



The Shrewsbury and  
Telford Hospital  
NHS Trust

# Annual Report

2024/25



**Our Vision:** To provide excellent  
care for the communities we serve

Shrewsbury and Telford Hospital NHS Trust  
Annual Report and Accounts 2024/25

Presented in accordance with the NHS Group Accounting Manual 2024/25  
pursuant to the Companies Act 2006




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## Foreword from the Chair in Common and Chief Executive

We continue to make good progress in improving the quality of care and our performance for patients. We will not stop on our improvement journey until we are delivering excellent care for our communities and an excellent working environment for staff.

We would like to thank staff for their professionalism, care and dedication to our patients in what has been another challenging year for the NHS. In 2024/25, we have continued to experience high demand for services, alongside industrial action.

2024 brought changes to our Board membership, including both of us joining the Trust during Autumn 2024. We also welcomed several new Executive and Non-Executive Board members, and everyone is determined to improve care for the communities we serve.

In May 2024, the Care Quality Commission (CQC) reported progress across a number of services, with the Trust improving its overall rating from 'inadequate' to 'requires improvement'. Following an inspection in October 2023, and a well-led inspection in November 2023, the Trust is now rated as 'good' for 'caring'. The 'safe' and 'responsive' domains, previously rated as 'inadequate', are now rated as 'requires improvement'. The 'effective' and 'well-led' domains remain rated as 'requires improvement'. End of life care, children and young people and maternity services progressed to 'good' across all domains.

We are determined to deliver safe, effective, reliable, and high-quality services to women and families now and into the future, and we are nearing completion of all the actions from the Independent Review of Maternity Services by Donna Ockenden. The Trust has made significant progress in maternity services, but we must do more to build trust and engage with families in a meaningful way. We will continue to listen and learn to ensure the changes we make are real, positive and can be sustained. We are grateful to the families who are meeting with us to share their experiences. We will continue to offer regular meetings with any families who want to be involved.

The CQC inspection also reflected the need for us to continue our work to improve urgent and emergency care, with services rated 'requires improvement' at Royal Shrewsbury Hospital (RSH) and 'inadequate' at Princess Royal Hospital (PRH). An action plan was developed to improve the privacy and dignity of patients in escalation areas, improve flow and reduce waiting times. The CQC's report was closely followed by the Dispatches documentary highlighting the pressures within our Emergency Departments. Through our CQC action plan, and working with our health and care partners, our teams have worked tirelessly to improve the standards of care in our urgent and emergency care pathways. Throughout 2024/25 we have seen a reduction in care on corridors, increased patient observations and reduced waiting times by increasing the use of Same Day Emergency Care. Supporting the health and wellbeing of our staff working

under this constant pressure remains a priority for us. Improving waiting times in urgent and emergency care is everyone's responsibility. We know, working with partners, we need to accelerate our improvements to give our patients and staff a better experience. In March 2025, we opened the first phase of works to transform our Emergency Department at RSH, as we create a bigger healthcare facility.

During 2024/25 we made improvements in our performance, which you can read more about in this report. We have made significant progress in reducing waiting times for diagnostic tests, including endoscopy and imaging. In quarter one 2025/26, we expect to have eliminated 65 week waits and continue to make good progress in reducing 52 week waits for patients. During 2024/25 we have significantly reduced the number of patients waiting in excess of a year for elective treatment from over 4,000 patients in August 2024 to 1,512 patients by the end of March 2025 (English patients only, NHS England standard). We have set ambitious targets for 2025/26 to reduce waiting times further and are working towards the national ambition to restore 18 week waits by 2029. In 2024/25 3,800 day surgery patients used our new Planned Care Hub at Princess Royal Hospital (PRH), which opened in June 2024. We also restored elective orthopaedic surgery to Ward five at PRH and are proud to have supported our first zero-day discharge patients following hip replacements.

Cancer remains one of our most challenged services and we are sorry patients are waiting longer than we would want for treatment in some specialties. In August 2024, we opened our new £3.6m Gamma Camera at Royal Shrewsbury Hospital (RSH), which is the largest single investment in nuclear medicine that Shropshire, Telford and Wrekin have seen historically. In addition, we are replacing a linear accelerator (LINAC) and have been building a new bunker to house the state-of-the-art equipment at RSH. This is a vital component in the treatment of cancer patients, delivering high-energy X-rays or electrons precisely to the tumour. This investment in modern equipment will increase cancer scanning capacity and resilience and reduce waiting times.

To deliver our vision of excellent care, we need to transform our digital infrastructure. In April 2024, our teams successfully upgraded our 20-year-old patient administration system. This was a massive undertaking, transferring over one million patient records and training more than 5,000 staff. Thank you to everyone involved. The migration to a new system highlighted the fragile digital infrastructure within the Trust, with complex interdependencies to other systems. During 2024/25 and following considerable challenges in the ability to generate an accurate activity and income position, our teams worked hard to develop a new Data Warehouse, which is essential to reporting our performance and will go live in 2025/26. We will continue with our multi-million pound digital investment in 2025/26 as we roll-out a patient portal to support electronic appointment letters, introduce a new Inventory Management System to deliver value for patients and prepare for our next significant upgrade which will transform radiology tests in

2026. To become an excellent Trust, we know we need to give our staff the tools to deliver modern care.

Long-term we know we need to change the way we work. The Hospitals Transformation Programme (HTP) is key to our success, and we were pleased to receive national approval in May 2024 for the £300m investment in local hospital services. Construction started in Summer 2024 for this once in a generation development. HTP will improve care for everyone through more modern healthcare facilities and ways of working. We are aiming to open the doors to our new services in 2028 and a significant amount of work is happening behind the scenes to ensure we have the right teams, in the right places to deliver the step-change needed to improve care. We will continue to work with local teams, partners and communities as our plans for two thriving hospitals continue to take shape. We would like to thank everyone for their patience through the essential building works.

Our estates transformation is more ambitious than HTP alone and in 2024/25 we continued to invest in our estates infrastructure. This includes our focus on becoming a Greener NHS and reducing our carbon footprint. The Trust has seen a 23% reduction in energy CO2 emissions since 2019. Our NHS Waste Clinical Strategy in 2024 has reduced the clinical waste we throw away. This is better for the environment and also saved £150,000, adding value for taxpayers. We were also pleased to have been awarded £16.2m to reduce our carbon footprint at RSH and we will be installing solar panels, electric vehicle charging points and upgrading the efficiency of our buildings. In 2025, work started on a new Energy Centre at RSH, upgrading our heating system and further improving our energy efficiency.

In early 2025, we secured multi-million-pound funding to replace Reinforced Autoclaved Aerated Concrete (RAAC) at PRH. Work has started to remove the RAAC near the kitchen area. We are making the most of this opportunity and will have a new kitchen and enhanced restaurant area at PRH to improve the experience for everyone. We will also create a better Doctor's Mess to support colleagues to rest, recharge and share best practice. We expect the works to finish in Spring 2026.

We were proud that the CQC highlighted our focus on training and innovation. As part of our Moving to Excellence programme we want to take this further in 2025/26 and we are working towards becoming a University Hospital Trust. This will deliver better care for patients through greater opportunities for training, innovation and research. In 2024 we were proud to be awarded £1 million to lead a research study which could revolutionise the diagnosis of colorectal cancer. The TRIOMIC study will reduce the time patients are waiting for a colorectal cancer diagnosis. A new test is being developed as part of the study, aiming to significantly reduce the number of patients who require an invasive colonoscopy. It also takes place away from a hospital setting at our Community Diagnostic Centre (CDC). The CDC fully opened in 2024 at Hollinswood

House in Telford and provides diagnostic tests, blood tests, teledermatology and renal services. The CDC supported 124,378 scans and appointments in 2024/25.

In 2025/26, more than ever before, we have a triple balancing act in the NHS: workforce, quality and finance. This means going back to basics – what the NHS is here to provide. Like other hospitals, we will have difficult decisions to make to stay within our budget and add value to taxpayers. In 2024/25 we made progress in stabilising our overspending, delivering a 60% reduction in monthly agency spending and delivering £34.3m in efficiencies (nearly double the efficiencies in 2023/24). To restore financial balance, we need to tackle escalation costs, increase productivity in our elective care and reduce waste. Working with partners, we agreed an underlying deficit of £45.1m and cost improvement plan (CIP) efficiencies of £41.4m for 2025/26. However, we need to go further than this and work towards restoring financial balance, with no deficit, in the coming years. This is absolutely the right thing to do to add value for our patients and taxpayers. To deliver this level of change, we know reform is needed. During 2025/26, we will be working with our teams to build a sustainable future, both clinically and financially, with the right staff, with the right skills, in the right places to meet our patients' needs. Patient safety will always come first. By focusing on quality and building a modern workforce, we can do things differently and balance our budgets. We will do this by staying true to our values and listening to our patients, communities and staff.

Everyone is valued in our organisation, and we want to be a great place to work. Our 2024 Staff Survey results showed we are making progress on our cultural transformation. We would like to accelerate our progress further in 2025/26, which we know will not be easy given the changes happening in the NHS. Our focus will be building a culture where everyone feels they belong, has a voice and has opportunities to grow.

In 2025 the Government will publish its 10 Year Plan for the NHS. As a Board we will reflect on these national priorities and align our priorities. Our focus will remain on bringing more care into the community through joined-up working, focusing on prevention, tackling inequalities and enabling digital transformation. We cannot do this in isolation and in 2025/26, we will build on our work with our local Provider Collaborative (group of NHS providers that deliver care) to deliver these national ambitions. In 2024 we created a Chair in Common role to bring greater alignment between the Trust and Shropshire Community Health NHS Trust (Shropcom) and will build upon the great work the trusts' teams have been doing together. This includes increasing the use of Virtual Ward and Outpatient Parenteral Antibiotic Therapy (OPAT) services. In 2025/26, we will encourage further conversations across teams to explore opportunities to share services, improve care and add value for taxpayers. We are grateful for the support and collaboration shown by all our multi-agency partners last year and the shared commitment to progress our system priorities.

In 2025/26 we want to go further and faster in our improvement programme. Despite the challenges we face, we also see the fantastic transformation happening across the Trust. In 2025/26, we will launch our Moving to Excellence transformation programme. This will replace our Getting to Good programme – as now is the time to aim higher than good. We have exciting plans to move our organisation forwards, through education, digital, clinical services and estates and we want to become an excellent Trust by 2028, delivering exceptional care. This is ambitious but given the incredible staff and volunteers who work with us, we believe it is doable. More information on our Moving to Excellence programme is on our website.

Finally, we would like to thank all our patients, communities and staff for their support on our improvement journey.



**Andrew Morgan**  
**Chair in Common**



**Jo Williams**  
**Chief Executive**

23 June 2025



# Part one:

# Performance Report



## Performance Overview

This section of our report provides detail as to what it is that we do here at SaTH, who we are, and our values and ambitions. It outlines the principal risks that the Trust faces in the delivery of our strategy and objectives and provides some details on how we performed over the financial year, 1 April 2024 to 31 March 2025.

## Statement from the Chief Executive

Over the past year, the Trust has navigated significant challenges across urgent and emergency care, elective treatment, cancer pathways, and diagnostics. Despite persistent pressure, proactive measures have been implemented to drive performance improvements for our patients and enhance patient outcomes. While some progress has been made, we recognise as a Trust that further work is needed to deliver improvements for our patients, meet national standards and deliver sustainable change.

Urgent and emergency care demand remained high throughout the year, impacting our ability to meet the 4-hour Emergency Access Standard. The Trust's performance averaged 52.2%, well below the national expectation of 76%, with ambulance handover delays continuing to be a significant challenge. To address these concerns, significant improvement work was undertaken within our Emergency Departments, acute medicine, and ward processes. This included a reduction in the average length of stay, improved early discharge rates, and enhanced ED triage effectiveness, moving the Trust's triage performance from the lower quartile to the middle quartile nationally. Additionally, expansion of Medical Same Day Emergency Care services contributed to a higher proportion of patients being treated outside of the main Emergency Department. While these initiatives have driven improvements, the Trust remains under Tier 1 regulatory monitoring, underscoring the ongoing need for targeted intervention.

Looking ahead, the Trust will continue implementing system-wide transformation programs, such as the Medicine Transformation Programme and the Stronger Together campaign, to drive further progress in patient flow and emergency care standards.

In elective care, Referral to Treatment (RTT) performance has been a key area of focus, with 47.7% of English patients waiting under 18 weeks, as of March 2025. The overall waiting list peaked at over 50,000 English patients before strategic interventions reduced it to 41,669 by year-end, with a similar profile in the Welsh waiting list. Delays in signing off the financial plan at the start of the year affected elective activity, and the introduction of the new Patient Administration System included a transition period in Quarter 1, leading to increased waiting times. However, targeted investments, including the opening of the PRH Elective Hub and improvements to RTT pathways, have contributed to recovery efforts. Moving into 2025/26, further investment will be directed toward diagnostic capacity and surgical efficiency to improve access to timely elective care.

Cancer services have seen mixed progress against national standards. While the Trust achieved strong performance in the 31-day treatment standard, significant gaps remain in the 28-day Faster Diagnosis Standard and ultimately in the 62-day referral-to-treatment indicator. Sustained improvement in the 62-day RTT performance has been achieved through focused improvements in Oncology and Radiotherapy, but further strategic efforts are needed. In

response, the Trust has established a Cancer Improvement Board, which will drive enhancements in diagnostic pathways, appointment capacity, and referral management. This initiative aims to improve early diagnosis rates and ensure timely access to specialist care.

Diagnostic performance also posed challenges, with 78.2% of patients waiting under six weeks for a scan as of March 2025 - falling short of the 99% constitutional target. While interventions stabilised performance in the latter half of the year, persistent bottlenecks remain in key areas such as Non-Obstetric Ultrasound, Cardio-Respiratory, and MRI. Dedicated funding has been allocated in 2025/26 to address these gaps, with a particular focus on increasing imaging capacity and streamlining diagnostic pathways.

## About the Trust

The Shrewsbury and Telford Hospital NHS Trust was established in its present form on 1 October 2003 and brought together healthcare organisations in Shrewsbury, Telford and Shropshire. The Trust is spread across several locations, with the main sites of Royal Shrewsbury Hospital (RSH) and The Princess Royal Hospital (PRH) in Telford, being positioned approximately 15 miles apart. Outreach and outpatient clinics managed by the Trust are also provided at Whitchurch Community Hospital, Bridgnorth Community Hospital, Ludlow Community Hospital, and the Wrekin Community Clinic. The Trust serves a community of circa 500,000 service users across Shropshire, Telford and Wrekin, and mid-Wales. We employ around 7,971 staff, all of whom contribute to providing high quality patient care in our hospitals and in our community services.

The Trust's management structure comprises four clinical divisions led by clinician and management partnerships, and one corporate division (including departments such as finance, estates, facilities, human resources, governance and risk). These are: 'Medicine and Emergency Care Division', 'Surgery, Anaesthetics and Cancer Division', 'Women and Children's Services Division', 'Clinical Support Services Division' and 'Corporate Services Division'.

The two main hospitals provide a wide range of acute hospital functions including Accident and Emergency, outpatients, diagnostics, critical care and inpatient medical care. The Trust has over 750 beds in total (including adults and children's).

PRH became the specialist centre for inpatient head and neck surgery in 2013, following the establishment of enhanced outpatient facilities and a dedicated head and neck ward. It is also currently the main centre for inpatient women and children's services following the opening of Shropshire Women and Children's Centre in 2014. RSH became the main specialist centre for acute surgery with a surgical assessment unit, surgical short stay unit and ambulatory care facilities. In 2022 cardiology services were also centralised at PRH.

In November 2023, the renal dialysis service moved from the PRH site to a new purpose designed facility for lower risk patients. The new facility will allow the Trust to meet future demand, together with updating the previous facility into a new inpatient ward.

Our programme of improvement has continued during the year with the £24million NHS England (NHSE) investment into the development of the Elective Hub.

The opening of phase 1 of the Elective Hub was delayed, however, associated elective activity commenced in July 2023, at reduced levels. The Elective Hub was handed over to the Trust in May, with the first patients being seen in early June after a period of staff orientation and training. This facility is aligned with our Hospital Transformation Programme (HTP) and is an important pillar in our referral to treatment (RTT) and cancer recovery plan during 2024/25, providing improved operating theatres including one additional theatre, and ringfenced beds for elective day case patients.

The first two phases of our new Community Diagnostic Centre (CDC) opened on the ground floor of Hollinswood House, Telford, in October 2023 and January 2024 respectively, providing additional non-urgent diagnostic capacity in phlebotomy, CT, ultrasound and MRI - supporting improvement towards the national diagnostic standard.

In line with the revisions to NHS England's oversight and support arrangements, NHSE has stood down all existing SaTH Safety Oversight and Assurance Committee meetings and STW ICB oversight meetings, replacing these with revised oversight arrangements which bring together the key areas of focus, aligned to NOF4. The organisation continues to work collaboratively in achieving its performance priorities and progressing the delivery of the Trust's Quality Improvement Plan ('Getting to Good').

'Getting to Good' has been a three-year improvement programme which has continued during 2024/25. This critical programme helped to drive and embed change throughout the organisation, ensuring that any improvements made were high quality and sustainable. In 2025/26 we launched our Moving to Excellence transformation programme. This replaces our Getting to Good programme.

## Workforce

Our staff are our most precious asset, and we are determined to create an environment where everyone truly feels welcome and valued. We are committed to being an anti-racism organisation which actively tackles racism in all its forms. Our anti-racism statement sets out this specific focus and priority for action, alongside our wider commitment to tackle discrimination.

Throughout the year, the Trust has continued to experience significant disruption to planned activity during periods of industrial action, and both clinical and non-clinical staff across the Trust have worked extremely hard to maintain the safety of our patients during these periods. To enable us to maintain access to urgent and emergency services and prioritise patients with the most serious and urgent health needs, it is regrettable that we had to cancel a significant number of inpatient treatments and outpatient appointments. While we fully recognise colleagues' right to take part in these strikes, we also understand the frustration and distress this causes for our patients and their families; the Trust Board welcomed some resolution.

Our services are closely involved in clinical and scientific research and, together with our close partners, Shropshire Community Health NHS Trust (SCHT), Midlands Partnership University NHS Foundation Trust (MPFT), The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJA), and our shared academic partner, Keele University, the Trust is working towards University Status. (We also work with other academic partners.)

We are committed to working in close collaboration with our partners. The Trust Chief People Officer this year expanded responsibilities to be responsible for the Human Resources (HR) and Organisational Development (OD) service for SCHT. This has strengthened collaboration and supports our shared services ambitions within the ICB. A full review of HR and OD activity across the Trusts is underway to drive service improvement and value for money.

The Trust has a strong commitment to its widening participation strategy, working with local schools and colleges, community groups and other partners to support local people from all backgrounds into the workplace. This includes initiatives such as:

- The Department of Work and Pensions sector-based work academy programme, which provides people with access to entry-level roles and important skills for future employment.
- An internship programme to help build the experience and independence of young people with autism or learning difficulties. Many former interns are now valued members of staff.

The Trust is committed to fostering an equal and inclusive environment and collects a range of employment data to monitor and address diversity issues and inequalities, including through the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). The results are published in an annual workforce monitoring report on our website and through reporting to NHS England. We also have a well-established reverse mentoring programme, and we continue to develop and support cultural competence amongst our managers and leaders.

A multi-faith spiritual care team, reflecting the diverse faiths and beliefs of our local communities, is available to support patients and staff. The Trust celebrates its rich diversity through events, conferences and its vibrant staff networks, which provide important platforms to support an inclusive and compassionate culture; ensure that the lived experiences of staff are shared; and that staff can provide challenge, direction and innovation.

## The Care Quality Commission

The last CQC inspection report for the Trust was published on 15<sup>th</sup> May 2024 following the inspection of the five core services: Urgent and emergency care; medicine; palliative and end of life care; maternity, and children and young people, which took place in October 2023 and was followed by the well-led inspection in November 2023. A copy of the inspection report can be found on the CQC's website at <https://www.cqc.org.uk/provider/RXW>

Improvements were noted by the CQC and the Trust moved to an overall rating of “requires improvement” from the previous overall “inadequate” rating.

Our current overall CQC ratings can be found below:

Overall	Safe	Effective	Caring	Responsive	Well Led	Overall
Royal Shrewsbury Hospital	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
Princess Royal Hospital	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Trust Overall	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

The Trust has continued to implement and embed improvement actions following the inspection. In November 2024 the Trust made a successful application to the CQC and three Section 31 conditions were removed from the Trust's registration. Two conditions remain in place on the Trust's registration, these both relate to the initial assessment of all patients and triage of children within 15 minutes in our Emergency Departments. Further detail can be found within our 2024/25 Quality Account on our website and within the Annual Governance Statement of this annual report.

## The Trust's Strategic Direction, Vision and Values

The Trust's vision and strategic direction is fully aligned to the overall Integrated Care System approach. In response to the NHS Long Term Plan and in collaboration with our partners across Shropshire, Telford and Wrekin Integrated Care System (ICS), the system-wide five-year Integrated Care Strategy, which focusses on the needs of our local population, was refreshed and approved by the Integrated Care Partnership in October 2024. This was informed by Lord Darzi's report into the state of the NHS in September 2024.



In addition, parallel to this, aligned to the ICS four core principles (a. improving outcomes in population health and healthcare, b. tackling inequalities in outcomes, experience and access, c. enhancing productivity and value for money, d. helping the NHS to support broader social and economic development) the System's Joint Forward Plan was also reviewed and where possible, aligned to the known priorities and focus expected in the new NHS 10 year plan to be published over the forthcoming months.

Many of the actions included in the Joint Forward Plan were completed including initiatives to strengthen the approach to health inequalities in prioritising elective waiting lists and waiting well initiatives, launching the diabetes transformation programme, increased targeted community case finding for hypertension, improvements in the service offer for people living with dementia and the development of a system estates and physical infrastructure strategy. SaTH plays a major role in many of the system priorities and has been fully involved in the updates to the Joint Forward Plan.

For 2025/26 the Joint Forward Plan focusses on the following areas:

- Person-centred care
- Place, Neighbourhoods and Collaboration
- Improving Access to Services – General Practice, Dentistry, Elective and Diagnostics, Urgent and Emergency Care, Cancer
- Clinical Transformation Priorities – Hospital Transformation, Diabetes, Cardiovascular Disease, Musculoskeletal, Mental Health, Children and Young People, Healthy Ageing and Frailty, End of Life
- Enablers - finance, digital, workforce and estates

The 'Place' plans are key to the delivery of the system strategy and are articulated in the Joint Forward Plan and delivered through the Place partnership committees. For 2025/26 the Joint Forward Plan will focus on the foundations for delivering a focus on prevention, the shift from acute services to community and, from analogue to digital.

As a core contributor to the Joint Forward Plan we have ensured that all of our strategic aims and major programmes of work contribute to the overall health and care system. As an organisation we continue to strengthen our relationships and work collaboratively with all of our partners to develop and progress our Strategies, plus Operational, System Transformation and Resource Plans for 2025/26. As part of this, the Trust continues to review opportunities for further collaborative working that enhances our local population health and wellbeing needs through Place-based working and provider collaboratives. Importantly, the Trust is represented at local Health and Wellbeing Boards and both Integrated Place Partnership Boards.

The 2022-27 Trust Strategy sets out our ambitions, detailing the ways in which we will improve the delivery and quality of care, support and develop our workforce, address key challenges

and further develop a culture of improvement across the organisation. Crucially, it also describes the values and behaviours to which we are committed.

We published the Trust’s Clinical Services Strategy in 2023 which provided the strategic context for our acute hospital-based services, as well as SaTH’s clinical role in the wider system, and we continue to make progress in all four components of the clinical services strategy. During 2024/25, significant work was undertaken to ensure continued alignment of programmes internally, as well as with the wider Integrated Care Board’s strategic direction and the strategies of our partners.

### Our Values

Our values help shape our behaviours and thinking, leading to better outcomes for our patients and staff. We developed our values by listening to feedback from colleagues across the Trust, using what we know about future service configurations and best practice, and innovative ideas from people to support, that are proven to work.



**Partnering**

Working effectively together with patients, families, colleagues, the local health and care system, universities and other stakeholders and through our improvement alliances.

**Ambitious**

Setting and achieving high standards for ourselves personally and for the care we deliver, both today and in the future. Embracing innovation to continuously improve the quality and sustainability of our services.

**Caring**

Showing compassion, respect and empathy for our patients, families and each other, caring about the difference we make for our community.

**Trusted**

Open, transparent and reliable, continuously learning, doing our best to consistently deliver excellent care for our communities.

### Our Progress In-Year

Extensive work has been undertaken during the last 12 months in relation to embedding and aligning our Trust strategy, enabling strategies and programmes of work from both an internal and external perspective. A review of our progress focussing on our six strategic themes will be undertaken and a refresh, if appropriate will be underaken following the launch of the 10 year NHS Plan, with an update given to the Board of Directors in 2025/26.



### In-Year Achievements include:

<ul style="list-style-type: none"> <li>• Improved awareness and governance with regular Board of Directors updates</li> <li>• Improvement in staff survey results</li> <li>• Revision and alignment of key supporting strategies such as our clinical services strategy, quality, communications, estates, EDI.</li> <li>• Continuation of NHS Impact (Improving Patient Care Together) programme</li> <li>• Continual review of our performance management framework including reporting dashboards (internal and external)</li> <li>• Extensive work on quality improvement in relation to our CQC inspection and “Getting to Good” programme of work</li> <li>• Focus on “Getting it Right First Time” (GIRFT) programme which includes numerous transformation programmes of work that contribute to our strategic direction such as Urgent and Emergency Care (UEC), Planned Care, Cancer, Maternity, Theatres, Outpatients</li> <li>• Implementation of best practice and NICE Guidance</li> <li>• Collaborative working with established networks, partners and providers</li> </ul>	<ul style="list-style-type: none"> <li>• Hospital Transformation Programme (HTP) progress</li> <li>• Implementation of our Digital Strategy and electronic patient record (EPR) programme</li> <li>• Supporting systemwide programmes of work such as Urgent and Emergency Care (UEC), Local Care Transformation Programme (LCTP), Hospitals Transformation Programme (HTP), Place and the development of Provider Collaboratives</li> <li>• Medium term financial recovery plan</li> <li>• Improved operational planning process aligned to our strategic themes</li> <li>• Cultural shift and awareness of our strategy</li> <li>• Strengthened collaborative working with partners through the development of our systems Joint Forward Plan, Public Health Management, Health Inequalities, Place Based Delivery and neighbourhood working, and Provider Collaboratives</li> <li>• Strengthened governance and reporting internally and externally on a range of programmes including the above</li> </ul>
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### Building on Our Achievements

We are committed to building on our achievements to date working collaboratively with our people and partners to deliver our vision “to provide excellent care to the communities we serve”. We will continue to review and update our Trust strategies to not only confirm the Trust’s vision for our staff, but also to align SaTH’s ambitions with those of our partners in the ICS. The forthcoming NHS 10 year plan, expected later in 2025, will provide valuable context for future strategy development, as a Trust and as a health and care system partner.

## Digital

The Trust continues to prioritise digital transformation as a key component of our Trust and digital strategies to enhance patient care, improve operational efficiency, and foster innovation. Building on the progress made in 2023/24, we further developed our digital solutions and capabilities across multiple service areas. Key Achievements for 2024-2025 have included the implementation of some major components of our CareFlow Electronic Patient Record (EPR). This included CareFlow Patient Administration System across inpatient and outpatient areas, CareFlow ED in both of our emergency departments, and Patient Flow boards on all wards. We also started our digital records journey with the introduction of a digital record in both emergency departments.

Additional schemes included:

Digital Improvements in 2024/2025	Benefits
<b>Paediatric Vitals</b>	Paediatric Vitals is a new flexible observation module that launched within Vitals 4.3 to meet national paediatric early warning score (PEWS) requirements. This allows the digital recording of Paediatric Observations in inpatient settings, including Emergency Care and Children's Assessment areas.
<b>Paediatric Sepsis Assessments within Vitals</b>	This is a function within paediatric vitals allowing nursing staff to complete sepsis screening electronically which is then signed off by the clinician reviewing the patient.
<b>Patient Engagement Portal (DrDoctor Pilot)</b>	When a patient is given an appointment at our hospital, they will start to receive a text to let them know that an appointment letter is available via an online Patient Portal. They will also receive text reminders about their appointments and short notice appointment offers. This project has reached its pilot stage within the ENT department and roll out to further clinical areas is expected in late 2025.
<b>Secretaries Workstation (SEW 2)</b>	Secretaries workstation (SEW) 2 is the upgrade from SEW 1 and includes standardised letter templates, audit trails and is integrated with the Clinical Portal. Patients and General Practitioners will receive letters more rapidly with this system.
<b>Surgical Assessment Unit (SAU) Electronic Whiteboard</b>	A digital whiteboard to track patients and their care. The additional functionality includes integration with CareFlow PAS and tracking/prioritisation of patients, ensuring safe, co-ordinated care.
<b>Windows 11 upgrade</b>	The upgrade from Windows 10 to Windows 11 is mandatory to comply with NHS England security requirements.

Our Trust digital strategy aligns with the ICS digital strategy, and is a key enabler in our clinical services strategy. Our ambitions for 2025/26 are to continue to focus on giving our staff the

right tools to deliver excellent care, working in the acute sites and working with partners and patients across the system.

## Hospital Transformation Programme (HTP)



### Introduction

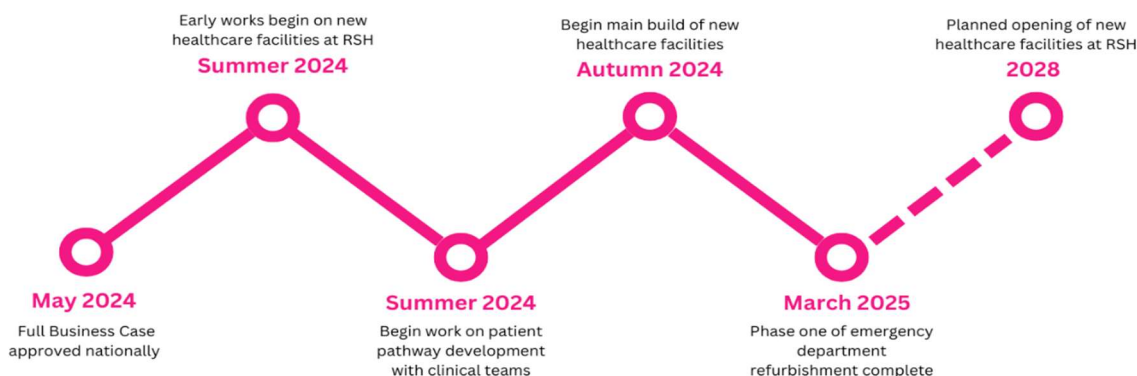
Through our Hospitals Transformation Programme (HTP) we are committed to delivering two thriving hospitals and making the most of our clinical services, specialist staff and space (estates) at both sites. The clinically led HTP plans will see the Princess Royal Hospital (PRH) site specialising in planned care, and the Royal Shrewsbury Hospital (RSH) site specialising in emergency care. In addition to this, 24/7 enhanced urgent care services will be available at both our hospitals. By separating planned care and emergency care, we can improve care for local people and deliver a healthier and more attractive place for our colleagues to work.

The national investment will help support the Trust's, and wider health and care systems', ambitions of delivering high quality, sustainable services for patients in modern facilities. HTP is a key component of the Integrated Care Board's (ICB) Joint Forward Plan (JFP), and the health system's plans for healthcare in Shropshire and Telford and Wrekin. It is also a key part of the plans for the health system in mid-Wales.

The clinically led programme will provide faster access to the right care and clinicians. It will result in shorter waiting times for planned surgery and emergency care. We will also continue our ongoing investment at both hospitals and the further development of community-based services to reduce waiting times and improve patient experience.

## Our progress

Throughout 2024/25 we have significantly progressed our plans for this much needed investment.



In May 2024 we received national approval for our Full Business Case, which was the final stage of approval.

Following this milestone, construction of the new healthcare facilities began in July 2024 at RSH. We have been making excellent progress and building work continues at pace and on time. We plan to open our new four-storey healthcare facilities in 2028.

Alongside the main building work, we have also commenced remodelling and refurbishment of our Emergency Department at RSH. This will provide the clinical space needed for teams to continue to make improvements and provide a positive urgent and emergency care experience for every patient, which forms part of our wider HTP plans.

We continue to work with our clinical teams and system partners to develop the patient pathways ahead of 2028. We are also learning from and working closely with other hospitals who have introduced similar ways of working to help inform our plans.

We will be continuing to keep local communities, patients and colleagues involved at every stage of the works, to help design a positive experience for everyone.

## Tackling Health Inequalities – annual report 2024/25

SaTH recognises its duty and responsibility to reduce health inequalities under the Health and Care Act 2022. The objective is to ensure that tackling inequalities in access, experience, and outcomes of healthcare services, is central to everything we do.

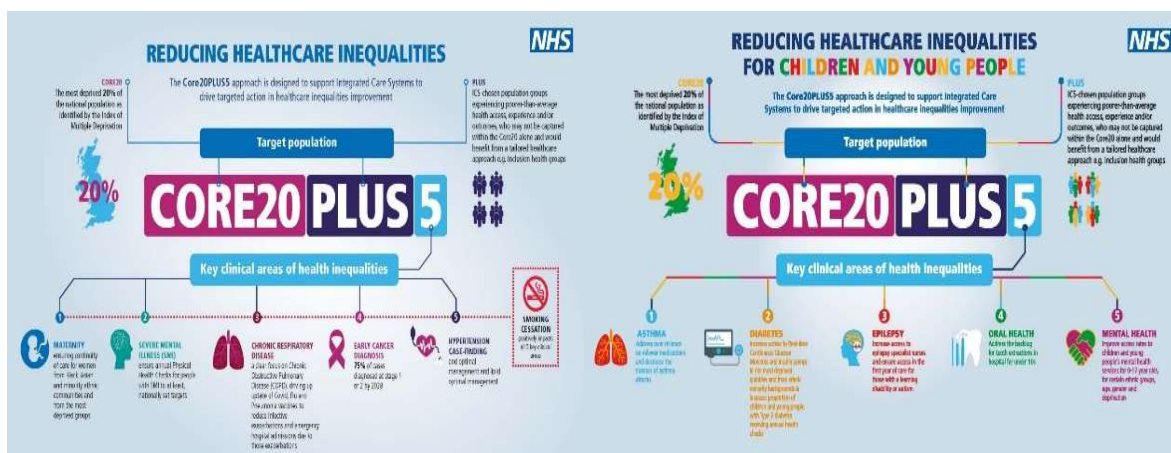
NHS England has defined health inequalities as ‘unfair and avoidable differences in health across the population between different groups within society’. These include how long people are likely to live, the health conditions they may experience, and access to care available to them.

As part of our statutory duty, we are required to reduce the inequalities experienced by our local communities with a focus on reducing healthcare inequalities (access and experience of healthcare) in line with the [National Healthcare Inequalities Improvement Programme](#), which is also known as the CORE20PLUS5 approach.



Core20PLUS5 Approach to Reducing Healthcare Inequality for Adults:

Core20PLUS5 Approach to Reducing Healthcare Inequality for Children and Young People:



Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. ‘Core20’ refers to the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD) score. There are seven different factors that form part of the score, which can be seen as a measure of socio-economic deprivation.

‘PLUS’ refers to specific groups of the population. This is an additional way of identifying other groups in society who experience health inequalities. Some PLUS groups are identified nationally, such as individuals with a learning disability or people experiencing homelessness. Others are based on local outcomes we see, specific to our Shropshire, Telford and Wrekin population, such as farming communities in rural areas.



The '5' focus refers to clinical areas requiring accelerated improvement for adults and a further 5 for children and young people.

During 2024/25, the Trust has built on the foundations commenced in 2023/24 and through the establishment of our health inequalities programme of work, we have seen significant improvements, strengthened governance, raised awareness, celebrated examples of good practice and most importantly we have started our journey to fully embed a culture that addresses health inequalities across current/future service delivery and redesign.

We recognise that we cannot address this wide ranging, multifactorial agenda alone, therefore our collaborative working with system partners is essential. As such, SaTH is a key partner of the ICS Prevention and Health Inequalities Group. We work collaboratively with system partners, proactively contributing to many of the health inequalities workstreams, where appropriate, across Shropshire, Telford and Wrekin (STW). Our ambitions are fully aligned with STW ICS pledges to tackle the problems of ill health, health inequalities and access to healthcare through a shared approach to ensuring health inequalities are mainstream activity that is core to, and not peripheral to, the work of the NHS.

### Health Inequalities - our Progress In-year

There are five priority objectives which underpin the National Healthcare Inequalities Improvement Programme and remain central in the 2025/26 Operational Planning Guidance to ensure focused action continues to take place:

- 1** **Restore Services Inclusively**  
Using local data to plan the inclusive restoration of healthcare services, ensuring that waiting list performance reports are delineated by ethnicity and deprivation.
- 2** **Mitigating Against Digital Exclusion**  
Enabling robust data collection to identify which populations are accessing face-to-face, telephone and virtual consultations (broken down by relevant protected characteristic) and ensuring the impact of digital innovation is assessed, considered and mitigated.
- 3** **Ensuring Datasets are Complete and Timely**  
To improve the collection and recording of ethnicity data across primary care, outpatients, A&E, mental health, community services and specialised commissioning.
- 4** **Accelerating Preventative Programmes**  
Driving initiatives which focus on the prevention of long-term conditions including those focused on lifestyle-related risk-factors and the clinical areas outlined in the [Core20PLUS5 for Adults and Children & Young People](#).
- 5** **Strengthen Leadership and Accountability**  
Ensuring named executive leads are appointed for tackling health inequalities, improving awareness and knowledge of the workforce and supporting access to relevant training and development.

In addition to the above, an assessment against our maturity as an anchor organisation will be undertaken in 2025/26 focussing on employment, procurement, environmental, estate and spaces to support our local communities.

In 2024/25, we commenced an evaluation of progress against these objectives and identified that we needed to strengthen our coordinated leadership across Prevention and Health

Inequalities both internally and within the wider system with a view to improving governance and accelerating progress in 2024/25. This led to the following actions:

- Newly established Systemwide Public Health Management and Prevention and Health Inequalities Groups
- The development of a high-level local and systemwide implementation plan
- Improved collaboration and joint working
- Executive lead(s) and responsible officers identified for health inequalities and all initiatives
- A clear programme of work aligned to internal IT infrastructure, governance, data collection/analysis and CORE20PLUS5 initiatives

### Health Inequalities - in-year achievements

<ul style="list-style-type: none"> <li>• Identified senior responsible officers</li> <li>• Established Public Health Management, Prevention and Health Inequalities Groups</li> <li>• Continued restoration of elective capacity, and reduced waiting times for the population</li> <li>• Mitigating digital exclusion with commencement of the development of digital strategy and implementation of EPR datasets alongside the outpatients' transformation programme of work, specifically reviewing patients who did not attend (DNA) from more deprived areas and comparing our uptake of virtual outpatient attendances compared to our peers.</li> <li>• Investing in digital systems and improving digital maturity for improved data accuracy and recording, e.g. ethnicity for all services particularly outpatients, A&amp;E and specialised services</li> <li>• New data dashboards are in development for cancer, elective and urgent care which will identify healthcare inequalities and draw out focus areas. A data quality dashboard is also in development where key inequality metrics are monitored for data completeness and accuracy</li> <li>• Systemwide development of health inequalities dashboard</li> <li>• Enhanced health inequalities leadership through additional roles and equality,</li> </ul>	<ul style="list-style-type: none"> <li>• Equity profiling exercise undertaken to drive targeted work within cancer programmes</li> <li>• Systemwide Cancer Champions Programme</li> <li>• Improved pathways for bowel cancer home testing kits to remove barriers where people do not have a fixed home</li> <li>• Codeveloped multi-lingual videos focused on improving cancer screening uptake</li> <li>• Targeted campaigns to improve late-stage diagnosis of prostate cancer in black men aged 40 plus</li> <li>• Focussed maternity programmes and the delivery of the Local Maternity &amp; Neonatal System equity and equality action plan with a focus on women from black, Asian and minority ethnic communities and from the most deprived groups</li> <li>• Flu and COVID-19 vaccinations offered to all staff</li> <li>• CORE20PLUS Ambassadors programme</li> <li>• Improved internal governance and reporting</li> <li>• Implementation of health inequalities programme of work</li> <li>• Continued participation in systemwide programmes including supporting the development of place-based neighbourhood working</li> <li>• Commenced review of implementing smoke free policy across system and our hospital sites</li> </ul>
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<div data-bbox="204 192 782 271">diversity and inclusion champions within the organisation including maternity</div> <ul style="list-style-type: none"> <li>Established alcohol service and enhanced pathways</li> <li>Established tobacco dependency service in Acute, Mental Health Inpatient and Maternity services</li> </ul>	<ul style="list-style-type: none"> <li>Integrated pathways between secondary care and community-based smoking cessation and lifestyle services</li> </ul>
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*Our Maternity team collecting their health inequality award at the Trust Annual Awards*

### [Our legal duty to collect, analyse and publish information on health inequalities](#)

On 28 November 2023, NHS England released a Statement of Information relating to the new legal duties for Integrated Care Boards (ICBs) and Foundation/Trusts to collect, analyse, publish, and use information on health inequalities under Section 13SA of the National Health Service Act 2006. Our Trust response to this requirement can be found in *Appendix 1*.

