NHS
The Shrewsbury and Telford Hospital
NHS Trust

2019 2020 Annual Report













Danger of fire
No smoking or naked flames


Sun Sport
Thugs target Utd chief Ed
BRU
TURN
Man U seal £55m deal despite Barca hijack bid
PARSONS

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A message from our Chair

Ben Reid OBE
Chair

Welcome to our Annual Report.

I don't think any of us could have imagined that this financial year would end with us facing the biggest challenge to the NHS locally and nationally that any of us have ever seen.

I want to pay tribute to all of the teams at SaTH, who have reacted to the coronavirus pandemic with professionalism, innovation and incredible teamwork.

My thanks, also, go to all of our incredible volunteers, the ones who were with us before the pandemic, and those who stepped forward to help when we were in the midst of it.

Finally, thank you to members of the public for following the Government guidelines and undoubtedly helping to save lives, and to those who have donated to SaTH. We had countless people fundraising for us, and so many more donating physical items, whether it was surplus or specially made PPE, or food and drink to keep our teams going. It really has shown how much people admire and respect the NHS.

Sometimes, it's hard to remember a time when coronavirus didn't dominate our lives, but SaTH was already facing a range of challenges before the pandemic struck.

I said last year that there would be no quick fixes to many of the issues we faced. We were determined to take a considered approach to ensure we get things right.

We continue to put every effort into moving out of Special Measures and to improve our rating with the Care Quality Commission. We have seen some real progress in this area, but we still have more to do.

We are also seeing improvements in our Maternity services which have, understandably, been in the spotlight throughout the year. We know there is more work to do in this area, but our new leadership team in the Women and Children's Care Group is committed to addressing these issues.

Our NHS Staff Survey results showed a slight improvement, but we are still a long way from where we want to be. We need to listen to what our people are telling us and act to improve what it feels like to work at SaTH. We know that staff experience and patient experience go hand-in-hand, so it is important we get this right.

The work our teams do in often challenging circumstances is incredible. Before coronavirus hit, we had seen demand on our services continue to increase but, despite the extra pressure this placed on the teams, the feedback we had through a number of routes, including publicly commissioned surveys, is testament to the caring nature of our staff and the high regard they are held in by our patients and their relatives and carers.

Finally, I want to thank our charitable partners who work so hard to raise significant sums to support our work. Charities like the League of Friends of the Royal Shrewsbury Hospital, the Friends of the Princess Royal Hospital and the Lingen Davies Cancer Fund make an invaluable contribution to SaTH.

We are aware of the scale of the challenges that face us over the coming year, but we are confident that, with the ongoing support of our workforce and the public, we will deliver the improvements necessary to ensure the people we serve get the quality of service they deserve.

A message from our Chief Executive

Louise Barnett
Chief Executive

2019-20 has been another difficult year for the Trust. Following our inspection by the Care Quality Commission in November, we remain in Special Measures and our overall Trust rating remains 'Inadequate

The Trust is embracing the feedback from the CQC and has developed a Quality Improvement Plan to address the issues raised to ensure our patients receive high quality care.

This CQC inspection noted significant improvements in Maternity. The Trust remains committed to listening to feedback from families and making further improvements to services and we continue to engage with the independent review commissioned by the Secretary of State for Health and Social Care.

Over the last 12 months, the Trust has failed to meet or consistently achieve the key access standards:

- Patients treated or admitted within four hours of arrival at A&E
- Patients having planned operations/ care within 18 weeks of referral
- Patients starting cancer treatment within 62 days of urgent GP referral
- Patients waiting over six weeks for a diagnostic test

There was a significant increase in the number of emergency admissions during 2019-20, which was higher than the plan. The Trust did not achieve the four-hour access standard throughout the year and had the highest number of 12 hour trolley waits to date.

This increase in emergency admissions unfortunately impacted on our ability to carry out routine elective activity, resulting in the Trust also failing to achieve the elective standard throughout the year.

12-hour trolley waits were higher than in previous years.

Whilst 62-day cancer performance made some improvement during the year, the Trust remained below the national standard.

Performance against the diagnostic standard was inconsistent with the Trust achieving this standard for six months during the year.

The Trust ended the year dealing with the COVID-19 (coronavirus) pandemic. This unprecedented challenge resulted in changes to the way we provide services for patients. The response to this challenge has been incredible and I would like to thank colleagues in the Trust, the local health and care community, our amazing volunteers and the many people and organisations in our community who have supported us throughout.

The Trust did not achieve its financial plan for 2019-20, ending the year with a deficit of £35.3m, which was £17.9m adverse to plan. This was mainly due to:

- continued high levels of vacancy across the Trust
- increased income offset by premium costs of provision (agency expenditure / increased capacity)
- cost Improvement Programme delivery shortfall
- costs of recovery and investment in trust management infrastructure
- acceleration of nurse recruitment programmes
- adjustments in respect of prior year CNST maternity incentive scheme

We continue to face a number of significant challenges but are working hard with our health and care partner organisations to improve and restore our services for the population we serve, as we move forward in 2020-21.

A year in pictures. Whilst th challenges, there were so

APRIL

Ward staff and dementia specialists created the 'Shrewsbury Scene' on Ward 21. The makeover included scenic wallpaper, murals and multi-functional areas, bringing colour, stimulation and entertainment for patients staying in hospital.

MAY

SaTH was crowned the 2019 Engagement Champion by engagement specialists, MES. The award recognised the Trust's People's Academy and Young People's Academy, which were set up last year to help people gain an insight into the NHS and how it works.

JUNE

Erica Richardson, Lead Diabetes Specialist Nurse, was thanked by the Prime Minister at a reception in Downing Street for her work helping people living with diabetes. Erica was invited to meet Theresa May along with other NHS staff, diabetes charity workers and innovators looking at prevention, care and researching a cure for diabetes.

JULY

Sarah and Mike Clifford thanked porters Nick Evans and Ruth Lowe for saving the life of their baby, Logan, when he unexpectedly stopped breathing. Ruth raised the alarm and Nick, a trained first aider, performed CPR. The pair later went on to win The Sun's 'Ultimate Lifesaver' Award.

AUGUST

A team at SaTH overhauled an NHS Screening Timeline for patients, leading to the resource being rolled out nationally by Public Health England. The timeline runs from conception up to the age of 70 and illustrates screening services that are available to people throughout their lives.

SEPTEMBER

Our Procurement team was ranked 5th out of 133 acute Trusts across the country. The Procurement League Table ranks NHS Trusts for their efficiency in buying goods and services, so this result means the team at SaTH is amongst the very best in the country at delivering value for money for both patients and tax payers.

e Trust has had some major me positive achievements.

OCTOBER

SaTH launched a rainbow badge for staff to demonstrate that they are aware of the issues that lesbian, gay, bisexual, transgender (LGBT+) people can face when accessing healthcare.

NOVEMBER

Following their Sun award, porters Nick Evans and Ruth Lowe appeared on Chris Evans's Breakfast Show—and the presenter donated £6,000 to the Children's Ward live on air.

DECEMBER

The Physics and Radiotherapy team was crowned Team of the Year at the Clinical Research Network West Midlands Awards 2019, run by the National Institute for Health Research. The annual awards showcase the dedication of teams and individuals in giving people the opportunity to take part in research and help to improve the health of the nation.

JANUARY

SaTH and Macmillan Cancer Support worked in partnership with other charities to build a new Macmillan Cancer Support Service and extend existing services at the Hamar Centre at RSH. The new extension and refurbishment allowed the relocation of the Macmillan Cancer Support Service and a new quiet room for patients and carers.

FEBRUARY

A team from SaTH was presented with a prestigious award recognising excellence in the provision of palliative care. Representatives from the Trust received the Dundas Medal at the Royal College of Surgeons of Edinburgh for the Taste for Pleasure initiative.

MARCH

The coronavirus pandemic changed the way we all lived our lives and the way our hospitals worked. Teams across the Trust pulled together to deal with a situation which no-one had seen in their lifetime.

SECTION ONE

PERFORMANCE REPORT

Section One of the Annual Report details our operational performance for the 2019-20 financial year.

It is divided into five sections which reflect our strategic objectives for the year.

Our objectives

PATIENT AND FAMILY

Listening to and working with our patients and families to improve healthcare

SAFEST AND KINDEST

Our patients and staff will tell us they feel safe and received kind care

HEALTHIEST HALF MILLION

Working with our partners to promote healthy choices for all our communities

LEADERSHIP

Innovative and inspirational leadership to deliver our ambitions

OUR PEOPLE

Creating a great place to work

Our priorities

MOVE BEYOND SPECIAL MEASURES

Demonstrate improvement. Re-establish organisational reputation for delivering what we say we will

ACHIEVE AGREED PERFORMANCE

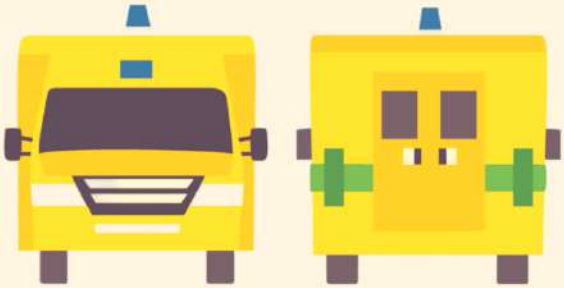
Improve performance in Emergency/ Referral-To-Treatment/Cancer/Diagnostics

BE A SUSTAINABLE ORGANISATION

Achieve our agreed control total

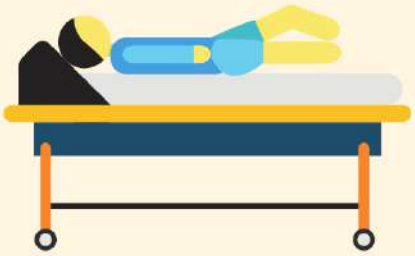
Our hospitals in 2019-20

44,000 AMBULANCES



118,000 (Type 1) A&E ATTENDEES

60,600 EMERGENCY ADMISSIONS (inc CDU)



ACCESS

74% OF PATIENTS ADMITTED, TRANSFERRED OR DISCHARGED WITHIN 4 HOURS OF ARRIVING AT A&E

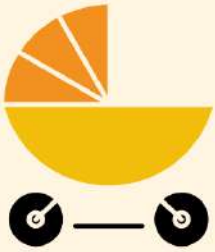
652,000 PATIENT CONTACTS

PLANNED CARE

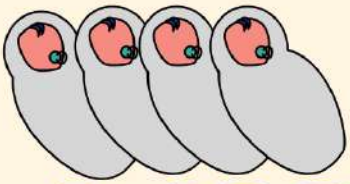
417,000
OUTPATIENT APPOINTMENTS

55,000
DAY CASE AND ELECTIVE INPATIENT SPELLS

WOMEN & CHILDREN'S



9,000 PAEDIATRIC INPATIENTS
113,000 OUTPATIENTS



4,422
BABIES DELIVERED

6,400
STAFF

1,000
VOLUNTEERS

4.2% SICKNESS RATE
90% APPRAISAL RATE
90% STATUTORY & MANDATORY TRAINING

NHS FRIENDS AND FAMILY TEST

93% OF A&E ATTENDEES WOULD RECOMMEND OUR HOSPITALS

96% OF OUTPATIENTS WOULD RECOMMEND SATH

97% OF INPATIENTS WOULD RECOMMEND OUR SERVICES

96% OF MATERNITY USERS WOULD RECOMMEND OUR TRUST

CORONAVIRUS

Response to the COVID-19 Pandemic

The year ended with SaTH, the NHS and the country facing what the Prime Minister called “the worst public health crisis for a generation”.

The impact at SaTH was first felt in mid-March 2020, when non-urgent elective operations were postponed.

On 21 March it was announced that the first patient being treated for COVID-19 at SaTH had, sadly, died. A few days later, all visiting was suspended at RSH and PRH as action began to slow the spread of the virus.

The Trust’s response to the pandemic was rapid. A number of ward moves took place at considerable pace to accommodate patients with respiratory problems with the Trust alert to changes in the number of COVID-19 cases to ensure it was able to respond accordingly in terms of staffing, capacity, and Personal Protective Equipment (PPE).

A COVID-19 Assurance Committee was established to meet weekly, attended by the Chief Executive, Trust Chair, Chair of the Quality & Safety Assurance Committee and other Executive Directors to provide assurance to the board on the approach being taken.

Throughout this complex process, SaTH has worked closely with local system health and care partners to ensure that all aspects of care, both in, and out of hospital, were taken into account.

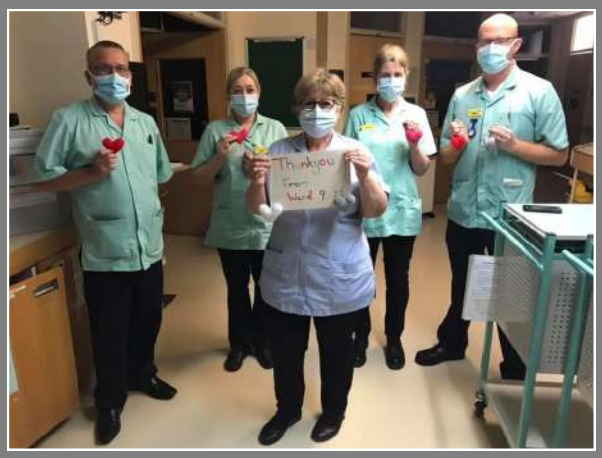
The Trust also significantly changed the way it works, with large numbers of support staff moving to home working to slow the spread of the virus and to free up additional space for those who needed to remain at the Trust, to accommodate ‘social distancing’.

We have also moved to telephone and virtual follow-up outpatient appointments, where this is appropriate. Early feedback suggests that many of these changes have been positively received by both patients and staff. We are looking to embrace the positive changes that we have made going forward.

Chief Executive Louise Barnett said: “This has been an unprecedented time, and I would like to thank all my colleagues across our organisation, in the hospitals and in community settings, along with partner organisations for their tremendous support in responding to the pandemic.”


3M

CORONAVIRUS



The coronavirus pandemic resulted in an overwhelming response from the community towards SaTH, with donations flooding into the Trust.

Donations ranged from surplus or specially-made PPE to home made scrubs, toiletries, uniform wash bags, takeaway meals and treats, with thousands of pounds also raised for SaTH Charity.

Louise Barnett, Chief Executive, said: "From lovely rainbow coloured cards from children to beautiful handwritten notes to staff with encouraging words, the support and generosity shown to us has been truly heart-warming.

"The way people have come forward with such kindness has been phenomenal. It means so much to us all knowing that we have the support from our local community."

The generosity of the local community enabled SaTH to create dedicated staff health and wellbeing hubs at PRH and RSH.

Ben Reid, Trust Chair, said: "The way people have come forward to show their support for our staff has been phenomenal. I would like to say a huge thank you to everyone who has got in touch and supported our teams throughout these challenging times."

STAFF PRODUCED 1,800 VISORS IN TWO DAYS

At the start of the response to the COVID-19 pandemic, staff from the Maxillofacial and Audiology departments created 1,800 visors in just two days. They have since produced thousands more.

In just two weeks, their idea was developed, before being approved for use. The visors were created using medical grade foam, acetate sheet and elastic.

Samantha Bunn, Principal Maxillofacial Prosthetist and Laboratory Manager at SaTH, said: “I was about to leave work when I thought there must be something that we could do to help. I thought we have skills that no one else has and it would be a shame not to use them as a team.

“Myself and a colleague started to put together different ideas while the rest of the team worked from home. Initially, we 3D printed visors, however the demand was too high for the numbers that we could produce with this technique.”

The production of the visors, along with donations from businesses and the national supply chain, meant SaTH was fully stocked.

PATIENT AND FAMILY

Listening to and working with our patients and families to improve healthcare

PATIENT EXPERIENCE

The Trust continues to listen in order to learn and improve. During 2019-20 we began a review of our approach to patient experience with a self-assessment, utilising the Patient Experience Framework with the support of the NHS Improvement national lead. The tool is assisting us to identify performance against CQC key themes which include:

- leadership
- organisational culture
- compassionate care
- safe staffing levels
- consistent incident reporting and learning lessons

and organisational diagnostics against key indicators:

- collecting feedback: capacity and capability to effectively collect feedback
- analysis and triangulation: the use of quality intelligence systems to make sense of feedback and to triangulate it with other quality measures
- reporting and publication: patient feedback to drive quality improvement and learning; the ability to use feedback effectively and systematically for quality improvement and organisational learning

Further work is planned including the development of an exemplar Patient Experience Strategy.

Each Care Group has undertaken self-assessment against the Patient Experience Framework to identify opportunities for improvement. The tool enables the same measures and evidence to be reviewed and themes to be identified.

Through collecting and responding to patient and carer feedback the Trust aims to continually improve the experience of people using our services.

We recognise that we need to engage much more with patients, their families and the community we serve to ensure they help us shape the services in the way they wish to see them delivered. This work will begin in the coming months.


Julia

PACE PANELS

SaTH has an established a Patient and Carer Experience (PaCE) Panel which consists of patient, carer, family, public and staff representatives who work together on quality improvement and patient experience. The Panel was established to listen to and involve patients and carers, ensuring that services are shaped around their needs.

Meetings have focused on reviewing patient experience action plans for each Care Group after assessing services using the Patient Experience Framework Tool.

PaCE Panel members have been involved in a range of activities, including quality ward walks; 'observe and act' visits; the establishment of the equality and diversity group; involvement in the equality, diversity and inclusion stakeholder event; Medical Examiner role; recruitment; the Living With and Beyond Cancer programme; readers' group; Patient-Led Assessments of the Care Environment (PLACE) assessments; patient food tasting; steering groups; and work with our Transforming Care Institute.

DEMENTIA CARE

SaTH has reviewed the Dementia Strategy in line with the Dementia Action Alliance Dementia Friendly Hospital Charter, in consultation with people living with dementia and carers.

The Dementia Team is compliant with the 90% national dementia screening target. We deliver face-to-face training to meet Tier 2 standards each month for all staff. This is delivered across all disciplines to promote improved person-centred care and multi-disciplinary working. All dementia support workers have completed NVQs in End of Life Care.

The Dementia Team has been at the forefront of improvements for patients' quality of care by developing dementia-friendly cafes and promoting afternoon tea on frailty wards at each site, through joint work with a care agency and volunteers.

The team has been supporting people living with dementia and their carers. This includes hand massage alongside our regular activities.

Over the last year there has been a focus on our nutrition and hydration work, which continues with a review of finger foods offered for patients in line with the international Dysphagia Diet standardisation initiative. The team has also continued to roll out droplet hydration systems.

COMMUNITY ENGAGEMENT

SaTH was crowned the 2019 Engagement Champion by engagement specialists, MES. The award recognised our People's Academy and Young People's Academy, set up last year to help people gain an insight into the NHS and how it works locally.

The People's Academy involves attending four sessions over four weeks, and includes presentations, behind-the-scenes visits, demonstrations, activities and opportunities for participants to ask senior staff questions.

Judges marked eight shortlisted entries for innovation, impact, meaningfulness and whether the work is truly embedded.

ADDITIONS TO THE PEOPLE'S ACADEMY PORTFOLIO

LEARNING DISABILITY ACADEMY

Working with partners, Patient Experience and the Trust lead for Learning Disabilities, the Engagement team developed a format for Learning Disability Academies, primarily to reduce any anxiety about coming into our hospitals. Each Academy focuses on a specific interaction with hospital services, and uses a video to show a "typical" visit, and opportunities to ask questions of clinical staff.

The first Academy looked at visits to Outpatients at RSH and the second at a visit to the Pre-Operative Assessment Clinic at PRH. The video has been amended following feedback, and an opportunity is provided for attendees to familiarise themselves with some of the equipment used during their visit. Clinical staff are available to answer questions.

The Academies finish with an opportunity to sample hospital food. Feedback has been very positive, and we hope to expand the offer.

JOBCENTRE ACADEMY

The Engagement team responded to a request from Telford Jobcentre to provide an Academy course for entry level vacancies, by creating a one day session involving Portering, Stores, Estates, Catering, Cleanliness and Medical Records/Administration. The Nursing team supported a classroom session looking at Health Care Assistants, Women's Services Assistants and other clinical support roles. An integral part of the course was a Dementia Friends Awareness session, and feedback has been very positive. We hope to hold up to four courses a year on both sites and extend invitations to the wider Jobcentre team.

36 community meetings attended

22 events attended

10 community meetings held

1 Equality Impact Assessment focus group

13 involvement opportunities

58 expressions of interest

EXTERNAL ENGAGEMENT

Some people put themselves forward for more than one opportunity, but in total more than 30 individuals have worked with teams in the Trust over the past year. Our standout moment was the response to the Patient-Led Assessment of the Care Environment (PLACE) inspections, where 18 people, including young people, came forward to be involved.

SAFEST AND KINDEST

Our patients and staff will tell us they feel safe and received kind care

SaTH continues to be rated ‘Inadequate’ by the Care Quality Commission (CQC) following an inspection in November 2019.

The Trust is rated ‘Inadequate’ for Safe, Effective, Responsive and Well-Led, and rated ‘Requires Improvement’ for Caring. Areas of ‘Outstanding Practice’ were, however, recognised in Outpatients at PRH, where a nurse-led wound clinic to provide continuity of care for patients has freed-up space in other clinics, and in surgery at RSH where the inspection team saw examples of “excellent support for patients living with dementia on most wards”.

Improvements have been recognised in Maternity services, including staff treating women with compassion and kindness, respecting their privacy and dignity, and taking account of their individual needs.

Chief Executive Louise Barnett, who joined SaTH in February 2020, has described the determination of the Trust’s leadership team to make the necessary changes to improve. She said the Trust would build on the CQC report “to make the sustainable changes needed to ensure the consistent delivery of safe, high-quality care that the people of Shropshire, Telford & Wrekin and mid Wales deserve”.

She said: “We will continue to work closely with our staff, patients and our regulators to improve the quality of care for all of our patients.”

A Quality Improvement Plan is in place to monitor progress and improve quality and safety, and the Trust is working closely with the Emergency Care and Intensive Support Team (ECIST) and the internal Transforming Care team to assure sustained improvement against all of the ‘Must Take’ and ‘Should Take’ actions listed in the CQC’s report.

We recognise the results from the latest CQC inspection and will continue to take actions to make positive changes in the way that we work. We shall strengthen our leadership, support our staff with training and development and continue to recruit more clinical staff in order that we can deliver the high standards of care we and our patients expect every day.

PERFORMANCE

2019-20 proved to be a challenging year for the Trust with regards to achievement of the performance trajectories against the four-hour A&E standard and Referral-to-Treatment target.

There was a significant increase in the number of emergency admissions during the year.(3.8% above the plan and 9% above plan until March). To be able to manage this level of increased demand, elective activity had to be displaced, resulting in an underperformance against the operational planning trajectory. Disappointingly, our four-hour performance in A&E deteriorated significantly, with the number of 12 hour trolley waits the highest the Trust has experienced.

The increase in emergency activity had a significant impact on the delivery of the 18 week Referral-to-Treatment (RTT) target. Both day surgery units were used for surgical and medical emergencies during the winter months, reducing the routine day case activity that could be undertaken. Therefore, the growth in the waiting list size has increased and the number of +40 week waits increased to 245 at the end of March 2020, resulting in 11x52 week waits.

During the latter part of March 2020, all routine elective activity was cancelled to respond to the COVID-19 pandemic.

Cancer performance improved throughout the year and there was improvement in the two-week wait performance, improving from 82% in April 2019 to 93% in March 2020. 62 day cancer performance also improved from 72% in April to 78% in March. However, the Trust recognises the effect of the pandemic on waiting times and we are striving to ensure targets are met.

Work has been undertaken in four tumour sites: lung, upper GI, colorectal, and head & neck, to improve performance. This work is ongoing and has used Transforming Care methodology to support the change.

A recent visit from the Intensive Support Team (IST) highlighted some areas of good practice in our monitoring and management of patients on a cancer pathway.

Performance against the Diagnostics target was achieved for most months. There were some capacity constraints in Radiology and Endoscopy during some months of the year, due to increasing demand and also service logistics and constraints. In March 2020, due to COVID-19, routine diagnostic capacity was reduced, resulting in a significant underperformance against the national target.

CASE STUDY: TASTE FOR PLEASURE

SaTH was awarded the Dundas Medal, which recognises excellence in palliative care. The medal was introduced by the Scottish charity PATCH (Palliation and The Caring Hospital) and The Royal College of Surgeons of Edinburgh, and aims to recognise improvements in end of life care for patients when they are in hospital.

The award recognises the work done by the End of Life Care and Speech and Language Therapy teams at SaTH to change the culture of nil by mouth for end of life patients through the introduction of Taste for Pleasure.

Taste for Pleasure means that when receiving end of life mouth care (cleaning and hydrating the mouth), hospital staff can use the patient's favourite flavours to provide moisture.

These flavours can be anything from blackcurrant squash and tea to whisky and Prosecco.

IMPROVE TREATMENT OF SEPSIS PATIENTS

The Trust acknowledges that there was a need to improve its responsiveness to compliance with best practice in relation to the management of sepsis. We therefore initiated a series of actions to achieve this, including:

- review and re-writing of the Sepsis and Deteriorating Patient Policy to provide clarity around roles and responsibilities, and set down a standardised approach to the management of sepsis patients
- roll out of new screening tools and sepsis pathway documents aligned with the above to ensure the process is known, can be followed by all, and is clearly documented for clarity of audit
- impact of the roll out to be monitored by specialties with the assistance of the Sepsis Team to look at compliance on screening and accuracy, responsiveness in management and the appropriateness of this management in line with national guidance, with an action plan for addressing areas which fall short of the required standard
- improvement work in our Emergency Departments with support from NHS Improvement, resulting in an increased number of assessment nurses and a reduced time to first assessment with improved recognition of sepsis

Audit data and impact of the roll out of the screening tools will be reported to the Deteriorating Patient Committee with quarterly updates to the Quality and Operational Group.

SEPSIS SREENING TOOL AND SEPSIS PATHWAY

The sepsis screening tool has been reviewed and altered in line with National Institute for Clinical Excellent (NICE) guidance and recommendations from the Sepsis Trust.

This tool has been trialled in the Emergency Departments and AMUs. Subsequent work has incorporated all specialties to ensure sepsis recognition is standardised throughout the organisation.

The sepsis pathway was developed to address lack of consistency across the organisation around sepsis documentation. This will ensure continuity of care for patients moving around the organisation and the impact will be monitored as with the screening tool.

Regular monitoring of the actions occurs through audit to ensure that continuous improvement can be embedded in the Trust.

SEPSIS NURSE

In July, SaTH appointed its first Sepsis Nurse Practitioner to strengthen sepsis care. Angela Windsor took on the role following her work at the Trust as a Resuscitation Officer.

