Shropshire Community Health NHS Trust

# Annual Report and Accounts 2016/17

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Presented in accordance with the NHS Finance Manual: Manual For Accounts 2016/17 pursuant to the Companies Act 2006

# Contents

## Annual Report and Accounts 2016/17




## 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 pals@shropcom.nhs.uk

# Foreword

## Welcome from the Chairman

**It is my pleasure to welcome you to our Annual Report and Accounts for 2016/17.**

This document will give you an overview of what we do, how well we have done and the challenges we face going forward, as well as a more detailed analysis of our activities and accounts if you would like to take a look at things in a bit more detail. Most of this information can also be found on our website at **www.shropscommunityhealth.nhs.uk**

We have had another busy and challenging year and I would like to take this opportunity to say thank you all our staff and volunteers who have helped us to deliver so many important services to our local population through their hard work and dedication. They really do help to improve lives in our communities, which of course is one of our core values.

We are also fortunate to have, and grateful for the great support we get from our patients and carers, who are directly involved in helping us to shape our services and making sure we are getting things right. We know that the next 12 months are going to be extremely important for shaping the future of community services in Shropshire and I look forward to working with all of our staff, volunteers, partner organisations and stakeholders to make sure we get that right. Whatever happens, we need to make sure we find a solution that delivers modern, sustainable, high quality and safe community services for the people of Shropshire and Telford & Wrekin for years to come.

I hope you will enjoy this Annual Report and Accounts and I look forward to your continued support us as we move into 2017/18.

Thank you,

**Mike Ridley, Chairman**

# Performance Report

## Performance Overview

The first section of the Annual Report and Accounts provides an overview of our performance over the last 12 months. This is a brief summary of who we are, what we do and how we have performed against our objectives during the year. There is a more detailed analysis of our performance later in the report.

## Chief Executive's Review of the Year

**There is no such thing as a quiet year in the NHS, and this has been no exception for Shropshire Community Health NHS Trust.**

We deliver a range of community services over 1,200 square miles, out of approximately 100 buildings, and many more homes, GP practices and community centres. Our dedicated and skilled staff - all 1,600 of them - work tirelessly to support children and adults to live well and independently, despite their condition or illness.

We not only deliver services today, but we are constantly thinking about the future, how to improve the quality of our services, what services need to be like in 5 to 10 years' time and importantly this year what sort of organisation we will need to be to deliver all of that.

I am really pleased to report that we have met the majority of our set national targets this year and also seen significant improvements in some of our local targets, such as some of our waiting lists and support for people leaving hospital.

In September 2016, the Care Quality Commission (CQC) told us that we need to improve in some areas of our services. Although they also rated our Dental Services and Children's Services as "Good" and told us all our staff demonstrated care, compassion, respect and dignity and therefore rated us as "Good" for the Caring domain. I have seen significant progress against our CQC Action Plan, particularly in the areas of End of Life care, Minor Injury Unit care and staffing and skill mix arrangements in some of our community teams. I am confident we have learned a great deal from the CQC Inspection and look forward to their return.

Thinking about the future, we have been actively involved in the development of the Neighbourhoods or Community work as part of the Sustainability and Transformation Plan (STP) and, with the support of our commissioners, we have developed a new service for our young people in Shropshire. The 0-25 Emotional Health and Well Being Service has been developed with our partners in mental health and the voluntary sector, and once implemented in 2017/18 will provide a much wider, more modern range of services for our children and young people with mental health issues.

The procurement and implementation of our new Electronic Patient Record (EPR) has been a critical project this year, and while implementation will not be complete until later this year, it is already improving our ability to deliver care effectively. This is a very good example where technology and the expertise of our corporate services directly improve patient care, staff working lives and patient safety.

# Performance Report

## Performance Overview

We agreed three main priorities this year:

- CQC – getting to good and beyond
- implement our Electronic Patient Record
- supporting and leading the redesign of our community services for the future

I am confident and proud that we have achieved what we said we would do this year in all of these priorities. Of course, this is all in the context of our statutory requirement to meet our targets and deliver our financial plan, as agreed with our Regulator at the beginning of the year.

Finally, the Board took a decision earlier this year that to continue to deliver high quality community services now and in the future our small organisation needs to be part of something bigger. So, we are exploring options with our Regulator and key partners to find a solution that will strengthen our opportunity to innovate, invest and grow community services for the benefit of all of the residents we serve now and in the future.

My last comments on the past year have to be words of admiration and thanks to our staff, who tirelessly care for our patients and carers, often in very challenging circumstances; our patients, carers and volunteers who support us every day to improve our services; our partners who we rely on to deliver the right services and finally our local communities who actively engage with us to ensure we provide services appropriate and relevant to their local needs.

A very big thank you to all of those who have contributed to the work we've done this year.

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 725,000 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.

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.

Our Executive Team 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***.

### Key Facts:

- **Organisation formed in 2011**
- **Serve a population of 471,000**
- **Employ 1,600 people**
- **We had about 725,000 community contacts in 2016/17**
- **Spent £76.9m delivering services**
- **Provide services from more than 100 sites across one of England's largest and sparsely populated counties.**

# **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 471,000 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 2016/17 our total income for the year was £79.4 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 (The 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.

# Performance Report: Performance Overview

## 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**

# **Performance Report:** Performance Overview

## 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.**

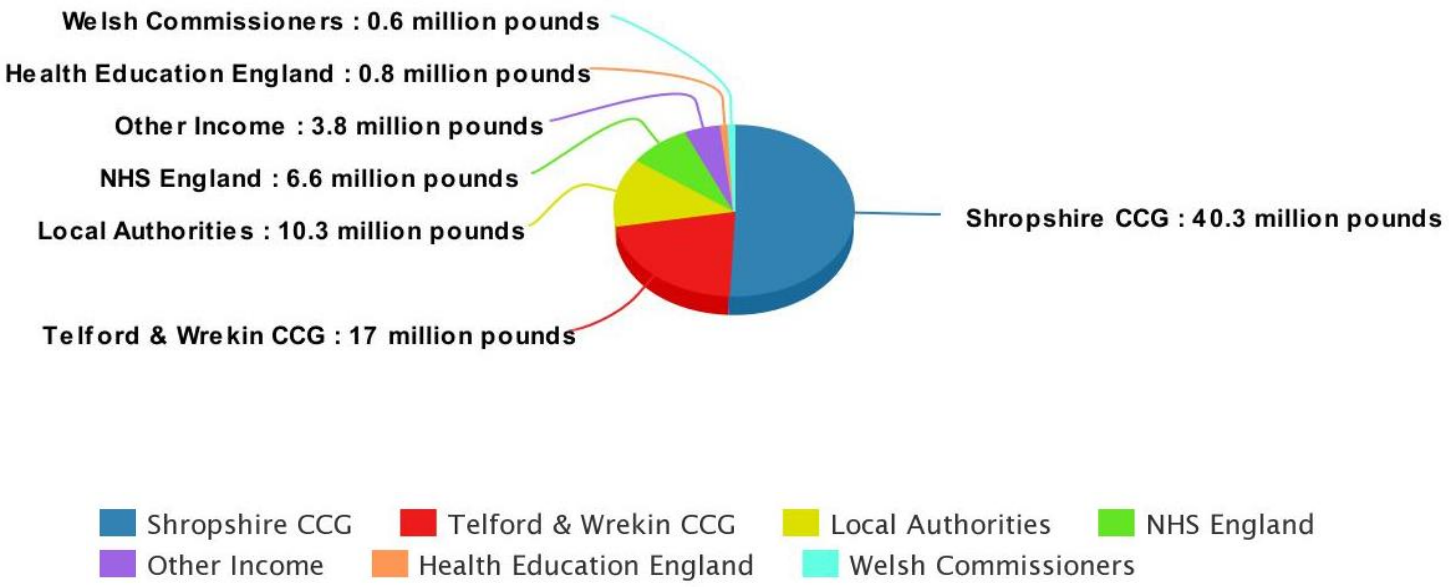
As a provider of community NHS services we receive the majority of our income from NHS commissioners (e.g. Clinical Commissioning Groups or CCGs in England and Local Health Boards in Wales) and a significant proportion from Local Authorities.

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 2016/17 year the Trust's total income was £79.4 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.



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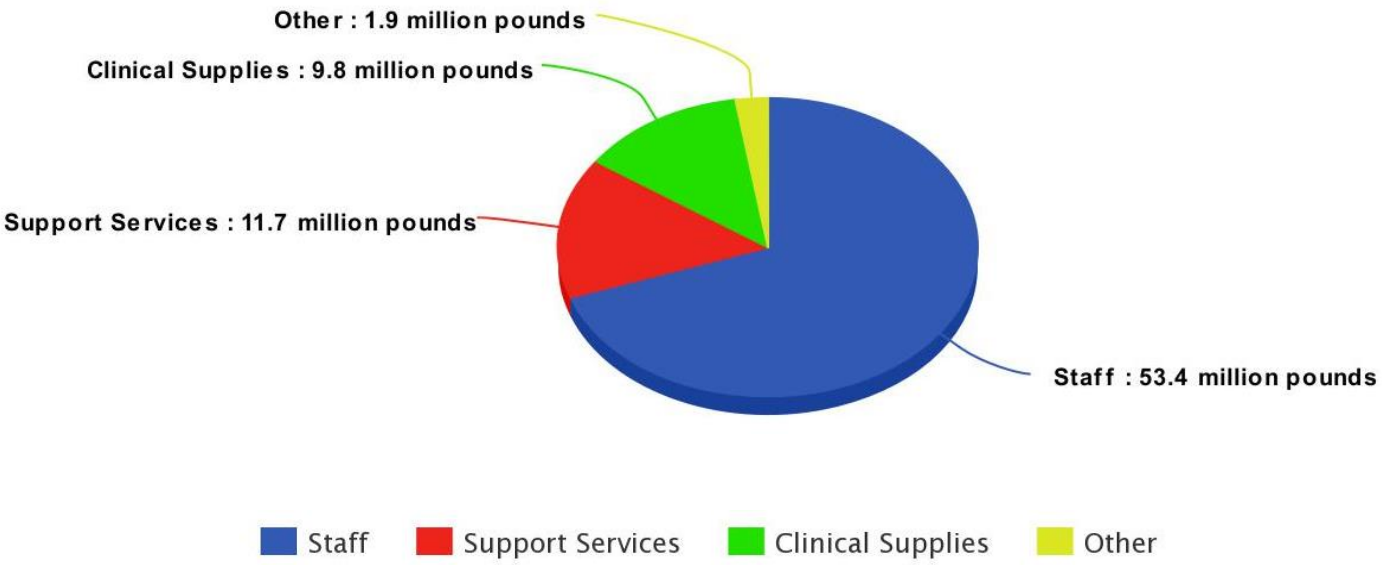
The income we receive is used to fund the services we provide the most significant element of which is to pay our staff. In 2016/17 we spent about £76.9 million delivering services.

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:




## 2016/17 Financial Results

Overall, in 2016/17 the Trust made a surplus of £2,596,000.

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

## 2016/17: A Performance Summary

### Once again we have had a challenging year, which has left us with plenty to celebrate and plenty to learn from and continue to improve.

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 have met the majority of our set national targets this year and also seen significant improvements in some of our local targets.
- 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 2016/17 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.

**Our future:** We have had to carefully manage the messages around the work being carried out to find a new and sustainable organisational form for our services. We are working with our regulators and commissioners to ensure this work is completed as quickly as possible, while also managing any expectations and anxieties at the same time. You can read more about this later in the Performance Summary.

**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.

**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.

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**System-wide transformation:** We play a key part in system-wide strategic planning, known as the Shropshire and Telford & Wrekin Sustainability and Transformation Plan (STP). This was initially set out in the NHS Shared Planning Guidance and the support the implementation of the Five Year Forward View. More specifically the development of STPs across the country recognised the need for increased integration across the health and social care sector, which requires a lot of collaborative planning and partnership working to help develop models of care fit for the future.

## Getting it Right

We fully recognise all of the challenges, issues and risks that have just been covered (some of which will be covered in more detail in this section, and other sections of the report) and have made sure they have been taken into account when planning and delivering services throughout 2016/17 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 have clear Key Performance Indicators (KPIs), which include those required by contractual and regulatory organisations, plus internal stretch targets aligned with workforce indicators, safer staffing metrics, patients and carer feedback, audit results, complaints and Patient and Advice Service (PALS) information and staff feedback. Performance against these indicators is monitored through:

- Service Delivery Group Quality Dashboards
- Integrated Performance Reports
- Detailed Quality Performance Reports

We also 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 18 of this report.

## Our Priorities

We set ourselves a number of priorities for 2016/17 to help us deliver the best possible services for the populations we serve. They included:

**Develop and implement a new 0-25 years Emotional Health and Well-being service:** We worked closely with other healthcare providers to design the new 0-25 Emotional Health and Wellbeing Service that will replace the existing CAHMS model this year. This is something our clinicians wanted for some time. The Clinical Commissioning Groups and Councils in Shropshire and Telford & Wrekin started the procurement process in 2016 and the process involved a huge amount of engagement work with young people, service users, parents, carers, staff, organisations and stakeholders and resulted in a service model fit for the future. This is an exciting opportunity to make a real difference to the children and young people who will receive this care and support.

**Implement a new Electronic Patient Record (EPR):** In March, we started rolling out our new Electronic Patient Record system. The first phase of this was to start using the system in our Minor Injury Units and Podiatry service. This has been the culmination of a lot of planning and preparation and represents the largest single financial investment the organisation has made. Subsequent phases of the implementation plan will see our remaining services “go live” before the end of 2017. 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,

# Performance Report: Performance Overview

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.

