NHS
The Shrewsbury and Telford Hospital
NHS Trust

Annual Report
2025/26

Moving to
EXCELLENCE

Shrewsbury and Telford Hospital 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

Contents

Page

Foreword from the Chair and Chief Executive 4

Part 1: Performance Report

- Performance Overview 7
- Statement from the Chief Executive 8
- Performance Analysis 22

Part 2: Accountability Report

- Corporate Governance Report 60
- Remuneration Report 83
- Staff Report 95
- Annual Governance Statement 108
- Statement of Accountable Officer's Responsibilities 133
- Statement of Directors' Responsibilities 134

Part 3: Annual Audited Accounts

- External Auditor's Opinion 2025/26 135
- Annual Audited Accounts 2025/26 140

Foreword from the Group Chair and Group Chief Executive

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.

2025/26 also signals a new era for The Shrewsbury and Telford Hospital NHS Trust (SaTH) as we reached new milestones in our improvement journey. We will continue to move forwards, respecting our past; continually listening, learning and improving.

The Trust exited special measures in early 2026, after seven years. It follows a review by NHS England (NHSE), which recognised the Trust has delivered significant, sustained and demonstrable improvements including in finance, performance and governance. We know that we have much more still to do, particularly in urgent and emergency care, but we are making tangible progress and are pleased this has been recognised by NHSE and partners.

In September, SaTH was awarded University status, which will foster the delivery of high quality care and attract further research and investment, creating an engaging environment for both academic and clinical advancement. As a university trust we will build on our ambition to deliver modern and transformative, evidence-based care for our patients and communities, who are at the heart of all we do.

We continue to be inspired by 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.

Through colleagues' hard work and determination, we have made significant progress in improving quality, productivity and performance that is leading to reduced waiting times. We are the most improved Trust nationally for elective care, and among the top trusts for the cancer 28-day Faster Diagnosis Standard. We are amongst the most improved Trusts in the country against the 62-day cancer referral to treatment times and have delivered our strongest performance in diagnostics for over five years. Thanks to these phenomenal improvements we are rapidly rising through NHS England's National Oversight Framework. We were among the lowest trusts in segment five and are now in segment three, 78th out of 134 trusts. We will keep going!

We are clear that it is not targets or statistics that drive our ambition, but our patients and colleagues who are waiting longer than we would want for treatment. We want everyone to have excellent care and colleagues to have the best work experience.

We continue to make strong progress in our Maternity Services and are determined to deliver safe, effective and high-quality services to women and families. We are grateful for the support of Donna Ockenden who is helping us connect and build trust with families. We are also grateful

to the families who are meeting with us to share their experiences and will continue to offer regular meetings to listen and learn.

We are honoured to be working with Katie Russell to be the first Trust to embed Poppy's Promise during 2026/27. The initiative was founded by Katie Russell, following the avoidable loss of her daughter Poppy, who tragically died at just twelve hours old due to failures in our care and communication. Poppy's Promise is a five-stage framework that supports colleagues to provide compassionate, consistent and patient-centred care. It aims to create a culture where empathy and communication are prioritised. We are fully committed to embedding this promise at every level of our Trust. We want to ensure that no patient or family ever feels unseen, unheard or uncared for.

We remain humble, as we have much more to do, especially in urgent and emergency care; to deliver the care we would want first time, every time. During Winter 2025, working with Shropshire Community Health NHS Trust (SCHT) and other partners, we invested multi-million pounds in projects to accelerate progress. This included the expansion of our acute medical and same day emergency care capacity at Princess Royal Hospital (PRH) and opening 56 new acute inpatient beds at Royal Shrewsbury Hospital (RSH), supported by an enhanced community offer.

We are showing statistically significant improvements in the 12-hour, 4 hour and ambulance performance, and the platform of improvements delivered in 2025/26 mean we start 2026/27 with our best performance since 2022. This trend is set to continue and our mission is to go further, and faster in our progress. 2026/27 will see further investment through phase two of our acute and phase three of our community urgent and emergency care transformation. Our ambition is to be among the best trusts in the country to receive care, and this includes urgent and emergency care.

The scale of transformation and improvement happening across the Trust is incredible. It is visible through the construction of our Hospitals Transformation Programme (HTP) £312m new building and bigger Emergency Department at RSH. This vast construction project remains on track to open in 2028. This programme is more than a new building; it fundamentally redesigns the way we will deliver care. In parallel, we are accelerating our focus on neighbourhood working to have the right services in our communities to enable two thriving hospitals.

There are many smaller, but significant improvements taking place throughout the Trust that also deserve recognition and celebration. We continue to invest in our digital evolution, with many teams trialling Artificial Intelligence and automated technology. We spent £46m (excluding HTP) on improving our estates in 2025/26, including working to remove Reinforced Autoclaved Aerated Concrete at PRH and breaking ground on a £16.2m decarbonisation project. With the support of partners, we launched a bereavement room at RSH to provide a calm, comfortable and safe space for staff dealing with bereavement. We also continue to improve our support to people who have learning disabilities and autism.

For the first time in 10 years, SaTH has delivered its financial plan. This is a significant achievement and a reflection of the hard work, discipline, and determination of our teams. Thanks to their efforts we delivered £41.5m in efficiencies – the highest level to date and more than double that achieved in 2023/24. Importantly, we maintained our focus on adding value for patients and this remains our priority. 2026/27 will be another year of tough decisions, as we commit to deliver a planned deficit of £30.5m (before Deficit Support Funding) and £40m of efficiencies. Our medium-term plan sets an ambitious programme of improvement and investment, which will lead the Trust to financial balance by 2029/30.

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, who work tirelessly to improve the experience of our patients.

On 1 April 2026 we formalised our Group with SCHT. This builds 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 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, 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.

Andrew Morgan
Group Chair
22 June 2026

Jo Williams
Group Chief Executive

Part one:
Performance Report

Performance Overview

This section of our report provides detail as to what it is that we do here at SaTH, who we are, and our values and ambitions. It outlines the principal risks that the Trust faces in the delivery of our strategy and objectives and provides some details on how we performed over the financial year, 1 April 2025 to 31 March 2026.

Statement from the Chief Executive

During 2025/26, the Trust has continued to operate under sustained pressure across urgent and emergency care, elective services, cancer pathways and diagnostics. Despite these challenges, significant progress has been delivered through a focused programme of improvement, underpinned by our *Stronger Together* campaign and increasing system collaboration.

Demand across urgent and emergency care remained exceptionally high throughout the year, and performance against the 4-hour standard averaged 52.2%, below the national expectation. Ambulance handover delays and prolonged waits in the Emergency Department continued to impact patient experience and flow. However, the Trust has delivered meaningful improvement through the creation of additional bed capacity, redesign of the acute medical model, and strengthened front door processes. This has resulted in improved time to initial assessment, with the 15-minute standard achieved in the majority of months in the latter part of the year. Early improvements in ambulance handover performance and 12-hour waits provide cautious optimism as we enter 2026/27, although the Trust remains in Tier 1 oversight and recognises the scale of challenge ahead.

Elective recovery has been a key priority, and the Trust has delivered a strong improvement trajectory during the year. The overall RTT waiting list reduced significantly, with English pathways falling from over 41,000 patients to approximately 32,700 by year end, alongside a comparable reduction in Welsh pathways. Through increased utilisation of the Elective Hub, improvements in outpatient productivity, and targeted diagnostic investment, the Trust has stabilised performance and reduced long waits. Notably, SaTH was the most improved Trust in England for the 18-week RTT standard and achieved zero patients waiting over 52 weeks for treatment by year end. Whilst performance remains below the national standard, the progress delivered represents a significant step forward in improving timely access to care.

Cancer services have demonstrated sustained and statistically significant improvement across all standards. The Trust ended the year as the most improved organisation nationally for the Faster Diagnosis Standard, achieving 86% of patients receiving a diagnosis within 28 days and consistently delivering above the 80% national standard from September 2025 onwards. Performance against the 31-day standard remained strong, exceeding the 96% national standard, while the 62-day pathway improved to 74.5%. These improvements reflect strengthened clinical pathways, improved diagnostic turnaround times, and enhanced governance through the establishment of a Cancer Improvement Board. Whilst further progress is required to meet the 62-day standard, the trajectory is positive and supported by a clear improvement plan.

Diagnostic performance has also improved following a challenging prior year, with 86.4% of patients waiting less than six weeks by March 2026. Whilst this remains below the 99% standard,

recovery has been supported through targeted interventions and investment. Capacity constraints remain in key modalities, including ultrasound and cardio-respiratory diagnostics, and further expansion is planned to support continued improvement.

Overall, whilst the Trust has not yet met all national performance standards, there has been clear and measurable progress during 2025/26. Through our *Moving to Excellence* transformation programme and system-wide working, we are strengthening the foundations required to deliver sustainable improvement. We remain committed to improving access, reducing delays, and ensuring high-quality care for our patients.

About the Trust

The Shrewsbury and Telford Hospital NHS Trust was established in its present form on 1 October 2003 and serves a population of approximately 500,000 people across Shropshire, Telford and Wrekin, and mid-Wales. The Trust operates across its two main hospital sites - Royal Shrewsbury Hospital (RSH) and Princess Royal Hospital (PRH) - as well as a network of community locations, employing circa 8,000 staff.

The Trust provides a wide range of acute and community services, including emergency care, elective surgery, diagnostics, critical care and outpatient services, supported by over 800 beds across its sites. Services are organised across four clinical divisions and a corporate division, enabling clear accountability for performance, quality and delivery.

During 2025/26, the Trust has continued to invest in its infrastructure and service models to support recovery and improve patient access. A key milestone was the increased utilisation of the Elective Hub at the Princess Royal Hospital, which has played a central role in improving surgical productivity and reducing elective waiting lists. This has been complemented by an outpatient transformation programme and strengthened diagnostic pathways to support timely progression of care.

Significant progress has also been made in expanding capacity to support urgent and emergency care demand. During the year, 96 additional beds and assessment spaces were created across both hospital sites, supported by modular ward developments and targeted estate improvements. These changes alongside redesigned acute medical pathways and enhanced front door arrangements, have begun to improve patient flow and reduce delays.

The Trust continues to work closely with system partners to deliver integrated models of care. This includes expansion of the Care Transfer Hub, development of integrated front door teams, and extended urgent community response services, all aimed at meeting patients' needs in the most appropriate setting, and improving patient experience.

Governance and improvement arrangements have been strengthened during the year, including the establishment of a Cancer Improvement Board to drive sustained progress in cancer performance. Alongside this, the Trust launched its *Moving to Excellence* transformation programme in 2025/26, which provides a structured framework for delivering high-quality, sustainable improvement across all services.

Whilst the Trust continues to face significant operational challenges, particularly in urgent and emergency care, the investments made during the year, and the progress achieved in elective and cancer services, position the organisation on a clear trajectory of improvement.

During 2025/26, the Trust agreed to enter into a group arrangement with Shropshire Community Health NHS Trust, formally established from 1 April 2026, creating the *Shropshire, Telford and Wrekin Community and Hospitals NHS Group*. This represents a significant step forward in strengthening collaboration across acute and community services, supporting the delivery of more integrated, patient-centred care. Through the Group model, the organisations will work more closely to improve patient flow, reduce delays in discharge, and enhance access to care closer to home. This approach will enable more coordinated pathways across urgent and emergency care, community services, and elective recovery, supported by shared clinical leadership, aligned priorities and improved use of system resources.

During the year, the Trust also formally exited the NHS England Recovery Support Programme, having been part of the programme since November 2018. This reflects the sustained progress made in strengthening organisational governance, financial management, operational performance and leadership capability. While significant challenges remain across key performance areas, exiting the programme marks an important milestone in the Trust's improvement journey, recognising increased organisational maturity and enhanced ability to deliver sustained improvement.

Looking ahead, the new Group arrangement, alongside the Trust's *Moving to Excellence* transformation programme, provides a strong platform to deliver further improvements in performance, quality and productivity. Together, these will support more seamless care for patients across organisational boundaries and ensure the long-term sustainability of services across Shropshire, Telford and Wrekin.

Workforce

The Trust employs 8,025 colleagues who play a vital role in delivering high-quality patient care across our hospitals and community services. Our workforce is our greatest asset, and we are committed to fostering an environment where everyone feels welcomed, respected, and valued. We are dedicated to being an anti-racist organisation that actively confronts racism in all its

forms. This commitment is outlined in our anti-racism statement, which sits alongside our broader efforts to eliminate discrimination and promote equality.

The Trust is also committed to widening participation and creating employment opportunities for local people from all backgrounds. Working in partnership with schools, colleges, community organisations, and other stakeholders, the Trust supports a range of initiatives aimed at improving access to employment and career development opportunities. This includes initiatives such as an internship programme to help build the experience and independence of young people with autism or learning difficulties. Many former interns are now valued colleagues.

The Trust is committed to promoting equality, diversity and inclusion and routinely collects a wide range of workforce data to identify, monitor and address inequalities. This includes compliance with the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES). Performance and outcomes are transparently published on the Trust's website, as well as through statutory reporting to NHS England.

To further support inclusive leadership, the Trust continues with its well-established reverse mentoring programme and continues to develop the cultural competence of its managers and leaders, ensuring they are equipped to lead diverse teams with confidence, empathy and understanding.

The Trust also actively celebrates its diversity through a range of events, conferences and its vibrant staff networks. These networks play a vital role in fostering an inclusive and compassionate culture, sharing lived experiences, and enabling staff to offer challenge, insight and innovation that supports ongoing organisational improvement.

Over the past year, the Trust has continued to face significant disruption to planned services during periods of industrial action. Clinical and non-clinical teams worked tirelessly to ensure patient safety throughout these challenging periods.

The Trust plays an active role in clinical and scientific research and has now achieved University Status. In addition, the Trust collaborates with a wider range of academic institutions to support innovation, education, and research development.

The Care Quality Commission

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

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

Our current overall CQC ratings can be found below:

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

The Trust has continued to implement and embed improvement actions following the inspection. In November 2024 the Trust made a successful application to the CQC and three Section 31 conditions were removed from the Trust's registration. At the start of 2025/26, two conditions previously imposed by the CQC were remaining on the Trust's Provider Licence. Following a successful application to the CQC, one of these conditions was removed in December 2025 and ongoing actions have continued throughout the year to progress the removal of the remaining condition.

A CQC Inspection of our Emergency Departments and Medical Wards took place on the 3rd and 4th March 2026. Initial verbal feedback was positive in relation to the improvements observed, however, we have not yet received the final inspection report.

Further detail can be found within our 2025/26 Quality Account on our website and within the Annual Governance Statement of this annual report.

The Trust's Strategic Direction, Vision and Values

The Trust's vision and strategic direction is fully aligned to the overall Integrated Care System approach in collaboration with our partners across Shropshire, Telford and Wrekin Integrated Care System (ICS), which is described in the system-wide five-year Integrated Care Strategy. In parallel to this, the System's Joint Forward Plan continues to be developed and aligned to the recently published NHS 10-year plan ('Fit for the Future: 10 Year Health Plan for England'), the NHS Oversight Framework, the Medium Term Planning Framework and the Neighbourhood Health Framework. The Trust continues to play its part in delivery of the system's strategic objectives and strengthening our collaboration with partners.

The 2022-27 Trust Strategy sets out our ambitions, detailing the ways in which we will improve the delivery and quality of care, support and develop our workforce, address key challenges and further develop a culture of improvement across the organisation. Crucially, it also describes the values and behaviours to which we are committed.

The Trust has continued to make progress in all the strategic themes of our Trust Strategy, and has contributed to completion of a number of actions included in the ICS Joint Forward Plan for 2025/26, including improvements in access and performance across emergency, elective, cancer and diagnostic pathways, and initiatives to strengthen prevention and the approach to health inequalities. Furthermore, the Hospital Transformation Programme building is progressing well, and remains a core part of our clinical quality and wider sustainability plans for the future.

As a core contributor to the Joint Forward Plan, we have ensured that all of our strategic aims and major programmes of work contribute to the overall health and care system. As an organisation we continue to strengthen our relationships and work collaboratively with all of our partners to develop Operational, Transformation and Resource Plans for 2026/27 in order to further progress our strategies. As part of this, the Trust continues to review opportunities for further collaborative working that enhance our local population health and wellbeing needs through Place-based working and provider collaboratives. Importantly, the Trust is represented at local Health and Wellbeing Boards and both Integrated Place Partnership Boards.

We published the Trust's Clinical Services Strategy in 2023 which provided the strategic context for our acute hospital-based services, as well as SaTH's clinical role in the wider system, and we continue to make progress in all four components of the clinical services strategy. During 2025/26, significant work was undertaken to ensure continued alignment of programmes

internally, as well as with the wider Integrated Care Board's strategic direction and the strategies of our partners. The Trust played a role in supporting the development and launch of an ICS-wide clinical strategy, cardiovascular renal and metabolic (CVRM) strategy, Healthy Ageing and Frailty strategy and has taken part in the National Neighbourhood Health Improvement programme, to enhance work already underway supporting the hospital to community shift required to realise the aspirations of our Hospitals Transformation Programme.

From 1 April 2026 we embarked upon an incredibly exciting time, forming a Group model arrangement with Shropshire Community Health NHS Trust becoming Shropshire, Telford and Wrekin Community and Hospitals NHS Group. This will be a key enabler to the delivery of our collective strategies, and provide a wealth of opportunities for greater integrated working that will positively benefit our staff and the communities we serve.

The forthcoming 2026/27 year will be our transition year as a Group. We are committed to building on our achievements to date working collaboratively with our people, partners and communities to deliver our Trust vision "to provide excellent care to the communities we serve". During 2026/27 we will review and update our strategies as a Group, to ensure continual alignment of our Trust, Group, ICB and National ambitions.

Digital

The Trust continues to prioritise digital transformation as a key component of our Trust and digital strategies to enhance patient care, improve operational efficiency, and foster innovation.

In 2025/26, the Trust progressed a broad digital programme spanning patient engagement, electronic patient record (EPR) optimisation, diagnostics modernisation, and essential infrastructure and cyber security. The programme has been shaped with clinical divisions and corporate services to prioritise delivery, protect business continuity, and continue improving digital maturity in support of safe and effective care.