The domains of indicators included within the statement align to the clinical areas outlined in the Core20PLUS5 for Adults and Children and Young People.

The purpose of exercising these powers is to:

- i. Understand healthcare needs, including by adopting population health management approaches, underpinned by working with people and communities



- ii. Understand health access, experience and outcomes, including by collecting, analysing and publishing information on health inequalities set out in the Statement and relevant domains
- iii. Publish information on health inequalities within or alongside annual reports in an accessible format
- iv. Use data to inform action, including as outlined in the Statement

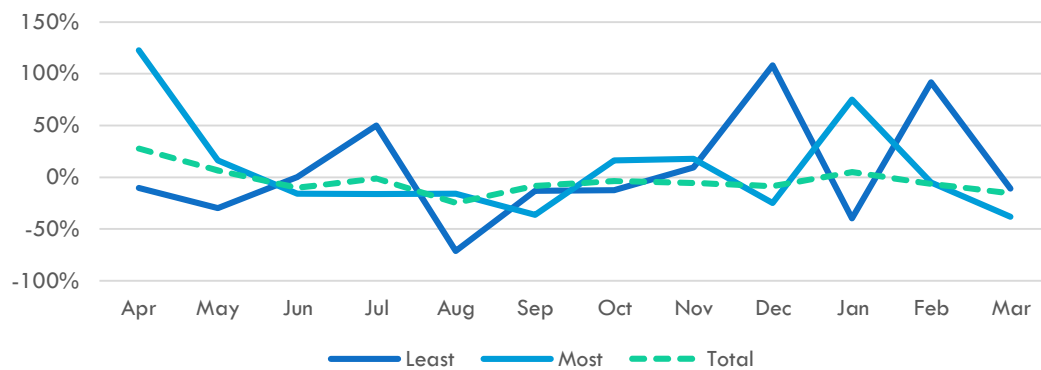
We have been collaboratively working with the Integrated Care Board (ICB) to support the development of a Health Inequalities Outcomes Dashboard which will allow the opportunity to identify inequity in health outcomes and service provision, but also the ability to monitor improvements in health outcomes over time and the indicative impact of programmes currently in place. This will give a vital 'system' view.

The dashboard currently identifies 61 draft indicators across four key cohorts (age, sex, ethnicity and socioeconomic status), which align with the objectives in the Operational Planning Guidance and the Core20PLUS5 for Adults and Children and Young People. Over the coming months the dashboard will continue to be developed, and key metrics agreed which will act as the enabler for working with our Population Health Management Group to develop system-wide knowledge and intelligence.

#### *Appendix 1 – Information on health inequalities to be collected, analysed and published.*

<b>Domain:</b> Elective recovery	<b>Indicator:</b> Elective activity vs pre-pandemic levels for under 18s and over 18s
Data currently unavailable due to ongoing Data Quality issues.	
<b>Domain:</b> Urgent and emergency care	<b>Indicator:</b> Emergency admission for under 18s
(1.)	

Emergency admissions for under 18's  
% change from 2023/24 - 2024/25



(2.)

IMD	23/24	24/25
Least	10.6%	10.6%
Most	19.1%	19.9%
Other	70.3%	69.5%

### What the data is telling us:

- Overall emergency admissions for under 18's fell by 4% from 2023/24 to 2024/25.
- There was a 4% drop in admissions for the least deprived patients, while the most deprived patients remained at the same levels.
- (1) Shows the % change in numbers of emergency admissions for those under 18, month on month, comparing 2023/24 to 2024/25. When compared to the total change of all admissions, the variance of the most and least deprived changes more significantly throughout the year, showing more seasonality.
- (1) There was a significant difference in December-February with the two groups trending oppositely. We look to undertake further analysis to understand these trends.
- (2) The share of admission from each deprivation group remained consistent in 2024/25, with a small increase of 0.8% of the most deprived accounting for all emergency admissions in under 18's.
- (2) In comparison, for patients aged over 18, the least and most deprived accounted for 11.6% and 11.5% respectively of the total share of emergency admissions in 2024/25.
- Over 18's similarity saw a decrease in admission, falling by 8% from the previous year.

<b>Domain:</b> Oral health	<b>Indicator:</b> Tooth extractions due to decay for children admitted as inpatients
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- There was a 7% reduction in the number of tooth extractions due to decay in 2024/25, from 2023/24, for children aged 10 and under.
- We will continue to monitor to draw further analysis based on deprivation/ethnicity.

<b>Domain:</b> Smoking cessation	<b>Indicator:</b> Proportion of adult acute inpatient settings offering smoking cessation services
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The chart displays the percentage of inpatient smoking cessation referrals accepted for patients in the most deprived areas (IMD Decile 1&2) for each month of 2023 and 2024. The 2024 data (light blue line) shows a significant peak in July at approximately 42%, compared to 2023 (dark blue line) which peaked in April at 20%. Overall, 2024 shows higher acceptance rates than 2023 for most of the year.

Month	2023 (%)	2024 (%)
Jan	15	26
Feb	22	22
Mar	10	23
Apr	20	29
May	15	24
Jun	16	10
Jul	5	42
Aug	18	26
Sep	18	18
Oct	8	17
Nov	15	25
Dec	25	22

**What the data is telling us:**

- 2024 saw an increase of the average number of smoking cessation referrals accepted by the most deprived inpatients that have identified as being a smoker, when compared to 2023.
- This includes an increase in inpatients from an Ethnic Community
- Further work is to be undertaken to validate and analyse the referrals made within the maternity setting.

<b>Domain:</b> Smoking cessation	<b>Indicator:</b> Proportion of maternity inpatient settings offering smoking cessation services
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- Maternity services at SaTH offer smoking cessation services for both the patient and their families to support the aim of reducing smoking at time of delivery rates. Work is underway to validate the data reported as part of these referrals.

\*\* For information, as part of our digital transformation programme the Trust has upgraded its IT system therefore not all information is available at this time. Roll out and implementation of the new system and analysis of data will continue throughout 2025/26.

## SaTH Improvement

The Trust's 'SaTH Improvement Hub' is made up of dedicated colleagues whose aim is to empower colleagues at all levels to have the confidence, capability, passion and knowledge, to test changes and make improvements at SaTH and the communities we serve.

During 2024/25 we have seen our fourth consecutive year of improvement against the staff survey question 3f, "I am able to make improvements happen in my area of work within the Trust". However, there is an acknowledgement that our score of 54% is just below the national average of 55%. As such, we will continue to work hard into the next financial year with a view to this further improving.

In the financial year, the Improvement Hub team have moved into the Trust's 'operational portfolio'. This presents an opportunity to further align improvement methodology with the 'how' we do business at SaTH. Our ambition in 2025/26 is to use this opportunity to further embed the principals of NHS Impact (Improving Patient Care Together) into a sample of directorates to test the benefits of this approach, and if successful, spread practices in line with the completion of the 'once in a generation' Hospitals Transformation Programme.

The team have also worked closely with the Integrated Care Board (ICB) during the year, assisting with the recruitment for a Quality Improvement Lead - who began working with the ICS in January 2025 - and supporting the accessibility of resources available to them. The aim of this work is to improve improvement capability across the ICB and develop shared resources and access to training and support.

## Going Concern Disclosure (note 1.2 of the Accounts)

The accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

The Board has carefully considered the principle of 'Going Concern' in the context of the Trust continuing to operate under the HM Treasury's Financial Reporting Guidelines (FReM). For the year ending 31 March 2025, the Trust is reporting a deficit of £24.4m on an adjusted financial performance basis, against a breakeven plan, supported by deficit funding of £44.3m.

The Trust maintained a cash balance of £61.518m at the end of 2024/25 (March 2024: £54.680m).

Every ICS/STP received a 2024/25 capital spending envelope derived from the system-level allocation, with The Shrewsbury and Telford Hospital NHS Trust receiving a total system envelope of £16.768m in 2024/25 (£18.429m in 2023/24). The 2024/25 system envelope includes a 10% reduction as per the NHSE Business Rules.

The Board of Directors have concluded that whilst the financial position for 2025/26 is very challenging, based upon enquiries with NHSE and the Department of Health and Social Care, they have a reasonable expectation that the Trust will have access to adequate resources (as in previous years) to continue in operational existence for at least 12 months from the date of approval of the financial statements and continue to provide services to its patients. Based on this expected continuation of services, the Trust continues to adopt the going concern basis in preparing the financial statements.

## Performance Analysis

This section provides a detailed analysis of the Trust's performance throughout 2024/25, and in doing so, brings together some of the principal performance measures that we use to determine the level of risk that we carry in the organisation.

The Board's role in monitoring the performance of the organisation is supported by an accountability structure which enables visibility by the public, staff and external stakeholders through its bi-monthly meetings streamed in public. It remains the responsibility of the Board of Directors to design and then implement agreed priorities, objectives and the overall strategy of the Trust.

The Board considers performance against national priorities set out in the NHS Oversight Framework, which describes how NHS England works alongside trusts to support the delivery of high quality and sustainable services for patients.

The Board has also developed a set of key performance indicators (KPIs), which are set out within a local performance management framework. These cover quality and safety measures as well as those performance, financial and workforce KPIs outlined in national framework.

An Integrated Performance Report is presented to each meeting of the Board of Directors, in the form of a scorecard accompanied by exception reporting, and explanatory narrative. This information is provided for the previous month, trends over time, and, where available or relevant, against a benchmark. These are linked to the Trust's strategic objectives, national priority indicators, and local priorities.

The Board is supported by the work of the Quality and Safety Assurance Committee in monitoring performance against quality and workforce indicators, whilst the Performance Assurance Committee reviews operational performance. The Finance Assurance Committee reviews financial performance, and the People & OD Assurance committee monitors workforce and organisational culture. The Board of Directors is also supported by the Audit and Risk Assurance Committee which provides assurance regarding the organisation's risk and control framework.

The executive directors continually review the performance of the Trust through a series of regular meetings, and monthly meetings with divisional colleagues at the operational Performance Review Meetings. Examples of what has positively improved from these meetings include: improved DM01 Diagnostic position; reduced backlog of patients waiting over 62 days for cancer treatment; and reduced number of patients waiting over 65 weeks for a routine or outpatient appointment. We also reduced our agency expenditure and achieved our cost improvement programme.

#### Our Key Performance Indicators 2024/25, by quarter (Q):

Measurement (metric)	end of Q1 (Apr- Jun)	end of Q2 (Jul- Sept)	end of Q3 (Oct- Dec)	end of Q4 (Jan- Mar)
Total elective activity undertaken (IP/DC)	Not Available			
Increase Productivity to 85% - Theatre Utilisation	79%	77%	79%	78%
RTT – Total Waiting List (English/Welsh)	53,280	53,074	51,652	46,816
Patients waiting more than 78 weeks to start consultant-led treatment (English/Welsh)	2	64	62	40
Patients waiting more than 65 weeks to start consultant-led treatment (English/Welsh)	1,330	662	396	145
Patients waiting more than 52 weeks to start consultant-led treatment (English/Welsh)	4,656	4,215	3,557	1,942
Diagnostics 6 week wait performance	63.4%	59.4%	56.6%	78.2%
Diagnostics patients waiting more than 6 weeks	5,653	7,509	8,376	3,437
Total patients waiting over 62 days to begin cancer treatment	481	404	394	378
Proportion of cancer patients meeting 62 days standard - Target 85%	56.9%	51.2%	63.3%	66.6%
Proportion of patients meeting faster cancer diagnosis standard (informed within 28 days) - Target 75%	67.0%	67.6%	66.7%	62.5%

Total outpatient attendances	Not Available			
Urgent and Emergency Care performance measure (4-hour performance (excluding planned returns and MIU activity))	52.2%	52.4%	50.4%	53.1%
15-minute ambulance breaches per quarter (ambulance handover >15 minutes)	7,271	7,894	8,016	7,954
	79.7%	82.17%	85.7%	82.9%
60-minute ambulance breaches per quarter (ambulance handover > 60 minutes)	3,047	2,374	3,836	3,394
	41.9%	30.1%	47.9%	42.7%
Number of patients spending more than 12 hours in emergency department per quarter	7,518	6,580	7,880	7,151
	19.0%	17.5%	20.1%	19.2%
Summary hospital-level mortality indicator	Not Available			
Methicillin-resistant <i>Staphylococcus aureus</i> (MRSA) bacteraemia infection rate (HOHA)	2	0	1	2
<i>Clostridium difficile</i> infection rate (HOHA)	8	21	20	17
<i>E. coli</i> bloodstream infections (HOHA)	13	12	15	14

Note: The Trust has experienced considerable challenges with the technical structure of our internal data warehouse and the ability to generate an accurate activity and income position. Despite various attempts to rectify issues, the Trust took the decision to cease national submissions that relate to Secondary Uses Service (SUS) and Service Level Agreement Monitoring (SLAM) until a time when assurances could be made that the data provides a true reflection of our position.

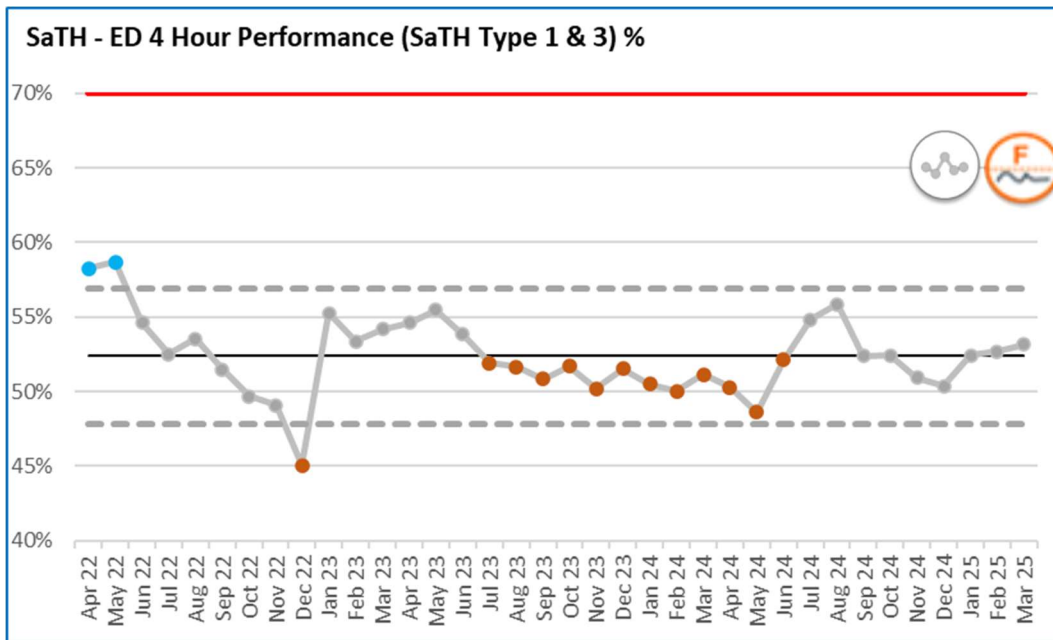
The impact of pausing the data submissions was considerable both internally and wider across the region, so it was imperative that an alternative data warehouse/reporting solution was put in place. It is anticipated that the Trust will be able to resume national reporting with submission of April 2025 data as well as make a retrospective submission of the data for the whole of financial year 2024/25 in May 2025.

## What we achieved

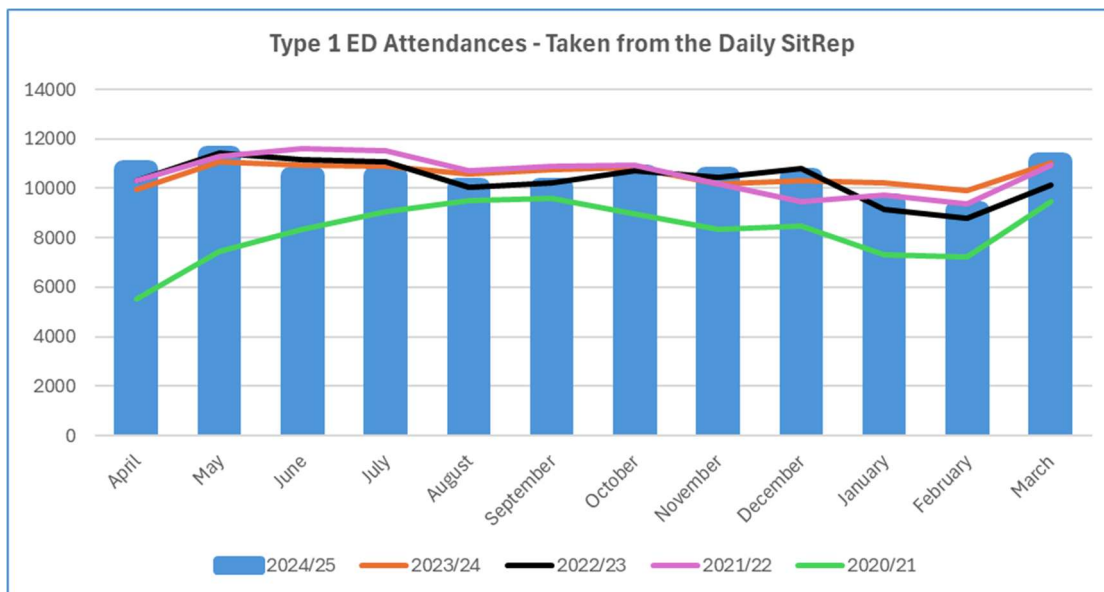
### 4 Hour Emergency Access Standard:

This measures compliance against the national standard of 76% of patients attending the Emergency Department (ED) should leave the department within 4 hours.

The Trust's performance from April 2022 to March 2025 is shown below:



In March 2025, 53.2% of patients were managed within 4 hours of arrival, against the revised national expectation of at least 76%, the total average 4-hour performance for 2024/25 was 52.2%.



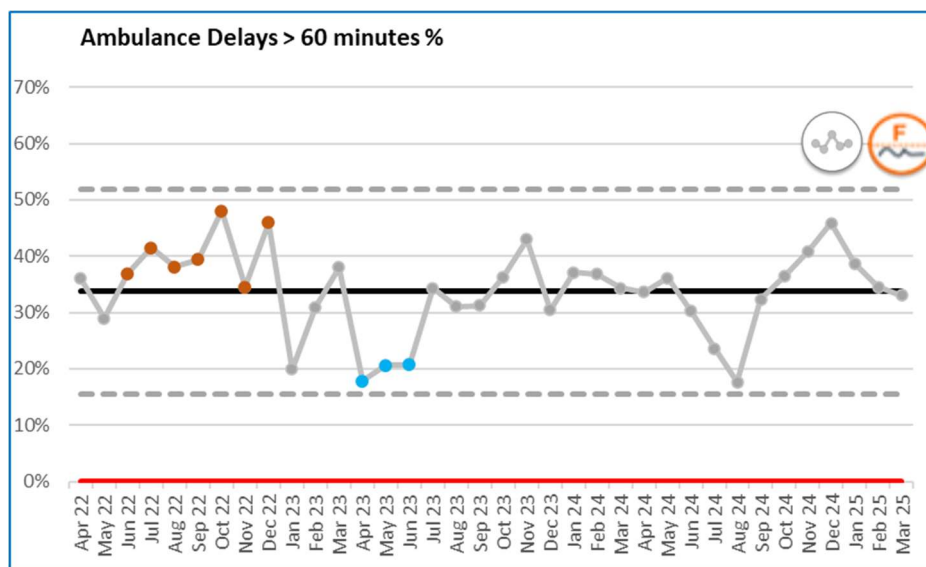
Urgent and emergency care demand remained high throughout the year. A&E performance, including ambulance handover delays, continues to be a challenge. As a result, the Trust remains in Tier 1 monitoring by the regulator. The System ended the year at 61.9% (including MIU) achievement of the 4-hour A&E wait standard, with 33.0% of ambulance waits of 60 minutes or more.

There has been significant improvement work undertaken within ED, acute medicine, and ward processes. In terms of key highlights, the ward process work has resulted in a 1.6-day reduction



in length of stay within Medicine alongside a 5.5% increase in discharges before 12:00, midday. Work within ED has resulted in an improvement in patients triaged within 15 minutes of arrival with the Trust moving from lower quartile to middle quartile performance when compared nationally. The percentage of non-elective medical patients attending as an emergency treated via our Medical Same Day Emergency Care (SDEC) service rather than ED increased from 30% to 37.1%. Non-elective medical admissions managed as 0-day length of stay (LoS) via SDEC also increased from 23% to 30% to achieve the national standard.

Several Trust and systemwide initiatives were also implemented throughout the year to progress improvement in this area, including an alternative to ED workstream led by SCHT and the commencement of the Medicine Transformation Programme alongside our existing Emergency Care Transformation Programme. The Trust also launched its Stronger Together campaign to drive improvement in Urgent and Emergency Care across the Organisation. There has also been a continued reduction of the number of patients with 'No Criteria to Reside' (NCTR) in an acute hospital bed. However, these improvements have not alleviated the pressures across the emergency and urgent care pathway sufficiently to meet the required performance standards. The CQC report published in May 2024, also highlighted that significant improvements are required across the urgent and emergency care pathway to improve patient experience with a number of 'requires improvement' and 'inadequate' ratings across both hospital sites. Improvement actions are in place and progress against these is tracked each month.



Offload to Assess (OTA) has continued to support reducing ambulance handover delays. This has contributed to more timely release of crews to respond to category 2 incidents (i.e. emergency calls where the patient's condition is serious but not immediately life-threatening, such as burns and strokes.). 3,268 patients were conveyed in March 2025, **this being the highest number reported for the last 4 years**. The Trust continues to work closely with WMAS to support improving overall ambulance handover performance. National validated data is

awaited, but it is expected that WMAS to be in the top 5 most improved Cat 2 ambulance response in 2024/25 relative to 2023/24.

The Trust is committed to delivering further improvements in Urgent and Emergency Care (UEC) services during 2025/26. The Trust's internal plan includes:

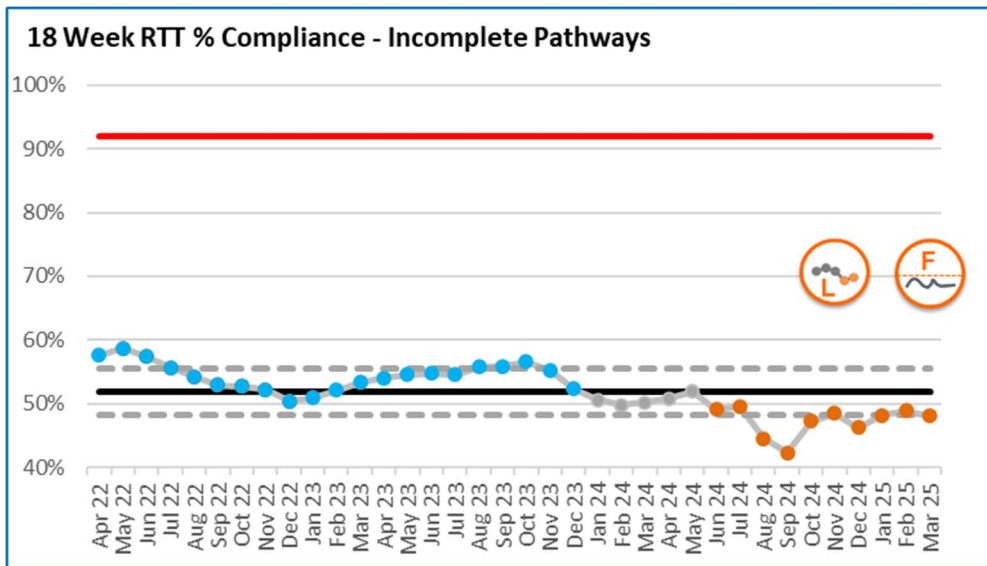
- Enhancing the Urgent Treatment Centres (UTC) so that an increased proportion of UEC patients are safely managed in the UTC.
- Increasing the capacity and enhancing the pathways for Same Day Emergency Care services so that a greater proportion of patients are managed as 0-day Length of Stay admissions.
- Increasing the RSH inpatient bed base by 56 beds through the introduction of two modular wards and increasing the Acute Medical Unit bed base by 10 beds at PRH.

Furthermore, the Trust's internal improvement plan is complimentary to the STW system-wide improvement plan which includes:

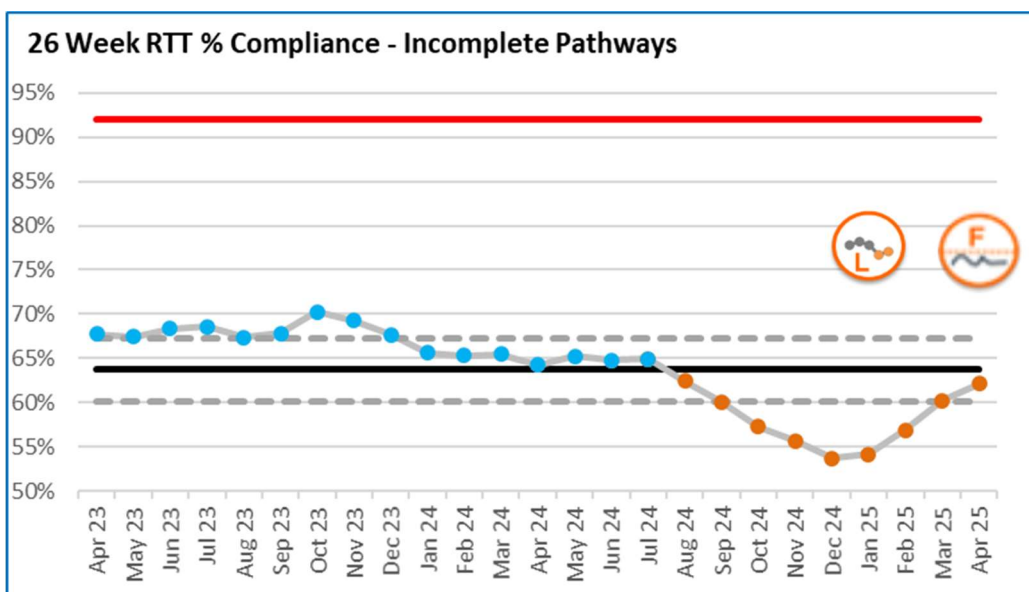
- Extended Urgent Community Response service.
- Introduction of substantive Integrated Front Door service with senior community practitioners working on both Acute Sites.
- Extended capacity of the Care Transfer Hub to support the management of complex discharge patients.

**Referral to Treatment (RTT):** This measures compliance against the national standard of 92% of patients should wait no longer than 18 weeks from GP referral to treatment (reported as a month end snapshot). This target is set at 26 weeks for patients in Wales.

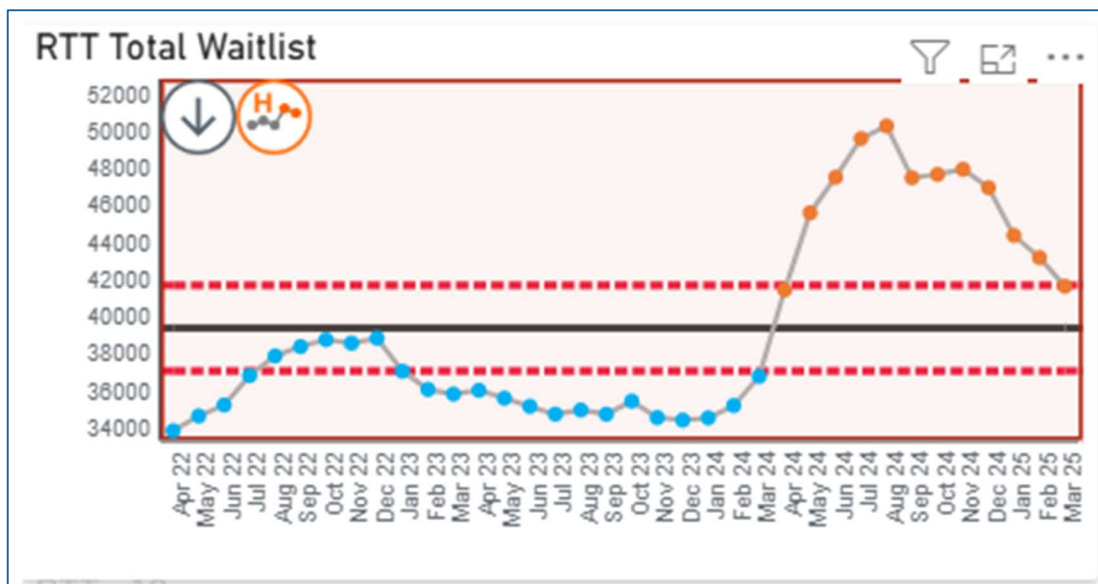
The Trust's 18-week RTT performance for English patients in March 2025 had 47.7% of patients waiting under 18 weeks.



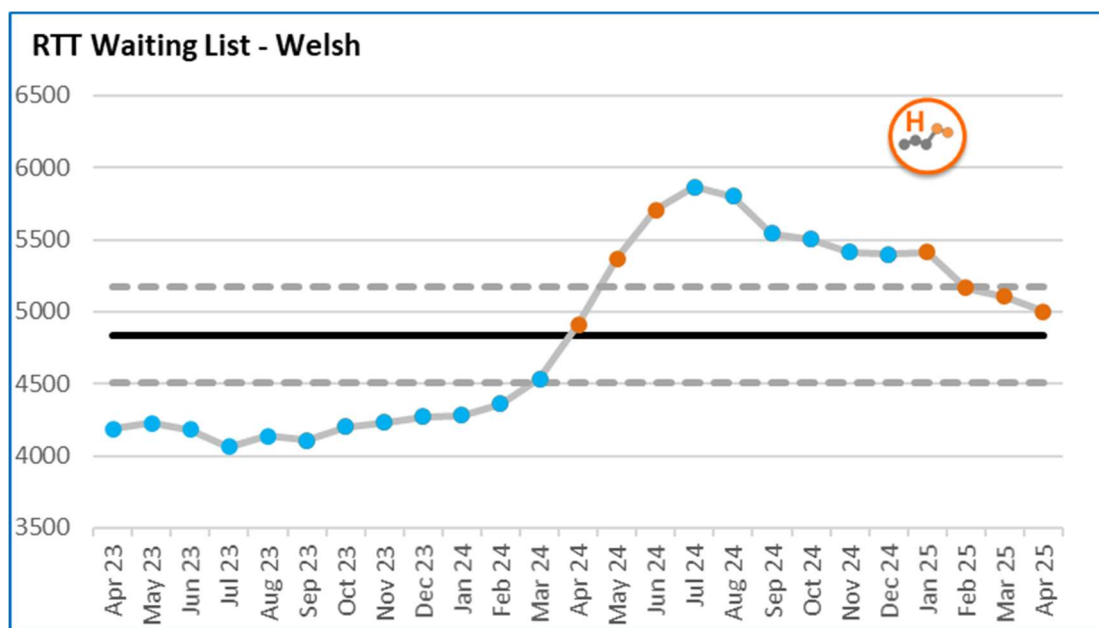
The Trust's 26-week RTT performance for Welsh patients in March 2025 had 60.2% patients waiting under 26 weeks.



The overall waiting list of English patients on an open RTT pathway grew significantly in the first half of the 2024/25 financial year to 50,333. Intervention was undertaken to reduce this to 41,669 by March 2025.



The overall waiting list of Welsh patients on an open RTT pathway grew to 5,799 before intervention was undertaken to reduce this to 5,106 by March 2025.



During the first quarter of 2024/25 there was a reduction in elective activity pending the sign-off of the financial element of the overall plan. This significantly reduced the delivered activity in this period and resulted in a significant increase in the overall waiting list. This impacted both patients waiting for an outpatient appointment, and for clinical treatments. In parallel, the transition period of adopting the Trust's new Patient Administration System also temporarily affected management of the elective Patient Tracking List (PTL). A corresponding drop in RTT performance can be seen in August and September before recovering to previous performance. To combat these issues the Trust has undertaken:

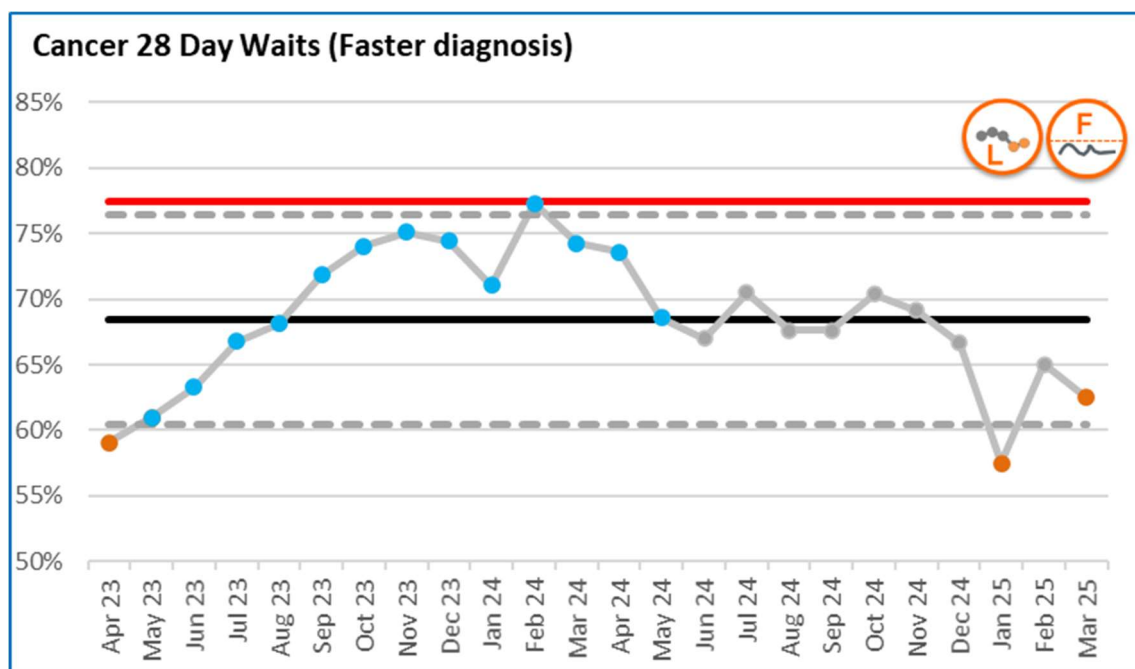
- Significant improvements have been made at the Elective Hub on the Princess Royal Hospital site to increase throughput and productivity. The Trust has worked with the national GIRFT programme to ensure high volume surgical specialties are able to maximise the use of the newly constructed unit.
- Significant investment in elective capacity to ensure more timely access to care. This will continue into 2025/26 to continue to reduce the number of patients who are waiting for treatment.
- Investment in diagnostic tests which support the RTT pathways.

### Cancer:

There are now three cancer standards, which combine all the previous standards:

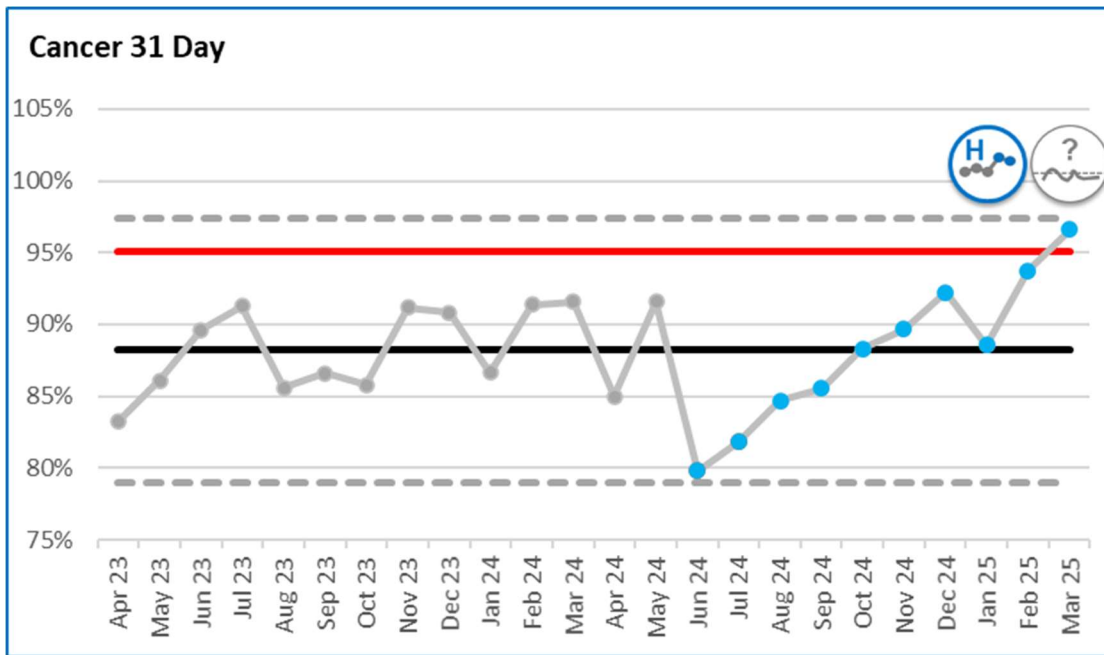
- the 28-day Faster Diagnosis Standard (77%)
- one headline 62-day referral to treatment standard (70%)
- one headline 31-day decision to treat to treatment standard (96%).

Percentage of service users waiting no more than 28 days to communication of definitive cancer/not cancer diagnosis:



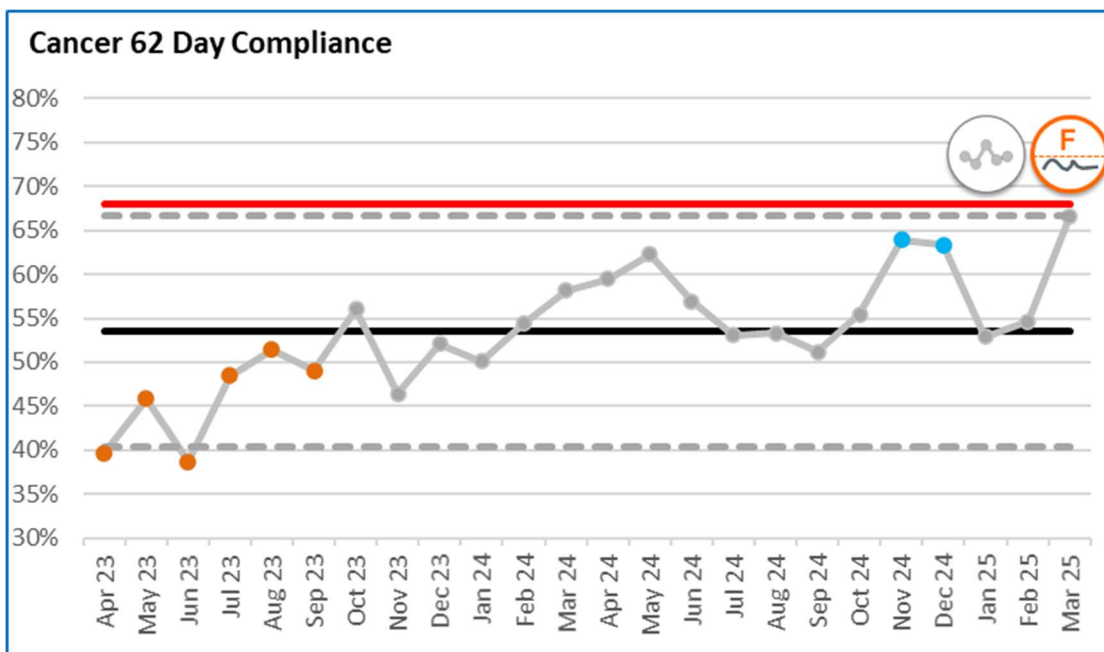
In March 2025, 62.5% of patients received a diagnosis within 28 days of referral.