**Develop a sustainable strategy for the future of our estate:** A significant element of our asset base is our estate, which supports the day-to-day operational and administrative functions. Our services operate from multiple locations across the county, which provides both operational and financial challenges. Our Board has now approved an Estates Management Strategy, which is an important part of managing our resources going forward and takes 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. The strategy outlines our aim to provide a range of optimal, fit-for-purpose accommodation and estate to support the operational and strategic delivery of all services. It recognises that our estate and accommodation must align and directly support patient care and the business of the Trust and sets out to deliver an estate that enhances the day to day lives of all service users, carers, staff, stakeholders and our communities. The strategy will be supported by an Asset Management Plan (the Strategy can be found on our website).

**Further develop our patient and carer feedback systems:** More of our teams and team leaders now have access to our patient and carer feedback systems and are helping to produce and deliver action plans to drive improvement across our services. You can read more about this later in this Performance Overview.

## Quality

We were inspected in 2016 by the Care Quality Commission and rated as “Requires Improvement”. We believe the report provided a fair reflection of our services at that time. We were pleased that almost every service that was inspected was rated as “Good” for being caring and responsive, which is at the heart of everything we do and shows we are getting that right, and if you look at the report summary (which is available on our website) the majority of the ratings against our services are “Good”.

Importantly, there were no surprises. We work hard to make sure we know about the things we need to improve, and more importantly that we have plans in place to do so. While the inspectors were only able to see a snapshot of what we do over a very short period of time, it was reassuring to see the vast majority of things they think we need to improve are things we told them about. This inspection gave us some useful feedback and added to the work we continuously do to review our services and highlight areas of good practice that can be shared, and to identify things we need to improve. Since the inspection was carried out our services have been responding to the action plans that were created as a result of the feedback we received and as a result of our own continuous improvement work. Our aim is now to “Get to Good” and beyond.

We continuously measure the quality of services and the impact that our approach is having on our service. Statistical Process Control (SPC) charts within our Quality Performance Reports provide key information to demonstrate the efficiency of interventions over time. In the past year we have continued to improve our systems and processes to collect data and ensure we have an accurate and timely picture of the quality of our services at any time. Central to this is the implementation of our new Electronic Patient Record (EPR), which we will continue to rollout during 2017, as previously outlined in this report.

We have recently refreshed our quality governance process to ensure quality development is clinically driven. This supports a continuous learning approach and enables is to share learning both when things go well, as well as when they do not.

## Organisational Change: Our Future

Our Board has a specific responsibility to consider the long-term planning of our services. It has become clear through a lot of detailed work and discussion that to achieve all of the things we want to do to create high quality community services in the future our organisation will have to be part of something different, probably bigger.

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Our regulator, NHS Improvement (NHSI) agreed with us and we started working with them to find a new and sustainable organisational form for our services. A Sustainability Board was set up to lead this work, which is chaired by NHSI and comprises representatives from our Board, our local commissioners, along with NHS England and the Health and Wellbeing boards of Shropshire and Telford & Wrekin Councils.

We have already, and will continue to influence the process to ensure any new formal partner will have the following attributes:

- Be financially stable and able to invest
- Have the ability to demonstrate a track record of transformation at scale
- Quality governance that can safely support complex health and care services and practitioners
- Achievement of good quality standards including, for example, at least a "Good" CQC rating
- Evidence of delivering community services
- Demonstrable evidence of working in partnership, specifically with health, social care and the Third Sector
- An organisation that is committed to Shropshire

We will not advocate a proposal that would see our services widely fragmented or "cherry picked" as we believe this would fundamentally damage our ability to achieve the capacity, capability and scale of community services we want to see being delivered.

We made this important decision from a position of strength, to give our services and staff the best opportunity to continue to flourish in the future. This will be a time of change, and some uncertainty, but also a time of great opportunity to realise our ambitions for our patients, their families and the people we employ.

As this process is designed to find a new organisational model to provide our services (for example having another public sector entity using the same assets to deliver them) this does not affect the going concern status of services. More details about this are contained within Note 1.1 of the Accounts (accounting policies).

## Our Workforce

Developing innovative workforce solutions will support the delivery of high quality care. As part of this we have continued to implement 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 leading work to develop new leadership training and support, strengthen the provision of supervision across the organisation, and further improvements have been seen in the quality of Personal Development Reviews for staff taking place, making them more meaningful and linking them to our values.

A key of focus over the past year has been our Health and Wellbeing Strategy, which has taken a proactive and engaging approach to enhancing the health and wellbeing of our staff through wellbeing initiatives, employee support mechanisms and joint working with staff, their representatives and local partners to identify and address areas for improvement.

Towards the end of 2016 we piloted a new Staff Recognition Scheme that comprised a variety of ways staff could be thanked and recognised for "Going the Extra Mile" – or GEM as the branding has been generated. This has now been launched across our services and ranges from staff receiving simple messages from colleagues on Thank You Cards through to our new Chairman's Awards, which are presented in public at each of our Board Meetings (you can find more details about this on our website).

## Developing Local Enhanced Community Services – Neighbourhoods

Whatever we plan to do in future, much of it will invetiably link in with the work of our partners. In 2015, 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). The Plan for Shropshire and Telford & Wrekin, which sets out how health and social care will be delivered for

# Performance Report: Performance Overview

the future, has now been published. 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 sits above existing transformation programmes already underway, such as our work on Neighbourhoods and the NHS Future Fit and review of acute health services in the county. The STP for Shropshire and Telford & Wrekin can be found on our website.

**Neighbourhood Care Models:** Our future transformation programme will focus heavily on developing new Neighbourhood models, which will be a key part of our contribution to Sustianability and Transformation Plan (STP). These new models of care will provide needs-based services in the community to reduce, or prevent, the need for acute intervention and treatments. We will reduce duplication of services, which will improve productivity and release time to care.

Developing lower cost delivery models will contribute towards bridging the financial gap in the STP need to address and ensure the long-term financial viability of clinical services. The health and the needs of our population are very different across the county. This is reflected in the neighbourhood footprints that form the structure of our service delivery models. Our future service offer is being designed around a 'Team and Hub' approach that builds upon the existing services within these communities. We will utilise public health data to identify future demand for services and to prioritise health needs within these communities. Neighbourhood Care Teams will be the first point of contact for patients who do not require emergency treatment. These teams will support and deliver planned care, condition-specific pathways such as Frailty and Respiratory, long-term conditions management, interface between teams and social capital/voluntary sector (step up and step down), point of care testing, End of Life care, domiciliary care and early intervention for mental health conditions.

## Patient, Carers and Volunteers

Patient and Carer involvement is central to how we improve quality. Our engaged and active Patient and Carer Panel work closely with us to develop and improve the services we provide. Panel members are involved in activity throughout the organisation, for example they are take part in interviewing new staff, observe and reflect on the care being provided, design services with us and sit on some of our key committees.

We have continued to make use of 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 has continued throughout 2016/17. We have used this information, along with the quantitative data from our systems, to create focused action plans that team leaders and managers can use to drive improvement across our services.

Our volunteers have also been instrumental at a national level in the design and implementation of a new Patient Story Toolkit. Patient stories are being used at more forums throughout the Trust to ensure the voices of patients and carers are heard, and most importantly, listened to.

## 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 £2,596,000.

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 2017/18.

# 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 2016/17.

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.

| Patient Activity Figures 2016/17 | |
|---|---|
| Community contacts | 723,285 |
| Outpatient attendances | 63,209 |
| Inpatient and day cases | 1,115 |
| Inpatient rehabilitation episodes | 1,841 |
| Radiology examinations | 11,387 |
| Minor injuries attendances | 28,232 |
| Equipment and products supplied | 283,966 |
| Prison healthcare contacts | 14,343 |

## 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 above shows how we measured against the Safety Thermometer in 2016/17.*

# **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) aligned to the CQC domains of quality – caring, responsive, effective, well led and safe services. This section of the Annual Report will provide information relating to our performance within these quality domains in relation to our targets, which are set internally, locally and nationally. The Trust is currently monitoring performance against 98 KPIs.

## Caring **Key Measures**

| Caring | Year end 15/16 | Apr 16 | May 16 | Jun 16 | Jul 16 | Aug 16 | Sep 16 | Oct 16 | Nov 16 | Dec 16 | Jan 17 | Feb 17 | March 17 | Year to date 16/17 | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | |
| New birth visits within 14 days | 90.74 | 92.29 | 93.27 | 92.17 | 97.59 | 96.01 | 92.43 | 90.50 | 91.62 | 91.24 | 94.38 | 93.33 | | **93.1%** | 90.00% |
| Access to Healthcare (LD) | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100% | 100% | **100%** | 100% |
| Single Sex Accommodation Breaches | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | 0 |

| Friends and Family | Year end 15/16 | Apr 16 | May 16 | Jun 16 | Jul 16 | Aug 16 | Sep 16 | Oct 16 | Nov 16 | Dec 16 | Jan 17 | Feb 17 | March 17 | Year to date 16/17 | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % of patients across trust extremely or likely to recommend – Community Services (UNIFY) | **98%** | 89% | 97% | 92% | 95% | 98% | 96% | 97% | 97% | 95.7% | 100% | 94.62% | 96.63% | **95.29%** | None |
| % of patients across trust extremely or likely to recommend – Mental Health Services (UNIFY) | **98%** | 88% | 94% | 98% | 95% | 95% | 94% | 92% | 80% | 85.7% | 100% | 100% | 97.785 | **92.6%** | None |
| **Local Inpatient Survey** | | | | | | | | | | | | | | | |
| % of in patients extremely or likely to recommend the ward they were treated in | **97%** | 85% | 96% | 100% | 93% | 93% | 97% | 100% | 95% | 92% | 91.91% | 83.3% | 84.89% | **91.9%** | None |
| % of inpatients that report they are treated with dignity & respect | **98%** | 100% | 100% | 100% | 97% | 100% | 100% | 100% | 97% | 100% | 97.06% | 95.83% | 88.10% | **98.5%** | None |
| % of discharged inpatients rate overall experience as excellent or very good | **91%** | 73% | 81% | 89% | 88% | 86% | 83% | 91% | 87% | 88% | 82.35% | 80.21% | 79.76% | **84.2%** | None |
| % of discharged inpatients who complete the survey | **20%** | 17% | 18% | 25% | 27% | 28% | 22% | 17% | 22% | 15.7% | 19.6% | 24% | 12.8% | **19.9%** | None |
| Complaints (number) | **67** | 10 | 11 | 19 | 15 | 5 | 15 | 7 | 8 | 2 | 9 | 5 | 8 | **114** | None |
| Complaints responded in timescale | **86.56** | 83.30 | 90.90 | 100 | 83 | 94.12 | 60.00 | 66.00 | 60.00 | 77% | 100 | 100% | 100 | **84.53%** | 95% |
| Response within 3 working days (%) | **94.38** | 90.90 | 100 | 94.70 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100% | 100 | **97.63%** | None |
| % Action Plans implemented | **100** | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100% | 100 | **100** | 100% |
| Upheld by ombudsman | **0** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | 0 |
| Number of claims for compensation | **6** | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 1 | 0 | 1 | 0 | **4** | 0 |

# **Performance Report:** Performance Analysis

## Responsive Key Measures

| Responsive | Year end 15/16 | Apr 16 | May 16 | Jun 16 | Jul 16 | Aug 16 | Sep 16 | Oct 16 | Nov 16 | Dec 16 | Jan 17 | Feb 17 | March 17 | Year to date 16/17 | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CQC Warning Notices | **0** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | 0 |
| Prop of patients not treated within 28 days of last min cancellation | **0.25** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | 0 |
| Delayed Transfers of Care (DTOC) | **10.61** | 8.00 | 10.00 | 8.00 | 21.00 | 13.00 | 10.00 | 20.00 | 26.00 | 23.00 | 25 | 18.18 | 15 | **24.3** | 3.5% |
| 18/52 RTT for admitted patients | **97.04** | 92.59 | 97.70 | 96.30 | 100 | 91.59 | 83.87 | 93.26 | 95.95 | 97.33 | 88.06 | 100 | | **100** | 90% |
| 18/52 RTT for non-admitted patients | **95.64** | 91.31 | 90.00 | 92.30 | 91.03 | 92.42 | 93.45 | 91.87 | 92.06 | 92.64 | 91.53 | 91.58 | | **91.58** | 95% |
| 18/52 RTT incomplete pathways | **93.36** | 92.80 | 93.97 | 92.01 | 90.37 | 90.62 | 89.11 | 87.86 | 88.26 | 86.74 | 90.4 | 92.64 | | **92.64** | 92% |
| Diagnostics for audio/ultrasound | **100** | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | **100** | 99% |
| Consultant Led Outpatients 6/52 | **40.66** | 61.86 | 58.68 | 48.30 | 59.52 | 67.48 | 66.85 | 61.85 | 61.74 | 47.02 | 54.73 | 45.77 | | **56.27** | 50% |
| Non Cons Led Outpatients 6/52 | **28.27** | 27.78 | 40.31 | 39.92 | 31.47 | 27.80 | 31.28 | 30.97 | 34.51 | 42.12 | 45.45 | 37.41 | | **35.40** | 50% |
| MIU discharged in 4 hours % | **99.98** | 100 | 99.95 | 100 | 100 | 100 | 100 | 99.95 | 99.95 | 99.87 | 100 | 100 | 100 | **99.97** | 95% |
| MIU Left without being seen % | **0** | 0.6 | 0.8 | 0.8 | 0.43 | 0.8 | 0.6 | 0.81 | 0.37 | 0.38 | 0.24 | 0.38 | 0.6 | **0.5%** | 5% |
| MIU assessed within 15 minutes | **100** | 100 | 91.67 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | **98.84%** | 95% |
| MIU Time to treatment decision | **10** | 12 | 14 | 12 | 12 | 12 | 11 | 10 | 9 | 8 | 9 | 11 | 10 | **11** | 60 mins |
| MIU Unplanned re-attendance | **1.81** | 1.60 | 1.49 | 1.45 | 2.26 | 1.75 | 1.89 | 1.57 | 1.55 | 1.72 | 2.07 | 1.51 | 2.74 | **1.78** | 5% |
| CES Response within 7 days | **99.14** | 99.19 | 99.14 | 99.10 | 99.17 | 99.01 | 99.06 | 99.06 | 99.04 | 99.02 | 99.10 | 99.01 | | **99.08** | 99% |
| DN response times within 24 hours | **98.26** | 100 | 98.51 | 94.02 | 93.27 | 95.87 | 96.15 | 88.97 | 82.72 | 80.39 | 87.5 | 87.6 | 94.67 | **93.19** | 100% |
| DN response times within 48 hours | **98.66** | 99.25 | 100 | 99.15 | 90.63 | 92.74 | 80.67 | 86.73 | 84.03 | 82.86 | 93.71 | 85.7 | 87.96 | **92.84** | 100% |