Building on the progress made in 2024/25, we further developed our digital solutions and capabilities across clinical and corporate areas. Key Achievements for 2025/26 have included the introduction of robotic process automation, ambient voice technology trials and a patient engagement portal. We have also continued the implementation and optimisation of our CareFlow Electronic Patient Record (EPR).

Additional schemes included:

Digital Improvements in 2025/2026	Benefits
Careflow EPR	A major upgrade of Careflow was undertaken providing a more robust platform and enhanced functionality for the users including ECDS v4 upgrade and implementation of patient and child protection demographics service.
Vitals HPCA and Narrative Integration	Aligned with the Vitals system and other cloud hosted SystemC products, digital forms have been enabled to be accessed through the Vitals observation system.
Patient Engagement Portal (DrDoctor)	Following a successful pilot in 2024/25 the Dr. Doctor Patient Engagement portal has been implemented Trustwide. Patients now receive tests to view their appointment details online. The next phase of the portal will include clinic outcomes letters and further ways to engage digitally with our patients.
Federated Data Platform	Replacing the legacy data warehouse solution with a modern data analytic platform reporting national CDS and SLAM activity.
Infrastructure improvements	An extensive programme of infrastructure improvements including network upgrade, priviliged access management, self-service password resets and directory management improvements. This work was underpinned by change to the digital on call and out of hours support.
Medilogik	Implemented to replace the Endobase application. Improved efficiency and reduced manual labour intensive processes in Endoscopy.

Our Trust digital strategy is nearing its end and we are now looking forward to developing the refreshed digital strategy covering the needs of our Group structure. We are also working with regional colleagues on the digital strategic aims for the Midlands and looking to maximise the additional investment offered by Frontline Productivity. This will deliver joint priorities tackling inefficiencies not only in individual organisations but working collaboratively to reduce duplication of effort across the region with procurement and programme management.

The coming year features major transformation programmes including the implementation of order communications, trustwide roll-out of ambient voice technology and the Patient Record Transformation Programme incorporating outpatient transformation, the UEC pathway and digital enablement for clinical pathways across acute and community. The Trust will continue to build on the Federated Data Platform into a business as usual operating model and to deploy further tools to support operational efficiency.

Our ambitions for 2026/27 will continue to focus on giving our staff the right tools and the right information to deliver safe and efficient patient care across acute and community settings.

Hospital Transformation Programme (HTP)

Introduction

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

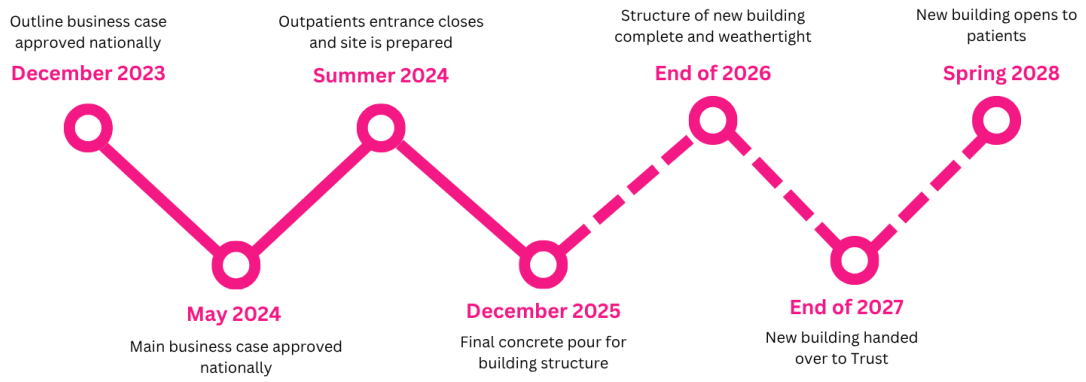
The national investment will help support the Trust's, and wider health and care system, ambitions of delivering high quality, sustainable services for patients in modern facilities. HTP is a key component of the Shropshire, Telford and Wrekin Community and Hospitals NHS Group and Integrated Care Board's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

The clinically led programme will provide faster access to the right care and clinicians. It will result in shorter waiting times for planned surgery and emergency care. We will also continue

our ongoing investment at both hospitals and the further development of community-based services to reduce waiting times and improve patient experience.

Our progress

Throughout 2025/26 we have significantly progressed our plans for this much needed investment.



2025/26 highlights:

- April 2025 – Divisions began work on clinical pathways and workforce models
- June 2025 – Lingen Davies launch £5m Sunflower Appeal to support expansion of Cancer Services
- September 2025 – second phase of ED refurbishment completes providing eight additional majors cubicles
- September 2025 – Transforming Princess Royal Hub opens in collaboration with charity partners
- September 2025 - Emergency Treatment and Transfer working group established to ensure safe patient transfers between hospitals
- November 2025 – partnership with Shrewsbury Severn Rotary club to support terrace gardens in the new building
- December 2025 – main building expansion reaches ‘topping out’ milestone
- March 2026 – third phase of Emergency Department refurbishment completes, providing improved space for patients needing ambulatory emergency care

We continue to work with our clinical teams and system partners to develop the patient pathways ahead of 2028. We have enhanced our governance arrangements to provide stronger oversight and support for both clinical pathways and workforce plans. We are also learning from and working closely with other hospitals who have introduced similar ways of working to help inform our plans. This includes visits to other organisations which has enhanced our learning and enabled us to adopt good practice. We continue to learn from their experiences and benchmark

our approach. It has been reassuring to confirm that our current and planned initiatives are aligned with those being implemented across comparable organisations.

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

Tackling Health Inequalities – 2025/26

Health inequalities are systematic, avoidable and unfair differences in health outcomes between different groups of people. These disparities arise due to social, economic and environmental factors, which influence people's ability to live a healthy life. Health inequalities are revealed in life expectancy, disease prevalence, access to healthcare and health outcomes. Health inequalities lead to shorter life expectancy, higher disease rates and poorer health outcomes in disadvantaged communities. People in lower-income or marginalised groups experience higher rates of chronic illness, mental health issues and preventable diseases. Limited access to healthcare, poorer housing and lower health literacy exacerbate disparities, resulting in higher emergency admissions and lower treatment adherence.

The Trust recognises that these inequalities increase the burden on the NHS, reduce workforce productivity and contribute to widening social and economic divides. Therefore, addressing these issues through targeted interventions, data-driven strategies, and community partnerships is essential for improving health equity.

In supporting the implementation of the NHS 10 year health plan, the NHS Oversight Framework, the Medium Term Planning Framework and our statutory duty, in conjunction with wider system partners and programmes of work we have continued to build on our foundational work. We have further embedded our own organisational health inequalities programme of work focussing on strengthening leadership, governance, and data quality whilst raising awareness and promoting an evidence-led improvement approach to tackling health inequalities across service improvements and delivery, aligned with key actions pertaining to Key Lines of Enquiry (KLOE) and the Core20PLUS5 for adults and children and young people.

Health inequalities data across Shropshire, Telford and Wrekin reflect a complex interplay of socio-economic, environmental and lifestyle factors, leading to disparities in health outcomes among different communities. Key variances include life expectancy, pockets of deprivation, smoking, obesity, mental health, access to services and rurality.

We recognise that to support the successful delivery of our health inequalities programme of work, robust data is essential for understanding our populations and ensuring fair access, positive experiences and better outcomes for all. It supports place-based approaches and population health management techniques, such as Core20Plus5, to narrow the inequality gap.

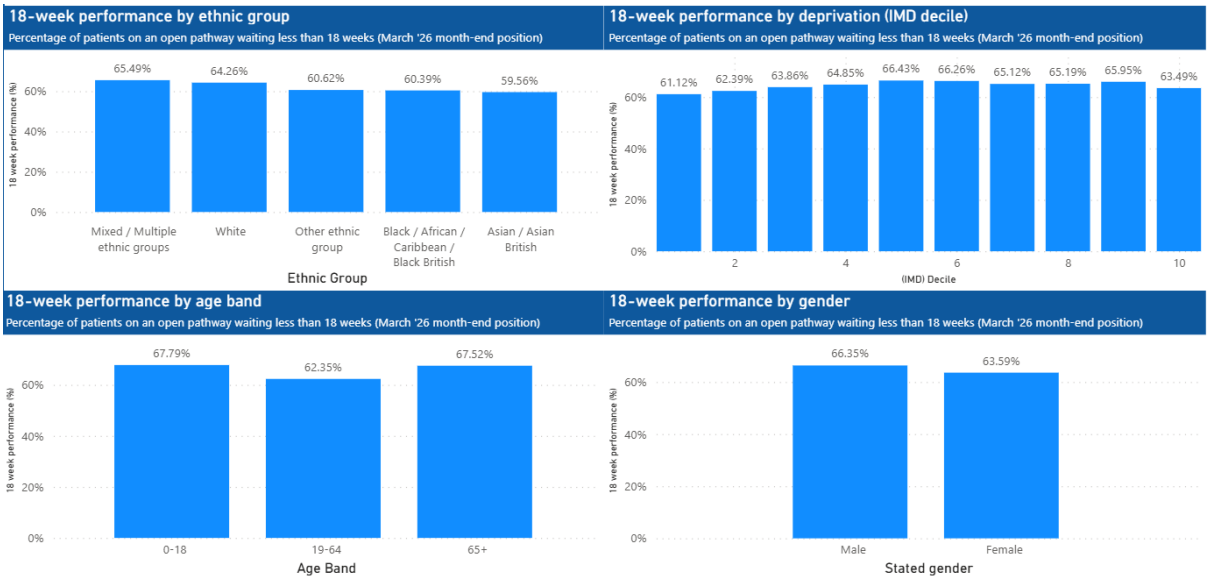
During 2025/26 we have focussed on embedding health inequalities data into service planning through:

- Improved data collection – ensuring ethnicity and deprivation data are routinely recorded and used for service improvement, whilst recognising further work is required during 2026/27.
- Health inequalities dashboard – tracking population trends, aligning actions with our accelerated programmes and Core20Plus5 priorities and reporting via internal and external committees for assurance
- Targeted interventions by identifying those impacted, segmenting the population using health and partner data, stratifying and prioritising, and implementing interventions, followed by evaluating the impacts and outcomes. An example of which includes the alignment of Joint Strategic Needs Assessment, Population health data, Health inequalities system dashboard and partnership data to inform our key transformational programmes of work such as UEC, Planned Care, Hospitals Transformation Programme and Neighbourhood Health.

In addition to the above we have made significant progress in:

- Strengthening our leadership and governance with a named executive lead and a detailed Health Inequalities programme of work embedded within the organisation
- Supporting a shared systemwide vision and local understanding of the needs of our population
- Strengthening collaborative working with our partners and local communities
- Extensive improvements in elective care during 2025/26, with our overall 18-week performance improving significantly, with particularly strong gains observed in the 0–18 age group which is now considerably above our average position. Differences in performance by gender are influenced in part by service mix, with specialties such as gynaecology contributing to the observed gap. Whilst variation remains across some ethnic groups and deprivation deciles, the gap is now better understood than in previous years. Improvements in data richness, including quality, completeness and timeliness, have strengthened our ability to identify and address inequalities. This improved understanding provides a stronger foundation for the next 12 months, enabling more targeted interventions to reduce variation and improve equitable access and outcomes across all patient groups.

Elective care 18 week performance 2025/26:



- Considerable service delivery and performance improvements achieved in:
  - Urgent and Emergency Care
  - Cancer
  - Diagnostics
  - Maternity
  - Systemwide Cardiovascular Renal Metabolic Strategy (CVRM) launched to support cardiovascular, renal and diabetes pathways
  - Smoking Cessation
  - Learning Disabilities and Autism

From 1 April 2026 we embarked upon an incredibly exciting time, forming a Group model arrangement with Shropshire Community Health NHS Trust becoming Shropshire, Telford and Wrekin Community and Hospitals NHS Group. This will be a key enabler to the delivery of our strategy and our prevention and health inequalities agenda.

During our transitional year 2026/27 we will be aligning our priorities and reviewing our priority areas to inform our ongoing programme of work. This will provide a wealth of opportunities for greater collaborative integrated working, that is data driven, supporting service transformation to meet the needs of our people, service users, families and the communities we serve.

SaTH Improvement

Over the 2025/26 year, the SaTH Improvement Team has played a central role in supporting the Trust to respond to sustained operational pressure while laying the foundations for a more consistent, system-wide approach to improvement. Working alongside clinical, operational and corporate colleagues, the team has focused on aligning improvement activity to strategic

priorities, strengthening leadership behaviours, and embedding practical Quality Management System (QMS) routines from board to ward.

During 2025/26, this approach has contributed to demonstrable improvements in access, flow, waste reduction and productivity. The Trust was recognised nationally for its improvement work, including becoming the most improved Trust in the country for 18-week referral-to-treatment performance and one of the most improved for diagnostic waiting times. Ward-level application of QMS principles, most notably on Ward 25, has delivered significant improvements in length of stay, discharge reliability and throughput, supporting system flow and reducing pressure on the acute floor and Emergency Department. In Planned Care, the consistent use of Performance Review Meetings (PRMs) has enabled teams to move beyond performance reporting towards active improvement, supporting sustained gains in theatres, outpatients and elective recovery. In addition, the Improvement Team has supported the successful implementation and optimisation of the Genesis Inventory Management System, improving stock visibility, reducing waste and releasing clinical time.

Our Improvement team's specific outcome measure, the staff survey question 3f "I am able to make improvements happen in my area of work", has declined for SaTH in the period under review despite the Improvement Team having prioritised building improvement capability and confidence across the organisation. However, training and coaching delivered through the Improvement Hub has been consistently well-received, with staff reporting increased confidence, clarity and permission to lead improvement in their own services.

Importantly, this year has also generated clear learning. Where improvement activity has been most successful, it has been underpinned by visible senior leadership, clear ownership, disciplined routines and alignment to a small number of strategic priorities. Where this has been absent, progress has been harder to sustain. These insights have directly informed the Trust's emerging Quality Management System approach.

As the organisation moves into 2026/27 within a new Group model, the role of the Improvement Team will increasingly shift from individual project support to embedding the conditions for sustainable improvement at scale. This includes supporting executive and divisional leaders to model QMS behaviours, strengthening governance and accountability, and ensuring improvement activity remains tightly aligned to what matters most for patients, staff and the communities we serve. The work undertaken this year provides strong evidence that, when applied consistently, this approach improves outcomes, builds confidence and creates a more resilient organisation.

Going Concern Disclosure

The Board has carefully considered the principle of 'Going Concern' in the context of the Trust continuing to operate under the HM Treasury's Financial Reporting Guidelines (FReM). For the year ending 31 March 2026, the Trust is reporting a surplus of £4.9m on an adjusted financial performance basis, against a breakeven plan, supported by non recurrent deficit funding of £45.1m and bonus deficit support funding of £4.9m. The Board has therefore reported that the Trust is a going concern, with no plans for any substantial changes to its portfolio of services.

Since the Trust has neither been notified that its services are no longer required nor received notice of material closure of NHS services currently run by the Trust, and services continue to be commissioned from the Trust by local and specialist commissioners. The Trust has submitted a compliant breakeven plan for 2026/27 underpinned by £30.5m of deficit support funding. The Trust therefore expects to operate as a going concern through to the end of the going concern period of 30 June 2027. The Trust Board has considered the advice in the DHSC's GAM that the anticipated continuation of the provision of a service in the future, as evidenced by the inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern. The Trust has therefore adopted this approach in preparing these accounts.

The Trust maintained a cash and cash equivalent balance of £73.0m at the end of 2025/26 (March 2025: £61.5m).

The Board of Directors have concluded that whilst the financial position for 2026/27 is very challenging, based upon enquiries with NHSE and the Department of Health and Social Care, they have a reasonable expectation that the Trust will have access to adequate resources (as in previous years) to continue in operational existence for at least 12 months from the date of approval of the financial statements and continue to provide services to its patients. Based on this expected continuation of services, the Trust continues to adopt the going concern basis in preparing the financial statements.

Performance Analysis

This section provides a detailed analysis of the Trust's performance throughout 2025/26, and in doing so, brings together some of the principal performance measures that we use to determine the level of risk that we carry in the organisation.

The Board's role in monitoring the performance of the organisation is supported by an accountability structure which enables visibility by the public, staff and external stakeholders

through its bi-monthly meetings in public. It remains the responsibility of the Board of Directors to design and then implement agreed priorities, objectives and the overall strategy of the Trust.

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

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

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

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

The Board Assurance Framework outlines the strategic risks to achievement of the organisation's objectives and is considered by the Board in public quarterly. Further information on risk management and the organisations major risks can be found within the Annual Governance Statement section of this report.

The executive directors continually review the performance of the Trust through a series of regular meetings, and monthly meetings with divisional colleagues at the operational Performance Review Meetings.