Her role is to facilitate a push forward in the way the Trust detects and treats sepsis and ensure that this work is sustainable, as well as focusing on the screening and treatment of sepsis patients and providing education and training to staff.

PATIENT SURVEYS

We recognise that more work needs to be done to achieve patients' expectations. Listening to patients' views is essential to providing a patient -centred health service.

The NHS Patient Survey Programme systematically gathers the views of patients about the care they have recently received.

The results of the latest Adult Inpatient Survey, published by the Care Quality Commission (CQC), showed that our patients had confidence and trust in the doctors, nurses and other clinical staff who cared for them and were treated with dignity and respect.

However, there were a number of areas where, although in line with most other trusts in the country, our results fell and those are being examined to see how and where we can improve.

Like the Inpatient Survey, the National A&E Survey, also published by the CQC again showed that patients were treated with dignity and respect and had confidence in the clinical staff looking after them.

SaTH scored 8/10 or higher on more than 70% of the questions in the latest Children and Young People's Patient Experience Survey from the CQC.

The results included scores of 9/10 or higher in children and young people (aged 8-15) feeling able to ask staff questions; staff answering those questions and staff talking through any worries that they had.

The Trust also scored 9/10 or higher for parents or carers of 0-15-year-olds saying staff gave them information about their child's care in a way they could understand and staff agreed a plan for their child's care with their involvement.

The 2019 CQC Maternity Survey found that women cared for by SaTH had confidence and trust in the staff caring for them during their labour and the birth of their baby. Women who responded to the survey said they were treated with dignity and respect during labour and birth,

and were able to get help when they needed it.

SaTH scored 8/10 or higher in 73% of the questions asked. Of the 35 questions in which SaTH achieved this score, 21 (60%) scored 9/10 or higher.

In the 2018 National Cancer Patient Experience Survey, patients gave their treatment at SaTH an average rating of almost 9/10.

We scored significantly higher than the national average in patients being told they could bring a family member or friend with them when they were first told they had cancer and also scored highly on patients being told who they could contact if they had any concerns after they had been discharged.

The survey found that 85% of patients felt they were informed in a sensitive way that they had cancer (in line with the national average) and 9/10 of patients were always treated with respect and dignity by staff.

NHS FRIENDS AND FAMILY TEST

A total of 43,094 Friends and Family Test cards were completed and returned during 2019-20. Of the cards completed, 97.1% of respondents said they would be extremely likely or likely to recommend the Trust's services. SaTH performed higher than the national average in all categories; Inpatient, Outpatient, A&E and Maternity.

INFECTION PREVENTION AND CONTROL

The Trust continues to drive a refreshed integrated multi-disciplinary approach to Infection Prevention and Control (IPC) across the whole patient journey whilst at the same time addressing the unprecedented IPC requirements for tackling the COVID-19 pandemic.

Achieving excellent standards of care and improving practice is essential to reduce infections in line with our zero tolerance approach to avoidable healthcare associated infections.

In October, NHS Improvement Midlands' Senior Infection Control Advisor undertook an inspection of IPC arrangements, supported by the IPC Lead for Shropshire and Telford & Wrekin CCGs. They reported a continued focus and energy, with significant improvement identified and the Trust was given a 'Green' rating for the first time in two years.

Despite the NHSI rating, the Care Quality Commission (CQC) raised concerns and NHS England/Improvement downgraded to rating to 'Red'. As a result, sustained improvements have been put into the Trust Quality Improvement Plan to hold staff to account from ward to board.

The most prominent source of infection is the use of urinary catheters, which can lead to urinary tract infections. Catheters cannot be eliminated but we continue to focus on aseptic technique in inserting, ongoing care of catheters, and encouraging review and removal as soon as possible, to greatly reduce risk.

We continue to focus on Sepsis, compliance with hygiene standards, antibiotic stewardship, early identification of risks and timely intervention to reduce infections.

The target for MRSA bacteraemia is zero and we ended the year with one. Collection contaminants was a major issue in 2018/19, when we had five cases, of which only one was a true bacteraemia and four were contaminants.

The Trust has worked hard to improve collection technique over the year and this has been reflected in a much lower contamination rate.

Our Clostridium difficile (C diff) target was 43. We finished the year with 54 cases. The target criteria was changed nationally to reflect community cases which were probably acquired in the Trust. Antibiotics continue to be the most common cause of C diff and we saw very few that suggest transmission in hospital.

Outbreak management continues to be a high priority for the team and we have done a lot of work in this area to ensure we are detecting and reporting outbreaks promptly, and taking actions at pace to reduce further cases.

PRESSURE ULCERS

Pressure ulcers are a key indicator of the quality and experience of patient care. An external review, commissioned in July, found the need for a more proactive approach to be implemented.

The Trust requirement is for all patients to have a risk assessment within two hours of admission. The standard is not always achieved in a consistent way.

The Lead Nurse for Tissue Viability has implemented and is embedding the review recommendations and utilising the Trust's Quality Improvement methodology to target areas where there is a high rate and incidence of pressure ulcers.

A gap analysis of NHSE/I recommendations was completed with clear actions aligned to the review recommendations and an action plan that is being implemented, monitored and audited.

We continue to strive to ensure we meet all the targets set and reduce the risk of harm to patients.

REDUCING FALLS

The increase in patient age, acuity and frailty means the Trust is seeing more patients who have experienced a fall and more patients with a higher risk of falling. During the year, an external review of the Falls Service was commissioned, which highlighted some gaps.

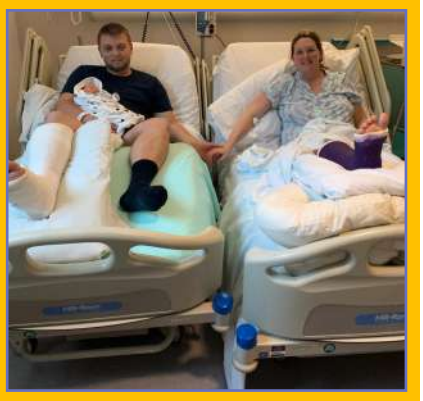
An analysis of 2019-20 falls data showed a decrease of 5.5% compared with the previous year based on pure numbers and a decrease of 5.7% when viewed in terms of 1,000 bed days. Ongoing monitoring of falls per 1,000 bed days and falls per 1,000 bed days resulting in moderate harm or above indicates the Trust is performing well against levels outlined by the Royal College of Physicians.

However, falls risk assessments were not always completed or updated on admission, on change in patient's condition or on discharge or transfer. Enhanced observational care was not in place or there were lapses, resulting in patient falls and nurses not always visible in bays. This is a consistent theme and a focus for improvement.

In response to the Falls Review findings, the Trust took the opportunity to re-focus and strengthen the approach to reducing harm as a result of falls under the single leadership of the Deputy Director of Nursing for Quality and Patient Safety. The Lead Nurse for Falls is implementing and striving to embed the Trust Quality Improvement methodology across the Trust, targeting areas where there is a high rate and incidence of falls.

Other improvements include increased awareness of falls prevention across the Trust, an increase in identification of older adults at risk of experiencing a first time or recurrent fall, a comprehensive holistic assessment tool that supports falls risk stratification, and earlier intervention for known falls.

CASE STUDY—GINNY, MIKE AND AMBER



For Ginny Magrath and Mike Roberts, a journey for a check-up on their unborn baby took a dramatic turn when a car crash left them both hospitalised and Ginny undergoing an emergency C-section. With Mike being treated in a different hospital, the experience could have been a much worse, if it was not for the care of staff at both PRH and RSH.

Ginny and Mike were travelling to PRH when the collision happened, leaving them both with badly broken ankles. Mike was taken to RSH and Ginny to PRH, to monitor their unborn baby. It was there the decision was taken for Ginny to have an emergency C-section. The couple's baby – Amber Harriet Roberts – was delivered safely four weeks early, weighing 6lb 10oz.

The couple praised staff for their treatment and the care shown to them to ensure the family could be together. Ginny said: "It was really scary and I was obviously concerned for Amber and for Mike. They said the safest thing was to perform the emergency C-section. I was very apprehensive, but the team were fantastic."

Doctors at RSH were preparing to admit Mike for an operation but did not want to split the family up and so arranged for him to be moved to PRH. Ginny said: "The Consultant at RSH said he didn't want to separate us, so he spoke to the Consultant at PRH and arranged for Mike to come to Telford and have his operation and recovery here."

It meant Mike was able to go to see Ginny and Amber, the couple's first child. Ginny said: "From what was a really scary time, the whole experience was just so positive. The care we had could not have been any better and I would just like to say a huge thank you to everyone involved in our treatment and in going the extra mile to make sure Mike and I could be together as much as possible."

SAFEGUARDING

Safeguarding Adults is a fundamental and integral part of delivering safe care and we are committed to improve in 2020-21. In 2018 the CQC inspected the Trust and and were not assured that systems were robust enough. Specific concerns were raised in relation to completion of mandatory training, including Mental Capacity Act. An independent external review was commissioned, resulting in 20 recommendations.

In order to ensure the Trust's statutory responsibilities are met, a Safeguarding Committee has been established to replace the former Safeguarding Operational Group, with reports to the Board.

A report and action plan have been presented to the Clinical Governance Executive, Quality and Safety Committee and reported to the Trust Board and a Board workshop on Safeguarding Adults is planned for 2020/21.

SAFEGUARDING CHILDREN & YOUNG PEOPLE

The Safeguarding Team continues to work with both Local Safeguarding Partnerships (for Telford & Wrekin and Shropshire).

Since September 2019, SaTH has had a Hospital-based Independent Domestic Violence Advisor from West Mercia Women's Aid on site at both hospitals to assist with Domestic Abuse, mainly in the Emergency Department and Maternity but also cases involving other areas of the hospital. The scheme is funded by the Police and Crime Commissioner and is working extremely well.

SEVEN-DAY SERVICES

A Seven-Day Services Working Group is chaired by Scheduled Care Group Clinical Director. Its role is to identify workforce gaps, financial implications and develop business plans for each area to enable implementation of four key standards:

- Time to Consultant Review
- Access to Diagnostics
- Access to Consultant-directed Interventions
- Ongoing Review

Time to Consultant Review: SaTH saw a reduction in performance due to increase in demand and the requirement to employ more staff. The Board of Directors has committed to investment in the clinical workforce.

Access to Diagnostics: Improvements have been made in weekend availability by formal arrangement of ultrasound at weekends. There is a transition from Consultant-led to Sonographer-led ultrasound at weekends which will enable SaTH to meet the full requirement. Ultrasound can be provided within one hour for critical patients.

MRI is also available at weekends by formal arrangements, again within one hour for critical patients. A business case for investment to meet this target fully is being worked up.

Access to Consultant-directed Interventions: Formal constructive discussions with neighbouring Trusts to determine different options to progress this standard are ongoing.

Ongoing Review: The most recent audit results demonstrated a significant improvement, with twice daily reviews achieving 100% for weekdays and weekends. This is due to an improved staffing model of the critical care units at weekends.

HEALTHIEST HALF MILLION

Working with our partners to promote healthy choices for all our communities

GP LIAISON AND ENGAGEMENT

GP liaison/engagement is focused on strengthening relationships with primary care and creating opportunities for clinical engagement between primary and secondary care to share learning and best practice.

The GP Liaison/Engagement remit covers:

- being a recognised first point of contact in the Trust for the GP practice teams in Shropshire, Telford & Wrekin and mid Wales
- providing a responsive and empathetic approach to dealing with GP concerns
- following a robust reporting process for two-way feedback between primary and secondary care
- maintaining a programme of productive personal contact with GP practices
- effective and meaningful communication with primary care through the recognisable GPConnect brand, for example the monthly GPConnect newsletter
- offering opportunities for enthusiastic and proactive Trust clinicians who are keen to engage with primary care to develop effective partnership working
- bringing together our clinicians and local GPs, through focused study days and Meet the Team events

In 2019-20, in partnership with the Medical Director at Shropshire CCG, a Joint Continuing Professional Development (CPD) Forum was set up for primary, secondary and community care clinicians.

A new collaborative project between primary and secondary care, the GP-Consultant Exchange Scheme, has also been established. The Scheme involves pairing a GP volunteer with one of our Consultants. Each pair spend one session in each other's workplace. The GP and Consultant volunteers then share their learning and reflective experiences at a later event for all participants to attend.


Reebok

IMPROVEMENTS IN CANCER CARE

SaTH and Macmillan Cancer Support are working in partnership the Lingen Davies Cancer Fund and RSH League of Friends to build a new Macmillan Cancer Support Service and extend existing services within the Hamar Centre at RSH.

SaTH provides counselling and well-being services at the Hamar Centre for people with cancer and other life-threatening conditions. The new extension and refurbishment of the Centre will see the existing Macmillan Cancer Support Service, which provides information and advice to people living with cancer and their loved ones, being relocated to a larger space within the Hamar Centre, and will include a new quiet room for patients and carers. Macmillan has invested over £380,000 in fundraised income to help deliver the new Centre.

The project also includes the construction of an extension to the building, providing more facilities for counselling and well-being services provided by the Trust. By relocating the Macmillan Cancer Support Service and expanding the facilities on offer, staff and volunteers will be able to support more people affected by cancer and other life-threatening conditions.

SaTH and Macmillan have also worked together on a new Living Well video made by staff and volunteers, which aims to provide more information and support to local people living with cancer, especially those in the most isolated areas in the region.

The video provides patients with an opportunity to hear from other people living with cancer as they reflect on their experience and learn what 'Living Well' means to them. It also provides patients with the opportunity to receive accurate and clear information about the four most commonly highlighted concerns of people affected by cancer. These include emotional wellbeing, fatigue and physical activity.

The video has been produced as part of The Macmillan Living With and Beyond Cancer Programme. The programme is a £350,000 project funded by Macmillan Cancer Support hosted by SaTH. The Trust is working in collaboration with Macmillan Cancer Support, Telford and Wrekin CCG, Shropshire CCG, Powys Teaching Health Board, Telford & Wrekin Council and Shropshire Council.

The programme aims to enable and empower patients to take an active role in their cancer care to help them recover as fully as possible and live life as well as they can with cancer, throughout their treatment and beyond.

RESEARCH AND INNOVATION

SaTH's Research and Innovation Team has recruited 1,106 patients to studies adopted by the National Institute for Health Research (NIHR). In addition, the team has supported the Trust's two Clinical Trial Scholars in their work with the Birmingham Clinical Trials Unit and with applications for funding their research from national funding bodies.

The R&I team underwent a dramatic re-deployment and expansion of the team and activity to enable SaTH to participate in appropriate COVID-19 research, temporarily suspending 89% of studies in response to the pandemic or at the sponsor's request.

Seven studies were opened in response to the pandemic with the aim of helping clinicians and scientists develop a better understanding of COVID-19; its presenting symptoms, how and why the virus affects certain people more than others and hopefully to help to develop effective treatments. Almost 800 patients took part.

CASE STUDY: DIABETES

In June, Erica Richardson, Lead Diabetes Specialist Nurse, was thanked by then Prime Minister Theresa May at a reception in Downing Street for her work helping people living with diabetes.

Erica was invited to meet Mrs May at Number 10, along with other NHS staff, diabetes charity workers and innovators looking at prevention, care and researching a cure for diabetes.

Erica said: "It was an honour to represent all those who work hard to provide training, support and research within the diabetes community, including the team at SaTH, who work tirelessly to do this.

"My aim in life is to always do my best in everything I do and my main aim as a Diabetes Specialist Nurse at SaTH has been, and always will be, to improve the care and services that we provide to those with diabetes."

SaTH played an active role in Type 2 Diabetes Prevention Week in April, which asked the public to speak to their GP practice about the NHS Diabetes Prevention Programme if they think they might be at risk.

SaTH, along with NHS England, Diabetes UK and Public Health England, worked to raise awareness of the causes and complications of Type 2 Diabetes and promoting the Healthier You: NHS Diabetes Prevention Programme, which helps those at risk of Type 2 Diabetes to reduce the risk by managing their weight and adopting a healthier lifestyle.

SATH CHARITY

The Trust has a dedicated charity that is structured to solely benefit patients, their families and our workforce. The Charity works alongside other charitable partners including the League of Friends at RSH, The Friends of PRH and the Lingen Davies Cancer Fund.

In 2019-20, SaTH Charity raised in excess of £700,000 which was used to improve the clinical outcomes or patients through the purchase of items not usually funded through NHS procurement routes. Additionally, funds were used to provide specialist training for staff that would have a direct impact on our patients.

Funds were also spent on making our patients more comfortable through items such as dedicated end of life Swan Rooms, televisions, radios and specialist items to support patients with dementia.

The Trust recognises that SaTH Charity also provides an opportunity for individuals and businesses to engage with the Trust and support our activities.

The Charity has a dedicated fund - Small Things Make a Big Difference - which supports staff with items that focus on their wellbeing. Items purchased include; fridges and microwaves for staff rooms and outdoor furniture to enable staff to enjoy their breaks in the fresh air.

LEADERSHIP

Innovative and Inspirational Leadership to deliver our ambitions

This year has been one of significant change at the very top of the organisation, with new members joining SaTH's Board.

Chief Executive Simon Wright left his post in July, with Paula Clark taking over as Interim Chief Executive before Louise Barnett took up the post in February. Louise joined SaTH from The Rotherham NHS Foundation Trust, having joined them as interim Chief Executive in October 2013, prior to being appointed to the substantive position in April 2014.

In May, Barbara Beal joined the Trust as Interim Director or Nursing, Midwifery and Quality following the departure of Deirdre Fowler.

Medical Director Dr Arne Rose joined in June, taking over from Dr Edwin Borman, who became Director for Clinical Effectiveness.

Also in June, we were joined by Interim Finance Director James Drury, who took over the post from Neil Nisbet, who became Programme Director for the Hospitals Transformation Programme.

In October, Rhia Boyode became Interim Workforce Director, with Victoria Rankin becoming Executive Lead for People for the Shropshire and Telford & Wrekin STP.

Bev Tabernacle was appointed Director of Strategy and Transformation. As the Trust looks to strengthen and improve its governance, SaTH established a new post of Director of Governance and Communications. The post is filled on a temporary basis by David Holden, with a substantive appointment being made in the coming months.

There have also been changes in the Senior Leadership at the Trust, most notably in the Women and Children's Care Group with the appointment of Janine McDonnell as Care Group Director and Nicola Wenlock as Director of Midwifery.

Dr Steve McKew became the new Care Group Medical Director for Clinical Support Services and Mr Ed Rysdale was appointed Clinical Director for Emergency Medicine.


Louisa

THE FUTURE OF OUR HOSPITALS

In 2019-20 the Hospitals Transformation Programme (HTP) replaced the Sustainable Services Programme as the project to transform hospital services for the people of Shropshire, Telford & Wrekin and mid Wales moved into its next phase.

The programme is responsible for implementing the reconfiguration of services at PRH and RSH which were designed as part of the NHS Future Fit programme.

PRH will become a dedicated Planned Care site and RSH will become a specialist Emergency Care site. Both hospitals will have a 24-hour urgent care facility. This will allow specialist doctors to treat the most serious cases at the Emergency Care site, which is safer and will provide better results for patients and reduce the amount of time people have to stay in hospital. SaTH is working with NHS England and NHS Improvement on an enhanced model which will ensure as much clinically appropriate care as possible is delivered at PRH.

In October, Matt Hancock, Secretary of State for Health and Social Care, accepted advice from an independent panel of experts that the reconfiguration should proceed.

The following month, SaTH submitted its draft Strategic Outline Case (SOC) to NHS England and NHS Improvement. This details the Trust's plans to address the significant challenges to the safety and sustainability of patient services, specifically in Emergency and Critical Care.

The HTP Team is now working on the next stage of business planning and is developing the Outline Business Case (OBC). This includes in depth analysis of activity and workforce modelling to ensure the creation of a model that is fit for the future. Staff are vital in helping us to construct our new services and will continue to be heavily involved via task and finish groups and workshops. We are also linking up with other hospitals who are delivering similar transformation programmes to share our approaches and learning.

FINANCE

In 2019-20 the Trust reported a deficit of £26.1m (£35.3m prior to Provider Sustainability Funding [PSF]) compared to a financial control total of a breakeven position (£17.4m deficit prior to PSF).

Key factors accounting for this were:

- continued increase in demand for urgent care services above planned levels giving rise to additional income of £12.6m
- delivery of additional income required more capacity at premium cost. Together with continued high levels of vacancies across the clinical workforce, this drove additional use of premium rate agency staff of £5.1m
- additional income generated incremental costs of delivery of £8.4m
- non-recurrent costs relating to investment to deliver financial benefit in 2020/21 and beyond (such as overseas recruitment, efficiency improvements and organisational development) of circa £5.9m
- increased costs of service delivery due to energy, clinical waste and higher estates maintenance costs due to backlog deterioration
- non-delivery of efficiency improvements of circa £7.5m
- non-delivery of control total and loss of PSF income of £8.2m

CASE STUDY—PROCUREMENT

The Procurement team achieved Level 2 accreditation in the NHS Standards of Procurement in November 2019. Earlier in the year, the team was ranked 5th out of 133 acute Trusts across the country for its efficiency in buying goods and services. This recognition reflected in the financial position through the delivery of financial savings of £1.6m in 2019-20.

Last year, the team was a finalist at the Health Service Journal's Value Awards, in the category of Financial or Procurement Initiative of the Year. The team was shortlisted for making savings of £1.8million in 2017-18 using 'lean methodology' from the Trust's Transforming Care Production System.

Paula Davies, Head of Procurement at SaTH, said: "I am extremely proud of the team and commend the hard work they put into ensuring we offer best value for money for the products and services we procure."

MEDICAL EDUCATION

POST GRADUATE

SaTH has launched a Priority Foundation Programme, an innovative Foundation Doctor rotation which will send doctors to New Zealand for a year. This programme is a collaborative scheme with Health Education England and the UK Foundation Programme Office to attract doctors to the region. The Postgraduate Education Team has started internal formal quality assurance (QA) visits to departments, giving a structured approach to improvements in local training. In the last 12 months SaTH has invested in a bespoke Clinical Fellowship programme to support and train locally employed doctors. We are working collaboratively with The Royal Wolverhampton NHS Trust to get a rotation of doctors through both of our Trusts into difficult-to-recruit-to specialties to provide a well-educated, stable and permanent workforce.

UNDERGRADUATE

SaTH is now the clinical placement site for half of all Year 4 and 5 Keele Medical School students. The Trust and its faculty are proud of the fact that Keele is ranked second in the Guardian rankings for the United Kingdom (only below Oxford and above Cambridge). The excellent teaching and student experience were confirmed at the formal QA visit by the Medical School in November. As a response to the COVID-19 pandemic, a new Medical Assistant (MA) role was created for Year 4 and 5 Undergraduate medical students to support frontline staff. The MA role in its original form (evenings and weekends) will continue all year round, even after the current situation is over.

MEDICAL EXAMINERS

In line with national guidance and best practice SaTH set up a Medical Examiner (ME) service which started on 1 April 2019. The Medical Examiner role is pivotal in improving learning from deaths by ensuring that all deaths in the hospital setting are independently reviewed in addition to the standard mortality review process. MEs also help junior medical staff complete death certificates or HM Coroner referrals. They speak to relatives in all circumstances and provide feedback, both positive and negative, to the appropriate teams. The identification of serious events is an important part of the role, feeding into patient safety groups. The service is staffed by three clerical officers and seven consultants, each of whom work one session per week. The service is presently only at RSH with expansion planned at PRH by the autumn 2020.

TRANSFORMING CARE

2019-20 was the penultimate year of the Trust's partnership with the Virginia Mason Institute in Seattle, which has seen the organisation make great strides in training and implementing the Transforming Care Production System (TCPS) as the organisation's single method for enabling staff to make improvements.

One of the key elements of the TCPS is the ability of all leaders in the organisation to create an environment in which all staff feel empowered to make sustainable improvements, that benefit both patients and staff. This is primarily achieved through the Lean for Leaders course, which enables participants to learn to apply Lean tools to support them lead change within their respective teams.

This year over 200 Lean for Leaders have been trained, which has significantly increased the capability to make improvements throughout the Trust.

This year also saw the first Patient representative embark on the course. Julie Southcombe, who has been involved in various improvement events as part of the Ophthalmology Value Stream, seized the opportunity to gain a deeper understanding of the tools and techniques used as part of the TCPS, that she will then be able to share with other patient representatives.

The learning for this year has been around staff leaving their areas, due to either being promoted, or change of roles, which has resulted in teams losing expertise and newly acquired skills to make and sustain improvements. To improve this, it is intended to take a more focused approach to the selection of Lean for Leaders that aligns with the organisational priorities, while at the same time, ensuring more than one member of staff per area enrols on the course.

Work continued to progress with seven Value Streams: sepsis, recruitment, Ophthalmology Outpatients, patient safety reporting, Radiology, Emergency Department, and Surgical pathway. Radiology, Ophthalmology and Recruitment were able to transition to their associated care groups, which provided capacity to look at different improvement opportunities, particularly those associated around the CQC, some of which were aligned to current Value Streams; Surgical pathway and ED.

As part of the Surgical pathway, a week-long workshop took place focusing on support to patients presenting with mental health needs. Looking specifically at 16-17 year-old patients, it was identified locally and from the CQC that there was a lack of clarity around their pathways, which at times, meant they were kept in an environment not always appropriate to their needs.

A patient mental health advocate was part of the team and provided real insight into the issues around presenting with underlying mental health issues.

This year has seen an increase in the Executive team and the Non-Executive team conducting regular 'Genba' walks to understand the improvement work that is being undertaken first hand. Additionally, it provides an opportunity to better understand why some leaders have declined taking part in the Lean for Leader programme and help support them in the future, as well as celebrating those leaders who are effectively using daily management as a means of ensuring they improve their standards.

Despite all the good work completed throughout the year, more work is required to embed and spread the methodology to enable staff make improvements. This is particularly important when addressing CQC concerns.

MEDICAL LEADERSHIP

There has been a drive to encourage uptake of Medical Leadership roles within the organisation with the appointment of a new Medical Appraisal Lead in November 2019. This post had been vacant for two years.

SaTH was successful in its bid for Medical Leadership Development funding and has partnered with the Faculty of Medical Leadership and Management (FMLM) to deliver this starting in the latter part of 2020. This will incorporate the Senior Medical Leadership Team, Clinical Directors, Corporate Leads, Aspiring Clinical Leaders and all Consultants and Senior Medical Staff.

This comprehensive programme will extend over a two-year period to support and improve the capabilities of medical leaders at SaTH.

In addition to this, the medical leadership structure (all leadership positions as well as all corporate functions, eg medical sepsis lead) will be under an improved financial portfolio and budget of the Medical Director. This means that the Medical Director will have more direct influence on the recruitment to, and the development of, these positions.

