AGM questions – 25 September 2025

Question 1: Submitted by Mrs Patricia McCormack
I would like to know how they plan to improvement the service in hospitals in general and A & E in particular following yet another appalling rating in the recently published league tables.
Responder: Ned Hobbs, Chief Operating Officer
Thank you for your question. We recognise the concerns raised in the recent league tables and are continuing to make improvements across all services. We have launched a comprehensive Urgent and Emergency Care (UEC) Improvement Programme here at SaTH. We're increasing bed capacity, improving ambulance handovers, and expanding Same Day Emergency Care (SDEC) to reduce pressure on our Emergency Departments (ED). We are opening 56 more inpatient beds at RSH, and 40 acute assessment and bed spaces at PRH. We're also introducing new direct access pathways to avoid unnecessary ED attendances, and we're strengthening site management and discharge processes to improve patient flow. Alongside that, we're investing in our workforce, improving culture, and using real-time data to track progress. It's a whole-system approach and we are seeing early signs of improvement. We know there is more work for us to do and everyone at SaTH is determined to accelerate our improvement in urgent and emergency care.
The following questions were submitted by Dianne Peacock, Co-Chair of Riverside Medical Practice PPG
Question 2:
It is positive to see Chairs in Common for Shropshire Community Health NHS Trust and The Shrewsbury and Telford NHS Hospital Trust for this SaTH board. However, given the difficulties with *patient flow* in and out of urgent and emergency care in both hospitals, it is difficult to understand why mention of primary care was conspicuously absent in the Annual Report. This is particularly concerning since an NHSE directive published in March 2024 stated that: *Every trust should have a designated lead for the primary–secondary care interface* … .[1] While progress with the primary/secondary interface will no doubt be reported within the STW ICB committees, would it be possible for the designated lead for this work (or a spokesperson) please provide a brief verbal summary of progress to date for this AGM?
Responder: Ned Hobbs, Chief Operating Officer
We recognise the importance of partnership working and are committed to continuing to strengthen the interface between primary and secondary care. The Urgent and Emergency Care (UEC) Improvement Programme at SaTH includes several workstreams that span the acute Trust, Primary Care, Shropshire Community Health NHS Trust (ShropCom), and local authorities. This work is overseen by the UEC Transformation Assurance Committee, and SaTH actively

participates in the System UEC Delivery Group, which includes representation from Primary Care, NHS England, and the Integrated Care Board (ICB).
In line with the NHS England directive issued in March 2024, SaTH has identified a designated lead for the primary–secondary care interface. This role is embedded within our UEC programme leadership and works closely with system partners to improve patient flow and integration across care settings.

Progress to date includes joint initiatives with Primary Care to improve discharge pathways, reduce avoidable admissions, and enhance communication between hospital and community teams. These efforts are being coordinated through system-wide forums and are aligned with the broader objectives of the ICB.
We recognise the importance of this work and are committed to continuing to strengthen the interface between primary and secondary care.

Question 3:

Other than the Care Transfer Hub for complex patients' discharge, how will the Integrated Front Door service model (which involves senior community practitioners working on both SaTH Acute Sites) be reflected in the partnership work required to provide specialist secondary care support and training on the community side of the front door for less complex patients who would previously have been cared for in hospital?

Responder: Ned Hobbs, Chief Operating Officer

The Integrated Front Door service model is designed to strengthen collaboration between acute and community services, ensuring patients receive the right care in the right place.

In addition to the Care Transfer Hub, the model includes the expansion of the Urgent Community Response (UCR) service to operate until midnight, seven days a week, across the county. This service, delivered by clinical practitioners from Shropshire Community Health NHS Trust (ShropCom), enables timely interventions in patients' homes, helping to avoid unnecessary hospital admissions.

For less complex patients who would previously have been cared for in hospital, the Integrated Front Door model supports earlier assessment and redirection to the appropriate community-based care. Senior community practitioners working on both SaTH acute sites will play a key role in this process, ensuring continuity and clinical oversight.

We are committed to continuing this collaborative approach and will monitor outcomes closely to ensure quality and safety for all patients.