## Effective Key Measures

| | Year End 15/16 | Apr 16 | May 16 | Jun 16 | Jul 16 | Aug 16 | Sep 16 | Oct 16 | Nov 16 | Dec 16 | Jan 17 | Feb 17 | March 17 | Year to date 16/17 | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Data Timeliness (2 days) | | 78.89 | 81.94 | 81.71 | 80.00 | 78.29 | 79.66 | 76.95 | 78.00 | 79.37 | 83.77 | 84.52 | 83.64 | **80.52** | 100% |
| Ethnic Coding Data Quality | **96.06** | 96.34 | 96.62 | 96.66 | 96.34 | 96.54 | 96.15 | 96.32 | 96.26 | 96.21 | 96.08 | 96.19 | 97.78 | **96.53** | 85% |
| Unallocated data | **0.48** | 0.37 | 0.45 | 0.49 | 0.56 | 0.49 | 0.62 | 0.57 | 0.62 | 0.58 | 0.55 | 0.85 | 0.97 | **0.61** | 0.50% |
| Use of NHS number | **98.36** | 98.34 | 99.91 | 98.57 | 98.61 | 98.07 | 98.33 | 98.39 | 98.70 | 98.27 | 98.55 | 98.76 | 98.64 | **98.57** | 95% |
| Bed Utilisation (overall) | **93.18** | 95.91 | 91.12 | 91.92 | 93.71 | 94.95 | 95.60 | 93.95 | 92.65 | 93.02 | 94.91 | 95.25 | 91.75 | **93.71** | 91% |
| Unexpected deaths | **5** | 1 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | **6** | 0 |
| Did Not Attend (DNA) rates | **3.40** | 3.28 | 3.14 | 3.33 | 3.24 | 3.50 | 3.28 | 3.36 | 3.38 | 3.35 | 3.54 | **3.37** | | **3.35** | 10% |
| Length of Stay (overall) | **19** | 21 | 17 | 19 | 18 | 18 | 23 | 18 | 17 | 16 | 18 | 17.2 | 18 | **18** | 20 |

## Well Led Key Measures

| Well Led – Supporting our staff | Year End 15/16 | Apr 16 | May 16 | Jun 16 | Jul 16 | Aug 16 | Sep 16 | Oct 16 | Nov 16 | Dec 16 | Jan 17 | Feb 17 | March 17 | Year to date 16/17 | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Appraisal rates - Trust | **84.30** | 83.37 | 82.30 | 80.63 | 76.69 | 78.26 | 79.30 | 80.00 | 82.00 | 81.7 | 86.8 | 88.71 | 90.8 | **90.80** | 95% |
| Employee Numbers (FTE) | **1265** | 1249 | 1249 | 1249 | 1247 | 1257 | 1240 | 1254 | 1252 | 1265 | 1263 | 1268 | 1266 | **1266** | |
| Information Governance Requirements | **86.54** | 84.45 | 87.27 | 89.08 | 88.04 | 88.29 | 86.78 | 88.80 | 90.83 | 91.33 | 88.3 | 91.04 | 94.19 | **94.19** | 95% |
| Leavers <1 year in service (FTE) | **1.04** | 0.90 | 4.00 | 0.60 | 0.47 | 1.38 | 3.80 | 1.11 | 1.70 | 1.70 | 0.7 | 0 | 1.04 | **1.45** | 1.33% |
| Leavers All (FTE) | **12.57** | 1.15 | 1.41 | 0.49 | 1.05 | 1.07 | 1.20 | 0.52 | 0.81 | 1.32 | 1.00 | 0.53 | 1.71 | **12.26** | 8.00% |
| Mandatory core requirements | **87.49** | 86.40 | 87.35 | 88.16 | 89.63 | 89.52 | 90.03 | 89.20 | 90.66 | 90.19 | 90.06 | 91.42 | 91.63 | **91.63** | 95% |
| Sickness Absence – total workforce | **4.55** | 4.51 | 4.20 | 3.86 | 4.25 | 4.20 | 4.40 | 5.28 | 5.61 | 6.43 | 6.04 | 5.18 | 4.18 | **4.80** | 4.15% |
| Total shifts exceeding NHSI capped rate | | 320 | 287 | 287 | 193 | 284 | 264 | 213 | 194 | 182 | 129 | 153 | 220 | **2726** | 0 |
| Total shifts non framework agreement | | 36 | 15 | 22 | 8 | 12 | 16 | 1 | 3 | 7 | 4 | 9 | 10 | **143** | 0 |

# **Performance Report:** Performance Analysis

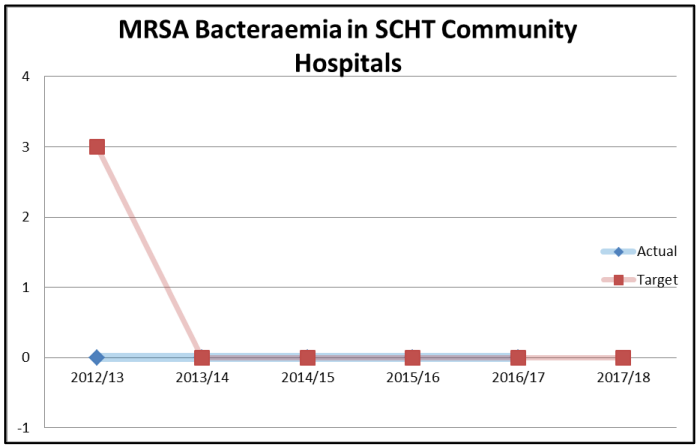
## Safe Key Measures

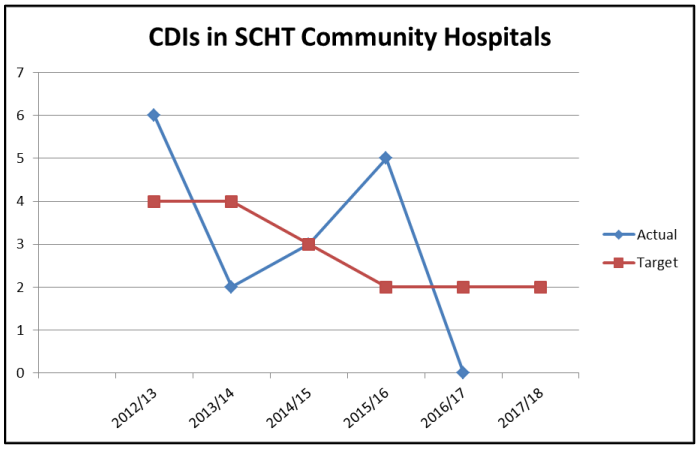
| Quality - Patient Safety | Year End 15/16 | Apr 16 | May 16 | Jun 16 | Jul 16 | Aug 16 | Sep 16 | Oct 16 | Nov 16 | Dec 16 | Jan 17 | Feb 17 | March 17 | Year to date 16/17 | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Infection Control** | | | | | | | | | | | | | | | |
| Clostridium Difficile incidence | 5 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | **2** |
| MRSA Bacteraemia rate | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | **0** |
| % of admissions screened for MRSA | 97 | 95.2 | 99.3 | 100 | 100 | 96.2 | 92.7 | 95.8 | 95.7 | 92.4 | 96.86 | 95.3 | 91.1 | **96.0** | **97%** |
| **Medication incidents** | | | | | | | | | | | | | | | |
| Incidents affecting patients directly | 108 | 6 | 14 | 8 | 2 | 8 | 5 | 4 | 5 | 4 | 4 | 5 | 5 | **70** | **NA** |
| **Pressure ulcer incidence reported** | | | | | | | | | | | | | | | |
| In service grade 2 | 68 | 9 | 3 | 6 | 3 | 5 | 8 | 5 | 8 | 2 | 14 | 11 | 11 | **74** | **0** |
| In service grade 3 | 14 | 2 | 3 | 0 | 2 | 1 | 1 | 0 | 0 | 1 | 2 | 0 | 0 | **10** | **0** |
| In service grade 4 | 5 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | **3** | **0** |
| **VTE % Risk assessment on admission** | 94.07 | 96.75 | 98.50 | 96.95 | 93.33 | 98.47 | 95.04 | 98.57 | 95.06 | 96.53 | 97.39 | 90.83 | 96.53 | **96.16** | **95** |
| **Never Events** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | **0** |
| **Serious Incidents (all)** | 29 | 1 | 2 | 0 | 2 | 3 | 3 | 1 | 2 | 4 | 2 | 0 | 0 | **20** | |
| **Falls** | | | | | | | | | | | | | | | |
| Falls resulting in serious injury | 10 | 0 | 1 | 0 | 0 | 1 | 0 | 1 | 2 | 2 | 0 | 0 | 1 | **8** | **0** |
| All falls in Community Hospitals | 289 | 23 | 26 | 18 | 29 | 33 | 18 | 22 | 28 | 28 | 21 | 22 | 35 | **303** | |
| **NHS Safety Thermometer** | | | | | | | | | | | | | | | |
| Harm Free Care – Trust overall % | 95.36 | 93.47 | 97.07 | 93.25 | 92.51 | 92.67 | 94.94 | 93.22 | 94.83 | 96.01 | 93.21 | 95.8 | 93.83 | **94.23** | **95%** |
| No new harms – Trust % | 98.49 | 97.59 | 98.53 | 97.82 | 97.10 | 97.37 | 99.05 | 98.08 | 98.32 | 99.28 | 98.21 | 99.7 | 98.53 | **99.5** | |
| **CAS Alerts open beyond due dates** | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | **0** |

### Protecting our patients against infections

As healthcare providers it is important that we have robust infection prevention and control measures and practices in place, and to reassure the public that reducing the risk of infection is a key priority for us. Altogether this supports the provision of high quality services for our patients and a safe working environment for our staff.

During 2016/17 there were no cases of Meticillin Resistant Staphylococcus aureus (MRSA) bacteraemia (against a target of zero), and no cases of Clostridium difficile (against a target of two) reported at the Trust.



# **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 improved on last year, which helped to protect staff, patients and families.

| | | |
|---|---|---|
| 2016/17 | Shropshire Community Health NHS Trust | 72.3% |
| 2015/16 | Shropshire Community Health NHS Trust | 67.6% |

## 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 2016/17 can be found in the “Caring Key Measures” section of this report on page 19.

### Compliments and Complaints

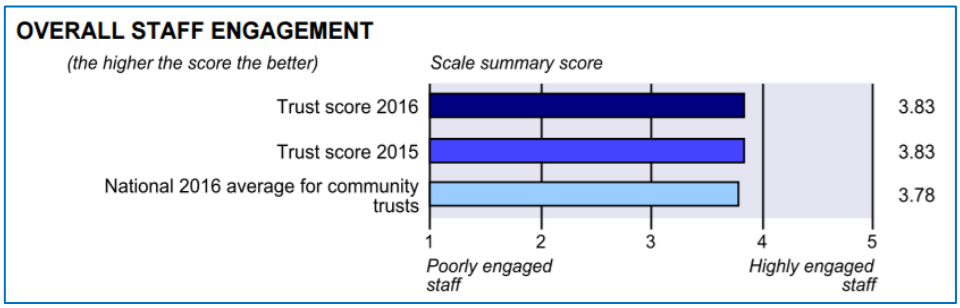
The compliments and complaints we receive are another valuable source of feedback about our services that we use to support our improvement plans. Between April 2016 and March 2017 we received **116 formal complaints** across all of our services. We have procedures in place to ensure we manage any complaints 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 (2016/17) we received **449 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 2016/17 **PALS dealt with 317 enquiries**, which is an 42.7% 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.

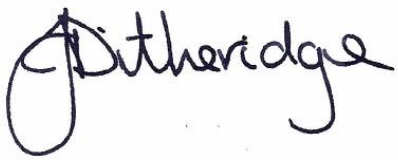
# **Performance Report:** Performance Analysis

## 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 about 52% (831 returned), which was an improvement from 47% (721 returned) in 2015. 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.

Some of the 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 3.75 out of 5 to 3.76. For Staff Motivation at Work we remain above average for organisations like ours at 4.01 out of 5, while our overall staff engagement score (illustrated above) also remains above the national average for NHS community trusts at 3.83 out of 5. 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. You can find the full NHS Staff Survey 2016 report at **www.nhsstaffsurveys.com**



Jan Ditheridge
Chief Executive

31 May 2017

# 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.**

NHS Improvement (NHSI) 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.

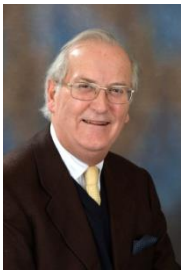
This report provides information about the membership of our Board as at the time this Annual Report and Accounts were approved:

**Mike Ridley, Chairman** (Term: July 2011 to December 2017)

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

**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 Preen, Director of Finance** (Appointed October 2015)

Ros is a member of the Chartered Institute of Management Accountants 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 was the Divisional Director for Medicine and Support Services then Deputy Director of Business Development & Transformation at South Warwickshire NHS Foundation Trust before moving to Shropshire. 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 21 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 2016/17 were Jane Mackenzie, Non-Executive Director (until 6 March 2017).

