Shropshire Community Health
NHS Trust

Annual Report and Accounts 2025/26

Shropshire Community Health NHS Trust Annual Report and Accounts 2025/26

Presented in accordance with the NHS Group Accounting Manual
2025/26 pursuant to the Companies Act 2006

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About this document

This document fulfils the Annual Reporting requirements for NHS trusts.

Copies of this document are available from our website at www.shropscommunityhealth.nhs.uk, by email to shropcom.communications@nhs.net, or in writing from: Group Chief Executive's Office, Shropshire Community Health NHS Trust, Mount McKinley, Shrewsbury Business Park, Anchorage Ave, Shrewsbury SY2 6FG.

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Foreword

Welcome from the Chair and Chief Executive

It is our great pleasure to welcome you to our Annual Report and Accounts for 2025/26.

2025/26 has been a pivotal year for the NHS, as we continue to prioritise quality care under sustained pressure, make tangible progress in reducing waiting times and align our priorities with the new, national 10 Year Plan. The NHS is facing a new era of evolution; reforming the way we work to design a modern NHS that rebuilds confidence in the communities we serve and delivers value for everyone. ShropCom has a vital role in delivering the 10 Year Plan and ambitious plans to deliver care closer to our communities. In 2025/26 we continued our work to pilot new initiatives and align our teams to local needs. Through our five-year plan we will work with partners to further invest in our neighbourhood offer.

The scale and diversity of our services is vast, ranging from health visiting, children and adult's nursing, dental care through to specialist prison healthcare. We have met incredible colleagues across our broad geography, who bring such dedication, energy and compassion to their work. It was inspiring to see the improvements being led in local teams with a shared, clear commitment to delivering the best care and experience for our patients. We want to take this opportunity to say thank you to our amazing colleagues and volunteers for everything you do every day for our patients. We have had the opportunity to visit many different teams and have seen first-hand the examples of excellence within our Trust. We look forward to meeting more colleagues during 2026/27.

We continue to be proud of the progress our teams are making for the communities we serve and you will read examples of this progress, and our award-winning teams, in this report. Through colleagues' hard work and determination, we have made significant progress in reducing waiting times, especially in our Speech and Language Therapy, Children's and Musculoskeletal services. We will build on this momentum in 2026/27 as we work towards delivering our NHS Constitution standards for everyone.

This Winter, ShropCom rapidly mobilised an enhanced community winter offer to support patients. Our new Integrated Front Door Service in the Emergency Departments, expanded urgent community response service and increased use of the Virtual Ward are already delivering benefits for patients. We have also continued to work with local teams to improve our specialist services, including Stoke Heath prison. By investing in new technology and enabling multi-disciplinary working our colleagues are continually improving the care and experience for our patients.

We cannot deliver this scale of transformation in isolation, and we are grateful for the support of our multi-agency partners, both across the system and within our communities. We would also like to thank our incredible charitable partners, and especially the League of Friends, who work tirelessly to improve the experience of our patients.

Throughout 2025/26 we worked on our 'Better Together' Case for Change which was aimed at formalising our relationship with Shrewsbury and Telford Hospital NHS Trust and on 1 April 2026 we formalised the Group 'Shropshire Telford and Wrekin Community and Hospitals NHS Group'. This will enable us to build on the excellent and transformative work already happening across both organisations, to drive further integration and enhance the quality of care for all the communities we serve. We aim to have one voice and one purpose – moving towards excellence. From 1 April 2026, we have shared Executives and Boards in Common, bringing together community and acute experience. We would like to take this opportunity to thank our colleagues for the professionalism and compassion they have continued to show during this transition.

The scale of transformation across the NHS, requires change and we recognise uncertainty for some colleagues. As well as caring for our patients, we need to care for our colleagues. Every single member of our team is vital to our services, no matter their position and it is important that we empower everyone so they can excel in what they do. In 2026/27 we want to make things better, not just different; we will invest in cultural transformation grounded in compassionate care, listening closely to our colleagues, patients, and partners. This includes strengthening skills, expanding training opportunities, and fostering a positive, inclusive culture where everyone can thrive.

Working as a Group is an enabler to better care but should not be a distraction. Our focus remains on delivering excellence for our patients and colleagues. We will continue to focus on our quality improvement and our ambitious transformation programmes and are committed to becoming amongst the best Trusts to receive care and work.

Thank you to everyone who is supporting us on our journey towards excellence.

We hope you enjoy this Annual Report and Accounts, and I look forward to your continued support in 2026/27. If you would like to look at things in a bit more detail. Most of this information can also be found on our website at **www.shropscommunityhealth.nhs.uk**

Andrew Morgan
Group Chair, June 2026

Jo Williams
Group Chief Executive, June 2026

Performance Report

Performance Overview

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

Chief Executive's Review of the Year

Foreword

As this is my first contribution to the Annual Report since joining Shropshire Community Health NHS Trust in September 2025, I would like to begin by reflecting on the warm welcome I received from colleagues across the organisation. Over the past seven months, I have been incredibly impressed by the breadth and quality of services we provide to our communities. What has stood out most is the compassion and professionalism with which care is delivered to our patients, as well as the unwavering dedication, expertise and commitment demonstrated by our teams every day. It has been a privilege to see first-hand the positive difference our staff make to the lives of those we serve, and I am proud to be part of such a caring and committed organisation.

While this report reflects on the achievements and challenges of the past year, we also look ahead with confidence and ambition. The NHS 10 Year Health Plan provides a clear direction for the future of health and care services, and the opportunities presented through our Group model place us in a strong position to deliver transformational change. Supported by our Better Together Case for Change, we have a compelling vision for how we can work more effectively across our organisations, strengthen services, improve outcomes for patients and make the very best use of our collective expertise and resources. By working collaboratively, embracing innovation and maintaining our focus on the needs of our patients and communities, we can build on our successes and create a sustainable future for the services we provide

Looking after our people

We understand that our people are the beating heart of our organisation and here at ShropCom we are fortunate to have a wealth of talented, innovative and passionate staff who make up our ShropCom family. It is, therefore, incredibly important to us that we look after our people and continue working towards a culture where all colleagues feel recognised, supported and rewarded.

In the last 12 months, we have continued to make strides towards this with our bi-monthly staff ACE Awards and our Long Service Awards, celebrating staff who have worked within the NHS for 25, 40 and 50 years.

Our health and wellbeing initiatives have remained highly successful, resulting in the expansion of programs such as a menopause support initiative, mindfulness workshops, and stress management sessions. We have also collaborated with partners from The Shrewsbury and Telford Hospitals NHS Trust (SaTH) to provide staff opportunities for professional development, including participation in Leadership courses such as the Galvanise program for employees from ethnic minorities.

Our reward and recognition calendar included celebration and inclusion dates throughout the year. Thanks to the workforce team for their innovative and caring approach.

We acknowledge areas for improvement identified in the 2025 Staff Survey. We are committed to ongoing progress, and we are addressing these challenges, so our colleagues feel valued, supported and empowered. By listening to staff and encouraging openness and collaboration, we aim to build on our successes and create positive change. Our efforts focus on making ShropCom a workplace where excellence, innovation and wellbeing are central.

Caring for our Communities

During 2025/26, Shropshire Community Health NHS Trust made significant progress in delivering its ambition to provide more care closer to home, working in close partnership with acute colleagues to promote integration ahead of the formalisation of The Group structure, as well as close working across the wider system to improve outcomes, patient experience and service sustainability.

Services redesign where required has commenced to support neighbourhood-based models of care, enabling earlier intervention, reducing avoidable hospital admissions and helping more people recover at home. This reflects the national ambition to provide more care closer to home through integrated, proactive and locally coordinated services.

As part of its neighbourhood approach, the Trust worked with the Integrated Care Board to close the Rehabilitation and Recovery Units (RRUs) based at SaTH, enabling investment to be redirected into community-based services that deliver responsive, higher value care in patients' own homes and support more people than ward-based provision.

This has enabled significant growth of alternatives to hospital admission in the following areas:

- Urgent Community Response (UCR) services until midnight
- Expansion of Virtual Wards delivering hospital level care at home
- Integrated Front Door Teams
- Care Transfer Hub now provides seven-day and extended hours 8-8, multi-agency coordination to support timely and safe discharge from hospital

While expanding urgent and emergency care has improved system flow and reduced avoidable admissions, the Trust recognises that prevention is equally vital to sustainable, long-term population health improvement. In line with national policy, several Integrated Neighbourhood MDT forums now bring together primary care, social care, voluntary sector and community partners to coordinate proactive, personalised care for those most at risk of admission or deterioration. This supports joined up, wrap-around care plans that help people stay safe, independent and well in their communities. Southwest Shropshire has gained national recognition for its innovative neighbourhood model, and work continues with primary care colleagues across the county to expand and tailor this to local needs.

Alongside service transformation, the Trust has maintained a strong focus on quality and safety, embedding a culture of continuous improvement across all services.

Key achievements include:

- Strengthened patient safety through enhanced falls prevention, digital monitoring tools and multidisciplinary working, including participation in the national ETOC programme
- Improvements in medication safety and wound care through pathway redesign
- High levels of infection prevention, with no recorded cases of several key healthcare-associated bloodstream infections

Patient experience has also remained a priority, with:

- 97.81% of Friends and Family Test responses rating services as good or very good
- Expanded engagement through focus groups and Observe and Act sessions
- Enhanced end-of-life care supported by personalised care planning and bereavement support

These improvements demonstrate a continued commitment to delivering compassionate, person-centred care across all services.

The Trust has delivered sustained progress in improving access to care, with improvements across both Referral to Treatment (RTT) and non-RTT pathways.

This has included:

- Reduction in long waits, including progress ahead of national targets towards eliminating 52and 65 week waits
- Increased proportion of patients seen within 18 weeks also significantly ahead of national targets

These improvements have been seen across both adult and children's services, ensuring more timely care and improved patient experience.

Significant progress has also been made in strengthening children's services, with improvements in quality, access and experience.

- High-quality Children in Care services, with 98–100% of health assessments rated as good as demonstrated through local audit
- Reduced waiting times across community paediatrics, speech and language therapy and Child Development Centre pathways

The achievements listed have positioned the Trust in a strong place as a key integrator and connector of care across the system, supporting healthier communities and ensuring services are responsive to the evolving needs of the population now and into the future, providing solid foundations for further expansion and achievements for 26/27 and beyond.

Managing our Resources

Our approach to managing resources is firmly rooted in a robust, organisation-wide improvement methodology and a clear focus on delivering value for patients. This is underpinned by strong governance, continuous monitoring and supporting our budget managers.

Dedicated governance structures, including the Cost Improvement Programme (CIP) Delivery Group, Productivity Delivery Group and oversight through the Finance Recovery Group, have ensured disciplined programme management, regular review, and rapid mitigation of risk, with all schemes closely tracked against milestones and outcomes.

In 2025/26, the Trust successfully identified 100% of the CIP target, This position was supported by clear evidence that all schemes had been identified and categorised as low risk, with delivery performing ahead of plan during the year. By month 10 of 25/26 100% of the CIP target for 2026/27 had also been identified, ensuring schemes are planned and ready for delivery from the start of the following financial year. This proactive approach ensures financial sustainability is embedded early, with a strong pipeline of improvement opportunities.

Within the Trust, productivity has been established as a key strategic workstream, sitting alongside CIP and transformation programmes. In practice, this means. Delivering more care, or better care, with the same or fewer resources, reducing waste, duplication, and delays within pathways and maximising the proportion of staff time that is spent directly on patient care ("time for care"). The productivity workstream has therefore enabled a reduction in length of stay for patients in community beds, an increased number of patients supported across community therapy caseloads and a reduction of waiting times for children requiring Schedule of Growth assessments.

Digital innovation has also played a critical role in supporting productivity and service redesign. Across the Trust, digital tools have been used to:

- Enable remote monitoring and alternative models of care
- Improve access and communication through patient information platforms such as DrDoctor
- Enhance clinical efficiency through systems such as TPro, supporting streamlined clinical documentation

At Trust level, wider digital initiatives, including enhanced data capability and real-time information, have further supported service improvement and operational decision-making. These digital enablers have reduced administrative burden, improved patient experience, and allowed clinicians to spend more time delivering care.

A key component of our improvement methodology resulting in enhanced management of resources has been ensuring that all staff are working at the top of their skills and expertise. The Admin Academy has been central to this approach, delivering:

- Standardisation of administrative roles and business processes
- Centralisation of key functions to improve efficiency and resilience
- Recognition and development of the non-clinical workforce

This work has both improved productivity and supported staff experience, while ensuring that clinical time is protected and prioritised for patient care.

Neighbourhood working is fundamental to our model of care and underpins how we mange our resources effectively. Through estate optimisation and co-location of teams, in locations such as Ludlow Hospital and Halesfield. Co-location of our various clinical community teams has:

- Enabled more efficient use of physical resources
- Strengthened multidisciplinary working
- Supported the integration of pathways across services
- Improved coordination of care
- More efficient use and resilience of workforce capacity

This approach is laying the foundations for future integrated health hubs, supporting a more resilient, sustainable workforce and ensuring services are designed around the needs of our communities.

Our support for budgets holders and providing information to support their resource management decisions plays also plays a key role in making the most of our resources to deliver value for patients. Our Budget holders provide feedback on areas where we can improve the support and visibility, they require to manage their budgets and make decisions to respond to challenges budget managers face through the year in managing their resources. The results from our annual budget manager survey show that continuous improvement in support is being achieved.

Future Goals and Objectives for 2026/27 Year Ahead

The overarching objective for 2026/27 is to accelerate the shift from hospital-based care to integrated, preventative, neighbourhood-based care, delivered through the Group model and aligned to national policy.

This will be achieved through:

- Hospital → Community shift, reducing acute dependency and bed usage
- Illness → Prevention, embedding proactive and population-based care
- Analogue → Digital, enabling integrated, data-driven service delivery

The Community Transformation Programme will act as the primary delivery mechanism for this expansion and change, aligning closely with the Hospital Transformation Programme, national neighbourhood health policy, and system-wide priorities to reduce acute demand and improve long-term sustainability.

A core element of delivery in 2026/27 will therefore be the continued development of Integrated Neighbourhood Teams (INTs) across both adults and children's services, bringing together multidisciplinary professionals across community, primary care, acute and system partners. These teams will focus on proactive management of priority cohorts, including frailty, long-term conditions, children and young people, and those with complex needs.

The Group model provides a critical enabler to this transformation, creating the conditions for integrated pathways across organisational boundaries. Through shared leadership, aligned governance, and collaborative working, the Group will support the development of seamless patient journeys and maximise collective capability across Shropshire Community Health NHS Trust and SaTH. This approach will also strengthen partnerships with Primary Care, Local Authorities, and the voluntary sector, ensuring that neighbourhood health is delivered in a coordinated and sustainable way across the system.

In 2026/27, a key operational priority will remain the ongoing expansion of urgent and emergency community services to support admission avoidance, improve flow, and reduce pressure on acute services for both adults and children. This will include further development of virtual wards, urgent community response, discharge to assess, and home-first models. There will also be a particular focus on the standardisation and enhancement of Minor Injury Units, alongside the progression of business cases and options for their evolution into Urgent Treatment Centres, ensuring equitable access to urgent care services across local communities.

The integration of therapies will be a significant early priority within this programme of work, acting as a key enabler of improved patient experience and recovery. By embedding therapy services within urgent

community response, intermediate care, and neighbourhood teams, the Group will support earlier discharge, reduce deconditioning, and enhance reablement outcomes. This aligns directly with quality priorities for 2026/27, including the proactive prevention of deconditioning and reduced harm, reinforcing the role of multidisciplinary care in improving both operational and clinical outcomes.

Alongside service transformation, there will be a continued focus on standardising and enhancing core community services, including community nursing, wound care, therapies, and outpatient pathways. This will be supported by improved digital integration, the development of single points of access, and more efficient administrative processes to ensure services are accessible, consistent, and responsive to local population needs.

Quality and experience will remain at the heart of delivery in 2026/27, with priorities centred on patient safety, patient experience, and organisational learning. The Trust will build on its strong foundations by focusing on enhancing patient outcomes, improving medication safety and pressure ulcer prevention, stronger engagement with patients and families, and strengthening quality improvement capability across the workforce. This will be underpinned by a continued commitment to shared learning across the Group, ensuring that improvements are embedded consistently across services and organisations.

Collectively, these priorities will support delivery of the Group's ambitions which include increasing the proportion of care delivered in community settings, reducing acute bed days, and improving urgent and emergency care performance. Through sustained collaboration, clear programme governance, and alignment with national and system priorities, the 2026/27 programme of work will provide a strong platform for longer-term transformation and improved health outcomes for the population of Shropshire, Telford and Wrekin and Dudley children

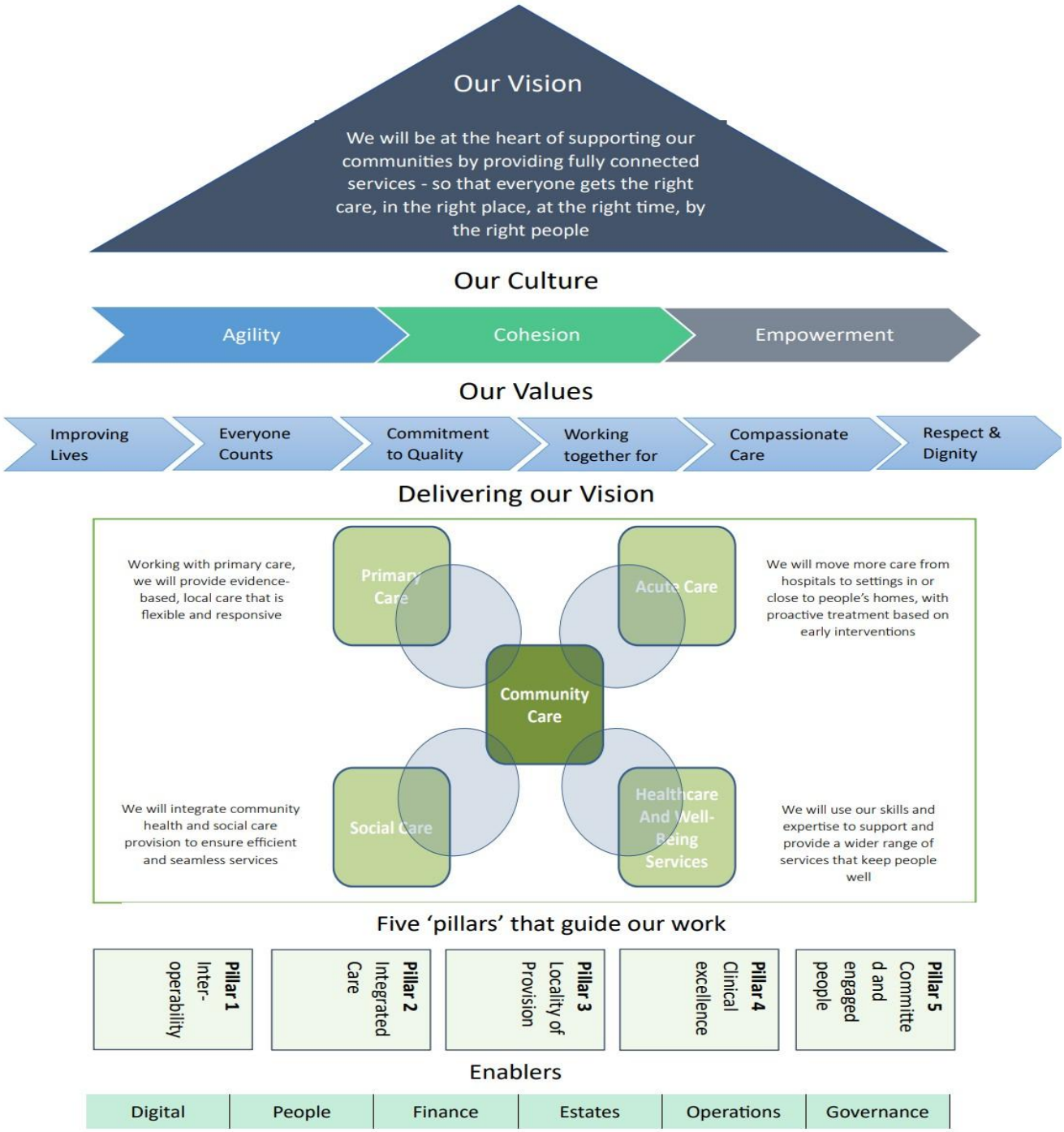
Thank you,

Jo Williams, Group Chief Executive
22 June 2026

Our Vision and Values

Our Vision and Values set out our ambitions and the core set of behaviours and beliefs that guide us in what we say and do.