Question 4a:

A Freedom of Information (ref: 25-0615 FOI SaTH) on the numbers of 'attendances' in the two main hospitals' emergency departments (EDs) and urgent treatment centres (UTCs) for calendar years 2023 and 2024 show that total numbers of attendances had risen, as had 'non-elective admissions' in both hospitals. It also appears that PRH was dealing with greater numbers of

attendances and non-elective admissions to and from EDs and UTCs than RSH in both years but this will need to be confirmed.

Since January 2025 how effective have the measures been to reduce ED and UTC attendances and non-elective admissions in RSH and PRH and what is the likelihood of reducing numbers in both centres for the whole of 2025 as we approach winter?

Responder: Ned Hobbs, Chief Operating Officer

This is correct PRH does have higher ED attendances and non-elective admissions at PRH.

Emergency Department (ED) and Urgent Treatment Centre (UTC) attendances along with non-elective admissions have increased since March 2025 this year. There are several initiatives in train to support improvement ahead of Winter including the implementation of the integrated front door model described above and also with the go-live of the new provider of the Care Co-ordination Centre /Single Point of Access /GP out of hours "Health Hero Integrated Care" from 1 October 2025. This along will complement our Winter plan along with the increase in bed capacity through the introduction of the modular wards at RSH with an additional 56 beds, at PRH through the UEC Recovery plan a further nine inpatient beds, 23 additional assessment spaces and an additional eight assessment unit beds.

Question 4b:

What do board members see as the main barriers to and risks involved in reducing the flow into ED and speeding up flow out of acute care before the work in both hospitals is completed in 2028?

Responder: Ned Hobbs, Chief Operating Officer

The Board is optimistic that any barriers that may exist will be addressed through the collaborative working with system partners. With the commissioning of the Integrated Front Door Service in the coming weeks, combined with the modular wards at RSH going live in December and the UEC recovery plan for PRH, these significant injections of improvement will support the organisation ahead of 2028.

Long-term we know that we need to fundamentally change the way we are working through our Hospitals Transformation Programme, which will bring more modern facilities and clinical models. Work is on track in our Hospitals Transformation Programme to deliver the long-term improvements for our patients and colleagues.

Question 5a:

The SaTH Annual Report 2024/25 describes percentage reductions of flow to non-elective care as a result of the *Medical Same Day Emergency Care (SDEC) service.*[2] It would be helpful for the public to have more information about SDEC.

Where are patients triaged and by whom, when referred to SDEC services?

Responder: Ned Hobbs, Chief Operating Officer

This depends on the portal of entry. If patients are transferred to Same Day Emergency Care (SDEC) from the Emergency Department they are triaged there

before being transferred. Patients can also be referred by GPs, the ambulance service, 111 services or through the Care Co-ordination Centre. On arrival patients receive a clinical triage and monitoring of observations.
Question 5b:
Which team clinically treats patients referred to SDEC, where are they treated and is it a 24/7 service?
Responder: Ned Hobbs, Chief Operating Officer
Medical Same Day Emergency Care (SDEC) is led by Acute Medicine Physicians. The SDEC areas are located on the Acute Medicine Floor at RSH and co-located with the Acute Medical Assessment Unit at PRH. This is not a 24 hour service it operates from 7am to 10pm, seven days a week. The NHS England service specification states that the model of SDEC should be provided for a minimum of 12 hours a day, seven days a week.
Question 5c:
What categories of treatment do patients receive in SDEC?
Responder: Ned Hobbs, Chief Operating Officer
Same Day Emergency Care (SDEC) serves patients with acute but non-life threatening conditions that require urgent assessment, diagnosis and treatment without the need for hospital admission. Conditions managed in SDEC include infections, deep vein thrombosis (blood clots), low-risk chest pain, anaemia and abnormal blood results. Patients must meet specific eligibility criteria such as being clinically stable and able to sit independently in a waiting room.
Question 5d:
How many patients in total have received SDEC in March 2024-April 2025 and how many of these patients have re-presented in ED within 7 days, if any?
Responder: Ned Hobbs, Chief Operating Officer
There were 12,746 patients that came through all Same Day Emergency Care (SDEC) routes in the specified time period. Of these 537 (4.2%) represented at ED in the 7 days following discharge.
Question 6:
Could board members please explain whether *persistent bottlenecks* in diagnostic performance[3] in key areas – such as *Non-Obstetric Ultrasound, Cardio-Respiratory, and MRI* – is related to local workforce capacity, equipment availability or diagnostic analysis & reporting of results as well as how the dedicated funding will be used?
Responder: Ned Hobbs, Chief Operating Officer
At the beginning of the year, our overall waiting list for diagnostics was 18,012 with 53% of patients receiving their diagnostic test within six weeks. At the end of July 2025 our overall waiting list for diagnostics was 12,071 with 83% of patients receiving their diagnostic test within six weeks. This is a 33% reduction in our