Our Key Performance Indicators 2025/26, by quarter (Q):

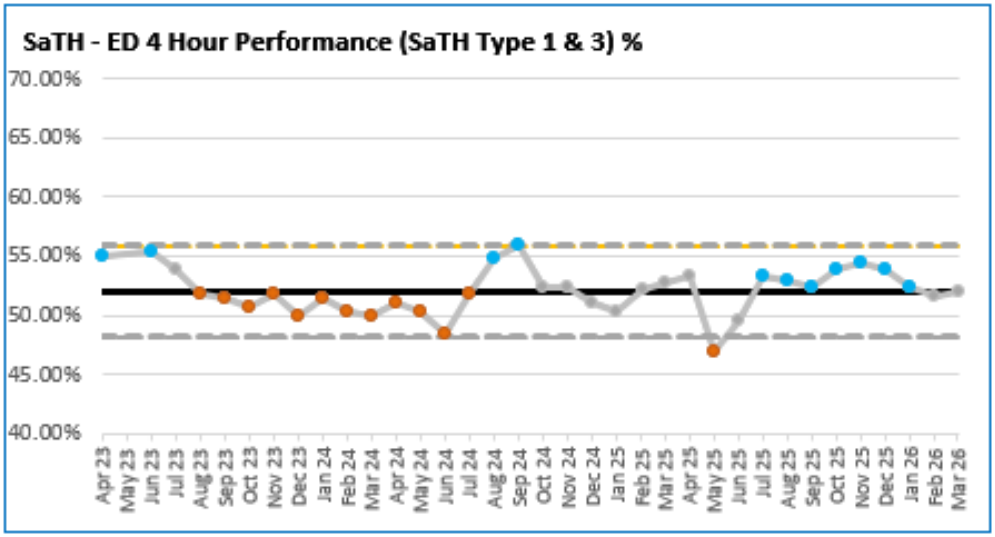
Measurement (metric)	2025/26 plan	end of Q1 (Apr-Jun)	end of Q2 (Jul-Sept)	end of Q3 (Oct-Dec)	end of Q4 (Jan-Mar)
Total elective activity undertaken (IP/DC)	82,923	Not Available			
Increase Productivity to 85% - Theatre Utilisation	85%	80%	81%	81%	81%
RTT – Total Waiting List (English /Welsh)	39,663	42,449	36,022	36,982	38,063
Patients waiting more than 78 weeks to start consultant-led treatment (Welsh only from May 25)	0	33	15	17	15
Patients waiting more than 65 weeks to start consultant-led treatment (Welsh only from Aug 25)	0	114	87	37	82
Patients waiting more than 52 weeks to start consultant-led treatment (Welsh only Mar 26)	376	1,103	369	212	196
Diagnostics 6 week wait performance	99%	82.20%	85.50%	81.70%	86.40%
Diagnostics patients waiting more than 6 weeks	66	2,039	1,692	2,249	2,184
Total patients waiting over 62 days to begin cancer treatment	130	306	241	184	142
Proportion of cancer patients meeting 62 days standard	80%	62.60%	65.20%	70.10%	74.50%
Proportion of patients meeting faster cancer diagnosis standard (informed within 28 days)	70.1%	72.50%	80.10%	83.00%	86.00%
Total outpatient attendances	581,336	Not Available			
Urgent and Emergency Care performance measure (4-hour performance (excluding planned returns and MIU activity)	60%	53.10%	53.80%	52.00%	52.80%
15-minute ambulance breaches per quarter (ambulance handover >15 minutes)	86%	7,984	7,554	7,915	7,930
		78.90%	76.20%	80.70%	80.80%
60-minute ambulance breaches per quarter (ambulance handover > 60 minutes)	36%	3,157	2,548	3,593	3,036
		31.20%	25.70%	36.60%	31.00%
Number of patients spending more than 12 hours in emergency department per quarter	17%	7,563	7,237	7,313	7,005
		22.90%	22.30%	22.30%	21.90%
Summary hospital-level mortality indicator	100	89.6	106	In arrears (by 6 months) not yet available	
Methicillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia infection rate (HOHA)	0	0	0	1	3
Clostridium difficile infection rate (HOHA)	98	17	23	15	18
E. coli bloodstream infections (HOHA)	146	8	16	15	16

Note: The challenges identified in 2024/25 relating to the technical structure of the Trust's internal data warehousing have persisted into 2025/26. While considerable improvements have been made and national submissions to the Secondary Uses Service (SUS) have been reinstated, issues remain regarding the consistency of data quality within these submissions. Service Level Agreement Monitoring (SLAM) is currently in the development and testing phase, which means the Trust is not yet able to produce a fully accurate view of activity and income. This remains a priority for the organisation, with progress closely monitored through the Data Warehouse Project Board and reported monthly to the Performance Assurance Committee. *Further details regarding data quality and the recovery plan can be found within the Annual Governance Statement section of this Annual Report.*

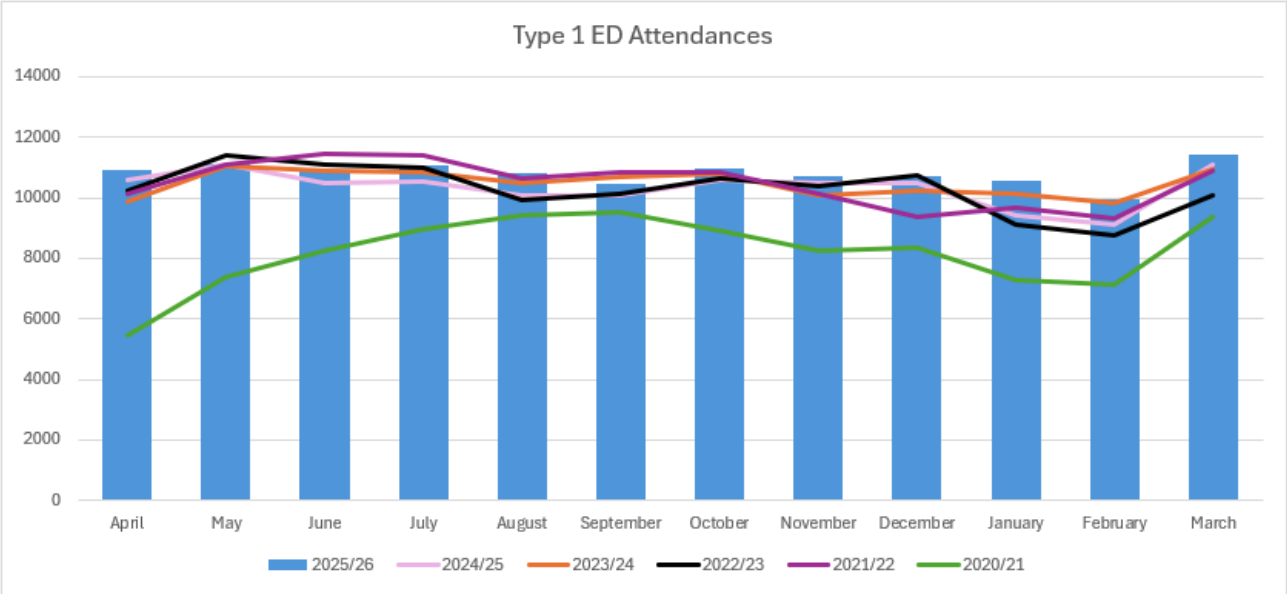
What we achieved

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

The Trust's performance from April 2023 to March 2026 is shown below:



In March 2026, 53% of patients were managed within 4 hours of arrival, against the revised national expectation of at least 76%, the total average 4-hour performance for 2025/26 was 52.2%.



Urgent and emergency care demand remained high throughout the year. A&E performance, including ambulance handover delays, continues to be a challenge. As a result, the Trust remains in Tier 1 monitoring by NHS England, with 31.1% of ambulance waits of 60 minutes or more.

The Trust's *Stronger Together* campaign — which prioritises faster access to care, reducing waits in the Emergency Department, and supporting shorter hospital stays — has underpinned a year of significant improvement activity across the Emergency Department, acute medicine, and inpatient wards. A key milestone was the creation of 96 additional beds and assessment areas (56 at RSH and 40 at PRH). This was achieved mainly through the opening of two new modular wards at RSH, alongside targeted capital estates work to increase capacity at PRH.

These additional beds, together with the redesign of the acute medical floor and a range of patient flow initiatives, are now starting to show measurable impact. The percentage of patients seen within 15 minutes increased from 57.3% in March 2025 to 68.5% in March 2026. Over the same period, the average time to initial adult assessment reduced from 20.91 minutes to 14.29 minutes, meeting the 15-minute standard in 8 of the last 12 months.

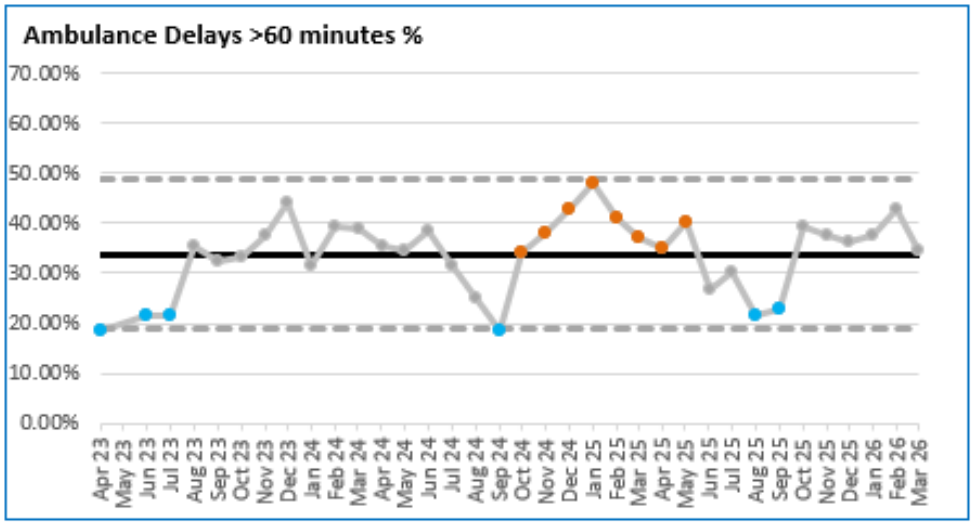
Alongside this, a series of system-wide changes were delivered throughout the year, working closely with colleagues at Shropshire Community Health Trust. These included extending the Care Transfer Hub to operate 8am–8pm, seven days a week; introducing an Integrated Front Door team across both acute sites; and expanding the Urgent Community Response service to operate until midnight, seven days a week.

Despite this progress, the scale of improvement has not yet been enough to fully ease demand across the urgent and emergency care pathway or to consistently meet performance standards.

Pressures remain high, particularly within Emergency Departments, with ongoing impacts on both patient experience and staff wellbeing.

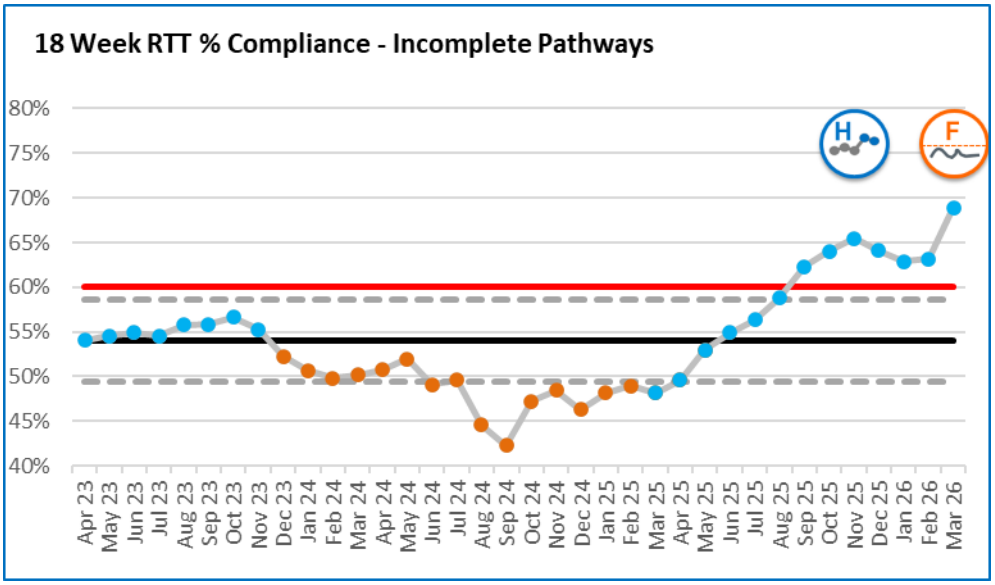
Looking ahead, delivery plans for 2026/27 and 2027/28 are being taken forward through the System Transformation Programme. Built around three core pillars — Community Urgent Care, Acute Flow and Care Coordination, and Discharge Transformation and Capacity Release — the programme reinforces the Trust's commitment, working with system partners, to reduce delays and improve experiences for patients and colleagues across urgent and emergency care.

Encouragingly, early performance in Quarter 1 2026/27 points to further improvement, with notable gains in 12-hour performance and average ambulance handover times, which are forecast to be among the strongest seen for several years.

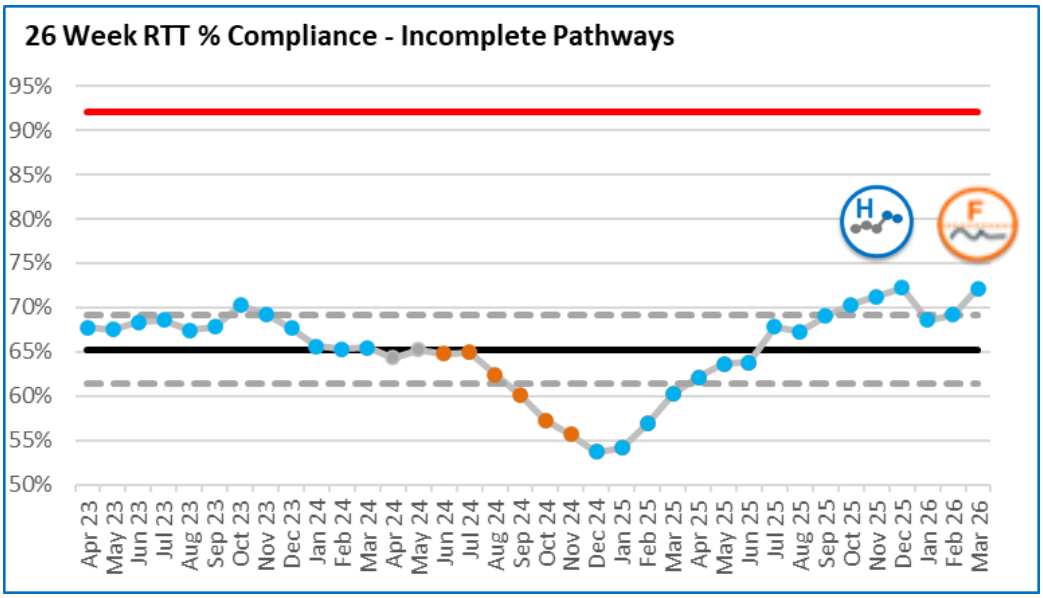


Referral to Treatment (RTT): This measures compliance against the national standard of 92% of patients should wait no longer than 18 weeks from GP referral to treatment (reported as a month end snapshot). This target is set at 26 weeks for patients in Wales.

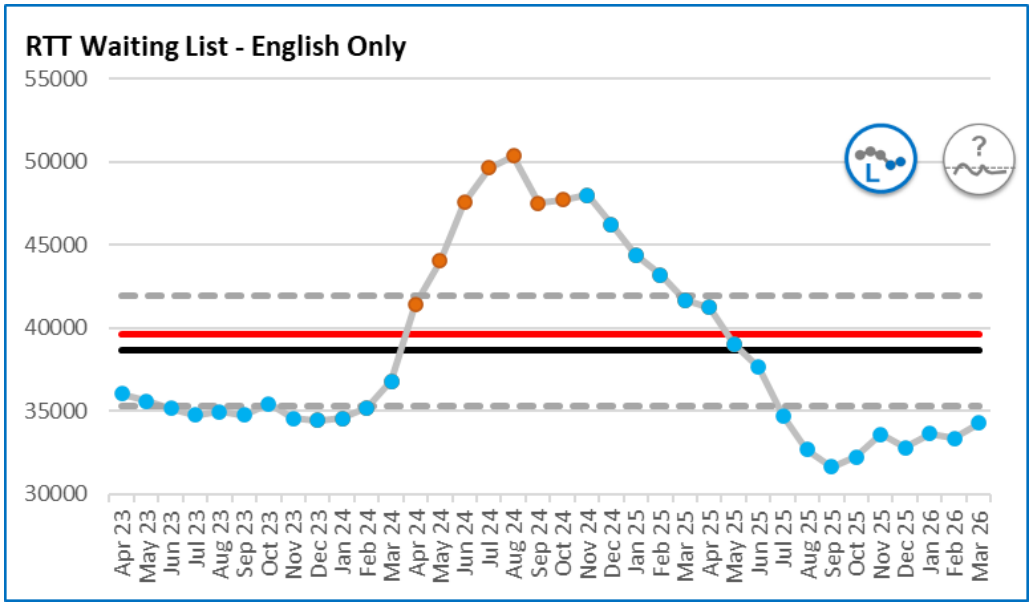
The Trust's 18-week RTT performance for English patients in March 2026 had 68.9% of patients waiting under 18 weeks.



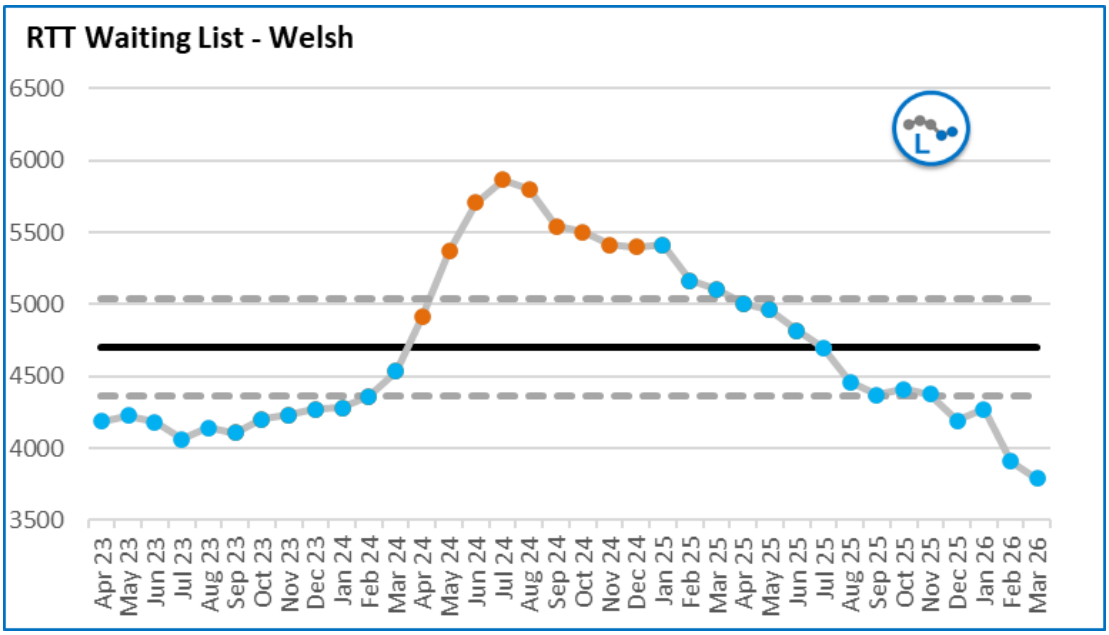
The Trust's 26-week RTT for Welsh patients in March 2026 had 72.12% patients waiting under 26 weeks.