In 2026/27 as we formalise our Group with The Shrewsbury and Telford Hospital NHS Trust following Board approval of the 'Better Together' Case for Change. We will work with our staff and stakeholders to develop our shared Vision and Values for the future; these will be taken through our Group Board and put on our website once finalised. Our current vision and values remain in place until that time.



Introducing Shropshire Community Health

Shropshire Community Health NHS Trust provides community-based health services for adults and children in Shropshire, Telford and Wrekin, and some services in surrounding areas too.

We specialise in supporting people's health needs at home and through outpatient and inpatient care.

Our focus is on prevention and keeping people out of crisis so that they can receive the care and support they need at, or as close to home as possible.

NHS community services may not always be as visible to the public as the larger acute hospitals, but they play a vital role in supporting many people who live with ongoing health problems. This is especially important in a large area such as ours, with increasing numbers of elderly people and others, including children and young people, with long-term health conditions.

Most of our work is with people in their homes, in community centres and clinics. A very small number of people also receive inpatient care in our community hospitals. We have introduced 2 innovative services with our Virtual Ward Service and Rehabilitation and Recovery Units. Virtual Ward provides consultant led care to a patient in their own home. The team consists of Doctors, Pharmacists, Nurses, Occupational Therapists, Physiotherapists, Paramedics, and Support workers. We currently have three pathways: Frail, Complex and Respiratory. The Virtual Ward service is open to all patients over the age of 18 who are registered with a Shropshire, Telford or Wrekin GP, regardless of where they live.

As a pivotal partner within the Shropshire, Telford and Wrekin integrated care system, we understand that high quality community services are vital to helping people live well within their own homes.

Key Facts:

- Organisation formed in 2011
- Serve a population of almost 500,000
- Employ circa 1600 staff
- Spent £133.6 m delivering services
- Provide services from more than 75 sites

Who we are and what we do

The Trust was established on 1 July 2011 by the Secretary of State for Health under the provisions of the National Health Service Act 2006.

We provide a wide range of community health services to about 497,000 adults and children in their own homes, local clinics, Virtual Ward, health centres, Rehabilitation and Recovery units, GP surgeries, schools, our community hospitals in Bishop's Castle, Bridgnorth, Ludlow and Whitchurch and 0-19 services in Dudley.

We realise that it can be confusing to know who is who in the ever-changing world of the National Health Service (NHS) is, so it may be helpful to explain the various local NHS bodies and where we fit.

We are part of the Shropshire, Telford and Wrekin Integrated Care System. As a provider of community NHS services, we receive most of our income from the Shropshire, Telford and Wrekin Integrated Care Board (ICB), the organisation responsible locally for buying (commissioning) a wide range of health services for patients. In 2025/26 our total income for the year was £136.7 million. You can find out more about how we get and spend our money in the Directors Report and Annual Accounts.

The ICBs buy services from organisations that deliver care to patients – often referred to as "providers". These are generally either acute services (main hospital services) or community health services such as community nursing, children and young people's services and community hospitals. They work with a range of partners including other NHS organisations, the local authorities, patient and service user groups and the voluntary sector.

We provide community services across the county and work closely with the other providers (The Shrewsbury and Telford Hospital NHS Trust, The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust and Midland Partnership NHS Foundation Trust) and many other organisations to care for the population of Shropshire. During 2024/25 we appointed a Chair in Common with Shrewsbury and Telford Hospital NHS Trust, and this marked the beginning of closer integration with our acute care colleagues with an intention announced by the Board in the latter part of 2024/25 to explore a group model with shared leadership and governance. During 2025/26 we worked with NHS England colleagues and internal and external stakeholders to develop the 'Better Together' case for change which was approved by the Board in the latter part of 2025. 'Shropshire Telford and Wrekin Community and Hospitals NHS Group' was established on 1st April 2026 and the forthcoming year is therefore a transition year for the Trust as it moves into a Group Model with shared leadership and governance.

Our aim is to make things better not just different, and our focus remains on delivering excellent care for patients.

Our Services

The services we deliver can be broken down into the following main areas, as illustrated in the tables below.

Children's & Young Families Division

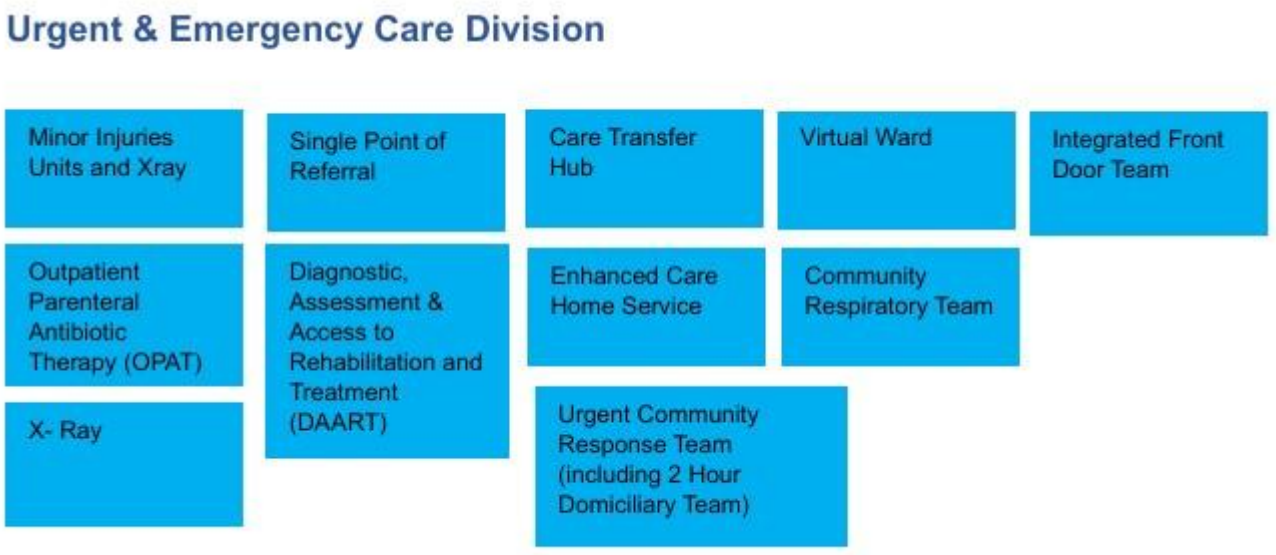
0-19 Public Health Nursing Service - Shropshire, Telford & Wrekin and Dudley (Health Visiting, School Nursing and Family Nurse Partnership (FNP) – including Emotional Health & Wellbeing team				
Community Children's Nursing Service	Special School Nursing Service	Paediatric Diabetes Service	Paediatric Asthma Service	Paediatric Psychology Service
Child Development Centres	Community Paediatrics	School Age Immunisation & Vaccination	Children in Care Health Team	Shropshire Wheelchair & Postural Services
COVID Vaccination Service	Children's Physiotherapy	Children's Respite Service	Targeted Admin	Paediatric Audiology Service
Community Children's Occupational Therapy	Paediatric Continence Service	Community Children's Speech & Language Therapy	Dudley Youth Justice Health Worker	Dudley MASH

Community Services Division

Community Hospital Inpatients	Adult Community Therapy	Adult Community Nursing	Admiral Nursing	
Adult Diabetes Specialist Nursing Team	Continence Service	Tissue Viability Nursing Service	Pulmonary Rehabilitation Service	Wound Healing Service

Planned Care Services

Day Surgery Bridgnorth	Podiatry	Physiotherapy Outpatients	Advanced Primary Care Services (APCS)	Falls Prevention
Long Covid	Community Dental Services	Community Outpatients	Musculoskeletal Services Shropshire and Telford (MSST)	Prison Healthcare
Community Neuro Rehabilitation Team (CNRT)				



Our Divisions manage the clinical services that provide direct care and support for our patients their families, and carers, this reflects the growth we have seen over the last two years across our incredible community services. Then, wrapped around our frontline staff, we have a range of corporate and support services.

You can find out more about our full range of services on our website at www.shropscommunityhealth.nhs.uk

How we are funded and how we spend our money

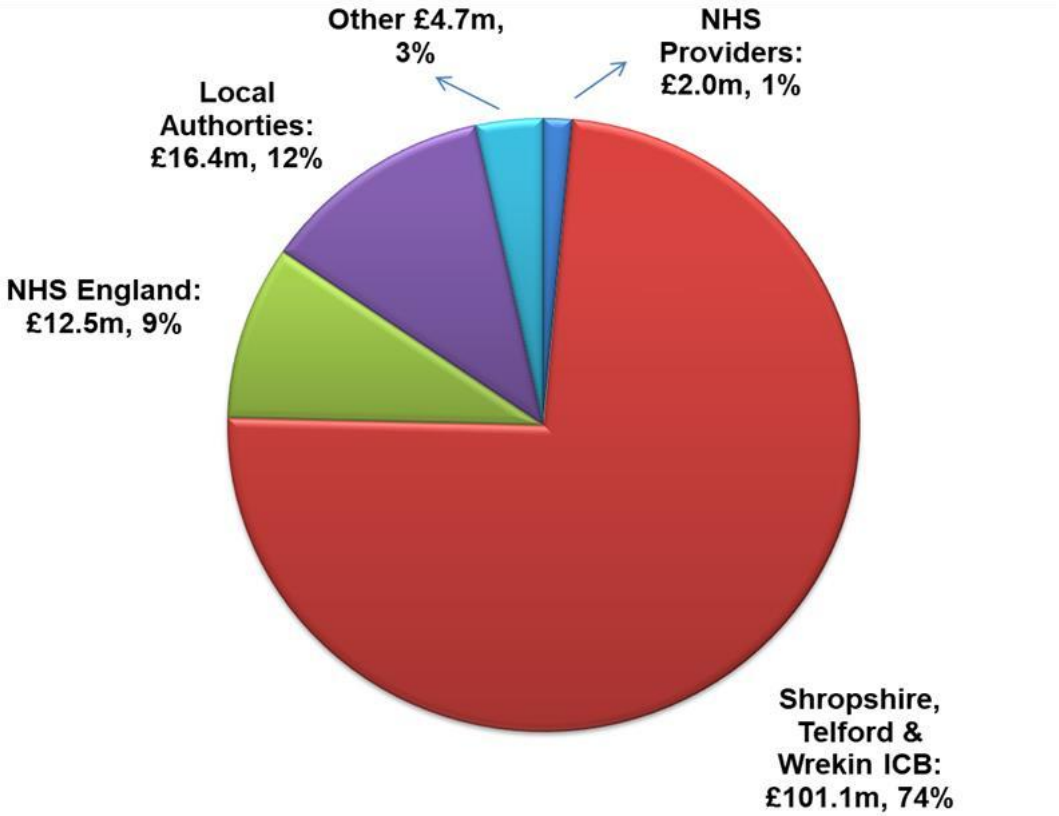
This section provides a very brief overview of how our finances are managed. You can find out more about our finances in the Remuneration Report and the Annual Accounts.

We receive most of our income from NHS commissioners, including Integrated Care Boards, NHS England, and Local Health Boards in Wales as well as from Local Authorities.

Our commissioners purchase healthcare services from us covering all age groups, including health visiting, district nursing, dentistry, rehabilitation, inpatient care at our community hospitals, outpatient appointments and prison healthcare. We work closely with our health and social care partners to prevent unnecessary hospital admissions and support early discharge where appropriate to do so.

For the 2025/26 financial year, the Trust's total income was £136.7 million and most of this came from Shropshire, Telford & Wrekin ICB, with additional income received from organisations including Local Authorities and NHS England. As in previous years, much of the Trust's income was in the form of block contract arrangements.

The chart below shows where we get our money from:



The income we receive is used to fund the services we provide, the most significant element of which is to pay our people. In 2025/26 we spent about £133.6 million delivering services.

Overall spend has been summarised into four main areas below:

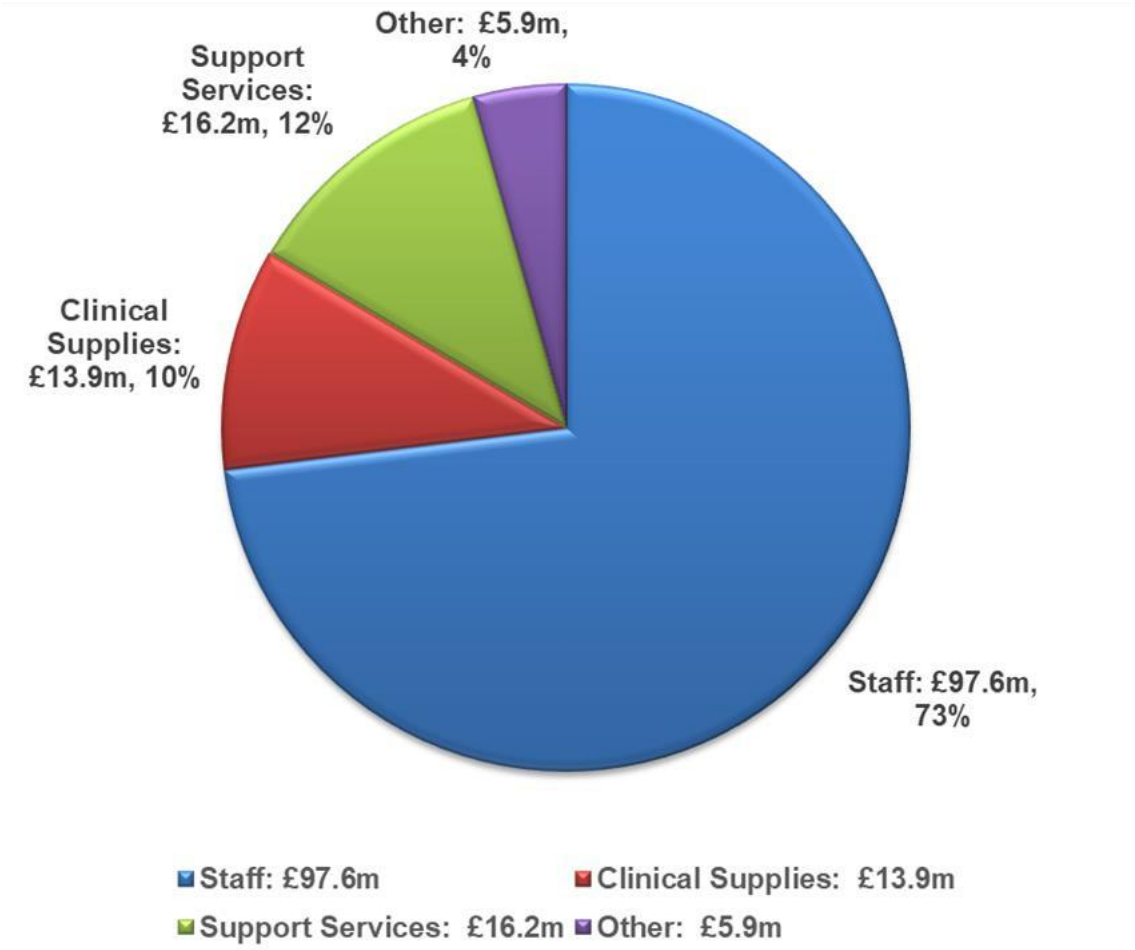
- **Our People** – this includes those who provide direct care (e.g. nurses, therapists, doctors, dentists, and healthcare assistants) as well as those people providing essential support (e.g. catering, cleaning, administration, technical, HR and finance).

- **Clinical Supplies** – such as drugs and dressings that are directly related to providing health care.

- **Support Services** – this refers to supporting services such as postage, telephones and staff training; non-clinical supplies (e.g. uniforms, linen, food and transport), and accommodation (e.g. rent, rates, water, gas and electricity).

- **Other** – other essential costs such as depreciation, finance charges and our contribution to NHS Resolution risk-pooling schemes, including the Clinical Negligence Scheme for Trusts (CNST).

The chart below illustrates how we use the money we are given to provide services:



2025/26 Financial Results

The Trust delivered an adjusted surplus of £3,910k for the year compared to our plan of £2,000k surplus. The key reason for the favourable variance to the annual plan was receipt of additional NHS England funding of £1,638k in late March; This national funding was allocated to NHS organisations which met a number of conditions.

After allowing for the revaluation of our land and buildings and the I&E charges from the Trusts Donated assets and Peppercorn Leases, the retained surplus for the year was £3,124k, inclusive of the nationally received funding noted above.

The Trust is pleased to have again met all statutory financial duties for the year.

A more detailed review of our finances can be found in the Annual Accounts section of this report.

2025/26: A Performance Summary

It has been another challenging year, which has left us with plenty to celebrate whilst continuing to learn and improve.

We are an organisation with a strong track record of delivering against our key objectives and targets, and most significantly in the year just gone:

- Improved NOF rating from NOF 2 to NOF 1 (top quartile nationally) recognising improvement across all domains including (quality, performance, workforce engagement and finance
- The Trust has maintained its rating of Good overall for its services, working with CQC to assess ourselves against the regulator's standards.
- We met our planned financial targets, with a robust pipeline for future productivity and financial sustainability
- Delivered 27 quality improvement projects, with 4 shortlisted for awards, demonstrating strong QI culture and innovation
- Evidence of improvement across key quality and safety domains
- Consistently low number of serious incidents (PSIIs) across all quarters
- Achieved major reductions in long waits, including, Elimination of 52 and 65 week waits
- Delivered significant national improvement in 18-week RTT performance
- Sustained continued reduction in non-RTT waiting times and improved access to first appointments
- Expanded Urgent Community Response (UCR): - Extended operating hours to midnight
- Delivered 2-hour response model target consistently
- Launched Integrated community front door, GP decision-maker at front door, Domiciliary care bridging (2-hour response)
- Extended discharge planning (to 8pm) and weekend therapy cover to improve patient outcomes
- Progressed Neighbourhood Health Model: Strengthening MDT working
- Successfully delivered elements of digital transformation strategy, including, Implementation of key digital systems (Tpro, DrDocter and Lucci (remote monitoring).
- Strong audit programme with clear improvement actions
- Reduction in use of temporary workforce
- Consistently high Friends & Family Test scores (~98% positive)
- Reduced falls in impatient areas through ETOC work

Key Challenges, Issues and Risks

- **Workforce Team Capacity:** Insufficient capacity results in key programmes of work not being delivered or insufficient traction being made in the areas of staff experience and engagement

- **Recruitment restrictions impact on staff morale and wellbeing:** Additional scrutiny of non-patient facing roles resulting in vacancies not being recruited to / recruitment temporarily paused with an impact on remaining staff

- **National, system and local changes impact on staff morale and wellbeing:** Required corporate office reductions will impact on staff and security of roles, the integration with SaTH will create significant organisational change, potential to impact on staff turnover, staff morale and performance

- **Timely completion of actions linked to learning responses:** Operational pressures impacting on staff ability to implement learning identified through PSIRF learning responses

- **Potential for harm due to waiting times:** Increases in demand post-Covid and inability to meet demand, recover waiting times resulting in increased waiting times, poor patient experience and potential for harm. Regulatory and system scrutiny and loss of reputation

- **Recruitment challenges:** Inability to meet safe staffing requirements, reliance on agency staff, impact on service delivery, reduction in standards of care and patient experience

- **Operational capacity to undertake all programmes of work:** Potential for operational pressures to impact on prioritisation of system programmes both internal and across the system

- **Internal governance and operational oversight arrangements for system programmes:** System programmes are taken through system governance and don't have links into the Trust's governance and operational oversight arrangements, potential for risks not to be identified and mitigated from the Trust's perspective when SROs sit outside of the organisation

- **Risk of cyber-attack:** Loss of data or operationality of systems, reputational damage, impact on service delivery

- **Digital Team capacity:** Lack of capacity results in programmes of work being paused or delayed, loss of momentum with digital agenda, staff unsupported with digital service needs. Potential to impact on improvement with RTT

Performance and Managing Risk

Our Board is responsible for the corporate governance of the organisation by maintaining the quality and safety of care, setting the direction and standards, and ensuring that the necessary systems and processes are in place to deliver the objectives. The Trust's structures, systems and processes are key to ensuring that standards are upheld.

The Trust recognises the importance of effective risk management and our Board Assurance Framework (BAF) details risks and controls related to all areas of quality, safety and financial. A Corporate Risk Register is also held within the Trust for risks that are trust-wide but are not assessed as high enough to be on the BAF and are mainly operational risks that will be a contributory factor to the level of risk for entries on the BAF.

Risk is considered at every Board Meeting and monitored down through the committees that report directly to the Board and through the services and teams throughout the organisation.

For furthermore detailed information about the Trust's risk management controls, please refer to the Corporate Governance Statement contained within this report.

Performance is monitored to assure both our Board and our commissioners and regulators that the services we are delivering are of high quality and meet the needs of our local population.

