Shropshire Community Health NHS
NHS Trust

Annual Report and Accounts 2015/16

Shropshire Community Health NHS Trust

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Presented in accordance with the NHS Finance Manual: Manual For Accounts 2015/16 pursuant to the Companies Act 2006

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Annual Report and Accounts 2015/16

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

Foreword

Welcome from the Chairman

I am pleased to be able to welcome you to our Annual Report and Accounts for 2015/16.

The document is designed to provide an overview of what we do, how well we have done and the challenges that lie ahead, as well as providing a more detailed analysis of our activities and accounts. Most of the information is also available on our website at **www.shropscommunityhealth.nhs.uk** where you can also find out more about us and keep up-to-date with our latest plans.

It has been another busy and challenging year for us and I would particularly like to take this opportunity to say thank you all our staff and volunteers. Once again their hard work and dedication has helped us to deliver so many important services to our local population. The things they do really help to improve lives in our communities – one of our core values.

We also have great support from our patients and carers, who are directly involved in helping us to shape our services and making sure we are getting things right, I am looking forward to seeing this shared working develop in the coming year. As ever, the next 12 months look set to be both interesting and challenging for us, and I look forward to working with all of our staff, volunteers, partner organisations and stakeholders to make sure we continue to provide comprehensive, high quality and safe community services.

I hope you will enjoy this Annual Report and Accounts and I look forward to your continued support us as we move into 2016/17.

Thank you,

Mike Ridley, Chairman

Performance Report

Performance Overview

Chief Executive's review of the Year

We have had another busy year, focussing very much on quality and our clinical strategy, and working with partners to develop local NHS and care systems across Shropshire and Telford & Wrekin.

At the same time we have balanced the books and delivered a small surplus, against the background of inevitable financial pressures. Our vision has continued to be to improve people's lives, particularly through supporting people living with more than one health condition, for whom local, convenient services are especially important. It is that vision which continues to motivate us, brought alive through the experiences of patients and staff who tell their stories at every Board meeting, and show what a positive difference it can make.

Partnerships are at the heart of our work and once again we have worked very closely with other local health and care organisations to improve urgent care, making sure community services play an optimal role in an effective flow of patients to get the right care in the right place and time. The development of our Integrated Community Services (ICS) and Rapid Response service to provide extended hours played a key role, and we welcomed support to the whole local health and care system from the Emergency Care Improvement Programme, a national team who worked with all of us to help us focus on the actions which would make most difference. We have also played an active part this year in wider planning across the local area, including the Future Fit programme, and the development of the 'Sustainability and Transformation' Plan for Shropshire, Telford and Wrekin - a new national requirement aimed at helping NHS organisations to plan together by area and for a longer timeframe. In Future Fit we have been putting forward our ideas about how we can improve access to urgent care services in our rural localities, in partnership with GPs, the local acute trust and others. The first phase of data gathering for 'Community Fit' has been completed and we are using the information from that to identify opportunities for us to work differently to deliver more care closer to home. The Sustainability and Transformation Plan has the challenging job of setting out how the ambitions of Future Fit and Community Fit can be delivered, with more services closer to home and ensuring that we have resources in the right place to achieve that.

We achieved most of the national performance targets relevant to us this year. The exception was for trauma and orthopaedic patients waiting to have treatment in an outpatient setting, where we did not meet the target for 95% of patients to have their treatment within 18 weeks of being referred. We are addressing this in our new TeMs service with other providers, which is working hard to catch up on an inherited position. Reducing expenditure on agency staffing has been both a Trust and national objective this year, and since the formation of an Agency Working Group we have successfully reduced the rate of spend and recruited to substantive posts, contributing to improved quality and financial position - although this remains an area for further work.

In March 2016 we welcomed a team of Care Quality Commission inspectors for a planned full assessment of our services, looking at how caring, safe, responsive, effective, responsive and well-led they are. It was a great opportunity for us all to consider the quality of the care we provide as part of continuously looking to improve. We anticipate it will be a few months until we receive the CQC report and we will work with services to implement any changes needed. During the year we also refreshed our Quality Strategy, setting out our ambitions to improve care across all the dimensions of quality.

Performance Report: Performance Overview

Patient and Carer involvement is an essential part of our work on quality, so we can design, deliver and monitor our services from the perspective of people who receive them. This is an area of work which has developed significantly this year, with our very active Patient and Carer Panel taking forward a range of ways for us to hear patients' voices – from 'Observe & Act' programmes where volunteers observe services being delivered and give feedback, to the design and implementation of a Patient Story Toolkit. We have developed an electronic system for capturing all the feedback and the key objective for the next year is to make sure all our teams are engaged and confident in tapping into that in order to turn 'you said' into 'we did' every time. Our volunteers deserve special thanks for all their hard work in this area. Our Leagues of Friends have been as active as ever by raising huge amounts of money for donations that improve patients' experience (such as providing £65,000 for a new ultrasound scanner at Ludlow Hospital) and directly supporting our services (for example by accommodating the Dementia Café at Bridgnorth Hospital where volunteers also work alongside the Dementia Champions).

In 2014/15, we started a programme of work to develop a new shared culture, vision and values with our staff, and we have done more this year – with the NHS Staff Survey in October giving us insight into our progress so far. In the course of the year, staff from all parts of the organisation attended a series of Away Days and looked at, for example, the application of our values, the fit of team objectives with Trust objectives, our new appraisal system, and equality and diversity. We have applied our values in new practical ways – for example making them central to what we look for in new staff, and in appraisal. Our Culture Working Group has taken forward a range of other work, including how we will approach the new 'Freedom to Speak Guardian' role, and the initiative "Our Way of Working – Values into Action", which supports teams to have the resources and permission to take responsibility for improvements they want to make. Once again, we saw a series of successful staff awards, both in our own annual awards as well as externally, including our Immunisation Team being presented with a Care with Confidence Award by Telford & Wrekin CCG for the response to a public health outbreak of Hepatitis A. There was also a Commendation from charity X-PERT Health for our Community Diabetes Team for its work to give people living with diabetes in Shropshire and Telford & Wrekin a chance to attend education sessions to help manage their condition. Our Staff Survey showed some encouraging signs that our culture is developing in the right direction – especially the year-on-year improvement in how engaged people feel, and to what extent they would recommend us as a place to work. It was also positive that we were rated 'good' in the national NHS 'Learning From Mistakes League' that looks at openness and transparency. However, other aspects of the staff survey show that we have more to do, and we want to make sure that we engage and involve everyone in understanding the results and acting on them.

Like the Chairman, I would like to thank all our staff and volunteers, and look forward to working together in 2016/17 to take up all the many opportunities for community services to make a real difference to peoples' lives.

Thank you,

Jan Ditheridge

Chief Executive

Performance Report: Performance Overview

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.

These were developed following a lot of work with our staff and stakeholders to make sure we got them right, and we have continued to work together to embed them into our everyday work and develop a shared culture.

Our Vision:

"We will work closely with our health and social care partners to give patients more control over their own care and find 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."

Our Values:

Improving Lives
We make things happen to improve people's lives in our communities.

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.

Performance Report: Performance Overview

Introducing Shropcom

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.

We specialise in supporting people's health needs at home and through outpatient and inpatient care.

Our focus is on prevention and keeping people out of crisis so that they can receive the care and support they need at, or as close to home as possible.

NHS community services may not always be as visible to the public as the larger acute hospitals, but they play a vital role in supporting very many people who live with ongoing health problems. 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.

We have about 740,000 community contacts each year, the vast majority of which are with people in their homes, in community centres and clinics. A very small number of people also receive inpatient care in our community hospitals (1,415 people received inpatient care in 2015).

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. We also have community teams that specifically work with patients who need additional or short-term care and support to help them return home from hospital as quickly as possible, or to avoid being admitted in the first place.

We have a relatively new Executive Team that has led extensive work to engage with patients,

staff and stakeholders in refining our Values, Vision and Goals. This has been a key part of the overall strategic work to shape our services now and for the future, and also working alongside our health and social care partners to deliver a co-ordinated approach to delivering services. Everything we do is aimed towards *Improving Lives in Our Communities*.

Formed in 2011

Serve a population of 471,000

Employ 1,600 people

We had nearly 740,000 community contacts in 2015/16

Spent £77.5m delivering services

Performance Report: Performance Overview

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 470,000 adults and children in their own homes, local clinics, health centres, GP surgeries, schools and our 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 2015/16 our total income for the year was £78.9 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.

We provide community services across the county, as well as neighbouring areas such as our School Nursing Service in Dudley, and work closely with the other providers (Shrewsbury and Telford Hospital NHS Trust, Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust and South Staffordshire and Shropshire Healthcare NHS Foundation Trust) and many other organisations to care for the population of Shropshire.

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. Services such as our community respiratory team, specialist diabetes nursing service, continence service, Children and Adolescent Mental Health Services 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 deliver can be broken down into three main areas, as illustrated in the tables below.

We have two Service Delivery Groups (SDGs) managing the clinical services that provide direct care and support for our patients - one for Adults and one for Children and Families. Then, wrapped around our frontline staff, we have a range of corporate and support services.

Adult SDG

- Community Hospitals
- Minor Injury Units
- Integrated Community Services
- Inter-Disciplinary Teams
- Long-Term Conditions & Frail Elderly
- Diabetes
- Tissue Viability
- Continence Services
- Shropshire Wheelchair Service
- Rheumatology
- Physiotherapy
- Podiatry
- Advanced Primary Care Services
- Prison Healthcare
- Diagnostics, Assessment and Access to Rehabilitation and Treatment (DAART)

Children and Families SDG

- Health Visitors
- Child and Adolescent Mental Health Services (CAMHS)
- Children's Therapy Services
- Community Children's Nurses
- School Nurses
- Family Nurse Partnership
- Child Development Centres
- Safeguarding
- New Born Hearing Screening
- Child Health and Audiology
- Community Paediatrics
- Immunisation and Vaccination
- Dental Services

Corporate/Support Services

- Finance
- Workforce/HR
- Organisational Development
- IT and Informatics
- Hotel Services
- Administration Support
- Business Development
- Performance
- Complaints and PALS
- Emergency Planning
- Patient Experience and Involvement
- Assurance (non-clinical)
- Quality
- Communications and Marketing

You can find out more about our full range of services on our website at www.shropscommunityhealth.nhs.uk

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How we are funded and how we spend our money

This section provides a very brief overview of how our finances are managed. You can find out more about our finances in the Remuneration Report and the Annual Accounts.

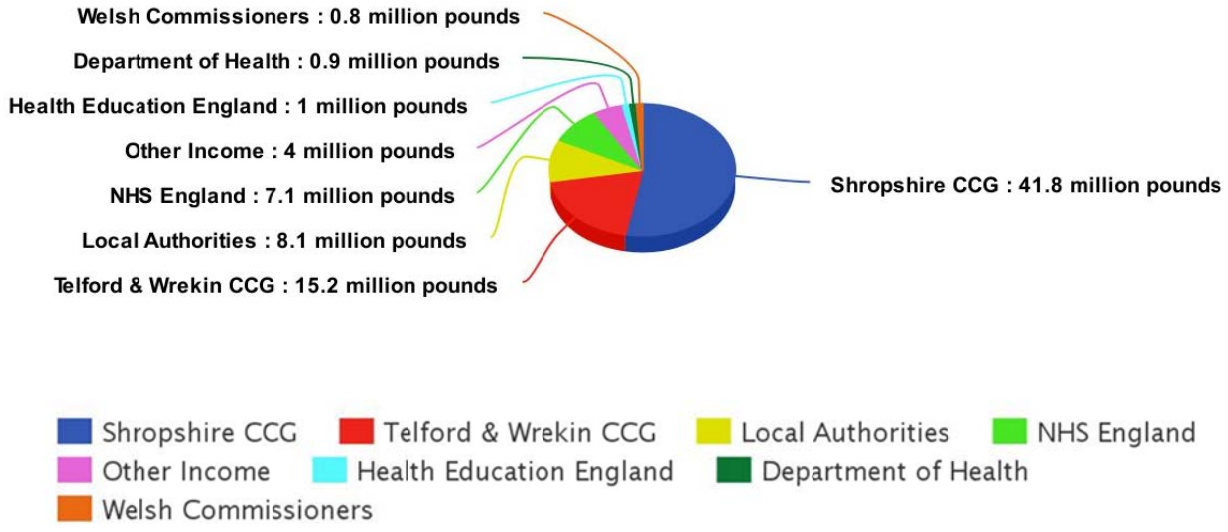
As a provider of community NHS services we receive the majority of our income from NHS commissioners (e.g. Clinical Commissioning Groups or CCGs in England and Local Health Boards in Wales) and a significant proportion from Local Authorities.

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, outpatient appointments and home visits. We work closely with other Health and Care providers, such as 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 2015/16 year the Trust's total income was £78.9 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.