The overall waiting list of English patients on an open RTT pathway reduced significantly in the first half of 2025/26 from the March 2025 position of 41,669 and has remained steady for the remainder of the year ending on 34,275,



The overall waiting list of Welsh patients on an open RTT pathway fell from to 5,106 in March 2025 to 3,788 in March 2026.



During 2025/26 the Trust had a sustained elective recovery performance following the challenges experienced in the previous year. Significant improvement has been seen in both the English and Welsh waiting lists, resulting in a reduction in delays for patients accessing care.

To support recovery and improve patient access, the Trust has delivered several key interventions:

- Increased utilisation of the Elective Hub at the Princess Royal Hospital, improving throughput and productivity, supported by engagement with the national GIRFT programme.

- An outpatient transformation programme which delivered benefits in booking utilisation and utilisation of estates
- Targeted investment in diagnostic services to support timely progression along RTT pathways.

These actions have contributed to a reduction in the overall waiting list and stabilisation of RTT performance, although delivery remains below the national standard and continues to be a key area of operational focus.

The Trust was the most improved Trust in England in the 18-week RTT standard and was one of only three Trusts in the country to have zero patients waiting over 52-weeks for treatment on an open RTT pathway (NHS England).

Cancer

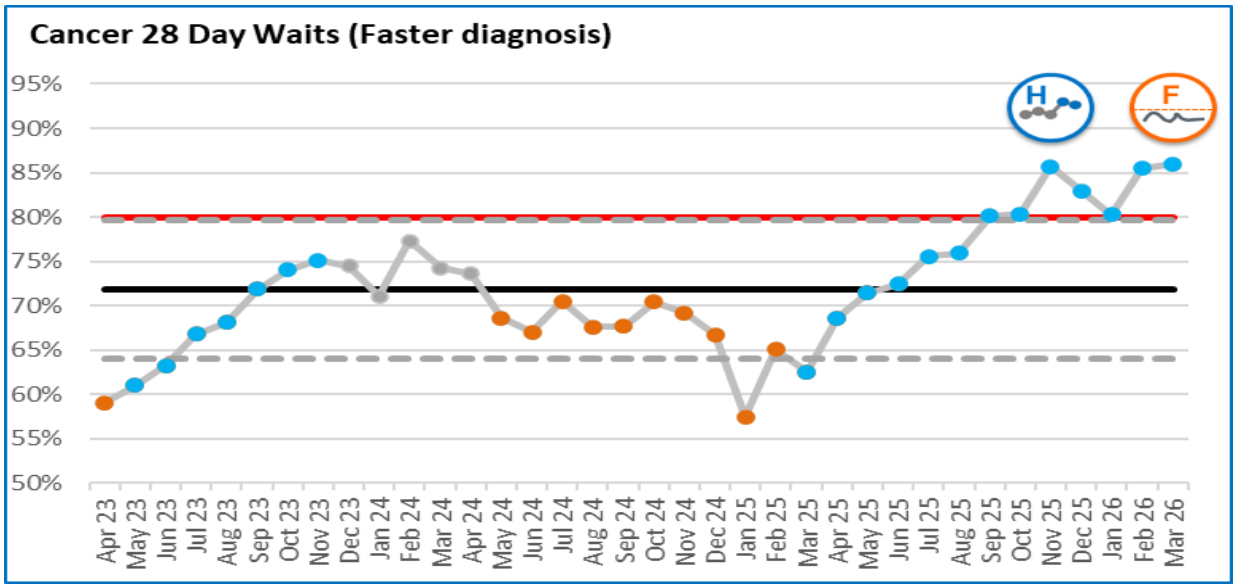
There are three cancer standards, which combine all the previous standards:

• the 28-day Faster Diagnosis Standard

• the 62-day referral to treatment standard

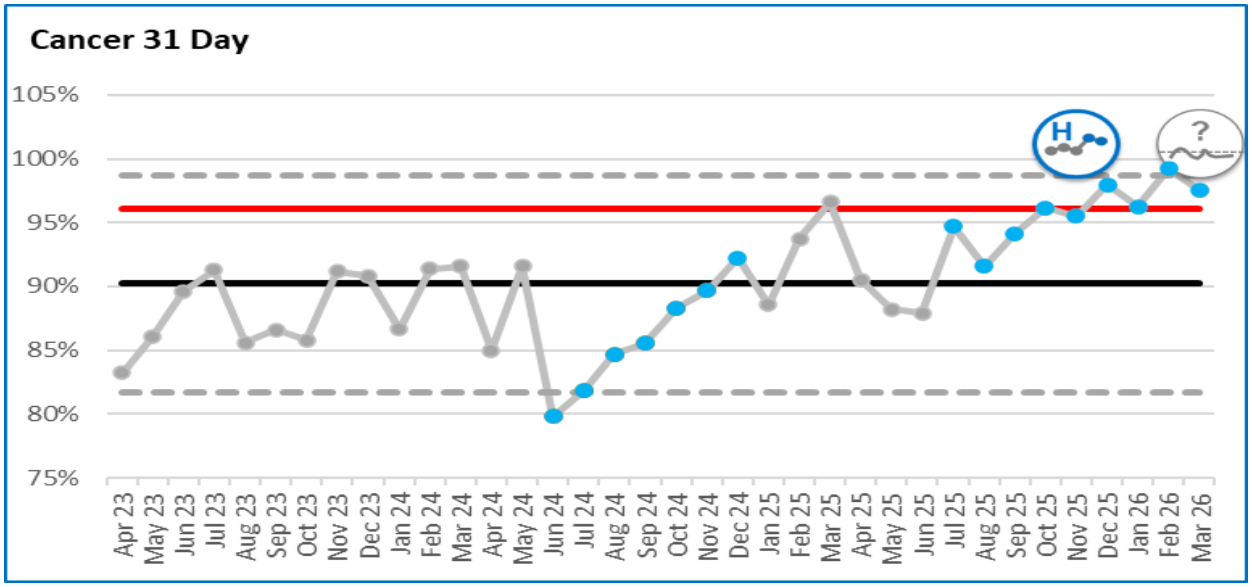
• the 31-day decision to treat to treatment standard.

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



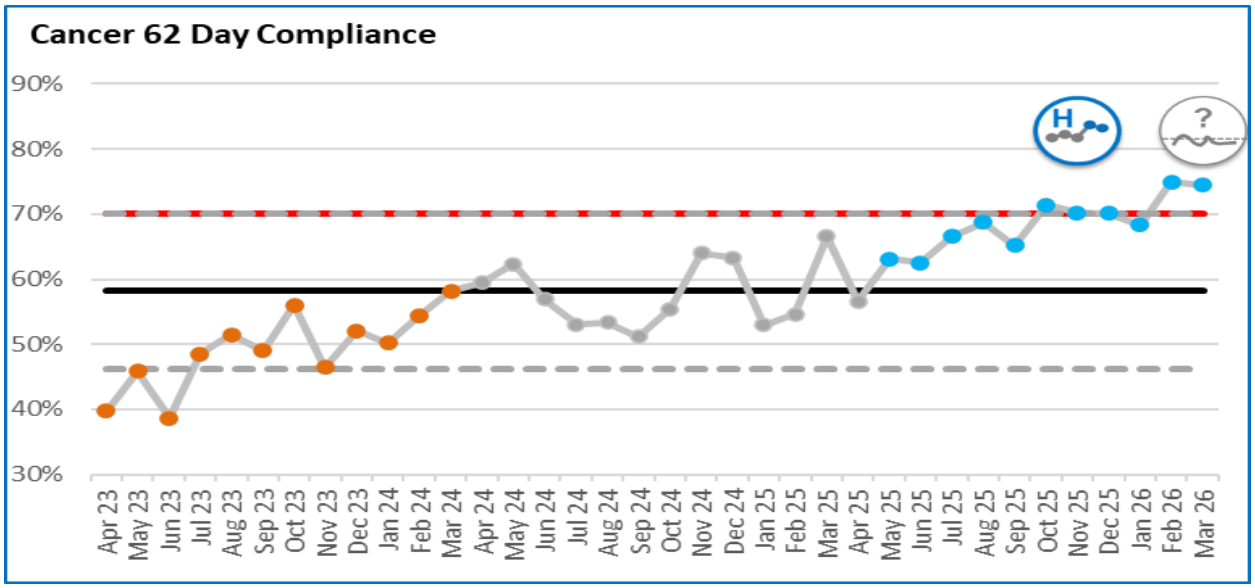
In March 2026, 86% of patients received a diagnosis within 28 days of referral.

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



In March 2026, 97.6% of patients received treatment within 31 days from diagnosis as part of the new combined metric.

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



In March 2026, 74.5% of patients with confirmed cancer received first treatment within 62 days of referral as part of the combined 62-day performance standard.

The above analysis demonstrates sustained and statistically significant improvement across all cancer standards during 2025/26, particularly within the Faster Diagnosis Standard. The Trust ended the year as the most improved organisation nationally for FDS performance and has consistently delivered above the national 80% standard from September 2025 onwards.

Performance against the 31-day standard also remained consistently above the 96% national standard from December 2025.

The improvement delivered in 2025/26 has been driven through a focused programme of high-priority transformation interventions across key cancer pathways. This has included strengthened pathway oversight, improved coordination of care, and targeted actions to reduce delays at key stages of the diagnostic and treatment process. Significant work has also been undertaken to improve diagnostic turnaround times, including streamlining access to diagnostic tests and reporting processes, supporting earlier clinical decision-making and faster progression through pathways.

The Trust has also strengthened leadership and governance arrangements for cancer services during the year. A new Cancer Improvement Board has been established to provide enhanced oversight, accountability and delivery assurance, alongside the development of a comprehensive two-year Cancer Improvement Plan for 2026/27 and 2027/28 focused on delivering sustainable improvements and excellence in cancer care.

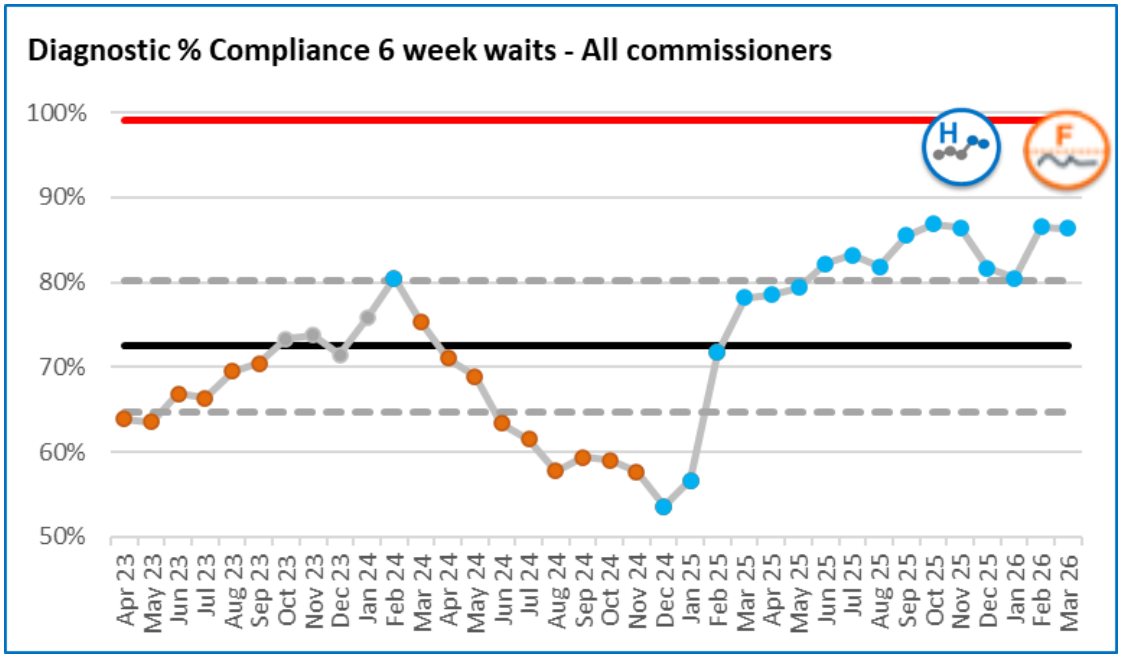
Whilst the Trust remains below the national 85% standard for the 62-day pathway, the data demonstrates sustained improvement compared with 2024/25 performance, reflecting the positive impact of the actions implemented during the year.

In summary, material and sustained improvements have been achieved during 2025/26 across the cancer access standards. The Trust has established a stronger operational and governance framework to support continued progress; however, further work remains necessary to ensure all patients consistently receive timely diagnosis and treatment.

Diagnostic (DM01):

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

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



The Trust's diagnostic performance with patients waiting less than 6 weeks for March 2026 was 86.4%.

Following a challenging 2024/25, the Trust implemented a range of interventions to stabilise and improve diagnostic performance. This resulted in a recovery trajectory throughout the year, although the national standard was not achieved.

Performance pressures remain in key modalities including non-obstetric ultrasound and cardio-respiratory diagnostics, reflecting sustained demand and capacity constraints.

To address these challenges, further investment and service development has been identified within 2026/27 plans to increase capacity, improve productivity and support continued recovery against the 6-week standard.

Quality Priorities – Priorities for Improvement 2025/26

The proposed quality priorities for 2025/26 were developed from a review of the previous year's priorities, the progress made in relation to achieving these and the ongoing key quality and safety challenges faced by the Trust. This meant that some of the 2024/25 quality priorities continued or were revised in 2025/26. In addition, some new priorities were included for 2025/26 which reflected the joint quality working with our System partners.

The resulting nine quality priorities for 2025/26 and the key actions we planned to take to achieve these overarching quality priority improvements were:

	QUALITY PRIORITIES 2025/26	
Domain	**Priority**	
SAFE	Priority 1	PSIRF* priorities:
		The deteriorating patient
		Reducing inpatient falls
		Omitted doses of time critical medication
		Missed radiology reporting
	Priority 2	Reduce Hospital Acquired Pressure Ulcers
	Priority 3	Achieve best compliance with nutritional assessments and nutritional care planning
EFFECTIVE	Priority 4	Improve the experience of our elective care pathways: • reducing our radiology waiting times, reducing radiology reporting delays
	Priority 5	Improve the experience of our emergency care pathway: • Improving time to triage/initial assessment • Improve the timeliness of handover for patients arriving by ambulances • Reducing the number of patients who spend more than 4 hours and more than 12 hours in our departments • Improve the number of patients reporting a positive experience of care in our EDs
	Priority 6	Implement System-wide working to improve the discharge planning processes and our patients experience of involvement in their discharge plans
	Priority 7	Improve Foot care for people with Diabetes who are admitted to the Trust
	Priority 8	Reduce the risk of mortality in patients presenting to the Trust who are acutely unwell
PATIENT EXPERIENCE	Priority 9	Improve the experience of patients and their loved ones who have a learning disability and/or autism

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

A detailed narrative which describes our quality improvement priority actions and their outcomes for the year can be found in our **Quality Account 2025/26**, which will become available on our website from 1 July 2026. It also outlines the quality improvement priorities for 2026/27. Copies may be obtained by contacting our Communications Department at communications@sath.nhs.uk

Freedom to Speak Up

The Freedom to Speak Up (FTSU) team is made up of one FTSU Guardian and 48 FTSU Ambassadors from a wide range of clinical and non-clinical backgrounds, reflecting the diversity of the Trust. Ambassadors volunteer alongside their day-to-day roles to raise awareness of the FTSU service and signpost colleagues to appropriate support. The network has continued to grow over the past year, with colleagues joining from both hospital sites and off-site services. We are working with managers and HR Business Partners to increase ambassador presence across all departments.

Planning has also begun for the 2026/27 programme, including joint work with Shropshire Community Health NHS Trust to develop a shared ambassador training programme.

FTSU concerns raised by quarter and year:

	Q1	Q2	Q3	Q4	Total	Increase/ Decrease	National Increase
2025/26	79	51	57	51	**238**	↑9%	Not yet available
2024/25	67	48	56	47	**218**	↑0.5%	↑18.6%
2023/24	47	52	68	50	**217**	↓23%	↑27.6%
2022/23	71	73	79	59	**282**	↓23%	↑25%
2021/22	100	113	90	66	**369**	↑21%	0%
2020/21	41	82	103	78	**304**	↑110%	↑26%

In 2025/26, a total of 238 contacts were received, showing a 9% increase in activity from the previous year. Of the concerns raised, 33% had elements of worker safety and wellbeing; 26% related to inappropriate behaviours or attitudes; 22% were linked to systems and processes; 12% were about patient safety; and 5% related to bullying and harassment, with the remaining 2% covering other issues.

The highest number of contacts came from Nursing and Midwifery colleagues 28%, followed by Administrative and Clerical staff 24%. Further contacts came from Medical and Dental 12%, Additional Clinical Services 11%, Estates and Ancillary 10%, and Allied Health Professionals 9%, with Students, Healthcare Scientists and other professional groups each contributing 1–3%. Overall, colleagues from different professional groups continued to use the service throughout the year.

Financial Performance 2025/26

In developing the operational plan for the financial year (FY) 2025/26 the Trust worked with system partners to develop a triangulated plan across activity, workforce and finance in response to delivering the Trust's strategy and the following priorities set out by NHS England:

- Reduce the time people wait for elective care.
  - ensure 65% of patients receive elective treatment within 18 weeks by March 2026, with a minimum 5% improvement.
  - 75% compliance against 62-day diagnosis standard by March 2026.
  - 80% compliance against the 28-day faster diagnosis standard by March 2026.

- Improve A&E waiting times and ambulance response times.
  - by March 2026, 78% of patients should be seen within four hours in A&E.
  - category 2 ambulance response times should average no more than 30 minutes throughout FY2025/26.

- Improve patient flow by reducing acute length of stay.
  - increasing the percentage of patients discharged by or on day seven of their admission.

- Operate within the allocated budget, reducing waste and improving productivity.
  - reduce spending on temporary staffing and support functions.
  - enhance procurement and contract management.
  - eliminate duplication and low value activities.

- Continue to prioritise the overall quality and safety of services.

