The Shrewsbury and Telford Hospital NHS
NHS Trust

Putting Patients First

Annual Report and Annual Accounts 2011/12

The Shrewsbury and Telford Hospital NHS Trust

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Presented in accordance to the NHS Finance Manual: Manual For Accounts 2011/12 pursuant to the Companies Act 2006

Contents

Annual Report

Appendices:

About this document

This document fulfils the Annual Reporting requirements for NHS Trusts and works towards the Annual Reporting for NHS Foundation Trusts.

We publish a shorter Annual Review as a companion document for patients, communities and partner organisations.

Further copies of this document and our Annual Review are available from our website at www.sath.nhs.uk, by email to communications@sath.nhs.uk or in writing from:

Chief Executive's Office, The Shrewsbury and Telford Hospital NHS Trust, Princess Royal Hospital, Grainger Drive, Apley Castle, Telford TF1 6TF

Chief Executive's Office, The Shrewsbury and Telford Hospital NHS Trust, Royal Shrewsbury Hospital, Mytton Oak Road, Shrewsbury, SY3 8XQ

This document is also available on request in other formats, including large print and translation into other community languages for people in Shropshire, Telford & Wrekin and mid Wales. Please contact us at the address above or by email at communications@sath.nhs.uk to request other formats.

Please contact us if you have suggestions for improving our Annual Report.

www.sath.nhs.uk

The Year In Profile

April to June 2011

The Trust unveiled its plans for a new £5 million Cancer and Haematology Centre to be built at the Royal Shrewsbury Hospital. A special event was held to showcase the new centre and offer a glimpse of the first designs. Patients and residents were given the opportunity to get involved in the new centre by coming up with a name, and contributing their artwork to be displayed inside once the new centre opened. The first phase of the new Lingen Davies Centre opened its doors to the first patients just one year later in April 2012 and the Centre is due to be fully open in Autumn 2012

Spring also saw a visit from one of the country's top clinicians - Mike Parker, President of The Association of Coloproctology of Great Britain & Ireland – who came on a fact finding mission to the Royal Shrewsbury Hospital, where post-operative survival rates for bowel cancer surgery were among the best in the UK.

July to September 2011

Every summer sees our Annual Trust Awards, which celebrate the extraordinary achievements of staff and volunteers in the Trust. With categories covering vital issues such as Ward of the Year, Quality and Safety and Leader of the Year, the awards go right to the heart of what matters for our patients and staff. The 2011 Awards saw Director of Infection Prevention and Control Dr Patricia O'Neill presented with the Leader of the Year in recognition of the major improvements in the control and prevention of infection in the Trust. Patricia was quick to point out that these achievements were a team effort – not just by our microbiologists and specialist infection control team but by everyone across the Trust who has contributed to improved hand hygiene, better medication practice and the many other factors that help to tackle infection. These achievements continued throughout the year with the Trust recording the lowest ever number of MRSA blood stream infections (one) and getting ever closer to our aspirations of zero-avoidable infections.

Thanks to the hard work of staff in our Emergency and Critical Care services we also found out that we had been successful in our bid for the Royal Shrewsbury Hospital to be designated as a Trauma Unit as part of new life-saving regional Major Trauma Network arrangements. The new network was launched just before the end of the year in March 2012.

October to December 2011

High standards of hydration and nutrition are a vital part of hospital care. Not only is it a key part of patient experience, but it also aids recovery and helps to avoid problems in hospital. In the Autumn, our hospital catering services were praised for their efforts to source local food. A survey published by the Countryside Alliance Foundation showed the Trust spent between 85% and 90% of its food budget on British produce. It also said that evidence has shown that investing in local produce means investing in higher quality food for patients, which in turn improves their recovery, and puts a little back into the local economy. Alongside this, our catering and nursing teams were making progress on new Protected Meal Times arrangements for the Trust. These aim to ensure that patients have more protected time without interruption for their meals. With new signage and training across the Trust, the Protected Mealtimes were launched across the Trust in February.

Another important initiative launched in the Autumn, led by frontline staff was the Bed bundle. This aims to support staff across the Trust to reduce unnecessary delays for patients. You can find out more about the Bed bundle later in this annual report.

January to March 2012

The first few months of 2012 were a busy period for our continued work to ensure the safety and sustainability of hospital services. Planning permission was granted for the new women and children's facilities at the Princess Royal Hospital (see artist's impression, right). The Full Business Case was completed and approved by the local NHS and by the regional Strategic Health Authority. Building work is set to start on the new Telford facilities during summer 2012 with the new services set to open in 2014. Over the next two years we will be continuing with the vital work to involve patients, children, parents and families in designing the new facilities. There will also be a major publicity drive towards the end of 2013.

Parliament also approved the new Health and Social Care Act which will lead to changes in the way that NHS services are planned and run, giving more power to local GPs and other clinicians in Clinical Commissioning Groups to shape services to meet the needs of patients and communities.

1. Chairman's Introduction

This has been a year of significant change at the Trust as we have positioned ourselves to face the challenge of becoming a Foundation Trust whilst at the same time preparing for the most radical reforms since the NHS was established over 60 years ago.

Despite the challenging environment, the Trust has been successful in delivering most of its quality and performance targets as well as delivering a small financial surplus. We now have a clear vision of where we need to focus our efforts to deliver a healthcare service which will satisfy the needs of our patients and stakeholders across Shropshire and Mid Wales and at the same time enable us to operate sustainability within increasingly constrained financial limits.

During the year, the Trust has successfully completed the Full Business Case for the reconfiguration of Women's and Children's services and Acute Surgery. This has now been approved by the Midlands and East SHA, funding has been secured from the Department of Health and construction work is scheduled to begin in July. When the redevelopment at PRH is complete in mid 2014, we will have a state of the art Women's and Children's unit which will enable us to offer an extended range of services. Acute surgery is now planned to move to RSH in July, 2012. This early move has assisted our designation as a Trauma Unit and will enable us to offer, for the first time, Abdominal Aortic Aneurysm (AAA) screening program.

The Lingen Davies Cancer centre has progressed during the year and opened its doors to patients in April, 2012. The project will be completed and fully operational in Autumn 2012. This facility has been funded entirely through charitable donations and we are extremely grateful to the efforts of everyone who has contributed. Cancer patients will also benefit from our decision to install a new linear accelerator.

The Trust's key objective this year has been to improve the quality and safety of care that patients receive in our hospitals by "Putting Patients First" in everything that we do. HSMR is one of the several indicators used to measure quality and safety of care and we have successfully improved our rating, as independently measured by the Dr. Foster organisation, from being one of the weakest performing Trusts in the country to a position where we are now better than the majority of hospitals. This is a very impressive improvement of which the whole organisation can be proud. We have also seen important improvements in the assessment and treatment of venous thromboembolism (VTE) and patient waiting times for both admitted patients and non-admitted patients and cancer patients. Waiting times have been a particular problem this year and I would like to apologise to patients who have had to endure excessive waits. We are making further improvements in our appointment and booking systems which I am confident will result in a much better and more friendly experience for patients in the future.

A&E has continued to be a challenge this year and we have not been able to achieve the 4 hour A&E target on a regular basis. This has been due in part to continuing escalation in the number of patients presenting at A&E. Another contributing factor has been the delayed transfers of care. Hospital is not the best place to be once a patient has received the specialist care we provide and it is important that we work with other parts of the healthcare system to make sure that our patients move on to the right level of care in the right place as soon as possible.

Each year the Trust provides hundreds of thousands of patient appointments, procedures and treatments. This includes nearly 350,000 consultant-led outpatient appointments, over 100,000 inpatient and daycases, and 6,700 maternity deliveries. We do this in increasingly challenging circumstances and we are therefore particularly pleased to be able to report a small financial surplus of £58,000. More importantly, however, during the course of the year, we have gone from a recurrent annual loss of £14 million to a balanced position at year end. Not withstanding this significant achievement, the

Trust is faced with the need to achieve further savings in 2012/13 as we struggle with a reduced contract from commissioners, which includes a reduction in the tariff price we receive and does not provide for increased costs through inflation and salary rises.

This year we have had to enter into some difficult conversations with staff. Pay accounts for over two thirds of our spend each year and the financial challenges that we are facing mean that we must manage our pay costs more effectively. Our staff have responded with professionalism that is admiral and throughout the year we have seen them working hard to deliver more with less.

One of the most important changes that we have introduced this year is a new devolved management structure which is clinically led. We are now putting effort into developing the directors and managers to operate this structure for the long term. Our plan is to improve our patient care offering and our efficiency by putting responsibility for clinical outcomes, service development, quality and efficiency of all our services close to the front line. This will be a big challenge over the next couple of years but if we are successful in creating this system of management in all our Centres, we will be able to face the future challenges with confidence.

In March, our Chief Executive, Adam Cairns, announced that he had accepted the position of Chief Executive of the Cardiff and Vale University Health Board in Wales. Adam has done a tremendous job at SaTH during his short stay with us and the Board is disappointed to see him go at this critical point in the Trust's development. However, he has built some solid foundations on which to build a successful future for SaTH and we wish him well in his new role.

Dr John Davies
Chairman

2. Chief Executive's Foreword

The NHS is facing an unprecedented period of both opportunity and challenge. Our patients quite rightly expect the highest standards of dignified care, using the latest available treatments and technologies in ways that are convenient, timely and accessible. Alongside this, the current economic climate has a significant impact on the resources available to us – as individuals and families, as an NHS, as the broader public sector.

Tough times need creative solutions. The NHS therefore has the opportunity to create new ways of providing care that both exceed our expectations and offer better value for money for the public purse. By getting better at assessing and treating venous thromboembolism we reduce complications for patients, which reduces length of stay in hospital and ongoing treatment and discomfort. By adopting the latest procedures, more patients can have their treatment as a day case, return home promptly and resume their normal life as early as possible. By reducing unnecessary delays for patients admitted to hospital as an emergency we can improve their recovery and reduce the risks associated with a stay in hospital. Importantly, by doing more to prevent a hospital admission in the first place we can help people to maintain their independence and resilience.

Not only do these improvements make care better for patients, they also mean that we can do more for patients with fewer resources. This is what we need to do more of to make sure all of us continue to have a safe and affordable NHS for the future.

During 2011/12 we have made progress in all of these areas in The Shrewsbury and Telford Hospital NHS Trust. Looking ahead we will need to do even more in order to maintain high standards of care whilst saving about five pence in every pound in each of the next two years.

We have ended the year as a consistently high performing organisation in the assessment of VTE. This is despite having one of the lowest rates of VTE assessment at the start of the year. These improvements are saving lives.

Our BED bundle approach is beginning to transform care for people who have unplanned admission to hospital. Through a few simple steps we can reduce delays for patients and release more time to care.

Our Leading Improvement in Patient Safety programme has set ambitious targets for reducing in-hospital mortality. Staff across the Trust have picked up the baton by putting in place new ways of providing safe care.

Working with colleagues in primary and community health services and in social care, we have a renewed focus on the needs of frail elderly patients – people with an increased likelihood of being admitted to hospital, for whom a stay in hospital can be particularly disorientating, and who face additional risks and problems due to confusion and falls.

This year has also seen the foundations for major improvements in services in the future. We have faced a long debate over many years without resolution about the safety and sustainability of vital hospital services such as children's inpatient services, acute surgery and the deteriorating condition of the women & children's building at the Royal Shrewsbury Hospital. Shortly after year end we received approval for plans which will see state-of-the-art women and children's inpatient facilities at the Princess Royal Hospital, and the Royal Shrewsbury Hospital strengthened as our main centre for inpatient acute surgery. Building work for these new facilities is due to start in 2012/13.

These plans are already delivering benefits with the Royal Shrewsbury Hospital designated as a Trauma Unit in the new regional Major Trauma Network arrangements. This will help to provide timely, joined up care for people with the most serious and complex injuries. As a result of our acute surgery plans, Royal Shrewsbury Hospital is also becoming the hub for a new screening service for Abdominal Aortic Aneurysms. This

service will ensure that life-threatening problems are spotted and treated early.

During the year, building work also continued on our new Lingen Davies Cancer Centre Development at the Royal Shrewsbury Hospital. Funded by £5m of local donations, phase one of the new facilities opened their doors in April 2012. The unit is due to be fully open in the Autumn, and the Lingen Davies Cancer Appeal is carrying on their vital fundraising with an appeal to raise nearly £400,000 for equipment and facilities for the new Centre. Thank you to everyone who has been involved.

In financial terms, the Trust ended the year in recurrent financial balance for the first time ever. This is a tremendous achievement, but is only the start of what we need to do to strengthen the financial foundations of the local NHS for the future. We have a major programme ahead to make sure we live within our means, and our Quality Improvement Strategy will make sure that the needs of patients remain at the heart of change.

During the year we have also faced some difficult issues. I am proud of the openness and integrity with which our staff have tackled these. NHS organisations depend on the trust and confidence of our patients. If we are open about when things go wrong and demonstrate clearly that real improvements are being made then quite rightly we should keep that confidence. This year our patients have faced longer waits for hospital treatment, problems with our ophthalmology services and other cases where our care has not always my the high standards that we aspire to. Importantly, patients have helped us to identify and solve these problems – by raising their comments and concerns, with their honest feedback, through involvement in reviews and workshop, by holding us to account to deliver the improvements we have promised. Our clinical and administrative staff have worked tremendously hard to resolve the issues that our patients have faced and I am both proud and thankful of the work that they have done.

You may be aware that this is my last Annual Report as Chief Executive of the Trust. During my time here I have been hugely impressed by the insight and input from our patients, the creativity and passion of our staff, and the strength of clinical leadership in this organisation that puts it in a great place for the future. Thank you to everyone I have worked with and I would like to offer my very best wishes to you all for the future.

I am leaving as the Trust embarks on the next phase of its journey to excellent healthcare for you, our patients and communities. The year ahead will need to build on the progress we have made on quality and safety, the openness and integrity with which we learn and improve, the renewed focus on meeting the needs of our patients and commissioners, and the continuing challenge to build our financial strength so that we can invest in the quality of services.

Major priorities for the year ahead will include completion of the Lingen Davies Cancer Centre, work to replace one of our linear accelerators which provide vital radiotherapy treatment for people with cancer, the start of building work for our new women and children's facilities at the Princess Royal Hospital, the establishment of Royal Shrewsbury Hospital as our main centre for inpatient acute surgery and much more besides.

We will be continuing with our journey to NHS Foundation Trust status by 2014. All NHS Trusts must become Foundation Trusts or be split up or taken over. We believe that that best future for local hospital services is to retain our local independence as a Foundation Trust with public governors from Shropshire, Telford & Wrekin and mid Wales taking a central role in shaping local health services. We will continue to ensure safe and sustainable hospital services through development and reconfiguration, including by strengthening our focus on rural health, integrated care and telehealth. Most importantly, we will continue to focus on our central organising principle of **Putting Patients First** in designing what we do.

Adam Cairns
Chief Executive

3. Introduction to the Trust

The Shrewsbury and Telford Hospital NHS Trust is the main provider of district general hospital services for nearly half a million people in Shropshire, Telford & Wrekin and mid Wales. We were established in 2003 following the merger of The Princess Royal Hospital NHS Trust and the Royal Shrewsbury Hospitals NHS Trust.

Our central organising principle is Putting Patients First. This guides all of our decisions, ensuring that we use our resources wisely to provide timely care that meets the standards of quality and safety that our patients and communities expect and deserve.

Our vision is to be ambitious about changing healthcare for the better. To support us to deliver this we have developed our strategy based on four strategic domains: Quality and Safety; Financial Strength; Learning and Growth; and Patients, GPs and Commissioners.

Underpinning our strategy, we have built on the principle of Putting Patients First to develop a clear framework of values: Putting Patients First; Honesty and Integrity; Being a clinically-led organisation; Working and collaborating together; Encouraging individual ability and creativity; and, Taking pride on our work and organisations

Our main service locations are the Princess Royal Hospital (PRH, above right) in Telford and the Royal Shrewsbury Hospital (RSH, bottom right) in Shrewsbury, which together provide 99% of our activity.

We also provide community and outreach services such as:

- Consultant-led outreach clinics (e.g. the Wrekin Community Clinic).
- Midwife-led units at Ludlow, Bridgnorth and Oswestry.
- Renal dialysis outreach services at Ludlow Hospital
- Community services including midwifery, audiology and therapies.

We employ over 5000 staff, and hundreds of staff and students from other organisations also work in our hospitals. We also benefit from support from over 500 volunteers working for the Trust and for our main charitable partners (our two Leagues of Friends and the Lingen Davies Cancer Appeal.

With a turnover just below £300m, we see 346,000 consultant-led outpatient appointments and admit 105,000 patients every year for inpatient, daycase and maternity care.

More information about the range and quality of our services is available on our website at **www.sath.nhs.uk**

4. Performance

Our strategy as a Trust is based on the central organising principle of Putting Patients First - ensuring safe, timely care within available resources.

Our 2011/12 Strategic Plan described our longer term strategic planning framework and our priorities for the year. It reinforced that Putting Patients First is our highest priority and our organising principle that will underpin all of our developing clinical strategies and operational plans. Our strategy has been developed using a "Balanced Scorecard" approach, reflecting that we need to deliver improvement and growth in four strategic domains in order to achieve success for our patients and our workforce. Our four strategic domains during 2011/12 were:

- **Quality and Safety**: Focussing on what internal processes we must excel at if we are to improve the quality and safety of our care
- **Patients, GPs and Commissioners**: Focussing on what we have to do to meet their needs.
- **Learning and Growth**: Focussing on how we prepare for the future through developing our staff, the technology we use and the innovation we create.
- **Financial Strength**: Focussing on what it will take to create the financial strength to enable us to invest in the quality of our service.

Across these four domains we identified 28 strategic themes to define and shape what we must do to deliver our strategy and achieve our vision of the future. These themes are:

	Strategic Themes for the Trust
Domain	**Themes**
Quality and Safety	Ensure that we learn from mistakes and embrace what works well Design care around patient needs Provide the right care, right time, right place, right professional Deliver services that offer safe, evidence-based practice Meet regulatory requirements and healthcare standards Ensure our patients suffer no avoidable harm
Patients, GPs and Commissioners	Involve patients in decisions about them Ensure our patients have a good experience Deliver services that are convenient and timely for patients Ensure access to clear care pathways to meet the needs of our patients Improve our appointments system and processes Improve our communication processes and the information we provide Work in partnership to ensure services meet local healthcare needs Engage appropriately with GPs to plan and deliver future services Reflect commissioners' plans in our capacity plans and deliver our contractual commitments
Learning and Growth	Learn to improve, innovate and cooperate continuously Develop game changing tele-health and other technologies Devolve responsibility and accountability and cooperate with each other Adopt and develop a clinically led structure Ensure that Information Management and Technology works for us Adopt behaviours that match our core values Build service redesign capacity and capability Invest in a more flexible and responsive workforce
Financial Strength	Develop and implement sustainable clinical strategies Develop and grow services which make a positive financial contribution Increase surpluses to reinvest in quality and innovation Maximise the productivity and efficiency of our services Eliminate waste and non-value-adding processes

During 2011/12 we made significant progress in progressing our strategic plans to achieve our objectives, a summary of this progress is shown in the following table. We recognise that unfortunately we were not able to achieve all that we would have wanted to however as a Trust all of our staff are committed to progressing our plans to continuously improve the services that we provide to patients.

	Progress during the Year Ended 31 March 2012
Domain	**Progress**
Quality and Safety	We have developed our Quality Improvement Strategy which describes our priorities for the improvements in patient safety, the improvements in patient experience and the improvements in patient outcomes that we are seeking. This strategy forms an integral part of our business plans to improve quality for the next 5 years and beyond. During 2011 we launched our LIPS (Leading Improvements in Patient Safety) Programme which we run in partnership with the Institute for Health Care Innovation and Improvement. More than 100 key clinical staff were involved in our groundbreaking launch. In order to develop greater patient visibility at a ward and hospital level work began on the introduction of patient/hospital at a glance screens to be sited in each ward across the Trust. The project will deliver a system that is both linked to the Trust's patient administration and the VitalPac patient early warning system. We strive for the highest standards of patient safety and in common with other Trusts we use a range of indicators such as the Hospital Standardised Mortality Rate (HSMR) to monitor safety. In the Dr Foster Hospital Guide for both 2010 and 2011 the HSMR for the Trust was significantly higher than national averages. Our clinical leaders have agreed a goal of reducing the level of in-hospital mortality by 20% over a period of two years from 2011. We have implemented a comprehensive programme to support delivery of this important goal, including through Leading Improvement in Patient Safety, and as a result there has been a solid downward trend in our HSMR. We have achieved more than a 10% reduction in the first year and we remain on trajectory to achieve our overall goal. In our Quality Improvement Strategy we have set ourselves the target of going further than this initial goal. From June 2010, acute trusts were required to submit evidence every month that they are risk assessing inpatients for Venous Thromboembolism (VTE) based on standard criteria. At the beginning of the financial year, recorded VTE assessments in the Trust were amongst the lowest in the country and well below national standards. Clinical staff have worked hard to change to deliver improvements in this area and through strong clinical leadership and improvement in technology the Trust is now consistently achieving national VTE standards. Problems with our booking and scheduling systems led to unacceptable delays for patients waiting for planned appointments, which in turn led to discomfort, anxiety and in some cases deterioration in the condition for which they were referred. In partnership with local GPs and PCTs we undertook a thorough review of the impact of these delays and apologise to patients who have been affected. Hospital Acquired Infections have a significant impact on both patient care and their experience whilst in hospital. The Trust has a strong track record in improving infection prevention and control, with significant reductions in both MRSA bacteraemia and Cdiff. The services that we provide must meet and comply with healthcare standards. In December 2011 the Trust achieved level 1 of the NHSLA Risk Management standards. We are now working towards level 2 with a planned assessment date of summer 2013. In February 2012 the Trust has also achieved level 2 of the CNST Maternity standards (previously level 1) As part of the national drive to deliver best practice in trauma care and to meet commissioning intentions, the Trust submitted its bid for the RSH site to be its designated Trauma Unit and to work alongside University Hospitals North Staffordshire as one of three Trauma Centres across the West Midlands. This bid was accepted and from March the new network arrangements came into effect. A priority and a challenge during the year has been to reduce the number of delayed transfers of care, where patients assessed as no longer needing the specialist care provided by our acute hospitals face delays waiting for the next step in their care pathway (e.g. awaiting agreement of a community care package, specialist or tertiary care, community hospital etc.) . Tackling delayed transfers requires joined up action across health and care partners, and at times the local health community has not been able to meet the targets for reducing delayed transfers during the year. We continue to work with local partners and patients to seek to reduce unnecessary delays for patients.

Patients, GPs and Commissioners	In February 2012 the Trust introduced protected meal times for all patients as part of its programme to improve inpatient care. This initiative recognises the vital part that nutrition plays. We also introduced hourly/2 hourly comfort rounds midway through 2011/12 to ensure that patients were supported on a regular basis for hydration, pain management and toileting. This process has been evaluated well by patients. All patients deserve to be seen in a timely manner and shouldn't have to endure long waits for treatment, waiting times form part of the national NHS Constitution. The Trust has seen improvement in performance against standards for cancer waiting times from 2010/11 to 2011/12 and is now consistently achieving against all standards. Key areas of improvement have included an improvement in flow management and investment in additional consultants Unfortunately the Trust has been unable to deliver and sustain performance against the A&E 4-hour 95% target during the year. Improving patient flow remains a key priority, with a number of workstreams being introduced in-year. The introduction of our new clinical leadership arrangements in 2011/12 including a dedicated Value Stream Lead for Unscheduled Care, is driving forward plans which will support sustained improvement The Trust began the year with a significant backlog of patients waiting longer than 18 weeks for a consultant-led appointment. Concerted work by our clinical teams reduced this from 25% of the total number of people waiting (open clocks) to a year end position of 5-6% which compares well with a regional average of 6-7%. Through a combination of improved processes and additional nonrecurring activity the Trust plan to maintain sustainable delivery of RTT targets from Q1 2012/13. A major programme of bed reduction has been underway during 2011/12 and will continue into 2012/13. This phase has presented some challenges to achieving and maintaining A&E access performance but the Trust is confident that once the new bed state is fully implemented, supported by clinically-led flow management, this target will be sustainably delivered. As part of the Trust's drive to improve patient flow through its unscheduled care service a number of service changes were introduced in 2011/12. These include: • An acute medical short stay facility at the Princess Royal hospital site within the medical assessment unit. • Increase in the use of ambulatory emergency care pathways at both the RSH and PRH sites. • Introduction of the Bed Bundle to act as an improvement approach to facilitate earlier transfers from Acute Medical Units and discharge from the hospital • Case management and discharge planning - A rapid improvement program that supported better multidisciplinary working and timely discharge lead to the development of the integrated case management team to support wards where the post hospital needs of the patient are complex. • Frail Elder project introduced the concept of a frail elder team to facilitate, where clinically appropriate, the discharge of patients within the first 72 hours of their hospital stay. • The development and implementation of an electronic referral form to initiate a social care assessment, thereby reducing the time taken versus a paper system. A review of why we failed to deliver waiting time targets highlighted the issues that we currently face with regard to our booking and scheduling processes. These processes are causing operational issues and causing significant frustration for our patients and our GPs. We have undertaken a Booking and Scheduling diagnostic and the results of that work have informed an Improvement Programme which commenced in April 2012. The Trust is continuing to work with primary care to review our clinical pathways. In 2012 we introduced an improved pre-assessment for Orthopaedic elective surgery. This will enable us to more effectively manage clinical risk of anaesthesia, optimise theatre and bed utilisation, and provide adequate and appropriate procedure and rehabilitation assessment to enable informed decision making and informed consent for the patient. The NHS reform will transfer commissioning responsibilities to GPs in 2013, this means that GPs will have a greater influence on the services that they want to commission for their patients. The Trust is committed to working with our local GPs and as part of our GP Engagement process we have continued to work closely with the local GP consortiums and the individual practices to discuss and shape future service models.