A Medical Taskforce Committee has been established which monitors and reviews all key components for the medical workforce to ensure there are appropriate process and governance surrounding job planning, medical appraisals, recruitment and retention, sickness, annual leave, locum and agency usage are carried out to the appropriate standards.

LEADERSHIP PRAISED

Chris Hopson, Chief Executive of NHS Providers, praised SaTH for its 'desire to learn and improve' when he visited the Trust.

Chris visited wards and departments including Maternity, Postnatal, Estates, Cardiology and Respiratory at PRH.

He said: "It was great to see the passion and enthusiasm of the next generation of leaders for continuous improvement and improvement methodology.

In Maternity, Chris met Jill Whitaker, Matron for Consultant Unit Maternity Services, who showed improvements including information boards which are used to share key data in an efficient manner during daily team 'huddles'.

Chris said: "I was very impressed with the thoughtfulness, desire to learn and improve, and patient and safety focus of senior and maternity service leaders, given past issues affecting maternity services. There is a strong commitment to providing an outstanding service for local women."

He said he was "struck by how reliant the NHS is on the brilliance, commitment, professionalism, resourcefulness, resilience and skill of its frontline leaders, from Ward Managers and Matrons to Corporate Service and business managers. They are often unsung heroes and heroines."

OUR PEOPLE

Creating a great place to work

RECRUITMENT

There has been an 8% increase in permanent staff over the last year, with an increase in overall Nursing and Medical numbers throughout the 2019-20 (4.5% increase in Nursing and 8% increase in Medical).

There has been significant investment in the workforce, particularly in areas such as the Emergency Department, where 21 Specialty Doctors have been appointed following a successful international recruitment campaign.

SaTH has been actively recruiting overseas nurses in partnership with Health Education England Global Recruitment since the summer of 2019. So far 99 overseas nurses have come to work at SaTH.

Due to the COVID-19 pandemic, further deployment was put on hold until travel restrictions are lifted. Recruitment work has continued to ensure the originally agreed numbers are all recruited to. A total of 212 Band 5 nurses have been appointed.

The nurses already in the UK are either qualified and working as Band 5 nurses or are on the temporary Nursing Midwifery Council (NMC) register awaiting their formal objective structured clinical examination (OSCE).

In 2019-20, SaTH recruited 30 Consultants. The Workforce and Medical Directorates are reviewing all aspects of medical recruitment, from succession planning, vacancy management, advertising and interviewing all the way to welcoming and embedding new doctors and leadership and mentoring support for newly appointed Consultants.

The Trust has expanded its network to facilitate recruitment in critical skills shortage areas. Examples include:

- Careers fairs both in the UK and Ireland
- University careers events
- National nurse career events
- RCN Congress

The Trust continues to have two monthly one-stop-shop events for nurse recruitment, alongside bespoke recruitment for specific wards.


Belinda

SAFE WORKING/STAFFING

SaTH's Guardian of Safe Working (GoSW) is now a member of the Senior Medical Leadership Team, enabling issues to be raised and dealt with proactively. In the past year there has been a focus on:

- supporting Junior Doctors in training with respect to their safe working hours
- providing regular forums and drop in sessions as platforms for doctor to raise concerns with BMA and FTSU being attendees at these
- ensuring compliance with a reporting system as mandated in the Junior Doctor Contract to enable junior doctors to report variations in their work schedule

The GoSW has also undertaken the role of Champion of the Fatigue and Facilities Charter, to bring concerns regarding rest to the attention of the Trust, as well as champion of the BMA Wellbeing Charter. In addition to this the GoSW has encouraged and promoted e-rostering software to enable cohesion of rotas/job plans/ work schedules to meet service needs.

A nursing establishment review has been undertaken for all inpatient wards, including those with escalation areas, to ensure reporting of safer staffing was fit for purpose and in line with national guidelines. A review of Paediatrics Services was also undertaken. Initial analysis suggests an opportunity for changes to workforce models and identified opportunities in the future nursing workforce, with Nursing Associates as a key role.

Discussions are taking place around priority areas for the deployment of Nursing Associates after taking advice from the National Nursing Associates Lead.

Further analysis of Enhanced Supervision across the organisation is required to inform future reviews and the numbers of Healthcare Assistants required. Registered Nurse-to-patient ratios are better than national recommendations (1:8) for days.

ENGAGEMENT CHAMPIONS

More than 120 people signed up to become Engagement Champions in a new role introduced as a result of NHS Staff Survey feedback. Champions act as a conduit for colleagues, relaying back ideas, suggestions or feedback to management and other senior leaders, while being a trusted voice to provide insight into climate, morale and engagement along with further areas to develop or review.

Having an engaged workforce is critical to SaTH becoming a better organisation. In the most recent NHS Staff Survey it became apparent the Trust was not putting enough emphasis on this. The key responsibilities of Engagement Champions are to champion the voice of frontline staff of the service they represent and share feedback from that service. They share learning and best practice, while empowering colleagues to make improvements.

DBS CHECKS

As a result of feedback from Engagement Champions, SaTH scrapped staff charges for criminal background checks. A DBS check can cost up to £60, with many staff needing it renewed every three years. It is hoped removing the charge will encourage more people to work at SaTH and build a long career, which will help recruitment and retention rates.

STAFF APP

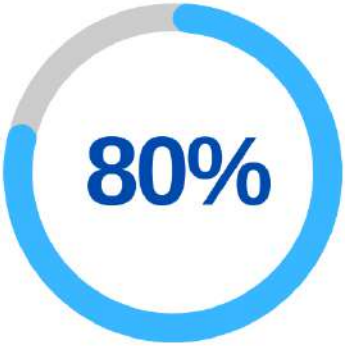
Also as a result of feedback from Champions, the Trust launched a staff app to share valuable information and resources with staff. *My SaTH* allows staff to read news and updates and access rotas, while also providing links to staff development, benefits and discounts. It also has a 'Help for Staff' section with links to Freedom To Speak Up Guardians, Health and Wellbeing offers and the Guardian for Safe Working.

OUR WORKFORCE

5,190 females

1,271 males

6,461 members of staff



5,537.94 WTE

80% of whom are in clinical roles

369 more staff in post than last year

375 work experience placements

109 new apprenticeships

JUNIOR DOCTOR ACCOMODATION

This year a project to renovate accommodation for Junior Doctors was completed.

Six houses at PRH were refurbished thanks to the support of the community, including town and parish councils and local tradespeople, who have donated money, time and furnishings following a DIY SOS-style appeal made by Telford & Wrekin Council.

The houses are now home to a total of 24 junior doctors and are offered for free for six months to help them settle into life as a working doctor at SaTH, and also help the Trust recruit staff to its ranks by making it a more attractive place to work.

The renovation project was the idea of Dr Chris Mowatt, Consultant Anaesthetist at SaTH.

Dr Mowatt said: “This has been a real partnership between the NHS and the community and shows just what can be done when we work together. The houses look fantastic, completely unrecognisable from how they originally were.

“This will really make coming and working in our hospitals an attractive opportunity for those doctors just starting out, and we hope that as they rotate around other hospitals they will spread the word about what a great place PRH is to work.”

Parish and town councils from across Telford & Wrekin donated more than £30,000 towards the project, along with businesses and individuals donating materials and resources.

The Trust also created a new Doctors’ Mess at PRH to replace the outdated facility which was based in a bungalow outside the main hospital and meant a lot of Doctors who couldn’t leave the hospital for emergency reasons never got to use it.

It also meant they did not have a cohesive meeting area within the hospital.

DIGITAL TRANSFORMATION

The Trust recognises the importance of investment in digital transformation as a key driver of sustainability. During 2019-20 the Trust successfully secured funding of £6m over the three years to take forward the implementation of a new Electronic Patient Record system and to develop further digital transformation.

Further progress on the implementation of Windows 10 has enhanced the capability of the Trust to undertake digital transformation and to move forward in areas such as remote working and virtual outpatient consultations. Further funding through Health System Led Investment went into the development of a new data warehouse and identifying infrastructure investment requirements to manage cyber security risks.

The Trust also invested in the implementation of an Emergency Department IT system, which was paused in March due to COVID-19 and will be restarted as soon as is practical. This scheme will bring demonstrable efficiencies in processes within the ED.

FREEDOM TO SPEAK UP

In March 2019 the Board agreed there was a necessity for a Lead Freedom to Speak Up (FTSU) Guardian and expansion of the team. In June the FTSU function moved under the Medical Director to separate them from the HR function. Guardians work to signpost staff if FTSU is not the right mechanism for their needs.

SaTH has also introduced FTSU advocates. There are currently 46 members of staff who take on this role voluntarily in addition to their substantive role and receive the appropriate training. Advocates work to support the FTSU function and signpost where necessary or escalate to the Guardians. There is a FTSU online learning module for Advocates and training sessions with the support of the National Guardian Office have been delivered.

All FTSU concerns are acknowledged within 48 hours of receipt.

VOLUNTEERS

SaTH has 713 volunteers, complemented by another 319 volunteers who support the League of Friends of RSH and Friends of PRH cafes at both hospital sites.

The Trust has a developed volunteer program with a broad spread of volunteer schemes. These include:

- +18 years and over – Placements are available in clinical and non-clinical areas and include ward helpers, maternity buddies and administrative support volunteers
- Young Volunteer Scheme (16-18 years old) – This scheme focuses on giving young people the opportunity to volunteer in a clinical area. Young volunteers' placements are six months to a year and offers the opportunity to rotate to different volunteer roles to gain a broad experience to potentially support career choices
- Staff Volunteer Scheme – Staff can apply for any of the volunteer roles that are available. This scheme is popular with non-clinical staff who are looking to gain a greater understanding of clinical practice and for staff members who are looking at a specific future career
- Making a Difference Days – For individuals or organisations who cannot commit to an ongoing volunteer placement but would like to give their time on a 'one-off' or ad hoc basis. Making a Difference Days are usually around a specific project

We have 18 different volunteer roles within the organisation. Volunteers have access to the Volunteer Team (Monday-Friday, office hours), however wards and departments also offer support to volunteers in their team. Volunteers are recognised as part of the team they volunteer with.

This year the Trust received a £25,000 grant from NHS England to develop a Response Volunteer Scheme, which was launched in March. Response Volunteers are assigned to a hospital rather than a specific ward or department. They carry a mobile phone, which means staff from across the hospital can contact them to help where it is most needed.

Response Volunteers carry out a variety of tasks to support the Trust including collecting medication from pharmacy, supporting patients with food and drink, signposting and spending time with patients. The scheme is being piloted at PRH but will be extended to RSH.

PERFORMANCE ANALYSIS

STRATEGIC CONTEXT

2020 saw the outbreak of the global COVID-19 pandemic, with the NHS at the heart of the UK's response. There are many stories of people going above and beyond to ensure patients received the treatment they required. This has been recognised nationally and locally with the weekly 'clap for carers' and the local community working together to support our Trust in a variety of ways, including volunteers joining our response to COVID-19 and donations made by individuals for our staff.

The pandemic has brought about significant transformation in the way SaTH is delivering services and how we are running the day-to-day business of the Trust.

Restoring patient services as safely and quickly as possible is one of our key objectives for 2020-21.

We will continue our work with colleagues, patients' families and our local partners through our Sustainability and Transformation Partnership (STP) to deliver improvements in our services and ultimately improve our patients' experience. One area of focus will be to embed the Integrated Discharge pathway created during the pandemic to ensure our patients are able to leave hospital as soon as they are medically fit to do so with the right care in place to support them.

During 2020-21, we will look to increase the ways in which we use digital technology to deliver our services. One of our objectives is to increase the number of virtual outpatient appointments which should improve patient experience and our efficiency.

During 2019-20 the NHS published its Long Term Plan which recognised the challenges the NHS is facing and outlined plans to address them. The NHS is seeing an increase in demand for services which is putting additional pressure on the quality of services provided, its financial resources, meeting performance standards and the workforce. We are dealing with these same challenges and recognise that we need to make significant improvements in these areas and those highlighted by the CQC following recent inspections.

In 2019-20, the Trust did not meet or consistently achieve the four key constitutional standards; four hour access, 18 week referral to treatment, 62 day cancer standard and six week diagnostic performance. Significant improvements are required for the Trust to consistently achieve these standards and we are working hard to make the necessary changes to improve this position for patients.

We have set a number of key objectives for delivery in 2020/2021 which will improve the quality, performance and efficiency of our services for patients:

- deliver our quality improvement plan (including emergency department improvement, CQC actions) and our quality priorities
- deliver our maternity improvement plan
- enhance same day emergency care services
- reduce our nursing vacancies
- increase staff engagement
- establish sound financial foundations and deliver our financial plan
- improve quality and timeliness of our performance information

We recognize the importance of taking a strategic as well as an operational approach to improve the sustainability of our services. The Hospitals Transformation Programme (HTP) is an important part of our future strategy. This aims to modernise our estate and facilities to meet the future needs of the population we serve. In November 2019 we submitted our strategic outline case and during 2020-21, we aim to submit our outline business case.

This has been a challenging year for the organization, however we are committed to making the necessary improvements to ensure that our patients and families receive high quality care each and every day, now and in the future.

Louise Barnett,
Chief Executive

KEY PERFORMANCE INDICATORS

Domain	Indicator	Description	Data Source	Thresholds	Performance in Year
Access (including A&E and 18 week Referral to Treatment [RTT])	Four-hour maximum wait in A&E from arrival to admission, transfer or discharge	The number of patients spending four hours or less in all types of A&E department / The total number of patients attending all types of A&E	Weekly SitReps	Performing: 95% Underperforming: 94%	**73.5%**
	12 hour trolley waits	The number of patients waiting in A&E departments for longer than 12 hours after a decision	Weekly SitReps	Performing: 0 Underperforming: >0	**1,140**
	1 hour ambulance handovers	Ambulance handovers not completed within 60 minutes	Weekly SitReps	Performing: 0 Underperforming: >0	**2,714**
	30 minute ambulance handovers	Ambulance handovers not completed within 30 minutes	Weekly SitReps	Performing: 0 Underperforming: >0	**9,189**
	RTT – admitted - 90% in 18 weeks	Total number of completed admitted pathways where the patient waited 18 weeks or less vs. Total number of completed	Monthly RTT returns via UNIFY	Performing: 90% Underperforming: 85%	**53.7%**
	RTT – non-admitted – 95% in 18 weeks	Total number of completed non -admitted pathways where the patient waited 18 weeks or less vs. Total number of completed		Performing: 95% Underperforming: 90%	**90.3%**
	RTT - incomplete pathways	Total number of patients on incomplete pathways less than 18 weeks vs. total number on		Performing: 92%	**75.7%**
	RTT – greater than 52 weeks	Total number of patients waiting longer than 52 weeks from referral to treatment		Performing: 0	**11**
	% of patients waiting over 6 weeks for a diagnostic test	To measure waits and monitor activity for 15 key diagnostic tests		Performing: <=1%	**22.4%**
	Number of last minute cancelled elective operations for non-clinical	Number of patients not treated within 28 days of last minute elective cancellation	Quarterly return via QMCO RTN UNIFY	Performing: 0	**785**
	Multiple cancellations of urgent operations	Number of last minute elective operations cancelled for non-clinical reasons	Monthly return via QMCO RTN UNIFY NHSE	Performing: 0	**0**
Cancer Waiting Times	2 week GP referral to 1st Outpatient	Please see cancer waiting times guidance for definition of these performance standards	QLIK Cancer Waiting Times Database	Performing: 93% Underperforming: 88%	**88.2%**
	2 week GP referral to 1st outpatient – breast symptoms			Performing: 93% Underperforming: 88%	**59.3%**
	31 day diagnosis to treatment for all cancers			Performing: 96% Underperforming: 91%	**97.8%**
	31 day second or subsequent treatment – drug			Performing: 98% Underperforming: 93%	**99.8%**
	31 day second or subsequent treatment – surgery			Performing: 94% Underperforming: 89%	**90.4%**
	31 day second or subsequent treatment –			Performing: 94% Underperforming: 89%	**97.9%**
	62 days urgent GP referral to treatment of all cancers			Performing: 85% Underperforming: 80%	**90.4%**
	62 day referral to treatment from screening			Performing: 90% Underperforming: 85%	**73.3%**
	62 day referral to treatment from hospital specialist			Performing: 85% Underperforming: 80%	**86.4%**
Infection Prevention and Control	MRSA	Actual number of MRSA vs.	Infection Control HPA Returns	Performing: No MRSA	1
	C.Diff	Actual number of C.Diff vs.		No more than 25 C.diff	54
Quality of Care	Duty of Candour	Number of breaches of duty of candour	Datix	Performing: 0	0
	Breaches of same	The number of breaches	Via UNIFY NHSE MSA	Performing: 0	403
Workforce	Sickness absence	Number of days sickness absence vs. available workforce	SaTH Returns	Performing: 3.99%	4.2%
	Appraisal	Number of eligible staff receiving appraisal in current performing vs. total eligible staff		Performing: 80% (Stretch target 100%)	90.4%
	Statutory and	Number of spells or attendance		Performing 80%	89.8%

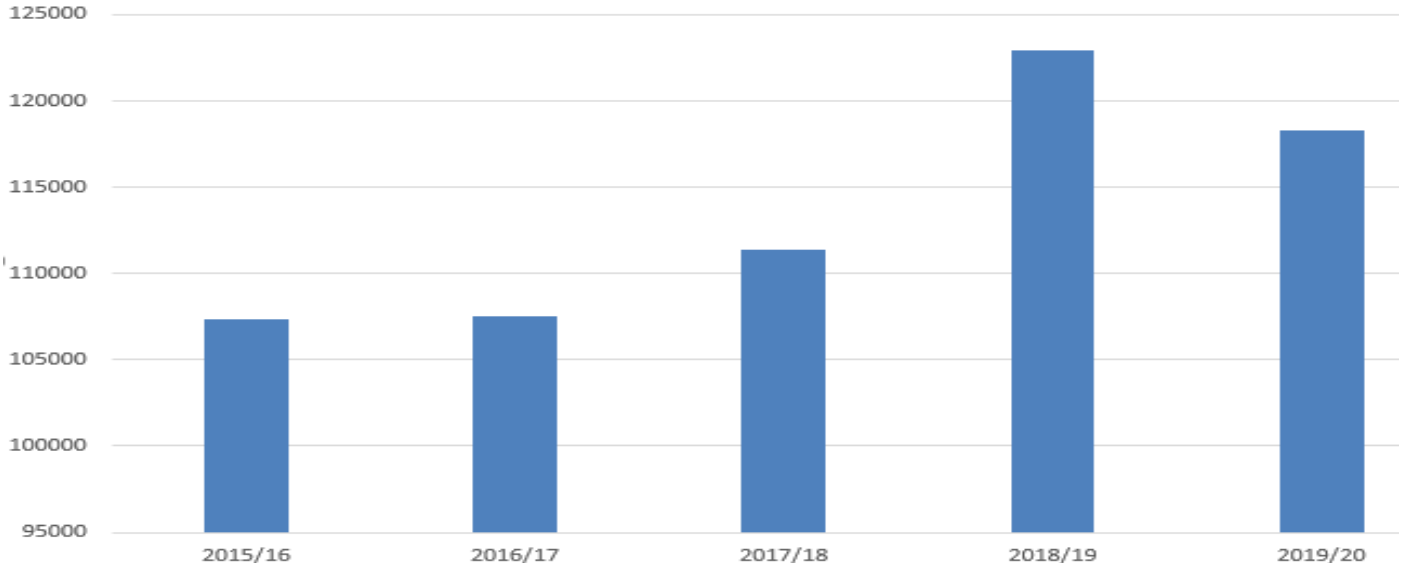
PERFORMANCE TRENDS

Summary of Service Activity by specialty

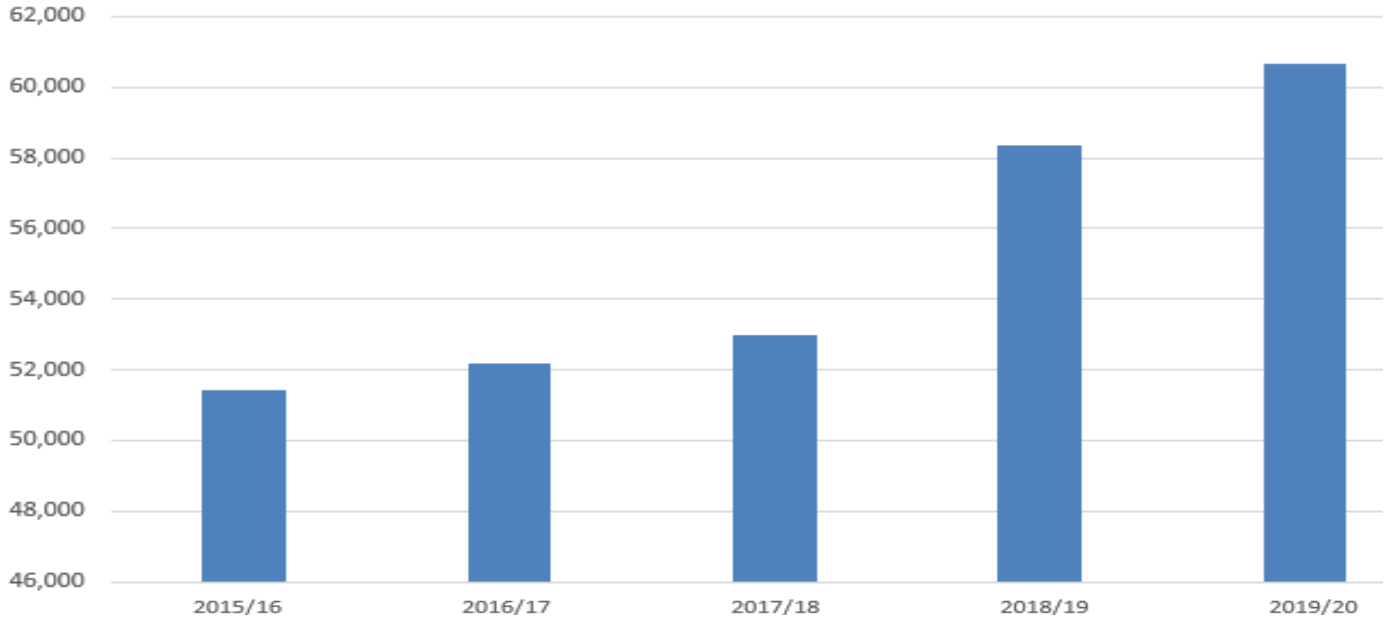
	Inpatients				Outpatients			
Specialty	**2016/17**	**2017/18**	**2018/19**	**2019-20**	**2016/17**	**2017/18**	**2018/19**	**2019-20**
A&E Outpatient & Spells	948	888	2,863	4,040	3,627	3,397		
Anaesthetics	-	-	-	1	557	533	631	667
Audiological medicine	1	1	1	3	666	1,012	1,153	1,060
Breast Surgery	698	731	655	574	15,865	15,382	15,107	14,161
Cardiology	2,919	3,075	3,103	3,115	21,354	21,761	21,184	19,752
Cardiothoracic Surgery	-	-	-		1,236	1,215	1,085	1,036
Chemical pathology	-	-	-		640	586	536	563
Clinical Haematology	5,384	5,681	6,085	6,316	14,012	15,071	16,238	18,751
Clinical Neuro-Physiology	-	-	-		570	451	217	141
Clinical Oncology	3,422	3,546	4,373	4,433	20,705	20,330	23,888	23,758
Clinical Physiology	-	-	-		16,041	16,499	15,723	13,895
Colorectal Surgery	926	996	1032	864	12,539	12,764	13,382	13,349
Dermatology	18	5		6	16,741	16,909	18,269	21,924
Diabetic Medicine	6	3	5	8	6,807	6,104	6,455	6,100
Diagnostic Imaging	-	-	-				4,528	4,854
Ear nose & throat	2,385	2,269	2,217	2,518	24,924	23,259	23,359	22,819
Endocrinology	119	106	123	96	2,881	3,136	3,852	3,264
Gastroenterology	17,990	17,655	18,507	19,206	10,341	9,945	10,282	11,429
General Medicine	22,688	23,708	25,984	28,221	2,440	1,947	1,870	1,866
General Surgery	7,983	7,099	7,739	7,700	924	641	1,016	1,002
Geriatric Medicine	152	254	299	218	5,071	4,922	5,311	4,881
Gynaecological Oncology	7	5	11	11	6,498	6,365	7,020	6,516
Gynaecology	4,138	4,037	4,088	4,095	25,349	23,658	22,163	19,330
Hepatology	7	5	8	8	2,312	2,482	2,502	3,362
Maxillo-Facial Surgery	613	726	669	732	184	157	698	219
Medical Oncology	368	485	488	437	723	1,781	1,085	1,889
Neonatology	2,184	1,809	1,603	1,728	934	1,076	893	1,945
Nephrology	290	355	214	318	6,915	6,118	6,697	5,979
Neurology	332	324	404	367	8,382	6,569	5,348	4,858
Neurosurgery					144			
Obstetrics/Maternity	5,543	5,056	4,822	4,630	1,748	1,334	1,143	890
Ophthalmology	2,974	3,795	3,872	3,675	48,407	45,689	46,097	44,587
Oral Surgery	685	703	668	607	10,529	10,354	9,426	8,984
Orthodontics	-	-	-		7,447	8,010	7,476	7,778
Paediatrics	8,738	8,537	9,065	9,073	24,452	24,060	23,750	23,201
Pain Management	621	538	448	255	1024	758	838	432
Plastic surgery	-	-	-		1,035	532	461	
Rehabilitation	70	60	27	34	-	-	-	
Respiratory Medicine	2,933	3,044	2,991	2,600	14,369	14,087	14,994	15,357
Respiratory Physiology	-	-	-	1	3,765	3,569	3,529	2,458
Restorative Dentistry	-	-	-		583	565	718	570
Stroke Medicine	234	175	244	188	2,015	1,657	2,148	1,953
Therapies	-	-	-		9,726	9,613	9,556	9,306
Trauma & Orthopaedics	6,055	5,781	5,169	5,118	38,636	36,503	37,193	37,977
Upper GI Surgery	1,169	1,044	1,083	891	6,661	6,525	7,133	7,134
Urology	6,024	6,115	6,430	6,367	19,330	19,049	20,010	19,618
Vascular Surgery	925	1,720	2,013	1,804	6,290	6,789	7,472	7,216
Grand Total	**109,549**	**110,331**	**117,303**	**120,258**	**425,399**	**413,164**	**422,436**	**416,831**

2018/19 saw the introduction of the CDU pathway change resulting in an increase of non-elective activity