Percentage of service users waiting no more than one month (31 days) from diagnosis to cancer treatment:



In March 2025, 96.6% of patients received treatment within 31 days from diagnosis as part of the new combined metric.

Percentage of service users waiting no more than two months (62 days) from urgent GP referral to first cancer treatment:



In March 2025, 66.6% of patients with confirmed cancer were treated within 62 days of referral, as part of the new 62-day combined performance indicator.

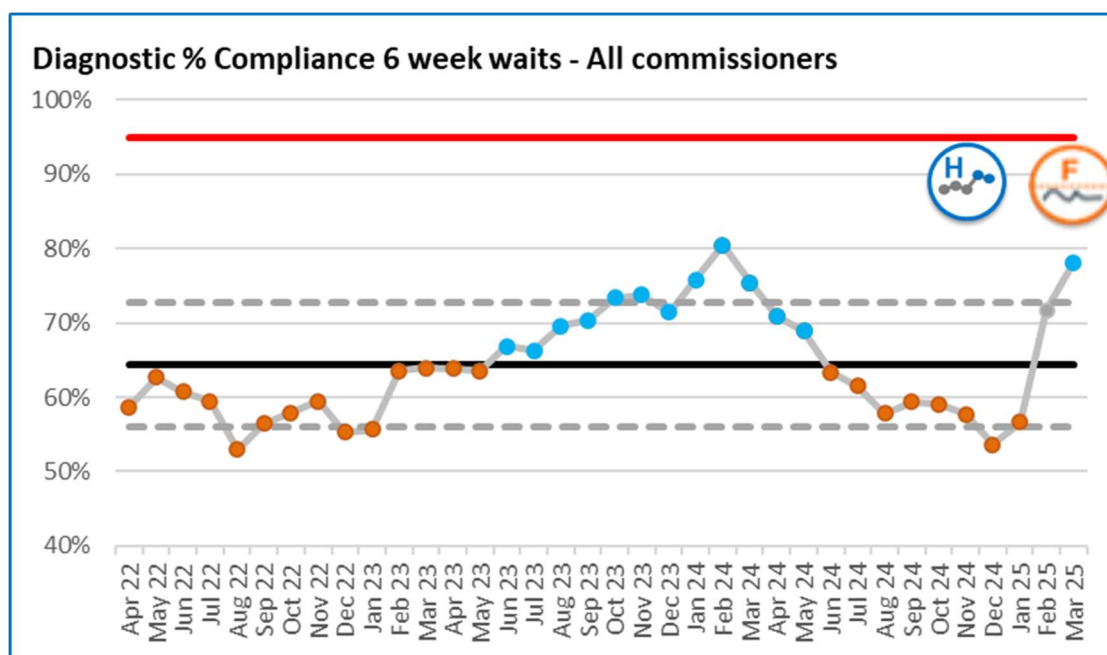
The Trust has seen sustained recovery in the 31-day target which has been achieved through focused work in Oncology and Radiotherapy. There has been a sustained improvement in the 62-day target in comparison to 2023/24; however, the Trust still remains well below the national target of 85%. The 28-day Faster Diagnosis Standard has not seen improvement over 2024/25 and is a priority focus in 2025/26. A new Cancer Improvement Board will lead improvement work in diagnostic pathways, appointment capacity and referral management heading into 2025/26.

There remains further work to support the treatment part of our pathways to ensure all patients receive timely care.

### Diagnostic (DM01):

This measures compliance against the national standard of 'no more than 1% of patients should be waiting 6 weeks or more at the month end for a diagnostic test'.

The Trust's performance against this national constitutional standard is illustrated below:



The Trust's diagnostic performance with patients waiting less than 6 weeks for March 2024 was 78.2%.

After a challenging first half of the year, significant interventions were put in place to tackle a continued decline in performance. The Trust finished in the year and recovered in line with the previous year, but still not achieving the 99% of patients under 6 weeks awaiting a scan. There remain challenges in Non-Obstetric Ultrasound, Cardio-Respiratory and MRI; investment has been set aside in 2025/26 to support further recovery.

## Quality Priorities – Priorities for Improvement 2024/25

As part of the “Getting to Good” Programme the Trust developed a Quality Strategy. The Quality Strategy for 2021-2024 was agreed by the Trust Board in March 2021.

The priorities within the Quality Strategy include nine key overarching priorities within the three core domains of: **Safe, Effective and Patient Experience**.

QUALITY PRIORITIES 2024/25		
<b>SAFE</b>	Priority 1	PSIRF* PRIORITIES
		Learning from events and developing a safety culture
		The deteriorating patient
		Inpatient falls
		Missed Radiology result
		Omitted doses of time critical medication
	Priority 2	Improve cognition screening/delirium
<b>EFFECTIVE</b>	Priority 3	Improved patient experience in our Emergency Departments
	Priority 4	Improve our admission and discharge processes, right care, right place, right time
	Priority 5	Address and improve care for people with Diabetes (System working)
	Priority 6	Improve foot care for people with Diabetes
<b>PATIENT EXPERIENCE</b>	Priority 7	Learning from experience
	Priority 8	Improve Quality Standards and demonstrate NICE guidance for mental health training
	Priority 9	Improve the care and experience for patients with Learning Disability and/or autism

\* Note: PSIRF is the *Patient Safety Incident Response Framework* (July 2024).

Our Quality Priorities in 2024/25 were based around these nine priorities and included key actions we planned to take to achieve these overarching quality priority improvements.

A detailed narrative which describes our quality improvement priority actions and their outcomes for the year can be found in our **Quality Account 2024/25**, which will become available on our website from 1 July 2025. It also outlines the quality improvement priorities for 2025/26. Copies may be obtained by contacting our Communications Department at [communications@sath.nhs.uk](mailto:communications@sath.nhs.uk)



## Freedom to Speak Up

The Freedom to Speak Up (FTSU) team is made up of a FTSU Lead and one FTSU Guardian. Supporting the team are approximately 40 ambassadors. Their role is to promote FTSU and signpost colleagues whose experience ranges from a variety of clinical and non-clinical backgrounds and who represent the diversity of the workforce across our Trust. The ambassadors undertake these roles on a voluntary basis in addition to their substantive posts. During 2024/25, 218 contacts were raised to the FTSU team, one higher than the previous year.

### FTSU concerns raised by quarter and year:

	Q1	Q2	Q3	Q4	Total	Increase/ Decrease	National Increase
2024/25	67	48	56	47	218	↑0.5%	Not yet available
2023/24	47	52	68	50	217	↓23%	27.6%
2022/23	71	73	79	59	282	↓23%	↑25%
2021/22	100	113	90	66	369	↑21%	0%
2020/21	41	82	103	78	304	↑110%	26%

During 2024/25, 33% of the concerns brought to the attention of our FTSU teams had elements of worker safety and wellbeing; 28% of concerns raised were relating to inappropriate behaviours/attitudes; 21% of concerns were associated with systems and processes; 8% to bullying and harassment, and 8% related to concerns about patient safety.

Of those speaking up, 23% were nurses and midwifery registered; 22% administrative colleagues; 21% additional clinical services; 11% allied health professionals; 10% medical and dental; 6% estates and ancillary; 6% unknown or other; and 2% healthcare scientists.

The staff survey 'raising concerns' questions, overall, remained the same as last year. Those for clinical safety increased slightly and those for raising concerns about anything decreased slightly.

An audit was undertaken of FTSU processes during 24/25 and received substantial assurance by MIAA, the Trust's internal auditors.

## Financial Performance 2024/25

In developing the operational plan for 2024/25 the Trust worked with system partners to develop a triangulated plan across activity, workforce and finance in response to delivering the Trust's strategy and the following priorities set out by NHS England:

- Maintain our collective focus on the overall quality and safety of our services, particularly maternity and neonatal services, and reduce inequalities in line with the Core20PLUS5 approach.
- Improve ambulance response and Accident and Emergency waiting times by supporting admissions avoidance and hospital discharge and maintaining the increased acute bed and ambulance service capacity that systems and individual providers committed to put in place for the final quarter of 2023/24.
- Reduce elective long waits and improve performance against the core cancer and diagnostic standards.
- Improve staff experience, retention and attendance.

The Trust set a deficit plan of £44.3m which was converted into a breakeven plan by NHS England providing non-recurrent funding of £44.3m to match the deficit plan. At the time of finalising the plan, several risks were identified in relation to the continued use of escalation areas, the costs of temporary workforce, the scale of the efficiency programme and the cost of delivery of the activity plan. Against the breakeven plan, the Trust recorded a full year retained deficit of £24.0m. This was in line with the revised forecast formally reported and agreed with NHS England at month 11 that reflected the risks that were being carried by the Trust. The underlying retained deficit for the Trust, i.e. (the financial position after the removal of one-off income and expenditure items) was £78.5m at the end of the year.

2024/25	£'000
Income from patient care activities	675,319
Other Operating Income	48,746
Operating Expenses	(741,826)
<b>Operating deficit</b>	<b>(17,761)</b>
Other gains and (losses)	(399)
<b>Deficit before interest</b>	<b>(18,160)</b>
Investment income	3,749
Finance costs	(240)
Public dividend capital dividends paid	(9,323)
<b>Retained deficit</b>	<b>(-23,974)</b>
<b>Adjusted for:</b>	
Impairments	6,978
Adjustments in respect of Donations / Grants	(7,494)
Remove net impact of inventories received from DHSC group bodies for COVID response	137
<b>Adjusted financial performance</b>	<b>(24,353)</b>

The main source of income for the Trust was via contracting with commissioners for health care services. In 2024/25, most of the Trust's income from NHS commissioners was in the form of Aligned Payments and Incentive (API) contracts. This is a form of blended payment, made up of fixed and variable elements. The fixed element relates, in the main, to unscheduled care and is paid at an agreed value for the expected annual level of activity. The variable element, in the main, relates to elective, scheduled care and is paid in line with activity delivered.

Within Trust expenditure, the largest category is pay expenditure totalling £499.8m which is equivalent to 68% of total operating expenditure. Other significant components include £125.0m on drugs and clinical supplies (17%), and estates and premises costs of £35.7m (5%).

The Trust invested £69.2m of capital expenditure (excluding grant funding) on medical equipment, digital infrastructure, improvements to existing buildings, and continued expansion of its estate during the financial year.

During 2024/25 the Trust commenced an Energy, Security and Decarbonisation Programme, for which, in addition to internally generated funds, the Trust received a Public Sector Decarbonisation Scheme grant of £8.1m to be spent on decarbonisation initiative on the Shrewsbury site. The Trust's internally generated funds covered £16.8m of the total investment of £69.2m, with the remainder of the capital expenditure of £52.4m being funded through Public Dividend Capital. This external funding has provided enabling works associated with the Hospital Transformation Programme (HTP) and the commencement of the build works for HTP; the first phase of removal of Reinforced Autoclaved Aerated Concrete (RAAC) at Princess Royal Hospital; the third and final year of the NHS England Frontline Digitisation Programme; the continuation of the Laboratory Information Management System (LIMS) and interoperability schemes and commencement as an incubator site for the Federated Data Platform.

## Sustainability

### Climate Change

The NHS is responsible for circa 4% of the nation's carbon emissions. In October 2020, NHS England published 'Delivering a Net-Zero National Health Service', a report that details the scale of the environmental problems faced by the NHS and the country. This report set ambitious targets requiring all NHS organisations to become net zero by 2040 for the NHS Carbon Footprint, and by 2045 for the NHS Carbon Footprint Plus.

### Green Plan

Green plans should set out the key actions each system and trust will take to deliver emissions reductions and support resilience to climate impacts over the next three years. The current

organisational Green Plan has been updated in line with the new NHS Green plan guidance issued in February 2025.

This also applies to the Shropshire, Telford and Wrekin Integrated Care System Green Plan, which is being updated. The system plan brings together organisational green plans within the health and care system. This document forms the basis for performance against the national climate change agenda and is the framework for co-operation between system partners.

### Measuring sustainability

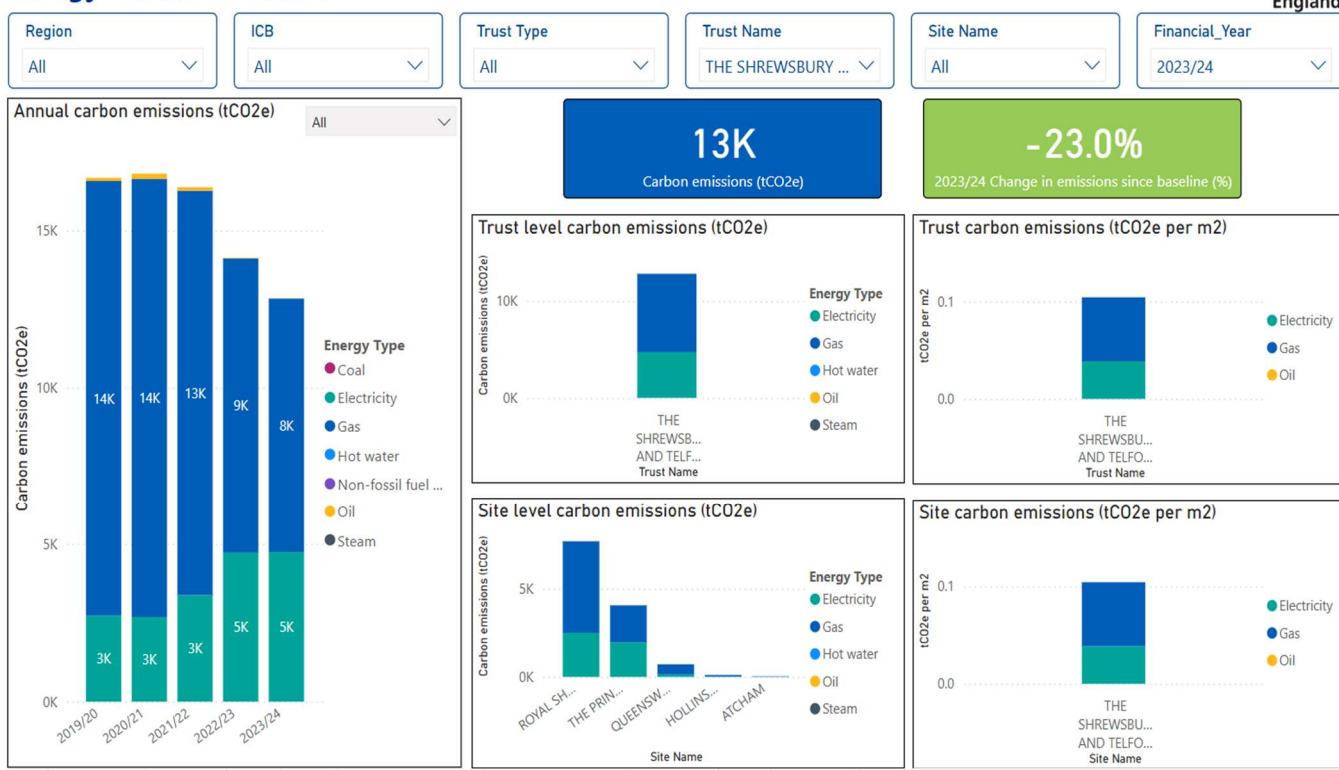
One of the ways we have measured our impact is through our Green Plan. The Trust has undertaken risk assessments and has a Trust Green Plan which takes account of UK Climate Projections 2018 (UKCP18).

The Green Plan and actions are reviewed quarterly through the Trust's active Climate Change Group.

### Carbon Management

In line with the NHS Energy Dashboard, we are able to track our carbon emissions by site. Estates Return Information Collection (ERIC) data is used by NHS England to track the energy usage and carbon emissions. The data below highlights the Trust's reduction in carbon emissions from 2019/2020 to 2023/24 by 23%. Whilst this data is positive, it will be monitored annually and will assist the Trust in identifying further areas of focus.

## Energy: Carbon emissions



## Energy Management

Following the implementation of the decarbonisation strategies for both acute hospital sites, backlog works have been undertaken in line with the relevant specifications.

In November 2023 the Trust applied for a Salix grant of circa £16.2million for investment in energy management and carbon reduction measures at the Royal Shrewsbury Hospital to address end of life critical steam infrastructure. The proposal for a new zero carbon energy centre and heat network was successful and the scheme is to be completed by March 2026. The Trust's partner Vital Energi will deliver this project.

We have continued to invest in our Business Management System (BMS) utilising computerised control systems and plan to instal building meters (funding dependant); this will further identify trends in energy consumption enabling better prediction and control of energy needs.

The Trust was successful in January 2025 in achieving grant funding for an LED lighting project across the sites which currently do not have LED lighting or daylight-saving lights. These sites were Douglas Court, William Farr House, Princess Royal Hospital and Royal Shrewsbury Hospital. This light replacement scheme at Douglas Court and William Farr House will reduce energy costs by circa £35,000.

We have implemented 12 electric vehicle charging points at our Royal Shrewsbury Hospital (RSH), Hollinswood House site and Princess Royal Hospital and continue to develop the infrastructure at our other sites, including applications for grant funding.

In line with the NHS Travel and Transport Strategy we have started to replace our fleet vehicles to become fully electrically powered.

The Trust was successful in achieving NHS Energy Efficiency Fund (NEEF) grant funding in 2023/24 for further photovoltaics at RSH, and other projects. This renewable energy generated savings of circa £100,000 in electricity. The Trust have been awarded additional GB Energy funding in April 2025 for a solar car canopy, this will be delivered in 2025/26.

### Energy Usage

The general pattern of energy consumption for the Trust is included in the following table. Electricity usage overall has increased slightly compared to 2023/24 which is indicative of the decarbonisation expectations. The gas usage also increased which was not expected and reasons behind this are being explored. Whilst the cost of energy has increased compared to 2023/24, we also expect a further inflation in energy prices as a result of international cost pressures.

Energy Usage:

Utility	Royal Shrewsbury Hospital	Princess Royal Hospital
Gas 2023/24	21,773,725	9,129,692
24/25	23,910,704kWh	18,540,586 kWh
Electric 23/24	9,112,669	7,093,555
24/25	10,022,869 kWh	8,160,331kWh

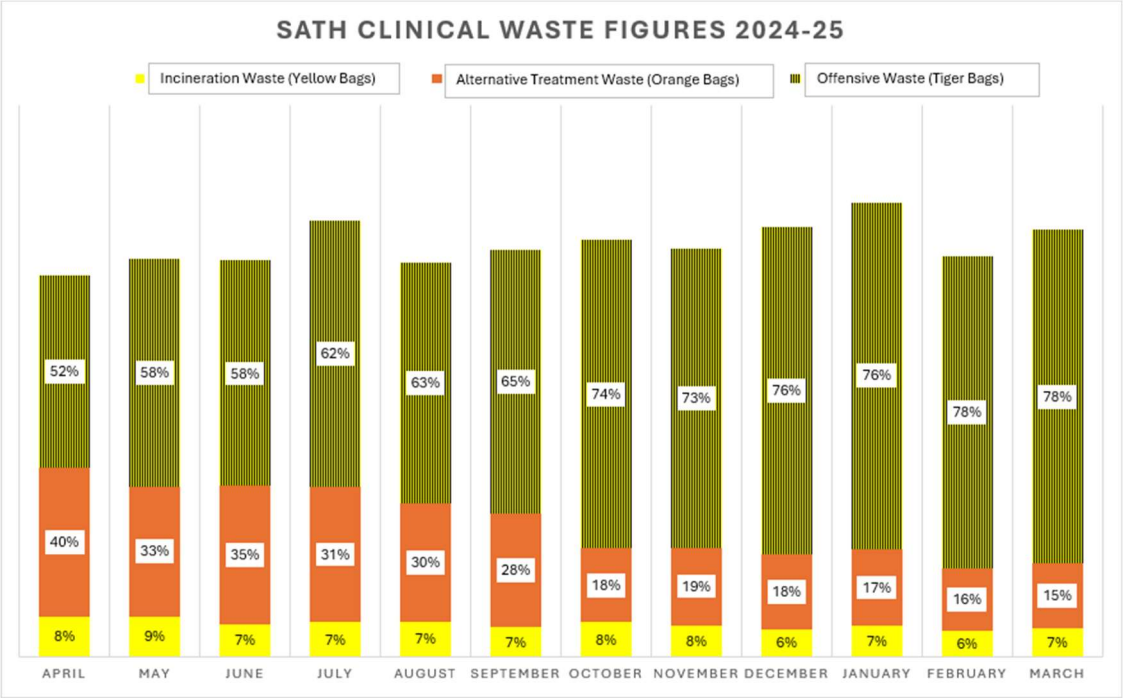
### Waste

The Trust continues to ensure compliance with disposal of its waste. All our domestic waste is sent to an energy recovery facility to generate electricity. Following the Trust's recycling pilot in key areas and the change to the waste legislation, a recycling programme is being rolled out. This will involve cardboard and dry mixed recycling segregation.

Following the introduction of the Clinical Waste Strategy in March 2023, the Trust recruited a Waste and Energy Manager to ensure compliance in line with the current Health Technical Memorandum requirements.

The Trust has successfully achieved the NHS England target of 20/20/60 segregation of clinical, infectious, and offensive waste by March 2025.

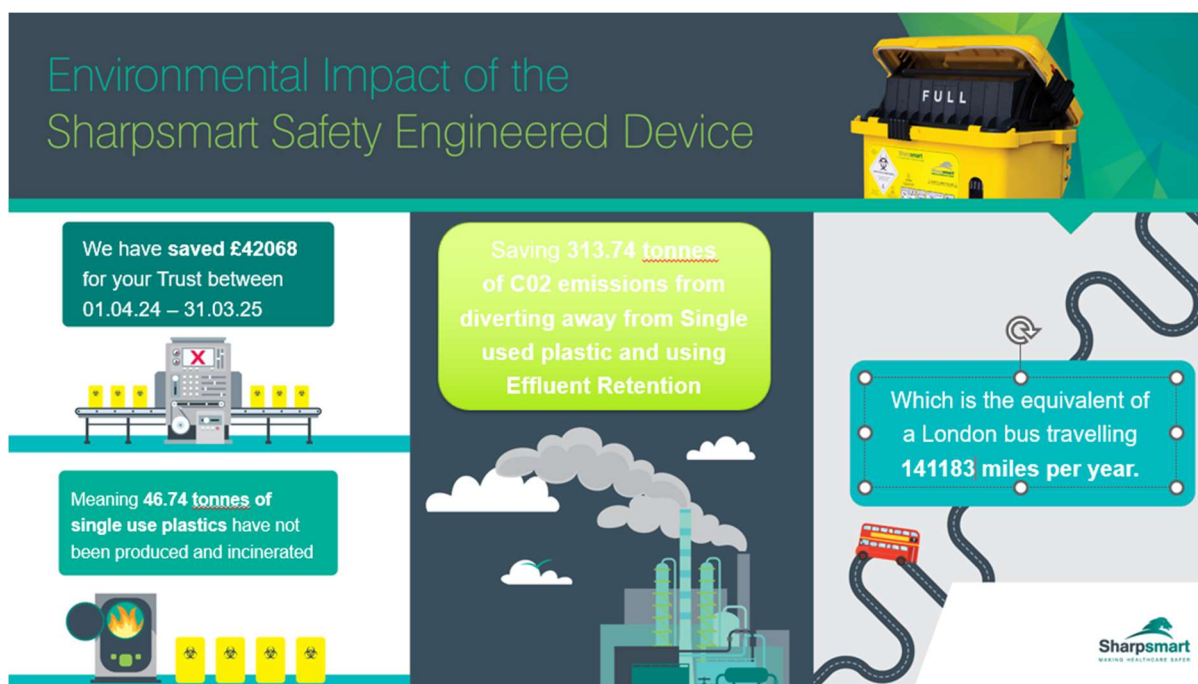
The waste figures for 2024-2025 at our acute sites are:



The Trust has achieved the NHS England waste targets since the introduction of the offensive waste roll out in March 2025

The Trust continues to take an environmentally friendly approach towards the disposal of ‘sharps’ waste, by employing a greener approach with the utilisation of re-used sharps containers. In 2024/25 the Trust have saved 46 tonnes of single use plastic from being burnt and 313 tonnes of CO2 emissions.





A furniture reuse system is in place across our sites to enable staff to internally exchange furniture between departments. Fourteen percent of staff are now active members of this 'reuse, reduce furniture and office stationery' scheme. We are proud of the fact that use of this scheme saved the Trust £29,000 (aided by donations from Shropshire Council) and 15 tonnes of carbon dioxide. This equated to circa five tonnes of potential waste saved from landfill.

The Trust also trialled a furniture repair scheme in 2024/25 for 12 weeks. This was successful and saved circa £5,000 of furniture procurement costs and disposal costs to landfill.

Our Walking Aid Return and Reuse Scheme was introduced at the end of August 2023 and refurbished and reused over 550 crutches, along with more than 75 walking frames and walking sticks. This saved the Trust approximately £3,000 and just over six tonnes of CO2e.

## Transport

The daily commute of our staff has a huge impact on the local environment in terms of vehicle numbers, noise, air quality and the demand for parking. We have a car-share web portal to encourage staff to share their commute and we also actively encourage staff to use public transport and the local cycle routes as means to get to work.

The latest staff travel survey was completed in March 2025. 801 staff completed the survey, and the data will be updated in the Green Travel Plan. There has been an increase in the staff survey completion from 585 in 2022.

The majority of staff work at the Royal Shrewsbury Hospital (59.30%) and Princess Royal Hospital (29.46%).

Most staff travel to work by car on their own (72.78%), followed by walking (7.62%), and cycling (5.62%).

Approximately 27% of staff choose not to bring their car to work, and instead use buses, cycles, e-bikes, shared lifts, motorcycles or walk to work. This is a reduction of car usage by a further 3% since the 2024 survey.

#### Travel Mode Table

Response					
Travel Mode	2019	2021	2023	2024	2025
<b>Walk</b>	8.00%	6.80%	7.50%	6.50%	7.62%
<b>Cycle</b>	5.90%	6.50%	3.90%	6.90%	5.62%
<b>Cycle Train</b>	0.00%	0.00%	0.00%	0.00%	No data
<b>Electric Bike</b>	0.20%	1.10%	no data	0.6	0.50%
<b>Bus</b>	3.10%	4.10%	4.40%	3.10%	3.12%
<b>Train</b>	0.50%	0.50%	0.30%	0.80%	0.37%
<b>Motorcycle</b>	0.70%	0.90%	0.50%	0.20%	0.75%
<b>Lift in car that than goes elsewhere</b>	1.70%	2.90%	1.80%	1.40%	2.37%
<b>Taxi</b>	0.70%	0.90%	1.80%	0.20%	0.37%
<b>Car Share</b>	4.00%	2.00%	5.00%	5.10%	6.49%
<b>SOV-Single Occupancy Vehicle</b>	75.20%	74.30%	74.80%	75.20%	72.78%

There were significant changes to car parking during 2024/25 and active sustainable travel has played a valuable role in reducing single occupancy vehicles on site. At RSH, 54 lift share spaces have been installed and at PRH, 8 spaces.

To alleviate car parking issues and provide further sustainable travel options on both acute hospital sites, the Trust procured two Park and Ride facilities in close proximity to both sites for staff. The Park and Ride facility at RSH is also now open to patients, which cuts down further on the amount of parking physically on the hospital site.

The Trust is commitment to improving active travel facilities and additional secure cycle shelters have been installed at RSH and PRH.

## Biodiversity

To enhance our Biodiversity across the Trust we have a Biodiversity and Green Space Strategy which links to our Trust and System-wide Green Plans.

We maintain our green spaces to include more pollinators to attract butterflies, bees and insects and continue to sow wildflower patches.

Both RSH and PRH are going through expansive construction development, which has impacted our green spaces. However, the Trust are committed to regenerating these spaces once building work is completed.

## Task force on climate related financial disclosures (TCFD)

The Group Accounting Manual has adopted a phased approach to incorporating the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports. TCFD recommended disclosures as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be fully incorporated into sustainability reporting requirements on a phased basis up to the 2025-26 financial year, with the exception of the requirement to disclose scope 1, 2 and 3 greenhouse gas emissions and the related risks as part of the metrics and targets pillar.

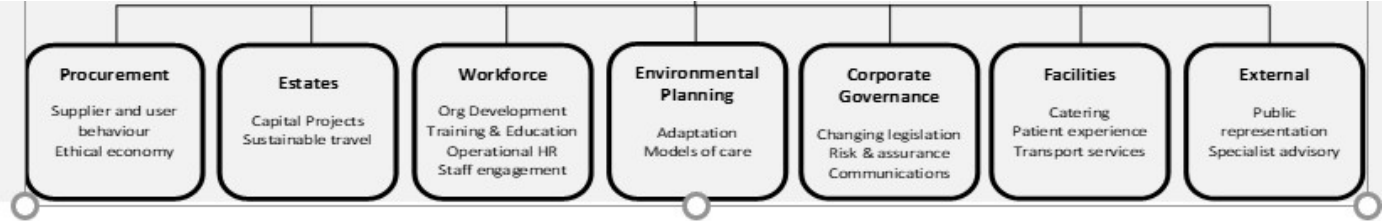
The phased approach incorporates the disclosure requirements of the governance, risk management and metrics and target pillars for 2025-26. These disclosures are provided below with appropriate cross referencing to relevant information elsewhere in this Report and in other external publications.

## Governance

SaTH has a well-established Climate Change Group which reports into the (Board) Performance Assurance Committee (PAC), reflecting the core standards which were previously issued by the NHS Sustainable Development Unit (replaced by the new Greener NHS National Programme.) Each of the standards has a part to play in delivering sustainable services. The targets set in our 2021-2026 Green Plan are based upon our most recent (2020) sustainability assessment.

Climate Change Group membership comprises representation from Estates, Facilities, Corporate Governance, Travel, Communications, Clinical and Medical staff, Workforce, Procurement and external partners, as can be seen below.

Climate Change Group membership:



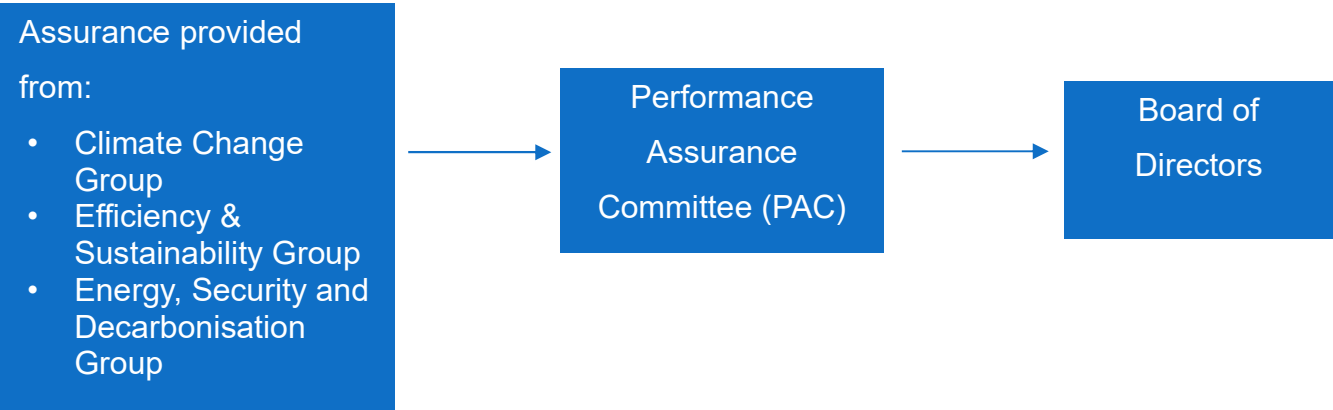
The Climate Change Group provides summary ‘key issues’ reports through to the Performance Assurance Committee together with a comprehensive annual report, which is also submitted to the Board of Directors’ public meeting. These documents are publicly available on the Trust’s website.

SaTH is also a core member of the ICS Climate Change Group. The Board received the Shropshire, Telford and Wrekin ICS Green Plan 2022-2025 on 09 June 2022. The ICS Green plan will be updated in line with the new NHS Green Plan guidance in July 2025.

The Lead Director for Environmental Sustainability at the Trust is Inese Robotham, Assistant Chief Executive, who chairs the Climate Change Group.

The long-term strategy of climate related issues is captured in the Energy, Security and Decarbonisation Steering Group which also reports into Performance Assurance Committee, which subsequently reports into Board.

The organisational chart below details the governance assurance arrangements in place:



In line with NHS guidance, the Trust has had a Green Place in place since 2021. The original Green Plan was planned for a delivery over five years (2021-2026) and over the first three years our Trust has achieved an action plan completion percentage of 65%.

The latest Green Plan guidance revision was published in February 2025 and supports NHS organisations’ Green Plan refresh for the next 3-year cycle with the aims of:

- Prioritising interventions that support world-leading patient care and population health, and reduce inequalities, while tackling climate change and broader sustainability issues.
- Supporting NHS organisations to plan and make considered investments while increasing efficiencies and delivering value for taxpayers.
- Ensuring every NHS organisation supports the ambition to reach net zero carbon emissions, reflecting learning from delivery to date.

The Trust has refreshed and updated its Green Plan to incorporate the key focus areas detailed in the NHS Guidance and to set out what the Trust needs to do over the next three years to further enhance our sustainability programme and climate change programme.

### Progress to Date

The key elements of these actions related to Estates (reducing associated energy consumption), Travel and Transport:

- Inclusion of sustainability as a material consideration in all business cases.
- Implementation of an annual travel survey to measure changes in the ways that staff travel to work and for work.
- Installation of 12 electric vehicle chargers across three sites and the conversion of our vehicle lease schemes to electric or ultra-low emission vehicles for all new leases.
- Installation of ambulance vehicle electric chargers at PRH.
- Installation of two new secure cycle shelters at both RSH and PRH.
- Implementation of a Park and Ride at RSH and PRH to reduce single occupancy vehicles on site.
- Completion of a range of estates energy improvements including enhanced roof insulation as well as solar panels at Royal Shrewsbury Hospital site.
- Development of Heat Decarbonisation plans for all our acute Trust sites.
- Attainment of Public Sector Decarbonisation Scheme (PSDS 3C) funding for a decarbonisation scheme at Royal Shrewsbury Hospital (£16.2m). When the work is complete, the investment will save the Trust an estimated £1m a year in energy costs and will reduce the hospital's emissions by over 3,000 tonnes of carbon each year.
- Successful National Energy Efficiency Funding (NEEF) for Royal Shrewsbury Hospital for solar panels and Light Emitting Diode (LED) lighting (£345K).
- Production of 609000kWh of renewable electricity on RSH site in 2024/25. This equates to approximate savings of £100K.
- Installation of 54 'lift-share spaces' at Royal Shrewsbury Hospital carpark, and 7 at PRH.
- Implementation of a range of measures to embed sustainability into Trust processes. This includes changes to financial planning and approval such as, business cases, capital plans and travel expenses. It also includes changes to HR processes such as sustainability sections in induction documents, job descriptions and staff statutory mandatory training.

- Expansion of WARP-IT scheme for staff to exchange unwanted goods, reducing waste at PRH and RSH.
- Appointment of a Waste and Energy Compliance manager in line with NHS guidance (0.5 WTE). This has resulted in improved waste compliance and successful implementation of the clinical waste strategy. The Trust has also appointed an Authorising Engineer for Waste.
- Introduction of NHS Clinical Waste Strategy and achievement of 74% Offensive, 6% Incineration, 20% clinical waste ahead of 60%, 20% and 20% strategy date targets.
- Trial of reduced use of IV paracetamol for post operative patients.
- Completion and revision of the following Trust documents: Heatwave Plan, Adaptation Plan and Biodiversity Plan.

The areas that the Trust did not have success in were as follows:

2021-2026 Green Plan action	Barrier to progress
All NEW building works over>£2m (incl. fees and VAT) to undergo Building Research Establishment Environmental Assessment Method (BREEAM) at Outline Business Case	<p>The main barriers to achievements were funding constraints at planning stages to incorporate BREEAM and sustainable initiatives into the designs.</p> <ul style="list-style-type: none"> <li>• Reducing Supplier Scope 3 emissions</li> <li>• We will require a transition to Ultra-Low Emission Vehicle (ULEV) as part of any logistics contracts.</li> <li>• New logistics contracts will include CO2 and other emissions related reduction targets.</li> <li>• To require copies of tenderers' Sustainability Policies and evidence that they are implemented at their own depots and as part of their construction activities.</li> </ul>
To include a question in annual staff survey about green space and wellbeing	Sustainability related question was not included in 2022, 2023 or 2024 Staff Surveys due to fixed question format; however, we are looking into other survey platforms such as Pulse Surveys and Staff Conversations. Feedback will be used to shape development priorities.
To move to a renewable electricity tariff.	The Trust had a contract for a renewable electricity tariff in line with the NHS Standard Contract; however, this was not renewed due to the increased costs of Renewable Energy Guarantees of Origin (REGOs) and lack of guarantee that the energy purchased was from a renewable source.

	Instead, more capital investment has been made on site in photovoltaic renewables.
Procurement	The Trust's non-patient Transport contractor (ERS Medical) plan to become carbon neutral by 2025 and to replace their vehicles with ULEV by 2030. NHS Supply Chain are also making significant deployments of zero emission heavy goods vehicles. It has been noted that consideration will be given to the Procurement process on Logistics contracts where relevant. However, the target has not been met.
New Actions	The Trust did not have actions previously for Net Zero Clinical Transformation and Digital Transformation in the 2021–2026 Green Plan. All sections outlined in the new Green Plan guidance are included in the Trust's Green Plan 2025-2028.

To measure SaTH's position and progress with respect to sustainability, we have refreshed and updated our Green Plan to incorporate the key focus areas detailed in the NHS Guidance:

- Workforce and Leadership
- Net Zero Clinical Transformation
- Digital Transformation
- Medicines
- Travel and Transport
- Estates and Facilities
- Supply Chain and Procurement
- Food and Nutrition
- Adaptation

To achieve the required actions, we will:

- Ensure that we have the right people delivering our net zero agenda.
- Consider how we can deliver care in a sustainable, balanced way.
- Harness digital technologies to approach a multifaceted challenge of delivering quality care outcomes, improving the quality of our care and diagnostics, reducing waste, and optimising our building services.
- Encourage our communities to avoid contributing to our carbon output.
- Focus on our supply chain's commitments to achieving net zero.
- Build on progress in reducing these "point of use" emissions, while improving patient care and reducing waste.



- Implement and govern the decarbonisation plans, continuing our transition to renewable energy, and in the interim making every kilowatt of fossil fuel energy count.
- Adopt practices to avoid creating waste that persists in nature, and recycling those we cannot.
- Adapt our services to meet the challenges of climate change and extreme weather events.
- Outline a plan to decarbonise NHS travel and transport, while also providing cost-saving and health benefits.

### The role of Management in assessing and managing climate related issues

Management has a key role in assessing and managing climate related issues. The Trust has in place a Trust Estates Sustainability Lead who leads in areas of sustainability and climate. The Climate Change Group has been established within the Trust to lead on climate related issues, meeting quarterly, and reporting into Performance Assurance Committee. The group supports the Trust and its managers by ensuring that:

- Climate Change and sustainability considerations inform its decisions.
- Its day-to-day activities contribute towards sustainable development.
- NHS resources and influence are used to build a healthy and sustainable environment.

Over the past twelve months the Trust has made significant progress towards the NHS Net Zero targets supported by financial investment from external and internal funding. This is reflected in the NHS England Energy dashboard which demonstrates a 23% reduction in the Trust's energy CO2 emissions since 2019.

We recognise that there is a lot more to progress in relation to areas of climate change and sustainable development and communicating this with our colleagues. We plan to communicate the refreshed Green Plan across the organisation in quarter 3, 2025/26.

### Risk Management Pillar

The Trust manages risk in line with its Risk Management Policy. The overarching aim of the Policy is to provide assurance that the Trust is providing high quality care in a safe environment, that it is complying with legal and regulatory requirements, and that it is achieving its strategic objectives and promoting its values.