# **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*
- 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*
- Rolf Levesley
  *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 Preen
  *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*
- 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

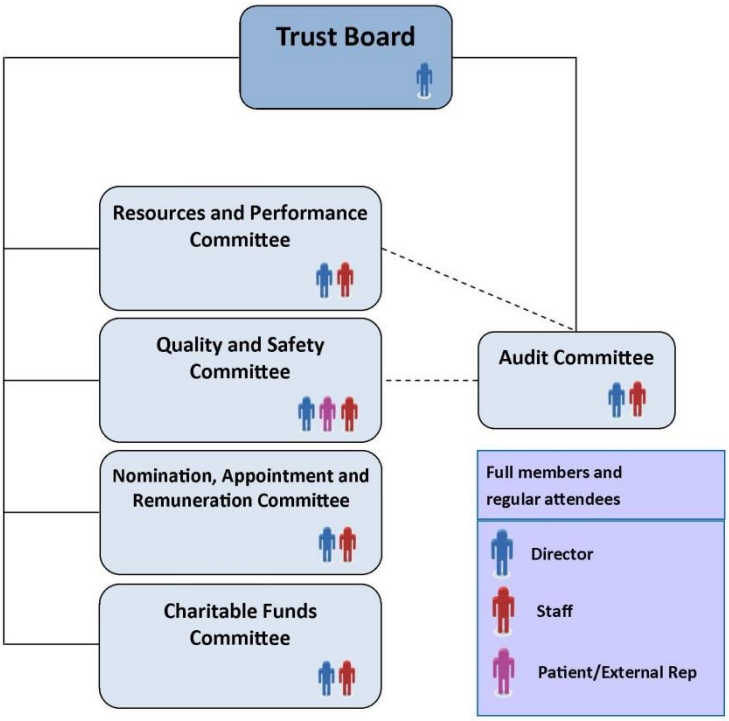
**Role and Purpose:**

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 Preen
  *Director of Finance*
- Steve Gregory
  *Director of Nursing and Operations*
- Julie Thornby
  *Director of Corporate Affairs*
- Nuala O'Kane
  *Non-Executive Direcor*
- Diana Owen
  *Head of Financial Accounting*

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<br>*Chair*<br>(From 1 July 2011) | Director, Crewe YMCA<br>Trustee of St Luke's Hospice<br>Daughter employed by CHKS |
| Ms Jan Ditheridge<br>*Chief Executive*<br>(From 30 September 2013) | The Elizabeth Bryan Foundation Trust - Trustee |
| Mr Rolf Levesley<br>*Non-Executive Director*<br>*(From 1 July 2011)* | South Staffordshire Housing Association and Housing Plus Group<br>Chair South Staffordshire Council for Voluntary Action |
| Mr Peter Phillips<br>*Non-Executive Director*<br>(From 21 October 2013) | Masteragency Ltd – Director<br>Arts Council England – Trustee<br>Witom Group Ltd - NED<br>GCS Ltd - NED<br>Access Skills Ltd - NED |
| Mr Steve Jones<br>*Non-Executive Director*<br>(From 1 July 2015) | Director Breeze Consultancy Services Ltd<br>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<br>Associate of Harvey Nash PLC Executive Search Company |
| Ms Nuala O'Kane<br>*Non-Executive Director*<br>(From 1 July 2015) | Director of Catalys – a capacity building consultancy Registered office Raddle Hall, Broseley, TF12 5BX 01952 883687 www.catalys.org<br>Part owner of Catalys, as above<br>Trustee of 'Together for Short Lives' – a national charity concerned with childrens' palliative care |
| Mr Steve Gregory<br>*Director of Nursing and Operations*<br>(From 13 January 2014) | Nil |
| Dr Mahadeva Ganesh<br>*Medical Director*<br>(From 11 August 2014) | Nil |
| Mrs Mel Duffy<br>*Director of Strategy*<br>(From 4 January 2016) | Nil |
| Ms Ros Preen<br>*Director of Finance*<br>(From 1 October 2015) | Trustee of the Health Care Financial Management Association (Charity) |

# **Accountability Report:** Corporate Governance Report

| **Non-voting board members** | |
|---|---|
| Ms Julie Thornby<br>*Director of Corporate Affairs*<br>(From 1 July 2011) | Nil |
| **Previous board members (voting and non-voting)** | |
| Ms Jane Mackenzie<br>*Non-Executive Director*<br>(From 1 September 2013) | Shropshire Unitary Councillor |

## 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.

# **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.

# **Accountability Report:** Corporate Governance Report

## Annual Governance Statement

### 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 the organisation's 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. The Trust received the final report in September from the Care Quality Commission (CQC) inspection which took place in March 2016. The overall rating for the Trust was 'requires improvement'. The rating for the CQC caring domain was 'good'. An action plan is in place to achieve improvements in the areas where CQC had concerns, and progress is regularly monitored by the Board and Quality and Safety Committee.

As Accountable Officer I work with partner organisations, including commissioners, (especially the Clinical Commissioning Groups), NHS England, NHS Improvement, 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 nonexecutive directors and five voting executive directors. There is also one non-voting director (Director of Corporate Affairs/Board Secretary). One non-executive director left the Trust in March 2017

# **Accountability Report:** Corporate Governance Report

Board Attendance

The Board has held 6 formal board meetings which have been held in public during 2016/17 and has met a further 6 times in private.
The chair attended all meetings. Attendance for formal meetings was as follows:

| | |
|---|---|
| May: | Full attendance for executive Directors, 3 of 5 non-executive directors attended |
| July: | 5 of 6 executive Directors attended, 4 of 5 non-executive directors attended |
| September: | Full attendance |
| November: | Full attendance for executive Directors, 3 of 5 non-executive directors attended |
| January: | Full attendance for non-executive directors, 5 of 6 executive Directors attended |
| March: | Full attendance |

Non-attendance has been for exceptional reasons including ill health, bereavement and attendance at long pre-arranged courses. Supportive measures have been put into place for one Board member who has found it difficult to attend meetings. They have since left the Trust.

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 to strengthen its enabling strategies and plans to support delivery of its overall objectives, for example in the areas of estates and IMT.

The Board continually self-assesses its performance, evaluating its meetings and those of its committees at the conclusion of business. Board development sessions have been held, and the Board has held specific discussions aimed at considering its own effectiveness and its impact on the organisation. These have included, for example, discussing feedback from the Trust's CQC inspection specifically relevant to the Board and its members and formulating related actions; self-assessing against the CQC/NHSI well-led framework, and considering feedback from the Trust's Culture Working Group when it was asked to look at the possibility of governance and well-led problems which had occurred in the NHS elsewhere happening at the Trust. Actions have been formed and progress monitored on them by the Board.

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.

# **Accountability Report:** Corporate Governance Report

### 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. We use the thermometer as a measure of service quality, helping us to identify where improvements have been made or are necessary.

The trust was inspected by the Care Quality Commission in March 2016. The Trust had an overall rating of 'Requires Improvement'. For the caring domain the Trust was rated as 'Good'. Community Dental Services and Community Health Services for Children, Young People and Families were rated as 'Good'. The Trust has developed an action plan for the areas requiring improvement. The plan is well underway in being delivered. Delivery of the plan is monitored within individual services and overall by the Quality and Safety Committee, a Committee of the Board.

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 2017, 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.

## 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

# **Accountability Report:** Corporate Governance Report

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 2016/17. 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 (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<br>Long term financial modelling<br>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)<br>Greater involvement of clinicians in initiatives.<br>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<br>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<br>Monitoring of quality indicators, carrying out clinical audits, investigating and learning from untoward events, complaints and claims. |

# **Accountability Report:** Corporate Governance Report

Trust Sustainability*

The Trust agreed at its November Board meeting that the Trust is not sustainable (clinically and financially) in its current organisational form. This has been agreed by NHS Improvement, which has established a Sustainability Board of which the Trust is a member.

As a result of this decision, the risk for trust sustainability was removed from the Board Assurance Framework in January 2017 and replaced with a new risk for transitioning to a new organisational form. Mitigation for the risk is through working with healthcare providers, commissioners and regulators on the preferred option for the future.

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<br>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<br>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<br>Risks are monitored by the Executive Team and overseen by the Audit Committee |

# **Accountability Report:** Corporate Governance Report

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.

In last year's statement I reported that an internal audit of waiting time quality had shown that improvements were needed. An action plan was developed which has now been delivered. Some issues still exist with processes that have been developed and are in place with Telford Muscoskeletal Service. These issues relate to cross organisation pathways and are currently being managed by staff carrying out additional validation checks.

The Trust is implementing an Electronic Patient Record (RiO), with an initial go live in March 2017 with subsequent implementation phases over a six month period. RiO provides a contemporaneous electronic clinical record; it also provides waiting list and RTT monitoring, the experience from other organisations is that this functionality. The experience from other organisations is that the functionality of combining the clinical and administrative data for patients into a single electronic record improves data quality. It will also allow for considerably more efficient audit and validation processes to be undertaken.

# **Accountability Report:** Corporate Governance Report

## Fraud and Security Management

The Trust has in place arrangements to address fraud, bribery and corruption, and security management issues. This includes the provision of Local Counter Fraud and Security Management Specialists. Annual work plans are formulated with progress towards delivering on the plan monitored by the Trust Director of Finance and reported to the Audit Committee. Service Condition 24 of the NHS Standard Contract, and the NHS Protect Standards for Providers, are used as benchmarks for performance. Yearly assessments of performance 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 2016, to the year end on the 31st March 2017 and up to the date of approval of the annual report and accounts.

The Risk Management Policy details the structure for the Trust's 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 programme of training related to the risks they encounter with the work they carry out. Managers, supervisors and team leaders attend risk 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.

# **Accountability Report:** Corporate Governance Report

The Audit Committee reviews the assurance that the Trust's 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 2016/17

- 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 on Patients' Monies and Property.

- 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 details 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 2016/17.

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 and now endorsed by NHS Improvement. 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 2016 to March 2017 the Trust reported 31 serious incidents. 17 of these related to Grade 3 or 4 pressure ulcers. The Trust report 9 patient falls in hospitals which resulted in serious injury, e.g. fractures

The other 5 incidents consisted of:

- A prisoner who misused substances
- A patient who received two x rays, one of which was in error
- A significant number of waiting time breaches
- Management of diabetes patient
- A child suicide

# **Accountability Report:** Corporate Governance Report

Following RCA investigations all these incidents will or have been reviewed by an Incident Review Group, 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 2016/17.

**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 2016/17 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 three areas where further work is necessary:

*Patients Monies and Property.*

Two community hospitals were reviewed and areas were identified where controls could be further strengthened. These were the completion of documentation, alignment of procedures and improvement of secure access arrangements. Actions were identified and have been implemented. These have included the installation of a ward safe box, changes to key holder arrangements and ensuring that staff are aware of, and complete, the correct documentation

*Safeguarding Arrangements – Adults and Children*

Areas were identified for improvement for training prior to employment, keeping training up to date and improvements needed to policies. Actions have been identified and are in the process of being implemented. Areas completed include the monitoring and actions taken where staff are not up to date with training, recording of incidents on patient records and updating contact details on the website. Areas still to be completed include flagging of concerns on patient records, improving documentation for concerns and referral and changes to policy.

*Discharge Management*

The Trust does not currently have an overall policy related to discharge. A Transfer of Care Policy is in development which will address these areas.

# **Accountability Report:** Corporate Governance Report

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

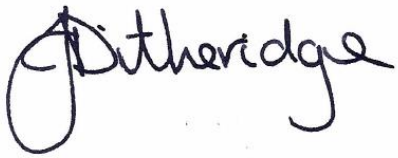
- Audit Committee programmes and reviews
- Internal and External Audits
- Counter Fraud and Security Management
- Risk Management Reports
- Staff and Patient Surveys
- Clinical Audit Reports
- CQC Self Assessment, inspections and reviews
- Counter Fraud Reports
- Management Reports
- Performance and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



Jan Ditheridge
Chief Executive

31 May 2017

# Accountability Report

## Remuneration and Staff Report

## Remuneration Report

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

The remuneration of the Chair and Non-Executive Directors is determined during the year by NHS Improvement (NHSI), 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 interim *Guidance on Pay for Very Senior managers in NHS Trusts and Foundation Trusts*, issued February 2017. 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 *Guidance*, 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 NHSI on behalf of the Secretary of State for Health in accordance with appraisal guidance provided by the NHSI. Performance review and appraisal of Non-Executive Directors is carried out by the Chair with guidance provided by NHSI. 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 2016/17 was £132,500* (2015/16 - £132,500). This was 4.65 times (2015/16 - 4.7) the median remuneration of the workforce, which was £28,462 (2015/16 - £28,180).

*(*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 2016/17, one (2015/16, one) employee received remuneration in excess of the highest paid Director/Member. Remuneration ranged from £15,251 to £172,727 (2015/16 £15,100 - £168,443). The total remuneration of the highest paid employee rose in 2016/17 because of a movement to the next point on the salary scale on completion of 19 years' service as a consultant, and the 1% increase in basic salary and Clinical Excellence Awards in April 2016.

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 2016/17 can be found in the Annual Accounts section of this report.

# **Accountability Report:** Remuneration and Staff Report

## Senior Manager Remuneration

The table below shows details about remuneration for 2016/17 (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 | | | | 25-27.5 | 155-160 |
| Ros Preen (Director of Finance) | 110-115 | | | | 12.5-15 | 125-130 |
| Mahadeva Ganesh (Medical Director) | 165-170 | | | | 82.5-85 | 245-250 |
| Steve Gregory (Director of Nursing & Operations) | 100-105 | | | | 45-47.5 | 145-150 |
| Julie Thornby (Director of Corporate Affairs) | 85-90 | | | | 22.5-25 | 105-110 |
| Mel Duffy (Director of Strategy) | 90-95 | | | | 65-67.5 | 155-160 |
| Mike Ridley (Chairman) | 20-25 | | | | | 20-25 |
| Rolf Levesley (Non-Executive) | 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) | 5-10 | | | | | 5-10 |
| Steve Jones (Non-Executive) | 5-10 | | | | | 5-10 |

**Notes**

1. All pension related benefits comprises the NHS Pensions Agency assessment of future pension benefits, excluding inflation, less employee contributions.