The Trust set a deficit plan of £45.1m which was converted into a breakeven plan by NHS England providing non-recurrent funding of £45.1m to match the deficit plan. At the time of finalising the plan, a number of significant risks were identified, including the continued use of additional capacity, the cost of temporary workforce, pay inflation, the scale and deliverability of the efficiency programme, delivery of the activity plan, and the pay settlement for clinical support workers.

Against the breakeven control total, the Trust delivered a full-year retained surplus of £4.9m. This favourable variance was driven by the receipt of additional non-recurrent bonus Deficit Support Funding (DSF) in-year.

After removing non-recurrent DSF, the Trust's underlying retained deficit position at the end of FY2025/26 was £45.1m. The Trust continues to actively monitor and manage its underlying financial position, and the ongoing impact on underlying sustainability is a key consideration in decisions to commit expenditure. The following table outlines the financial position for FY2025/26.

2025/26	£'000
Income from patient care activities	727,942
Other Operating Income	50,118
Operating Expenses	(780,567)
Operating deficit	**(2,507)**
Other gains and (losses)	(198)
Deficit before interest	**(2,705)**
Investment income	3,189
Finance costs	(350)
Public dividend capital dividends paid	(9,625)
Retained deficit	**(9,491)**
Adjusted for:	
Impairments	21,984
Adjustments in respect of Donations / Grants	(7,572)
Adjusted financial performance	**4,921**

The main source of income for the Trust was via contracting with commissioners for health care services. In FY2025/26, the majority of the Trust's income from NHS commissioners was in the form of Aligned Payments and Incentive (API) contracts. This is a form of blended payment, made up of fixed and variable elements. The fixed element relates, in the main, to unscheduled care and is paid at an agreed value for the expected annual level of activity. The variable element, in the main, relates to elective, scheduled care and is paid in line with activity delivered. During 2025/26 variable income was received aligned to contracted levels, and additional allocations were made available during Quarter 4 for elective sprint.

Within Trust expenditure, the largest category is pay expenditure totalling £523.2m which is equivalent to 67% of total operating expenditure. Other significant components include £126.5m on drugs and clinical supplies (16%), and estates and premises costs of £23.9m (3%).

The Trust invested £149.7m of capital expenditure (excluding grant funding) on medical equipment, digital infrastructure, improvements to existing buildings, and continued expansion

of its estate during the financial year.

The Trust's internally generated funds covered £22.5m of the total investment (including IFRS 16 Lease expenditure), with the remainder of the capital expenditure of £127.2m being funded through Public Dividend Capital. This external funding has been utilised to continue build works associated with the Hospital Transformation Programme (HTP), continuing the works for removal of Reinforced Autoclaved Aerated Concrete (RAAC) at Princess Royal Hospital, various Estates Safety works, Return to Constitutional capital schemes, the continuation of the Laboratory Information Management System (LIMS) and interoperability schemes and a Histopathology Modernisation Scheme. In addition, the Trust completed a modular ward build at the Royal Shrewsbury Hospital site.

During FY2025/26 the Trust continued an Energy, Security and Decarbonisation Programme, for which, in addition to internally generated funds, the Trust received the second year of a Public Sector Decarbonisation Scheme grant of £8.1m to be spent on decarbonisation initiative on the Shrewsbury site.

Fraud, Bribery and Corruption

The Trust's Anti-Fraud, Bribery and Corruption Policy and Response Plan was updated in January 2024 and sets out the arrangements that the Trust maintains to deter, prevent, detect and investigate instances of fraud, corruption and bribery carried out against the Trust, and the wider NHS. The policy was approved by the Board in March 2024 on a three-year review. The policy was updated again in early 2026 to reflect a new corporate fraud offence of 'failure to prevent fraud' and is currently going through the Trust's policy governance/approval process, with consideration at Audit and Risk Assurance Committee in May 2026, and subsequently Board of Directors.

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

Equality, Diversity and Inclusion

See the Staff Report section of this Annual Report.

Public Participation

Engagement with our communities

Strategic approach - We are committed to ensuring that our patients and local community have the opportunity to get involved with us in a timely and meaningful way. The Public Participation team (community engagement, volunteers and SaTH Charity) deliver this to our communities,

and this is reported both to our Trust Board and the Public Assurance Forum on a quarterly basis. After extensive engagement last year, we have strategies for Community Engagement, Volunteers and SaTH Charity, which are being combined into one overarching Public Participation Strategy 2026-2030 and an annual activity report 2025/26.

Community engagement

Public Assurance Forum - The Forum is co-chaired by a non-executive director and a forum-elected lay Chair (representing North Powys Health Forum). The Forum membership consists of Trust representatives from the Divisions and representatives from a wide range of health and community groups, including those from seldom heard communities. The aim of the Public Assurance Forum is to bring a public and community perspective to services at the Shrewsbury and Telford Hospital NHS Trust to ensure that services are developed in partnership with our local communities.

Community membership - We have over 5,300 individual members and 470 organisational members. Our members receive a monthly email newsletter (#GetInvolved) with information about what is happening in the Trust, opportunities to get involved, upcoming events and information from our system/community partners. We also hold monthly Hospital Update Meetings online for the public to find out more about what is happening at the Trust and ask questions. In addition, we hold regular "About Health Events" – one-hour lectures delivered by health professionals on a specific topic. In the last year these have included menopause, health and wellbeing for cancer patients, cardiovascular disease, Hospitals Transformation Programme, Patient Portal and diabetes footcare. These are all recorded and published on our website About Health Recordings – SaTH

Health Inequalities - We reach out to those communities where there may be health inequalities barriers to healthcare. Core20Plus5 is a national approach designed to reduce healthcare inequalities using community connectors to improve trust and access in areas/groups with high inequality. We have actively listened to our communities and have been building relationships with seldom-heard groups including Gypsy, Roma and Traveller communities; people with sensory impairments, including Deaf, Deafblind, Hard of Hearing and visually impaired people; people living with dementia and their carers; rural and agricultural communities, including farming populations; people experiencing digital exclusion or with limited access to online services; people with long-term health conditions, including diabetes, cardiovascular disease, cancer and sight loss; older people, including those experiencing social isolation or frailty; unpaid carers, including carers of people with long-term conditions or dementia; Armed Forces community and the local Cancer Champions network.

Hospitals Transformation Programme (HTP) Engagement - We continue to support engagement for HTP. In 2025/26, the Public Participation team attended 51 meetings to discuss HTP with our communities. In addition, we have held five public focus groups, including our

quarterly divisional focus groups, as well as bespoke focus groups on specific topics (Communications, Critical Care and Oncology Garden, and Wayfinding). This year we held 31 public drop-in events across Shropshire, Telford and Wrekin, and Mid Wales. There are also quarterly About Health events presented by the HTP team, where the public can ask questions about the Programme directly to the team. Find out more on our website: https://www.sath.nhs.uk/about-us/get-involved/public-participation-2/get-involved-with-us-2/htp-focus-groups/

Volunteers

Volunteers - Our patients, their friends and families and our workforce are supported by our amazing volunteers who give up their time to help. At the Trust, we accept volunteers from 16 years old, and we have no upper age limit. Currently we have 214 active volunteers and in 2025/26 they gave almost 26,000 hours to the Trust. We know how important it is that volunteers truly feel part of the NHS family and have introduced monthly coffee and catch-up sessions as well as the opportunity to attend regular wellbeing and mindfulness sessions. We have also revamped our monthly Volunteer Newsletter and held a couple of volunteer focus groups to get first hand feedback.

Roles - We have over 30 well-established roles which are available on our website Volunteering – SaTH . We also launched some new roles last year including our *Volunteer Driver Service* in June 2025, to provide transport for patients being discharged from hospital which has now carried out over 1,700 journeys. The project also provides transport for outpatients, maternity and renal, and has 17 volunteer drivers. We launched the *Outpatient Buggy Driver* role to support patients getting to clinics and now have a full rota. There is also an *Outpatient Checking Service* piloted in Ophthalmology from September where two volunteers spoke to 360 patients to check whether they intended to attend their appointment - 32 patients were unsure and 16 of these rearranged and 16 no longer required the appointment, but without the call it is possible these 32 patients (nearly 9%) would not have attended. We are working with IT to enable volunteers to telephone from home, rather than coming onsite as we could then look to increase the number of volunteers supporting this.

Young Volunteers - To support our young volunteers (16-25-year-olds) to access volunteering opportunities at the Trust we successfully applied to become an Approved Activity Provider for volunteering with the Duke of Edinburgh's Award scheme and are one of the few NHS Trusts to offer this opportunity to young people.

Volunteer to Career (VtC) - Our Volunteer to Career programme continues to provide opportunities to volunteers with an interest in a career within healthcare and over the past year has continued to be popular with volunteers and have successful outcomes. VtC aims to give hands-on experience to people contemplating a career in the NHS, through volunteering, support in developing their skills and knowledge, and with mentoring, supported by the Head of

Non-Medical Education. The programme is now offered to all new volunteers with an interest in a career within the NHS and we run two 6-month cohorts each year.

National recognition - In February 2026 the Director and Head of Public Participation were invited to attend a reception in the House of Commons where Helpforce (a national charity to support volunteering in health and social care) brought together policy leaders to explore how the healthcare and voluntary, community and social enterprise (VCSE) sectors can play their full role in transforming the impact of volunteers. They also presented their landmark report, 'Reimagining Healthcare Volunteering' which prominently featured the volunteering services we currently offer, along with referencing the impact and success of our Volunteer Driver Service.

Our Volunteer to Career programme was showcased by Helpforce and we were invited to present details of it to the Health Service Journal (HSJ) judging panel. We were also invited to the Award ceremony in March 2026 where Helpforce won the HSJ Award for 'Staffing Solution of the Year'.

SaTH Charity

Full details about the Shrewsbury and Telford Hospital NHS Trust Charity (number 1107883), including latest annual report and accounts, can be found on the Charity Commission website here:
https://register-of-charities.charitycommission.gov.uk/charity-search/-/charity-details/4013618

Sustainability

Climate Change

Our everyday activities are having a profound impact on the environment with irrevocable consequences - biodiversity loss and mass extinction, plastics in our food chain, acidification of our seas and climate change that will bring about frequent and often disastrous weather events. We must therefore maintain momentum in minimising our contribution to carbon in the atmosphere, products that persist in nature, and the destruction of other species due to loss of natural habitats. Extreme weather events and infectious diseases are now a very real and tangible part of our lives. Human activities have already set in motion these occurrences and therefore, we must adapt.

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

Green Plan

Green plans should set out the key actions each system and trust will take to deliver emissions reductions and support resilience to climate impacts over the next three years. The current organisational Green Plan has been updated in line with the new NHS Green plan guidance issued in February 2025.

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

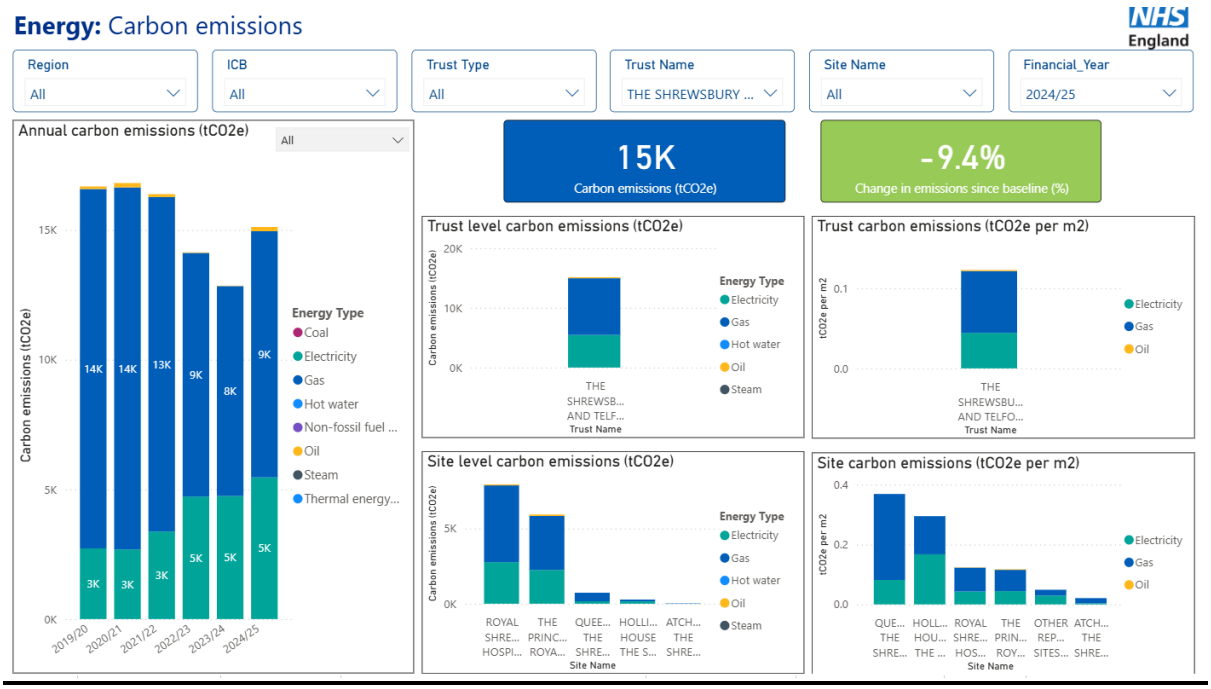
Measuring sustainability

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

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

Carbon Management

In line with the NHS Energy Dashboard, we are able to track our carbon emissions by site, although the data lags behind by a year. Estates Return Information Collection (ERIC) data is used by NHS England to track the energy usage and carbon emissions. The data below highlights the Trust's increase in carbon emissions from -23% in 2023/24 to -9% in 2024/25. This has been investigated and was linked to a faulty gas meter. The Trust is anticipating a reduction in 2025/26 data.



Energy Management

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

In November 2023, the Trust applied for a Salix grant of circa £16.2million for investment in energy management and carbon reduction measures at the Royal Shrewsbury Hospital to address end of life critical steam infrastructure. The project is due to be commissioned in August 2026 in conjunction with our partners Vital Energi.

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

The Trust was successful in November 2025 in achieving £100,000 grant funding to support our transition to LED lighting across sites which currently do not have LED lighting or daylight-saving

lights. These sites were Queensway Central Sterile Services Department (CSSD), areas within Princess Royal Hospital and Royal Shrewsbury Hospital. This is supporting our strategy to reducing energy across our sites.

In line with the NHS Travel and Transport Strategy we have started to replace our fleet vehicles to become fully electrically powered. The Trust are transitioning to an Electric Vehicle (EV) fleet with four vehicles currently operational. To support this transition, we have installed 32 chargers across our sites. The Trust was successful in obtaining £35,000 of accelerated charger funding from the Department of Health and Social Care to support our vehicles in 2025.

The Trust was awarded additional GB Energy funding for a 340kwh solar car canopy, which has been constructed at Princess Royal Hospital. The solar car canopy is anticipated to deliver £70,000 savings per year.

Energy Usage

The general pattern of energy consumption for the Trust is included in the following table. Electricity usage overall has increased slightly compared to 2023/24 which is indicative of the decarbonisation expectations (because decarbonisation uses more electricity). The gas usage also increased at Royal Shrewsbury Hospital which was not expected and an issue with the gas main was identified and rectified. Whilst the cost of energy has increased compared to 2023/24, we also expect a further inflation in energy prices as a result of international cost pressures.

Energy usage table:

Utility	Royal Shrewsbury Hospital (RSH)	Princess Royal Hospital (PRH)	Other sites	Total
Gas				
2023/24	21,773,725 kWh	9,129,692 kWh	4,765,069 kWh	**35,668,486 kWh**
2024/25	23,910,704 kWh	18,540,586 kWh	4,648,598 kWh	**47,099,888 kWh**
2025/26	23,597,130 kWh	6,177,400 kWh	6,174,678 kWh	**35,949,208 kWh**
Electric				
2023/24	9,112,669 kWh	7,093,555 kWh	1,822,489 kWh	**18,028,713 kWh**
2024/25	10,022,869 kWh	8,160,331kWh	1,830,675 kWh	**20,013,875 kWh**
2025/26	10,762,479 kWh	9,813,135 kWh	1,671,464 kWh	**22,247,078 kWh**
Water				
2025/26	236,537 m3	130,030 m3	28,397 m3	**394,964 m3**

The numbers in the table above are indictive of the Trust's expectations, a reduction in gas and an increase in electricity. The Trust is investing in both acute hospital sites looking at low carbon

technologies. This is aided by the Combined Heat and Power (CHPs) at both sites, and both are end of life and no longer used.

The annual report also includes water for 2025/26. As part of our new Green Plan and water contract we are looking to reduce our water consumption.

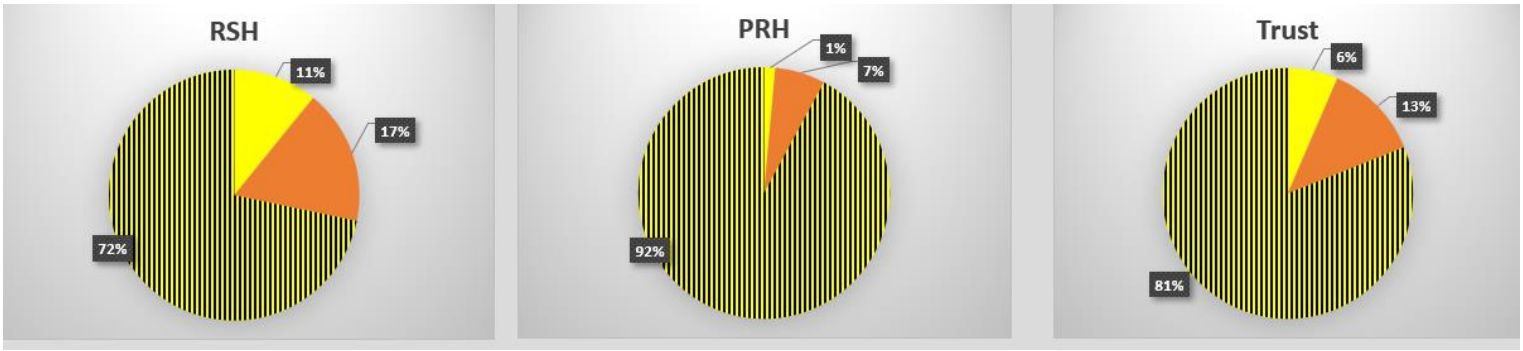
Waste

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

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

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

The waste figures for 2025/26 at our acute sites are below:



Waste Stream	Total Spend	Total Weight
Offensive (yellow stripes)	£327,973	885.02 tonnes
Infectious (yellow)	£81,560	137.12 tonnes
High Temperature Incineration HTI (orange)	£69,308	70.69 tonnes
Others	£25,420	25.89 tonnes

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

The Trust continues to take an environmentally friendly approach towards the disposal of ‘sharps’ waste, by employing a greener approach with the utilisation of re-used sharps containers. In 2025/26 the Trust have saved 46 tonnes of single use plastic from being burnt and 313 tonnes of CO2 emissions.