Learning and Growth	The Trust is developing a Workforce Strategy and an Organisational Development Strategy that will enable the organisation to achieve its vision – putting patients first. Informed by the 2009 Boorman Report we have also developed an approach to Health and Wellbeing. We are proactive about the Health and Wellbeing of our Workforce, a wide range of initiatives has been implemented with a strong focus on engagement, recognition and empowerment. Staff Engagement is an important element of our Workforce Strategy. The Trust has recently adopted 'Listening into Action' a developed Staff Engagement Model which has been successful in a number of NHS organisations. The Trust held staff conversations with over 400 staff to better understand what it is like to work here. Since the launch of this programme – Making Change Happen over 80 staff have begun to work on enabling projects to start to empower staff to make changes for the benefit of patients, their colleagues and the organisation. In order to achieve our long term vision the Trust recognises that high quality and skilled leadership is required at all levels of the organisation. We have recently established our Leadership Academy to support leaders at all levels, both through formal programmes and informal support mechanisms. During the year we established a new Leadership Academy. This provides an overarching strategic approach to the development of skilled leaders in the Trust, providing the opportunity for personal development, action learning, skills acquisition, career and personal guidance, coaching and mentoring that is driven by the organisational strategy. A key development during the year was the development of a Senior Leaders development programme in partnership with Warwick University Business School which is focused on the needs of Centre Chiefs and their teams. The first cohort is under way and a second cohort of this programme will run from October 2012. The development of our Organisational Development (OD) Strategy will further inform our Leadership Development programmes. It will set our approach for Talent Identification and development to support both our organisation and the wider NHS, as we will be an organisation that nurtures talent and facilitates growth. Our OD Strategy will ensure that we address our organisation as a whole. During 2011/12 we have put in place a clinically led management structure with our clinical services delivered in 11 Clinical Centres, each led by a Consultant or other specialist (e.g. Pharmacist, Therapist). Alongside our Centres, we have four cross-cutting programmes, or Value Streams, to support improved patient care across the Trust and with our external partners. These cover cancer care, scheduled care, telehealthcare and unscheduled care and are each led by a Consultant. Providing care in rural settings is a challenge for all services within the Trust we are looking at innovative ways to provide services that are close and convenient to patients through utilising telemedicine. A trial of state of the art Video-conferencing equipment began in quarter 4 of 2011/12 to link up the Trust's two hospital sites for education and training events and for cross site meeting purposes. This development marks the start of phase one of the roll out of telehealth technology into clinical practice within the Trust. Developing future strategies that respond to the changing needs of our patients requires a robust planning process. The Trust has introduced its new strategic planning framework and considerable work has taken place with the clinical centres to develop business plans that will deliver the Trusts overall objectives. These Centre Business Plans have been developed through comprehensive planning workshops involving a wide range of clinical and support staff and will support the long term development or our clinical strategies. Centre Business Plans will also inform our Integrated Business Plan which supports our FT application. The financial challenge within the NHS is driving the need for efficiencies and commissioners are seeking efficiency improvements. Future services will be tested to ensure that they provide value for money and as part of this process commissioners will undertake market testing and competitive tendering. Commissioners have declared their intention to review some of the services that the Trust currently provides and ensuring that we are able to respond to this process is critical to our long term sustainability of some services. The Trust will develop a commercial development plan to identify how we respond to this changing commercial environment.

Financial Strength	Information about progress and delivery of our goals for improving Financial Strength can be found in the Sustainability Report later in this section and the Financial Review in Section 6.

Looking ahead to 2012/13

During 2012/13 we will build on the work that has already been completed. Our Clinical Centres and management teams will work closely with our patients and commissioners to ensure that we deliver healthcare that is safe and well organised. We want our services to be rated very highly by our patients and our staff. Our long term goal is to provide an integrated healthcare service that is designed around patients needs. Putting Patients First will always be our priority and in order to improve and enhance the care and experiences of our patients we have identified five key Service Development Plans as follows:

	Service Development Plans
Theme	**Plans and priorities**
Reconfiguration of Acute Surgery and Women and Children's Services	The Full Business Case for the Future Configuration of Hospital Services is set for consideration by the Strategic Health Authority in early 2012/13. Subject to this the transfer of services associated with the reconfiguration programme will commence in 2012, initially through the establishment of RSH as the main centre for inpatient acute surgery and PRH as our main centre for inpatient head & neck surgery. The development of the new women and children's inpatient facilities will also begin in 2012, with completion of the final stage planned for 2014.
Expansion and development of Cancer Services	The reconfiguration of services and the development of cancer and cardiology services are our priority during the next one to two years. Work has already commenced on the commissioning of the new linear accelerator to replace and improve on the equipment currently available. Phase one of the new Cancer Centre opened its doors to its first patients shortly after year end and will be fully open by autumn 2012.
Development of Cardiology Services	
Repatriation of patient services from outside the county	We will continue to identify services that are currently provided outside the county that can safely and appropriately be provided within the county's two main hospitals. The repatriation of market share will progress steadily during the next five years. Individual specialities will develop plans with commissioners to support this ensuring capacity is aligned to commissioners' plans.
Expansion of private practice through joint venture arrangements	Within this current financial climate NHS income is unlikely to increase significantly however non NHS income will help us to improve the longer term viability of clinical services. We plan to expand our private practice to increase our market share and deliver additional income, with the aim of delivering significant growth from 2014/15.

There are a number of key outcomes that our service developments will deliver. These include:

- Clinically safe and sustainable services in the future that reflect local demographic changes
- Improved efficiency and utilisation of our assets
- Increased capacity to meet forecast growth in identified specialties
- Increased patient choice associated with repatriation
- Strong working relationships with commissioners as the provider of choice
- Delivery of services within community settings
- Partnership working arrangements
- Robust systems and processes to support service delivery

Summary of DH Performance Framework in the Year Ended 31 March 2012

The Department of Health Performance Framework sets out the key priorities for NHS organisations. At the end of year the Trust performed well against all domains of the Framework with the exception of 18 week referral to treatment times and A&E four hour wait, A summary of performance against the Framework is provided below.

Summary of Performance in Year Ended 31 March 2012					
Domain	**Indicator**	**Numerator / Denominator**	**Data Source**	**Thresholds**	**Performance in Year Ended 31 March 2012**
A&E	Four-hour maximum wait in A&E from arrival to admission, transfer or discharge	The number of patients spending four hours or less in all types of A&E department / The total number of patients attending all types of A&E department	Weekly SitReps	Performing: 95% Underperforming: 94%	94.31%
Infection Prevention and Control	MRSA	Actual number of MRSA vs. planned trajectory for MRSA	HPA returns	Performing: at or below target Underperforming: >1SD	1 case
	C.diff	Actual number of C diff vs. planned trajectory for C diff			41 cases
18 week Referral to Treatment	RTT - admitted - 95th percentile	Waiting time at 95th percentile for admitted patients	Monthly RTT returns	Performing: <=23 Underperforming: <27.7:	42.10 weeks
	RTT - non-admitted - 95th percentile	Waiting time at 95th percentile for non-admitted patients		Performing: <=18.3 Underperforming: N/A	28.15 weeks
	RTT - incomplete - 95th percentile	Waiting time at 95th percentile for incomplete pathways		Performing: <=28 Underperforming: <36	33.11 weeks
	RTT - admitted - 90% in 18 weeks	Total number of completed admitted pathways where the patient waited 18 weeks or les vs. Total number of completed admitted pathways in quarter		Performing: 90% Underperforming: 85%	68.59%
	RTT - non-admitted - 95% in 18 weeks	Total number of completed non- admitted pathways where the patient waited 18 weeks or les vs. Total number of completed admitted pathways in quarter		Performing:95% Underperforming: 90%	87.31%
Cancer Waiting Times	2 week GP referral to 1st outpatient	Please see cancer waiting times guidance for definitions of these performance standards	Cancer Waiting Times Database	Performing: 93% Underperforming: 98%	97.86%
	2 week GP referral to 1st outpatient - breast symptoms			Performing: 93% Underperforming: 98%	98.23%
	31 day second or subsequent treatment - surgery			Performing:94% Underperforming: 89%	94.47%
	31 day second or subsequent treatment - drug			Performing:98% Underperforming: 93%	98.83%
	31 day diagnosis to treatment for all cancers			Performing: 96% Underperforming: 91%	97.54%

Cancer Waiting Times (continued)	Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment (radiotherapy treatments)	Please see cancer waiting times guidance for definitions of these performance standards	Cancer Waiting Times Database	Performing: 94% Underperforming: 89%	98.78%
	62 day referral to treatment from screening			Performing: 90% Underperforming: 85%	93.52%
	62 day referral to treatment from hospital specialist			Performing:85% Underperforming: 80%	92.55%
	62 days urgent GP referral to treatment of all cancers			Performing:85% Underperforming: 80%	85.38%
Stroke Services	Patients that have spent more than 90% of their stay in hospital on a stroke unit	Number of patients who spend at least 90% of their time on a stroke unit vs. Number of people who were admitted to hospital following a stroke	Stroke Audits	Performing:80% Underperforming: 60%	87.80%

2011/12 was a year when we continued to make significant progress to improve quality and safety, reduced cancer waiting times and ended the year in recurring financial balance for the first time since the Trust was established in 2003. However, we also faced particular challenges in relation to waiting times both for 18 week referral to treatment and the A&E four-hour target.

The Trust has not achieved its 18-week referral-to-treatment (RTT) targets for either admitted or non-admitted patients for 2011/12. During the year the Trust identified a significant backlog of patients waiting over 18 weeks for consultant-led treatment. During the summer 2011 this backlog represented 25% of the total number of people waiting (open clocks), compared to a regional average of 6-7%. Through a combination of improved processes and additional non-recurring activity the backlog is now 5-6% and the Trust expects to be delivering the overall RTT targets for admitted and non-admitted patients from 2012/13.

The Trust achieved all its cancer targets for 2011/12. In-year, the area of greatest concern has been the overall 62-day target which was below target for each of the first 4 months of the year. However, performance has been above target for each subsequent month. The Trust achieved 'year-to-date' delivery in January and has sustained this.

The Strategic Health Authority introduced a revised Provider Management Regime in January 2012 (beginning with and reporting December performance). In shadow form until April 2012, the process includes the Trust formally signing off completed performance templates at Trust Board before submitting them on a monthly basis. With the new Provider Management Regime coming fully into effect in 2012/13 we plan to begin reporting on this in our Annual Report from next year.

Overview of Quality Performance in the year ended 31 March 2012

During 2011/12 the Trust Board has focused both on improving quality and on improving the way we measure quality so that we have clear benchmarks in place for agreeing our priorities and targets for the future. With the implementation of Devolution and Cooperation during the year, there is strengthened clinical leadership in place across the Trust. With eleven Clinical Centres led by their

Centre Chiefs the Trust Board therefore has greater confidence in systems for monitoring quality and leading quality improvements. This supports our central organising principle of Putting Patients First.

In last year's Annual Report we described our intention to develop a Quality Improvement Strategy. This was developed during the year with involvement of patients and frontline staff, and was approved by the Board in March. This strategy describes our priorities for improvement in patient safety, patient experience and patient outcomes. It also ensures that these improvements measurable so that we can track progress.

The Trust is clearly committed to continuous Quality Improvement and has worked with staff and patients to outline the areas for Quality Improvement for 2012 and beyond. Through our strategy, the Board and clinical leaders across the Trust will be supported to promote innovative ways to improve clinical outcomes whilst focusing on promoting and maintaining health and well being. One example of our commitment has been the "Leading Improvement in Patient Safety" (LIPS) programme commissioned by the Trust Board in 2011. During 2011 over 100 members of staff were involved in a major learning and improvement initiative as part of LIPS, and this has been re-commissioned with a second cohort taking place early in 2012/13. LIPS will continue to be one of our main vehicles for quality improvement going forward.

We have continued to work closely with our commissioning and GP colleagues in the last year to refine clinical pathways. One important example of this was the "Keeping it in the County" that ended in 2010/11 and has continued through 2011/12 through our Future Configuration of Hospital Services programme. Central to this work has been a robust process of quality impact assessment, drawing on the feedback we have received from patients, staff and partner organisations. Working with Clinical Commissioning Groups and the wider local health and care community will be core to ensuring care is delivered in the best interests of the patients, whether that is in their home or within the specialist clinical centre within the hospital. In essence providing the right care in the right place and by the right professional will be key to our success.

Our performance against measures of quality has been monitored closely by the Board, supported by detailed scrutiny by the Quality and Safety Committee, which is a formal committee of the Trust Board. With the establishment of the new Clinical Centres in October 2011, Centre Chiefs working with their wider clinical teams now have a central role in monitoring quality improvement and accounting for progress. The Trust has worked with clinical staff to establish key performance indicators to monitor Quality from the ward to the Board. This provides a basis for collective ownership and a continuous improvement drive.

The Quality Improvement Strategy provides a five year framework from which the Trust can be held to account for the annual improvements it aspires to deliver. The annual improvement outcomes from this Strategy will be published through the Quality Account each year. The Strategy document itself will need to be an evolving and iterative document being influenced by national policy and local requirements, however at the heart of our strategy are the improvements that staff and patients feel passionate. As a Trust we have both the obligation and the desire to focus on what matters most to our patients and our staff with the finite resources available to us. Quality improvement must go hand in hand with financial improvement so that we can secure the necessary resources to invest in future success. Our Quality Impact Assessment process, which we have refined and developed, will be central to this as it makes sure that the quality impact of our plans for the future is assessed and benefits are delivered.

An open and honest assessment of our progress and challenges to improve quality during 2011/12, and our priorities for quality improvement in 2012/13, can be found in the Quality Report at Appendix 1.

Summary of Service Activity in the year ended 31 March 2012

During 2011/12 we saw:

- 56,301 elective and day case episodes (a 2.82% decrease on 2010/11)
- 41,962 non-elective inpatient episodes (a 2.84% increase on 2010/11)
- 6,746 maternity episodes (a 0.01% decrease on 2010/11)
- 346,635 consultant-led outpatient appointments (a 7.64% increase on 2010/11)
- 110,425 accident and emergency attendances (a 3.85% increase on 2010/11)

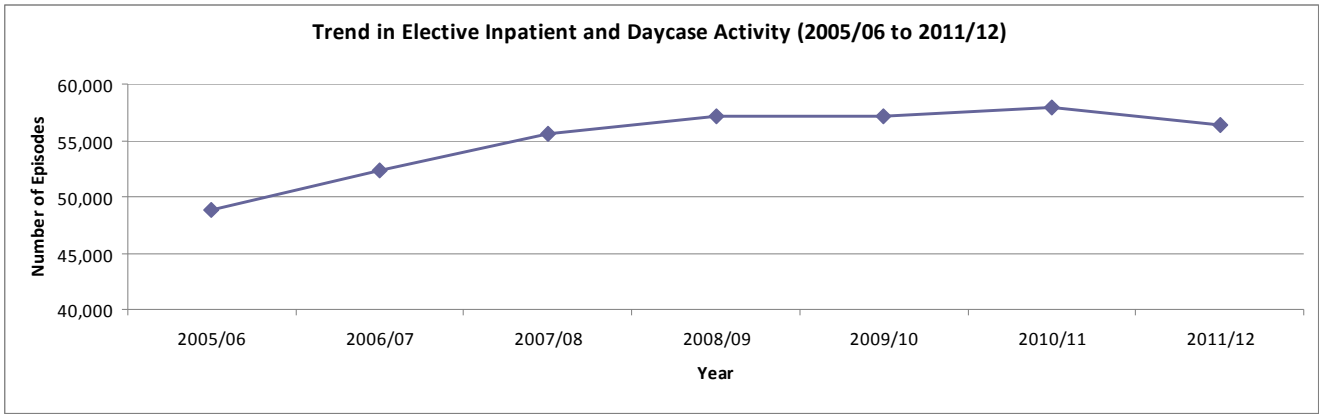
	Consultant-Led Patient Activity by Speciality				
Centre	Speciality	Inpatient/Daycase		Outpatient	
		2010/11	2011/12	2010/11	2011/12
ECC:	A&E Outpatient	8	18	3,413	3,520
H&N:	ENT	3,130	3,358	17,641	19,593
	Oral and Maxillofacial	1,883	2,063	10,570	11,012
	Orthodontics		0	11,150	10,137
	Audiological Medicine		0	1,221	2,638
Med:	Cardiology	1,824	2,135	11,998	13,015
	Dermatology	15	35	12,992	14,536
	General Medicine*	21,500	22,307	30,715	29,878
	Neurology	220	313	8,341	8,414
MSK:	Trauma and Orthopaedics	7,130	7,240	53,321	53,294
	Pain Management	1,001	1,061	2,334	3,209
	Rheumatology		0	1,860	1,167
Onc:	Oncology	8,269	8,725	11,475	12,424
	Haematology	4,786	5,499	9,184	9,862
Oph:	Ophthalmology	7,971	4,047	35,180	47,936
Surg:	Anaesthetics		0	767	272
	Gastroenterology	13,510	14,760	8,977	9,882
	General Surgery**	11,164	11,497	31,182	31,619
	Neurosurgery		0	192	175
	Urology	5,792	4,457	12,995	14,662
W&C:	Gynaecology	3,935	3,998	17,589	19,129
	Obstetrics / Maternity	6,792	6,746	11,620	12,096
	Paediatrics	6,590	6,750	16,733	17,494
	Psychotherapy		0	15	32
Diag:	Chemical Pathology		0	567	639
Total		105,520	105,009	322,032	346,635

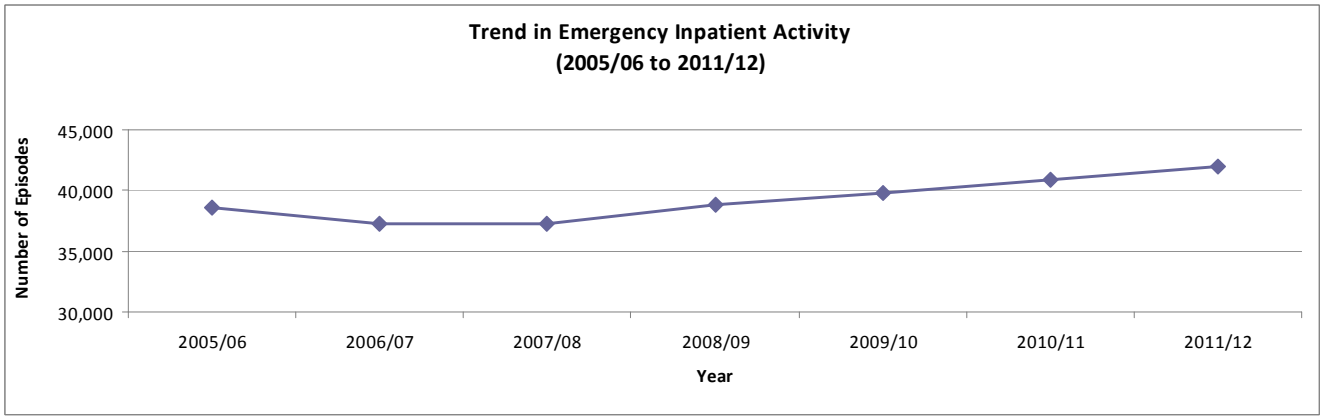
*Includes General Medicine, Renal Medicine (Nephrology), Diabetic Medicine, Endocrinology, Geriatric Medicine

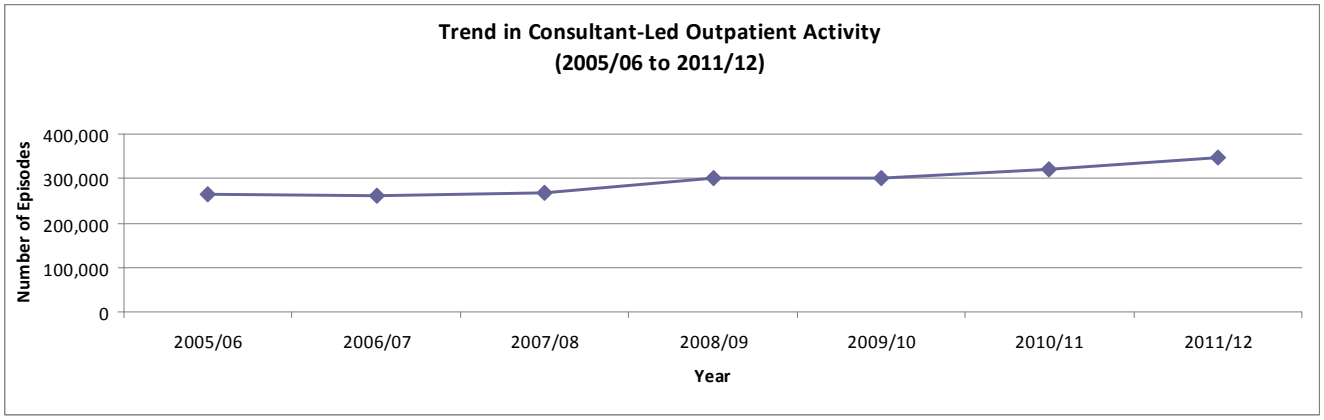
** Includes General Surgery, Vascular Surgery, Upper GI Surgery, Colorectal Surgery, Breast Surgery

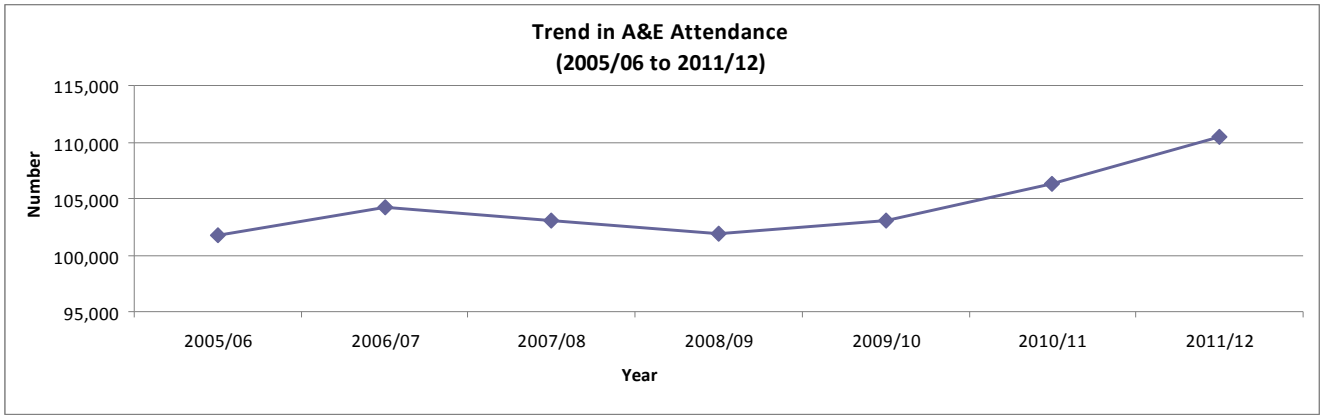
During the course of the year there was a transfer of activity from day case episodes to consultant-led outpatient appointments (procedures). This was in line with changes in national definitions and rules.

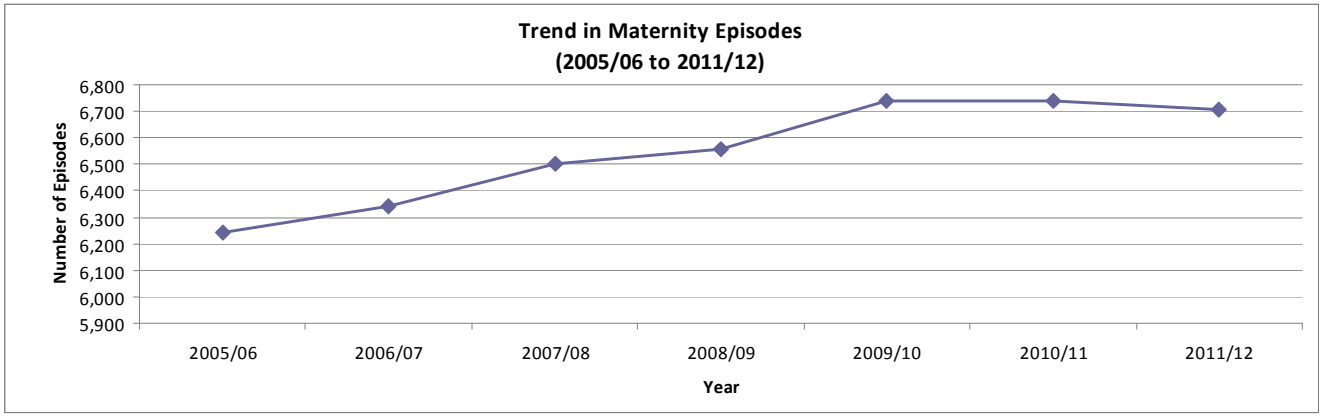
This is also demonstrated in the graphs below which show trends in activity since 2005/06.











As part of our commitment to openness, all NHS organisations include standard compliance statements relating to issues such as emergency preparedness, information governance, sustainability and complaints & principles of remedy. These statements are set out below.

Emergency Preparedness

The Trust is well prepared for major incidents and business continuity risks through an approach to resilience planning that has been strengthened during the year. A dedicated Emergency Planning Manager is in post who has updated and reviewed the Major Incident Plan and ensured compliance with the Civil Contingencies Act 2004 and related regulations and guidance including the NHS emergency planning guidance 2005. The plan has been tested during the year with two live multi-agency exercises, a table top exercise and two communications tests.

Information Governance

The Shrewsbury and Telford Hospital NHS Trust complies with the Treasury's guidelines on setting charges for information. Information on possible charges for information requested under the Freedom of Information Act and the Data Protection Act are freely available on the Trust website. All charges are in line with Department of Health guidelines.

The Trust takes its responsibilities for protecting patient information seriously, and we expect high standards of information governance from our staff. The tables overleaf identify the incidents relating to person identifiable information which were reported in the Trust in 2011/12.

Summary of significant incidents involving person identifiable data reported to the Information Commissioner in 2011/12					
Item	**Date**	**Nature of Incident**	**Nature of Date Involved**	**Number of people potentially affected**	**Notification Steps**
1	There were no significant incidents involving person identifiable data reported to the Information Commissioner during 2011/12				
Notes to table: This table sets out significant incidents relating to personal data reported to the Information Commissioner in 2011/12, in accordance with guidance from the Department of Health (Gateway 9912)					

Summary of other incidents involving person identifiable data in 2011/12		
Category	**Nature of Incident**	**Number**
I	Loss of inadequately protected electronic equipment devices or paper documents from secured NHS premises	2
II	Loss of inadequately protected electronic equipment devices or paper documents from outside secured NHS premises	1
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	8
IV	Unauthorised disclosure	35
V	Other	1
Notes to table: This table sets out other incidents relating to personal data in 2011/12, in accordance with guidance from the Department of Health (Gateway 9912)		

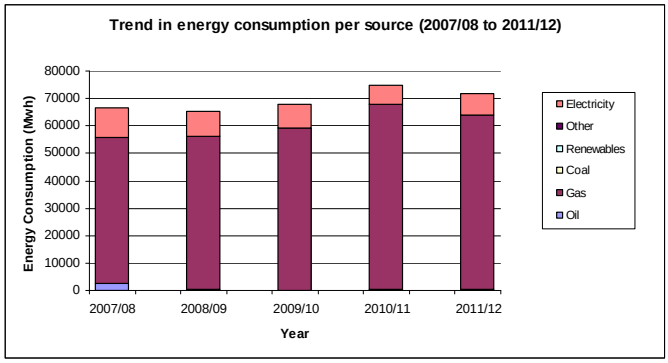
Sustainability

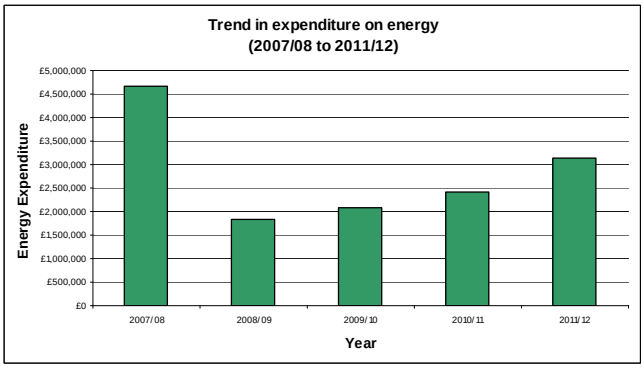
The NHS aims to reduce its carbon footprint by 10% between 2009 and 2015. Reducing the amount of energy used in our organisation contributes to this goal. There is also a financial benefit which comes from reducing our energy bill.