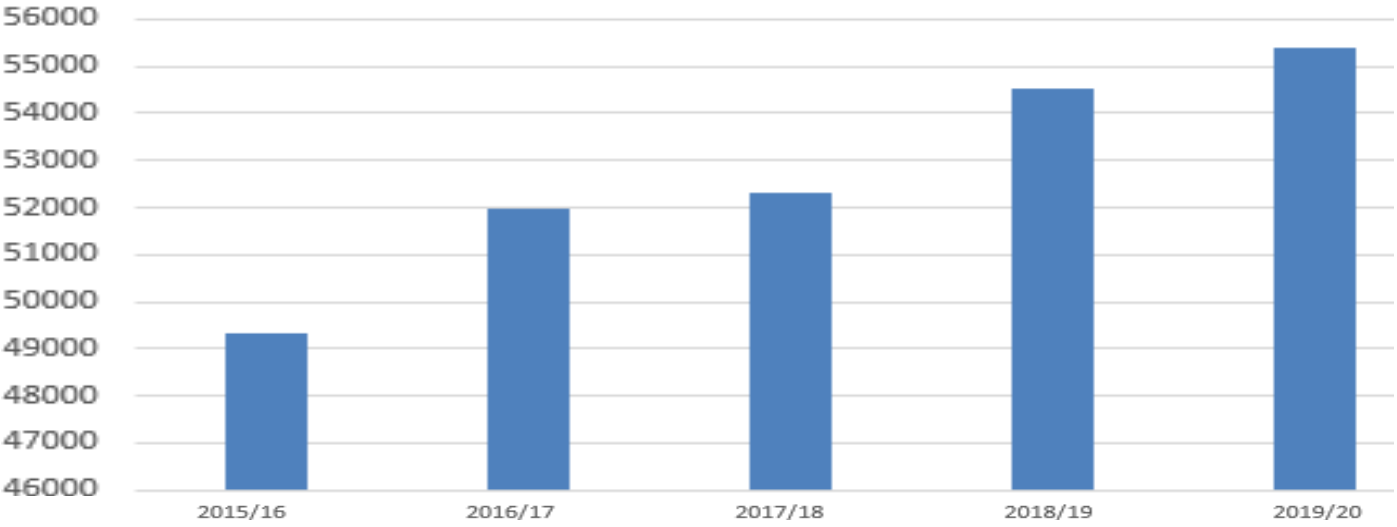
A&E attendance (Type 1 only)



Emergency admissions (including CDU)

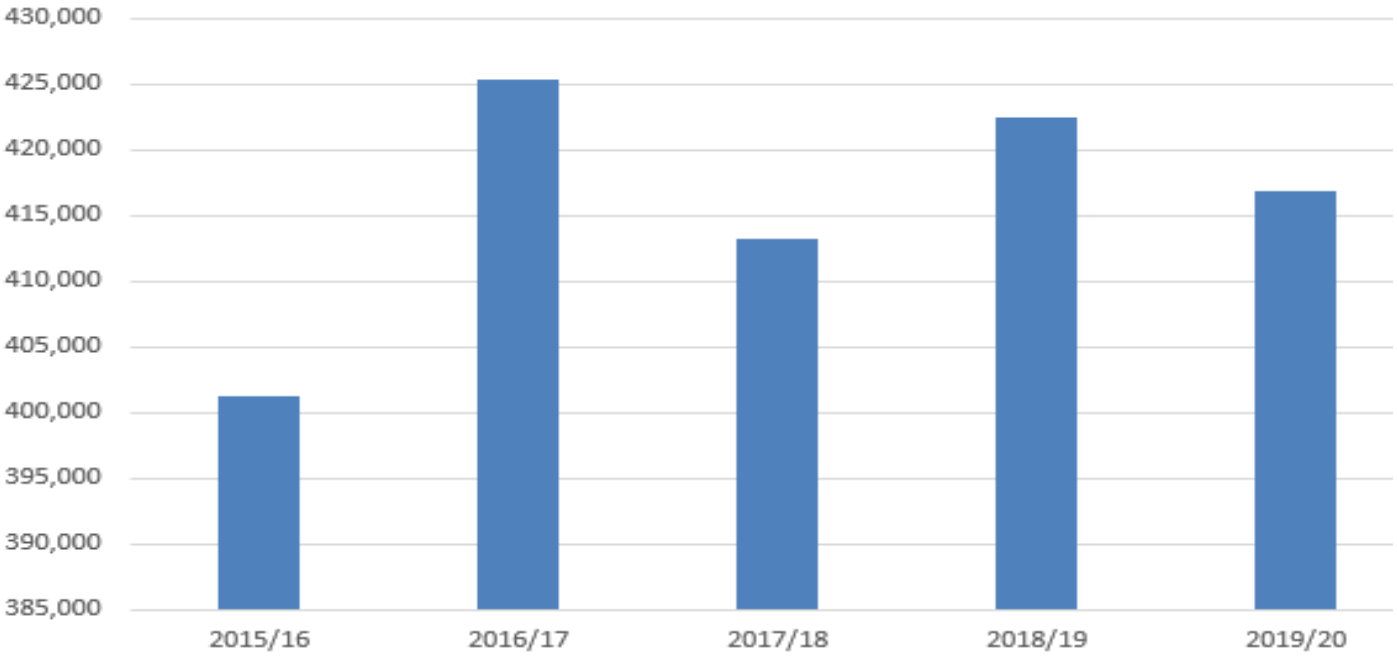


Elective Inpatient and Day Case admissions

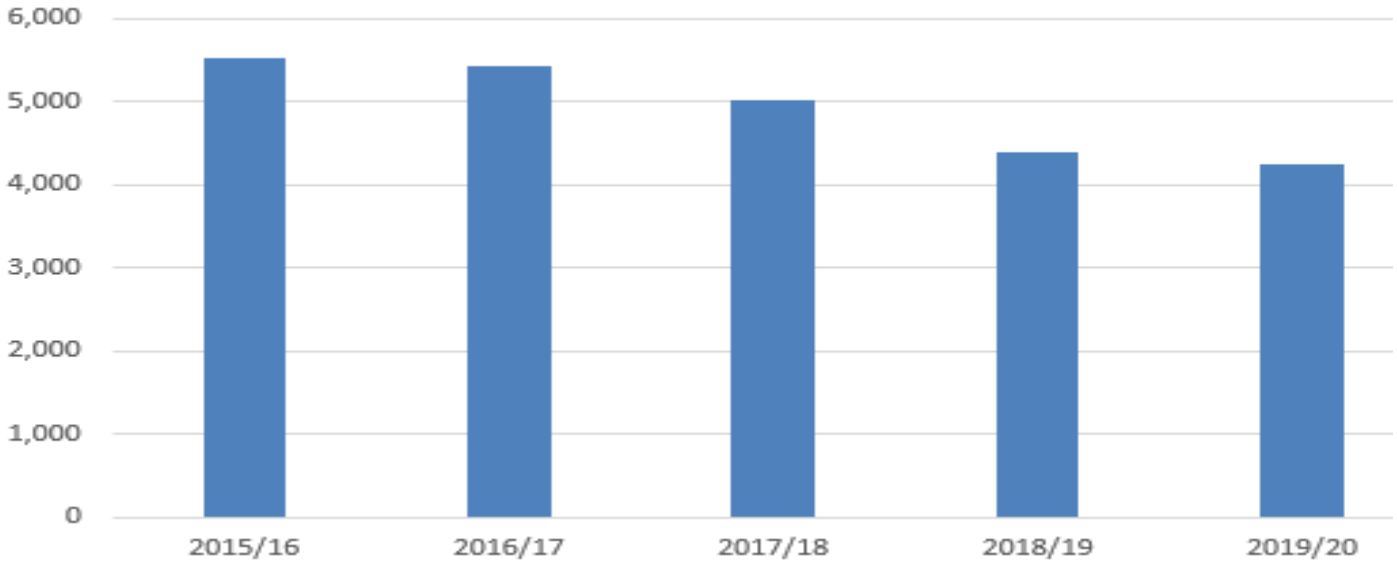


*Chargeable activity only

Outpatient activity



Maternity admissions



SUSTAINABILITY

Sustainability means spending public money well, the smart and efficient use of natural resources, and building healthy, resilient communities. Demonstrating that we consider social and environmental impacts ensures we meet legal requirements in the Public Services (Social Value) Act (2012). Our Sustainable Development Management Plan is being refreshed into a 'Green Plan' to form the basis of our Sustainability Programme for the next five years. As a part of the NHS, it is our duty to contribute towards the ambition set in 2014 of reducing carbon emissions by 34% by 2020-21.

MEASURING SUSTAINABILITY

One of the ways we measure our impact is through the Sustainable Development Assessment Tool (SDAT). In 2019 we scored 72% (a 7% improvement on 2018). The SDAT shows the Trust is *starting* to contribute to the following International Sustainable Development Goals:

…and is *clearly* contributing to the following:

ENERGY USED

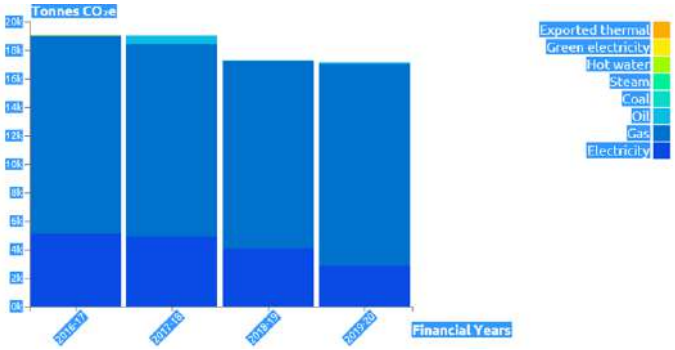
This is primarily dictated by weather and 'static' loads from lighting and clinical equipment. Oil is used only if gas and electricity supplies fail. Electricity from the grid significantly reduced due to good performance by our power plants in generating electricity from gas, which helps reduce costs. Energy use is up on previous years as we become more technology and equipment-orientated. LED lighting at RSH will reduce energy consumption by an estimated 4 million kWh annually. We are also planning for future hospital services, considering how we will provide energy at the lowest carbon intensity.

ENERGY CONSUMPTION IN kWh

	2016-17	2017-18	2018-19	2019-20
Electricity	9,884,210	11,046,347	11,465,884	8,920,855
Gas	66,250,148	63,724,636	62,848,027	68,335,904
Oil	327,165	1,844,769	215,123	396,260
Coal	0	0	0	0
Steam	0	0	0	0
Hot Water	0	0	0	0
Green electricity	53,315	0	0	0
Total	76,514,838	76,615,752	74,529,034	77,653,019

ENERGY-RELATED CARBON EMISSIONS

Emissions are reducing but not on track to meet the NHS target. Switching to green electricity will reduce carbon emissions by 3-5,000 tonnes annually (63%-105% of the target). The LED scheme will contribute further, as will future plans for low carbon heat and electricity.



WASTE PRODUCED

Waste divides into domestic and clinical. It is managed by licensed carriers and at licensed treatment facilities, where it generates energy. During the year, only 74 tonnes (4%) of our waste went to landfill.

WASTE IN TONNES

	2016-17	2017-18	2018-19	2019-20
Waste recycling weight	85	77	78	152
Other recovery weight (energy recovery)	1,500	880	728	1,627
Incineration disposal weight	0	159	253	0
Landfill disposal weight	96	586	582	74
Total	1,681	1,702	1,641	1,853

Our furniture and commodity recycling scheme, WarpIt, has saved £155,515 during the past 12 months.

WATER USAGE

This varies owing to activity and factors connected with legacy heating systems. We use large quantities to thoroughly flush systems to maintain safe operation.

	2016-17	2017-18	2018-19	2019-20
Water volume (m³)	212,427	218,921	200,043	224,515
Waste water volume (m³)	169,942	175,137	160,034	179,538
Water and sewage cost (£)	416,256	469,224	406,957	440,752

SECTION TWO

ACCOUNTABILITY REPORT

This section of the Annual Report focuses on our governance, providing information about the legal status of our Trust, the processes and structures by which we maintain our commitment to good governance.

DIRECTORS' REPORT

OUR TRUST

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

The members of the Trust Board at year end are outlined in the following pages, including a summary of their experience.

THE TRUST BOARD

NHS Trust Boards play a key role in shaping the strategy, vision and purpose of an organisation. They are responsible for holding the organisation to account for the delivery of the strategy and to ensure value for money.

They are also responsible for assuring that risks to the organisation and the public are managed and mitigated effectively. Led by an independent chair and composed of a mixture of both executive and independent non-executive members, the Trust Board has a collective responsibility for the performance of the organisation.

The main focus of the Trust Board is providing high standards of health care.

The framework by which we use to meet and monitor these high standards is known as clinical governance. The highest priority of the Trust Board is to ensure that effective governance arrangements are in place. All NHS providers are required to register with the Care Quality Commission, the independent regulator of health and social care in England. The Care Quality Commission's inspection regime provides further assurance around the quality of our services to the communities we serve.

FINANCIAL MONITORING AND CONTROL

NHS services are paid for with public funds and NHS Trusts must ensure that services are good value for money.

The Trust Board is responsible for financial management and to ensure that effective financial control systems are in place. For further assurance and transparency, the Trust's financial affairs are scrutinised by:

- the Trust's independent internal auditors; as part of their local audit programme
- the Trust's independent external auditors; as

part of the statutory review of our annual accounts

- NHS Improvement, the national regulator which is responsible for supporting and developing NHS Trusts in England
- National and parliamentary scrutiny bodies, such as the Health Select Committee

The Trust's accounts are published annually and can be seen within our Annual Reports.

ACCOUNTABILITY

NHS Trusts are accountable to the Department of Health via NHS Improvement, the financial regulator of NHS Trusts in England. NHS Improvement supports NHS Trusts to ensure patients receive consistently safe, high quality, compassionate care within local health systems that are financially sustainable.

PROBITY

All Board members must be open about their own business interests which may impact on the decisions of the Trust. All such interests must be made public and are recorded in a public register. This is published in our Trust Board Papers after each Board meeting.

CODE OF OPENNESS/FREEDOM OF INFORMATION

Our Code of Openness ensures transparency about the activities undertaken at the Trust. It is intended to promote confidence with our staff, patients and the public. An example of our commitment to being open and transparent is by holding meetings of the Trust Board in public and publishing minutes and papers of Trust Board meetings. The Trust is also obliged to comply with the Freedom of Information Act 2000; visit the Freedom of Information pages on our website for further information.

MEMBERS OF THE BOARD

Ben Reid, OBE
Chair
Member: Sustainability Committee; Maternity Oversight Group

Ben, a qualified accountant is the former Group Chief Executive of the Mid-Counties Co-operative, a position he has held for 30 years. He has held Non-Executive appointments including Chair of Walsall Healthcare NHS Trust (2004-2016) and most recently, Chair of Dudley and Walsall Mental Health NHS Trust. He has also held senior level positions with Lincolnshire Area Health Authority.

Ben's previous Board roles include West Midlands Chair of the Learning and Skills Council, Chair of West Midlands Regional Assembly and Chair of various regeneration bodies.

Professor Trevor Purt
Non-Executive Director
Member: Performance Committee, Sustainability Committee; Emergency Department Oversight Group

Trevor brings an extensive experience of healthcare organisations within the public, commercial and independent sectors. He has been Chief Executive of a number of NHS Trusts, most recently Betsi Cadwaladr University Health Board, which he left in 2016.

Following that role, Trevor became Vice President and Partner for International Healthcare at IBM Watson Healthcare until his retirement last year.

His interests include theatre, travel, music and flying—he holds a private pilot's licence.

Tony Bristlin
Non-Executive Director
Member: Audit & Risk Committee; Sustainability Committee, Charitable Funds Committee

Tony is a senior finance leader with a record of success in global shared services, finance transformation and internal audit.

He has more than 20 years' experience in the aviation industry, working in audit and finance.

He is a Fellow of the Chartered Institute of Management Accountants and a Member of the Institute of Chartered Accountants England and Wales, having graduated with an MBA (with Distinction) from Manchester Business School.

Clive Deadman
Non-Executive Director
Member: Performance Committee; Sustainability Committee

Clive brings 30 years' experience from senior commercial, finance and business development roles. He studied Chemistry at Cambridge University and worked in Africa before spending eight years in the Venture Capital industry. Since joining the utility sector in 1992, Clive has held a range of executive director roles in electricity distribution, water and wastewater utilities.

Clive holds a number of directorships in the housing and utilities sector. He is currently a Non-Executive Director for Metropolitan Housing Trust, one of the largest owners and operators of social housing in the UK, a position he has held since 2013.

Teresa Boughey
Non-Executive Director
Member: Workforce Committee; Audit & Risk Committee

Teresa is the founder and CEO of Jungle HR, a national award-winning strategic HR consultancy. She has more than 25 years' HR experience at senior manager and director level and has worked across a variety of sectors.

Teresa is a member of the Women and Work, and Women and Enterprise all-party Parliamentary Groups and has authored the Amazon #1 bestselling book *Closing the Gap—5 Steps to Creating an Inclusive Culture*.

Dr David Lee
Non-Executive Director
Member: Performance Committee; Quality & Safety Committee

David has been a GP for 30 years and has worked in medical leadership roles within both the NHS and the independent sector. He is Medical Director of CSC, a multi-national corporation providing information technology services and professional services. He combines this with work as a GP in Shropshire.

David is a committed proponent of clinical leadership and the benefit of effective clinical leadership for patients using health services and for the organisations which provide or commission them. In addition to his medical qualifications, David has an MBA from Leeds University and is currently training as an executive coach. David and his family moved to Shropshire 13 years ago.

Brian Newman
Non-Executive Director
Member: Quality & Safety Committee

Brian has over 30 years' experience at managing director level in a variety of international businesses, including, for eight years, as MD of GKN plc's global Wheels Division, which has headquarters in Telford. He also has considerable Trade Association board experience including as chairman of the board of the British Fluid Power Association.

Brian, who is a Freeman of the Shrewsbury Drapers Company, is married with three adult sons.

Tony Allen
Associate Non-Executive Director
Member: Performance Committee; Charitable Fund Committee; Workforce Committee; Recruitment & Retention Committee

Tony has previously served as a Non-Executive Director with Liverpool Community NHS Trust, where he Chaired the trust's Audit Committee. He has also served as Independent Advisor to the Audit Committee of the British Dental association.

Tony has 10 years' experience as head of finance in the private sector with organisations including National Museums Liverpool and the Institute of Occupational Safety and Health.

David Brown
Associate Non-Executive Director
Member: Quality & Safety Committee; Audit & Risk Committee

David has 50 years' senior executive experience. Since 2014, he has run his own consultancy, specialising in business turn-around, managing change, strategic assessment, business development, and staff motivation.

David Graduated from the University of London with a BSc Hons in Geology. He has seen military service in the First Gulf War as well as Northern Ireland, Cyprus, Oman, Belize, Israel and the Falklands.

His interests include languages and he speaks Portuguese, German, and French.

MEMBERS OF THE BOARD

Louise Barnett
Chief Executive (from February 2020)
Executive Director

Louise joined SaTH from her role as Chief Executive at The Rotherham NHS Foundation Trust, having joined them as interim Chief Executive in October 2013, prior to being appointed to the substantive position in April 2014.

She has previously held a number of NHS board positions, including Interim Chief Executive, and Director of Human Resources and Organisational Development at Peterborough and Stamford Hospitals NHS Foundation Trust and Non-Executive Director at Sherwood Forest Hospitals NHS Foundation Trust.

Dr Arne Rose
Medical Director (from June 2019)
Executive Director

Arne, originally from Kiel in Germany and who now lives in Birmingham, joined SaTH from his role as Associate Medical Director for Integration and Transformation at University Hospitals of Derby and Burton NHS Foundation Trust.

Outside of work Arne carries out work for Restore UK, a charity which helps Syrian refugees settle in the UK.

Barbara Beal
Interim Director of Nursing, Midwifery and Quality (from May 2019)
Executive Director

Barbara is a highly experienced Director of Nursing, Midwifery, Quality and Patient Safety. She developed her career in the acute sector, but her experience has seen her work across the broader health economy, including with both providers and commissioners.

Barbara has held the positions of Chief Nurse at Sherwood Forest Hospital NHS Foundation Trust, Executive Director of Nursing at Shropshire Clinical Commissioning Group, Executive Director of Nursing at Walsall Healthcare NHS Trust and Chief Nurse at London North West University Healthcare NHS Foundation Trust.

Nigel Lee
Chief Operating Officer
Executive Director

Nigel began his career as a helicopter pilot in the RAF, in both Search & Rescue and Special Forces roles. He served in Northern Ireland, the Falkland Islands and Iraq. His experience in healthcare began as hospital director for the BUPA hospital on the Wirral, before Divisional Director roles at Alder Hey Children's Hospital and Aintree University Hospital.

He has had senior operational roles with the Cheshire and Merseyside Major Trauma Network, as well as with a range of service configuration developments in the Merseyside area. Nigel joined SaTH from his role as Director of Secondary Care for the North Wales Health Board, where he was responsible for three hospital sites, Women's Services and the Specialist Cancer Centre.

James Drury
Interim Finance Director (from June 2019)
Executive Director

James has 11 years' experience as an NHS finance director in the regulator, provider and commissioner sectors. His previous roles have included Director of Finance for NHS England (South Central) and Project Director for the Buckinghamshire, Oxfordshire and Berkshire West System Transformation Partnership (STP).

David Holden
Interim Director of Governance
Director

David is an experienced Executive Board level Director with over 30 years' experience. His specialties include corporate affairs, clinical and corporate governance, organisational development, risk management, Board assurance and regulatory compliance.

David has used his experience to help organisations learn, improve and embed changes in clinical and Board assurance processes that last and are robust.

Dr Edwin Borman
Director for Clinical Effectiveness
Director

Edwin joined the Trust as Medical Director in April 2013. Prior to this, he was Clinical Director for Anaesthetic, Critical Care and Pain Services at University Hospitals of Coventry and Warwickshire NHS Trust. He became Director for Clinical Effectiveness in June 2019.

Throughout his career Edwin has taken a keen interest in the standards of medical practice, education, ethics, equality and diversity, representation and leadership. This has included chairing the British Medical Association's (BMA) Junior Doctors Committee and its International Committee, serving for over 20 years as a BMA Council member and for 15 years as a GMC Council member.

Bev Tabernacle
Director of Strategy and Transformation
Director

Bev joined SaTH from the Robert Jones and Agnes Hunt Orthopaedic Hospital, initially as Interim Chief Executive.

She has wide experience and has worked clinically and operationally across hospital, community and social care. She was one of the first Nurse Consultants in the country for Older People and is passionate about ensuring the delivery of care to patients is responsive and person-centred.

In 2009 Bev won the Chief Nursing officer award from the Nursing Times for work undertaken with A/E departments relating to Domestic Violence.

Rhia Boyode
Acting Workforce Director (from October 2019)
Director

Rhia has a wealth of experience as a senior leader, helping shape, implement and drive transformational people agendas. For the last aeven years she has been deputising for HR Directors within large global organisations as part of the Senior Leadership team. Before that, Rhia spent 10 years working for an organisational development consultancy in partnership with Primary Care Trusts and Foundation Trusts. Her role involved partnering with senior leaders to design and facilitate organisational development agendas and supporting engagement, good people management practice, learning and development and embedding values and behaviours

Julia Clarke
Director of Corporate Services
Director

Julia was born, and has lived, in Shropshire all her life as do her two sons and three grandchildren.

She has worked at SaTH for over 34 years, initially working part-time in the patient administration team. She became lead for clinical audit, complaints, legal services and risk management. She was the lead Director for the delivery of the Lingen Davies Centre, which was funded entirely by charitable donations.

Julia currently leads the Trust's Communications and Community Engagement agenda, its environmental sustainability work, charity fundraising and the Estates facilities services.

Simon Wright. Chief Executive (until July 2019)

Paula Clark. Interim Chief Executive (July 2019—February 2020)

Dr Edwin Borman. Medical Director (until June 2019)

Neil Nisbet. Finance Director (until June 2019)

Victoria Rankin. Workforce Director (until October 2019)

Declaration of interests

Our Standing Orders require all Board members to declare any outside interests which are relevant and material to their position.

A register of all such declarations is maintained and updated on an ongoing basis and confirmed at the end of each financial year by the Trust Secretary.

Interests of Board members are published with the Trust Board papers, which can be found at **www.sath.nhs.uk/about-us/trust-information**

DECLARATION FROM DIRECTORS

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

Board Meetings

The Trust Board met eight times during the year, including the Annual General Meeting, and 12 times in total. Meetings of the Trust Board are held in public, although due to the COVID-19 pandemic, the Board meeting of 26 March 2020 was held as a closed session. Board papers are published on the Trust website. Information about attendance at Trust Board meetings is included in the Annual Governance Statement at Appendix 2.

The Board received reports from the nine committees chaired by the Non-Executive Directors: Audit & Risk Committee, Performance Committee , Quality & Safety Committee, Workforce Committee, Recruitment & Retention Committee, Sustainability Committee, Maternity Oversight Committee, Emergency Department Oversight Group, and the Charitable Fund Committee.

Audit & Risk Committee

The Audit & Risk Committee's chief function is to advise the Board on the adequacy and effectiveness of the Trust's systems of internal control and its arrangements for risk management, control and governance processes and securing economy, efficiency and effectiveness (value for money). The audit committee met regularly throughout the year. Chaired by Non-Executive Director Tony Bristlin, the committee comprises three Non-Executive Directors (including the committee chair). The other committee members during the year were Teresa Boughey and David Brown. Tony Allen, Associate Non-Executive Director, was also in attendance. Other Non-Executive Directors are welcome to attend. Committee meetings are attended regularly by the internal and external auditors, Finance Director, Director of Corporate Governance and Head of Assurance. Other Executive Directors attend by invitation. The committee met on six occasions during the year. This included one special meeting to review the annual accounts

Disclosure of Personal Data Related Incidents

The Trust takes its responsibilities for protecting patient information seriously, and we expect high standards of information governance from our staff.

There were 14 significant incidents relating to person identifiable information which were formally reported at the Trust in 2019-20.

Annual Governance Statement

The Trust has produced a full Governance Statement which details the governance framework of the Trust, including the governance responsibilities of committees, how the Trust identifies and assesses risk, the principal risks to achieving the organisational objectives, and serious incidents occurring in the last year.

The statement details how the organisation ensures the effectiveness of its systems of internal control and any issues that have occurred during the year.

This statement can be found in full in Appendix 2: Financial Statement / Annual Accounts.

Equality and Diversity

The Trust aims to provide high quality services to our community and to enable staff to fulfil their potential free from disadvantage and discrimination. To this end we have adopted the NHS Equality Delivery System (EDS2) and the NHS Workforce Race Equality Scheme (WRES), the NHS Workforce Disability Equality Scheme (WDES) and the Gender Pay Gap Regulations. We publish our results and objectives on our Trust website. We continually review our processes and activities and involve a range of stakeholders in our decision-making as well as continuing to work according to our Trust Values in all that we do.