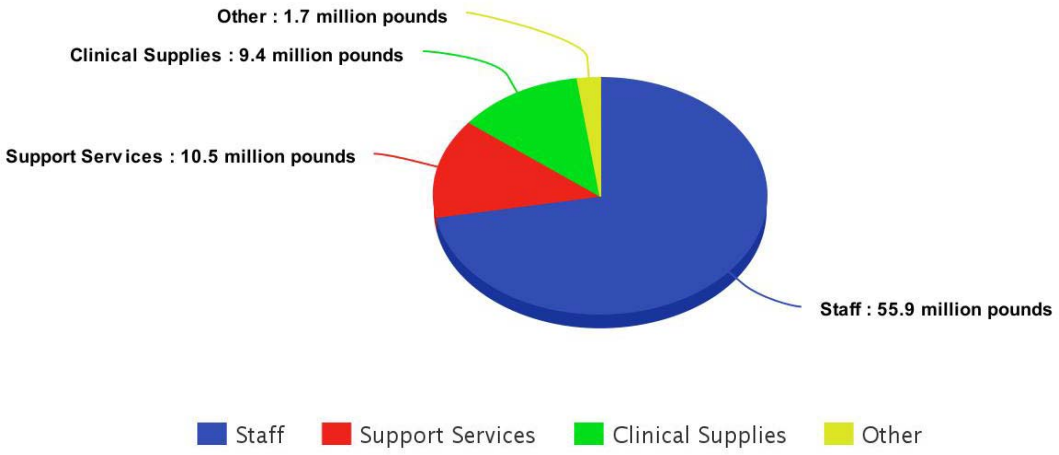
Performance Report: Performance Overview

The income we receive is used to fund the services we provide the most significant element of which is to pay our staff. In 2015/16 we spent about £77.5 million delivering services.

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 depreciation, finance charges and our contribution to the national Clinical Negligence Scheme for Trusts.

The chart below illustrates how we use the money we are given to provide services:



2015/16 Financial Results

Overall, in 2015/16 the Trust made a surplus of £1,355,000.

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

A more detail review of our finances can be found in the Annual Accounts section of this report.

Performance Report: Performance Overview

2015/16: A Performance Summary

It has been another challenging year for us, and the NHS as a whole, and once again we have plenty to be proud about.

We are an organisation with a strong track record of delivering against our key objectives and targets, and most significantly in the year just gone:

- We met our planned financial targets and finished the year by making a small surplus.
- We achieved the national performance targets relevant to us for admitted patients. We have also achieved the targets for non-admitted patients in all specialties, apart from Trauma and Orthopaedics.
- We continued to improve the quality of our services and invested in key areas to strengthen operational capacity.
- We continued to strengthen our relationship with commissioners and other partners and are actively supporting strategic change across the local health and social care system.

Key Challenges, Issues and Risks

We face a range of challenges and risks when planning and delivering our services. These range from the rurality of the area we serve to the current economic climate which we are all living in. Making sure we recognise and manage these issues is a key part of our planning process, and like the services we deliver they are ever-changing. Some of the key challenges, issues and risks we have faced in 2015/16 include:

Finances: Like the rest of the NHS, we need to manage rising costs and an increase in the demand for health care services at the same time that the UK is experiencing one of the most challenging financial climates in recent times.

This pressure on public finances has effectively led to a reduction in real funding, while the need to meet rising demand and still make savings remains. There has also been additional pressure placed on the local health and social care system because of the financial deficits being forecast by some of our commissioning and partner organisations.

Our communities: We are a relatively small, specialist NHS trust serving an extremely large and sparse geographical area (twice the size of Greater London). This, combined with a population that is increasing in age and the complexity of health and social care needs, presents some significant challenges for us when planning and delivering services.

Staffing: We have experienced difficulties in recruitment and retention, which has led to a reliance on the use of short-term, ad hoc agency staff. This has an impact on the quality and continuity of care we deliver and also places an additional financial pressure on the organisation.

Extended Services: There is an ever-increasing call for more seven-day services in the NHS and providing this places additional pressure on resources. As a key part of the local urgent care system we have had to extend access to some of our services, such as Rapid

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Response and our Integrated Community Services. These teams provide targeted support to help people needing a hospital admission, and if someone is ready to leave hospital then to support them in getting back to, or as close to home without any unnecessary delays.

Our Estate: We are responsible for maintaining a large estate over a wide geographical area, which requires a lot of resources to ensuring our facilities are fit-for-purpose and meet statutory and mandatory obligations. This presents some operational and financial pressures to the organisation, such as committing large amounts of capital to address backlog maintenance.

Changing Culture: We recognise there is a risk that a lack of staff engagement in new ways of working and commitment to our new values and goals could impact on the quality of care we deliver and the experience our patients have.

Getting it Right

We fully recognise all of the challenges, issues and risks that have just been covered and have made sure they have been taken into account when planning and delivering services throughout 2015/16 and beyond. This is part of a continual process of reviewing and improving what we do (and we will look at what we have done in more detail later in this section of the report).

Our Board recognises the importance of effective risk management and our assurance framework details risks and controls related to all areas of quality and safety. Risk is discussed at every Board Meeting and also monitored down through the committees that report directly to the Board and through the services and teams throughout the organisation.

Performance

We monitor our activity and performance against a range of indicators including national, contractual and local targets. This is an important part of ensuring we deliver high quality services. We provide regular and detailed updates on our performance in the monthly reports that are presented to our Board (which are published on our website) and you can find a more detailed look at our performance in the Performance Analysis on page 17 of this report.

Quality

During 2015/16 we refreshed our Quality Strategy, which describes the major quality initiatives that are being addressed over the next three years. We expect our strategy to be dynamic and we will continually review our plans. Our Quality Strategy reflects our strategic ambitions and those of our major stakeholders. It also demonstrates our commitment to learn, develop and grow with the purpose of improving care across all of the quality dimensions.

In March 2016, we were named as one of the top performing NHS organisations in the country for being open and transparent. The Learning from Mistakes League, which was published as part of a package of measures to improve safety and transparency in the NHS, rated us as being “Good”. This reflects the work we have carried out together to strengthen our reporting culture and empower staff to make improvements.

During March 2016 we welcomed the Care Quality Commission (CQC) for a planned full assessment of our services. We are expecting to receive the final report and assessment during the summer.

Shaping our Services

Any work we carry out to shape services has to take into account the make-up of our communities across Shropshire and Telford & Wrekin, and the area itself (as we provide in both urban and rural communities). This means making sure we get the balance right when developing new models of care to support people in their homes, or as close to home as possible.

We have refreshed our Clinical Strategy to reflect our ambitions for the next four years. Our strategy reflects our commitment to providing the highest standards of clinical quality. It demonstrates how we are listening to our patients, staff and partners, and how we will

Performance Report: Performance Overview

work with them to deliver services that are relevant to the people who use them.

In the past year we have looked at the way we help to support frail older people so that they do not need to be admitted to hospital by, for example, extending our 7-day Rapid Response service into the evenings. We have also extended our joint Integrated Community Service (which we manage in partnership with Shropshire Council) to provide access over 7 days until 8pm.

We have successfully led the development of new models of care, such as our TeMS service which delivers coordinated care for adult musculoskeletal patients from Telford & Wrekin. This new Integrated Community MSK Service has brought a number of healthcare providers together to streamline the way patients are referred, assessed and treated.

One of the initiatives we have been running to support the development of our clinical services is 'Our Way of Working – Values into Action'. This builds on the NHS Change Model and aims to provide a mechanism, based on our Values, to give staff the permission and resources they need to take responsibility for leading change in their area of work.

Our Workforce

Another area we are working on is our Workforce Strategy, which aims to support the development of our staff and the delivery of our transformation plans.

Our Organisational Development Team has been developing a new framework to provide leadership opportunities around service improvement and change management. There has also been a lot of work carried out around improving Personal Development Reviews for staff, making them more meaningful and linking them to our values. This work was based, in part, around feedback we had from our staff through the national NHS Staff Survey. We have already seen an improvement in the quality of appraisals taking place and level of completion rates.

There has been some success in recruiting to vacancies in 2015/16 and we have seen a reduction in our reliance on agency staffing, which we will continue to work on during the coming year.

We have seen an improvement in the level of attendance at work thanks to more people using the formal policy we have in place for managing absence, which has been streamlined to make it easier for staff to use.

The work we started in 2014/15 to develop a new shared culture and embed our new values has continued and this programme of engagement has been reflected in the results of the latest NHS Staff Survey. Two key findings in this year's survey show that we have improved in terms of our staff score for those who would recommend us as a place to work or receive treatment, and our overall staff engagement score has increased (and sits above the national average for NHS community trusts). Knowing how our staff feel about where they work is a key part of driving improvement, so we have just launched a new staff Pulse Survey to provide a regular snapshot of how things are across the organisation. This will add to the feedback we already receive and allow us to focus on areas where we need to do better and also highlight the areas of good practice that we need to share and build on.

Patient, Carers and Volunteers

Involving our patients and carers in designing, delivering and monitoring services is a key part of improving quality. We have developed a highly engaged and active Patient and Carer Panel that works closely with us to develop and improve the services we provide to our patients. Panel members are involved in activity through the organisation, for example they are take part in interviewing new staff, designing services and sit on some of our key committees.

Our Patient and Carer Members, along with our other volunteers, have been instrumental at a national level in the design and implementation of the Patient Story Toolkit. Patient stories are being used at more forums throughout the Trust

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to ensure the patient and the carer's voices are heard, and most importantly, listened to.

This year we have invested in an electronic feedback system for our patients, their families and carers to tell us what they think of our services. This adds to the systems we already have in place for gathering feedback that our volunteers help us to gather and interpret as part of our Feedback Intelligence Group, the success of which we will continue to build on in 2016/17. We will use this information, along with the quantitative data from our systems, to really understand whether our services are caring, responsive, effective, well-led and safe.

Saving and Investing

Once again we were set some challenging financial targets to meet, especially given the scarcity of resources in the current economic climate. Despite this, we were able manage our finances effectively and finished the year with a small surplus of £1,355,000.

The business case for our new Electronic Patient Record system (EPR) has now been approved. This new system will simplify how we communicate and importantly share information with our patients and partners, and help to improve mobile working, while providing a significant reduction in the amount of paper records we produce. All of these benefits play an important part in supporting us to deliver safer, modern and high quality health services for the communities we serve. It will also help us to save valuable resources that can be used in other areas. Work has now moved to the next stage and we are developing plans to roll the new system out in the coming year.

As a significant element of our asset base is our estate, the work that we have started on reviewing our Estates Strategy will be an important part of managing our resources going forward. This will take into account our mandatory obligations, the existing challenges associated with managing multiple facilities across a large geographical area and the need to support new models of care supporting people closer to home.

We recognise that the clinical and financial sustainability of our organisation is intrinsically linked to the development of new models of care and our ability to deliver these models and work in partnership with our health and social care partners. This will continue to be the focus of our planning for 2016/17.

Working Together

Whatever we plan to do in future, much of it will invetiably link in with the work of our partners. In December, the NHS shared-planning guidance set out a new approach to help ensure that health and care services are planned by place - rather than solely around individual institutions - and over a period of five years, rather than just a single year. Central to this guidance is the design and delivery of Sustainability and Transformation Plans (STPs). Details have now been published outlining the 44 'footprint' areas that will bring local health and care leaders, organisations and communities together to develop STPs - local blueprints for improved health, care and finances over the next five years. The aim is to improve health, care and finances through shared working and learning. One of these STPs will cover Shropshire and Telford & Wrekin, which we recommended as opposed to being part of an even larger geographical area. An STP Partnership Board has been established and comprises all the major health care providers and commissioners in the two communities, as well as the two local authorities. This overarching framework will sit above existing transformation programmes already underway, such as the NHS Future Fit and Community Fit review of health services in the county, and more details about the STP will made available as it develops during the coming year.

Performance Report

Performance Analysis

Our 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 on the right provides an indication of our overall activity during 2015/16.

The vast majority of contact we have with people is in their own home or another community setting, while a very small number of people will require inpatient care and support in one of our Community Hospitals (1,415 people received inpatient care in 2015).

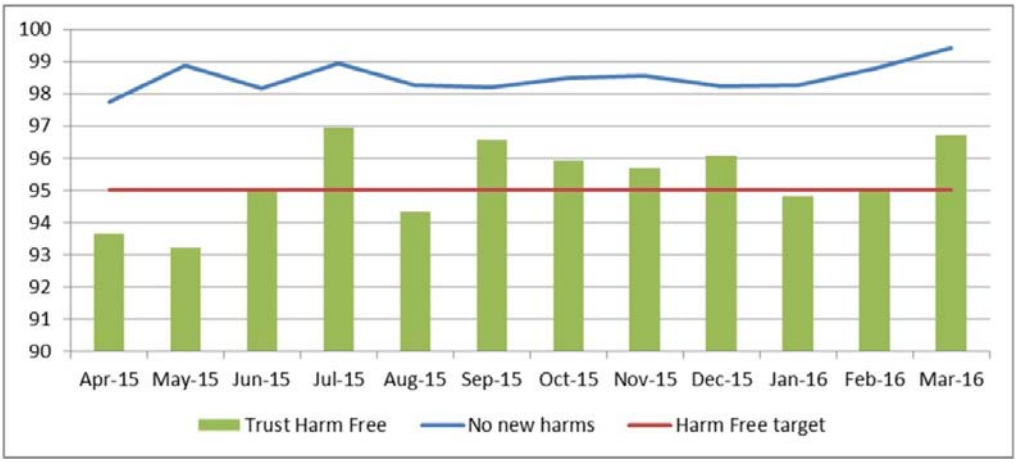
Patient Activity Figures 2015/16	
Community contacts	739,077
Outpatient attendances	43,688
Inpatient and day cases	1,186
Inpatient rehabilitation episodes	1,791
Radiology examinations	12,197
Minor injuries attendances	24,253
Equipment and products supplied	243,421
Prison healthcare contacts	13,355

Safety Thermometer

The NHS Safety Thermometer is a tool that allows our nursing teams to measure four specific harms and the proportion of their patients that are free from all of these harms on one specific day each month. It acts as a temperature check and can be used in conjunction with other indicators such as incident reporting, staffing levels and patient feedback to indicate where a problem may occur in a clinical area.