Our total energy consumption has fallen during the year, from 74,947 to 71,823 MWh, and our relative energy consumption has also fallen, from 0.68 to 0.65 MWh/square metre. Whilst we do not have any specific contracts for renewable energy we generate 16% of our energy on site.

Despite reduction in energy usage, high levels of fuel inflation have meant that our energy costs have increased by 30% in 2011/12, the equivalent of 129 hip operations. However, they remain significantly below levels in 2007/08 following a number of successful initiatives to reduce energy costs including the Combined Heat and Power programme.

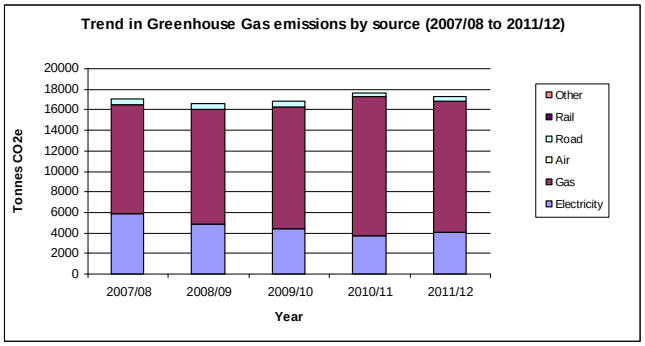
We have put plans in place to reduce carbon emissions and improve our environmental sustainability. Over the next 10 years we expect to save £287,000 as a result of these measures.

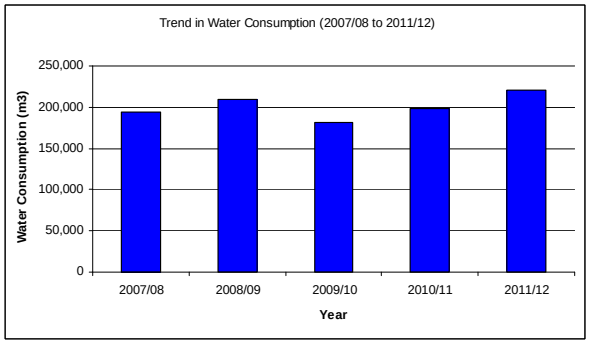




Our measured greenhouse gas emissions have reduced by 0,365 tonnes since 2010/11 (see overleaf).

We recover or recycle 257 tonnes of waste, which is 17% of the total waste we produce. Our expenditure on waste has reduced from £609k in 2010/11 to £593k in 2011/12.





Our water consumption has increased by 22,773 cubic metres since 2010/11. In 2011/12 we spent £368,722 on water.

During 2011/12 our gross expenditure on the CRC Energy Efficiency Scheme was £4,570. The CRC Energy Efficiency Scheme is a mandatory scheme aimed at improving energy efficiency and cutting emissions in large public and private sector organisations.

During 2011/12 our total expenditure on business travel was £904,651.

Our organisation has an up to date Sustainable Development Management Plan. Having an up to date Sustainable Development Management plan is a good way to ensure that an NHS organisation fulfils its commitment to conducting all aspects of its activities with due consideration to sustainability, whilst providing high quality patient care. The NHS Carbon Reduction Strategy asks for the boards of all NHS organisations to approve such a plan.

Adaptation to climate change will pose a challenge to both service delivery and infrastructure in the future. It is therefore appropriate that we consider it when planning how we will best serve patients in the future. We consider both the potential need to adapt the organisation's activities and buildings and estates as a result of climate change. Sustainability issues are included in our analysis of risks facing our organisation.

NHS organisations have a statutory duty to assess the risks posed by climate change. Risk assessment, including the quantification and prioritisation of risk, is an important part of managing complex organisations. In addition to our focus on carbon, we are also committed to reducing wider environmental and social impacts associated with the procurement of goods and services. This is set out within our policies on sustainable procurement. We have started work on calculating the carbon emissions associated goods and services we procure.

Julia Clarke is the Board Level Lead for Sustainability. A Board Level lead for Sustainability ensures that sustainability issues have visibility and ownership at the highest level of the organisation.

Staff engagement and awareness is vital to sustained improvement and in the year ahead we plan to strengthen this through, for example, considering the inclusion of sustainability issues within the job descriptions for staff.

Our organisation has a Sustainable Transport Plan, and this is developing further during 2012/13 as part of the development of our wider Travel and Transport Plan incorporating the impact of the Future Configuration of Hospital Services. The NHS places a substantial burden on the transport infrastructure, whether through patient, clinician or other business activity. This generates an impact on air quality and greenhouse gas emissions. We therefore recognise through this plan that it is important that we consider what steps are appropriate to reduce or change travel patterns.

Complaints and Principles of Remedy

The Parliamentary and Health Service Ombudsman has set out six Principles of Remedy that should be used by the NHS, namely: Getting it right; Being customer focused; Being open and accountable; Acting fairly and proportionately; Putting things right; and, Seeking continuous improvement.

The Trust has continued to take steps to incorporate the “Principles of Remedy” into its complaint handling. The Complaints Policy underwent an interim review in October 2011 and is due for further amendment in May 2012 to reflect changes in practice and process that we have introduced based on feedback from our patients and from our Centres. This includes a greater emphasis on Clinical Centres undertaking investigations and providing learning outcomes, with the Patient Services team providing a central point of contact and co-ordination, to assess and handle each case individually, and provide quality assurance with the support of the Corporate Nursing team. There has also been progress in respect of inter-agency co-operation being formalised in a joint working agreement for Shropshire and Staffordshire Health and Adult Social Care

services. This aims to provide a single and straightforward approach to handling complaints that cross service boundaries to facilitate resolution of concerns in a single response, whenever possible.

Complaint handling summary of activity for 2011/12

In 2011/12, 737 complaints were received and of those closed within the reporting period, 99% received a response within 6 months.

5% of cases handled were subject to referral to the Parliamentary and Health Service Ombudsman, but none were accepted for investigation at the second stage of the complaints process. The majority were referred back to the Trust for local resolution (for example, because the complainant had referred them to the Ombudsman before the local complaints process had concluded) or for further work at a local level. A number of cases were deemed for no further action. One case that had previously been accepted for investigation by the Ombudsman in 2010 was concluded and resulted in an upheld decision against the Trust in 2011.

Further information about complaints handling and enquiries to the Trust's Patient Advice and Liaison Service can be found in the Quality Account 2011/12.

5. Strategic Context

This is a changing and challenging strategic context for the NHS as we aim to meet growing demand, demographic changes and rising costs in the face of the changing legislation, changing markets and continued economic challenge.

Local Context

Over 99% of our services are provided to patients from Shropshire, Telford & Wrekin and northern and eastern areas in Powys. We are the main provider of acute hospital services for these communities. Whilst this puts us in a strong market position, key factors affecting our plans and priorities will include:

- Financial challenges facing local commissioners seeking efficiency savings and transfer of services from hospital to community settings
- Impact of patient choice
- Impact of local commissioning approach, including development of a "strategic partnering" for acute services in Wales that focuses on Wales-based health service providers
- Changing market context including testing the market through Any Willing Provider
- Impact on local commissioning arrangements of the transition from PCTs to Clinical Commissioning Groups
- Reflecting local demographics in our plans and priorities – such as ageing population, increasing prevalence of long term conditions, rural access
- The need for continued action by health and social care partners to reduce delayed transfers of care, which create unnecessary delays for patients and mean that acute hospital beds are not available for other patients.

Key issues for the year ahead include developing and maintaining our relationships with emerging Clinical Commissioners and working in partnership to manage the risks arising from transition in the commissioning and strategic planning tiers of the NHS.

Legislative Context

During the year the Government passed the Health and Social Care Act which will lead to significant changes within the NHS. Key factors affecting NHS Trusts include:

- Transition from PCTs to GP commissioning.
- Strengthened role of Monitor as the sector regulator, with new licensing arrangements for providers of health and care services.
- Revised engagement and scrutiny arrangements, with the establishment of statutory Health and Wellbeing Boards and Local HealthWatch
- Continued divergence in health legislation and policy between England and Wales
- Requirement for all NHS Trusts to become NHS Foundation Trusts, with a new failure regime for organisations that are not able to achieve FT status.

Political Context

There is a continued focus on quality and safety of health care, with quality measures increasingly reflected in NHS contracting. The Trust has made good progress on quality in 2011/12 and will need to continue this in order to maintain our licence to operate. For example, we are seeing the lowest ever recorded figures for MRSA and Cdiff, consistently achieving standards for assessment of risk of venous thromboembolism (VTE) and we have maintained our performance in key patient services. Our Quality Improvement Strategy sets out our plans for continued improvement.

Looking ahead to 2012/13 will see the report following the inquiry into Stafford Hospital

which is expected to have wide-ranging recommendations for quality, governance and commissioning in the NHS.

At the end of 2012/13 the local health economy will also be set for the first re-election to the unitary authority in Shropshire.

Social Context

Key issues both locally and nationally include responding to the needs of an increasing ageing population with complex needs such as long term conditions and dementia, the rising rate of obesity and increasing expectations on the standards and range of services available within a context of economic pressure. New media provide opportunities for new ways to access services, engage with services, lobby and seek redress. The Trust and the NHS as a whole will need to find new ways to harness this potential for the benefit of our patients and our financial sustainability.

Economic Context

Overall the NHS needs to make efficiency savings of £20bn over five years, and the impact of this on the Shropshire and Telford & Wrekin Health Economy will be in the region of £200m. This contributes to cost improvement programmes in the Trust and we will need to deliver savings in the region of 5p in every pound for each of the next two years. NHS organisations will need to work together with innovation and rigour to tackle these challenges whilst maintaining services for patients.

This has driven our strategy and priorities in 2011/12 and we have ended the year in recurring financial balance for the first time since the Trust was established.

Environmental Context

The Trust recognises that as a major employer and provider of services we have a significant impact on our environment and must take steps to reduce this. From this year we have begun to include expanded sustainability information in our Annual Report (see Section 4) as part of our accountability for progress and delivery. Given rising energy costs, reducing our energy consumption not only delivers our sustainability plans but also has direct benefit on the bottom line.

Whilst energy costs increased in 2011/12 the impact has been reduced by our previous work to introduce Combined Heat and Power. Continued progress will be needed in 2012/13. Other priorities include working with our communities on travel and transport planning, and developing plans for more integrated rural and telehealthcare.

Technological Context

New drugs, treatments and technologies continue to emerge for the NHS and whilst these create new opportunities for patients they also present a significant cost pressure within finite resources. Initiatives such as the Cancer Drugs Fund are now becoming fully established to help balance access and capacity. Key opportunities also include using technology to improve services and reduce overall costs to health and care, for example through telehealthcare solutions that provide more care nearer to the patient or bringing clinician and patient together without the need for travel. We have been developing our approach during 2011/12 and telehealthcare forms a key plank for our strategy going forward.

6. Financial Review

Finance Directors Report for the year ended 31 March 2012.

Financial Overview

The Trust's turnover in 2011/12 was £299.9m and made a small financial surplus of £59k.

In making this surplus the Trust was faced with an underlying recurrent deficit of £14.4m at the start of the year and although significant cost savings plans were identified and delivered, the Trust received £6.5m financial support during the year. Through this programme of support and delivery the Trust ended the year in recurrent financial balance for the first time since it was established in 2003. This provides the financial foundations that will be needed for the delivery of sustainable high quality services in the current economic climate.

Expenditure

From our total budget:

- 68% (£200.1m) was spent on staff who provide health care (e.g. doctors, nurses, midwives, therapists, healthcare assistants, radiographers) or who provide essential support services (e.g. portering, catering, cleaning, technical and scientific staff, HR, payroll).
- 17% (£51.1m) was spent on drugs, dressings and other costs directly related to providing health care.
- 9% (£28.4m) was spent on essential supplies (e.g. uniforms, linen, food and transport), accommodation (e.g. electricity, gas, water, rates, furniture) and administrative & support services (e.g. postage, telephones, training).

The remainder (6%) covered other essential costs such as finance charges in the form of depreciation charges and dividend charges (public dividend capital), and our contribution to the national Clinical Negligence Scheme for Trusts.

Income

The majority of our income 90% (£271.1m) was for clinical services, with the remainder 10% (£28.7m) for non-clinical services such as education. Nearly 92% of our clinical income came directly from our three main "commissioners" who purchased services from us on behalf of local patients and communities. These were:

- Shropshire Primary Care Trust (49% of our direct clinical income during 2011/12).
- Telford and Wrekin Primary Care Trust (35% of our direct clinical income during 2011/12).
- Powys Teaching Health Board / Bwrdd Iechyd Addysgu Powys (7% of our direct clinical income during 2011/12).

In addition to these direct contracts and service level agreements, these three organisations also commissioned certain specialist services (e.g. renal services, neonatal services) through regional consortium arrangements such as the West Midlands Specialised Commissioning Group and Health Commission Wales. Income from these regional specialised commissioning arrangements as well as "other clinical income" (such as private patients, overseas visitors and the NHS Injury Cost Recovery Scheme) accounted for the remaining 9% of income.

Finance Report

The national priorities for the NHS were set out in the NHS Operating Framework 2011/12. For the fourth year, the national priorities continued to be:

- improving cleanliness and reducing healthcare associated infections
- improving access
- keeping adults and children well, improving their health and reducing health inequalities
- improving patient experience, staff satisfaction, and engagement; and
- preparing to respond in a state of emergency such as an outbreak of pandemic flu.

The Trust Board approved a financial plan to deliver a breakeven position with the year end position delivering a £59k surplus (including £6.5m of financial support). Over the period the Trust has faced the following impacts within its financial position:

- National Tariff increases in income of £4.2m
- Increased volumes and increased mix of complex cases in income of £23.2m
- Increased usage of high cost drugs in income of £3.4m
- Investment in the skill mix of staff together with additional costs associated with employing staff of £17m
- Full implementation of the European Working Time Directive of £2m
- Increase usage of temporary and agency staff at premium rates of £5m
- Increased costs of delivering activity via non pay costs of drugs and clinical supplies of £6.6m

In line with NHS requirements the Trust reports its accounts in compliance with the NHS Trusts Manual for Accounts 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. For the year 2011/12 there has been 1 new accounting standard adopted by the Trust relating to the treatment of donated assets. As required by the adoption of this standard the prior year comparative figures have been restated within the annual accounts.

Financial Duties

The Trust achieved all of its statutory financial duties:

- To achieve a break even position on the Statement of Comprehensive Income. A surplus (before asset impairments and impact of donated assets) of £59k was recorded.
- To achieve a capital cost absorption rate of 3.5% The Trust achieved a rate of 3.5%.
- To meet the External Financing Limit which is the limit placed on net borrowing. The Trust's target of £1,029k was achieved with actual external financing of £1,027k.
- To meet the Capital Resource Limit which is the limit placed on net capital expenditure. The Trust's target of £10,200k was achieved with an actual charge against the capital resource limit of £9,200k.

Capital Programme and the Trust Estate

The Board continued to invest in the development of the Trust's facilities. In 2011/12 the Trust invested £9.2million, including:

- £2,300k for a new linear accelerator to replace existing equipment within the cancer services centre.
- £1,800k relating to initial costs of the 'Keeping It In The County' reconfiguration of services project.
- £600k to complete the off site decontamination facility.
- £450k to upgrade the Trust's telecommunications infrastructure.
- £300k for upgrades to the Trust's patient monitoring equipment.

In addition to this the Trust continued with the development of a new £5m Cancer and Haematology Centre development with financial support from a range of charitable partners including £3.2m from the Lingen Davies Cancer Appeal, £1m from the Shropshire Blood Trust Fund, £300,000 from the League of Friends of the Royal Shrewsbury Hospital, £250,000 from the Head and Neck Trust Fund and £50,000 from Head and Neck (Shropshire and Mid Wales). We are very grateful to all these charitable supporters and to Lingen Davies for their latest appeal to raise £386,000 for equipment, furniture and fittings.

Towards the end of the year we also received confirmation that we had been successful in securing an investment of £35m in public dividend capital to support the "Keeping It In The County" reconfiguration of hospital services. The Full Business Case received final approval from the NHS Midlands and East strategic health authority cluster shortly after year end in May 2012.

Managing Risks

The Trust's Risk Management Strategy defines leadership, structure and the risk management processes, to ensure a continuous assessment of risk throughout the organisation. The strategy is reviewed annually. In the National Health Service Litigation Authority (NHSLA) General Standards the Trust currently holds Level 1 and the Trust's is working toward a level 2 assessment. The Trust also currently holds Clinical Negligence Scheme for Trusts (CNST) Level 2 in maternity and is working towards a level 3 assessment.

The Board Assurance Framework provides a simple but comprehensive method for the effective and focused management of the principal risks to meeting the organisations objectives. The Trust has made significant progress on achieving an integrated approach to governance and has developed its assurance system by aligning the Trust's current objectives, Board Assurance Framework, Care Quality Commission Standards, and risk registers. The Trust Board identified 9 principal risks for 2011/12. These risks focused on the following areas:

1 Inadequate Financial Performance
2 Failure to deliver reconfiguration
3 Failure to meet performance requirements
4 Poor patient flow
5 Poor patient care
6 Health and Social Care Act
7 Inadequate management capacity and capability
8 Failure to ensure right staff, right patient
9 Poor information systems

The Chief Executive chairs the Risk Management Executive, and the other Directors with delegated responsibility for risk management sit on this committee which is the Executive committee responsible for managing risk and compiling the Corporate Risk Register.

Further information can be found within the Annual Governance Statement which is included with the Annual Accounts in Appendix 5.

Supplementary Financial Information

Carrying valuation of land: As at 31 March 2012 the Trust's Directors confirm the carrying valuation of land is £26.29m and reflects the market valuation for existing use.

Treatment of pensions liabilities in the accounts: Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period. The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. Further details of these valuations can be found within the Notes to the Accounts of the Trust's Annual Accounts for 2011/12.

External Constraints and Key Dependencies: The Trust is governed by the Department of Health and its performance is monitored locally by West Midlands Strategic Health Authority along with other NHS organisations regionally and locally (e.g. the Care Quality Commission). The Trust's ongoing activity is dependent upon continued referral of patients from local healthcare commissioners, the most significant of which are Shropshire County PCT, Telford & Wrekin PCT and Powys Teaching Health Board. In England, patient referral is also dependent on the choices made by patients following the introduction of patient choice across a growing range of health care services. During the year the West Midlands Strategic Health Authority formed part of a new SHA cluster arrangement for the Midlands and East of England, Shropshire County PCT and Telford & Wrekin PCT formed part of a new PCT cluster arrangement for West Mercia and increasing responsibility for performance management was devolved from the SHA cluster to the PCT cluster.

Related Party Transactions: During the year, none of the Department of Health ministers, Trust Board members or members of the key management staff or other related parties undertook any material transactions with the Trust.

Better Payment Practice Code: The Better Payment Practice Code requires the Trust to aim to pay valid invoices by the due date or within 30 days of receipt of goods or valid invoice, whichever is later. In 2011/12 the Trust achieved 80% in the year for non NHS invoices and 91% for NHS invoices (by value). The Trust made minimal payments of interest to small businesses under The Late Payment of Commercial Debts (Interest) Act 1998.

Non-NHS Bills	Year Ended 31 March 2012		Year Ended 31 March 2011	
Item	**Number**	**£000**	**Number**	**£000**
Total Bills Paid	89,887	98,915	79,843	77,157
Total Bills Within Target	75,177	78,743	28,605	33,104
Total	84%	80%	36%	43%

NHS Bills	Year Ended 31 March 2012		Year Ended 31 March 2011	
Item	**Number**	**£000**	**Number**	**£000**
Total Bills Paid	2,170	19,505	2,259	22,361
Total Bills Within Target	1,921	17,716	798	9,412
Total	89%	91%	35%	42%

Prompt Payment Code: The Trust is an approved signatory of the Prompt Payment Code.

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

External Auditors: The Trust's external auditors are appointed by the Trust Board. During the year the Trust's activities and accounts were audited by KPMG LLP, One Snowhill, Snow Hill, Queensway, Birmingham, B4 6GH. The baseline annual audit fee for the year was £171,000 (excluding VAT) and included the core audit work of the financial statements, the whole of government accounts and the value for money audit. KPMG LLP did not complete any further work for the Trust that was outside of the core statutory audit.

7. Our Staff and Partners

Our workforce is our most valuable asset and drives our future success. As a Trust we spend 68% of our resources on pay and continue to focus on supporting and developing our workforce to deliver services for the future within the resources available to us.

Workforce Profile

In 2011/12 our substantive workforce grew by 253 staff, bringing the number employed to 5390. Given that many of our staff work part-time this represents 4521 whole-time equivalent (wte). Our substantive workforce at 31 March 2012 included approximately:

- 513 wte doctors and dentists (11.3%)
- 1,366 wte nursing and midwifery staff (30.2%)
- 578 wte scientific, technical and therapies staff (12.8%)
- 1,213 wte other clinical staff (26.8%)
- 852 wte non-clinical staff (18.8%)

In addition to this the available workforce at year end included over 400wte further staffing through bank and agency.

Expenditure on staff accounts for approximately 68% of our expenditure.

There are currently over 500 volunteers active in the Trust and we work closely with our main charitable partners (including Leagues of Friends at our two main hospitals, WRVS and the Lingen Davies Cancer Appeal).

Workforce Strategy

We are ambitious about ensuring that our organisation is a great place to work. Our aim is to develop our workforce as our strongest ambassadors, proud to work for our organisation and of the care we will deliver.

In October 2011 the Trust appointed a Workforce Director for the first time, providing senior leadership for our workforce strategy and workforce development. Since her appointment, Victoria Maher has led the development of a Workforce Strategy driven by our organising principle – Putting Patients First - to support the organisation to achieve our vision to be ambitious about changing healthcare for the better by adopting a planned yet visionary approach to the leadership of our workforce.

During the year we completed our work to develop our new clinically-led management structure based around eleven Clinical Centres. We have also continued the work to put in place systems and processes to support them to manage and deliver quality, safety, performance, finance and workforce targets. This work will continue into 2012/13 as the Centres become fully established and begin their first full year of operation.

Our workforce priorities for 2011/12

A major focus for 2011/12 has been to improve patient flow both within our hospitals and at the interface with primary and community care. Based on benchmarking with similar organisations across the country, the Trust recognised that we had significantly more inpatient beds than the average. As we still receive the same income as other hospitals based on national tariff the result was that our resources – including our staff – were spread too thinly. We set ourselves challenging targets to achieve the standards in the best performing hospitals by improving flow, reducing unnecessary delays and improving safety. This has included a new strategy (the BED Bundle) to improve patient care, make better use of our resources and support a reduction in our bed base. There has been a significant workforce element to this work, both to support staff to put in place new working practices but also to consult, engage and support staff through the bed reduction programme.

Alongside this we have undertaken a detailed review of ward establishment, using measures such as dependency and acuity rates to review our nurse to bed ratios. This is driving our future ward staffing model which is set out in a detailed workforce plan.

A further priority has been the Future Configuration of Hospital Services Programme. This aims to ensure safe and sustainable hospital services in Shrewsbury and Telford, with a particular focus on maternity, children's services and acute surgery. During the year we have undertaken detailed workforce planning to support the future shape of services, as part of the development of the Outline Business Case in Autumn 2011 and the Full Business Case in Spring 2012. A significant development and support programme will be put in place to support over 600 staff directly affected by the proposals and over a thousand further staff who are indirectly affected by these plans.

Looking Ahead

All NHS organisations need an ambitious change agenda to maintain quality and meet growing demand whilst resources reduce in real terms. The Shrewsbury and Telford Hospital NHS Trust is no exception, and our priorities going forward must focus on supporting our workforce whilst living within our means.

Based on the contracts we expect from our commissioners, the Trust will make plans to reduce the workforce by around 10% over the next year. This is broadly similar to our annual turnover of 8%, so by taking co-ordinated action to keep control of recruitment (particularly of temporary, bank and agency staff), manage reductions through turnover and offer a mutually agreed resignation scheme our aim is to keep redundancies in our permanent workforce to a minimum

In addition to the considerable change agenda we have identified two key workforce priorities for the year ahead. The first relates to Staff Survey results (see Appendix 2). Our results this year do not represent the employment experience we want our workforce to have. Moving forward we will focus on what needs to take place to ensure our organisation is a great place to work and ensuring our staff deliver excellent patient care. Our focus will be to improve our results by 10% in two key factors: staff recommending the Trust as a place to receive care, and staff recommending the Trust as a place to work. We will use our workforce strategy to support improvements in these areas.

Our second priority is to reduce our sickness absence levels. Our current sickness absence rate is 4.3% (down from 4.4% last year) and we have set a target of 3.4% to be achieved by 31st March 2013. Absence creates a cost and quality impact for the organisation, for example through the additional costs of temporary staff who are less familiar with the organisation. By taking a strategic approach to health and wellbeing alongside improved staff engagement and a revised sickness policy we will deliver an increase in staff satisfaction, a reduction in absence and a decrease in costs.

Health and Wellbeing

The health and well-being of staff is imperative to ensure the delivery of safe and quality services to our patients. This means that as an organisation, we support staff to assess and take responsibility for their own health, as well as promoting healthy options and providing preventative services to our Workforce.

Informed by the 2009 Boorman Review we have refreshed our approach to Health and Wellbeing. During 2012/13 we will be strengthening our approach to engagement, recognition and empowerment.

During the year we have introduced or supported a number of new initiatives to support staff health improvement, including drop-in sessions for smoking cessation and weight loss advice. The Trust also offers fast-track access to physiotherapy for staff referred through Occupational Health.

Staff Engagement

We continue to maintain strong working relationships with our staff-side representatives based on partnership working. In addition we use a range of mechanisms to provide information to, and consult with our staff. During the year this has included an intranet site for staff, monthly Quality News email newsletter, Staff Update Quarterly newsletter to all staff in payslips, open staff briefings by the Chief Executive and other Directors, workshops and roadshows to raise awareness of specific issues (e.g. BED bundle, protected mealtimes), a series of six Staff Conversations led by the Chief Executive to help us to understand what is important to our staff, and a new "buddying" system where each of the Executive Directors is linked with one or more of our Clinical Centres.

