Shropshire Community Health NHS
NHS Trust

Annual Report and Accounts 2014/15

Shropshire Community Health NHS Trust

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About this document

This document fulfils the Annual Reporting requirements for NHS trusts.

Copies of this document are available from our website at www.shropscommunityhealth.nhs.uk, by email to communications@shropcom.nhs.uk or in writing from: Chief Executive's Office, Shropshire Community Health NHS Trust, William Farr House, Mytton Oak Road, Shrewsbury, SY3 8XL.

If you would like this report in a different format, such as large print, or need it in a different language, please contact our Patient Advice and Liaison Service who can arrange that on 0800 032 1107 or email Soma.Moulik@shropcom.nhs.uk

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Foreword

Welcome from the Chief Executive

I am delighted to welcome you to our Annual Report 2014/15. It is particularly special to me as it is a record of my first full year as Chief Executive of Shropshire Community Health NHS Trust. The report is packed with examples of how our services support people to live independently and well at or close to home despite their illness, condition or disability. I am particularly proud of the fact that we have secured contracts to provide new services for children in Dudley and Musculo Skeletal Services in Telford & Wrekin. This is a signal that the quality of our services is being recognised.

We have worked hard this year to refresh our strategy, to reflect national and local policy and developments. We also took the time to check out if our values really reflect who we are and I'm really pleased with the outcome – a set of values that reflect why we come to work. These are to improve lives, to ensure everyone counts, a commitment to quality, to work together for patients and to deliver compassionate care with respect and dignity.

The outstanding achievement for me this year is the development of the Patient and Carer Panel. This is a new approach to ensure that patients and carers are genuinely involved in everything we do and I encourage you to read more about this in the report, and maybe even get involved.

I hope you find this report informative, interesting and that it helps you to understand the amazing work our staff do to support nearly half-a-million people live well in our communities.

I look forward to meeting many more of you over the coming year.

Jan Ditheridge
Chief Executive

A reflection from the Chairman

Throughout the year we have held a number of events to celebrate our successes with our patients, carers, staff and partner organisations. It was great to share best practice, as we did at our annual Staff Awards; this really did shine the spotlight on some truly inspirational examples of the tremendous work our staff do. We had more than 100 people attend our Annual General Meeting as we decided to make it more about focusing on what we do rather than simply looking through reports. Then, we invited the volunteers who support the services we provide to join us for a Christmas celebration as a way of bringing people together – which can be difficult to do given the area we serve being more than twice the size of Greater London – and most importantly for us to say "thank you".

There have been a number of new appointments to the Board over the past 12 months, including Steve Gregory, our Director of Nursing and Operations, Andrew Ferguson joining us as Director of Strategy, and Dr Mahadeva Ganesh and Dr Peter Clowes taking on the joint Medical Director role. I am confident we now have a team that will meet the challenges ahead to continually improve our services.

The Board has taken the opportunity to refresh our plans and our strategic objectives and to ensure that we are setting the tone for the organisation to encourage and promote compassionate care and to ensure it is a great place to work. It is all about getting our culture right. As an organisation, we will continue along the path towards Foundation Trust status, but our first priority will always be to provide the very best community services to our local people.

I would like to finish by thanking all of our staff for the amazing things they do, and also our patients, carers, volunteers and partners for helping them to do it.

Mike Ridley
Chairman

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Introducing Shropshire Community Health NHS Trust

Shropshire Community Health NHS Trust provides community-based health services for adults and children in Shropshire, Telford and Wrekin, and some services in surrounding areas too.

These range from district nursing and health visiting to providing specialist community care and inpatient care in four community hospitals for adults and children who have a wide range of mental and physical health needs.

While NHS community services may not always be as visible to the public as the main hospitals, they play a vital role in supporting very many people who live with ongoing health problems, enabling them in many cases to continue to live at home. This is especially important in a large area such as ours, with increasing numbers of elderly people and others, including children and young people, with long-term health conditions.

As a Community Trust, we have a unique role as an essential 'connector' in the local health system, working directly alongside the many organisations that also provide care and support to people.

We are proud to be a Trust dedicated to providing services in local communities, working closely with GPs and the main hospitals, and with health staff experienced in community-working.

Given the central role that community health services play in delivering NHS care, it is vital that they are as patient-focused and efficient as possible.

In a time when there is large-scale change for the NHS nationally, we are creating stability and developing local services for local people as a relatively new NHS organisation dedicated to community-based services. We want to strengthen and improve those services in the new NHS and at the same time ensure that we stay true to the traditional caring values of the NHS.

We know that we need to continually innovate in the way that we deliver our services and we will continue to work closely with staff, GPs, the local acute hospitals and social care to make sure we are adopting the best, most effective care for patients.

Good community health services prevent the need for some patients to be admitted to hospital, including those with chronic conditions such as diabetes, asthma, chest disease, arthritis, hypertension, osteoporosis and stroke. People have told us that we should help patients manage their own condition and stay healthy enough not to have to spend time in hospital, unless they really need to. This is especially important as we continue to care for an ageing population.

However, when people do need to be admitted to hospital, we work closely with local acute hospitals to provide any support that the patient needs.

Everything we do is aimed towards **Improving Lives in Our Communities**.

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Our Vision and Values

Our Vision and Values set out our ambitions and the core set of behaviours and beliefs that guide us in what we say and do, which will enable us to achieve those goals.

These were developed following a lot of work with our staff and stakeholders to make sure we got them right, and we will look at this in more detail later in this report.

Vision

"We will work closely with our health and social care partners to give patients more control over their own care and make necessary treatments more readily available. We will support people with multiple health conditions, not just single diseases, and deliver care as locally and conveniently as possible for our patients. We will develop our current and future workforce and introduce innovative ways to use technology."

Values

Improving Lives

We make things happen to improve peoples' lives.

Everyone Counts

We make sure no-one feels excluded or left behind - patients, carers, staff and the whole community.

Commitment to Quality

We all strive for excellence and getting it right for patients, carers and staff every time.

Working Together for Patients

Patients come first. We work and communicate closely with other teams, services and organisations to make that a reality.

Compassionate Care

We put compassionate care at the heart of everything we do.

Respect and Dignity

We see the person every time - respecting their values, aspirations and commitments in life - for patients, carers and staff.

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Who we are and what we do

The Trust was established in 1 July 2011 by the Secretary of State for Health under the provisions of the National Health Service Act 2006.

We provide a wide range of community health services to about 475,000 adults and children in their own homes, local clinics, health centres, GP surgeries and community hospitals in Bishops Castle, Bridgnorth, Ludlow and Whitchurch.

We realise that it can be confusing to know who is who in the ever-changing world of the National Health Service (NHS), so it may be helpful to explain the various local NHS bodies and where we fit.

Within the county of Shropshire there are two Clinical Commissioning Groups (CCGs) – Shropshire CCG and Telford & Wrekin CCG. These organisations are responsible for buying (commissioning) a wide range of health services for their patients. As a provider of community NHS services we receive the majority of our income from these commissioners, among others. In 2014/15 our total income for the year was £75.3 million. You can find out more about how we get and spend our money in the Directors Report and Annual Accounts.

The CCGs buy services from organisations that deliver care to patients – often referred to as "providers". These are generally either acute services (main hospital services) or community services such as community nursing, children and young people's services and community hospitals. They work with a range of partners including other NHS organisations, the local authorities, patient and service user groups and the voluntary sector.

Shropshire Community Health NHS Trust (SCHT) provides community services across the county and works closely with the acute providers (Shrewsbury and Telford Hospital NHS Trust and Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust) and many other organisations to care for the population of Shropshire.

Our services comprise a major part of all NHS care delivered to residents of Shropshire, Telford and Wrekin and some surrounding areas. Indeed, it's worth bearing in mind that over 90% of all the contacts that people have with the NHS are outside main acute hospitals.

While our services are varied, many of them deliver care and treatment for children and adults, including frail elderly people, who live with long-term illnesses or disabilities and want to maintain as normal a life as possible at home. We are committed to helping them maintain independence and a good quality of life at home. Services such as our community respiratory team, specialist diabetes nursing service, continence service and community paediatric nurses are just some of the teams who deliver that.

We also provide palliative care to help people achieve the best quality of life towards the end of their life.

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Our Services

The services we provide fall into three broad categories, which include:

Community Hospitals and Outpatient Services including:

- Inpatient beds in community hospitals – most often for older patients – providing step down care after a stay in an acute hospital, or step up care where a patient is referred by their GP when they need bed-based care
- Diagnostic tests, such as x-ray, endoscopy, ECG and ultrasound
- Minor Injury Units
- Advanced primary care services, such as dermatology, respiratory, gynaecology, orthopaedics, ENT and allergy
- Rheumatology
- Urgent assessment services (DAART) and diagnostics
- Physiotherapy
- Prison healthcare

Children's and Family Services including:

- Health Visiting
- School Nursing
- Child and Adolescent Mental Health Services (CAMHS)
- Community Dentistry
- Safeguarding
- Health Promotion
- Community Paediatric Services
- Child Development Centres
- Podiatry

Community Services including:

- Community Nursing Service and Specialist Teams
- Tissue Viability Nursing
- Diabetes Specialist Nursing
- Continence Services
- Community Neuro Rehabilitation
- Integrated Community Services (ICS)

You can find out more information about all of our services on our website at **www.shropscommunityhealth.nhs.uk**

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Our Staff

We employ about 1,600 people at a range of locations across Shropshire, Telford & Wrekin and surrounding areas.

It is important that our staff feel involved in our work and able to make a positive difference as we know this has a direct impact on the quality of the care we provide to patients.

We also want our staff to be proud of where they work and help us to be able to deliver the best possible care to the communities we serve.

Staff involvement

To be successful in achieving our aims we need to continuously involve and engage our staff as they are the biggest asset we have. Effective communication and engagement not only contributes to increased morale, but also has a positive knock-on effect on the performance of staff, improved patient care and customer service.

We provide a range of ways for staff to communicate with each other across the organisation and to feedback their thoughts and ideas to the Trust Board. There are opportunities for staff at all levels to get involved in, for example, designing new services or developing new values.

Board members also take part in regular visits to meet different teams and departments. This gives staff a chance to feedback any thoughts or concerns and to generally improve communication and engagement across the organisation.

Our staff also help us to understand more about what our patients and carers want and think by providing feedback and sharing their stories and experiences with us.

For more formal staff involvement we have an agreed framework with our Trade Union and Professional Organisation (TUPOs) partners to regulate consultation and industrial relations within the Trust.

The agreement is designed to foster the effective involvement of staff and their representatives at the earliest possible stage in influencing decisions and in joint information sharing, learning and problem solving.

We also have a Local Negotiating Committee, whose role it is to negotiate terms and conditions of service for medical staff within national arrangements.

Recognising achievement

We celebrate the achievements that our staff have made every year. We had our annual Staff Awards in October 2014 – which you can read more about later in this report – that highlighted some great examples of what our staff do well. We also presented education and long-service awards at the event and it was a great celebration of what people have achieved.

As well as recognising achievement, it is important to provide opportunities for staff to learn and develop in a personal capacity, and in turn benefit the communities we serve and the Trust. This is something we will continue to do in the coming year.

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NHS Staff Survey results

The national NHS Staff Survey is one of the important ways in which we receive feedback from our staff. Results of the 2014/15 NHS staff survey were published in February 2015.

We have seen improvements in our scores since last year, particularly where we have focussed our attention – in areas such as increasing the numbers of appraisals undertaken and in the health and wellbeing of our staff.

Our overall engagement scores and scores for staff recommending the Trust as a place to work or receive treatment also increased for a second year running.

We are amongst the best Community Trusts for the low number of staff who say that they have experienced bullying and harassment, and for staff telling us that they are experiencing work related stress.

We know that we have work to do on some areas such as the quality of appraisals and ensuring that we support staff to identify their learning needs and then attend the training and development they need.

We need to think more about equality and diversity, and we need to ensure that leaders, managers and staff know how to communicate with each other in a meaningful way. Over the coming months we will be working towards achieving this through work which is already underway and through supporting our staff to live our values.

It is important that we demonstrate that we listen to what staff tell us in the annual survey and show what we have done as a result of the feedback it provides. Some of the key issues our staff told us about in 2013 revolved around staff wanting to feel safer, more supported and better-trained at work. Last year we did a lot of work to address the concerns that were raised, including:

- **Health and Wellbeing:** We implemented our Health and Wellbeing Strategy last year to focus on supporting staff at both a personal and professional level. The highlights of the work carried out so far were showcased at a series of roadshow events across our sites in November.
- **Celebrating Success:** Recognising achievements and sharing best-practice is an important part of working together to get the best out of everyone and we have been doing this wherever possible. The highlight last year was the Celebrating Success and Staff Awards event.
- **Appraisals:** We think it is important that people get the opportunity to have well-structured and productive appraisals, and we provided more training and support for managers to make this happen. We recognise there is still more to do here.
- **Bundle Training Days:** We were asked to bundle training sessions together to make it easier for staff working in the community to keep up-to-date with their mandatory training requirements. As a result, a new programme of core mandatory training update days have run this year, which has been a big success. However, as a response to ongoing feedback from staff the programme will change again to further streamline mandatory training.
- **Values and Culture:** A lot of work has been carried out with staff in the last 12 months to agree our new Values and reset the tone of the organisation – our Culture. There is more about this later in the report.

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Equality and diversity

We are committed to eliminating all forms of discrimination and to the equal treatment of all employees and job applicants. This is how we expect all of our staff to behave.

We believe that people should be valued as individuals and are committed to all employees being able to achieve their full potential in an environment characterised by dignity and mutual respect and where individual differences and contributions of staff are recognised and valued.

We have adopted the Department of Health's Equality Delivery System, a tool which will help us to deliver our statutory requirements in promoting equality and the value of diversity of our staff and service users.

As a result of using this tool, we agreed specific objectives for improvement with local community groups. For example, the staff training film Just Ask the Question that we produced in partnership with local Clinical Commissioning Groups, Shrewsbury and Telford Hospital NHS Trust and Shropshire Council has been consistently used in staff induction sessions as part of our Equality and Diversity mandatory training course. We have also worked with voluntary groups who have advised us how to make sure our services are as easy to use as possible, for example by partially-sighted people.

More information about our approach to Equality and Diversity, including our Equal Opportunities Policy, can be found at www.shropscommunityhealth.nhs.uk

We have been successful in maintaining the status of the 'Two Ticks' Disability Symbol, after demonstrating that we have a positive attitude to employing individuals with disabilities.

Gender distribution of directors, senior managers and staff

	Gender			
	Female		Male	
	FTE	Head count	FTE	Head count
Directors (executive and non-executive)	**5**	**5**	**6.6**	**8**
Senior Managers	**18.3**	**19**	**16.0**	**16**
Staff	**1099.1**	**1454**	**108.6**	**120**
TOTAL TRUST	**1122.8**	**1479**	**130.6**	**142**

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Staff health and wellbeing

We value our staff and know it is important to help them to stay healthy. We know that having good staff health and wellbeing will have a direct and positive impact on the quality of service we deliver.

Last year we introduced a Health and Wellbeing Strategy. Key parts of the strategy include:

- Wellbeing initiatives, employee support mechanisms and joint working to identify areas for improvement
- Working with employees to ensure our organisation identifies and minimises those issues which may impact negatively on staff health
- Ensuring that managers have the key skills, knowledge and ability to support employees to improve health and wellbeing
- Ensuring that we increase awareness of our employees as to what is important in ensuring their own health and wellbeing

At the end of 2014/15, we launched an activity challenge for our staff and our plans for 2015/16 will continue to develop our work around health and wellbeing and have joined-up with the Local Authority 'Help to Change Team' with the aim of supporting our workforce to live healthy lives, setting a good example to our patients.

Managing attendance

The most common reasons for sickness absence are coughs, colds and influenza and gastro-intestinal problems. However, more time off work is caused by musculoskeletal problems (23.6%) and stress/anxiety (22.4%). Our Human Resources and Occupational Health teams have undertaken extensive measures to reduce the time lost to sickness absence.

The Occupational Health Service (OHS) strives to provide a responsive, proactive, preventive, confidential service which balances the needs of the organisation and the individuals employed.

Flu Vaccination

The Occupational Health Service led our winter flu campaign for staff. All members of staff were given the opportunity to access the flu vaccination at various locations around the county. The final flu vaccination uptake was 67.2%, which is an increase of 2.4% on last year's figure, and this saw us in the top three performing NHS community trusts in the country.

Organisational Development

Over the past year our Organisational Development team has:

- recruited a clinical educator to help clinical leads in developing their workforces
- devised a set of core mandatory training subjects for all staff via face-to-face annual updates
- delivered Home Office Prevent training to 783 staff
- created an education programme for healthcare assistants

Sharing our story

There have been plenty of positive stories from across the Trust this year. We have shared these publicly to both raise the profile of our services and help people understand who we are.

Dementia Friends

Last summer, members of the Trust Board were keen to find out first-hand how they can make a real difference for people living with dementia.

With one in three people now expected to be affected by dementia, it is important that the NHS – and society as a whole – develops a better understanding of what these conditions mean and the different ways in which they can impact on people's lives.

Members of the Board took part in a session to help them to become Dementia Friends. The Dementia Friends initiative was launched by the Alzheimer's Society to give more people an understanding of dementia and the small things that could make a difference to people living in their community.

Jan Ditheridge, Chief Executive, said: "It is critical that anybody can access our services whatever their needs, which means we have to make sure we understand the services and care required whatever patients and carers needs are. This session gave us an opportunity to stop and think about what it really means to be a person with dementia or a carer of a person with dementia, and therefore what we need to do to ensure that we have services and staff who can meet their needs and ensure their experience is a positive one while they are in our care."

School Nursing Service

It has been a hugely successful 12 months for our School Nursing Service, which has been on the receiving end of local and national awards in recognition of the quality of service they provide, as well as winning tenders to provide services elsewhere in the region.

During the summer of 2014 the Team was named the School Nursing Team of the Year in the prestigious Nursing Standard Awards. They were then given a Special Commendation by Shropshire Council for their achievements and recognition for both their dedication and innovation.

Towards the end of the year Jo France, School Nurse Manager and Professional Lead at Shropshire Community Health NHS Trust, was then shortlisted in the NHS Innovator of the Year category in the West Midlands Regional Finals. While Jo did not pick up the top prize at the ceremony in Birmingham in December, simply being selected as a finalist from a huge pool of dedicated NHS staff from across the region is another accolade for her team.

This high quality service was clearly recognised when the team successfully won the contract to provide School Nursing Services in Dudley earlier this year, which was another clear indicator of the service going from strength-to-strength.

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Family Nurse Partnership

Providing support for young families is an important part of what we do. In October last year we launched our Family Nurse Partnership (FNP) Service in Shropshire.

This service provides intensive targeted home visiting support to teenage girls aged 19 years and under who are pregnant and then looking after their young child to ensure they are getting the right health and emotional support for themselves and their baby. The FNP programme aims to enable young mums to:

- Have a healthy pregnancy
- Improve their child's health and development
- Plan their own futures and achieve their aspirations

Jo Bettison, the Implementation Project Manager for the FNP Team, said: "This support will be really valuable for young mums to help them through what can be a very challenging time, and at the same time we want to help them prepare for and focus on the future and their aspirations for life."

We launched our Family Nurse Partnership Service in Telford & Wrekin in 2009, and this has been a success so far and helped to provide valuable information to help put plans in place for the service to now be rolled out in parts of Shropshire.

Health in pregnancy, and the quality of the care babies receive during the first years of life, can have a long lasting impact on their future health, happiness, relationships and achievement of their aspirations.

The Family Nurse Partnership programme is underpinned by a robust evidence base. This demonstrates that if delivered well, it has the potential to change the life chances of some of the most vulnerable parents and babies, with long-term positive impacts on health, social and educational outcomes.

Reviewing the Year with our patients, partners and staff

All too often Annual General Meetings prove to be uninspiring events, which is why we decided to make a lot more of the opportunity to bring a wide range of people together in 2014.

The event, which took place at the Holiday Inn, Telford, featured activities and information about our services and staff, patient stories and presentations by service users.

The event was well attended and plans are already underway to build on its success and host an even more interactive and informative event later this year.

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Celebrating Success

More than 100 people packed in to the Shropshire Education and Conference Centre in October for a day designed to showcase the great things our staff do for their patients and colleagues.

The all-day, Celebrating Success event featured key note speakers Jenny Stevens, Clinical Research Manager at the Clinical Research Network (CRN) West Midlands, and Chris Connell, Implementation Consultant (West) for the National Institute of Health and Care Excellence (NICE). There were also presentations and displays from staff and interactive workshops.

The ‘crowning glory’ of the day was the Staff Awards ceremony, which featured some great examples of individual and team excellence from a large field of nominations made by members of staff, patients and carers.

Find out more about the winners in the Quality and Safety section of this report.

Jan Ditheridge, Chief Executive, said: “The event was a real success and was a great way for us to recognise the hard work and dedication of our staff, and to thank them for everything they do. Community staff are the real unsung heroes - working out in local communities, in people's homes, clinics, prisons and community hospitals and not always the first health professional we think about. The things we celebrated show just how valuable they are and I would like to congratulate all of the award winners, and also recognise that they provide just a snapshot of all the good work being carried out by our staff in so many roles.”

Integrated Community Services

One of the big developments over the winter was working with Shropshire Council to expand our Integrated Community Services (ICS) after a successful first year in operation. Initially, this service was designed to serve the Shrewsbury and Atcham (Central) area, but it has now been rolled out to cover the whole of Shropshire (excluding Telford & Wrekin, which has a different model in operation called the Rapid Response Team).

The Central region ICS team was created as a pilot to make it easier for people who were well enough to be cared for in their own home or elsewhere in the community to leave

hospital. The team brings together specialists such as Nurses, Therapists, Social Workers and Voluntary Sector colleagues, who work with people to leave hospital; addressing their specific care, reablement or rehabilitation needs.

Key Features of the ICS Model

ICS brings together health and social care, along with community and voluntary services, to provide a more focussed service for complex patients to help avoid an admission to, or support a discharge from hospital.

The service provides assessment, rehabilitation, reablement and treatment (or recovery) in the community. Maintaining people at home when they become ill or supporting their discharge home to assess will be the main aim of the service. Home refers to normal place of residence.

People are provided with the necessary support to maximise their independence and recover from illness or injury before being assessed for their longer-term health and social care needs.