The national target for the Safety Thermometer is that it demonstrates that more than 95% of patients are free from any of the four harms on the data collection day. The chart shows “Trust harm free” scores which relates to all patients with one of the four harms whether they came into our care with it or developed it under our care and the “no new harms” score which relates to the percentage of patients in our care that did not develop one of the four harms whilst in our service.

The graph to the right shows how we measured against the Safety Thermometer in 2015/16.



Performance Report: Performance Analysis

A summary of our performance against local and national targets

We monitor our performance against a range of Key Performance Indicators (KPIs) structured against 10 corporate objectives, which is presented as an Integrated Performance Report (see tables below). This provides an overall assessment of our performance and is structured against the ten corporate objectives that have been agreed by the Board. Each objective is assessed against a range of performance indicators that are intended to be proxy measures for overall progress against the objective.

Performance indicators are drawn from a number of sources; the Trust Development Authority (TDA) Accountability Framework, commissioner negotiations, identified internal targets and Care Quality Commission (CQC) targets. For some objectives the measures relate to the delivery of projects, for example, IT implementation and service redesign.

The TDA issued a revised accountability framework in April 2015, this set out 133 performance indicators. All the Trust indicators (TDA and local) continue to be internally reviewed and 142 have been considered relevant to the Trust. The Trust performance scorecard shows the status of all performance indicators.

All Indicators

17	12	58

Safe

5	2	11

Indicator	RAG	Trend
Clostridium Difficile - incidence rate	▲	→
Clostridium Difficile - Variance from plan	★	→
MRSA bacteraemia rate	★	→
Proportion of admissions screened for MRSA	★	→
Central Alerting System (CAS) - Outstanding	★	→
Falls - Number of Falls	★	↓
Falls - Number of Patients	★	↓
Grade 2 Pressure Ulcers - avoidable	▲	→
Grade 3 Pressure Ulcers - avoidable	▲	→
Grade 4 Pressure Ulcers - avoidable	▲	→
Medication Incidents that affect patients Safety	n/a	→
Never Events	★	→
Never events - incidence rate	★	→
Never events - repeat events*	★	→
Safety Thermometer - harm free care	★	↑
Serious Incidents (all)	=	→
Serious Incidents - falls	▲	→
Serious Incidents rate	●	?
VTE Venous Thromboembolism Risk Assessment	●	↑
WHO Surgical Checklist Compliance	★	→

Caring

3

Indicator	RAG	Trend
New Birth Visits % within 14 days	★	↑
Access to Healthcare for people with Learning Disability	★	→
Single Sex Accomodation Breaches	★	→

Responsive

4	2	15

Indicator	RAG	Trend
Complaints - % of action plans implemented (well founded complaints) to ensure continuous improve	★	→
Complaints - acknowledged within 3 working days	n/a	↓
Complaints - upheld by the Ombudsman	★	→
Complaints -(All) - % responded to within timescales	n/a	↓
CQC Conditions or Warning Notices	★	→
Number of Claims for compensation received	▲	→
Proportion of patients not treated within 28 days of last minute cancellation	▲	→
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	★	↓
Community Equipment Store - Response within 7 days	★	↑
Diagnostics for Audio/Ultrasound	★	↑
District Nurse response within 24 hours (urgent)	●	↓
District Nurse response within 48 hours (non-urgent)	●	↓
MIU Assessment Times assessed within 15 minutes	★	↑
MIU Percentage of people who leave MIU without being seen	★	↑
MIU Total time in department - discharged within 4 hours	★	↓
MIU Treatment Times (Arrival to Seen Time) - Median wait of 60 mins	★	↓
MIU Unplanned Re-Attendances (within 7 days of discharge)	★	↓
Outpatients > 6 week - consultant led	★	↓
Outpatients > 6 week - non consultant led	★	↑
Proportion of Delayed Transfers of Care	▲	→
Referral to Treatment Incomplete 52+ Week Waiters	★	→

Effective

1	1	6

Indicator	RAG	Trend
Data entry within 21 days	●	↓
Ethnic coding data quality	★	↑
Unallocated data	★	↑
Use of NHS number	★	↑
Bed utilisation (overall)	★	↑
Deaths - unexpected	▲	→
Did Not Attend rates (DNA)	★	↑
Length of Stay (overall)	★	↓

Performance Report: Performance Analysis

Well Led

2	2	2

Indicator	RAG	Trend
Appraisal Rates		
Employee Numbers (FTE)	n/a	
Information Governance Requirements		
Leavers < 1 year in service (FTE)		
Leavers All (FTE)		
Other Mandatory Core Requirements		
Sickness absence - all		

Delivered in Suitable Environments

1	2

Indicator	RAG	Trend
Delivery of maintenance programmes		
Development of estates strategy		
Peat Rating		

Increased Range of Services

1

Indicator	RAG	Trend
Proportion of Tenders successfull		

Making best use of technology

1	4

Indicator	RAG	Trend
Termination of services to GPs and CCGs		
Delivery of WIFI infrastructure		
EPR implementation		
Performance and Quality reporting		
Systems availability		

Financially Sustainable

1	1	6

Indicator	RAG	Trend
Actual efficiency recurring/non-recurring compared to plan - Forecast compared to plan		
Actual efficiency recurring/non-recurring compared to plan - Year to date actual compared to plan		
Bottom line I&E position - Forecast compared to plan		
Bottom line I&E position - Year to date actual compared to plan		
Forecast underlying surplus/deficit compared to plan		
Forecast year end charge to capital resource limit		
Is the trust forecasting a funding requirement for liquidity purposes?		
Non-commissioner funded agency expenditure	n/a	
Overall CoS rating		

Designed around the Patient

3	2	6

Indicator	RAG	Trend
ICS - Admission Avoidance		
ICS - Average Length of Stay ICS		
ICS - Community Hospital (Average LOS) Discounting P3 D2A		
ICS - Core Team WTE Per Week		
ICS - Discharged No Further Support		
ICS - DTOC Delayed Days across all hospital settings (SATH, CH's & Redwoods, OOC)		
ICS - Integrated Community Services staus		
ICS - Maximum ICS Domiciliary Care Hours Per Week		
ICS - MFFD Average Wait	n/a	?
ICS - Timely Supported Discharge Per Week		
ICS Readmission Overall		
NI 125		

Bullet points	
	Above or on target
	Below target but within the tolerance level
	Below target and the tolerance level
Trends	
	Above target and remains the same as previous reported position
	Above target and is better than previous reported position
	Below target but within the tolerance level and remains the same as previous reported position
	Below target but within the tolerance level and remains the same as previous reported position
	Below target and outside of tolerance levels and remains the same as previous reported position
	Performance is below target and outside of tolerance levels and worse than previous reported position

Graphics	
	Above or on target
	Below target but within the tolerance level
	Below target and the tolerance level
?	No data available for indicator
?!	No data and no target data set for indicator
!	Unknown Comparator/ Status
n/a	No target set for indicator (Not applicable)

You can find more details about our performance against quality standards in our regular reports to the Trust Board and our annual Quality Account (all of which are available from our website at **www.shropscommunityhealth.nhs.uk**).

Performance Report: Performance Analysis

Protecting our patients, staff and the community against influenza

Once again we ran a very successful campaign to vaccinate our staff against flu. The figures released at the end of February revealed we were the top performing community trust in the country, which helped to protect staff, patients and families.

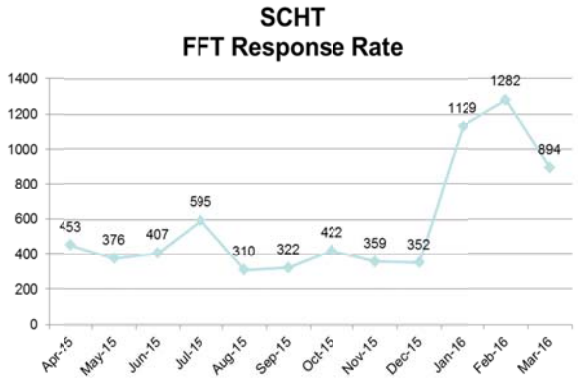
Trust	Sep 2015 – Feb 2016	Sep 2014 – Feb 2015
Shropshire Community Health NHS Trust	68.4%	67.2%
Leeds Community Healthcare NHS Trust	64.8%	67.4%
Liverpool Community Health NHS Trust	59.8%	67.1%

Listening our patients and staff

A key part of driving forward improvement involves giving the people who use and provide our services a chance to tell us what we are doing well and what we need to do better, and making sure we listen to them when they do. It is also important we maintain a healthy cycle of communication by feeding back how this vital information is being acted on.

NHS Friends and Family Test

The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way to give your views after receiving care or treatment across the NHS. Our performance for 2015/16 can be seen in the tables below.



Performance Report: Performance Analysis

Compliments and Complaints

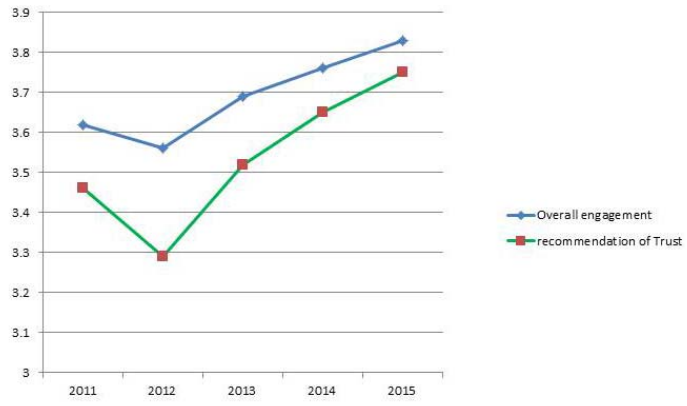
The compliments and complaints we receive are another valuable source of feedback about our services that we use to support our improvement plans. Between April 2015 and March 2016 we received **85 formal complaints** across all of our services. We have procedures in place to ensure we manage any complaints 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.

During the same period of time (2015/16) we received **476 compliments** about our services.

Our Patient Advice and Liaison Service (PALS) handles a great deal of the contact we have with service users and their families and once again we have seen an increase in the number enquiries the service has managed. In 2015/16 PALS dealt with 360 enquiries, which is an 11% increase (325) on the previous year and a 62% increase (222) in the number of enquiries managed since the Trust was established in 2011.This shows how much patients, carers and relatives value the PALS service when they have an enquiry, concern or a complaint.

Staff Engagement

The NHS Staff Survey gives our staff a chance to have their say about our working life in the NHS. It seeks views on areas such as job satisfaction and wellbeing, training and development, health and safety, and staff engagement and involvement. It paints a clear and invaluable picture of what working here is like and the areas we need to focus on in order to improve our working lives. It was good to see that more of us responded to the survey this year. In all, our response rate was 47.2% (721 returned), which was a big improvement from 39.6% (614 returned) in 2014. We would still like to see more people completing the survey though as this would give us an even better understanding of how things are.

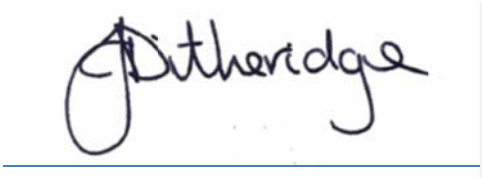


Our overall engagement score reflects how staff feel they can contribute to making improvements at work, whether they would recommend us as a place to work or receive treatment and how motivated they feel at work.

Two key findings in this year's survey show that we have improved since last years in terms of our staff score for those who would recommend us as a place to work or receive treatment, which has gone from 3.65 out of 5 to 3.75. Also, our overall staff engagement score has gone from 3.76 out of 5 to 3.82, which is above the national average for NHS community trusts and can be seen in the graph to the right, along with a summary of key points. We will now be carrying out a more detailed analysis of the survey results and will work together to identify any areas where we need to improve. We have also launched a new Pulse Survey for staff that will give us more regular feedback about how things are.