The introduction of Listening into Action during the year is already beginning to deliver seen benefits and we intend to build on this in the year ahead.

Shortly after the year end, in April 2012, we are also are carrying out an Organisational Cultural Assessment survey to better understand how people feel about the Trust.

We are working closely with our staff-side colleagues and with staff through our change programmes to ensure that the workforce is well supported and remains well motivated. We have in place communication and engagement strategies and the Trust is running a series of workshops designed to help those who manage and are affected by change to respond and deal with it more effectively.

In order to ensure that the impact of bed closures and reconfiguration of hospital services on other clinical services is taken into account, a multi-professional approach has been taken with the engagement of representatives from all areas, as well as our staff-side colleagues.

Equality and Diversity

The Trust has a strong commitment to equality and diversity.

Our Employment of People with Disabilities Policy recognises the significant value that people with disabilities can provide in the Trust and the framework of support that needs to be in place to support this. We encourage employment applications from all individuals based on the skills, experience and knowledge that they can contribute to the organisation. We monitor the effectiveness of our policy in is monitored in a number of ways including: audit of equal opportunity monitoring forms; and, submitting an annual staff profile report to the Trust Board. From this year we have also begun to include a staff diversity profile within our annual report (see Appendix 3) to support our openness and accountability to improve equality.

The Trust understands that it has an important role to play in the communities it serves, both as an employer and a provider of healthcare services. The Equality & Diversity policy makes clear the Trust's commitment to preventing discrimination and promoting equality and diversity in both spheres of responsibility.

The Trust has endorsed the adoption of the Equality Delivery System, an NHS-wide performance and equality assurance framework, and work is on-going to incorporate it into existing systems and structures.

To ensure compliance with the Equality Duty section of the Equality Act 2010, (the Act), the Trust has published certain information in relation to its workforce and policies and services that may affect people within protected characteristics. Publication of this information helps us to demonstrate our commitment to:

- Eliminating unlawful discrimination, harassment and victimisation, and any other conduct prohibited by the Act.
- Advancing equality of opportunity between people who share a "protected

characteristic" (as defined in the Act) and people who do not share it.

- Fostering good relations between people who share a protected characteristic, and people who do not share it.

The Trust has also developed its Equality and Diversity goals for 2012/13 as part of its commitment to deliver healthcare services that are equitable to all users. The services delivered should be appropriate to everyone's needs regardless of age, disability, gender re-assignment, marriage and civil partnership, pregnancy and maternity, race including nationality and ethnicity, religion or belief, sex or sexual orientation.

The Trust aims to ensure:

- an environment in which employees, patients and visitors are treated with consideration, dignity and respect, free from harassment and intimidation.
- employees and job applicants do not receive less favourable treatment on the grounds of any of the above reasons
- that patients and visitors do not suffer detriment, disadvantage or unequal treatment for any of the above reasons

The Trust has again been awarded the disability 'Two Ticks' symbol, and actively seeks to promote the standards that this represents. We are monitored on an annual basis by the Employment Service to ensure we are compliant with all of the standards the symbol represents.

Approximately 80% of our workforce is female, and 9% are from ethnic minority backgrounds, compared to a local population figure of about 2%.

Pay and Conditions

Pay and conditions for the significant majority of NHS employees are set out in Agenda for Change terms and conditions and the Consultant Contract. In 2011/12 there was no general national uplift against the pay points on either the Agenda for Change payscale or the consultant contract, other than for staff on lower pay brackets of Agenda for Change. This was reflected locally.

However, Agenda for Change and Medical and Dental staff terms and conditions of employment provide for annual pay increments towards a "top of scale" point. This means that in 2011/12, approximately 60% of our staff employed on Agenda for Change terms and conditions continued to receive a pay increase by progressing to the next pay point. In addition, 20% of consultants received seniority increments. In 2011/12 these increments accounted for an increase of over £1m in the Trust's pay bill.

During the year a number of HR policies have been updated to ensure that they comply with legislation and employment best practice and are fit for purpose in our organisation.

- Dignity at Work: This has been updated to reflect the latest guidance and requirements from the NHS Litigation Authority and legislative changes.
- Verification of Professional Registration : This has been updated to reflect the new online checking processes for the Nursing and Midwifery Council and to give guidance on responsibilities for managers undertaking checks online at the recruitment stage (where an online facility is available) for all professions where registration is required. Clarification is also provided on the procedure to be followed if employee fails to maintain registration.
- Recruitment & Selection: This has been updated to reflect the latest guidance and requirements from the NHS Litigation Authority and legislative changes.
- Disability: This has been updated to replace the Pre-employment Health Questionnaire with a Work Based Health Assessment Questionnaire as defined in equality legislation.
- References: This is new policy was introduced in Spring 2011 to clarify the roles

and responsibilities in relation to giving references on behalf of the Trust.

- Management of Corporate and Local Induction: This policy was updated to reflect NHSLA requirements and incorporated a more robust monitoring process to ensure that new staff complete local and corporate induction.
- Management of Organisational Change: This policy has been updated to provide clarification for all those involved in organisational change. The policy now outlines more clearly the principles and processes to be used when implementing change.

Learning and Development

During 2011/12, the Trust has continued to work in partnership with a range of Higher and Further Educational institutions to ensure that staff have the clinical, professional and leadership managerial skills to provide safe and effective services to our patients.

As a teaching hospital, and under the leadership of Hospital Dean, Dr John Jones, the Trust provides teaching and clinical placements for students engaged on the Keele University MBChB accredited by the General Medical Council. During 2011/12, we provided accredited teaching and placements for medical students on years 3, 4 and 5. Some of the final year students then applied for our Foundation Doctor positions and will be staying on with the organisation, providing a level of continuity and a high quality service to our patients. Another measure of the success of the Undergraduate School is that we have been asked by Keele to host the final Observed Structured Clinical Examinations (OSCEs) early in 2012-13.

At Postgraduate Level, the Trust provided over 80 Foundation Doctor positions in conjunction with the West Midlands Deanery. An essential part of clinical development, these training positions combine a comprehensive education programme with practical skills enhancement to recently qualified doctors. The Trust also supports Core Medical and Dental Training positions at all levels, as well as providing placement and administrative support for the Vocational Training Scheme for GPs across Shropshire.

The Trust worked in partnership with Staffordshire University to provide practical placements for nursing students in both hospitals, with qualified Trust nursing staff acting as mentors to these nurses in training.

Recognising the importance of having skilled staff at all levels of the organisation, the Trust invested in the vocational development of staff in Agenda for Change Bands 1-4 and over 140 staff completed National Vocational Qualifications during 2011/12, including Healthcare Assistants, Porters and Domestic and Catering Staff.

The Trust launched its Leadership Academy November 2011 to provide an overarching strategic approach to the development of skilled leaders at all levels of the organisation. A key element has included the development of a Senior Leader development programme in partnership with Warwick Business School which is focused on the needs of the Centre Chiefs and their leadership teams. The first cohort is under way and a second cohort of this programme will run from October 2012. In conjunction with Staffordshire University, the Postgraduate Certificate in Management in Healthcare Environment by Negotiated Learning continues to provide middle managers in clinical and non-clinical roles with the opportunity to take their learning back into their own ward or work area. A range of other leadership development opportunities and support have been established during 2011/12, including the development of 14 accredited coaches. The Trust will expand this programme in 2012/13.

During 2011/12, the Trust provided an extensive programme of training and support to all staff including statutory and mandatory training, clinical skills development and personal and professional skills development.

Priorities for 2012-13 will include:

- Ensuring the learning and development programme puts patients first
- Continuing to improve our Leadership skills
- Ensuring that all staff meet fundamental requirements (in line with our NHS Litigation Authority level 2 commitment)
- Supporting the Centres to manage their staff effectively
- Supporting staff to carry out their roles well in changing circumstances
- Delivering high quality education to staff and students within resource constraints

NHS Constitution for England

The NHS Constitution sets out the rights and responsibilities for patients, staff and NHS organisations in the NHS in England. During 2011/12 the Trust has continued to strive for the highest standards of care in line with the NHS Constitution. However, as described elsewhere in this Annual Report we have faced particularly challenges in relation to waiting times for planned care and in Accident & Emergency. Improvement in waiting times is a key priority for 2012/13 and we will be working with the NHS West Mercia PCT Cluster to implement a campaign to raise awareness of rights and responsibilities in the NHS Constitution.

Building relationships with GPs

Understanding how well we are doing and how patients and GPs view our services is a key factor to inform our plans and the development of our clinical services.

For many of our patients their views and experiences are communicated to us through their GPs. We recognise the importance of strong relationships and robust communication channels with our GPs who in many cases are our patients' representatives. In 2008 we appointed a GP Liaison Manager to establish a GP Liaison service to provide a dedicated point of contact. Our GP Liaison Manager works closely with local practices to develop and strengthen relationships providing a proactive and responsive support to GPs in their dealings with the Trust; gathering feedback on issues affecting GPs and working with Trust colleagues to support continuous improvement. The GP Liaison service has become an established source of support within GP practice teams, and there is daily contact with a number of practices across the Trust's catchment area to pick up concerns and resolve problems.

During 2011/12 we established a formal process, conducted through a short questionnaire, to collect feedback from GP practice teams to help us to understand how satisfied they are with our services. The results from this GP Satisfaction Survey form part of our Integrated Performance Report which is presented regularly to the Trust Board. Listening to, and acting on this feedback, is essential to guide us in making changes to the way we do business in order that we provide the quality of services that our patients deserve. Building relationships with GPs is recognised as a Trust priority, and we will need to continue to build and strengthen engagement between GPs and Clinical Centres, as GPs take on their roles of both providing and commissioning health care. We also produce regular GPConnect newsletters which are issued to all general practice teams, with news updates from the Trust; and details of educational and learning events for GPs.

Our priorities for 2012/13 and beyond include the further development of these key relationships The Trust intends to utilise a number of strategic initiatives including, a formal GP Engagement Strategy and an account management approach to maintain and improve relationships with local GPs and to develop new relationships with GPs out of the county. Working in partnership with GPs and the local Clinical Commissioning Groups will ensure that we deliver services that are patient focused and meet the needs of our local population.

8. Improving Our Services

Every year we undertake a wide range of programmes to improve our services. This section of our Annual Report provides four examples of our work in 2011/12.

Artist impressions of the new women and children's facilities

Safe and Sustainable Hospital Services

During the year we have continued with our major programme to ensure the safety and sustainability of local hospital services. We face significant challenges to maintain safe local hospital services in the county future. These challenges particularly affect inpatient acute surgery, inpatient children's services and the services currently provided in the deteriorating women and children's building at the Royal Shrewsbury Hospital. Addressing these challenges has meant finding new ways to keep services safe and keep them local.

Central to our plans has been our aim to keep as many services as possible at both hospitals. Overall, these changes are expected to affect about 1 in every 50 patient contacts with most services continuing as they are now. This will include most outpatient appointments, planned surgery and procedures (most of which are undertaken in an outpatient setting or as a daycase procedure), emergency medical care, diagnostic procedures, midwife-led births, A&E attendances and more.

Following the Keeping It In The County consultation in 2010/11, the valuable feedback we received from our patients, communities, staff and partner organisations has helped us to develop and agree the Outline Business Case which was approved in Autumn 2011. This set out plans for the Royal Shrewsbury Hospital to become our main centre for inpatient acute surgery and the Princess Royal Hospital to become our main centre for inpatient women and children's services.

The next step has been the development of the Full Business Case which was approved by NHS Midlands and East shortly after year end in May 2012.

Building work for the new Women and Children's Unit at the Princess Royal Hospital will begin during 2012 ready for the new services to open in 2014. Alongside this the Royal Shrewsbury Hospital is set to become the main centre for acute surgery this summer.

Improving Unscheduled Care

Too many patients spend too long in hospital, often due to unnecessary delays in their care or treatment or because of something that has happened to them during their stay (e.g. if they have fallen). By reducing unnecessary delays we can offer a better experience for our patients, improve safety and reduce the risk of harm, use our resources more wisely and release time to care.

With this in mind, frontline staff in the Trust devised the BED Bundle. This sets out four simple actions that will have a big impact on better care. The B refers to a Board Round by 9.30am every day, where a senior clinician makes sure that there is a plan for patients for the day (e.g. those awaiting discharge). This complements the more detailed consultant ward rounds. The E refers to Expected Date of Discharge (EDD), our aim being that every patient has an EDD that is know to ward staff, the patient and their relatives. This helps to ensure that there is a plan in place that everyone knows about. The D refers to discharging 50% of patients before midday. This is about getting into the habit of timely discharge (for example, reducing delays in discharge letters and treatments to take home) and making sure that beds are available for new patients coming into hospital. The final element of the BED Bundle is "Before 10" which encourages all medical wards to accept a patient from the Medical Assessment Units by 10am in the morning. This helps to keep the flow of patients through our hospital. Overall this helps to ensure that the right patient gets the right care in the right place at the right time from the right clinician.

Renal patients at the Trust are being given more freedom than ever before thanks to new portable dialysis equipment. This allows patients to carry out shorter, more regular dialysis sessions at home, meaning many can have an unrestricted diet, reduce their medication, and travel away from the UK taking the equipment with them.

Pictured above is renal patient David Whysall with Avril O'Gorman, home haemodialysis sister at the Trust, and Andrew Walker, clinical nurse specialist for Kimal PLC, the company responsible for distributing the new equipment.

Providing Care Closer to Home

As a Trust we are not just a provider of acute hospital care, but have an important role in providing and supporting integrated, person-centred care in the community. During the year we have continued to support local initiatives to provide care closer to home, for example through consultant-led outreach clinics at the Robert Jones and Agnes Hunt Orthopaedic and District Hospital and at community hospitals in Bridgnorth, Ludlow, Newtown, Welshpool and Whitchurch.

One major development that took place in the past year was the opening of a new renal unit at Ludlow Community Hospital. This satellite unit managed by the Trust means some patients no longer have the added burden of a 60-mile round trip to Shrewsbury alongside their treatment, which can usually be four-hour dialysis sessions three times a week. Providing care closer to people's homes is a priority for the Trust, and there is scope for the service to expand in future to meet the demand for local kidney dialysis services.

This development also means that patients holidaying in and around South Shropshire can now benefit from the excellent services being offered by the new unit. Ludlow is situated in an area of outstanding natural beauty close to the Welsh borders and a popular tourist destination. There is a wide variety of accommodation available within easy reach of the unit.

Our pilot programme for Early Supported Discharge for patients following stroke was also very successful, and we hope to gain support from our commissioners to continue and extend this service during 2012/13. This service forms part of a wider programme for the improvement of stroke services, including the expansion of our stroke thrombolysis service which treated its 100th patient during the year.

Working with Charitable Partners to Improve Care

Every year the Trust and our patients benefit from the incredible efforts of fundraisers to support local hospital services. Our main charitable fundraising partners include the Lingen Davies Cancer Appeal, the League of Friends of the Princess Royal Hospital and the League of Friends of the Royal Shrewsbury Hospital. Alongside this our patients and services benefit from direct donations to the Trust's own charitable funds as well as support from a wide range of local charitable and voluntary groups focusing on specific conditions and services such as diabetes, heart services, breast cancer and many more besides.

The most significant development that has taken place in the past year thanks to the dedication and effort of fundraisers supporting the Trust is the work to build a new £5 million cancer and haematology centre at the Royal Shrewsbury Hospital. The Lingen Davies Cancer Appeal was at the forefront of this campaign raising £3.2m, and their focus is now on an appeal to raise nearly £400,000 for equipment and facilities.

The League of Friends of the Royal Shrewsbury Hospital has had another busy year making donations of nearly one million pounds (£932,758) to support services across the hospital. This money helped to strengthen patient care by putting funds towards the new cancer and haematology centre (£300,000), replacing and upgrading patient monitors (£175,000), and new resuscitation machines for the Maternity Department (£120,000).

It has been a landmark year for The League of Friends of the Princess Royal Hospital who passed the £3 million fundraising mark since they were established. The group has been supporting the hospital for 27 years and helped to provide a wide range of new equipment, such as £35,000 for new non invasive ventilation kit. In all the group made donations worth £204,233 to the hospital in the past 12 months.

We have also benefited from the generosity of individuals and groups from across Shropshire, Telford & Wrekin, and mid Wales throughout the year and are grateful for their continued support. Charitable donations continue to make a significant difference to the services we can offer to our patients.

A friendly Stormtrooper™ helps League of Friends Chairman Jayne Mott with the summer raffle.

9. Our Organisational Structure

The Shrewsbury and Telford Hospital NHS Trust is an NHS Trust established in accordance with the National Health Service Act 2006 and related legislation. It is led by a Board of Directors responsible for all aspects of the Trust's performance including high standards of clinical and corporate governance.

Members of the Trust Board: Chairman and Non-Executive Directors

Dr John Davies, Chairman

Dr Davies has held a wide variety of Executive and Director level appointments in both the UK and overseas. These have mainly been in the oil and chemicals sector. John graduated with a PhD in chemical engineering from Birmingham University and then moved to the USA to work for Amoco in Chicago. During a 20 year career with Amoco he held positions in research, production, marketing and finance, including assignments in Madrid and London. Following a period as Managing Director-Finance at Texas Eastern Corporation, John was appointed Chief Executive of the Kemira Group, based in Chester, with responsibility for 5 operating sites across the UK. In 1998, John joined Biocode Inc, a company specialising in providing innovative biotechnology solutions for product security, as Chief Executive. This business was successfully sold in 2005 and since then he has developed a portfolio of consultancy and non executive activities.

- Term: January 2010 to December 2013 (first term)
- Political activity: None
- Trustee of Market Drayton Action for Health
- Councillor of Moreton Say Parish Council
- *Formerly Chairman of Moreton Say Parish Council (expired interest)*

Mrs Sue Assar, Non-Executive Director

Sue Assar worked for the NHS as a senior manager for over 30 years in a variety of hospital and Health Authority posts in the south east and north west of England. Her last substantive post was as Chief Executive of Central Manchester PCT, a position she held for six years. She now works as a management consultant and retains a keen interest in health and health services.

- Term: June 2008 to May 2012 (first term)
- Political activity: None
- Director of Assar Consulting Limited which seeks to do business with the NHS.

Sue's term of office ended shortly after the year end in May 2012 and she did not apply for reappointment.

Mr Martin Beardwell, Non-Executive Director and Vice-Chairman

Martin retired from a career in personnel management in 1992. During his career he worked in both private and public sectors, and his special interests were in industrial relations and training & development. He was elected as Fellow of the Chartered Institute of Personnel and Development. Martin came to Shropshire in 1974 to set up the personnel function for the former Salop Area Health Authority. Following retirement from mainstream employment he continued as an HR consultant. He also served as a magistrate in Shropshire for 33 years and as a member of Employment Tribunals for 19 years. Martin has been a Non Executive director of the Trust since it was established in October 2003 and was elected Vice Chairman in 2007.

- Term: October 2011 to September 2013 (third term)
- Political activity: Martin was elected to Shropshire County Council as a Liberal Democrat Councillor for Quarry division in 1993. He became a senior politician and was Leader of the Council in 1999. He did not seek re-election in 2005.
- Director, Impact Alcohol Advisory Services

Mr Dennis Jones, Non-Executive Director

Dennis is a former qualified accountant (CIPFA) and has over 20 years experience in senior level financial and corporate services management. He was deputy corporate director for education at Shropshire County Council, where his responsibilities included strategic financial planning and management, and subsequently Director of Finance and Administration for the General Teaching Council for England, where he had responsibility for financial and corporate services including establishing and leading on audit, internal control and risk management. In March 2008, Dennis retired from this post having joined the Trust as non-executive director in December 2007. In addition, he had director responsibility for the delivery of two major public services in Shropshire, has developed and managed performance management systems and undertook a lead role in establishing a new public sector organisation, including a period where he acted as interim Chief Executive.

- Term: December 2011 to November 2015 (second term)

- Political activity: None
- No interests to declare

Mr Barry Simms, Non-Executive Director

Barry is a former Fellow of the Chartered Institute of Cost and Management Accountants. He was previously finance director and deputy managing director of AEA Battery Systems as well as finance director of AGM Batteries Limited. Prior to this he had a long career in the automotive components industry having held directorships with European subsidiaries of Dana Inc. and several UK subsidiaries of GKN plc. In addition to his executive operational management experience his expertise was in business start-ups and change-management, whilst actively involved in management development and team building. He also had executive involvement in Mergers and Acquisitions, as well as divestments activities whilst cultivating relationships with investors and the relevant local political community.

- Term: June 2008 to May 2012 (first term)
- Political activity: None
- No interests to declare

Barry Simms was reappointed for a second term of office shortly after the year end from June 2012.

Dr Peter Vernon, Non-Executive Director

Dr Peter Vernon is currently managing director of innovation consultancy Alberi Limited. He has considerable experience of implementing strategic plans in an operational environment from his work in a range of roles in the UK and abroad for Boots Healthcare International, including Head of Professional Marketing, responsible for the development of a global marketing strategy and as General Manager for the firm's Italian business with profit and loss responsibility. Peter formerly worked in the fields of research and development for Unilever.

- Term: January 2011 to December 2015 (second term)
- Political activity: None
- Managing Director of Alberi Limited
- Director of H10 Limited
- Related to the Directorate Manager of Facilities

Dr Simon Walford, Non-Executive Director

Dr Simon Walford, of Bridgnorth, has extensive experience in specialist medical practice and senior NHS medical management. He was a consultant physician specialising in diabetes and endocrinology in the NHS for over 20 years, the medical director at the Royal Wolverhampton Hospitals NHS Trust, a clinical advisor to the Care Quality Commission and a senior medical advisor in the Department of Health focusing in transforming emergency care. He left the NHS in 2007 to work in independent practice as a clinical management consultant. He has held a number of non-executive roles in not-for-profit organisations, and is currently Chairman of Governors of Wolverhampton Grammar School and a member of the Board of the University of Wolverhampton.

- Term: October 2010 to September 2014 (first term)
- Political activity: None
- Chairman of Governing Body, Wolverhampton Grammar School
- Governor, University of Wolverhampton
- Director, Wolverhampton Academies Trust
- In receipt of an NHS Pension

Members of the Trust Board; Chief Executive and Executive Directors

Mr Adam Cairns, Chief Executive

Adam joined the Trust in July 2010 having previously been Chief Executive of Airedale NHS Foundation Trust, leading a significant turnaround of the Trust including their achievement of NHS Foundation Trust status. He started work in the NHS as a National Management Trainee in 1983. He has held a variety of senior posts in Yorkshire and the North West. His previous posts include Director of Communications and Corporate Affairs at Leeds Teaching Hospitals NHS Trust, Director of Acute Medicine and Cardiovascular Services at Leeds Teaching Hospitals NHS Trust and Director of Service Contracting and Director of the Yorkshire Heart Centre at the United Leeds Teaching Hospitals Trust. Adam is the former founding nonexecutive Director of Medipex, the NHS intellectual property exploitation company.

- Appointed July 2010
- Occasional paid consultancy work for Guidepoint Global Advisers

Adam Cairns will be leaving the Trust in June 2012 for a new role as Chief Executive of Cardiff and Vale University Health Board.

Mrs Julia Clarke, Director of Compliance and Risk Management (Company Secretary) - non-voting

Julia joined the Trust in March 1986 working part-time until 1993 when she was appointed Head of Clinical Audit. Since that time she has held a number of different roles across the Trust, primarily focusing on governance and compliance, working closely with clinical staff across both hospital sites. She was born in Telford and now lives in Shrewsbury and has strong family links to all parts of Shropshire and Mid-Wales. She has a keen interest in security issues for staff and patients and is Deputy Chairman of the NHS National Security Management Accreditation Board and is also a Fellow of the Chartered

Institute of Personnel and Development and a member of the institute of Chartered Secretaries and Administrators

- Appointed January 2004 (Director of Corporate Affairs until September 2010)
- Chairman of Shropshire Council's Standards Committee
- Deputy Chairman of the National Security Management Professional Accreditation Board
- Shropshire Education & Conference Centre SECC Trustee

Dr Ashley Fraser, Medical Director

Dr Ashley Fraser is a histopathologist by background. This is his second appointment as a local Medical Director having previously been the Medical Director of the former Royal Shrewsbury Hospitals NHS Trust until 2002. Recently he was Medical Director of NHS Employers, a national body that represents trusts in England on workforce issues including pay & negotiations and recruitment policy & practice. In this role he led the Medical Workforce Programme which included Medical Leadership, Revalidation, Accreditation and Medical Performance & Professionalism as key workstreams.

- Appointed May 2011
- Trustee of Shropshire Education and Conference Centre Company Limited;
- Chairman of Shropshire Education and Conference Centre Company Limited;
- Hon. Colonel 202 (Midlands) Field Hospital;
- Co-opted Member of the BMA Medical Managers Sub Committee.

Dr Fraser formally retired from the Trust on 31 March 2012 but has kindly agreed to return as medical director during 2012/13.

Mrs Vicky Morris, Chief Nurse and Director of Quality and Safety

Vicky was appointed in January 2011 having first joined the Trust in an interim capacity in 2010. This is Vicky's third executive director position having previous worked as Executive Director of Nursing at two specialist Trusts. Vicky trained at Guy's Hospital in London and worked in a range of clinical and managerial roles before her first appointment to a Board level position in 2003. Vicky was nominated to the national NHS Top Leaders Programme in 2010, and has also led major regional programmes such as the "Image of Nursing" in 2009/10.

- Appointed January 2011
- No interests to declare

Mr Neil Nisbet, Finance Director

Neil joined the Trust in April 2011, having previously been a Finance Director for twelve years and most recently Director of Organisational Resources and Director of Finance at Wolverhampton City PCT.

- Appointed April 2011
- No interests to declare

Mrs Debbie Vogler, Director of Business and Enterprise (formerly Director of Strategy) – non-voting

Debbie started her career in the NHS in 1978 as a Microbiologist, achieving her Fellowship in Biomedical Sciences in 1983. In 1996 she moved to Heart of England NHS Trust and held a number of general manager posts before taking a project Director post to lead their Foundation Trust application. She was subsequently appointed to the former Birmingham and the Black Country SHA to lead the FT Diagnostic Programme. In this role, Debbie supported the national roll out of both the FT and PCT Fitness for Purpose assessments and, following the merger of the three SHAs in the West Midlands, she was successful in obtaining the post of FT development lead for NHS West Midlands. She joined the Trust in 2006 as the Director of Strategy, with her role changing to Director of Business and Enterprise in January 2012.