Promoting and supporting health campaigns

Throughout the year we regularly promote and support campaigns aimed at keeping people healthy.

This involves things like campaigns to raise awareness of issues such as hand hygiene, infection prevention and control, World COPD Day, Flu Safe, diabetes and many more.

As always, our staff were happy to give what time they could to help work with the media and help us to deliver these important messages to the communities we serve.

Our Queen's Nurses

In February, two of our nurses joined an exclusive club of community healthcare professionals after being awarded the prestigious title of Queen's Nurse.

Narinder Kular and Sara Logan have been given the accolade by the Queen's Nursing Institute, which recognises high standards of patient care, learning and leadership. There are only around 600 Queen's Nurses across the UK.

Attaining this title is no mean feat and involves carrying out project work, showing evidence of professional development and providing feedback from patients and other healthcare professionals. Those who are given the title benefit from being able to attend developmental workshops, apply for grants, develop links with equally committed healthcare professionals and form part of a very effective and respected network of experts.

Narinder Kular is a Nurse Consultant for Children with Complex Care whose career in the NHS spans nearly 30 years. Some of the highlights of the work she has carried out included writing a chapter for the recently published "Children and Young People's Nursing

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at a Glance", and developing an education training pack to improve breast feeding in an inner-city area, which was a project amounting to almost £100,000.

She said: "Being given the title of Queen's Nurse is a marvellous accolade. You join an exclusive club of nurses that are recognised for their ability to improve patient care and quality. The Queen's Nurse title will allow future opportunities to network with like-minded professionals. I hope it will reinvigorate my commitment to improve the lives of children and young people in the division in which I work. I will continue to provide excellent care respecting the values of parents and carers in Shropshire."

Sara Logan has been a Community Children's Nurse for 8 years and has a background in Paediatric Nursing that began at Great Ormond Street, 26 years ago. Sara's project work involved developing a care pathway to help infants and children return to oral feeding after being enterally fed via gastrostomy or nasogastric tube. Sara has received some very positive feedback from patients and carers, some of which was recently shared at a public Trust Board meeting.

She said: "This is a great achievement as you have to go through quite a rigorous process to be awarded the title of Queen's Nurse. Becoming a Queen's Nurse is an honour and will assist me in building networks and continuing to develop my work on enteral feeding and gastrostomy care for children in the community. The Queen's Nurse title will also enable me to become involved in work being undertaken at the Department of Health around Community Children's Nursing."

They join Jo France, School Nurse Manager and Professional Lead, who has also been honoured with the title of being a Queen's Nurse.

Qni The Queen's Nursing Institute

Shropshire Wheelchair Service hitting the silver screen

One of the things that really got people talking has been the role we played in producing one of the most successful big-screen blockbusters of the year – albeit a very small part.

The Theory of Everything, which depicts the amazing life of Professor Stephen Hawking, has achieved great success at the Golden Globes and the Oscars. What many people may not realise though is that staff at Shropshire Wheelchair & Posture Service helped filmmakers get their portrayal of one of the world's most renowned scientists as accurate as possible, specifically one of the wheelchairs he used as a young man.

The Service got involved after the production crew appealed to the National Wheelchair Managers Forum for helping finding a wheelchair that Professor Hawking used in the late 1970s. As Chair of the group, Krys Jarvis, who is also Wheelchair Service Manager at the Wheelchair & Posture Service, was able to help as they had the exact piece of equipment they were looking for at their base in Shrewsbury.

Krys said: "When I was first contacted it was very exciting to be potentially involved in the making of a film. The researchers for the film were extremely grateful for the help as the acquisition of authentic, now obsolete wheelchairs was proving to be challenging. The film shows the level of determination needed to overcome the limitations of disability and the role that technology plays in achieving everyone's full potential, which is the aim of our service when assessing each individual. The wheelchair

is now proudly on display in the reception of the Shropshire Rehabilitation Centre where this service is based."

For providing assistance in the production of the film both Krys Jarvis and Shropshire Community Health NHS Trust are included in the film's credits. It was a proud moment for members of Shropshire's Wheelchair & Posture Service, who help to meet the posture and mobility needs of thousands of people with a long term disability of all ages across the whole of Shropshire.

Helping to make change for the better

This year, Krys Jarvis has also been invited to join a new group to help to transform the quality and effectiveness of services for disabled people across the country by Britain's most successful Paralympian, Baroness Tanni Grey-Thompson.

The National Wheelchair Leadership Alliance has been formed to act as an advocate for people who use wheelchairs, their carers and families. It provides a high profile and highly influential panel with an acute understanding of the challenges and issues for people who use wheelchairs and wheelchair services. After showing an expression of interest in joining the Alliance, Krys attended the inaugural meeting at the House of Lords at the end of January.

Working together to improve Musculoskeletal services for people in Telford & Wrekin

A new model of delivering care for adult Musculoskeletal (MSK) patients from Telford & Wrekin is about to be launched.

Telford & Wrekin Clinical Commissioning Group recently announced that we would be leading a new Integrated Community MSK Service in partnership with The Shrewsbury and Telford Hospital NHS Trust, the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust, and Pain Management Solutions.

MSK services support patients who are having problems affecting the joints, spine, bones and the tissues around them.

The new service will bring healthcare professionals together to streamline the way patients are referred, assessed and treated. It will provide a Musculoskeletal, Clinical Assessment and Treatment Service, which includes Orthopaedics, Rheumatology, MSK Related Pain, Podiatry including Orthotics and Physiotherapy.

The aim is to deliver a high quality, patient-centred service as an alternative to hospital-based care for patients within Telford & Wrekin that have been referred by General Practitioners and other Health Care professionals.

By providing a single point of referral for all MSK activity this multi-disciplinary team will be able to ensure patients are being seen by the right people in the right place as quickly as possible.

Where a patient does need more specialist hospital care then the service will manage any pre-operative work, offer a choice of healthcare provider and then start any early supported discharge planning as appropriate.

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Working with our patients, carers and communities

The success we have had working with our patients and carers to strengthen services in the past year is something we should be shouting about - so that's exactly what we've done.

The amount that has been achieved since we set up our Patient and Carer Panel just over a year ago has been remarkable. We now have panel members, and other volunteers, involved in activities throughout the Trust.

And it is not only locally that this success is being recognised. In March, a group of staff attended a national conference being hosted by the King's Fund charity to lead a workshop on working with patients and communities.

The work carried out by our Patient and Carer Panel was chosen from more than 100 examples of good partnership working, and this was a great opportunity to show other healthcare professionals exactly what we are doing in Shropshire.

In a short space of time our Patient and Carer Panel has played an important part in shaping our plans for the future, as well as supporting the services we deliver every day.

Some of the ways in which the Panel has been helping us include: Training staff in Sit & See, sitting on interview panels, supporting staff/public events, taking part in Trust Board Patient Experience Development Days, sharing patient stories, helping us recruit and train volunteers, and joining Trust committees, groups and workstreams - among other things.

The presentation received very positive feedback at the event and could be shared with other staff at the Trust in the near future. The slides are available on the King's Fund website (more details below).

The aim of the event was to explore how we can improve and develop community health services. It also provided a forum for the sharing of good practice in community health care.

You can find out more about our Patient and Carer Panel in the Quality and Safety section of this report.

Saying Thank You

Once again we have had tremendous support over the year from the volunteers who support our services across Shropshire and Telford & Wrekin.

In December we held a Christmas Thank You Event to help us show our appreciation for everything they have done on behalf of our patients, carers and staff.

The event was well-attended with volunteers from across the area turning up to join in the celebration. It was a good chance for individuals and groups to meet each other and members of staff.

Strategic Report

Our Values

Over the past 18 months a lot of work has been carried out with our staff and stakeholders to develop our new Values.

This was all part of helping to reset the tone of the organisation, working with our staff and patients and carers to understand “how we do things round here” - our Culture - and “what our guiding principles are” - our Values.

All of us want to be proud of where we work and what we do. By building a core set of values that we can all buy into, and that guide us in what we say and do, this is something we can achieve.

Developing the shared values (which you will have seen earlier in this report) involved a lengthy process of engagement to make sure we got it right. Now we are working to embed these new Values into everything we do. For example, we will be starting to use values-based recruitment to ensure new staff coming to work with us share the views and behaviours we feel will ultimately benefit all of our patients, carers and staff.

We also decided to develop some ways of helping to bring our Values to life, such as producing a logo that we can use to promote them visually. Thanks to the creativity of Dr Emma Lawrence, Manager of our Community Neuro Rehab Team, we were able to produce a number of different design ideas that we then shared with staff to decide which would be developed into our preferred logo. This is the image that you can see below.

Strategic Report

Quality and Safety

Given the central role that community health services play in delivering NHS care, it is vital that they are as high in quality, safe, patient-focused and efficient as possible.

Most of the contact people have with the NHS is not in acute hospitals. Many more NHS patients consult their GP or are visited in their own home by a District Nurse or Health Visitor.

In a time when there is large-scale change for the NHS nationally, we are creating stability and developing local services for local people as an NHS organisation dedicated to community-based services. We want to strengthen and improve those services and at the same time ensure that we stay true to the traditional caring values of the NHS.

We know that we need to continually innovate in the way that we deliver our services and we will be working closely with staff, GPs, the local acute hospitals and social care to make sure we are adopting the best, most effective care for patients.

Steve Gregory
Director of Nursing and Operations

Delivering high quality care

Our aim is to be the best at what we do, and that is to deliver the highest quality of care and support for the people we serve. We know that quality requires commitment to act, to be inquisitive, to think, to do the right things in the right way using the best available evidence.

The Trust's Quality Strategy is predicated upon the following guiding principles:

- Care that is clinically effective
- Care that is safe
- Care that provides as positive an experience as possible
- Is aware of the following delivery dimensions, safe, effective, caring, responsive and well-led
- Makes intelligent use of all available information, data and feedback, including the Patient and Carer Panel

Strategic Report

Strengthening our services for the future

In 2015/16 we will be introducing a number of important and exciting quality and safety initiatives to help us meet the current and future challenges and demands on our healthcare system. These come under a number of different areas of work, which we will take a closer look at now.

Safe services

During 2015/16 we will launch our Three-Year Safety Improvement Plan. This has been developed during the past year and structured around the five pledges of the Sign Up to Safety Campaign. The priorities that we have identified (transitional care, supporting our staff in a values based way, preventing medication errors, handover and discharge) will show our commitment to all our patient groups across all ages and services. We are especially aware of the need to provide safe effective services for vulnerable groups of patients, particularly those in community settings.

We will continue to support our staff to deliver safe, effective and appropriate care across all our services. This involves making sure they have the right level of training, support and resources to do their jobs.

Making sure we have the right systems in place to gather feedback and monitor risk is also crucial if we are going to be able to highlight areas where we are doing well – which will allow us to share best practice and celebrate success – and also to quickly identify areas where we need to do better and changes need to be made.

Effective services

We will be making improvements to our corporate induction and mandatory training programmes over the next year to ensure that our staff are well informed and responsive to our patients, their families and carers. As part of this, development needs will be identified and addressed through the appraisal process for all our staff.

We are committed to showing people how we have implemented change following feedback from both members of the public and staff through a process called “You said….we did”. This is something we will be developing further and making more visible over the coming year.

Caring Services

During 2014/15 we engaged stakeholders and staff in reviewing and updating our values, placing greater emphasis on person-centred care. We will continue to treat people with compassion, dignity and respect and continue to embed the principles of the 6 Cs. The Trust will track the effectiveness of this through feedback, in particular via the Friends and Family test which will be used to show that people are respected and valued as individuals and empowered to contribute to their own care.

Responsive services

In our most recently published Quality Account we said that we know it is incredibly important to listen to and respond to feedback from a variety of sources to enhance and improve the care that our services provide. Over the coming year, the introduction of the Friends and Family Test across all services, as well as many surveys run by our services, will give us exciting and immediate opportunities to really change and improve the experience of people that use our services. This is in addition to the activity of the Patient and Carer Panel further, which we will talk about a bit more later on in this section of the Report.

Well-led services

Over the past year we have worked with staff and patient representatives to develop our core values. Our focus over the next year is to embed these values and to ensure that all staff at all levels of the organisation are aware of, and committed to them and reflect them in their day-to-day work to show that this is how we do things.

The increased visibility of Board members and feedback from them to teams will continue as will "Our Way of Working – Values into action", a way of helping teams to become proficient in the use of improvement methodology to lead on service improvement at a grass roots level.

Delivery of operational performance standards

During the coming year we will continue to place high priority on the delivery of operational performance standards and continue to meet local and national targets. These will be continually reviewed and where problems are identified we will act quickly to make sure our patients are getting the high quality services they expect and deserve.

Workforce planning

Our Workforce Strategy recognises that in the long term there will be an increasing care need in the community, and to be successful in meeting that demand we need a workforce that is fit for purpose. To help us drive forward our ambitions we recognise the need to work across historical boundaries and this will be a challenge. Therefore to support this approach we are:

- engaging with our staff
- developing and refining new leadership opportunities around service improvement and change management
- improving the completion rates and quality of appraisals
- looking at how we manage absence from work
- developing more integrated teams, supported by:
    - giving staff more training and skills
    - developing strong generic roles
    - joint training and rotations through different care settings

The outcome of this will be that we continue to have the right people with the right skills in the right place as our services evolve and expand.

Some of the challenges we could face in the coming year are:

- extension of 7-day working practices
- the implementation of Safer Care and the implications for nurse staffing levels in community hospitals and community teams
- integration with other agencies is likely to have implications, such as staff training and working with joint protocols

Quality Account

In June 2014 we published our annual Quality Account, which reviewed the progress we made on quality and safety during 2013/14. In the same document we identified four priorities for 2014/15 once again developed in consultation with representatives from our Patient and Carer Panel and our partners as well as members of staff.

We have worked hard on achieving the elements of these priorities over the year and a full review of our progress will be reflected in our Quality Account in which we will also look forward to the coming year. Our identified priorities are reflected in the table below and some of the work we have done towards them is reported on over the next few pages.

Priority one	Involvement of the Patient and Carer Panel in the work of the Trust
Priority two	Keeping everyone safe in our care
Priority three	Supporting our staff to do their jobs well
Priority four	Working with partners to provide seamless care

Strategic Report

Sign up to Safety

Sign up to Safety is a national campaign that aims to listen to patients, carers and staff, learn from what they say when things go wrong and take action to improve patients' safety. Sign up to Safety is designed to help realise the ambition of making the NHS the safest healthcare system in the world by creating a system devoted to continuous learning and improvement.

This campaign required us to describe how we are going to support the five pledges below – this we have done and submitted them to the national campaign.

1. **Put safety first.** Commit to reduce avoidable harm in the NHS by half and make public the goals and plans developed locally.

2. **Continually learn.** Make their organisations more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe their services are.

3. **Honesty.** Be transparent with people about their progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.

4. **Collaborate.** Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.

5. **Support.** Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress.

Patient Safety

We now have to put together a three-year patient safety improvement plan based on some priorities that we think we can really work on. This has to be done in the next few months and we will be asking clinical teams to provide us with expertise to ensure that this is a really useful plan and also ask our patients and carers to contribute to make sure the plan meets their needs and aspirations. We will ensure that this is fully reflected in our Quality Account over the next three years.

Examples of how we are working to improve safety are eliminating avoidable pressure ulcers and reducing the number of falls in our Community Hospitals.

As we reported in our review last year we are working towards our aim to completely eliminate pressure ulcers that were avoidable and attributable to the care that we provide to patients. We continue to report all pressure ulcers and we review all of these to understand whether there is anything we could have done differently to prevent them happening. This understanding can then be shared across our services and we continue to support and train our staff and staff in care homes and agencies to prevent pressure ulcers.

Strategic Report

As last year, we have seen a reduction in the number of pressure ulcers we have reported. The table shows reported pressure ulcers over the past three years.

	2012/13	2013/14	2014/15
Grade 2	251	165	106
Grade 3	50	36	27
Grade 4	11	5	5

We have also seen a continued reduction in the number of patient falls that we record in our Community Hospitals as shown in the table below. This is due to several different actions to reduce falls including assessing patients for their risk of falls when they come into our hospitals.

	2012/13	2013/14	2014/15
Number of falls	402	346	303
Number of patients that fell	270	277	207
Patients that sustained serious harm	2	2	2

Safe Staffing

Over the last few years attention has focussed on making sure that services have the right staff, in the right place at the right time.

A set of guidelines was produced to support organisations to have a consistent and evidenced-based approach to achieving safe staffing. During the past year, we have reported community hospital staffing on a monthly basis and undertaken each six months a more intense and evidence based workforce review.

The review culminated in changes to the nursing establishment in the inpatient services. We will continue to monitor and take action where required to maintain safe care.

Over the forthcoming year we will be taking forward a review of our community staffing ensuring that care is aligned to patient need and that the workforce has the right skills and competencies to deliver care across different pathways.

Strategic Report

Board to Team/Service visits

During the last year, Trust Board members have conducted joint visits (involving a Non-Executive and Executive Director) to more than 30 teams. This is in addition to the routine visits that take place, the purpose of which are to ensure that staff know who the Board members are, to be able to have a conversation about the team they are working in and feedback any suggestions or comments about what could be different. During this time the Board has visited both clinical and non-clinical services.

Patient Stories (to the Board)

To help us learn from the first-hand experiences of our patients, their families and carers about the care and support we have provided we now make time at each of our public Trust Board meetings to listen to a patient story.

These stories provide a mix of positive, negative and mixed experiences from people to give us a valuable insight into the services we deliver. They can highlight examples of good practice or things we need to do better that may not be picked up by traditional performance measures, but importantly have made a real difference to the people who come to talk to us.

We are grateful to all the people that have come to share their stories with us so far and will be inviting many more in future.

Celebrating Success

In October, we held a very successful event as part of the Staff Awards at which clinical staff from across our services presented to their colleagues. This was valuable in that it enabled staff to understand more of what their colleagues in other services do and to celebrate their success with them. Alongside the presentations we invited teams to provide posters which were displayed for people to study at their leisure. The event was very well received and we will be repeating it later this year.

The Staff Awards ceremony was all about celebrating what we do well. Every year our staff and volunteers do amazing things that make a real difference to our patients and carers. From inspirational leaders to those who go the extra mile - we all know of people we can learn from and that is exactly what this event was all about.

The 2014 Staff Awards winners were:

Effectiveness Award

- Early Years Children's Physiotherapy Team

Working in Partnership Award

- Community Neuro Rehabilitation Team

Strategic Report

Unsung Hero Award

- Rachel Stringfellow (Office Manager/PA for the Paediatric Psychology Service at Monkmoor)
- Tom Knight (Porter/Records Assistant at Coral House)

Improving Patients' Experience Award

- Tier 3 Children and Adolescent Mental Health Service for Telford & Wrekin and Shropshire - winners
- Helen Craddock and Amanda Jones (Health Visitors)

Lifetime Achievement Award

- Paul Cooper (Estates Advisor)

Leader of the Year Award

- Alison Parkinson (Clinical Services Manager, Targeted Children's Services)
- Clare Guerreiro (Occupational Health Business Manager)

Staff Member of the Year Award (indirect patient care)

- Theresa Taff (Senior Financial Accountant)

Staff Member of the Year Award (direct patient care)

- Jenny Paul (Highly Specialist Occupational Therapist with the Community Neuro Rehab Team in Shrewsbury)

Team of the Year Award

- Care of the Next Infant (CONI) Co-ordinators

Strategic Report

Working with our communities

We think it is really important to involve patients and the public in the planning and development of our services. If we are going to be able to effectively meet the needs of a population increasing in terms of size, age, medical needs and diversity of ethnicity, then we have to have strong links with our communities. We need to know what our communities need from us and we need this information quickly and continuously. This should not be done through periodical engagement exercises, but by strengthening the links we already have in place so that we have a permanent open channel of communication and engagement in place with our stakeholders, whether they are patients, staff or partner organisations.

We already have strong links with a variety of groups, such as the Friends groups supporting our Community Hospitals and other volunteer organisations, that we have been able to work closely with over the years and we will continue to strengthen these.

Volunteers play a number of important roles, for example they help us to collect patient feedback in our Community Hospitals. Since January 2015, we have extended the Friends and Family question (would you recommend this service to your friends and family should they require it?) to all our services and the feedback that we receive enables us to look at how we provide services to best suit those who use them. In January and February 2015, 95% and 97.5% of people that used our services would be either extremely likely or likely to recommend them.

We can use this information alongside other feedback such as contacts with our Patient Advice and Liaison Service (PALS) and any formal complaints we receive to understand where we could further improve our services.

Patient and Carer Panel and Patient/Carer feedback

One area where we have had great success in 2014/15 has been launching our Patient and Carer Panel. This really has brought patients and carers into the heart of everything we do. From planning services and hiring staff to delivering training and reviewing services, our Panel members have been given the chance to make a meaningful contribution to our services.

The Panel now has members sitting in key Trust committees, such as the Quality and Safety Committee and the Feedback Intelligence Group, and is also involved in interviewing and recruiting new members of staff – from the ward to the Board. Members also work closely with a wide range of key stakeholders, from Healthwatch to voluntary and statutory sector organisations. It has representation from organisations such as umbrella carers' bodies, local government and the Local Health Economy Patient Experience Group.

Strategic Report

Some other ways in which the Panel has been helping us include:

- **Training staff in Sit & See:** This approach involves working with volunteers, clinical and non-clinical staff, in observation exercises that highlight positive examples of care, kindness and compassion, as well as recording poor practice and areas of concern.
- **Interviews:** Members have taken part in interviews for new staff, including Executive Directors and Nurses.
- **Staff/Public Events:** Members have given presentations and acted as advocates for patients and carers at a number of events, including our AGM and Staff Awards.
- **Trust Board Patient Experience Development Day:** This involved group discussions with Board members. It gave the Board an opportunity to think collectively about whether or not we have the right systems, processes and culture in place to optimise patient and carer feedback, and to facilitate their involvement in our service redesign (speed dating approach with volunteers/service users and Board members in smaller groups).
- **Patient Stories:** Sharing our patient stories is an important way of helping staff throughout the Trust to learn from the experiences of people who have used our services. This is something we are keen to do more of and we have already had successful meetings to help us gather more of these stories.
- **Volunteers:** The Panel has made improvements to the way we recruit and train our volunteers, including the development of our terms of reference, creating a volunteer handbook, and improving training courses.
- **Co-production/Focus Groups:** Panel members, specific service users, carers and staff have started a rolling programme of activity for services. The first being undertaken by Child and Adolescent Mental Health Services.
- **Friends & Family Test:** Our staff and volunteers have made a really good start to collecting this feedback from our patients, but we need to keep up the good work and make sure we are gathering as much of this as we can.
- **Direct Patient Involvement in groups and workstreams:** Members take part in meetings (e.g. Quality & Safety Committee, Minor Injury Units Forum) and work on Clinical Effectiveness, Infection Control and Complaints.
- **You said we did:** Such as joint actions with carers' umbrella groups to demonstrate improvement, including:
    - distributing leaflets/contact details from the Community Council of Shropshire's Carers Team in Community Hospitals
    - made available carers' e-learning course for staff

Performance

Monitoring our activity and performance against a range of indicators – including national, contractual and local targets – is an important part of ensuring we deliver high quality services.