Year	2025									2026			Total
CustomerName	April	May	June	July	August	September	October	November	December	January	February	March	
⊞ Shrewsbury + Telford Hospital NHS FT	3.433	3.238	2.878	3.299	3.142	2.998	3.643	2.925	3.484	3.609	3.187	3.002	38.839
Total	3.433	3.238	2.878	3.299	3.142	2.998	3.643	2.925	3.484	3.609	3.187	3.002	38.839

A furniture reuse system is in place across our sites to enable staff to internally exchange furniture between departments. Fourteen percent of staff are now active members of this reuse, reduce furniture and office stationery scheme. We have had a significant number of office moves are part of our Hospitals Transformation programme. We are proud of the fact that use of this scheme saved the Trust £52,768 and 25.7 tonnes of carbon dioxide.

The Trust trialled a furniture repair scheme in 2025. This was successful and has been expanded saving circa £7,312 of furniture procurement costs and disposal costs to landfill.

Our Walking Aid Return and Reuse Scheme was introduced at the end of August 2023; however, due to the significant building works on site this has been paused. The Trust will recommence this as soon as possible.

Transport

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

The latest staff travel survey was completed in March 2026. 473 staff completed the survey, and the data will be updated in the Green Travel Plan. There has been a decrease in the staff survey completion from 801 in 2025.

The majority of staff work at the Royal Shrewsbury Hospital (66%) and Princess Royal Hospital (26%), with 8% working at other sites for those that responded to the survey.

There has been a reduction in the single vehicle occupancy rate of those who answered. Most staff travel to work by car on their own (70%), followed by an increase in car sharing (9%) and cycling (7%) and walking (5%).

Approximately 30% of staff choose not to bring their car to work, and instead use buses, cycles, e-bikes, shared lifts, motorcycles or walk to work. This is a reduction of car usage by a further 2% since the 2025 survey.

Travel mode table

Response	**Mode Share %**				
Travel Mode	**2021**	**2023**	**2024**	**2025**	**2026**
Walk	6.8%	7.50%	6.50%	7.62%	5%
Cycle	6.5%	3.90%	6.90%	5.62%	7.4%
Cycle Train	0.0%	0.00%	0.00%	No data	0.0
Electric Bike	1.1%	No data	0.6%	0.50%	0.6%
Bus	4.1%	4.40%	3.10%	3.12%	3.8%
Train	0.5%	0.30%	0.80%	0.37%	1%
Motorcycle	0.9%	0.50%	0.20%	0.75%	1.2%
Lift in car that then goes elsewhere	2.9%	1.80%	1.40%	2.37%	1.4%
Taxi	0.9%	1.80%	0.20%	0.37%	0.4%
Car Share	2.0%	5.00%	5.10%	6.49%	9%
Single Occupancy Vehicle (SOV)	74.4%	74.80%	75.20%	72.78%	69.5%

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

To alleviate car parking issues and provide further sustainable travel options on both acute hospital sites, the Trust have procured two Park and Ride facilities near both sites for staff. The Park and Ride facility at RSH is also open to patients to provide additional parking. The Trust are working closely with our ICS partners to promote active travel and exploring opportunities.

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

Biodiversity

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

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

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

Task force on climate related financial disclosures (TFCD)

The Group Accounting Manual has adopted a phased approach to incorporating the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector

annual reports. TCFD recommended disclosures as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, have been implemented in sustainability reporting requirements on a phased basis up to the 2025/26 financial year. Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHS England. Further adaptation has been made by the Group Accounting Manual in relation to the requirement to develop scenario analysis as part of the strategy recommended disclosures.

TCFD recommended disclosures as interpreted and adapted by the Group Accounting Manual are provided below.

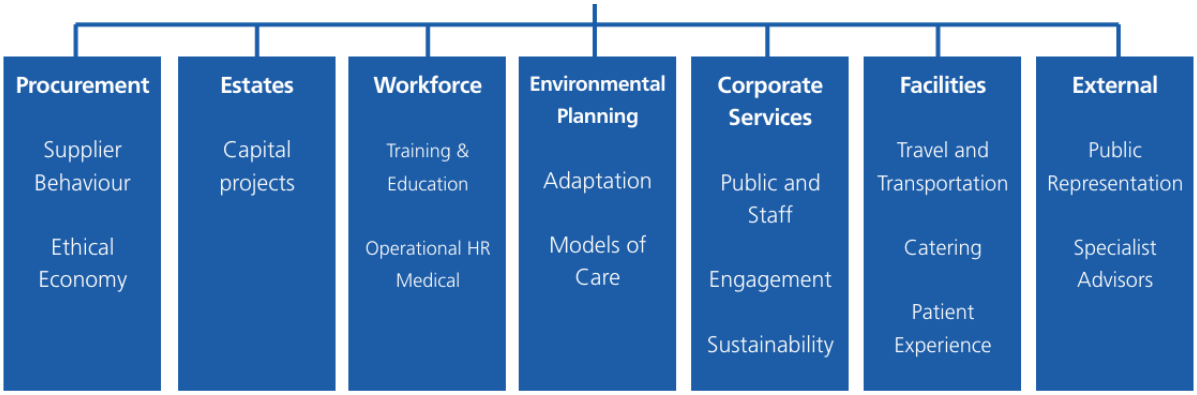
Governance

The Trust acknowledges the impact that we have on our communities and local economy, society and environment. We are committed to integrate sustainable development into our business.

SaTH has a well-established Climate Change Group which reports into the Performance Assurance Committee (PAC), reflecting the core standards detailed within the Greener NHS National Programme. Each of which has a part to play in delivering sustainable services. The targets set in our 2025-2028 Green Plan are based upon our most recent (2020) sustainability assessment.

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

Climate Change Group membership:



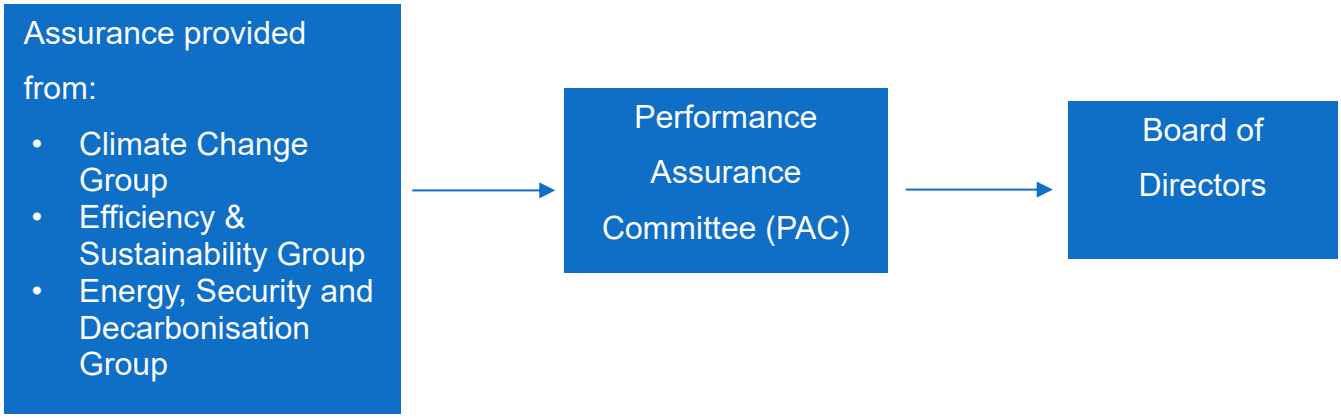
The Climate Change Group provides summary 'key issues' reports through to the Performance Assurance Committee together with a comprehensive annual report, which is also submitted to the Board of Directors' public meeting. These documents are publicly available on the Trust's website.

SaTH is also a core member of the ICS Climate Change Group. The Board received the refreshed 2025 Green Plan and the Shropshire, Telford and Wrekin ICS Green Plan 2025 - 2028.

The Lead Director for Environmental Sustainability at the Trust is Matt Neal, Group Chief Estates, Facilities, and Capital Officer who chairs the Climate Change Group.

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

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



Metric and Targets Pillar

In line with NHS guidance, the Trust refreshed its Green Plan in October 2025. The Green Plan action programme provides the main delivery framework for sustainability, and the Trust uses a set of operational and programme metrics (for example, energy and renewables performance, delivery of funded decarbonisation schemes, travel and transport indicators, waste and recycling measures and procurement levers) to assess progress and to inform decision-making.

Targets and performance are monitored through the Green Plan governance structure (including the Climate Change Group and reporting to the Performance Assurance Committee and Board) and through delivery programmes across estates, travel and transport, procurement, and clinical transformation. In line with the Group Accounting Manual's 2025/26 requirements, the Trust reports against the metrics and targets pillar; however, the requirement to disclose Scope 1, 2 and 3 greenhouse gas emissions (and related risks) is treated as an exception within these disclosures. Where relevant targets are defined nationally (e.g., NHS net zero ambitions) or locally (e.g., programme delivery milestones), these are used to set direction and track progress, and the Trust will continue to develop and refine its local metric set over time.

Metric	What it measures / why it matters	Target / ambition	Progress / examples (2025/26)
Delivery of funded decarbonisation schemes	Progress on capital programmes that reduce carbon, improve energy resilience and reduce operating costs.	Deliver Green Plan and estates decarbonisation milestones aligned to NHS net zero ambition (local milestones in development).	PSDS (Public Sector Decarbonisation Funding) 3C funding secured for a £16.2m decarbonisation scheme at Royal Shrewsbury Hospital (estimated to reduce emissions by >3,000 tonnes of carbon each year and save circa. £1m per annum in energy costs when complete). Commenced in 2024 and due to complete in August 2026.
Onsite renewables generation	Local renewable electricity supports decarbonisation and reduces exposure to energy price volatility.	Increase onsite renewables generation	Funding from GB Energy in 2025/26 has provided a solar car canopy at PRH – 431 kwh system, anticipated to save the Trust £70,000 a year.
Elective Vehicle (EV) charging infrastructure	Supports staff/patient/operational fleet transition to lower-emission vehicles.	Continue to expand and optimise EV charging to support transition	32 electric vehicle chargers across Royal Shrewsbury Hospital, Princess Royal Hospital, Sentinel Works and Hollinswood House (including ambulance charging at PRH).
Travel demand / car sharing indicators	Encourages modal shift and reduces single occupancy travel, supporting air quality and emissions reduction.	Reduce single occupancy travel	Annual travel survey implemented; lift-share spaces managed: 54 at RSH and 8 at PRH.
Waste reduction and recycling	Reduces environmental impact and can reduce	Improve segregation and increase recycling	Cardboard recycling introduced: 115 tonnes. WARP-IT reuse scheme

	disposal costs; supports circular economy.		savings increased from £29,000 to £52,000. Inhaler recycling introduced with Pharmacy; reusable cups/food containers introduced in canteen provision; Simply Recycling rollout commenced.
Procurement levers (social value)	Supports supplier engagement and broader sustainability outcomes (including climate, health and inequalities).	Apply social value and sustainability criteria where applicable	10% social value included on threshold applicable tenders and tracked through projects.

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

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

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

Progress to date

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

- Inclusion of sustainability as a material consideration in all business cases.
- Implementation of an annual travel survey to measure changes in the ways that staff travel to work and for work.
- Installation of 32 (increase from 12 in 2025) electric vehicle chargers across Royal Shrewsbury Hospital, Princess Royal Hospital, Sentinel Works and Hollinswood House and the conversion of our vehicle lease schemes to electric or ultra-low emission vehicles for all new leases.
- Inclusion of 10% social value on threshold applicable tenders which are tracked through projects.
- Completion of a range of estates energy improvements including enhanced roof

insulation as well as solar panels at Royal Shrewsbury Hospital site.

- Development of Heat Decarbonisation plans for all our acute Trust sites.
- Attainment of Public Sector Decarbonisation Scheme (PSDS 3C) funding for a decarbonisation scheme at Royal Shrewsbury Hospital (£16.2m). When the work is complete, the investment will save the Trust an estimated £1m a year in energy costs and will reduce the hospital's emissions by over 3,000 tonnes of carbon each year.
- Successful GB Energy funding of £1million for a soalr car canopy at Princess Royal Hospital.
- Additional £100,000 LED lighting scheme at Royal Shrewsbury Hospital, Princess Royal Hospital and Queensway.
- Management of 54 'lift-share spaces' at Royal Shrewsbury Hospital and 8 at PRH.
- Commenced simply recycling roll out to all satelite areas and the main acute sites within a recyling programme.
- Implementation of a range of measures to embed sustainability into Trust processes. This includes changes to financial planning and approval such as, business cases, capital plans and travel expenses. It also includes changes to Human Resource processes such as sustainability sections in induction documents, job descriptions and staff statutory mandatory training.
- Increase of WARP-IT scheme for staff to exchange unwanted goods, reducing waste at PRH and RSH from £29,000 (2024/25) to £52,000 saving (2025/26).
- Introduction of reuseable cup and food containers within our canteen provision.
- Introduction of inhaler recycling in collaboration with Pharmacy Department.
- Maintaining waste management in line with the NHS clinical waste strategy (60,20,20): 74% Offensive waste, 6% Incineration, 20% clinical waste.
- The Trust has an allocated Net Zero Clinical Transformation and Digital Transformation in the 2025 – 2028 Green Plan.

There are areas that the Trust is working towards, as follows:

2025 - 2028 Green Plan action	Areas for improvement
Agile Working Strategy	An agile working strategy task and finish group has been established and the Trust is working to achieve this as part of the digital transformation workstream.
Travel	The amount of 'grey fleet' mileage has increased since 2019. The Trust is trying to reduce this in line with the agile working strategy.
Procurement	The Trust has been unable to reduce single use items. A working group has been identified to look at the scope for introducing reusables across a variety of departments.

Clinical	Following the inclusion of a net zero clinical lead in the 2025 - 2028 Green Plan there will be further opportunities, for example, use of IV paracetamol for post operative patients.

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

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

To achieve the required actions, we will:

- Ensure that we have the right people delivering our net zero agenda.
- Consider how we can deliver care in a sustainable, balanced way.
- Harness digital technologies to approach a multifaceted challenge of delivering quality care outcomes, improving the quality of our care and diagnostics, reducing waste, and optimising our building services.
- Encourage our communities to avoid contributing to our carbon output.
- Focus on our supply chain's commitments to achieving net zero.
- Build on progress in reducing these "point of use" emissions, while improving patient care and reducing waste.
- Implement and govern the decarbonisation plans, continuing our transition to renewable energy, and in the interim making every kilowatt of fossil fuel energy count.
- Adopt practices to avoid creating waste that persists in nature, and recycling those we cannot.
- Adapt our services to meet the challenges of climate change and extreme weather events.
- Outline a plan to decarbonise NHS travel and transport, while also providing cost-saving and health benefits.

The role of management in assessing and managing climate related issues

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

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

Over the past twelve months the Trust has made significant progress towards the NHS Net Zero targets which have been highlighted by the financial investment from external and internal funding. We recognise that there is a lot more to progress in relation to areas of climate change and sustainable development and communicating this with our colleagues.

Strategy Pillar

The Trust's approach to climate-related risks and opportunities is set out through our Green Plan 2025–2028, our participation in the Shropshire, Telford and Wrekin ICS Green Plan, and the work programmes overseen by the Climate Change Group and Energy, Security and Decarbonisation Steering Group. This provides a structured framework for identifying, prioritising and responding to climate-related risks and opportunities over the short term (0–3 years), medium term (3–10 years) and long term (10+ years), in line with NHS net zero ambitions.

Climate-related risks and opportunities can affect the Trust's ability to deliver services, the resilience of our estate and infrastructure, our workforce and patient experience, and the affordability of our operating model. Under a global warming pathway of 2°C or lower, we anticipate increasing regulatory and reporting requirements, higher expectations on supply chain emissions, and the need to accelerate decarbonisation of heat, power, anaesthetic gases, medicines and transport. These considerations are reflected in strategic and operational planning through estates and capital programmes (including investment cases that consider sustainability), energy and utilities planning, procurement approaches (including social value), and delivery of the Green Plan action programme. Financial impacts may materialise through changes in energy and carbon-related costs, the need for capital investment (and associated financing), potential disruption costs linked to severe weather, and opportunities to improve efficiency and reduce running costs through energy conservation and low-carbon technologies.

Key climate-related risks: Extreme weather impacts (heatwaves, flooding, storms) affecting site access, clinical operations and business continuity; transition risk from decarbonising heat and power (technology availability, capital affordability, delivery dependencies); rising energy price volatility; air quality impacts affecting patient and staff health; and supply chain disruption and Scope 3 expectations.

Key climate-related opportunities: Improved energy efficiency and onsite renewables to reduce costs and emissions; fleet and travel interventions (including electric vehicle infrastructure and agile working approaches) to reduce travel emissions; procurement and social

value levers to influence suppliers; waste reduction and recycling initiatives; and service redesign and digital transformation that reduce resource use while maintaining or improving care quality.