- Appointed November 2006 (Director of Strategy until December 2011)
- No interests to declare

Executive Directors who left the Trust during the year:

Tina Cookson, Chief Operating Officer to October 2011

- None

Board Evaluation

In support of our wider organisational development and specifically our NHS Foundation Trust application the Trust has implemented a Board Development programme in line with the key components of High Performing Boards and Monitor's requirements. During 2011/12 we have focused on Board Capacity and Capability with a review led by Chantry Vellacott looking at (a) Board Papers (b) Board Capacity and Capability Assessment and (c) Board Development Workshop and Action Plan. This work is continued in 2012/13, aligned with our FT application process.

Board Meetings

The Trust Board met 12 times during the year in addition to the Annual General Meeting. Meetings of the Trust Board are held in public. Board papers are published on the Trust website.

Trust Board Attendance	Year Ended 31 March 2012
Name and Title	**Attendance**
Dr John Davies Chairman	11 of 12 1 of 1 AGM
Sue Assar Non-Executive Director	12 of 12 1 of 1 AGM
Martin Beardwell Non-Executive Director	12 of 12 1 of 1 AGM
Dennis Jones Non-Executive Director	10 of 12 1 of 1 AGM
Barry Simms Non-Executive Director	11 of 12 1 of 1 AGM
Dr Peter Vernon Non-Executive Director	8 or 12 1 of 1 AGM
Dr Simon Walford Non-Executive Director	9 of 12 1 of 1 AGM
Adam Cairns Chief Executive	10 of 12 1 of 1 AGM
Julia Clarke Director of Compliance and Risk Management (Company Secretary)	9 of 12 0 of 1 AGM
Tina Cookson Chief Operating Officer	To October 2011 6 of 7 1 of 1 AGM
Dr Ashley Fraser Medical Director	9 of 12 1 of 1 AGM
Vicky Morris Chief Nurse / Director of Quality and Safety	10 of 12 1 of 1 AGM
Neil Nisbet Finance Director	11 of 12 1 of 1 AGM
Debbie Vogler Director of Business and Enterprise	7 of 12 1 of 1 AGM

Notes: Debbie Vogler extended sickness absence for two Trust Board meetings

The Board receives reports from the Audit Committee, Finance and Performance Committee, Charitable Funds Committee, Quality and Safety Committee, Remuneration Committee. All committees are chaired by non-executive directors. In addition the Trust Board receives reports from the Hospital Executive Committee, chaired by the chief executive, and regular reports on finance, performance, quality and risk. These reports ensure that the Trust Board can reach informed and considered decisions and ensure the Trust meets its objectives.

Audit Committee

The Audit Committee exists to ensure that the Trust's activities and financial systems comply with relevant guidance and codes of conduct and to provide assurance that risk management and internal control are effective. The audit committee met regularly throughout the year. Chaired by non-executive director Dennis Jones the committee comprises three non-executive directors (including the committee chair). Committee meetings are attended regularly by the internal and external auditors, finance director, director of compliance and risk management and chief compliance officer. Other executive directors attend by invitation. The committee met on six occasions during the year. This included one special meeting to review the annual accounts.

Audit Committee Attendance	Year Ended 31 March 2012
Name and Title	**Attendance**
Dennis Jones (Chair) Non-Executive Director	6 of 6
Sue Assar Non-Executive Director	6 of 6
Dr Simon Walford Non-Executive Director	4 of 6
Attendees	
Chris Benham Assistant Director of Finance	6 meetings
Julia Clarke Director of Compliance and Risk Management (Company Secretary)	4 meetings
Dr Ashley Fraser Medical Director	4 meetings
Clare Jowett Chief Compliance Officer	4 meetings
Vicky Morris Chief Nurse and Director of Quality and Safety	1 meeting
Neil Nisbet Finance Director	4 meetings
Counter Fraud	4 meetings
External Audit	5 meetings
Internal Audit	5 meetings

More information about the Trust's external auditors can be found in Section 6.

Remuneration Committee

The Remuneration Committee sets and implements policy for the remuneration of executive directors (and other senior designated staff) and considers the performance of the executive directors. It is chaired by the Trust chairman and comprises all other non-executive directors. The chief executive and the workforce director attend by invitation.

The committee met on three occasions in 2011/12 (30 June 2011, 24 November 2011 and 23 February 2012).

The Remuneration Committee has developed an annual business cycle to ensure a planned approach is achieved. A key focus for the year ahead is the performance of the organisation and the contribution of the executive team, and the committee will formally receive performance information relating to the executive team twice a year. The committee will continue to ensure the appropriate structure of executive team and senior managers within the organisation; including regular feedback on the clinically led management structure put in place through Devolution and Co-operation.

Within its planning the committee will also consider the national landscape regarding pay and ensure appropriate action if required.

Remuneration Committee Attendance	Year Ended 31 March 2012
Name and Title	**Attendance**
Dr John Davies Chairman	3 of 3
Sue Assar Non-Executive Director	2 of 3
Martin Beardwell Non-Executive Director	2 of 3
Dennis Jones Non-Executive Director	2 of 3
Barry Simms Non-Executive Director	2 of 3
Dr Peter Vernon Non-Executive Director	3 of 3
Dr Simon Walford Non-Executive Director	2 of 3
Attendees	
Adam Cairns Chief Executive	3 of 3
Victoria Maher Workforce Director	From October 2011 2 of 2
William Wraith, Head of Human Resources	To July 2011 1 of 1

Other Board Committees

The tables below set out the non-executive attendance at the other committees of the Trust Board during the year.

Charitable Funds Committee Attendance	Year Ended 31 March 2012
Name and Title	**Attendance**
Sue Assar (Chair) Non-Executive Director	From July 2011 3 of 3
Martin Beardwell Non-Executive Director	4 of 4
Dennis Jones Non-Executive Director	3 of 4
Dr Peter Vernon (Chair) Non-Executive Director	To July 2011 1 of 1

Finance and Performance Committee Attendance	Year Ended 31 March 2012
Name and Title	**Attendance**
Barry Simms (Chair) Non-Executive Director	8 of 10
Dr John Davies Chairman	10 of 10
Dennis Jones Non-Executive Director	9 of 10
Martin Beardwell Non-Executive Director	10 of 10

Quality and Safety Committee Attendance	Year Ended 31 March 2012
Name and Title	**Attendance**
Dr Peter Vernon (Chair) Non-Executive Director	8 of 9
Martin Beardwell Non-Executive Director	9 of 9
Dr Simon Walford Non-Executive Director	7 of 9
Vicky Morris Chief Nurse	9 of 9
Dr Ashley Fraser Medical Director	7 of 9
Tina Cookson Chief Operating Officer	To October 2011 2 of 6

Hospital Executive Committee

The Hospital Executive Committee is responsible for the day-to-day running of the Trust, its operational policies and performance. The Hospital Executive Committee comprises the Trust's senior clinical and corporate leaders. The members of the Hospital Executive Committee at the end of the year were as follows:

Centre Chiefs

- Dr Saif Awwad, Centre Chief for Oncology and Consultant Clinical Oncologist
- Mr Ewan Craig, Centre Chief for Ophthalmology and Patient Access and Consultant Ophthalmologist
- Mr Tony Fox, Centre Chief for Surgery and Consultant General and Vascular Surgeon
- Dr David Hinwood, Centre Chief for Diagnostics (job share) and Consultant Radiologist
- Dr John Jones, Centre Chief for Medicine and Consultant Gastroenterologist
- Dr Rob Law, Centre Chief for Emergency and Critical Care and Consultant Anaesthetist
- Dianne Lloyd, Centre Chief for Therapies and occupational therapist
- Prof Archie Malcolm, Centre Chief for Diagnostics (job share) and Consultant Histopathologist
- Bruce McElroy, Centre Chief for Pharmacy and pharmacist
- Mr Piers Moreau, Centre Chief for Musculoskeletal Services and Consultant Orthopaedic Surgeon
- Mr Andrew Prichard, Centre Chief for Head & Neck Services and Consultant ENT Surgeon
- Mr Andrew Tapp, Centre Chief for Women and Children's Services and Consultant Obstetrician and Gynaecologist

Clinical Champions / Value Stream Leads

- Mr Chris Beacock, Deputy Medical Director and Consultant Urological Surgeon
- Mr Mark Cheetham, Value Stream Lead for Scheduled Care and Consultant General and Colorectal Surgeon
- Dr Kevin Eardley, Value Stream Lead for Unscheduled Care and Consultant Renal Physician
- Dr Mark Prescott, Value Stream Lead for Telehealthcare (job share) and Consultant Physician in Emergency Medicine
- Dr Narayanan Srihari, Value Stream Lead for Cancer Care and Consultant Clinical Oncologist
- Dr Darren Warner, Value Stream Lead for Telehealthcare (job share) and Consultant Physician in Diabetes and Endocrinology

Chief Executive and Executive Directors

- Adam Cairns, Chief Executive (Chair)
- Julia Clarke, Director of Compliance and Risk Management (Company Secretary)
- Dr Ashley Fraser, Medical Director and Consultant Histopathologist
- Victoria Maher, Workforce Director
- Vicky Morris, Chief Nurse and Director of Quality and Safety
- Neil Nisbet, Finance Director
- Adrian Osborne, Communications Director
- Steve Peak, Transformation Director
- Andrew Stenton, Interim Director of Operations
- Debbie Vogler, Director of Business and Enterprise

The Hospital Executive Committee was fully established in this form from October 2011 when the Clinical Centres were established in the Trust.

Shortly before the year end, Trust Chief Executive Adam Cairns announced that he had been appointed to a new role as Chief Executive of Cardiff and Vale University Health Board and would be leaving the Trust during Q1 2012/13. Recruitment is under way for his successor with an announcement expected during Q1 2012/13.

Audit Declaration

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

Register of Interests

The Trust holds a register of interests of the members of the Trust Board. Directors are asked to declare any interests that are relevant or material on appointment and should a conflict arise during their term. The register of interests, which is updated and published annually, is maintained by the Board Secretary and available to the public via our website at www.sath.nhs.uk within the papers of the Trust Board meeting. A copy can be obtained from the Trust or viewed by appointment. The declarations of interests of the members of the Trust Board during the year are included above.

Trust membership

The Trust is currently working on its application for NHS Foundation Trust status. As part of this we are developing a shadow membership of Public Members and Staff Members. Ahead of authorisation as an NHS Foundation Trust we will hold our first elections for elected Public Governors and Staff Governors on the Trust's Council of Governors. When we are authorised as an NHS Foundation Trust our Annual Report will include information about our membership and how we engage with them.

Information about Trust membership is available from our website at www.sath.nhs.uk of from the Trust Membership Office on 01743 261473 or members@sath.nhs.uk

10. Remuneration Report

The salary and pension entitlements for the Trust's senior managers and directors for the financial year are shown in Appendix 4. This includes the real increase in pensions during the reporting year, the value of accrued pension at the end of the reporting year and related pension lump sum at age 60, the value of "Cash Equivalent Transfer Value" (CETV) and the real increase of CETV during the year.

The remuneration report describes the remuneration of the senior managers and directors of the Trust, namely the voting and non-voting directors who are members of the Trust Board. This includes the Chairman, Non-Executive Directors, Chief Executive, Finance Director, Chief Nurse, Medical Director, Chief Operating Officer (until October 2011), Director of Business and Enterprise and Director of Compliance and Risk Management.

The remuneration of the Chairman and Non-Executive Directors are determined by the independent Appointments Commission which is responsible for non-executive appointments to NHS Trusts on behalf of the Secretary of State for Health.

The remuneration of the Chief Executive and all other Executive Directors is determined annually by the Remuneration Committee and is based on national guidance issued by the Department of Health. The Remuneration Committee comprises the Chairman and Non-Executive Directors of the Trust. Directors or other staff may be required to attend the Committee to present information and reports. Details of the remuneration committee can be found in Section 9.

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

The expenses of the members of the Trust Board are reported on an annual basis on the Trust website.

Performance review and appraisal of the Trust Chairman is undertaken by the Chairman of West Midlands Strategic Health Authority on behalf of the Secretary of State in accordance with appraisal guidance provided by the Appointments Commission. Performance review and appraisal of the Non-Executive Directors is undertaken by the Trust Chairman in accordance with appraisal guidance provided by the Appointments Commission.

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

The Chairman and Non-Executive Directors are appointed for terms of up to four years in accordance with Appointments Commission guidance and procedures. Information about the terms and durations can be found in Section 9.

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

Salary increments for the Chief Executive and Executive Directors are discretionary (other than for part of the salary of the Medical Director which was linked to the national pay awards for medical consultants) and there is no

contractual entitlement to any increase in salary. Any increments are therefore based on performance against agreed criteria. Last year there was no general increase in the national Agenda for Change pay scale for NHS staff nor in pay for medical consultants. The Trust decided not to award its executives a pay increase in 2011/12. The Trust does not operate a bonus system.

Other than for the remuneration shown in Appendix 4, no financial awards were made to past or present senior managers.

There were no severance payments made to the Directors of the Trust in 2011/12.

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

The banded remuneration of the highest paid director in The Shrewsbury and Telford Hospital NHS Trust in 2011/12 was £160-165k (2010/11, £190-195k). In 2011/12 the highest paid director was the Chief Executive and in the prior year the highest paid director was the previous Medical Director.

This was 6.83 times (2010/11, 7.90) the median remuneration of the workforce which was £24,072 (2010/11, £24,059) based on whole-time equivalent.

In 2011/12, 25 (2010/11, 14) employees received remuneration in excess of the highest-paid director. Remuneration ranged from £160-165k to £225-230k (2010/11, £190-195k to £285-290k).

Total remuneration includes salary, non-consolidated performance-related pay (not applicable to any member of staff in 2011/12), benefits in kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The main reasons for the reduction in the pay multiple from 2010/11 to 2011/12 are:

- Change in Medical Director and associated remuneration
- Chief Executive's remuneration had full year effect in 2011/12 and part year effect in 2010/11

The salaries and pension entitlements of the Trust's senior managers and directors for 2011/12 and 2010/11 are shown in Appendix 4.

Adam Cairns
Chief Executive
7 June 2012

Appendix 1

Quality Report 2011/12

Quality Report 2011/12

Our Annual Report and Annual Accounts 2011/12 has been developed to meet the reporting requirements for NHS Trusts set out in the NHS Finance Manual: Manual For Accounts, and to incorporate where appropriate the reporting requirements for NHS Foundation Trusts.

The inclusion of NHS Foundation Trust reporting requirements supports us on our journey to NHS Foundation Trust status.

NHS Foundation Trusts are required to include a Quality Report as an appendix to their Annual Report. The Quality Report is developed to reflect the reporting requirements for the mandatory Quality Account.

We will include a Quality Report in our Annual Report and Annual Accounts from 2012/13. In 2011/12 our Quality Account is published as a separate document and is available from our website at www.sath.nhs.uk. It is also available on request from the Chief Nurse / Director of Quality and Safety, The Shrewsbury and Telford Hospital NHS Trust, Royal Shrewsbury Hospital, Mytton Oak Road, Shrewsbury SY3 8XQ.

Appendix 2

Staff Survey Results

Staff Survey Results

Summary of Staff Survey Results

Response Rate	2011		2010		
	SaTH	National Average for Acute Trusts	SaTH	National Average for Acute Trusts	Change
Response Rate	56%	54%	54%	54%	Improved by 2% and exceeds national average

Top 4 Ranking Scores	2011		2010		
	SaTH	National Average for Acute Trusts	SaTH	National Average for Acute Trusts	Change
Key Finding 2 - % of staff agreeing that their role makes a difference to patients	91%	90%	87%	90%	Increased by 4%
Key Finding 19 - % of staff saying hand washing materials are always available	69%	66%	75%	67%	Decreased by 6%
Key Finding 21 - % of staff reporting errors, near misses or incidents witnessed in the last month	97%	96%	99%	95%	Decreased by 2%
Key Finding 37 - % of staff believing the Trusts provides equal opportunities for career development or promotion	91%	90%	91%	90%	No Change

Bottom 4 Ranking Scores	2011		2010		
	SaTH	National Average for Acute Trusts	SaTH	National Average for Acute Trusts	Change
Key Finding 9 - % of staff using flexible working options	53%	61%	57%	63%	Decreased by 4%
Key Finding 15 – Support for immediate managers	3.44	3.61	3.51	3.61	Decreased by 0.07
Key Finding 17 - % of Staff suffering work-related injury in last 12 months	21%	16%	23%	16%	Decreased by 2%
Key Finding 23 - % of staff experiencing physical violence from patients, relatives or the public in the last 12 month	13%	8%	10%	8%	Increased by 3%

Appendix 3

Staff Profile Statistics

Profile of staff employed by the Trust at 31 March 2012

Age	31 March 2012	
	Head Count	Percentage
16-20	36	0.7%
21-30	974	18.1%
31-40	1,222	22.7%
41-50	1,677	31.1%
51-60	1,211	22.5%
61+	270	45.0%
Total	5,390	100.0%

Disability	31 March 2012	
	Head Count	Percentage
Yes	113	12.1%
No	3,188	59.1%
Not recorded/disclosed	2,089	38.8%
Total	5,390	100.0%

Ethnicity	31 March 2012	
	Head Count	Percentage
Asian or Asian British	265	4.9%
Black or Black British	63	1.2%
Chinese or Other	95	1.8%
Mixed	31	0.6%
White	4,680	86.8%
Not recorded/disclosed	256	4.7%
Total	5,390	100.0%

Gender	31 March 2012	
	Head Count	Percentage
Female	4,318	80.1%
Male	1,072	19.9%
Total	5,390	100.0%

Relationship Status	31 March 2012	
	Head Count	Percentage
Civil Partnership	8	0.1%
Divorced	397	67.4%
Legally Separated	47	0.9%
Married	3,253	60.4%
Single	1,518	28.2%
Widowed	57	1.0%
Not Recorded/Disclosed	110	2.0%
Total	5,390	100.0%

Religion/Culture	31 March 2012	
	Head Count	Percentage
Atheism	266	4.9%
Buddhism	14	0.3%
Christianity	2,483	46.1%
Hinduism	67	1.2%
Islam	73	1.4%
Judaism	1	0.0%
Sikhism	20	0.4%
Other	97	1.8%
I do not wish to disclose	2,234	41.4%
Not stated	135	3.0%
Total	5,390	100.0%

Sexual Orientation	31 March 2012	
	Head Count	Percentage
Bisexual	14	0.3%
Gay	12	0.2%
Heterosexual	2,967	55.0%
Lesbian	3	0.1%
I do not wish to disclose	2,253	41.8%
Not stated	141	2.6%
Total	5,390	100.0%

Future Annual Reports will include annual trend data for the Staff Profile.

Appendix 4

Remuneration Tables

The Shrewsbury and Telford Hospital NHS Trust Accounts for the Period Ended 31 March 2012

The tables below set out the salary and pension entitlements of senior managers, namely the directors who were members of the Trust Board during the year either as voting or non-voting members.

Remuneration	Year Ended 31 March 2012		Year Ended 31 March 2011	
Name and Title	Salary (bands of £5000) £000	Benefits in Kind (to nearest £100) £	Salary (bands of £5000) £000	Benefits In Kind (to nearest £100) £
Dr John Davies Chairman	20-25	0	20-25	0
Sue Assar Non-Executive Director	5-10	0	5-10	0
Martin Beardwell Non-Executive Director	5-10	0	5-10	0
Dennis Jones Non-Executive Director	5-10	0	5-10	0
Barry Simms Non-Executive Director	5-10	0	5-10	0
Dr Peter Vernon Non-Executive Director	5-10	0	5-10	0
Dr Simon Walford Non-Executive Director (from 1.10.10)	5-10	0	0-5	0
Adam Cairns Chief Executive (from 1.7.10)	160-165	7100	120-125	3000
Julia Clarke Director of Compliance and Risk Management (company secretary) (non-voting)	85-90	0	85-90	0
Tina Cookson Chief Operating Officer (to 31.10.11)	65-70	0	30-35	0
Dr Ashley Fraser Medical Director (from 16.3.11)	160-165	2800	5-10	100
Vicky Morris Chief Nurse / Director of Quality and Safety (from 17.1.11)	90-95	2900	15-20	700
Neil Nisbet Finance Director (from 1.4.11)	110-115	5500	0	0
Debbie Vogler Director of Business and Enterprise (non-voting)	85-90	800	85-90	1000

Notes:

- All members are voting members unless indicated to the contrary

- Tina Cookson's salary in 2010/11 re-charged from NHS Stoke-on-Trent
- No members of the Trust Board received "other remuneration" in 2010/11 or 2011/12
- Figure represent actual remuneration rather than full-year effect

Pension Benefits	Year Ended 31 March 2012							
Name and Title	Real increase (decrease) in pension at age 60 (bands of £2500) £000	Real increase (decrease) in pension lump sum at age 60 (bands of £2500) £000	Total accrued pension at age 60 at 31 March 2012 (bands of £5000) £000	Lump sum at age 60 related to accrued pension at 31 March 2012 (bands of £5000) £000	Cash equivalent transfer value at 31 March 2012 £000	Cash equivalent transfer value at 31 March 2011 £000	Real increase (decrease) in cash equivalent transfer value £000	Employer's contribution to stakeholder pension £000
Adam Cairns Chief Executive	2.5-5	2.5-5	55-60	175-180	1,030	867	136	0
Julia Clarke Director of Compliance and Risk Management (Company Secretary) (non-voting)	2.5-5	(10-12.5)	20-25	50-55	380	395	(28)	0
Tina Cookson Chief Operating Officer to 31/10/11	5-7.5	15-17.5	40-45	125-130	738	559	162	0
Dr Ashley Fraser Medical Director	5-7.5	12.5-15	75-80	230-235	0	0	0	0
Vicky Morris Chief Nurse / Director of Quality and Safety	2.5-5	10-12.5	25-30	75-80	424	306	108	0
Neil Nisbet Finance Director	5-7.5	15-17.5	35-40	105-110	620	452	155	0
Debbie Vogler Director of Business and Enterprise (non-voting)	0-2.5	(0-2.5)	35-40	110-115	670	595	57	0

Notes:

- Dr Ashley Fraser retired on 31 March 2012. He served a leave of absence from the Trust in April 2012 and returned from 1 May 2012 as a non-contributing member of the NHS Pension Scheme, continuing as the Trust's Medical Director.

Appendix 5

Annual Accounts 2011/12

Statement of the Chief Executive's Responsibilities as the Accountable Officer of The Shrewsbury and Telford Hospital NHS Trust

The Chief Executive of the NHS has designated that the Chief Executive of the Trust 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 Department of Health. 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.

Adam Cairns
Chief Executive
7 June 2012

Annual Governance Statement

Scope of Responsibility

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 whilst safeguarding the public funds and the organisation's assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Accountable Officer Memorandum.

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Shrewsbury and Telford Hospital NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Shrewsbury and Telford Hospital NHS Trust for the year ended 31 March 2012 and up to the date of approval of the annual report and accounts.

As the Accountable Officer for the Trust I ensure that the Trust works closely with the Strategic Health Authority (SHA) and other partner organisations, through various reporting processes. Examples of such processes are:

A Risk Management Strategy, updated and reviewed each year by the Trust Board is in place. It clearly defines the risk management structures, accountabilities and responsibilities throughout the Trust and reflects the Trust's management and governance structure. All serious incidents are reported to NHS Midlands and East and Commissioners and to other bodies in line with current reporting requirements (e.g. the Care Quality Commission (CQC)). As Accountable Officer for the Trust I have overall accountability and responsibility for ensuring the Trust meets its statutory and legal requirements and adheres to guidance issued by the Department of Health in respect of Governance.

The Trust Board agrees the Annual Financial Plan, which is then reported to the NHS Midlands and East. In addition to this the Trust sends regular financial monitoring returns throughout the year.

The Quality Account is published annually. It discusses the care provided for patients, describing what is done well but also what needs to be improved.

The Assurance Framework sets out the Trust's objectives and provides a clear template to identify any risks to achieving those objectives and a clear framework against which to measure progress.

The governance framework of the organisation

In 2010/11, the Trust reviewed its committee structure and corporate governance arrangements to ensure that it met the latest governance requirements. The Trust considered a wide range of best practice recommendations and guidance. This was further informed by the Francis Inquiry and the Healthy NHS Board.

The Board of Directors met publicly every month throughout the year (with an additional meeting for the AGM in September) and the agenda included an opportunity for members of the public to ask questions related to the matters under discussion.

The Board has five standing Committees and additionally there are two executive committees accountable to the Trust Board through the Accountable Officer.

Two of the standing Committees are Non-Executive Committees (Audit, Remuneration). Although these Committees have a membership consisting of only Non-Executive Directors, other Directors will attend as required:

- The Audit Committee is responsible for oversight and scrutiny of the Trust's systems of internal control and risk management. It is the senior Board committee taking a wide responsibility for scrutinising the risks and controls which affect all aspects of the organisation's business. The Audit Committee met 6 times during 2011/12. It is chaired by a Non-Executive Director, who is a qualified accountant and who submits a regular report to the Trust Board
- The Remuneration Committee is responsible for determining the broad remuneration policy and performance management framework and to set individual remuneration arrangements for the Trust's senior managers. The Committee meets at least once a year, and more often as required.

Three other Committees are chaired by a Non-Executive Director (Finance and Performance, Quality and Safety, and Charitable Funds). The Non-Executive Directors provide challenge to the Directors at these committees and this is recorded in the meeting minutes.

- The Finance and Performance Committee is a formal sub-committee of the Board. It was established to provide additional assurance to the Board on finance and performance including national and local targets. The Committee met on 10 occasions during 2011/12

and submits a report to the Trust Board following every meeting.

- The Clinical Quality and Safety Committee is a formal sub-committee of the Board. It was established to provide assurance to the Board on Clinical Quality & Safety, (including Clinical Effectiveness, Patient Safety and Patient Experience) utilising best practice metrics that provide robust clinical governance processes to deliver safe, high quality and patient centred care. The Committee started the year meeting monthly but moved to bimonthly meetings in November. A report is submitted to the Trust Board following every meeting.
- The Charitable Funds Committee is a formal sub-committee of the Board. It was established to provide assurance to Corporate Trustees and to oversee the investment and utilisation of Trust Funds.

The remaining two Committees (Hospital Executive Committee and Risk Management Executive) are chaired by the Chief Executive and are executive in nature.

- The Hospital Executive Committee oversees the Trust' s policy and delivery of its objectives. It is chaired by the Chief Executive and meets monthly. The role of the Hospital Executive Committee is to inform and implement the Trust Board's policy and the strategic directions of the organisation and to reach decisions on and monitor the progress of, the Trust business and organisations objectives on matters delegated to it by the Trust Board. The summary of this meeting is submitted to the Trust Board.
- The Risk Management Executive is responsible for providing leadership for the co-ordination and prioritisation of clinical, non-clinical and organisational risk, ensuring that all significant risks are properly considered and communicated to the Trust Board. The Risk Management Executive provides assurance to the Trust Board that the systems for risk management and internal control are effective. The summary of this meeting is submitted to the Trust Board. A Risk Management Executive annual report has been produced comparing the work undertaken over the year, with the terms of reference. This resulted in areas for improvement for 2012/13.