You can find the full NHS Staff Survey 2015 report at **www.nhsstaffsurveys.com**

Performance Report: Performance Analysis



Jan Ditheridge
Chief Executive

27 May 2016

Accountability Report

Corporate Governance Report

Our Board (Directors Report)

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 Chief Executive and supported by the Non-Executive Director-led Nomination, Appointments and Remuneration Committee.

This report provides information about the membership of our Board as at the time this Annual Report and Accounts were approved:

Mike Ridley, Chairman (Term: July 2011 to December 2016)

Mike has 25 years' experience as an NHS Finance Director and is a former Chief Executive of South Worcestershire and North & South Stoke Primary Care Trusts (PCTs). He retired from full time employment in the NHS in 2006 and has since been Chairman of the Central and Eastern Cheshire PCT Audit Committee until his appointment as Chair of Shropshire Community Health NHS Trust when it was formed in 2011.

Rolf Levesley, Non-Executive Director (Term: July 2011 to June 2017)

Rolf is a qualified solicitor and served as Head of Legal Services and Chief Executive in a local authority. Rolf is Chair of South Staffordshire Housing Association, a Board member on the Housing Plus Group, a Board member of South Staffordshire CVA and Chair of the registered charity Friends of Conakry Refugee School. Rolf has been as a Non-Executive Director of the Trust since 2011 and serves as Deputy Chair, as well as being the Non-Executive contact for Whistleblowing.

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

Peter has extensive private sector financial and commercial experience. He is a Fellow of both the Institute of Chartered Accountants in England and Wales and of the Association of Corporate Treasurers. Peter is the Chairman of Arts Council England for the Midlands. He joined the Trust as a Non-Executive Director in 2013 and is the Chair of the Trust's Audit Committee.

Accountability Report: Corporate Governance Report

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.

Steve Jones, Non-Executive Director (Term: July 2015 to June 2017)

Steve has also served as Chairman & Board member of P3 a national social inclusion charity delivering services across the country to support clients who have become excluded from mainstream society. He has recently been appointed Chairman of Wrekin Housing Trust, one of the largest social landlords in the Midlands with some 12,000 households providing accommodation across Telford and Wrekin, Shropshire and Staffordshire to tenants including those requiring extra care.

Nuala O'Kane, Non-Executive Director (Term: July 2015 to June 2017)

Nuala was CEO of the Donna Louise Trust Children's Hospice in Stoke on Trent from 2007 until 2014. Prior to that she was the Director of Fundraising at Hope House Children's Hospice from 1994 until 2007. Nuala has worked in the voluntary sector for over 30 years for a number of different organisations including Help the Aged, OXFAM and Marie Curie Cancer Care. Nuala was a Councillor on Telford and Wrekin Council for 12 years until 2003.

Jan Ditheridge, Chief Executive (Appointed September 2013)

Jan has been Chief Executive since 2013 and has overall clinical, financial and leadership responsibility for the organisation. 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 responsible for leading and managing clinical services. He 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. He played a critical role in the leadership team that ensured South Staffordshire and Shropshire Healthcare became one of the first Mental Health NHS Foundation Trusts.

Accountability Report: Corporate Governance Report

Dr Mahadeva Ganesh, Medical Director (Appointed August 2014)

Dr Ganesh 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.

Ros Francke, Director of Finance (Appointed October 2015)

Ros is a member of the Chartered Institute of Management Accounts and has worked in NHS Healthcare for over 25 years, crossing sectors from acute, mental health and commissioning. Ros is responsible for setting the financial strategy and has taken IM&T, Informatics and Performance into her portfolio.

Mel Duffy, Director of Strategy (Appointed January 2016)

Mel has held a variety of roles in both provider and commissioner settings and has spent the last 12 years working as the Divisional Director for Medicine and Support Services then Deputy Director of Business Development & Transformation at South Warwickshire NHS Foundation Trust. In her current role Mel is responsible for strategy and business development and plays a key part in large-scale transformational change programmes.

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

Julie is an experienced Director with about 20 years at Board level in the NHS, in community services and PCTs, including Board Secretary experience. Julie joined Shropshire PCT in 2008 and helped to gain the approvals for the Community Trust to be set up and was then appointed as a Director of the Trust when is began in 2011.

Each director confirms that as far as he/she is aware there is no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and has taken “all the steps that he or she ought to have taken” to make himself/herself aware of any such information and to establish that the auditors are aware of it.

Other directors who served on the Trust Board during 2015/16 were Michael Sommers, Non-Executive Director (until 30 June 2015), Angela Saganowska, Non-Executive Director (until 30 June 2015), Trish Donovan, Director of Finance (until 30 June 2015), Dr Peter Clowes, Medical Director (until August 2015), Andrew Ferguson, Director of Strategy (until 31 October 2015) and Sarah Lloyd (interim Director of Finance from July to October 2015).

Accountability Report: Corporate Governance Report

Committee Membership and Attendance

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

Quality and Safety Committee

Role and Purpose:

The Quality and Safety Committee oversees the review of quality assurance on all aspects of quality. This includes reviewing information against the five quality domains of caring, responsive, effective, well-led and safety. The primary aim is to ensure the robustness of systems, processes and behaviours, monitor trends, and take action to provide assurance to the Board.

Membership:

- Rolf Levesley (Chair)
  Non-Executive Director
- Jan Ditheridge
  Chief Executive
- Steve Gregory
  Director of Nursing of Operations
- Dr Mahadeva Ganesh
  Medical Director
- Julie Thornby
  Director of Corporate Affairs
- Jane MacKenzie
  Non-Executive Director
- Nuala O'Kane
  Non-Executive Director

Other invitees, including a number of senior managers and patient representatives, are also expected to attend meetings.

Audit Committee

Role and Purpose:

The Audit Committee provides an overarching governance role, including overseeing the adequacy of the Trust's arrangements for controlling risks and being assured that they are being mitigated. In order to do this it reviews the work of other governance committees, making sure the systems and controls used are sound.

Membership:

- Peter Phillips (Chair)
  Non-Executive Director
- Steve Jones (Vice Chair)
  Non-Executive Director
- Nuala O'Kane
  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.

Accountability Report: Corporate Governance Report

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:

- Steve Jones (Chair)
  Non-Executive Director
- Rolf Levesley (Vice Chair)
  Non-Executive Director
- Jan Ditheridge
  Chief Executive
- Steve Gregory
  Director of Nursing of Operations
- Peter Phillips
  Non-Executive Director
- Ros Francke
  Director of Finance
- Mel Duffy
  Director of Strategy

The Chairman and all other Non-Executive Directors are invited to attend and other Trust Directors and managers and health professional staff attend for specific items.

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).

Membership:

- Mike Ridley (Chair)
  Chairman
- Rolf Levesley
  Non-Executive Director
- Jane Mackenzie
  Non-Executive Director
- Peter Phillips
- *Non-Executive Director*
- Steve Jones
  Non-Executive Director
- Nuala O'Kane
  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.

Accountability Report: Corporate Governance Report

Charitable Funds Committee

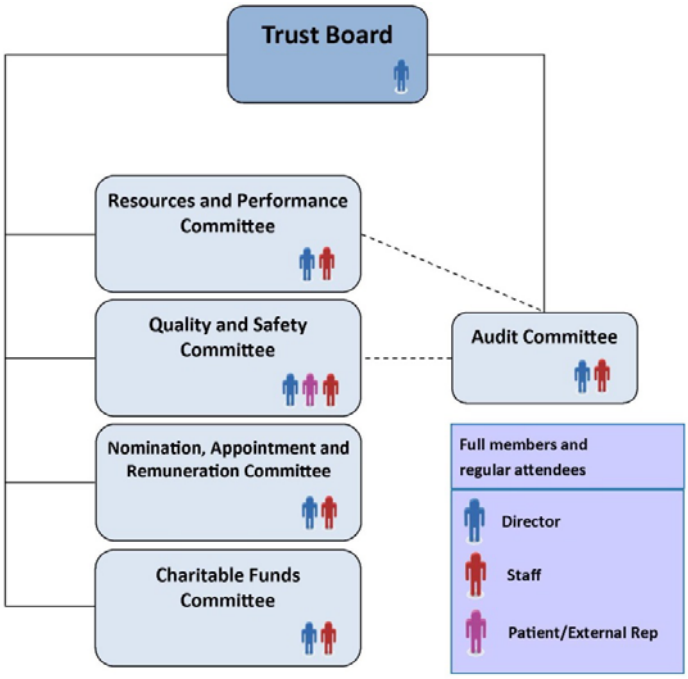
Role and Purpose:

The Charitable Funds Committee is responsible for managing and monitoring charitable funds held by the Trust on behalf of the Board.

Membership:

- Mike Ridley (Chair)
  Chairman
- Ros Francke
  Director of Finance
- Steve Gregory
  Director of Nursing and Operations
- Julie Thornby
  Director of Corporate Affairs
- Diana Owen
  Head of Financial Accounting
- Andy Rogers
  Communications and Marketing Manager

Other members of staff are invited to attend as required.



You can find more details about our governance structures and committees in the About Us (Who We Are) section of our website at **www.shropscommunityhealth.nhs.uk**

Accountability Report: Corporate Governance Report

Trust Board Members – Disclosure of Interests

Name	Interest
Voting Board Members	
Mr Mike Ridley *Chair* (From 1 July 2011)	Director, Crewe YMCA Daughter employed by CHKS
Ms Jan Ditheridge *Chief Executive* (From 30 September 2013)	Nil
Mr Rolf Levesley *Non-Executive Director* *(From 1 July 2011)*	South Staffordshire Housing Association and Housing Plus Group Chair South Staffordshire Council for Voluntary Action
Mr Peter Phillips *Non-Executive Director* (From 21 October 2013)	Masteragency Ltd – Director Arts Council England – Trustee Witon Group Ltd - NED GCS Ltd - NED Access Skills Ltd - NED
Ms Jane Mackenzie *Non-Executive Director* (From 1 September 2013)	Shropshire Unitary Councillor
Mr Steve Jones *Non-Executive Director* (From 1 July 2015)	Director Breeze Consultancy Services Ltd Group Board Director Wrekin Housing Group of which one of its members Choices may seek to secure NHS contracts for care from time to time Associate of Harvey Nash PLC Executive Search Company
Ms Nuala O'Kane *Non-Executive Director* (From 1 July 2015)	Director of Catalys – a capacity building consultancy Registered office Raddle Hall, Broseley, TF12 5BX 01952 883687 www.catalys.org Part owner of Catalys, as above Trustee of 'Together for Short Lives' – a national charity concerned with childrens' palliative care
Mr Steve Gregory *Director of Nursing and Operations* (From 13 January 2014)	Nil
Dr Mahadeva Ganesh *Medical Director* (From 11 August 2014)	Nil

Accountability Report: Corporate Governance Report

Mrs Mel Duffy *Director of Strategy* (From 4 January 2016)	Nil
Mrs Ros Francke *Director of Finance* (From 1 October 2015)	Trustee of the Health Care Financial Management Association (Charity)
Non-voting board members	
Ms Julie Thornby *Director of Corporate Affairs* (From 1 July 2011)	Nil
Previous board members (voting and non-voting)	
Mrs Sarah Lloyd *Interim Director of Finance* (From 1 July 2015 until 30 September)	Nil
Mr Andrew Ferguson *Director of Strategy* (From 1 September 2014 until 31 October 2015)	Nil
Dr Peter Clowes *Medical Director* (From 11 August 2014-31 August 2015)	Declaration outstanding.
Mrs Trish Donovan *Director of Finance* (From 1 August 2013 until 30 June 2015)	Director of Vinterior Limited a retail interior business unlikely to ever seek to do business with the NHS.
Mr Michael Sommers *Non-Executive Director* (From 1 July 2011 until 30 June 2015)	Nil

Accountability Report: Corporate Governance Report

Statement of the Chief Executive's Responsibilities as the Accountable Officer

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

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

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

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

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

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 in the Annual Accounts section of this report.

Accountability Report

Remuneration Report

Remuneration Report

This report describes the remuneration of Very Senior Managers at the Trust, namely members of the Board.

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

Remuneration of the Chief Executive and Trust Directors takes place within the *Pay Framework for Very Senior Managers (VSM) in Strategic and Special Health Authorities, Primary Care Trusts and Ambulance Trusts*, updated June 2013. The combined population of Shropshire and Telford & Wrekin is used as a guide for setting the salary of the Chief Executive. Other VSM salaries are determined as a proportion of the Chief Executive salary as defined in the *Pay Framework*, although flexibility is exercised in recruiting to hard-to-fill director posts. VSM salaries are scrutinised and approved by the Nomination, Appointments and Remuneration Committee (more details about this committee can be found in the Corporate Governance Report).

Performance review and appraisal of the Chair was undertaken during the year by the Chair of the NHS TDA on behalf of the Secretary of State for Health in accordance with appraisal guidance provided by the NHS TDA. Performance review and appraisal of Non-Executive Directors is carried out by the Chair with guidance provided by the NHS TDA. Performance review and appraisal of the Chief Executive is carried out by the Trust Chair in accordance with criteria set by the Remuneration Committee and guidance from the Department of Health. Performance review and appraisal of Directors is carried out by the Chief Executive in accordance with criteria set by the Remuneration Committee and guidance from the Department of Health.