The table below provides an indication of overall activity carried out by the Trust in 2014/15.

Patient Activity Figures 2014/15	
Community contacts	685,451
Outpatient attendances	36,755
Inpatient & days cases	1,149
Occupied Bed days	36,075
Radiology examinations	13,096
Minor Injuries Attendances	24,997
Equipment & products supplied	229,061
Prison Healthcare contacts	10,666

A summary of our performance against the national targets

All but one of our national indicators was reported on target last year, which are illustrated in the table on the following page.

The one area that remained below target was the Safety Thermometer - Harm Free Care. The trend on the Safety Thermometer through 14/15 has shown an increase in pressure ulcers described as already being present when the patient came into our Trusts care. The target is against a measure that 95% of patients are considered harm free. Performance is measured monthly and for the year averaged 93.8%.

Further information on performance against quality standards is included in our annual Quality Account.

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National Indicators	
Key Indicator	**Status**
Ethnic coding data quality	
Use of NHS number	
Overall CoS rating	
MRSA bacteraemia pre 48hr cases	
Post 72hr cases Clostridium difficile diagnosed	
Access to Healthcare for people with Learning Disability	
Complaints - acknowledged within 3 working days	
Safety Thermometer - harm free care	
Single Sex Accomodation Breaches	
VTE Venous Thromboembolism Risk Assessment	
18 week Referral To Treatment (RTT) for admitted patients	
18 week Referral To Treatment (RTT) for non admitted patients	
18 week Referral To Treatment (RTT) incomplete pathways	
A&E 4 Hour Waits (MIU)	
A&E Left Without Being Seen	
A&E Time to Initial Assessment	
A&E Time to Treatment Decision	
A&E Unplanned Re-Attendance Rate	
Diagnostics for Audio/Ultrasound	

Other targets

Other key areas of focus used by senior management include contractual and local indicators, as well as access and waiting time information. These are reported in detail in the Trust's monthly performance report (which is reported to the Trust Board and published on our website) or in bespoke departmental reports.

In January 2015 the Trust Board approved a new Performance Management Framework (PMF) for 2015/16. Going forward, the new PMF will ensure alignment between clinical and non-clinical operational performance, activity, finance and quality to enable the Board and Trust management to:

- Assess performance against targets
- Determine what action is necessary to address performance issues
- Predict future performance and key actions
- Focus resource and attention in required areas

Key areas of focus in the future include:

- Waiting times - although many of our services are not subject to the national referral to treatment (RTT) target, we aspire to ensure waiting time is minimised in all areas
- Continuation of Length of Stay reductions for Community Hospital activity
- Reducing the "Did Not Attend" rate for outpatient activity

Strategic Report

Patient-led assessments

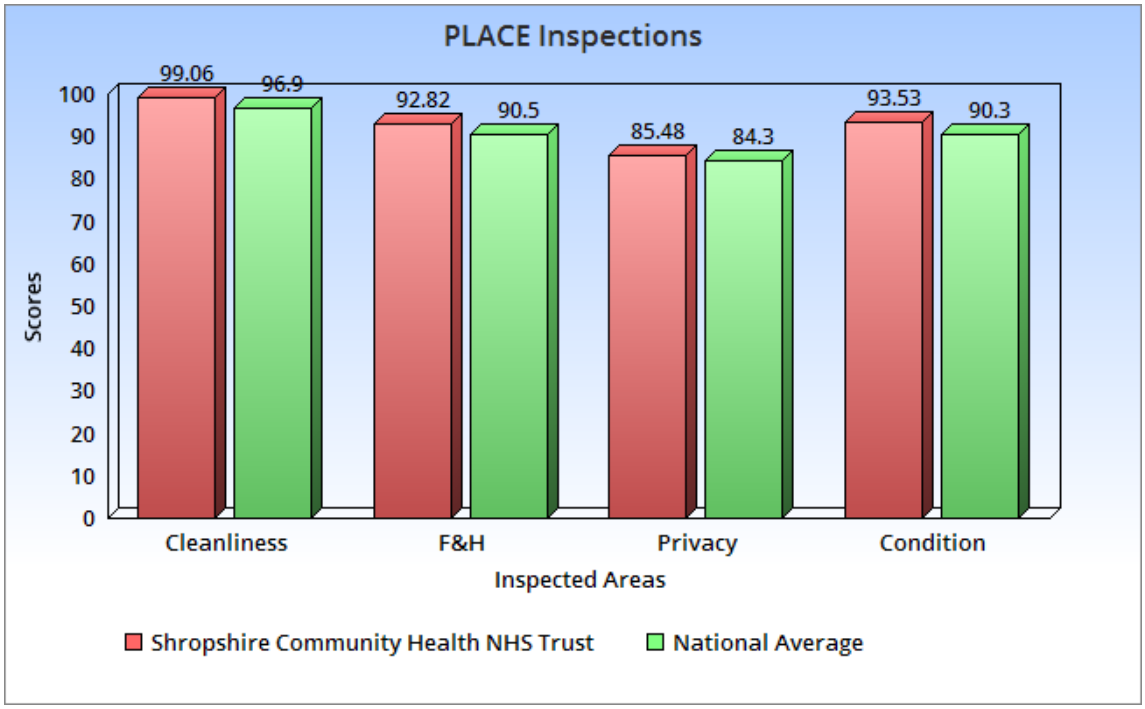
The latest round of Patient-Led Assessments of the Care Environment (PLACE) have shown this Trust to be performing above the national average when it comes to delivering non-clinical services in our Community Hospitals.

PLACE inspections provide a snapshot of how an organisation is performing against a range of non-clinical criteria, which have been identified as important by patients and members of the public. These are:

- Cleanliness
- Food and Hydration
- Privacy, Dignity and Wellbeing
- Condition, Appearance and Maintenance

These inspections are carried out by teams made up from local NHS staff, independent healthcare providers, and most importantly members of the public. They help us to identify areas where we are doing well and can share best-practice, and also areas where we need to improve to make sure patients, visitors and staff in our Community Hospitals are getting the best possible experience.

The scores in the table below show, as a percentage, how successfully we are meeting the criteria we are being assessed against and how we compare to other NHS Community Trusts in 2014.



Strategic Report

Looking to the future – where have we come from and where are we going?

The Trust's five year plan highlighted 2014/15 as a key year. A new executive team was established and extensive work has been undertaken to engage patients, staff and stakeholders in refining our values, vision and goals.

We have had a successful year in terms of making the best use of the resources available to us and balancing our books, making sure we meet the performance targets set for us nationally and locally, improving the quality of the services we deliver and strengthening relationships with our stakeholders.

In this next section of the report we will set out our vision for the future and take a broad look at how we intend to deliver our plans.

Andrew Ferguson
Director of Strategy

Our vision for the future

Strategic context and direction

This year we revised our vision, values and strategic objectives to reflect the increasing emphasis nationally and locally on the pivotal role of community services. The Trust vision states that:

"We will work closely with our health and social care partners to give patients more control over their own care and make necessary treatments more readily available. We will support people with multiple health conditions, not just single diseases, and deliver care as locally and conveniently as possible for our patients. We will develop our current and future workforce and introduce innovative ways to use technology."

This overarching vision will be delivered through four strategic goals agreed by the Trust Board, these are:

- To deliver high quality care
- To support people to live independently at home
- To deliver integrated care
- To develop sustainable community services

Strategic Report

For 2015/16 the Trust has identified 12 key priorities to deliver, these are set out in the table below.

Developing systems and culture of continuous improvement	Strengthening teams with greater autonomy	Delivering against performance targets	Defining and delivering productivity improvements
Defining and strengthening the role of the Trust in urgent care	Developing the model of care for community teams	Strengthening the role of community hospitals	Achieving integration across: health /social care / acute / primary
Implementing key elements of IM&T strategy	Defining and implementing the future estates strategy	Growing defined service areas	Securing a sustainable organisation

Each of these areas has a defined programme of work associated with it. At the core of these priorities is the aim of creating a positive environment where teams across all services feel empowered to make decisions and improve services. Strengthening teams will help achieve this but there are also key strategic initiatives that we will prioritise.

Implementing our IM&T strategy will be a significant step forward, we will procure a new Electronic Patient Record which will offer greater opportunities to integrate information and provide better access to information across the community. During 2014/15 we introduced hand held tablet devices across the Health Visiting service, which have proved a successful precursor to the broader implementation of the EPR.

Improving productivity is a priority across all our services and corporate departments. Some of our strategic initiatives will support this drive, for example strengthening integration of teams and creating greater autonomy, these initiatives supported by an emphasis on continuous improvement will help us to move towards a more streamlined organisation and allow us to increase our responsiveness to patients.

The NHS Future Fit programme will continue to be a key driver for strategic change across the health and social care economy. This work is reviewing the way acute and community hospital services are delivered in Shropshire and Telford & Wrekin.

There are already some very good health services in our communities, but they have developed over many years to try to best meet the people's needs and expectations. As these needs and expectations continue to change, coupled with the quality standards that we should aspire to for our population within the challenging economic environment, it has become clear that the time has come to look again at how we design services so we can meet the needs of our population and provide excellent healthcare services locally for the next 20 years.

A lot of public and professional engagement has been carried out to make sure the shortlist of options that is developed, and eventually goes out for formal consultation, truly reflects best what people want and need.

Strategic Report

As the key provider of community health services in Shropshire and Telford & Wrekin we are at the heart of this work and the findings of the NHS Future Fit programme so far have reinforced our vision of providing as much as possible for people as close to, or in their own homes.

To date Future Fit has very much focussed on hospital based care. In 2015/16 there will be a greater emphasis on the strategic planning of community services. Two key areas of work will be taken forward. Firstly a specific programme focusing on Rural Urgent Care centres, this will define their role as part of the overall urgent care network and clarify where they can be implemented across the county. The second major initiative is 'Community Fit' which will consider the future organisation and delivery of the broad range of community services. These initiatives represent an exciting opportunity for community services to be centre stage in the planning and development of services.

During 2014/15 our commissioners supported the expansion of our Integrated Community Service (ICS) – which you will have read more about earlier in this Annual Report – and this is the first step in strengthening community services to support this strategic direction. The Trust is also fully engaged with the local Better Care Fund programmes that aim to strengthen links between health and social care, which is crucial as we aim to design seamless services around the needs of our patients.

Organisational sustainability

During 2014/15 the Trust Board reviewed its future plans in light of the Five Year Forward View, the Dalton Review and local strategic plans. These consider why change is needed, what success might look like, and how we might get there.

The Board agreed that the Trust should reaffirm its commitment to being an organisation dedicated towards delivering strong community services and therefore should work towards becoming a Community Foundation Trust.

Our finances

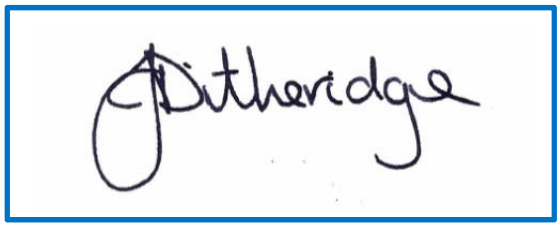
Our plans for the next financial year involve building on the success we had in balancing our books last year and delivering a small surplus as we progress towards a more sustainable long-term financial plan. In order to do this we need to use our resources effectively to continue delivering our services, invest for the future and make the savings we are required to make by the Department of Health.

All NHS services face the increasing challenge of rising demand and reducing funding, but we feel there are opportunities for us to address these challenges through transformational change and identifying new, sustainable ways of delivering services.

More details about the direction under which these accounts are being reported and the Trust's status as a going concern can be found in the Director's Report and Annual Accounts sections of this report respectively.

Strategic Report

This Strategic Report has been approved by the Board of Shropshire Community Health NHS Trust.



Jan Ditheridge
Chief Executive

30 July 2015

Directors Report

The Trust Board

The Trust Board is responsible for the leadership, management and governance of the organisation and setting the strategic direction.

The NHS Trust Development Authority (TDA) appoints all of the organisation's Non-Executive Directors, including the Chairman. The Chief Executive is appointed by the Chairman and Non-executive Directors. The Executive Directors are recruited by the Non-Executive Director-led Nomination, Appointments and Remuneration Committee and supported by the Chief Executive.

Membership of the Trust Board as at the time this Annual Report and Accounts were approved:

Mike Ridley, Chairman (Term: July 2011 to December 2015)

Mike has 25 years of experience as an NHS Finance Director and is a former Chief Executive of South Worcestershire and North and South Stoke Primary Care Trusts (PCTs). He retired from full time employment in the NHS in 2006 and has been Chair of Shropshire Community Health Trust since it was formed in 2011.

Michael Sommers, Non-Executive Director (Term: July 2011 to June 2015)

Mike is a career marketing man who spent 20 years in fast moving consumer goods manufacturing and later retailing, leading marketing departments in several major UK firms. After a brief stint in financial services with TSB he became managing director of MGM Cinemas - the UK's leading cinema network at that time. He is now a marketing consultant who has served as a Non-Executive Director of the Trust since 2011.

Angela Saganowska, Non-Executive Director (Term: July 2011 to June 2015)

Angela has gained important experience working with local authorities in Birmingham, Leicester and Wrexham on health and well-being issues, and she has also worked on strategic partnerships and business planning with Sandwell Mental Health Trust. Angela is a qualified Social Worker with previous links to Barnardo's. She has acted as a hospital manager under the mental health act for the South Staffordshire and Shropshire Mental Health Foundation Trust.

Directors Report

Rolf Levesley, Non-Executive Director (Term: July 2011 to June 2015)

Rolf is a qualified solicitor and spent the early part of his working life as a litigation lawyer. He then became Head of Legal Services in a local authority and spent the last five years of his working life as a local authority Chief Executive. Rolf is currently a member of the Standards Committee of West Mercia Police Authority, a Board member of South Staffordshire CVA and Chair of the registered charity Friends of Conakry Refugee School.

Jane Mackenzie, Non-Executive Director (Term: September 2013 to August 2017)

Jane is a highly specialist Speech and Language Therapist and Art Therapist with over 25 years clinical experience working in community settings across England and Wales, and until recently was the England Policy Officer for the Royal College of Speech and Language Therapists. Jane has had particular experience working as a specialist Speech and Language Therapist for people with learning disabilities in Shropshire, Powys and Ceredigion.

Peter Phillips, Non-Executive Director (Term: October 2013 to October 2017)

Peter has extensive private sector financial and commercial experience at PLC main board level. Peter is a Fellow of both the Institute of Chartered Accountants in England and Wales and of the Association of Corporate Treasurers. Peter joined the Trust as a Non-Executive Director in 2011 and is the Chair of the Trust's Audit Committee. He is also a National Council Member of Arts Council England and their Chairman for the Midlands area.

Jan Ditheridge, Chief Executive (Appointed September 2013)

Jan joined the Trust as interim Chief Executive in September 2013 before taking on the role permanently later that year. She is an experienced strategic leader with a background encompassing a broad variety of clinical, operational and leadership roles across health, social care and the private sector. She also has a wealth of expertise in the areas of transformation, delivery, clinical quality and effective performance management. Jan is dual qualified as a registered general and mental health nurse.

Steve Gregory, Director of Nursing and Operations (Appointed January 2014)

Steve is a Registered Nurse with a strong track record of modernising services and strongly believes in giving clinicians really good professional leadership and support. He has been involved in leading complex change programmes to support patients in better ways. Before moving into community health services he played a critical role in the leadership team that ensured South Staffordshire and Shropshire Healthcare became one of the first Mental Health Foundation Trusts.

Directors Report

Andrew Ferguson, Director of Strategy (Appointed September 2014)

Andrew Ferguson took up the post of Director of Strategy in September 2014 having previously served as Deputy Director of Strategy and Business Development at Worcestershire Health and Care NHS Trust. Andrew plays a key role in developing the Trust's vision and plans for the future and helping to develop the services the organisation provides.

Trish Donovan, Director of Finance (Appointed August 2013)

Trish joined the Trust in August 2013 from North Staffordshire Combined Healthcare NHS Trust, where she was the Director of Finance and Performance, as well as Deputy Chief Executive. She has had extensive experience across a range of NHS organisations – including acute and mental health trusts in both NHS and Foundation Trusts. A member of the Chartered Institute of Management Accountants, Trish has 6 years of board level experience in business areas such as contracting, IM&T and estates functions as well as finance.

Dr Mahadeva Ganesh – Medical Director (Appointed August 2014)

Dr Ganesh was appointed as one of the Trust's Medical Directors in August 2014. He is a Consultant Paediatrician who has been working in Shropshire since 1999. In 2011, Dr. Ganesh became the Clinical Lead for the Community Paediatric medicine team. He is the designated doctor for Safeguarding across Shropshire and Telford & Wrekin, and Lead Consultant for the Community Paediatric Audiology Service.

Dr Peter Clowes, Medical Director (Appointed August 2014)

Dr Clowes has been a GP in Shrewsbury for more than 30 years and played key roles in many of the NHS organisations both planning and providing care for the communities of Shropshire and Telford & Wrekin. He was appointed as one of the Trust's Medical Directors in August 2014.

Julie Thornby, Director of Corporate Affairs (non-voting member) (Appointed July 2011)

Julie is a very experienced Director, having about 20 years at Board level in the NHS, in community services and PCTs including Board Secretary experience. Julie has a proven track record in delivering governance arrangements, and public and staff engagement, to achieve organisational change. Her directorate provides support to both clinical and non-clinical in areas such as Corporate Governance, Risk, Communications and Marketing and Equality and Diversity.

Other directors who served on the Trust Board during 2014/15 were Tessa Norris, Director of Operations (until 19 December 2014) and Dr Alastair Neale (until 31 July 2014).

Directors Report

Trust Board Members - Disclosure of Interests

Name	Interest
Voting Board Members	
Mr Mike Ridley Chair	Director, Crewe YMCA. Daughter is a Senior Analyst with CHKS.
Ms Jan Ditheridge Chief Executive	Nil
Mr Michael Sommers Non-Executive Director	Nil
Mr Rolf Levesley Non-Executive Director	Non-Executive Chair and Director at South Staffordshire Housing Association and Housing Plus Group. Chair of South Staffordshire Council for Voluntary Services.
Ms Angela Saganowska Non-Executive Director	Hospital Manager under the Mental Health Act South Staffordshire and Shropshire NHS Mental Health Foundation Trust. Role is solely to review individuals detained under the Mental Health Act. Role has no strategic or operational responsibilities.
Mr Peter Phillips Non-Executive Director	Chairman of Quality Compliance Systems Ltd which provides compliance manuals for care homes, domiciliary care, GP and dental practices.
Ms Jane Mackenzie Non-Executive Director	Member of the Shropshire Older Peoples Assembly (SOPA) steering group. Shropshire unitary councillor. May decide to work as a Speech and Language Therapist locally in the future.
Mrs Trish Donovan Director of Finance	Director of Vinterior Ltd a retail interior business unlikely to ever seek to do business with the NHS. Director of Shrewsbury Business Improvement District (BID)
Mr Steve Gregory Director of Nursing and Operations	Nil

Directors Report

Dr Mahadeva Ganesh Medical Director	Mountain Healthcare. Private contractor of forensic medical examination for children suspected of sexual abuse. Work carried out separate to current work.
Dr Peter Clowes Medical Director	Clinical Lead for Urgent Care, Shropshire CCG.
Mr Andrew Ferguson Director of Strategy	Nil
Non-voting board members	
Ms Julie Thornby Director of Corporate Affairs	Nil
Previous Board members (voting and nonvoting)	
Ms Tessa Norris – Director of Operations *(From 1 July 2013 – until 19 December 2014)*	Nil
Dr Alastair Neale – Medical Director *(until 31 July 2014)*	Trustee of Sebakwe Black Rhino Trust – a conservation and children's charity in Zimbabwe. I provide occasional private clinical work to Cruckton Hall School Hanwood which specializes in ADHD and ASD.

Committee Membership and Attendance

There are a number of key committees in place that help the Trust Board to manage and monitor the Trust effectively. The committee structure provides information and updates to the Trust Board to contribute to its assessment of assurance.

Audit Committee

Role and Purpose:

The Audit Committee provides an overarching governance role and reviews the work of other governance committees within the Trust, whose work can provide relevant assurance to the Audit Committee's own scope of work.

Membership:

- Peter Phillips (Chairman) – Non-Executive Director
- Angela Saganowska – Non Executive Director
- Mike Sommers – Non Executive Director

Other Executive Directors and Senior Managers of the Trust are regularly invited to attend meetings of the Audit Committee; Director of Corporate Affairs, Julie Thornby, is Executive Lead. Non-Executive Directors (excluding the Chairman) are invited to attend.

Quality and Safety Committee

Role and Purpose:

The Quality and Safety Committee oversees the review of quality assurance on all aspects of quality throughout the Trust. This includes reviewing information against the three quality domains of safety, effectiveness and patient experience. The primary aim is to ensure the robustness of systems, processes and behaviours, monitor trends, and take action to provide assurance to the Trust Board.

Membership:

- Angela Saganowska (Chair) – Non Executive Director
- Mike Ridley – Chairman
- Rolf Levesley – Non Executive Director
- Steve Gregory - Director of Nursing of Operations
- Dr Peter Clowes- Medical Director

- Dr Mahadeva Ganesh – Medical Director
- Jan Ditheridge – Chief Executive
- Julie Thornby – Director of Corporate Affairs
- Milly Smith and Roger Buckley – Patient Representative

Other attendees include: Deputy Director of Operations, Deputy Director of Nursing and Quality and Quality Facilitator. Other Trust managers and health professional staff attend for specific items. Director of Nursing and Operations, Steve Gregory is Executive Lead. All other NEDs are invited to attend.