2. There was no remuneration waived by directors or allowances paid in lieu to directors in 2016/17.

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

# **Accountability Report:** Remuneration and Staff Report

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 and Staff 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 2017 (bands of £5,000) | Lump sum at pension age re accrued pension at 31 March 2017 (bands of £5,000) | Cash Equivalent Transfer Value at 31 March 2016 | Cash Equivalent Transfer Value at 31 March 2017 | Real increase in Cash Equivalent Transfer Value |
|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Jan Ditheridge (Chief Executive) | 0-2.5 | 5-7.5 | 45-50 | 145-150 | 915 | 982 | 67 |
| Ros Preen (Director of Finance) | 0-2.5 | 0-2.5 | 30-35 | 80-85 | 485 | 511 | 26 |
| Mahadeva Ganesh (Medical Director - shared post) | 5-7.5 | 15-17.5 | 35-40 | 105-110 | 648 | 792 | 144 |
| Steve Gregory (Director of Nursing & Operations) | 2.5-5 | 7.5-10 | 50-55 | 150-155 | 820 | 891 | 71 |
| Julie Thornby (Director of Corporate Affairs) | 0-2.5 | 2.5-5 | 35-40 | 105-110 | 626 | 672 | 46 |
| Mel Duffy (Director of Strategy) | 2.5-5 | 5-7.5 | 25-30 | 65-70 | 320 | 375 | 55 |

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. **Cash Equivalent Transfer Values**

   A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with SI 2008 No.1050 *Occupational Pension Schemes (Transfer Values) Regulations 200823*.

5. **Real Increase in CETV**

   This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

# **Accountability Report:** Remuneration and 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 2016/17 had a headcount of 1,592.

| | Female | | Male | | All | |
|---|---|---|---|---|---|---|
| | FTE | Headcount | FTE | Headcount | FTE | Headcount |
| **Directors** | 5.9 | 6 | 5.0 | 5 | 10.9 | 11 |
| **Senior Managers** | 40.9 | 49 | 18.6 | 19 | 59.5 | 68 |
| ***Band 8A*** | 25.1 | 30 | 13.0 | 14 | 38.1 | 44 |
| ***Band 8B*** | 7.2 | 9 | 3.7 | 3 | 10.8 | 12 |
| ***Band 8C*** | 7.7 | 9 | 2 | 2 | 9.7 | 11 |
| ***Band 8D*** | 0.9 | 1 | 0 | 0 | 0.9 | 1 |
| **Other Staff** | 1097.5 | 1377 | 111.3 | 137 | 1208.8 | 1514 |
| **All Employees** | **1144.3** | **1432** | **134.9** | **161** | **1279.2** | **1593** |

**Staff Numbers** (the analysis of staff numbers below is subject to audit)

| **Staff Numbers (Average Full Time Equivalent)** | | | |
|---|---|---|---|
| | | **Permanently** | |
| | **Total** | **Employed** | **Other** |
| | | | |
| Medical and dental | 40 | 27 | 13 |
| Ambulance staff | 0 | | |
| Administration and estates | 248 | 243 | 5 |
| Healthcare assistants and other support staff | 97 | 83 | 14 |
| Nursing, midwifery and health visiting staff | 665 | 649 | 16 |
| Nursing, midwifery and health visiting learners | 0 | | |
| Scientific, therapeutic and technical staff | 240 | 235 | 5 |
| Social Care Staff | 6 | | 6 |
| Healthcare Science Staff | 0 | | |
| Other | 43 | 42 | 1 |
| **Total staff numbers** | 1,339 | 1,279 | 60 |

# **Accountability Report:** Remuneration and Staff Report

**Staff Costs** (the analysis of staff costs below is subject to audit)

| | Total | Permanently Employed | Other |
|---|---|---|---|
| | £000 | £000 | £000 |
| Salaries and wages | 44,698 | 39,702 | 4,996 |
| Social security costs | 3,439 | 3,439 | |
| Employer contributions to NHS BSA - Pensions Division | 5,207 | 5,207 | |
| Other pension costs | 0 | | |
| Termination benefits | 3 | 3 | |
| **Total staff costs** | 53,347 | 48,351 | 4,996 |

**Staff Sickness Absence**

| | Total |
|---|---|
| | £000 |
| Total days lost | 13,122 |
| Total staff years | 1,260 |
| Average working days lost | 10.4 |

**Note:** The above figures are based on the 2016 calendar year, due to timing difficulties with financial year data. The Department of Health considers the resulting figures to be a reasonable proxy for the financial year.

**Equality and Diversity**

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.
- Values-based recruitment.
- 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.

We retained the Two Ticks award in 2016/17. We work closely with Jobcentre Plus and Enable to ensure there is appropriate support for employees who are disabled, or become disabled. Where possible, we also offer work experience placements to individuals through these organisations.

# **Accountability Report:** Renumeration and 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 2017 | 1 |
| *Of which, the number that have existed:* | |
| for less than one year at the time of reporting | 0 |
| for between one and two years at the time of reporting | 1 |
| for between 2 and 3 years at the time of reporting | 0 |
| for between 3 and 4 years at the time of reporting | 0 |
| for 4 or more years at the time of reporting | 0 |

| | Number |
|---|---|
| Number of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017 | 1 new |
| Number of new engagements which include contractual clauses giving Shropshire Community Health the right to request assurance in relation to income tax and National Insurance obligations | 1 |
| Number for whom assurance has been requested (see comments below) | 0 |
| *Of which:* | |
| assurance has been received | 0 |
| assurance has not been received | 0 |
| engagements terminated as a result of assurance not being received | 0 |

# **Accountability Report:** Renumeration and Staff Report

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

| | |
|---|---|
| Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year | 0 |
| Number of individuals that have been deemed "board members, and/or senior officers with significant financial responsibility" during the financial year. Note: This figure includes both off-payroll and on-payroll engagements. | 12 |

There are no off-payroll arrangements for Board members.

There are currently 11 Board members as set out earlier in this report. The disclosure above showing 12 individuals reflects one change during the year where an officer held post for part of the year.

## Exit Packages

The information relating to Exit Packages in the following tables is subject to audit.

**2016/17**

| 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 were made | Cost of special payment element incl in exit packages |
|---|---|---|---|---|---|---|---|---|
| | Number | £s | Number | £s | Number | £s | Number | £ |
| Less than £10,000 | | | 1 | 2,942 | 1 | 2,942 | | |
| £10,000-£25,000 | | | | | | | | |
| £25,001-£50,000 | | | | | | | | |
| £50,001-£100,000 | | | | | | | | |
| £100,001 - £150,000 | | | | | | | | |
| £150,001 - £200,000 | | | | | | | | |
| >£200,000 | | | | | | | | |
| **Total** | 0 | 0 | 1 | 2,942 | 1 | 2,942 | 0 | 0 |

# **Accountability Report:** Renumeration and Staff Report

### 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 were made | Cost of special payment element incl in exit packages |
|---|---|---|---|---|---|---|---|---|
| | Number | £s | Number | £s | Number | £s | Number | £ |
| Less than £10,000 | | | 3 | 4,201 | 3 | 4,201 | | |
| £10,000-£25,000 | | | | | | | | |
| £25,001-£50,000 | | | | | | | | |
| £50,001-£100,000 | | | | | | | | |
| £100,001 - £150,000 | | | | | | | | |
| £150,001 - £200,000 | | | | | | | | |
| >£200,000 | | | | | | | | |
| **Total** | 0 | 0 | 3 | 4,201 | 3 | 4,201 | 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 these tables 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 tables.

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

### Analysis of other departure

| Analysis of other departures | 2016/17 | | 2015/16 | |
|---|---|---|---|---|
| | Agreements | Total value | Agreements | Total value |
| | Number | £000s | Number | £000s |
| Voluntary redundancies including early retirement contractual costs | | | | |
| Mutually agreed resignations (MARS) contractual costs | | | | |
| Early retirements in the efficiency of the service contractual costs | | | 1 | 2 |
| Contractual payments in lieu of notice | 1 | 3 | 2 | 2 |
| Exit payments following Employment Tribunals or court orders | | | | |
| Non-contractual payments requiring HMT approval | | | | |
| Total | 1 | 3 | 3 | 4 |

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.

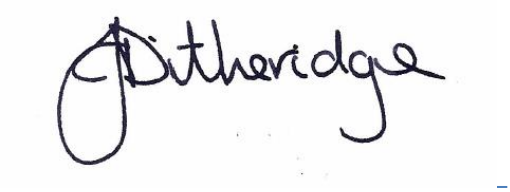
The Remuneration Report includes disclosure of exit payments payable to individuals named in that Report.

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

# **Accountability Report:** Renumeration and Staff Report

## Expenditure on Consultancy

Expenditure on consultancy totalled £270,000 for 2016/17. Of this, £153,000 related to a productivity project for adult services, for which the business case was approved by NHS Improvement.



Jan Ditheridge
Chief Executive

31 May 2017

Shropshire Community Health NHS
NHS Trust

# Annual Accounts

# 2016/17

## 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 31-5-17

## 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**

31-5-17 Date.....Chief Executive

31-5-17 Date.....Finance Director

Shropshire Community Health NHS
NHS Trust

# Annual Governance Statement 2016/17

## 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 the organisation's 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. The Trust received the final report in September from the Care Quality Commission (CQC) inspection which took place in March 2016. The overall rating for the Trust was 'requires improvement'. The rating for the CQC caring domain was 'good'. An action plan is in place to achieve improvements in the areas where CQC had concerns, and progress is regularly monitored by the Board and Quality and Safety Committee.

As Accountable Officer I work with partner organisations, including commissioners, (especially the Clinical Commissioning Groups), NHS England, NHS Improvement, 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 nonexecutive directors and five voting executive directors. There is also one non-voting director (Director of Corporate Affairs/Board Secretary). One non-executive director left the Trust in March 2017

Board Attendance

The Board has held 6 formal board meetings which have been held in public during 2016/17 and has met a further 6 times in private.
The chair attended all meetings. Attendance for formal meetings was as follows:

| | |
|---|---|
| May: | Full attendance for executive Directors, 3 of 5 non-executive directors attended |
| July: | 5 of 6 executive Directors attended, 4 of 5 non-executive directors attended |
| September: | Full attendance |
| November: | Full attendance for executive Directors, 3 of 5 non-executive directors attended |
| January | Full attendance for non-executive directors, 5 of 6 executive directors attended. |
| March | Full attendance |

Non-attendance has been for exceptional reasons including ill health, bereavement and attendance at long pre-arranged courses. Supportive measures have been put into place for one Board member who has found it difficult to attend meetings. They have since left the Trust.

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 to strengthen its enabling strategies and plans to support delivery of its overall objectives, for example in the areas of estates and IMT.

The Board continually self-assesses its performance, evaluating its meetings and those of its committees at the conclusion of business. Board development sessions have been held, and the Board has held specific discussions aimed at considering its own effectiveness and its impact on the organisation. These have included, for example, discussing feedback from the Trust's CQC inspection specifically relevant to the Board and its members and formulating related actions; self-assessing against the CQC/NHSI well-led framework, and considering feedback from the Trust's Culture Working Group when it was asked to look at the possibility of governance and well-led problems which had occurred in the NHS elsewhere happening at the Trust. Actions have been formed and progress monitored on them by the Board.

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. We use the thermometer as a measure of service quality, helping us to identify where improvements have been made or are necessary.

The trust was inspected by the Care Quality Commission in March 2016. The Trust had an overall rating of 'Requires Improvement'. For the caring domain the Trust was rated as 'Good'. Community Dental Services and Community Health Services for Children, Young People and Families were rated as 'Good'. The Trust has developed an action plan for the areas requiring improvement. The plan is well underway in being delivered. Delivery of the plan is monitored within individual services and overall by the Quality and Safety Committee, a Committee of the Board.

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 2017, 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.

## 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 2016/17. 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 (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<br>Long term financial modelling<br>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)<br>Greater involvement of clinicians in initiatives.<br>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<br>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<br>Monitoring of quality indicators, carrying out clinical audits, investigating and learning from untoward events, complaints and claims. |

Trust Sustainability*

The Trust agreed at its November Board meeting that the Trust is not sustainable (clinically and financially) in its current organisational form. This has been agreed by NHS Improvement, which has established a Sustainability Board of which the Trust is a member.

As a result of this decision, the risk for trust sustainability was removed from the Board Assurance Framework in January 2017 and replaced with a new risk for transitioning to a new organisational form. Mitigation for the risk is through working with healthcare providers, commissioners and regulators on the preferred option for the future.

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<br>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<br>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<br>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.

In last year's statement I reported that an internal audit of waiting time quality had shown that improvements were needed. An action plan was developed which has now been delivered. Some issues still exist with processes that have been developed and are in place with Telford Muscoskeletal Service. These issues relate to cross organisation pathways and are currently being managed by staff carrying out additional validation checks.

The Trust is implementing an Electronic Patient Record (RiO), with an initial go live in March 2017 with subsequent implementation phases over a six month period. RiO provides a contemporaneous electronic clinical record; it also provides waiting list and RTT monitoring, the experience from other organisations is that this functionality. The experience from other organisations is that the functionality of combining the clinical and administrative data for patients into a single electronic record improves data quality. It will also allow for considerably more efficient audit and validation processes to be undertaken.