Scenario analysis and resilience

In line with TCFD recommendations, the Trust has considered the resilience of our strategy and operations against a range of climate-related scenarios across short term (0–3 years), medium term (3–10 years) and long term (10+ years) horizons. This includes a transition scenario aligned to limiting warming to 2°C or lower (reflecting accelerated decarbonisation, regulatory and supply chain change) and a higher physical-risk scenario (reflecting more frequent and severe heatwaves, flooding and storms). The scenario analysis is used to inform priorities within the Green Plan 2025–2028, estates and capital programmes (including our Heat Decarbonisation Plans for acute sites), and emergency preparedness and business continuity planning. Recent and planned SaTH delivery examples that support strategy resilience include securing Public Sector Decarbonisation Scheme (PSDS 3C) funding for a £16.2m decarbonisation scheme at Royal Shrewsbury Hospital (estimated to reduce emissions by over 3,000 tonnes of carbon each year and save around £1m per annum in energy costs when complete), investing in energy efficiency measures (including insulation and LED lighting), expanding onsite renewables and developing further renewable projects such as the £1m solar car canopy at Princess Royal Hospital.

Transition (≤2°C) – strategy implications: Accelerated decarbonisation increases the need for invest-to-save schemes and delivery capacity for heat and power decarbonisation, energy efficiency and onsite renewables. For SaTH this includes progressing Heat Decarbonisation Plans and delivery of the PSDS 3C £16.2m Royal Shrewsbury Hospital scheme, alongside efficiency measures (e.g., LED lighting and insulation) and renewable generation projects (e.g., solar PV at RSH and the planned solar car canopy at PRH). Transition requirements also increase expectations for low-carbon clinical pathways (e.g., reducing nitrous oxide and lower carbon medicines) and for sustainable procurement and supplier engagement (including social value requirements).

Higher physical-risk scenario – resilience implications: Increased likelihood of disruption from heat, flooding and storms can affect building performance, plant reliability, staff and patient travel, patient flows, and supply chain continuity across Trust sites. SaTH mitigations and resilience measures include maintaining and updating relevant plans (e.g., heatwave/adverse weather response through EPRR and business continuity), prioritising estate measures that improve building performance during heat (such as insulation and targeted upgrades), and investing in local energy resilience through energy efficiency and onsite renewables. Travel disruption risk reinforces the value of travel demand measures (including agile working where appropriate), lift-share spaces, and the provision of electric vehicle and ambulance charging

infrastructure to support the transition to cleaner transport without compromising operational readiness.

Embedding in decision-making: Climate considerations are incorporated into relevant business cases and capital planning (including making sustainability a material consideration in business cases) and are tracked through governance routes. Examples of delivery informed by these considerations include expanding EV charging to 32 chargers across Royal Shrewsbury Hospital, Princess Royal Hospital, Sentinel Works and Hollinswood House (including ambulance charging at PRH), incorporating social value into applicable tenders, and implementing clinical and waste-related initiatives such as piped nitrous oxide removal funding at PRH, inhaler recycling with Pharmacy, and increased cardboard recycling. The Trust will continue to develop its evidence base (including estates condition, energy and climate risk data) to refine scenario analysis and prioritise interventions that improve service resilience and reduce emissions.

Risk Management Pillar

The Trust manages risk in line with its Risk Management Policy and associated processes for identifying, assessing, managing and monitoring risks. Climate-related risks are considered alongside other principal risks to the Trust's strategic objectives and service delivery, and are recorded, monitored and escalated through the Trust's established risk management framework (including the Datix risk register and reporting to appropriate committees).

The Trust identifies climate-related risks through multiple sources, including the Climate Change Group (which considers risks arising from the Green Plan programme, estates and infrastructure, energy security, travel and transport, procurement, and clinical transformation), insights from incident/business continuity planning, and changes in external requirements (e.g., national targets, regulation and reporting expectations). Identified risks are documented on the Datix risk register with defined risk owners, controls and actions, and are reviewed and updated in accordance with the Trust's risk management cycle. For example, the Trust has an overall risk relating to the risk of not achieving net zero by 2040, reflecting dependencies on funding availability and technology readiness.

The Trust also identifies air pollution as a climate-related risk, including impacts from tailpipe and non-tailpipe emissions from vehicles on site and on surrounding routes, smoking on site, emissions from boilers and catering equipment, dust from construction activity, fumes from cleaning products, and air pollution from nearby businesses and homes. Actions to mitigate and manage this risk are taken through relevant work programmes (including travel and transport initiatives, estates decarbonisation and efficiency schemes, and on-site operational controls) and are tracked through the Datix risk register.

The Trust is committed to considering climate-related issues when reviewing organisational plans and monitoring performance. Climate-related risks are integrated into the Trust's overall

risk management approach through the Datix risk register, routine divisional/directorate risk reviews, and escalation routes to the Risk Management Committee, Audit & Risk Assurance Committee (ARAC) and the Board, as appropriate. The Board incorporated climate-related risks within its risk appetite statement in 2024/25 (approved September 2024), supporting consistent assessment and decision-making for climate-related risks across the organisation.

The following outlines the process for managing our climate-related risks:

- **Identifying climate-related risks:** risks and emerging issues are identified through the Climate Change Group, estates and capital planning (including Heat Decarbonisation Plans), operational resilience and business continuity activity, and review of external policy and guidance.
- **Assessing climate-related risks:** risks are assessed using the Trust's standard risk scoring methodology (considering likelihood and impact) and are reviewed over short, medium and long-term horizons where relevant, reflecting both physical and transition risks.
- **Managing and monitoring climate-related risks:** risks are recorded on Datix with defined owners, controls and actions; progress is monitored through relevant delivery groups (e.g., Climate Change Group and Energy, Security and Decarbonisation Steering Group) and through routine risk review cycles.
- **Integration and escalation:** climate-related risks are managed within the Trust's overall governance and assurance framework, with escalation through divisional/directorate processes and to the Risk Management Committee, Audit and Risk Assurance Committee and the Board as appropriate, aligned to the Trust's risk appetite.

Organisational arrangements for managing climate related risks

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

Board of Directors	The Board of Directors has overall responsibility for ensuring the Trust has effective systems for managing risk to enable the organisation to deliver its objectives.
Audit & Risk Assurance Committee (ARAC)	ARAC receives the Trust Risk Report to seek assurance that the structures and processes in place regarding operational risk management within the Trust are robust. The Committee will liaise with other board assurance committees and internal and external audit to support this role and will report to the Board with a level of assurance gained from the information presented to them.

Risk Management Committee	The purpose of the Risk Management Committee is to support the Audit & Risk Assurance Committee, by obtaining objective assurance that the framework and systems for risk management are robust and effective. The Risk Management Committee has overall responsibility for establishing a pro-active approach to risk management across the various divisions and directorates across the Trust. Divisions/Directorates will be expected to present new risks/provide updates on all risks with a current (residual) rating of 15 and above, to allow for constructive challenge, and provide assurances that effective controls to mitigate the risk are in place.
Operational Divisions/Corporate Directorate	The Divisions/Directorate are responsible for reviewing and controlling the risks within their areas.
Specialities/Wards/ Corporate Departments	Speciality Governance/Wards/Corporate Department Teams are responsible for reviewing and controlling the risks within their areas.

Signed by:

Jo Williams
Group Chief Executive
22 June 2026

Part two:

Accountability Report

Corporate Governance Report

The Directors Report

The Board of Directors present their report and audited financial statements for the financial year ended 31 March 2026.

In accordance with its Establishment Order, the Board of Directors comprises seven non-executive directors and five executive directors, one of whom is the Chief Executive. All directors are required to comply with Trust policies, including the need to declare any actual or potential conflict of interest, and must comply with the Fit and Proper Persons Test requirements.

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

Directors serving during the 2025/26 year were:

Non-executive directors (voting Board members)

Andrew Morgan (Group Chair)

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

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

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

Teresa Boughey

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

She is the Founder and CEO of Jungle HR, a multi-award-winning strategic consultancy, and brings over 25 years' senior-level HR and business transformation experience across a range of sectors. A published bestselling author and TEDx speaker, her book, *Closing the Gap – 5 Steps to Creating an Inclusive Culture*, was ranked Amazon No.1 and Highly Commended at the Business Book Awards for its contribution to diversity and inclusion. Mrs Boughey is a Board Advisor at Royal Holloway University, School of Business and Management. Mrs Boughey is also a recognised policy influencer, serving as a member of the Modernising Employment All Party Parliamentary Group and contributing to the development of the first UK National Hiring Strategy, which was launched in Westminster in March 2026. She was also invited as a keynote speaker on Responsible Employers, contributing to the associated Government and industry guidance.

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

selected to join NHS England's flagship Aspiring Chairs Programme in 2025, graduating in March 2026.

Raj Dhaliwal

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

Previous roles have included being responsible for lending operations for business banking and mortgages, for ensuring over £36bn of lending approvals were safely disbursed within a controlled manner and also for technology change standards.

Currently he is Head of Group Technology Architecture & End User Developed Application Standards, and responsible for the policy and standards at an Enterprise level.

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

Sarah Dunnett

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

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

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

Rosi Edwards

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

Remuneration Committee and the Charitable Funds Committee and is currently serving on the Quality and Safety Assurance Committee and the People and Organisational Development Assurance Committee. At system level, she attends the Shropshire Telford and Wrekin Integrated Care Board Quality and Performance Committee.

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

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

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

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

Professor Trevor Purt

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

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

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

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

Richard Miner

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

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

Wendy Nicholson MBE

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

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

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

She has worked closely with Ministers and across multiple government departments including DfE, DWP, Ministry of Defence, Ministry of Justice, Home Office, and the Cabinet Office –

working on issues including FGM, maternal and child obesity, immunisation programmes, Military families' health, adult and young carers; workforce planning; child deaths and safeguarding, Commissioning guidance for Public Health Services; and, the vulnerability Framework during Covid.

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

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

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

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

Associate non-executive directors (non-voting)

Simon Crowther

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

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

Mr Crowther's professional background includes significant interactions with the NHS, having worked with University Hospitals Coventry and Warwickshire NHS Trust on operational scorecards and Birmingham and Solihull Mental Health NHS Foundation Trust on strategy

deployment. Born and raised in Shrewsbury, he maintains strong ties to the area, providing a deep understanding of the community served by SaTH.

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

Professor Heidi Fuller (from April 2025)
Professor Heidi Fuller joined the Trust board in April 2025. In her substantive role, Heidi is the Head of School for Allied Health Professions and Pharmacy at Keele University, which is home to students across a range of programmes spanning Pharmacy Pharmaceutical Science, Medical Technologies, Allied Health Therapies, and Active Living and Sports. Alongside, Heidi is the Research Director at the Wolfson Centre for Inherited Neuromuscular Disease, a Muscular Dystrophy UK “Centre of Excellence”, based at the Robert Jones and Agnes Hunt Orthopaedic Hospital. The Centre comprises of a multidisciplinary team of NHS clinicians, postdoctoral researchers and students who undertake laboratory and clinical research focused on neuromuscular disease and injury.

Heidi received her first degree in Biomolecular Science at Bangor University in Wales, before undertaking an industry sponsored PhD in molecular biology and biochemistry. Prior to becoming Head of School, Heidi worked in a variety of academic research and education focused roles, most recently as the Dean of Education for the Faculty of Medicine and Health Sciences at Keele University which houses students across schools of Medicine, Nursing and Midwifery, Allied Health Professions and Pharmacy. Within this role, Heidi led strategic priorities relating to development of new education programmes and growth to meet health workforce demands, academic quality assurance and enhancement, and internationalisation of programmes in global and public health.

Heidi holds several roles external to the University, including being a consultant for the Muscular Dystrophy UK Research Committee and the Italian Medicines Agency funding panel. She has also recently undertaken consultancy assignments including hospital inspections for the Falkland Islands Government Health Service, the Ministry of Health, Tourism and Sports in Anguilla, the Ministry of Health and Social Services in Montserrat, and a molecular diagnostics service review for the Gibraltar Health Authority.

Jonathan Sargeant (from April 2025)
Mr Sargeant is a member of the Finance Assurance Committee, Audit and Risk Assurance Committee and the Charitable Funds Committee. He joined the Trust board as an Associate Non-Executive Director in April 2025.

Mr Sargeant is a qualified Chartered Management Accountant with over 25 years’ experience as an NHS Director covering both acute, community and an ambulance trust as Finance

Director. Mr Sargeant has a depth of experience in producing large strategic business cases having worked on cases for new hospitals and substantial rebuilds at several trusts through his career. In his last role before retirement Mr Sargeant was deputy CEO at Doncaster and Bassetlaw University Hospitals NHS Trust with responsibility for Transformation and Strategy.

He is also a Trustee for the Ashgate Hospice Charity in Chesterfield.

Executive directors (voting Board members)

Joanne Williams – Group Chief Executive Officer

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

Jo was appointed substantive CEO at Shrewsbury and Telford (SaTH) in July 2025 and subsequently took up the role of Group CEO from 1 September 2025.

Jo has worked in a wide range of senior management roles across several acute trusts, including University Hospital of Birmingham (UHB), Wythenshawe Hospital (UHSM), and Chesterfield Royal Hospital (CRH). This work has focused on delivering operational performance, leading service transformation, and improving patient care.

Alongside 26 years in the NHS, Jo has experience in procurement, including work within the NHS, a role 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 committed to building an inclusive organisational culture where everyone can be themselves and flourish, with staff health, wellbeing, and engagement placed at the heart of organisations. For work at The Royal Orthopaedic Hospital, Birmingham she was awarded “CEO of the Year” at the Inclusive Awards 2024.

With a strong focus on putting patients, families, and NHS colleagues at the centre of everything undertaken, Jo leadership style and experience have also been recognised through the award of Honorary Doctorates from Aston University and Birmingham City University, which continue to be actively supported and championed.

Jo is a Trustee at Arthritis UK and is passionate about ensuring people can access the treatments and support they need to live the life they choose, with real hope of a cure in the future.

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

Having worked in many Hospitals during her 42-year career, she has enjoyed all levels of posts from Staff Nurse, Junior Sister, Senior Sister, Service Improvement Manager, Matron, Divisional Director of Nursing, Deputy Chief Nurse and then Chief Nurse. The SaTH Interim Chief Nursing Officer appointment from 1 December 2024 is her 5th Chief Nurse post.

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

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

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

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

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

Since joining SaTH, Mr Hobbs has led the Trust's improvement programmes for Elective Care, Diagnostics, Cancer and Urgent & Emergency Care services. Mr Hobbs was appointed Deputy

Chief Executive Officer and commenced these duties (in addition to his Chief Operating Officer role) in February 2026. Mr Hobbs also took on the role of Chair of the West Midlands Radiotherapy Network in January 2026.

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

Dr John Jones – Medical Director

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

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

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

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

Adam Winstanley – Acting Director of Finance

Mr Winstanley joined the NHS in 2006 after graduating from Aston University with a degree in Accounting for Management, spending the early part of his career in the provider sector within the West Midlands. He joined SaTH in April 2022 as Deputy Director of Finance (Operational), stepping up to the Acting Director of Finance role in January 2025.

Mr Winstanley is a keen advocate of developing financial knowledge of all colleagues to ensure there is a thorough understanding of finance within organisations to assist in the provision of high quality care to our patients and communities. This was acknowledged in 2024 with the finance department winning both the Finance Team of the Year and the Havelock Training awards at the national Healthcare Finance Management Association (HFMA) conference.

In addition, Mr Winstanley grew up in Shropshire and has many family members as part of our communities and users of SaTH's healthcare services. He now lives in Staffordshire with his wife and three children.

Executive directors (non-voting)

Rhia Boyode – Group Chief People Officer

Ms Boyode has an accomplished career spanning Organisational Development and Human Resources across both the private and public sectors globally.

In October 2025, Rhia Boyode was appointed Group Chief People Officer for both SaTH and Shropshire Community Health NHS Trust (working together since 1 April 2026 as Shropshire, Telford & Wrekin Community and Hospitals NHS Group).

Ms Boyode holds a Master of Science degree in Human Resource Management and is a Fellow of the Chartered Institute of Personnel and Development (CIPD).

Nigel Lee – Director of Strategy and Partnerships

Beginning his career as a helicopter pilot in the RAF both in Search and Rescue and Operations Support roles, Mr Lee served in Northern Ireland, the Falkland Islands, and Iraq. He completed tours in the Defence Procurement Agency and Ministry of Defence on major procurement and workforce programmes and strategic planning, before starting his healthcare career in 2006 as a hospital director for a BUPA hospital in the Wirral. From there, he became divisional director at Alder Hey Children's Hospital and subsequently Aintree University Hospital.

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

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

Anna Milanec – Director of Governance

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

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

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

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

Tracey Cotterill - Interim Director of Financial Recovery (since April 2025)
Tracey joined the Trust in April 2025 as Interim Director of Financial Recovery. She is an experienced qualified accountant and was awarded an MBA in 2012.

She has held a number of board level roles in the NHS during a career in finance spanning over 30 years. As well as working in acute, community and mental health providers, she has worked in other public sector services and the private sector, both in the UK and Canada.

Tracey is particularly interested in how digital solutions can support the NHS to meet the growing demands for healthcare and address health inequalities.

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

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

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

Executive directors who left or changed their positions during the year:
Helen Troalen, Director of Finance – on secondment from 23/6/2025 to 03/04/26.

The membership of the Board is updated on our website, along with a statement about the Board's Balance: https://www.sath.nhs.uk/about-us/trust-information/trust-board-members/

The Board of Directors and meetings

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

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

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

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

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

During 2025/26 the Board of Directors formally met in public seven times (excluding the Annual General Meeting). Attendance at the meetings is shown within the following table:

Board meeting dates in public 2026/26 Board members	8 May 2025	10 July 2025	11 Sep 2025	23 Sep 2025**	13 Nov 2025	15 Jan 2026	12 Mar 2026
Mr Andrew Morgan	√	√	√	√	x	√	√
Ms Joanne Williams	√	√	√	√	√	√	√
Mrs Teresa Boughey	√	√	√	x	√	√	x
Mrs Rhia Boyode*	√	x	√	√	√	√	√
Ms Tracey Cotterill*	√	√	√	√	√	√	√
Mr Simon Crowther*	√	√	√	√	√	x	√
Mr Rajinder Dhaliwal	√	√	√	√	√	√	x
Ms Sarah Dunnett	√	√	√	x	√	√	√
Ms Rosi Edwards	√	√	√	√	√	√	√
Prof Heidi Fuller*	√	√	x	x	√	√	√
Ms Paula Gardner	√	√	√	x	√	√	√
Mr Ned Hobbs	√	x	√	√	√	√	√
Dr John Jones	√	√	x	√	√	√	√
Mr Nigel Lee*	√	√	√	√	√	√	√
Ms Anna Milanec*	√	√	√	√	√	√	√
Mr Richard Miner	√	√	√	x	√	√	√
Ms Wendy Nicholson MBE	√	√	√	√	√	√	√
Prof Trevor Purt	√	√	√	√	√	√	√
Ms Inese Robotham*	√	√	√	√	√	√	x
Mr Jonathan Sargeant*	√	√	√	√	x	√	√
Mr Adam Winstanley	√	√	√	√	√	√	√

* Non-voting Board member

** Note: 23 September 2025 was a Board meeting held in Common with Shropshire Community Health NHS Trust Board.

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

The public Annual General Meeting was held on 25 September 2025.