Resource and Performance Committee

Role and Purpose:

The Resource and Performance Committee has delegated authority from the Board to oversee, co-ordinate, review and assess the financial and performance management arrangements within the Trust. The Committee assists in ensuring that Board members have a sufficiently robust understanding of key performance and financial issues to enable sound decision-making.

Membership:

- Mike Sommers (Chair) – Non Executive Director
- Rolf Levesley – Non Executive Director
- Peter Phillips – Non Executive Director
- Trish Donovan – Director of Finance
- Jan Ditheridge – Chief Executive
- Steve Gregory – Director of Nursing and Operations
- Andrew Ferguson – Director of Strategy

Other attendees include the Chairman and the Medical Director. Other Trust managers and health professional staff attend as required. Director of Finance, Trish Donovan is the Executive Lead. All other NEDs are invited to attend.

Information Governance Committee

Role and Purpose:

The IG Committee oversees the development of the Trust's Information Governance strategy to provide assurance to the Board on arrangements for handling and using information, including personal information, safely and securely, consistent with all legal requirements and national standards.

Membership:

- Rolf Levesley (Chair) - Non Executive Director
- Trish Donovan – Director of Finance/ SIRO
- Julie Thornby – Director of Corporate Affairs
- Andrew Ferguson – Director of Strategy
- Steve Gregory – Director of Nursing and Operations (Caldicott Guardian)
- Andrew Crookes – Head of Informatics
- Gill Richards – IG Manger

Other Executive Directors and senior managers will be invited as required. Director of Strategy, Andrew Ferguson, is the Executive Lead. All other NEDs are invited to attend.

Nomination, Appointment and Remuneration Committee

Role and Purpose:

The Committee has an overall responsibility in respect of the structure, size and composition of the board and matters of pay and employment conditions of service for the Chief Executive, Executive Directors and Senior Managers (including the Board Secretary). In order that the Trust shall deliver sound stewardship of public funds the Committee must ensure that the Trust conducts its business in accordance with:

- legal requirements,
- the principles of probity,
- good people management practice, and
- proper corporate governance.

Directors Report

Membership:

- Mike Ridley (Chair) – Chairman
- Rolf Levesley - Non Executive Director
- Angela Saganowska - Non Executive Director
- Jane Mackenzie – Non Executive Director
- Mike Sommers (Chair) – Non Executive Director
- Peter Phillips – Non Executive Director

The Chief Executive attends the Committee in an advisory capacity, except where his/her own salary, performance or position is being discussed; on such occasions they must not be present during the meeting.

Annual Governance Statement

The Trust has produced a full Governance Statement which details the governance framework of the Trust, including the governance responsibilities of committees, how the Trust identifies and assesses risk, the principal risks to achieving the organisational objectives, and serious incidents occurring in the last year. The statement details how the organisation ensures the effectiveness of its systems of internal control and any issues that have occurred during the year. This statement is available and can be found later in the Annual Accounts.

Audit Declaration

These accounts are prepared under the direction of the Secretary of State for Health, which states that:

1. The Accounts submitted under Section 232 Schedule 15 of the National Health Service Act 2006 shall show, and give a true and fair view of the Trust's gains and losses, cash flows and financial state at the end of the financial year.

2. The Accounts shall meet the accounting requirements of the NHS Trust Manual for Accounts in force for the relevant financial year, which shall be agreed with the Treasury.

Each director confirms that as far as he/she is aware there is no relevant audit information of which the Trust's auditors are unaware and he/she has taken all the steps that he/she ought to have taken as a director to make him/herself aware of any relevant audit information and to establish that the Trust's auditors are aware of that information.

Health, safety and security

As an NHS trust we have a duty to ensure the health and safety of our patients, visitors and staff – as well and any information about them.

Health and Safety

Shropshire Community Health Trust is committed to providing a healthy and safe workplace for all employees, patients, visitors and other persons affected by its activities. The Trust promotes Health and Safety in the workplace by allocating sufficient resources to provide supervision, training, information and support to staff. The Trust will operate safe working practices, and will regularly monitor management of delivery of all aspects of the Health and Safety Policy.

Health and safety focuses on the risks of injury and ill health which can arise from the wide range of work activities necessary to deliver health care services. In 2013/14 we reported 9 incidents under the reporting of injuries, diseases and dangerous occurrences regulations 2013 (RIDDORs), which was a reduction/increase from 10 in 2013/14.

Emergency Preparedness

Over the last twelve months we have continued to collaborate successfully with stakeholders and other agencies to make sure that emergency plans are in place, regularly reviewed, tested and updated. We continue to participate in multi-agency training and exercises, rigorously testing our plans and enabling our staff to respond effectively to different emergency scenarios, such as the winter period, business continuity incidents or disease outbreaks.

New training programs are in place to support the treatment of casualties presenting at Minor Injuries Units contaminated with chemicals or other hazardous substances and the Trust led an exercise to review its plans, and those of our its stakeholders and other agencies, to respond to a case of Ebola being identified in the county.

NHS trusts are required by NHS England to be complaint with a set of core standards for Emergency Preparedness, Resilience & Response (EPRR). Our major incident plans were audited by NHS England against those new national core standards and found to be compliant and whilst there were no real incidents in the last year, exercising our plans has shown that they are robust.

Risk Management

The Trust has a risk management system in place to manage organisational, financial and clinical risks. The system is set out within the Risk Management Policy.

Risks are identified through events that have happened – for example, through incidents and complaints, through meetings and by formal risk reviews. The risks identified are managed and monitored at a level that is appropriate to the risk rating. Mitigation measures are identified and, along with details of the risk, are recorded using a web-based system.

The Audit Committee, through its annual work plan, seeks assurance that risks are being effectively managed throughout the Trust. There is an annual audit programme in place to test the Trust's risk control systems.

Security Management

The Trust employs a Local Security Management Specialist (LSMS) to provide specialist evidence-based advice on all security matters, both in relation to addressing violence and aggression as well as property/asset protective measures.

Directors Report

Measures to combat fraud, bribery and corruption

The Trust employs a Local Counter Fraud Specialist (LCFS), who is responsible for taking forward all anti-fraud, bribery and corruption arrangements at the Trust in accordance with national standards. They report directly to the Trust Director of Finance.

The Local Counter Fraud Specialist produced an anti-fraud, bribery and corruption work plan for 2014/2015, which detailed a programme of work to address the issue of fraud, bribery and corruption across the Trust's area of responsibility. This has included:

- delivering an awareness campaign including anti-fraud, bribery and corruption training,
- producing articles in Trust newsletters, and distributing awareness leaflets and posters
- communicating anti-fraud, bribery and corruption alerts to managers
- reviewing and implementing anti-fraud, bribery and corruption policies and procedures including:
    - Anti-Fraud, Bribery and Corruption Strategy
    - Anti-Fraud, Bribery and Corruption Response Policy
    - Anti-Bribery Policy and Procedure
    - Communications Strategy
    - LCFS/ Internal Audit Protocol
    - LCFS/Human Resources Protocol
- reviewing and testing employment and remuneration policies and procedures
- undertaking mandatory national fraud initiatives and proactive exercises
- undertaking local proactive exercises
- investigating concerns of fraud, bribery and/or corruption
- seeking appropriate sanctions for proven fraud, bribery and corruption
- seeking redress for proven fraud, bribery and corruption

Disclosure of serious untoward Incidents involving data loss or confidentiality breaches

During the past 12 months the Trust has reported no data security significant incidents (SI).

Charges for accessing information

The Trust complies with all current regulations and guidance in relation to charging people wishing to access information; either under the Data Protection Act, or under The Freedom of Information Act.

Compliments and Complaints

Whether people are happy or unhappy with the service they have received from the Trust, we want to hear about their experiences. By giving us feedback, people can help us to identify and build on what we are doing well, and also to find out what may not be going as well so we can improve our services.

Complaints

We have procedures in place to ensure we manage any complaints in line with national policy, including the "Principles of Good Complaints Handling" and "Principles of Remedy" set out by the Parliamentary and Health Service Ombudsman.

In 2014/15, the Trust received **72 formal complaints** (compared with 77 the previous year) across all services. The top three categories into which complaints fell were:

- Clinical Treatment - **22**
- Appointments - **13**
- Communications - **13**

Where a patient or relative remains dissatisfied following the Trust's response to their complaint, they may forward their complaint to the Parliamentary and Health Service Ombudsman for review. On receipt, the Ombudsman will undertake an assessment and may take the following options:

- Ask the Trust to take further steps to resolve the complaints
- Close the case without investigation
- Decide to investigate the case further

In 2014/15 five complaints were referred to the Ombudsman's office. Of these, one was upheld, two were not upheld and we are still waiting for a decision on the remaining two matters.

People who wish to complain about NHS services are able to access free support and advice from an independent organisation called POhWER on 0300 456 2370 or via email at pohwer@pohwer.net

Further information about complaints procedure is available on our website at www.shropscommunityhealth.nhs.uk or by contacting the Complaints Manager on 01743 277616, via email on complaints@shropcom.nhs.uk, or by writing to Complaints Manager, Shropshire Community Health NHS Trust, William Farr House, Mytton Oak Road, Shrewsbury, SY3 8XL.

Compliments

Compliments can be received in various ways, for example through letters or cards of thanks and donations. In the past 12 months we received **568 compliments**.

Patient Advice and Liaison Service (PALS)

The Patient Advice and Liaison Service is an NHS service which is free and confidential, providing information and advice to patients and service users, their families and carers. PALS can help sort out any problems, liaising with NHS staff members and others, if requested, to help sort things out quickly. PALS also provides information and 'signposting' to local and national support groups and when appropriate explains how to make a complaint. PALS provides a person-centred service, listening and responding to contacts from patients, their family and carers and offers support and advice at any point on their 'journey' through the NHS. This information is recorded and collated in an anonymised format and reported to the Trust's Quality and Safety Committee on a quarterly basis, to contribute to the governance arrangements, patient experience feedback systems and service design and development. The information provided from PALS contacts give the Trust useful intelligence on areas and issues of concern and the management and learning from PALS helps to show that the Trust is listening to their patients and making effective changes to improve quality in care.

Background

A key objective of the organisation is the willingness to change, improve and evolve in response to concerns and issues raised through PALS and the need for improvement. The lessons learned and trends identified through monitoring data collected through PALS plays a key role in improving the quality of care received by patients and is a priority for the Trust. PALS act as a focal point for feedback from patients to inform and influence service development and as an early warning system for the Trust. Those using PALS will often present a number of issues, which go beyond health. These include issues with housing, welfare benefits, and social services among others. PALS put these users in touch with the right service, opening dialogue with the relevant organisation thus providing a seamless service, acting as a gateway to independent support or advice.

Data

In the period from 01 April 2014 to 31 March 2015, PALS dealt with a total of 377 enquiries in comparison to 213 received last financial year. Most of these were about services that are directly provided by the Trust, for example, podiatry, community hospitals, children's services and others. However, we received a significant number of enquiries relating to issues about other NHS Trusts which have been listened to with compassion and care and transferred to the relevant authorities.

The 377 enquiries were spread across the following service areas:

- **Community hospitals and outpatient services** which include the 4 Community hospitals (Whitchurch, Ludlow, Bridgnorth and Bishop's Castle), Physiotherapy, Advanced Primary Care Service, Podiatry and others – **162**

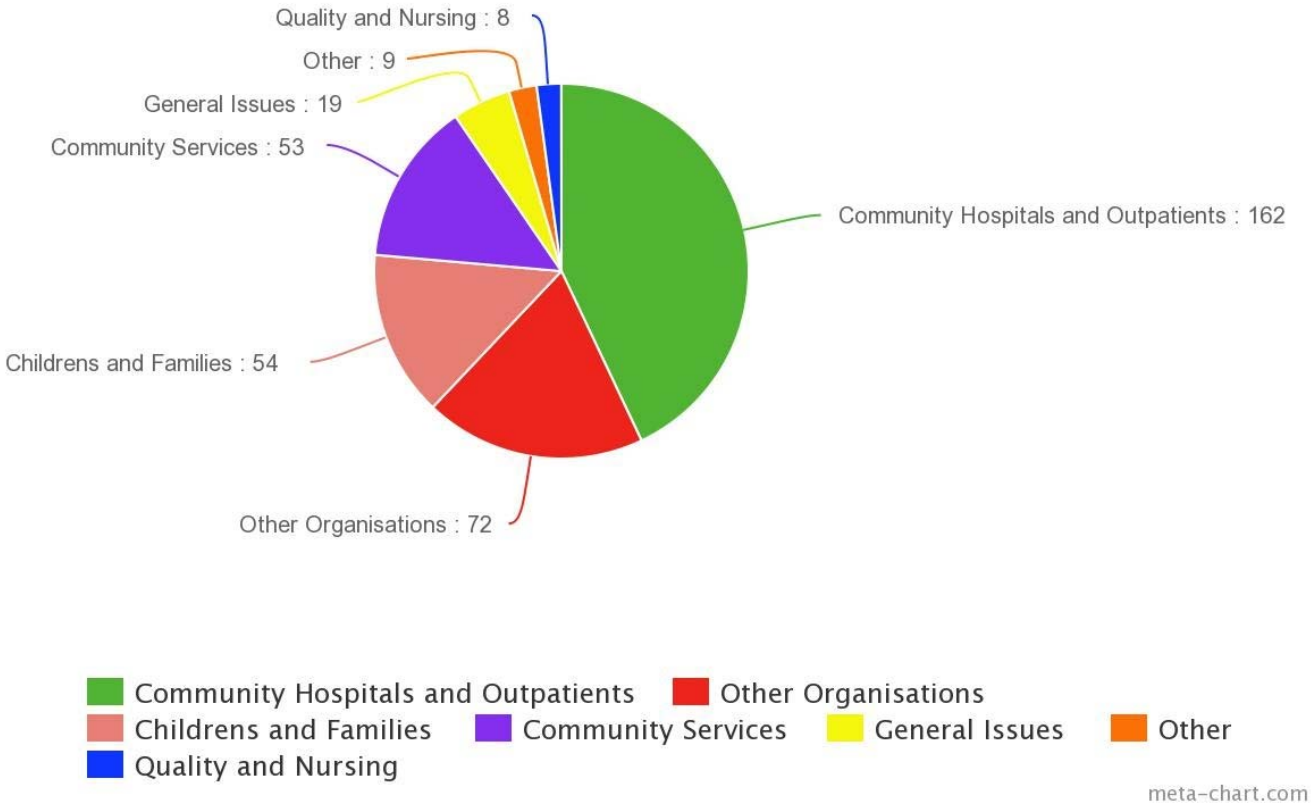
- **Children and Families** which include Child and Adolescent Mental Health service (CAMHS), Community Paediatrics, Health Visiting, School Nursing, Therapies and others – **54**

- **Community Services** which include Shropshire Wheelchair Services, Community Equipment Services, Continence, District Nursing, Diabetes Specialist Nursing Service, Tissue Viability and others – **53**

- **Other Trusts** – **72**, includes issues relating to GPs and the local hospitals.

Directors Report

- **General issues and information** which include information on our services, local NHS services, national support organisations, concerns about other Trusts – **19**
- **Quality and Nursing** – **8**
- **Other** – **9** (out of which 3 related to Integrated Care Services)



When service-users contact the PALS service, it's because they are upset or distressed about some aspect of their health care. Our PALS promotes a swift investigation and personal feedback to enquirers, which is a highly effective and an appreciated method of resolution to concerns and, for the majority of service users, is the first choice to register their feedback about our services and getting their concerns addressed. We are always looking for ways to improve the way we do things and try out new approaches to listen to our patients and service users. The focus is on getting the best outcome for both individuals and services. Therefore every concern, feedback or suggestion is seen as an opportunity to help make care better. We adopt a proactive approach and, if we know that something may have gone wrong, we get in contact, say sorry and find out what we need to do to prevent the issue recurring. People's needs, not the process, drive our work and this has already made a difference. As well as resolving individual concerns, wherever possible, a number of improvements have been made through PALS as a direct result of patient feedback.

Directors Report

Some of the most frequently raised Subjects include:

- Staff attitude/behaviour and communication
- Appointments
- Quality of clinical care and treatment
- Access to services

In Shropshire Community Health NHS Trust we continually review our services with the intention that there is flexibility to accommodate the various differences that patients present so that our services are based on need and those policies and plans address the needs of people across the range. The aim of PALS is to ensure that there is a learning outcome so that small changes could be put into practice to make a big difference to patient care and improve the overall patient experience.

Listening, Learning and Improving

PALS act as a catalyst for driving quality improvement by encouraging a change in culture, existing practices and behaviour. As a Trust we seek out, listen and act on patient feedback ensuring that patients and carer voices are heard and directly influences improvements in the services that we offer. Some examples of changes are:

- improvement in access and signage
- improvement in facilities and environment
- answer phone messages set up
- notices put up in waiting areas
- change in process and improvement in communication and professional behaviour

Conclusion

Shropshire Community Health NHS Trust is very open and welcoming of any feedback from our service-users. We strive to ensure that constructive and well-structured changes are initiated as a result of direct feed-back from our patients, for the benefit of those who are and will be using our services in the future. PALS will continue to implement changes in a tried and tested way, so that the Trust can make a positive difference to maintain the quality of service provision and make improvements where necessary.

Contact Us

PALS can be contacted on Freephone 0800 032 1107, by email at pals@shropcom.nhs.uk, or by writing to PALS, Shropshire Community Health NHS Trust, William Farr House, Mytton Oak Road, Shrewsbury, SY3 8XL.

Directors Report

Finance and Payroll

This section provides a very brief overview of how the Trust is funded and how that money is spent. You can find out more about our finances in the remuneration report and the Annual Accounts sections of this report.

How we are funded and how we spend our money

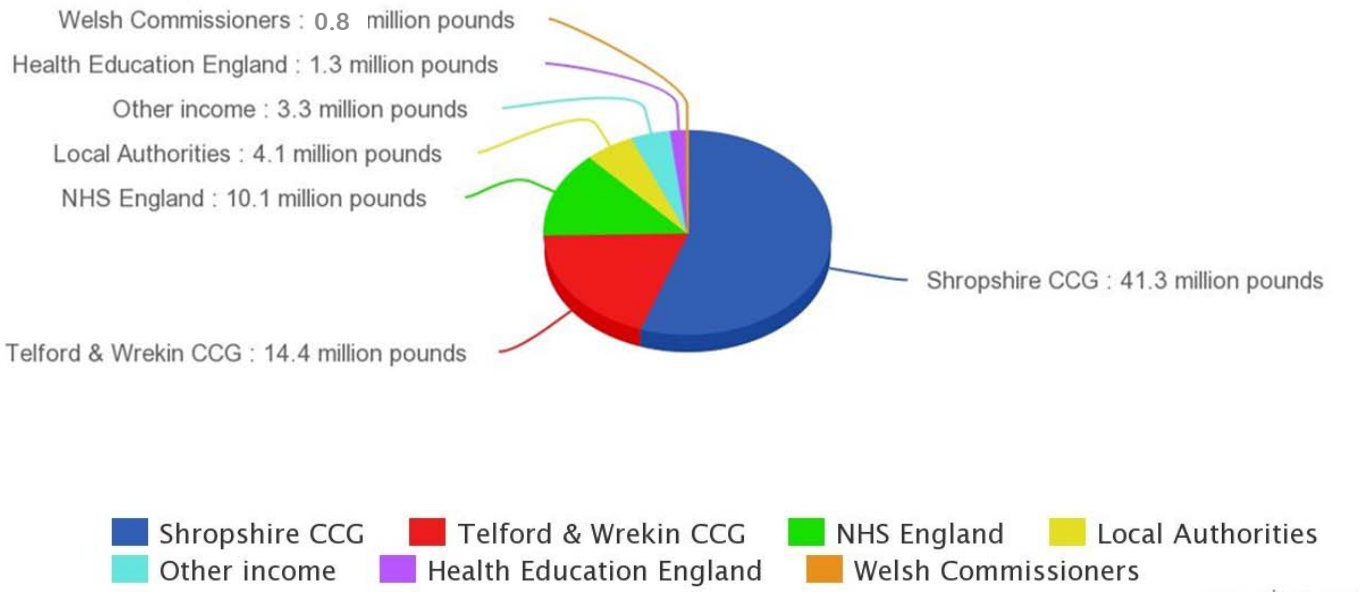
As a provider of community NHS services we receive the majority of our income from NHS commissioners (e.g. Clinical Commissioning Groups or CCGs in England and Local Health Boards in Wales) and a significant proportion from Local Authorities.

These commissioners purchase NHS care services from us for all age groups within the population they serve. This includes service such as district nursing, health visiting, rehabilitation, inpatient care at our community hospitals, out-patient appointments and home visits. We work closely with other Health and Care providers in the Local Health Economy most notably with the acute hospitals where our staff support discharge and ongoing care and with local authorities through our integrated health and social care teams.

For the 2014/15 year the Trust's total income was £75.3 million.

The majority of our income came from our two main commissioners – Shropshire County CCG and Telford & Wrekin CCG – with additional funding coming from other organisations, such as NHS England who carry out specialist commissioning or local authorities for whom we provide services, such as the School Nursing Service.

The chart below shows where we get our money from.