## Fraud and Security Management

The Trust has in place arrangements to address fraud, bribery and corruption, and security management issues. This includes the provision of Local Counter Fraud and Security Management Specialists. Annual work plans are formulated with progress towards delivering on the plan monitored by the Trust Director of Finance and reported to the Audit Committee. Service Condition 24 of the NHS Standard Contract, and the NHS Protect Standards for Providers, are used as benchmarks for performance. Yearly assessments of performance 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 2016, to the year end on the 31st March 2017 and up to the date of approval of the annual report and accounts.

The Risk Management Policy details the structure for the Trust's 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 programme of training related to the risks they encounter with the work they carry out. Managers, supervisors and team leaders attend risk 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 Trust's 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 2016/17

- 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 on Patients' Monies and Property.

- 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 details 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 2016/17.

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 and now endorsed by NHS Improvement. 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 2016 to March 2017 the Trust reported 31 serious incidents. 17 of these related to Grade 3 or 4 pressure ulcers. The Trust report 9 patient falls in hospitals which resulted in serious injury, e.g. fractures

The other 5 incidents consisted of:

- A prisoner who misused substances
- A patient who received two x rays, one of which was in error
- A significant number of waiting time breaches
- Management of diabetes patient
- A child suicide

Following RCA investigations all these incidents will or have been reviewed by an Incident Review Group, 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 2016/17.

**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 2016/17 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 three areas where further work is necessary:

*Patients Monies and Property.*

Two community hospitals were reviewed and areas were identified where controls could be further strengthened. These were the completion of documentation, alignment of procedures and improvement of secure access arrangements. Actions were identified and have been implemented. These have included the installation of a ward safe box, changes to key holder arrangements and ensuring that staff are aware of, and complete, the correct documentation

*Safeguarding Arrangements – Adults and Children*

Areas were identified for improvement for training prior to employment, keeping training up to date and improvements needed to policies. Actions have been identified and are in the process of being implemented. Areas completed include the monitoring and actions taken where staff are not up to date with training, recording of incidents on patient records and updating contact details on the website. Areas still to be completed include flagging of concerns on patient records, improving documentation for concerns and referral and changes to policy.

*Discharge Management*

The Trust does not currently have an overall policy related to discharge. A Transfer of Care Policy is in development which will address these areas.

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 ..... J Ditheridge

**Date** ..... 31-5-17 .....

**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 2017 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, as interpreted and adapted by the Department of Health Group Accounting Manual 2016/17 (the "2016/17 GAM") and the requirements of the National Health Service Act 2006.

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 Trust's Directors 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 Trust's Directors, 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, the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the "Code of Audit Practice") 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 by exception where we are not satisfied.

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

**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 2016, 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 2017, 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.

**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 2017 and of its expenditure and income for the year then ended; and
- the financial statements have been prepared properly in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health Group Accounting Manual 2016/17 and the requirements of the National Health Service Act 2006.

**Opinion on other matters**

In our opinion:

- the parts of the Accountability Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health Group Accounting Manual 2016/17 and the requirements of the National Health Service Act 2006; and
- the other information published together with the audited financial statements in the Foreword, Performance Report and the Accountability Report for the financial year for which the financial statements are prepared 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 Annual Governance Statement does not comply with the guidance issued by NHS Improvement; or
- we have referred a matter to the Secretary of State under section 30 of the Act because we had reason to believe that the Trust, or an officer of the Trust, was about to make, or had made, a decision which involved or would involve the body incurring unlawful expenditure, or was about to take, or had 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 have reported a matter in the public interest under section 24 of the Act in the course of, or at the conclusion of the audit; or

- we have made a written recommendation to the Trust under section 24 of the Act in the course of, or at the conclusion of the audit; or
- we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

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

**Certificate**

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

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

The Colmore Building
20 Colmore Circus
Birmingham
West Midlands
B4 6AT

31 May 2017

## Statement of Comprehensive Income for year ended 31 March 2017

| | NOTE | 2016-17 £000s | 2015-16 £000s |
|---|---|---|---|
| Gross employee benefits | 10.1 | **(53,347)** | (55,856) |
| Other operating costs | 8 | **(22,956)** | (21,162) |
| Revenue from patient care activities | 5 | **74,996** | 75,796 |
| Other operating revenue | 6 | **4,381** | 3,144 |
| **Operating surplus/(deficit)** | | **3,074** | 1,922 |
| Investment revenue | 12 | **19** | 23 |
| Other gains and (losses) | 13 | **(32)** | (8) |
| Finance costs | 14 | **0** | 0 |
| **Surplus/(deficit) for the financial year** | | **3,061** | 1,937 |
| Public dividend capital dividends payable | | **(527)** | (530) |
| 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** | | **2,534** | 1,407 |

## Other comprehensive income

| | | 2016-17 £000s | 2015-16 £000s |
|---|---|---|---|
| Impairments and reversals taken to the revaluation reserve | | **0** | 0 |
| Net gain/(loss) on revaluation of property, plant & equipment | 16 | **1,083** | 1,937 |
| 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** | | **1,083** | 1,937 |
| **Total comprehensive income for the year** | | **3,617** | 3,344 |

## Financial performance for the year

| | 2016-17 £000s | 2015-16 £000s |
|---|---|---|
| Retained surplus/(deficit) for the year | **2,534** | 1,407 |
| 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 | **62** | (52) |
| Adjustment re absorption accounting | **0** | 0 |
| **Adjusted retained surplus/(deficit)** | **2,596** | 1,355 |

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 7 to 37 form part of this account.

## Statement of Financial Position as at 31 March 2017

| | NOTE | 31 March 2017 £000s | 31 March 2016 £000s |
|---|---|---|---|
| **Non-current assets:** | | | |
| Property, plant and equipment | 16 | **23,627** | 21,769 |
| Intangible assets | 17 | **0** | 0 |
| Investment property | 19 | **0** | 0 |
| Other financial assets | | **0** | 0 |
| Trade and other receivables | 22.1 | **111** | 68 |
| **Total non-current assets** | | **23,738** | 21,837 |
| **Current assets:** | | | |
| Inventories | 21 | **272** | 448 |
| Trade and other receivables | 22.1 | **3,167** | 3,798 |
| Other financial assets | 24 | **0** | 0 |
| Other current assets | 25 | **0** | 0 |
| Cash and cash equivalents | 26 | **7,531** | 5,747 |
| **Sub-total current assets** | | **10,970** | 9,993 |
| Non-current assets held for sale | 27 | **0** | 0 |
| **Total current assets** | | **10,970** | 9,993 |
| **Total assets** | | **34,708** | 31,830 |
| | | | |
| **Current liabilities** | | | |
| Trade and other payables | 28 | **(6,130)** | (7,010) |
| Other liabilities | 29 | **0** | 0 |
| Provisions | 35 | **(287)** | (146) |
| Borrowings | 30 | **0** | 0 |
| Other financial liabilities | 31 | **0** | 0 |
| DH revenue support loan | 30 | **0** | 0 |
| DH capital loan | 30 | **0** | 0 |
| **Total current liabilities** | | **(6,417)** | (7,156) |
| **Net current assets/(liabilities)** | | **4,553** | 2,837 |
| **Total assets less current liablilities** | | **28,291** | 24,674 |
| | | | |
| **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:** | | **28,291** | 24,674 |
| | | | |
| **FINANCED BY:** | | | |
| Public Dividend Capital | | **589** | 589 |
| Retained earnings | | **21,089** | 18,546 |
| Revaluation reserve | | **6,613** | 5,539 |
| Other reserves | | **0** | 0 |
| **Total Taxpayers' Equity:** | | **28,291** | 24,674 |

The notes on pages 7 to 37 form part of this account.

The financial statements on pages 2 to 37 were approved by the Audit Committee on behalf of the Board on 31st May 2017 and signed on its behalf by:

**Chief Executive:** Date: 31-5-17

## Statement of Changes in Taxpayers' Equity
## For the year ending 31 March 2017

| | Public Dividend capital | Retained earnings | Revaluation reserve | Other reserves | Total reserves |
|---|---|---|---|---|---|
| | £000s | £000s | £000s | £000s | £000s |
| **Balance at 1 April 2016** | **589** | **18,546** | **5,539** | **0** | **24,674** |
| **Changes in taxpayers' equity for 2016-17** | | | | | |
| Retained surplus/(deficit) for the year | | **2,534** | | | **2,534** |
| Net gain / (loss) on revaluation of property, plant, equipment | | | **1,083** | | **1,083** |
| 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 | | **9** | **(9)** | **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 Trusts established in year | **0** | | | | **0** |
| Temporary and permanent PDC received - cash | **0** | | | | **0** |
| Temporary and permanent PDC repaid in year | **0** | | | | **0** |
| 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** | **0** |
| Other pensions remeasurement | | **0** | | **0** | **0** |
| **Net recognised revenue/(expense) for the year** | **0** | **2,543** | **1,074** | **0** | **3,617** |
| **Balance at 31 March 2017** | **589** | **21,089** | **6,613** | **0** | **28,291** |
| | | | | | |
| **Balance at 1 April 2015** | 1,489 | 17,131 | 3,610 | 0 | 22,230 |
| **Changes in taxpayers' equity for the year ended 31 March 2016** | | | | | |
| 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 assets held for sale | | | 0 | | 0 |
| Impairments and reversals | | | 0 | | 0 |
| Other gains / (loss) | | | | 0 | 0 |
| Transfers between reserves | | 8 | (8) | 0 | 0 |
| **Reclassification Adjustments** | | | | | |
| 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 Trusts established in year | 0 | | | | 0 |
| New PDC received - cash | 0 | | | | 0 |
| PDC repaid in year | (900) | | | | (900) |
| 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** | (900) | 1,415 | 1,929 | 0 | 2,444 |
| **Balance at 31 March 2016** | 589 | 18,546 | 5,539 | 0 | 24,674 |

## Information on reserves

1 **Public dividend capital**
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities. Additional PDC may also be issued to NHS Trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as the public dividend capital dividend.

2 **Income and expenditure reserve**
The balance of this reserve is the accumulated surpluses and deficits of the Trust.

3 **Revaluation Reserve**
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

## Statement of Cash Flows for the Year ended 31 March 2017

| | NOTE | 2016-17 £000s | 2015-16 £000s |
|---|---|---|---|
| **Cash Flows from Operating Activities** | | | |
| Operating surplus/(deficit) | | **3,074** | 1,922 |
| Depreciation and amortisation | 8 | **1,237** | 1,104 |
| Impairments and reversals | 18 | **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 |
| Release of PFI/deferred credit | | **0** | 0 |
| (Increase)/decrease in Inventories | | **176** | 23 |
| (Increase)/decrease in Trade and Other Receivables | | **588** | (891) |
| (Increase)/decrease in Other Current Assets | | **0** | 0 |
| Increase/(decrease) in Trade and Other Payables | | **(1,459)** | 268 |
| (Increase)/decrease in Other Current Liabilities | | **0** | 0 |
| Provisions utilised | | **(6)** | (8) |
| Increase/(decrease) in movement in non cash provisions | | **147** | 136 |
| **Net Cash Inflow/(Outflow) from Operating Activities** | | **3,757** | 2,554 |
| **Cash Flows from Investing Activities** | | | |
| Interest received | | **19** | 23 |
| (Payments) for Property, Plant and Equipment | | **(1,437)** | (1,227) |
| (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) | | **1** | 3 |
| 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** | | **(1,417)** | (1,201) |
| **Net Cash Inflow/(Outflow) before Financing** | | **2,340** | 1,353 |
| **Cash Flows from Financing Activities** | | | |
| Gross Temporary and Permanent PDC received | | **0** | 0 |
| Gross Temporary and Permanent PDC repaid | | **0** | (900) |
| 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 re finance leases & On-SoFP PFI & LIFT | | **0** | 0 |
| Interest paid | | **0** | 0 |
| PDC Dividend (paid)/refunded | | **(556)** | (511) |
| Capital grants and other capital receipts (excluding donated/government granted cash receipts) | | **0** | 0 |
| **Net Cash Inflow/(Outflow) from Financing Activities** | | **(556)** | (1,411) |
| **NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS** | | **1,784** | (58) |
| **Cash & Cash Equivalents (& Bank Overdraft) at beginning of period** | | **5,747** | 5,805 |
| Effect of exchange rate changes in balance of cash held in foreign currencies | | **0** | 0 |
| **Cash & Cash Equivalents (& Bank Overdraft) at year end** | **26** | **7,531** | 5,747 |

# 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 Accounting Manual, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Accounting Manual 2016-17 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.

### Going Concern

These accounts have been prepared on a going concern basis.
Management have considered historical, current and future financial performance, as well as risks that could affect the going concern assessment. Continuation of the provision of the Trust's services is anticipated, so the fact that the Trust may cease to exist as a standalone organisation in the future, does not affect our going concern status.

## 1.2 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.

## 1.3 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)**

**1.3.1 Critical judgements in applying accounting policies**

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

1. Determining whether substantially all the significant risks and rewards of ownership of leased assets have transferred to determine whether a lease is a finance lease or an operating lease.

2. Determining whether charitable funds are a subsidiary of the Trust, and whether they are material, to determine whether or not to consolidate. See Note 1.2 : charitable funds.

3. Determining that the Electronic Patient Record (EPR) software is integral to the operation of the purchased hardware so is classed as a tangible asset.

**1.3.2 Key sources of estimation uncertainty**

1. Land and buildings (£20.2m) 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 7% (£1.4m) to be considered material.

**1.4 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 is 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.

**1.5 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 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.

# NOTES TO THE ACCOUNTS

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

### Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. The schemes 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, the schemes are accounted for as though they were defined contribution schemes: the cost to the NHS body of participating in a 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.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

### 1.6 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.

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

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

#### Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

# NOTES TO THE ACCOUNTS

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

Revaluations of property, plant and equipment 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 in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use.
- Specialised buildings – depreciated replacement cost, modern equivalent asset basis.