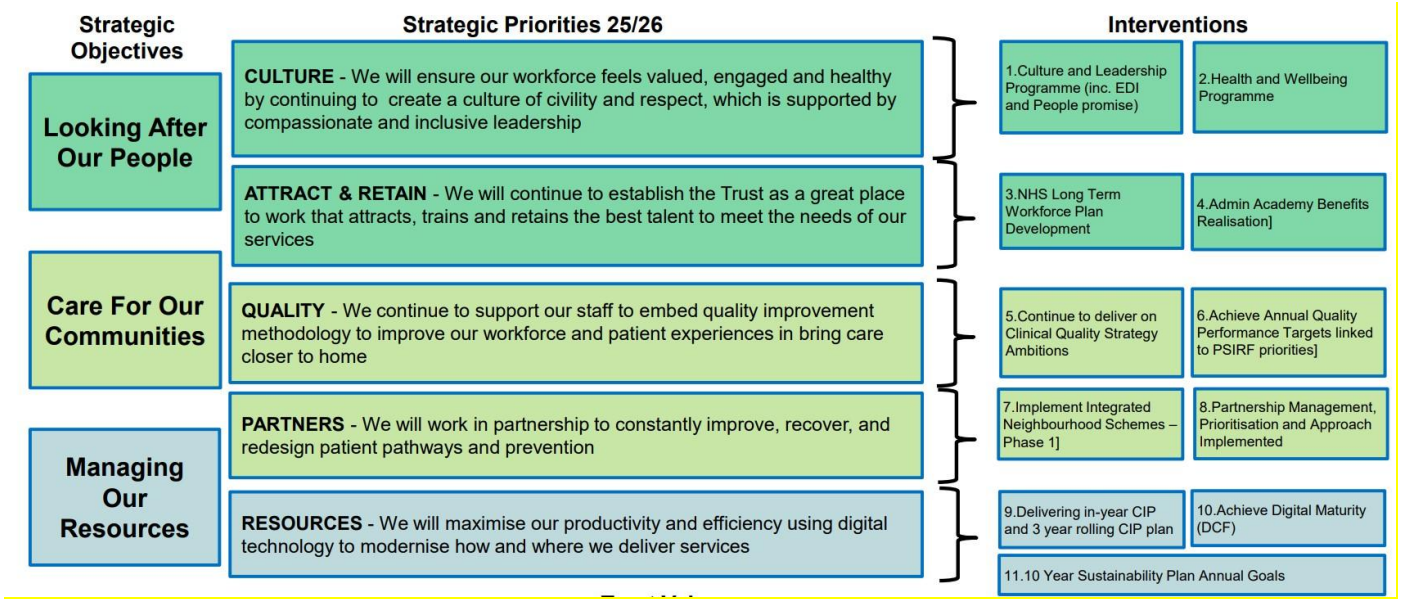
We monitor our performance against clear Key Performance Indicators (KPIs), which are aligned with workforce indicators, safer staffing metrics, patients and carer feedback, audit results, complaints and Patient and Advice Service (PALS) information and staff feedback.

The Trust has measures in place to address fraud, bribery and corruption, and security management issues. This includes the provision of Local Counter Fraud and Security Management Specialists. In addition, the Trust has in place processes to ensure it is able to respond to unexpected events and mitigate any potential impacts. The Trust has made the following commitment in this regard:

'The Trust is committed to Emergency Preparedness, Resilience and Response (EPRR) and business continuity management. We will work internally and with partner organisations to increase and test our organisational resilience. Better resilience and collaboration with responder agencies will enable the Trust to continue to deliver quality healthcare services throughout incidents and disruptive events'.

Our Priorities

We are committed to continuing to improve the quality of our services and to continue to work in partnership with colleagues from across the health and care economy to develop and embed new models of care. These commitments, and the challenges described above, have shaped our transformation programme and our Strategic Priorities. For 2025/26 we committed to the following strategic priorities and for 2026/27 and beyond these are being developed as part of the Group Model and will therefore be approved at the July Board of Directors and then published on our website.



Listening to our patients and staff

A key part of driving forward improvement involves giving the people who use and provide our services a chance to tell us what we are doing well and what we need to do better and making sure we listen to them when they do. It is also important we maintain a healthy cycle of communication by feeding back how this vital information is being acted on.

Compliments and Complaints

The compliments and complaints we receive are another valuable source of feedback about our services that we use to support our improvement plans. Between April 2025 and March 2026, we received 119 formal complaints compared to 92 formal complaints for 2024/25 and 105 formal complaints for 2023/24 across our services.

Our complaints handling aligns with national best practice across the full complaint's pathway. Through this process, we are reviewing our approach to accessibility, timeliness, investigation quality, fairness, learning, and senior oversight. The self-assessment is enabling us to identify areas of strength alongside opportunities for improvement, to inform ongoing service development, staff support and governance assurance.

The team is proactively improving compassionate engagement whereby they are contacting all consenting complainants by telephone at the very beginning of the process, to discuss their concerns, offer support, and ensure they feel heard. This proactive method has already brought noticeable improvements, resulting in early resolutions and eliminating the need for formal complaint investigations.

We recognise that being assigned as an Investigating Officer to a complaint can impact on an already busy workload. Therefore, to support our Investigating Officers, we implemented a weekly team's drop in session. The aim of the meeting is to provide a space for updates, support, and discussion around any challenges Investigating Officers may be experiencing.

The Trust received 806 compliments in 2025/26, reflecting a significant growth of 25% in positive feedback from patients, families and carers.

Friends and Family Test (FFT)

The Trust received an overall satisfaction rate across the 12-month period of 97.84%, with less than 1% referring to their care as poor or very poor. This is based on a total of 3520 submissions.

We are continuously evaluating ways to capture FFT feedback from our service users across all services. This includes digital submissions through QR codes as well as handwritten cards to ensure accessibility for those who may not use digital channels. Additionally, we are currently exploring SMS options for feedback collection. We are also looking to adapt out FFT visuals to attract the attention of younger service users.

We have recently set up our analytics platform, IQVIA, to deliver monthly highlight reports to the divisional managers to allow them to review key data indicating potential improvement opportunities. All FFT data is analysed and presented at bi-monthly divisional governance meetings and our quarterly Patient Experience Committee to discuss in further detail. This includes highlighting theme and trends and any areas of concern requiring focussed discussions and action.

Volunteers

We have recently rolled out our Volunteer Recruitment Campaign to strengthen and complement our current volunteer group.

With the support of our divisional managers, we are continuing to develop role profiles to enable us to assign specific skill sets to specific roles. We have streamlines and strengthened our volunteer's recruitment process and with this have introduced a mandatory training package to ensure all volunteers are equipped with foundation knowledge prior to beginning their placement.

Volunteers make an important contribution to patient experience by providing time, compassion, and practical support that complements clinical care. Through welcoming patients, offering reassurance, supporting navigation of services, and reducing feelings of anxiety or isolation, volunteers help patients feel valued, respected, and supported. Volunteers add value by supporting non-clinical aspects of care, enabling staff to focus on clinical priorities and contributing to a more positive, compassionate care environment.

We also need to recognise the valuable contribution our partnership with the League of Friends provides to our community hospitals where they provide additional support and services to our patients and staff.

Staff Experience

In keeping with the Trust's strategic objective of *Looking After Our People,* our workforce continues to be our most valued asset, with engagement being at the forefront of our priorities.

We are committed to fostering a culture in which all staff feel valued and heard. We gather feedback on staff experience through multiple channels, including the annual NHS Staff Survey (NSS), the National Quarterly Pulse Survey, Shropcom Question Time, and additional methods, each of which informs our strategic direction.

The results of our 2025 staff survey indicate progress since 2021. We recognise that transforming workplace culture is a long-term process, and we remain committed to tackling the areas for improvement highlighted in our latest results.

Our results have been distributed widely, and we have launched a staff survey dashboard that allows managers to review team results. Managers and Team Leads are empowered to develop local actions with their teams, utilising the Manager's Toolkit for support.
The time we spend listening to what our staff are feeling and need at work is crucial. We know there are positive correlations between staff engagement and patient experience, and we are determined to improve morale and the working experiences of our staff by listening to our people to identify meaningful actions to support an engaged workforce.

You can find the full NHS Staff Survey 2025 report at **www.nhsstaffsurveys.com**

Environment and Sustainability

The Trust remains committed to reducing the impact of its services on the environment. The Trust launched their Green plan for 2025-28, building on the 2022-25 Green Plan, along with system partners. The Green Plan remains a focal point for the estates strategy to make every kilowatt of energy count. We continue to develop our prime estate through investments to reduce our carbon emissions, focusing on the internal environment such as LED lighting in our community estate, the continuation of upgrades to heating systems and energy controls and explore options across our freehold estate for solar power arrays as we continue towards a decarbonized estate. To date we continue to report a reduction in our Measured Carbon Footprint year on year.

During 2025-26 the Trust continued to invest in understanding and managing its backlog maintenance exposure through improving its infrastructure and internal environment to improve compliance against current standards in both its freehold and leasehold estate. Investments into our Community Hospitals enable the estate to support necessary physical interventions for healthcare and that we have great places to work in accessible locations. Throughout 2025-26 the Trust continued its review of its estate portfolio and relocated services to optimize space more efficiently resulting in a reduction in its overall operational floor area at the end of the current year.

The Capital programme for 2026-27 continues to focus on value for money initiatives that improve our estate, reduce operating costs and contribute to a reduction in backlog maintenance liabilities. We continue to review our estate and look to build on existing relationships with our landlords to identify investments that benefit the community and staff across our portfolio as we continue to transition to a more sustainable estate.

Saving and Investing

Once again, the Trust set some challenging financial targets for the year in line with the current NHS financial environment and the wider economic climate in the country. Despite this we were able to manage our finances and our risks effectively and finished the year with an adjusted surplus of £3,910k. The surplus was larger than planned due to receipt of additional NHS England funding of £1,638k received in late March; this funding was allocated to organisations across the NHS which met a number of conditions. After allowing for the revaluation of our land and buildings and the I&E charges from the Trusts Donated assets and Peppercorn Leases, the retained surplus for the year was £3,124k.

We recognise that the clinical and financial sustainability of our organisation is intrinsically linked to the development of new models of care, attracting and retaining staff, and working in close partnership with our health and social care colleagues.

Task force on climate-related financial disclosures (TCFD)

Shropshire Community Health NHS Trust's Green Plan 2025-2028 provides the strategic framework for embedding sustainability into service delivery, estates, procurement, workforce engagement and reporting. Building on the 2022-25 plan, it responds to climate change and air pollution as major risks to health, wellbeing and service resilience, while aligning the Trust with national NHS policy, system priorities and legislative expectations. Its purpose is to show how the Trust will contribute to NHS net zero ambitions through a practical three-year programme linked to longer-term carbon reduction and organisational resilience.

The delivery of our Green plan is managed through the Trust's existing governance structures. Oversight is provided through reporting to the Resource and Performance Committee and the Board, with management responsibilities spread across the operational areas needed to deliver the plan, including estates, procurement, digital, clinical services, medicines, transport and adaptation. This shows that sustainability is intended to be embedded within normal decision-making, assurance and partnership working rather than treated as a separate programme.

The Green plan sets out the Trust's strategic response to climate-related risks and opportunities across nine core areas: leadership and workforce, sustainable models of care, digital, travel and transport, estates and facilities, medicines, procurement, food and nutrition, and adaptation. It links environmental action to service improvement, efficiency and population benefit, with measures to reduce emissions, modernise ways of working, strengthen sustainable procurement, improve buildings and utilities, reduce waste and increase resilience. It also reflects the realities of a community trust, including dispersed sites, home-based care and reliance on a number of leased premises.

Climate-related risks are integrated into the Trust's broader risk management approach. The plan identifies strategic and programme delivery risks, including delivery failure, funding constraints, inability to meet carbon targets, non-compliance with requirements and the direct effects of climate change on buildings, services, staff and communities. It also recognises key dependencies, particularly landlord action on leased estates and the need for sufficient estates management capacity. Mitigations include board oversight, strengthened resources, funding bids, training, policy development, auditing and climate adaptation planning.

The plan is framed around the NHS net zero targets for the NHS Carbon Footprint and Carbon Footprint Plus, supported by workstream-specific actions and reporting arrangements. Delivery actions will be monitored, and performance will be tracked through measures such as utilities use, travel, digital uptake, prescribing, waste, LED conversion and renewable generation, with progress reported through committee and board structures and summarised in the annual report. We have Solar PV arrays installed at 3 of our properties and have generated over 325,000 kW of electricity consumed internally. The finance section recognises both the potential savings from better resource use and the need for some longer-term investments that may not deliver immediate financial returns. For example, investment in Electric Vehicle charging infrastructure.

Jo Williams, Group Chief Executive
22 June 2026

Accountability Report

Directors Report

The Trust Board is responsible for the leadership, management and governance of the organisation and setting the strategic direction.

NHS Improvement (NHSI) appoints all the organisation's Non-Executive Directors, including the Chair. The Chief Executive is appointed by the Chair and Non-executive Directors. The Executive Directors are recruited by the Chief Executive and supported by the Nominations and Remuneration Committee, which is a wholly Non-Executive Director committee. This report provides information about the membership of our Board as of 31 March 2026.

Andrew Morgan, Chair in Common (Group Chair since 1 April 2026) (Term: October 2024 - October 2027)

Andrew was appointed Chair in Common of both ShropCom and The Shrewsbury and Telford Hospital NHS Trust (SaTH) in October 2024. Andrew has more than 40 years' experience across many NHS sectors. He retired from full-time executive roles in the NHS in June 2024, including the last 20 years as a Chief Executive Officer (CEO). His most recent role was as Group CEO for Lincolnshire Community Health Services NHS Trust and United Lincolnshire Hospitals NHS Trust.

Attendance: 9 of 11

Tina Long, Deputy Chair / Non-Executive Director (Term: November 2018 to November 2026)

Tina has over 40 years of experience in clinical and strategic nursing roles. She worked as Chief Nurse of the Greater Manchester Health and Social Care Partnership until June 2019. Her appointment as a non-executive director brings her full circle, having started her career as a Ward Sister for the old Shropshire Health Authority in 1979. She joined the Trust as a Non-Executive Director in November 2018. Tina is the Chair of the Resource and Performance Committee and is the NED champion for Emergency Planning and was Acting Chair February 2023 – November 2024.

Attendance:7 of 11

Harmesh Darbhanga, Non-Executive Director (Term: November 2018 to June 2026)

Harmesh brings a strong background of accountancy and financial management to the role, having spent more than 20 years working in senior roles at Wrexham County Borough Council. He also has extensive experience as a Non-Executive Director, including at The Shrewsbury and Telford Hospital NHS Trust. He joined the Trust as a Non-Executive Director in November 2018 and is the Chair of the Audit Committee. Harmesh is also the NED champion for Freedom to Speak Up and Diversity & Inclusion. Attendance: 10 of 11

Catherine Purt, Non-Executive Director (Term: July 2021 to January 2027)

Cathy has worked in both the private and public sector and has held Accountable Officer posts at two Clinical Commissioning Groups (CCGs) as well as Executive Director posts in Acute Hospitals. She has also worked for the European Commission in the Middle East, where she specialised in the delivery of healthcare projects to vulnerable communities. Cathy is also a trained chef and works sessionally in a cookery school. Cathy is the NED champion for Workforce and is Chair of the People Committee

Attendance: 10 of 11

Jill Barker, Non-Executive Director (Term: Appointed 1 January 2022 to November 2026)

Jill has worked for over 30 years at Board and senior level in the NHS, predominantly in Community and Mental Health services in North Wales, West Sussex, Surrey, and Berkshire. She has been committed to close collaboration with partner organisations to establish successful admission avoidance services with primary care, local authorities, and acute hospitals. In Berkshire she established an integrated community palliative care service with the local hospice and an integrated Community Mental Health team with the Local Authorities and the voluntary sector. Jill returned home to Shropshire in 2018 where she originally trained as a physiotherapist.

Jill joined Shropcom in January 2022 as an Associate Non-Executive Director before being made a Non-Executive Director in November 2024 and now chairs the Trust's Quality and Safety Committee and is a member the Audit and People Committees. Jill is passionate about patient care and working with other partners in the system to ensure seamless care to patients and in particular for those living in rural communities. Jill is the Trust's Rural Health Champion.

Attendance: 10 of 11

Jo Williams, Chief Executive in Common (Group Chief Executive since 1 April 2026) (Appointed September 2025)

Jo took up the post of Chief Executive for Shropshire Community Trust in September 2025, as the Chief Executive in Common for both ShropCom and for the Shrewsbury and Telford Hospital NHS Trust and on the formation of the Group on 1 April became the Group CEO.

Jo was previously the Chief Executive Officer at the Royal Orthopaedic Hospital for five years having originally joined the Trust in an interim role as the Chief Operating Officer. Prior to this Jo was the Deputy Chief Operating Officer at University Hospitals Birmingham NHS Foundation Trust for three years.

Jo has worked in a variety of senior management roles in several acute trusts including Univery Hospital of Birmingham, Wythenshawe Hospital and Chesterfield Royal Hospital delivering operational performance, leading service transformation and patient care improvement projects. As well as 24 years in the NHS she also worked in procurement in the NHS, as a capital buyer for Nuffield Hospitals

commissioning the Manor Hospital in Oxford and nine years as a buyer supplying the manufacturing industry.

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

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

Attendance: 5 of 6

Dr Ganesh Mahadeva, Medical Director (Appointed as Interim October 2022 and substantively February 2024)

Ganesh is a Consultant Paediatrician by background and has lived in Shropshire for over 23 years, combining clinical work with medical leadership and management roles both locally and as an advisor to the Newborn Hearing programme nationally. He worked as the designated doctor for safeguarding for Shropshire and took strategic and professional lead on all aspects of the health service contribution to safeguarding children across all the providers. He led the New-born Hearing Screening programme for Shropshire and established balance services for children.

Attendance: 10 of 11

Sarah Lloyd, Director of Finance (Appointed April 2021) and **Deputy Chief Executive** (Appointed October 2024)

Sarah has extensive experience working in healthcare settings including mental health, commissioning and community services and is a member of the Chartered Institute of Management Accountants. She is an executive board member and is responsible for advising the Board and wider organisation on financial matters including financial governance and stewardship. Sarah is also the Trust lead for Contracting, Procurement, Estates Services, Digital Services, Planning and Counter Fraud.

Attendance: 10 of 11

Clair Hobbs, Director of Nursing, Quality and Clinical Delivery (Appointed November 2021)

Clair, a registered Nurse, has experience of both acute Trusts and community services. Prior to Shropcom Clair was the Deputy Director of Nursing at Shrewsbury and Telford Hospital (SaTH).

Previous roles have included Ward Manager in Cardiology, Community Matron for long-term conditions, Senior Matron in Adult Community Services across the city

of Wolverhampton, and Head of Nursing at New Cross Hospital. She is passionate about improving patient care.

Attendance: 9 of 11

Shelley Ramtuhul, Director of Governance (Appointed October 2022)

Shelley initially joined the Trust on an interim basis in November 2021 as part of a joint arrangement with the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust before being appointed substantively in October 2022. Shelley is a non-voting member of the Board.

Shelley started her career in private legal practice representing defendants in civil litigation before joining NHS Resolution in 2006 where she represented NHS Trusts across the country. She has since worked in several NHS Trusts with experience of leading a variety of corporate and governance services.

Attendance: 11 of 11

Claire Horsfield, Director of Operations and Chief AHP (Appointed May 2023)

Claire, a registered physiotherapist, is a member of the Board. Claire was previously the Deputy Director of Quality and Chief AHP within the Trust.

Claire has a special interest in MSK and is also responsible for Allied Health Professionals within the Trust.

Attendance: 11 of 11

Rhia Boyode, Director of People (Working via an SLA with Shrewsbury and Telford Hospital NHS Trust May 2024)

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

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

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

In addition to her role at Shropshire Community Trust, Rhia is Director of People and OD for The Shrewsbury and Telford NHS Trust.

Attendance: 10 of 11

Directors who have left the Trust.

Alison Sargent, Non-Executive Director left the Trust in August 2025

Patricia Davies, Chief Executive, left the Trust in August 2025

Going forward the Trust has entered into a Group with Shrewsbury and Telford Hospital NHS Trust, and this has resulted in changes to the Trust Board Executives with a new Board going forward from the 1st of April, details of the Board are available on the Trust's website.

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.

Accountability Report

Committee Membership and Attendance

There are several key committees that have helped the Board to manage and monitor the organization throughout 2025/26. The committee structure provides information and updates to the Board to contribute to its assessment of assurance.

Audit Committee

Role and Purpose:

The Audit Committee provides an overarching governance role, including overseeing the adequacy of the Trust's arrangements for controlling risks and being assured that they are being mitigated. To do this, it reviews the work of other governance committees, making sure the systems and controls used are sound.