All of the Committee Chairs present a summary of each meeting to the Board throughout the year highlighting areas of concern. For example the Audit Committee highlighted concerns in relation to medical records and Finance and Performance Committee highlighted concerns related to CIP performance and capital planning.

The Trust is starting to review the effectiveness of each Committee by a comparison of the workplan against the agreed terms of reference. This will be rolled out to all Committees in 2012/13.

The attendance records of all the Committees demonstrated that they operated in line with the requirements of their Terms of Reference.

In support of our wider organisational development and specifically our NHS Foundation Trust application the Trust has implemented a Board Development programme in line with the key components of High Performing Boards and Monitor's requirements. During 2011/12 we have focused on Board Capacity and Capability with a review led by Chantry Vellacott looking at (a) Board Papers (b) Board Capacity and Capability Assessment and (c) Board Development Workshop and Action Plan. This work is continued in 2012/12, aligned with our FT application process. The review was conducted with reference to: –

- The Intelligent Board (Dr Foster: 2006)
- Integrated Governance Handbook (DoH: 2006)
- NHS FT Code of Governance (Monitor: 2006) & Monitor briefing on effective governance (2008)
- New Voices, New Accountabilities (FTN)
- The Higgs Report (2003) - The Combined Code on Corporate Governance (Financial Reporting Council: 2003)
- The Healthy Board (DoH & National Leadership Council: 2010)

The assessment was conducted through a series of one-to-one meetings with the Chair, Chief Executive, and all executive and non-executive directors over the period 18th July 2011 to 30th August 2011, preceded by a Board observation on 30th June 2011.

This review resulted in a Board capacity and capability action plan, and was agreed by the Trust following consideration of the recommendations. The action plan contains three schedules of points arising. These schedules set out the points specific to each of the three aspects – (i) organisational understanding, (ii) operation of the Board and its committees and (iii) capable Board to deliver.

No departures from the Corporate Governance Code were highlighted.

Risk Assessment

The Board Assurance Framework provides a simple but comprehensive method for the effective and focused management of the principal risks to meeting the organisations objectives. The Trust has made significant progress on achieving an integrated approach to governance and has developed its assurance system by aligning the Trust's current objectives, Board Assurance Framework, Care Quality Commission Standards, and risk registers.

The Board Assurance Framework is developed annually by the Board who review known and potential risks which

threaten the achievement of the organisational objectives, the existing control measures and where assurances are gained. It is formally presented to the Board twice a year with quarterly updates to at least four meetings of the Audit Committee per year.

The framework is used to identify where there are gaps in control and assurance with action plans drawn up to address these where appropriate. The Assurance Framework also mapped back to the Care Quality Commission Essential Standards of Quality and Safety.

Each presentation includes:

- A high level summary with a RAG rating for each risk and an indication of whether the control of the risk is improving
- Board Assurance Framework Heat Map
- Detailed Board Assurance Framework and Action plan
- Schedule and status of external assurances

The Chief Executive chairs the Risk Management Executive, and the other Directors with delegated responsibility for risk management sit on this committee which is the Board sub-committee responsible for managing risk and compiling the Corporate Risk Register.

The Risk Management Executive Group receive all Centre risks rated above an acceptable level (according to the Risk Management Strategy) to review and ensure consistency before referring to the Board. These are then reviewed and updated by the relevant manager every month. The Audit Committee and Trust Board reviews outcome summaries of the Risk Management Executive meetings. Centres report to the Audit Committee on their key risks and governance arrangements.

The Trust has a risk matrix which identifies risks across a number of criteria including patient experience, objectives risk, business interruption/HR issues/adverse publicity, and financial implications. The likelihood of each risk is also considered, giving an overall risk rating score, which is then mitigated according to the controls in place to minimise the risk.

Risk assessment is a key feature of all normal management processes. All Centres, Departments, Ward and Team leaders have an ongoing programme of proactive risk assessments. The acceptability of risk is a complex issue and will vary according to local circumstances. The risk tool allows for the categorisation of risks into levels of acceptability effectively governed by the timing of subsequent actions.

Registers of risks are held on the web-based risk register system. This allows risk and action owners to update the status of assigned risks and actions. The system holds a structured set of risk registers for each centre and corporate department, as well as strategic and Trust-wide risks. It enables the compilation of organisational risk registers and reporting at corporate, operational, centre or departmental level. Risks are mapped to the key organisation objectives.

The principal risks facing the organisation during 2011/12 were organised into nine key themes; some of which were identified as new risks. The risks were as follows:

1. Inadequate Financial Performance

This risk carried forward from 2010/11 and had a number of components including failure to achieve Income and Expenditure (I&E) surplus, liquidity and CIP plans. Scrutiny of plans took place through the Programme Board and Finance & Performance Committee. The Trust had a financial plan to achieve a balanced position at year end but delivered a small surplus following transitional support of £6.5m from the SHA which was non-repayable.

2. Failure to deliver reconfiguration

This risk relates to a failure to deliver key milestones in Future Configuration of Hospital Services (FCHS) resulting in unsustainable service delivery. The project has been monitored by the Programme Board with a detailed project plan with clear milestones & delivery targets to ensure individuals held responsible for their defined actions. Actions have been on track.

3. Failure to meet performance requirements

This risk had a number of interrelated components including failure to deliver national targets linked to a mismatch in capacity and demand. At the year end, performance underachieved the 95% A&E targets (94.31%); the RTT target was also underachieved for admitted patients in March (82.02% against 90% target); the non-admitted target was achieved. This overall performance was a significant improvement on the earlier position and was the result of a considerable effort to improve the situation as the Trust had been the worst performer in the Country earlier in the year. At the end of the year, the backlog of patients waiting to be treated was a sustainable 600-700, compared to 5000 earlier in the year.

The targets for infection control, stroke and cancer were met.

4. Poor patient flow

Delayed transfers of care was one component of poor patient flow and the position in relation to this target improved significantly over the year. Poor patient flow also impacted on the number of inpatient outliers and the ability to achieve national targets (see previous risk).The organisation focussed on mitigating this risk with the implementation of the Bed Bundle and has seen a significant improvement in patient flow which has allowed the closure of 100 beds.

5. Poor patient care

This risk has been mitigated by a number of actions. The Trust trained over 100 clinicians Leading Improvement in Patient Safety (LIPS) methodology in June 2011 and

these methodologies have been used to progress a number of projects. At the beginning of the year, the Trust's Hospital Standardised Mortality Ratio (HSMR) was higher than the national average. Significant progress has been made throughout the year and there has been a downward trend which has seen bigger improvements than the national index

Interventions are being targeted at wards with higher than average numbers of complaints, pressure ulcers and falls with the aim of providing support and development to improve quality to patients

6. Health and Social Care Act

This risk was newly identified in 2011/12 and related to the fragmentation of commissioning responsibility between PCT & cluster resulting in lack of clarity around decision making. Regular meetings have been held with PCT and cluster colleagues and, although the Department of Health has introduced greater clarity with the cluster role more clearly defined, the process of Clinical Commissioning Groups is still not clear.

7. Inadequate management capacity and capability

This risk was newly described at a time of reorganisation. Throughout the year, the management vision described in the Trust document, 'Devolution and Cooperation' has been implemented, largely mitigating the risk at senior level.

8. Failure to ensure right staff, right patient

There were two components to this risk. The first related to insufficient clinical leadership across the organisation (resulting in lack of improvement in safe patient care). This risk was recognised during 2010/11 and as a result the trust programme of reorganisation ('Devolution and Cooperation') from three divisions to 11 clinical centres was put into place. Each clinical centre is led by a senior clinician in the role of Centre Chief. A development programme is in place to support the transition to clinical management.

The second component of the risk related to the lack of suitably trained or supervised staff delivering care. The nurse recruitment strategy has been successful in reducing the numbers of nursing vacancies. However, it is proving more challenging to fill medical posts due to a lack of suitable applicants. The agreed reconfiguration options currently being discussed will mitigate these risks. The Outline Business Case was approved in September 2011 and the Full Business Case approved by Board in April 2012.

9. Poor information systems

It has been recognised that there is a lack of resource, knowledge and infrastructure for IT and performance management. There were problems in relation to patient waiting times which arose from this risk. A significant amount of effort has been invested to improve the operation of systems led by the Director of Operations.

The issues were highlighted by the Finnamore review into the Sema PAS system which was issued in November 2011.

Issues with the resilience of the IT networks were highlighted in year and although unlikely, the impact on the Trust would be catastrophic should the risk materialise. Options for enhancing the resilience of the networks were explored with additional measures put in place.

There were two data lapses in the year which the PCT asked to be classified as level 2 incidents (these are the incidents which are reported to the Information Commissioner). The first incident related to the theft of confidential information from a locked and alarmed car. The information was subsequently retrieved and had not been removed from the brief case. However as this information covered less than 20 individuals, it did not meet the criteria for a level 2 incident. There was a full investigation into this case. The second incident concerned the transmission of a large number of staff records via email to an approved business partner, without sufficient security measures in place. There was no evidence that the records had been intercepted however, the Trust took this incident very seriously and put in more stringent security measures and a programme of staff training in the relevant HR department.

The national priorities for the NHS were set out in the NHS Operating Framework 2011/12. For the fourth year, the national priorities continued to be:

- improving cleanliness and reducing healthcare associated infections
  The Trust has continued to improve infection prevention and control, with significant reductions in both MRSA bacteraemia and C difficile during 2011/12
- improving access
  Unfortunately the Trust has been unable to deliver and sustain performance against the A&E 4-hour 95% target during the year. Improving patient flow remains a key priority, with a number of workstreams being introduced in-year. The introduction of new clinical leadership arrangements in 2011/12 including a dedicated Value Stream Lead for Unscheduled Care is driving forward plans which will support sustained improvement.
  The Trust began the year with a significant backlog of patients waiting longer than 18 weeks for a consultant-led appointment. Concerted work by our clinical teams reduced this from 25% of the total number of people waiting (open clocks) to a year end position of 5-6% which compares will with a regional average of 6-7%. Through a combination of improved processes and additional nonrecurring activity the Trust plan to maintain sustainable delivery of RTT targets from Q1 2012/13.
- improving patient experience, staff satisfaction, and engagement
  The Trust has developed our Quality Improvement

Strategy which describes our priorities for the improvements in patient safety, patient experience and patient outcomes that we are seeking. This strategy forms an integral part of our business plans to improve quality for the next 5 years and beyond. During 2011 the Trust launched a LIPS (Leading Improvements in Patient Safety) Programme which is run in partnership with the Institute for Health Care Innovation.
Staff Engagement is an important element of our Workforce Strategy. The Trust has recently adopted 'Listening into Action' a developed Staff Engagement Model which has been successful in a number of NHS organisations.

- preparing to respond in a state of emergency such as pandemic flu.
  The Trust is well prepared for major incidents and business continuity risks through an approach to resilience planning that has been strengthened during the year. A dedicated Emergency Planning Manager is in post who has updated and reviewed the Major Incident Plan and ensured compliance with the Civil Contingencies Act 2004 and related regulations and guidance including the NHS emergency planning guidance 2005. The plan has been tested during the year with two live multi-agency exercises, a table top exercise and two communications tests.

The Risk and Control Framework

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

The Risk Management Policy and Strategy clearly defines leadership, structure and the risk management process, to ensure a continuous assessment of risk throughout the organisation.

Leadership starts with the Chief Executive Officer having overall responsibility, with powers to delegate to other Directors. The leadership is further embedded by having ownership at a local level, with operational managers having the responsibility for risk identification, assessment and control.

All new members of staff are required to attend a mandatory induction, an element of which covers the key elements of risk management. This is further supplemented by their local induction. The organisation provides annual mandatory and statutory training for different levels of staff depending on their responsibilities as detailed in the Risk Management Training Policy - training for all staff is encouraged and supported by the Trust. There has also been a concentrated approach in relation to incident reporting and root cause analysis training across the organisation. All senior managers have also received training in risk and assurance processes. The Trust also has an active Institution of Occupational Safety and Health (IOSH) training programme.

Training is designed to demonstrate the processes and tools available to enable staff to identify and treat risk and to explain how risk is escalated through teams to the Trust Executive and Board. Risk management awareness training was provided throughout 2011/12 at all levels of the organisation, including the Board. Some elements of risk management training are mandatory and attendance at these sessions continues to be recorded with follow-up by service managers and heads of services on those staff who have not attended the appropriate training sessions. During 2011/12, the statutory training programme included a session on vulnerable adults. In addition the Trusts corporate induction programme includes awareness sessions on risk related areas including incident reporting, Health and Safety, Governance, Information Governance, Fire, Moving and Handling and Security.

There are many ways in which the Trust seeks to learn from good practice, for example:

- Healthy incident reporting and alert mechanisms
- Pro-active risk assessment with a risk reporting policy finalised providing clear guidance to Centres.
- Co-ordinated response to Internal and External Audit recommendations, with Executive Director involvement through recommendation tracking
- A clear schedule of assurances which complements the Assurance Framework and provides assurance to the Board.
- Sharing results of health and safety audits.
- Senior Risk Group that considers all risk-related issues.
- High Risk Review Group to review all serious incidents, and complaints

The risk management strategy requires an ongoing programme of risk assessment and review using the guidance, tools, and matrices in the Risk Management Strategy, the guidance for ongoing risk assessment, and the risk register procedure. Risk assessment is covered on induction and in sessions held by the risk and safety teams throughout the year. Sources of specialist advice and assistance available for managing risk include Chief Compliance Officer, Patient Safety Team, Health and Safety Team, Security Manager, Vulnerable Adults Lead, Safeguarding Nurse, Legal Services Manager, and Information Governance Manager.

The Board Assurance Framework identifies any gaps in control or assurance and there is an associated action plan to address these. The gap action plan and progress is reported to each session of the Audit Committee and regularly to the Trust Board with the Assurance Framework.

Whilst positive opinions were issued in respect of the majority of audits for the period, red or amber/red opinions were provided in four instances: (excluding the split amber red opinion on payroll processing which related to a partner trust)

- Data Quality (Delayed transfers of care / Cancelled operations) – RED opinion – there were six high, two medium and two low recommendations. The recommendations related to developing procedure notes for monitoring and reporting these indicators. The follow up audit demonstrated that management have taken action to address these issues.
- Finnamore's 'PAS Change Management Support Outpatients' Report' – Follow up on actions – Red opinion. Internal Audit followed up the actions from this report and identified a lack of evidence relating to the mapping of the Finnamore actions to the project plan of the group charged with delivering the improvements.
- Charitable Funds – Amber Red opinion. (This was a split opinion report and the finance controls received a green opinion). There was one high and two medium recommendations for ward level controls relating to potential delays in processing donations. Actions included ensuring that ward staff were aware of the correct procedures when receiving donations in including completion of the relevant forms which should be readily available on wards. The recommendations have been brought to the attention of the new Centre managers and have been reinforced by training. Following the audit, the Non Executive Directors have also looked at donation records as part of their programme of ward visits.
- Junior Doctors and EWTD – Amber Red opinion. There were five medium recommendations including developing a EWTD policy and a system for monitoring compliance. Three of these recommendations have now been fully actioned with the remaining two in progress – development of a policy and a reporting mechanism to Trust Board.
- Compliance with NICE guidance – Amber Red opinion with two high recommendations relating to gaps in assurance for some NICE clinical guidelines. The Clinical Audit Department recently took on responsibility for coordinating NICE guidance gap analysis, following the retirement of the R&D coordinator in May 2009. This resulted in 36 clinical guidelines which had not been assessed for compliance. As of the end of March, all of these guidelines had been sent to the relevant clinicians and the gap analyses were in progress. Steps have been taken to ensure that NICE communications are promptly reviewed and action taken with regular reports at Q&S Committee as a standing item.

Actions are in place to address these limited assurance items.

Internal Audit's review of the Trust's Assurance Framework found that "Taking account of the issues identified, we are of the opinion that the design and operation of the Assurance Framework is adequate to support the Trust's Annual Governance Statement".

The Trust was registered with the CQC without conditions on 1 April 2010. A responsive review was undertaken in November 2011 and the CQC found the Trust was not compliant with all of the outcomes. A tool for monitoring ward-to-board assurance with the CQC essential standards commenced implementation during the year and will drive responsibility and accountability for delivery of these standards to patients to ward level.

At RSH, the CQC had a minor concern in relation to assessments, care plans and risk assessments (Outcome 4). They reported that these were not individualised or comprehensive which could impact on people's needs not being met safely and effectively.

At PRH the CQC had moderate concerns with Outcome 4 (care and welfare of people who use services) and minor concerns with Outcome 1 (respecting and involving people who use services), Outcome 5 (meeting nutritional needs), Outcome 7 (safeguarding people who use services), and Outcome 13 (staffing).

For outcome 4 they said "Staff demonstrate a good knowledge of people's needs however people are not always having their needs met in a timely manner causing distress, frustration and discomfort. Assessments and care plans are not personalised or comprehensive. Failure to fully record, assess and plan the delivery of all aspects of care and treatment places people at risk of their needs not being met."

For outcome 1 the CQC reported that "delays in providing responses for assistance compromises people's dignity. Improvements are also needed to ensure that where possible individuals needs, wishes and preferences are fully documented."

For outcome 5 the CQC reported that "Meal time is quiet and relaxed however not everyone receives the support they require to eat and this could impact on their health and wellbeing."

For outcome 7 the CQC expressed concern that "Information isn't shared between staff at all levels so that allegations of abuse may not be managed appropriately by the proper authorities. People could be at risk of harm from abuse because of poor communication"

And for outcome 13 they said that "people are not always getting their care and support needs met in a timely manner due to the poor deployment of staff."

In addition, the CQC published their report on a review of privacy (outcome 1) and nutrition (outcome 5). This was part of a national programme of reviews of 100 organisations which were chosen at random. The review highlighted a minor concern in relation to treatment of vulnerable adults.

The Director of Quality and Safety /Chief Nurse has delegated responsibility for Quality. The Quality Improvement Strategy was approved by the Trust Board in March 2012 and provides a basis for collective ownership and continuous improvement drive over the next five years. The strategy will be an evolving and iterative document, influenced by national policy and local requirement; however the core of the document are the improvements that staff and patients feel passionate about and we have a desire and obligation to meet those improvements.

The Quality Governance Framework assesses the combination of structures and processes in place, both at and below board level, which enable a trust board to assure the quality of care it provides. The Trust has undertaken a self-assessment against the ten core quality questions. In Board Development meetings, and in other forums, the Board and Quality and Safety Committee have reviewed the initial base-line Quality Governance Framework and ensured that the evidence base against each of the core questions are robust based on current systems and processes. This provided a baseline score at the end of March of and there will be a formal review process through the Board over the next 18 months.

The performance of Quality has been monitored closely by the Board with detailed, monthly reviews part of the role of the Quality and Safety Committee. In an important transition to the Clinical Centres, the Centre Chiefs are core to monitoring Quality Improvement. The Centres came into being in October 2011 and the Trust has worked with clinical staff to establish Key Performance Indicators to monitor quality from the ward to the Board. The score from the Quality Governance Framework will improve as centres establish robust governance arrangements to support quality care and delivery with clear evidence to back up these arrangements at each level.

The Quality Account is published annually. It discusses the care provided for patients, describing what is done well but also what needs to be improved. The Quality Account will be audited by the Trust's external auditors by June 2012 in order to provide assurance that the information contained within the account is accurate. The Auditors will provide a signed limited assurance report which will state whether anything has come to their attention that leads them to believe that the Quality Account has not been materially prepared in line with the National Health Service (Quality Accounts) Regulations 2010. In addition, the auditors will test three indicators in the Quality Account and will issue a report to the trust's management on three indicators.

The Hospital Executive Committee, Quality and Safety Committee and Trust Board receive and review Quality Impact Assessments required across all aspects of change, cost improvement programmes or capital build.

The Trust has a Local Counter Fraud Specialist (LCFS) whose work is directed by an annual workplan agreed by the Audit Committee. The Qualitative Assessments used by NHS Protect to measure effectiveness award SATH a rating of 'adequate performance' in LCFS provision. The LCFS has continued to give induction presentations as well as ad hoc presentations to groups of staff working in areas where they need to be particularly vigilant to the possibility of fraud (e.g. temporary staffing, HR and creditors team). These sessions raise awareness and increase confidence to report suspicions of fraud to the LCFS whilst emphasising the zero tolerance approach of the Trust to fraud.

An organisation's assets include information as well as more tangible parts of the estate. Information may have limited financial value on the balance sheet but it must be managed appropriately and securely. All information used for operational purposes and financial reporting purposes needs to be encompassed and evidence maintained of effective information governance processes and procedures with risk based and proportionate safeguards. The Trust has a process for managing and controlling risks to information. It has undertaken the assessment using the Information Governance (IG) Toolkit and reports to the Information Governance Forum. This included progress on key IG initiatives:

- Updated key policies
- Reinvigorated the Data Quality Group
- Formalised the process for reporting centralised data returns
- Established Clinician Engagement Project

The Information Governance Toolkit Assessment was completed and submitted by the Trust by the 31 March 2012. The overall result for SaTH was 70% (Not satisfactory). 88% of Trust staff have received mandated information governance training in the past 12 months.

The Trust attained at least level 2 in the 22 key requirements and achieved level 2 in 42/44 requirements overall. However, the mandatory requirement is for all NHS organisations to achieve level 2 compliance in all requirements otherwise a 'not satisfactory' score is awarded.

The Trust Finance Director is the Senior Information Risk Officer, with the Medical Director as the Caldicott Guardian.

The Trust has worked closely with key partner organisations to address risks in the community and for

disaster planning. These organisations include Police, Ambulance Service, Fire, Health and Safety Executive and Local Authorities. The Trust works with the West Mercia Resilience Forum to study and exercise/test arrangements for localised fluvial and run off flooding. The Trust will continue to work with its partners to understand and minimise the risks associated with flooding due to climate change. Risk assessments are undertaken on behalf of the whole Local Resilience Forum by the Environment Agency. The Trust has been a part of a number of exercises in recent years looking at the specific issues within the West Mercia Area (including Shropshire).

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

As an employer, with staff entitled to membership of the NHS Pension scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments in to the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

There is a Carbon Reduction Strategy and action plan approved by the Board which is monitored through the Trust's Good Corporate Citizen Forum. The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UK Climate Impact Programmes (UKCIP) 2009 weather projects, to ensure that the organisation's obligations under the Climate Change Act and the adaptation Reporting requirements are complied with.

In the National Health Service Litigation Authority (NHSLA) General Standards the Trust currently holds level 1. The Trust also currently holds Clinical Negligence Scheme for Trusts (CNST) Level 2 in maternity.

Review of the effectiveness of risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by:

- Internal Audit Plan and Reports.
- External Audit Plan and Reports.
- Programme Management Office Reports.
- Improvement Programme Board Reports.
- Health & Safety Reports.
- Clinical Audit Reports.
- Complaints Reports.
- Claims Reports.
- Incident Reports.
- Clinical Governance Reports.
- Patient Environment Action Teams (PEAT) Assessments.
- NHSLA and CNST standards.
- International Organisation for Standardisation (ISO) accredited standards in Medical Engineering.
- Patient feedback from National NHS Patient surveys and local surveys.
- Health Overview & Scrutiny Committee Reports.
- Staff feedback from National NHS Staff Surveys.
- Royal College reports.
- External accreditation.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, Audit Committee, Finance & Performance Committee, Quality and Safety Committee, Hospital Executive Committee, and Risk Management Executive. A plan to address weaknesses and ensure continuous improvement of the system is in place.

The Trust Board is responsible for ensuring that the Trust follows the principles of sound governance and this responsibility rests unequivocally with the Board. The Board is required to produce statements of assurance that it is doing its "reasonable best" to ensure the Trust meets its objectives and protect patients, staff, the public and other stakeholders against risks of all kinds. The Trust Board is able to demonstrate:

- That they have been informed through assurances about all risks not just financial.
- That they have arrived at their conclusions on the totality of risk based on all the evidence presented to them.

The Trust's ability to handle risk is further enhanced through the Governance and Committee/Group structure. Each Committee/Group has terms of reference that clearly define their role and responsibilities with clearly stated deputies.

The Trust Board has received assurance on the effectiveness of the controls within the organisation through the following means:

- Reports from Committees set up by the Trust Board.
- Reports from Executive Directors and key managers.
- External Reviews.
- Assurance Framework, which was constructed by the full Board at a development session in 2011, is scrutinised and challenged by Non-Executive Directors at each Audit Committee and received and reviewed by the Board.
- Internal Audit provide the Board, through the Audit Committee, and the Accounting Officer with an independent and objective opinion on risk management, control and governance and their effectiveness in achieving the organisation's agreed objectives. This opinion forms part of the framework of assurances that the Board receives. The annual Internal Audit Plan is aligned to the Trust's Assurance Framework and Risk Register.

Within the 2010/11 Annual Audit Report the Trust's external auditors reported concerns around two key themes:

(i) The Trust does not have robust systems and processes to managed effectively actions to achieve cost reductions. The Trust achieved only 30% of its total cost improvement plan of £12.1m in 2010/11 and required non-recurrent financial support to achieve breakeven in 2010/11.

(ii) The successful delivery of reconfiguration will be key to the provision of sustainable clinical services.

The Trust has created a Project Management Office (PMO) to ensure the formulation and delivery of robust cost improvement programmes and a project group to progress reconfiguration.

Significant Issues

The Trust has three significant issues to disclose.

- Never events: The Trust had a cluster of 6 similar 'never events' reported in ophthalmology when the wrong strength of lens was inserted during cataract surgery. Root cause analysis meetings have been held involving staff and affected patients, Commissioners and the CQC. Amended procedures and further training have been put in place to prevent a recurrence. The Quality & Safety Committee has had continuing oversight of these events and has reviewed the root cause analyses and subsequent decisions and remediation.
- Outpatient management: During 2010/11 issues relating to the management of outpatients were highlighted in the Statement of Internal Control. An external review took place and the resulting action plan has been progressed through the year. The review highlighted a significant number of patients waiting for follow up appointments. Due to the emphasis on these cases the waiting times for new patients was consistently outside the national targets during 2011/12. Enhanced performance management arrangements brought performance back into line with the targets by year end.
- Finance: The Trust had a financial plan to achieve a balanced position at year end but delivered a small surplus following transitional support of £6.5m from the SHA which was non-repayable.