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. Alternative sites have not been valued for this Trust.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use. Where a piece of equipment has a life of more than 10 years and a net book value in excess of £30,000 it is indexed using the inflation figure quoted in the NHS planning guidance for the year.

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.

### 1.8 Intangible assets

**Recognition**

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

# NOTES TO THE ACCOUNTS

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

Intangible assets acquired separately are initially recognised at cost. Software that is integral to the operation 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; and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

**Measurement**

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

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost (modern equivalent assets basis) and value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

**1.9 Depreciation, amortisation and impairments**

Freehold land, assets under construction or development, and assets held for sale are not depreciated/amortised.

Otherwise, depreciation or amortisation is charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, on a straight line basis over their estimated useful lives. 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 the shorter of the lease term and the estimated useful lives.

At each financial year-end, the Trust checks whether there is any indication that its property, plant and equipment or intangible non-current assets have suffered an impairment loss. If there is indication of such an impairment, 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 at the financial year end.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. 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.

# NOTES TO THE ACCOUNTS

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

### 1.10 Donated assets

Donated non-current assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at 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 treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

### 1.11 Government grants

Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at 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.

### 1.12 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.

### 1.13 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 of interest on the remaining balance of the liability. Finance charges are recognised in calculating the Trust's surplus/deficit.

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

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

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

# NOTES TO THE ACCOUNTS

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

**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.

**1.14 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.

**1.15 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.

**1.16 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 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.

# NOTES TO THE ACCOUNTS

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

### 1.17 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.

### 1.18 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

### 1.19 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.

### 1.20 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.

Financial assets are initially recognised at fair value. Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

# NOTES TO THE ACCOUNTS

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

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 that occurred after the initial recognition of the asset and that have an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced directly/through a provision for impairment of receivables.

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

**1.21 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 historic 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.

**1.22 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.

**1.23 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.

# NOTES TO THE ACCOUNTS

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

**1.24 Public Dividend Capital (PDC) and PDC dividend**

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

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets 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.

**1.25 Losses and Special Payments**

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

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

**1.26 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 1.2 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'.

**1.27 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)**

**1.28 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 2016-17. 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 from Contracts with Customers - 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 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.

**1.29 Gifts**

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

## 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 2016-17 (and 2015-16) there were no income generation activities whose full cost exceeded £1m or was otherwise material.

## 5. Revenue from patient care activities

| | **2016-17 £000s** | 2015-16 £000s |
|---|---|---|
| NHS Trusts | **675** | 775 |
| NHS England | **4,498** | 6,926 |
| Clinical Commissioning Groups | **58,497** | 58,374 |
| Foundation Trusts | **575** | 40 |
| Department of Health | **0** | 0 |
| NHS Other (including Public Health England and Prop Co) | **0** | 0 |
| Additional income for delivery of healthcare services | **0** | 900 |
| Non-NHS: | | |
| Local Authorities | **9,870** | 7,623 |
| Private patients | **0** | 0 |
| Overseas patients (non-reciprocal) | **0** | 0 |
| Injury costs recovery | **79** | 58 |
| Other Non-NHS patient care income | **802** | 1,100 |
| **Total revenue from patient care activities** | **74,996** | 75,796 |

## 6. Other operating revenue

| | **2016-17 £000s** | 2015-16 £000s |
|---|---|---|
| Recoveries in respect of employee benefits | **99** | 315 |
| Patient transport services | **0** | 0 |
| Education, training and research | **864** | 1,083 |
| Charitable and other contributions to revenue expenditure - NHS | **0** | 0 |
| Charitable and other contributions to revenue expenditure -non- NHS | **0** | 0 |
| Receipt of charitable donations for capital acquisitions | **45** | 160 |
| Support from DH for mergers | **0** | **0** |
| Receipt of Government grants for capital acquisitions | **0** | 0 |
| Non-patient care services to other bodies | **83** | 135 |
| Sustainability & Transformation Fund (STF) income *(see note below)* | **1,934** | 0 |
| Income generation (Other fees and charges) | **627** | 644 |
| Rental revenue from finance leases | **0** | 0 |
| Rental revenue from operating leases | **207** | 328 |
| Other revenue | **522** | 479 |
| **Total other operating revenue** | **4,381** | 3,144 |

The STF is a mechanism to allocate the £1.8bn centrally held support to NHS provider organisations, based on the achievement of a number of performance targets, both financial and activity based.

## 7. Overseas visitors disclosure

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

## 8. Operating expenses

| | 2016-17 £000s | 2015-16 £000s |
|---|---|---|
| Services from other NHS Trusts | **2,484** | 1,954 |
| Services from CCGs/NHS England | **0** | 2 |
| Services from other NHS bodies | **0** | 16 |
| Services from NHS Foundation Trusts | **394** | 249 |
| **Total Services from NHS bodies*** | **2,878** | 2,221 |
| Purchase of healthcare from non-NHS bodies | **0** | 0 |
| Purchase of social care | **0** | **0** |
| Trust chair and non-executive directors | **54** | 54 |
| Supplies and services - clinical | **6,964** | 7,213 |
| Supplies and services - general | **601** | 658 |
| Consultancy services | **270** | 25 |
| Establishment | **2,576** | 2,656 |
| 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 | **188** | 298 |
| Premises | **6,671** | 5,442 |
| Hospitality | **7** | 14 |
| Insurance | **129** | 205 |
| Legal fees | **183** | 146 |
| Impairments and reversals of receivables | **11** | (59) |
| Inventories write down | **0** | 0 |
| Depreciation | **1,237** | 1,104 |
| 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 | **56** | 55 |
| Audit fees | **41** | 40 |
| Other auditor's remuneration [detail] | **0** | 0 |
| Clinical negligence | **128** | 110 |
| Research and development (excluding staff costs) | **0** | 0 |
| Education and training | **298** | 299 |
| Change in discount rate | **0** | 0 |
| Capital grants in kind | **0** | 0 |
| Other | **664** | 681 |
| **Total operating expenses (excluding employee benefits)** | **22,956** | 21,162 |
| | | |
| **Employee benefits** | | |
| Employee benefits excluding Board members | **52,595** | 55,099 |
| Board members | **752** | 757 |
| **Total employee benefits** | **53,347** | 55,856 |
| | | |
| **Total operating expenses** | **76,303** | 77,018 |

*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.

In previous years, NHS Property Services charged one lease figure for each property to cover rent, service charge and facilities management. For 2016-17 they are separate charges, so only the rent figure is shown in this note. Therefore significant reductions in lease payments and future year's payments are shown. Prior year figures have not been adjusted as to do so would be impractical.

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

| | 2016-17 | | | | |
|---|---|---|---|---|---|
| | **Land** | **Buildings** | **Other** | **Total** | 2015-16 |
| | **£000s** | **£000s** | **£000s** | **£000s** | £000s |
| **Payments recognised as an expense** | | | | | |
| Minimum lease payments | | | | **2,319** | 3,341 |
| Contingent rents | | | | **0** | 0 |
| Sub-lease payments | | | | **0** | 0 |
| **Total** | | | | **2,319** | 3,341 |
| **Payable**: | | | | | |
| No later than one year | 0 | 1,883 | 267 | **2,150** | 3,576 |
| Between one and five years | 0 | 1,753 | 129 | **1,882** | 4,120 |
| After five years | 0 | 4,830 | 2 | **4,832** | 12,620 |
| **Total** | **0** | **8,466** | **398** | **8,864** | 20,316 |
| Total future sublease payments expected to be received: | | | | 0 | 0 |

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. Future payments for all other NHSPS leases are 1 year.

### 9.2. Trust as lessor

The leases are property leases.

| | **2016-17** | 2015-16 |
|---|---|---|
| | **£000s** | £000s |
| **Recognised as revenue** | | |
| Rental revenue | **207** | 328 |
| Contingent rents | **0** | 0 |
| **Total** | **207** | 328 |
| **Receivable**: | | |
| No later than one year | **225** | 206 |
| Between one and five years | **247** | 180 |
| After five years | **3,735** | 3,780 |
| **Total** | **4,207** | 4,166 |

# 10. Employee benefits

## 10.1 Employee benefits

| | 2016-17 £000s | 2015-16 £000s |
|---|---|---|
| **Employee benefits - gross expenditure** | | |
| Salaries and wages | **44,698** | 48,009 |
| Social security costs | **3,439** | 2,592 |
| Employer contributions to NHS BSA - Pensions Division | **5,207** | 5,251 |
| Other pension costs | **0** | 0 |
| Termination benefits | **3** | 4 |
| **Total employee benefits** | **53,347** | 55,856 |
| **Employee costs capitalised** | **0** | 0 |
| **Gross employee benefits excluding capitalised costs** | **53,347** | 55,856 |

## 10.2 Retirements due to ill-health

| | 2016-17 Number | 2015-16 Number |
|---|---|---|
| Number of persons retired early on ill health grounds | **0** | 5 |
| | **£000s** | £000s |
| Total additional pensions liabilities accrued in the year | **0** | 287 |

## 10.3 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 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 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.

## 10.3 Pension costs (continued)

**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.

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

# 11. Better Payment Practice Code

## 11.1 Measure of compliance

| | **2016-17 Number** | **2016-17 £000s** | 2015-16 Number | 2015-16 £000s |
|---|---|---|---|---|
| **Non-NHS Payables** | | | | |
| Total Non-NHS trade invoices paid in the year | **20,348** | **17,369** | 22,300 | 18,758 |
| Total Non-NHS trade invoices paid within target | **20,112** | **17,149** | 21,979 | 18,372 |
| Percentage of Non NHS trade invoices paid within target | **98.8%** | **98.7%** | 98.6% | 97.9% |
| **NHS Payables** | | | | |
| Total NHS trade invoices paid in the year | **1,591** | **15,506** | 1,487 | 14,573 |
| Total NHS trade invoices paid within target | **1,542** | **14,712** | 1,439 | 13,999 |
| Percentage of NHS trade invoices paid within target | **96.9%** | **94.9%** | 96.8% | 96.1% |

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

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

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

## 12. Investment revenue

| | 2016-17 £000s | 2015-16 £000s |
|---|---|---|
| **Rental revenue** | | |
| PFI finance lease revenue (planned) | **0** | 0 |
| PFI finance lease revenue (contingent) | **0** | 0 |
| Other finance lease revenue | **0** | 0 |
| **Subtotal** | **0** | 0 |
| **Interest revenue** | | |
| LIFT: equity dividends receivable | **0** | 0 |
| LIFT: loan interest receivable | **0** | 0 |
| Bank interest | **19** | 23 |
| Other loans and receivables | **0** | 0 |
| Impaired financial assets | **0** | 0 |
| Other financial assets | **0** | 0 |
| **Subtotal** | **19** | 23 |
| **Total investment revenue** | **19** | 23 |

## 13. Other gains and losses

| | 2016-17 £000s | 2015-16 £000s |
|---|---|---|
| Gain/(Loss) on disposal of assets other than by sale (PPE) | **(33)** | (11) |
| 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 | **1** | 3 |
| 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** | **(32)** | (8) |

## 14. Finance costs

There were no finance costs.

## 15. Audit costs - other auditor remuneration

There was no other auditor remuneration.

## 16.1. Property, plant and equipment

| 2016-17 | 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 2016** | **4,061** | **15,769** | **0** | **0** | **3,191** | **34** | **2,539** | **131** | **25,725** |
| Additions of Assets Under Construction | | | | 82 | | | | | **82** |
| Additions Purchased | 0 | 120 | 0 | | 126 | 0 | 1,672 | 0 | **1,918** |
| Additions - Non Cash Donations (i.e. physical assets) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Additions - Purchases from Cash Donations & Government Grants | 0 | 0 | 0 | 0 | 39 | 0 | 6 | 0 | **45** |
| Additions Leased (including PFI/LIFT) | 0 | 0 | 0 | | 0 | 0 | 0 | 0 | **0** |
| Reclassifications | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Reclassifications as Held for Sale and reversals | 0 | 0 | 0 | 0 | (12) | 0 | 0 | 0 | **(12)** |
| Disposals other than for sale | 0 | 0 | 0 | 0 | (364) | 0 | (308) | (49) | **(721)** |
| Upward revaluation/positive indexation | 0 | 502 | 0 | 0 | 3 | 0 | 0 | 0 | **505** |
| Impairments/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 - Absorption Accounting | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| **At 31 March 2017** | **4,061** | **16,391** | **0** | **82** | **2,983** | **34** | **3,909** | **82** | **27,542** |
| | | | | | | | | | |
| **Depreciation** | | | | | | | | | |
| **At 1 April 2016** | 0 | 237 | 0 | | 2,000 | 34 | 1,575 | 110 | **3,956** |
| Reclassifications | 0 | 0 | 0 | | 0 | 0 | 0 | 0 | **0** |
| Reclassifications as Held for Sale and reversals | 0 | 0 | 0 | | (12) | 0 | 0 | 0 | **(12)** |
| Disposals other than for sale | 0 | 0 | 0 | | (334) | 0 | (305) | (49) | **(688)** |
| Upward revaluation/positive indexation | 0 | (578) | 0 | | 0 | 0 | 0 | 0 | **(578)** |
| 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 | 626 | 0 | | 304 | 0 | 300 | 7 | **1,237** |
| Transfers to NHS Foundation Trust on authorisation as FT | 0 | 0 | 0 | | 0 | 0 | 0 | 0 | **0** |
| Transfers (to)/from Other Public Sector Bodies - Absorption Accounting | 0 | 0 | 0 | | 0 | 0 | 0 | 0 | **0** |
| **At 31 March 2017** | **0** | **285** | **0** | **0** | **1,958** | **34** | **1,570** | **68** | **3,915** |
| **Net Book Value at 31 March 2017** | **4,061** | **16,106** | **0** | **82** | **1,025** | **0** | **2,339** | **14** | **23,627** |
| | | | | | | | | | |
| **Asset financing:** | | | | | | | | | |
| Owned - Purchased | 4,061 | 15,711 | 0 | 82 | 616 | 0 | 2,333 | 14 | **22,817** |
| Owned - Donated | 0 | 395 | 0 | 0 | 409 | 0 | 6 | 0 | **810** |
| 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 2017** | **4,061** | **16,106** | **0** | **82** | **1,025** | **0** | **2,339** | **14** | **23,627** |

**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 2016** | 1,239 | 4,208 | 0 | 0 | 91 | 1 | 0 | 0 | **5,539** |
| Movements | 0 | 1,073 | 0 | 0 | 1 | 0 | 0 | 0 | **1,074** |
| **At 31 March 2017** | **1,239** | **5,281** | **0** | **0** | **92** | **1** | **0** | **0** | **6,613** |

**Additions to Assets Under Construction in 2016-17**

| | £000's |
|---|---|
| Land | 0 |
| Buildings excl Dwellings | 82 |
| Dwellings | 0 |
| Plant & Machinery | 0 |
| **Balance as at YTD** | **82** |

## 16.2. Property, plant and equipment prior-year

| 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 reserves | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Impairments/reversals charged to operating expenses | 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 - 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 - 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** |

## 16.3 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 2016/17, desk-top revaluations of the same assets were undertaken by the VOA with an effective date of 31st March 2017. BCIS indices, provided to the Trust by the Valuation Office Agency were used to reflect changes in value of other assets not previously valued (£423k), and where there has been capital expenditure since the 2014 full valuation date (£777k).