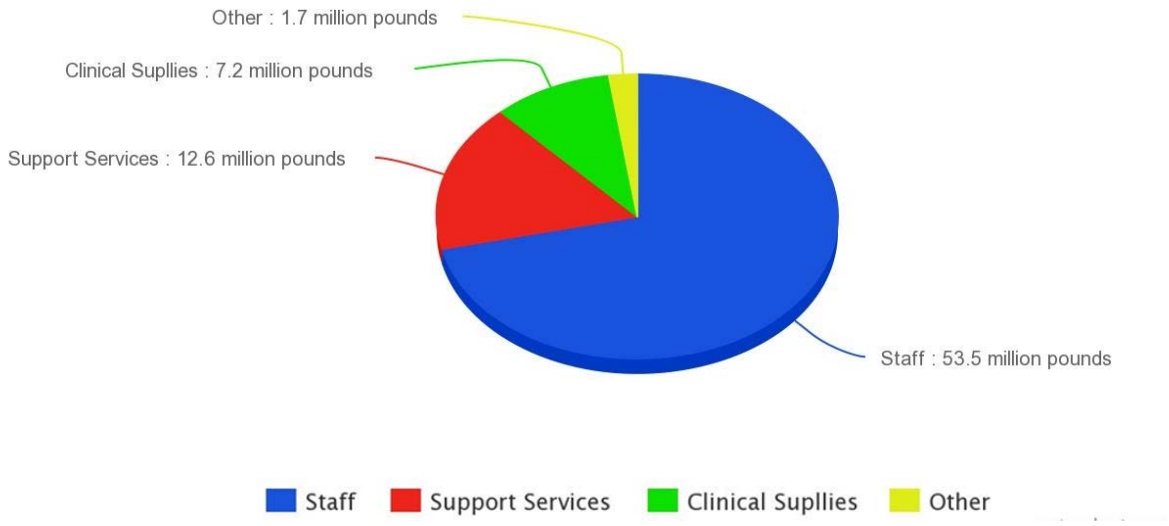


Directors Report

The income we receive is used to fund the services we provide the most significant element of which is to pay our staff. Overall spend has been summarised into four main areas below:

- **Our Staff** – this includes those who provide direct care (e.g. doctors, nurses, therapists, health visitors and healthcare assistants) as well as those people providing essential support and back office functions (e.g. catering, cleaning, admin, technical, HR and finance).
- **Support Services** – this refers to supporting services such as postage, telephones and staff training; non-clinical supplies (e.g. uniforms, linen, food and transport), and accommodation (e.g. rent, rates, water, gas and electricity).
- **Clinical Supplies** – such as drugs and dressings that are directly related to providing health care.
- **Other** – other essential costs such as finance charges and our contribution to the national Clinical Negligence Scheme for Trusts.

The chart below illustrates this split:



2014/15 Financial Results

Overall, in 2014/15 the Trust made a surplus of £352,000, which will be available to reinvest, through our capital programme, in future years to support service provision.

All financial targets including our statutory financial duty have been met for the year.

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Directors Report

Off-payroll arrangements

The tables below show arrangements that the Trust had during the year with individuals who provided services for which they were paid on a self-employed basis or through their own companies. Employment through agencies is not included. Only arrangements lasting 6 months or more, with a value of over £220 per day, are shown. The information below is not subject to audit.

	Number
Number of existing engagements as of 31 March 2015	2
Of which, the number that have existed:	
for less than one year at the time of reporting	2
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

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2014 and 31 March 2015	2
Number of new engagements which include contractual clauses giving Shropshire Community Health NHS Trust the right to request assurance in relation to income tax and National Insurance obligations	2
Number for whom assurance has been requested	0
Of which:	
assurance has been received	0
assurance has not been received	0
engagements terminated as a result of assurance not being received	0

The standard contract for self-employed workers contains binding clauses requiring the contractor to comply with all relevant statutes and regulations relating to income tax and national insurance contributions in respect of fees paid by the Trust, and indemnifying the Trust against any liabilities incurred in respect of such contributions. It also requires the contractor to demonstrate to the Trust his/her compliance with such legislation on request. The contractor's agreement to these terms is judged to constitute an appropriate level of risk assessment and management.

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. Note: This figure includes both off-payroll and on-payroll engagements.	15

There are no off payroll arrangements for board members.

There are currently 13 board members as set out earlier in this report. The disclosure above showing15 individuals reflects changes during the year where some officers held posts for part of the year.

Directors Report

Better Payment Practice Code

As required by the Department of Health, the creditor payment policy of the Trust is to comply with both the CBI Better Payment Practice Code and Government Accounting Rules. This requires that all invoices are paid within 30 days of the receipt of goods or a valid invoice, whichever is later, unless other payment terms have been agreed with the supplier.

There are two measures of performance – numbers of invoices and value of invoices. 98% of the total number of invoices and 97% of the total value of invoices were paid within the 30 day target. The Department of Health expects 95% as a minimum.

Further details of compliance with the code are given in Note 11 of the Annual Accounts.

Prompt Payments Code

The Trust has signed up to the Prompt Payments Code. Suppliers can have confidence that signatories to the Code will pay them promptly.

External Auditors

The Trust's external auditors are Grant Thornton. External audit work has related entirely to statutory audit requirements and cost £54,000.

Pension Liabilities

The Past and present employees are covered by the provisions of the NHS Pension 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 not designed in a way that would enable individual NHS bodies to identify their share of scheme assets and liabilities.

Therefore, the cost to the Trust is taken as equal to the contributions paid for the year. Note 10.6 in the Annual Accounts provides further details on the pension costs.

Severance Payments

The Trust has not made any severance payments during the year.

Exit packages

Details of exit packages are given in Notes 10.4 and 10.5 of the full Annual Accounts.

Note that details of compensation payable to former senior managers is subject to audit.

Sickness Absence Data

More detailed information relating to sickness absence can be found in Note 10.3 of the Annual Accounts.

Remuneration Report

The remuneration report describes the remuneration of the senior managers at the Trust, namely members of the Trust Board.

The remuneration of the Chair and Non-Executive Directors is determined during the year by the NHS Trust Development Authority, which is responsible for non-executive appointments to NHS trusts on behalf of the Secretary of State for Health.

The remuneration of the Chief Executive and all other Executive Directors is determined annually by the Nomination, Appointments and Remuneration Committee and is based on national guidance issued by the Department of Health.

Details of the Remuneration Committee can be found in the Directors Report.

The expenses of the members of the Trust Board are reimbursed in accordance with the Trust Expenses Policy, which is available from the Trust website.

Performance review and appraisal of the Trust Chair was undertaken during the year by the Chair of the NHS Trust Development Authority on behalf of the Secretary of State in accordance with appraisal guidance provided by the NHS Trust Development Authority.

Performance review and appraisal of the Non-Executive Directors is undertaken by the Trust Chair in accordance with appraisal guidance provided by the NHS Trust Development Authority. Performance review and appraisal of the Chief Executive was undertaken during the year by the Trust Chair and the Chief Executive of the NHS Trust Development Authority in accordance with criteria set by the Remuneration Committee and guidance from the Department of Health.

Performance review and appraisal of the Executive Directors is undertaken by the Chief Executive in accordance with criteria set by the Remuneration Committee and guidance from the Department of Health.

The Chair and Non-Executive Directors are appointed for terms of up to four years in accordance with NHS Trust Development Authority guidance and procedures. They are able to apply for a further term by open application.

The Chief Executive and Executive Directors are appointed on permanent contracts in line with NHS terms and conditions. The period of notice required to terminate the employment of the Chief Executive or other Executive Director is six months. There is no contractual entitlement to a termination payment for any member of staff.

The remuneration of the Chief Executive and Executive Directors (other than for part of the salary of the Medical Director, which is linked to national pay awards for medical consultants) is set in accordance with the Department of Health's Very Senior Manager's Pay Framework. Given the current financial challenges facing the NHS the Trust chose not to award any performance-related pay increases in 2014/15.

Last year there was a 1% general increase in the national Agenda for Change pay scale for NHS staff and for pay for medical consultants.

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid Director in their organisation and the median remuneration of the organisation's workforce. The information provided on 'pay multiples' is subject to audit.

The banded remuneration of the highest paid Director in Shropshire Community Health NHS Trust in the financial year 2014/15 was £132,500 (2013/14 - £152,500). This was 4.75 times the median remuneration of the workforce, which was £27,901 (2013/14 – £27,901).

Banded remuneration is the mid-point between £130,000 and £135,000, which is the band within which the remuneration of the highest paid Director falls.

Remuneration Report

In 2014/15, two employees received remuneration in excess of the highest-paid Director (there were 0 in 2013/14).

Remuneration ranged from £14,294 to £154,288 (2013-14 - £14,294 to £154,288).

The highest paid Director in 2013/14 has returned to a purely clinical role with no Director's responsibilities. This accounts for the change in ratio between the highest paid Director and the median salary in 2014/15.

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

More detail about the salary and pension entitlements for the Trust's senior managers and Directors for the financial year 2014/15 can be found in the Annual Accounts section of this report.

Senior Manager Remuneration and Pensions (this information is subject to audit)

Remuneration : 2014/15							
Name and title		Salary (bands of £5,000)	Taxable expense payments (to nearest £100)	Performance pay & bonuses (bands of £5,000)	Long term performance pay/bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	Total (bands of £5,000)
		£000	£00	£000	£000	£000	£000
Jan Ditheridge (Chief Executive)		130-135				205-207.5	335-340
Trish Donovan (Director of Finance)		105-110				10-12.5	115-120
Alistair Neale (Medical Director)	To Jul 14 only	50-55				30-32.5	80-85
Mahadeva Ganesh (Medical Director - shared post)	From Aug 14 only	85-90				0	85-90
Peter Clowes (Medical Director - shared post)	From Aug 14 only	20-25					20-25
Tessa Norris (Director of Operations)	To Dec 14 only	65-70				7.5-10	70-75
Steve Gregory (Director of Nursing & Operations)		100-105				42.5-45	140-145
Julie Thornby (Director of Corporate Affairs)		85-90				0	75-80
Andrew Ferguson (Director of Strategy)	From Sep 14 only	50-55				30-32.5	80-85
Mike Ridley (Chairman)		20-25					20-25
Angela Saganowska (Non-Executive)		5-10					5-10
Mike Sommers (Non-Executive)		5-10					5-10
Rolf Levesley (Non-Executive)		5-10					5-10
Jane Mackenzie (Non-Executive)		5-10					5-10
Peter Phillips (Non-Executive)		5-10					5-10

Notes

1. All pension related benefits comprises the NHS Pensions Agency assessment of future pension benefits, less employee contributions. In 2013/14 the values did not exclude employee contributions.

2. In addition to the salary figure disclosed above, Tessa Norris also received a termination benefit of £182k, which was a redundancy payment calculated in line with Agenda for Change rules. No other payments were made in connection with the termination. The figure is included in the exit packages notes to the accounts (notes 10.4 and 10.5).

3. There was no remuneration waived by directors or allowances paid in lieu to directors in 2014/15.

4. The post of Medical Director has been shared for most of the year between Mahadeva Ganesh and Peter Clowes. Peter Clowes also receives remuneration from Shropshire CCG and as a GP, although details of that remuneration cannot be disclosed.

Remuneration Report

Remuneration : 2013/14							
Name and title		Salary (bands of £5,000)	Taxable expense payments (to nearest £100)	Performance pay & bonuses (bands of £5,000)	Long term performance pay/bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	Total (bands of £5,000)
		£000	£00	£000	£000	£000	£000
Jan Ditheridge (Chief Executive)	From Oct 13 only	65-70				72.5-75	135-140
Julia Bridgewater (Interim Chief Executive)	To Sep 13 only	35-40				N/A	N/A
Trish Donovan (Director of Finance)	From Aug 13 only	70-75				30-32.5	100-105
Chris Calkin (Interim Director of Finance)	Jun-Jul 13 only	40-45					
Owen White (Interim Director of Finance)	To May 13 only	35-40					
Alistair Neale (Medical Director)		150-155				122.5-125	275-280
Tessa Norris (Director of Operations)	From Jul 13 only	65-70				50-52.5	115-120
Nette Carder (Interim Director of Operations)	To Jul 13 only	80-85					
Maggie Bayley (Director of Nsg, AHPs, Quality & Workforce	To Jan 14 only	105-110				17.5-20	100-105
Julie Thornby (Director of Governance & Strategy)		85-90				15-17.5	100-105
Steve Gregory (Director of Nursing)	From Jan 14 only	20-25				N/A	N/A
Mike Ridley (Chairman)		20-25					
Chris Bird (Non-Executive)	To Oct 13 only	0-5					
Angela Saganowska (Non-Executive)		5-10					
Mike Sommers (Non-Executive)		5-10					
Rolf Levesley (Non-Executive)		5-10					
Jane Mackenzie (Non-Executive)	From Sep 13 only	0-5					
Peter Phillips (Non-Executive)	From Oct 13 only	0-5					

Notes

1. The salary figure for Maggie Bayley includes £25k for pay in lieu of notice. This is included in the exit packages notes to the accounts (notes 10.4 and 10.5).

2. There was no remuneration waived by directors or allowances paid in lieu to directors in 2013/14.

3. Owen White, Chris Calkin & Nette Carder are interims paid via agencies. Therefore the reported salary is actually the full cost to the Trust.

4. Pension related figures for Julia Bridgewater (current and prior year) and Steve Gregory (prior year) are not available as they were not employed by this Trust.

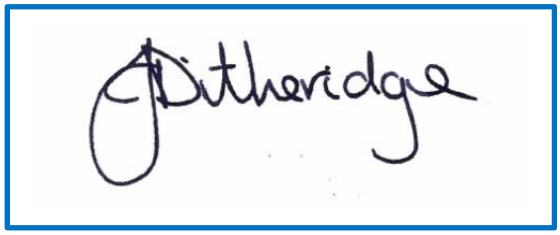
Pension Entitlements (this information is subject to audit)

Remuneration Report

Name and title		Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at age 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2015 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2015 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2014	Cash Equivalent Transfer Value at 31 March 2015	Real increase in Cash Equivalent Transfer Value
		£000	£000	£000	£000	£000	£000	£000
Jan Ditheridge (Chief Executive)		7.5-10	27.5-30	40-45	130-135	628	873	229
Trish Donovan (Director of Finance)		0-2.5	2.5-5	35-40	110-115	622	676	37
Alistair Neale (Medical Director)	To Jul 14 only	0-2.5	17.5-20	50-55	150-155	790	957	146
Mahadeva Ganesh (Medical Director - shared post)	From Aug 14 only	0-2.5	2.5-5	25-30	75-80	525	562	22
Tessa Norris (Director of Operations)	To Dec 14 only	0-2.5	0-2.5	25-30	80-85	530	576	32
Steve Gregory (Director of Nursing & Operations)		0-2.5	5-7.5	40-45	130-135	676	756	62
Julie Thornby (Director of Corporate Affairs)		0-2.5	0-2.5	30-35	95-100	564	600	20
Andrew Ferguson (Director of Strategy)	From Sep 14 only	0-2.5	5-7.5	25-30	80-85	467	515	35

Notes

1. As Non-Executive members do not receive pensionable remuneration, there are no entries in respect of pensions for these members.
2. There are no additional benefits that will become receivable by the individual if they retire early.
3. There were no employer's contributions to stakeholder pensions.



Jan Ditheridge
Chief Executive

30 July 2015

Sustainability Report

Sustainability

Sustainability has become increasingly important as the impact of people's lifestyles and business choices are changing the world in which we live.

How the NHS behaves - as an employer, a purchaser of goods and services, a manager of transport, energy, waste and water, as a landholder and commissioner of building work and as an influential neighbour in many communities - can make a big difference to people's health and to the well-being of society, the economy and the environment.

In order to fulfil our responsibilities for the role we play, Shropshire Community Health NHS Trust has the following sustainability mission statement in our Sustainable Development Management Plan:

"The Trust aims to improve health, reduce inequalities and improve the quality of life of people who live and work within Shropshire. The Trust must therefore fully understand its social and environmental responsibility as an organisation. It must recognise that as a provider of health care it has a significant impact on the local environment. The Trust is therefore committed to managing and minimising these impacts."

We are committed to continuously working with our staff, patients, carers, communities, and partner organisations to find new and more efficient ways of working, and to reduce the impact we have on the environment.

The Trust produces a Sustainability Report in accordance with guidance from the Department of Health's Sustainable Development Unit. This is included at as Appendix A to this Annual Report and Accounts.

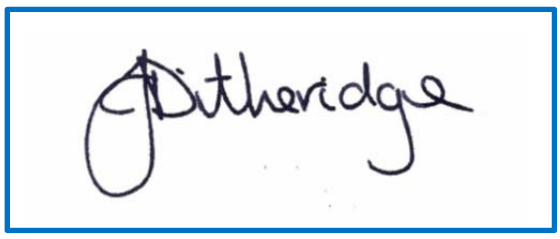
Statement of Accountable Officer's Responsibilities

Statement of the Chief Executive's Responsibilities as the Accountable Officer of Shropshire Community Health NHS 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.



Jan Ditheridge
Chief Executive

30 July 2015

Annual Accounts

Introducing the Annual Accounts

As an NHS trust we are responsible for ensuring we are getting the best possible value for the money we receive to run services. We are required to deliver efficiency improvements across our services year-on-year, reflecting the increasingly challenging financial climate. This means we have to continually review how we spend our funding and our approach is increasingly the redesign of services so that they are more efficient whilst ensuring we do not compromise on the quality and safety of service provision.

Our workforce is both our biggest cost and our biggest asset, accounting for over 70% of our total spend. The remainder of our funding meets the costs associated with the buildings and facilities from which we deliver services, as well as medicines and clinical supplies, equipment and technology that all support service delivery.

Being able to not only balance the books, but to forecast and deliver a modest but sustainable surplus in the coming years is something we are committed to doing as we look towards our long-term future as a provider of high quality community NHS services.

We are delighted to confirm that we met our financial duties for the 2014/15 year and this is set out in more detail within the annual accounts and notes that follow.

Trish Donovan
Director of Finance

Foreword to the Accounts

These accounts for the year ended 31 March 2015 have been prepared by Shropshire Community Health NHS Trust on a going concern basis and in accordance with the NHS Finance Manual: Manual for Accounts 2014/15.

Shropshire Community Health NHS
NHS Trust

Annual Accounts 2014/15

2014-15 Annual Accounts of Shropshire Community Health NHS Trust

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.

nb: sign and date in any colour ink except black

Signed.....Jan Ditheridge.....Chief Executive

Date.....2-06-15.....

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

nb: sign and date in any colour ink except black

02-06-15 .....Date..... Ian Dutton ridge .....Chief Executive

02.06.2015 .....Date.....Finance Director

Shropshire Community Health NHS
NHS Trust

Annual Governance Statement 2014/15

Scope of responsibility

The Board is accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. Alongside this, I have responsibility for safeguarding quality standards, public funds and the organisation's assets for which I am responsible and as set out in the Accountable Officer Memorandum.

I have gained assurance on the system of internal control for the last year by considering a range of governance activity, and participating in many aspects of it. This has included the work of the Board and its committees. During the year the Board reviewed its strategic objectives and the risks to these objectives which make up the Board Assurance Framework (BAF). Internal control has been monitored through reviewing the BAF and Corporate Risk Registers, internal and external audit reports, independent consultant reports and by meeting with commissioners, individual staff and teams.

As Accountable Officer I work with partner organisations, including commissioners, especially the Clinical Commissioning Groups, NHS England, the Trust Development Authority, Local Authorities, voluntary organisations and patient representative groups, to ensure that the Trust meets its obligations in fulfilling service agreements with commissioning bodies, meets statutory duties and ensures proper stewardship of public money.

The Board has adopted a code of conduct and assessed itself as compliant against it. This draws upon best practice which includes Department of Health governance standards, including the NHS National Code of Conduct, Nolan principles, Fit & Proper Persons Test and updated standards for NHS Boards. The Trust acknowledges the UK Corporate Governance Code and its application with NHS Bodies. All board members are required to confirm on an annual basis that they will comply with the Fit and Proper Persons Test and the code of conduct. An annual reminder is sent to all staff asking for any declarations of interest or gifts and hospitality to be declared. A register of all declarations is maintained and is available publicly. These arrangements are reflected in this statement.

Board and Committee Structure

The Board consists of the Chair, five non-executive directors, and six executive directors. The following changes have been made in the last year:

- The Director of Nursing and Director of Operations post have been merged to form a Director of Nursing and Operations post.
- A new post of Director of Strategy has been formed. This post, as well as strategic directions includes the informatics portfolio previously held by the Director of Finance and Performance.
- The Medical Director stepped down to concentrate on clinical work. This is now a joint post giving broader medical expertise.

Board Attendance

The Board has held 6 formal board meetings which have been held in public during 2014/15 and has met informally a further 6 times to allow for board development.

Chair	Full attendance
Chief Executive	Full attendance
Director of Finance	Full attendance
Medical Director	5 out of 6 meetings
Director of Nursing/Operations	Full attendance
Director of Strategy	3 out of 3 meetings
Non Executive Directors (5)	3 had full attendance, 2 attended 5 out of 6 meetings.
Director of Corporate Affairs (non voting)	4 out of 6 meetings

The Board has been supported by 5 committees throughout the year:

- Resources and Performance Committee
- Quality and Safety Committee
- Audit Committee
- Information Governance Committee
- Nomination, Remuneration and Appointments Committee

In addition to these a Charitable Funds Committee was added in January 2015.

These committees provide reports to the Board, following their meetings.

The Board's prime roles are assurance, strategy and developing organisational culture. Its meetings cover comprehensive items on quality, finance and strategy. It receives a governance report at each meeting dealing with risk assessment and the Board Assurance Framework, and corporate governance compliance. The Board receives reports relating to Finance and Quality at each meeting. These are supported by a performance management framework which highlights to the Board any potential or actual problems in meeting its objectives. The Trust over the last year has worked with staff, patients and patient representatives to formulate a refreshed set of values. These values have been widely publicised and will be a key factor in the Trusts service delivery and development. The Board will consider these values and will refresh its internal control systems to reflect their delivery.

The Board continually self assesses its performance, evaluating its meetings and those of its committee at the conclusion of business. During the year it has undertaken a series of board workshops or individual training sessions as part of its board development programme. These have included mandatory training such as health and safety and the development of a revised Trust vision, objectives and values. In addition to this self assessment the Trust Development Authority and Manchester Business School have completed independent assessments of Board performance and have provided reports to the Board for their consideration. These assessments identified areas of good practice about how the Board operates e.g. challenge by non-executive directors and well-structured meetings, agendas and papers. The assessments also identified areas for improvements such as clearer action points and increasing the focus on strategic impact of decision-making and the risks involved. Further board discussions have led to a board development programme which will be put in place during 2015/16. The programme will be based upon the Well-Led Framework published by Monitor.

Internal Auditors carry out annual audits on governance arrangements and the Board Assurance Framework. These, with their other audits contribute to their opinion, which is detailed later in this statement.

Quality Performance

The Trust produces an annual quality account in line with Department of Health Guidance. This account looks back at performance in the last year and sets priorities for the following year. The Board approves the account prior to publication. The Quality and Safety Operational Group monitors performance against the priorities and reports to the Quality and Safety Committee any concerns or risks. This committee prepares a report to the Board which would include any serious issues arising out of the delivery of Quality Account priorities.