The Trust identifies climate related risks through the Climate Change Group and these risks are managed through the Datix risk register. The Trust has an overall risk identified for 'not achieving Net Zero by 2040'; this is due to limitations in funding and technologies available.

The Trust is committed to considering climate related issues when reviewing organisational plans and monitoring performance. The Board incorporated climate related risks as part of its risk appetite statement in 2024/25, which was approved by the Board in September 2024.

### Organisational arrangements for managing climate related risks

The organisational management of risk forms part of the Trust's overall governance approach. The key forums for the management of risk in the Trust are outlined below:

<b>Board of Directors</b>	The Board of Directors has overall responsibility for ensuring the Trust has effective systems for managing risk to enable the organisation to deliver its objectives.
<b>Audit and Risk Assurance Committee (ARAC)</b>	ARAC receives the Trust Risk Report to seek assurance that the structures and processes in place regarding operational risk management within the Trust are robust. The Committee will liaise with other board assurance committees and internal and external audit to support this role and will report to the Board with a level of assurance gained from the information presented to them.
<b>Risk Management Committee</b>	The purpose of the Risk Management Committee is to support the Audit and Risk Assurance Committee, by obtaining objective assurance that the framework and systems for risk management are robust and effective. The Risk Committee has overall responsibility for establishing a pro-active approach to risk management across the various divisions and directorates across the Trust. Divisions/Directorates are expected to present new risks/provide updates on all risks with a current (residual) rating of 15 and above, to allow for constructive challenge, and provide assurances that effective controls are in place to mitigate the risks.
<b>Operational Divisions/Corporate Directorate</b>	The Divisions/Directorate are responsible for reviewing and controlling the risks within their areas.
<b>Specialities/Wards/Corporate Departments</b>	Speciality Governance/Wards/Corporate Department Teams are responsible for reviewing and controlling the risks within their areas.

**Signed by:**



**Jo Williams**  
**Chief Executive**  
**23 June 2025**

## Part two:

# Accountability Report



## Corporate Governance Report

### The Directors Report

The Board of Directors present their report and audited financial statements for the financial year ended 31 March 2025.

In accordance with its Establishment Order, the Board of Directors comprises seven non-executive directors and five executive directors, one of whom is the Chief Executive. All directors are required to comply with Trust policies, including the need to declare any

actual or potential conflict of interest, and must comply with the Fit and Proper Persons Test requirements.

Whilst non-executive directors are not employees of the Trust and are appointed to provide independent challenge to the Board of Directors, each board member brings a variety of individuals skills and experience to the Board.

## **Directors serving during the 2024-25 year were:**

### **Non-executive directors (voting Board members)**

#### **Andrew Morgan (Chair in Common) - (from 01 October 2024)**

Mr Morgan was appointed as Chair in Common across Shropshire Community Health NHS Trust and The Shrewsbury and Telford Hospital NHS Trust in October 2024.

Prior to this, Mr Morgan spent 42 years working full-time in the NHS before his retirement at the end of June 2024. His NHS career spanned many different sectors of the NHS and many different geographical areas, including Dorset, Hertfordshire, Bedfordshire, London, Norfolk and Waveney, and Lincolnshire. He spent over 20 years as a CEO in the NHS and has been a CEO of many different organisations, including a Strategic Health Authority, Primary Care Trusts, an Ambulance Service, a Community Health Trust and an Acute Hospitals Trust. His most recent role before his retirement was as Group CEO across Lincolnshire Community Health Services NHS Trust and United Lincolnshire Hospitals NHS Trust.

Mr Morgan is a Social Policy graduate and has management and social science qualifications. He is married and has a grown-up daughter who lives in Australia.

#### **Teresa Boughey**

Mrs Boughey is Chair of the People and Organisational Development Assurance Committee and the Charitable Funds Committee, and also serves as a member of the Remuneration Committee, and Audit and Risk Assurance Committee.

She is the Founder and CEO of Jungle HR, a multi-award-winning strategic consultancy, and brings over 25 years' senior-level HR and business transformation experience across a range of sectors. A published bestselling author and TEDx speaker, Mrs Boughey is also a recognised policy influencer, serving as a Business Board Member of the All-Party Parliamentary Group for Women and Enterprise, where she Chairs the ESG Workstream, and sits on the Parliamentary Steering Committee for the Modernising Employment APPG. She is a Board Advisor at Royal Holloway University, School of Business and Management. Her book, *Closing the Gap – 5 Steps to Creating an Inclusive Culture*, was ranked Amazon No.1 and Highly Commended at the Business Book Awards for its contribution to diversity and inclusion.

A Chartered Fellow of the CIPD and holder of a Master's degree in Human Resource Management, Mrs Boughey was appointed by the Board as Senior Independent Director and Non-Executive Director Lead for Doctor Case Management on 8 December 2022.

### **Raj Dhaliwal**

Mr Dhaliwal has over 20 years of banking experience, having covered roles across multiple disciplines and geographies.

Recently he led lending operations for business banking and mortgages, being responsible for ensuring over £36bn of lending approvals were safely disbursed within a controlled manner.

Currently he is Head of Group Technology Change Standards, owning the global policy and standard specifically for technology change.

Outside of this, Mr Dhaliwal spends time volunteering as a special constable for West Midlands Police.

### **Sarah Dunnett (full Non-Executive Director from 08 October 2024)**

Ms Dunnett joined the Trust as a Associate Non-Executive Director in February 2024 and became a Non-Executive Director on 08 October 2024. She chairs the Quality and Safety Assurance Committee, and is also a member of the Hospital Transformation Programme Assurance Committee, and the Performance Assurance Committee.

Ms Dunnett is a registered nurse, having qualified as a Registered General Nurse and Registered Mental Nurse. She has 15 years of experience in health and social care regulation, starting as an inspector, working in both acute and mental health sectors and finishing as a head of inspection of hospitals. In that role she was the lead for enforcement for hospitals and a member of the enforcement oversight board, where she contributed to policy and training developments. Her role required her to work collaboratively with other regulators, regionally and nationally.

Currently, Ms Dunnett works for an organisation delivering independent health and social care investigations. She leads on high profile reviews, using a systems-based approach within the Patient Safety Response Framework to identify learning and change needed following adverse incidents.

### **Rosi Edwards**

Ms Edwards joined the Trust in June 2022. She chaired the Trust's Quality and Safety Assurance Committee from February 2023 to August 2024 and has chaired the Performance Assurance Committee since September 2024. She has been on Audit and Risk Assurance Committee, the Remuneration Committee and the Charitable Funds Committee and is currently serving on the

Quality and Risk Assurance Committee and the People and Organisational Development Assurance Committee. At system level, she attends the Shropshire Telford and Wrekin Integrated Care Board Quality and Performance Committee.

She was previously a Non-Executive Director at the Royal Wolverhampton NHS Trust, from 2013 to 2021, where she chaired the Quality Governance Assurance Committee and was a member of the Audit Committee, and Remuneration Committee. She was also non-executive director lead for learning from Deaths, End of Life Care and Freedom to Speak Up.

During a career of over 30 years as a regulator in occupational health and safety and health, starting as HM Inspector of Factories and eventually as Regional Director for Wales, Midlands and the Southwest in the Health and Safety Executive, she developed practical expertise in risk management and the assessment of organisations' ability to manage risk.

She speaks French and Italian and was appointed chair of a tripartite committee of international experts for the International Labour Organisation, producing within a tight schedule an agreed Code of Practice on Safety in the Use of Machinery, has worked as an Occupational Health and Safety Consultant for the Organisation for Economic Co-operation and Development on a project to streamline the regulatory system in Italy, and has been an Executive Reviewer for the Care Quality Committee.

She is Honorary President of Birmingham Health, Safety and Environment Group, a well-regarded occupational health and safety group covering organisations in West Midlands.

### **Professor Trevor Purt**

Professor Purt is the Chair of the Audit and Risk Assurance Committee and Hospital Transformation Programme Assurance Committee, and also a member of the Remuneration Committee. He was appointed as Vice Chair from 1 November 2023 and is also the non-executive director lead for both cyber and the hospital transformation programme.

He is both a Chartered Engineer and Chartered Surveyor after having initially trained in architecture. Professor Purt has been a CEO or equivalent both in the public and private sectors for over 25 years, and as a senior NHS leader he has led some of the largest NHS organisations in the UK with experience from both the provider and commissioning sectors, as well as working at both regional and national levels, including ICS development.

Professor Purt's last role was in the private sector, where he was Vice President for IBM Watson's Healthcare Consultancy business for Europe, the Middle East and Asia, with a specific remit around population health and wider health and social care system integration and service reconfiguration.

In addition, Professor Purt also sits on West Mercia Police's Audit and Standards Committee, was a Secretary of State appointee to the NMC, has served as a trustee and board member of the NHS Confederation, and The Prince's Trust.

### **Richard Miner**

Richard is a Fellow of the Institute of Chartered Accountants in England and Wales (FCA). After qualifying in practice, he became a partner in national accountancy firm PKF (now merged with BDO) before moving into industry as Group Finance Director with an international speciality paper manufacturer. He currently acts as a part-time and flexible finance director with a number of ambitious and private equity backed organisations, as well as Managing Trustee for Dinwoodie Charitable Company, a medical education charity.

Richard's NHS experience started in 2006 as a Non-Executive Director with Birmingham East and North Primary Care Trust before joining the Board of Dudley Group NHS Foundation Trust which he served between 2010 and 2021, in both cases as part of the Finance and Performance Committees and as Audit Chair. He currently chairs the Finance Assurance Committee and sits on the both the Remuneration and Charitable Funds Committees. He was initially appointed to the Board of SaTH on 1 August 2023 and has recently been re-appointed for a further two years.

### **Wendy Nicholson MBE (from 01 January 2025 as full Non-Executive Director)**

Wendy Nicholson MBE joined the Trust in 2024, she is a member of the Quality and Safety Assurance Committee, People and Organisational Development Assurance Committee, Paediatric Transformation Assurance Committee (non-Board committee) and is the Non-Executive Director Maternity and Neonatal Safety Champion.

Ms Nicholson is a Registered Nurse (Adult and Child) and Educator (Registered Nurse Teacher) with over 40 years' experience within health, social care and Higher Education, working previously as Deputy Chief Nurse and Head of the World Health Organisation Collaborating Centre for Public Health Nurses and Midwives within the Office for Health Improvement and Disparities at the Department of Health and Social Care and Public Health England.

Ms Nicholson has led several national programmes and policy initiatives, including the modernisation of the national Healthy Child Programme, the establishment of one of the first Sure Start programmes in England, regional leadership for the Teenage Pregnancy Programme in the North-West, and the creation of the Community Nurse Strategy (Care Closer to Home) and the School Nursing Vision.

She has worked closely with Ministers and across multiple government departments including DfE, DWP, Ministry of Defence, Ministry of Justice, Home Office, and the Cabinet Office – working on issues including FGM, maternal and child obesity, immunisation programmes, Military families' health, adult and young carers; workforce planning; child deaths and



safeguarding, Commissioning guidance for Public Health Services; and, the vulnerability Framework during Covid.

Ms Nicholson has considerable experience in collaborating with NHSE, regulators, local government, and social care sectors. Her work spans local, regional, national, and international levels, including partnerships and research with stakeholders in the Netherlands, Greece, Slovenia, Australia, Central and Eastern European Alliance and Overseas Territories.

Her scholarly contributions include numerous articles and authoring international health and public health texts, together with blogs and professional twitter chats. Wendy is an accomplished presenter international and speaker with extensive media experience.

In recognition of her services to nursing and children's services, Ms Nicholson was awarded an MBE in the Queen's Birthday Honours in 2019. She is a Fellow of the Queen's Nursing Institute and a Florence Nightingale Scholar. Additionally, she volunteered as an independent visitor for looked after children and served on the BBC Children in Need Large Grants Committee.

Her specialised interests encompass addressing inequalities, particularly those affecting children and families, prevention, public health, safeguarding, community engagement, and patient experience. Wendy is an Executive Coach and Mentor (ILM 7) and has served as a visiting Lecturer at Keele University, focusing on leadership and political awareness. She also currently serves as a Non-Executive Director within University Hospitals North Midlands NHS Trust.

#### [Associate non-executive directors \(non-voting\)](#)

##### **Simon Crowther**

Simon Crowther is a member of the Charitable Funds Assurance Committee and the Finance Assurance Committee. Joining the Board during February 2024, he brings extensive experience in strategic leadership, digital technology, and commercial strategy.

As the CEO of i-nexus Global plc, Simon leads a strategy software company serving global blue-chip customers. With over 18 years of experience, he has successfully steered his company through strategic realignments and financial stabilisations, ensuring high staff retention and raising substantial funding.

Mr Crowther's professional background includes significant interactions with the NHS, having worked with University Hospitals Coventry and Warwickshire NHS Trust on operational scorecards and Birmingham and Solihull Mental Health NHS Foundation Trust on strategy deployment. Born and raised in Shrewsbury, he maintains strong ties to the area, providing a deep understanding of the community served by SaTH.

Mr Crowther is committed to leveraging his strategic insight and leadership skills to contribute effectively to SaTH's mission and goals.

#### Non-executive directors who left during the year:

Dr Catriona McMahon (Trust Chair) – to 30 June 2024

David Brown – to 30 September 2024

#### Executive directors (voting Board members)

##### **Joanne Williams – Interim Chief Executive Officer (from 14 September 2024)**

Mrs Williams joined the Trust as Interim Chief Executive Officer (CEO) in September 2024 on secondment from The Royal Orthopaedic Hospital in Birmingham, where she was appointed as Chief Executive Officer in May 2019 following her role as Chief Operating Officer appointed in July 2017.

She has worked in a variety of senior management roles in several acute trusts including University Hospital of Birmingham (UHB), Wythenshawe Hospital (UHSM) and Chesterfield Royal Hospital (CRH) delivering operational performance, leading service transformation and patient care improvement projects. As well as 24 years in the NHS, she also worked in procurement in the NHS, as a capital buyer for Nuffield Hospitals commissioning The Manor Hospital in Oxford, and nine years as a buyer supplying the manufacturing industry.

Mrs Williams is passionate about building an inclusive organisational culture where everyone can be themselves and flourish to achieve their full potential putting good staff health, wellbeing, and engagement at the heart of organisations. For her work at The Royal Orthopaedic Hospital, Birmingham, she was awarded “CEO of the Year Award” at the Inclusive Awards 2024.

She has a relentless drive to put patients, families and the people who work in the NHS at the heart of everything she does and in recent years, her leadership style and experience has led to her to be awarded an Honorary Doctorate at Aston University and Birmingham City University, which she proudly continues to support and champion.

##### **Paula Gardner – Chief Nursing Officer (from 1 December 2024)**

Ms Gardner started her career as a nurse in 1983 and trained at Worcester Hospitals. She lives in Lichfield with her husband and has two daughters.

Having worked in many Hospitals during her 42-year career, she has enjoyed all levels of posts from Staff Nurse, Junior Sister, Senior Sister, Service Improvement Manager, Matron, Divisional Director of Nursing, Deputy Chief Nurse and then Chief Nurse. The SaTH appointment is her 5<sup>th</sup> Chief Nurse post.

Paula holds a Master's degree in Health and Social Care, and is passionate about making a meaningful impact on patients, their families and colleagues.

### **Ned Hobbs – Chief Operating Officer (From 22 October 2024)**

Mr Hobbs joined the Trust in October 2024, having previously been Chief Operating Officer and Deputy Chief Executive at Walsall Healthcare NHS Trust.

Mr Hobbs graduated from the University of Nottingham with a first-class degree in Pure Mathematics before joining the NHS Graduate Management Training scheme in 2008 in the West Midlands region. He completed his Masters in Health and Public Leadership from the University of Birmingham's Health Services Management Centre in 2011 and has carried out a variety of operational management roles – predominantly in the acute hospital sector. He also graduated from the NHS England and Ashridge Business School Aspiring Chief Operating Officer programme in 2019.

Prior to joining SaTH, Mr Hobbs led Walsall Healthcare's operational response to the COVID-19 pandemic and delivered strong access performance with consistently upper quartile (nationally) ambulance handover and 4-hour Emergency Access Standard performance, and upper quartile Cancer 62-day Referral to Treatment and 28-day Faster Diagnosis Standard performance. He was Executive lead in securing Getting It Right First Time Elective Surgical Hub accreditation for the Trust in 2023 and led improvements to access to routine elective care too, with the Trust in the upper quartile nationally for both 18-week and 52-week Referral to Treatment measures.

In addition to his responsibilities as Chief Operating Officer, Mr Hobbs was appointed Deputy Chief Executive Officer at Walsall Healthcare in July 2023 and also commenced a 1-day per week secondment with the NHS England national Urgent and Emergency Care team in June 2023. This secondment was stood down upon taking up the Chief Operating Officer position at SaTH to devote full time to the role.

Mr Hobbs lives in Shrewsbury with his wife, daughter and son.

### **Helen Troalen – Director of Finance**

Ms Troalen joined the NHS in 2003 as a graduate trainee and qualified as a management accountant in 2007. Her career has spanned over 20 years in the NHS with roles in both the provider and commissioner sectors. She has also worked in a regional role at NHS London. Prior to joining the Trust, Ms Troalen was Deputy Chief Financial Officer at The Royal Wolverhampton NHS Trust for four years. Prior to that she was the Deputy Chief Finance Officer at a large collaborative of clinical commissioning groups in north-west London, also for four years.

Ms Troalen has a particular focus on improving services for patients and the role that robust financial stewardship can play in effective organisations. Being involved in the redesign of stroke and major trauma services in London remains a particular career highlight.

### **Dr John Jones – Medical Director**

Dr Jones has lived in Shropshire and has worked at the Trust for over 20 years, primarily as a consultant physician and gastroenterologist.

Dr Jones was an undergraduate at Christ's College Cambridge University and then a clinical student at Oxford University. He has worked in hospitals in Gloucester, Oxford, Stoke-on-Trent and the East Midlands before moving to Shropshire after completion of his PhD.

He has strong interest in medical education and regulation and carries out a number of roles for the GMC including as an educational visitor for new medical schools. He led the introduction of the first Keele University curriculum to our hospitals. He has previously worked for the Parliamentary and Health Service Ombudsman in Manchester.

Although the majority of Dr Jones' time is now spent in the executive role, he continues in clinical practice with a particular focus on specialist endoscopy for patients with suspected cancer.

### **Executive directors (non-voting)**

#### **Rhia Boyode – Chief People Officer**

Ms Boyode has spent most of her career in Organisational Development in the private sector supporting Global FTSE companies.

She went on to pursue a career in Human Resources which progressed to her leading the full range of HR and OD services for many years as a Head of HR Globally within Transportation, Automotive and Aerospace before joining the NHS as a Deputy Director going on to become a Board level Executive Director.

She has a Master of Science degree in Human Resource Management from Salford University of Manchester (Business School) and is a Fellow of the Chartered Institute of Personnel and Development (CIPD).

In addition to her role at The Shrewsbury and Telford Hospital NHS Trust, Mrs Boyode is Chief People Officer for Shropshire Community Health NHS Trust.

#### **Nigel Lee – Director of Strategy and Partnerships**

Beginning his career as a helicopter pilot in the RAF both in Search and Rescue and Operations Support roles, Mr Lee served in Northern Ireland, the Falkland Islands, and Iraq. He completed tours in the Defence Procurement Agency and Ministry of Defence on major

programmes and strategic planning, before starting his healthcare career in 2006 as a hospital director for a BUPA hospital in the Wirral. From there, he became divisional director at Alder Hey Children's Hospital and subsequently Aintree University Hospital.

Mr Lee has had senior operational roles with the Cheshire and Merseyside Major Trauma Network as well as a range of service configuration developments in the Merseyside area. Before joining the Trust in March 2018 as the Chief Operating Officer, Mr Lee was working as the Director of Secondary Care for the North Wales Health Board, where he was responsible for four hospital sites, women's services and the specialist cancer centre. He led elective and diagnostics improvement projects and played a lead role in the whole-system urgent and emergency care development programme.

Mr Lee took up the Director of Strategy and Partnerships role in 2023, focusing on the Trust's strategic work and development of integration with partners across the Integrated Care System. He has also led the Trust's digital programme. Since 1 August 2023, Mr Lee has also worked in a combined role as Chief Strategy Officer for the Integrated Care Board, leading on health inequalities improvements, developing the system's Integrated Care Strategy and supporting integrated neighbourhood working.

### **Anna Milanec – Director of Governance**

During her career, Ms Milanec has gained both public and private sector experience in highly regulated environments, working both nationally and abroad.

Beginning her working life in the global financial services sector, Ms Milanec worked as part of specialised compliance and governance teams, within portfolios encompassing multi-national organisations that required adherence to international law and regulatory requirements. (Membership of the Chartered Institute for Securities and Investment was allowed to lapse upon leaving the finance industry, relocating to England, and joining the NHS in 2010.)

Since that time, Ms Milanec has supported boards of directors to improve their governance, risk and compliance frameworks. She has previously successfully led two NHS organisations to eliminate existing governance conditions on their Provider Licences. In November 2020, she joined the Trust to support it with its own improvement journey.

Ms Milanec is a Fellow of the International Compliance Association, a Chartered Governance Professional and is a Fellow of the Institute of Governance Professionals. She also holds a Master of Science degree in Corporate Governance and Administration.

### **Inese Robotham – Assistant Chief Executive**

Ms Robotham joined the Trust in March 2023 from Swansea University Health Board where she was in the role of Chief Operating Officer, and she has held similar roles in Dorset County Hospital NHS Foundation Trust and Worcestershire Acute Hospitals NHS Trust.

Ms Robotham started her NHS career in 2001 as an Information Analyst and then progressed through a number of operational management and leadership posts. With over 20 years NHS experience in both high performing and challenged organisations, Ms Robotham brings a wealth of knowledge and expertise across a number of areas including partnership working, operational delivery and large-scale transformational change.

Ms Robotham holds a MSc in Leadership for Healthcare Improvement from the University of Birmingham and is passionate about creating the conditions for continuous improvement and enabling staff to deliver the best possible care to the local communities.

#### **Executive directors who left their positions during the year:**

**Louise Barnett – Chief Executive Officer** – to 13 September 2024

**Hayley Flavell – Director of Nursing** – to 01 January 2025

**Sara Biffen – Chief Operating Officer** – to 03 November 2024 (subsequently started role as HTP Delivery Director with the organisation)

#### **Acting positions during the year:**

Prof. Trevor Purt was Acting Trust Chair from 1 July 2024 to 30 September 2024.

Adam Winstanley was Acting Director of Finance from 20 January 2025 onwards.

### **The Board of Directors and meetings**

The Trust is governed by the Board of Directors. The overarching governance arrangements are described in detail within the organisation's Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation, which are reviewed annually and approved by the Board.

The Chair in Common proactively encourages Board members to constructively challenge and explore proposals made to the Board and assist in developing proposals on strategy, priorities, risk mitigations and standards.

Standing items on the Board meeting agenda relate to strategy, governance, patient feedback, quality and safety of care, people issues, finance, integrated performance and key issues summary reports from meetings of the Board's assurance committees. The Board Assurance Framework is also reported on a quarterly basis as a standing agenda item and outlines the risks to achievement of the organisation's objectives. Detailed reports have been received by the Board on a broad range of other strategic issues during the year.

The importance of the triangulation of understanding, challenge and assurance between committees is recognised and reflected through cross-membership and reporting, and through the receipt of summary reports to the Board of Directors.

Members of the public are invited to observe meetings of the Board and can also submit questions to the Board. The details of this are publicised on the Trust's website. Board papers are also published on the Trust website before each meeting and can be found by following this link: <https://www.sath.nhs.uk/about-us/trust-information/board-papers/>

During 2024/25 the Board of Directors formally met in public six times (excluding the Annual General Meeting). Attendance at the meeting is shown within the following table:

<b>Board meeting dates held in public - attendance 2024-25</b>	9 May 2024	11 July 2024	12 Sep 2024	14 Nov 2024	16 Jan 2025	13 Mar 2025
<b>Board Members</b> (*=non-voting)						
Dr Catriona McMahon	√					
Mr Andrew Morgan				√	√	√
Mrs Louise Barnett	√	x	√			
Ms Joanne Williams				√	√	x
Ms Sara Biffen	√	√	√			
Mrs Teresa Boughey	√	√	x	√	√	√
Mrs Rhia Boyode*	√	x	√	√	√	x
Mr David Brown	√	√	√			
Mr Simon Crowther*	√	x	√	√	√	√
Mr Rajinder Dhaliwal	√	√	√	√	√	√
Ms Sarah Dunnett (voting from 8/10/24)	√	√	√	√	√	√
Ms Rosi Edwards	√	√	√	√	√	√
Mrs Hayley Flavell	√	√	√	√		
Ms Paula Gardner					√	√
Mr Ned Hobbs				√	√	√
Dr John Jones	√	√	x	√	√	√
Mr Nigel Lee*	√	√	√	√	√	√
Ms Anna Milanec*	√	x	√	√	√	√



Mr Richard Miner	√	√	√	√	x	√
Ms Wendy Nicholson MBE (voting from 1/1/25)	√	√	x	√	√	√
Prof Trevor Purt	√	√	√	x	√	x
Ms Inese Robotham*	x	√	√	√	√	√
Ms Helen Troalen	√	√	√	√	√	x

In addition, the Board met in private 15 times during the year.

The public Annual General Meeting was held on 30 September 2024.

The Board received (in public) reports from six committees chaired/co-chaired by the non-executive directors:

- Audit and Risk Assurance Committee
- Quality and Safety Assurance Committee
- Performance Assurance Committee\* (established September 2024)
- Finance Assurance Committee\* (established September 2024)
- People and Organisational Development Assurance Committee
- Hospitals Transformation Programme Assurance Committee (established May 2024).

(\* = replacing the previous Finance and Performance Assurance Committee.)

In addition, during 2024/25 the Trust had:

- a Remuneration Committee, its membership being made up of four non-executive directors, including the Chair in Common (who chairs the committee), with delegated authority to make decisions on behalf of the Board.
- a Charitable Funds Committee, which reports to the Board when the Board meets as the Corporate Trustee of charitable funds.

### **Board Balance Statement – a statement about the balance, completeness and appropriateness of the Board - 13 March 2025 (as published on the Trust’s website)**

The original Establishment Order (2003) for the Trust advised that “the Board shall have, in addition to the chairman, 5 executive and 6 non-executive directors”, making a total of twelve voting board directors at that time.

In November 2004, an Amendment to the original Establishment Order updated the number of non-executive directors to seven, in addition to the Chairman, making a total of 13 voting board directors. This composition has continued to the current day, with the addition of several non-voting executive and non-voting non-executive directors (the latter being known as 'associate non-executive directors') being part of the wider board, and attending the board meetings, board activities and board development.

During the 2024/2025 financial year, there have been several changes to the Board personnel, i.e. appointment of a Chair-in-Common (together with SHT)) in place of the former Trust Chair, and the transition of an existing experienced, associate non-executive director to a "full" voting non-executive director following the end of the term of office of an existing non-executive director.

With regard to our executive team, the Trust welcomed a new Chief Executive (currently interim) in September 2024, a Chief Nursing Officer (currently interim), and a Chief Operating Officer.

In addition, and in common with evolving structures across the NHS, our People and OD Director now splits her time between the Trust and SHT, and our Director of Strategy and Partnerships has also taken on a split role with the STW ICS as their Chief Strategy Officer.

There is a clear separation of the roles of the Chair-in-Common and the Chief Executive. The Chair has responsibility for the running of the Board, setting the agenda and for ensuring that all directors are fully informed of matters relevant to their roles. The Chief Executive has responsibility for implementing the strategies agreed by the Board and for managing the day-to-day business of the Trust, together with her executive team.

The Board of Directors regularly reviews its effectiveness and that of its assurance committees and believes that the Trust is led by an effective Board; the Board is collectively responsible for the exercise of the performance of the Trust, the setting of culture, and the setting of its strategy. No individual group or individuals dominate the meetings of the Board.

The Board considers that the Non-Executive Directors bring a wide range of business, commercial, financial and clinical knowledge required for the successful direction of the Trust.

All the Non-Executive Directors are considered to be independent in accordance with the Code of Governance for NHS provider trusts.

All directors are subject to an annual review of their performance and contribution to the management and leadership of the Trust.

Diversity is a vital part of the continued assessment and enhancement of board composition, and the Board recognises the benefits of diversity amongst its members.

At the present time, the Board is satisfied as to its balance, completeness and appropriateness and will keep these matters under review, in conjunction with NHS England who are responsible for appointing chairs and other non-executive directors of NHS Trusts.

## Audit and Risk Assurance Committee

The Audit and Risk Assurance Committee's is responsible for the review and providing assurance to the Board of Directors of the overall governance, risk management and internal control procedures of the organisation's activities, including oversight of the integrity of the financial statements. It is a statutory committee of the Board of Directors.

The priorities for the committee are to monitor the integrity of the Trust's financial statements and to review the Trust's financial and non-financial controls and management systems.

The committee receives regular reports from the Trust's internal and external auditor and from the local counter fraud service. Executive directors and subject matter experts normally attend the meetings as well as the external auditor, KPMG LLP, and internal auditors, Merseyside Internal Audit Agency (MIAA).

The committee met regularly throughout the year. Chaired by Non-Executive Director Professor Trevor Purt, the committee comprises three non-executive directors (including the committee chair). Attendance at the meeting is shown within the following table:

<b>Audit and Risk Assurance Committee (ARAC) Attendance 2024/25</b>	<b>15 Apr 2024</b>	<b>13 May 2024</b>	<b>14 June 2024</b>	<b>2 Sept 2024</b>	<b>25 Nov 2024</b>	<b>17 Feb 2025</b>
<b>Non-executive committee members:</b>						
Trevor Purt (Committee Chair)	√	√	√	X (whilst Acting Trust Chair)	√	√
Teresa Boughey	√	√	√	√	√	√
David Brown (member from 2/9/24, for one month only)				√		

Richard Miner	√	√	x			
Rajinder Dhaliwal (member from 14/06/24)			x	√ (Interim ARAC Chair)	√	√

During the year, the committee reviewed and updated its terms of reference; it also reviewed the Trust's Standing Financial Instructions, Standing Orders and Scheme of Reservation and Delegation, which were approved by the Board in January 2025.

The committee receives and monitors the policies and procedures associated with anti-fraud, bribery and corruption. An independent local counter fraud service provided by MIAA produces an anti-fraud progress report giving updates on both reactive and proactive work undertaken in the Trust. The Anti-Fraud Work Plan is subject to approval by the Audit and Risk Assurance Committee annually.

The purpose of internal audit is to provide the Trust, via the Audit and Risk Assurance Committee and the Chief Executive, with an independent and objective opinion on risk management, control and governance and their effectiveness in achieving the Trust's agreed objectives. To provide this opinion, the internal auditor reviews the risk management and governance processes annually within the Trust and usually on a three-year cyclical basis the operation of internal control systems within the Trust. Further detail regarding the work of the internal auditors is included within the Annual Governance Statement section of this report.

## Remuneration Committee

The Remuneration Committee is a statutory committee of the Board of Directors. It has delegated authority from the Board to determine the remuneration and terms of service of the Board executive directors and other senior managers and to be responsible for identifying and appointing candidates to fill all the executive director positions on the Board. The committee is also authorised to consider any matter relating to the continuing in office of any Board Executive Director. Note: NHS England is responsible for appointing chairs and other non-executive directors of NHS trusts.

Earlier in the year, the membership of the Committee did consist of all of the non-executive director Board members and the Trust Chair/Chair in Common who chairs the committee. However, the committee reviewed its terms of reference and new terms of reference were approved by the Board in September 2024 with revised non-executive director membership of four members, including the Chair in Common. In addition to the non-executive members

of the committee, regular executive attendees are invited to each meeting.

The attendance at meetings during the year is shown in the following table:

<b>Remuneration Committee meeting dates 2024/25 – attendance</b>	<b>03/06/2024</b>	<b>27/08/2024</b>	<b>14/10/2024</b>	<b>22/11/2024</b>	<b>09/12/2024</b>
<b>Members</b>					
Dr Catriona McMahon (Trust Chair - Chair)	√				
Andrew Morgan (Chair in Common - Chair)			√	√	x
Prof Trevor Purt (Non- Executive Director - Vice Chair)	√	√ (Chair)	√	√	√ (Chair)
David Brown (Non- Executive Director)	√				
Teresa Boughey (Non- Executive Director)	√	√	√	√	√
Rosi Edwards (Non- Executive Director)	x				
Richard Miner (Non- Executive Director)	√	√	√	√	√
Raj Dhaliwal (Non- Executive Director)	x	x	√		

## Quality and Safety Assurance Committee

The purpose of the Quality and Safety Assurance Committee (QSAC) is to seek and obtain evidence of assurance on the effectiveness of the Trust's clinical quality and safety governance structure, systems, and processes and the quality and safety of the services provided to achieve consistently high-quality effective care, ensure continuous improvement and to meet legal and regulatory obligations. The committee meets monthly. The Non-Executive Director chair changed from Rosi Edwards to Sarah Dunnett from September 2024.

The attendance at meetings during the year is shown in the following table:

Quality & Safety Assurance Committee Attendance 2024/25														
Name	Title	Role	2024-2025											
			Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Rosi Edwards*	Non-Executive Director	Member	✓	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	✓
Sarah Dunnett**	Non-Executive Director	Member	✓	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	✓
David Brown	Non-Executive Director	Member	✓	✓	✓	✓	✓	X						
Wendy Nicholson***	Non-Executive Director	Member		✓	✓	✓	X	X	✓	✓	X	✓	✓	✓
John Jones	Executive Medical Director	Member	✓	✓	✓	✓	✓	✓	✓	X*	✓	✓	✓	✓
Hayley Flavell	Executive Director of Nursing	Member	✓	✓	✓	X*	X*	✓	✓	✓				
Paula Gardner	Chief Nursing Officer	Member									✓	✓	✓	✓
* Rosi Edwards was QSAC Chair to August 2025 and Sarah Dunnett from September 2025														
** Sarah Dunnett was appointed as a full Non-Executive Director from 08 October 2024														
*** Wendy Nicholson MBE was appointed as a full Non-Executive Director from 01 January 2025														
<u>Note:</u>														
x* Denotes deputy in attendance														
The October 2024 meeting was not quorate														

## Finance Assurance Committee

At the end of August 2024, the last meeting of the Finance and Performance Assurance Committee was held. The Board established a separate Finance Assurance Committee and a Performance Assurance Committee in September 2024. The Finance Assurance Committee meets monthly and is chaired by Richard Miner, Non-Executive Director.

The purpose of the Finance and Performance Assurance Committee is to:

- Undertake on behalf of the Board of Directors objective scrutiny and seek evidence of assurance of the Trust's financial performance plans, major investment decisions, capital plans and relevant regulatory compliance.
- Provide the Board with an objective review of the financial position of the Trust and assurance on the delivery of the Trust's financial objectives.
- Consider processes for the preparation and the content of strategic and operational financial plans.

The attendance at meetings during the year is shown in the following tables:

<b>Finance &amp; Performance Assurance Committee Attendance (to September 2024)</b>								
Name	Title	Role	2025					
			30-Apr	28-May	25-Jun	30-Jul	27-Aug	
Richard Miner (Chair)	Non-Executive Director	Member	✓	✓	✓	✓	✓	
Rajinder Dhaliwal	Non-Executive Director	Member						
David Brown	Non-Executive Director	Member	✓	✓	✓	✓	✓	
Simon Crowther	Associate Non-Executive Director	Member	x	✓	✓	✓	x	
Helen Troalen	Executive Director of Finance	Member	✓	✓	✓	✓	✓	
Sara Biffen	Acting Chief Operating Officer	Member	✓	✓	✓	✓	✓	
Nigel Lee	Director of Strategy & Partnerships	Executive attendee	✓	✓	✓	x	✓	

Finance Assurance Committee Attendance (from September 2024)									
Name	Title	Role	2024-2025						
			Sept	Oct	Nov	Dec	Jan	Feb	Mar
Richard Miner (Chair)	Non-Executive Director	Member	✓	✓	✓	✓	x	✓	✓
Sarah Dunnett	Non-Executive Director ( <i>short-term member</i> )	Member				✓			
Simon Crowther	Associate Non-Executive Director	Member	✓	✓	✓	x	✓	✓	✓
Helen Troalen	Executive Director of Finance	Member	✓	✓	✓	✓	x	x	x
Hayley Flavell	Director of Nursing	Member	✓	✓	x				
Paula Gardner	Interim Chief Nursing Officer	Member				✓	✓	✓	✓
Prof Trevor Purt	Non-Executive Director ( <i>short-term member</i> )	Member			✓		✓		
Rosi Edwards	Non-Executive Director ( <i>short-term member</i> )	Member					✓	✓	✓
Adam Winstanley	Deputy Director of Finance/ Acting Director of Finance (from 20 Jan 2025)	Attendee/ Designated Deputy	✓	✓	✓	✓	✓	✓	✓

## Performance Assurance Committee

The Performance Assurance Committee was established in September 2024 following the Finance and Performance Assurance Committee being stood down. The Committee is responsible for providing independent assurance to the Board regarding the development and delivery of the Trust's annual business plan, including:

- the performance of the Trust across a range of performance indicators within the Integrated Performance Report.
- Ensuring that the Trust has an appropriate Estates Strategy and Digital Strategy.

The committee also has oversight of the development of a long-term strategy that addresses all identified operational business risks and opportunities, including those deriving from partnership work. The committee meets monthly and is chaired by Rosi Edwards, Non-Executive Director.

Performance Assurance Committee - Attendance									
Name	Title	Role	2024-2025						
			Sept	Oct	Nov	Jan	Feb	Mar	
Rosi Edwards (Chair)	Non-Executive Director	Member	✓	✓	✓	✓	✓	✓	
Sarah Dunnett	Non-Executive Director	Member	✓	✓	✓	✓	✓	✓	
Rajindar Dhaliwal	Non-Executive Director	Member	✓	✓	✓	✓	✓	✓	
Sara Biffen	Acting Chief Operating Officer	Member	✓	✓					
Ned Hobbs	Chief Operating Officer (from 22 Oct 2024)	Member		✓	✓	✓	✓	✓	
Inese Robotham	Assistant Chief Executive	Member	✓	✓	✓	✓	✓	✓	
Nigel Lee	Director of Strategy & Partnerships	Executive attendee		✓	x	✓	x	✓	
Note: There was no meeting held in December 2024.									

## People and Organisational Development Assurance Committee

The Board formally established a People and Organisation Development Assurance Committee in 2023. The committee receive assurances on the delivery of the NHS People Promises;



compliance with key national and statutory people/workforce/organisational development requirements; and provides the Board with an objective review with regard to the culture of the organisation. The terms of reference for this committee were reviewed and approved by the Board in January 2025. The committee meets bi-monthly. The chair of the meeting is Teresa Boughey, Non-Executive Director.

The attendance at meetings during the year is shown in the following table:

<b>People &amp; OD Assurance Committee Attendance</b>								
Name	Title	Role	2024-2025					
			Apr	Jun	Aug	Oct	Dec	Feb
Teresa Boughey (Chair)	Non-Executive Director	Member	✓	✓	✓	✓	✓	✓
Trevor Purt	Non-Executive Director	Member	x	✓	x	x	x	✓
David Brown	Non-Executive Director	Member	✓	✓	✓			
Rosi Edwards	Non-Executive Director					✓	✓	✓
Wendy Nicholson	Associate Non-Executive Director	Member		✓	x	✓	✓	✓
Rhia Boyode	Director of People & OD/ Chief People Officer	Member	✓	x	✓	✓	✓	✓
Sara Biffen	Acting Chief Operating Officer	Member	✓	✓	✓	x		
Nigel Lee	Director of Strategy and Partnerships	Member				✓	✓	✓

## Hospitals Transformation Programme Assurance Committee

The Hospitals Transformation Programme (HTP) Assurance Committee was established during May 2024 with its revised terms of reference approved by the Board in July 2024. The Committee provides independent assurance to the Board of Directors regarding the processes, procedures, and management of the HTP and associated work to support the successful achievement of the HTP Investment Objectives and realisation of the stated benefits. The committee meet bi-monthly. The chair of the meeting is Trevor Purt, Non-Executive Director.