Adam Cairns
Chief Executive
7 June 2012

Foreword to the Accounts

These accounts for the year ended 31 March 2012 have been prepared by The Shrewsbury and Telford Hospital NHS Trust in accordance with the NHS Finance Manual: Manual for Accounts 2011/12

Adam Cairns
Chief Executive
7 June 2012

Annex to Appendix 5

Primary Financial Statements and Notes to the Accounts

Statement of Comprehensive Income for year ended 31 March 2012

	NOTE	2011-12 £000	2010-11 £000 (restated)
Employee benefits	10.1	**(200,011)**	(186,489)
Other costs	8	**(95,892)**	(86,668)
Revenue from patient care activities	5	**271,131**	257,070
Other operating revenue	6	**28,719**	20,760
Operating Surplus		**3,947**	4,673
Investment revenue	12	**21**	21
Other gains and (losses)	13	**0**	(131)
Finance costs	14	**(13)**	(20)
Surplus for the financial year		**3,955**	4,543
Public dividend capital dividends payable		**(5,122)**	(5,018)
Retained deficit for the year		**(1,167)**	(475)
Other comprehensive Income			
Impairments and reversals		**(1,032)**	0
Net gain/(loss) on revaluation of property, plant & equipment		**10,090**	0
Total comprehensive income for the year		**7,891**	(475)

Financial performance for the year		
Retained deficit for the year	**(1,167)**	(475)
Impairments	**1,053**	351
Adjustments relating to donated asset elimination	**173**	150
Adjusted retained surplus	**59**	**26**

A Trust's Reported NHS financial performance position is derived from its retained surplus/(deficit) and adjusted for the following:-

Impairments to Fixed Assets - an impairment charge is not considered part of the organisation’s operating position.
Adjustments relating to donated asset elimination - from this year donated asset reserves have been eliminated.

PDC dividends have been underpaid in aggregate, the amounts due from the Trust is:

PDC dividend: balance payable at 31 March	**(111)**	**(3)**

The notes on pages 5 to 41 form part of this account.

Statement of Financial Position as at 31 March 2012

	NOTE	31 March 2012 £000	31 March 2011 (restated) £000	31 March 2010 (restated) £000
Non-current assets:				
Property, plant and equipment	15	**167,833**	156,123	156,367
Intangible assets	16	**1,269**	1,070	493
Investment property		**0**	0	0
Other financial assets	24	**0**	0	0
Trade and other receivables	22.1	**1,443**	2,389	2,392
Total non-current assets		**170,545**	159,582	159,252
Current assets:				
Inventories	21	**5,349**	4,652	4,253
Trade and other receivables	22.1	**12,827**	12,757	14,974
Other financial assets	24	**0**	0	0
Other current assets	25	**0**	0	0
Cash and cash equivalents		**1,202**	233	441
Total current assets		**19,378**	17,642	19,668
Non-current assets held for sale	27	**0**	0	0
Total current assets		**19,378**	17,642	19,668
Total assets		**189,923**	177,224	178,920
Current liabilities				
Trade and other payables	28	**(29,846)**	(26,670)	(28,994)
Other liabilities	29	**0**	0	0
Provisions	35	**(556)**	(832)	(191)
Borrowings	30	**0**	(4)	(5)
Other financial liabilities		**0**	0	0
Total current liabilities		**(30,402)**	(27,506)	(29,190)
Total non-current assets less net current liabilities		**159,521**	149,718	149,730
Non-current liabilities				
Trade and other payables	28	0	0	0
Other Liabilities	31	0	0	0
Provisions	35	(390)	(478)	(511)
Borrowings	30	0	0	(4)
Other financial liabilities		0	0	0
Total non-current liabilities		**(390)**	(478)	(515)
Total Assets Employed:		**159,131**	149,240	149,215
FINANCED BY:				
TAXPAYERS' EQUITY				
Public Dividend Capital		145,622	143,622	143,122
Retained earnings		(30,702)	(29,535)	(29,060)
Revaluation reserve		44,211	35,153	35,153
Total Taxpayers' Equity:		**159,131**	149,240	149,215

The notes on pages 6 to 41 form part of this account.

The financial statements on pages 2 to 5 were approved by the Board on 7 June 2012 and signed on its behalf by

Chief Executive:  **Date:** **07-Jun-12**

Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2012

	Public Dividend capital	Retained earnings	Revaluation reserve	Total reserves
	£000	£000	£000	£000
Balance at 1 April 2011	143,622	(29,535)	35,153	**149,240**
Changes in taxpayers' equity for 2011-12				
Retained deficit for the year	0	(1,167)	0	**(1,167)**
Gross gain on revaluation of property, plant, equipment	0	0	10,090	**10,090**
Net gain / (loss) on revaluation of intangible assets	0	0	0	**0**
Net gain / (loss) on revaluation of financial assets	0	0	0	**0**
Net gain / (loss) on revaluation of assets held for sale	0	0	0	**0**
Impairments and reversals	0	0	(1,032)	**(1,032)**
Movements in other reserves	0	0	0	**0**
Transfers between reserves	0	0	0	**0**
Release of reserves to SOCI	0	0	0	**0**
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	**0**
New PDC Received	2,000	0	0	**2,000**
PDC Repaid In Year	0	0	0	**0**
PDC Written Off	0	0	0	**0**
Other Movements in PDC In Year	0	0	0	**0**
Net recognised revenue/(expense) for the year	2,000	(1,167)	9,058	9,891
Balance at 31 March 2012	**145,622**	**(30,702)**	**44,211**	**159,131**
Changes in taxpayers' equity for 2010-11				
Balance at 1 April 2010	143,122	(29,060)	35,153	149,215
Retained deficit for the year	0	(475)	0	(475)
Gross gain / (loss) on revaluation of property, plant, equipment	0	0	0	0
Net gain / (loss) on revaluation of intangible assets	0	0	0	0
Net gain / (loss) on revaluation of financial assets	0	0	0	0
Net gain / (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
New PDC Received	500	0	0	500
PDC Repaid In Year	0	0	0	0
PDC Written Off	0	0	0	0
Other Movements in PDC In Year	0	0	0	0
Net recognised revenue/(expense) for the year	500	(475)	0	25
Balance at 31 March 2011	**143,622**	**(29,535)**	**35,153**	**149,240**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED
31 March 2012

	NOTE	2011-12 £000	2010-11 £000
Cash Flows from Operating Activities			
Operating Surplus		**3,947**	**4,673**
Depreciation and Amortisation	8	**9,450**	**8,384**
Impairments and Reversals	8	**1,053**	**351**
Other Gains / (Losses) on foreign exchange		**0**	**0**
Donated Assets received credited to revenue		**(882)**	**(694)**
Interest Paid		**0**	**0**
Dividend paid		**(5,014)**	**(5,023)**
Increase in Inventories		**(697)**	**(399)**
Decrease in Trade and Other Receivables		**878**	**1,715**
(Increase)/Decrease in Other Current Assets		**0**	**0**
(Decrease)/Increase in Trade and Other Payables		**(2,798)**	**1,258**
(Increase)/Decrease in Other Current Liabilities		**0**	**0**
Provisions Utilised	35	**(792)**	**(163)**
Increase in Provisions	35	**415**	**751**
Net Cash Inflow from Operating Activities		**5,560**	**10,853**
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest Received		**19**	**21**
Payments for Property, Plant and Equipment		**(10,049)**	**(12,323)**
Payments for Intangible Assets		**(399)**	**(453)**
Payments for Investments with DH		**0**	**0**
Payments for Other Financial Assets		**0**	**0**
Proceeds of disposal of assets held for sale (PPE)		**0**	**0**
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**
Rental Revenue		**0**	**0**
Net Cash Outflow from Investing Activities		**(10,429)**	**(12,755)**
NET CASH OUTFLOW BEFORE FINANCING		**(4,869)**	**(1,902)**
CASH FLOWS FROM FINANCING ACTIVITIES			
Public Dividend Capital Received		2,000	500
Public Dividend Capital Repaid		0	0
Loans received from DH - New Capital Investment Loans		0	0
Loans received from DH - New Working Capital Loans		0	0
Other Loans Received		0	0
Loans repaid to DH - Capital Investment Loans Repayment of Principal		0	0
Loans repaid to DH - Working Capital Loans Repayment of Principal		0	0
Other Loans Repaid		0	0
Capital Element of Payments in Respect of Finance Leases	33	(4)	(5)
Capital grants and other capital receipts including donated asset receipts		3,842	1,199
Net Cash Inflow from Financing Activities		**5,838**	**1,694**
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**969**	**(208)**
Cash and Cash Equivalents at Beginning of the Period	26	233	441
Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign Currencies		0	0
Cash and Cash Equivalents at year end	26	**1,202**	**233**

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 NHS Trusts Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2011-12 NHS Trusts Manual for Accounts 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 NHS Trusts Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3 Critical accounting judgements and key sources of estimation uncertainty

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

1.3.1 Critical judgements in applying accounting policies

The management has had to make no critical judgements, apart from those involving estimations (see below) in the process of applying the Trust's accounting policies.

1.3.2 Key sources of estimation uncertainty

Key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are included in the relevant accounting policy note.

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

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 are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.5 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 leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Retirement benefit costs

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

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

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

1.6 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

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

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

Valuation

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

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

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

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

Until 31 March 2008, the depreciated replacement cost of specialised buildings has been estimated for an exact replacement of the asset in its present location. 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.

Within the year the Trust instructed the District Valuer to perform a brought into use valuation for two significant assets. The effect of this was to recognise an impairment in the value the two assets by £788,000. This amount related to an impairment of a new pharmacy aseptic unit of £444,000 and an impairment relating to a new offsite decontamination facility of £344,000.

The Trust also instructed the District Valuer to perform an interim revaluation of assets at 31 March 2012. The effect of this was to recognise an increase in the value of fixed assets by £10,280,235. In addition, and as part of this year end valuation the Trust recognised an impairment of £1,297,375 resulting in an overall net increase in the valuation of fixed assets of £8,982,860.

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

Until 31 March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1 April 2008 indexation has ceased. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

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

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 £5,000.

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

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

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

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

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

1.9 Depreciation, amortisation and impairments
Tangible fixed assets are depreciated at rates calculated to write them down to estimated residual value on a straight-line basis over their estimated useful lives:

Freehold buildings - over estimated useful life not exceeding 84 years.
Leaseholds - over the primary lease term.
Furniture and fittings - 5 to 15 years.
Transport Equipment - 7 to 10 years.
IT equipment - 5 to 10 years.
Plant and machinery - 5 to 20 years.

Intangible fixed assets are depreciated at rates calculated to write them down to estimated residual value on a straight-line basis over their estimated useful lives:

Software Licences - 5 years

Freehold land, properties under construction, and assets held for sale are not depreciated.

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

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

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

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME) from 2011-12. This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set.
AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

1.10 Donated assets
Following the accounting policy change outlined in the Treasury FREM for 2011-12, a donated asset reserve is no longer maintained. Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

This accounting policy change has been applied retrospectively and consequently the 2010-11 results have been restated.

1.11 Government grants
The Trust does not hold any Government grants within the year or prior year. Therefore there is a nil impact following the accounting policy change outlined in the Treasury FREM for 2011-12.

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

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. For donated and government-granted assets, a transfer is made to or from the relevant reserve to the profit/loss on disposal account so that no profit or loss is recognised in income or expenses. The remaining surplus or deficit in the donated asset or government grant reserve is then 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 on interest on the remaining balance of the liability. Finance charges are recognised in calculating the Trust's surplus/deficit.

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

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

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

The Trust as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

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

1.14 Private Finance Initiative (PFI) transactions

The Trust has no PFI agreements.

1.15 Inventories

Inventories are valued at the lower of cost and net realisable value using the replacement cost. This is considered to be a reasonable approximation to fair value.

1.16 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.

1.17 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 rate of 2.2% in real terms (2.8% for employee early departure obligations).

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.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

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 - 1. Accounting Policies (Continued)

1.18 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.

1.19 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.

1.20 EU Emissions Trading Scheme

EU Emission Trading Scheme allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the NHS body makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.21 Contingencies

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

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

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

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

1.22 Financial assets

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

Financial assets are initially recognised at fair value.

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.

Financial assets at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the Trust's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

Held to maturity investments

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Available for sale financial assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/deficit on de-recognition.

Loans and receivables

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

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

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

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

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

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

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

1.23 Financial liabilities

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

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

Financial guarantee contract liabilities

Financial guarantee contract liabilities are subsequently measured at the higher of:

The premium received (or imputed) for entering into the guarantee less cumulative amortisation.

The amount of the obligation under the contract, as determined in accordance with IAS 37 Provisions, Contingent Liabilities and Contingent Assets.

Financial liabilities at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the Trust's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

Other financial liabilities

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

1.24 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.25 Foreign currencies

The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Trust's surplus/deficit in the period in which they arise.

1.26 Third party assets

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

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

1.27 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.

1.28 Losses and Special Payments

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

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

1.29 Subsidiaries

There are no material entities in which the Trust has the power to exercise control to obtain economic or other benefits.

For 2010-11 and 2011-12 in accordance with the directed accounting policy from the Secretary of State, the Trust does not consolidate the NHS charitable funds for which it is the Corporate Trustee.

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

1.30 Associates

There are no material entities in which the Trust has the power to exercise significant influence to obtain economic or other benefits.

1.31 Joint ventures

There are no material entities in which the Trust has joint control with one or more other parties to obtain economic or other benefits.

1.32 Joint operations

There are no joint operations in which the Trust participates in with one or more other parties.

1.33 Research and Development

Research and development expenditure is charged against income in the year in which it is incurred, except in so far 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 Operating Cost Statement on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

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

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2011-12. The application of the Standards as revised would not have a material impact on the accounts for 2011-12, were they applied in that year:

IAS 1 Presentation of financial statements (Other Comprehensive Income) - subject to consultation
IAS 12 - Income Taxes (amendment) - subject to consultation
IAS 19 Post-employment benefits (pensions) - subject to consultation
IAS 27 Separate Financial Statements - subject to consultation
IAS 28 Investments in Associates and Joint Ventures - subject to consultation
IFRS 7 - Financial Instruments: Disclosures (annual improvements) - effective 2012-13
IFRS 9 Financial Instruments - subject to consultation - subject to consultation
IFRS 10 Consolidated Financial Statements - subject to consultation
IFRS 11 Joint Arrangements - subject to consultation
IFRS 12 Disclosure of Interests in Other Entities - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation
IPSAS 32 - Service Concession Arrangement - subject to consultation.

2. Pooled budgets

The Trust has no pooled budget arrangements.

3. Operating segments

The Board as 'Chief Operating Decision Maker' has determined that the Trust operates in one material segment, which is the provision of healthcare services. The segmental reporting format reflects the Trust's management and internal reporting structure.

The provision of healthcare (including medical treatment, research and education) is within one main geographical segment, the United Kingdom, and materially funded by Departments of HM Government in England.

Income from activities (medical treatment of patients) is analysed by customer type in note 5 below. Other operating income is analysed in note 6 and materially consists of revenues from medical education and the provision of services to other NHS bodies. Total income from individual customers within the whole of HM Government is considered material, and is disclosed in the related parties transactions in note 41.

During the year the Trust has completed its organisational restructure from a divisional structure to clinically lead centres. As part of this change the Trust has introduced service line reporting to assist in a service line management performance regime that will be fully operational for the full year ending 31 March 2013. The Trust will aim to disclose the relevant financial reporting disclosures within the segmental reporting note for the year ending 31 March 2013.

4. Income generation activities

The Trust undertakes income generation activities with an aim of achieving profit, which is then used in patient care. The Trust has no income generation activities whose full cost exceeded £1m.

5. Revenue from patient care activities

	2011-12	2010-11
	£000	£000
NHS trusts	**271**	807
Primary care trusts - tariff	**167,231**	161,087
Primary care trusts - non-tariff	**70,976**	63,554
Primary care trusts - market forces factor	**4,508**	3,419
Foundation trusts	**698**	122
Non-NHS:		
Private patients	**2,289**	2,131
Overseas patients (non-reciprocal)	**94**	29
Injury costs recovery*	**1,443**	1,757
Other**	**23,621**	24,164
	271,131	257,070

*Injury cost recovery income is subject to a provision for impairment of receivables of 10.5% (previously 9.6% to September 2011) to reflect expected rates of collection.

**Non-NHS-Other includes income of £22m from Welsh bodies (2010-11: £24m).

6. Other operating revenue

	2011-12	2010-11
	£000	£000
Education, training and research	**11,539**	11,536
Receipt of donations for capital acquisitions	**882**	694
Non-patient care services to other bodies	**3,618**	3,612
Income generation	**2,816**	2,678
Other revenue *	**9,864**	2,240
	28,719	20,760
Total operating revenue	**299,850**	277,830

* Other revenue includes £6,500,000 financial support from the SHA (2010-11: £nil).

7. Revenue

	2011-12	2010-11
	£000	£000
From rendering of services	**299,850**	277,830

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

8. Operating expenses (excluding employee benefits)	**2011-12**	2010-11
	£000	£000
Purchase of healthcare from non NHS bodies	**1,240**	986
Trust chair and non executive directors	**66**	57
Supplies and services - clinical	**49,883**	46,001
Supplies and services - general	**4,440**	4,385
Consultancy services	**1,926**	972
Establishment	**4,364**	4,432
Transport	**3,331**	2,983
Premises	**12,276**	10,943
Impairments and Reversals of Receivables	**469**	481
Inventories write down	**61**	78
Depreciation	**9,201**	8,274
Amortisation	**249**	110
Impairments and reversals of property, plant and equipment	**1,053**	351
Audit fees	**205**	213
Clinical negligence	**6,001**	5,244
Education and Training	**705**	699
Other	**422**	459
	95,892	86,668
Employee benefits		
Employee benefits excluding Board members	**198,858**	185,461
Board members	**1,153**	1,028
Total employee benefits	**200,011**	186,489
Total operating expenses	**295,903**	273,157

9 Operating Leases

The Trust has two operating leases relating to investments in replacing the boiler plants. The term of the lease at the Princess Royal Hospital is 12 years and commenced 1 July 2003. The term of the lease at the Royal Shrewsbury Hospital is 15 years and commenced 1 April 2007.

The Trust has a contract for the provision of Biochemistry and Haematology service, comprising immunoassay, clinical chemistry, haematology, software and pre-analytics. The term of the contract is seven years and commenced 1 May 2007.

The Trust has a contract for computerised digital imaging and archiving service contracts within Radiology. The term of the contract, which covers the Royal Shrewsbury Hospital and the Princess Royal Hospital, is 7 years and commenced on 17 March 2012.

The Trust has a lease for printing services for both hospitals. The term of the lease is 5 years and commenced 1 September 2009.

The Trust has two property leases for off site office accommodation and an off site sterile services facility with lease terms of 3 years and 20 years respectively both commencing 1 April 2010.

The Trust has entered into a lease, commencing 1 April 2010, for the provision of staff residential accommodation facilities at the Royal Shrewsbury Hospital.

The Trust also leases cars and adhoc medical equipment.

9.1 Trust as lessee

	2011-12			2010-11
	Buildings £000	**Other £000**	**Total £000**	Total £000
Payments recognised as an expense				
Minimum lease payments	**541**	**3,442**	**3,983**	3,974
Contingent rents	**0**	**0**	**0**	0
Sub-lease payments	**0**	**0**	**0**	0
Total	**541**	**3,442**	**3,983**	3,974
Payable:				
No later than one year	**475**	**3,483**	**3,958**	3,777
Between one and five years	**985**	**10,045**	**11,030**	8,973
After five years	**2,687**	**8,464**	**11,151**	10,705
Total	**4,147**	**21,992**	**26,139**	23,455

9.2 Trust as lessor

The Trust does not have any leasing arrangements where it acts as a lessor.

10 Employee benefits and staff numbers

10.1 Employee benefits

	Total £000	Permanently employed £000	Other £000
Employee Benefits 2011-12			
Salaries and wages	170,978	149,035	21,943
Social security costs	11,926	11,926	0
Employer contributions to NHS Pensions scheme	17,694	17,694	0
Other pension costs	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	0	0	0
Total employee benefits	200,598	178,655	21,943
Employee costs capitalised	587	511	76
Net Employee Benefits excluding capitalised costs	200,011	178,144	21,867

	Total £000	Permanently employed £000	Other £000
Employee Benefits 2010-11			
Salaries and wages	158,596	142,318	16,278
Social security costs	11,276	11,276	0
Employer contributions to NHS Pensions scheme	16,792	16,792	0
Other pension costs	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	0	0	0
Total employee benefits	186,664	170,386	16,278
Employee costs capitalised	175		
Net Employee Benefits excluding capitalised costs	186,489		

10.2 Staff Numbers

	2011-12			2010-11
	Total Number	Permanently employed Number	Other Number	Total Number
Average Staff Numbers				
Medical and dental	606	540	66	568
Administration and estates	1,044	924	120	970
Healthcare assistants and other support staff	1,072	942	130	1,018
Nursing, midwifery and health visiting staff	1,437	1,359	78	1,321
Scientific, therapeutic and technical staff	677	654	23	666
TOTAL	4,836	4,419	417	4,543
Of the above - staff engaged on capital projects	14	9	5	5

10.3 Staff Sickness absence and ill health retirements

	2011-12 Number	2010-11 Number
Total Days Lost	**44,175**	**42,706**
Total Staff Years	**4,380**	**4,225**
Average working Days Lost	10.09	10.11

These figures are calendar year figures (January - December) not financial year figures.

	2011-12 Number	2010-11 Number
Number of persons retired early on ill health grounds	**4**	2
	£000s	£000s
Total additional pensions liabilities accrued in the year	**448**	102

10.4 Exit Packages

There were no exit packages in this year or the prior year.

A restructurings provision (note 35) has been created relating to changes in the Trust's senior management team. This provision does not contain any elements that are within the definition of an exit package.

10.5 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

a) Full actuarial (funding) valuation

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

The last formal actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes have been suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision. Employer and employee contribution rates are currently being determined under the new scheme design.

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data are accepted as providing suitably robust figures for financial reporting purposes. However, as the interval since the last formal valuation now exceeds four years, the valuation of the scheme liability as at 31 March 2012, is based on detailed membership data as at 31 March 2010 updated to 31 March 2012 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

c) Scheme provisions

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

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

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

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

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

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

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

11 Better Payment Practice Code

11.1 Measure of compliance

	2011-12 Number	2011-12 £000	2010-11 Number	2010-11 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**89,887**	**98,915**	79,843	77,157
Total Non-NHS Trade Invoices Paid Within Target	**75,177**	**78,743**	28,605	33,104
Percentage of NHS Trade Invoices Paid Within Target	**83.64%**	**79.61%**	35.83%	42.90%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**2,170**	**19,505**	2,259	22,361
Total NHS Trade Invoices Paid Within Target	**1,921**	**17,716**	798	9,412
Percentage of NHS Trade Invoices Paid Within Target	**88.53%**	**90.83%**	35.33%	42.09%

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

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

There were immaterial amounts paid under this act during this year or the prior year.

12 Investment Income

	2011-12 £000	2010-11 £000
Interest Income		
Bank interest	**21**	18
Other loans and receivables	**0**	3
Subtotal	**21**	21
Total investment income	**21**	21

13 Other Gains and Losses

	2011-12 £000	2010-11 £000
Loss on disposal of property, plant and equipment	**0**	(131)
Total	**0**	(131)

14 Finance Costs

	2011-12 £000	2010-11 £000
Interest		
Provisions - unwinding of discount	**13**	20
Total interest expense	**13**	20

15.1 Property, plant and equipment

2011-12	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	**Total**
	£000	£000	£000	£000	£000	£000	£000	£000	**£000**
Cost or valuation:									
At 1 April 2011	26,305	128,636	2,744	369	35,773	278	7,673	4,547	**206,325**
Additions Purchased	0	1,097	0	4,376	2,329	0	1,003	48	**8,853**
Additions Donated	0	23	0	3,271	747	0	25	36	**4,102**
Additions Government Granted	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	43	0	(106)	0	0	14	0	**(49)**
Reclassifications as Held for Sale	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	0	0	0	(1,881)	0	(56)	0	**(1,937)**
Upward revaluation/positive indexation	0	9,796	294	0	0	0	0	0	**10,090**
Impairments/negative indexation	(15)	(1,017)	0	0	0	0	0	0	**(1,032)**
Reversal of Impairments	0	0	0	0	0	0	0	0	**0**
Cumulative dep'n adjustment following revaluation	0	(12,304)	(304)	0	0	0	0	0	**(12,608)**
At 31 March 2012	**26,290**	**126,274**	**2,734**	**7,910**	**36,968**	**278**	**8,659**	**4,631**	**213,744**
Depreciation									
At 31 March 2011	0	21,971	213		20,775	72	5,368	1,803	**50,202**
Other adjustments at 1 April 2011 *	0	0	0		0	0	0	0	**0**
At 1 April 2011	0	21,971	213		20,775	72	5,368	1,803	**50,202**
Reclassifications		0	0		0	0	0	0	**0**
Reclassifications as Held for Sale	0	0	0		0	0	0	0	**0**
Disposals other than for sale	0	0	0		(1,881)	0	(56)	0	**(1,937)**
Upward revaluation/positive indexation	0	0	0		0	0	0	0	**0**
Impairments	0	1,243	0	0	0	0	0	0	**1,243**
Reversal of Impairments	0	(190)	0	0	0	0	0	0	**(190)**
Charged During the Year	0	4,933	111		3,116	22	693	326	**9,201**
Cumulative dep'n adjustment following revaluation	0	(12,304)	(304)	0	0	0	0	0	**(12,608)**
At 31 March 2012	**0**	**15,653**	**20**	**0**	**22,010**	**94**	**6,005**	**2,129**	**45,911**
Net book value at 31 March 2012	26,290	110,621	2,714	7,910	14,958	184	2,654	2,502	**167,833**
Purchased	26,290	108,048	2,714	4,639	12,057	184	2,581	2,393	**158,906**
Donated	0	2,573	0	3,271	2,901	0	73	109	**8,927**
Government Granted	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2012	**26,290**	**110,621**	**2,714**	**7,910**	**14,958**	**184**	**2,654**	**2,502**	**167,833**
Asset financing:									
Owned	26,290	110,621	2,714	7,910	14,958	184	2,654	2,502	**167,833**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
Total	**26,290**	**110,621**	**2,714**	**7,910**	**14,958**	**184**	**2,654**	**2,502**	**167,833**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	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**
At 1 April 2011	9,956	23,945	0	1,252	0	0	0	**35,153**
In year movements	(15)	9,073	0	0	0	0	0	**9,058**
At 31 March 2012	9,941	33,018	0	1,252	0	0	0	**44,211**

* Other adjustments at 1 April 2011 represents a reclassification between cumulative cost and accumulative depreciation, there is no overall impact within the net book value.