The Trust has arrangements in place to manage Infection Prevention and Control and the Safeguarding of Children and Vulnerable Adults. These include external partnership arrangements with Local Authorities, Police and Shrewsbury and Telford Hospital Trust.

The Trust completes the Safety Thermometer monthly, and is an active contributor to the local health economy Harm Free Care Group. The Trust has seen a continued fall in the number of pressure ulcers developed under its care, and in patient falls at community hospitals.

The Trust assesses itself against CQC requirements, and at the time of writing, an assessment was being carried out against the 5 key questions, safe, effective, caring, responsive and well led. These assessment will support compliance with the new fundamental standards introduced in April 2015 and will identify any improvements to be made.

The regulatory Duty of Candour was introduced in November 2014. The Trust has introduced a system which prompts staff to ask themselves "does the Duty of Candour apply" with all incidents. Incidents that lead to moderate or severe harm are relatively rare with the Trust, this system has identified the good communication practice in place with services for all incidents, regardless of the harm. The Duty has been widely publicised to staff and support given to individual staff where needed.

Patient and Carer Panel and Patient/Carer feedback

Over the past year the Patient and Carer Panel that was established in January 2014 has become more and more involved in the work of the Trust. Amongst many other activities, our volunteers have received training in a technique called "Sit and See" which is an observational tool that is used to record and celebrate positive examples of care, kindness and compassion as well as record poor practice and areas of concern. We have carried out observations in many of our clinical areas and provided instant feedback to our clinicians one of whom said "it is really nice to hear that it has been noticed when we do things well – it is really motivating for the staff and reassuring for me". Other training that has been made available to volunteers includes in house clinical audit training and also a session led by NHS England to improve the use of and feedback following Patient Stories being shared with the Board and other committees. This will enable them to become even more in our work throughout the coming year.

Volunteers are crucial in helping us to collect patient feedback especially within our Community Hospitals. Since January 2015 we have extended the friends and family question (would you recommend this service to your friends and family should they require it) to all our services and the feedback that we receive will enable us to look at how we provide services to best suit those who use them. In January and February 2015, 95% and 97.5% of people that used our services would be either extremely likely or likely to recommend them.

We can use this information alongside other feedback such as contacts with our Patient Advice and Liaison Service (PALS) and any formal complaints we receive to understand where we could further improve our services.

Financial Performance

NHS Trusts are required to deliver statutory and other financial duties. For the year ended 31 March 2015, the Trust met these duties, as summarised below, and set out in more detail within the financial statements:

- to break-even on Income & Expenditure – achieved
- to maintain capital expenditure below a set limit – achieved
- to remain within an External Financing Limit (EFL) - achieved

Within this, the Trust faced significant challenge in delivering the efficiency programme for the year, with plans remaining under development throughout the first half of the year. However, the target was met by year end, with non recurrent measures replacing in-year shortfalls in recurrent initiatives where required.
Whilst this area remains of significant challenge, the Trust's transformational approach to generate and implement efficiency measures has been revised and strengthened.

Checking the correct discharge of statutory functions is managed via the Trust risk management system. No areas of non compliance have been identified

Identification of Trust Risks

The Trust's risk management arrangements are set out in the Risk Management Policy. This sets out how risks are indentified, assessed and managed through the hierarchy of risk register levels, which are overseen in specific defined ways through the organisation, culminating in the Board overseeing the highest risks to achievement of strategic objectives (the Board Assurance Framework).

The Audit Committee reviews the Board Assurance Framework and tests assurances with management. Internal Audit have reviewed the framework in place within the Trust during 2014/15. Their findings are detailed later in this statement. The Audit Committee reports its finding to the Board, which reviews the framework at each meeting.

The major risks (defined as scoring 15 or above) detailed in the Board Assurance Framework are detailed in the table below:

Title	Risk	Mitigation
Insufficient delivery of Clinical Quality and Safety standards	Care does not meet the standards that the public, commissioners and regulators expect.	Defined and effective Quality Governance Structure Monitoring of quality indicators, carrying out clinical audits, investigating and learning from untoward events, complaints and claims.
Shortfalls on data quality	Data is not accurate or timely. Does not allow the trust to effectively manage its services and activity and to be able to plan for the future	Collation of data into data warehouse and use of specialist reporting software. Audit of systems and actions to implement audit recommendations. Data validation.

Risk to transforming services as a result of local and national contexts	Competing health priorities do not allow sufficient resources to transform community services	Trust involvement in health economy service changes (Future Fit) Greater involvement of clinicians in initiatives. Development of integrated strategy and divisional plans.
Risk to transforming services as a result of shortfalls in Trust systems eg IMT	Administration systems do not support changing services	Electronic Patient Record (EPR) replacement project underway Implementation of interim targeted solutions where need is indentified.
Risk to transforming services as a result of workforce issues eg staff numbers and availability of new skills	Trust does not develop staff or is unable to recruit staff with skills to meet increased care complexity in community settings	Future workforce planning. Clinical skills audit and action plan. Working with partners to identify service change. Provision of skills development training.
Meeting Financial Targets	Trust fails to meet targets for CIPs, breakeven, external finance limit, capital expenditure or agreed surpluses	Financial monitoring Long term financial modelling Cost improvement plans evaluation and monitoring
Risk of delay in achieving change to organisational culture	The organisation does not develop or change quickly enough to take advantage of development opportunities	Organisational development plan. Engagement with staff by CEO and Directors.
Trust Sustainability	Trust does not grow sufficiently to sustain its services.Block contracts, rather than tariff, do not meet increases in demands.Service tenders are awarded to other providers.	Tender processes.Contract discussions with commissioners, including changes in demand. Efficiency - focus on reduction of overhead costs. Engagement with commissioners on development of better care fund.

Risk Identification and recording

Risks are identified through:

- The recording and investigation of incidents, complaints and claims.
- Specific group and committee sessions to identify and analyse risks.
- Clinical, internal and external audit.
- Other work carried out by groups and committees.
- External and internal reports and inspections.
- Other external bodies, e.g. commissioners, CQC.
- Being raised by individual managers and staff.
- Performance Management Framework reports
- Patient feedback

All risks are rated using a 5 by 5 risk matrix. Risk consequences are defined on the matrix using four categories:

- Injury or harm
- Finance
- Service delivery
- Reputation

Dependant on the rating, risks are recorded at 4 levels:

Departmental	Risks that are low level and can be managed locally Risks are monitored at team level, e.g. through team

	meetings
Directorate	Risks of a moderate level that impact on the directorate's service objectives Risks are monitored at divisional/directorate quality groups, and are overseen by the Quality and Safety Operational Group
Corporate	Risks that are moderate but Trust-wide and have impact on the Trust's strategic objectives Risks are monitored by the Executive Team and overseen by the Audit Committee

The mitigation controls are identified at all risk levels, along with any further actions necessary to further control or mitigate the risks. The risk management policy identifies the groups and committees whose responsibility it is to monitor risks at the four levels, the effectiveness of their controls and the implementation of actions to further mitigate the risks.

All risks are recorded on Datix, the Trust's risk management software.

Data Security

The Trust has robust measures in place to protect sensitive information. This includes paper based information and electronic data. An assessment of the risks related to information security has taken place and is reviewed annually. Where concerns are raised these are investigated thoroughly and further data controls are introduced where necessary. The Trust has an Information Governance Committee which is a sub committee of the Board. This committee, supported by operational groups, assesses and tests the robustness of the systems employed. All mobile electronic devices used by the Trust are fully encrypted to ensure that unauthorised personnel cannot access the data.

No serious incidents were reported relating to data security.

Data Quality

The Trust has systems in place to verify data quality, including elective waiting time data. These include:

- Validation of data reports and results by service managers and systems users
- Planned internal audits of data by informatics staff.
- Audits by Baker Tilly staff on selected data sets and processes. Where issues are raised action plans are developed and monitored to meet recommendations.
- Electronic data validation e.g. missed mandatory fields and data out of permitted ranges.
- Performance data monitoring by Trust groups and committees and subsequent enquiries.
- Commissioner scrutiny of activity and quality data.
- User training on systems, e.g. clinical coding.

Fraud and Security Management

The Trust has in place arrangements to manage fraud and security. This includes the provision of Local Counter Fraud and Security Specialists. Annual workplans are formulated which are reported to the Audit Committee. NHS Protect standards are used as benchmarks for performance. These are reported to the Audit Committee and NHS Protect as required.

The risk and control framework

The system of internal control is designed to manage risks to a reasonable level, rather than to eliminate all risks; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The purpose of the risk and control framework is to ensure risk is managed at a level that allows the Trust to meet its strategic objectives. The system of internal control is based on an ongoing process designed to:

- Identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives,
- Evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.
- Where risk cannot be prevented to mitigate the consequences, e.g. by putting into place response plans, or provide deterrents e.g. awareness of sanctions relating to fraud.

The system of internal control has been in place within the Trust from the 1st April 2014, to the year end on the 31st March 2015 and up to the date of approval of the annual report and accounts.

The Risk Management Policy details the structure for the Trusts risk and control mechanisms. This includes the duties of individuals, groups and committees and the responsibility for the identification of risks, controls, further mitigation control and assurances.

All staff undertake a program of training related to the risks they encounter with the work they carry out. Managers, supervisors and team leaders attend risks management training, which includes explanation and familiarisation with the Trust's risk management framework, and their roles in using it to identify and mitigate risk.

The Board attended a Risk Management/Board Assurance Framework workshop run by internal auditors in February 2015.

The Quality and Safety Committee has the overall responsibility for the monitoring of the Trust's Risk Registers, which is conducted via the Quality and Safety Operational Group (with exceptions being notified to the Quality and Safety Committee). The Audit Committee, through its work programme, scrutinises the registers and risk management processes, seeking additional assurance where necessary.

The Resources and Performance Committee considers the detailed work and reports related to finance, business and cost improvements, performance indicators and contract monitoring performance indicators. It identifies any risks associated with these areas and reports these to the Board for inclusion in the risk management framework where it is appropriate to do so. It monitors the effectiveness of any controls in place and the implementation of further controls.

The Audit Committee reviews the assurance that the Trusts internal control systems are effective. It does this by:

- Reviewing assurances relating to risks on Board Assurance Framework and Corporate Risk Register.
- Reviewing processes and performance related to Fraud and Security.
- Seeking and reviewing assurances from internal and external auditors.
- Reviewing financial systems.

The Audit Committee has not found any significant issues in the year 2014/15.

Serious Incidents are reported to the Commissioners and the Care Quality Commission through the National Reporting and Learning Service. All of these incidents are investigated using the Root Cause Analysis methodology provided by the National Patient Safety Agency. The purpose of the investigation is to identify the key contributory factors that if addressed would prevent re-occurrence. Service Improvement Plans are developed and implemented where necessary.

In the year April 2014 to March 2015 the Trust reported 45 serious incidents. 40 of these related to Grade 3 or 4 pressure ulcers. Of these 40 pressure ulcers, investigations determined that 3 were identified as not due to pressure, but other causes, e.g. trauma or moisture.

The other 5 consisted of:

- A prisoner who attached a ligature to their neck. The prisoner made a full and speedy recovery.
- A patient who died following a fall at a community hospital, however, on investigation the two events were found to be not connected
- 2 Fracture falls at community hospitals.
- A Gastro Intestinal out break at community hospital.

Following RCA investigations all these incidents were reviewed by an RCA challenge panel, which looks at the circumstances, the quality of investigation, lessons learned and how these lesson can be shared across the organisation.

The Trust did not report any Never Events in 2014/15.

NHS TDA Accountability Framework 2014/15

The Trust has taken into account the TDA Accountability Framework for 2014/15. The sections of this report detailing Quality and Finance detail how the Trust meets standard to deliver high quality care which is clinically and financially sustainable.

In relation to the indicators from the framework the following points are highlights:

- There were no Mixed Sex Accommodation Breaches
- The Trusts turnover rate remained low
- CDIFF and MRSA targets were met
- There were no Never Events
- CAS alerts were dealt within target times.

<u>Staffing</u>

In line with national guidance staffing levels are reported to the Board. No significant risks have been raised as a result of the report. The Trust has recognised that attracting staff within rural areas can be difficult, and is using a diverse range of recruitment methods, including social media.

Sickness Absence

The Trust continues to seek improvement in the sickness rate. The overall rate has been static over the year however, short term sickness has improved due to support given to manager on its management and emphasis on staff health and wellbeing. Long term sickness management is currently under review to ensure continued support for protracted health problems.

Referral to Treatment Targets

The Trust met the 18 weeks referral to treatment targets with admitted and non admitted patients within the set tolerances. Where breaches have occurred an exception report is produced to identify system and process improvements. These are reviewed with clinical commissioning groups and action plans agreed and monitored

Review of the effectiveness of risk management and internal control

The Head of Internal audit provides an opinion on the effectiveness of the System of Internal Control.

The opinion for 2014/15 is:

Based on the work undertaken in 2014/15, significant assurance can be given that there is a generally sound system of internal control. designed to meet the organisations objectives, and that controls are generally being applied consistently. However some weaknesses were identified that put the achievement of particular objectives at risk.

The issues raised are

Cost Improvement Program - Quality Impact Assessments
Appraisals - Compliance with Trust Policy

With the above, recommendations made by internal auditors are being progressed, in particular:

- The appraisal process is being reviewed and will be updated with a values based approach.
- The QIA process has been strengthened with NED involvement on the panel, and a more robust review and authorisation approach.

Auditors raised that limited progress had been made with their recommendations within their Service Level Agreement review conducted in 2013/14. These recommendations have been re-allocated and are now in progress, the finance department is working with services to indentify and review SLA requirements. A comprehensive register will be introduced during 2015/16.

The systems for providing assurance that risks are being managed effectively are monitored by the Audit Committee. Assurance sources include:

- Audit Committee programmes and reviews
- Internal and External Audits
- Counter Fraud and Security Management
- Risk Management Reports
- Staff and Patient Surveys
- Clinical Audit Reports
- CQC Self Assessment, inspections and reviews

- Counter Fraud Reports
- Management Reports
- Performance and Quality Reports
- Review of Governance Arrangements

The above and any other sources of assurance are reviewed by the Trust Board, Audit Committee, Resources and Performance Committee, Quality and Safety Committee and individual members of staff who contribute to the system for internal control.

Following review of the above the Audit Committee has confirmed that there is an effective risk management process in place.

Significant Issues

No significant issues have been identified at the year end or during the year.

Accountable Officer:
Jan Ditheridge, Chief Executive Officer

Organisation:
Shropshire Community Health NHS Trust

Signature : 

Date : 02-06-15

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF SHROPSHIRE COMMUNITY HEALTH NHS TRUST

We have audited the financial statements of Shropshire Community Health NHS Trust for the year ended 31 March 2015 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is 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, being:

- the table of salaries and allowances of senior managers [and related narrative notes] on pages 58 and 59
- the table of pension benefits of senior managers [and related narrative notes] on page 59 and 60
- pay multiples [and related narrative notes] on pages 57 and 58.

This report is made solely to the Board of Directors of Shropshire Community Health NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 44 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2014. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust's directors and 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 in respect of the accounts, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards also 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 which comprises the sections titled: Foreword, Strategic Report, Directors Report, Remuneration Report, Sustainability Report, Statement of Accountable Officer's Responsibilities, Annual Accounts, to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of Shropshire Community Health NHS Trust as at 31 March 2015 and of its 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

In our opinion:

- the part of the Remuneration Report subject to audit has been prepared properly in accordance with the requirements 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 annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we report by exception

We report to you if:

- in our opinion the governance statement does not reflect compliance with the NHS Trust Development Authority's Guidance
- we refer the matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 8 of the Audit Commission Act 1998.

We have nothing to report in these respects.

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

Respective responsibilities of the Trust and auditor

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

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice 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 in October 2014.

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

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

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

- securing financial resilience
- 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 in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2015.

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

Conclusion

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

Certificate

We certify that we have completed the audit of the accounts of Shropshire Community Health NHS Trust in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Mark Stocks
for and on behalf of Grant Thornton UK LLP, Appointed Auditor

20 Colmore Plaza, Birmingham B4 6AT

2 June 2015

Statement of Comprehensive Income for year ended 31 March 2015

	NOTE	2014-15 £000s	2013-14 £000s
Gross employee benefits	10.1	**(53,407)**	(54,368)
Other operating costs	8	**(21,041)**	(21,682)
Revenue from patient care activities	5	**72,144**	72,569
Other operating revenue	6	**3,142**	3,536
Operating surplus/(deficit)		**838**	55
Investment revenue	12	**25**	19
Other gains and (losses)	13	**(42)**	(29)
Finance costs	14	**(4)**	0
Surplus/(deficit) for the financial year		**817**	45
Public dividend capital dividends payable		**(458)**	0
Transfers by absorption - gains		**0**	0
Transfers by absorption - (losses)		**0**	0
Net Gain/(loss) on transfers by absorption		**0**	0
Retained surplus/(deficit) for the year		**359**	45
Other Comprehensive Income			
Impairments and reversals taken to the revaluation reserve		**0**	(480)
Net gain/(loss) on revaluation of property, plant & equipment		**412**	494
Net gain/(loss) on revaluation of intangibles		**0**	0
Net gain/(loss) on revaluation of financial assets		**0**	0
Other gain /(loss) (explain in footnote below)		**0**	0
Net gain/(loss) on revaluation of available for sale financial assets		**0**	0
Net actuarial gain/(loss) on pension schemes		**0**	0
Other pension remeasurements		**0**	0
Reclassification adjustments			
On disposal of available for sale financial assets		**0**	0
Total other comprehensive income for the year		**412**	14
Total comprehensive income for the year		**771**	59

Financial performance for the year

	2014-15 £000s	2013-14 £000s
Retained surplus/(deficit) for the year	**359**	45
Prior period adjustment to correct errors and other performance adjustments	**0**	0
IFRIC 12 adjustment (including IFRIC 12 impairments)	**0**	0
Impairments (excluding IFRIC 12 impairments)	**0**	184
Adjustments in respect of donated gov't grant asset reserve elimination	**(7)**	5
Adjustment re absorption accounting	**0**	0
Adjusted retained surplus/(deficit)	**352**	234

The adjustment to arrive at reported financial performance relates to the favourable impact on the Trust of:
- the change in accounting policy from 2011/12 for assets funded by donations or government grants.
- the impairment of Trust land and buildings following the required 5 yearly revaluation (2013/14 only).

The notes on pages 5 to 36 form part of this account.

Statement of Financial Position as at 31 March 2015

	NOTE	31 March 2015 £000s	31 March 2014 £000s
Non-current assets:			
Property, plant and equipment	15	**19,689**	19,344
Intangible assets	16	**0**	0
Investment property	18	**0**	0
Other financial assets		**0**	0
Trade and other receivables	22.1	**52**	104
Total non-current assets		**19,741**	19,448
Current assets:			
Inventories	21	**471**	462
Trade and other receivables	22.1	**2,923**	3,225
Other financial assets	24	**0**	0
Other current assets	25	**0**	0
Cash and cash equivalents	26	**5,805**	5,713
Sub-total current assets		**9,199**	9,400
Non-current assets held for sale	27	**0**	0
Total current assets		**9,199**	9,400
Total assets		**28,940**	28,848
Current liabilities			
Trade and other payables	28	**(6,692)**	(6,844)
Other liabilities	29	**0**	0
Provisions	35	**(18)**	(545)
Borrowings	30	**0**	0
Other financial liabilities	31	**0**	0
DH revenue support loan	30	**0**	0
DH capital loan	30	**0**	0
Total current liabilities		**(6,710)**	(7,389)
Net current assets/(liabilities)		**2,489**	2,011
Total assets less current liablilities		**22,230**	21,459
Non-current liabilities			
Trade and other payables	28	**0**	0
Other liabilities	31	**0**	0
Provisions	35	**0**	0
Borrowings	30	**0**	0
Other financial liabilities	31	**0**	0
DH revenue support loan	30	**0**	0
DH capital loan	30	**0**	0
Total non-current liabilities		**0**	0
Total assets employed:		**22,230**	21,459
FINANCED BY:			
Public Dividend Capital		**1,489**	1,489
Retained earnings		**17,131**	16,757
Revaluation reserve		**3,610**	3,213
Other reserves		**0**	0
Total Taxpayers' Equity:		**22,230**	21,459

The notes on pages 5 to 36 form part of this account.