Statement of the Chief Executive's Responsibility as Accountable Officer

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, 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.....

Louise Barnett, Chief Executive
25 June 2020

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 Trust has considered the situation with regard to 'going concern' and, after making enquiries, the directors have a reasonable expectation that SaTH will have access to adequate resources to continue in operational existence for the foreseeable future being for twelve months from the date of signature of these accounts.

This expectation is based on the following:

- Confirmation that the enhanced block payments from NHSE and NHS Improvement based on pre Covid-19 levels of expenditure in place until 31st October covering cost base and in additions costs relating to COVID-19
- Understanding that the allocations in place for 2020/21 to cover the provision of services under the mandate, which provides assurance that NHS funding will continue
- Understanding that for the financial year 2021/22 the Trust at this point in time would not yet have formal contracts in place with its commissioners at the date of the signature of the accounts, however, given that services are reasonably still expected to be commissioned, government funding will be in place and that temporary revenue support arrangements are in place and will remain so.

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.....

Louise Barnett, Chief Executive
25 June 2020

Signed.....

James Drury, Interim Finance Director
25 June 2020

REMUNERATION AND STAFF REPORT

Remuneration for directors is set by our Remuneration Committee. Director salaries are reviewed at appointment then, annually, a benchmarking exercise is undertaken to ensure remuneration remains appropriate. Remuneration figures represent actual remuneration rather than full-year effect.

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

The banded remuneration of the highest paid director in The Shrewsbury and Telford Hospital NHS Trust in the financial year 2019-20 was in the salary banding of £245,000 to £250,000 (2018-19, £175,000 to £180,000). This was 9.23 times (2018-19, 6.7 times) the median remuneration of the workforce, which was £26,801 (2018-19, £26,564).

In 2019-20, 3 (2018-19, 21) employees received remuneration in excess of the highest-paid director. Remuneration ranged from £254,000 to £309,000 (2018-19, £179,000 to £248,000).

Total remuneration includes salary, non-consolidated performance-related pay (not applicable to any member of staff in 2019-20 or 2018-19), benefits in kind as well but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The median remuneration of the workforce remained fairly static. The increase in the median ratio is due to a new interim appointment who was the highest-paid director in the organisation during the financial year 2019-20.

RENUMERATION REPORT

The table below shows the salary entitlements of senior managers (members of the Trust Board). This information is subject to audit.

	2019-20							2018-19					
Name and Title	Salary (bands of £5,000) £000	Other Remuneration (bands of £5,000) £000	Expense payments (taxable) total to nearest £100 £	Performance pay and bonuses (bands of £5,000) £000	Long term performance pay and bonuses (bands of £5,000) £000	All pension-related benefits (bands of £2,500) £000	TOTAL (bands of £5,000) £000	Salary (bands of £5,000) £000	Expense payments (taxable) total to nearest £100 £	Performance pay and bonuses (bands of £5,000) £000	Long term performance pay and bonuses (bands of £5,000) £000	All pension-related benefits (bands of £2,500) £000	TOTAL (bands of £5,000) £000
Ben Reid Chairman	30-35	-	2,400	-	-	-	30-35	30-35	-	-	-	-	30-35
Simon Wright Chief Executive (to 30/06/2019)	40-45	35-40	-	-	-	45-47.5	125-130	180-185	-	-	-	40-42.5	200-205
Paula Clark Interim Chief Executive (from 01/07/2019 to 09/02/2020)	120-125	-	-	-	-	Not in NHS Pension Scheme	120-125	-	-	-	-	-	-
Louise Barnett Chief Executive (from 10/02/2020)	25-30	-	-	-	-	70-72.5	95-100	-	-	-	-	-	-
Voting Directors													
Nigel Lee Chief Operating Officer	130-135	-	-	-	-	Opted out of NHS Pension Scheme	130-135	125-130	-	-	-	247.5-250	375-380
Dr Edwin Borman Medical Director (to 16/06/2019)	35-40	-	-	-	-	7.5-10	45-50	175-180	-	-	-	47.5-50	225-230
Dr Arne Rose Medical Director (from 17/06/2019)	160-165	30-35	-	-	-	Not in NHS Pension Scheme	190-195	-	-	-	-	-	-
Barbara Beal Interim Director of Nursing (from 15/06/2019)	110-115	-	-	-	-	Not in NHS Pension Scheme	110-115	-	-	-	-	-	-
Neil Nisbet Finance Director (to 17/06/2019)	30-35	-	1,600	-	-	0	30-35	140-145	6,600	-	-	0-2.5	140-145
James Drury Interim Finance Director (from 18/06/2019)	110-115	-	-	-	-	45-47.5	160-165	-	-	-	-	-	-
Non-Executive Directors													
Tony Allen Associate Non Executive Director	5-10	-	1,800	-	-	-	5-10	0-5	-	-	-	-	0-5
Teresa Boughey Non Executive Director (from 01/09/2019)	5-10	-	-	-	-	-	5-10	-	-	-	-	-	-
Anthony Bristlin Non Executive Director	5-10	-	3,100	-	-	-	10-15	0-5	-	-	-	-	0-5
David Brown Non Executive Director (from 01/09/2019)	5-10	-	400	-	-	-	5-10	-	-	-	-	-	-
Anthony Carroll Associate Non Executive Director (left 31/10/2019)	0-5	-	1,800	-	-	-	5-10	0-5	-	-	-	-	0-5
Harmesh Darbhanga Associate Non Executive Director (left 29/05/2019)	0-5	-	-	-	-	-	0-5	5-10	-	-	-	-	5-10
Clive Deadman Non Executive Director	5-10	-	1,100	-	-	-	5-10	5-10	-	-	-	-	5-10
Amanda Edwards Non Executive Director (left 31/05/2019)	0-5	-	100	-	-	-	0-5	0-5	-	-	-	-	0-5
Dr David Lee Non Executive Director	5-10	-	-	-	-	-	5-10	5-10	-	-	-	-	5-10
Brian Newman Associate Non Executive Director	5-10	-	-	-	-	-	5-10	5-10	-	-	-	-	5-10
Trevor Purt Non Executive Director (from 01/09/2019)	5-10	-	400	-	-	-	5-10	-	-	-	-	-	-
Dr Christopher Welner Associate Non Executive Director (left 01/05/2019)	0-5	-	-	-	-	-	0-5	5-10	-	-	-	-	5-10
Band of Highest Paid Director's Remuneration (FYE)	245-250							175-180					
Median Total Remuneration	28,801							28,584					
Ratio	8.23							6.70					

The table below shows the pension entitlements of senior managers (members of the Trust Board). This information is subject to audit.

Name & Title	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2020 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2020 (bands of £5,000) £000	Cash Equivalent Transfer Value at 1 April 2019 £000	Real increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2020 £000	Employer's contribution to stakeholder pension £000
Simon Wright Chief Executive (to 30/06/2020)	0-2.5	0	50-55	105-110	888	3	965	
Louise Barnett Chief Executive (from 10/02/2020)	0-2.5	0-2.5	45-50	85-90	699	5	777	
Dr Edwin Borman Medical Director (to 16/06/2019)	0-2.5	0-2.5	80-85	250-255	1,897	8	2,008	
Neil Nisbet Finance Director (to 17/06/2019)	0	0	55-60	165-170	1,282	0	1,330	
James Drury Interim Finance Director (from 18/06/2019)	0-2.5	0-2.5	30-35	55-60	463	24	525	

STAFF REPORT

We employ over 6,400 staff and hundreds of staff and students from other organisations also work in our hospitals.

This report provides details about the make-up of our workforce, which at the end of 2019-20 increased by 369 to 6,461. When taking into account those employed on part-time contracts, the full-time equivalent (FTE) number increased by 351 to 5,538. Expenditure on staff accounts for approximately 66% of overall Trust expenditure, the same as the previous year. A more detailed breakdown of staff numbers can be found in the table below. The number of staff reported in Section One of the Annual Report is in absolute terms. The table below refers to staff groups by Full Time Equivalent (FTE).

Staff Group	FTE	%
Doctors and dentists	608.73	11.0%
Nursing and midwifery staff	1,615.28	29.2%
Scientific, technical and therapies staff	677.31	12.2%
Other clinical staff	1,505.13	27.2%
Non-clinical staff	1,131.00	20.4%
Total	**5,537.94**	

Bank Employees	Headcount
No. of Bank Employees (No Substantive	1,441

Senior Managers are those employed at Agenda for Change (AfC) Bands 8a-9. In 2019-20 the number of Senior Managers (inc Bank) at the Trust was:

Senior Managers by AfC Band	Headcount	%
Band 8a	1	2.38%
Band 8b	9	21.43%
Band 8c	18	42.86%
Band 8d	9	21.43%
Band 9	3	7.14%
Personal Salary	2	4.76%
Total	**42**	

The table below gives the gender breakdown of the Trust in 2019-20.

Gender Breakdown	Male	Female
Board Level Directors	5	5
Non Executive Directors/Chair	9	1
Senior Managers	11	28
All other employees	1,249	5,156
Total	1,274	5,190

The table below gives information on staff sickness

Sickness Absence Information	
Sickness Absence %	4.38%
% Over Target Sickness of 3.99%	0.39%
Total FTE Calendar Days Lost	85,211
Average FTE Calendar Days Lost Per Employee	13
No. Ill Health Retirements	9
No. Voluntary Resignations - Health	39

Staff policies applied during the financial year

For giving full and fair consideration to applications for employment by the company made by disabled persons, having regard to their particular aptitudes and abilities:

The Trust is committed to the full and fair consideration of applications for employment from disabled people. Our Recruitment and Selection Policy and our Managing Health and Wellbeing Policy, reflects current practice and will outline our commitment under the Disability Confident Scheme. The Trust is continuing to review and cluster all its Human Resources (HR) policies to make them more user-friendly and Equality Impact Assessments are carried out for each cluster of policies to ensure they reflect best practice in industry standards and take into account the current legislative requirements in relation to people with disabilities. The Trust Board is committed to the Equality Delivery System (EDS2) as a means of monitoring and reporting on its progress in all protected characteristics.

For continuing the employment of, and for arranging appropriate training for, employees of the company who have become disabled persons during the period when they were employed by the company:

For existing staff, the Trust runs an Alternative Employment Register for those who become unable to carry out their substantive contract so they can look at all the alternative posts that are available within the Trust which match their skill set, to enable them to carry on working within the Trust. Additional supportive training is also identified on a case-by-case basis where appropriate and reasonable adjustments are made.

Otherwise for the training, career development and promotion of disabled persons employed by the Trust:

All members of staff, regardless of disability or any protected characteristic, have access to development and training opportunities through the Trust's education programmes and this is monitored and reported annually to the Board as part of the Equality and Diversity Annual report. Access to promotion opportunities is available through the nationally recognised NHS Jobs portal for advertising of jobs.

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.

The Trust is required to disclose:

- All off-payroll engagements as of 31 March 2020, greater than £245 per day and that last longer than six months (see table 1 below).
- All new off-payroll engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020, greater than £245 per day and that last for longer than six months (see table 2 below).
- Any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2019 and 31 March 2020 (see table 3 below).

Off-payroll engagements

Table 1: Off-payroll engagements longer than 6 months

For all off-payroll engagements as of 31 March 2020, for more than £245 per day and that last longer than six months:	Number
Number of existing engagements as of 31 March 2020	1
Of which, the number that have existed:	
for less than one year at the time of reporting	-
for between one and two years at the time of reporting	-
for between 2 and 3 years at the time of reporting	-
for between 3 and 4 years at the time of reporting	-
for 4 or more years at the time of reporting	-

Table 2: New Off-payroll engagements

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020, for more than £245 per day and that last for longer than six months	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020	1
Of which:	-
Number assessed as caught by IR35	-
Number assessed as not caught by IR35	-
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	-

Table 3: Off-payroll board member/senior official engagements

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2019 and 31 March 2020	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	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.	22

Reporting of compensation schemes—exit packages 2019-20

	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
Exit package cost band (including any special payment element)			
<£10,000	-	25	**25**
£10,000 - £25,000	-	2	**2**
£25,001 - 50,000	-	2	**2**
£50,001 - £100,000	-	-	**-**
£100,001 - £150,000	-	1	**1**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**-**	**30**	**30**
Total cost (£)	£0	£322,000	**£322,000**

2018/19

	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
Exit package cost band (including any special payment element)			
<£10,000	-	28	**28**
£10,000 - £25,000	-	-	**-**
£25,001 - 50,000	-	1	**1**
£50,001 - £100,000	-	-	**-**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**-**	**29**	**29**
Total resource cost (£)	£0	£112,000	**£112,000**

Exit packages: other (non-compulsory) departure payments

	2019/20		2018/19	
	Payments agreed Number	Total value of agreements £000	Payments agreed Number	Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	1	140	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	29	182	30	112
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**30**	**322**	**30**	**112**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

Staff costs

	Permanent £000	Other £000	2019/20 Total £000	2018/19 Total £000
Salaries and wages	193,950	1,198	**195,148**	180,358
Social security costs	19,439	-	**19,439**	18,616
Apprenticeship levy	1,050	-	**1,050**	971
Employer's contributions to NHS pension scheme	35,939	-	**35,939**	23,323
Temporary staff - Bank	-	20,782	**20,782**	18,470
Temporary staff - Agency	-	26,725	**26,725**	16,746
Total gross staff costs	**250,378**	**48,705**	**299,083**	**258,484**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**250,378**	**48,705**	**299,083**	**258,484**
Of which				
Costs capitalised as part of assets	1,522	-	**1,522**	1,108

Average number of employees (WTE basis)

	Permanent Number	Other Number	2019/20 Total Number	2018/19 Total Number
Medical and dental	594	79	**673**	625
Ambulance staff	3	-	**3**	-
Administration and estates	1,094	71	**1,165**	1,116
Healthcare assistants and other support staff	1,109	186	**1,295**	1,213
Nursing, midwifery and health visiting staff	1,568	278	**1,846**	1,692
Nursing, midwifery and health visiting learners	5	-	**5**	16
Scientific, therapeutic and technical staff	629	30	**659**	633
Healthcare science staff	305	-	**305**	293
Total average numbers	**5,307**	**644**	**5,951**	**5,589**
Of which:				
Number of employees (WTE) engaged on capital projects	29	1	**30**	20

Louise Barnett
Chief Executive

APPENDIX ONE

ANNUAL ACCOUNTS

The Shrewsbury and Telford Hospital NHS Trust

Annual accounts for the year ended 31 March 2020

Statement of Comprehensive Income

	Note	2019/20 £000	2018/19 £000
Operating income from patient care activities	3	384,954	340,533
Other operating income	4	36,899	28,653
Operating expenses	7, 9	(447,676)	(387,050)
Operating surplus/(deficit) from continuing operations		**(25,823)**	**(17,864)**
Finance income	12	101	86
Finance expenses	13	(967)	(713)
PDC dividends payable		(2,188)	(2,817)
Net finance costs		**(3,054)**	**(3,444)**
Other gains / (losses)	14	(369)	(127)
Share of profit / (losses) of associates / joint arrangements		-	-
Gains / (losses) arising from transfers by absorption	43	-	-
Corporation tax expense		-	-
Surplus / (deficit) for the year from continuing operations		**(29,246)**	**(21,435)**
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations		**-**	**-**
Surplus / (deficit) for the year		**(29,246)**	**(21,435)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	739	(2,738)
Revaluations	19	553	1,029
Total comprehensive income / (expense) for the period		**(27,954)**	**(23,144)**
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		(29,246)	(21,435)
Remove net impairments not scoring to the Departmental expenditure limit		3,552	2,651
Remove I&E impact of capital grants and donations		(21)	41
Remove 2018/19 post audit PSF reallocation (2019/20 only)		(416)	-
Adjusted financial performance surplus / (deficit)		**(26,131)**	**(18,743)**

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

Impairments to Fixed Assets - an impairment charge is not considered part of the organisation’s operating position.

I&E impact of capital grants and donations.

2018/19 post audit PSF reallocation (2019/20 only).

Statement of Financial Position

	Note	31 March 2020 £000	31 March 2019 £000
Non-current assets			
Intangible assets	16	6,410	2,619
Property, plant and equipment	17	161,305	154,569
Investment property	20	-	-
Investments in associates and joint ventures		-	-
Other investments / financial assets		-	-
Receivables	25	1,446	1,534
Other assets		-	-
Total non-current assets		**169,161**	**158,722**
Current assets			
Inventories	24	8,423	9,392
Receivables	25	18,128	17,335
Other investments / financial assets		-	-
Other assets		-	-
Non-current assets for sale and assets in disposal groups		-	-
Cash and cash equivalents	28	1,700	1,700
Total current assets		**28,251**	**28,427**
Current liabilities			
Trade and other payables	29	(31,982)	(24,313)
Borrowings	31	(82,721)	(20,840)
Other financial liabilities	32	-	-
Provisions	34	(1,266)	(546)
Other liabilities	30	(1,312)	(1,265)
Liabilities in disposal groups		-	-
Total current liabilities		**(117,281)**	**(46,964)**
Total assets less current liabilities		**80,131**	**140,185**
Non-current liabilities			
Trade and other payables	29	-	-
Borrowings	31	-	(41,655)
Other financial liabilities	32	-	-
Provisions	34	(141)	(148)
Other liabilities	30	-	-
Total non-current liabilities		**(141)**	**(41,803)**
Total assets employed		**79,990**	**98,382**
Financed by			
Public dividend capital		215,008	205,446
Revaluation reserve		27,306	26,014
Financial assets reserve		-	-
Other reserves		-	-
Merger reserve		-	-
Income and expenditure reserve		(162,324)	(133,078)
Total taxpayers' equity		**79,990**	**98,382**

The notes on pages 7 to 49 form part of these accounts.

Signed 

Name Louise Barnett

Position Chief Executive

Date 25 June 2020

Statement of Changes in Equity for the year ended 31 March 2020

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**205,446**	**26,014**	**(133,078)**	**98,382**
Surplus/(deficit) for the year	-	-	(29,246)	**(29,246)**
Gain/(loss) arising from transfers by mofieid absorption	-	-	-	**-**
Transfers by absorption: transfers between reserves	-	-	-	**-**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	-	-	**-**
Other transfers between reserves	-	-	-	**-**
Impairments	-	739	-	**739**
Revaluations	-	553	-	**553**
Transfer to retained earnings on disposal of assets	-	-	-	**-**
Share of comprehensive income from associates and joint ventures	-	-	-	**-**
Other recognised gains and losses	-	-	-	**-**
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	-	**-**
Public dividend capital received	9,562	-	-	**9,562**
Public dividend capital repaid	-	-	-	**-**
Public dividend capital written off	-	-	-	**-**
Other movements in public dividend capital in year	-	-	-	**-**
Other reserve movements	-	-	-	**-**
Taxpayers' and others' equity at 31 March 2020	**215,008**	**27,306**	**(162,324)**	**79,990**

Statement of Changes in Equity for the year ended 31 March 2019

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2018 - brought forward	**201,372**	**27,723**	**(111,643)**	**117,452**
Prior period adjustment	-	-	-	**-**
Taxpayers' and others' equity at 1 April 2018 - restated	**201,372**	**27,723**	**(111,643)**	**117,452**
Impact of implementing IFRS 15 on 1 April 2018	-	-	-	**-**
Impact of implementing IFRS 9 on 1 April 2018	-	-	-	**-**
Surplus/(deficit) for the year	-	-	(21,435)	**(21,435)**
Transfers by absorption: transfers between reserves	-	-	-	**-**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	-	-	**-**
Other transfers between reserves	-	-	-	**-**
Impairments	-	(2,738)	-	**(2,738)**
Revaluations	-	1,029	-	**1,029**
Transfer to retained earnings on disposal of assets	-	-	-	**-**
Share of comprehensive income from associates and joint ventures	-	-	-	**-**
Other recognised gains and losses	-	-	-	**-**
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	-	**-**
Public dividend capital received	4,074	-	-	**4,074**
Public dividend capital repaid	-	-	-	**-**
Public dividend capital written off	-	-	-	**-**
Other movements in public dividend capital in year	-	-	-	**-**
Other reserve movements	-	-	-	**-**
Taxpayers' and others' equity at 31 March 2019	**205,446**	**26,014**	**(133,078)**	**98,382**

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.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statement of Cash Flows

	Note	2019/20 £000	2018/19 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(25,823)	(17,864)
Non-cash income and expense:			
Depreciation and amortisation	7.1	10,778	10,897
Net impairments	8	3,552	2,651
Income recognised in respect of capital donations	4	(1,052)	(977)
Amortisation of PFI deferred credit		-	-
Non-cash movements in on-SoFP pension liability		-	-
(Increase) / decrease in receivables and other assets		(768)	981
(Increase) / decrease in inventories		969	(1,623)
Increase / (decrease) in payables and other liabilities		4,565	(1,557)
Increase / (decrease) in provisions		718	(30)
Tax (paid) / received		-	-
Operating cash flows from discontinued operations		-	-
Other movements in operating cash flows		-	-
Net cash flows from / (used in) operating activities		**(7,061)**	**(7,522)**
Cash flows from investing activities			
Interest received		100	82
Purchase and sale of financial assets / investments		-	-
Purchase of intangible assets		(4,580)	(484)
Sales of intangible assets		-	-
Purchase of PPE and investment property		(16,203)	(16,760)
Sales of PPE and investment property		-	-
Receipt of cash donations to purchase assets		1,052	977
Prepayment of PFI capital contributions		-	-
Investing cash flows from discontinued operations		-	-
Cash from acquisitions / disposals of subsidiaries		-	-
Net cash flows from / (used in) investing activities		**(19,631)**	**(16,185)**
Cash flows from financing activities			
Public dividend capital received		9,562	4,074
Public dividend capital repaid		-	-
Movement on loans from DHSC		20,195	22,950
Movement on other loans		-	-
Other capital receipts		-	-
Capital element of finance lease rental payments		-	-
Capital element of PFI, LIFT and other service concession payments		-	-
Interest on loans		(941)	(634)
Other interest		-	-
Interest paid on finance lease liabilities		-	-
Interest paid on PFI, LIFT and other service concession obligations		-	-
PDC dividend (paid) / refunded		(2,124)	(2,683)
Financing cash flows of discontinued operations		-	-
Cash flows from (used in) other financing activities		-	-
Net cash flows from / (used in) financing activities		**26,692**	**23,707**
Increase / (decrease) in cash and cash equivalents		**-**	**-**
Cash and cash equivalents at 1 April - brought forward		**1,700**	**1,700**
Prior period adjustments			-
Cash and cash equivalents at 1 April - restated		**1,700**	**1,700**
Cash and cash equivalents transferred under absorption accounting	43	-	-
Unrealised gains / (losses) on foreign exchange		-	-
Cash and cash equivalents at 31 March	28	**1,700**	**1,700**

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 2019/20 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. International Accounting Standard 1 requires the Board to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. In the context of non-trading entities in the public sector the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative other than, the dissolution of the Trust without transfer of its services to another entity within the public sector.

In preparing the financial statements the Board of Directors has considered the Trust's overall financial position against the requirements of IAS1. The Board has also based its assessment on guidance from NHS England and NHS Improvement about what is required to undertake a Trust's Going Concern assessment.

Continuity of service

The Trust’s planned deficit, pre support funding, for the period April 2019 to March 2020 was £17.4m. The actual deficit reported for the same period is £35.3m, being £17.9m adverse to plan.

It is critical that the Trust has certainty regarding cash inflows over the next few months due to the impact of COVID-19. To facilitate this NHS England and NHS Improvement has agreed to make enhanced block payments to all NHS Providers, based on actual levels of pre-COVID 19 spending, for the first seven months of 2020/21 (to October 2020) guaranteeing a minimum level of income and additionally covering costs relating to COVID-19. This covers all services directly commissioned by NHSE, CCG and specialised commissioning hubs.

NHS England and NHS Improvement have not yet confirmed financial arrangements that will be in place for the rest of 2020/21 and beyond. It remains the case that the Government has issued a mandate to NHS England for the continued provision of services in England in 2020/21 and CCG allocations have been set for the remainder of 2020/21. While these allocations may be subject to minor revision as a result of the COVID-19 financial framework, the guidance has been clarified to inform CCGs that they will be provided with sufficient funding for the year. Providers are therefore assured that they can continue to expect NHS funding to flow at similar levels to that previously provided where services are reasonably still expected to be commissioned. This will cover both ongoing services and additional COVID-19 related expenditure.

This supports the assumption that while mechanisms for contracting and payment are not definitively in place, it is clear that NHS services will continue to be funded, and government funding is in place for this for the financial year 2020/21.

Further, in additional guidance on the cash and capital regime published by DHSC in April 2020 (https://www.england.nhs.uk/wp-content/uploads/2020/04/C0096-Cash-regime-guidance-1-April-2020.pdf), DHSC has confirmed that temporary revenue support arrangements will continue, in order to support providers with demonstrable cash needs.

For the financial year 2021/22 the Trust at this point in time would not yet have formal contracts in place with its commissioners at the date of the signature of the accounts, however, given that services are reasonably still expected to be commissioned, government funding will be in place and that temporary revenue support arrangements are in place and will remain so.

The Board of Directors therefore believe that it is likely that the current payments will remain in place for the remainder of 2020/21, that the range of services commissioned and provided for 2021/22 and therefore the level of potential funding will not materially change and that temporary revenue support arrangements will be in place. These assumptions underpin a cash flow forecast, which has been prepared for the next 12 months that evidences satisfactory cash balances based on reasonable assumptions about costs and income.

As is the case with many other Trusts, the Trust is reliant on cash funding from Department of Health and Social Care to continue its operations, and received support loans totalling £18.573m for 2019/20. These have been drawn down in line with forecasts.

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. The affected loans totalling £82,721k are classified as current liabilities within these financial statements. As the repayment of these loans will be funded through the issue of PDC, this does not present a going concern risk for the Trust.

With full knowledge of the above, as the Trust has not received any notice of discontinuation or notice of transfer of its services to another entity, the Trust has prepared the accounts on a going concern basis.

Note 1.3 Interests in other entities

Associates
There are no associate entities those over which the trust has the power to exercise a significant influence.

Joint ventures
There are no joint ventures in which the trust participates in with one or more other parties.

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

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. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete. This accrual is disclosed as a contract receivable as entitlement to payment for work completed is usually only dependent on the passage of time.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.

Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

The Trust does not receive income where a patient is readmitted within 30 days of discharge from a previous planned stay. This is considered an additional performance obligation to be satisfied under the original transaction price. Income is adjusted to reflect the readmissions charge.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

As per paragraph 121 of the Standard the Trust does not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less. The GAM does not require the Trust to disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date. The GAM has mandated the exercise of the practical expedient offered in C7A of the Standard that requires the Trust to reflect the aggregate effect of all contracts modified before the date of initial application.