The attendance at meetings during the year is shown in the following table:

<b>HTP Assurance Committee Attendance 2024/25</b>									
Name	Title	Role	2024-2025						
			May	Jun	Jul	Sept	Nov	Jan	Mar
Trevor Purt (Chair)	Non-Executive Director	Member	✓	✓	✓	✓	✓	✓	✓
Raj Dhaliwal	Non-Executive Director	Member		✓	✓	✓	✓	✓	✓
Sarah Dunnett	Non-Executive Director	Member	✓	✓	✓	✓	✓	✓	✓

## Disclosures – Code of Governance for NHS Provider Trusts

The Code of Governance for NHS Provider Trusts brings together best practice of the NHS and the private sector and was put in place from 1 April 2023. It applies on a *comply or explain* basis. Each section of the Code is built around a set of principles emphasising the value of good corporate governance to long-term sustainable success. Each section also incorporates a set of more detailed provisions to implement these. The Trust's Corporate Governance Team has

undertaken an assessment against the detailed provisions of the Code to enable the Board/Trust to provide disclosures to meet the requirements of the Code of Governance, as part of this annual report.

The Trust complies with all but one of the relevant provisions within the Code of Governance for NHS Provider Trusts (there are some provisions which only apply to Foundation Trusts and therefore, do not apply to The Shrewsbury and Telford Hospital NHS Trust).

Based on the *comply or explain* basis of the Code, the following disclosures are made:

Code of Governance provision reference	Relevant provision clause:	SaTH Disclosure:
Section B, 2.5	'The chair of the audit committee, <i>ideally</i> , should not be the deputy or vice chair or senior independent director.'	<p>The longstanding chair of the Audit and Risk Assurance Committee (ARAC) was appointed as the Vice Chair of the Trust from 1 November 2023. This is not perceived to be an issue to the audit chair's independence or potential conflicts of interest but will continue to be monitored.</p> <p><u>Note:</u> The Vice Chair was not a member of ARAC when appointed as Acting Trust Chair from 1 July 2024 to 30 September 2024. A replacement Non-Executive Director ARAC chair member was appointed and in place during this period.</p>

## External Auditors' Remuneration

Fees payable to the external auditors, KPMG LLP (net of VAT) during the year for statutory audit services amounted to £169,100 (2023/24: £121,000). No additional work was undertaken by the external auditors for the Trust.

## Public Sector Payment Policy – Better Payment Practice Code

In accordance with the Better Payments Practice Code and government accounting rules, the Trust's payment policy is to pay creditors by the due date, or within 30 days of receipt of a valid invoice, (whichever is the later) unless other terms have been agreed.

In 2024/25, the Trust paid 97.1% (2023/24: 90.1%) of non-NHS trade invoices within target, and 93.2% (2023/24: 85.5%) of NHS trade invoices within target. More details can be found in note 46 to the accounts.

## **Fraud, Bribery and Corruption**

The Trust's Anti-Fraud, Bribery and Corruption Policy and Response Plan was updated in January 2024 and sets out the arrangements that the Trust maintains to deter, prevent, detect and investigate instances of fraud, corruption and bribery carried out against the Trust, and the wider NHS. The policy was approved by the Board in March 2024 on a three-year review.

The Trust has a qualified Local Counter Fraud Specialist (contracted from MIAA) that supports the Trust in reducing the risk of fraud through annual fraud risk assessment, which informs an annual Anti-Fraud Work Plan. The Anti-Fraud Work Plan is subject to approval by the Audit and Risk Assurance Committee, with Anti-Fraud Progress Reports and an Annual Report presented to Audit and Risk Assurance Committee throughout the year.

## **Modern Slavery**

Under Section 54 of the Modern Slavery Act, we are committed to ensuring that employees of the Trust are not exploited, that they are safe, that they have the right to work and remain in the country, and that their employment standards and human rights are adhered to. The Trust expects the same from its suppliers and is committed to working with them to ensure any issues are identified and proactively managed. Some controls in place include:

- Employment checks of individuals and of agencies which supply temporary staff.
- Use of NHS General Terms and Conditions of Contract for Goods and Services which cover all suppliers to the Trust including medicines.
- Due diligence within our procurement and tendering processes to test that selected suppliers, and third parties are compliant with the legislation.

## **Declaration from directors as to audit information**

The Directors are responsible for preparing the Annual Report and Accounts and consider the report to be a fair, balanced and understandable account of the performance for the year ended 2024/25.

Each director knows of no information which would be relevant to the auditors for the purpose of their audit report and of which, the auditors are not aware and, that they have taken all the steps that they should have taken to make themselves aware of any such information and to establish that the auditors are aware of it.

## Register of Interests

Directors are asked to declare any interests that are relevant or material upon appointment and as soon as possible should a conflict arise during their term. The agendas of the Board and meetings of its committees contain an item allowing directors to declare any interests which may conflict with the scheduled meeting business.

The Board of Directors receives the Board member interests at its meeting held in public on a twice annual basis. The Register of Interests and Register of Gifts and Hospitality have been updated and maintained during the year, presented to the Audit and Risk Assurance Committee and placed on the Trust's website. The registers can be found via the following link:

<https://www.sath.nhs.uk/about-us/trust-information/registers-of-interests/>

## Public Participation

### Engagement with our communities

The Shrewsbury and Telford Hospital NHS Trust is committed to ensuring that the patient-public voice is at the centre of shaping our health services, both now and in the future. As an organisation we are committed to ensuring that our patients and local community have the opportunity to get involved in a timely and meaningful way. In October 2021, our Board of Directors approved our five-year Public Participation Plan, which outlines how we will engage with our local communities. We want to build greater public confidence, trust and understanding by listening and being responsive to the needs of our local communities. The Public Participation team (community engagement, volunteers and SaTH Charity) deliver this to our communities, and this is reported both to our Trust Board and the Public Assurance Forum on a quarterly basis. The action plan from the Public Participation Plan has now been completed, recently the SaTH Charity's five-year strategy (2025-2030) was approved by the Corporate Trustee and during 2025-2026 strategies will be developed for volunteering and Community Engagement.

The Public Assurance Forum is co-chaired by a non-executive director and a forum-elected lay Chair (representing North Powys Health Forum). The forum membership consists of Trust representatives from the Divisions and representatives from a wide range of health and community groups (including those from seldom heard communities). The aim of the Public Assurance Forum is to bring a public and community perspective, and scrutiny of processes, decision making and wider work, which takes place at the Shrewsbury and Telford Hospital NHS Trust. It is an advisory group whose role is to ensure that decisions about services and the delivery of care are developed in partnership with our local communities. Standing agenda items include: an update on our Hospitals Transformation Programme and our six-monthly engagement report supporting this Programme; our annual Public Participation Action Plans for

Community Engagement; volunteers and SaTH Charity; and updates from member organisations and SaTH divisional colleagues.

To support our communities to get involved, we offer a free community membership scheme (for individuals and organisations). Our members receive a monthly email (#GetInvolved) update which has information about what is happening in the Trust, opportunities to get involved/upcoming events and information from our system/community partners.

Our target for the year 2024/25 was to increase our community membership by 10% across both individual and organisational members, which we have exceeded. Currently we have over 5260 individual members and 469 organisations.

Community membership scheme type	Members at 01/04/2024	Target Members (10% ↑)	Members at 31/03/2025	Actual increase
<b>Individuals</b>	<b>4441</b>	<b>4885</b>	<b>5260</b>	<b>18.4%</b>
<b>Organisations</b>	<b>413</b>	<b>454</b>	<b>469</b>	<b>13.5%</b>

### Hospitals Transformation Programme Engagement

The Public Participation Team has been supporting the Trust to engage with local communities around the Hospitals Transformation Programme (HTP). Since January 2023, SaTH has developed existing and new methods to inform and engage with the public around HTP.

In 2024/25, the public participation team attended 90 events in person and 36 online events to discuss HTP with our communities. In addition, we have held 15 public focus groups, including our quarterly divisional focus groups as well as bespoke focus groups on specific topics. This year we have held 15 public drop-in events across Shropshire, Telford and Wrekin, and Mid Wales.

You can find out more on our website: <https://www.sath.nhs.uk/about-us/get-involved/public-participation-2/get-involved-with-us-2/http-focus-groups/>

In 2024/25, the public participation team attended 90 events in person and 36 online events to discuss HTP with our communities. In addition, we have held 15 public focus groups, including our quarterly divisional focus groups as well as bespoke focus groups on specific topics. This year we have held 15 public drop-in events across Shropshire, Telford and Wrekin, and Mid Wales.

### Social Inclusion

Working with all our communities is a fundamental part of our work, and it is important that, as a health service, we reach out to those communities where there may be barriers to healthcare

and health inequalities. A key focus of our work with seldom heard communities is to ensure that they have opportunity to contribute to programmes within the Trust. This year, the community engagement team has been reaching out to organisations who support individuals and communities who may be impacted by health inequalities, such as, Gypsy and traveller communities, homelessness and rough sleeping, rurality, veterans and looked after children.

## Volunteers

Our patients, their friends and families and our workforce are supported by an amazing group of people who give up their time to help – our volunteers.

At the Trust, we can accept volunteers from 16 years old and we have no upper age. Currently we have 251 active volunteers who are consistently providing over 2,000 hours of support every month to various wards and departments. Most individuals volunteer for three-four hours a week, whilst others give far more hours to our hospitals each week.

Over the past year our Volunteer to Career programme (VtC) has continued to be popular with volunteers and have successful outcomes. VtC aims to give hands-on experience to people contemplating a career in the NHS, through volunteering, developing their skills and knowledge and mentoring. The programme started in December 2022 and is focusing on careers within maternity. In 2024/25, two cohorts of the programme were delivered, one focusing on Radiology and another in midwifery. Our volunteers within Radiotherapy contributed over 461 hours of volunteering and our maternity volunteers have contributed over 893 hours.

This year we have joined in partnership with the national charity Helpforce to extend our Volunteer to Career programme to Veterans and their families. We are currently recruiting volunteers to this bespoke cohort and participants will have the chance to look at different roles in the NHS.

In November the Director and Head of Public Participation were invited to the House of Commons with over 80 leaders from across government, the NHS and voluntary and community sectors, attending for the launch of a new report by Helpforce - “Unlocking the Power of Volunteering to support our NHS”. Within the report SaTH’s Volunteer to Career programme was highlighted as an area of good practice.

A very BIG thank you to all our Volunteers, past and present.



Full details about the Shrewsbury and Telford Hospital NHS Trust Charity (number 1107883), including latest annual report and accounts, can be found on the Charity Commission website here:

<https://register-of-charities.charitycommission.gov.uk/charity-search/-/charity-details/4013618>

## Remuneration Report

This Remuneration Report considers the senior managers of the organisation. 'Senior managers' are defined as those persons in senior positions having the authority or responsibility for directing or controlling the major activities of the Trust. This means, those persons who influence the decisions of the organisation as a whole, rather than those who take decisions at divisional or departmental level. For the purposes of this report, this covers the Trust's non-executive directors and executive directors (voting and non-voting), and also includes those who have stepped down from their substantive roles during the year, but who either continue to work for the organisation in a different role, or who have been seconded into other roles for part of the year.

### Remuneration Policy

The Trust's approach to Remuneration Policy for Directors is in line with guidance issued by NHS England in order that directors' pay remains both competitive and provides value for money. The Trust has a Remuneration Committee that agrees the remuneration packages for executive directors and other senior managers on locally agreed pay. The Remuneration Committee has met regularly during the year.

Remuneration figures in the following tables represent actual remuneration rather than full year effect, and the band of the highest paid directors' remuneration excludes pension related benefits and is based on annualised, full time equivalent remuneration.

The expense payments for the Chair and non-executive directors are 'home to base' mileage, taxed at source.



The tables that follow are subject to audit:

## Salary and Pensions entitlements of senior managers 2024/25

### Remuneration of senior managers 2024/25 - subject to audit

2024/25							
Name and Title	Salary £000	Other Remuneration £000	Expense payments (taxable) £0	Performance pay and bonuses £000	Long term performance pay and bonuses	All pension-related benefits £000	TOTAL £000
<b>Executive Directors:</b>							
Louise Barnett Chief Executive (to 13/09/24) ∞	285-290	-	700	15-20	-	180-185	485-490
Sara Biffen Acting Chief Operating Officer (to 03/11/24) ○	160-165	-	-	-	-	0	160-165
Hayley Flavell Director of Nursing (to 31.12.2024) ◇	160-165	-	-	-	-	15-25	175-180
Dr John Jones Medical Director	270-275	-	-	-	-	60-65	330-335
Nigel Lee Director of Strategy & Partnerships	160-165	-	800	-	-	30-35	190-195
Helen Troalen Director of Finance	165-170	-	-	-	-	20-25	185-190
Inese Robotham Assistant Chief Executive	160-165	-	200	-	-	25-30	185-190
Rhia Boyode Chief People Officer	180-185	-	-	-	-	Opted out of NHS pension scheme	180-185
Anna Milanec Director of Governance	130-135	-	-	-	-	20-25	150-155
Edward Hobbs Chief Operating Officer (from 22/10/24)	70-75	-	-	-	-	60-65	130-135

Joanne Williams Interim Chief Executive Officer (from 14/09/2024)	115-120	-	2,000	-	-	25-30	145-150
Paula Gardner Chief Nursing Officer (from 01/12/2024)	55-60	-	700	-	-	No pension	55-60
Adam Winstanley Acting Director of Finance (from 20/01/2025)	20-25	-	-	-	-	30-35	50-55
<b>Non-Executive Directors (NED):</b>							
Dr Catriona McMahon Chair (to 30/06/24)	10-15	-	3,200	-	-	-	15-20
Teresa Boughey, NED	10-15	-	300	-	-	-	10-15
Richard Miner, NED	10-15	-	700	-	-	-	10-15
David Brown, NED (to 30/09/2024)	5-10	-	-	-	-	-	5-10
Wendy Nicholson MBE, NED (from 01/01/2025)*	10-15	-	-	-	-	-	10-15
Sarah Dunnett, NED (from 08/10/2024)**	10-15	-	-	-	-	-	10-15
Simon Crowther, Associate NED	10-15	-	900	-	-	-	10-15
Trevor Purt, NED	20-25	-	900	-	-	-	25-30
Rajinder Dhaliwal, NED	10-15	-	900	-	-	-	10-15
Rosi Edwards, NED	10-15	-	-	-	-	-	10-15
Andrew Morgan (Chair in Common) (from 01/10/2024)	30-35	-	2,700	-	-	-	35-40

∞ Whilst Louise Barnett stepped down as CEO of the organisation from 13 September 2024, she remained employed by the Trust for the remainder of the financial year working with a linked organisation. It should be noted that the total remuneration for 2024/25 includes elements of pay relating to prior years that were paid in 2024/25, and the associated pension impact.

◇ Whilst Sara Biffen stepped down as Acting COO from 3<sup>rd</sup> November 2024, she remained employed by the Trust.

○ Whilst Hayley Flavell stepped down as Director of Nursing from 31 December 2024, she remained employed by the Trust for the remainder of the financial year working with a linked organisation

\* Full NED from 01/01/25 (Associate NED prior)

\*\*Full NED from 08/10/24 (Associate NED prior)

Remuneration of senior managers 2023/24 (comparison) - subject to audit

2023/24							
Name and Title	Salary £000	Other Remuneration £000	Expense payments (taxable) £0	Performance pay and bonuses £000	Long term performance pay and bonuses	All pension-related benefits £000	TOTAL £000
<b>Executive Directors:</b>							
Louise Barnett Chief Executive	240-245	-	-	-	-	0	240-245
Sara Biffen Acting Chief Operating Officer	150-155	-	100	-	-	0	150-155
Hayley Flavell Director of Nursing	150-155	-	-	-	-	40-45	190-195
Dr John Jones Medical Director	260-265	-	-	-	-	0	260-265
Nigel Lee Interim Director of Strategy & Partnerships	150-155	-	600	-	-	510-515	660-665
Helen Troalen Director of Finance	160-165	-	-	-	-	20-25	185-190
Inese Robotham Assistant Chief Executive	150-155	-	100	-	-	0	150-155
Rhia Boyode Director of People & Organisation Development	190-195	-	-	-	-	Opted out of NHS pension scheme	190-195
Anna Milanec Director of Governance	120-125	-	-	-	-	0-5	125-130
<b>Non-Executive Directors (NED):</b>							
Dr Catriona McMahon Chair	55-60	-	3,600	-	-	-	60-65

Teresa Boughey, NED	10-15	-	500	-	-	-	10-15
Richard Miner, NED <sup>3</sup>	5-10	-	-	-	-	-	5-10
David Brown, NED	10-15	-	-	-	-	-	10-15
Simon Crowther, Associate NED <sup>1</sup>	0-5	-	-	-	-	-	0-5
Wendy Nicholson MBE, Associate NED <sup>2</sup>	0-5	-	-	-	-	-	0-5
Trevor Purt, NED	10-15	-	500	-	-	-	10-15
Rajinder Dhaliwal, NED	10-15	-	200	-	-	-	10-15
Rosi Edwards, NED	10-15	-	-	-	-	-	10-15
Timothy Little, Associate NED <sup>***</sup>	10-15	-	900	-	-	-	10-15
Sarah Dunnett, Associate NED <sup>****</sup>	0-5	-	-	-	-	-	0-5

<sup>1</sup> Commenced 5.2.24

<sup>2</sup> Commenced 13.3.24. Novice NED.

<sup>3</sup> Commenced 1.8.24

\*\*\* Left 29.2.24

\*\*\*\* Commenced 1.2.24

To note: Choices whether to opt into, or out of, the NHS Pension scheme, may distort salary or 'all pension related benefits' figures in a given year.

### All Pension Related Benefits

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. Rather, it is a calculation that is intended to convey an estimation of the benefit that being a member of the pension scheme could provide. The table below provides further information on the pension benefits accruing to the individual.

Salary and pension entitlements are provided for the 'executive directors' as non-executive directors do not receive pensionable remuneration.

All Pension Related Benefits 2024/25 – **subject to audit**

	2024/25							
Name and Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2025 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2025 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2024	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2025	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Louise Barnett Chief Executive (to 13/09/2024)	10-12.5	12.5-15	75-80	185—190	1,418	218	1,731	0
Hayley Flavell Director of Nursing (to 01/01/2025)	0-2.5	0	65-70	175-180	1,374	43	1,507	0
Helen Troalen Director of Finance	0-2.5	0	45-50	115-120	847	35	940	0
Dr John Jones Medical Director	2.5-5	0-2.5	80-85	210-215	1,711	105	1,931	0
Sara Biffen Acting Chief Operating Officer	0	0	75-80	200-205	1,770	0	1,849	0
Inese Robotham Assistant Chief Executive	0-2.5	0	50-55	125-130	1,005	45	1,118	0
Anna Milanec Director of Governance	0-2.5	0	30-35	0	526	41	603	0
Nigel Lee, Director of Strategy and Partnerships	2.5-5	0	30-35	0	457	48	536	0
Edward Hobbs Chief Operating Officer (from 22/10/2024)	2.5-5	0	40-45	0	469	50	550	0

Joanne Williams Chief Executive (from 14/09/2024)	2.5-5	0	55-60	135-140	1,106	52	1,232	0
Adam Winstanley Acting Director of Finance (from 20/01/2025)	2-2.5	0-2.5	35-40	10-15	465	35	531	0

### Fair Pay Disclosure – **subject to audit**

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 at the Shrewsbury and Telford Hospital NHS Trust in the financial year 2024-25 was in the salary banding of £270,000 to £275,000 (2023-24: £260,000 to £265,000). This was 8.61 times (2022-23: 7.67 times) the median remuneration of the workforce, which was £31,685 (2023-24, £34,234).

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

The median remuneration ratio of the workforce increased by 12.26% (2023-24: 12.50%).

	2024-25	2023-24
The yearly percentage change in the highest paid director's remuneration	4.15%	20.04%
The yearly percentage change in the total average employee remuneration	1.05%	5.22%
The ratio between the highest paid director's remuneration and the pay and benefits of the employee on the 25 <sup>th</sup> percentile of pay and benefits of the Trust's employees for the financial year	10.35%	10.22
The ratio between the highest paid director's remuneration and the pay and benefits of the employee on the 75 <sup>th</sup> percentile of pay and benefits of the Trust's employees for the financial year	7.49%	5.4
25 <sup>th</sup> percentile of pay	£25,354	£25,564
75 <sup>th</sup> percentile of pay	£48,725	£48,581
Average annualised pay	£54,125	£53,562

Range of pay for an FTE of 1	£12,514 - £261,844	£10,324 - £339,948
Number of employees receiving remuneration in excess of the highest paid director	17	24

Year	25 <sup>th</sup> percentile pay ratio	Median pay ratio	75 <sup>th</sup> percentile pay ratio
2024/25	10.35	7.49*	5.60
2023-24	10.27	7.67*	5.40

*\*The median pay ratio is a measure of wage dispersion. Pay is in line with national guidance for very senior managers within NHS Trusts and where appropriate all executive pay offers are discussed with NHSE and approved by the Trust's Remuneration Committee.*

### Reporting of compensation schemes - Exit Packages agreed in 2024/25

This section provides an analysis of exit packages agreed with staff during the 2024/25 year (along with a 2023-24 comparison) and is subject to audit. Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme.

### Exit Packages 2024/25 – subject to audit

Exit packages 2024/25				
Exit package cost band (including any special payment element).	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages	Total cost of exit packages
<£10,000	-	46	46	£133,647
£10,000 - £25,000	-	1	1	£21,057
£25,001 - £50,000	-			
£50,001 - £100,000	-			
£100,001 - £150,000	-			
£150,001 - £200,000	-			
>£200,000	-			
Total number of exit packages by type	-	47	47	



Total cost (£)	£0	£154,704	£154,704	£154,704
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**Exit Packages 2023/24 (comparison) – subject to audit**

Exit packages 2023/24				
Exit package cost band (including any special payment element).	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages	Total cost of exit packages
<£10,000		21	21	£65,772
£10,000 - £25,000		1	1	£12,000
£25,001 - £50,000				
£50,001 - £100,000				
£100,001 - £150,000				
£150,001 - £200,000				
>£200,000				
Total number of exit packages by type	0	22	22	
Total cost (£)	-	£77,772	£77,772	£77,772

**Exit packages: other (non-compulsory) departure payments – subject to audit**

Other non-compulsory departure payments				
Type	2024/25		2023/24	
	Number of payments agreed	Total value of agreements £000	Number of payments agreed	Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	47	155	21	66
Exit payments following Employment Tribunals or court orders	-	-	1	12

Non-contractual payments requiring HMT approval	-	-	-	-
<b>Total</b>	<b>47</b>	<b>155</b>	<b>22</b>	<b>78</b>
Of which, non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

### Reporting related to the Review of Tax Arrangements of Public Sector Appointees

Following the *Review of the tax arrangements of public sector appointees* published by the Chief Secretary to the Treasury on 23 May 2012, departments and their arm's length bodies must publish information on their highly paid and/or senior off-payroll engagements. Reporting entities must also disclose any off-payroll engagements of Board members and/or senior officials with significant financial responsibility.

The Trust has a policy that all substantive staff are paid through the payroll. No executive Board members were engaged on an off-payroll basis in 2024/25. On 6 April 2017, public bodies became responsible for collecting tax from those contractors subject to HMRC's IR35 rules; all contractors are subject to a review to determine whether they are affected by the rules. The number of contractors engaged as of 31 March 2025 is shown in the tables below where daily rates exceed £245 per day and the engagement has lasted longer than six months.

### Off-payroll disclosures - subject to audit:

For all off-payroll engagements as of 31 March 2025, for more than £245 per day and that last longer than six months:	<b>Number 2024/25</b>	<b>Number 2023/24</b>
Number of existing engagements as of 31 March 2025	3	12
<i>Of which, the number that have existed:</i>	-	-
for less than one year at the time of reporting	0	5
for between one and two years at the time of reporting	1	3
for between two and three years at the time of reporting	0	2
for between three and four years at the time of reporting	1	1
for four or more years at the time of reporting	1	1

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2024 and 31 March 2025, for more than £245 per day and that last for longer than six months	Number 2024/25	Number 2023/24
Number of new engagements, or those that reached six months in duration, between 1 April 2024 and 31 March 2025	3	12
Of which:	-	-
Number assessed as caught by IR35	3	-
Number assessed as not caught by IR35	0	12
Number engaged directly (via PSC contracted to department) and are on the departmental payroll	-	-
Number of engagements reassessed for consistency/assurance purposes during the year	-	-
Number of engagements that saw a change to IR35 status following the consistency review	-	-

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2024 and 31 March 2025	Number 2024/25	Number 2023/24
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0	0
Total number of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure includes both on payroll and off-payroll engagements.	24	20

# Staff Report



We employ around 7,971 staff, all of whom contribute to providing high quality patient care in our hospitals and in our community services. The majority are permanently employed clinical staff who are directly involved in delivering patient care. We also employ a significant number of people in non-clinical roles including in our scientific, technical, and administrative teams who provide vital expertise and support. The following table provides a breakdown of our workforce:

Average number of employees (WTE basis) – subject to audit				
Type	Permanent number (WTE)	Other number (WTE)	2024/25 Total number (WTE)	2023/24 Total number (WTE)
Medical and dental	883	135	<b>1,018</b>	940
Ambulance staff	7	-	<b>7</b>	10
Administration and estates	1,779	84	<b>1,863</b>	1,846
Healthcare assistants and other support staff	1,668	230	<b>1,898</b>	2,009
Nursing, midwifery and health visiting staff	2,076	302	<b>2,378</b>	2,323
Nursing, midwifery and health visiting learners	3	-	<b>3</b>	5
Scientific, therapeutic and technical staff	543	37	<b>580</b>	560
Healthcare science staff	195	21	<b>216</b>	213
Social care staff	-	-	-	-
Other	8	-	<b>8</b>	-
Total average numbers	<b>7,162</b>	<b>809</b>	<b>7,971</b>	7,906
Of which: Number of employees (WTE) engaged on capital projects	63	2	<b>65</b>	39

Note: The numbers above show the average number of staff (Whole Time Equivalent) employed at the Trust. The above disclosure is audited by the Trust's external auditors.

### Communicating with staff

We are committed to keeping our staff informed of changes across the organisation, involving them in decision-making and engaging them in the Trust's performance. We work hard to ensure that our staff are aware of both internal and external developments that may affect the organisation and the wider NHS. We place great importance on staff engagement as there is a positive correlation with the quality of patient care. In 2024/25, our Engagement scores in the annual NHS Staff Survey remained the same. The engagement theme questions provide insight into people's levels of motivation, involvement and advocacy, with the score for the sub-theme of Motivation being above the average for our sector.

Our range of well-established communication channels include regular Team Briefings from the Chief Executive and senior leaders; topic or audience specific newsletters; daily messages on computer desktops; and extensive intranets where staff can find policies, guidance and online tools. Our recent internal communications survey enabled us to understand how effective our communications are and adjust our strategy accordingly. In the last 12 months we have responded to staff feedback by making the recordings of the Chief Executive's monthly Team Briefing called cascade which is available for colleagues; reviewing the frequency of the session to enable more colleagues to join; and creating a new recognition and leadership calendar on the intranet to recognise the diverse range of events that are held throughout the year – including religious and cultural celebrations and masterclasses on culture and leadership. Our Staff Bulletin is emailed to all staff once a week and we are continuing our work to deliver a single, accessible, Trust-wide intranet.

We produce a popular magazine, called Chatterbox, and regular e-newsletters, for staff and patients. We work closely with the chairs of staff side for medical and dental and agenda for change colleagues, our staff networks and other staff representatives to ensure the voices of employees are listened to and taken into account. Throughout 2024/25 staff have been encouraged to provide their views to help shape decisions on a range of issues including the development of the hospital transformation programme and how we deliver our NHS people promise commitments. The joint staff committees meet regularly, acting as a valuable consultative forum for key developments affecting staff, with sub-groups looking at policy and pay issues. The Trust has seven Non-executive Directors who contribute to the development of the organisation and represent colleagues' views at Board level.

### Staff Survey

The NHS Staff Survey is the largest annual workforce survey in the world and has been conducted every year since 2003. The 2024 survey asked staff questions which are aligned to the NHS People Promises and themes. The results are benchmarked against our comparator group which is made up of 122 acute and combined acute and community trusts. The Trust's response rate in 2024 was 51%, with 4,085 responses received from the 8,083 eligible staff at the point of the 2024 fieldwork period. This sees our highest physical number of responses to date for the survey. This is above the national average of 49%, and 6% higher than the Trust's 2023 response rate of 45%.

In 2024, the Trust scored above the national average in one area: We work flexibly. At sub-score level the results were above national average in Motivation and Diversity and Inclusion.

We are committed to sharing best practices and promoting continuous improvement in all areas of the organisation.



The response rate for our bank staff was 24% with 261 completing the survey. The Trust's scores for this staff group show that most People Promise elements were below national average, with the exception of 'We work flexibly' which was slightly above the national average score.

It is important to recognise that our scores for recommending the organisation as a place to work and to receive care are noticeably lower than the sector. These scores are often linked to psychological safety and relationships with line managers, therefore continued focus in these areas will help to improve these results.

Question	National average	Trust score
Staff agreeing that the care of patients/ service users is the organisation's top priority	74.42%	66.93%
Staff recommending the Trust to a friend or relative as a place to receive care or treatment	61.54%	45.75%
Staff recommending the Trust to a friend or relative as a place to work	60.90%	48.77%

### Staff Survey Results

Staff were asked if they were the target of unwanted behaviours of a sexual nature from patients and from staff/colleagues. This is in relation to NHS England's sexual safety charter which aims to help protect staff from harassment and inappropriate behaviour and we support the drive to tackle these issues.

Our score for unwanted behaviours experienced by our staff from patients is 7.53% compared to the national average score of 7.98%. However, staff experiencing unwanted behaviours from staff/colleagues is 3.98% compared to the national average score of 3.53%. The Trust is committed to cultivating a culture where our staff are protected from all forms of unwanted and harmful behaviours, and we are working on improvement actions to ensure all staff feel safe.

### Addressing areas of concern

The results of the 2024 staff survey indicate that the employee experience at The Shrewsbury and Telford Hospital NHS Trust has slightly improved for four out of the seven people promises.



Despite a significant increase in participation, with 600 more staff taking part, the results highlight ongoing concerns that need to be addressed and provide a clearer picture of areas requiring attention. Evidence from NHSE suggests increased participation will bring a broader range of perspectives, potentially highlighting issues that may have been underrepresented in previous surveys and this can lead to shift in scores giving us a more comprehensive understanding of staff experience. Whilst the results indicate further challenges, the increased participation shows greater engagement and provides valuable insights for improvement. We are committed to fully understanding and addressing the issues reported in the survey. We recognise that a number of organisational challenges such as the introduction of car parking charges, industrial action and staff burnout may have impacted the results. We are committed to working with senior leaders and managers across the Trust to ensure as many staff as possible take up the opportunity to provide their views through the NHS staff survey in 2025/26. The Board has placed a renewed focus on addressing the areas of concern raised by our staff and ensuring that the Trust is a welcoming, fair and inclusive place to work.

### Culture and Leadership development

We were part of the NHS Leadership Academy pilot for scope for growth which is now included into our striving for excellence programme (STEP) which includes modules on career conversations to ensure that all managers have the skills to support their team's career aspirations. Our Leadership Framework is aligned to the People Promise Themes. The Culture Dashboard continues to be a key tool to measure our progress for cultural transformation within the Trust. The six key domains have remained the same as last year, with the exception of Vision and Values which has decreased by 1%. Our Culture Group and programme is reported through our new 'Moving Towards Excellence' improvement programme.

As a testament to this work, we were also a "spotlight" trust and invited to present at the NHSE Learning event in March, *The Power of Compassion for Inclusion: Leading Culture Change and Building Belonging | NHS England Events*, where over 200 organisations listened to our journey and have requested our information on our flagships, culture dashboard, flexible working tool kit and other programmes of work.

### Equality, Diversity and Inclusion (EDI)

We want our workforce to reflect the diversity of our local community. In turn we want our services to be developed in partnership with our communities, shaped around their needs to ensure the very best care is being delivered.

We have an unwavering commitment to creating an inclusive and equitable environment for all staff, patients and service users. We recognise that EDI is not just a box to tick; it is fundamental

to delivering high-quality and compassionate care. By embracing diversity in all its forms – race, ethnicity, gender, sexual orientation, disability, religion, and belief – we ensure that everyone feels valued, respected, and empowered to reach their full potential. An Equality, Diversity and Inclusion Policy is in place and was approved by the Board on 9 May 2024.

Our EDI workstreams have been aligned to the NHS Long Term Workforce Plan and underpinned by NHS Impact, NHS EDI six high-impact action Improvement Plan, NHS People Plan, People Promise and NHS Future HR and OD report. Our aims are to:

**Improve staff experience**, and we have:

- Grown our four staff networks with over 500 colleagues now engaging with them, these represent Race Equality, Disability, LGBTQ+ and Multi-Faith.
- Our Armed Forces Network continues to grow and have the “Veteran Aware” accreditation. We support the programme to address health inequalities in our veterans and support them and their families to find suitable jobs.
- Introduced and trained EDI champions in areas across the Trust. Their purpose is to help raise awareness of best practice and to offer peer support on equality, diversity and inclusion issues.
- Achieved Disability Confident Leader (Level 3) status, demonstrating how we recruit and retain people with disabilities, and how we ensure our processes, training and culture enable all staff to flourish. Examples of this include (but are not limited to): we have introduced a new guidance for supporting neurodivergent employees in the workforce recognising reasonable adjustments that may be needed to support from recruitment to working experience. Updated our workplace adjustment passport, reviewed our recruitment practices and training offer to managers.
- Rolled out training to our clinical leaders regarding active bystander, cultural competency, anti-racism and LGBTQIA+ awareness.
- Supported our BAME colleague only leadership development programme, Galvanise. This has intention of improving the ethnic diversity amongst our senior leaders. To date, delegates that have completed the course, 40% of participants have gained a promotion since joining the programme with another 30% actively seeking career progression.
- Our Education Prospectus and Training and Development Policy outlines an inclusive approach to developing our employees and supports the use of widening participation schemes to provide a more accessible means of working at SaTH.
- All key employment policies are inclusive and regularly reviewed to ensure they are relevant.

- Continued to commit to fostering a workplace where all staff feel valued, respected and free from discrimination. This includes initiatives to address issues of bullying, harassment and unconscious bias. We have seen a reduction in colleagues experiencing bullying and harassment in staff survey data (2023 – 89.1% had never experienced to 91.1% in 2024 vs our comparators at 90.4%). However, there are still cases being identified internally that are not reflective of our values internally.

### **Deliver equitable patient care:**

We are committed to ensuring all patients receive high-quality individualised care which is free from discrimination. To achieve this, we have identified objectives for 2024/25, building upon the key areas outlined in the 2023/24 Shropshire, Telford & Wrekin Health Inequalities Implementation Plan. These priorities align with the five key lines of enquiry outlined in the 2024/25 Operational Planning Guidance.

### **Engage with our communities:**

We build strong relationships with the diverse communities we serve, ensuring that their voices are heard, and their needs are met by implementing more work to promote equality of access and experience.

To measure our progress in achieving our aims we will continue to:

- Review and improve our services to meet the needs of our patients, carers and colleagues
- Collect and analyse patient and colleague experience and feedback
- Work with patients and carers to ensure information is shared in their preferred format
- Work closely with our education providers to promote NHS Careers
- Continue to grow our David Forbes-Nixen intern programme
- Listen to our staff and build our allyship and networks to support this
- Provide education and training to our colleagues
- Continue to foster a culture of kindness, civility, respect and inclusion
- Prioritise our commitment to ensure diversity and inclusion right across all roles and especially at senior roles

- Continue and grow our commitment to widening participation working with the Prince's Trust, Enable and local colleges
- Support our colleagues to stay healthy
- Continue to deliver and build our leadership masterclasses and development programmes for all leaders across the Trust
- Provide support for coaching, cultural reviews, Schwartz rounds and on-going educational and development opportunities
- Reviewing and expand our Occupational Health and our Health and Wellbeing offer with specific focus on our improvement priorities identified through the Equality Delivery System 2022 and EDI Improvement Plan.

We are committed to supporting staff with long- term health conditions, disabilities or who are neurodivergent – including if this is acquired during their employment. The Trust promotes and supports the Department of Work and Pensions' 'Disability Confident scheme', which is designed to demonstrate how we recruit and retain people with disabilities, and how we ensure our processes, training and culture enable all staff to flourish.

The Trust supports a number of initiatives to ensure equal and inclusive access to learning and employment. These include:

- Interactive workshops and mandatory training on bias, micro-aggression and incivility, authentic allies and advancing cultural competence.
- We have introduced new guidance for supporting neurodivergent employees in the workforce recognising reasonable adjustments that may be needed to support from recruitment to working experience.
- Developing and empowering our vibrant LGBT+, multicultural, disability, and armed forces staff networks
- Offer peer to peer support on equality, diversity and inclusion issues
- Ensuring equality objectives are in place for all Board members
- Reviewing and updating all people processes to eliminate bias and structural barriers
- A supported internship programme for individuals with autism or disabilities
- A Fellowship programme called Galvanise to help improve ethnic diversity amongst senior leaders 40% of participants have gained a promotion since participating in the programme, with another 30% actively seeking promotion following the course.
- A dedicated Armed Forces programme addressing health inequalities in veterans and supporting them and their families to find suitable jobs king closely with partners and The Prince's Trust to create more employment opportunities and training for local people
- Providing Industry placements for T-Level (health) students

Please see our Equality, Diversity and Inclusion reports including our Equality Delivery System 2022 action plan and Gender Pay Gap via our website [Equality, Diversity & Inclusion – SaTH](#)

### Addressing Bullying and Harassment

We have delivered our Civility, Respect, Inclusion and Kindness programme to over 1,300 colleagues across the Trust, signed up to the Sexual Safety Healthcare Organisation Charter. We delivered active bystander workshops to empower staff to call out poor behaviour; continued to grow our networks across the organisation and encouraged collaborative working with the Speak Up champions, reviewed the allegations process to ensure transparency when raising concerns.

### Health and Wellbeing

We increased access to the occupational health psychological therapies service; delivered wellbeing training for managers; established permanent staff wellbeing zones; organised health information webinars led by our intervention specialists; delivered regular menopause clinics for our staff to get expert advice and support. We continue to embed our Staff Psychology service to support wellbeing for teams and individuals and continue to expand our Health and Wellbeing offer, covering mental, physical and emotional health, as well as financial wellbeing, by launching the Menopause Support and Education Programme for all colleagues.

### NHS Staff Survey Results

Comparison of NHS Staff Survey Results for 2021-24 against National Average (Acute and Acute & Community Trusts).

	National Average 2021	Trust Score 2021	National Average 2022	Trust Score 2022	National Average 2023	Trust Score 2023	National Average 2024	Trust Score 2024
Response Rate	46%	45%	44%	49%	45%	45%	49%	51%
<b>People Promise element</b>								
We are compassionate and inclusive	7.19	6.76	7.18	6.85	7.24	7.06	7.21	7.08
We are recognised and rewarded	5.81	5.51	5.72	5.54	5.94	5.86	5.92	5.81

We each have a voice that counts	6.67	6.21	6.65	6.24	6.70	6.45	6.67	6.47
We are safe and healthy	5.88	5.57	5.88	5.67	6.08	6.02	6.09	6.02
We are always learning	5.24	4.89	5.35	5.09	5.62	5.41	5.64	5.48
We work flexibly	5.95	5.57	6.00	5.75	6.20	6.17	6.24	6.26
We are a team	6.58	6.26	6.64	6.39	6.75	6.63	6.74	6.61
<b>Theme</b>								
Staff engagement	6.84	6.29	6.80	6.32	6.91	6.59	6.84	6.59
Morale	5.73	5.31	5.68	5.42	5.90	5.79	5.93	5.84

## Next steps

The results from the staff survey are being reviewed in conjunction with other feedback, gathered throughout the year, which will give us a more complete understanding of what we are doing well and what needs to improve. We are working with stakeholders across the Trust to respond to the results by creating robust Trust-wide and local level action plans to drive positive change across the organisation. These include:

- Continuing to improve the working experience of all staff by increasing career progression opportunities.
- Investing in our staff wellbeing offer and ensuring equality, diversity and inclusion underpins all that we do.
- Embedding an equality, diversity and inclusion improvement programme with continued focus on anti-racism, disability confident and LGBT+ inclusivity for some clinical leaders
- Refocusing culture and leadership programmes following a pause.
- Strengthening our workplace adjustments process to improve the visibility of solutions available to our people through Access To Work and local reasonable adjustments solutions of our physical and digital work environments.
- Ensuring action plans – for divisions undergo continuous review, with updates shared during local performance review meetings.
- Communicating our progress towards delivering our staff survey action plans during regular Trust-wide cascade, local managers will disseminate communications in Team Briefings and their local forums to show our staff that their feedback is valued, and their voices are heard.
- Reviewing our approach to ensure ownership at local level is a key priority to encourage as many staff as possible to take part in the 2025 survey so that we can gather feedback from a broader range of staff and linking in with our regional and system partners to learn from best practice.

