

8.2.12 Trade and other receivables

	Current		Non-Current	
	31 Mar 14 £000s	31 Mar 13 £000s	**31 Mar 14 £000s**	31 Mar 13 £000s
NHS receivables - revenue	**3,634**	0	**0**	0
NHS prepayments and accrued income	**2,416**	0	**0**	0
Non-NHS receivables - revenue	**2,073**	0	**0**	0
Non-NHS prepayments and accrued income	**552**	0	**0**	0
Provision for the impairment of receivables	**(538)**	0	**0**	0
VAT	**97**	0	**0**	0
Total	**8,234**	**0**	**0**	**0**
Total current and non current	**8,234**	**0**		
Included in NHS receivables are prepaid pension contributions:	**0**			

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

Receivables past their due date but not impaired

	31 March 2014 £000s	31 March 2013 £000s
By up to three months	**3,419**	
By three to six months	**114**	
By more than six months	**317**	
Total	**3,850**	**0**
Analysis of overdue debt	**£000s**	
NHS	2,686	
Non NHS	1,164	
Total	**3,850**	

Provision for impairment of receivables

	2013-14 £000s	2012-13 £000s
Balance at 1 April 2013	**0**	
Amount written off during the year	**0**	
Amount recovered during the year	**0**	
(Increase)/decrease in receivables impaired	**(538)**	
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	**0**	
Balance at 31 March 2014	**(538)**	**0**

The table below shows an analysis of this provision

Analysis of Bad Debt Provision	**£000s**
NHS Injury Cost Recovery Scheme bad debt provision (based on 12.6% of balance)	54
2013-14 provision for bad debt - individuals	5
Legacy bad debt - individuals	9
Legacy bad debt - non healthcare bodies	151
Legacy bad debt - healthcare bodies	319
Balance at 31 March 2014	**538**

Trade and other payables

	Current		Non-Current	
	31 Mar 14	31 Mar 13	**31 Mar 14**	31 Mar 13
	£000s	£000s	**£000s**	£000s
NHS payables - revenue	**2,343**	0	**0**	0
NHS payables - capital	**0**	0	**0**	0
NHS accruals and deferred income	**0**	0	**0**	0
Non-NHS payables - revenue	**5,535**	0	**0**	0
Non-NHS payables - capital	**2,927**	0	**0**	0
Non-NHS accruals and deferred income	**0**	0	**0**	0
Social security costs	**1,767**	0		
VAT	**5**	0	**0**	0
Tax	**582**	0		
Payments received on account	**37**	0	**0**	0
Other	**83**	0	**0**	0
Total	**13,279**	**0**	**0**	**0**
Total payables (current and non-current)	**13,279**	**0**		
Included above:				
to Buy Out the Liability for Early Retirements Over 5 Years	**0**	0		
number of Cases Involved (number)	**0**	0		
outstanding Pension Contributions at the year end	**0**	0		

8.2.13 Cash and cash equivalents

	31 March 2014	31 March 2013
	£000s	£000s
Opening balance	**0**	0
Net change in year	**6,717**	0
Closing balance	**6,717**	**0**
Made up of		
Cash with Government Banking Service	**6,716**	0
Commercial banks	**0**	0
Cash in hand	**1**	0
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**6,717**	**0**
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**6,717**	**0**
Service users' money held by the Trust not included above	**0**	**0**

8.2.14 Deferred revenue

	Current		Non-Current	
	31 Mar 14	31 Mar 13	**31 Mar 14**	31 Mar 13
	£000s	£000s	**£000s**	£000s
Opening balance at 1 April 2013	**0**	0	**0**	0
Deferred revenue addition	**220**	0	**0**	0
Transfer of deferred revenue	**0**	0	**0**	0
Current deferred income at 31 March 2014	**220**	**0**	**0**	**0**
Total deferred income (current and non-current)	**220**	**0**		

8.2.15 Provisions

Comprising:	**Total**	**Early Departure Costs**	**Legal**	**Other**	**Redundancy**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**
Balance at 1 April 2013	0	0	0	0	0
Transfers under Modified Absorption Accounting - PCTs & SHAs	**19**	0	19	0	0
Arising During the Year	**387**	371	16	0	0
Utilised During the Year	**(51)**	(32)	(19)	0	0
Reversed Unused	**(25)**	0	(3)	(22)	0
Unwinding of Discount	**0**	0	0	0	0
Balance at 31 March 2014	**330**	**339**	**13**	**(22)**	**0**
Expected Timing of Cash Flows:					
No Later than One Year	**13**	0	13	516	0
Later than One Year and not later than Five Years	**0**	0	0	0	0
Later than Five Years	**317**	317	0	0	0

Amount included in the provisions of the NHS Litigation Authority in respect of clinical negligence liabilities:

As at 31 March 2014	0
As at 31 March 2013	0

Early departure costs relate to the Local Government Pension Fund liability relating to the staff TUPE'd from Gloucestershire County Council to the Trust.