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.

Land and buildings revaluation and indexation resulted in overall increases in value of £1,033k and £47k respectively.

Asset lives for each class of asset fall into the following ranges:
- Buildings excluding dwellings : 15 to 50 years
- Plant & machinery : 5 to 15 years
- Transport equipment : 5 to 8 years
- Information technology : 2 to 8 years
- Furniture & fittings : 5 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 £2.0m.

The carrying amount of surplus assets was £5k.

## 17. Intangible non-current assets

There were no intangible non-current assets.

## 18. Analysis of impairments and reversals recognised in 2016-17

There were no impairments or reversals recognised in 2016-17.

## 19. Investment property

There was no investment property.

## 20. Commitments

### 20.1 Capital commitments

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

| | **31 March 2017 £000s** | 31 March 2016 £000s |
|---|---|---|
| Property, plant and equipment | **423** | 0 |
| Intangible assets | **0** | 0 |
| **Total** | **423** | 0 |

### 20.2 Other financial commitments

There were no other financial commitments.

## 21. Inventories

| | Drugs | Consumables | Work in Progress | Energy | Loan Equipment | Other | Total |
|---|---|---|---|---|---|---|---|
| | £000s | £000s | £000s | £000s | £000s | £000s | £000s |
| **Balance at 1 April 2016** | **0** | **151** | **0** | **0** | **297** | **0** | **448** |
| Additions | 0 | 1,190 | 0 | 0 | 1,995 | 0 | **3,185** |
| Inventories recognised as an expense in the period | 0 | (1,236) | 0 | 0 | (2,125) | 0 | **(3,361)** |
| 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 2017** | **0** | **105** | **0** | **0** | **167** | **0** | **272** |

## 22.1 Trade and other receivables

| | Current | | Non-current | |
|---|---|---|---|---|
| | **31 March 2017** | 31 March 2016 | **31 March 2017** | 31 March 2016 |
| | **£000s** | £000s | **£000s** | £000s |
| NHS receivables - revenue | **800** | 1,484 | **0** | 0 |
| NHS receivables - capital | **0** | 0 | **0** | 0 |
| NHS prepayments and accrued income | **1,678** | 630 | **0** | 0 |
| Non-NHS receivables - revenue | **307** | 1,241 | **75** | 63 |
| Non-NHS receivables - capital | **0** | 0 | **0** | 0 |
| Non-NHS prepayments and accrued income | **279** | 349 | **53** | 19 |
| PDC Dividend prepaid to DH | **0** | 0 | **0** | 0 |
| Provision for the impairment of receivables | **(15)** | (10) | **(17)** | (14) |
| VAT | **103** | 100 | **0** | 0 |
| Current/non-current part of PFI and other PPP arrangements prepayments and accrued income excluding PFI lifecycle | **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 | **14** | 3 | **0** | 0 |
| **Total** | **3,167** | 3,798 | **111** | 68 |
| **Total current and non current** | **3,278** | 3,866 | | |
| 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 2017** | 31 March 2016 |
|---|---|---|
| | **£000s** | £000s |
| By up to three months | **702** | 1,926 |
| By three to six months | **94** | 68 |
| By more than six months | **10** | 12 |
| **Total** | **806** | 2,006 |

## 22.3 Provision for impairment of receivables

| | 2016-17 £000s | 2015-16 £000s |
|---|---|---|
| **Balance at 1 April** | **(24)** | (107) |
| Amount written off during the year | **3** | 24 |
| Amount recovered during the year | **0** | 67 |
| (Increase)/decrease in receivables impaired | **(11)** | (8) |
| Transfers to NHS Foundation Trust on authorisation as FT | **0** | 0 |
| Transfers (to)/from Other Public Sector Bodies under Absorption Accounting | **0** | 0 |
| **Balance at 31 March** | **(32)** | (24) |

The majority of 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 2017 £000s | 31 March 2016 £000s |
|---|---|---|
| **Opening balance** | **5,747** | 5,805 |
| Net change in year | **1,784** | (58) |
| **Closing balance** | **7,531** | 5,747 |
| **Made up of** | | |
| Cash with Government Banking Service | **7,513** | 5,731 |
| Commercial banks | **0** | 0 |
| Cash in hand | **18** | 16 |
| Liquid deposits with NLF | **0** | 0 |
| Current investments | **0** | 0 |
| **Cash and cash equivalents as in Statement of Financial Position** | **7,531** | 5,747 |
| Bank overdraft - Government Banking Service | **0** | 0 |
| Bank overdraft - Commercial banks | **0** | 0 |
| **Cash and cash equivalents as in Statement of Cash Flows** | **7,531** | 5,747 |
| 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

There were no non-current assets held for sale.

## 28. Trade and other payables

| | Current | | Non-current | |
|---|---|---|---|---|
| | **31 March 2017 £000s** | 31 March 2016 £000s | **31 March 2017 £000s** | 31 March 2016 £000s |
| NHS payables - revenue | **1,559** | 1,651 | **0** | 0 |
| NHS payables - capital | **2** | 27 | **0** | 0 |
| NHS accruals and deferred income | **628** | 597 | **0** | 0 |
| Non-NHS payables - revenue | **782** | 1,075 | **0** | 0 |
| Non-NHS payables - capital | **908** | 275 | **0** | 0 |
| Non-NHS accruals and deferred income | **1,245** | 1,547 | **0** | 0 |
| Social security costs | **73** | 482 | | |
| PDC dividend payable to DH | **3** | 32 | | |
| Accrued interest on DH Loans | **0** | 0 | | |
| VAT | **0** | 0 | **0** | 0 |
| Tax | **70** | 368 | | |
| Payments received on account | **0** | 0 | **0** | 0 |
| Other | **860** | 956 | **0** | 0 |
| **Total** | **6,130** | 7,010 | **0** | 0 |
| **Total payables (current and non-current)** | **6,130** | 7,010 | | |
| **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 | **699** | 800 | | |

## 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 2017** | 31 March 2016 | **31 March 2017** | 31 March 2016 |
| | **£000s** | £000s | **£000s** | £000s |
| **Opening balance at 1 April 2016** | **77** | 40 | **0** | 0 |
| Deferred revenue addition | **0** | 60 | **0** | 0 |
| Transfer of deferred revenue | **(77)** | (23) | **0** | 0 |
| **Current deferred Income at 31 March 2017** | **0** | 77 | **0** | 0 |
| Total deferred income (current and non-current) | **0** | 77 | | |

## 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 obligations as lessor.

## 35. Provisions

| | Total | Comprising: 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 2016** | **146** | 0 | 18 | 0 | 0 | 0 | 128 | 0 |
| Arising during the year | **147** | 0 | 8 | 0 | 0 | 0 | 139 | 0 |
| Utilised during the year | **(6)** | 0 | (6) | 0 | 0 | 0 | 0 | 0 |
| Reversed unused | **0** | 0 | 0 | 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 2017** | **287** | **0** | **20** | **0** | **0** | **0** | **267** | **0** |
| | | | | | | | | |
| **Expected Timing of Cash Flows:** | | | | | | | | |
| No Later than One Year | **287** | 0 | 20 | 0 | 0 | 0 | 267 | 0 |
| Later than One Year and not later than Five Years | **0** | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Later than Five Years | **0** | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

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

| | |
|---|---|
| **As at 31 March 2017** | 66 |
| **As at 31 March 2016** | 43 |

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 2017 | 31 March 2016 |
|---|---|---|
| | £000s | £000s |
| **Contingent liabilities** | | |
| NHS Litigation Authority legal claims | **(13)** | (11) |
| Employment Tribunal and other employee related litigation | **0** | 0 |
| Redundancy | **0** | 0 |
| Other | **0** | 0 |
| **Net value of contingent liabilities** | **(13)** | (11) |
| | | |
| **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 NHS Improvement. 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 2017 are in receivables from customers, as disclosed in the trade and other receivables note.

**Liquidity risk**

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

## 39.2 Financial Assets

| | At 'fair value through profit and loss' | Loans and receivables | Available for sale | Total |
|---|---|---|---|---|
| | £000s | £000s | £000s | £000s |
| Embedded derivatives | **0** | | | **0** |
| Receivables - NHS | | **2,478** | | **2,478** |
| Receivables - non-NHS | | **203** | | **203** |
| Cash at bank and in hand | | **7,531** | | **7,531** |
| Other financial assets | **0** | **0** | **0** | **0** |
| **Total at 31 March 2017** | **0** | **10,212** | **0** | **10,212** |
| | | | | |
| 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 |

## 39.3 Financial Liabilities

| | At 'fair value through profit and loss' | Other | Total |
|---|---|---|---|
| | £000s | £000s | £000s |
| Embedded derivatives | **0** | | **0** |
| NHS payables | | **2,189** | **2,189** |
| Non-NHS payables | | **3,096** | **3,096** |
| Other borrowings | | **0** | **0** |
| PFI & finance lease obligations | | **0** | **0** |
| Other financial liabilities | **0** | **0** | **0** |
| **Total at 31 March 2017** | **0** | **5,285** | **5,285** |
| | | | |
| 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 |

## 40. Events after the end of the reporting period

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

## 41. Related party transactions

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

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

Health Education England
NHS England
NHS Pension Scheme
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.
Jane Mackenzie, Non-Executive Director until 5 March 2017, is a Councillor at Shropshire Council.

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 £82,000 (£306,000 in 2015/16) and total expenditure was £176,000 (£292,000 in 2015/16) most of which was grants to the Trust.

## 42. Losses and special payments

The total number of losses cases in 2016-17 and their total value was as follows:

| | **Total Value of Cases £s** | **Total Number of Cases** |
|---|---|---|
| Losses | **14,584** | **119** |
| Special payments | **4,605** | **7** |
| Gifts | **0** | **0** |
| **Total losses and special payments and gifts** | **19,189** | **126** |

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 |

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 | 2016-17 £000s |
|---|---|---|---|---|---|---|
| Turnover | 80,802 | 79,679 | 76,105 | 75,286 | 78,940 | 79,377 |
| Retained surplus/(deficit) for the year | 1,600 | 1,447 | 45 | 359 | 1,407 | 2,534 |
| Adjustment for: | | | | | | |
| Timing/non-cash impacting distortions: | | | | | | |
| Pre FDL(97)24 agreements | 0 | 0 | 0 | 0 | 0 | 0 |
| Prior Period Adjustments | 0 | 0 | 0 | 0 | 0 | 0 |
| Adjustments for impairments | 0 | 0 | 184 | 0 | 0 | 0 |
| Adjustments for impact of policy change re donated/government grants assets | (203) | 49 | 5 | (7) | (52) | 62 |
| Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12* | 0 | 0 | 0 | 0 | 0 | 0 |
| Absorption accounting adjustment | | 0 | 0 | 0 | 0 | 0 |
| Other agreed adjustments | 0 | 0 | 0 | 0 | 0 | 0 |
| Break-even in-year position | **1,397** | **1,496** | **234** | **352** | **1,355** | **2,596** |
| Break-even cumulative position | **1,397** | **2,893** | **3,127** | **3,479** | **4,834** | **7,430** |

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 % | 2016-17 % |
|---|---|---|---|---|---|---|
| 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 | 3.27 |
| Break-even cumulative position as a percentage of turnover | 1.73 | 3.63 | 4.11 | 4.62 | 6.12 | 9.36 |

Note - larger surpluses in 2015/16 due to agreed capital to revenue transfer, and in 2016/17 due to STF funding (see note 6).

## 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.

| | **2016-17 £000s** | 2015-16 £000s |
|---|---|---|
| Cash flow financing | **(1,784)** | (842) |
| Finance leases taken out in the year | **0** | 0 |
| Other capital receipts | **0** | 0 |
| **External financing requirement** | **(1,784)** | (842) |
| External financing limit (EFL) | **527** | (224) |
| **(Over)/underspend spend against EFL** | **2,311** | 618 |

## 43.4 Capital resource limit

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

| | **2016-17 £000s** | 2015-16 £000s |
|---|---|---|
| Gross capital expenditure | **2,045** | 1,258 |
| Less: book value of assets disposed of | **(33)** | (11) |
| Less: capital grants | **0** | 0 |
| Less: donations towards the acquisition of non-current assets | **(45)** | (159) |
| **Charge against the capital resource limit** | **1,967** | 1,088 |
| Capital resource limit | **2,179** | 1,160 |
| **(Over)/underspend against the capital resource limit** | **212** | 72 |

## 44. Third party assets

There were no third party assets.