### Temporary and Agency staff

The Trust has continued its focus on reducing the use of agency staff and is now compliant with NHS England's agency 'cap' which sets maximum pay levels for agency staff. We use robust procedures to monitor and report on agency spend and have made significant reductions in agency use in 2024/25.

Agency usage, as a percentage of all temporary staffing usage, has seen another reduction and is now at its lowest rate for many years. However, there are still significant variances by staff group, particularly medical staff and we continue to deliver reductions via the Medical Workforce Efficiency Programme.

Staff Costs – subject to audit				
			2024/25	2023/24
Type	Permanent £000	Other £000	Total £000	Total £000
Salaries and wages	376,289	1,743	378,032	324,013
Social Security Costs	36,963	-	36,963	33,671
Apprenticeship levy	1,809	-	1,809	1,674
Employer's contributions to NHS pension scheme	67,663	-	67,663	52,956
Temporary Staff	-	19,662	19,662	41,349
<b>Total gross staff costs</b>	<b>482,724</b>	<b>21,405</b>	<b>504,129</b>	<b>453,663</b>
Recoveries in respect of seconded staff	-	-	-	-
<b>Total Staff Costs</b>	<b>482,724</b>	<b>21,405</b>	<b>504,129</b>	<b>453,663</b>
<b>of which</b>				
Costs capitalised as part of the assets	-	4,292	4,292	2,745

### Expenditure on Consultancy

The Trust spent £746,000 on consultancy during 2024/25 (£926,000 in 2023/24).

### Analysis of staff numbers

The figures in the following tables are calculated based on headcount in the organisation as of 31 March 2025, unless otherwise indicated.



The Trust had 306 new starters in medical and dental roles over the last 12 months (up to March 2025) inclusive of 203 Deanery doctors. During the same period, the organisation had 259 leavers, of which 152 were Deanery doctors.

Medical & Dental Starters & Leavers (Headcount)		
Job Role	New Starters	Leavers
Consultant	35	33
Associate Specialist	0	1
Specialty Doctor	20	14
Deanery Postgraduate Doctor - Foundation Level	82	40
Deanery Postgraduate Doctor (ST1-8)	121	112
Locally Employed Doctor - Foundation Level	0	5
Locally Employed Doctor - Specialty Registrar (ST1-8)	48	54
<b>Total:</b>	<b>306</b>	<b>259</b>

#### Staff gender distribution

A breakdown of the number of persons who were directors of the Trust, senior managers, and other employees is shown below.

Gender Breakdown (headcount) 2024/25	Male	Female	Total	Percentage of total
Board level directors	3	6	9	0.11%
Non-Executive Directors/Chair	5	4	9	0.11%
Senior Managers	22	44	66	0.79%
All other employees	1890	6405	8349	98.99%
<b>Grand Total</b>	<b>22.64%</b>	<b>77.36%</b>	<b>8349</b>	

#### Turnover

Staff turnover figures are published by NHS Digital using data drawn from the Electronic Staff Record (ESR) data warehouse. The latest version, which covers the year to 2024, can be found on the NHS Digital website: <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics>

### Sickness absence

The Trust's staff sickness absence data for 2024\* is provided below:

Staff Sickness Absence 2024	2024 (Number)	2023 (Number)
Total days lost	<b>86,671</b>	79,948
Total staff years	<b>7,143</b>	6,676
<b>Average working days lost (per WTE)</b>	<b>12.1</b>	<b>12</b>

Source: NHS Digital - Sickness Absence Publication - based on data from the ESR Data Warehouse

\*The sickness absence figures are reported on a calendar basis (2024), rather than for the 2024/25 financial year. These statistics are published by NHS Digital, using data drawn for January 2024 to December 2024 from the ESR data warehouse.

### Safe Working Environment

The Trust commissioned a Staff Psychology Service, which commenced in March 2023, as part of its commitment to improving the psychological safety and wellbeing of its staff. This is in recognition of the trauma and burnout that can occur in NHS staff working under pressure in acute settings. The Trust commissioned a Staff Psychology Service, which commenced in March 2023, as part of its commitment to improving the psychological safety and wellbeing of its staff. This is in recognition of the trauma and burnout that can occur in NHS staff working under pressure in acute settings. The Staff Psychology Service offers a range of evidence based psychological interventions to individuals who have experienced psychological or emotional distress in relation to their experiences at work. For instance:

- Specialist assessment and formulation
- Therapies such as Counselling, Cognitive Behaviour Therapy (CBT), Dialectical Behaviour Therapy (DBT) Skills, Psychodynamic Therapy, Compassion Focused Therapy and more for a range of work-related mental health problems
- Trauma therapies e.g. Eye Movement Desensitisation and Reprocessing (EMDR)
- Support for individuals undergoing formal processes, for instance grievances, investigations, tribunals etc.
- Supportive signposting to other organisations (where needed)

- Consultancy for colleagues (usually those in leadership or senior roles) who may be experiencing difficult situations within their team and would value space to think about what might be happening and how to approach it.

Interventions are also available for teams who may be struggling and include:

- Post Event Team Reflections (PETRs), formerly known as Debriefs, for teams to experiencing a traumatic event to help them process their feelings
- Pro Social Framework: offered to help build team relationships through helping them reach agreements about, values, behaviours and how they will work together as a team
- Tree of Life: a narrative approach which also looks at building relationships within teams through understanding the contributions of individuals and the strengths that can be achieved through bringing these together within the team.
- Reflective practice sessions can also be offered as a preventive measure, where teams are enabled to regularly reflect on the emotional impact of their work so that this does not become overwhelming.
- Care Spaces: an opportunity for a team to pause and listen to each other in a structured way.
- Consulting to develop ways to support teams with the psychological impact of change, such as the upcoming Hospital Transformation Programme (HTP).

Within the last year (2024/25) the service expanded the above offer to accept referrals from the Shropshire Community Trust Occupational Health team and has supported their colleagues at individual and team level.

The service also offers support to the wider Trust, including:

- Training sessions e.g., facilitating hot debriefs, looking after wellbeing, trauma and trauma-informed care and training on understanding yourself when working with challenging patients
- Support for the Staff Bereavement Offer
- Participation in developing Suicide Prevention and Postvention strategies for the Trust
- Supporting Schwartz Rounds
- Coordinating the SATH Peer Listening Service

The Leadership and OD team work together to share learnings and best practise, as well as to deliver an active Leadership programme to increase our capability to manage the health, safety and welfare of our workforce.

We ran a successful 'financial wellbeing' which included activities, discussions and demonstrations about a range of health, safety and wellbeing at work topics for our divisions engaging with our staff side representatives.

#### Trade union facility time disclosures at 31 March 2025

The following information is published in accordance with The Trade Union (Facility Time Publication Requirements) Regulations 2017. The relevant period is 1<sup>st</sup> April 2024 to 31<sup>st</sup> March 2025.

Trade unions and numbers of representatives	Number
Total number of employees who were relevant union officials during the relevant period	31
Number of employees in the organisation (WTE)	7,319.92

Percentage (%) of time spent on facility time	Number of employees
0%	20
0 – 50%	9
51 – 99%	0
100%	2

Percentage (%) of pay bill spent on facility time	% / £
Total cost of facility time	£101,060
Total pay bill	£500,018,093
Percentage facility time (the % of the Trust's total pay bill that is spent on facility time)	0.02%

Paid trade union activities	
Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as:	
Total hours spent on paid trade union activities by relevant union officials during the relevant period divided by total paid facility time hours, multiplied by 100.	2.25%

**Signed by**



**Jo Williams**  
**Chief Executive**

23 June 2025

## Annual Governance Statement – 2024/25

### 1. Scope of Responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of The Shrewsbury and Telford Hospital NHS Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS 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 Trust Accountable Officer Memorandum*.

### 2. The purpose of the system of internal control

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 (the Trust) for the year ended 31 March 2025 and up to the date of approval of the annual report and accounts.

### 3. Capacity to handle risk

I have the overall responsibility as Chief Executive and Accountable Officer, for the management of risk in the organisation.

Each member of the executive team has an area of responsibility for risk management in accordance with their portfolios and as reflected in their role descriptions, which supports me in my role as Accountable Officer.

I am also supported in my role through the assurance committees of the Board of Directors, each under the chairmanship of a Non-Executive Director, with appropriate contribution from members of the Executive Team. These committees comprise the Audit and Risk Assurance

Committee, Quality and Safety Assurance Committee, Finance Assurance Committee (established September 2024), Performance Assurance Committee (established September 2024), People and Organisational Development Assurance Committee and the Hospitals Transformation Programme Assurance Committee, which held its first meeting in May 2024. A statutory Remuneration Committee is in place which has delegated authority from the Board to determine the remuneration and terms of service of the Board Executive Directors and other Very Senior Managers, and to be responsible for identifying and appointing candidates to fill vacant Executive Director positions on the Board.

The Audit and Risk Assurance Committee, comprising of independent Non-Executive Directors, oversees the systems of internal control and the overall assurance processes associated with managing risk throughout the organisation.

A framework of operational committees sits below the board assurance committees, which provide the process through which risks are monitored throughout the organisation and up to the Board (ward to board). In addition, the Senior Leadership Committee (Operational and Transformation), the monthly communications “Cascade”, and divisional and operational meetings, all provide forums at which risks to the organisation are considered.

The role of the Board of Directors is to effectively govern the organisation, and in doing so, to deliver high quality care for the population it serves. The Board of Directors receives the Chairs’ highlight reports and assurances from the Quality & Safety Assurance Committee relating to the management of all serious patient safety incidents, including Never Events, as well as receiving the monthly integrated performance report which includes performance on all quality and performance matters.

The Trust continues its journey of improvement with conditions remaining on its Provider Licence, imposed by both principal healthcare regulators. There have been improvements and innovation in some services, as highlighted through a number of external visits and independent reports. However, the Trust recognises that there are still areas that need more focus. But the foundations that have been built over the last four to five years have developed and established recognisable healthcare performance frameworks and tools which are typically used and embedded across other healthcare organisations. This means that newly recruited colleagues are now more able to recognise and assimilate these on joining the Trust, bringing the benefit of experience gained elsewhere and contributing to our improvement journey.

A Chair in Common (across SaTH and Shropshire Community Trust) was appointed on 01 October 2024, along with an Interim Chief Executive Officer on 16 September 2024. During May 2025, the Boards of Shropshire Community Health NHS Trust (Shropcom) and The Shrewsbury and Telford Hospital NHS Trust (SaTH) have agreed to appoint a shared Chief



Executive (CEO). This shared role will lead both organisations working with the Chair in Common. The two trusts are also exploring opportunities to form a Group. Working as a Group would mean shared Executives and Non-Executive Directors across both organisations.

There has been a change in several Non-Executive and Executive director posts at SaTH in recent years, leading to a restructure of executive portfolios and bringing in more experience and skills to the Board. In-year changes to the voting directors can be found within the *accountability report* section of the annual report.

There are governance arrangements in place throughout the divisional triumvirate structures and divisional performance is overseen and monitored by the executive team. Key risks to delivery of services are identified through the monthly Performance Review Meetings with the executive team.

#### **4. The risk and control framework**

The Trust seeks to manage and mitigate risk as far as possible. However, it is understood that delivering healthcare carries inherent risks that cannot be completely eradicated but can be reduced through effective identification and risk mitigation where possible. The process begins with the systematic identification of risks via structured risk assessments and incorporated within risk registers. All risks are assessed and scored using an approved scoring matrix which considers the potential likelihood, consequence, and overall severity of each risk. This results in each risk being awarded a score of between 1 (low) to 25 (extreme). The effectiveness of the existing control measures is assessed, and associated gaps and action plans agreed and monitored to ensure management of the risk.

The Board Assurance Framework provides the Trust with a system to identify and monitor risks which may affect achieving the organisation's strategic objectives/goals. Each risk is mapped to corresponding controls and assurances, both internal and external.

Over the last 12 months we have focussed on improving the escalation of risk through the divisions. The Trust has used the Datix system to record risk since June 2022. This provides an integrated approach to the management of risk, enabling the triangulation of incidents and complaints.

It is planned that Audit & Risk Assurance Committee review the Trust's Risk Management Strategy in the first half of 2025-26 (last approved during June 2021) following further review of the Trust's Risk Appetite Statement for 2024-25 which was approved by the Board in September 2024.

The current Risk Management Policy expires during 2027 but will be subject to earlier review with comments sought from Policy Approval Group members and the policy reviewed in line with a revised Risk Management Strategy.

The Risk Management Group Terms of Reference were updated during 2024-25 to include representation from Executive Directors and to increase the visibility of risks.

Quarterly risk management reports are presented to Audit & Risk Assurance Committee and Board to ensure appropriate assurance is provided regarding risks on the Trust risk register. Monthly Key Issues reports are produced by the divisions to support this assurance.

An improved quarterly Board Assurance Framework (BAF) document was introduced from quarter 1 in 2022-23 and has continued to be updated during 2024-25 and to be actively considered by the Board, following prior consideration at its assurance committees. Training has continued to be rolled out across the organisation to support the continual development of a robust risk management framework and the Trust's capability to consistently manage and mitigate risk.

The risk management face-to-face and virtual training programme was piloted on 20 September 2023 and has been rolled out across the Trust. Over 200 members of staff have received this training since September 2023. Evening risk management training sessions are provided for night shift workers via Microsoft Teams. The syllabus of the training has been continuously adapted to capture the risk appetite statement and, separately, to cater for neurodivergent staff.

Separate risk management e-learning training was designed in conjunction with the Learning Management System (LMS) Team and went live in December 2023.

Risk Management updates/issues are communicated through weekly Operational Delivery Group slides, the Trust-wide newsletter "Chatterbox", staff Information Bulletin, with the use of live monthly "Cascade" updates and other communications.

We have a Senior Independent Director in place who is available to any colleague should they have concerns that they feel they are unable to raise via normal communication channels with the Chair in Common (across SaTH and Shropshire Community Trust), Chief Executive Officer, or any of the Board members.

## 5. Major risks to the organisation

The Annual Governance Statement for 2023/24 identified a number of risks that were carried forward into 2024/25, some of which continue to remain current. A commentary for each of these risks is provided below.

### a) Quality of care, including standards of performance and licence conditions

This relates to the failure to deliver high quality patient care, leading to poor patient experience, avoidable harm, and poor clinical outcomes.

Throughout 2024-25, the Trust has continued to focus on several areas of improvement including VTE, recognising the deteriorating patient, reducing the number of falls with harm, pressure ulcers, and healthcare acquired infections, in particular Clostridium Difficile.

Another priority is the timely response to patient concerns and complaints and embedding the learning from these. Quality boards are in place across the Trust to provide oversight of quality, safety, and patient experience performance indicators in one place. They are placed where people accessing the area can view them, for information and transparency. The quality boards include a 'You Said, We Did' section, enabling areas to demonstrate actions taken in response to feedback.

The need for the Trust to maintain its continuous improvement journey is vital. The CQC last inspected the Trust in October / November 2023, with the final report following this inspection, published in May 2024. Improvements were seen, especially noted in End-of-Life Care (EOLC), Maternity and Children and Young People (CYP), which were both rated as good overall and in all domains. Urgent and Emergency Care remains challenging with the Emergency Department at the Royal Shrewsbury Hospital rated overall as "requires improvement", and at the Princess Royal Hospital the Emergency Department has an "inadequate" rating for the safe and responsive domains, and an overall rating of "inadequate". There remains a risk of prolonged delays in urgent and emergency care pathways with impact both on quality and experience of care. Work will continue both internally and on external pathways to reduce the numbers of patients and time spent in our emergency departments.

The CQC's report was closely followed by a Channel 4 Dispatches documentary which was aired on 24 June 2024, highlighting the pressures within our Emergency Departments. Through our CQC action plan, and working with our health and care partners, our teams have worked tirelessly to improve the standards of care in our urgent and emergency care pathways. Through 2024/25 we have seen a reduction in care on corridors, increased patient observations and reduced waiting times by increasing the use of Same Day Emergency Care.

In the May 2024 CQC inspection report, the Trust moved from the previous rating of 'Inadequate' to 'Requires Improvement' overall, with the individual ratings for each domain being as follows: - Safe – Requires Improvement

- Effective – Requires Improvement
- Caring – Good
- Responsive – Requires Improvement
- Well-led – Requires Improvement
- Use of Resources – Requires Improvement

There were 79 “must” and “should do” actions included in the May 2024 CQC report, which is significantly less than previous inspections. The revised CQC Improvement Plan continues to ensure robust actions are in place regarding the CQC “must” and “should” do actions from the report and these areas of focus are also included in the improvement and transformation programmes. These improvement actions will continue to be reviewed monthly with the Divisions and progress is reported through the Trust’s Quality Operational Committee, the Quality and Safety Assurance Committee, as well as reporting progress to the CQC.

An application was made to the CQC in November 2024 in relation to consideration of the removal of three conditions. These related to not admitting children and young people with isolated mental health issues (recorded in two CQC domains) and risk assessments and care planning. In December 2024, confirmation was received from the CQC that this application had been successful. The Trust now has two remaining Section 31 conditions both of which relate to the Emergency Departments: - paediatric triage within 15 minutes, and time to initial assessment within 15 minutes.

The Trust has continued to hold formal quarterly engagement meetings with the CQC to discuss and highlight improvements made in core services provided by the Trust. An ongoing dialogue between the Trust and its local CQC regulators enables timely escalation of any issues, should this be required.

The ongoing implementation and robust reporting of progress and monitoring of improvements is coordinated and monitored by the Trust’s “Getting to Good” improvement plan which sets out the programmes of work and underlying projects that encompass key deliverables which the Trust is progressing in order to improve quality of care for patients. This includes a focus on quality governance, maternity, elective recovery as well as culture, to support the required improvements. At the start of 2025/26, we launched our Moving to Excellence transformation programme. This replaces our Getting to Good programme.

There have been regular updates throughout 2024-25 on progress to the Board with “Getting to Good” programme updates and external reporting to the quarterly System Review

Meetings, which are attended by representatives from the national regulators, and key regional stakeholders. The Board has also received monthly updates on progress with the System Integrated Improvement Plan (SIIP).

The Trust continues to strengthen its Quality Governance Framework. The Patient Safety Incident Response Framework, which is part of the NHS Patient Safety Strategy, was implemented across the Trust in December 2023. Incidents and near misses continue to be discussed at the weekly Review Action and Learning from Incidents Group (RALIG) chaired by the Medical Director.

b) Access and waiting time performance.

Urgent and emergency care demand remained high throughout the year and continues into the current financial year. A&E performance, including ambulance handover delays, continues to be a challenge. As a result, the Trust remains in Tier 1 monitoring by the regulator. The Trust ended the year at 61.9% (including MIU) achievement of the 4-hour A&E wait standard, with 33.0% of ambulance waits of 60 minutes or more.

There has been significant improvement work undertaken within Emergency Department (ED), acute medicine, and ward processes. In terms of key highlights the ward process work has resulted in a 1.6-day reduction in length of stay within Medicine, alongside a 5.5% increase in discharges before 12:00, midday. Work within ED has resulted in an improvement in patients triaged within 15 minutes of arrival with the Trust moving from lower quartile to middle quartile performance when compared nationally. The percentage of non-elective medical patients attending as an emergency treated via our Medical Same Day Emergency Care (SDEC) service rather than ED, increased from 30% to 37.1%. Non-elective medical admissions managed as 0-day LoS zero day via SDEC also increased from 23% to 30% to achieve the national standard.

Several Trust and systemwide initiatives were also implemented throughout the year to progress improvement in this area, including an alternative to ED workstream led by Shropshire Community Trust and the commencement of the Medicine Transformation Programme alongside our existing Emergency Care Transformation Programme. The Trust also launched its Stronger Together campaign to drive improvement in Urgent and Emergency Care across the Organisation. There has also been a continued reduction of the number of patients with 'No Criteria to Reside' (NCTR) in an acute hospital bed. However, these improvements have not alleviated the pressures across the emergency and urgent care pathway sufficiently to meet the required performance standards. The CQC report published in May 2024, also highlighted that significant improvements are required across the urgent and emergency care pathway to improve patient experience with a number of 'requires

improvement' and 'inadequate' ratings across both hospital sites. Improvement actions are in place and progress against these is tracked each month.

We continue to face significant pressures, particularly within our Emergency Departments, and this is impacting on the experience of our patients and the wellbeing of colleagues. Plans are in place for 2025/26, working with system partners to improve waiting times and patient experience.

The first half of 2024/25 was challenging on elective waiting times. The referral to treatment waiting list grew significantly and capacity did not match demand resulting in a deteriorating performance position. Despite the challenges, through quarter 3 and quarter 4 of 2024/25 positive progress was made, including:

- Theatres - increased number of core theatre lists, including children's surgery lists.
- Reinstated elective orthopaedic joint replacement lists – first day-case hip patient achieved, reducing hospital stays.
- Significant progress on reducing elective waiting lists; and in top quartile of Trusts nationally for day case activity.
- Access to diagnostics – DM01 March performance was 78.2%. Increased performance in targeted modalities including MRI, NOUS, flexi-sigmoidoscopy, cystoscopy and gastroscopy.

At year-end we have reduced the number of patients waiting over 65 weeks to less than 30, whilst being on track to reach zero by June 2025.

Cancer performance has remained a challenge throughout 2024/25 and at year-end, we fell short of the national targets set for the 28-day Faster Diagnosis Standard (FDS), 62-day and 104-day backlog indicators. A cancer improvement team is now in place with an intensified focus on access to diagnostics and pathway redesign.

Information on our performance during the year can be found in more detail within the Performance Report section of the annual report.

### c) Financial performance

The Trust set a deficit plan of £44.3m for the financial year (FY) 24/25 which was converted into a breakeven plan by NHS England providing non-recurrent funding of £44.3m to match the deficit plan. At the time of finalising the plan for FY24/25, a number of significant risks were identified in relation to the continued use of escalation areas, the costs of temporary workforce, the scale of the efficiency programme and the cost of delivery of the activity plan.

Against the breakeven plan, the Trust recorded a full year retained deficit of £24.0m, a significant variance from plan. At the end of month 11 (February) FY24/25, the Trust formally reported and agreed a revised forecast with NHSE of £18.2m, that reflected the risks that were being carried by the Trust. The full year retained deficit of £24.0m was not in line with this revised forecast as a result of the abandonment of a build project which resulted in a £5.8m impairment charge

The underlying retained deficit for the Trust, i.e. (the financial position after the removal of one-off income support) was £78.5m at the end of the year. The Trust continues to track and monitor the underlying financial position, ensuring that the impact on the underlying financial position is considered when making decisions to commit expenditure.

The main drivers of the FY24/25 deficit were the use of additional escalation capacity to help prevent overcrowding in the emergency departments and to cope with the pressures on services, the use of temporary staffing in the escalation areas, cover for staff who were unavailable to work due to sick leave, study leave and parenting leave, and income slippage for the funding of insourcing within Endoscopy to support delivery of performance targets.

The cost of this escalation over the FY24/25 financial year was £18.0m (compared to plan of £9.6m. The FY24/25 plan was £19.0m less than FY23/24, where the total escalation cost was £28.6m) and, as such, is the largest driver of the deterioration in the Trust's financial position.

Whilst the Trust took a risk-based approach to planning for FY24/25, the extent to which the risk materialised was significant and the mitigation insufficient.

In planning for the new financial year, the Trust has agreed to a stretching financial plan with a planned efficiencies of £41.4m (6.4%). The Trust remains committed to the delivery of high-quality services reflecting the needs of the population and the importance of balancing the delivery of high-quality care, workforce demands, operational pressures, and financial resources.

There are several significant risks to the delivery of the FY25/26 plan. In particular, the need to significantly reduce reliance on escalation capacity, the associated dependency on expensive temporary workforce and overall workforce reduction.

The Trust is committed to strengthening partnership working across health and care, and several of the critical actions to improve the financial performance are dependent upon these collaborative arrangements.



A key objective for FY24/25 was to continue to strengthen budget holder engagement and education, and to harness this to deliver the increased efficiency requirement. As a result of this there has been significant improvements made during the year to reduce premium workforce costs including the elimination of off-framework nursing agency and HCA agency unrelated to the provision of escalation capacity. The agency budget for FY24/25 was £15.1m (£10.7m for 'business as usual' and £4.4m for escalation) but the Trust spent £19.4m with the overspend being fully driven by additional escalation costs to plan.

In FY23/24, the Trust spent the annual equivalent of £31.0m at the end of March 2024 (the 'exit run rate'), with this reducing to £12.0m by the end of March 2025. Further reductions are expected in FY25/26 with the agency plan set at £9.1m.

The Trust also delivered its largest capital programme of £69.2m during the financial year, which included £52.4m of nationally funded developments including the Hospital Transformation Programme at Royal Shrewsbury Hospital.

There focus on training and engagement of finance staff, following the achievement of Future Finance Focused level two accreditation will continue into FY25/26. The Trust is continuing to work towards level three and build on its success of gaining two Healthcare Financial Management Association (HFMA) Awards in December 2024.

#### d) Regulatory Fire Issues - Regulatory Reform (Fire Safety) Order, 2005

The Trust is currently subjected to two legal notices under the above legislation:

- Enforcement Notice EN255
- Alterations Notice No 306

Regarding EN255 (focus on the physical environment), this Notice had a completion deadline of 31<sup>st</sup> March 2023. We have completed all the regulatory requirements in the Notice except for the physical intrusive works on the Wards in the Ward Block at the Royal Shrewsbury Hospital. A full compartmentation survey has been carried out on the Protected Means of Escape (stairwells and lift lobbies), these firestopping works were completed during April 2025. Protection Officers from Shropshire Fire & Rescue Service (SFRS) audited the Ward Block on 30<sup>th</sup> April 2025. It is anticipated, that EN255 will be withdrawn, and that a further Enforcement Notice will be issued solely for the Compartmentation Issues in the Ward Block Wards. SFRS have been regularly informed of our progress with regular visits, and meetings, on site to review progress.

The Trust also received an Alterations Notice, Serial No. 306 on 02 September 2024 regarding restriction to use of Hollinswood House. This notice states:

*'You must notify this authority (Fire Authority) before you:  
Change the use of the premises to provide care for bariatric patients on floor one, two or three.  
Please note that the ground floor is unaffected by this notice.'*

This notice will remain active for the life of the building whilst occupied by the Trust.

The Board has continued to receive regular direct updates on the position with fire safety during 2024/25. In March 2025, the Board received the Annual Fire Safety Audit Report that was carried out by the Trust's Authorising Engineer (Fire). Delivery of the action plan is overseen by the Fire Audit Action Plan Oversight Group which is chaired by the Assistant Chief Executive and meets monthly.

#### e) Update on implementing the recommendations of the independent review of maternity services

The Independent Review of Maternity Services at the Trust, chaired by Mrs Donna Ockenden, examined cases arising mainly between 2000 and 2019, involving 1,486 families and the review of 1,592 clinical incidents.

The first Ockenden report<sup>1</sup> was published in December 2020, and was followed by the final report<sup>2</sup>, which was published in March 2022. These reports highlighted significant failings in maternity care at the Trust.

The Review found repeated failures in the quality of care and governance, as well as failures of external bodies to effectively monitor the care provided. These failures included there not being enough suitably experienced staff, a lack of ongoing training, a lack of investigation and governance at the Trust, and a culture of not involving nor listening to the families involved.

The combined reports included 210 actions: 93 'Local Actions for Learning' to be implemented solely by the Trust, and 117 'Immediate and Essential Actions' for implementation of all providers of maternity care in England.

Based on a rigorous assurance validation process, progress with delivering the actions on 11 March 2025, is, as follows (rounded percentages):

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<sup>1</sup> Ockenden Review (December 2020), Emerging Findings and Recommendations from the Independent Review of Maternity Services at Shrewsbury and Telford NHS Trust.

<sup>2</sup> Ockenden Review (March 2022), findings Conclusions and Essential Actions from the Independent Review of Maternity Services at Shrewsbury and Telford NHS Trust; Our Final Report

190/210 (90.5%) have been delivered fully and evidenced and assured as working as they should be. Of the remainder:

- 12/210 (5.7%) actions are on track to be delivered within their expected timeframes, with none at risk.
- 1/210 (0.5%) is 'off track' but will revert to being on track and delivered pending ongoing substantive recruitment.
- 7/210 (3.3%) actions are de-scoped. This means they are outside of the Trust's control to deliver, and they are dependent upon the actions of third parties, such as NHS England or the Care Quality Commission. These continue to be reviewed with the respective agencies.

After the publication of the Independent Maternity Review report, the Executive Medical Director commissioned the Royal College of Physicians (RCP), supported by other royal colleges, to undertake an independent review of the neonatology service at the Trust. This was to ascertain if any aspects of care provided at the Trust influenced its higher-than-average perinatal mortality rate, specifically neonatal deaths. The review team did not identify evidence to indicate that the quality of care provided to babies by the neonatal services was substandard or directly contributing to the unit's outlier status in terms of perinatal mortality. Whilst identifying aspects of good care, the review also found examples of poor care and made recommendations for the Trust to improve the care provided in the future. Good progress is being made implementing the recommendations. In response to this review, the Maternity Transformation Assurance Committee (MTAC) has been expanded to include overseeing the governance and assurance of the delivery of the required actions. This is now the Maternity and Neonatal Transformation Assurance Committee (MNTAC), which reports to the Quality, Safety, and Assurance Committee (QSAC), which is a committee of the Board of Directors. The Board has in place a Non-Executive Director Maternity and Neonatal Safety Champion, Wendy Nicholson MBE.

The Integrated Maternity and Neonatal Report continues to report to the Board of Directors each time it meets in public. The report comprises progress against actions from the Independent Maternity Review, the commissioned Neonatal Review, and matters such as the Clinical Negligence Scheme for Trusts (CNST, which manages all clinical negligence claims against member NHS bodies), and the Three-Year Delivery Plan for maternity services.

By February 2025, the Trust declared full compliance with year six of the Clinical Negligence Scheme for Trusts safety actions and delivered fully on all elements of the Saving Babies Lives Care Bundle (version Three) by the end of March 2024.

The CQC maternity survey 2024 results were generally positive for the Trust and its service users. There are some areas of improvement required, and the Trust is working alongside the Maternity and Neonatal Voices Partnership to address these.

The achievement of all these quality and safety initiatives will assist the Trust to mitigate the maternity risks highlighted within this Annual Governance Statement and Annual Report. Also, notwithstanding the improvements made, there is still further work to do to continue to improve, engage effectively with service users and families, and assure the care and services we deliver to women and families.

Finally, West Mercia Police continues to investigate allegations of poor maternity care at the Trust, entitled Operation Lincoln. The independent police investigation is exploring whether there is evidence to support a criminal case against the Trust or any individuals involved. The Trust continues to co-operate fully with the investigation.

#### f) Political NHS Landscape

The new NHS regulatory landscape is set to bring significant changes to healthcare across the UK. This regulatory shift aims to improve patient safety, enhance the quality of care, and ensure greater financial accountability within the NHS. However, with the introduction of stricter compliance measures and increased enhanced oversight, SaTH will need to adapt to new ways of working, increased use of digital and additional innovation, to ensure it meets the new standards and regulatory targets.

### **6. Statement of Emergency Preparedness Resilience and Response (EPRR) Performance**

In line with the requirements as a Category 1 Responder under the Civil Contingencies Act (2004), and the responsibilities set out in the Health and Care Act (2022), NHS Act (2006) and the NHSE Core Standards for emergency preparedness, resilience and response guidance as described within the NHSE EPRR Framework (2022), the Shrewsbury and Telford Hospital NHS Trust needs to demonstrate and be able to plan for, and respond to a range of incidents and emergencies, using a risk-based approach.

The Trust must have an Accountable Emergency Officer (AEO) who is a board level director and responsible for EPRR in the organisation; this responsibility has been assigned to the Chief Operating Officer, who is supported by a non-executive board member.

The Trust continues to comply with its statutory commitments to Emergency Preparedness Resilience and Response (EPRR) and this commitment can be quantified during the completion of the annual NHS EPRR Core Standards Assurance process whereby the trust self-assesses itself against 62 criteria. This is subsequently followed up with a *confirm and*

*challenge* process alongside NHS England and the Integrated Care Board. In 2024, the Trust was assessed as “partially compliant” overall, reflecting that 51 of the Core Standards were assessed as “fully compliant” and 11 of the standards assessed as “partially compliant”. The Trust submitted a large amount of evidence in support of the submission on 31 August 2024 which was rigorously scrutinised by NHS England. The Trust has identified several areas for improvement as a result of the learning from the new process, and the Emergency Planning Team have developed a detailed work programme to support its 2025 submission.

The focus for 2024/25 has been to ensure that all necessary EPRR response plans are reviewed, updated and re-established in line with national guidance best practice. The Trust regularly facilitates and participates in EPRR activities on a local and regional footprint, including testing and exercising of our plans and procedures whilst maintaining a robust training and debriefing to ensure all lessons learned are captured and inform improvements to our processes.

## **7. NHS Provider Licence section 4 (governance)**

The NHS Provider Licence is the main tool for regulating providers of NHS services. Several additional undertakings applied during 2021-22 to the Trust by NHSI/E, increased the number of requirements with which to comply.

Oversight of all NHS trusts, NHS foundation trusts and Integrated Care Boards is undertaken by NHS England using the *NHS Oversight Framework*. Following the publication of the *Code of Governance for NHS Providers* which applied to all NHS Trusts from 1 April 2023, the Trust adheres to the Code on a ‘comply or explain’ basis.

The Board has undertaken a review of its Standing Orders, Scheme of Reservation and Delegation and Standing Financial Instructions during the year, along with reviewing the terms of reference of its committees. With reference to the requirements of the Trust’s Standing Orders and Standing Financial Instructions, no gaps in legal compliance have been identified during the year.

## **8. Fit and Proper Person Framework and Board effectiveness**

All voting and non-voting executive and non-executive board members of the Trust are subject to the NHS England Fit and Proper Person Test (FPPT) Framework (the Framework). Overall accountability for adherence to the framework, remains with the Trust Chair, whilst the Company Secretary is responsible for carrying out the actions set out in the Framework, which was rolled out during 2023-24, including the refresh of the Trust’s Fit & Proper Person Policy.

As part of the directors’ appraisal process, the Leadership Competency Framework, which

was published in 2024, is also utilised.

The Board intends to undertake an external independent Well Led review at an agreed time.

## **9. Committees of the Board**

The principal board assurance committee structure which discharges overall responsibilities for risk management is summarised below:

- The Board of Directors is responsible for establishing principal strategic and corporate objectives and for driving the organisation forward to achieve these. It is also responsible for ensuring that effective systems are in place to identify and manage the risks associated with the achievement of these objectives through the Board Assurance Framework and the Corporate Risk Register.
- The Audit and Risk Assurance Committee (ARAC) is responsible for the review and providing assurance to the Board of Directors of the overall governance, risk management and internal control procedures of the organisation's activities, including oversight of the integrity of the financial statements.
- The Quality and Safety Assurance Committee (QSAC) is established to seek and obtain evidence of assurance on the effectiveness of the Trust's clinical quality and safety governance structure, systems, and processes and the quality and safety of the services provided to achieve consistently high-quality effective care, ensure continuous improvement and to meet legal and regulatory obligations.
- The Finance Assurance Committee (FAC) is responsible on behalf of the Board of Directors for objective scrutiny and seeking evidence of assurance of the Trust's financial performance plans, major investment decisions, capital plans and relevant regulatory compliance. It provides the Board with an objective review of the financial position of the Trust and assurance on the delivery of the Trust's financial objectives, including identifying any significant risks and associated mitigating actions. It also considers processes for the preparation and the content of strategic and operational financial plans, including annual revenue, capital and workforce budgets, and test the key assumptions and risks underpinning such plans.
- The Performance Assurance Committee is responsible for providing independent assurance to the Board of Directors regarding: - the development and delivery of the Trust's annual business plan; performance of the Trust across a range of performance indicators within the Integrated Performance Report; and to ensure appropriate Estates and Digital strategies are

in place. It also oversees the development of a long-term strategy that addresses all identified operational business risks and opportunities, including those deriving from partnership work.

- The People & Organisation Development Assurance Committee receives assurances that staffing processes are safe, sustainable, and effective and that the NHS People Promises are being delivered.
- The Hospitals Transformation Assurance Committee is responsible for providing independent assurance to the Board of Directors regarding the processes, procedures, and management of the Hospitals Transformation Programme (HTP) and associated work to support the successful achievement of the HTP Investment Objectives and realisation of the stated benefits.

Risk assessment is a key feature of all 'business-as-usual' management processes. All areas of the Trust have an ongoing programme of risk assessment which inform local risk registers. Operational risks are identified and evaluated using a five-by-five risk matrix, which feeds into the risk appraisal process. The risk registers are reviewed regularly through governance structures at both operational and corporate level, dependent on the severity of each risk. Each risk and related action have an identified owner who is responsible for risk monitoring, reporting and for implementing actions to mitigate the risk within a specified period.

The Board of Directors is responsible for the approval of the Trust's Risk Management Strategy. The strategy describes an integrated approach to ensure that all risks to the achievement of the Trust's objectives are identified, evaluated, monitored and managed appropriately. It defines how risks are linked to one or more of the Trust's strategic or operational objectives, and clearly defines the risk management structures, accountabilities, and responsibilities throughout the Trust.

The Board Assurance Framework (BAF) is the mechanism which is used to identify and monitor the Trust's strategic objectives/goals and manage the associated risks that may compromise their achievement. The BAF is reviewed on a quarterly basis by the Executive Directors and is formally reviewed quarterly by board assurance committees and the Board of Directors.

Operational and other corporate risks categorised as 'extreme' risks, are also reviewed by the Audit and Risk Assurance Committee as part of its regular monitoring of risk management. To aid this, the Trust's Corporate Risk Register was introduced during December 2023 and continues to be used.

## **10. Workforce, general compliance matters and equality, diversity and inclusion**

The Trust's People Strategy sets out its workforce priorities and plans aligned with the Trust's organisational strategy. As part of the annual business planning cycle an annual workforce planning process is run to triangulate staffing with predicted activity levels and finance plans.

Divisional level plans are aggregated to form an overall Trust plan, with strategies and business cases to close potential workforce shortfalls considered through the relevant committees.

Workforce metrics are monitored regularly to ensure safe staffing levels. Local and Trust-wide strategies are in place to support the recruitment and retention of staff as well as to reduce our reliance on temporary staff.

Longer-term workforce plans include the consideration and implementation of new roles, such as Operating Department Practitioners, Health Care Support Workers and Nursing Associate roles within the appropriate governance frameworks.

To ensure staff have the right skills commensurate with their role, a wide range of training and development is provided both Trust-wide and within divisions. Ongoing training requirements are monitored through annual appraisal and revalidation, performance development review and monthly statutory and mandatory training reports. Staffing levels are reviewed regularly, and e-rostering systems are in place for nursing and medical staff.

Staffing levels are managed to ensure resources are deployed for optimum efficiency considering patient acuity. In accordance with the 'Developing Workforce Safeguards. The Trust has a number of workforce controls in place to reduce reliance on agency staff; for example, local sign-off on the use of agency staff and restrictions on usage for specific groups and bands of staff, depending on safe staffing levels.

Key performance indicators are reviewed monthly at Trust, Division and cost centre level. The Trust regularly reviews 'Model Hospital' metrics to ensure safe staffing levels and to benchmark workforce productivity, including skill mix and staff costs per weighted activity unit.

The Shrewsbury and Telford Hospital NHS Trust is required to register with the Care Quality Commission (CQC). The Trust is not fully compliant with the registration requirements of the CQC and the current conditions which have been imposed are described earlier in this statement within its major risks.

The trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the trust with reference to the guidance)



within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

The Trust made the process of declaring interests easier for staff from 02 May 2023 via the use of the Electronic Staff Record (ESR). By 31 March 2024, the Trust had achieved 80% compliance with declarations within the ESR by those classed as 'decision makers', in line with the requirements of the Counter Fraud Authority Standard. This performance has continued during 2024/25.

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 into 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.

Control measures are in place to provide assurance that all obligations under equality, diversity and human rights legislation are complied with. This includes Workforce Race Equality Standard Workforce Disability Equality Standard, Equality Impact Assessments and People Strategy objectives.

One of the Trust's key enablers to the organisation objectives in 2024/25 is to live the people promise in our teams through valuing difference and inclusion. However, we recognise that we have more to do which includes:

- Commissioning development programmes for leaders and developing positive pathways offer similar to our Galvanise programme for career development of staff with protected characteristics.
- Undertaking continuous Trust-wide engagement on current issues and listening to the experiences of our staff.
- Developing the maturity of staff networks and working together to co-create and action work across the Trust.
- Supporting divisions to embed inclusive practices and behaviours with associated action plans and accountability with clear governance by the People & OD Assurance Committee and Trust Board.
- Ensuring equality objectives are in place for all leaders.
- Refreshing people processes to eliminate bias and structural barriers.
- Ensuring all new policies, hospital transformational work, or changes to buildings and space have completed an equality impact assessment.

The trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme. The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. Further information on climate change and sustainability can be found within the Sustainability Report and climate disclosures within the Annual Report.

## **11. Review of economy, efficiency, and effectiveness of the use of resources**

The Board of Directors and its assurance committees have a key role in review of the effective use of resources. The Board of Directors retains oversight of the overall business/operating planning process, budgets and use of staffing resources and establishment.

The Finance Assurance Committee meets monthly and has a key role in review of investment decisions, and monthly financial performance, providing assurance to the Board of Directors. The Performance Assurance Committee meets monthly and has a key role in review of operational performance matters, providing assurance to the Board of Directors.

In 2024/25, the Audit and Risk Assurance Committee focused on the effectiveness of controls in relation to a number of areas which were the focus of internal audit reviews (as detailed later within this report). The Committee also played a crucial role in overseeing the integrity of financial reporting, and the independence and performance of the external auditors.

The Quality and Safety Assurance Committee has provided assurance to the Board of Directors on efficient and effective quality of patient care. The Committee monitored progress against the Trust's quality improvement plan and key safety metrics.

Internal and external auditors provide assurance in respect of the internal control environment and the use of the organisation's resources. Audit findings and recommendations are monitored and progressed by operational committees and the Audit and Risk Assurance Committee has an overarching overview for assurance purposes through the internal audit progress reports.

Any internal audit report which offers *Limited* assurance results in the development of a management action plan with an agreed timescale for improvement, and progress is monitored by the Audit and Risk Assurance Committee. Serious issues are escalated to the Board of Directors.

The governance structure at Executive level and below provides opportunities for specific divisions, service lines and departments to be challenged on their efficient, effective and economic use of resources within the respective services which they provide. All budget

holders are provided with monthly financial information to help them ensure resources are used economically, efficiently and effectively.

## **12. Information Governance**

The Trust has an established process for managing the Information Governance agenda, led by the Director of Governance (Trust Senior Information Risk Owner), the Medical Director as Caldicott Guardian, and supported by a Data Protection Officer, who is also the Head of Information Governance.

The Trust uses NHSE's Data Security and Protection Toolkit (DSPT) to measure performance, and improvements over the previous year have been noted, although the Trust continues to work through its agreed improvement plan with NHSE. The Trust aims to submit its 2023/24 submission by the end of June 2024. The Trust submitted its 2023/24 submission in June 2024 (Standards Met). We have submitted the latest DSPT (Cyber Assessment Framework (CAF) aligned with the DSPT 2024/25) to our lead auditors and are awaiting sight of the report.

The Information Governance Committee's purpose is to support and drive the broader information governance agenda and to provide the Board of Directors with the assurance that effective information governance best practice mechanisms are in place within the organisation. It is responsible for monitoring and controlling risks relating to data security and to sign off the Data Security and Protection Toolkit (DSPT) submissions.

The Trust reported one incident to the Information Commissioners Office between 1<sup>st</sup> April 2024 to 31<sup>st</sup> March 2025 relating to inappropriate access to patient system(s).

The Trust manages threats to cyber security on an ongoing basis. Frequent reports of progress in implementing recommendations regarding nationally circulated cyber security threat information is issued by NHS England to a few senior leaders in the organisation, with a role to oversee the oversight of cyber threats and management of cyber risks to the organisation. An annual 'Penetration Test' is undertaken by an external party, which provides assurance and recommendations for improvement as to any vulnerabilities appearing within the Trust's systems.

## **13. Data Quality and governance**

Data quality remained a key focus area for the Trust in 2024/25, especially with the implementation of the new Patient Administration System (PAS) Careflow, which necessitated an additional layer of data quality scrutiny.

The Data Quality Group has been re-established following the PAS implementation and continues to provide the strategic direction for data quality and oversee and gain assurance

on the quality of the data within the Trust's Patient Administration System and any other system which directly affects key standards (e.g., A&E, maternity), patient safety or financial sustainability.

The recovery agenda across both elective and emergency pathways has brought extra scrutiny to the quality of data within the Trust and both our waiting list and emergency care data have improved considerably in 2024/25. The Data Quality Group will continue to work to ensure processes are appropriately implemented to ensure key patient data is fit for purpose, quality-assured and valid. This will be done through specific focus metrics and milestones for improvement, which will be reported through to the monthly Performance Review Meetings to ensure the focus remains on having robust data for our patients.

The integrated performance report is shared with the Board monthly. The document continues to be developed in response to the requirements of the organisation.

The Trust has experienced considerable challenges with the technical structure of our internal data warehouse and the ability to generate an accurate activity and income position. Despite various attempts to rectify issues, the Trust took the decision to cease national submissions that relate to Secondary Uses Service (SUS) and Service Level Agreement Monitoring (SLAM) until a time when assurances could be made that the data provides a true reflection of our position.

The impact of pausing the data submissions was considerable both internally and wider across the region, so it was imperative that an alternative data warehouse/reporting solution was put in place. It is anticipated that the Trust will be able to resume national reporting with submission of April 2025 data as well as make a retrospective submission of the data for the whole of financial year 2024/25 in May 2025.

#### **14. Review of effectiveness**

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within The Shrewsbury and Telford Hospital NHS Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board of Directors and the Audit and Risk Assurance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board of Directors and its committees have met regularly and kept arrangements for internal control under review through discussion and approval of policies and practice and monitoring of outcomes agreed as indicators of effective controls. The Board and its committees review the Integrated Performance Report monthly, which covers the key national priority and regulatory indicators and locally derived key performance indicators. The report provides more detailed briefings on any areas of adverse performance. This report is supplemented by several more granular reports reviewed by board committees, and regular performance review meetings with the Divisions. The selection of appropriate metrics is subject to regular review, with changes in definitions or strategic priorities reflected in the selection.

Internal and external auditors provide assurance in respect of the internal control environment and the use of the organisation's resources. Audit findings and recommendations are monitored and progressed by the committees of the Board and the Audit and Risk Assurance Committee has an overarching overview for assurance purposes through the internal audit progress reports.

The purpose of the Head of Internal Audit Opinion is to contribute to the assurances available to the Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control. The opinion has assisted in the preparation of this Annual Governance Statement.

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Board Assurance Framework and on the controls reviewed as part of the internal audit work. The Head of Internal Audit opinion for 2024-25 gave an overall **Substantial Assurance** opinion on the system of internal control in place during the year:

**"The overall opinion for the period 1st April 2024 to 31st March 2025 provides Substantial Assurance, can be given that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently."**

Issues relating to the formulation of the opinion included work conducted through the risk based internal audit plan for 2024/25, as can be seen in the following table:

Opinion provided	Title of core and risk-based reviews issued
0 <b>high</b> assurance opinions:	-
3 <b>substantial</b> assurance opinions:	Key Financial Systems. Conflicts of Interest. Freedom to Speak Up.
3 <b>moderate</b> assurance opinions:	Bank and Agency. Divisional Risk Management. Technical Review Medical Devices.
2 <b>limited</b> assurance opinions:	Waiting List Management – Patient Initiated Follow Up (PIFU). National Cost Collection.
Nil <b>no</b> assurance opinions	-
0 reviews without an assurance rating	-

The Assurance Framework internal audit opinion for the period 1st April 2024 to 31st March 2025 was as follows:

Opinion	
Structure	“The organisation’s AF is structured to meet the NHS requirements of assurance best practice model.”
Risk Appetite	“The organisation considers risk appetite regularly and the risk appetite is used to inform the management of the AF.”
Engagement	“The AF is visibly used by the organisation, but assurance reporting via the Quadruple A Chair Key issues reports to Board should be strengthened.”
Quality & Alignment	“The AF clearly reflects the risks discussed by the Board.”

The Data Security and Protection Toolkit (DSPT) internal audit opinion on the validity of the organisation’s intended final DSPT submission was as follows:

<b>Assessment of Self-Assessment</b>	
In our view, the organisation's self-assessment against the Toolkit deviates only minimally from the Independent Assessment and, as such, the assurance level in respect of the veracity of the self-assessment is:	<b>Substantial Assurance</b>
<b>National Data Guardian Standards</b>	
Across the National Data Guardian Standards our assurance rating is based on a mean risk rating score at the National Data Guardian (NDG) standard level. Scores have been calculated using the guidance from the independent assessment Guidance document. As a result of this our overall assurance level across all 10 NDG Standards is rated as:	<b>Moderate Assurance</b>

A report was produced at the conclusion of each audit assignment and, where scope for improvement was found, recommendations were made, and appropriate action plans agreed with management. 39 recommendations were raised during the year relating to the risk-based audits, all of which were accepted by management. None of the recommendations were critical, but five were high risk recommendations; one high risk recommendation for each of the following reviews: Bank and Agency; Divisional Risk Management; Technical Review Medical Devices; Waiting List Management - Patient Initiated Follow Up (PIFU); and National Cost Collection.

My review as Accountable Officer is also informed by:

- Opinion and reports from our external auditors
- Financial accounts and systems of internal control
- Matters brought before the Board of Directors, and Board Assurance Committees
- Trust risk registers
- In-year submissions against performance to NHS England
- Department of Health and Social Care performance requirements/ indicators
- Compliance with the Care Quality Commission essential standards for quality and safety for all regulated activities
- Progress against the information governance assurance framework including the Data Security and Protection Toolkit
- Investigation reports and action plans following serious incidents (RALIG)
- The work of the Trust's Anti-Fraud Specialist who carries out a detailed work plan and specialist investigations.

## 15. Conclusion

As the Accountable Officer, I am reporting that there are **no significant internal control issues** that have been identified for 2024/25 year.

However, as highlighted above, there are several significant risks which may affect delivery of the Trust's objectives, which are reflective of the CQC's 'requires improvement' rating for the Trust, and the provision of NHS England's oversight through their Recovery Support Programme.

Formal action plans have been agreed to address the risks in all areas where these have been identified. Implementation of the recommendations are being tracked and reported to the Board of Directors, and regulators, on a continuing basis.

The system of internal control has been in place at the Trust for the year ended 31 March 2025 and up to the date of approval of the Annual Report and Accounts.

**Organisation:**

**The Shrewsbury and Telford Hospital NHS  
Trust**

**Signed by Accountable Officer/  
Chief Executive, Jo Williams**



**Date:**

**23 June 2025**



## Statement of Chief Executive's responsibilities as the accountable officer of the Trust

The Chief Executive of NHS England has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the *NHS Trust Accountable Officer Memorandum*. 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 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, other items of comprehensive income and cash flows for the year.

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

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.

Signed



**Jo Williams**

**Chief Executive**

23 June 2025

## Statement of directors' responsibilities in respect of the accounts

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

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

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

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

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS trust's performance, business model and strategy

By order of the Board;

**Signed by**



**Jo Williams**  
**Chief Executive**



**Adam Winstanley**  
**Acting Director of Finance**

23 June 2025

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

## **REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS**

### **Opinion**

We have audited the financial statements of The Shrewsbury and Telford Hospital NHS Trust ("the Trust") for the year ended 31 March 2025 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity and the Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2025 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State for Health and Social Care with the consent of HM Treasury on 23 June 2022 as being relevant to NHS Trusts in England and included in the Department of Health and Social Care Group Accounting Manual 2024/25; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

### **Basis for opinion**

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

### **Going concern**

The directors have prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to either cease the Trust's services or dissolve the Trust without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the directors' conclusions, we considered the inherent risks associated with the continuity of services provided by the Trust over the going concern period.

Our conclusions based on this work:

- we consider that the directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified, and concur with the directors' assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the Trust will continue in operation.

### **Fraud and breaches of laws and regulations – ability to detect**

#### *Identifying and responding to risks of material misstatement due to fraud*

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an

opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit and Risk Assurance Committee and internal audit and inspection of policy documentation as to the Trust's high-level policies and procedures to prevent and detect fraud including the internal audit function, and the Trust's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Assessing the incentives for management to manipulate reported financial performance as a result of the need to achieve financial performance targets delegated to the Trust by NHS England.
- Reading Board and Audit and Risk Assurance Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, and taking into account possible pressures to meet delegated targets, we performed procedures to address the risk of management override of controls in particular the risk that Trust management may be in a position to make inappropriate accounting entries. On this audit we did not identify a fraud risk related to revenue recognition due to the block nature of the funding provided to the Trust during the year, the simple recognition criteria and low individual value of other income streams. We therefore assessed that there was limited opportunity for the Trust to manipulate the income that was reported.

In line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we also identified a fraud risk related to non-pay expenditure (excluding depreciation), particularly in relation to completeness of year-end accruals. This fraud risk is in response to pressure to manipulate expenditure in order to report that the planned financial position has been met.

We performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included journals reducing expenditure in March 2025 and unexpected account combinations with revenue and cash.
- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias.
- Inspecting cash payments and expenditure transactions in the period following 31 March 2025 to assess whether expenditure had been recognised in the correct accounting period, and had not been materially understated.

*Identifying and responding to risks of material misstatement related to compliance with laws and regulations*

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the directors and other management (as required by auditing standards), and from inspection of the Trust's regulatory and legal correspondence and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

The Trust is subject to laws and regulations that directly affect the financial statements including the financial reporting aspects of NHS legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

As described in the section of this report dealing with other legal and regulatory matters, we made a referral to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 on 8 May 2025, relating to the Trust's failure to comply with its "breakeven duty" set out in paragraph 2(1) of Schedule 5 to the National Health Service Act 2006.

Whilst the Trust is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

#### *Context of the ability of the audit to detect fraud or breaches of law or regulation*

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

#### **Other information in the Annual Report**

The directors are responsible for the other information, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

#### **Remuneration and Staff Reports**

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared in all material respects, in accordance with the Department of Health and Social Care Group Accounting Manual 2024/25.

#### **Directors', Accountable Officer's and Audit and Risk Assurance Committee's responsibilities**

As explained more fully in the statement set out on page 135, the directors are responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to either cease the services provided by the Trust or dissolve the Trust without the transfer of their services to another public sector entity. As explained more fully in the statement of the Chief Executive's responsibilities on page 134, the Chief Executive as the Accountable Officer of the Trust, is responsible for ensuring that annual statutory accounts are prepared in a format directed by the Secretary of State.

The Audit and Risk Assurance Committee is responsible for overseeing the Trust's financial reporting process.

### **Auditor's responsibilities**

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at [www.frc.org.uk/auditorsresponsibilities](http://www.frc.org.uk/auditorsresponsibilities).

### **REPORT ON OTHER LEGAL AND REGULATORY MATTERS**

#### **Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources**

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

#### **Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources**

As explained in the statement set out on page 134, the Chief Executive, as the Accountable Officer, is responsible for ensuring that value for money is achieved from the resources available to the Trust. We are required under section 21(2A) of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We are also not required to satisfy ourselves that the Trust has achieved value for money during the year.

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

### **Statutory reporting matters**

We are required by Schedule 2 to the Code of Audit Practice to report to you if:

- we issue a report in the public interest under section 24 and Schedule 7 of the Local Audit and Accountability Act 2014; or
- we make written recommendations to the Trust under section 24 and Schedule 7 of the Local Audit and Accountability Act 2014; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We made a section 30 referral to the Secretary of State on 8 May 2025 in respect of the Trust's breach of its "breakeven duty" set out in paragraph 2(1) of Schedule 5 to the National Health Service Act 2006 for the year ended 31 March 2025.

We have nothing else to report in these respects.

## **THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES**

This report is made solely to the Board of Directors of The Shrewsbury and Telford Hospital NHS Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Board of Directors 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 Directors of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

## **DELAY IN CERTIFICATION OF COMPLETION OF THE AUDIT**

As at the date of this audit report, we are unable to confirm that we have completed our work in respect of the trust accounts consolidation pack of the Trust for the year ended 31 March 2025 because we have not received confirmation from the National Audit Office ("NAO") that the NAO's audit of the Department of Health and Social Care accounts is complete.

Until we have completed this work, we are unable to certify that we have completed the audit of the financial statements of The Shrewsbury and Telford Hospital NHS Trust for the year ended 31 March 2025 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the NAO Code of Audit Practice.



Andrew Cardoza  
**for and on behalf of KPMG LLP**  
*Chartered Accountants*  
One Snowhill  
Snow Hill Queensway  
Birmingham  
B4 6GH

26 June 2025

# Annual Accounts for the year ending 31 March 2025





The Shrewsbury And Telford Hospital NHS Trust

Annual accounts for the year ended 31 March 2025

## Statement of Comprehensive Income

		2024/25	2023/24
	Note	£000	£000
Operating income from patient care activities	2	675,319	585,825
Other operating income	3	48,746	38,497
Operating expenses	6,9	(741,826)	(671,315)
<b>Operating deficit from continuing operations</b>		<b>(17,761)</b>	<b>(46,993)</b>
Finance income	11	3,749	1,878
Finance expenses	12	(240)	(214)
PDC dividends payable		(9,323)	(10,855)
<b>Net finance costs</b>		<b>(5,814)</b>	<b>(9,191)</b>
Other gains / (losses)	13	(399)	(639)
Share of profit / (losses) of associates / joint arrangements	21	-	-
Gains / (losses) arising from transfers by absorption	44	-	1,680
Corporation tax expense		-	-
<b>Deficit for the year from continuing operations</b>		<b>(23,974)</b>	<b>(55,143)</b>
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations	15	-	-
<b>Deficit for the year</b>		<b>(23,974)</b>	<b>(55,143)</b>
<b>Other comprehensive income</b>			
<b>Will not be reclassified to income and expenditure:</b>			
Impairments	8	(5,441)	(2,281)
Revaluations	18	1,942	4,152
Share of comprehensive income from associates and joint ventures	21	-	-
Fair value gains / (losses) on equity instruments designated at fair value through OCI	22	-	-
Other recognised gains and losses		-	(1,662)
Remeasurements of the net defined benefit pension scheme liability / asset	38	-	-
Other reserve movements		-	-
<b>May be reclassified to income and expenditure when certain conditions are met:</b>			
Fair value gains/(losses) on financial assets mandated at fair value through OCI	22	-	-
Recycling gains/(losses) on disposal of financial assets mandated at fair value through OCI	13	-	-
Foreign exchange gains / (losses) recognised directly in OCI		-	-
<b>Total comprehensive income / (expense) for the period</b>		<b>(27,473)</b>	<b>(54,934)</b>
The accompanying notes form part of these financial statements.			
<b>Adjusted financial performance (control total basis):</b>			
Surplus / (deficit) for the period		(23,974)	(55,143)
Remove net impairments not scoring to the Departmental expenditure limit		6,978	3,760
Remove (gains) / losses on transfers by absorption		-	(1,680)
Remove I&E impact of capital grants and donations		(7,494)	(1,534)
Prior period adjustments		-	-
Remove non-cash element of on-SoFP pension costs		-	-
Remove impact of IFRS 16 on IFRIC 12 schemes		-	-
Remove net impact of inventories received from DHSC group bodies for COVID response		137	15
Remove loss recognised on peppercorn lease disposals		-	-
Remove loss recognised on return of donated COVID assets to DHSC		-	-
<b>Adjusted financial performance surplus / (deficit)</b>		<b>(24,353)</b>	<b>(54,582)</b>

## Statement of Financial Position

		31 March 2025 £000	31 March 2024 £000
	Note		
<b>Non-current assets</b>			
Intangible assets	15	24,658	21,996
Property, plant and equipment	16	394,007	358,881
Right of use assets	19	19,472	19,085
Investment property	20	-	-
Investments in associates and joint ventures	21	-	-
Other investments / financial assets	22	-	-
Receivables	25	1,828	1,847
Other assets	27	-	-
<b>Total non-current assets</b>		<b>439,965</b>	<b>401,809</b>
<b>Current assets</b>			
Inventories	24	10,108	9,911
Receivables	25	13,787	11,142
Other investments / financial assets	22	-	-
Other assets	27	-	-
Non-current assets for sale and assets in disposal groups	28.1	-	-
Cash and cash equivalents	29	61,518	54,680
<b>Total current assets</b>		<b>85,413</b>	<b>75,733</b>
<b>Current liabilities</b>			
Trade and other payables	30	(88,333)	(68,600)
Borrowings	32	(3,559)	(3,795)
Other financial liabilities	33	-	-
Provisions	34	(267)	(295)
Other liabilities	31	(4,141)	(1,405)
Liabilities in disposal groups	28.2	-	-
<b>Total current liabilities</b>		<b>(96,300)</b>	<b>(74,095)</b>
<b>Total assets less current liabilities</b>		<b>429,078</b>	<b>403,447</b>
<b>Non-current liabilities</b>			
Trade and other payables	30	-	-
Borrowings	32	(15,812)	(15,128)
Other financial liabilities	33	-	-
Provisions	34	(649)	(679)
Other liabilities	31	-	-
<b>Total non-current liabilities</b>		<b>(16,461)</b>	<b>(15,807)</b>
<b>Total assets employed</b>		<b>412,617</b>	<b>387,640</b>
<b>Financed by</b>			
Public dividend capital		636,537	584,087
Revaluation reserve		79,937	83,436
Financial assets reserve		-	-
Other reserves		-	-
Merger reserve		-	-
Income and expenditure reserve		(303,857)	(279,883)
<b>Total taxpayers' equity</b>		<b>412,617</b>	<b>387,640</b>

The accompanying notes form part of these financial statements.



Jo Williams  
Chief Executive Officer  
23 June 2025

## Statement of Changes in Taxpayers Equity for the year ended 31 March 2025

	Public dividend capital	Revaluation reserve	Financial assets reserve	Other reserves	Merger reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000	£000	£000
<b>Taxpayers' and others' equity at 1 April 2024 - brought forward</b>	<b>584,087</b>	<b>83,436</b>	-	-	-	(279,883)	<b>387,640</b>
Surplus/(deficit) for the year	-	-	-	-	-	(23,974)	(23,974)
Impairments	-	(5,441)	-	-	-	-	(5,441)
Revaluations	-	1,942	-	-	-	-	1,942
Public dividend capital received	52,450	-	-	-	-	-	52,450
<b>Taxpayers' and others' equity at 31 March 2025</b>	<b>636,537</b>	<b>79,937</b>	-	-	-	(303,857)	<b>412,617</b>

## Statement of Changes in Taxpayers Equity for the year ended 31 March 2024

	Public dividend capital	Revaluation reserve	Financial assets reserve	Other reserves	Merger reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000	£000	£000
<b>Taxpayers' and others' equity at 1 April 2023 - brought forward</b>	<b>415,207</b>	<b>81,423</b>	-	-	-	(222,936)	<b>273,694</b>
Surplus/(deficit) for the year	-	-	-	-	-	(55,143)	(55,143)
Other transfers between reserves	-	142	-	-	-	(142)	-
Impairments	-	(2,281)	-	-	-	-	(2,281)
Revaluations	-	4,152	-	-	-	-	4,152
Other recognised gains and losses	-	-	-	-	-	(1,662)	(1,662)
Public dividend capital received	168,880	-	-	-	-	-	168,880
<b>Taxpayers' and others' equity at 31 March 2024</b>	<b>584,087</b>	<b>83,436</b>	-	-	-	(279,883)	<b>387,640</b>

The accompanying notes form part of these financial statements.

## **Information on reserves**

### **Public dividend capital**

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

### **Revaluation reserve**

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

### **Financial assets reserve**

This reserve comprises changes in the fair value of financial assets measured at fair value through other comprehensive income. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure, unless the assets are equity instruments measured at fair value through other comprehensive income as a result of irrevocable election at recognition.

### **Merger reserve**

This legacy reserve reflects balances formed on previous mergers of NHS bodies.

### **Income and expenditure reserve**

The balance of this reserve is the accumulated surpluses and deficits of the trust.

## Statement of Cash Flows

		2024/25	2023/24
	Note	£000	£000
<b>Cash flows from operating activities</b>			
Operating surplus / (deficit)		(17,761)	(46,993)
<b>Non-cash income and expense:</b>			
Depreciation and amortisation	6	27,380	23,833
Net impairments	8	12,768	3,760
Income recognised in respect of capital donations	3	(8,463)	(2,548)
(Increase) / decrease in receivables and other assets		(1,645)	12,263
(Increase) / decrease in inventories		(197)	(137)
Increase / (decrease) in payables and other liabilities		23,950	(16,708)
Increase / (decrease) in provisions		(63)	(221)
<b>Net cash flows from / (used in) operating activities</b>		<b>35,969</b>	<b>(26,751)</b>
<b>Cash flows from investing activities</b>			
Interest received		3,749	1,878
Purchase of intangible assets		(4,284)	(7,555)
Purchase of PPE and investment property		(75,088)	(70,765)
Receipt of cash donations to purchase assets		8,463	561
<b>Net cash flows from / (used in) investing activities</b>		<b>(67,160)</b>	<b>(75,881)</b>
<b>Cash flows from financing activities</b>			
Public dividend capital received		52,450	168,880
Capital element of lease rental payments		(3,703)	(4,257)
Interest paid on lease liability repayments		(235)	(194)
PDC dividend (paid) / refunded		(10,484)	(10,418)
<b>Net cash flows from / (used in) financing activities</b>		<b>38,029</b>	<b>154,011</b>
<b>Increase / (decrease) in cash and cash equivalents</b>		<b>6,838</b>	<b>51,379</b>
<b>Cash and cash equivalents at 1 April - brought forward</b>		<b>54,680</b>	<b>3,301</b>
<b>Cash and cash equivalents at 31 March</b>	29.1	<b>61,518</b>	<b>54,680</b>

## **Notes to the Accounts**

### **Note 1 Accounting policies and other information**

#### **Note 1.1 Basis of preparation**

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2024/25 issued by the Department of Health and Social Care. The accounting policies contained in the GAM 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 GAM permits a choice of accounting policy, the accounting policy that 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 are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

#### **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.

#### **Note 1.2 Going concern**

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

The Board has carefully considered the principle of 'Going Concern' in the context of the Trust continuing to operate under the HM Treasury's Financial Reporting Guidelines (FRM). For the year ending 31 March 2025, the Trust is reporting a deficit of £23.974m on an adjusted financial performance basis, against a breakeven plan, supported by deficit funding of £44.3m.

The Trust maintained a cash balance of £61.518m at the end of 2024/25 (31 March 2024: £54.680m).

Every ICS/STP received a 2024/25 capital spending envelope derived from the system-level allocation, with The Shrewsbury and Telford Hospital NHS Trust receiving a total system envelope of £16.768m in 2024/25 (£18.429m in 2023/24). The 2024/25 system envelope includes a 10% reduction as per the NHSE Business Rules.

The Board of Directors have concluded that whilst the financial position for 2025/26 is very challenging, based upon enquiries with NHSE and the Department of Health and Social Care, they have a reasonable expectation that the Trust will have access to adequate resources (as in previous years) to continue in operational existence for at least 12 months from the date of approval of the financial statements and continue to provide services to its patients. Based on this expected continuation of services, the Trust continues to adopt the going concern basis in preparing the financial statements.

#### **Note 1.3 Interests in other entities**

##### **NHS Charitable Fund**

The Trust is the Corporate Trustee to the Shrewsbury and Telford Hospital NHS Trust Charity. The Trust has assessed its relationship to the charitable fund and determined it not to be a subsidiary because the Trust is not exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102.

#### **Note 1.4 Revenue from contracts with customers**

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

#### **Revenue from NHS contracts**

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS) which replaced the National Tariff Payment System on 1 April 2023. The NHSPS sets out rules to establish the amount payable to Trusts for NHS-funded secondary healthcare.

Aligned payment and incentive (API) contracts form the main payment mechanism under the NHSPS. In 2024/25 API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

High costs drugs and devices excluded from the calculation of national prices are reimbursed by NHS England based on actual usage or at a fixed baseline in addition to the price of the related service.

The Trust also receives income from commissioners under Best Practice Tariff (BPT) schemes. Delivery under this scheme is part of how care is provided to patients. As such, BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and accounted for as variable consideration under IFRS 15. Payment for BTP is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation.

Elective recovery funding provides additional funding to integrated care boards to fund the commissioning of elective services within their systems. In 2024/25, Trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the Trust contributes to system performance and therefore the availability of funding to the Trust's commissioners.

#### **Revenue from research contracts**

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

#### **NHS injury cost recovery scheme**

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, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.



## **Note 1.5 Other forms of income**

### **Grants and donations**

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

### **Apprenticeship service income**

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's apprenticeship service account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

## **Note 1.6 Expenditure on employee benefits**

### **Short-term employee benefits**

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement 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.

### **Pension costs**

#### *NHS Pension Scheme*

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

**Note 1.7 Expenditure on other goods and services**

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

**Note 1.8 Discontinued operations**

Discontinued operations occur where activities either cease without transfer to another entity, or transfer to an entity outside of the boundary of the Whole of Government Accounts, such as private or voluntary sectors. Such activities are accounted for in accordance with IFRS 5. Activities that are transferred to other bodies within the boundary of the Whole of Government Accounts are 'machinery of government changes' and treated as continuing operations.

## **Note 1.9 Property, plant and equipment**

### **Recognition**

Property, plant and equipment is capitalised where:

- 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 be provided to, the trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- 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 cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

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

### *Subsequent expenditure*

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

### **Measurement**

#### *Valuation*

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

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

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

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

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

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

## *Depreciation*

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

## *Revaluation gains and losses*

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

## *Impairments*

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised. Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

## **De-recognition**

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

## **Donated and grant funded assets**

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

### Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	4	67
Dwellings	12	44
Plant & machinery	4	27
Transport equipment	7	10
Information technology	3	10
Furniture & fittings	5	23

### Note 1.10 Intangible assets

#### Recognition

Intangible assets are non-monetary assets without physical substance controlled by the Trust. They are capable of being sold separately from the rest of the trust's business or arise from contractual or other legal rights. Intangible assets are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

#### *Internally generated intangible assets*

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

#### *Software*

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset where it meets recognition criteria.

#### Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

#### *Amortisation*

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

#### Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Information technology	5	12
Development expenditure	-	-
Websites	-	-
Software licences	3	10
Licences & trademarks	-	-
Patents	-	-
Other (purchased)	-	-

### **Note 1.11 Inventories**

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

The Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

### **Note 1.12 Investment properties**

Investment properties are measured at fair value. Changes in fair value are recognised as gains or losses in income/expenditure.

Only those assets which are held solely to generate a commercial return are considered to be investment properties. Where an asset is held, in part, for support service delivery objectives, then it is considered to be an item of property, plant and equipment. Properties occupied by employees, whether or not they pay rent at market rates, are not classified as investment properties.

### **Note 1.13 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. Cash, bank and overdraft balances are recorded at current values.

### **Note 1.14 Financial assets and financial liabilities**

#### **Recognition**

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

#### **Classification and measurement**

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at fair value through income and expenditure.

Financial liabilities classified as subsequently measured at fair value through income and expenditure.

#### **Financial assets and financial liabilities at amortised cost**

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

### **Financial assets measured at fair value through other comprehensive income**

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition.

### **Financial assets and financial liabilities at fair value through income and expenditure**

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive Income.

### **Impairment of financial assets**

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

### **Derecognition**

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

## **Note 1.15 Leases**

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

### **The Trust as a lessee**

#### *Recognition and initial measurement*

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.72% applied to new leases commencing in 2024 and 4.81% to new leases commencing in 2025.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

#### *Subsequent measurement*

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

### **The Trust as a lessor**

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. 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.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

#### *Finance leases*

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 to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

#### *Operating leases*

Income from operating leases is recognised on a straight-line basis or another systematic 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 as an expense on a straight-line basis over the lease term.



## Note 1.16 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2025:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	4.03%	4.26%
Medium-term	After 5 years up to 10 years	4.07%	4.03%
Long-term	After 10 years up to 40 years	4.81%	4.72%
Very long-term	Exceeding 40 years	4.55%	4.40%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2025:

	Inflation rate	Prior year rate
Year 1	2.60%	3.60%
Year 2	2.30%	1.80%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.40% in real terms (prior year: 2.45%).

## Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at Note 34.2 but is not recognised in the Trust's accounts.

## 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 NHS Resolution 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 when the liability arises.

## Note 1.17 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in Note 35 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 35, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

#### **Note 1.18 Public dividend capital**

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at <https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts>.

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

#### **Note 1.19 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.

#### **Note 1.20 Corporation tax**

The Trust is not required to pay corporation tax as it is an NHS trust and has no trading company.

#### **Note 1.21 Climate change levy**

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

#### **Note 1.22 Foreign exchange**

The functional and presentational currency of the trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items are translated at the spot exchange rate on 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

### **Note 1.23 Third party assets**

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

### **Note 1.24 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.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

### **Note 1.25 Gifts**

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

### **Note 1.26 Transfers of functions to or from other NHS bodies/local government bodies**

For property, plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

**Note 1.27 Early adoption of standards, amendments and interpretations**

No new accounting standards or revisions to existing standards have been early adopted in 2024/25.

**Note 1.28 Standards, amendments and interpretations in issue but not yet effective or adopted**

IFRS 17 Insurance Contracts - the effective date for IFRS 17 is now 1 April 2025 for NHS bodies.

**Note 1.29 Critical judgements in applying accounting policies**

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

Charitable Funds: Following Treasury's agreement to apply IAS 27 (Consolidation and Separate Financial Statements) to NHS Charities from 1 April 2013, The Shrewsbury and Telford Hospital NHS Trust has established that as the Trust is the Corporate Trustee of the linked NHS charity, it effectively has the power to exercise control so as to obtain economic benefits so therefore may have needed to consolidate its NHS Charity Accounts into its NHS Trust Accounts. The Trust has considered the income, expenditure, assets and liabilities of the NHS Charity to be immaterial in the context of the accounts of the NHS Trust and has not consolidated these into the Trust's accounts.

**Note 1.30 Sources of estimation uncertainty**

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

In the application of the NHS 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.

Provisions: Provisions are made from probable legal and constructive obligations of uncertain timings and amount as at the reporting date. These are based on estimates using relevant and reliable information as is available at the time the financial statements are prepared. These provisions are estimates of the actual costs of future cash flows and are dependent on future events. Any difference between expectations and the actual future liability will be accounted for in the period when such determination is made.

Pensions: The NHS Pensions Scheme provides cover for past and present employees, and is subject to a full valuation every five years (see note 10). The Trust carries provisions in certain instances relating to early retirement, based on latest actuarial information provided by the NHS Pensions Agency. This is therefore subject to change which is recognised in the period to which it arises.

Insurance: The Trust maintains insurance against potential legal claims, which are managed by NHS Resolution. The Trust makes provisions for the estimated excess liabilities due under this policy, in line with information provided by the NHS Resolution. Uncertainty in estimation may relate to the timing of potential settlements, although the liability to the Trust will be limited to the level of excess.

Revaluation: The Trust commissioned Cushman and Wakefield ('C&W') to undertake an interim valuation of the Trust's estate as at 31 March 2025. Specialised buildings are valued at Depreciated Replacement Cost defined as Modern Equivalent Asset.

Valuation of property, plant and equipment is based upon an assessment undertaken by professional property valuers which by its nature includes an element of subjectivity. It is impracticable to disclose the extent of the possible effects of an assumption or another source of estimation uncertainty at the end of the reporting period as there are a number of factors that can affect the valuation.

**Note 2 Operating income from patient care activities**

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

<b>Note 2.1 Income from patient care activities (by nature)</b>	<b>2024/25</b>	<b>2023/24</b>
	<b>£000</b>	<b>£000</b>
<b>Acute services</b>		
Income from commissioners under API contracts - variable element*	-	109,856
Income from commissioners under API contracts - fixed element*	563,773	393,785
High cost drugs income from commissioners	41,380	26,900
Other NHS clinical income	339	1,419
<b>All services</b>		
Private patient income	1,074	1,034
National pay award central funding***	1,220	234
Additional pension contribution central funding**	26,752	16,033
Other clinical income	40,781	36,563
<b>Total income from activities</b>	<b>675,319</b>	<b>585,825</b>

\*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2023/25 NHS Payment Scheme documentation.

<https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/>

\*\*Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.3% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%, 2023/24: 20.6%) and related NHS England funding (9.4%, 2023/24: 6.3%) have been recognised in these accounts.

\*\*\*Additional funding was made available directly to providers by NHS England in 2024/25 and 2023/24 for implementing the backdated element of pay awards where government offers were finalised after the end of the financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

**Note 2.2 Income from patient care activities (by source)**

	<b>2024/25</b>	<b>2023/24</b>
	<b>£000</b>	<b>£000</b>
<b>Income from patient care activities received from:</b>		
NHS England	63,118	91,446
Integrated care boards	569,464	454,234
Other NHS providers	339	1,129
Non-NHS: private patients	1,074	1,034
Non-NHS: overseas patients (chargeable to patient)	569	175
Injury cost recovery scheme	1,223	1,244
Non NHS: other	39,532	36,563
<b>Total income from activities</b>	<b>675,319</b>	<b>585,825</b>
<b>Of which:</b>		
Related to continuing operations	675,319	585,825
Related to discontinued operations	-	-

**Note 2.3 Overseas visitors (relating to patients charged directly by the provider)**

	2024/25	2023/24
	£000	£000
Income recognised this year	569	175
Cash payments received in-year	105	51
Amounts added to provision for impairment of receivables	468	85
Amounts written off in-year	8	40

**Note 3 Other operating income**

	2024/25			2023/24		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	1,455	-	1,455	401	-	401
Education and training	19,724	-	19,724	17,608	-	17,608
Non-patient care services to other bodies	1,936	-	1,936	2,576	-	2,576
Receipt of capital grants and donations and peppercorn leases	-	8,463	8,463	-	2,548	2,548
Charitable and other contributions to expenditure	-	-	-	-	190	190
Other income	17,168	-	17,168	15,174	-	15,174
<b>Total other operating income</b>	<b>40,283</b>	<b>8,463</b>	<b>48,746</b>	<b>35,759</b>	<b>2,738</b>	<b>38,497</b>
<b>Of which:</b>						
Related to continuing operations			48,746			38,497
Related to discontinued operations			-			-

**Note 4 Additional information on contract revenue (IFRS 15) recognised in the period**

	<b>2024/25</b>	<b>2023/24</b>
	<b>£000</b>	<b>£000</b>
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	1,405	297
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-	-



**Note 5 Operating leases - The Shrewsbury And Telford Hospital NHS Trust as lessor**

The Trust has no operating lease agreements where it is acting as the lessor.

**Note 6 Operating expenses**

	2024/25	2023/24
	£000	£000
Purchase of healthcare from non-NHS and non-DHSC bodies	222	2
Staff and executive directors costs	499,837	450,918
Remuneration of non-executive directors	180	158
Supplies and services - clinical (excluding drugs costs)	55,939	55,525
Supplies and services - general	8,486	6,794
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	61,199	56,291
Inventories written down	291	304
Consultancy costs	746	926
Establishment	6,587	9,962
Premises	32,767	34,267
Transport (including patient travel)	792	814
Depreciation on property, plant and equipment	23,184	20,718
Amortisation on intangible assets	4,196	3,115
Net impairments	12,768	3,760
Movement in credit loss allowance: contract receivables / contract assets	892	373
Increase/(decrease) in other provisions	111	159
Change in provisions discount rate(s)	3	(10)
Fees payable to the external auditor		
audit services- statutory audit	203	145
Internal audit costs	114	114
Clinical negligence	18,378	15,788
Legal fees	554	360
Insurance	102	114
Education and training	1,580	2,657
Variable lease payments not included in the liability	9,566	6,132
Car parking & security	1,961	970
Losses, ex gratia & special payments	20	25
Other	1,148	934
<b>Total</b>	<b>741,826</b>	<b>671,315</b>
<b>Of which:</b>		
Related to continuing operations	741,826	671,315
Related to discontinued operations	-	-

## Note 7 Other auditor remuneration

No other auditor remuneration was paid to the external auditor.