The reversed other provisions relate to a bad debt provision transferred from NHS Gloucestershire for debts which have since been collected.

8.2.16 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 commissioners and the way those commissioners are 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. Trust 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 2014 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk
The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not therefore exposed to significant liquidity risks.

Financial Assets

	At 'fair value through profit and loss' £000s	Loans and Receivables £000s	Total £000s
Receivables - NHS		3,634	**3,634**
Receivables - non-NHS		2,170	**2,170**
Cash at bank and in hand		6,717	**6,717**
Other financial assets	0	0	**0**
Total at 31 March 2014	**0**	**12,521**	**12,521**
Receivables - NHS		0	0
Receivables - non-NHS		0	0
Cash at bank and in hand		0	0
Other financial assets	0	0	0
Total at 31 March 2013	**0**	**0**	**0**

Financial Liabilities

	At 'fair value through profit and loss' £000s	Loans and Receivables £000s	Total £000s
NHS payables		2,343	**2,343**
Non-NHS payables		10,816	**10,816**
Other financial liabilities	0	120	**120**
Total at 31 March 2014	**0**	**13,279**	**13,279**
NHS payables		0	0
Non-NHS payables		0	0
Other financial liabilities	0	0	0
Total at 31 March 2013	**0**	**0**	**0**

8.2.17 Related Party Transactions

During the year, none of the Department of Health Ministers, the 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.

8.2.18 Losses and Special Payments

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**

The total number of losses cases in 2012-13 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	0	0
Special payments	0	0
Total losses and special payments	**0**	**0**

8.2.19 Financial Performance Targets

Breakeven Performance

	2013-14 £000s	2012-13 £000s
Turnover	**108,980**	0
Retained surplus/(deficit) for the year	**(3,024)**	0
Adjustment for:		
Adjustments for Impairments	**5,845**	0
Adjustments for impact of policy change re donated/government grants assets	**(165)**	0
Adsorption Accounting Adjustment	**(650)**	0
Other agreed adjustments	**0**	0
Break-even in-year position	**2,006**	**0**
Break-even cumulative position	**2,006**	**0**

	2013-14 %	2012-13 %
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	0.00
Break-even cumulative position as a percentage of turnover	1.84	0.00

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.

	2013-14 £000s	2012-13 £000s
External financing limit (EFL)	**3,112**	0
Cash flow financing	**2,221**	0
Unwinding of Discount Adjustment	**0**	0
Finance leases taken out in the year	**0**	0
Other capital receipts	**0**	0
External financing requirement	**2,221**	0
Under/(Over) Spend against EFL	**891**	**0**

Capital resource limit

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

	2013-14 £000s	2012-13 £000s
Gross capital expenditure	**5,007**	0
Less: book value of assets disposed of	**(193)**	0
Less: capital grants	**0**	0
Less: donations towards the acquisition of non-current assets	**(319)**	0
Charge against the capital resource limit	**4,495**	**0**
Capital resource limit	**4,495**	0
(Over)/underspend against the capital resource limit	**0**	**0**

8.2.20 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 2014 £000s	31 March 2013 £000s
Third party assets held by the Trust - service user money	**1**	**0**

8.3 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 2014 on pages 99 to 102. 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 the National Health Service 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 136, 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 2014 and of the Trust's expenditure and income for the year then ended; and
- have been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service 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 the National Health Service 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 Department of Health's requirements;
- 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

Trust's responsibilities

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.

Auditor's responsibilities

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.

Basis of conclusion

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 April 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 2014.

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 April 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 2014.

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 2014

9. Trust Statements

9.1 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 by Chief Executive

Date: 6 June 2014

9.2 Statement of Directors' responsibilities in respect of the accounts

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

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

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

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

By order of the Board:

Paul Jennings

Signed by Chief Executive

Date: 6 June 2014

Glyn Howells

Signed by Director of Finance

Date: 6 June 2014

Paul Jennings, Chief Executive

Glyn Howells, Director of Finance


Let's say our numbers

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Understanding You