Membership & Attendance for 2025/26:

- Harmesh Darbhanga (Chair) (6 of 7)
  Non-Executive Director
- Cathy Purt (2 of 7)
  Non-Executive Director
- Jill Barker (6 of 7)
  Non-Executive Director
- Tina Long (2 of 3)
  Non-Executive Director

The Director of Governance is a standing attendee at the Audit Committee. All other Non-Executive Directors (excluding the Chairman) are invited to attend as are the External and Internal Auditors, and the Director of Finance.

Other Executive Directors, including the CEO and other senior managers of the Trust are regularly invited to attend meetings of the Audit Committee for specific items.

Charitable Funds Committee

Role and Purpose:

The Charitable Funds Committee is responsible for managing and monitoring charitable funds held by the Trust on behalf of the Board.

Membership & Attendance for 2025/26:

- Cathy Purt (Chair) (3 of 3)
  Non-Executive Director
- Sarah Lloyd (3 of 3)
  Director of Finance

- Clair Hobbs (2 of 3)
  Director of Nursing, Quality and Clinical Delivery

Other members of staff are invited to attend as requested: David Court, Claire Horsfield, Jonathan Gould

Quality and Safety Committee

Role and Purpose:

The Quality and Safety Committee oversees the review of quality assurance on all aspects of quality. This includes reviewing information against the five quality domains of caring, responsive, effective, well-led and safety. The primary aim is to ensure the robustness of systems, processes and behaviours, monitor trends, and take action to provide assurance to the Board.

Membership & Attendance for 2025/26:

- Jill Barker (Chair) (9 of 10)
  Non-Executive Director
- Clair Hobbs (Executive Lead) (9 of 10)
  Director of Nursing, Quality and Clinical Delivery
- Tina Long (8 of 10) *Non-Executive Director*
- Claire Horsfield (10 of 10)
  Director of Operations
- Dr Ganesh Mahadeva (8 of 10) *Medical Director*
- Shelley Ramtuhul (5 of 10)
  Director of Governance

The Chair in Common, Chief Executive in Common and all other Non-Executive Directors are invited to attend, and other Executive Directors, senior managers, and health professional staff attend for specific items.

Resource and Performance Committee

Role and Purpose:

The Resource and Performance Committee has delegated authority from the Board to oversee, coordinate, review and assess the financial and performance management arrangements within the Trust. The Committee assists in ensuring that Board members have a sufficiently robust understanding of key performance and financial issues to enable sound decision-making.

Membership & Attendance for 2025/26:

- Tina Long (Chair) (6 of 6)
  Non-Executive Director

- Harmesh Darbhanga (5 of 6) *Non-Executive Director*
- Jill Barker (2 of 6) *Non-Executive Director*
- Sarah Lloyd (6 of 6) *Director of Finance*
- Claire Horsfield (6 of 6) *Director of Operations*
- Clair Hobbs (3 of 6) *Director of Nursing, Quality and Clinical Delivery*
- Shelley Ramtuhul (3 of 6) *Director of Governance*

Other Trust Directors and managers and health professional staff attend the Resource and Performance Committee for specific items. The members will be supported by the following who will attend when required: Medical Director, Deputy Director of Finance, Associate Director of Workforce, Deputy Director of Operations, Deputy Director of Nursing Quality and Clinical Delivery, Head of Information.

Nomination, Appointment and Remuneration Committee

Role and Purpose:

The Committee has an overall responsibility in respect of the structure, size and composition of the board and matters of pay and employment and the conditions of service for the Chief Executive in Common (and latterly the Group Chief Executive), Executive Directors and Senior Managers. **Membership & Attendance for 2025/26**

- Andrew Morgan (Chair) (6 of 8) *Non- Executive Director*
- Tina Long (6 of 8) *Non-Executive Director*
- Harmesh Darbhanga (8 of 8) *Non-Executive Director*
- Alison Sargent (0 of 2) *Non-Executive Director*
- Cathy Purt (7 of 8) *Non-Executive Director*
- Jill Barker (7 of 8) *Non-Executive Director*

The Chief Executive in Common and Chief People Officer attend the Committee in an advisory capacity, except where his/her own salary, performance or position is being discussed.

People Committee

Role and Purpose:

The People Committee has delegated authority from the Board to oversee, co-ordinate, review and assess the workforce strategy and management arrangements within the Trust. The Committee assists in ensuring that Board members have a sufficiently robust understanding of key performance relating to workforce matters to ensure service delivery.

Membership & Attendance for 2025/26:

- Cathy Purt (Chair) (8 of 9) *Non-Executive Director*
- Jill Barker (6 of 9) *Non-Executive Director*
- Rhia Boyode (7 of 9) *Chief People Officer*
- Claire Horsfield (8 of 9) *Director of Operations*
- Shelley Ramtuhul (7 of 9) *Director of Governance*

You can find more details about our governance structures and committees in the About Us (Who We Are) section of our website at **www.shropscommunityhealth.nhs.uk**

You can see a register of Board member and attendees' interests at https://www.shropscommunityhealth.nhs.uk/foi-lists-and-registers

Accountability Report

Statement of Directors' Responsibilities in Respect of The Accounts

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

- apply on a consistent basis accounting policy 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.
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

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

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

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

By order of the Board.

Chief Finance Officer
22 June 2026

Group Chief Executive
22 June 2026

Accountability Report

Statement of the Chief Executive's Responsibilities as the Accountable Officer

The Chief Executive of NHS England has designated that the Chief Executive should be the Accountable Officer to the Trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of NHS Improvement. 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 have been applied to the purposes intended by Parliament and conform to the authorities which govern them.
- effective and sound financial management systems are in place; and
- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the situation at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

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

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

I can confirm that the Annual Report and Accounts are fair, balanced and understandable and that I take personal responsibility for the Annual Report and Accounts and the judgments required for determining that it is fair, balanced and understandable.

Jo Williams, Group Chief Executive
22 June 2026

Corporate Governance Report

Annual Governance Statement

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the 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.

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 risks of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Shropshire Community Health 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 Shropshire Community Health NHS Trust for the year ended 31 March 2026 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Management of risk underpins achievement of the Trust's Strategy and related priorities. Risk management is the responsibility of all staff and imperative to providing safe quality care for patients and staff. Risk plays a key role in informing decision making and is significant for the Trust's business planning process where public accountability in delivering health services is required.

The Trust Board has overall responsibility for the management of risk. The Board provides leadership by ensuring that the Trust has an effective Risk Management Strategy and clear assurance reporting pathways. The Board monitors strategic risks through bi-monthly review of the Board Assurance Framework (BAF) through receipt of Audit Committee reports providing assurance on the effectiveness of Trust's internal risk control systems.

All Board Sub-Committees are responsible for monitoring and reviewing risks relevant to their remit, including extent to which they are assured by the evidence presented with respect to the management of the risk. Each Committee has responsibility for escalating identified concerns to the Board.

The Trust has clear set out roles in its Risk Management Policy in relation to risk management.

- Chief Executive is the accountable officer for the management of risk, responsible for maintaining sound internal control systems that support the achievement of the Board's policies, aims and objectives, whilst safeguarding funds and assets.
- The Trust Secretary supports the Chief Executive in the role as accounting officer of the organisation and has responsibility for risk in relation to corporate governance framework, compliance and assurance including the Board Assurance Framework.

- The Director of Nursing, Quality and Clinical Delivery and the Medical Director are responsible for ensuring that arrangements are in place to identify, mitigate and monitor risks associated with clinical care and treatment, patient involvement, serious incidents, safeguarding, infection control and professional standards for nursing and allied health professional's staff. The Director of Nursing, Quality and Clinical Delivery is also the accountable officer for Emergency Planning, Preparedness and Resilience.
- The Director of Finance has delegated responsibility for risks associated with the management, development and implementation of systems of financial risk management, performance, strategy and estate.
- The Director of Operations has delegated responsibility for risks associated with operational management including overall emergency planning and resilience and business continuity.
- The Director of Nursing, Quality and Clinical Delivery has delegated responsibility for risk associated with workforce planning, staff welfare, recruitment and retention.
- The Trust Chair and Non-Executive Directors exercise non-executive responsibility for the promotion of risk management through participation in the Trust Board and its Committees. They are responsible for scrutinising systems of governance and have a particular role in this Trust for chairing Board Committees. The Trust provides mandatory and statutory training that all staff is required to complete, in addition new staff attend mandatory induction that encompasses key elements of risk. There are many ways that the organisation seeks to learn from good practice, and this includes incident reporting procedures and debriefs, complaints, claims and proactive risk assessment.

The Board is constituted to consist of the Chair, five Non-Executive Directors, and five voting Executive Directors. There have been other regular attendees at the Board:

- The Director of Governance.
- The Director of Workforce

The Board has been supported by the five committees set out above throughout the year and these committees, except the Nominations and Remuneration Committee, provide reports to the Board, following their meetings.

The Board's prime roles are assurance, strategy and developing organisational culture. Its meetings cover comprehensive items on quality, finance and strategy. It receives a governance report at each meeting dealing with risk assessment and the Board Assurance Framework, and corporate governance compliance.

The Board receives reports relating to Finance and Quality at each meeting. These are supported by a performance management framework which highlights to the Board any potential or actual problems in meeting its objectives.

All staff undertake a programme of training related to the risks they encounter with the work they carry out. Managers, supervisors and team leaders attend risk management training, which includes explanation and familiarisation with the Trust's risk management framework, and their roles in using it to identify and mitigate risk. Managers are supported by the Governance Team who provide guidance on all aspects of risk management.

The Risk and Control Framework

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

The purpose of the risk and control framework is to ensure risk is managed at a level that allows the Trust to meet its strategic objectives. The system of internal control is based on an ongoing process designed to:

- Identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives,
- Evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.
- Where risk cannot be prevented to mitigate the consequences, e.g., by putting response plans into place, or provide deterrents e.g., awareness of sanctions relating to fraud.

The Risk Management Policy details the structure for the Trust's risk and control mechanisms. This includes the duties of individuals, groups and committees and the responsibility for the identification of risks, controls, further mitigation control and assurances.

The Quality and Safety Committee has overall responsibility for monitoring the Trust's risk for the quality and safety of services and the working environment.

The Resource and Performance Committee considers the detailed work and reports related to finance, business and cost improvements, performance indicators and contract monitoring performance indicators. It identifies any risks associated with these areas and reports these to the Board for inclusion in the risk management framework where it is appropriate to do so. It monitors the effectiveness of any controls in place and the implementation of further controls.

The People Committee has the overall responsibility for all workforce issues and overseeing performance against the workforce metrics. The committee has a particular focus on staffing, recruitment and retention, staff wellbeing, staff development as well as oversight of statutory employment responsibilities.

The Audit Committee, through its work programme, scrutinises the registers and risk management processes, seeking additional assurance where necessary.

The Audit Committee reviews the assurance that the Trust's internal control systems are effective by:

- Reviewing assurances relating to the Board Assurance Framework and Corporate Risk Register.
- Reviewing processes and performance related to Fraud and Security.
- Seeking and reviewing assurances from internal and external auditors.
- Reviewing financial systems.
- Ensuring that there is an effective internal and external audit function providing appropriate independent assurance to the Trust Board. Reviewing the work and findings of the external auditor. Receiving an annual review of effectiveness of the auditors.
- Reviewing the findings of other significant assurance functions, both internal and external to the Trust.
- Reviewing the work of other committees within the Trust, whose work can provide relevant assurance to the Audit Committee's own scope of work.
- Requesting and reviewing reports and positive assurances from Directors and managers on the overall arrangements for governance, risk management and internal control.
- Reviewing and approving the Annual Report and financial statements (as a delegated

responsibility of the Board) and ensuring that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

The Audit Committee reports to the Board of Directors on an annual basis on its work in support of the Annual Governance Statement, specifically commenting on whether the Board Assurance Framework (BAF) is fit for purpose and governance arrangements are fully integrated.

The Trust's risk management arrangements are set out in the Risk Management Policy. This sets out how risks are identified, assessed and managed through the hierarchy of risk register levels, which are overseen in specific defined ways through the organisation, culminating in the Board overseeing the highest risks to achievement of strategic objectives (the Board Assurance Framework). The Audit Committee reviews and tests assurances with management related to the Board Assurance Framework entries. The Audit Committee reports its findings to the Board, which reviews the framework entries at each meeting.

Risks are identified through:

- The recording and investigation of incidents, complaints and claims.
- Specific group and committee sessions to identify and analyse risks.
- Clinical, internal and external audit.
- Other work carried out by groups and committees.
- External and internal reports and inspections.
- Other external bodies, e.g., commissioners, CQC.
- Being raised by individual managers and staff.
- Performance Management Framework reports
- Patient feedback

All risks are rated using a 5 by 5 risk matrix. Risk consequences are defined on the matrix using four categories:

- Injury or harm
- Finance
- Service delivery
- Reputation

Depending on the rating, risks are recorded at four levels:

Departmental	Risks that are low level and can be managed locally. Risks are monitored at team level, e.g., through team meetings
Divisional	Risks of a moderate level that impact on the directorate's service objectives Risks are monitored at divisional/directorate quality

	groups and are overseen by the Quality and Safety Delivery Group, via a subgroup which considers the risk in detail.
Corporate	Risks that are moderate but Trust-wide and have impact on the Trust's strategic objectives. Risks are monitored by the Executive Team and overseen by the Audit Committee.
Board	Significant risks to the Trust's corporate objectives are monitored by the Board

At each level the overseeing committee considers the risk potential, and the level of control in place, and decides whether a risk can be accepted. Mitigation controls are identified at all risk levels, along with any actions necessary to further control or mitigate the risks. The risk management policy identifies the groups and committees whose responsibility is to monitor risks at the four levels, the effectiveness of their controls and the implementation of actions to further mitigate the risks. All risks are recorded on Datix, the Trust's risk management software.

Any service change is subject to a full Quality and Equality Impact Assessment (QEIA) process, monitored by the Quality and Safety Committee. This process identifies any risks, and any mitigation or change that needs to be put into place.

The Trust has in place a well-established incident reporting system and culture. All staff use an online form which is submitted to their line manager. Governance staff provide local training to services and have an overview of all incidents. Line Managers investigate the circumstances of all incidents; any incidents that result in or have potential to result in harm are scrutinized by the Trust's Patient Safety Incident Panel with appropriate learning responses determined. These responses range from a full systems-based investigations to SWARM huddles or after-action reviews. In addition, on an annual basis the Trust determines its local safety priorities for which thematic reviews are undertaken and considered by the Quality and Safety Committee. Learning and advice, including encouragement to report are publicised through the Trust's staff communication systems, including the staff newsletter and individual alerts to staff.

The Trust is fully compliant with the registration requirements of CQC and operates to the standards of the NHS England well-led framework.

The Trust has arrangements in place to manage Infection Prevention and Control and the Safeguarding of Children and Vulnerable Adults. These include external partnership arrangements with Local Authorities, Police and Shrewsbury and Telford Hospital Trust.

The Trust has not reported any Never Events during the year 2025/26 and has fully embedded the Patient Incident Safety Response Framework in line with NHS England requirements.

The Trust is committed to openness and transparency in its work and decision making. As part of that commitment the trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the trust with reference to the guidance) within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

Board members are required to notify and record any interests relevant to their role on the Board. The register is presented to the Board for review at each meeting of the board or its committees, members are asked to declare any interests in relation to agenda items being considered, abstaining from involvement if required, and advise the Trust Secretary of any new interests which need to be included on the register.

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

The Trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan for 2025-28 following the guidance of the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The Trust continues to commit to driving sustainable development to deliver our strategic objectives, enable delivery of high-quality care, to be the employer of choice and to make the best use of our resources. Our Green Plan includes actions to support and enable the Trust to deliver on its carbon reduction plans into the future as we transition to a net zero economy across the Shropshire County working collaboratively with our partners in the public sector and the wider Shropshire community.

Significant work is undertaken to ensure the Trust has the appropriate workforce in place to support service delivery. A number of mechanisms are in place to monitor staffing levels and staff competencies, helping to ensure the provision of safe and effective care. Information relating to staffing levels is reviewed monthly by the People Committee and the Board through the Workforce Performance Report. In addition, the Trust carries out nursing establishment reviews every six months, with findings reported to the Board of Directors.

The Guardian of Safe Working regularly monitors and reports on Junior Doctor compliance with safe working hours and formally escalates any exception reports to the Board of Directors. The Trust also continues to explore and develop new workforce roles, including expanding apprenticeship opportunities across the Trust to further support care delivery. Current initiatives include Nursing Associates, Nurse Apprentices, and Advanced Clinical Practitioners.
In line with the recommendations set out in *Developing Workforce Safeguards*, the Trust applies a triangulated approach to maintaining assurance over workforce strategies and safe staffing systems.

As an employer of staff eligible for membership of the NHS Pension Scheme, the Trust has controls in place to ensure compliance with all employer obligations under the Scheme regulations. This includes ensuring that salary deductions, employer contributions, and payments into the Scheme are processed in accordance with Scheme rules, and that member pension records are maintained accurately and updated within the timescales specified in the Regulations.

NHS Provider Licence section 4 (governance)

The NHS Provider Licence is the main tool for regulating providers of NHS services. Oversight of all NHS trusts, NHS foundation trusts and Integrated Care Boards is undertaken by NHS England using the System Oversight Framework. Following the publication of the new Code of Governance for NHS Providers which applied to all NHS Trusts from 1 April 2023, the Trust adheres to the Code on a 'comply or explain' basis. The Board has undertaken a review of its Standing Orders, Scheme of Reservation and Delegation and Standing Financial Instructions during the year, along with reviewing the terms of reference of its committees. With reference to the requirements of the Trust's Standing Orders and Standing Financial Instructions, no gaps in legal compliance have been identified during the year.

Review of economy, efficiency and effectiveness of the use of resources

NHS Trusts are required to deliver statutory and other financial duties. For the year ended 31 March 2026, the Trust met these duties, as summarised below, and set out in more detail within the financial statements:

- to break even at adjusted level on Income & Expenditure – achieved.
- to maintain capital expenditure below a set limit – achieved

Within this, the Trust delivered a challenging efficiency programme of £5.6m compared to our target of £5.4m for the year. The recurrent savings delivered in the year were £3.6m, in line with our target. Nonrecurrent savings delivered were £2.0m, which exceeded target by £0.2m. The over delivery against our efficiency programme was one of the key drivers enabling the Trust to increase its final income and expenditure surplus compared to our original plan. Whilst this area remains a significant challenge, the Trust's will continue to develop our transformational approach to generating and implementing efficiency measures. All efficiency programmes undergo a Quality, Equality Impact Assessment prior to implementation, to ensure that quality of care is not adversely affected.

Checking the correct discharge of statutory functions is managed via the Trust risk management system. No areas of non-compliance have been identified.

The Resource and Performance Committee monitor resources at its monthly meeting and prepare a report for each Board meeting. Financial systems are audited by the Trust's Internal Auditors, consistently gaining a rating of either full or substantial assurance.

The Trust monitors performance against quality standards via a performance framework, reporting through Board committees to the Board. These standards include quality of care, efficiency of service delivery, performance against national standards, contract delivery and finance. Where indicated recovery plans are formulated, actioned and monitored.

The Trust has a strong track record in relation to Value for Money, and no matters have been brought to the attention of our External Auditors in this regard.

Anti-Fraud

The Trust has been rated as overall green on anti-fraud arrangements, which means the Trust meets the requirements of national anti-fraud standards.

Information Governance

The Trust has established robust systems, controls, and processes to protect personal confidential information held in both paper and digital formats.

The Trust completes the Data Security and Protection Toolkit (DSPT), which is now aligned to the National Cyber Security Centre's Cyber Assessment Framework (CAF). The CAF-aligned DSPT adopts an outcome-based approach and sets out the National Data Guardian's data security standards, which align with the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018. Completion of the DSPT self-assessment provides evidence that the Trust is working towards, or meeting, the required outcomes and standards for data security and protection.

Through the Data Security and Protection Assurance Group and the Trust's established reporting framework, the Trust Board receives regular assurance on progress against the DSPT/CAF assessment and visibility of any identified data protection or information security risks. This assurance framework is supported by specialist sub-groups comprising subject matter experts who contribute evidence, carry out assessment activities, and test the effectiveness of controls. All Trust-issued electronic devices are encrypted, and access is appropriately managed to reduce the risk of unauthorised access to information.

Digital transformation within governance further strengthens the Trust's approach to DSPT and CAF assurance by moving from manual, fragmented processes to integrated digital systems. Improved systems support consistent evidence management, clearer accountability, real-time risk tracking, and stronger audit trails. This enables a more proactive, data-driven approach to cyber and information governance, reducing duplication and providing timely assurance that controls are effective and continuously monitored.