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.

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.

Provider Sustainability Fund (PSF) and Financial Recovery Fund (FRF)
The PSF and FRF enable providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration. PSF funding was available in 2018/19 and 2019/20 but FRF funding was only introduced in 2019/20.

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 consolidated 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 Trust makes monthly payments to the apprenticeship levy. The trust draws down training costs from the apprenticeship levy to obtain benefits back from the scheme. This is paid directly to the accredited training provider on behalf of the Trust.

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 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 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.

Land and property 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 land and property 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. Properities 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 all of the following criteria 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. 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.

Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

The trust has no PFI or LIFT agreements.

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	2	45
Dwellings	25	32
Plant & machinery	5	26
Transport equipment	10	10
Information technology	3	10
Furniture & fittings	10	23

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.10 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They 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.

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
Software licences	3	7

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 the high turnover of stocks.

Note 1.12 Investment properties

The trust does not hold any assets which are held solely to generate a commercial return.

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 Carbon Reduction Commitment scheme (CRC)
The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

Note 1.15 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 finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are subsequently measured at fair value through income and expenditure.

Financial liabilities are 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 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 a simplified approach to impairment for contract and other receivables, contract assets and lease receivables. All debts more than three months old are set up as potential credit losses except those that could be offset against any salary payments. All overseas accounts are set up as potential credit losses on a monthly basis.The trust does not normally recognise expected credit losses in relation to other NHS bodies.

Income received under the NHS injury cost recovery scheme 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. Each year, the Compensation Recovery Unit (CRU) advises a percentage probability of not receiving the income. For 2019/20 this figure is 21.79% which is included in Note 25.2.

The trust does not have any other financial assets that require impairment.

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 1.16 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The trust as a lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

The trust as a lessor

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

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

Note 1.17 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 for 31 March 2020:

		Nominal rate
Short-term	Up to 5 years	0.51%
Medium-term	After 5 years up to 10 years	0.55%
Long-term	Exceeding 10 years	1.99%

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 31 March 2020:

	Inflation rate
Year 1	1.90%
Year 2	2.00%
Into perpetuity	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.5% in real terms.

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 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 1.18 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 1.19 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, except for
(i) donated and grant funded assets and assets purchased in response to COVID-19
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

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 the audit of the annual accounts.

Note 1.20 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 1.21 Corporation tax
The trust has no corporation tax liability.

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 accruals 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 / from other NHS bodies / local government bodies

There have been no functions that have been transferred to/from the trust from/to other NHS/local government bodies.

Note 1.27 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2019/20.

Note 1.28 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases will replace *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2021. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2021, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 1.27% but this may change between now and adoption of the standard.The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2021 for existing finance leases.

For leases commencing in 2021/22, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

HM Treasury revised the implementation date for IFRS 16 in the UK public sector to 1 April 2021 on 19 March 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity from April 2021 and beyond, a quantification of the expected impact of applying the standard in 2021/22 is currently impracticable. However, the trust does expect this standard will have a material impact on non-current assets, liabilities and depreciation.

Other standards, amendments and interpretations

IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

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 have not consolidated these into the trust's accounts.

Note 1.30 Sources of estimation uncertainty

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.

Accruals: The trust has estimated income and expenditure where amounts are unaccounted for yet still owed/owing at the end of the accounting period so as to record revenue and expenses in the period in which they incurred.

Provisions: Provisions have been made for 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.

Income: The trust has estimated income by calculating over and under performance of contracts with NHS commissioners based on forecast outturns with relevant income adjustments made. Discussions are held with commissioners on a regular basis regarding activity levels against their contracts, particularly towards and immediately after the year-end.

Revaluation: The trust commissioned Deloitte Real Estate to undertake revaluation of the trust's estate as at 31 March 2020. Residential Land and Dwellings are valued at Market Value in existing use. Specialised buildings are valued at Depreciated Replacement Cost defined as Modern Equivalent Asset. An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Note 2 Operating Segments

The trust operates in one material segment which is the provision of heathcare services with the Trust Board as it's chief operating decision maker deciding how to allocate resources and assessing performance.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.

Note 3.1 Income from patient care activities (by nature)	**2019/20 £000**	**2018/19 £000**
Acute services		
Elective income	48,600	48,029
Non elective income	138,908	125,201
First outpatient income	26,986	26,196
Follow up outpatient income	24,328	22,738
A & E income	19,813	16,432
High cost drugs income from commissioners (excluding pass-through costs)	32,841	30,405
Other NHS clinical income	79,769	64,877
All services		
Private patient income	1,203	1,042
Agenda for Change pay award central funding*		3,949
Additional pension contribution central funding**	10,891	
Other clinical income	1,615	1,664
Total income from activities	**384,954**	**340,533**

*Additional costs of the Agenda for Change pay reform in 2018/19 received central funding. From 2019/20 this funding is incorporated into tariff for individual services.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. For 2019/20, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	**2019/20 £000**	**2018/19 £000**
NHS England*	73,562	54,363
Clinical commissioning groups	277,508	249,166
Department of Health and Social Care	-	3,949
Other NHS providers	1,144	1,116
NHS other	129	129
Local authorities	-	-
Non-NHS: private patients	1,203	1,042
Non-NHS: overseas patients (chargeable to patient)	159	130
Injury cost recovery scheme**	1,446	1,534
Non NHS: other***	29,803	29,104
Total income from activities	**384,954**	**340,533**
Of which:		
Related to continuing operations	384,954	340,533
Related to discontinued operations	-	-

*Includes £10.891m employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019.

** Injury cost recovery income is subject to a provision for impairment of receivables of 21.79% for 2019/20 (previously 21.89%) to reflect expected rates of collection.

*** Non-NHS-Other includes income of £29.78m from Welsh bodies (2018-19: £29.02m).

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2019/20	2018/19
	£000	£000
Income recognised this year	159	130
Cash payments received in-year	50	92
Amounts added to provision for impairment of receivables	92	26
Amounts written off in-year	2	5

Note 4 Other operating income

	2019/20			2018/19		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	198	-	**198**	224	-	**224**
Education and training	12,965	-	**12,965**	12,371	-	**12,371**
Non-patient care services to other bodies	1,689		**1,689**	1,926		**1,926**
Provider sustainability fund (PSF)	2,909		**2,909**	5,184		**5,184**
Financial recovery fund (FRF)	1,914		**1,914**			
Marginal rate emergency tariff funding (MRET)	4,758		**4,758**			
Receipt of capital grants and donations		1,052	**1,052**		977	**977**
Charitable and other contributions to expenditure		-	**-**		-	**-**
Support from the Department of Health and Social Care for mergers		-	**-**		-	**-**
Rental revenue from finance leases		-	**-**		-	**-**
Rental revenue from operating leases		-	**-**		-	**-**
Amortisation of PFI deferred income / credits		-	**-**		-	**-**
Other income*	11,414	-	**11,414**	7,971	-	**7,971**
Total other operating income	**35,847**	**1,052**	**36,899**	**27,676**	**977**	**28,653**
Of which:						
Related to continuing operations			**36,899**			**28,653**
Related to discontinued operations			**-**			**-**

*The majority of 'Other Income' is for car parking, radiology, cardiorespiratory, dietetics, speech therapists and maternity pathways.

Note 5 Additional information on contract revenue (IFRS 15) recognised in the period

	2019/20	2018/19
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	1,265	1,166
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-	-

Note 6 Fees and charges

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

Note 7.1 Operating expenses

	2019/20	2018/19
	£000	£000
Purchase of healthcare from non-NHS and non-DHSC bodies	779	414
Staff and executive directors costs	297,561	257,376
Remuneration of non-executive directors	100	80
Supplies and services - clinical (excluding drugs costs)	30,050	27,219
Supplies and services - general	5,565	5,596
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	43,898	39,484
Inventories written down	491	198
Consultancy costs	2,363	579
Establishment	7,472	5,038
Premises	19,706	14,820
Transport (including patient travel)	738	721
Depreciation on property, plant and equipment	9,873	9,931
Amortisation on intangible assets	905	966
Net impairments	3,552	2,651
Movement in credit loss allowance: contract receivables / contract assets	507	395
Increase/(decrease) in other provisions	192	400
Change in provisions discount rate(s)	(8)	2
Audit fees payable to the external auditor		
audit services- statutory audit*	101	84
other auditor remuneration (external auditor only)**	4	10
Internal audit costs	105	105
Clinical negligence	13,297	12,975
Legal fees	364	266
Insurance	42	22
Education and training	1,521	882
Rentals under operating leases	7,464	5,856
Car parking & security	472	419
Hospitality	4	-
Losses, ex gratia & special payments	37	31
Other	521	530
Total	**447,676**	**387,050**
Of which:		
Related to continuing operations	447,676	387,050
Related to discontinued operations	-	-

*audit services- statutory audit of £84,180 plus £16,836 of VAT

**other auditor remuneration (external auditor only) of £3,000 plus £600 of VAT

Note 7.2 Other auditor remuneration

	2019/20	2018/19
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	4	10
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	-
Total	**4**	**10**

Note 7.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £5m (2018/19: £5m).

Note 8 Impairment of assets

	2019/20	2018/19
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	-	-
Over specification of assets	-	-
Abandonment of assets in course of construction	-	-
Unforeseen obsolescence	-	-
Loss as a result of catastrophe	-	-
Changes in market price	3,552	2,651
Other	-	-
Total net impairments charged to operating surplus / deficit	**3,552**	**2,651**
Impairments charged to the revaluation reserve	(739)	2,738
Total net impairments	**2,813**	**5,389**

The trust commissioned Deloitte Real Estate to undertake revaluations of the Trust's Estate as at 31 March 2020. As a result of these revaluations impairments of £3,552k have been charged to SoCI and net increase of £739k to Revaluation Reserve in respect of impairments charge of £979k and reversal of impairments of £1,718k.

Note 9 Employee benefits

	2019/20 Total £000	2018/19 Total £000
Salaries and wages	195,148	180,358
Social security costs	19,439	18,616
Apprenticeship levy	1,050	971
Employer's contributions to NHS pensions*	35,939	23,323
Pension cost - other	-	-
Other post employment benefits	-	-
Other employment benefits	-	-
Termination benefits	-	-
Temporary staff (bank)	20,782	18,470
Temporary staff (agency)	26,725	16,746
Total gross staff costs	**299,083**	**258,484**
Recoveries in respect of seconded staff	-	-
Total staff costs	**299,083**	**258,484**
Of which		
Costs capitalised as part of assets	1,522	1,108

*2019/20: Includes £10.891m employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019.

Note 9.1 Retirements due to ill-health

During 2019/20 there were 6 early retirements from the trust agreed on the grounds of ill-health (3 in the year ended 31 March 2019). The estimated additional pension liabilities of these ill-health retirements is £296k (£95k in 2018/19).

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 two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2020, is based on valuation data as 31 March 2019, updated to 31 March 2020 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 report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6%, and the Scheme Regulations were amended accordingly.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

Note 11 Operating leases

Note 11.1 Shrewsbury and Telford Hospital NHS Trust as a lessor

There are no operating lease agreements where Shrewsbury and Telford Hospital NHS Trust is the lessor.

Note 11.2 Shrewsbury and Telford Hospital NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where the Shrewsbury and Telford Hospital NHS Trust is the lessee.

The trust has a contract for computerised digital imaging and archiving service contracts within Radiology. The term of the contract, which covers the Royal Shrewsbury Hospital and the Princess Royal Hospital, is 10 years and commenced on 1 January 2016.

The trust has an operating lease relating to an investment in replacing the boiler plant at the Royal Shrewsbury Hospital, the term of the lease is 15 years and commenced 1 April 2007.

The trust has a print managed service contract for both hospitals. The lease commenced 1 July 2017 for 5 years.

A lease for the off site office accommodation commenced on 21 July 2015 for 10 years. The lease for the off site sterile services is for 20 years commencing 1 April 2010. A lease for accommodation for the Fertility department facility commenced 13 June 2018 with a break clause after 5 years.

The trust has entered into leases for the provision of staff and office accommodation facilities at the Royal Shrewsbury Hospital.

The trust has several managed service contracts for the provision of services within the Pathology and Radiology departments.

The Trust has taken out leases during the year for high value diagnostic equipment in Radiology across both sites.

The Trust leases various properties/units through NHS Property Services and other NHS organisations.

The Trust also has lease cars.

	2019/20 £000	2018/19 £000
Operating lease expense		
Minimum lease payments	7,464	5,856
Contingent rents	-	-
Less sublease payments received	-	-
Total	**7,464**	**5,856**

	31 March 2020 £000	31 March 2019 £000
Future minimum lease payments due:		
On buildings leases:		
- not later than one year;	1,396	635
- later than one year and not later than five years;	4,751	2,431
- later than five years.	5,370	2,885
Total	**11,517**	**5,951**
Future minimum sublease payments to be received	-	-
Future minimum lease payments due:		
On other leases:		
- not later than one year;	5,957	4,650
- later than one year and not later than five years;	15,939	15,038
- later than five years.	1,929	1,916
Total	**23,825**	**21,604**
Future minimum sublease payments to be received	-	-
Future minimum lease payments due:		
On all leases:		
- not later than one year;	7,353	5,285
- later than one year and not later than five years;	20,690	17,469
- later than five years.	7,299	4,801
Total	**35,342**	**27,555**
Future minimum sublease payments to be received	-	-

Note 12 Finance income

Finance income represents interest received on assets and investments in the period.

	2019/20	2018/19
	£000	£000
Interest on bank accounts	101	86
Interest income on finance leases	-	-
Interest on other investments / financial assets	-	-
Other finance income	-	-
Total finance income	**101**	**86**

Note 13.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2019/20	2018/19
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	972	680
Other loans	-	-
Overdrafts	-	-
Finance leases	-	-
Interest on late payment of commercial debt	-	-
Total interest expense	**972**	**680**
Unwinding of discount on provisions	(5)	33
Other finance costs	-	-
Total finance costs	**967**	**713**

Note 13.2 The late payment of commercial debts (interest) Act 1998/Public Contract Regulations 2015

The trust has no late payment interest that requires disclosure within this note.

Note 14 Other gains / (losses)

	2019/20	2018/19
	£000	£000
Gains on disposal of assets	-	-
Losses on disposal of assets	(369)	(127)
Total gains / (losses) on disposal of assets	**(369)**	**(127)**
Gains / (losses) on foreign exchange	-	-
Fair value gains / (losses) on investment properties	-	-
Fair value gains / (losses) on financial assets / investments	-	-
Fair value gains / (losses) on financial liabilities	-	-
Other gains / (losses)	-	-
Total other gains / (losses)	**(369)**	**(127)**

Note 15 Discontinued operations

There are no discontinued operations.

Note 16.1 Intangible assets - 2019/20

	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019 - brought forward	**279**	**6,972**	**95**	**7,346**
Transfers by absorption	-	-	-	**-**
Additions	3	123	4,656	**4,782**
Impairments	-	-	-	**-**
Reversals of impairments	-	-	-	**-**
Revaluations	-	-	-	**-**
Reclassifications	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	**-**
Disposals / derecognition	(234)	(2,441)	-	**(2,675)**
Valuation / gross cost at 31 March 2020	**48**	**4,654**	**4,751**	**9,453**
Amortisation at 1 April 2019 - brought forward	**198**	**4,529**	**-**	**4,727**
Transfers by absorption	-	-	-	**-**
Provided during the year	44	861	-	**905**
Impairments	-	-	-	**-**
Reversals of impairments	-	-	-	**-**
Revaluations	-	-	-	**-**
Reclassifications	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	**-**
Disposals / derecognition	(222)	(2,367)	-	**(2,589)**
Amortisation at 31 March 2020	**20**	**3,023**	**-**	**3,043**
Net book value at 31 March 2020	**28**	**1,631**	**4,751**	**6,410**
Net book value at 1 April 2019	**81**	**2,443**	**95**	**2,619**

Note 16.2 Intangible assets - 2018/19

	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2018 - as previously stated	**410**	**6,383**	**47**	**6,840**
Prior period adjustments	-	-	-	**-**
Valuation / gross cost at 1 April 2018 - restated	**410**	**6,383**	**47**	**6,840**
Transfers by absorption	-	-	-	**-**
Additions	14	220	48	**282**
Impairments	-	-	-	**-**
Reversals of impairments	-	-	-	**-**
Revaluations	-	-	-	**-**
Reclassifications	(23)	421	-	**398**
Transfers to / from assets held for sale	-	-	-	**-**
Disposals / derecognition	(122)	(52)	-	**(174)**
Valuation / gross cost at 31 March 2019	**279**	**6,972**	**95**	**7,346**
Amortisation at 1 April 2018 - as previously stated	**276**	**3,446**	**-**	**3,722**
Prior period adjustments	-	-	-	**-**
Amortisation at 1 April 2018 - restated	**276**	**3,446**	**-**	**3,722**
Transfers by absorption	-	-	-	**-**
Provided during the year	60	906	-	**966**
Impairments	-	-	-	**-**
Reversals of impairments	-	-	-	**-**
Revaluations	-	-	-	**-**
Reclassifications	(16)	229	-	**213**
Transfers to / from assets held for sale	-	-	-	**-**
Disposals / derecognition	(122)	(52)	-	**(174)**
Amortisation at 31 March 2019	**198**	**4,529**	**-**	**4,727**
Net book value at 31 March 2019	**81**	**2,443**	**95**	**2,619**
Net book value at 1 April 2018	**134**	**2,937**	**47**	**3,118**

Note 17.1 Property, plant and equipment - 2019/20

	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
Valuation/gross cost at 1 April 2019 - brought forward	**14,531**	**104,335**	**2,151**	**6,114**	**49,896**	**388**	**11,915**	**2,659**	**191,989**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Additions	-	8,081	173	6,569	2,594	-	1,611	124	**19,152**
Impairments	(443)	(7,781)	(212)	-	-	-	-	-	**(8,436)**
Reversals of impairments	-	1,103	-	-	-	-	-	-	**1,103**
Revaluations	-	408	20	-	-	-	-	-	**428**
Reclassifications	-	935	(1)	(3,008)	650	-	1,348	76	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(5,108)	-	(3,997)	(1,093)	**(10,198)**
Valuation/gross cost at 31 March 2020	**14,088**	**107,081**	**2,131**	**9,675**	**48,032**	**388**	**10,877**	**1,766**	**194,038**
Accumulated depreciation at 1 April 2019 - brought forward	**-**	**221**	**-**	**-**	**28,414**	**272**	**6,823**	**1,690**	**37,420**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Provided during the year	-	4,678	19	-	3,649	36	1,333	158	**9,873**
Impairments	-	(2,371)	(20)	-	-	-	-	-	**(2,391)**
Reversals of impairments	-	(2,129)	-	-	-	-	-	-	**(2,129)**
Revaluations	-	(125)	-	-	-	-	-	-	**(125)**
Reclassifications	-	(1)	1	-	1	(1)	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(4,825)	-	(3,997)	(1,093)	**(9,915)**
Accumulated depreciation at 31 March 2020	**-**	**273**	**-**	**-**	**27,239**	**307**	**4,159**	**755**	**32,733**
Net book value at 31 March 2020	**14,088**	**106,808**	**2,131**	**9,675**	**20,793**	**81**	**6,718**	**1,011**	**161,305**
Net book value at 1 April 2019	**14,531**	**104,114**	**2,151**	**6,114**	**21,482**	**116**	**5,092**	**969**	**154,569**

Note 17.2 Property, plant and equipment - 2018/19

	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
Valuation / gross cost at 1 April 2018 - as previously stated	**13,157**	**108,438**	**486**	**5,041**	**46,125**	**375**	**11,200**	**2,316**	**187,138**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Valuation / gross cost at 1 April 2018 - restated	**13,157**	**108,438**	**486**	**5,041**	**46,125**	**375**	**11,200**	**2,316**	**187,138**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Additions	-	5,617	-	4,725	3,118	13	1,028	337	**14,838**
Impairments	(58)	(12,141)	-	-	-	-	-	-	**(12,199)**
Reversals of impairments	1,433	(33)	652	-	-	-	-	-	**2,052**
Revaluations	-	-	1,014	-	-	-	-	-	**1,014**
Reclassifications	(1)	2,454	(1)	(3,652)	1,109	-	(313)	6	**(398)**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(456)	-	-	-	**(456)**
Valuation/gross cost at 31 March 2019	**14,531**	**104,335**	**2,151**	**6,114**	**49,896**	**388**	**11,915**	**2,659**	**191,989**
Accumulated depreciation at 1 April 2018 - as previously stated	**-**	**170**	**-**	**-**	**25,137**	**235**	**5,713**	**1,549**	**32,804**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 1 April 2018 - restated	**-**	**170**	**-**	**-**	**25,137**	**235**	**5,713**	**1,549**	**32,804**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Provided during the year	-	4,809	16	-	3,606	37	1,323	140	**9,931**
Impairments	-	(4,481)	-	-	-	-	-	-	**(4,481)**
Reversals of impairments	-	(277)	-	-	-	-	-	-	**(277)**
Revaluations	-	-	(15)	-	-	-	-	-	**(15)**
Reclassifications	-	-	(1)	-	-	-	(213)	1	**(213)**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(329)	-	-	-	**(329)**
Accumulated depreciation at 31 March 2019	**-**	**221**	**-**	**-**	**28,414**	**272**	**6,823**	**1,690**	**37,420**
Net book value at 31 March 2019	**14,531**	**104,114**	**2,151**	**6,114**	**21,482**	**116**	**5,092**	**969**	**154,569**
Net book value at 1 April 2018	**13,157**	**108,268**	**486**	**5,041**	**20,988**	**140**	**5,487**	**767**	**154,334**

Note 17.3 Property, plant and equipment financing - 2019/20

	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
Net book value at 31 March 2020									
Owned - purchased	14,088	103,223	2,021	9,457	16,426	81	6,618	927	**152,841**
Finance leased	-	-	-	-	-	-	-	-	**-**
On-SoFP PFI contracts and other service concession arrangements	-	-	-	-	-	-	-	-	**-**
Off-SoFP PFI residual interests	-	-	-	-	-	-	-	-	**-**
Owned - government granted	-	-	-	-	-	-	-	-	**-**
Owned - donated	-	3,585	110	218	4,367	-	100	84	**8,464**
NBV total at 31 March 2020	**14,088**	**106,808**	**2,131**	**9,675**	**20,793**	**81**	**6,718**	**1,011**	**161,305**

Note 17.4 Property, plant and equipment financing - 2018/19

	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
Net book value at 31 March 2019									
Owned - purchased	14,531	100,531	2,151	6,018	16,970	116	5,046	876	**146,239**
Finance leased	-	-	-	-	-	-	-	-	**-**
On-SoFP PFI contracts and other service concession arrangements	-	-	-	-	-	-	-	-	**-**
Off-SoFP PFI residual interests	-	-	-	-	-	-	-	-	**-**
Owned - government granted	-	-	-	-	-	-	-	-	**-**
Owned - donated	-	3,583	-	96	4,512	-	46	93	**8,330**
NBV total at 31 March 2019	**14,531**	**104,114**	**2,151**	**6,114**	**21,482**	**116**	**5,092**	**969**	**154,569**

Note 18 Donations of property, plant and equipment

During 2019/20 various pieces of medical equipment have been donated by Royal Shrewsbury Hospital League of Friends; Friends of Princess Royal Hospital; The Shrewsbury and Telford Hospital NHS Trust Charitable Funds and Lingen Davies Cancer Fund.

Note 19 Revaluations of property, plant and equipment

The trust commissioned Deloitte Real Estate to undertake revaluations of the Trust's Estate as at 31 March 2020. The valuations have been prepared by David Cooney MA. MRICS under the supervision of Edwin Bray MRICS, a Partner at Deloitte LLP both of whom are RICS registered valuers. The valuations have been undertaken having regard to International Financial Reporting Standards ("IFRS") as applied to the United Kingdom public sector and in accordance with HM Treasury Financial Reporting Manual (FReM) and Department of Health Group Accounting Manual (DOH GAM) for Guidance. For valuations undertaken as at 31 March 2020, regard has been taken to the Royal Institution of Chartered Surveyors (RICS) Valuation – Global Standards 2020 including the UK national supplement. Compliance with the RICS Valuation Standards also ensures compliance with the International Valuation Standards ("IVS") and DHSC group accounting manual 2018 to 2019 (DOH GAM). As a result of these revaluations the Net Book Value of the Estate was valued downwards by by £2,260k as follows:

Revaluation Reserve – total £1,292k increase, representing a revaluation upwards of £553k and net increase of £739k relating to reversals and impairments charged - impairments charged of £979k and reversal of impairments of £1,718k. Impairments charged to SoCI of £3,552k.

The downward revaluation did not arise due to a clear consumption of economic benefits for service potential.

In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 ('Red Book') the valuer has declared a 'material valuation uncertainty' in the valuation report due to the outbreak of Covid-19, declared by the World Health Organisation as a global pandemic on 11 March 2020 impacting on global financial markets. The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. With the valuer having declared this material valuation uncertainly, the valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the trust.

The gross carrying amount of fully depreciated assets as at 31 March 2020 is £8,870k.

Note 20.1 Investment Property

The trust has no investment property that requires disclosure within this note.

Note 21 Investments in associates and joint ventures

The trust has no investments in associates or joint ventures.

Note 22 Other investments / financial assets (current and non-current)

The trust has no other current or non-current investments or 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 2020 £000	31 March 2019 £000
Drugs	2,571	2,319
Work In progress	-	-
Consumables	5,706	6,895
Energy	146	178
Other	-	-
Total inventories	**8,423**	**9,392**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £74,261k (2018/19: £70,322k). Write-down of inventories recognised as expenses for the year were £491k (2018/19: £198k).

Note 25.1 Receivables

	31 March 2020 £000	31 March 2019 £000
Current		
Contract receivables	11,662	13,787
Contract assets	-	-
Capital receivables	-	-
Allowance for impaired contract receivables / assets	(945)	(774)
Allowance for other impaired receivables	-	-
Deposits and advances	-	-
Prepayments (non-PFI)	2,395	2,394
Interest receivable	8	7
Finance lease receivables	-	-
PDC dividend receivable	37	101
VAT receivable	2,684	831
Corporation and other taxes receivable	-	-
Clinician pension tax provision reimbursement funding from NHSE*	937	-
Other receivables	1,350	989
Total current receivables	**18,128**	**17,335**

*Clinicians who are members of the NHS Pension Scheme and who as a result of work undertaken in this tax year (2019/20) 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. The Clinical pension tax reimbursement receivable is an estimate of the tax charge owed to clinicians who want to take advantage of this commitment. A contra entry has been set up in Provisions (see Note 34.1).