### Note 7.1 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1 million (2023/24: £5 million).

## Note 8 Impairment of assets

	2024/25 £000	2023/24 £000
<b>Net impairments charged to operating surplus / deficit resulting from:</b>		
Abandonment of assets in course of construction	5,790	-
Changes in market price	6,978	3,760
<b>Total net impairments charged to operating surplus / deficit</b>	<b>12,768</b>	<b>3,760</b>
Impairments charged to the revaluation reserve	5,441	2,281
<b>Total net impairments</b>	<b>18,209</b>	<b>6,041</b>

The Trust commissioned Cushman and Wakefield to undertake a desktop update valuation of the Trust's Estate as at 31 March 2025. The valuation has resulted in the following, classified under 'Changes in Market Price':

- impairments to the value of £8,473k have been charged to Statement of Comprehensive Income and previous impairments of £1,495k have been reversed, giving a net of impairments of £6,978k to Statement of Comprehensive Income;

- impairments of £6,196k have been charged to the Revaluation Reserve and previous impairments of £755k have been reversed, giving a net impairment of £5,441k to the Revaluation Reserve.

In addition, a further impairment of £5,790k resulting from an abandonment of a build project has been charged to Statement of Comprehensive Income.

**Note 9 Employee benefits**

	2024/25	2023/24
	Total	Total
	£000	£000
Salaries and wages	378,032	324,013
Social security costs	36,963	33,671
Apprenticeship levy	1,809	1,674
Employer's contributions to NHS pensions	67,663	52,956
Temporary staff (including agency)	19,662	41,349
<b>Total gross staff costs</b>	<b>504,129</b>	<b>453,663</b>
Recoveries in respect of seconded staff	-	-
<b>Total staff costs</b>	<b>504,129</b>	<b>453,663</b>
<b>Of which</b>		
Costs capitalised as part of assets	4,292	2,745

**Note 9.1 Retirements due to ill-health**

During 2024/25 there were 9 early retirements from the trust agreed on the grounds of ill-health (3 in the year ended 31 March 2024). The estimated additional pension liabilities of these ill-health retirements is £791k (£202k in 2023/24).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

## **Note 10 Pension costs**

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at [www.nhsbsa.nhs.uk/pensions](http://www.nhsbsa.nhs.uk/pensions). Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

### **a) Accounting valuation**

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 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 Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

### **b) Full actuarial (funding) valuation**

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

**Note 11 Finance income**

Finance income represents interest received on assets and investments in the period.

	2024/25	2023/24
	£000	£000
Interest on bank accounts	3,749	1,878
<b>Total finance income</b>	<b>3,749</b>	<b>1,878</b>

**Note 12.1 Finance expenditure**

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2024/25	2023/24
	£000	£000
<b>Interest expense:</b>		
Interest on lease obligations	235	194
<b>Total interest expense</b>	<b>235</b>	<b>194</b>
Unwinding of discount on provisions	5	20
<b>Total finance costs</b>	<b>240</b>	<b>214</b>

**Note 12.2 The late payment of commercial debts (interest) Act 1998**

	2024/25	2023/24
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	-	-
Amounts included within interest payable arising from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-

**Note 13 Other gains / (losses)**

	2024/25	2023/24
	£000	£000
Gains on disposal of assets	18	17
Losses on disposal of assets	(417)	(656)
<b>Total gains / (losses) on disposal of assets</b>	<b>(399)</b>	<b>(639)</b>
<b>Total other gains / (losses)</b>	<b>(399)</b>	<b>(639)</b>

**Note 14 Discontinued operations**

There are no discontinued operations.

**Note 15.1 Intangible assets - 2024/25**

	Software licences £000	Internally generated information technology £000	Intangible assets under construction £000	Total £000
<b>Valuation / gross cost at 1 April 2024 - brought forward</b>	<b>5,443</b>	<b>17,484</b>	<b>10,513</b>	<b>33,440</b>
Additions	762	2,938	2,949	<b>6,649</b>
Reclassifications	271	6,048	(6,110)	<b>209</b>
<b>Valuation / gross cost at 31 March 2025</b>	<b>6,476</b>	<b>26,470</b>	<b>7,352</b>	<b>40,298</b>
<b>Amortisation at 1 April 2024 - brought forward</b>	<b>2,147</b>	<b>9,297</b>	-	<b>11,444</b>
Provided during the year	826	3,370	-	<b>4,196</b>
<b>Amortisation at 31 March 2025</b>	<b>2,973</b>	<b>12,667</b>	-	<b>15,640</b>
<b>Net book value at 31 March 2025</b>	<b>3,503</b>	<b>13,803</b>	<b>7,352</b>	<b>24,658</b>
<b>Net book value at 1 April 2024</b>	<b>3,296</b>	<b>8,187</b>	<b>10,513</b>	<b>21,996</b>

**Note 15.2 Intangible assets - 2023/24**

	Software licences £000	Internally generated information technology £000	Intangible assets under construction £000	Total £000
<b>Valuation / gross cost at 1 April 2023 - as previously stated</b>	<b>4,930</b>	<b>15,717</b>	<b>8,749</b>	<b>29,396</b>
<b>Valuation / gross cost at 1 April 2023 - restated</b>	<b>4,930</b>	<b>15,717</b>	<b>8,749</b>	<b>29,396</b>
Additions	81	502	3,652	4,235
Reclassifications	432	1,265	(1,888)	(191)
<b>Valuation / gross cost at 31 March 2024</b>	<b>5,443</b>	<b>17,484</b>	<b>10,513</b>	<b>33,440</b>
<b>Amortisation at 1 April 2023 - as previously stated</b>	<b>1,405</b>	<b>6,924</b>	<b>-</b>	<b>8,329</b>
<b>Amortisation at 1 April 2023 - restated</b>	<b>1,405</b>	<b>6,924</b>	<b>-</b>	<b>8,329</b>
Provided during the year	742	2,373	-	3,115
<b>Amortisation at 31 March 2024</b>	<b>2,147</b>	<b>9,297</b>	<b>-</b>	<b>11,444</b>
<b>Net book value at 31 March 2024</b>	<b>3,296</b>	<b>8,187</b>	<b>10,513</b>	<b>21,996</b>
<b>Net book value at 1 April 2023</b>	<b>3,525</b>	<b>8,793</b>	<b>8,749</b>	<b>21,067</b>



**Note 16.1 Property, plant and equipment - 2024/25**

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
<b>Valuation/gross cost at 1 April 2024 - brought forward</b>	<b>13,500</b>	<b>214,686</b>	<b>1,514</b>	<b>84,472</b>	<b>65,160</b>	<b>414</b>	<b>23,616</b>	<b>2,828</b>	<b>406,190</b>
Transfers by absorption	-	-	-	-	-	-	-	-	-
Additions	-	4,926	-	59,755	3,195	-	3,461	85	71,422
Impairments	-	(17,204)	-	(5,790)	-	-	-	-	(22,994)
Reversals of impairments	540	581	(3)	-	-	-	-	-	1,118
Revaluations	-	(2,064)	(23)	-	-	-	-	-	(2,087)
Reclassifications	-	25,592	-	(33,189)	3,216	232	3,937	3	(209)
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	(4,163)	-	(1,056)	(61)	(5,280)
<b>Valuation/gross cost at 31 March 2025</b>	<b>14,040</b>	<b>226,517</b>	<b>1,488</b>	<b>105,248</b>	<b>67,408</b>	<b>646</b>	<b>29,958</b>	<b>2,855</b>	<b>448,160</b>
<b>Accumulated depreciation at 1 April 2024 - brought forward</b>	<b>-</b>	<b>761</b>	<b>-</b>	<b>-</b>	<b>31,634</b>	<b>376</b>	<b>13,563</b>	<b>975</b>	<b>47,309</b>
Transfers by absorption	-	-	-	-	-	-	-	-	-
Provided during the year	-	8,602	41	-	5,967	37	4,469	286	19,402
Impairments	-	(2,535)	-	-	-	-	-	-	(2,535)
Reversals of impairments	-	(1,128)	(4)	-	-	-	-	-	(1,132)
Revaluations	-	(3,992)	(37)	-	-	-	-	-	(4,029)
Reclassifications	-	-	-	-	-	-	-	-	-
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	(3,745)	-	(1,056)	(61)	(4,862)
<b>Accumulated depreciation at 31 March 2025</b>	<b>-</b>	<b>1,708</b>	<b>-</b>	<b>-</b>	<b>33,856</b>	<b>413</b>	<b>16,976</b>	<b>1,200</b>	<b>54,153</b>
<b>Net book value at 31 March 2025</b>	<b>14,040</b>	<b>224,809</b>	<b>1,488</b>	<b>105,248</b>	<b>33,552</b>	<b>233</b>	<b>12,982</b>	<b>1,655</b>	<b>394,007</b>
<b>Net book value at 1 April 2024</b>	<b>13,500</b>	<b>213,925</b>	<b>1,514</b>	<b>84,472</b>	<b>33,526</b>	<b>38</b>	<b>10,053</b>	<b>1,853</b>	<b>358,881</b>

**Note 16.2 Property, plant and equipment - 2023/24**

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
<b>Valuation / gross cost at 1 April 2023 - as previously stated</b>	<b>13,500</b>	<b>197,306</b>	<b>1,503</b>	<b>45,576</b>	<b>63,204</b>	<b>413</b>	<b>24,255</b>	<b>2,774</b>	<b>348,531</b>
Prior period adjustments	-	-	-	-	-	-	-	-	-
<b>Valuation / gross cost at 1 April 2023 - restated</b>	<b>13,500</b>	<b>197,306</b>	<b>1,503</b>	<b>45,576</b>	<b>63,204</b>	<b>413</b>	<b>24,255</b>	<b>2,774</b>	<b>348,531</b>
Transfers by absorption	1,526	154	-	-	-	-	-	-	1,680
Additions	325	6,782	-	59,215	5,523	-	1,933	601	74,379
Impairments	(1,851)	(8,251)	-	-	-	-	-	-	(10,102)
Reversals of impairments	-	61	-	-	-	-	-	-	61
Revaluations	-	1,134	2	-	-	-	-	-	1,136
Reclassifications	-	17,500	9	(20,319)	2,753	1	208	40	192
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	(6,320)	-	(2,780)	(587)	(9,687)
<b>Valuation/gross cost at 31 March 2024</b>	<b>13,500</b>	<b>214,686</b>	<b>1,514</b>	<b>84,472</b>	<b>65,160</b>	<b>414</b>	<b>23,616</b>	<b>2,828</b>	<b>406,190</b>
<b>Accumulated depreciation at 1 April 2023 - as previously stated</b>	<b>-</b>	<b>459</b>	<b>-</b>	<b>-</b>	<b>31,601</b>	<b>368</b>	<b>12,644</b>	<b>1,319</b>	<b>46,391</b>
Prior period adjustments	-	-	-	-	-	-	-	-	-
<b>Accumulated depreciation at 1 April 2023 - restated</b>	<b>-</b>	<b>459</b>	<b>-</b>	<b>-</b>	<b>31,601</b>	<b>368</b>	<b>12,644</b>	<b>1,319</b>	<b>46,391</b>
Transfers by absorption	-	-	-	-	-	-	-	-	-
Provided during the year	-	7,278	40	-	5,702	7	3,693	244	16,964
Impairments	-	(3,459)	-	-	-	-	-	-	(3,459)
Reversals of impairments	-	(541)	-	-	-	-	-	-	(541)
Revaluations	-	(2,976)	(40)	-	-	-	-	-	(3,016)
Reclassifications	-	-	-	-	1	1	-	(1)	1
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	(5,670)	-	(2,774)	(587)	(9,031)
<b>Accumulated depreciation at 31 March 2024</b>	<b>-</b>	<b>761</b>	<b>-</b>	<b>-</b>	<b>31,634</b>	<b>376</b>	<b>13,563</b>	<b>975</b>	<b>47,309</b>
<b>Net book value at 31 March 2024</b>	<b>13,500</b>	<b>213,925</b>	<b>1,514</b>	<b>84,472</b>	<b>33,526</b>	<b>38</b>	<b>10,053</b>	<b>1,853</b>	<b>358,881</b>
<b>Net book value at 1 April 2023</b>	<b>13,500</b>	<b>196,847</b>	<b>1,503</b>	<b>45,576</b>	<b>31,603</b>	<b>45</b>	<b>11,611</b>	<b>1,455</b>	<b>302,140</b>

**Note 16.3 Property, plant and equipment financing - 31 March 2025**

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	14,040	216,223	1,166	96,948	31,262	233	12,973	1,593	374,438
Owned - donated/granted	-	8,586	322	8,300	2,290	-	9	62	19,569
<b>Total net book value at 31 March 2025</b>	<b>14,040</b>	<b>224,809</b>	<b>1,488</b>	<b>105,248</b>	<b>33,552</b>	<b>233</b>	<b>12,982</b>	<b>1,655</b>	<b>394,007</b>

**Note 16.4 Property, plant and equipment financing - 31 March 2024**

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	13,500	205,255	1,182	84,472	30,632	38	10,031	1,780	346,890
Owned - donated/granted	-	8,670	332	-	2,894	-	22	73	11,991
<b>Total net book value at 31 March 2024</b>	<b>13,500</b>	<b>213,925</b>	<b>1,514</b>	<b>84,472</b>	<b>33,526</b>	<b>38</b>	<b>10,053</b>	<b>1,853</b>	<b>358,881</b>

#### **Note 17 Donations of property, plant and equipment**

During 2024/25 donations have been received from Royal Shrewsbury Hospital League of Friends, The Shrewsbury and Telford NHS Trust Charitable Funds and Lingen Davies Cancer Fund for the purchase of medical equipment and building works. In addition, a Public Sector Decarbonisation Scheme grant of £8.1m has been received.

#### **Note 18 Revaluations of property, plant and equipment**

The Trust commissioned Cushman and Wakefield to undertake a desktop update valuation of the Trust's Estate as at 31 March 2025. The properties were inspected internally and externally by Craig Chatwin BSc (Hons) MRICS, Adam Griffiths BSc (Hons) MRICS and Steven Gandley BSc (Hons) MRICS on 15 and 16 February 2021. David Wilson, MRICS, has been signatory of Valuation Reports provided to Shrewsbury and Telford Hospital NHS Trust for a continuous period since 31 March 2021. Jonathan Stickells, MRICS is also a signatory of this report. The valuation has been prepared in accordance with RICS Valuation - Global Standards, which incorporate the International Valuation Standards ('IVS') and the RICS UK National Supplement (the 'RICS Red Book') edition correct at the Valuation Date. It follows that the valuation is compliant with IVS.

As a result of these revaluations the net book value of the Estate was valued downwards by £10,477k as follows:  
Revaluation Reserve - total £3,499k downwards, representing a revaluation upwards of £1,942k and a net decrease of £5,441k relating to upward reversals totalling £755k and decrease of £6,196k. The Impairment Charge to SoCl is £6,978k - representing an impairment charge to the value of £8,473k and reversal of previous impairments of £1,495k.

#### **Note 19 Leases - The Shrewsbury And Telford Hospital NHS Trust as a lessee**

This note details information about leases for which the Trust is a lessee.

The Trust is a lessee in a number of leases relating to property and equipment. These include property leases for a number of the Trust's services including Diagnostics, Fertility and Maternity Services. In addition, the Trust has several leases for equipment including MRI and CT scanners, X-Ray equipment and Endoscopy and Pathology Services equipment.

**Note 19.1 Right of use assets - 2024/25**

	Property (land and buildings)	Plant & machinery	Transport equipment	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000
<b>Valuation / gross cost at 1 April 2024 - brought forward</b>	<b>16,853</b>	<b>9,238</b>	<b>316</b>	<b>26,407</b>	<b>4,795</b>
Additions	2,587	1,812	132	4,531	143
Remeasurements of the lease liability	(321)	-	-	(321)	130
Disposals / derecognition	-	(722)	(139)	(861)	-
<b>Valuation/gross cost at 31 March 2025</b>	<b>19,119</b>	<b>10,328</b>	<b>309</b>	<b>29,756</b>	<b>4,597</b>
<b>Accumulated depreciation at 1 April 2024 - brought forward</b>	<b>3,116</b>	<b>4,046</b>	<b>160</b>	<b>7,322</b>	<b>1,150</b>
Provided during the year	1,725	1,970	87	3,782	483
Disposals / derecognition	-	(722)	(98)	(820)	-
<b>Accumulated depreciation at 31 March 2025</b>	<b>4,841</b>	<b>5,294</b>	<b>149</b>	<b>10,284</b>	<b>1,280</b>
<b>Net book value at 31 March 2025</b>	<b>14,278</b>	<b>5,034</b>	<b>160</b>	<b>19,472</b>	<b>3,317</b>
<b>Net book value at 1 April 2024</b>	<b>13,737</b>	<b>5,192</b>	<b>156</b>	<b>19,085</b>	<b>3,645</b>
Net book value of right of use assets leased from other NHS providers					1,642
Net book value of right of use assets leased from other DHSC group bodies					1,675

**Note 19.2 Right of use assets - 2023/24**

	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Total £000	Of which: leased from DHSC group bodies £000
<b>Valuation / gross cost at 1 April 2023 - brought forward</b>	<b>15,450</b>	<b>9,128</b>	<b>334</b>	<b>24,912</b>	<b>4,351</b>
Prior period adjustments	-	-	-	-	-
<b>Valuation / gross cost at 1 April 2023 - restated</b>	<b>15,450</b>	<b>9,128</b>	<b>334</b>	<b>24,912</b>	<b>4,351</b>
Additions	1,224	215	128	1,567	407
Remeasurements of the lease liability	179	(58)	-	121	37
Disposals / derecognition	-	(47)	(146)	(193)	-
<b>Valuation/gross cost at 31 March 2024</b>	<b>16,853</b>	<b>9,238</b>	<b>316</b>	<b>26,407</b>	<b>4,795</b>
<b>Accumulated depreciation at 1 April 2023 - brought forward</b>	<b>1,514</b>	<b>2,029</b>	<b>107</b>	<b>3,650</b>	<b>562</b>
Prior period adjustments	-	-	-	-	-
<b>Accumulated depreciation at 1 April 2023 - restated</b>	<b>1,514</b>	<b>2,029</b>	<b>107</b>	<b>3,650</b>	<b>562</b>
Provided during the year	1,602	2,048	104	3,754	588
Disposals / derecognition	-	(31)	(51)	(82)	-
<b>Accumulated depreciation at 31 March 2024</b>	<b>3,116</b>	<b>4,046</b>	<b>160</b>	<b>7,322</b>	<b>1,150</b>
<b>Net book value at 31 March 2024</b>	<b>13,737</b>	<b>5,192</b>	<b>156</b>	<b>19,085</b>	<b>3,645</b>
<b>Net book value at 1 April 2023</b>	<b>13,936</b>	<b>7,099</b>	<b>227</b>	<b>21,262</b>	<b>3,789</b>
Net book value of right of use assets leased from other NHS providers					1,754
Net book value of right of use assets leased from other DHSC group bodies					1,891

**Note 19.3 Revaluations of right of use assets**

No Right of Use assets have been revalued in 2024/25.

**Note 19.4 Reconciliation of the carrying value of lease liabilities**

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 32.1.

	2024/25	2023/24
	£000	£000
<b>Carrying value at 1 April</b>	<b>18,923</b>	<b>21,620</b>
Prior period adjustments	-	-
<b>Carrying value at 1 April - restated</b>	<b>18,923</b>	<b>21,620</b>
Transfers by absorption	-	-
Lease additions	4,531	1,567
Lease liability remeasurements	(321)	121
Interest charge arising in year	235	194
Early terminations	(59)	(128)
Lease payments (cash outflows)	(3,938)	(4,451)
Other changes	-	-
<b>Carrying value at 31 March</b>	<b>19,371</b>	<b>18,923</b>

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 6. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

**Note 19.5 Maturity analysis of future lease payments**

	Of which leased from DHSC group bodies:		Of which leased from DHSC group bodies:	
	Total		Total	
	31 March	31 March	31 March	31 March
	2025	2025	2024	2024
	£000	£000	£000	£000
<b>Undiscounted future lease payments payable in:</b>				
- not later than one year;	3,559	462	3,795	518
- later than one year and not later than five years;	11,155	1,712	9,715	1,803
- later than five years.	4,657	1,136	5,413	1,265
<b>Total gross future lease payments</b>	<b>19,371</b>	<b>3,310</b>	<b>18,923</b>	<b>3,586</b>
Finance charges allocated to future periods	-	-	-	-
<b>Net lease liabilities at 31 March 2025</b>	<b>19,371</b>	<b>3,310</b>	<b>18,923</b>	<b>3,586</b>
<b>Of which:</b>				
Leased from other NHS providers		1,654		1,765
Leased from other DHSC group bodies		1,656		1,821

**Note 20 Investment Property**

The Trust has no investment property that require disclosure within this note.

**Note 20.1 Investment property income and expenses**

The Trust has no investments in associates or joint ventures.



**Note 21 Investments in associates and joint ventures**

The Trust has no investments in associates or joint ventures.

**Note 22 Other investments / financial assets (non-current)**

The Trust has no other investments/financial assets.

### Note 23 Disclosure of interests in other entities

The Trust has no interests in unconsolidated subsidiaries, joint ventures, associates or unconsolidated structured entities that require disclosures within this note.

### Note 24 Inventories

	31 March 2025 £000	31 March 2024 £000
Drugs	3,519	3,274
Consumables	6,385	6,458
Energy	204	179
<b>Total inventories</b>	<b>10,108</b>	<b>9,911</b>

Inventories recognised in expenses for the year were £137k (2023/24: £453k). Write-down of inventories recognised as expenses for the year were £291k (2023/24: £304k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2023/24 the Trust received £190k of items purchased by DHSC. Distribution of inventory by the Department ceased in March 2024.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

The deemed cost of these inventories was charged directly to expenditure on receipt with the corresponding benefit recognised in income.

**Note 25.1 Receivables**

	31 March 2025 £000	31 March 2024 £000
<b>Current</b>		
Contract receivables	8,910	7,777
Allowance for impaired contract receivables / assets	(1,741)	(1,221)
Prepayments (non-PFI)	4,280	3,056
PDC dividend receivable	981	-
VAT receivable	1,286	1,464
Other receivables	71	66
<b>Total current receivables</b>	<b>13,787</b>	<b>11,142</b>
<b>Non-current</b>		
Contract receivables	1,223	1,243
Other receivables	605	604
<b>Total non-current receivables</b>	<b>1,828</b>	<b>1,847</b>
<b>Of which receivable from NHS and DHSC group bodies:</b>		
Current	4,935	2,855
Non-current	605	604

**Note 25.2 Allowances for credit losses**

	2024/25		2023/24	
	Contract receivables and contract assets £000	All other receivables £000	Contract receivables and contract assets £000	All other receivables £000
<b>Allowances as at 1 April - brought forward</b>	<b>1,221</b>	<b>-</b>	<b>1,130</b>	<b>-</b>
Prior period adjustments			-	-
<b>Allowances as at 1 April - restated</b>	<b>1,221</b>	<b>-</b>	<b>1,130</b>	<b>-</b>
New allowances arising	1,085	-	504	-
Reversals of allowances	(193)	-	(131)	-
Utilisation of allowances (write offs)	(372)	-	(282)	-
<b>Allowances as at 31 Mar 2025</b>	<b>1,741</b>	<b>-</b>	<b>1,221</b>	<b>-</b>

**Note 25.3 Exposure to credit risk**

The majority of the Trust's revenue comes from contracts with other public sector bodies therefore the Trust has low risk, as disclosed in the trade and other receivables note.

**Note 26 Finance leases (The Shrewsbury And Telford Hospital NHS Trust as a lessor)**

The Trust has no finance leases.

**Note 27 Other assets**

The Trust has no other assets that require disclosure within this note.

**Note 28.1 Non-current assets held for sale and assets in disposal groups**

The Trust has no non-current assets held for sale or assets in disposal groups.

**Note 28.2 Liabilities in disposal groups**

The Trust has no other liabilities in disposal groups that require disclosure within this note.

**Note 29.1 Cash and cash equivalents movements**

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	<b>2024/25</b>	<b>2023/24</b>
	<b>£000</b>	<b>£000</b>
<b>At 1 April</b>	<b>54,680</b>	<b>3,301</b>
Prior period adjustments	-	-
<b>At 1 April (restated)</b>	<b>54,680</b>	<b>3,301</b>
Transfers by absorption	-	-
Net change in year	6,838	51,379
<b>At 31 March</b>	<b>61,518</b>	<b>54,680</b>
<b>Broken down into:</b>		
Cash at commercial banks and in hand	17	17
Cash with the Government Banking Service	61,501	54,663
<b>Total cash and cash equivalents as in SoFP</b>	<b>61,518</b>	<b>54,680</b>
<b>Total cash and cash equivalents as in SoCF</b>	<b>61,518</b>	<b>54,680</b>

**Note 29.2 Third party assets held by the trust**

The Shrewsbury And Telford Hospital NHS Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	<b>31 March</b>	<b>31 March</b>
	<b>2025</b>	<b>2024</b>
	<b>£000</b>	<b>£000</b>
Bank balances	2	3
<b>Total third party assets</b>	<b>2</b>	<b>3</b>

**Note 30.1 Trade and other payables**

	31 March 2025 £000	31 March 2024 £000
<b>Current</b>		
Trade payables	9,760	13,826
Capital payables	28,070	29,371
Accruals	34,920	24,120
Receipts in advance and payments on account	24	10
Social security costs	4,474	276
Other taxes payable	5,471	487
PDC dividend payable	-	180
Pension contributions payable	5,490	113
Other payables	124	217
<b>Total current trade and other payables</b>	<b>88,333</b>	<b>68,600</b>

**Of which payables from NHS and DHSC group bodies:**

Current	1,830	1,603
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**Note 30.2 Early retirements in NHS payables above**

The payables note above includes amounts in relation to early retirements as set out below:

	31 March 2025 £000	31 March 2025 Number	31 March 2024 £000	31 March 2024 Number
- to buy out the liability for early retirements over 5 years	-	-	-	-
- number of cases involved	-	-	-	-



**Note 31 Other liabilities**

	31 March 2025 £000	31 March 2024 £000
<b>Current</b>		
Deferred income: contract liabilities	4,141	1,405
<b>Total other current liabilities</b>	<b>4,141</b>	<b>1,405</b>

**Note 32.1 Borrowings**

	31 March 2025 £000	31 March 2024 £000
<b>Current</b>		
Lease liabilities	3,559	3,795
<b>Total current borrowings</b>	<b>3,559</b>	<b>3,795</b>
<b>Non-current</b>		
Lease liabilities	15,812	15,128
<b>Total non-current borrowings</b>	<b>15,812</b>	<b>15,128</b>

**Note 32.2 Reconciliation of liabilities arising from financing activities**

	<b>Lease Liabilities</b>	<b>Total</b>
	<b>£000</b>	<b>£000</b>
<b>Carrying value at 1 April 2024</b>	<b>18,923</b>	<b>18,923</b>
<b>Cash movements:</b>		
Financing cash flows - payments and receipts of principal	(3,703)	<b>(3,703)</b>
Financing cash flows - payments of interest	(235)	<b>(235)</b>
<b>Non-cash movements:</b>		
Additions	4,531	<b>4,531</b>
Lease liability remeasurements	(321)	<b>(321)</b>
Application of effective interest rate	235	<b>235</b>
Early terminations	(59)	<b>(59)</b>
<b>Carrying value at 31 March 2025</b>	<b>19,371</b>	<b>19,371</b>

	<b>Lease Liabilities</b>	<b>Total</b>
	<b>£000</b>	<b>£000</b>
<b>Carrying value at 1 April 2023</b>	<b>21,620</b>	<b>21,620</b>
<b>Cash movements:</b>		
Financing cash flows - payments and receipts of principal	(4,257)	<b>(4,257)</b>
Financing cash flows - payments of interest	(194)	<b>(194)</b>
<b>Non-cash movements:</b>		
Additions	1,567	<b>1,567</b>
Lease liability remeasurements	121	<b>121</b>
Application of effective interest rate	194	<b>194</b>
Early terminations	(128)	<b>(128)</b>
<b>Carrying value at 31 March 2024</b>	<b>18,923</b>	<b>18,923</b>

**Note 33 Other financial liabilities**

The Trust has no other financial liabilities.

**Note 34.1 Provisions for liabilities and charges analysis**

	<b>Pensions: early departure costs £000</b>	<b>Pensions: injury benefits £000</b>	<b>Legal claims £000</b>	<b>Clinicians Pension Provision £000</b>	<b>Total £000</b>
<b>At 1 April 2024</b>	<b>47</b>	<b>152</b>	<b>141</b>	<b>634</b>	<b>974</b>
Change in the discount rate	-	3	-	(6)	(3)
Arising during the year	42	29	93	15	179
Utilised during the year	(45)	(72)	(56)	(44)	(217)
Reversed unused	-	-	(53)	-	(53)
Unwinding of discount	1	4	-	31	36
<b>At 31 March 2025</b>	<b>45</b>	<b>116</b>	<b>125</b>	<b>630</b>	<b>916</b>
<b>Expected timing of cash flows:</b>					
- not later than one year;	45	72	125	25	267
- later than one year and not later than five years;	-	30	-	90	120
- later than five years.	-	14	-	515	529
<b>Total</b>	<b>45</b>	<b>116</b>	<b>125</b>	<b>630</b>	<b>916</b>

Early departure costs and injury benefits relate to a provision for future payments payable to NHS Pensions Agency in respect of former employees.

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

Clinicians who are members of the NHS Pension Scheme and who as a result of work undertaken face a tax charge in respect of the growth of their NHS pension benefits above their pension savings annual allowance threshold will be able to have this charge paid by the NHS pension scheme. A contra entry has been set up in Receivables (see Note 25.1)

**Note 34.2 Clinical negligence liabilities**

At 31 March 2025, £350,541k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of The Shrewsbury And Telford Hospital NHS Trust (31 March 2024: £323,812k).

**Note 35 Contingent assets and liabilities**

	31 March 2025 £000	31 March 2024 £000
<b>Value of contingent liabilities</b>		
NHS Resolution legal claims	(43)	(39)
<b>Gross value of contingent liabilities</b>	<b>(43)</b>	<b>(39)</b>
<b>Net value of contingent liabilities</b>	<b>(43)</b>	<b>(39)</b>

**Note 36 Contractual capital commitments**

	31 March 2025 £000	31 March 2024 £000
Property, plant and equipment	240,914	23,706
Intangible assets	36	659
<b>Total</b>	<b>240,950</b>	<b>24,365</b>

**Note 37 Other financial commitments**

The Trust has no other financial commitments.

**Note 38 Defined benefit pension schemes**

The Trust has no other defined benefit pensions schemes.

**Note 39 On-SoFP PFI, LIFT or other service concession arrangements**

The Trust has no on-SOFP PFI, LIFT or other service concession arrangements.

## **Note 40 Financial instruments**

### **Note 40.1 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 NHS Trust has with commissioners and the way those commissioners are financed, the 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 that 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. The Trust's 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 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.

The Trust may also borrow from government for revenue financing subject to approval by NHS England. Interest rates are confirmed by the Department of Health and Social Care (the lender) at the point borrowing is undertaken. The Trust has no revenue or capital loans in place as at 31 March 2025.

The Trust therefore has low exposure to interest rate fluctuations.

#### **Credit risk**

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposure as at 31 March 2025 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 ICBs, 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 subject to the availability of temporary revenue support funding and the demonstration of cash requirement.

**Note 40.2 Carrying values of financial assets**

	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
<b>Carrying values of financial assets as at 31 March 2025</b>				
Trade and other receivables excluding non financial assets	9,068	-	-	9,068
Cash and cash equivalents	61,518	-	-	61,518
<b>Total at 31 March 2025</b>	<b>70,586</b>	<b>-</b>	<b>-</b>	<b>70,586</b>

	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
<b>Carrying values of financial assets as at 31 March 2024</b>				
Trade and other receivables excluding non financial assets	8,469	-	-	8,469
Cash and cash equivalents	54,680	-	-	54,680
<b>Total at 31 March 2024</b>	<b>63,149</b>	<b>-</b>	<b>-</b>	<b>63,149</b>

**Note 40.3 Carrying values of financial liabilities**

	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
<b>Carrying values of financial liabilities as at 31 March 2025</b>			
Obligations under leases	19,371	-	19,371
Trade and other payables excluding non financial liabilities	72,874	-	72,874
Provisions under contract	916	-	916
<b>Total at 31 March 2025</b>	<b>93,161</b>	<b>-</b>	<b>93,161</b>

	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
<b>Carrying values of financial liabilities as at 31 March 2024</b>			
Obligations under leases	18,923	-	18,923
Trade and other payables excluding non financial liabilities	66,084	-	66,084
Provisions under contract	974	-	974
<b>Total at 31 March 2024</b>	<b>85,981</b>	<b>-</b>	<b>85,981</b>

**Note 40.4 Maturity of financial liabilities**

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	<b>31 March 2025 £000</b>	<b>31 March 2024 £000</b>
In one year or less	76,700	70,174
In more than one year but not more than five years	11,289	9,814
In more than five years	5,172	5,993
<b>Total</b>	<b>93,161</b>	<b>85,981</b>

**Note 40.5 Fair values of financial assets and liabilities**

The book value (carrying value) is a reasonable approximation of fair value for the Trust's financial assets and liabilities.



**Note 41 Losses and special payments**

	2024/25		2023/24	
	Total	Total value of cases £000	Total	Total value of cases £000
	number of cases		number of cases	
	Number		Number	
<b>Losses</b>				
Cash losses	1	1	-	-
Bad debts and claims abandoned	690	372	365	270
Stores losses and damage to property	37	291	40	304
<b>Total losses</b>	<b>728</b>	<b>664</b>	<b>405</b>	<b>574</b>
<b>Special payments</b>				
Ex-gratia payments	93	230	78	224
<b>Total special payments</b>	<b>93</b>	<b>230</b>	<b>78</b>	<b>224</b>
<b>Total losses and special payments</b>	<b>821</b>	<b>894</b>	<b>483</b>	<b>798</b>
Compensation payments received				

**Note 42 Gifts**

	2024/25		2023/24	
	Total	Total value of cases £000	Total	Total value of cases £000
	number of cases		number of cases	
	Number		Number	
Gifts made	-	-	-	-

**Note 43 Related parties**

The Department of Health and Social Care is regarded as the parent department.

The main entries within the public sector that the trust has had dealings with during the year are listed below.

These are entities where income and/or expenditure has been in excess of £250,000.

NHS Shropshire, Telford and Wrekin ICB  
NHS Birmingham and Solihull ICB  
NHS Black Country ICB  
NHS Cheshire and Merseyside ICB  
NHS Herefordshire and Worcestershire ICB  
NHS Staffordshire and Stoke-on-Trent ICB  
NHS England  
NHS Property Services  
NHS Resolution  
Midlands Partnership University NHS Foundation Trust  
Oxford Health NHS Foundation Trust  
Sandwell And West Birmingham Hospitals NHS Trust  
Shropshire Community Health NHS Trust  
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust  
The Royal Wolverhampton NHS Trust  
University Hospitals Birmingham NHS Foundation Trust  
University Hospitals of North Midlands NHS Trust  
Shropshire Unitary Authority  
Telford and Wrekin (Borough of)  
Powys Local Health Board  
Betsi Cadwaladr University Local Health Board  
Cwm Taf Morgannwg University Local Health Board  
NHS Pension Scheme  
HM Revenue and Customs  
UK Health Security Agency  
Care Quality Commission

The Trust is linked to the Shrewsbury and Telford Hospital NHS Trust Charity. The Annual Report and Accounts for the Shrewsbury and Telford Hospital NHS Charity are submitted separately to the Charity Commission and are not consolidated into the Trust's Accounts.

The Trust is also linked to Royal Shrewsbury Hospital League of Friends, Friends of Princess Royal Hospital and Lingen Davies Cancer Fund, who donate various pieces of medical equipment to the Trust. The Trust hires facilities from Shropshire Education and Conference Centre.

**Note 44 Prior period adjustments**

The Trust has made no prior period adjustments where comparative information has been restated due to either a change in accounting policy or material prior period error.

**Note 45 Events after the reporting date**

There are no events after the reporting date that need to be included in this note.

**Note 46 Better Payment Practice code**

	2024/25	2024/25	2023/24	2023/24
	Number	£000	Number	£000
<b>Non-NHS Payables</b>				
Total non-NHS trade invoices paid in the year	133,965	279,391	162,599	297,001
Total non-NHS trade invoices paid within target	130,055	268,134	146,527	271,616
Percentage of non-NHS trade invoices paid within target	<b>97.1%</b>	<b>96.0%</b>	<b>90.1%</b>	<b>91.5%</b>
<b>NHS Payables</b>				
Total NHS trade invoices paid in the year	2,295	12,299	2,268	13,022
Total NHS trade invoices paid within target	2,140	11,226	1,939	9,796
Percentage of NHS trade invoices paid within target	<b>93.2%</b>	<b>91.3%</b>	<b>85.5%</b>	<b>75.2%</b>

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

**Note 47 Capital Resource Limit**

	2024/25	2023/24
	£000	£000
Gross capital expenditure	82,281	80,302
Less: Disposals	(459)	(767)
Less: Donated and granted capital additions	(8,463)	(868)
Plus: Loss on disposal from capital grants in kind and peppercorn lease disposals	-	-
<b>Charge against Capital Resource Limit</b>	<b>73,359</b>	<b>78,667</b>
Capital Resource Limit	73,359	78,667
<b>Under / (over) spend against CRL</b>	<b>-</b>	<b>-</b>

**Note 48 Breakeven duty financial performance**

	2024/25
	£000
Adjusted financial performance surplus / (deficit) (control total basis)	(24,353)
Remove impairments scoring to Departmental Expenditure Limit	5,790
<b>Breakeven duty financial performance surplus / (deficit)</b>	<b>(18,563)</b>

**Note 49 Breakeven duty rolling assessment**

	<b>2008/09</b>	<b>2009/10</b>	<b>2010/11</b>	<b>2011/12</b>	<b>2012/13</b>	<b>2013/14</b>
	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>
Breakeven duty in-year financial performance		712	26	59	81	65
Breakeven duty cumulative position	(22,891)	(22,179)	(22,153)	(22,094)	(22,013)	(21,948)
Operating income		262,882	277,980	299,850	309,362	314,106
<b>Cumulative breakeven position as a percentage of operating income</b>		(8.4%)	(8.0%)	(7.4%)	(7.1%)	(7.0%)

	<b>2014/15</b>	<b>2015/16</b>	<b>2016/17</b>	<b>2017/18</b>	<b>2018/19</b>	<b>2019/20</b>
	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>
Breakeven duty in-year financial performance	(12,130)	(14,649)	(5,631)	(17,400)	(18,743)	(25,715)
Breakeven duty cumulative position	(34,078)	(48,727)	(54,358)	(71,758)	(90,501)	(116,216)
Operating income	316,794	326,477	350,244	359,041	369,186	421,853
<b>Cumulative breakeven position as a percentage of operating income</b>	(10.8%)	(14.9%)	(15.5%)	(20.0%)	(24.5%)	(27.5%)

	<b>2020/21</b>	<b>2021/22</b>	<b>2022/23</b>	<b>2023/24</b>	<b>2024/25</b>
	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>
Breakeven duty in-year financial performance					
Breakeven duty cumulative position	(3,752)	(10,890)	(47,206)	(54,582)	(18,563)
Operating income	(119,968)	(130,858)	(178,063)	(232,645)	(251,208)
<b>Cumulative breakeven position as a percentage of operating income</b>	511,443	535,142	556,605	624,322	724,065
	(23.5%)	(24.5%)	(32.0%)	(37.3%)	(34.7%)

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