For the 2025–2026 assessment period, the Trust is assessing itself against the CAF-aligned DSPT framework. A baseline submission was completed on 31 December 2025, with the final submission due by 30 June 2026. This represents a significant change from previous years, requiring the application of new national guidance, assessment against defined contributing outcomes, and the provision of proportionate evidence to demonstrate effective management of cyber security and information governance risks.

For the period 1 April 2025 to 31 March 2026, the Trust reported one incident to the Information Commissioner's Office (ICO) as a personal data breach. Appropriate remedial action was implemented to mitigate future risk, and no regulatory action was taken by the ICO. A summary of the case is provided below:

Case: A practitioner sent an email to a parent containing health promotion materials; however, the email also included an incorrect attachment relating to a safeguarding report for a different child. The importance of checking email addresses and attachments is routinely reinforced through Trust communication channels.

Data Quality and Governance

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.

This account looks back on performance in the last year and sets priorities for the following year. The Board approves the account prior to publication. Arrangements are in place via service delivery groups

and trust wide groups to report quality and safety matters to the Quality and Safety Committee, which in turn reports to the Board. This includes progress against the priorities set out in the Quality Account.

Shropshire Community Health NHS Trust recognises the importance of reliable information as a fundamental requirement for the speedy and effective treatment of patients, management of staff and stakeholder contracts.

Data quality is crucial, and the availability of complete, accurate and timely data is important in supporting patient care, clinical governance and management and service agreements for healthcare planning and accountability.

The following are some of the key points that support data quality processes:

- Data quality checks using a wide spectrum of measures and indicators, which ensure that data is meaningful and fit for purpose.
- Data Quality/Validation exercises are undertaken with services on both a regular and ad hoc basis.
- Functionality within RiO, the Trust's main clinical system, allows services to monitor and manage certain data quality items real time and manage waiting lists and Referral to Treatment via the front end.
- Compliance with the Data Quality assurance section within the Data Security and Protection Toolkit.
- An Information Quality Assurance policy exists defining roles and responsibilities for data quality including audits.
- There is a Data Quality Subgroup that reports to the Data Security and Protection Assurance Group, where key elements of Data Quality including action plans are reviewed and any issues are progressed accordingly.
- Information Systems and any associated procedures are reviewed in line with national requirements e.g., Data Assurance Board notifications for information standards and data collections.
- External Data Quality metrics are reviewed, and actions are implemented where the position is off track.
- Data Quality is reported through operational groups and overall Data Quality Maturity Index is reported to Committees/Board.

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 NHS trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, the Quality and Safety Committee, the People Committee and the Resource and Performance Committee. A plan to address weaknesses and ensure continuous improvement of the system is in place.

Review of the effectiveness of risk management and internal control

Internal Audit 2025/26

During 2025/26 the Trust's internal auditors undertook the following audits to provide an overview of the effectiveness of the controls in place for the full year. The following reports were issued for this financial year:

- Assurance Framework Opinion
- Risk Management – Core Controls
- Data Protection & Security Toolkit 2025/26
- Key Financial Processing Controls
- Freedom to Speak Up
- Data Quality Cyclical Review
- Quality Spot Checks – Reception Screening
- Staff Health and Wellbeing

The internal audit work for the 12-month period from 1 April 2025 to 31 March 2026 was carried out in accordance with the internal audit plan approved by management and the Audit Committee. The plan was based upon discussions held with management and was constructed in such a way as to gain a level of assurance on the main financial and management systems reviewed. There were no restrictions placed upon the scope of the audit and the work complied with Public Sector Internal Audit Standards.

Head of Internal Audit Opinion

The role of internal audit is to provide an opinion to the Board, through the Audit Committee (AC), on the adequacy and effectiveness of the internal control system to ensure the achievement of the organisation's objectives in the areas reviewed. Overall, the Head of Internal Audit opinion was one of **substantial assurance** that there is a good system of internal controls, designed to meet the Trust's objectives, and that controls are being applied consistently across various services. In forming this opinion Internal Audit took into account that:

- The Trust has been given a rating of 2 from the National Oversight Framework, defined as a 'high performing organisation'
- The Trust performed with a surplus and a favourable variance to its plan
- Pay costs remained within overall pay funding
- Cost improvements were progressed better than planned with the impact of these improvements being captured
- The Quality and Safety Committee reported its review and assurances on the significant progress across patient safety, clinical effectiveness and policy compliance, noting strengthened processes and improved oversight
- A strengthened position for RTT performance demonstrating continuous improvement since 2023/24 placing the Trust ahead of the national trajectory

- Assurance regarding the operating performance framework which provide assurance through sub committee oversight and Chair's reports on a suite of 53 performance KPIs

- The Trust's performance to date and the actions being taken to minimise risks and improve performance where required

- The Trust being on track with plans to establish Group Model working with Shrewsbury and Telford Hospital NHS Trust, including operation new Committees in Common and mapping assurances and reporting

The Trust has accepted the recommendations made by auditors in respect of all the internal audit reviews during the year and has put in place action plans to address the recommendations made. These recommendations are tracked for completion and re-audited where appropriate.

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

- Audit Committee programmes and reviews.
- Internal and External Audits
- Counter Fraud and Security Management
- Risk Management Reports
- Staff and Patient Surveys
- Clinical Audit Reports
- CQC Self-Assessment, inspections and reviews
- Counter Fraud Reports
- Management Reports
- Performance and Quality Reports
- Review of Governance Arrangements
- Ensuring that policies and procedures are embedded and acted on locally.

Conclusion

It is therefore concluded that there were no significant gaps in control or significant internal control issues identified during 2025/26. The Trust continued to implement robust processes to address all recommendations arising from reviews undertaken.

Jo Williams, Group Chief Executive
22 June 2026

Modern Slavery Act 2015 – Annual Statement for 2025/26

Background

The Modern Slavery Act was passed into UK law on 26th March 2015. The Act introduces offences relating to holding another person in slavery, servitude and forced or compulsory labour and about human trafficking. It also makes provisions for the protection of victims.

Organisations such as Shropshire Community Health NHS Trust, that supply goods or services, and have a total turnover of £36m or more are required under Part 6, (Transparency in supply chains), to publish an annual statement setting out the steps that they have taken to ensure that slavery and human trafficking do not exist in their business OR their supply chains.

Shropshire Community Health NHS Trust

Shropshire Community Health NHS Trust provides community health services from well over 50 sites within Shropshire and the West Midlands.

We are committed to ensuring that there is no modern slavery or human trafficking in any part of our activity and where possible, to requiring our suppliers to subscribe to a similar ethos. Any incidence will be acted upon immediately, and any required local or national reporting carried out.

All consumable goods and most contracts are purchased through Shropshire Healthcare Procurement Service (SHPS), a consortium of Shropshire healthcare providers, hosted by the Shrewsbury and Telford Hospitals NHS Trust.

Estates maintenance services are provided by Midlands Partnership NHS Foundation Trust for Trust properties, except for some larger properties shared with multiple healthcare providers which are managed by NHS Property Services.

Arrangements in place

Procurement: All contracts established by SHPS use either NHS Framework Agreements for the Supply of Goods and Services, the NHS Terms and Conditions for Supply of Goods, or the NHS Terms for Supply of services. All have Anti-Slavery clauses, which require providers/contractors to comply with Law and Guidance, use Industry Good Practice and to notify the authority if they become aware of any actual or suspected incident of slavery or human trafficking.

In addition to the above SHPS will investigate any concern raised with the service. This could be by national or local media publicity, through supply chain contacts or by individuals.

Estates: Midlands Partnership NHS Foundation Trust, our provider of estates services, have produced a statement regarding slavery, setting out measures they have in place to ensure that slavery and trafficking do not exist in their activity.

Employment: As an NHS Employer we are required to comply with the NHS employment check standard for all directly recruited staff.

The six checks which make up the NHS Employment Check Standards are:

1. Verification of identity checks

2. Right to work checks
3. Professional registration and qualification checks
4. Employment history and reference checks
5. Criminal record checks
6. Occupational health checks

No individual is permitted to commence employment with the Trust without these checks having been completed. The checks are carried out centrally by the recruitment team and recorded on the Trust workforce information system (ESR).

All recruiting managers are trained in safer recruitment practices. Where other staffing methods (e.g., agency) are used, contracts include a requirement to comply with the NHS employment check standard.

Training and Awareness: All SHPS staff have, or are working towards, professional purchasing qualifications.

The issues relating to Modern Slavery have been raised through articles in the Trust staff magazine Inform and by other briefing mechanisms. These will be repeated periodically. If staff have concerns about the supply chain or any other suspicions related to modern slavery, they will be encouraged to raise these concerns through line management and report the issues to appropriate agencies. This will be raised particularly with clinical staff that may be in contact with vulnerable people.

Conclusion

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the financial year ending 31 March 2026.

Remuneration Report

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

The remuneration of the Chair in Common and Non-Executive Directors was determined during the year by NHS England (NHSE), which is responsible for non-executive appointments to NHS trusts on behalf of the Secretary of State for Health.

Remuneration of the Chief Executive in Common and Trust Directors took place within the interim *Guidance on Pay for Very Senior managers in NHS Trusts and Foundation Trusts*, issued March 2018. The combined population of Shropshire and Telford & Wrekin was used as a guide for setting the salary of the Chief Executive in Common. Other VSM salaries are determined as a proportion of the Chief Executive salary as defined in the *Guidance*, although flexibility is exercised in recruiting to hard-to-fill director posts. VSM salaries are scrutinised and approved by the Nomination, Appointments and Remuneration Committee (more details about this committee can be found in the Corporate Governance Report).

Performance review and appraisal of the Chair in Common was undertaken during the year by the Senior Independent Director and overseen by the Regional NHSE Team on behalf of the Secretary of State for Health in accordance with appraisal guidance provided by the NHSE. Performance review and appraisal of Non-Executive Directors is carried out by the Chair in Common with guidance provided by NHSE. Performance review and appraisal of the Chief Executive was carried out by the Chair in Common in accordance with criteria set by the Remuneration Committee and guidance from the Department of Health. Performance review and appraisal of Directors was carried out by the Chief Executive in accordance with criteria set by the Remuneration Committee and guidance from the Department of Health.

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid Director/Member in their organisation and the median remuneration of the organisation's workforce. The information provided on 'pay multiples is subject to audit.

More details about the salary and pension entitlements for the Trust's VSMs for the year 2025/26 can be found in the Annual Accounts section of this report.

Senior Manager Remuneration

The table below shows details about remuneration for 2025/26 (this information is subject to audit).

Remuneration: 2025/26							
				Performance	Long term	All pension	
Name and title	Dates in Post	Salary	Taxable	pay &	performance	related	
		(Bands of	expense	bonuses	pay/bonuses	benefits	Total
		£5,000)	payments (to	(Bands of	(Bands of	(Bands of	(Bands of
			nearest £100)	£5,000)	£5,000)	£2,500)	£5,000)
		£000	£00	£000	£000	£000	£000
Patricia Davies (Chief Executive)	01/04/25-31/08/25	75-80	100			5.0-7.5	80-85
Jo Williams (Chief Executive in Common)	01/09/25-31/03/26	65-70	0			12.5-15.0	80-85
Sarah Lloyd (Director of Finance)	01/04/25-31/03/26	140-145	100			52.5-55.0	195-200
Dr Mahadeva Ganesh (Medical Director)	01/04/25-31/03/26	105-110	100			0	105-110
Clair Hobbs (Director of Nursing and Clinical Delivery)	01/04/25-31/03/26	130-135	0			45.0-47.5	175-180
Claire Horsfield (Director of Operations and Chief AHP)	01/04/25-31/03/26	115-120	0			67.5-70.0	185-190
Shelley Ramtuhul (Director of Governance and Company Secretary)	01/04/25-31/03/26	110-115	0			0	110-115
Rhia Boyode (Chief People Officer)	01/04/25-31/03/26	70-75	0			0	70-75
Andrew Morgan (Chair in Common)	01/04/25-31/03/26	30-35	1,000			0	35-40
Tina Long (Non-Executive Director)	01/04/25-31/03/26	15-20	800			0	15-20
Harmesh Darbhanga (Non-Executive Director)	01/04/25-31/03/26	10-15	0			0	10-15
Cathy Purt (Non-Executive Director)	01/04/25-31/03/26	10-15	400			0	10-15
Alison Sargent (Non-Executive Director)	01/04/25-07/08/25	0-5	200			0	0-5
Jill Barker (Associate Non-Executive Director)	01/04/25-31/03/26	10-15	800			0	10-15

Notes

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

2. There was no remuneration waived by directors or allowances paid in lieu to directors in 2025/26.

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

4. Patricia Davies left the employment of the Trust on the 31st of August 2025.

5. Jo Williams joined the Trust on 1 September 2025 in a shared role with Shrewsbury and Telford Hospital. The figures above relate only to her employment with this Trust. Her total banded salary as Chief Executive in Common across both organisations for the period from the 1st of September 2025 to the 31st of March 2026 was £135k–£140k.

6. Rhia Boyode holds a shared post with Shrewsbury and Telford Hospital, and the figures above relate only to her employment with this Trust. Her total banded salary as Chief People Officer across both organisations for 2025/26 was £175k–£180k.

7. Andrew Morgan holds a shared post with Shrewsbury and Telford Hospital, and the figures above relate only to his employment with this Trust. His total banded salary as Chair in Common across both organisations for 2025/26 was £65k–£70k.

8. Alison Sargent left the employment of the Trust on the 7th of August 2025.

The table below shows details about remuneration for 2024/25

Remuneration: 2024/25							
				Performance	Long term	All pension	
Name and title	Dates in Post	Salary	Taxable	pay &	performance	related	
		(Bands of	expense	bonuses	pay/bonuses	benefits	Total
		£5,000)	payments (to	(Bands of	(Bands of	(Bands of	(Bands of
			nearest £100)	£5,000)	£5,000)	£2,500)	£5,000)
		£000	£00	£000	£000	£000	£000
Patricia Davies (Chief Executive)	01/04/24-31/03/25	175-180				22.5-25.0	200-205
Sarah Lloyd (Director of Finance)	01/04/24-31/03/25	135-140				15.0-17.5	150-155
Dr Mahadeva Ganesh (Medical Director)	01/04/24-31/03/25	100-105				27.5-30.0	125-130
Clair Hobbs (Director of Nursing and Clinical Delivery)	01/04/24-31/03/25	125-130				17.5-20.0	145-150
Shelley Ramtuhul (Director of Governance and Company Secretary)	01/04/24-31/03/25	105-110				0	105-110
Claire Horsfield (Director of Operations and Chief AHP)	01/04/24-31/03/25	105-110				22.5-25.0	130-135
Rhia Boyode (Chief People Officer)	01/05/24-31/03/25	60-65				0	60-65
Andrew Morgan (Chair)	01/10/24-31/03/25	20-25				0	20-25
Tina Long (Acting Chair)	01/04/24-30/09/24	20-25				0	20-25
Tina Long (Non-Executive Director)	01/10/24-31/03/25	15-20				0	15-20
Harmesh Darbhanga (Non-Executive Director)	01/04/24-31/03/25	10-15				0	10-15
Peter Featherstone (Non-Executive Director)	01/04/24-11/11/24	5-10				0	5-10
Cathy Purt (Non-Executive Director)	01/04/24-31/03/25	10-15				0	10-15
Alison Sargent (Non-Executive Director)	01/04/24-31/03/25	10-15				0	10-15
Jill Barker (Associate Non-Executive Director)	01/04/24-31/03/25	10-15				0	10-15

Notes

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

2. There was no remuneration waived by directors or allowances paid in lieu to directors in 2024/25.

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

4. Peter Featherstone left the employment of the Trust on 11th of November 2024.

5. Rhia Boyode started employment with the Trust on the 1st of May 2024, a shared post with Shrewsbury and Telford Hospital and the above figures relate to her employment at this Trust.

6. Andrew Morgan started employment with the Trust on the 1st of October 2024, a shared post with Shrewsbury and Telford Hospital and the above figures relate to his employment at this Trust.

7. Tina Long was Acting Chair until the 1st of October 2024 and then a Non-Executive Director for the rest of the reporting year.

8. Dr Mahadeva Ganesh (Medical Director) worked part time during 2024/25 for the Trust and worked for the ICB as Interim Chief Medical Officer for part of the year. The above figures only relate to his role with this Trust.

Pension Entitlements

The table below shows information about pension entitlements for 2025/26 (this information is subject to audit).

Pension entitlements 2025/26								
					Lump sum at			
Name and title	Dates in Post		Real increase	Total accrued	pension age	Cash	Cash	
		Real increase	in pension	pension at	re accrued	Equivalent	Equivalent	Real increase
		in pension	lump sum at	pension age	pension at	Transfer	Transfer	in Cash
		at pension age	pension age	at 31 March	31 March	Value at	Value at	Equivalent
		(Bands of	(Bands of	2025 (bands	2026 (bands	31 March	31 March	Transfer
		£2,500)	£2,500)	of £5,000)	of £5,000)	2025	2026	Value
		£000	£000	£000	£000	£000	£000	£000
Patricia Davies (Chief Executive)	01/04/25-31/08/25	0.0-2.5	0	65-70	165-170	1,496	1,562	13
Jo Williams (Chief Executive in Common)	01/09/25-31/03/26	0.0-2.5	0	60-65	135-140	1,232	1,315	13
Sarah Lloyd (Director of Finance)	01/04/25-31/03/26	2.5-5.0	0.0-2.5	60-65	150-155	1,303	1,407	65
Dr Mahadeva Ganesh (Medical Director)	01/04/25-31/03/26	0	0	0	0	41	0	0
Clair Hobbs (Director of Nursing and Clinical Delivery)	01/04/25-31/03/26	2.5-5.0	0.0-2.5	45-50	105-110	891	969	46
Claire Horsfield (Director of Operations and Chief AHP)	01/04/25-31/03/26	2.5-5.0	5.0-7.5	35-40	85-90	670	763	67
Shelley Ramtuhul (Director of Governance and Company Secretary)	01/04/25-31/03/26	0	0	0	0	0	0	0
Rhia Boyode (Chief People Officer)	01/04/25-31/03/26	0	0	0	0	0	0	0

Notes

1. Non-executive directors do not receive pensionable remuneration; there are no entries in respect of pensions for these directors.
2. There are no additional benefits that will become receivable by the individual if they retire early.
3. There were no employer's contributions to stakeholder pensions.
4. Jo Williams started her role as Chief Executive in Common with the Trust and Shrewsbury and Telford Hospital on the 1st of September 2025 the real increases are only for the proportion relating to this post.
5. Dr Mahadeva Ganesh has now reached Normal Pension Age (NPA) so no longer has a Cash Equivalent Transfer Value.

6. Shelley Ramtuhul and Rhia Boyode chose not to be covered by the pension arrangements during the reporting year.

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

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

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

10. The table below shows information about pension entitlements for 2024/25

Pension entitlements 2024/25								
					Lump sum at			
Name and title	Dates in Post		Real increase	Total accrued	pension age	Cash	Cash	
		Real increase	in pension	pension at	re accrued	Equivalent	Equivalent	Real increase
		in pension	lump sum at	pension age	pension at	Transfer	Transfer	in Cash
		at pension age	pension age	at 31 March	31 March	Value at	Value at	Equivalent
		(Bands of	(Bands of	2025 (bands	2025 (bands	31 March	31 March	Transfer
		£2,500)	£2,500)	of £5,000)	of £5,000)	2024	2025	Value
		£000	£000	£000	£000	£000	£000	£000
Patricia Davies (Chief Executive)	01/04/24-31/03/25	0.0-2.5	0	65-70	165-170	1,354	1,496	29
Sarah Lloyd (Director of Finance)	01/04/24-31/03/25	0.0-2.5	0	55-60	145-150	1,184	1,303	23
Dr Mahadeva Ganesh (Medical Director)	01/04/24-31/03/25	0.0-2.5	0	0-5	0	0	41	29
Clair Hobbs (Director of Nursing and Clinical Delivery)	01/04/24-31/03/25	0.0-2.5	0	40-45	105-110	801	891	20
Claire Horsfield (Director of Operations and Chief AHP)	01/04/24-31/03/25	0.0-2.5	0	30-35	80-85	594	670	22
Shelley Ramtuhul (Director of Governance and Company Secretary)	01/04/24-31/03/25	0	0	0	0	0	0	0
Rhia Boyode (Chief People Officer)	01/05/24-31/03/25	0	0	0	0	0	0	0

Notes

1. Non-executive directors do not receive pensionable remuneration; there are no entries in respect of pensions for these directors.

2. There are no additional benefits that will become receivable by the individual if they retire early.

3. There were no employer's contributions to stakeholder pensions.

4. Dr Mahadeva Ganesh has re-joined the 2015 Pension scheme in 2024/25. The pension regulations changed in year and those who have taken 1995 benefits can now re-join the 2015 scheme.