Non-current		
Contract receivables	-	-
Contract assets	1,446	1,534
Capital receivables	-	-
Allowance for impaired contract receivables / assets	-	-
Allowance for other impaired receivables	-	-
Deposits and advances	-	-
Prepayments (non-PFI)	-	-
Interest receivable	-	-
Finance lease receivables	-	-
VAT receivable	-	-
Corporation and other taxes receivable	-	-
Other receivables	-	-
Total non-current receivables	**1,446**	**1,534**
Of which receivable from NHS and DHSC group bodies:		
Current	10,452	10,227
Non-current	-	-

Note 25.2 Allowances for credit losses

	2019/20		2018/19	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	**774**	**-**	**-**	**739**
Prior period adjustments			-	-
Allowances as at 1 April - restated	**774**	**-**	**-**	**739**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018			739	(739)
Transfers by absorption	**-**	**-**	-	-
New allowances arising	575	-	453	-
Changes in existing allowances	-	-	-	-
Reversals of allowances	(68)	-	(58)	-
Utilisation of allowances (write offs)	(336)	-	(360)	-
Changes arising following modification of contractual cash flows	-	-	-	-
Foreign exchange and other changes	-	-	-	-
Allowances as at 31 Mar 2020	**945**	**-**	**774**	**-**

Injury cost recovery income is subject to a provision for impairment of receivables of 21.79% for 2019/20 (previously 21.89%) to reflect expected rates of collection.

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

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

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 exposure to credit risk. The maximum exposures as at 31 March 2020 are in receivables from customers, as disclosed in the trade and other receivables note.

Note 26 Other assets

The trust has no other assets that require disclosure within this note.

Note 27 Liabilities in disposal groups

The trust has no other liabities in disposal grouped that require disclosure within this note.

Note 28 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.

	2019/20	2018/19
	£000	£000
At 1 April	**1,700**	**1,700**
Prior period adjustments	-	-
At 1 April (restated)	**1,700**	**1,700**
At start of period for new FTs	**-**	**-**
Transfers by absorption	-	-
Net change in year	-	-
At 31 March	**1,700**	**1,700**
Broken down into:		
Cash at commercial banks and in hand	30	30
Cash with the Government Banking Service	1,670	1,670
Deposits with the National Loan Fund	-	-
Other current investments	-	-
Total cash and cash equivalents as in SoFP	**1,700**	**1,700**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**1,700**	**1,700**

Note 28.1 Third party assets held by the trust

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.

	31 March 2020	31 March 2019
	£000	£000
Bank balances	6	6
Monies on deposit	-	-
Total third party assets	**6**	**6**

Note 29.1 Trade and other payables

	31 March 2020 £000	31 March 2019 £000
Current		
Trade payables	6,152	8,003
Capital payables	7,449	4,298
Accruals	17,703	11,925
Receipts in advance and payments on account	18	1
Social security costs	172	-
VAT payables	-	-
Other taxes payable	400	1
PDC dividend payable	-	-
Other payables	88	85
Total current trade and other payables	**31,982**	**24,313**
Non-current		
Trade payables	-	-
Capital payables	-	-
Accruals	-	-
Receipts in advance and payments on account	-	-
VAT payables	-	-
Other taxes payable	-	-
Other payables	-	-
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	2,281	2,400
Non-current	-	-

Note 30 Other liabilities

	31 March 2020 £000	31 March 2019 £000
Current		
Deferred income: contract liabilities	1,312	1,265
Deferred grants	-	-
Deferred PFI credits / income	-	-
Lease incentives	-	-
Other deferred income	-	-
Total other current liabilities	**1,312**	**1,265**
Non-current		
Deferred income: contract liabilities	-	-
Deferred grants	-	-
Deferred PFI credits / income	-	-
Lease incentives	-	-
Other deferred income	-	-
Net pension scheme liability	-	-
Total other non-current liabilities	**-**	**-**

Note 31.1 Borrowings

	31 March 2020 £000	31 March 2019 £000
Current		
Bank overdrafts	-	-
Drawdown in committed facility	-	-
Loans from DHSC	82,721	20,840
Other loans	-	-
Obligations under finance leases	-	-
Total current borrowings	**82,721**	**20,840**
Non-current		
Loans from DHSC	-	41,655
Other loans	-	-
Obligations under finance leases	-	-
Total non-current borrowings	**-**	**41,655**

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. The affected loans totalling £82,721k are classified as current liabilities within these financial statements.

Note 31.2 Reconciliation of liabilities arising from financing activities - 2019/20

	Loans from DHSC	Other loans	Finance leases	Total
	£000	£000	£000	£000
Carrying value at 1 April 2019	**62,495**	**-**	**-**	**62,495**
Cash movements:				
Financing cash flows - payments and receipts of principal	20,195	-	-	**20,195**
Financing cash flows - payments of interest	(941)	-	-	**(941)**
Non-cash movements:				
Transfers by absorption	-	-	-	**-**
Additions	-	-	-	**-**
Application of effective interest rate	972	-	-	**972**
Change in effective interest rate	-	-	-	**-**
Changes in fair value	-	-	-	**-**
Early terminations	-	-	-	**-**
Other changes	-	-	-	**-**
Carrying value at 31 March 2020	**82,721**	**-**	**-**	**82,721**

Note 31.3 Reconciliation of liabilities arising from financing activities - 2018/19

	Loans from DHSC	Other loans	Finance leases	Total
	£000	£000	£000	£000
Carrying value at 1 April 2018	**39,409**	**-**	**-**	**39,409**
Prior period adjustment	**-**	**-**	**-**	**-**
Carrying value at 1 April 2018 - restated	**39,409**	**-**	**-**	**39,409**
Cash movements:				
Financing cash flows - payments and receipts of principal	22,950	-	-	**22,950**
Financing cash flows - payments of interest	(634)	-	-	**(634)**
Non-cash movements:				
Impact of implementing IFRS 9 on 1 April 2018	90	-	-	**90**
Transfers by absorption	-	-	-	**-**
Additions	-	-	-	**-**
Application of effective interest rate	680	-	-	**680**
Change in effective interest rate	-	-	-	**-**
Changes in fair value	-	-	-	**-**
Early terminations	-	-	-	**-**
Other changes	-	-	-	**-**
Carrying value at 31 March 2019	**62,495**	**-**	**-**	**62,495**

Note 32 Other financial liabilities

The trust has no other financial liabilities that require disclosure within this note.

Note 33 Finance leases

The Shrewsbury and Telford Hospital NHS Trust have no finance leases where the trust is the lessee or lessor.

Note 34.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Clinical pension tax reimbursement	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2019	**42**	**215**	**151**	**-**	**286**	**694**
Transfers by absorption	**-**	**-**	**-**	**-**	**-**	**-**
Change in the discount rate	**-**	**(8)**	**-**	**-**	**-**	**(8)**
Arising during the year	**41**	**73**	**155**	**937**	**-**	**1,206**
Utilised during the year	(41)	(67)	(60)	-	(235)	**(403)**
Reversed unused	**-**	**-**	**(26)**	**-**	**(51)**	**(77)**
Unwinding of discount	**-**	**(5)**	**-**	**-**	**-**	**(5)**
At 31 March 2020	**42**	**208**	**220**	**937**	**-**	**1,407**
Expected timing of cash flows:						
- not later than one year;	42	67	220	937	-	**1,266**
- later than one year and not later than five years;	-	141	-	-	-	**141**
- later than five years.	-	-	-	-	-	**-**
Total	**42**	**208**	**220**	**937**	**-**	**1,407**

Early departure costs relate to a provision for future payments payable to the NHS Pensions Agency in respect of former employees who took early retirement.

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 in this tax year (2019/20) 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. The Clinical pension tax reimbursement provision has been calculated using the total number of consultants multiplied by a pre-calculated national 'average discounted value per nomination' of £3,345. A contra entry has been set up in Receivables (see Note 25.1).

'Other' provision relates to the CRC scheme which is no longer required.

Note 34.2 Clinical negligence liabilities

At 31 March 2020, £377,538k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Shrewsbury and Telford Hospital NHS Trust (31 March 2019: £343,644k).

Note 35 Contingent assets and liabilities

	31 March 2020 £000	31 March 2019 £000
Value of contingent liabilities		
NHS Resolution legal claims	(88)	(73)
Employment tribunal and other employee related litigation	-	-
Redundancy	-	-
Other	-	-
Gross value of contingent liabilities	**(88)**	**(73)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(88)**	**(73)**
Net value of contingent assets	**-**	**-**

The contingent liabilities represent the difference between the expected values of provisions for legal claims carried at note 34.1 and the maximum potential liability that could arise from these claims.

Note 36 Contractual capital commitments

	31 March 2020 £000	31 March 2019 £000
Property, plant and equipment	841	108
Intangible assets	1,854	-
Total	**2,695**	**108**

Note 37 Other financial commitments

The trust is not committed to making any payments under non-cancellable contracts which are not leases, PFI contracts or other service concession arrangements.

Note 38 Defined benefit pension schemes

The Trust has no other defined benefit pension schemes.

Note 39 Financial instruments

Note 39.1 Financial risk management

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

The trust's treasury management operations are carried out by the finance department, within parameters defined formally within the trust's standing financial instructions and policies agreed by the Board of Directors. 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 trust borrows from government for capital expenditure, subject to affordability as confirmed by NHS England & NHS Improvement. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The trust therefore has low exposure to interest rate fluctuations.

The trust may also borrow from government for revenue financing subject to approval by NHS England & NHS Improvement. Interest rates are confirmed by the Department of Health and Social Care (the lender) at the point borrowing is undertaken.

The trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the trust's revenue comes from contracts with other public sector bodies, the trust has low exposure to credit risk. The maximum exposures as at 31 March 2020 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 Clinical Commissioning Groups, 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.

Note 39.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2020	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	14,458	-	-	**14,458**
Other investments / financial assets	-	-	-	**-**
Cash and cash equivalents	1,700	-	-	**1,700**
Total at 31 March 2020	**16,158**	**-**	**-**	**16,158**

Carrying values of financial assets as at 31 March 2019	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	15,542	-	-	**15,542**
Other investments / financial assets	-	-	-	**-**
Cash and cash equivalents	1,700	-	-	**1,700**
Total at 31 March 2019	**17,242**	**-**	**-**	**17,242**

Note 39.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	82,721	-	**82,721**
Obligations under finance leases	-	-	**-**
Other borrowings	-	-	**-**
Trade and other payables excluding non financial liabilities	31,391	-	**31,391**
Other financial liabilities	-	-	**-**
Provisions under contract	220	-	**220**
Total at 31 March 2020	**114,332**	**-**	**114,332**

Carrying values of financial liabilities as at 31 March 2019	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	62,495	-	**62,495**
Obligations under finance leases	-	-	**-**
Other borrowings	-	-	**-**
Trade and other payables excluding non financial liabilities	24,310	-	**24,310**
Other financial liabilities	-	-	**-**
Provisions under contract	151	-	**151**
Total at 31 March 2019	**86,956**	**-**	**86,956**

Note 39.4 Maturity of financial liabilities

	31 March 2020 £000	31 March 2019 £000
In one year or less	114,332	45,301
In more than one year but not more than two years	-	18,705
In more than two years but not more than five years	-	22,950
In more than five years	-	-
Total	**114,332**	**86,956**

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. The affected loans totalling £82,721k are classified as due within one year or less within these financial statements.

Note 39.5 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 40 Losses and special payments

	2019/20		2018/19	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	2	-	8	7
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	302	337	346	353
Stores losses and damage to property	23	491	16	198
Total losses	**327**	**828**	**370**	**558**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	2	10
Extra-contractual payments	-	-	-	-
Ex-gratia payments	52	384	71	209
Special severance payments	-	-	-	-
Extra-statutory and extra-regulatory payments	1	35	-	-
Total special payments	**53**	**419**	**73**	**219**
Total losses and special payments	**380**	**1,247**	**443**	**777**
Compensation payments received		-		-

£60k of the ex-gratia payments in 2019/20 (£85k in 2018/19) are included in legal claims in Note 34.1 Provisions for liabilities and charges analysis rather than Note 7.1 Operating expenses.

Note 41 Gifts

The total value of gifts made does not exceed £300,000 so no disclosure is required.

Note 42 Related parties

The Department of Health and Social Care is regarded as the parent department. The main entities within the public sector that the trust has had dealings with during the year are:
NHS Shropshire CCG
NHS Telford and Wrekin CCG
NHS South East Staffs And Seisdon Peninsular CCG
NHS Stafford And Surrounds CCG
NHS England
Health Education England
NHS Property Services
NHS Resolution
Leeds Teaching Hospitals NHS Trust
Mid Cheshire Hospitals NHS FT
Shropshire Community Health NHS Trust
St Helens and Knowsley Hospital Services NHS Trust
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS FT
The Royal Wolverhampton NHS Trust
University Hospitals of North Midlands NHS Trust
Powys Local Health Board
Betsi Cadwaladr University Local Health Board
Cwm Taf Local Health Board
NHS Improvement
NHS Pension Scheme
NHS Blood and Transplant
HM Revenue and Customs

The trust is linked to the Shrewsbury and Telford Hospital NHS 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.

Note 43 Transfers by absorption

There were no transfers by absorption in the year where the trust has been either the receiving or divesting party.

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

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. Given this relates to liabilities that existed at 31 March 2020, DHSC has updated its Group Accounting Manual to advise this is considered an adjusting event after the reporting period for providers. Outstanding interim loans totalling £82,721k as at 31 March 2020 in these financial statements have been classified as current as they will be repayable within 12 months.

Note 46 Better Payment Practice code

	2019/20	2019/20	2018/19	2018/19
Non-NHS Payables	**Number**	**£000**	**Number**	**£000**
Total non-NHS trade invoices paid in the year	137,020	165,375	116,217	138,737
Total non-NHS trade invoices paid within target	40,524	64,607	37,998	55,134
Percentage of non-NHS trade invoices paid within target	29.6%	39.1%	32.7%	39.7%
NHS Payables				
Total NHS trade invoices paid in the year	3,292	11,627	2,993	8,729
Total NHS trade invoices paid within target	2,795	9,687	2,433	7,234
Percentage of NHS trade invoices paid within target	84.9%	83.3%	81.3%	82.9%

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 External financing limit

The trust is given an external financing limit against which it is permitted to underspend

	2019/20	2018/19
	£000	**£000**
Cash flow financing	29,757	27,024
Finance leases taken out in year	-	
Other capital receipts	-	
External financing requirement	**29,757**	**27,024**
External financing limit (EFL)	29,838	27,024
Under / (over) spend against EFL	**81**	**-**

Note 48 Capital Resource Limit

	2019/20	2018/19
	£000	**£000**
Gross capital expenditure	23,934	15,120
Less: Disposals	(369)	(127)
Less: Donated and granted capital additions	(1,052)	(977)
Plus: Loss on disposal from capital grants in kind	-	-
Charge against Capital Resource Limit	**22,513**	**14,016**
Capital Resource Limit	22,883	15,166
Under / (over) spend against CRL	**370**	**1,150**

Note 49 Breakeven duty financial performance

	2019/20
	£000
Adjusted financial performance surplus / (deficit) (control total basis)	(26,131)
Remove impairments scoring to Departmental Expenditure Limit	-
Add back income for impact of 2018/19 post-accounts PSF reallocation	416
Add back non-cash element of On-SoFP pension scheme charges	-
IFRIC 12 breakeven adjustment	-
Breakeven duty financial performance surplus / (deficit)	**(25,715)**

Note 50 Breakeven duty rolling assessment

	1997/98 to 2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
	£000	£000	£000	£000	£000	£000
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
Cumulative breakeven position as a percentage of operating income		(8.4%)	(8.0%)	(7.4%)	(7.1%)	(7.0%)

	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
	£000	£000	£000	£000	£000	£000
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
Cumulative breakeven position as a percentage of operating income	(10.8%)	(14.9%)	(15.5%)	(20.0%)	(24.5%)	(27.5%)

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APPENDIX TWO

ANNUAL GOVERNANCE STATEMENT


ONLY HSP

The Shrewsbury and Telford Hospital NHS Trust Organisation Code: RXW

Annual Governance Statement – 2019/20

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*[1].

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 on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of The Shrewsbury and Telford Hospital NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in The Shrewsbury and Telford Hospital NHS Trust for the year ended 31 March 2020 and up to the date of approval of the annual report and accounts.

3 Capacity to handle risk

The Trust Board ("the Board") has overall responsibility for the activity, integrity, and strategy of the Trust and is accountable, through its Chair, to NHSI/E. The role of the Board is responsible for the following key functions:

- To set strategic direction, define Trust objectives and agree Trust operating plans
- To monitor performance and ensure corrective action is taken where required
- To ensure financial stewardship
- To ensure high standards possible of corporate and clinical governance
- To appoint, appraise (and remunerate) directors
- To ensure dialogue with external stakeholders.

The Chief Executive Officer is the Accountable Officer for the Trust and for ensuring that the Trust meets its statutory and legal requirements. The Chief Executive Officer is supported by a Director responsible for Corporate Governance who is also the current lead director for risk management and fulfils the role of Company Secretary. The Director oversees the development of corporate risk management strategies and policies interpreting national guidance to fit the local context and the Board Assurance Framework in conjunction with the entire Board. All the Directors have delegated authority for specific areas of risk.

[1]The Accountable Officer Memorandum for Chief Executives of NHS Trusts can be found at: http://www.info.doh.gov.uk/doh/finman.nsf/072561aa006322660725618c006b09a0/3bf24de22efb45cd802568f70038d723

The Non-Executive Directors are accountable to the Secretary of State (SoS). They are expected to hold the Executive to account and to use their skills and experience to make sure that the interests of patients, staff and the Trust as a whole remain paramount. They have a significant responsibility for scrutinising the business of the Trust particularly in relation to risk and assurance.

The organisation provides annual mandatory and statutory training for different levels of staff depending on their responsibilities as detailed in the Risk Management Training Policy (RM04). Risk management training and support was provided throughout 2019/20 at appropriate levels of the organisation. The Trust seeks to learn from good practice particularly through the development of our Transforming Care Institute; from other areas by benchmarking practice against national standards and reports; reviews of incidents, complaints, and claims and exemplar programmes.

4 The risk and control framework

The Trust's Risk Management Strategy (RM01) is approved by the Trust Board. 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 Risk Management Strategy was presented to the Audit Committee in October 2019 in advance of its scheduled review in 2020. It was noted that changes have taken place since this iteration of the strategy was issued in 2017 and this needs to be updated.

Risk assessment is a key feature of all normal management processes. All areas of the Trust have an ongoing programme of risk assessment which inform the local risk registers. Operational risks are identified and evaluated using the Trust risk matrix which feeds into the decision making process about whether a risk is considered acceptable or not. Unacceptable risks require treatment by way of control measures and action plans to mitigate them. The risk registers are reviewed regularly through governance structures at both operational and corporate level, dependent on the severity of each risk. If a risk cannot be resolved at a local level there is an established route for escalation through the operational management structure and ultimately to the Trust Board. Each risk and related action have an identified owner who is responsible for monitoring and reporting on the risk appropriately and for implementing changes to mitigate the risk in a specified time frame. The highest rated risks are reviewed monthly at a corporate level.

The organisation's current overall risk appetite has been described by the Trust Board as 'open', as the Trust is prepared to consider all delivery options and select those with the highest probability of productive outcomes, even where there are elevated levels of associated risk. However, it is acknowledged that the health care landscape changes rapidly and so the Board's appetite for risk should be reviewed regularly

A review of risk management has been commissioned by the new Chief Executive and is currently underway led by the Interim Director of Governance. This will make recommendations which will be implemented to strengthen the risk management approach going forwards. This will include a review and revisions to the Risk Management Strategy, risk appetite and risk management framework, including training for colleagues across the organisation to support the effective management of risk.

In October 2018 the CQC undertook a full inspection of Trust services and concluded an overall 'Inadequate' rating[2]. Individual ratings against each domain were:

- Safe - Inadequate
- Effective - Requires improvement
- Caring - Good
- Responsive - Requires improvement
- Well-led - Inadequate

In response, the different elements of Quality Governance were brought together in the overarching Quality Improvement Plan intended to collate the evidence of completion of all 'must do' and 'should do' actions and ensure compliance with all CQC requirements. Regular reviews of progress were undertaken and presented to the Board and also to the System Oversight and Assurance Committee (SOAG).

The Trust has been supported by an Improvement Director, appointed as part of the NHSI/E special measures regime.,

During 2019/20, the Interim Director of Nursing, Midwifery and Quality has had delegated responsibility for the Quality and Safety agenda. Performance has been monitored closely by the Board and scrutiny and assurance is the delegated responsibility of the Quality and Safety Committee. While improving Quality Governance has been a priority since being placed into the special measures regime in 2019, the Trust did not have sufficiently robust governance arrangement in place throughout the organisation to provide the necessary assurance regarding the improvement actions. Work is currently being undertaken by the incoming CEO and Interim Chief Nurse to strengthen these arrangements to ensure appropriate assurance to the board of directors going forwards.,.

Further to a follow-up inspection in November 2019, the CQC varied the (Section 31) conditions already imposed on the Trust in respect of regulated activities specifically in relation to the quality of care. Unannounced inspections in February 2020 to the Trust's Emergency Department resulted in the CQC raising a number of further concerns and the Trust was required to provide details of immediate actions it intended to take to ensure the issues identified were addressed.

As a result of the in-year inspection, nine requirement notices were issued to the Trust. The CQC also issued eight new conditions of registration and varied two existing conditions of registration as well as issuing a section 29A Warning Notice following their visit in February 2020. The Trust remains 'Inadequate' overall, with individual ratings against each domain as follows:

- Safe - Inadequate
- Effective - Inadequate
- Caring - Requires improvement
- Responsive - Inadequate
- Well-led – Inadequate

It has been acknowledged that although systems, processes, monitoring, and actions were in place in relation to the improvements required, these were not sufficient to achieve the require improvement and further work is ongoing to ensure these actions are implemented, embedded and consistently applied. Weekly reporting has also been undertaken to the Care Quality Commission which is shared with the Clinical Commissioning Group and NHSE/I. In

[2] CQC inspection findings for SaTH are published in full at: https://www.cqc.org.uk/provider/RXW

addition, separate reporting arrangements are in place with the CCG as part of the commissioner provider relationship to ensure appropriate challenge and scrutiny regarding the quality of care being provided for the population we serve.

The Trust Board gathers assurance that performance information provided by Care Groups and service areas is current, accurate, and reliable and has been validated. However, there has been a particular instance during the year whereby incorrect assurances were provided to the Board. This matter has been appraised by the internal auditor and all consequent recommendations are being rigorously implemented by the Board to eliminate the risk of any similar situation reoccurring in the future. The incident has been fully disclosed to the Trust's regulators and a statement of unconfirmed compliance is to be included within the Trust's annual self-certification submission against the conditions of the NHS Provider Licence - Condition 4 (governance).

All serious incidents (SI) identified by the Trust were reported to Commissioners and other bodies. The Trust has established an Executive Serious Incident Review Group to oversee the root cause analysis undertaken for each SI and is responsible for monitoring consequent action plans. The Interim Chief Nurse and Medical Director have made further changes to strengthen the process of scrutiny and action planning, to ensure that the Trust learns from the incidents.

The annual Clinical Audit Plan is linked to the Trust priorities and risks and is monitored by the Clinical Audit Committee, which reports to the Quality and Safety Committee of the Board. A patient panel has been established which enables suitably trained patients and members of the public to contribute to clinical audits. The patient panel concept continues to be recognised nationally as an area of good practice.

During 2019/20, the Finance Director was the nominated Senior Information Risk Officer (SIRO), responsible along with the Medical Director as Caldicott Guardian for ensuring there is a control system in place to maintain the security of information. The result of the Data Security & Data Protection Toolkit Assessment provides assurance that this is being managed. After an initial assessment, the Trust formalised an Improvement Plan with NHS Digital[3], and although the Trust had planned to undertake its next self-assessment in March 2020, NHS Digital extended the submission deadline to September 2020 in light of the national COVID-19 situation[4]. Further details are set out in section 6.

The Board Assurance Framework (BAF) enables the Board to undertake focused management of the Trust's strategic risks. The BAF structure was reviewed and revised following feedback from the CQC and the Trust's Internal Auditor in 2018/19.The BAF includes three levels of ratings assessment, three levels of assurance, mitigations, forthcoming actions and direction of travel. Each risk has an executive lead and is overseen by a Board Committee, whereby management actions and amendments are recommended which are proactively monitored and reported to the Trust Board. Work was also undertaken in-year with the NHSI Improvement Director and Assurance Committees to review and revise all the risks. From this, the Quality & Safety Committee recommended to the Board that an additional risk around sepsis care/deteriorating patient be added which was agreed. The BAF risks at the conclusion of the year are:

[3] NHS Digital is '…the national information and technology partner to the health and social care system' https://digital.nhs.uk/about-nhs-digital

[4] NHS Digital revised DSPT submission deadline for 2020: https://www.dsptoolkit.nhs.uk/News/74

  - IF we do not have meaningful engagement and co-production with our community THEN patients will not be at the centre of everything we do.
  - IF our maternity services do not evidence learning and improvement THEN the public will not be confident that the service is safe.
- IF we do not work successfully in partnership, THEN our current traditional service models for both unscheduled and scheduled care will be insufficient to meet escalating demand.
- IF we do not implement all of the 'integrated improvement plan' which responds to CQC concerns THEN we cannot evidence provision of improving care to our patients.
- IF we do not have effective systems in place to consistently identify and escalate and manage patients with sepsis or other deteriorating medical conditions, THEN patients will not have the best outcomes possible. for
- IF we do not have system-wide effective processes in place THEN we will not achieve national performance standards for key planned activity.
- IF we do not deliver our control total and meet the trajectory to live within our financial means THEN we cannot meet our financial duties nor invest in service development and innovation.
- IF we do not invest in our ageing estate nor replace old equipment THEN we cannot provide a safe environment..
- IF we do not deliver our Hospitals Transformation Programme (HTP) THEN we cannot ensure our patients get the best care.
- IF we do not have an agreed Digital Strategy THEN we cannot effectively underpin service improvement.
- IF we do not have sufficient, competent and capable Directors THEN we cannot deliver the Trust's agenda.
- IF we do not have positive staff engagement THEN we cannot support a culture of safety and continuous improvement.
-
- IF we do not have a recruitment strategy and retention strategy along with demand-based rostering for key clinical staff THEN we cannot ensure the sustainability of services.
-

A further significant risk to delivery of the Trust's strategic objectives emerged in early 2020 with the outbreak of the Coronavirus COVID-19 which quickly escalated into a pandemic. At its March 2020 meeting, the Board reviewed the Trust's delegated authority including quoracy arrangements at the Board of Directors and at Committee meetings. In addition, the Trust has established a daily Strategic Command Group to oversee all Covid related operational matters and a weekly Covid Assurance Committee. Membership of the Committee includes the Chair of the Trust, Chief Executive Officer, Medical Director, Chief Operating Officer and the Chair of the Trust's Quality and Safety Committee (a Non-Executive Director who is also a General Practitioner). Quoracy of the Committee is one Non-Executive and one Executive Director. The Covid Assurance Committee received delegated authority to act in a similar way as the Trust Board should the need arise.