overall waiting list. We are on target to reach the national target of 99% of patients receiving their diagnostic test within six weeks by March 2026.

In our most challenged imaging modalities of MRI and Non-Obstetric Ultrasound the waiting list reductions have been 51% and 46% respectively since the beginning of the year.

We have removed all our backlogs in reporting imaging scans, through the introduction of a second outsourcing reporting provider and we continue to use the private sector to support our scanning capacity while we expand our internal capacity.

We have seen challenges in local workforce capacity in some areas, however to ensure we have improved our performance and can sustain this we have utilised insourcing while substantive recruitment is ongoing.

Question 7:

What plans are in place locally (involving SaTH, Shropshire Community Health Trust and the STW PCNs) to make greater use of and to better resource our remaining community hospitals and clinics (Whitchurch Community Hospital, Bridgnorth Community Hospital, Ludlow Community Hospital and Wrekin Community Clinic)?

Responder: Nigel Lee, Director of Strategy and Partnerships

The NHS 10-year plan highlighted three important shifts, with hospital to community and analogue to digital as two of these. Working closely with Shropshire Community Health NHS Trust (Shropcom), as a Group, will mean we can review the optimum use of the valuable estate, not only for bed-based care, but as part of the neighbourhood health service offer.

Our focus going forwards needs to be on building community and family hubs for local communities and considering how best we can support patients and families as locally as possible to their own homes. The future model of clinics will be included in this. Moving care out of the physical hospital should not be confused with physically moving the specialists or the infrastructure; this is where technology will play a key role in enabling teams to support patients in different ways. Our focus is developing the right services that will meet local needs and not being constrained by buildings, using new technologies and reforming our workforce to help patients stay in their own home, and independent, for longer.

Question 8:

A recent email from SaTH #GetInvolved reported on current plans. This included two new wards installed next to the Treatment Centre at RSH due to open later in the year. Also, two rehabilitation wards in RSH and PRH being made available for medical patients thus increasing the number of emergency beds available to address winter pressures. Alongside this, it was stated there would be a £3.6m investment in *more community-based care*. Can the Board please report on progress to date, from an integrated systems perspective, on exactly how and

where the £3.6 million investment in community-based care has been allocated to date or is planned?

Responder: Nigel Lee, Director of Strategy and Partnerships and Ned Hobbs, Chief Operating Officer

Nigel Lee: This decision was taken as an ICS (system) to help deliver better care and a better experience for our patients this Winter. Our priority is to ensure patients receive the right care, in the right place and by the right staff for their needs.

The Urgent Community Response teams will be managed by the Shropshire Community Health NHS Trust (ShropCom). This is a good example of how we can deliver the shift from 'hospital to community' and a decision by system partners to make investment in the right place for patients. As a Group, we will work together to support this important project.

Ned Hobbs - Five areas have been identified for service expansion to develop community pathways, following established models and previous winter schemes in 2024/25. These include:

- Urgent Community Response (two-hour response)
- Enhancing the Care Transfer Hub to improve discharge pathways; care transfer hubs will facilitate efficient referrals, discharges, and better alignment with community and social care resources so that patients receive appropriate care in a timely manner.
- Front door coordination and redirection to community pathways
- Two-hour domiciliary care response and bridging service.

Ahead of Winter, a plan has been implemented to expand the above services with the closure of the rehabilitation and recovery units, aiming to support reinvestment and reduce reliance on bedded capacity, particularly for frail and vulnerable patients. By strengthening the urgent community response teams and enhancing the Care Transfer Hub, this will support enhanced avoidance of unnecessary admissions but also facilitates swifter, more coordinated discharges—ensuring patients are cared for in the most appropriate environment promoting a care closer to home model of care.