5. Shelley Ramtuhul and Rhia Boyode chose not to be covered by the pension arrangements during the reporting year.

6. See notes 7, 8 and 9 above as well.

Fair pay disclosures

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid Director/Member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid Director/Member in the organisation in the financial year 2025-26 was £142,500* (2024-25, £177,500). The relationship to the remuneration of the organisation's workforce is disclosed in the table below. These disclosures exclude the costs of non-executive directors. The information provided on 'pay multiples' is subject to audit.

2025 to 2026	**25th percentile**	**Median**	**75th percentile**
Total remuneration (£)	29,401	39,510	47,810
Salary component of total remuneration (£)	29,401	39,510	47,810
Pay ratio information	4.8	3.6	3.0
2024 to 2025	**25th percentile**	**Median**	**75th percentile**
Total remuneration (£)	28,066	37,338	45,586
Salary component of total remuneration (£)	28,066	37,338	45,586
Pay ratio information	6.3	4.8	3.9

The above table shows that the banded remuneration of the highest paid Director/Member in Shropshire Community Health NHS Trust in the financial year 25/26 was:

3.0 times (2024/25 - 3.9) the 75th percentile remuneration of the workforce, which was £47,810 (2024/25 - £45,586).
• 3.6 times (2024/25 - 4.8) the median remuneration of the workforce, which was £39,510 (2024/25 - £37,338).

• 4.8 times (2024/25 – 6.3) the 25th percentile remuneration of the workforce, which was £29,401 (2024/25 - £28,066).

The percentage change in remuneration from the previous financial year in respect of the highest paid director was 3.6% (2024/25 – 6.0%). The average percentage change in remuneration from the previous financial year in respect of employees of the entity was 4.7% (2024/25 4.4%). This increase in director pay and employee pay is due to the national pay award and reflects the changes to the staff mix.

In 2025/26, eleven (2024/25, seven) employees received remuneration more than the highest paid Director/Member. Remuneration ranged from £14,763 to £225,538 (2024/25 £23,615 to £268,769).

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

*(*Banded remuneration is the mid-point between £140,000 and £145,000, which is the band within which the remuneration of the highest paid Director falls).*

Staff Report

We employ nearly 2,000 people who provide a wide range of services from locations across Shropshire, Telford & Wrekin and surrounding areas.

This report provides information about the make-up of our workforce, which at the end of the year 2025/26 had a headcount of 1,958.

Staff Numbers

	Female		Male		All	
2026	FTE	Headcount	FTE	Headcount	FTE	Headcount
Executive Directors	3.00	3	0.64	1	3.64	4
Senior Managers	**69.92**	**76**	**24.49**	**26**	**94.40**	**102**
Band 8a	47.53	51	10.99	12	58.51	63
Band 8b	9.03	11	6.90	7	15.93	18
Band 8c	9.36	10	2.60	3	11.96	13
Band 8d	3.00	3	3.00	3	6.00	6
Band 9	1.00	1	1.00	1	2.00	2
Other Staff	1,329.69	1,660	172.63	192	1,502.32	1,852
Grand Total	**1,402.61**	**1,739**	**197.76**	**219**	**1,600.37**	**1,958**

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

Average number of employees (WTE basis)

	Permanent Number	Other Number	2025/26 Total Number	2024/25 Total Number
Medical and dental	22	5	**27**	26
Ambulance staff	0	0	**0**	0
Administration and estates	378	15	**393**	408
Healthcare assistants and other support staff	279	36	**314**	329
Nursing, midwifery and health visiting staff	636	51	**687**	681
Nursing, midwifery and health visiting learners	19	0	**19**	18
Scientific, therapeutic and technical staff	248	7	**255**	250
Healthcare science staff	0	0	**0**	0
Social care staff	0	0	**0**	0
Other	4	0	**4**	6
Total average numbers	**1,586**	**114**	**1,699**	**1,718**

Staff Numbers by Ethnicity

Ethnicity	Headcount	FTE
A White - British	1,659	1341.86
B White - Irish	6	4.55
C White - Any other White background	25	21.85
C3 White Unspecified	4	2.71
CA White English	8	6.06
CC White Welsh	1	1.00
CD White Cornish	1	0.40
CK White Italian	1	0.20
CN White Gypsy/Romany	1	1.00
CP White Polish	8	6.65
CX White Mixed	3	2.47
CY White Other European	3	1.99
D Mixed - White & Black Caribbean	7	5.57
E Mixed - White & Black African	1	1.00
F Mixed - White & Asian	3	3.00
G Mixed - Any other mixed background	5	4.80
H Asian or Asian British - Indian	56	50.27
J Asian or Asian British - Pakistani	12	10.28
L Asian or Asian British - Any other Asian backgroun	5	4.00
LG Asian Sinhalese	1	1.00
LK Asian Unspecified	6	5.80
M Black or Black British - Caribbean	12	10.98
N Black or Black British - African	58	56.41
P Black or Black British - Any other Black backgroun	2	1.60
PC Black Nigerian	4	3.53
PE Black Unspecified	1	1.00
R Chinese	3	2.95
S Any Other Ethnic Group	2	1.80
SB Japanese	1	0.80
SE Other Specified	3	2.20
Unspecified	1	1.00
Z Not Stated	55	41.64
Grand Total	**1,958**	**1600.37**

Staff Costs

The analysis of staff costs below is subject to audit:

Staff costs

	Permanent	Other	2025/26 Total	2024/25 Total
	£000	£000	£000	£000
Salaries and wages	69,335	1,333	**70,668**	67,555
Social security costs	8,468	0	**8,468**	6,199
Apprenticeship levy	325	0	**325**	312
Employer's contributions to NHS pension scheme	14,989	0	**14,989**	14,369
Pension cost - other	20	0	**20**	24
Other post employment benefits	0	0	**0**	0
Other employment benefits	0	0	**0**	0
Termination benefits	0	0	**0**	0
Temporary staff	0	3,012	**3,012**	4,909
Total gross staff costs	**93,137**	**4,345**	**97,482**	**93,368**

Staff Sickness Absence

Source: NHS Digital - Sickness Absence and Workforce Publications - based on data from the ESR Data Warehouse

Period covered: January to December 2025

Data items: ESR does not hold details of the planned working/non-working days for employees, so days lost and days available are reported based upon a 365-day year. For the Annual Report and Accounts the following figures are used:

The number of FTE-days available has been taken directly from ESR. This has been converted to FTE years in the first column by dividing by 365.

The number of FTE-days lost to sickness absence has been taken directly from ESR. The adjusted FTE days lost has been calculated by multiplying by 225/365 to give the Cabinet Office measure.

The average number of sick days per FTE has been estimated by dividing the FTE Days by the FTE days lost and multiplying by 225/365 to give the Cabinet Office measure. This figure is replicated on returns by dividing the adjusted FTE days lost by Average FTE.

Equality, Diversity & Inclusion

We aim to make diversity and inclusion central to our work, delivering sustainable, high-quality care to our communities. We drive efforts to create a positive culture, address workforce inequalities, and foster belonging. Becoming an inclusive organisation that values its diverse workforce and treats all staff equally is one of our priorities.

We have made progress over the last twelve months, we have continued to embed equality, diversity and inclusion for our staff and patients. We continue to engage with our staff voice networks who contribute to identifying improvements that we can make in the Trust, and work with the networks to co-create actions and material; this year the networks supported the development of neuro diverse guidelines ; this will further enhance our line manager capability and support individuals in being able to strive at work. Our staff networks also review our EDI related data and support the development of our relevant action plans to improve equality, diversity and inclusion. We continue to review our practices and policies to ensure we make Shropcom a fairer and more inclusive place to work. We know there is still much more we can do to embed our commitment to equality, diversity and inclusion within all our processes and to ensure we provide opportunities for all our staff to thrive and progress.

We report annually on the Workforce Race Equality Standard (WRES), Gender Pay Gap, and Workforce Disability Equality Standard (WDES). The data, alongside other equality monitoring information enables us to understand how well we are performing, and to take positive action to ensure all employees, regardless of race, gender or disability, have equal pay, career progression opportunities and fair treatment in the workplace leading to improved experiences.

Our People policies are developed with our values in mind and management training is designed to eliminate discrimination on all grounds, which includes disability. Our Policy and Procedure on Equality and Diversity 'Everyone Counts' explains how the Trust will not discriminate against any member of staff with regard to training, promotion and career development.

We have signed up to the Sexual Misconduct Charter, which encouraged NHS providers to adopt a zero tolerance approach to sexual misconduct in the workplace and to create a culture at work where everyone feels safe.

As part of our Staff Survey staff were asked if they were the target of unwanted behaviours of a sexual nature from patients and from staff/colleagues. The response for unwanted behaviours experienced by our staff from patients is 8.1%. However, staff experiencing unwanted behaviours from staff/colleagues is 1.8%. As part of our commitment to our People and wider communities, we are committed to ensuring everyone feels safe, included and respected at work, with the continuation of our work around sexual safety.

There is more information available on the Trusts website regarding its work to promote equality, diversity and inclusion for our workforce and service users.

Off-Payroll Arrangements

The table below shows arrangements that the Trust had during the year with individuals who provided services for which they were paid on a self-employed basis or through their own companies. Employment through agencies is not included. Only arrangements lasting six months or more, with a value of more than £245 per day, are shown.

Table 1: Off-payroll engagements longer than 6 months

For all off-payroll engagements as of 31 March 2026, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2026	0

The standard contract for off payroll workers contains binding clauses requiring the contractor to comply with all relevant statutes and regulations relating to income tax and national insurance contributions in respect of fees paid by the Trust and indemnifying the Trust against any liabilities incurred in respect of such contributions.

It also requires the contractor to demonstrate to the Trust his/her compliance with such legislation on request.

Deductions are made for PAYE for off payroll workers where appropriate in accordance with IR35 guidance.

The contractor's agreement to these terms is judged to constitute an appropriate level of risk assessment and management.

Table 2: New Off-payroll engagements

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2025 and 31 March 2026, for more than £245 per day and that last for longer than six months.

	Number
No. of new engagements, or those that reached six months in duration, between 1 April 2025 and 31 March 2026	0
Of which...	
No. assessed as caught by IR35	0
No. assessed as not caught by IR35	0
No. engaged directly (via PSC contracted to department) and are on the departmental payroll	0
No. of engagements reassessed for consistency / assurance. purposes during the year.	0
No. of engagements that saw a change to IR35 status following the consistency review	0

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 2025 and 31 March 2026

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year.	0
Total no. 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 must include both on payroll and off-payroll engagements.	0 off-payroll 13 on payroll

For the year 2025/26 there were 12 Board members as set out earlier in this report. The disclosure above showing 13 individuals reflects changes during the year where some officers held post for part of the year.

Exit Packages

The information relating to Exit Packages is subject to audit. Redundancy and other departure costs are paid in accordance with the provisions of NHS Agenda for Change rules on pay. Exit costs are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pensions scheme. Ill-health retirement costs are met by the NHS Pensions scheme. During 2025/26, four redundancy payments were agreed totalling £174,475. Four contractual payments in lieu of notice were made totalling £33,096, and one special payment agreement of £35,000 was approved by Trust and HMT/DHSC but was not paid by year end.

Reporting of compensation schemes - exit packages 2025/26

During the year, four redundancy payments and four contractual payments in lieu of notice were agreed and paid.
One special payment was approved during the year but had not been accepted at year end.

	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	0	3	**3**
£10,000 - £25,000	2	1	**3**
£25,001 - 50,000	1	1	**2**
£50,001 - £100,000	0	0	**0**
£100,001 - £150,000	1	0	**1**
£150,001 - £200,000	0	0	**0**
>£200,000	0	0	**0**
Total number of exit packages by type	**4**	**5**	**9**
Total cost (£)	174,475	68,096	**£242,571**

Reporting of compensation schemes - exit packages 2024/25

One redundancy payment and one contractual payments in lieu of notice was agreed in the period

	exit packages Number	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of
Exit package cost band (including any special payment element)				
<£10,000		0	1	**1**
£10,000 - £25,000		0	0	**0**
£25,001 - 50,000		0	0	**0**
£50,001 - £100,000		1	0	**1**
£100,001 - £150,000		0	0	**0**
£150,001 - £200,000		0	0	**0**
>£200,000		0	0	**0**
Total number of exit packages by type		**1**	**1**	**2**
Total cost (£)		65,882	2,872	**£68,754**

Exit packages: other (non-compulsory) departure payments

	2025/26		2024/25	
	Payments agreed Number	Total value of agreements £000	Payments agreed Number	Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	4	33	1	3
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT / DHSC approval	1	35	0	0
Total	**5**	**68**	**1**	**3**
Of which:				
Non-contractual payments requiring HMT / DHSC approval made to individuals where the payment value was more than 12 months' of their annual salary	0	0	0	0

Other departures

A single exit package can be made up of several components, each of which need to be counted separately.

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

Expenditure on Consultancy

There was no expenditure on consultancy in 2025/26 and no expenditure on consultancy in 2024/25.

Jo Williams, Group Chief Executive
22 June 2026

Trust Accounts Consolidation (TAC) Summarisation Schedules for Shropshire Community Health NHS Trust for the year ended 31 March 2026

Summarisation schedules numbers TAC01 to TAC34 and accompanying WGA sheets for 2025/26 have been completed and this certificate accompanies them.

Finance Director Certificate

1. I certify that the attached TAC schedules have been compiled and are in accordance with:
    - the financial records maintained by the NHS trust.
    - accounting standards and policies which comply with the Department of Health and Social Care's Group Accounting Manual and
    - the template NHS provider accounting policies issued by NHS England, or any deviation from these policies has been fully explained in the Confirmation questions in the TAC schedules.

2. I certify that the TAC schedules are internally consistent and that there are no validation errors.

3. I certify that the information in the TAC schedules is consistent with the financial statements of the NHS Trust.

Signature: ……

Sarah Lloyd
Chief Finance Officer
22 June 2026

Chief Executive Certificate

1. I acknowledge the attached TAC schedules, which have been prepared and certified by the Finance Director, as the TAC schedules which the Trust is required to submit to NHS England.

2. I have reviewed the schedules and agree with the statements made by the Director of Finance above.

Signature: ……

Jo Williams
Group Chief Executive
22 June 2026

Independent auditor's report to the directors of Shropshire Community Health NHS Trust

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of Shropshire Community Health NHS Trust (the 'Trust') for the year ended 31 March 2026, which comprise the statement of comprehensive income, the statement of financial position, the statement of changes in taxpayers' equity, the statement of cash flows and notes to the financial statements, including material accounting policy information. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2025-26.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2026 and its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2025-26; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2024) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the directors' use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Trust's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the Trust to cease to continue as a going concern.

In our evaluation of the directors' conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2025-26 that the Trust's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the Trust. In doing so we had regard to the guidance provided in Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2024) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the Trust and the Trust's disclosures over the going concern period.

In auditing the financial statements, we have concluded that the directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report and accounts, other than the financial statements and our auditor's report thereon. The directors are responsible for the other information contained within the annual report and accounts. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in November 2024 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the requirements of the Department of Health and Social Care Group Accounting Manual 2025-26 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2025-26; and
- based on the work undertaken in the course of the audit of the financial statements, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we make a written recommendation to the Trust under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

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

Responsibilities of directors

As explained more fully in the Statement of directors' responsibilities in respect of the accounts, the directors are responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions and for being satisfied that they give a true and fair view, and for such internal control as the directors determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the directors are responsible for 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.

Auditor's responsibilities for the audit of the financial statements

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 an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a 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 the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements. Irregularities, including fraud, are instances of non-compliance with laws and regulations. The extent to which our procedures are capable of detecting irregularities, including fraud, is detailed below.

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the Trust and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2025-26).
- We enquired of management and the audit committee, concerning the Trust's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the audit committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the Trust's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls and fraud in income and expenditure recognition. We determined that the principal risks were in relation to:
  - the appropriate posting of journals which impacted on the reported financial position; and
  - managements approach to key accounting estimates
- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on large and unusual items and significant journals at the end of the financial year which impacted the Trust's financial position;
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of land and building valuations; and
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- We communicated relevant laws and regulations and potential fraud risks to all engagement team members, including the potential for management override of controls in journals and in the significant accounting estimates. We remained alert to any indications of non-compliance with laws and regulations, including fraud, throughout the audit.
- The engagement partner's assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the Trust operates
  - understanding of the legal and regulatory requirements specific to the Trust including:
    - the provisions of the applicable legislation

  - NHS England's rules and related guidance
  - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The Trust's operations, including the nature of its income and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - The Trust's control environment, including the policies and procedures implemented by the Trust to ensure compliance with the requirements of the financial reporting framework.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – 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, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2026.

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

Responsibilities of the Accountable Officer

As explained in the Statement of the chief executive's responsibilities as the accountable officer of the Trust, the Chief Executive, as Accountable Officer, is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(2A)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in March 2026. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for Shropshire Community Health NHS Trust for the year ended 31 March 2026 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have received confirmation from the National Audit Office that the audit of the NHS group consolidation is complete for the year ended 31 March 2026. We are satisfied that this work does not have a material effect on the financial statements for the year ended 31 March 2026.

Use of our report

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

Richard J J Anderson

Richard Anderson, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

Birmingham
23 June 2026

Shropshire Community Health
NHS Trust

Annual accounts for the year ended 31 March 2026

Statement of Comprehensive Income

	Note	2025/26 £000	2024/25 £000
Operating income from patient care activities	3	132,074	129,218
Other operating income	4	3,254	3,556
Operating expenses	6,8	(132,731)	(130,354)
Operating surplus from continuing operations		**2,597**	**2,420**
Finance income	10	1,384	1,439
Finance expenses	11	(308)	(316)
PDC dividends payable		(377)	(408)
Net finance costs		**699**	**715**
Other gains / (losses)	12	(172)	(7)
Surplus for the year		**3,124**	**3,128**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(1,603)	276
Revaluations	16	2,495	432
Other reserve movements		0	(1)
Total comprehensive income for the period		**4,016**	**3,835**

Statement of Financial Position

	Note	31 March 2026 £000	31 March 2025 £000
Non-current assets			
Intangible assets	13	3	6
Property, plant and equipment	14	31,911	30,043
Right of use assets	17	11,492	12,828
Receivables	19	265	202
Total non-current assets		**43,671**	**43,079**
Current assets			
Inventories	18	139	205
Receivables	19	3,581	2,866
Cash and cash equivalents	20	29,164	27,074
Total current assets		**32,884**	**30,145**
Current liabilities			
Trade and other payables	21	(12,882)	(11,889)
Borrowings	22	(2,027)	(2,030)
Provisions	23	(1,422)	(3,226)
Total current liabilities		**(16,331)**	**(17,145)**
Total assets less current liabilities		**60,224**	**56,079**
Non-current liabilities			
Borrowings	22	(9,054)	(9,740)
Provisions	23	(1,048)	(755)
Total non-current liabilities		**(10,102)**	**(10,495)**
Total assets employed		**50,122**	**45,584**
Financed by			
Public dividend capital		2,915	2,393
Revaluation reserve		7,533	6,974
Income and expenditure reserve		39,674	36,217
Total taxpayers' equity		**50,122**	**45,584**

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

Name Jo Williams
Position Chief Executive
Date 22 June 2026

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2026

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2025 - brought forward	**2,393**	**6,974**	**36,217**	**45,584**
Surplus for the year	0	0	3,124	**3,124**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	0	(295)	295	**0**
Impairments	0	(1,603)	0	**(1,603)**
Revaluations	0	2,495	0	**2,495**
Transfer to retained earnings on disposal of assets	0	(38)	38	**0**
Public dividend capital received	522	0	0	**522**
Other reserve movements	0	0	0	**0**
Taxpayers' equity at 31 March 2026	**2,915**	**7,533**	**39,674**	**50,122**

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2025

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2024 - brought forward	**2,393**	**6,533**	**32,823**	**41,749**
Surplus for the year	0	0	3,128	**3,128**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	0	(267)	267	**0**
Impairments	0	276	0	**276**
Revaluations	0	432	0	**432**
Transfer to retained earnings on disposal of assets	0	0	0	**0**
Public dividend capital received	0	0	0	**0**
Other reserve movements	0	0	(1)	**(1)**
Taxpayers' equity at 31 March 2025	**2,393**	**6,974**	**36,217**	**45,584**

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	2025/26 £000	2024/25 £000
Cash flows from operating activities			
Operating surplus		2,597	2,420
Non-cash income and expense:			
Depreciation and amortisation	6.1	4,709	4,461
Net impairments	7	638	308
Income recognised in respect of capital donations	4	(7)	(11)
(Increase) in receivables and other assets		(1,025)	(210)
decrease / (Increase) decrease in inventories		66	(20)
Increase in payables and other liabilities		1,325	2,580
(decrease) / Increase in provisions		(1,530)	809
Net cash flows from operating activities		**6,773**	**10,337**
Cash flows from investing activities			
Interest received		1,399	1,429
Purchase of PPE and investment property		(4,126)	(1,794)
Sales of PPE and investment property		8	0
Initial direct costs or up front payments in respect of new right of use assets		(22)	(210)
Receipt of cash donations to purchase assets		7	11
Net cash flows (used in) investing activities		**(2,734)**	**(564)**
Cash flows from financing activities			
Public dividend capital received		522	0
Capital element of lease rental payments		(2,018)	(1,812)
Interest paid on lease liability repayments		(308)	(316)
PDC dividend (paid)		(145)	(410)
Net cash flows (used in) financing activities		**(1,949)**	**(2,538)**
Increase in cash and cash equivalents		**2,090**	**7,235**
Cash and cash equivalents at 1 April - brought forward		**27,074**	**19,839**
Cash and cash equivalents at 31 March	20	**29,164**	**27,074**

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 2025/26 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.