The financial statements on pages 1 to 37 were approved by the Board on 2nd June and signed on its behalf by

Chief Executive: Jan Ditheridge Date: 02-06-15

Statement of Changes in Taxpayers' Equity
For the year ending 31 March 2015

	Public Dividend capital	Retained earnings	Revaluation reserve	Other reserves	Total reserves
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2014	**1,489**	**16,757**	**3,213**	**0**	**21,459**
Changes in taxpayers' equity for 2014-15					
Retained surplus/(deficit) for the year		359			**359**
Net gain / (loss) on revaluation of property, plant, equipment			412		**412**
Net gain / (loss) on revaluation of intangible assets			0		**0**
Net gain / (loss) on revaluation of financial assets			0		**0**
Net gain / (loss) on revaluation of available for sale financial assets			0		**0**
Impairments and reversals			0		**0**
Other gains / (loss)				0	**0**
Transfers between reserves		15	(15)	**0**	**0**
Reclassification Adjustments					
Transfers to/(from) other bodies within the resource account boundary		0	0	0	**0**
Transfers between revaluation reserve & retained earnings in respect of assets transferred under absorption		0	0		**0**
On disposal of available for sale financial assets			0		**0**
Reserves eliminated on dissolution		0	0	0	**0**
Originating capital for Trust established in year	0				**0**
New temporary and permanent PDC received - cash	0				**0**
New temporary and termanent PDC repaid in year	0				**0**
PDC written off	0				**0**
Transferred to NHS Foundation Trust	0	0	0	0	**0**
Other movements	0	0	0	0	**0**
Net actuarial gain/(loss) on pension				0	**0**
Other pensions remeasurement				0	**0**
Net recognised revenue / (expense) for the year	**0**	**374**	**397**	**0**	**771**
Balance at 31 March 2015	**1,489**	**17,131**	**3,610**	**0**	**22,230**

Balance at 1 April 2013	1,000	3,401	95	0	4,496
Changes in taxpayers' equity for the year ended 31 March 2014					
Retained surplus/(deficit) for the year		45			45
Net gain / (loss) on revaluation of property, plant, equipment			494		494
Net gain / (loss) on revaluation of intangible assets			0		0
Net gain / (loss) on revaluation of financial assets			0		0
Net gain / (loss) on revaluation of assets held for sale			0		0
Impairments and reversals			(480)		(480)
Other gains / (loss)				0	0
Transfers between reserves		44	(44)	0	0
Transfers under Modified Absorption Accounting - PCTs & SHAs		16,415			16,415
Transfers under Modified Absorption Accounting - other bodies		0			0
Reclassification Adjustments					
Transfers to/(from) other bodies within the Resource Account Boundary	**0**	0	0	0	0
Transfers between revaluation reserve & retained earnings reserve in respect of assets transferred under absorption		0	0		0
On disposal of available for sale financial assets			0		0
Reserves eliminated on dissolution		0	0	0	0
Originating capital for Trust established in year	0				0
New temporary and permanent PDC received - cash	77				77
New PDC received / (repaid) - PCTs/SHA legacy items paid for by DH	412				412
New temporary and permanent PDC repaid in year	0				0
PDC written off	0				0
Transferred to NHS Foundation Trust	0	0	0	0	0
Other movements	0	0	0	0	0
Net actuarial gain / (loss) on pension				0	0
Other pension remeasurement				0	0
Net recognised revenue / (expense) for the year	489	16,504	(30)	0	16,963
Transfers between reserves in respect of modified absorption - PCTs & SHAs		(3,148)	3,148	0	0
Transfers between reserves in respect of modified absorption - other bodies		0	0	0	0
Balance at 31 March 2014	1,489	16,757	3,213	0	21,459

Statement of Cash Flows for the Year ended 31 March 2015

	NOTE	2014-15 £000s	2013-14 £000s
Cash Flows from Operating Activities			
Operating surplus / (deficit)		**838**	55
Depreciation and amortisation		**1,061**	1,184
Impairments and reversals		**0**	184
Other gains / (losses) on foreign exchange		**0**	0
Donated assets received credited to revenue but non-cash		**0**	0
Government granted assets received credited to revenue but non-cash		**0**	0
Interest paid		**(4)**	0
Dividend (paid) / refunded		**(445)**	0
Release of PFI/deferred credit		**0**	0
(Increase) / decrease in Inventories		**(9)**	(132)
(Increase) / decrease in Trade and Other Receivables		**354**	(2,176)
(Increase) /decrease in Other Current Assets		**0**	0
Increase / (decrease) in Trade and Other Payables		**(265)**	298
(Increase) / decrease in Other Current Liabilities		**0**	0
Provisions utilised		**(71)**	(59)
Increase / (decrease) in movement in non cash provisions		**(456)**	540
Net Cash Inflow / (Outflow) from Operating Activities		**1,003**	(106)
Cash Flows from Investing Activities			
Interest received		**25**	19
(Payments) for Property, Plant and Equipment		**(946)**	(517)
(Payments) for Intangible Assets		**0**	0
(Payments) for Investments with DH		**0**	0
(Payments) for Other Financial Assets		**0**	0
(Payments) for Financial Assets (LIFT)		**0**	0
Proceeds of disposal of assets held for sale (PPE)		**10**	1
Proceeds of disposal of assets held for sale (Intangible)		**0**	0
Proceeds from Disposal of Investment with DH		**0**	0
Proceeds from Disposal of Other Financial Assets		**0**	0
Proceeds from the disposal of Financial Assets (LIFT)		**0**	0
Loans made in respect of LIFT		**0**	0
Loans repaid in respect of LIFT		**0**	0
Rental revenue		**0**	0
Net Cash Inflow / (Outflow) from Investing Activities		**(911)**	(497)
Net Cash Inflow / (Outflow) before Financing		**92**	(603)
Cash Flows from Financing Activities			
Gross Temporary and Permanent PDC received		**0**	489
Gross Temporary and Permanent PDC repaid		**0**	0
Loans received from DH - New Capital Investment Loans		**0**	0
Loans received from DH - New Revenue Support Loans (previously Working Capital Loans)		**0**	0
Other loans received		**0**	0
Loans repaid to DH - Capital Investment Loans repayment of principal		**0**	0
Loans repaid to DH - Working Capital Loans/Revenue Support Loans		**0**	0
Other loans repaid		**0**	0
Cash transferred to NHS Foundation Trusts or on dissolution		**0**	0
Capital element of payments in respect of Finance Leases & On-SoFP PFI & LIFT		**0**	0
Capital grants & other capital receipts (excluding donated/government granted cash receipts)		**0**	0
Net Cash Inflow / (Outflow) from Financing Activities		**0**	489
NET INCREASE / (DECREASE) IN CASH AND CASH EQUIVALENTS		**92**	(114)
Cash and Cash Equivalents (and Bank Overdraft) at beginning of the period		**5,713**	5,827
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		**5,805**	5,713

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS Trusts shall meet the accounting requirements of the Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2014-15 issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 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.

1.2 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.

1.3 Movement of assets within the DH Group

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

Other transfers of assets and liabilities within the Group are accounted for in line with IAS20 and similarly give rise to income and expenditure entries.

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

1.4 Charitable Funds

Under the provisions of IFRS 10 *Consolidated Financial Statements*, those Charitable Funds that fall under common control with NHS Trusts are consolidated within the entity's financial statements. As the Trust is the corporate trustee of the linked NHS Charity (Shropshire Community Health NHS Trust General Charitable Fund), it effectively has the power to exercise control so as to obtain economic benefits. However the balance and transactions are immaterial in the context of the group and transactions have not been consolidated. Details of the transactions with the charity are included in the Note 41 : related parties.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.5 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.5.1 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.

1. Determining whether substantially all the significant risks and rewards of ownership of leased assets have transferred, to determine whether a lease is a finance lease or an operating lease.
2. Determining whether charitable funds are a subsidiary of the Trust, and whether they are material, to determine whether or not to consolidate.

1.5.2 Key sources of estimation uncertainty

1. Land and buildings (£17.8m) are valued periodically by an external valuer who makes assumptions concerning values. Estimates are also made concerning the lives of those assets. If the valuations were 1% different, this would amount to £0.2m. The valuations would need to be different by 8% (£1.4m) to be considered material.

1.6 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. Revenue relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay.

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.

1.7 Employee Benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that the employees are permitted to carry forward leave into the following year.

Notes to the Accounts - 1. Accounting Policies (Continued)

Retirement benefit costs
Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

1.8 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.

1.9 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised if:
- it is held for use in delivering services or for administrative purposes;

- it is probable that future economic benefits will flow to, or service potential will be supplied to the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or

- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

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

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

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:
- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

Notes to the Accounts - 1. Accounting Policies (Continued)

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 IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value. The Trust policy on equipment indexation is that where a piece of equipment has a life of more than 10 years and a net book value in excess of £30,000 it is indexed using the Health Services Cost Index (HSCI).

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

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

1.10 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably, and where the cost is at least £5000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

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

Notes to the Accounts - 1. Accounting Policies (Continued)

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

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

1.11 Depreciation, amortisation and impairments
Freehold land, properties under construction, and assets held for sale are not depreciated.

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

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

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

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME). This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set.
AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

1.12 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.

1.13 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.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.14 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.

1.15 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.

1.16 Inventories

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

Notes to the Accounts - 1. Accounting Policies (Continued)

1.17 Cash and cash equivalents

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

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

1.18 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. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's published discount rates.

The Trust has not applied the Treasury's discount rates because settlement of the provisions is expected within one year and the impact of discounting is not material .

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.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.19 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 35.

1.20 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.

1.21 Contingencies

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

Notes to the Accounts - 1. Accounting Policies (Continued)

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

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

1.22 Financial assets

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

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

Loans and receivables

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

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 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.

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 expenditure and the carrying amount of the asset is reduced directly/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.

1.23 Financial liabilities

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

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

Notes to the Accounts - 1. Accounting Policies (Continued)

Other financial liabilities
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

The value of the financial liabilities measured at amortised cost, is the same as the carrying value of those liabilities.

1.24 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.

1.25 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.

1.26 Third party assets
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 44 to the accounts.

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

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

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

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

Notes to the Accounts - 1. Accounting Policies (Continued)

1.29 Subsidiaries

Material entities over which the Trust has the power to exercise control are classified as subsidiaries and are consolidated. The Trust has control when it is exposed to or has rights to variable returns through its power over another entity. The income and expenses; gains and losses; assets, liabilities and reserves; and cash flows of the subsidiary are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Trust or where the subsidiary's accounting date is not co-terminus. See note 1.4 re charitable funds.

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

1.30 Associates

Material entities over which the Trust has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the Trust's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the Trust share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the Trust from the entity. See note 1.4 re charitable funds.

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

1.31 Research and Development

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

1.32 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 2014-15. The application of the Standards as revised would not have a material impact on the accounts for 2014-15, were they applied in that year:
IFRS 9 Financial Instruments - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation
IFRS 15 Revenue from Contracts with Customers

2. Pooled Budgets

There were no pooled budgets.

3. Operating Segments

The Trust has only one operating segment - healthcare. This is in line with reporting to decision makers.

4. Income Generation Activities

The Trust undertakes income generation activities with an aim of achieving profit, which is then invested to support patient care. In 2014-15 (and 2013-14) there were no income generation activities whose full cost exceeded £1m or was otherwise material.

5. Revenue from Patient Care Activities

	2014-15 £000s	2013-14 £000s
NHS Trusts	**674**	549
NHS England	**9,600**	8,008
Clinical Commissioning Groups	**57,148**	58,446
Foundation Trusts	**39**	36
Department of Health	**0**	0
NHS Other (including Public Health England and Prop Co)	**0**	0
Additional income for delivery of healthcare services	**0**	
Non-NHS:		
Local Authorities	**3,675**	4,702
Private patients	**0**	0
Overseas patients (non-reciprocal)	**0**	0
Injury costs recovery	**58**	57
Other	**950**	771
Total revenue from patient care activities	**72,144**	72,569

6. Other Operating Revenue

	2014-15 £000s	2013-14 £000s
Recoveries in respect of employee benefits	**281**	306
Patient transport services	**0**	0
Education, training and research	**1,461**	1,564
Charitable and other contributions to revenue expenditure - NHS	**0**	0
Charitable and other contributions to revenue expenditure - non-NHS	**0**	0
Receipt of donations for capital acquisitions - charity	**103**	102
Support from DH for mergers	**0**	
Receipt of Government grants for capital acquisitions	**0**	0
Non-patient care services to other bodies	**0**	0
Income generation	**655**	660
Rental revenue from finance leases	**0**	0
Rental revenue from operating leases	**158**	158
Other revenue	**484**	746
Total other operating revenue	**3,142**	3,536
Total operating revenue	**75,286**	76,105

7. Overseas Visitors Disclosure

No services were identified during the year for which the Trust should charge overseas visitors.

8. Operating Expenses

	2014-15 £000s	2013-14 £000s
Services from other NHS Trusts	**1,550**	1,832
Services from CCGs/NHS England	**0**	3
Services from other NHS bodies	**0**	55
Services from NHS Foundation Trusts	**163**	276
Total Services from NHS bodies*	**1,713**	2,166
Purchase of healthcare from non-NHS bodies	**161**	173
Trust Chair and Non-Executive Directors	**54**	51
Supplies and services - clinical	**7,174**	6,601
Supplies and services - general	**627**	607
Consultancy services	**171**	699
Establishment	**2,950**	3,554
Transport	**0**	0
Service charges - On-SOFP PFIs and other service concession arrangements	**0**	
Service charges - On-SOFP LIFT contracts	**0**	
Total charges - Off-SOFP PFIs and other service concession arrangements	**0**	
Total charges - Off-SOFP LIFT contracts	**0**	
Business rates paid to local authorities	**447**	
Premises	**5,044**	5,011
Hospitality	**9**	8
Insurance	**206**	241
Legal Fees	**119**	146
Impairments and reversals of receivables	**33**	43
Inventories write down	**0**	0
Depreciation	**1,061**	1,184
Amortisation	**0**	0
Impairments and reversals of property, plant and equipment	**0**	184
Impairments and reversals of intangible assets	**0**	0
Impairments and reversals of financial assets	**0**	0
Impairments and reversals of non current assets held for sale	**0**	0
Audit fees	**43**	54
Other auditor's remuneration	**0**	0
Clinical negligence	**113**	126
Research and development (excluding staff costs)	**0**	0
Education and training	**349**	225
Change in discount rate	**0**	0
Other	**767**	609
Total operating expenses (excluding employee benefits)	**21,041**	21,682
Employee Benefits		
Employee benefits excluding Board members	**52,674**	53,738
Board members	**733**	630
Total Employee Benefits	**53,407**	54,368
Total Operating Expenses	**74,448**	76,050

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

9. Operating Leases

9.1 Trust as lessee

The most significant lease payments are to NHS Property Services. A number of premises used by the Trust transferred from local PCTs to NHS Property Services in 2013/14. Under DH guidance, the Trust was not permitted to own/lease these properties, mainly because they are non-clinical. Whilst no formal leases are yet in place with NHS Property Services, invoices have been received by the Trust and payments have been made.

The remaining leases are for properties leased by the Trust directly, and lease cars for staff.

	Land £000s	Buildings £000s	Other £000s	**2014-15 Total £000s**	2013-14 £000s
Payments recognised as an expense					
Minimum lease payments				**3,234**	3,290
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total				**3,234**	3,290
Payable:					
No later than one year	0	3,254	316	**3,570**	3,018
Between one and five years	0	4,652	181	**4,833**	3,706
After five years	0	4,133	0	**4,133**	2,882
Total	**0**	**12,039**	**497**	**12,536**	9,606
Total future sublease payments expected to be received:				**0**	0

The analysis showing when future lease payments will be payable has been amended for 2013/14 as the Trust has new information about the likely lease term of 2 NHS Property Services leases.

9.2 Trust as lessor

Leases are property leases with other NHS bodies.

	2014-15 £000	2013-14 £000s
Recognised as revenue		
Rental revenue	**158**	158
Contingent rents	**0**	0
Total	**158**	158
Receivable:		
No later than one year	**158**	158
Between one and five years	**0**	0
After five years	**0**	0
Total	**158**	158

10. Employee Benefits and Staff Numbers

10.1 Employee benefits

	2014-15		
	Total	Permanently employed	Other
	£000s	£000s	£000s
Employee Benefits - Gross Expenditure			
Salaries and wages	**46,074**	**39,439**	**6,635**
Social security costs	**2,572**	**2,572**	**0**
Employer contributions to NHS BSA - Pensions Division	**5,020**	**5,020**	**0**
Other pension costs	**0**	**0**	**0**
Termination benefits	**(259)**	**(259)**	**0**
Total employee benefits	**53,407**	**46,772**	**6,635**
Employee costs capitalised	**0**	**0**	**0**
Gross Employee Benefits excluding capitalised costs	**53,407**	**46,772**	**6,635**

The termination benefits figure is negative in 2014/15 due to reversal of a the prior year redundancy provision - see Note 35

Employee Benefits - Gross Expenditure 2013-14	Total	Permanently employed	Other
	£000s	£000s	£000s
Salaries and wages	45,618	39,582	6,036
Social security costs	2,727	2,727	0
Employer contributions to NHS BSA - Pensions Division	5,071	5,071	0
Other pension costs	0	0	0
Termination benefits	952	952	0
TOTAL - including capitalised costs	54,368	48,332	6,036
Employee costs capitalised	0	0	0
Gross Employee Benefits excluding capitalised costs	54,368	48,332	6,036

Prior period figures have been amended from those in the 2013/14 accounts to aid comparability between years as classification of costs between "Permanent" and "Other" has changed. £1.2m relating to recharges from other organisations has been reclassified from "Permanent" to "Other" and £0.8m relating to Trust bank staff has been reclassified from "Other" to "Permanent".

10.2 Staff numbers

	2014-15			2013-14
	Total Number	Permanently employed Number	Other Number	Total Number
Average Staff Numbers				
Medical and dental	**43**	**29**	**14**	35
Ambulance staff	**0**	**0**	**0**	0
Administration and estates	**258**	**238**	**20**	291
Healthcare assistants and other support staff	**105**	**82**	**23**	87
Nursing, midwifery and health visiting staff	**712**	**660**	**52**	709
Nursing, midwifery and health visiting learners	**0**	**0**	**0**	0
Scientific, therapeutic and technical staff	**229**	**218**	**11**	226
Social Care Staff	**7**	**0**	**7**	7
Other	**49**	**48**	**1**	59
TOTAL	**1,403**	**1,275**	**128**	1,414
Of the above - staff engaged on capital projects	0	0	0	0

10.3 Staff sickness absence and ill health retirements

	2014-15	2013-14
Total days lost	**13,371**	13,607
Total staff years	**1,267**	1,286
Average working days lost	**10.55**	10.58

The sickness absence figures are reported on a calendar year basis as required by the Department of Health.

Number of persons retired early on ill health grounds	**1**	5
Total additional pensions liabilities accrued in the year (£'000)	**42**	139

10.4 Exit packages agreed in 2014-15

	2014-15			2013-14		
Exit package cost band (including any special payment element)	***Number of compulsory redundancies**	***Number of other departures agreed**	**Total number of exit packages by cost band**	*Number of compulsory redundancies	*Number of other departures agreed	Total number of exit packages by cost band
	Number	**Number**	**Number**	Number	Number	Number
Less than £10,000	**1**	**2**	**3**	17	3	20
£10,000-£25,000	**1**	**0**	**1**	15	0	15
£25,001-£50,000	**0**	**0**	**0**	3	1	4
£50,001-£100,000	**0**	**0**	**0**	1	0	1
£100,001 - £150,000	**0**	**0**	**0**	0	0	0
£150,001 - £200,000	**1**	**0**	**1**	0	0	0
>£200,000	**0**	**0**	**0**	0	0	0
Total number of exit packages by type (total cost)	**3**	**2**	**5**	36	4	40
Total resource cost (£s)	**203,376**	**735**	**204,111**	508,000	39,000	547,000

Redundancy and other departure costs have been paid in accordance with the provisions of NHS Agenda for Change rules on pay. 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.

10.5 Exit packages - Other departures analysis

	2014-15		2013-14	
	Agreements Number	**Total value of agreements £000s**	**Agreements Number**	**Total value of agreements £000s**
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	2	1	4	39
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval	0	0	0	0
Total	2	1	4	39
Non-contractual payments made to individuals where the payment was more than 12 months of their annual salary	0	0	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 Note 10.4 which will be the number of individuals.

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

10.6 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.

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

a) Accounting valuation
A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2015, is based on valuation data as 31 March 2014, updated to 31 March 2015 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations were allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

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

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

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

10.6 Pension costs (continued)

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Price Index (RPI).

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

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

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

11. Better Payment Practice Code

11.1 Measure of compliance

	2014-15 Number	**2014-15 £000s**	2013-14 Number	2013-14 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**22,557**	**17,960**	23,875	17,834
Total Non-NHS Trade Invoices Paid Within Target	**22,006**	**17,430**	23,268	17,464
Percentage of NHS Trade Invoices Paid Within Target	**97.6%**	**97.0%**	97.5%	97.9%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**1,656**	**13,254**	1,583	11,039
Total NHS Trade Invoices Paid Within Target	**1,607**	**12,809**	1,544	10,547
Percentage of NHS Trade Invoices Paid Within Target	**97.0%**	**96.6%**	97.5%	95.5%

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

11.2 The Late Payment of Commercial Debts (Interest) Act 1998

There were no payments under the Late Payment of commercial Debts (Interest) Act 1998.