The system plan is on track and the aim is to fully close the rehabilitation and recovery units by early December through a phased approach. ShropCom are leading on behalf of the system operationalising all schemes working closely with SaTH and wider partners.

Question 9: Submitted by David Sandbach

I note that the pension related benefits awarded to Mrs Barnett for 2024 / 25 are significantly more circa £80,000 than for financial year 2023/24.

Can people assume that past pension payments were incorrect as reported in the annual accounts for 2023 /24?

Responder: Rhia Boyode, Chief People Officer

No this is not the case, our auditors have independently assessed our accounts as accurate for 2024/25 and 2023/24.

As highlighted in the annual report Mrs Barnett received elements of pay relating to prior years that were paid in 2024/25 which has an associated pension impact. We cannot comment further on individual cases.

Question: 10: Submitted by David Sandbach

Which regulations were used to justify the payments to Mrs Barnett and Mrs Flavell. Would it be possible for this to be explained during the meeting?

Responder: Rhia Boyode, Chief People Officer

We follow robust contractual NHS guidance for all employees. Our Remuneration Committee oversees decisions on senior pay.

Whilst we can't comment on individual cases. Supporting the departure of senior employees from any organisation, in a manner which causes the least disruption to the organisation, supports the individual and offers value for money, happens in any sector and the NHS is no different.

Senior executives are employed on contracts of employment with long notice periods, primarily to protect the organisation, if the executive resigns, as the long notice period allows the organisation adequate time to find a replacement, for these crucial roles.

We work as one NHS and NHS trusts will commonly seek secondment opportunities for senior executives, during their notice periods, to ensure value for the public purse. Any decisions are not made in isolation and follow detailed discussion with regional and national NHS organisations, who provide appropriate guidance and oversight.

Question 11: Submitted by David Sandbach

Can some detailed explanation be offered during the meeting which will help people to understand the circumstances behind these statements:

"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."

""In addition, a further impairment of £5,790k resulting from an abandonment of a build project has been charged to Statement of Comprehensive Income."

Responder: Adam Winstanley, Acting Director of Finance

The Trust finished the 2024/25 financial year with a retained deficit of £24.0m (performance adjusted of £24.4m). This deficit was £5.8m adverse to the forecast agreed by NHSE and related to the abandonment of a capital project, namely the original modular ward scheme. With the original contractor facing financial difficulties and the need to have additional capacity to support patient care over the winter of 2025/26 the Board made the decision to appoint a new contractor to ensure completion.

Under accounting standards the costs associated with the abandonment of a capital project must be charged to revenue and as such this was an unplanned deterioration to the forecast. This accounting treatment was supported by both NHS England and our auditors.

With the appointment of new contractors, ModuleCo, we are looking forward to the scheme being completed in late 2025.

We are unable to comment further due to the commercial and contractual nature of the project.

Question 12:

Losing 62 consultant staff over a two year period looks very worrying especially bearing in mind this research: Nurse and doctor turnover and patient outcomes in NHS acute trusts in England: retrospective longitudinal study | The BMJ

Given the BMJ research a 6 – 8% consultant staff turnover is understandable however 10+% is not.

Responder: John Jones, Executive Medical Director

Growing our consultant workforce is critical for sustainable high quality services and we are therefore delighted that we have been able to increase our full time equivalent consultant numbers from 276 in 2022 to 310 in 2025. Recognising the national availability of candidates for permanent roles we are pleased to have increased our permanent consultants by 10 whole time equivalents over this period. This means we still have 50 full time equivalent fixed term temporary consultants who, by intention, will leave and hence create a higher turnover of total consultants than would be seen in a more established university Trust with a greater proportion of permanent consultant staff.

Currently, approximately 50% of our consultant turnover is in this smaller category of fixed term consultants. We are confident that our Hospitals Transformation Programme, our recognition as a university Trust and our development of many high quality services will continue to mean a greater proportion of permanent consultants and therefore a reduction in the calculated turnover.