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director/Member 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/Member in Shropshire Community Health NHS Trust in the financial year 2015/16 was £132,500* (2014/15 - £132,500). This was 4.7 times (2014/15 - 4.75) the median remuneration of the workforce, which was £28,180 (2014/15 - £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).*

In 2015/16, one (2014/15 - two) employee received remuneration in excess of the highest-paid Director. Remuneration ranged from £15,100 to £168,443 (2014/15 - £14,294-£154,288). The total remuneration of the highest paid employee rose in 2015/16 because of a backdated increase in the level of Clinical Excellence Award (7 to 8), which was implemented in July 2015, but backdated to April 2014. The majority of the increase in remuneration therefore consisted of a single back payment.

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 VSMs for the year 2015/16 can be found in the Annual Accounts section of this report.

Accountability Report: Remuneration Report

Senior Manager Remuneration

The table below shows details about remuneration for 2015/16 (this information is subject to audit).

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				5-7.5	135-140
Trish Donovan (Director of Finance)	To Jun 15 only	25-30				0	20-25
Sarah Lloyd (Interim Director of Finance)	Jul to Sep 15 only	20-25				57.5-60	80-85
Ros Francke (Director of Finance)	From Oct 15 only	55-60				0	50-55
Mahadeva Ganesh (Medical Director - shared post)		145-150				60-62.5	210-215
Peter Clowes (Medical Director - shared post)	To Aug 15 only	55-60					55-60
Steve Gregory (Director of Nursing & Operations)		95-100				52.5-55	150-155
Julie Thornby (Director of Corporate Affairs)		85-90				2.5-5	85-90
Andrew Ferguson (Director of Strategy)	To Oct 15 only	50-55				25-27.5	75-80
Mel Duffy (Director of Strategy)	From Jan 16 only	20-25				22.5-25	40-45
Mike Ridley (Chairman)		20-25					20-25
Angela Saganowska (Non-Executive)		0-5					0-5
Mike Sommers (Non-Executive)	To Jun 15 only	0-5					0-5
Rolf Levesley (Non-Executive)	To Jun 15 only	5-10					5-10
Jane Mackenzie (Non-Executive)		5-10					5-10
Peter Phillips (Non-Executive)		5-10					5-10
Nuala O'Kane (Non-Executive)	From Jul 15 only	0-5					0-5
Steve Jones (Non-Executive)	From Jul 15 only	0-5					0-5

Notes

1. All pension-related benefits comprise the NHS Pensions Agency assessment of future pension benefits, less employee contributions.

2. There was no remuneration waived by directors or allowances paid in lieu to directors in 2015/16.

3. There were no payments/awards to past directors, or compensation on early retirement or loss of service.

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

Accountability Report: Remuneration Report

The table below shows details about remuneration for 2014/15 (this information is subject to audit).

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 comprise the NHS Pensions Agency assessment of future pension benefits, less employee contributions.

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

3. 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 was included in the exit packages notes to the accounts (notes 10.4 and 10.5).

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

Accountability Report: Remuneration Report

Pension Entitlements

The table below shows information about pension entitlements (this information is subject to audit).

Name and title		Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2016 (bands of £5,000)	Lump sum at pension age re to accrued pension at 31 March 2016 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2015	Cash Equivalent Transfer Value at 31 March 2016	Real increase in Cash Equivalent Transfer Value
		£000	£000	£000	£000	£000	£000	£000
Jan Ditheridge (Chief Executive)		0-2.5	2.5-5	45-50	135-140	873	915	32
Trish Donovan (Director of Finance)	To Jun 15 only	0	0	35-40	110-115	676	0	N/A
Sarah Lloyd (Interim Director of Finance)	Jul to Sep 15 only	0-2.5	0-2.5	20-25	60-65	268	327	56
Ros Francke (Director of Finance)	From Oct 15 only	0-2.5	0	30-35	85-90	453	485	27
Mahadeva Ganesh (Medical Director - shared post)		2.5-5	10-12.5	25-30	85-90	562	648	80
Steve Gregory (Director of Nursing & Operations)		2.5-5	7.5-10	45-50	140-145	756	820	55
Julie Thornby (Director of Corporate Affairs)		0-2.5	0-2.5	30-35	100-105	600	626	19
Andrew Ferguson (Director of Strategy)	To Oct 15 only	0-2.5	2.5-5	25-30	85-90	515	0	N/A
Mel Duffy (Director of Strategy)	From Jan 16 only	0-2.5	0-2.5	20-25	60-65	292	320	25

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.

4. On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report. Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension Scheme are based on the previous discount rate and have not been recalculated.

Accountability Report

Staff Report

Staff Report

We employ nearly 1,600 people who provide a wide range of services from locations across Shropshire, Telford & Wrekin and surrounding areas.

This report provides information about the make-up of our workforce, which at the end of the year 2015/16 had a headcount of 1,582.

	Female		Male		All	
	FTE	Headcount	FTE	Headcount	FTE	Headcount
Directors	6.0	6	5.0	5	11.0	11
Senior Managers	16.9	19	14.0	14	30.9	33
Band 8A	8.0	0	9.0	0	17.0	0
Band 8B	4.0	0	3.0	0	7.0	0
Band 8C	4.0	0	2.0	0	6.0	0
Band 8D	0.9	0	0.0	0	0.9	0
Other Staff	1121.5	1400	115.8	138	1237.4	1538
All Employees	**1144.4**	**1425**	**134.8**	**157**	**1279.3**	**1582**

Staff Numbers

Further analysis on staff numbers are provided in Note 10.2 of the Annual Accounts.

Staff Sickness

Sickness absence figures are given in Note 10.3 of the Annual Accounts.

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 and we retained the 'Two Ticks' award in 2015/16.

Our Recruitment Policy and supporting management training is designed to eliminate discrimination on the grounds of disability, including the following provisions:

- Guaranteed interview if declaring a disability meet the essential application criteria of the job specification.
- Any required adaptations for interview are made.
- In terms of continued employment we make every effort to retain employees if they are disabled or become disabled. The Managing Attendance policy promotes reasonable adjustments for individuals as required.

Our Policy and Procedure on Equality and Diversity 'Everyone Counts' explains how the Trust will not discriminate against any member of staff with regards to training, promotion and career development.

Accountability Report: Staff Report

Off-Payroll Arrangements

The table below shows 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 six months or more, with a value of more than £220 per day, are shown.

	Number
Number of existing engagements as of 31 March 2016	5
Of which, the number that have existed:	
for less than one year at the time of reporting	1
for between one and two years at the time of reporting	4
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 2015 and 31 March 2016	1 new 2 reached 6 months
Number of new engagements which include contractual clauses giving the Trust the right to request assurance in relation to income tax and National Insurance obligations	3
Number for whom assurance has been requested (see comments below)	2
Of which:	
assurance has been received	0
assurance has not been received	2
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

Accountability Report: Staff Report

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.	18

There are no off-payroll arrangements for Board members.

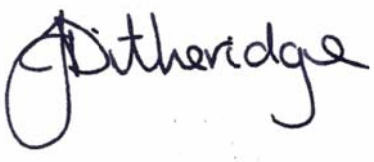
There are currently 13 Board members as set out earlier in this report. The disclosure above showing 18 individuals reflects changes during the year where some officers held posts for part of the year.

Exit Packages

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

Expenditure on Consultancy

Expenditure on consultancy totalled £25,000 for 2015/16.



Jan Ditheridge
Chief Executive

27 May 2016

Shropshire Community Health NHS
NHS Trust

Annual Accounts

2015/16

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.

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

I confirm that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

NB: sign and date in any colour ink except black

Signed.....Chief Executive

Date 27-05-16

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

27-05-16 Date..... Jan Ditheridge ..... Chief Executive

27-05-16 Date R Vardee ..... Finance Director

Shropshire Community Health NHS
NHS Trust

Annual Governance Statement 2015/16

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. The Board and Audit Committee continually review 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, particularly the membership and purpose of the Board and its committees, and the systems for internal control and risk management. All board members are required to confirm on an annual basis that they comply with the Fit and Proper Persons Test and the code of conduct. All staff are reminded each year to declare any gifts or hospitality

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 five voting executive directors. There is also one non voting director (Director of Corporate Affairs/Board Secretary). The following changes have been made in the last year:

- The Director of Strategy changed for the Board meeting in January
- The Director of Finance left the Trust in June 2015, An interim covered the position at the July and September Board meetings, and the substantive post holder attended from October onwards
- The Medical Director post was held jointly at the May meeting, and singly from then on
- Two Non Executive Directors were changed from July onwards.

Board Attendance

The Board has held 6 formal board meetings which have been held in public during 2015/16 and has met a further 6 times in private.

Chair	Full attendance
Chief Executive	Full attendance
Director of Finance	Full attendance
Medical Director	Full attendance
Director of Nursing/Operations	Full attendance
Director of Strategy	5 out of 6 meetings
Non Executive Directors (5)	3 meetings were attended by 4 NEDs, 3 all attended
Director of Corporate Affairs (non voting)	5 out of 6 meetings

Non-attendance has been for exceptional reasons including sickness and attendance at long pre-arranged courses.

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

- Resources and Performance Committee
- Quality and Safety Committee
- Audit Committee
- Nomination, Remuneration and Appointments Committee
- Charitable Funds Committee

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 its staff to strengthen their awareness of the Trust's overall objectives and recognise how their own objectives contribute to the delivery of the Trust's overall aims.

The Board continually self-assesses its performance, evaluating its meetings and those of its committees at the conclusion of business. Further board discussions have led to a board development programme which was put in place during 2015/16, facilitated by the NHS Leadership Academy. The programme is based upon the Well-Led Framework published by Monitor. A number of workshop sessions have been held, which have helped to ensure the effective integration of new Board members into Board working, have provided an opportunity to review respective Board roles and responsibilities, and have been used by the Board to complete a self assessment against the ten Monitor/CQc characteristics of a well-led organisation.

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. Arrangements are in place via service delivery groups and trust wide groups to report quality and safety matters to the Quality and Safety Committee, which in turn reports to the Board. This includes progress against the priorities set out in the Quality Account.

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 NHS Safety Thermometer monthly. The Trust has seen a continued fall in the number of pressure ulcers developed under its care, and in patient falls at community hospitals. However there has been an increase in the patient falls resulting in fractures.

The trust was inspected by the Care Quality Commission in March 2016. Initial feedback has been received and the Trust awaits the formal report and rating in due course.

The Trust engages with service users through the patient and carer panel and continues to develop the contribution that volunteers make across our services.

Financial Performance

NHS Trusts are required to deliver statutory and other financial duties. For the year ended 31 March 2016, the Trust met these duties, as summarised below, and set out in more detail within the financial statements:

NHS Trusts are required to deliver statutory and other financial duties. For the year ended 31 March 2016, 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 most 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 a 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.

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 identified, 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 2015/16. 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 risks (detailed in the Board Assurance Framework are detailed in the table below:

Title	Risk	Mitigation
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
Recruitment/Agency costs	Costs of agency staff particularly where vacancies are difficult to recruit to. Meeting national requirements for agency usage. Potential patient safety risks.	Review and monitoring usage and cost. Recruitment initiatives. Ensuring sage staffing levels
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 services.
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 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.
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 identified.
Clinical Quality	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.

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. Information governance is reported to the Board through the Resources and Performance Committee and Quality and Safety Committee. These committees are supported by operational groups which assess and test 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 RSM 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.

An internal audit of waiting time data found discrepancies with referral dates on a significant proportion of sample records. An action plan is currently being drawn up to improve the recording of referral dates. In some cases such as muscular skeletal services; all referrals have been screened for reliability of clock start times and validation of clock stop times. Routine utilisation of Electronic Referral Systems has also greatly improved data reliability. Monthly data snapshots are undertaken routinely across all relevant services to validate both activity levels as well as 18 week RTT times.

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 2015, to the year end on the 31st March 2016 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 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 and Quality and Safety Service Delivery Groups (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.

Key outcomes for 2015/16

- The committee has been assured on the management of financial systems from the work carried out by internal auditors

- Additional assurance has been requested for the implementation of recommendations made by auditors relating to referral to treatment data and lease cars.

- The committee has sought and received additional assurance related to the management of service level agreements

- The committee has reviewed the Board Assurance Framework , corporate register, and directorate registers at each meeting. Additional information and assurance has been requested as necessary, particularly related to listed mitigation measures

- The committee has been satisfied that the Board Assurance Framework represents the key risks to Trust objectives, and detail the mitigation and assurance associated with the risks

- The committee has received assurance relating to clinical quality through clinical audit and CQC compliance reports

- The Audit Committee has not found any significant issues in the year 2015/16.

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 2015 to March 2016 the Trust reported 32 serious incidents. 19 of these related to Grade 3 or 4 pressure ulcers. Of these 19 pressure ulcers, investigations determined that one was identified as not due to pressure, but other causes, e.g. trauma or moisture.