Note 1.1.1 Accounting convention

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

Note 1.2 Going concern

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

Note 1.3 Charitable Funds

Under the provisions of IFRS 10 Consolidated Financial Statements, those charitable funds that fall under common control with NHS Trusts are consolidated within the entity's financial statements. As the Trust is the corporate trustee of the linked NHS Charity (Shropshire Community Health NHS Trust General Charitable Fund), it effectively has the power to exercise control so as to obtain economic benefits. However, the balance and transactions are immaterial in the context of the group and transactions have not been consolidated. Details of the transactions with the charity are included in Note 27: related party transactions.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102.

Note 1.4 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

The Trust has a very small number of contracts that cross financial years with most of the income and performance obligations satisfied in year. Performance obligations are invoiced monthly with 30-day credit terms and hence the contract balances at year end mainly relate to obligations completed in March.

This year end the Trust has had some performance obligations with NHS Shropshire, Telford and Wrekin ICB, Shropshire Council and Telford Council for specific work programmes and the Clinical Research Network for research and development projects.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned payment and incentive contracts form the main payment mechanism under the NHSPS. API contracts contain both a fixed and variable element.

Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. However, where expected activity value for elective services exceeds £0.1m the total variable payment is subject to set payment limits. The set payment limit is agreed between commissioners and providers based on planned levels of elective activity for the year.

The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

The Trust also receives income from commissioners under the Best Practice Tariff (BPT) scheme. Delivery under this scheme is part of how care is provided to patients. As such BPT payments are not considered distinct performance obligations in their own right; instead, they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS 15. Payment for BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed, subject to the set payment limits set out above.

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.5 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's apprenticeship service account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.6 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.7 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

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

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement

Valuation

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

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front-line services or back-office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current value in existing use is defined as market value except where a building is so specialised in nature no active market exists from which to draw satisfactory transactional evidence. In this case a valuer will adopt a depreciated replacement cost (DRC) model on a modern equivalent asset (MEA) basis.

A DRC model estimates current value in existing use 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. 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.

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

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

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 are not depreciated until the asset is brought into use.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of ‘other impairments’ are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as ‘held for sale’ once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their ‘fair value less costs to sell’. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as ‘held for sale’ and instead is retained as an operational asset and the asset’s useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	3	86
Plant & machinery	5	15
Information technology	2	10
Furniture & fittings	10	10

Note 1.9 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance controlled by the Trust. They are capable of being sold separately from the rest of the trust's business or arise from contractual or other legal rights. Intangible assets are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset where it meets recognition criteria.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. From 1 April 2025, subsequent measurement of intangible assets is at cost less amortisation.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Impairments

Where indicators of impairment exist, the recoverable amount is assessed as the higher of its fair value and the cost to replace the service capacity. Where this is lower than the carrying value an impairment is recognised in expenditure. The recoverable amount of intangible assets under construction is assessed annually, irrespective of indicators of impairment.

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
Software licences	2	5
Other (purchased)	5	5

Note 1.10 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

Note 1.11 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 1.12 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets and financial liabilities are classified as subsequently measured at amortised cost.

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.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

DHSC group bodies will not recognise stage 1 or stage 2 impairments. This is due to the fact DHSC will provide a guarantee of last resort against the debts of DHSC group bodies. Therefore, receivables relating to NHS bodies will not be impaired. With non-NHS debt the Trust will use the expected loss model of impairment. This model will use historical receivable information as at 31st March in previous years to compile expected loss rates. These expected loss rates will be applied to aged receivables at year end adjusting for any forward-looking information available at this time to calculate the lifetime expected loss allowance as at the year end.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.13 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as a lessor
All leases are classified as operating leases.

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

Note 1.14 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.

The Trust has not applied the Treasury's discount rates to the majority of the provisions as settlement is expected within one year and the impact of discounting is not material.
The provision arising from the 2019/20 clinicians' pensions scheme is calculated by NHS England using the Treasury's discount rates as cashflows are expected later than one year.
Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.95% in real terms (prior year: 2.40%).

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 23.3 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 1.15 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at

https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.16 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 1.17 Losses and special payments

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

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.18 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2025/26.

Note 1.19 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following IFRS Standards to be applied in 2025/26:

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard has been adopted by the UK Endorsement Board to be effective for accounting periods beginning on or after 1 January 2027. The Standard has not yet been adopted by the FReM and early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - applicable to eligible subsidiaries for reporting periods beginning on or after 1 January 2027.The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. As the Trust has no subsidiaries this will have no impact on the Trust.

Changes to valuation of property, plant and equipment (PPE) assets – The DHSC GAM for 2026/27 and associated consultation response document confirms future changes which will impact on the financial statements.

From 2026/27 NHS bodies' valuation methodology will be a mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years. The requirement in IAS 16 to revalue an asset when its fair value differs materially from its carrying value is being withdrawn for the public sector. Given the variation in PPE valuations in any given year, and future changes in indices, it is not possible to quantify the impact of applying these changes in future periods. PPE and right of use assets currently subject to revaluation have a total book value of £29.3m as at 31 March 2026.

For 2028/29:

The 'Alternative site' valuation option within MEA will be removed from the 1st of April 2028. This will have no impact on the Trust as no assets are valued in as 'Alternative site'.

Note 1.20 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:

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

1. Determining whether charitable funds are a subsidiary of the Trust, and whether they are material, to determine whether or not to consolidate.

Note 1.21 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

1. Land and Buildings £28.6m are valued periodically by an external valuation specialist who makes assumptions concerning values, and estimates are also made concerning the remaining lives of these assets. If the valuations were 1% different, this would amount to £0.29m. The valuations would have to be different by 10.95% (£3.13m) to be considered material.

1.2 Peppercorn Land and Buildings £0.68m are also valued periodically by an external valuation specialist who makes assumptions concerning values. These valuations are therefore not considered material

2. Lease terms have been estimated as a number of Leases do not have formal documentation or do not have written agreements (mainly with NHS Property Services). In this case a judgement on Lease Terms has been made to match business plans or commercial reality. The valuation of Leases using the cost model at the 31st of March 2026 is £10.8m. If the lease term or the cost model valuation were 1% different, this would amount to £0.1m. The valuations would have to be different by 29% (£3.13m) to be considered material.

Note 2 Operating Segments

The Trust has one operating segment being healthcare services, this is in line with the organisations management reporting structure.

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)	2025/26 £000	2024/25 £000
Community services		
Income from commissioners under API contracts*	107,718	105,804
Income from other sources (e.g. local authorities)	18,421	17,733
All services		
National pay award central funding***		6
Additional pension contribution central funding**	5,935	5,675
Other clinical income	0	0
Total income from activities	**132,074**	**129,218**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2025/26 NHS Payment Scheme documentation.

https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

**Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.38% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%) and related NHS England funding (9.4%) have been recognised in these accounts.

***Additional funding was made available directly to providers by NHS England in 2024/25 for implementing the backdated element of pay awards where government offers were finalised after the end of the 2023/24 financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2025/26 £000	2024/25 £000
NHS England	11,131	10,979
Integrated care boards	102,522	100,506
Other NHS providers	1,348	1,357
Local authorities	16,294	15,392
Injury cost recovery scheme	155	144
Non NHS: other	624	840
Total income from activities	**132,074**	**129,218**
Of which:		
Related to continuing operations	132,074	129,218

Note 4 Other operating income

	2025/26			2024/25		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	292	0	**292**	265	0	**265**
Education and training	1,419	265	**1,684**	1,401	244	**1,645**
Non-patient care services to other bodies	35		**35**	34		**34**
Income in respect of employee benefits accounted on a gross basis	34		**34**	33		**33**
Receipt of capital grants and donations and peppercorn leases		7	**7**		11	**11**
Revenue from operating leases		186	**186**		186	**186**
Other income	1,016	0	**1,016**	1,382	0	**1,382**
Total other operating income	**2,796**	**458**	**3,254**	**3,115**	**441**	**3,556**
Of which:						
Related to continuing operations			3,254			3,556
Related to discontinued operations			0			0

An additional analysis of significant items of income included in 25/26 Other operating income - £1,016k (24/25 £1,382k) : Property Rentals £361k (24/25 £333k), Catering £49k (24/25 £53k), Estates Recharge to Foundation Trust £66k (24/25 £64k), Pharmacy Staffing Income £178k (24/25 £405k), FCP Physio Staffing Income £131k (24/25 £97k), Admiral Nursing Funding £54k (24/25 £51K), Meals on Wheels Income £35K (24/25 £35K)

Note 5 Operating leases - Shropshire Community Health NHS Trust as lessor

This note discloses income generated in operating lease agreements where Shropshire Community Health NHS Trust is the lessor.

The Trust leased out parts of 5 properties in 2025/26 being: Bridgnorth Health Centre with 79 years remaining, Bridgnorth and Whitchurch Maternity Units 1 year remaining, Hadley Health Centre 0.25 years remaining and Whitchurch Community Hospital which the Trust stopped being the lessor for during the financial year.

Note 5.1 Operating lease income

	2025/26	2024/25
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	186	186
Variable lease receipts / contingent rents	0	0
Total in-year operating lease income	**186**	**186**

Note 5.2 Future lease receipts

	31 March 2026	31 March 2025
	£000	£000
Future minimum lease receipts due in:		
- not later than one year	171	169
- later than one year and not later than two years	52	52
- later than two years and not later than three years	52	52
- later than three years and not later than four years	52	52
- later than four years and not later than five years	52	52
- later than five years	3,849	3,901
Total	**4,228**	**4,278**

Note 6.1 Operating expenses

	2025/26	2024/25
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	5,072	5,265
Purchase of healthcare from non-NHS and non-DHSC bodies	505	1,013
Staff and executive directors costs	97,307	93,302
Remuneration of non-executive directors	108	124
Supplies and services - clinical (excluding drugs costs)	6,843	6,461
Supplies and services - general	888	920
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	1,497	1,456
Consultancy costs	0	0
Establishment	3,057	3,021
Premises	9,101	9,850
Depreciation on property, plant and equipment	4,706	4,455
Amortisation on intangible assets	3	6
Net impairments	638	308
Movement in credit loss allowance: contract receivables / contract assets	13	16
Increase/(decrease) in other provisions	(485)	839
Fees payable to the external auditor		
audit services- statutory audit*	216	137
Internal audit costs	65	69
Clinical negligence	380	326
Legal fees	66	132
Insurance (as a policy holder)	123	107
Research and development	99	108
Education and training	737	797
Expenditure on short term leases	30	41
Redundancy	175	66
Car parking & security	127	118
Hospitality	26	5
Losses, ex gratia & special payments	13	10
Other services, eg external payroll	569	492
Other	852	910
Total	**132,731**	**130,354**
Of which:		
Related to continuing operations	132,731	130,354

An additional analysis of significant items of expenditure included in 'Other' in 2025/26 totalling £852k (24/25 £910k): Ministry of Justice Bed watch & Escort Scheme £486k (24/25 £473k), Care Quality Commission Subscription £64k (24/25 £63k), Other Subscription £53k (24/25 £86k) , Mayfair Centre Revenue Grant £64k (24/25 £62k), Office / Building Removals £24k (24/25 £13k), Disclosure and Barring £11k (24/25 £21k).

*The fees payable to the external auditor in 2025/26 of £216k include:

£180k for the 2025/26 Statutory Audit Fees and
£36k for non-recoverable VAT

Note 6.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1,000k (2024/25: £1,000k).

Note 7 Impairment of assets

	2025/26	2024/25
	£000	£000
Net impairments charged to operating surplus resulting from:		
Changes in market price	638	308
Other	0	0
Total net impairments charged to operating surplus	**638**	**308**
Impairments charged to the revaluation reserve	1,603	(276)
Total net impairments	**2,241**	**32**

Total impairments of £2,241k arise from a reduction in the valuation of land and buildings following a full revaluation undertaken by the Trust's new valuers, Cushman & Wakefield, as at 31 March 2026. This resulted in valuation decreases across several sites, primarily the Trust's community hospitals: Bridgnorth Hospital £754k, Whitchurch Hospital £496k and Bishops Castle Hospital £289k. In addition, the valuation of the Trust's IFRS 16 peppercorn leases gave rise to an impairment of £378k.

The £638k charge relates to revaluation adjustments on building works and peppercorn leases that were not covered by the revaluation reserve or by reversals of impairments previously recognised in income and expenditure.

Note 8 Employee benefits

	2025/26 Total £000	2024/25 Total £000
Salaries and wages	70,668	67,555
Social security costs	8,468	6,199
Apprenticeship levy	325	312
Employer's contributions to NHS pensions	14,989	14,369
Pension cost - other	20	24
Temporary staff (including agency)	3,012	4,909
Total gross staff costs	**97,482**	**93,368**
Recoveries in respect of seconded staff	0	0
Total staff costs	**97,482**	**93,368**
Of which		
Costs capitalised as part of assets	0	0

Note 8.1 Retirements due to ill-health

During 2025/26 there were 3 early retirements from the trust agreed on the grounds of ill-health (4 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £261k (£176k in 2024/25).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

Note 10 Finance income

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

	2025/26	2024/25
	£000	£000
Interest on bank accounts	1,384	1,439
Total finance income	**1,384**	**1,439**

Note 11 Finance expenditure

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

	2025/26	2024/25
	£000	£000
Interest expense:		
Interest on lease obligations	308	316
Total finance costs	**308**	**316**

Note 12 Other gains / (losses)

	2025/26	2024/25
	£000	£000
Losses on disposal of assets	(172)	(7)
Total gains / (losses) on disposal of assets	**(172)**	**(7)**
Other gains / (losses)	0	0
Total other gains / (losses)	**(172)**	**(7)**

Note 13.1 Intangible assets - 2025/26

	Software licences	Other (purchased)	Total
	£000	£000	£000
Cost at 1 April 2025 - brought forward	**75**	**17**	**92**
Additions	0	0	**0**
Reclassifications	0	0	**0**
Disposals / derecognition	0	0	**0**
Cost at 31 March 2026	**75**	**17**	**92**
Amortisation at 1 April 2025 - brought forward	**69**	**17**	**86**
Provided during the year	3	0	**3**
Impairments	0	0	**0**
Reversals of impairments	0	0	**0**
Reclassifications	0	0	**0**
Disposals / derecognition	0	0	**0**
Amortisation at 31 March 2026	**72**	**17**	**89**
Net book value at 31 March 2026	**3**	**0**	**3**
Net book value at 1 April 2025	**6**	**0**	**6**

Note 13.2 Intangible assets - 2024/25

	Software licences	Other (purchased)	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2024 - as previously stated	**95**	**17**	**112**
Additions	0	0	**0**
Impairments	0	0	**0**
Reversals of impairments	0	0	**0**
Revaluations	0	0	**0**
Reclassifications	0	0	**0**
Disposals / derecognition	(20)	0	**(20)**
Valuation / gross cost at 31 March 2025	**75**	**17**	**92**
Amortisation at 1 April 2024 - as previously stated	**87**	**13**	**100**
Provided during the year	2	4	**6**
Impairments	0	0	**0**
Reversals of impairments	0	0	**0**
Revaluations	0	0	**0**
Reclassifications	0	0	**0**
Disposals / derecognition	(20)	0	**(20)**
Amortisation at 31 March 2025	**69**	**17**	**86**
Net book value at 31 March 2025	**6**	**0**	**6**
Net book value at 1 April 2024	**8**	**4**	**12**

Note 14.1 Property, plant and equipment - 2025/26

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2025 - brought forward	**4,355**	**21,734**	**344**	**2,877**	**5,958**	**22**	**35,290**
Additions	0	2,175	724	442	453	0	**3,794**
Impairments	(5)	(2,343)	0	0	0	0	**(2,348)**
Reversals of impairments	7	768	0	0	0	0	**775**
Revaluations	21	1,228	0	0	0	0	**1,249**
Reclassifications	0	568	(568)	0	0	0	**0**
Disposals / derecognition	0	(257)	0	(413)	(547)	(6)	**(1,223)**
Valuation/gross cost at 31 March 2026	**4,378**	**23,873**	**500**	**2,906**	**5,864**	**16**	**37,537**
Accumulated depreciation at 1 April 2025 - brought forward	**0**	**264**	**0**	**2,038**	**2,923**	**22**	**5,247**
Provided during the year	0	992	0	182	1,211	0	**2,385**
Impairments	2	392	0	0	0	0	**394**
Reversals of impairments	(2)	(103)	0	0	0	0	**(105)**
Revaluations	0	(1,246)	0	0	0	0	**(1,246)**
Reclassifications	0	0	0	0	0	0	**0**
Disposals / derecognition	0	(116)	0	(380)	(547)	(6)	**(1,049)**
Accumulated depreciation at 31 March 2026	**0**	**183**	**0**	**1,840**	**3,587**	**16**	**5,626**
Net book value at 31 March 2026	**4,378**	**23,690**	**500**	**1,066**	**2,277**	**0**	**31,911**
Net book value at 1 April 2025	**4,355**	**21,470**	**344**	**839**	**3,035**	**0**	**30,043**

Although a full revaluation of Land and Buildings occurred in 2025/26 the accumulated depreciation was not fully reversed as a small number of buildings were not part of the revaluation and were indexed.

Note 14.2 Property, plant and equipment - 2024/25

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - as previously stated	**4,344**	**21,296**	**596**	**3,009**	**4,780**	**22**	**34,047**
Additions	0	488	253	26	1,508	0	**2,275**
Impairments	(7)	(88)	0	0	0	0	**(95)**
Reversals of impairments	18	351	0	0	0	0	**369**
Revaluations	0	(818)	0	2	0	0	**(816)**
Reclassifications	0	505	(505)	0	0	0	**0**
Disposals / derecognition	0	0	0	(160)	(330)	0	**(490)**
Valuation/gross cost at 31 March 2025	**4,355**	**21,734**	**344**	**2,877**	**5,958**	**22**	**35,290**
Accumulated depreciation at 1 April 2024 - as previously stated	**0**	**208**	**0**	**2,012**	**2,343**	**21**	**4,584**
Provided during the year	0	962	0	184	905	1	**2,052**
Impairments	0	383	0	0	0	0	**383**
Reversals of impairments	0	(63)	0	0	0	0	**(63)**
Revaluations	0	(1,226)	0	0	0	0	**(1,226)**
Reclassifications	0	0	0	0	0	0	**0**
Disposals / derecognition	0	0	0	(158)	(325)	0	**(483)**
Accumulated depreciation at 31 March 2025	**0**	**264**	**0**	**2,038**	**2,923**	**22**	**5,247**
Net book value at 31 March 2025	**4,355**	**21,470**	**344**	**839**	**3,035**	**0**	**30,043**
Net book value at 1 April 2024	**4,344**	**21,088**	**596**	**997**	**2,437**	**1**	**29,463**

Note 14.3 Property, plant and equipment financing - 31 March 2026

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	4,378	23,135	500	816	0	2,277	0	**31,106**
Owned - donated/granted	0	555	0	250	0	0	0	**805**
Total net book value at 31 March 2026	**4,378**	**23,690**	**500**	**1,066**	**0**	**2,277**	**0**	**31,911**

Note 14.4 Property, plant and equipment financing - 31 March 2025

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	4,355	20,833	344	492	0	3,035	0	**29,059**
Owned - donated/granted	0	637	0	347	0	0	0	**984**
Total net book value at 31 March 2025	**4,355**	**21,470**	**344**	**839**	**0**	**3,035**	**0**	**30,043**

Note 14.5 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2026

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	362	899	0	0	0	0	0	**1,261**
Not subject to an operating lease	4,016	22,791	500	1,066	0	2,277	0	**30,650**
Total net book value at 31 March 2026	**4,378**	**23,690**	**500**	**1,066**	**0**	**2,277**	**0**	**31,911**

Note 14.6 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2025

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	362	1,025	0	0	0	0	0	**1,387**
Not subject to an operating lease	3,993	20,445	344	839	0	3,035	0	**28,656**
Total net book value at 31 March 2025	**4,355**	**21,470**	**344**	**839**	**0**	**3,035**	**0**	**30,043**

Note 15 Donations of property, plant and equipment

In 2025/26 the Trust received £7k of cash donations to purchase plant and equipment from the League of Friends (LoF).In 2024/25 the Trust received £11k from the League of Friends.