12. Investment Revenue

	2014-15 £000s	2013-14 £000s
Rental revenue		
PFI finance lease revenue (planned)	**0**	0
PFI finance lease revenue (contingent)	**0**	0
Other finance lease revenue	**0**	0
Subtotal	**0**	0
Interest revenue		
LIFT: equity dividends receivable	**0**	0
LIFT: loan interest receivable	**0**	0
Bank interest	**25**	19
Other loans and receivables	**0**	0
Impaired financial assets	**0**	0
Other financial assets	**0**	0
Subtotal	**25**	19
Total investment revenue	**25**	19

13. Other Gains and Losses

	2014-15 £000s	2013-14 £000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	**(25)**	(29)
Gain/(Loss) on disposal of assets other than by sale (intangibles)	**0**	0
Gain/(Loss) on disposal of financial assets other then held for sale	**0**	0
Gain (Loss) on disposal of assets held for sale	**(17)**	0
Gain/(loss) on foreign exchange	**0**	0
Change in fair value of financial assets carried at fair value through the SoCI	**0**	0
Change in fair value of financial liabilities carried at fair value through the SoCI	**0**	0
Change in fair value of investment property	**0**	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	**0**	0
Total	**(42)**	(29)

14 Finance Costs

	2014-15 £000s	2013-14 £000s
Interest		
Interest on loans and overdrafts	**0**	0
Interest on obligations under finance leases	**0**	0
Interest on obligations under PFI contracts:		
- main finance cost	**0**	0
- contingent finance cost	**0**	0
Interest on obligations under LIFT contracts:		
- main finance cost	**0**	0
- contingent finance cost	**0**	0
Interest on late payment of commercial debt	**0**	0
Total interest expense	**0**	0
Other finance costs	**4**	0
Provisions - unwinding of discount	**0**	0
Total	**4**	0

15.1 Property, Plant and Equipment

2014-15	Land £000's	Buildings excluding dwellings £000's	Dwellings £000's	Assets under construction £000's	Plant & machinery £000's	Transport equipment £000's	Information technology £000's	Furniture & fittings £000's	Total £000's
Cost or valuation:									
At 1 April 2014	**3,887**	**13,628**	**0**	**93**	**3,193**	**155**	**1,923**	**131**	**23,010**
Additions of Assets Under Construction				148					**148**
Additions Purchased	0	310	0		156	0	329	0	**795**
Additions - Non Cash Donations (i.e. physical assets)	0	0	0	0	0	0	0	0	**0**
Additions - Purchases from Cash Donations & Government Grants	0	0	0	36	67	0	0	0	**103**
Additions Leased	0	0	0		0	0	0	0	**0**
Reclassifications	0	241	0	(241)	0	0	0	0	**0**
Reclassifications as Held for Sale and reversals	0	0	0	0	(27)	(31)	0	0	**(58)**
Disposals other than for sale	0	0	0	0	(340)	0	(235)	0	**(575)**
Upward revaluation/positive indexation	174	(276)	0	0	3	0	0	0	**(99)**
Impairments/negative indexation	0	0	0	0	0	0	0	0	**0**
Reversal of Impairments	0	0	0	0	0	0	0	0	**0**
Transfers to NHS Foundation Trust	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	**0**
At 31 March 2015	**4,061**	**13,903**	**0**	**36**	**3,052**	**124**	**2,017**	**131**	**23,324**
Depreciation									
At 1 April 2014	**0**	**184**	**0**	**0**	**1,735**	**138**	**1,525**	**84**	**3,666**
Reclassifications	0	0	0		0	0	0	0	**0**
Reclassifications as Held for Sale and reversals	0	0	0		(5)	(25)	0	0	**(30)**
Disposals other than for sale	0	0	0		(317)	0	(234)	0	**(551)**
Upward revaluation/positive indexation	0	(511)	0		0	0	0	0	**(511)**
Impairments	0	0	0	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	0	0	0	**0**
Charged during the year	0	518	0		361	11	155	16	**1,061**
Transfers to NHS Foundation Trust	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	**0**	0	0	0	0	**0**
At 31 March 2015	**0**	**191**	**0**	**0**	**1,774**	**124**	**1,446**	**100**	**3,635**
Net Book Value at 31 March 2015	**4,061**	**13,712**	**0**	**36**	**1,278**	**0**	**571**	**31**	**19,689**
Asset financing:									
Owned - Purchased	4,061	13,363	0	0	870	0	571	31	**18,896**
Owned - Donated	0	349	0	36	385	0	0	0	**770**
Owned - Government Granted	0	0	0	0	23	0	0	0	**23**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	**0**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2015	**4,061**	**13,712**	**0**	**36**	**1,278**	**0**	**571**	**31**	**19,689**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land £000's	Buildings £000's	Dwellings £000's	Assets under construction £000's	Plant & machinery £000's	Transport equipment £000's	Information technology £000's	Furniture & fittings £000's	Total £000's
At 1 April 2014	1,093	2,022	0	0	91	6	0	0	**3,212**
Movements	146	269	0	0	(15)	(2)	0	0	**398**
At 31 March 2015	**1,239**	**2,291**	**0**	**0**	**76**	**4**	**0**	**0**	**3,610**

Additions to Assets Under Construction in 2014-15

	£000's
Land	0
Buildings excl Dwellings	148
Dwellings	0
Plant & Machinery	0
Balance as at YTD	**148**

15.2 Property, Plant and Equipment prior-year

2013-14	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Cost or valuation:									
At 1 April 2013	**0**	**0**	**0**	**0**	**3,097**	**169**	**1,881**	**131**	**5,278**
Transfers under Modified Absorption Accounting - PCTs & SHAs	2,887	13,694	0	301	0	0	0	0	**16,882**
Transfers under Modified Absorption Accounting - Other Bodies	0	0	0	0	0	0	0	0	**0**
Additions of Assets Under Construction				160					**160**
Additions Purchased	0	131	0		86	0	62	0	**279**
Additions - Non Cash Donations (i.e. Physical Assets)	0	0	0	0	0	0	0	0	**0**
Additions - Purchases from Cash Donations & Government Grants	0	0	0	0	102	0	0	0	**102**
Additions Leased	0	0	0		0	0	0	0	**0**
Reclassifications	0	368	0	(368)	0	0	0	0	**0**
Reclassifications as Held for Sale and Reversals	1,000	0	0	0	0	(14)	0	0	**986**
Disposals other than for sale	0	(23)	0	0	(98)	0	(20)	0	**(141)**
Revaluation	0	488	0	0	6	0	0	0	**494**
Impairments/negative indexation charged to reserves	0	(480)	0	0	0	0	0	0	**(480)**
Reversal of impairments charged to reserves	0	0	0	0	0	0	0	0	**0**
Removal of cumulative depreciation at date of revaluation	0	(550)	0	0	0	0	0	0	**(550)**
Transfers to Foundation Trust	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	**0**
At 31 March 2014	**3,887**	**13,628**	**0**	**93**	**3,193**	**155**	**1,923**	**131**	**23,010**
Depreciation									
At 1 April 2013	**0**	**0**	**0**	**0**	**1,478**	**138**	**1,290**	**67**	**2,973**
Reclassifications	0	0	0		0	0	0	0	**0**
Reclassifications as Held for Sale and Reversals	0	0	0		0	(14)	0	0	**(14)**
Disposals other than for sale	0	0	0		(98)	0	(13)	0	**(111)**
Revaluation	0	0	0		0	0	0	0	**0**
Impairments/negative indexation charged to operating expenses	0	184	0	0	0	0	0	0	**184**
Reversal of Impairments charged to operating expenses	0	0	0	0	0	0	0	0	**0**
Charged During the Year	0	550	0		355	14	248	17	**1,184**
Removal of cumulative depreciation at date of revaluation	0	(550)	0		0	0	0	0	**(550)**
Transfers to Foundation Trust	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0		0	0	0	0	**0**
At 31 March 2014	**0**	**184**	**0**	**0**	**1,735**	**138**	**1,525**	**84**	**3,666**
Net Book Value at 31 March 2014	**3,887**	**13,444**	**0**	**93**	**1,458**	**17**	**398**	**47**	**19,344**
Asset financing:									
Owned - Purchased	3,887	13,086	0	93	1,025	17	398	47	**18,553**
Owned - Donated	0	358	0	0	392	0	0	0	**750**
Owned - Government Granted	0	0	0	0	41	0	0	0	**41**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	**0**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2014	**3,887**	**13,444**	**0**	**93**	**1,458**	**17**	**398**	**47**	**19,344**

15.3 Property, Plant and Equipment

The last 5 yearly full land and buildings revaluation was undertaken by the Valuation Office Agency (VOA) with an effective date of 31st March 2014. The surveyor was Jon Jones BSc(Hons) MRICS).

In 2014/15, desk-top revaluations of the same assets were undertaken by the VOA with an effective date of 31st March 2015. BCIS indices, provided to the Trust by the Valuation Office Agency were used to reflect changes in value of other assets not previously valued (£121k), and where there has been capital expenditure since the 2014 full valuation date (£105k).

The valuations were undertaken in accordance with International Financial Reporting Standards (IFRS) as interpreted and applied by the NHS, and the requirements of the RICS Valuation Professional Standards.

The land and buildings revaluation and indexation resulted in overall increases in value of £392k and £17k respectively.

Asset lives for each class of asset fall into the following ranges:
- Buildings excluding dwellings : 5 to 55 years
- Plant & machinery : 5 to 15 years
- Information technology : 3 to 5 years
- Furniture & fittings : 5 to 10 years

No asset lives have been changed during the year.

Capital assets donated in the year were from the League of Friends of the Community Hospitals, as well as the Trust's own charitable funds.

The gross carrying amount of fully depreciated assets still in use was £1.6m.

The carrying amount of surplus assets was nil.

16. Intangible Non-Current Assets

There were no intangible non-current assets.

17. Analysis of Impairments and Reversals Recognised in 2014-15

There were no impairments or reversals recognised in the year.

18. Investment Property

There was no investment property.

19. Commitments

19.1 Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2015 £000s	31 March 2014 £000s
Property, plant and equipment	**14**	132
Intangible assets	**0**	0
Total	**14**	132

19.2 Other financial commitments

There were no other financial commitments.

20. 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	**96**	**0**	**1,554**	**0**
Balances with Local Authorities	**591**	**0**	**642**	**0**
Balances with NHS bodies outside the Departmental Group	**0**	**0**	**0**	**0**
Balances with NHS bodies inside the Departmental Group	**1,916**	**0**	**2,441**	**0**
Balances with Public Corporations and Trading Funds	**0**	**0**	**0**	**0**
Balances with Bodies External to Government	**320**	**52**	**2,055**	**0**
At 31 March 2015	**2,923**	**52**	**6,692**	**0**
Prior period:				
Balances with Other Central Government Bodies	70	0	1,635	0
Balances with Local Authorities	541	0	348	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS bodies inside the Departmental Group	2,353	0	2,522	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with Bodies External to Government	261	104	2,339	0
At 31 March 2014	3,225	104	6,844	0

Prior period figures have been amended from those in the 2013/14 accounts to aid comparability between years as some line descriptors and content of the analysis has changed.

21. Inventories

	Drugs £000s	**Consumables £000s**	**Work in Progress £000s**	**Energy £000s**	**Loan Equipment £000s**	**Other £000s**	**Total £000s**
Balance at 1 April 2014	**0**	**180**	**0**	**0**	**282**	**0**	**462**
Additions	0	2,089	0	0	2,234	0	**4,323**
Recognised as an expense in period	0	(2,083)	0	0	(2,231)	0	**(4,314)**
Write-down (including losses)	0	0	0	0	0	0	**0**
Reversal of write-down previously taken to SOCI	0	0	0	0	0	0	**0**
Transfers (to) Foundation Trusts	0	0	0	0	0	0	**0**
Transfers (to)/from other public sector bodies under Absorption Accounting	0	0	0	0	0	0	**0**
Balance at 31 March 2015	**0**	**186**	**0**	**0**	**285**	**0**	**471**

22.1 Trade and Other Receivables

	Current		Non-current	
	31 March 2015	31 March 2014	**31 March 2015**	31 March 2014
	£000s	£000s	**£000s**	£000s
NHS receivables - revenue	**1,029**	2,353	**0**	0
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**887**	0	**0**	0
Non-NHS receivables - revenue	**720**	802	**52**	45
Non-NHS receivables - capital	**0**	0	**0**	0
Non-NHS prepayments and accrued income	**336**	95	**10**	66
PDC Dividend prepaid to DH	**0**			
Provision for the impairment of receivables	**(97)**	(77)	**(10)**	(7)
VAT	**42**	49	**0**	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income	**0**	0	**0**	0
Interest receivables	**1**	1	**0**	0
Finance lease receivables	**0**	0	**0**	0
Operating lease receivables	**0**	0	**0**	0
Other receivables	**5**	2	**0**	0
Total	**2,923**	3,225	**52**	104
Total current and non current	**2,975**	3,329		
Included in NHS receivables are prepaid pension contributions:	**0**			

The great majority of trade is with CCGs and NHS England. As these NHS bodies are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

22.2 Receivables past their due date but not impaired

	31 March 2015	31 March 2014
	£000s	£000s
By up to three months	**280**	931
By three to six months	**81**	311
By more than six months	**56**	64
Total	**417**	1,306

22.3 Provision for impairment of receivables

	2014-15 £000s	2013-14 £000s
Balance at 1 April 2014	**(84)**	(57)
Transfers under Modified Absorption Accounting - PCTs & SHAs		0
Transfers under Modified Absorption Accounting - Other Bodies		0
Amount written off during the year	**10**	16
Amount recovered during the year	**60**	30
(Increase)/decrease in receivables impaired	**(93)**	(73)
Transfer to NHS Foundation Trust	**0**	
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	**0**	0
Balance at 31 March 2015	**(107)**	(84)

The majority of the provision relates to over performance on healthcare SLAs, where it is considered unlikely that the Trust will receive full payment. This accounts for £78,000 of the total provision (£60,000 in 2013/14).

The balance relates to the NHS Injury Costs Recovery Scheme and non-contracted activity with a local authority.

23. NHS LIFT Investments

There were no NHS LIFT investments.

24. Other Financial Assets

There were no other financial assets.

25. Other Current Assets

There were no other current assets.

26. Cash and Cash Equivalents

	31 March 2015 £000s	31 March 2014 £000s
Opening balance	**5,713**	5,827
Net change in year	**92**	(114)
Closing balance	**5,805**	5,713
Made up of		
Cash with Government Banking Service	**5,785**	5,691
Commercial banks	**0**	0
Cash in hand	**20**	22
Liquid deposits with NLF	**0**	0
Current investments	**0**	0
Cash and cash equivalents as in Statement of Financial Position	**5,805**	5,713
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in Statement of Cash Flows	**5,805**	5,713
Patients' money held by the Trust, not included above	**0**	0

27. Non-Current Assets Held for Sale

	Land	Buildings, excl. dwellings	Dwellings	Asset Under Construction and Payments on Account	Plant and Machinery	Transport and Equipment	Information Technology	Furniture and Fittings	Intangible Assets	Financial Assets	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2014	0	0	0	0	0	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	0	0	0	0	22	6	0	0	0	0	**28**
Less assets sold in the year	0	0	0	0	(22)	(6)	0	0	0	0	**(28)**
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	**0**
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	0	**0**
Transfers to Foundation Trust	0	0	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	0	0	**0**
Balance at 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Balance at 1 April 2013	1,000	0	0	0	0	0	0	0	0	0	**1,000**
Transfers under Modified Absorption Accounting - PCTs & SHAs	0	0			0				0		**0**
Transfers under Modified Absorption Accounting - Other Bodies	0	0	0	0	0	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	0	0	0	0	0	0	0	0	0	0	**0**
Less assets sold in the year	0	0	0	0	0	0	0	0	0	0	**0**
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	**0**
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	(1,000)	0	0	0	0	0	0	0	0	0	**(1,000)**
Transfers to Foundation Trust	0	0	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from other public sector bodies	0	0	0	0	0	0	0	0	0	0	**0**
Balance at 31 March 2014	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2014	0	0	0	0	0	0	0	0	0	0	0

The equipment that was classed as held for sale and subsequently sold was medical equipment and vehicles which were no longer required.

28. Trade and Other Payables

	Current		Non-current	
	31 March 2015	31 March 2014	**31 March 2015**	31 March 2014
	£000s	£000s	**£000s**	£000s
NHS payables - revenue	**1,169**	1,980	**0**	0
NHS payables - capital	**0**	0	**0**	0
NHS accruals and deferred income	**1,259**	542	**0**	0
Non-NHS payables - revenue	**1,345**	1,234	**0**	0
Non-NHS payables - capital	**271**	171	**0**	0
Non-NHS accruals and deferred income	**1,030**	1,194	**0**	0
Social security costs	**425**	459		
PDC Dividend payable to DH	**13**	0		
VAT	**0**	0	**0**	0
Tax	**377**	414		
Payments received on account	**0**	0	**0**	0
Other	**803**	850	**0**	0
Total	**6,692**	6,844	**0**	0
Total payables (current and non-current)	**6,692**	**6,844**		
Included above:				
Outstanding pension contributions at year end	**687**	698		

29. Other Liabilities

There were no other liabilities.

30. Borrowings

There were no borrowings.

31. Other Financial Liabilities

There were no other financial liabilities.

32 Deferred revenue

	Current		Non-current	
	31 March 2015	31 March 2014	**31 March 2015**	31 March 2014
	£000s	£000s	**£000s**	£000s
Opening balance at 1 April 2014	**0**	54	**0**	0
Deferred revenue addition	**40**	0	**0**	0
Transfer of deferred revenue	**0**	(54)	**0**	0
Current deferred Income at 31 March 2015	**40**	0	**0**	0
Total deferred income (current and non-current)	**40**	0		

33. Finance Lease Obligations as Lessee

There were no finance lease obligations as lessee.

34. Finance Lease Obligations as Lessor

There were no finance lease obligations as lessor.

35. Provisions

	Total £000s	Early Departure Costs £000s	Legal Claims £000s	Restructuring £000s	Continuing Care £000s	Equal Pay (incl. Agenda for Change £000s	Other £000s	Redundancy £000s
Balance at 1 April 2014	**545**	0	10	0	0	0	0	535
Arising during the year	**8**	0	8	0	0	0	0	0
Utilised during the year	**(71)**	0	0	0	0	0	0	(71)
Reversed unused	**(464)**	0	0	0	0	0	0	(464)
Unwinding of discount	**0**	0	0	0	0	0	0	0
Change in discount rate	**0**	0	0	0	0	0	0	0
Transfers to NHS Foundation Trusts	**0**	0	0	0	0	0	0	0
Transfers (to)/from other public sector bodies under absorption accounting	**0**	0	0	0	0	0	0	0
Balance at 31 March 2015	**18**	**0**	**18**	**0**	**0**	**0**	**0**	**0**
Expected Timing of Cash Flows:								
No Later than One Year	**18**	0	18	0	0	0	0	0
Later than One Year and not later than Five Years	**0**	0	0	0	0	0	0	0
Later than Five Years	**0**	0	0	0	0	0	0	0

Amount included in the Provisions of the NHS Litigation Authority in respect of Clinical Negligence liabilities:

As at 31 March 2015	11
As at 31 March 2014	0

The redundancy provision was reversed unused as the planned restructure of the operations directorate did not take place due to other organisational changes at Executive level, and the potential risk of destabilising service delivery during this period.

36. Contingencies

	31 March 2015 £000s	31 March 2014 £000s
Contingent liabilities		
NHS Litigation Authority legal claims	**(8)**	
Employment Tribunal and other employee related litigation	**0**	0
Redundancy	**0**	
Other	**0**	(2)
Amounts recoverable against contingent liabilities	**0**	0
Net value of contingent liabilities	**(8)**	(2)
Contingent assets		
Contingent assets	**0**	0
Net value of contingent assets	**0**	0

37. PFI and LIFT - Additional Information

There were no PFI or LIFT schemes.

38. Impact of IFRS Treatment - Current Year

There was no impact of IFRS treatment in the current year.

39. Financial Instruments

39.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with 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 and therefore has low exposure to currency rate fluctuations.

Interest rate risk
The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the Trust Development Authority. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk
Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2015 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk
The Trust's operating costs are incurred under contracts with primary care organisations, 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.

39.2 Financial Assets

	At 'fair value through profit and loss'	Loans and receivables	Available for sale	Total
	£000s	£000s	£000s	£000s
Embedded derivatives	**0**			**0**
Receivables - NHS		**1,916**		**1,916**
Receivables - non-NHS		**844**		**844**
Cash at bank and in hand		**5,805**		**5,805**
Other financial assets	**0**	**0**	**0**	**0**
Total at 31 March 2015	**0**	**8,565**	**0**	**8,565**
Embedded derivatives	0			0
Receivables - NHS		2,353		2,353
Receivables - non-NHS		763		763
Cash at bank and in hand		5,713		5,713
Other financial assets	0	0	0	0
Total at 31 March 2014	0	8,829	0	8,829

39.3 Financial Liabilities

	At 'fair value through profit and loss'	Other	Total
	£000s	£000s	£000s
Embedded derivatives	**0**		**0**
NHS payables		**2,428**	**2,428**
Non-NHS payables		**2,762**	**2,762**
Other borrowings		**0**	**0**
PFI & finance lease obligations		**0**	**0**
Other financial liabilities	**0**	**0**	**0**
Total at 31 March 2015	**0**	**5,190**	**5,190**
Embedded derivatives	0		0
NHS payables		2,522	2,522
Non-NHS payables		3,286	3,286
Other borrowings		0	0
PFI & finance lease obligations		0	0
Other financial liabilities	0	0	0
Total at 31 March 2014	0	5,808	5,808

40. Events After the End of the Reporting Period

There were no events after the end of the reporting period.

41. Related Party Transactions

The following material transactions are total payments made to or received from organisations where Trust Board members have declared an interest.

Board Member & Interest Declared	Organisation		2014-15 £000s	2013-14 £000s
Peter Clowes	Shropshire CCG	Payments	0	0
Clinical Lead for Urgent Care		Receipts	40,826	42,030
Jane Mackenzie	Shropshire Council	Payments	469	223
Councillor		Receipts	2,075	2,135

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. These entities are:

Health Education England
NHS England
NHS Property Services
Shrewsbury & Telford Hospitals NHS Trust
Shropshire CCG
Telford & Wrekin CCG

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 Shropshire Council and Telford & Wrekin Council in respect of joint enterprises.

The Trust has also received revenue and capital payments from charitable funds, the trustees for which are also members of the Trust board. There is a separate set of accounts and annual report for the Trust's charitable funds.

Total income for the charitable funds was £214,000 (£229,000 in 2013/14) and total expenditure was £298,000 (£304,000 in 2013/14) most of which was grants to the Trust.

42. Losses and Special Payments

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

	Total Value of Cases £s	**Total Number of Cases**
Losses	**1,288**	**64**
Special payments	**845**	**4**
Total losses and special payments	**2,133**	**68**

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	3,575	3
Special payments	6053	12
Total losses and special payments	9,628	15

There were no cases exceeding £300,000.

43. Financial Performance Targets

43.1 Breakeven performance

	2011-12 £000s	2012-13 £000s	2013-14 £000s	2014-15 £000s
Turnover	80,802	79,679	76,105	**75,286**
Retained surplus/(deficit) for the year	1,600	1,447	45	**359**
Adjustment for:				
Timing/non-cash impacting distortions:				
Pre FDL(97)24 agreements	0	0	0	**0**
Adjustments for impairments	0	0	184	**0**
Adjustments for impact of policy change re donated/government grants assets	(203)	49	5	**(7)**
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12	0	0	0	**0**
Absorption accounting adjustment		0	0	**0**
Other agreed adjustments	0	0	0	**0**
Break-even in-year position	**1,397**	**1,496**	**234**	**352**
Break-even cumulative position	**1,397**	**2,893**	**3,127**	**3,479**

Adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

	2011-12 %	2012-13 %	2013-14 %	2014-15 %
Materiality test (I.e. is it equal to or less than 0.5%):				
Break-even in-year position as a percentage of turnover	1.73	1.88	0.31	**0.47**
Break-even cumulative position as a percentage of turnover	1.73	3.63	4.11	**4.62**

43.2 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%.

43.3 External financing

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

	2014-15 £000s	2013-14 £000s
External financing limit (EFL)	**70**	855
Cash flow financing	**(92)**	603
Unwinding of Discount adjustment		0
Finance leases taken out in the year	**0**	0
Other capital receipts	**0**	0
External financing requirement	**(92)**	603
Under/(over) spend against EFL	**162**	252

43.4 Capital resource limit

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

	2014-15 £000s	2013-14 £000s
Gross capital expenditure	**1,046**	541
Less: book value of assets disposed of	**(52)**	(30)
Less: capital grants	**0**	0
Less: donations towards the acquisition of non-current assets	**(103)**	(102)
Charge against the capital resource limit	**891**	409
Capital resource limit	**1,020**	577
(Over)/underspend against the capital resource limit	**129**	168

44. Third Party Assets

There were no third party assets.