The other 13 consisted of:

- A prisoner who committed suicide.
- A prisoner who attempted suicide, and made a full recovery
- A prisoner who had heart problems in prison, and later died in acute hospital
  10 fracture falls, 8 occurring in Community Hospitals, the other in the Falls Prevention Service

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 lessons can be shared across the organisation.

The Trust did not report any Never Events in 2015/16.

NHS TDA Accountability Framework 2015/16

The Trust has taken into account the TDA Accountability Framework for 2015/16. 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 with one exception detailed below

The Trust did not meet the timescale for DH/2014/003 testing of fire and smoke dampers and ensuring the integrity of fire stopping. Inspection of the four community hospitals revealed a number of significant problems requiring remedial work. This has now been completed and the alert has been signed off.

Staffing

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 fallen slightly over the year, helped by a reduction in long term absence following the implementation of an improved sickness management process. Musculo-skeletal issues are now the top reason for sickness absence, and a programme of appropriate early interventions is in development.

Referral to Treatment Targets

The Trust has a system in place to monitor and validate Referral to Treatment Targets (RTT) Where breaches have occurred for stopped clocks an exception report is produced to identify system and process improvements. These are reviewed internally at the Quality and Safety Committee, and with clinical commissioning groups and action plans agreed and monitored.

Detailed action relating to the above plans are created and monitored at a local service level with oversight delivered through the service delivery unit business days.

During the year there has been a change to the target structure. The Trust recognises that further work is needed both as a result of these changes and the Internal Audit of RTT data quality detailed below. The Patient Access policy is under revision, systems will be re-enforced in all service areas and data will be spot checked to ensure compliance. This is due to be completed by May31st, with checking a continual process

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 2015/16 is:

The organisation has an adequate and effective framework for risk management, governance and internal control. However our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective.

The opinion highlights two areas where further work is necessary

Data Quality – Referral to Treatment (Incomplete pathways)

The review highlighted that there was a process in place for the recording of referral times however; the application of the process needed strengthening. Based on sample testing in support of the 'open clocks' reporting data for October 2015, errors in regards to the recording of referral dates were not consistently reflective of the actual referral dates. In some cases the referral documentation was not date stamped upon receipt. It should be noted, however, that the sample testing highlighted errors which would not have affected the accuracy of the performance against the Referral to Treatment indicators.

From testing it was also identified that validation checks of breaches were found not to be consistently undertaken.

Whilst the data collection and calculation of compliance with the performance indicators is consistent, the underlying data as described consisted of weaknesses in terms of accuracy and reliability.

Recommendations have been agreed for improvement and are in the process of being implemented

Lease Car – Authorisation Process

Findings from the review of the Trust's car leasing authorisation processes highlighted a number of key areas where the control framework and application of required controls needed to be improved. T esting confirmed that although there were standardised contract agreements templates in place for the leasing of a car, they were not being consistently completed or reviewed by the Car Leasing Manager at The Shrewsbury and Telford Hospital NHS Trust.

This posed a risk that employees may have signed up to incorrect or, in the worst case, no terms and conditions for the three year leasing period. This may leave the Trust at risk of the employee being signed up to more favourable terms and conditions than they are entitled to.

Where no terms and conditions are in place there is a risk that the employee is not liable for any costs that may be occurred and the onus would then be placed on the Trust, other than the employee being aware of the Policy in place and continuing to take the benefit of the lease car arrangement.

The Policy provided detailed guidance for new employees when applying for a lease car but there was no clear documented process for the actions that must be taken once the contract is due for renewal or if the employee has transferred from another Trust. Therefore, it was unable to determine whether, from sample testing, employees were on the correct terms and conditions set by the Trust when leasing a car.

Recommendations for improved control have been agreed, and in conjunction with Shrewsbury and Telford Hospital Trust, who operate the car leasing scheme, are being actioned.

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

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 (the "Trust") for the year ended 31 March 2016 under the Local Audit and Accountability Act 2014 (the "Act"). 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 International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2015/16 Government Financial Reporting Manual (the 2015/16 FReM) as contained in the Department of Health Group Manual for Accounts 2015/16 (the 2015/16 MfA) and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to the National Health Service in England (the Accounts Direction).

We have also audited the information in the Remuneration Report that is subject to audit, being:

- the pay multiples and related narrative notes at page 32
- the table of senior manager remuneration and related narrative notes at page 33 - 34
- the table of pension entitlements of senior managers and related narrative notes at page 35.

This report is made solely to the Directors of Shropshire Community Health NHS Trust as a body, in accordance with Part 5 of the Act and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by Public Sector Audit Appointments Limited. Our audit work has been undertaken so that we might state to the Directors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Directors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of Directors, the Accountable Officer and auditor

As explained more fully in the Statement of Directors' Responsibilities, 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 require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

As explained in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources. We are required under Section 21(3)(c) and Schedule 13 paragraph 10(a) of the Act to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report our opinion as required by Section 21(4)(b) of the Act.

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

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Directors; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the Annual Report and Accounts 2015/16 to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria issued by the Comptroller and Auditor General in November 2015, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined these criteria as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016, and to report by exception where we are not satisfied.

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of Shropshire Community Health NHS Trust as at 31 March 2016 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the 2015/16 FReM as contained in the 2015/16 MfA and the Accounts Direction.

Opinion on other matters

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the 2015/16 FReM as contained in the 2015/16 MfA and the Accounts Direction; and
- the other information published together with the audited financial statements in the annual report and accounts is consistent with the audited financial statements.

Matters on which we are required to report by exception

We are required to report to you if:

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

We have nothing to report in these respects.

Certificate

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

Grant Patterson, Director

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

Colmore Plaza, 20 Colmore Circus, Birmingham B4 6AT

27th May 2016

Statement of Comprehensive Income for year ended 31 March 2016

	NOTE	2015-16 £000s	2014-15 £000s
Gross employee benefits	10.1	**(55,856)**	(53,407)
Other operating costs	8	**(21,162)**	(21,041)
Revenue from patient care activities	5	**75,796**	72,144
Other operating revenue	6	**3,144**	3,142
Operating surplus/(deficit)		**1,922**	838
Investment revenue	12	**23**	25
Other gains and (losses)	13	**(8)**	(42)
Finance costs	14	**0**	(4)
Surplus/(deficit) for the financial year		**1,937**	817
Public dividend capital dividends payable		**(530)**	(458)
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		**1,407**	359

Other comprehensive income

		2015-16 £000s	2014-15 £000s
Impairments and reversals taken to the revaluation reserve		**0**	0
Net gain/(loss) on revaluation of property, plant & equipment	15	**1,937**	412
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		**1,937**	412
Total comprehensive income for the year*		**3,344**	771

Financial performance for the year

	2015-16 £000s	2014-15 £000s
Retained surplus/(deficit) for the year	**1,407**	359
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**	0
Adjustments in respect of donated gov't grant asset reserve elimination	**(52)**	(7)
Adjustment re absorption accounting	**0**	0
Adjusted retained surplus/(deficit)	**1,355**	352

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 notes on pages 6 to 39 form part of this account.

Statement of Financial Position as at 31 March 2016

	NOTE	31 March 2016 £000s	31 March 2015 £000s
Non-current assets:			
Property, plant and equipment	15	**21,769**	19,689
Intangible assets	16	**0**	0
Investment property	18	**0**	0
Other financial assets		**0**	0
Trade and other receivables	22.1	**68**	52
Total non-current assets		**21,837**	19,741
Current assets:			
Inventories	21	**448**	471
Trade and other receivables	22.1	**3,798**	2,923
Other financial assets	24	**0**	0
Other current assets	25	**0**	0
Cash and cash equivalents	26	**5,747**	5,805
Sub-total current assets		**9,993**	9,199
Non-current assets held for sale	27	**0**	0
Total current assets		**9,993**	9,199
Total assets		**31,830**	28,940
Current liabilities			
Trade and other payables	28	**(7,010)**	(6,692)
Other liabilities	29	**0**	0
Provisions	35	**(146)**	(18)
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		**(7,156)**	(6,710)
Net current assets/(liabilities)		**2,837**	2,489
Total assets less current liablilities		**24,674**	22,230
Non-current liabilities			
Trade and other payables	28	**0**	0
Other liabilities	29	**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:		**24,674**	22,230
FINANCED BY:			
Public Dividend Capital		**589**	1,489
Retained earnings		**18,546**	17,131
Revaluation reserve		**5,539**	3,610
Other reserves		**0**	0
Total Taxpayers' Equity:		**24,674**	22,230

The notes on pages 6 to 39 form part of this account.

The financial statements on pages 2 to 39 were approved by the Board on 27th May 2016 and signed on its behalf by:

Chief Executive: Jan Ditheridge Date: 27-05-16

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

	Public Dividend capital £000s	Retained earnings £000s	Revaluation reserve £000s	Other reserves £000s	Total reserves £000s
Balance at 1 April 2015	1,489	17,131	**3,610**	0	22,230
Changes in taxpayers' equity for 2015-16					
Retained surplus/(deficit) for the year		1,407			1,407
Net gain / (loss) on revaluation of property, plant, equipment			1,937		1,937
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		8	(8)	0	0
Reclassification adjustments					
Transfers between reserves in respect of assets transferred under absorption	0	0	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
Permanent PDC received - cash	0				0
Permanent PDC repaid in year	(900)				(900)
PDC written off	0	0			0
Transfer due to change of status from Trust to 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	(900)	1,415	1,929	0	2,444
Balance at 31 March 2016	589	18,546	5,539	0	24,674
Balance at 1 April 2014	1,489	16,757	3,213	0	21,459
Changes in taxpayers' equity for the year ended 31 March 2015					
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 assets held for sale			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	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
Originating capital for Trust established in year	0				0
New temporary and permanent PDC received - cash	0				0
New temporary and permanent PDC repaid in year	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	0	374	397	0	771
Balance at 31 March 2015	1,489	17,131	3,610	0	22,230

Statement of Cash Flows for the year ended 31 March 2016

	NOTE	2015-16 £000s	2014-15 £000s
Cash Flows from Operating Activities			
Operating surplus/(deficit)		**1,922**	838
Depreciation and amortisation	8	**1,104**	1,061
Impairments and reversals	17	**0**	0
Other gains/(losses) on foreign exchange	13	**0**	0
Donated assets received credited to revenue but non-cash	6	**0**	0
Government Granted assets received credited to revenue but non-cash		**0**	0
Interest paid		**0**	(4)
PDC Dividend (paid)/refunded		**(511)**	(445)
Release of PFI/deferred credit		**0**	0
(Increase)/decrease in Inventories		**23**	(9)
(Increase)/decrease in Trade and Other Receivables		**(891)**	354
(Increase)/decrease in Other Current Assets		**0**	0
Increase/(decrease) in Trade and Other Payables		**268**	(265)
(Increase)/decrease in Other Current Liabilities		**0**	0
Provisions utilised		**(8)**	(71)
Increase/(decrease) in movement in non cash provisions		**136**	(456)
Net Cash Inflow/(Outflow) from Operating Activities		**2,043**	1,003
Cash Flows from Investing Activities			
Interest received		**23**	25
(Payments) for Property, Plant and Equipment		**(1,227)**	(946)
(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)		**3**	10
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		**(1,201)**	(911)
Net Cash Inflow/(Outflow) before Financing		**842**	92
Cash Flows from Financing Activities			
Gross Temporary (2014/15 only) and Permanent PDC received		**0**	0
Gross Temporary (2014/15 only) and Permanent PDC repaid		**(900)**	0
Loans received from DH - New Capital Investment Loans		**0**	0
Loans received from DH - New Revenue Support 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 and On-SoFP PFI and LIFT		**0**	0
Capital grants and other capital receipts (excluding donated / government granted cash receipts)		**0**	0
Net Cash Inflow/(Outflow) from Financing Activities		**(900)**	0
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**(58)**	92
Cash and Cash Equivalents (and Bank Overdraft) at beginning of period		**5,805**	5,713
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	**26**	**5,747**	5,805

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

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 SOCI, and is disclosed separately from operating costs.

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

1.4 Charitable Funds

Under the provisions of IFRS 10 Consolidated Financial Statements, those Charitable Funds that fall under common control with NHS bodies 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 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 Note 41 : related parties.

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.

NOTES TO THE ACCOUNTS

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

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 NHS 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 (£19.6m) 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% (£1.6m) 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 annual leave earned but not yet taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Retirement benefit costs

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

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

NOTES TO THE ACCOUNTS

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

1.8 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received, with the exception of lease car rentals which are recognised when the annual rental is due. 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, 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 current value in existing use.

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 current value in existing use 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. Current values are determined as follows:

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

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

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

NOTES TO THE ACCOUNTS

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

Fixtures and equipment are carried at depreciated cost as this is not considered to be materially different from current value. The Trust's policy on equipment indexation is that where 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 £5,000.

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

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

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

NOTES TO THE ACCOUNTS

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

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.

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

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

NOTES TO THE ACCOUNTS

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. See note 1.8 re lease car rentals. 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-out* cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

NOTES TO THE ACCOUNTS

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 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.

NOTES TO THE ACCOUNTS

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

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.