Note 16 Revaluations of property, plant and equipment

The Trust employed new valuers Cushman and Wakefield so the 5 yearly full land and buildings revaluation took place in this year with an effective date of 31st March 2026. The next full revaluation is due on the 31st March 2031.

The full valuation exercise included valuations for Land and Buildings. This included a revision to the useful lives of the Buildings.

Of the £25.251m net book value of land and buildings held for operational use that was subject to valuation by the Valuer, £3.138m relates to land and £20.663m relates to buildings that have been valued on a depreciated replacement cost basis. Here the valuer bases their assessment on the cost to the Trust of replacing the service potential of the assets. £1.217m of land and £0.233m of buildings were valued at Existing Use Value (EUV).

BCIS indices, provided to the Trust by Cushman and Wakefield were used to reflect changes in value of other building assets with the Net Book Value of £0.103m and that are over a year old increasing the Net Book value to £0.106m.

The Building assets the valuer was not made aware of, have not been revalued with most assets procured in the last quarter of 2025/26. The net book value of these assets is £2.580k with £0.500m relating to assets under construction.

PPE Revaluation

Land and buildings revaluation amounted to an increase of £633k. The value of land increased by £23k and buildings increased by £610k an increase of £607k in relation to the full valuation by Cushman and Wakefield and £3k for buildings indexed using BCIS indices. Revaluation values overall increased by 0.5% for Land, 2.9% for buildings and 2.8% for buildings that were indexed using the BCIS indices.

Indexation to equipment assets is only applied to assets with a net book value of £30k or over and an economic life of greater than 10 years, the Trust has no assets that meet this criteria in 2025/26 so no indexation was applied to any equipment assets.

Peppercorn Lease Revaluation

Peppercorn Leases for Land and Building were also revalued as at the 31.03.2026 and this decreased the valuation by £378k, of which £197k was for land and £181k for buildings.

See the table below for the revaluation movements and the Statement of Changes in Taxpayers Equity and Note 7 Impairment of assets

	Revaluation charged to the Revaluation Reserve £000	Impairments and Reversal of impairments charged to the Revaluation Reserve £000	Impairments and Reversal of impairments charged to I&E £000	Total £000
PPE Revaluation	2,495	(1,573)	(289)	**633**
Peppercorn Lease Revaluation	0	(30)	(349)	**(378)**
	2,495	**(1,603)**	**(638)**	**255**

The gross carrying amount of fully depreciated assets still in use was £2.5m.

Note 17 Leases - Shropshire Community Health NHS Trust as a lessee

This note details information about leases for which the Trust is a lessee.

The majority of the leases the Trust has as a lessee, are for buildings. These are for both fixed rental agreements which are not dependant on an index or rate and Peppercorn lease agreements where no rent is paid.

The Trust has equipment leases mainly for pool cars and vans

The Trust also has a number of Peppercorn leases for land and for buildings

Note 17.1 Right of use assets - 2025/26

	Property (land and buildings)	Plant & machinery	Transport equipment	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2025 - brought forward	**17,039**	**4**	**230**	**17,273**	**9,630**
Additions	674	0	16	**690**	112
Remeasurements of the lease liability	748	0	0	**748**	45
Movements in provisions for restoration / removal costs	19	0	0	**19**	8
Impairments	(30)	0	0	**(30)**	0
Revaluations	(404)	0	0	**(404)**	0
Disposals / derecognition	(826)	0	(30)	**(856)**	(204)
Valuation/gross cost at 31 March 2026	**17,220**	**4**	**216**	**17,440**	**9,591**
Accumulated depreciation at 1 April 2025 - brought forward	**4,346**	**2**	**97**	**4,445**	**2,711**
Provided during the year	2,245	1	75	**2,321**	1,176
Impairments	349	0	0	**349**	0
Revaluations	(404)	0	0	**(404)**	0
Disposals / derecognition	(733)	0	(30)	**(763)**	(130)
Accumulated depreciation at 31 March 2026	**5,803**	**3**	**142**	**5,948**	**3,757**
Net book value at 31 March 2026	**11,417**	**1**	**74**	**11,492**	**5,834**
Net book value at 1 April 2025	**12,693**	**2**	**133**	**12,828**	**6,919**

Net book value of right of use assets leased from other NHS providers	769
Net book value of right of use assets leased from other DHSC group bodies	5,065

Note 17.2 Right of use assets - 2024/25

	Property (land and buildings)	Plant & machinery	Transport equipment	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**13,240**	**3**	**92**	**13,335**	**7,926**
Additions	3,715	0	146	**3,861**	1,689
Remeasurements of the lease liability	94	0	0	**94**	95
Movements in provisions for restoration / removal costs	94	0	0	**94**	2
Impairments	(1)	0	0	**(1)**	0
Reversal of impairments	3	0	0	**3**	0
Revaluations	(21)	0	0	**(21)**	0
Reclassifications	(3)	1	2	**0**	0
Disposals / derecognition	(82)	0	(10)	**(92)**	(82)
Valuation/gross cost at 31 March 2025	**17,039**	**4**	**230**	**17,273**	**9,630**
Accumulated depreciation at 1 April 2024 - brought forward	2,121	1	34	**2,156**	1,561
Provided during the year	2,328	1	74	**2,403**	1,199
Impairments	0	0	0	**0**	0
Reversal of impairments	(12)	0	0	**(12)**	0
Revaluations	(43)	0	0	**(43)**	0
Reclassifications	1	0	(1)	**0**	0
Disposals / derecognition	(49)	0	(10)	**(59)**	(49)
Accumulated depreciation at 31 March 2025	**4,346**	**2**	**97**	**4,445**	**2,711**
Net book value at 31 March 2025	**12,693**	**2**	**133**	**12,828**	**6,919**
Net book value at 1 April 2024	**11,119**	**2**	**58**	**11,179**	**6,365**

Net book value of right of use assets leased from other NHS providers	719
Net book value of right of use assets leased from other DHSC group bodies	6,200

Note 17.3 Revaluations of right of use assets

The Trust has 7 peppercorn leases, 6 for Land and 1 for a building. The buildings on the land leases are valued in PPE as tenant improvements see note 16.

With peppercorn leases the cost model is not an appropriate proxy for current value in existing use. In these cases the Trust has used the revaluation model under IFRS 16 to establish a valuation. Cushman and Wakefield valued these leases at 31st March 2026 (£683k). The land leases decreased by £197k and the building lease decreased by £181k.

Note 17.4 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 22.1.

	2025/26	2024/25
	£000	£000
Carrying value at 1 April	**11,770**	**9,870**
Lease additions	668	3,651
Lease liability remeasurements	748	94
Interest charge arising in year	308	316
Early terminations	(87)	(33)
Lease payments (cash outflows)	(2,326)	(2,128)
Other changes	0	0
Carrying value at 31 March	**11,081**	**11,770**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 6.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Income generated from subleasing right of use assets is £0k and is included within revenue from operating leases in note 4.

Note 17.5 Maturity analysis of future lease payments

	Total 31 March 2026 £000	Of which leased from DHSC group bodies: 31 March 2026 £000	Total 31 March 2025 £000	Of which leased from DHSC group bodies: 31 March 2025 £000
Undiscounted future lease payments payable in:				
- not later than one year;	2,305	1,250	2,301	1,257
- later than one year and not later than five years;	7,224	4,067	7,483	4,451
- later than five years.	2,624	885	2,941	1,642
Total gross future lease payments	**12,153**	**6,202**	**12,725**	**7,350**
Finance charges allocated to future periods	(1,072)	(235)	(955)	(326)
Net lease liabilities at 31 March 2026	**11,081**	**5,967**	**11,770**	**7,024**
Of which:				
Leased from other NHS providers		779		727
Leased from other DHSC group bodies		5,188		6,297

Note 18 Inventories

	31 March 2026	31 March 2025
	£000	£000
Consumables	139	205
Other	0	0
Total inventories	**139**	**205**
of which:		
Held at fair value less costs to sell	0	0

Inventories recognised in expenses for the year were £1,428k (2024/25: £1,089k). Write-down of inventories recognised as expenses for the year were £0k (2024/25: £0k).

Note 19.1 Receivables

	31 March 2026 £000	31 March 2025 £000
Current		
Contract receivables	2,434	1,635
Allowance for impaired contract receivables / assets	(39)	(35)
Prepayments (non-PFI)	837	659
Interest receivable	109	124
PDC dividend receivable	30	262
VAT receivable	64	84
Other receivables	146	137
Total current receivables	**3,581**	**2,866**
Non-current		
Allowance for impaired contract receivables / assets	(35)	(28)
Prepayments (non-PFI)	37	10
Other receivables	263	220
Total non-current receivables	**265**	**202**
Of which receivable from NHS and DHSC group bodies:		
Current	1,874	1,119
Non-current	121	108

The increase in Contract receivables is due to additional funding from Shropshire, Telford and Wrekin ICB confirmed in March

Note 19.2 Allowances for credit losses

	2025/26		2024/25	
	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	**63**	**0**	**50**	**0**
New allowances arising	13	0	16	0
Changes in existing allowances	1	0	1	0
Reversals of allowances	(1)	0	(1)	0
Utilisation of allowances (write offs)	(2)	0	(3)	0
Allowances as at 31 Mar 2026	**74**	**0**	**63**	**0**

The credit losses in 2025/26 also include an allowance of £71k for unsuccessful compensation claims in relation to the NHS injury cost recovery scheme.

Note 19.3 Exposure to credit risk

Credit loss provision - Non NHS contract receivables	Gross Amount	Lifetime Expected Loss Allowance
	£'000	£'000
Days past invoice date		
0-30 days	526	0
31-60 days	8	0
61-90 days	20	0
Over 90 days	64	2
Total	**618**	**2**

Note 20 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.

	2025/26	2024/25
	£000	£000
At 1 April	**27,074**	**19,839**
Net change in year	2,090	7,235
At 31 March	**29,164**	**27,074**
Broken down into:		
Cash at commercial banks and in hand	7	4
Cash with the Government Banking Service	29,157	27,070
Total cash and cash equivalents as in SoFP	**29,164**	**27,074**
Total cash and cash equivalents as in SoCF	**29,164**	**27,074**

Note 21 Trade and other payables

	31 March 2026 £000	31 March 2025 £000
Current		
Trade payables	2,872	3,391
Capital payables	923	1,255
Accruals	4,918	3,495
Receipts in advance and payments on account	1,184	934
Social security costs	1,011	835
Other taxes payable	720	694
Pension contributions payable	1,195	1,170
Other payables	59	115
Total current trade and other payables	**12,882**	**11,889**
Of which payables from NHS and DHSC group bodies:		
Current	4,467	4,031
Non-current	0	0

The increase in accruals of £1.4m from 2024/25 primarily relates to an increase in NHS Accruals and the settlement of the CSW banding review.

Note 22.1 Borrowings

	31 March 2026 £000	31 March 2025 £000
Current		
Lease liabilities	2,027	2,030
Total current borrowings	**2,027**	**2,030**
Non-current		
Lease liabilities	9,054	9,740
Total non-current borrowings	**9,054**	**9,740**

Note 22.2 Reconciliation of liabilities arising from financing activities

	Lease Liabilities	Total
	£000	£000
Carrying value at 1 April 2025	**11,770**	**11,770**
Cash movements:		
Financing cash flows - payments and receipts of principal	(2,018)	**(2,018)**
Financing cash flows - payments of interest	(308)	**(308)**
Non-cash movements:		
Additions	668	**668**
Lease liability remeasurements	748	**748**
Application of effective interest rate	308	**308**
Early terminations	(87)	**(87)**
Other changes	0	**0**
Carrying value at 31 March 2026	**11,081**	**11,081**

	Lease Liabilities	Total
	£000	£000
Carrying value at 1 April 2024	**9,870**	**9,870**
Cash movements:		
Financing cash flows - payments and receipts of principal	(1,812)	**(1,812)**
Financing cash flows - payments of interest	(316)	**(316)**
Non-cash movements:		
Additions	3,651	**3,651**
Lease liability remeasurements	94	**94**
Application of effective interest rate	316	**316**
Early terminations	(33)	**(33)**
Other changes	0	**0**
Carrying value at 31 March 2025	**11,770**	**11,770**

Note 23.1 Provisions for liabilities and charges analysis

	Legal claims	Other	Total
	£000	£000	£000
At 1 April 2025	**15**	**3,966**	**3,981**
Change in the discount rate	0	(9)	**(9)**
Arising during the year	5	671	**676**
Utilised during the year	0	(1,056)	**(1,056)**
Reversed unused	0	(1,130)	**(1,130)**
Unwinding of discount	0	8	**8**
At 31 March 2026	**20**	**2,450**	**2,470**
Expected timing of cash flows:			
- not later than one year;	20	1,402	**1,422**
- later than one year and not later than five years;	0	316	**316**
- later than five years.	0	732	**732**
Total	**20**	**2,450**	**2,470**

Claims

The provision in Other (£2,450k) relates to 4 provisions:

1) £1,029k relates to dilapidation provisions for leased properties.

2) £664k is the estimated probable impact of various pay reviews.

3) £636k is the estimated probable impact of service reviews

4) A £121k provision relating to the 2019/20 clinicians' pensions scheme and this is the Trusts estimated liability as at 31 March 2026 provided by NHS England.

Note 23.2 Provisions for liabilities and charges analysis 2024/25

	Legal claims	Other	Total
	£000	£000	£000
At 1 April 2024	**15**	**3,063**	**3,078**
Change in the discount rate	0	(1)	**(1)**
Arising during the year	0	934	**934**
Utilised during the year	0	(35)	**(35)**
Unwinding of discount	0	5	**5**
At 31 March 2025	**15**	**3,966**	**3,981**
Expected timing of cash flows:			
- not later than one year;	15	3,211	**3,226**
- later than one year and not later than five years;	0	421	**421**
- later than five years.	0	334	**334**
Total	**15**	**3,966**	**3,981**

Claims

The provision in Other (£3,966k) relates to 4 provisions:

1) £1,586k relates to dilapidation provisions for leased properties.

2) £1,453k is the estimated probable impact of various pay reviews.

3) £817k is the estimated probable impact of service reviews

4) A £110k provision relating to the 2019/20 clinicians' pensions scheme and this is the Trusts estimated liability as at 31 March 2025 provided by NHS England.

Note 23.3 Clinical negligence liabilities

At 31 March 2026, £1,240k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Shropshire Community Health NHS Trust (31 March 2025: £872k).

Note 24 Contractual capital commitments

	31 March 2026 £000	31 March 2025 £000
Property, plant and equipment	328	789
Intangible assets	0	0
Total	**328**	**789**

Note 25 Financial instruments

Note 25.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with commissioners and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

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

Since the financial instruments are all short term in nature, the Trust considers that the carrying amounts disclosed are a reasonable approximation of fair value and no further estimate of fair value is reported.

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

Currently the Trust has no loans with the only borrowings for Lease Liabilities. However, it could borrow from the government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings would be 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 a very 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 2026 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 organisations, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Note 25.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2026	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	2,757	**2,757**
Other investments / financial assets	0	**0**
Cash and cash equivalents	29,164	**29,164**
Total at 31 March 2026	**31,921**	**31,921**

Carrying values of financial assets as at 31 March 2025	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	1,943	**1,943**
Other investments / financial assets	0	**0**
Cash and cash equivalents	27,074	**27,074**
Total at 31 March 2025	**29,017**	**29,017**

Note 25.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2026	Held at amortised cost	Total book value
	£000	£000
Obligations under leases	11,081	**11,081**
Trade and other payables excluding non financial liabilities	8,508	**8,508**
Provisions under contract	2,470	**2,470**
Total at 31 March 2026	**22,059**	**22,059**

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost	Total book value
	£000	£000
Obligations under leases	11,770	**11,770**
Trade and other payables excluding non financial liabilities	8,015	**8,015**
Provisions under contract	3,981	**3,981**
Total at 31 March 2025	**23,766**	**23,766**

The amortised value of the liabilities is a reasonable approximation of the fair value

Note 25.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2026 £000	31 March 2025 £000
In one year or less	12,235	13,607
In more than one year but not more than five years	7,540	7,839
In more than five years	3,356	3,275
Total	**23,131**	**24,721**

Note 26 Losses and special payments

	2025/26		2024/25	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	0	0	1	0
Bad debts and claims abandoned	140	2	181	3
Stores losses and damage to property	1	9	0	0
Total losses	**141**	**11**	**182**	**3**
Special payments				
Ex-gratia payments	2	4	5	10
Special severance payments	1	35	0	0
Total special payments	**3**	**39**	**5**	**10**
Total losses and special payments	**144**	**50**	**187**	**13**
Compensation payments received				

The vast majority of abandoned bad debt relates to prescription charges at the Trusts Minor Injury Units with 136 cases at a cost of £1k.

Note 27 Related parties

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

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

Health Education England
Midlands Partnership NHS Foundation Trust
NHS England
NHS Pension Scheme
NHS Property Services
Community Health Partnerships
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
The Shrewsbury & Telford Hospitals NHS Trust
Shropshire, Telford & Wrekin ICB
HM Revenue and Customs

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Shropshire Council, Telford & Wrekin Council and Dudley Council.

The Trust has also received revenue payments from charitable funds, the trustees for which are also members of the Trust board by way of corporate trustee. The charitable funds are not consolidated into the Trust accounts as there is a separate annual accounts and annual report for the charity.

Note 28 Events after the reporting date

Shropshire Community Health NHS Trust and The Shrewsbury and Telford Hospitals NHS Trust agreed to establish a Group between the organisations in September 2025.The Group was established on the 1st of April 2026 with a shared Board and each Trust remaining a separate statutory organisation, with separate reporting. This will only impact the "Staff and executive directors costs" and the "Remuneration of non-executive directors" in the Financial Statements.

Note 29 Better Payment Practice code

	2025/26 Number	2025/26 £000	2024/25 Number	2024/25 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	19,993	25,409	23,510	24,945
Total non-NHS trade invoices paid within target	19,256	24,925	23,004	24,561
Percentage of non-NHS trade invoices paid within target	96.3%	98.1%	97.8%	98.5%
NHS Payables				
Total NHS trade invoices paid in the year	960	17,509	862	16,904
Total NHS trade invoices paid within target	924	17,074	830	16,371
Percentage of NHS trade invoices paid within target	96.3%	97.5%	96.3%	96.8%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed.

Note 30 Capital Resource Limit

	2025/26 £000	2024/25 £000
Gross capital expenditure	5,232	6,230
Less: Disposals	(267)	(40)
Less: Donated and granted capital additions	(7)	(11)
Plus: Loss on disposal from capital grants in kind and peppercorn lease disposals	0	0
Charge against Capital Resource Limit	**4,958**	**6,179**
Capital Resource Limit	4,958	6,179
Under / (over) spend against CRL	**0**	**0**

Note 31 Adjusted financial performance

	2025/26 £000	2024/25 £000
Surplus for the period per SOCI	3,124	3,128
Remove net impairments not scoring to the departmental expenditure limit	638	308
Remove I&E impact of capital grants and donations	148	136
Adjusted financial performance surplus	**3,910**	**3,572**

Note 32 Breakeven duty financial performance

	2025/26 £000
Adjusted financial performance surplus	3,910
Remove impairments scoring to Departmental Expenditure Limit	0
Add back non-cash element of On-SoFP pension scheme charges	0
IFRIC 12 breakeven adjustment	0
Breakeven duty financial performance surplus	**3,910**

Note 33 Breakeven duty rolling assessment

	1997/98 to 2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		0	0	1,397	1,496	234	352	1,355	2,596
Breakeven duty cumulative position	0	0	0	1,397	2,893	3,127	3,479	4,834	7,430
Operating income		0	0	80,802	79,679	76,105	75,286	78,940	79,377
Cumulative breakeven position as a percentage of operating income		0.0%	0.0%	1.7%	3.6%	4.1%	4.6%	6.1%	9.4%

	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	2,758	2,492	971	244	2,761	1,092	224	3,572	3,910
Breakeven duty cumulative position	10,188	12,680	13,651	13,895	16,656	17,748	17,972	21,544	25,454
Operating income	77,861	80,942	88,443	96,552	99,620	105,480	112,057	132,774	135,328
Cumulative breakeven position as a percentage of operating income	13.1%	15.7%	15.4%	14.4%	16.7%	16.8%	16.0%	16.2%	18.8%