Following the CQC inspection in 2018, the Trust was rated inadequate for well-led. The Trust made a number of changes to strengthen the Board (details shown in Table 1) while continuing to receive external support to work through an improvement plan; built upon all subsequent recommendations from CQC findings and previous independent reviews to form the Well-Led action plan. This plan was agreed between the Board of Directors and NHSI/E.

The Trust has included the requirement for members of the Trust Board to make a declaration against the Fit and Proper Persons Test and following review, has robust arrangements in place for new appointments to the Board (whether non-executive or executive). The Board is satisfied that all Directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability. The Chairman and Non-Executive Directors have a broad base of skills and experience and each Non-Executive Director also brings individual and personal experience of their community and the NHS to guide the work of the Trust, including financial, commercial, community engagement, and health care.

Directors are required to adhere to the highest standard of conduct in the performance of their duties. In respect of their interaction with others, the Trust Board operates under an explicit Code of Conduct, which is compliant with the NHS Code of Governance. The Board of Directors of the Trust are required to comply with the commitments set out in the Code of Conduct, which includes the principles set out by the Nolan Committee in Standards in Public Life. Once appointed, Board Members are required to sign a declaration to confirm that they will comply with the Code in all respects.

All new Non-Executive Directors have a detailed induction programme tailored to individual requirements and Board responsibilities. The Chair is subject to an annual assessment of performance by NHSI. The Trust Board undertakes on-going Board development, using external expertise where required. The Chief Executive Officer is subject to formal review by the Chairman of the Trust. Executive Directors are subject to annual appraisals by the Chief Executive Officer and Non-Executive Directors are subject to annual appraisals by the Chairman, both of whom inform individual development plans for all Board members.

Continuous professional development of clinical staff, including medical staff, supports the Trust's objective to deliver high quality clinical services. The Trust has policies, processes and procedures in place to ensure all medical practitioners who provide care on behalf of the Trust have met the relevant professional registration and revalidation requirements.

The Trust has created a Leadership Academy and Lean for Leaders programme for leaders at all levels of the organisation, which aligns effort and resources to shared organisational goals, ensuring all effort and initiatives link together to create added value. The latter programme rolls out our Transforming Care Production System; the Trust's improvement methodology which we are embedding at individual, team and organisational level.

A review of the performance of the formal Assurance committees of the Trust Board is undertaken annually and best practice recommendations implemented, with clear focus on key strategic imperatives, assurance of systems, the reduction of duplication and delivery against robust plans. The Trust Chairman commissioned an independent assessment to gain assurance that the structure and functionality remained fit-for-purpose in evaluating the Committee structure during the year. Acting on issues identified, two further committees were established in-year to oversee and provide assurance to the Board regarding key strategic risks identified in the Board Assurance Framework; Recruitment & Retention Committee and Emergency Department Oversight Committee, in addition to the Maternity Oversight Committee which had been established in the previous year; working alongside other Assurance Committees in overseeing improvements and reporting to the Board.

NHS Trust Boards comprise Executive Directors together with Non-Executive Directors and a Chair who are appointed by the NHSI Appointments Panel on behalf of the Secretary of State. The Chief Executive Officer is directly accountable to the Board for meeting their

objectives, and as Accountable Officer, to the Chief Executive of the NHS for the performance of the organisation. The Chair and Non-Executive Directors are responsible for monitoring the executive management of the organisation and are responsible to the Secretary of State for the discharge of these responsibilities. Notwithstanding the in-year movements, substantive membership of the Board of Directors consists of the Trust Chair, six independent Non-Executive Directors and five Executive Directors (including the Chief Executive).

There are also currently two Associate Non-Executive Directors, and four other Directors who attend the Board and are all non-voting. It is recognised that Non-Executive Directors will leave the Trust from time to time and the utilisation of an Associate-level 'pool' of additional people with appropriate skills is a useful approach (for instance for succession planning).

Each Executive Director and Director has delegated authority for the delivery of specific objectives. The Trust commenced the year with the following Executive roles:

- Chief Executive Officer - Statutory accountable officer, overall management of the Trust and its performance
- Finance Director – Finance, fraud prevention, contracts, Senior Information Risk Owner (SIRO), information and IT
- Chief Operating Officer – Operational delivery including business continuity and major incident planning
- Director of Nursing, Midwifery, and Quality – Nursing and midwifery practice, patient safety and experience
- Medical Director – Medical practice and education, Caldicott Guardian, Research and Development

In addition to the Executive Directors, there are a number of other non-voting directors which during 2019/20 included:

- Director of Corporate Governance – Trust Board Secretary, corporate governance, legal services, security, communications, and community engagement, estates and facilities (non-voting)
- Workforce Director – Human resources, training and development, and organisational development (non-voting).

During the year the Board also established two additional Board-level Director roles: Director of Transformation & Strategy and Director of Clinical Effectiveness & Innovation; intended to add capacity and capability, an issue concluded by CQC after their Well-Led assessment in early 2019. In November 2019, the Director of Corporate Governance's diverse portfolio was changed to focus on Corporate Services, Public Engagement and Charitable Fundraising, whilst the Board was strengthened through the appointment of an experienced interim Director of Governance in March 2020, is responsible for Corporate Governance and also took on all Company Secretary duties.

The Board approves an annual schedule of business as a standing item which identifies the key matters and reports to be presented in the coming quarter. The Trust Board met a total of eight times in public during the year (including the Annual General Meeting), and Board papers are published on the Trust website[5]. The Board of Directors also met an additional four times where a private session only was held.

[5]The Trust's website: https://www.sath.nhs.uk/

Table 1: SaTH Board of Directors and Trust Board meeting attendance in 2019/20

Title	Name	Attendance
Chairman	Ben Reid	12/12
Non-Executive Director	Tony Bristlin	11/12
Non-Executive Director	Clive Deadman	10/12
Non-Executive Director	David Lee	8/12
Non-Executive Director	Brian Newman	9/12
Non-Executive Director (to May-19)	Harmesh Darbhanga	0/2
Non-Executive Director (to May-19)	Amanda Edwards	2/2
Non-Executive Director (to May-19)	Chris Weiner	0/1
Non-Executive Director (to Sep-19)	Anthony Carroll	4/7
Non-Executive Director (from Sep-19)	Teresa Boughey	4/6
Non-Executive Director (to Oct-19)	Tony Allen	3/3
Non-Executive Director (from Dec-19)	Trevor Purt	2/2
Chief Executive (to Jul-19)	Simon Wright	2/2
Chief Executive (from Jul-19 to Feb-20)	Paula Clark	7/7
Chief Executive (from Feb-20)	Louise Barnett	1/1
Chief Operating Officer	Nigel Lee	10/11
Medical Director (to May-19)	Edwin Borman	2/2
Medical Director (from Jun-19)	Arne Rose	8/9
Finance Director (to May-19)	Neil Nisbet	1/2*
Interim Finance Director (from Jun-19)	James Drury	8/9
Interim Director of Nursing, Midwifery & Quality	Barbara Beal	10/11

The Board also has overall responsibility for the effectiveness of the governance framework and requires that each of its Committees has agreed terms of reference which are reviewed annually and describe membership, duties, responsibilities, and accountabilities, and the process for assessing and monitoring effectiveness.

The Board has refined its governance structure during the year and currently operates with the support of committees reporting directly to the Trust Board. All committees have at least one Non-Executive Director member. Committee Chairs present summary reports at Board meetings held in public.

Two of the Board Committees are Non-Executive (Audit & Risk Assurance *and* Remuneration Committees). Although these Committees have a membership consisting of only Non-Executive Directors, Executive Directors will attend as required. Five other Committees are chaired by a Non-Executive Director (Charitable Funds, Finance & Performance, Quality & Safety, Sustainability and Workforce).

Minutes of these meetings evidence the extent that Non-Executive Directors oversee progress and provide challenge to the Executive.

On the recommendations of the Internal Auditor, the Audit Committee expanded its remit as the senior assurance committee for organisational risk management, to become the Audit & Risk Assurance Committee in December 2019. The Committee is also responsible for oversight and scrutiny of the Trust's systems of internal control and ensures that there are effective internal audit arrangements in place that meet mandatory NHS Internal Audit Standards. As a Non-Executive Committee, it provides assurance to the Board. The Committee reviews the work and findings of Internal and External Audit and maintains

oversight of the Trust's Counter Fraud arrangements. Attendance through the year was in line with the requirements of the Terms of Reference. The Audit Committee met 6 times during 2019/20. It was chaired by a Non-Executive Director, who provides a written summary of each meeting to the Trust Board.

The annual review of the Trust's Standing Orders, Standing Financial Instructions and Reservation and Delegation of Powers was undertaken and approved by the Board in August 2019. The Standing Orders were adhered to throughout the year and no suspensions were recorded. However, in March, the incoming CEO triggered a further review and the updated documents were approved by the board of directors.

The Trust's policy on Managing Conflicts of Interest in the NHS was revised in 2017 to take account of revised national guidance published by NHSI/E. This recommendation has been implemented to include permanent medical staff, senior managers, specialist nurses, and procurement and stores staff. In line with the policy, Trust Board members are explicitly asked to declare any business interests on every occasion that the Board convenes. Subsequently, a formal Register of Interests is held and updated during the year by the Trust Board Secretary and is a standing item at every Trust Board meeting. The Trust has published an up-to-date register of interests, including gifts and hospitality for decision-making staff (as defined by the Trust's policy) within the past twelve months as required by NHSI/E guidance. This will be reviewed during 2020/21 to ensure that this complies with good practice.

The Trust's Community Engagement team provide support to departments when they are looking at changing a service to ensure there is appropriate public involvement. This can take a number of different forms including but not restricted to: identifying key stakeholders, surveys, focus groups and attendance at existing meetings. In addition, the Community Engagement team provide advice and support to departments completing Equality Impact Assessments, using established contacts to provide assurance that the documentation takes into consideration all potential outcomes. The Trust will be undertaking significant steps in 2020/21 to increase community engagement activity to ensure that patient feedback and experience shapes the improvement and development of services.

The Risk Management framework has a number of elements including policies which require staff to report incidents via the web-based reporting system. All papers to Trust Board and Committees are required to consider risks and assurance and to undertake an Equality Impact Assessment; this forms part of the standard cover sheet for each paper developed further to independent review by internal auditors, Deloitte in December 2018. The approach has been refined in August 2019 and embedded to ensure that Board papers have a standard approach. This will be further reviewed in 2020/21.All new and revised policies are required to have an Equality Impact Assessment undertaken as part of the Trust's established quality assurance process.

Incident reporting is in place across the Trust via a web-based reporting system supplemented by paper forms. A network of safety advisers encourage reporting and the Trust supports an open culture, enabling any concerns to be raised in confidence with our Freedom to Speak Up (FTSU) Guardians. A weekly rapid review meeting of moderate and severe harm incidents is well established, which promotes better learning from complaints and incidents as well as assurance around duty of candour.

NHS Improvement issued Developing Workforce Safeguards in October 2018, which provides a comprehensive set of guidelines on workforce planning and includes new recommendations on reporting and governance of staffing planning in accordance with the National Quality Board guidance for all clinical staff. NHSI began assessing Trusts against the standards in April 2019, and the Trust is ensuring full compliance with these recommendations. The Board receives monthly workforce assurance reports from the Workforce and Quality & Safety Committees.

The NHS Provider Licence is the main tool for regulating providers of NHS services. While NHS Trusts are exempt from the requirement to apply for and hold the licence, directions from the Secretary of State require NHSI to ensure that NHS Trusts comply with conditions equivalent to the licence as it deems appropriate. However, for the reasons described elsewhere in this document, the Trust is unable to declare compliance with the relevant conditions of the licence for 2019/20.

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. The Trust held its second annual Equality, Diversity and Inclusivity Stakeholder event in January 2020. Groups were invited to discuss potential service improvements to meet the needs of the local community. A dedicated Equality, Diversity & Inclusion Lead commenced in post for the Trust in March 2020, in recognition of increasing BME representation within our workforce and communities.

The Trust had a sustainable development management plan in place for 2019/20, and takes account of UK Climate Projections 2018 (UKCP18). In this respect, the Trust can confirm that its obligations under the Climate Change Act (2008) and the Adaptation Reporting requirements are complied with.

5 Review of economy, efficiency, and effectiveness of the use of resources
NHS Trusts must appoint an external auditor in compliance with the Local Audit and Accountability Act 2014 to audit its accounts. For 2019/20, the Trust's External Auditor gave an unqualified opinion for the Trust's financial statements and a qualified opinion for the Trust's Use of Resources (Value-for money rating).
The basis for the qualified opinion included the following:

- Cost Improvement Programme delivery and recurrent versus non-recurrent schemes;
- Planned versus actual outturn;
- Significant one-off items affecting the outturn position;
- CQC report issued in November 2018 and the latest CQC report issued in April 2020;
- Operational performance targets versus plan.

The Trust also appoints an internal auditor to assess systems of internal control. The Head of Internal Audit provides an opinion on the overall arrangements for gaining assurance through the BAF, and on the controls reviewed as part of Internal Audit's risk based
annual plan. Internal Audit's most recent review of the Trust's Assurance Framework (June 2020) gave limited assurance overall. During the year, Internal Audit

reported on six core audits, five of which related to financial control and management. Internal Audit issued a Substantial assurance rating for two core audits; Moderate assurance ratings for three core audits and Limited assurance for one core audit.

· The moderate assurance ratings relate to Income and Debtors (one high priority recommendation); and Fixed Assets (two high priority recommendations).

· The limited assurance ratings relate to Cash Management (two high priority recommendations).

Actions to rectify these weaknesses are being implemented. Based on the assurances given for the core reports issued and the current financial position of the Trust, the Internal Auditor issued an overall opinion for the year of limited assurance.

As part of their annual internal audit plan, Internal Audit also delivers a number of risk-based advisory and performance reviews. In discussion with the Trust, these are focused on areas identified as offering the greatest scope for improvement to maximise the benefit and learning to the Trust. Three performance reviews were completed in 2019/20:

High risk rating:

· Workforce – recruitment processes (4 high and 15 medium priority recommendations) (limited assurance)

· CNST Submission (12 high and 6 medium priority recommendations)

Medium risk rating:

· Datix Clinical Incident Management processes (9 high and 5 medium priority recommendations) (limited assurance)

Table 2: Internal Audit opinions to date and prior year comparisons

Review Area	IA Risk Rating	2017/18 Rating	2018/19 Rating	2019/20 Rating
Governance statement: Integrated governance and risk management				
Board Assurance Framework	Medium	Substantial	Moderate	tbc
Core Internal Audits - Financial Control and Management				
Cash and Treasury Management	Medium	Moderate	Limited	Limited
Income and Debtors	Medium	Moderate	Moderate	Moderate
Payments and Creditors	Medium	Substantial	Substantial	Substantial
Budgetary Control	High	Limited	Limited	Not audited
Fixed Assets	Medium	Not audited	Not audited	Moderate
Core Internal Audits - Other reviews				
Payroll	Medium	Substantial	Substantial	Substantial
IT Controls	High	Moderate	Moderate	Moderate

- The moderate assurance ratings relate to Income and Debtors (one high priority recommendation); and Fixed Assets (two high priority recommendations).
- The limited assurance ratings relate to Cash Management (two high priority recommendations).

The Trust utilises a **Local Counter Fraud Specialist (LCFS)** whose work is directed by an annual workplan agreed for the commencement of each year by the Audit & Risk Assurance Committee and provides a formal update report at each meeting. As well as investigating cases of alleged fraud notified to the LCFS by the Trust, there have been proactive exercises to detect potential fraud, where the LCFS has examined medics' annual leave and waiting list initiatives to identify any potential improvements in practice.

The purpose of the Internal Audit workplan is to provide assurance that system of internal control is working effectively. Management response to audit recommendations is to address significant control weaknesses. Where the Internal Auditor has made recommendations for improvement, formal action plans have been agreed and implementation is tracked throughout the year. From 106 recommendations made within the scope of the workplan, three actions are yet to be fully closed off at year-end.

5 Information Governance

As stated previously in section 4, the Trust uses NHS Digital's **Data Security and Protection Toolkit (DSPT)** to measure performance, and has identified further improvements to achieve full compliance to the required standards. Improvements over the previous year have been noted for 2019/20, although the Trust continues to work through its agreed improvement plan with NHS Digital.

Information Governance incidents are reported via the Trust's incident reporting system and there have been a number of incidents which have been reported to the Information Commissioner Office (ICO) in 2019/20.

Of the 22 incidents recorded within the Trust, 8 were not required to report further. From the remaining 14 incidents, 4 were reported to the Department of Health and Social Care/ NHS England and the ICO and 10 reported solely to the ICO. The incident themes are as follows:

- Patients receiving other patient letters which has included discharge summaries and outpatient letters
- Staff members accessing / disclosing confidential patient information without a legitimate reason or in error
- Confidential patient information being lost or stolen

Communications and training for staff to ensure we work within the Trust Information Governance policies is ongoing. The Trust Information Governance Training Package is being reviewed in light of these incidents and in line with the National Data Guardian's (NDG) data security standards

6 Data Quality and governance

The Board of Directors is currently not assured that there are effective processes and controls to ensure the accuracy of all data. It is important to be assured regarding the accuracy and quality of data to inform decision making. There have been occasions during the year where concerns have materialised regarding the data quality. To address this, reviews have been undertaken regarding individual issues and actions identified to ensure appropriate measures are in place to provide the appropriate level of assurance to the board of directors for the future. In particular the Trust has agreed to adopt a data quality kite mark, which will provide transparency regarding the level of assurance in place for each key indicator on the Board integrated performance report. This is a significant piece of work which has commenced and will be fully implemented in 2020/21.

Oversight and assurance is provided by the Sustainability Committee.

7 Significant Issues

8.1 Progress on the significant Issues for 2019/20 outlined in the 2018/19 AGS

In the 2018/19 Annual Governance Statement, the Trust disclosed six significant issues for 2019/20. Progress on these issues is outlined below.

- **Medium Term Financial Plan**

For 2019/20 the Trust agreed and planned for a control total deficit of £17.4m but reported an actual outturn deficit of £35.3m (excluding Provider Sustainability Funding and Marginal Rate Emergency Tariff income). The key drivers of the variance to the plan were:

- Increased income offset by premium costs of provision (agency expenditure / increased capacity)
- Cost Improvement Programme shortfall (£7.5m)
- Costs of recovery and investment in trust management infrastructure (£3.0m)
- Acceleration of nurse recruitment programmes (£2.8m)
- Adjustments in respect of prior year CNST maternity incentivisation (£1.0m)

Uncertainty regarding Covid-19 has meant that budgeting for 2020/21 has required a modified approach and will develop in-year based on based on guidance released. Budget variations will be agreed linked to recovery and restoration discussions.

- **Patient Flow**

Accident & Emergency performance against the 4 hour standard has not improved significantly during the year and there remains a need to improve underlying processes within urgent care and emergency services. The Trust developed an improvement action plan supported by Emergency Care Intensive Support Team (ECIST) and is making progress to improve performance both within the EDs and across the urgent and emergency pathway. The Trust is also working with partner organisations to agree system priorities to support improved performance.

SoS Review of Maternity Services

Following a serious case in Maternity services in 2009 and a number of external reviews, the Secretary of State for Health & Social Care commissioned an independent review ('the Ockenden Review') of Maternity Services at SaTH. The most recent CQC inspection noted significant improvements, with the PRH-based service being rated as 'Good' in three of the five assessment domains. TTrust is fully committed to acting on the learnings from the review which remains ongoing with the full final report expected to be published in late 2020/21.

- **CQC/Special measures**

Outcomes from the CQC inspection of Trust services between November 2019 and January 2020 have in fact worsened. The CQC issued nine requirement notices and also took urgent action and issued eight new conditions of registration and varied two existing conditions of registration as well as issuing a section 29A warning notice. Whilst three areas of outstanding practice were highlighted and improvements in Maternity Services acknowledged, the Board will be fully focused on implementing improvements during the coming year.

- **Board Stability**

There has been a lack of stability at Trust Board level including the executive team. However working with NHSI/E the Trust is taking steps to secure a substantive Executive Team, with 3 out of the five Executive Director roles in place at the year end. Recruitment to the remaining posts will take place during 2020/21.

- **Estate/Equipment fragility and IT**

The Trust's Capital Resource Limit was limited £22.883m for 2019/20 and this was allocated to various building maintenance programmes, additional modular buildings, replacement medical equipment, and IT-related projects. As a result of the impact of the COVID-19 there has been a concentrated focus on urgent clinical priorities for alterations to the physical environment; adaptations to mechanical ventilation and to reduce risk of contagion; as well increasing potential oxygen demand in anticipation of a surge in demand. The Trust has been building capacity and capability of its Information team during the year, notably the appointment of an Director of Digital Transformation, and has been awarded £6m as part of the government's Digital Aspirant Programme to launch an Electronic Patient Record (EPR) and more significantly enabling ongoing service transformation plans.

7.2 2020/21 Significant Issues

There are a number of significant issues facing the Trust in 2020/21;

- Improving quality of care to meet required standards and address licence conditions
- Implementing the recommendations of the independent review of Maternity Services ('the Ockenden Review')
- Strengthening leadership and governance
- Improving financial performance

- Increasing workforce engagement and recruitment
- Ensuring sufficient capacity and infrastructure, with Sustainability and Transformation Partnership (STP) partners, to meet future demand
- Continued management of the response to the COVID-19 pandemic

8 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 Trust who have responsibility for the development and maintenance of the internal control framework. 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 and its committees, including the Audit & Risk Assurance Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

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

- That it has been informed through assurances about all risks to the delivery of objectives, not just financial.
- That it has arrived at its conclusions on the totality of risk based on all the evidence presented to it as a unitary Board.

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

- Reports from Committees established by the Trust Board, particularly the Audit & Risk Assurance Committee
- Reports from Executive Directors and key managers
- Internal and External Audit
- External Reviews undertaken by regulatory bodies and other stakeholders including those commissioned by the Trust
- Board Assurance Framework
- Clinical Audit

The Internal Audit function provides the Board, through the Audit & Risk Assurance Committee and the Accounting Officer, with an independent and objective opinion on risk management, control, and governance and their effectiveness in achieving the organisation's agreed objectives and forms part of the framework of assurances that the Board receives.

9 Conclusion

As the Accountable Officer, I am reporting that a number of **significant control issues** have been noted for the 2019/20 year. These are described in sections 4 and 8.2 and relate primarily to:

- Quality of care for patients
- Governance arrangements and regulatory compliance
- Leadership capacity and capability

- Financial and operational planning

These issues have been disclosed to our regulators and formal action plans have been agreed to address control weaknesses in these areas where these have been identified. Progress is reported to the Board of Directors and board assurance committees.

The system of internal control has been in place at the Trust for the year ended 31 March 2020 and up to the date of approval of the Annual Report and Accounts.

Accountable Officer: **Louise Barnett**

Organisation: **The Shrewsbury and Telford Hospital NHS Trust**

Signed

Chief Executive

Date: 25 June 2020

KPMG

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 2020 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers Equity and 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 state of the Trust's affairs as at 31 March 2020 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 with the consent of the Treasury as being relevant to NHS Trusts in England and included in the Department of Health and Social Care Group Accounting Manual 2019/20.

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 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").

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least a year from the date of approval of the financial statements. In our evaluation of the Director's conclusions we considered the inherent risks to the Trust's operations and analysed how these risks might affect the Trust's financial resources, or ability to continue its operations over the going concern period. We have nothing to report in these respects.

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 absence of reference to a material uncertainty in this auditor's report is not a guarantee that the Trust will continue in operation.

Other information in the Annual Report

The Accountable Officer is responsible for the other information presented in the Annual Report together with the financial statements. 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. In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2019/20. We have nothing to report in this respect.

Remuneration and Staff Report

In our opinion the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2019/20.

Directors' and Accountable Officer's responsibilities

As explained more fully in the statement set out on page 70, 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 dissolve the Trust without the transfer of its services to another public sector entity. As explained more fully in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, on Page 69, the Accountable Officer is responsible for ensuring that annual statutory accounts are prepared in a format directed by the Secretary of State.

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.

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 to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in its use of resources.

Adverse conclusion

As a result of the matters outlined in the basis for adverse conclusion paragraph below, we are unable to satisfy ourselves that, in all significant respects The Shrewsbury and Telford Hospital NHS Trust put in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources for the year ended 31 March 2020.

Basis for adverse conclusion

In considering the adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources we identified two significant use of resources risks upon completion of value for money risk assessment against the criteria identified within the Code of

Audit Practice. The two areas of risk were sustainable deployment of resources and informed decision making.

In April 2020, the Care Quality Commission (CQC) published the results from its latest inspection of the Trust carried out in November 2019 to January 2020. This rated the Trust overall as 'Inadequate' including rating four of the five of the CQC sub categories for Safe, Effective, Responsive and Well-led as 'Inadequate'.

The Trust has also reported a deficit of £26.1 million for 2019/20 and now has a cumulative deficit of £116.2 million.

In addition the Trust has also failed to meet a number of operational targets for the year. In particular the Trust has failed to meet its accident and emergency target, its 62 day cancer target and its diagnostic waiting time target.

This means we do not have sufficient assurance of the Trust having put in place suitable arrangement for the sustainable deployment of resources or informed decision making. It is as a result of these matters that we have issued an adverse conclusion.

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 69, 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(3)(c), as amended by schedule 13 paragraph 10(a), 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 the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in December 2019 and updated in April 2020 as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. 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 issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

We are required to report to you if 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.

On 20 March 2020, we referred a matter to the Secretary of State under section 30 (1)(b) of the 2014 Act in relation to the potential breach of the Trust's breakeven duty due to the estimated

breakeven duty deficit of £25.7 million in 2019/20, and the cumulative breakeven duty position of a deficit of £116.2 million at 31 March 2020.

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 the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of The Shrewsbury and Telford Hospital NHS Trust for the year ended 31 March 2020 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Andrew Cardoza
for and on behalf of KPMG LLP
Chartered Accountants
One Snowhill
Birmingham
B4 6GH

25 June 2020

This document fulfils the Annual Reporting requirements for NHS Trusts. It is presented in accordance with the Department of Health Group Manual for Accounts 2019-20.

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

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

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

Or

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

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

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

Proud To Care
Make It Happen
We Value Respect
Together We Achieve