15.2 Property, plant and equipment

2010-11	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	**Total**
	£000	£000	£000	£000	£000	£000	£000	£000	**£000**
Cost or valuation:									
At 1 April 2010	26,305	118,473	2,743	6,981	35,442	148	6,816	4,303	**201,211**
Additions - purchased	0	4,224	1	112	2,577	129	853	163	**8,059**
Additions - donated	0	6	0	0	669	0	4	8	**687**
Additions - government granted	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	5,933	0	(6,593)	352	1	0	73	**(234)**
Reclassified as held for sale	0	0	0	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	(131)	(3,267)	0	0	0	**(3,398)**
Revaluation & indexation gains	0	0	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	0	0	**0**
Reversals of impairments	0	0	0	0	0	0	0	0	**0**
At 31 March 2011	**26,305**	**128,636**	**2,744**	**369**	**35,773**	**278**	**7,673**	**4,547**	**206,325**
Depreciation									
At 1 April 2010	0	17,112	102		21,356	63	4,739	1,472	**44,844**
Reclassifications		0	0		0	0	0	0	**0**
Reclassifications as Held for Sale	0	0	0		0	0	0	0	**0**
Disposals other than for sale	0	0	0		(3,267)	0	0	0	**(3,267)**
Upward revaluation/positive indexation	0	0	0		0	0	0	0	**0**
Impairments	0	351	0	0	0	0	0	0	**351**
Reversal of Impairments	0	0	0	0	0	0	0	0	**0**
Charged During the Year	0	4,508	111		2,686	9	629	331	**8,274**
At 31 March 2011	0	21,971	213	0	20,775	72	5,368	1,803	50,202
Net book value	**26,305**	**106,665**	**2,531**	**369**	**14,998**	**206**	**2,305**	**2,744**	**156,123**
Purchased	26,305	104,366	2,531	369	12,010	206	2,220	2,659	**150,666**
Donated	0	2,299	0	0	2,988	0	85	85	**5,457**
Government Granted	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2011	26,305	106,665	2,531	369	14,998	206	2,305	2,744	**156,123**
Asset financing:									
Owned	26,305	106,665	2,531	369	14,998	206	2,301	2,744	**156,119**
Held on finance lease	0	0	0	0	0	0	4	0	**4**
	26,305	106,665	2,531	369	14,998	206	2,305	2,744	**156,123**

15.3 (cont). Property, plant and equipment

Tangible fixed assets are depreciated at rates calculated to write them down to estimated residual value on a straight-line basis over their estimated useful lives:
Freehold buildings - over estimated useful life not exceeding 84 years.
Leaseholds - over the primary lease term.
Furniture and fittings - 5 to 15 years.
Transport Equipment - 7 to 10 years.
IT equipment - 5 to 10 years.
Plant and machinery - 5 to 20 years.

The majority of donated assets have been donated by the Friends of the Royal Shrewsbury Hospital; Friends of The Princess Royal Hospital Telford; The Shrewsbury and Telford Hospital NHS Trust Charitable Funds and the Lingen Davies Cancer Relief Fund.

16.1 Intangible non-current assets

2011-12	Software internally generated	Software purchased	Licences & trademarks	Patents	Development expenditure	Total
	£000	£000	£000	£000	£000	**£000**
Cost or valuation:						
At 1 April 2011	0	1,223	0	0	0	**1,223**
Additions - purchased	0	336	0	0	0	**336**
Additions - internally generated	13	0	0	0	0	**13**
Additions - donated	0	50	0	0	0	**50**
Additions - government granted	0	0	0	0	0	**0**
Reclassifications	0	49	0	0	0	**49**
Reclassified as held for sale	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	**0**
Revaluation & indexation gains	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	**0**
Cumulative amortisation adjustment following revaluation	0	0	0	0	0	**0**
At 31 March 2012	13	1,658	0	0	0	**1,671**
Amortisation						
At 1 April 2011	0	153	0	0	0	**153**
Reclassifications	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	**0**
Revaluation or indexation gains	0	0	0	0	0	**0**
Impairments charged to operating expenses	0	0	0	0	0	**0**
Reversal of impairments charged to operating expenses	0	0	0	0	0	**0**
Charged during the year	0	249	0	0	0	**249**
Cumulative amortisation adjustment following revaluation	0	0	0	0	0	**0**
At 31 March 2012	0	402	0	0	0	**402**
NBV at 31 March 2012	13	1,256	0	0	0	1,269
Net book value at 31 March 2012 comprises:						
Purchased	13	1,201	0	0	0	**1,214**
Donated	0	55	0	0	0	**55**
Total at 31 March 2012	13	1,256	0	0	0	**1,269**

Revaluation reserve balance for intangible non-current assets

	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2011	0	0	0	0	0	0
In year movements	0	0	0	0	0	0
At 31 March 2012	0	0	0	0	0	0

16.2 Intangible non-current assets

2010-11	Software internally generated	Software purchased	Licences & trademarks	Patents	Development expenditure	Total
	£000	£000	£000	£000	£000	**£000**
Cost or valuation:						
At 1 April 2010	0	536	0	0	0	**536**
Additions - purchased	0	446	0	0	0	**446**
Additions - internally generated	0	0	0	0	0	**0**
Additions - donated	0	7	0	0	0	**7**
Additions - government granted	0	0	0	0	0	**0**
Reclassifications	0	234	0	0	0	**234**
Reclassified as held for sale	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	**0**
Revaluation & indexation gains	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	**0**
At 31 March 2011	0	1,223	0	0	0	**1,223**
Amortisation						
At 1 April 2010	0	43	0	0	0	**43**
Reclassifications	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	**0**
Revaluation or indexation gains	0	0	0	0	0	**0**
Impairments charged to operating expenses	0	0	0	0	0	**0**
Reversal of impairments charged to operating expenses	0	0	0	0	0	**0**
Charged during the year	0	110	0	0	0	**110**
At 31 March 2011	0	153	0	0	0	**153**
Net book value at 31 March 2011	0	1,070	0	0	0	**1,070**
Net book value at 31 March 2011 comprises:						
Purchased	0	1,064	0	0	0	**1,064**
Donated	0	6	0	0	0	**6**
Total at 31 March 2011	0	1,070	0	0	0	**1,070**

16.3 Intangible non-current assets

The intangible assets held by the Trust relate to the purchase of software licenses and software that has been internally generated. These assets are written down over a useful economic life of 5 years.

There are no revaluation reserve balances for intangible assets.

17 Analysis of impairments and reversals recognised in 2011-12

	2011-12 Total £000	
Property, Plant and Equipment impairments and reversals taken to SoCI		
Loss or damage resulting from normal operations	0	
Over-specification of assets	788	*
Abandonment of assets in the course of construction	0	
Total charged to Departmental Expenditure Limit	788	
Unforeseen obsolescence	0	
Loss as a result of catastrophe	0	
Other	0	
Changes in market price	265	**
Total charged to Annually Managed Expenditure	265	
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve		
Loss or damage resulting from normal operations	0	
Over Specification of Assets	0	
Abandonment of assets in the course of construction	0	
Unforeseen obsolescence	0	
Loss as a result of catastrophe	0	
Other	0	
Changes in market price	1,032	**
Total impairments for PPE charged to reserves	1,032	
Total Impairments of Property, Plant and Equipment	2,085	
Intangible assets impairments and reversals charged to SoCI		
Loss or damage resulting from normal operations	0	
Over-specification of assets	0	
Abandonment of assets in the course of construction	0	
Total charged to Departmental Expenditure Limit	0	
Unforeseen obsolescence	0	
Loss as a result of catastrophe	0	
Other	0	
Changes in market price	0	
Total charged to Annually Managed Expenditure	0	
Intangible Assets impairments and reversals charged to the Revaluation Reserve		
Loss or damage resulting from normal operations	0	
Over-specification of assets	0	
Abandonment of assets in the course of construction	0	
Unforeseen obsolescence	0	
Loss as a result of catastrophe	0	
Other	0	
Changes in market price	0	
Total impairments for Intangible Assets charged to Reserves	0	
Total Impairments of Intangibles	0	
Financial Assets charged to SoCI		
Loss or damage resulting from normal operations	0	
Total charged to Departmental Expenditure Limit	0	
Loss as a result of catastrophe	0	
Other	0	
Total charged to Annually Managed Expenditure	0	
Financial Assets impairments and reversals charged to the Revaluation Reserve		
Loss or damage resulting from normal operations	0	
Loss as a result of catastrophe	0	
Other	0	
TOTAL impairments for Financial Assets charged to reserves	0	
Total Impairments of Financial Assets	0	
Non-current assets held for sale - impairments and reversals charged to SoCI.		
Loss or damage resulting from normal operations	0	
Abandonment of assets in the course of construction	0	
Total charged to Departmental Expenditure Limit	0	
Unforeseen obsolescence	0	
Loss as a result of catastrophe	0	
Other	0	
Changes in market price	0	
Total charged to Annually Managed Expenditure	0	
Total impairments of non-current assets held for sale	0	
Investment Property impairments charged to SoCI		
Loss as a result of catastrophe	0	
Other	0	
Changes in market price	0	
Total charged to Annually Managed Expenditure	0	
Total Investment Property impairments charged to SoCI	0	
Total Impairments charged to Revaluation Reserve	1032	
Total Impairments charged to SoCI - DEL	788	
Total Impairments charged to SoCI - AME	265	
Overall Total Impairments	2,085	
Of which:		
Impairment on revaluation to "modern equivalent asset" basis	0	
Donated and Gov Granted Assets, included above		
Donated Asset Impairments: amount charged to SOCI - DEL	6	
Donated Asset Impairments: amount charged to SOCI - AME	0	
Donated Asset Impairments: amount charged to revaluation reserve	0	
Total Donated Asset Impairments	6	
Government Granted Asset Impairments: amount charged to SoCI - DEL	0	
Government Granted Asset Impairments: amount charged to SoCI - AME	0	
Government Granted Asset Impairments: amount charged to revaluation reserve	0	
Total Gov Granted asset Impairments.	0	
TOTAL DONATED/GOVERNMENT GRANTED ASSET IMPAIRMENTS	6	

* This impairment relates to the brought into use revaluation of two significant assets. An impairment relating to a new pharmacy aseptic unit of £444,000 and an impairment relating to a new offsite decontamination facility of £344,000 were recognised in the year.

** This impairment relates to the year end valuation of the Trust's assets as described in note 1.7 of page 9.

18 Investment property

The Trust has no investment property.

19 Commitments

19.1 Capital commitments

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

	31 March 2012	31 March 2011
	£000	£000
Property, plant and equipment *	**2,503**	423
Intangible assets	**0**	0
Total	**2,503**	423

* The current year includes £1,891,000 capital commitments for an asset under construction that is fully funded by donated income.

19.2 Other financial commitments

The Trust has not entered into any non-cancellable contracts in the current year (2010-11: none).

20 Intra-Government and other balances

	Current receivables £000s	**Non-current receivables £000s**	**Current payables £000s**	**Non-current payables £000s**
Balances with other Central Government Bodies	7,062	0	4,534	0
Balances with Local Authorities	5	0	36	0
Balances with NHS Trusts and Foundation Trusts	915	0	768	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	4,845	1,443	24,508	0
At 31 March 2012	**12,827**	**1,443**	**29,846**	**0**
prior period:				
Balances with other Central Government Bodies	7,312	632	6,345	0
Balances with Local Authorities	53	0	5	0
Balances with NHS Trusts and Foundation Trusts	386	0	1,046	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	5,006	1,757	19,274	0
At 31 March 2011	**12,757**	**2,389**	**26,670**	**0**

21 Inventories

	Drugs £000	Consumables £000	Energy £000	Total £000
Balance at 1 April 2011	1,844	2,615	193	4,652
Additions	218	466	74	758
Write-down of inventories (including losses)	(55)	(6)	0	(61)
Balance at 31 March 2012	2,007	3,075	267	5,349

22.1 Trade and other receivables

	Current		Non-current	
	31 March 2012 £000	31 March 2011 £000	**31 March 2012 £000**	31 March 2011 £000
NHS receivables - revenue	**5,848**	5,610	**0**	632
NHS prepayments and accrued income	**1,492**	1,876	**0**	0
Non-NHS receivables - revenue	**2,553**	2,583	**1,443**	1,757
Non-NHS prepayments and accrued income	**2,760**	2,893	**0**	0
Provision for the impairment of receivables	**(429)**	(426)	**0**	0
VAT	**601**	220	**0**	0
Interest receivables	**2**	1	**0**	0
Total	**12,827**	12,757	**1,443**	2,389
Total current and non current	**14,270**	15,146		

The great majority of trade is with Primary Care Trusts, as commissioners for NHS patient care services. As Primary Care Trusts 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 2012 £000	31 March 2011 £000
By up to three months	**5,971**	6,235
By three to six months	**168**	79
By more than six months	**123**	31
Total	**6,262**	6,345

22.3 Provision for impairment of receivables

	2011-12 £000	2010-11 £000
Balance at 1 April 2011	**(426)**	(333)
Amount written off during the year	**466**	388
Amount recovered during the year	**66**	(4)
Increase in receivables impaired	**(535)**	(477)
Balance at 31 March	**(429)**	**(426)**

Injury cost recovery income is subject to a provision for impairment of receivables of 10.5% (previously 9.6% to September 2011) to reflect expected rates of collection.

Invoices raised to overseas visitors are provided for immediately as a high number of these invoices are not collected.

Specific provisions are made against any invoices that are outstanding and deemed to be non-collectable including those that have been sent to the Trust's debt collection agency.

23 NHS LIFT investments

The Trust has no NHS LIFT investments.

24 Other financial assets

There were no other financial assets in this year or the prior year.

25 Other current assets

There were no other current assets in this year or the prior year.

26 Cash and Cash Equivalents

	31 March 2012 £000	31 March 2011 £000
Opening balance	**233**	441
Net change in year	**969**	(208)
Closing balance	**1,202**	233
Made up of		
Cash with Government Banking Service	**1,191**	222
Commercial banks	**0**	0
Cash in hand	**11**	11
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**1,202**	233
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**1,202**	233
Patients' money held by the Trust, not included above	1	1

27 Non-current assets held for sale

There were no non-current assets held for sale in this year or the prior year.

28 Trade and other payables

	Current		Non-current	
	31 March 2012 £000	31 March 2011 £000	**31 March 2012 £000**	31 March 2011 £000
NHS payables - revenue	**479**	1,104	**0**	0
NHS accruals and deferred income	**608**	3,406	**0**	0
Non-NHS payables - revenue	**6,885**	9,527	**0**	0
Non-NHS payables - capital	**5,073**	2,167	**0**	0
Non-NHS accruals and deferred income *	**12,610**	6,622	**0**	0
Social security costs	**1,871**	1,688		
Tax	**2,279**	2,156		
Payments received on account	**41**	0	**0**	0
Total	**29,846**	26,670	**0**	0
Total payables (current and non-current)	**29,846**	26,670		

* Non-NHS accruals and deferred income includes £2,990,000 of deferred income relating to donated income in respect of a donated asset that is under construction at 31 March 2012 (31 March 2011: £nil).

Included in Non-NHS payables - revenue above:		
Outstanding Pension Contributions at the year end	0	2,084

There were no pension contributions outstanding at 31 March 2012 as these were paid on 28 March 2012 (31 March 2011: £2,084,000).

29 Other liabilities

There were no other liabilities in this year or the prior year.

30 Borrowings

	Current		Non-current	
	31 March 2012 £000	31 March 2011 £000	**31 March 2012 £000**	31 March 2011 £000
Finance lease liabilities	**0**	4	**0**	0
Total	**0**	**4**	**0**	**0**
Total other liabilities (current and non-current)	**0**	**4**		

31 Other financial liabilities

There were no other financial liabilities in this year or the prior year.

32 Deferred income

	Current		Non-current	
	31 March 2012 £000	31 March 2011 £000	**31 March 2012 £000**	31 March 2011 £000
Opening balance at 01/04/11	**3,589**	987	**0**	0
Deferred income addition *	**4,575**	3,589	**0**	0
Transfer of deferred income	**(3,589)**	(987)	**0**	0
Current deferred Income at 31 March 2012	**4,575**	3,589	**0**	0
Total other liabilities (current and non-current)	**4,575**	**3,589**		

* Deferred income addition includes £2,990,000 of deferred income relating to donated income in respect of a donated asset that is under construction at 31 March 2012 (31 March 2011: £nil).

33 Finance lease obligations as lessee

The Trust had a finance lease for IT hardware for the Oracle finance system within the Shropshire Healthcare Finance Consortium. The hardware cost for the whole consortium was £87,300 and has a life expectancy of 5 years. The Shrewsbury and Telford Hospital NHS Trust element is 33.46% of the consortium.

Amounts payable under finance leases (Other)	**Minimum lease payments**		**Present value of minimum lease**	
	31 March 2012 £000	31 March 2011 £000	**31 March 2012 £000**	31 March 2011 £000
Within one year	**0**	4	**0**	4
Between one and five years	**0**	0	**0**	0
After five years	**0**	0	**0**	0
Less future finance charges	**0**	0		
Present value of minimum lease payments	**0**	4	**0**	4
Included in:				
Current borrowings			**0**	4
Non-current borrowings			**0**	0
			0	4

34 Finance lease receivables as lessor

The Trust does not have any leasing arrangements where it acts as a lessor.

35 Provisions

	Total	Pensions Relating to Other Staff	Legal Claims	Restructuring	Other
	£000s	£000s	£000s	£000s	£000s
Balance at 01/04/11	1,310	200	164	595	351
Arising During the Year	455	5	155	164	131
Utilised During the Year	(792)	(39)	(145)	(553)	(55)
Reversed Unused	(40)	0	(21)	(19)	0
Unwinding of Discount	13	10	0	0	3
Balance as at 31/03/12	**946**	**176**	**153**	**187**	**430**
Expected Timing of Cash Flows:					
No Later than One Year	**556**	**39**	**153**	**187**	**177**
Later than One Year and not later than Five Years	**342**	**137**	**0**	**0**	**205**
Later than Five Years	**48**	**0**	**0**	**0**	**48**

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:	
As at 31 March 2012	42,665
As at 31 March 2011	38,367

Pensions relating to other staff is a provision for future payments payable to the NHS Pensions Agency in respect of former employees who took early retirement.

Legal claims relate to non clinical cases with employees and members of the general public.

Restructurings provision relates to changes within the Trust's senior management team. The relevant individuals have been consulted and the provision represents the expected direct expenditure arising from this change.

Other provision relates to Injury Benefits relating to former staff and contains provisions payable to former employees forced to retire due to injury suffered in the workplace (£308,000) and the CRC scheme (£122,000).

36 Contingencies

	31 March 2012	31 March 2011
	£000	£000
Contingent liabilities		
Contingent liabilities	**(81)**	**(86)**
Net Value of Contingent Liabilities	**(81)**	**(86)**

The contingent liabilities represent the difference between the expected values of provisions for legal claims carried at note 35 and the maximum potential liability that could arise from these claims.

37 PFI and LIFT

The Trust has no PFI or LIFT commitments.

38 Impact of IFRS treatment - current year

The Trust has no transactions that require disclosure within this note.

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 primary care trusts and the way those primary care trusts are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk
The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

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

Credit risk
Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2012 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 Trusts, 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' £000	Loans and receivables £000	Total £000
Embedded derivatives	0	0	0
Receivables - NHS	0	0	0
Receivables - non-NHS	0	0	0
Cash at bank and in hand	0	1,202	1,202
Other financial assets	0	0	0
Total at 31 March 2012	0	1,202	1,202
Embedded derivatives	0	0	0
Receivables - NHS	0	632	632
Receivables - non-NHS	0	0	0
Cash at bank and in hand	0	233	233
Other financial assets	0	0	0
Total at 31 March 2011	0	865	865

39.3 Financial Liabilities	At 'fair value through profit and loss' £000	Other £000	Total £000
Embedded derivatives	0	0	0
NHS payables	0	153	153
Non-NHS payables	0	0	0
Other borrowings	0	0	0
PFI & finance lease obligations	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2012	0	153	153
Embedded derivatives	0	0	0
NHS payables	0	164	164
Non-NHS payables	0	0	0
Other borrowings	0	0	0
PFI & finance lease obligations	0	4	4
Other financial liabilities	0	0	0
Total at 31 March 2011	0	168	168

The fair value of financial assets and financial liabilities are equal to the carrying amount.

40 Events after the end of the reporting period

There are no material events after the reporting period that require adjusting or disclosing within these financial statements.

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, have undertaken any material transactions with the Shrewsbury and Telford Hospital NHS 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:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£000	£000	£000	£000
Shropshire County PCT	199	138,901	0	1,081
Telford and Wrekin PCT	219	94,269	55	2,971
NHS Litigation Authority	6,164	0	1	0
NHS Blood and Transplant	2,158	0	186	0
Department of Health	83	0	0	0
West Midlands Strategic Health Authority *	48	10,724	12	14
Birmingham East and North PCT	20	10,042	0	9
South Staffordshire PCT	0	1,389	0	81
North Staffordshire PCT	0	637	0	7
Dudley PCT	0	552	0	7
Robert Jones and Agnes Hunt Orthopaedic Hospital Foundation Trust	1,127	2,540	34	53
Mid Cheshire Hospitals NHS Foundation Trust	941	0	154	0
University Hospital of North Staffordshire NHS Trust	897	230	201	330
Shropshire Community Health NHS Trust	282	2,219	142	325

* The West Midlands Strategic Health Authority is part of the NHS Midlands and East SHA cluster.

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 and Wrekin Council for business rates.

The Trust had a number of material transactions with Welsh bodies for healthcare: Powys Local Health Board, Betsi Cadwaladr University Health Board and the Health Commission of Wales.

The Trust has also received revenue and capital payments from a number of charitable funds, certain of the trustees for which are also members of the Trust board. The audited accounts/the summary financial statements of the Funds Held on Trust will be published separately.

42 Losses and special payments

The total number of losses cases in 2011-12 and their total value was as follows:

	Total Number of Cases	**Total Value of Cases £s**
Losses	364	529,754
Special payments	62	173,584
Total losses and special payments	426	703,338

The total number of losses cases in 2010-11 and their total value was as follows:

	Total Number of Cases	**Total Value of Cases £s**
Losses	227	571,337
Special payments	30	75,768
Total losses and special payments	257	647,105

43. Financial performance targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

43.1 Breakeven performance	**2005-06 £000**	**2006-07 £000**	**2007-08 £000**	**2008-09 £000**	**2009-10 £000**	**2010-11 £000**	**2011-12 £000**
Turnover	189,152	205,748	227,241	247,233	262,882	277,980	299,850
Retained surplus/(deficit) for the year	(12,142)	(2,840)	4,102	4,127	(11,652)	(325)	(1,167)
Adjustment for:							
Timing/non-cash impacting distortions:							
Use of pre - 1.4.97 surpluses [FDL(97)24 Agreements]	0	0	0	0	0	0	0
2006/07 PPA (relating to 1997/98 to 2005/06)	0						
2007/08 PPA (relating to 1997/98 to 2006/07)	0	0					
2008/09 PPA (relating to 1997/98 to 2007/08)	0	0	(5,635)				
Adjustments for Impairments				30	12,364	351	1,053
Consolidated Budgetary Guidance - Adjustment for Dual Accounting under IFRIC12*					0	0	0
Adjustments for impact of policy change re donated/government grants assets							173
Other agreed adjustments	0	0	0	0	0	0	0
Break-even in-year position	(12,142)	(2,840)	(1,533)	4,157	712	26	59
Break-even cumulative position	(22,675)	(25,515)	(27,048)	(22,891)	(22,179)	(22,153)	(22,094)

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other 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.

In line with the Trust's Long Term Financial Model the Trust is planning to deliver surpluses over the 5 year period that will reduce the overall cumulative deficit.

	2005-06 %	**2006-07 %**	**2007-08 %**	**2008-09 %**	**2009-10 %**	**2010-11 %**	**2011-12 %**
Materiality test (i.e. is it equal to or less than 0.5%):							
Break-even in-year position as a percentage of turnover	-6.42	-1.38	-0.67	1.68	0.27	0.01	0.02
Break-even cumulative position as a percentage of turnover	-11.99	-12.40	-11.90	-9.26	-8.44	-7.97	-7.37

The amounts in the above tables in respect of financial years 2005/06 to 2008/09 inclusive have **not** been restated to IFRS and remain on a UK GAAP basis.

43.2 Capital cost absorption rate

Until 2008/09 the Trust was required to absorb the cost of capital at a rate of 3.5% of forecast average relevant net assets. The rate is calculated as the percentage that dividends paid on public dividend capital bears to the actual average relevant net assets.

From 2009/10 the dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets and therefore the actual capital cost absorption rate is automatically 3.5%.

43.3 External financing

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

	2011-12 £000	2010-11 £000
External financing limit	**1,029**	**736**
Cash flow financing	**4,869**	1,902
Other capital receipts	**(3,842)**	(1,199)
External financing requirement	**1,027**	**703**
Undershoot	**2**	**33**

43.4 Capital resource limit

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

	2011-12 £000	2010-11 £000
Gross capital expenditure	**13,354**	9,199
Less: book value of assets disposed of	**0**	(131)
Less: capital grants	**0**	0
Less: donations towards the acquisition of non-current assets	**(4,152)**	(694)
Charge against the capital resource limit	**9,202**	**8,374**
Capital resource limit	**10,200**	8,505
Underspend against the capital resource limit	**998**	**131**

44 Third party assets

The Trust held cash and cash equivalents which relate to monies held by the NHS Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

31 March 2012 £000s	**31 March 2011** £000s
1	1

KPMG

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF DIRECTORS OF SHREWSBURY AND TELFORD HOSPITAL NHS TRUST

We have audited the financial statements of Shrewsbury and Telford Hospital NHS Trust for the year ended 31 March 2012 on pages 1 to 41 in the Annex to Appendix 5 of the Annual Report and Annual Accounts 2011/12. These financial statements have been prepared under applicable law and the accounting policies set out in the Statement of Accounting Policies.

This report is made solely to the Board of Directors of Shrewsbury and Telford Hospital NHS Trust, as a body, in accordance with Part II of the Audit Commission Act 1998. Our audit work has been undertaken so that we might state to the Board of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of Directors and auditor

As explained more fully in the Statement of Directors' Responsibilities set out on page 2 of Appendix 5, the Directors are responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of Shrewsbury and Telford Hospital NHS Trust as at 31 March 2012 and of its expenditure and income for the year then ended; and

- have been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on other matters prescribed by the Code of Audit Practice 2010 for local NHS bodies

In our opinion:

- the part of the Remuneration Report subject to audit has been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England; and

- the information given in the director's report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

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

- in our opinion, the Governance Statement does not reflect compliance with the Department of Health's requirements;
- any referrals to the Secretary of State have been made under section 19 of the Audit Commission Act 1998; or
- any matters have been reported in the public interest under the Audit Commission Act 1998 in the course of, or at the end of, the audit.

Andrew Bostock for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
One Snowhill
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B4 6GH

8 June 2012

The Shrewsbury and Telford Hospital NHS Trust

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