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.

NOTES TO THE ACCOUNTS

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

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.

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.

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.

In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

NOTES TO THE ACCOUNTS

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

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).

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.

NOTES TO THE ACCOUNTS

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

1.32 Accounting Standards that have been issued but have not yet been adopted

The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2015-16. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

- IFRS 9 *Financial Instruments* – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.

- IFRS 15 *Revenue for Contracts with Customers* - Application required for accounting periods beginning on or after 1 January 2017, but not yet adopted by the FReM: early adoption is not therefore permitted.

- IFRS 16 *Leases* – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

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. Therefore no further analysis is required.

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 2015-16 (and 2014-15) there were no income generation activities whose full cost exceeded £1m or was otherwise material.

5. Revenue from patient care activities

	2015-16 £000s	2014-15 £000s
NHS Trusts	**775**	674
NHS England	**6,926**	9,600
Clinical Commissioning Groups	**58,374**	57,148
Foundation Trusts	**40**	39
Department of Health	**0**	0
NHS Other (including Public Health England and Prop Co)	**0**	0
Additional income for delivery of healthcare services	**900**	0
Non-NHS: Local Authorities	**7,623**	3,675
Private patients	**0**	0
Overseas patients (non-reciprocal)	**0**	0
Injury costs recovery	**58**	58
Other	**1,100**	950
Total revenue from patient care activities	**75,796**	72,144

1. The additional income for delivery of healthcare services is income from DH for the agreed capital to revenue transfer. Due to a forecast capital underspend, the Trust's Capital Resource Limit (see Note 43.4) was reduced by £900k and returned as revenue from DH, increasing the revenue surplus.
2. Movements in revenue from NHS England to Local Authorities relate to Health Visitor commissioning changes.

6. Other operating revenue

	2015-16 £000s	2014-15 £000s
Recoveries in respect of employee benefits	**315**	281
Patient transport services	**0**	0
Education, training and research	**1,083**	1,461
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	**160**	103
Support from DH for mergers	**0**	0
Receipt of Government grants for capital acquisitions	**0**	0
Non-patient care services to other bodies	**135**	65
Income generation (Other fees and charges)	**644**	655
Rental revenue from finance leases	**0**	0
Rental revenue from operating leases	**328**	158
Other revenue	**479**	419
Total other operating revenue	**3,144**	3,142

Prior period figures have been amended from those in the 2014/15 accounts to aid comparability between years as share services income has been re-classified from "Other" to "Non-Patient Care Services to Other Bodies".

7. Overseas visitors disclosure

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

8. Operating expenses

	£000s	£000s
Services from other NHS Trusts	**1,954**	1,550
Services from CCGs/NHS England	**2**	0
Services from other NHS bodies	**16**	0
Services from NHS Foundation Trusts	**249**	163
Total Services from NHS bodies*	**2,221**	1,713
Purchase of healthcare from non-NHS bodies	**0**	161
Purchase of Social Care	**0**	
Trust Chair and non-executive Directors	**54**	54
Supplies and services - clinical	**7,213**	7,174
Supplies and services - general	**658**	627
Consultancy services	**25**	171
Establishment	**2,656**	2,950
Transport	**0**	0
Service charges - ON-SOFP PFIs and other service concession arrangements	**0**	0
Service charges - On-SOFP LIFT contracts	**0**	0
Total charges - Off-SOFP PFIs and other service concession arrangements	**0**	0
Total charges - Off-SOFP LIFT contracts	**0**	0
Business rates paid to local authorities	**298**	447
Premises	**5,442**	5,044
Hospitality	**14**	9
Insurance	**205**	206
Legal Fees	**146**	119
Impairments and reversals of receivables	**(59)**	33
Inventories write down	**0**	0
Depreciation	**1,104**	1,061
Amortisation	**0**	0
Impairments and reversals of property, plant and equipment	**0**	0
Impairments and reversals of intangible assets	**0**	0
Impairments and reversals of financial assets [by class]	**0**	0
Impairments and reversals of non current assets held for sale	**0**	0
Internal Audit fees	**55**	
Audit fees	**40**	43
Other auditor's remuneration	**0**	0
Clinical negligence	**110**	113
Research and development (excluding staff costs)	**0**	0
Education and training	**299**	349
Change in discount rate	**0**	0
Other	**681**	767
Total operating expenses (excluding employee benefits)	**21,162**	21,041
Employee benefits		
Employee benefits excluding Board members	**55,099**	52,674
Board members	**757**	733
Total employee benefits	**55,856**	53,407
Total operating expenses	**77,018**	74,448

*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 leases have yet been agreed 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.

	2015-16				
	Land	**Buildings**	**Other**	**Total**	2014-15
	£000s	**£000s**	**£000s**	**£000s**	£000s
Payments recognised as an expense					
Minimum lease payments				**3,341**	3,234
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total				**3,341**	3,234
Payable:					
No later than one year	0	3,250	326	**3,576**	3,570
Between one and five years	0	3,953	167	**4,120**	4,833
After five years	0	12,620	0	**12,620**	12,697
Total	**0**	**19,823**	**493**	**20,316**	21,100
Total future sublease payments expected to be received:				0	0

The analysis showing when future lease payments will be payable has been amended for 2014/15 as the Trust has new information about the likely lease term of one of the NHS Property Services leases.

Likely lease terms of 25 years and 5 years have been indicated by NHSPS on two properties owned by them and leased by the Trust. As such, we have calculated future lease payments on these properties utilising a lease term of 25 years and 5 years respectively from 1/4/2013.

9.2. Trust as lessor

Leases are property leases. 2 of these, where Trust properties are used by GPs, only started being invoiced for in 2015/16.

	2015-16	2014-15
	£000	£000s
Recognised as revenue		
Rental revenue	**328**	158
Contingent rents	**0**	0
Total	**328**	158
Receivable:		
No later than one year	**206**	158
Between one and five years	**180**	0
After five years	**3,780**	0
Total	**4,166**	158

10. Employee benefits and staff numbers

10.1. Employee benefits

	2015-16 Total £000s	2015-16 Permanently employed £000s	2015-16 Other £000s
Employee Benefits - Gross Expenditure			
Salaries and wages	**48,009**	**40,037**	**7,972**
Social security costs	**2,592**	**2,592**	**0**
Employer Contributions to NHS BSA - Pensions Division	**5,251**	**5,251**	**0**
Other pension costs	**0**	**0**	**0**
Termination benefits	**4**	**4**	**0**
Total employee benefits	**55,856**	**47,884**	**7,972**
Employee costs capitalised	**0**	**0**	**0**
Gross Employee Benefits excluding capitalised costs	**55,856**	**47,884**	**7,972**

Employee Benefits - Gross Expenditure 2014-15	Total £000s	Permanently employed £000s	Other £000s
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 - including capitalised costs	53,407	46,772	6,635
Employee costs capitalised	0	0	0
Gross Employee Benefits excluding capitalised costs	53,407	46,772	6,635

10.2. Staff numbers

	2015-16 Total Number	2015-16 Permanently employed Number	2015-16 Other Number	2014-15 Total Number
Average staff numbers				
Medical and dental	**43**	28	15	43
Ambulance staff	**0**	0	0	0
Administration and estates	**243**	238	5	258
Healthcare assistants and other support staff	**135**	81	54	105
Nursing, midwifery and health visiting staff	**711**	662	49	712
Nursing, midwifery and health visiting learners	**0**	0	0	0
Scientific, therapeutic and technical staff	**240**	231	9	229
Social care staff	**7**	0	7	7
Healthcare science staff	**0**	0	0	0
Other	**53**	48	5	49
TOTAL	**1,432**	**1,288**	**144**	1,403
Of the above - staff engaged on capital projects	**0**	0	0	0

10.3. Staff sickness absence and ill health retirements

	2015-16 Number	2014-15 Number
Total days lost	13,167	13,371
Total staff years	1,260	1,267
Average working days lost	10.45	10.55

	2015-16 Number	2014-15 Number
Number of persons retired early on ill health grounds	**5**	1
	£000s	£000s
Total additional pensions liabilities accrued in the year	**287**	42

10.4. Exit packages agreed in 2015-16

2015-16

Exit package cost band (including any special payment element)	*Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed.	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£s	Number	£s	Number	£s	Number	£
Less than £10,000	0	0	3	4,201	3	4,201	0	0
£10,000-£25,000	0	0	0	0	0	0	0	0
£25,001-£50,000	0	0	0	0	0	0	0	0
£50,001-£100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Total	0	0	3	4,201	3	4,201	0	0

2014-15

Exit package cost band (including any special payment element)	*Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed.	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£s	Number	£s	Number	£s	Number	£
Less than £10,000	1	6,279	2	735	3	7,014	0	0
£10,000-£25,000	1	15,285	0	0	1	15,285	0	0
£25,001-£50,000	0	0	0	0	0	0	0	0
£50,001-£100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	1	181,812	0	0	1	181,812	0	0
>£200,000	0	0	0	0	0	0	0	0
Total	3	203,376	2	735	5	204,111	0	0

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

	2015-16		2014-15	
	Agreements Number	**Total value £000s**	**Agreements Number**	**Total value £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	**1**	**2**	0	0
Contractual payments in lieu of notice	**2**	**2**	2	1
Exit payments following Employment Tribunals or court orders	**0**	**0**	0	0
Non-contractual payments requiring HMT approval*	**0**	**0**	0	0
Total	**3**	**4**	2	1
Non-contractual payments made to individuals where the payment value was more than 12m 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 two NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

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

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

11. Better Payment Practice Code

11.1. Measure of compliance

	2015-16 Number	2015-16 £000s	2014-15 Number	2014-15 £000s
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the year	**22,300**	**18,758**	22,557	17,960
Total Non-NHS Trade invoices paid within target	**21,979**	**18,372**	22,006	17,430
Percentage of NHS Trade invoices paid within target	**98.56%**	**97.94%**	97.56%	97.05%
NHS Payables				
Total NHS Trade invoices paid in the year	**1,487**	**14,573**	1,656	13,254
Total NHS Trade invoices paid within target	**1,439**	**13,999**	1,607	12,809
Percentage of NHS Trade invoices paid within target	**96.77%**	**96.06%**	97.04%	96.64%

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

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

	2015-16 £000s	2014-15 £000s
Rental revenue		
PFI finance lease revenue (planned)	**0**	0
PFI finance lease revenue (contingent)	**0**	0
Other finance lease revenue	**0**	0
Subtotal	**0**	0
Interest revenue		
LIFT: equity dividends receivable	**0**	0
LIFT: loan interest receivable	**0**	0
Bank interest	**23**	25
Other loans and receivables	**0**	0
Impaired financial assets	**0**	0
Other financial assets	**0**	0
Subtotal	**23**	25
Total investment revenue	**23**	25

13. Other gains and losses

	2015-16 £000s	2014-15 £000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	**(11)**	(25)
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	**3**	(17)
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	**(8)**	(42)

14. Finance Costs

	2015-16 £000s	2014-15 £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	**0**	4
Provisions - unwinding of discount	**0**	0
Total	**0**	4

15.1. Property, plant and equipment

2015-16	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:									
At 1 April 2015	**4,061**	**13,903**	**0**	**36**	**3,052**	**124**	**2,017**	**131**	**23,324**
Additions of Assets Under Construction				0					**0**
Additions Purchased	0	396	0		131	0	566	6	**1,099**
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	19	0	0	140	0	0	0	**159**
Additions Leased (including PFI/LIFT)	0	0	0		0	0	0	0	**0**
Reclassifications	0	36	0	(36)	0	0	0	0	**0**
Reclassifications as Held for Sale and reversals	0	0	0	0	0	(90)	0	0	**(90)**
Disposals other than for sale	0	0	0	0	(152)	0	(44)	(6)	**(202)**
Upward revaluation/positive indexation	0	1,415	0	0	20	0	0	0	**1,435**
Impairment/reversals charged to operating expenses	0	0	0	0	0	0	0	0	**0**
Impairments/reversals charged to reserves	0	0	0	0	0	0	0	0	**0**
Transfers to NHS Foundation Trust on authorisation as FT	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 2016	**4,061**	**15,769**	**0**	**0**	**3,191**	**34**	**2,539**	**131**	**25,725**
Depreciation									
At 1 April 2015	**0**	**191**	**0**		**1,774**	**124**	**1,446**	**100**	**3,635**
Reclassifications	0	0	0		0	0	0	0	**0**
Reclassifications as Held for Sale and reversals	0	0	0		0	(90)	0	0	**(90)**
Disposals other than for sale	0	0	0		(141)	0	(44)	(6)	**(191)**
Upward revaluation/positive indexation	0	(502)	0		0	0	0	0	**(502)**
Impairment/reversals charged to reserves	0	0	0		0	0	0	0	**0**
Impairments/reversals charged to operating expenses	0	0	0		0	0	0	0	**0**
Charged during the year	0	548	0		367	0	173	16	**1,104**
Transfers to NHS Foundation Trust on authorisation as FT	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 2016	**0**	**237**	**0**	**0**	**2,000**	**34**	**1,575**	**110**	**3,956**
Net Book Value at 31 March 2016	**4,061**	**15,532**	**0**	**0**	**1,191**	**0**	**964**	**21**	**21,769**
Asset financing:									
Owned - Purchased	4,061	15,138	0	0	748	0	964	21	**20,932**
Owned - Donated	0	394	0	0	443	0	0	0	**837**
Owned - Government Granted	0	0	0	0	0	0	0	0	**0**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	**0**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2016	**4,061**	**15,532**	**0**	**0**	**1,191**	**0**	**964**	**21**	**21,769**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2015	1,239	2,291	0	0	76	4	0	0	**3,610**
Movements	0	1,917	0	0	15	(3)	0	0	**1,929**
At 31 March 2016	**1,239**	**4,208**	**0**	**0**	**91**	**1**	**0**	**0**	**5,539**

Additions to Assets Under Construction in 2015-16 : nil

15.2. Property, plant and equipment prior-year

2014-15	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£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 (including PFI/LIFT)	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)**
Revaluation	174	(276)	0	0	3	0	0	0	**(99)**
Impairments/negative indexation charged to reserves	0	0	0	0	0	0	0	0	**0**
Reversal of Impairments charged to reserves	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)**
Revaluation	0	(511)	0		0	0	0	0	**(511)**
Impairments/negative indexation charged to operating expenses	0	0	0	0	0	0	0	0	**0**
Reversal of Impairments charged to operating expenses	0	0	0	0	0	0	0	0	**0**
Charged during the year	0	518	0		361	11	155	16	**1,061**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	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**

15.3. Property, plant and equipment (continued)

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 2015/16, desk-top revaluations of the same assets were undertaken by the VOA with an effective date of 31st March 2016. BCIS indices, provided to the Trust by the Valuation Office Agency were used to reflect changes in value of other assets not previously valued (£410k), and where there has been capital expenditure since the 2014 full valuation date (£355k).

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 £1,865k and £52k

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
- Transport equipment : 5 to 8 years
- Information technology : 3 to 5 years
- Furniture & fittings : 10 to 10 years

Asset lives were reviewed. Changes in lives resulted in minimal change in depreciation charges.

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 £1.9m.

The carrying amount of surplus assets was £11k.

16. Intangible non-current assets

There were no intangible non-current assets.

17. Analysis of impairments and reversals recognised in 2015-16

There were no impairments or reversals recognised in 2015-16.

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 2016 £000s	31 March 2015 £000s
Property, plant and equipment	**0**	14
Intangible assets	**0**	0
Total	**0**	14

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	**231**	**0**	**1,652**	**0**
Balances with Local Authorities	**1,085**	**0**	**684**	**0**
Balances with NHS bodies outside the Departmental Group	**0**	**0**	**0**	**0**
Balances with NHS bodies inside the Departmental Group	**2,114**	**0**	**2,307**	**0**
Balances with Public Corporations and Trading Funds	**0**	**0**	**0**	**0**
Balances with Bodies External to Government	**368**	**68**	**2,367**	**0**
At 31 March 2016	**3,798**	**68**	**7,010**	**0**
Prior period:				
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

21. Inventories

	Drugs	Consumables	Work in Progress	Energy	Loan Equipment	Other	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2015	**0**	**186**	**0**	**0**	**285**	**0**	**471**
Additions	0	2,201	0	0	2,410	0	**4,611**
Inventories recognised as an expense in the period	0	(2,236)	0	0	(2,398)	0	**(4,634)**
Write-down of inventories (including losses)	0	0	0	0	0	0	**0**
Reversal of write-down previously taken to SOCI	0	0	0	0	0	0	**0**
Transfers to NHS Foundation Trust on authorisation as FT	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 2016	**0**	**151**	**0**	**0**	**297**	**0**	**448**

22.1. Trade and other receivables

	Current		Non-current	
	31 March 2016	31 March 2015	**31 March 2016**	31 March 2015
	£000s	£000s	**£000s**	£000s
NHS receivables - revenue	**1,484**	1,029	**0**	0
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**630**	887	**0**	0
Non-NHS receivables - revenue	**1,241**	720	**63**	52
Non-NHS receivables - capital	**0**	0	**0**	0
Non-NHS prepayments and accrued income	**349**	336	**19**	10
PDC Dividend prepaid to DH	**0**	0		
Provision for the impairment of receivables	**(10)**	(97)	**(14)**	(10)
VAT	**100**	42	**0**	0
Current/non-current part of PFI & other PPP arrangements, prepayments & 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	**3**	5	**0**	0
Total	**3,798**	2,923	**68**	52
Total current and non current	**3,866**	2,975		
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 2016	31 March 2015
	£000s	£000s
By up to three months	**1,926**	280
By three to six months	**68**	81
By more than six months	**12**	56
Total	**2,006**	417

22.3. Provision for impairment of receivables

	2015-16 £000s	2014-15 £000s
Balance at 1 April 2015	**(107)**	(84)
Amount written off during the year	**24**	10
Amount recovered during the year	**67**	60
(Increase)/decrease in receivables impaired	**(8)**	(93)
Transfers to NHS Foundation Trust on authorisation as	**0**	
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	**0**	0
Balance at 31 March 2016	**(24)**	(107)

The provision relates to the NHS Injury Costs Recovery Scheme.

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 2016 £000s	31 March 2015 £000s
Opening balance	**5,805**	5,713
Net change in year	**(58)**	(92)
Closing balance	**5,747**	5,805
Made up of		
Cash with Government Banking Service	**5,731**	5,785
Commercial banks	**0**	0
Cash in hand	**16**	20
Liquid deposits with NLF	**0**	0
Current investments	**0**	0
Cash and cash equivalents as in Statement of Financial Position	**5,747**	5,805
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in Statement of Cash Flows	**5,747**	5,805
Third Party Assets - Bank balance (not included above)	**0**	0
Third Party Assets - Monies on deposit	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 2015	0	0	0	0	0	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	0	0	0	0	0	0	0	0	0	0	**0**
Less assets sold in the year	0	0	0	0	0	0	0	0	0	0	**0**
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	**0**
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	0	**0**
Transfers to Foundation Trust on authorisation as FT	0	0	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	0	0	**0**
Balance at 31 March 2016	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2016	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Balance at 1 April 2014	0	0	0	0	0	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	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)/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

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

28. Trade and other payables

	Current		Non-current	
	31 March 2016	31 March 2015	**31 March 2016**	31 March 2015
	£000s	£000s	**£000s**	£000s
NHS payables - revenue	**1,651**	1,169	**0**	0
NHS payables - capital	**27**	0	**0**	0
NHS accruals and deferred income	**597**	1,259	**0**	0
Non-NHS payables - revenue	**1,075**	1,345	**0**	0
Non-NHS payables - capital	**275**	271	**0**	0
Non-NHS accruals and deferred income	**1,547**	1,030	**0**	0
Social security costs	**482**	425		
PDC Dividend payable to DH	**32**	13		
Accrued interest on DH loans	**0**			
VAT	**0**	0	**0**	0
Tax	**368**	377		
Payments received on account	**0**	0	**0**	0
Other	**956**	803	**0**	0
Total	**7,010**	6,692	**0**	0
Total payables (current and non-current)	**7,010**	**6,692**		
Included above:				
To buy out liability for early retirements over 5 yrs	**0**	0		
Number of cases involved (number)	**0**	0		
Outstanding pension contributions at year end	**800**	687		

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 income

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
Opening balance at 1 April 2015	**40**	0	**0**	0
Deferred revenue addition	**60**	40	**0**	0
Transfer of deferred revenue	**(23)**	0	**0**	0
Current deferred Income at 31 March 2016	**77**	40	**0**	0
Total deferred income (current and non-current)	**77**	40		

33. Finance lease obligations as lessee

There were no finance lease obligations as lessee.

34. Finance lease receivables as lessor

There were no finance lease receivables as lessor.

35. Provisions

		Comprising:						
	Total	**Early Departure Costs**	**Legal Claims**	**Restructuring**	**Continuing Care**	**Equal Pay (incl. Agenda for Change)**	**Other**	**Redundancy**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Balance at 1 April 2015	**18**	0	18	0	0	0	0	0
Arising during the year	**141**	0	13	0	0	0	128	0
Utilised during the year	**(8)**	0	(8)	0	0	0	0	0
Reversed unused	**(5)**	0	(5)	0	0	0	0	0
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 on being authorised as FT	**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 2016	**146**	**0**	**18**	**0**	**0**	**0**	**128**	**0**
Expected Timing of Cash Flows:								
No later than 1 year	**146**	0	18	0	0	0	128	0
Later than 1 year and not later than 5 years	**0**	0	0	0	0	0	0	0
Later than 5 years	**0**	0	0	0	0	0	0	0

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

As at 31 March 2016	43
As at 31 March 2015	11

The provisions in the "Other" class relate to expected dilapidation costs for leased properties the Trust has vacated or given notice to vacate.

36. Contingencies

	31 March 2016	31 March 2015
	£000s	£000s
Contingent liabilities		
NHS Litigation Authority legal claims	**(11)**	(8)
Employment tribunal and other employee related litigation	**0**	0
Redundancy	**0**	0
Other	**0**	0
Net value of contingent liabilities	**(11)**	(8)
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. The Trust 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 2016 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk
The Trust's operating costs are incurred under contracts with 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' £000s	Loans and receivables £000s	Available for sale £000s	Total £000s
Embedded derivatives	**0**			**0**
Receivables - NHS		**2,114**		**2,114**
Receivables - non-NHS		**1,460**		**1,460**
Cash at bank and in hand		**5,747**		**5,747**
Other financial assets	**0**	**0**	**0**	**0**
Total at 31 March 2016	**0**	**9,321**	**0**	**9,321**
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

39.3. Financial liabilities

	At 'fair value through profit and loss' £000s	Other £000s	Total £000s
Embedded derivatives	**0**		**0**
NHS payables		**2,275**	**2,275**
Non-NHS payables		**3,053**	**3,053**
Other borrowings		**0**	**0**
PFI & finance lease obligations		**0**	**0**
Other financial liabilities	**0**	**0**	**0**
Total at 31 March 2016	**0**	**5,328**	**5,328**
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

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		2015-16 £000s	2014-15 £000s
Peter Clowes Clinical Lead for Urgent Care	Shropshire CCG	Payments	2	0
		Receipts	41,829	40,826
Jane Mackenzie Councillor	Shropshire Council	Payments	223	469
		Receipts	3,581	2,075

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 £307,000 (£214,000 in 2014/15) and total expenditure was £293,000 (£298,000 in 2014/15) most of which was grants to the Trust.

42. Losses and special payments

The total number of losses cases in 2015-16 and their total value was as follows:

	Total Value of Cases £s	**Total Number of Cases**
Losses	2,728	85
Special payments	18,280	9
Total losses and special payments	21,008	94

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

There were no cases over £300,000

43. Financial performance targets

43.1. Breakeven performance

	2011-12 £000s	2012-13 £000s	2013-14 £000s	2014-15 £000s	2015-16 £000s
Turnover	80,802	79,679	76,105	75,286	**78,940**
Retained surplus/(deficit) for the year	1,600	1,447	45	359	**1,407**
Adjustment for:					
Timing/non-cash impacting distortions:					
Pre FDL(97)24 agreements	0	0	0	0	**0**
2007/08 PPA (relating to 1997/98 to 2006/07)					
2008/09 PPA (relating to 1997/98 to 2007/08)					
Adjustments for impairments	0	0	184	0	**0**
Adjustments for impact of policy change re donated/government grants assets	(203)	49	5	(7)	**(52)**
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12*	0	0	0	0	**0**
Absorption accounting adjustment		0	0	0	**0**
Other agreed adjustments	0	**0**	0	0	**0**
Break-even in-year position	**1,397**	**1,496**	**234**	**352**	**1,355**
Break-even cumulative position	**1,397**	**2,893**	**3,127**	**3,479**	**4,834**

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 %	2015-16 %
Materiality test (I.e. is it equal to or less than 0.5%):					
Break-even in-year position as a percentage of turnover	1.73	1.88	0.31	0.47	**1.72**
Break-even cumulative position as a percentage of turnover	1.73	3.63	4.11	4.62	**6.12**

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 based on the pre audited accounts 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.

	2015-16 £000s	2014-15 £000s
External financing limit (EFL)	**(224)**	70
Cash flow financing	**(842)**	(92)
Finance leases taken out in the year	**0**	0
Other capital receipts	**0**	0
External financing requirement	**(842)**	(92)
Under/(over) spend against EFL	**618**	162

43.4. Capital resource limit

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

	2015-16 £000s	2014-15 £000s
Gross capital expenditure	**1,258**	1,046
Less: book value of assets disposed of	**(11)**	(52)
Less: capital grants	**0**	0
Less: donations towards the acquisition of non-current assets	**(159)**	(103)
Charge against the capital resource limit	**1,088**	891
Capital resource limit	**1,160**	1,020
(Over)/underspend against the capital resource limit	**72**	129

44. Third party assets

There were no third party assets.