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

- Audit and Risk Assurance Committee
- Quality and Safety Assurance Committee

- Performance Assurance Committee
- Finance Assurance Committee
- People and Organisational Development Assurance Committee
- Hospitals Transformation Programme Assurance Committee.
- Group Transition Committee (a joint committee with Shropshire Community Health NHS Trust, established August 2025)

In addition, during 2025/26 the Trust had:

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

Audit and Risk Assurance Committee

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

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

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

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

Audit and Risk Assurance Committee attendance report 2025/26 - meeting dates: Non-executive committee members:	14 Apr 2025	19 May 2025	23 June 2025	1 Sept 2025	24 Nov 2025	16 Feb 2026
Trevor Purt (Chair)	√	√	√	√	√	√
Teresa Boughey	x	√	√	√	√	√
Rajinder Dhaliwal	√	√	√	√	√	√
Jonathan Sargeant		x	x	√	√	√
Regular executive attendees:						
Adam Winstanley, Acting Director of Finance	√	√	√	x	√	√
Anna Milanec, Director of Governance	√	√	√	√	√	√

During the year, the committee reviewed and updated its terms of reference; it also reviewed the Trust's Standing Financial Instructions, Standing Orders and Scheme of Reservation and Delegation, which were approved by the Board in January 2026.

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

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

Remuneration Committee

The Remuneration Committee is a statutory committee of the Board of Directors. It has delegated authority from the Board to determine the remuneration and terms of service of

the Board executive directors and other senior managers and to be responsible for identifying and appointing candidates to fill all the executive director positions on the Board. The committee is also authorised to consider any matter relating to the continuing in office of any Board Executive Director. Note: NHS England is responsible for appointing chairs and other non-executive directors of NHS trusts.

The membership of the Committee consists of four Non-Executive Directors, including the Group Chair. In addition to the non-executive members of the committee, regular executive attendees are invited to each meeting.

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

Remuneration Committee Attendee report 2025/2026 Members	28/04/2025	15/05/2025	09/06/2025	24/07/2025	20/10/2025	11/12/2025*	29/01/2026*	26/03/2026*
Andrew Morgan (Group Chair - Chair)	√	x	√	√	√	√	√	√
Prof Trevor Purt (Non-Executive Director - Vice Chair)	√	√ (Chair)	√	√	√	√	√	√
Teresa Boughey (Non-Executive Director)	√	√	x	√	√	x	√	√
Richard Miner (Non-Executive Director)	√	√	√	√	√	√	√	√
Attendees								
Anna Milanec (Director of Governance)	x	√	√	√	x	x	x	x
Rhia Boyode (Group Chief People Officer - Executive Lead)	√	√	√	x	√	√	√	√
Jo Williams (Group Chief Executive)	√	x	x	x	√	√	√	√

* denotes that the meeting was held in common with Shropshire Community Health NHS Trust

Quality and Safety Assurance Committee

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

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

Quality and Safety Assurance Committee Attendance 2025/26

Members:			2025/26									
Name	Title	Role	April	May	June	July	Sept	Oct	Nov	Jan	Feb	Mar
Sarah Dunnett [chair]	Non-Executive Director	Member	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rosi Edwards	Non-Executive Director	Member	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Heidi Fuller	Associate Non-Executive Director	Member		✓	✓	✓	✓	✓	✓	✓	✓	✓
Wendy Nicholson MBE	Non-Executive Director	Member	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Paula Gardner	Interim Chief Nursing Officer	Member	✓	✓	X	✓	✓	✓	X	✓	✓	✓
John Jones	Executive Medical Director	Member	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Note: there was no meeting held in August and December 2025.

Finance Assurance Committee

The Finance Assurance Committee is responsible on behalf of the Board of Directors for objective scrutiny and seeking evidence of assurance of the Trust's financial performance plans, major investment decisions, capital plans and relevant regulatory compliance. It provides the Board with an objective review of the financial position of the Trust and assurance on the delivery of the Trust's financial objectives, including identifying any significant risks and associated mitigating actions. It also considers processes for the preparation and the content of strategic and operational financial plans, including annual revenue, capital and workforce budgets, and test the key assumptions and risks underpinning such plans.

The Finance Assurance Committee meets monthly and is chaired by Richard Miner, Non-Executive Director.

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

Finance Assurance Committee - Attendance 2025/26

		2025											2026			
Name	**Role**	**Apr**	**May**	**Jun (extra 16.06.2025)**	**Jun**	**Jul**	**02.09.2025**	**Sept**	**Oct**	**Nov**	**Dec (extra 02.12.2025)**	**Dec**	**Jan**	**Feb (Extra 02.02.2026)**	**Feb**	**Mar**
Richard Miner [Chair]	Member	✓	✓	x	✓	✓	✓	✓	✓	x	✓	✓	✓	✓	✓	✓
Simon Crowther	Member	✓	✓	✓	✓	✓	✓	✓	✓	✓ (Chair)	✓	✓	✓	✓	✓	✓
Helen Troalen	Member	✓														
Adam Winstanley	Member		✓	✓	✓	x	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Trevor Purt	Member			✓ (Chair)												
Paula Gardner	Member	✓	✓	x	x	✓	✓	✓	✓	x	x	✓	✓	✓	✓	✓
Jonathan Sargeant	Member		✓		x	✓	x	✓	✓	✓	✓	✓	✓	x	✓	✓

Performance Assurance Committee

The Performance Assurance Committee is responsible for providing independent assurance to the Board of Directors regarding: - the development and delivery of the Trust's annual business plan; performance of the Trust across a range of performance indicators within the Integrated Performance Report; and to ensure appropriate Estates and Digital strategies are in place. It also oversees the development of a long-term strategy that addresses all identified operational business risks and opportunities, including those deriving from partnership work.

The committee meets monthly and is chaired by Rosi Edwards, Non-Executive Director.

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

Performance Assurance Committee Attendance 2025/26

Members:		2025/26									
Name	**Role**	**April**	**May**	**June**	**July**	**Sept**	**Oct**	**Nov**	**Jan**	**Feb**	**Mar**
Rosi Edwards [committee chair]	Member	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sarah Dunnett	Member	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rajindar Dhaliwal	Member	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ned Hobbs	Member	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Inese Robotham	Member	✓	✓	✓	✓	✓	✓	✓	x	x	x
Note: There was no meeting held during August or December 2025.											

People and Organisational Development Assurance Committee

The People and Organisation Development Assurance Committee receives assurances that staffing processes are safe, sustainable, and effective and that the NHS People Promises are being delivered. From November 2025, the committee has held its meetings in common with Shropshire Community Health NHS Trust and met as a People Committee in common, as part of the Group Model development.

The committee meets bi-monthly. The SaTH chair of the meeting is Teresa Boughey, Non-Executive Director.

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

SATH People & OD Assurance Committee Attendance

					2025-2026					
Name	**Title**	**Role**	**Apr**	**Jun**	**Aug**	**Oct**	**Nov (SaTH only)**	**Nov***	**Jan***	**Mar***
Teresa Boughey (Chair)	Non-Executive Director	Member	x	✓	✓	✓	✓	✓	✓	✓
Trevor Purt	Non-Executive Director	Member	✓							
Rosi Edwards	Non-Executive Director	Member	✓	✓	✓	✓	✓	✓	✓	✓
Wendy Nicholson MBE	Non-Executive Director	Member	✓	x	✓	✓	✓	✓	✓	✓
Heidi Fuller	Associate Non-Executive Director	Member		✓	✓	✓	x	x	✓	✓
Rhia Boyode	Chief People Officer	Member	✓	x	✓	✓	✓	✓	✓	✓
Nigel Lee	Director of Strategy and Partnerships	Member	✓	✓	✓	✓	✓	✓	✓	✓
* denotes meeting held in common with Shropshire Community Health NHS Trust										

Hospitals Transformation Programme Assurance Committee

The Hospitals Transformation Programme (HTP) Assurance Committee provides independent assurance to the Board of Directors regarding the processes, procedures, and management of the HTP and associated work to support the successful achievement of the HTP Investment Objectives and realisation of the stated benefits. The committee meets bi-monthly. The chair of the meeting is Trevor Purt, Non-Executive Director.

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

HTP Assurance Committee Attendance 2025/26			2025				2026	
Name	**Title**	**Role**	**May**	**July**	**Sept**	**Nov**	**Jan**	**March**
Professor Trevor Purt	Non-Executive Director	Chair / Member	✓	✓	✓	x	✓	✓
Mr Raj Dhaliwal	Non-Executive Director	Member	x	✓	✓	✓	✓	✓
Ms Sarah Dunnett	Non-Executive Director	Member	✓	✓	✓	✓	✓	✓
Dr John Jones	Medical Director	Member	✓	✓	x	✓	✓	✓
Mr Matthew Neal	Director of HTP/Group Chief Estates, Facilities and Capital Officer	Member	✓	✓	✓	✓	✓	✓
Mr Ned Hobbs	Chief Operating Officer and Deputy Chief Executive	Member	✓	✓	x	✓	✓	x
Mr Adam Winstanley	Acting Director of Finance	Member	x	✓	✓	✓	✓	✓

Group Transition Committee

Following consideration of the terms of reference in July 2025, the terms of reference of the Group Transition Committee were approved by the Board in public in September 2025. The Group Chair is the chair of the meeting.

The Committee has been established as a joint committee with Shropshire Community Health NHS Trust. The Group Transition Committee exists to scrutinise the robustness of and provide assurance to each Board on the development and delivery of a group model, the integration agenda and strategic aims and objectives for the benefit of our population.

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

Group Transition Committee attendance 2025/26 **Members:**								
Name	**Title**	**Role**	**09/10/2025**	**20/10/2025**	**11/12/2025**	**20/01/2026**	**18/02/2026**	**17/03/2026**
Andrew Morgan	Group Chair	Member	√	√	√	√	√	√
Tina Long	Non-Executive Director	Member	√	√	√	√	x	√
Trevor Purt	Non-Executive Director	Member	√	√	√	√	√	√
Jo Williams	Group Chief Executive	Member	√	√	√	√	√	√
Nigel Lee	Director of Strategy and Partnerships	Member	√	√	√	√	√	√
Sarah Lloyd	Director of Finance & Deputy Chief Executive (SCHT)	Member	√	√	√	√	√	√
Shelley Ramtuhul	Director of Governance (SCHT)	Member	√	x	√	√	√	x
Anna Milanec	Group Chief Governance Officer	Member	√	√	√	√	√	√
Jenny Fullard	Group Chief Communications Officer	Member	√	√	√	√	√	√
Rhia Boyode	Group Chief People Officer	Member	x	√	√	√	x	√
Penny Bason	Group Project Manager	Member				√	√	√

Disclosures – Code of Governance for NHS Provider Trusts

The Code of Governance for NHS Provider Trusts brings together best practice of the NHS and the private sector and was put in place from 1 April 2023. It applies on a *comply or explain* basis. Each section of the Code is built around a set of principles emphasising the value of good corporate governance to long-term sustainable success. Each section also incorporates a set of more detailed provisions to implement these. The Trust's Corporate Governance Team undertakes an assessment against the detailed provisions of the Code to enable the Board/Trust to provide disclosures to meet the requirements of the Code of Governance, as part of this annual report.

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

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

Code of Governance provision reference	Relevant provision clause:	SaTH Disclosure:
Section B, 2.5	'The chair of the audit committee, *ideally*, should not be the deputy or vice chair or senior independent director.'	The longstanding chair of the Audit and Risk Assurance Committee (ARAC) was appointed as the Vice Chair of the Trust from 1 November 2023. This is not perceived to be an issue to the audit chair's independence or potential conflicts of interest but will continue to be monitored.

External Auditors' Remuneration

Fees payable to the external auditors, KPMG LLP (net of VAT) during the year for statutory audit services amounted to £187,555 (2024/25: £169,100). No additional work was undertaken by the external auditors for the Trust

Public Sector Payment Policy – Better Payment Practice Code

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

In 2025/26, the Trust paid 98.0% (2024/25: 97.1%) of non-NHS trade invoices within target, and 96.1% (2024/25: 93.2%) of NHS trade invoices within target. More details can be found in note 44 to the accounts.

Modern Slavery

In accordance with Section 54 of the Modern Slavery Act 2015, the Trust is committed to preventing modern slavery and human trafficking within its own operations and across its supply chains. We are committed to ensuring that Trust employees and agency workers are not exploited, are safe, have the legal right to work and remain in the UK, and that their employment standards and human rights are upheld.

The Trust expects the same standards from its suppliers and partners and is committed to working collaboratively with them to identify, mitigate and, where possible, eliminate the risk of modern slavery.

In line with the National Health Service (Procurement, Slavery and Human Trafficking) Regulations 2025, which come into force on 17 May 2026, the Trust has strengthened its approach to modern slavery risk management across the full commercial lifecycle, using a proportionate and risk-based approach to procurement and contract management.

Key controls and assurances include:

- **Workforce safeguarding and employment checks**
  - Robust pre-employment checks for directly employed staff.
  - Assurance checks on employment agencies supplying temporary staff, including right-to-work verification and compliance with employment standards.

- **Embedding modern slavery requirements in procurement**
  - Application of the NHS General Terms and Conditions of Contract for Goods and Services, which include obligations on suppliers relating to modern slavery and human trafficking.
  - Inclusion of modern slavery clauses requiring suppliers to comply with the Modern Slavery Act 2015 and cascade obligations through their supply chains.

- **Mandatory modern slavery risk assessments**
  - Completion of a documented modern slavery risk assessment for all in-scope procurements, regardless of value, in line with statutory NHS regulations.
  - Risk assessments are undertaken before advertising or awarding contracts, ensuring modern slavery considerations are embedded early in procurement decision-making.

- **Risk-based due diligence and supplier assurance**

- Proportionate due diligence based on assessed risk (low, medium, or high), including the use of NHS-approved tools such as the Modern Slavery Assessment Tool (MSAT) for relevant contracts.
- Assessment of supplier transparency, policies, controls, and remediation arrangements.

- **Contract management and ongoing monitoring**
  - Active management of modern slavery risk throughout the contract term, including escalation where concerns are identified.
  - Collaboration with framework providers and system partners to ensure assessments remain current and effective.

- **Alignment with national NHS guidance**
  - Implementation of actions aligned to NHS England guidance on tackling modern slavery in NHS procurement, supporting consistent and standardised practice across the health system.

Declaration from directors as to audit information

The Directors are responsible for preparing the Annual Report and Accounts and consider the report to be a fair, balanced and understandable account of the performance for the year ended 2025/26.

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

Register of Interests

Directors are asked to declare any interests that are relevant or material upon appointment and as soon as possible (within 28 days) should a conflict arise during their term. The agendas of the Board and meetings of its committees contain an item allowing directors to declare any interests which may conflict with the scheduled meeting business.

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

Remuneration Report

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

Remuneration Policy

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

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

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

The tables that follow are subject to audit:

Salary and pensions entitlements of senior managers 2025/26

Remuneration of senior managers 2025/26 - **subject to audit**

2025/26							
Name and Title	**Salary £000**	**Other Remuneration £000**	**Expense payments (taxable) £0**	**Performance pay and bonuses £000**	**Long term performance pay and bonuses**	**All pension-related benefits £000**	**TOTAL £000**
Executive Directors:							
Joanne Williams, Chief Executive in Common (from 01.09.25)	70-75		300			12.5-15	80-85
Joanne Williams, Chief Executive (to 31.08.25)	90-95		800			20-22.5	115-120
Dr John Jones, Medical Director	270-275					197.5-200	470-475
Adam Winstanley, Acting Director of Finance	150-155					145-147.5	295-300
Helen Troalen, Director of Finance*	165-170		2,900			35-37.5	200-205
Paula Gardner, Chief Nursing Officer	165-170		5,100			No pension	175-180
Edward Hobbs, Chief Operating Officer	155-160					45-47.5	200-205
Inese Robotham, Assistant Chief Executive	160-165					25-27.5	185-190
Tracey Cotterill (from 23.04.2025), Interim Director of Financial Recovery	210-215					Opted out of NHS pension scheme	210-215

Rhia Boyode, Group Chief People Officer	135-140					Opted out of NHS pension scheme	135-140
Anna Milanec, Director of Governance	130-135					25-27.5	155-160
Nigel Lee, Director of Strategy & Partnerships	155-160		300			27.5-30	185-190
Non-Executive Directors (NED):							
Andrew Morgan, Chair in Common	30-35		4,200				35-40
Teresa Boughey, NED	10-15		100				10-15
Rajinder Dhaliwal, NED	10-15		300				10-15
Richard Miner, NED	10-15		800				10-15
Trevor Purt, NED (Vice Chair)	25-30		600				25-30
Rosi Edwards, NED	10-15						10-15
Sarah Dunnett, NED	10-15						10-15
Wendy Nicholson, NED	10-15						10-15
Simon Crowther, Associate NED	10-15		800				10-15
Jon Sargeant, Associate NED	10-15						10-15
Heidi Fuller, Associate NED	10-15		200				10-15

Note:

1*. Helen Troalen was on secondment from 23/6/2025 to 03/04/26 and the costs were fully re-charged.

2. Jo Williams joined the Trust on 1 September 2025 in a shared role with Shropshire Community Health NHS Trust. 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.

3.Rhia Boyode holds a shared post with Shropshire Community Health NHS Trust, 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 £210k - £215k. It should be noted that the total remuneration for 2025/26 includes elements of pay relating to prior years but were paid only in 2025/26.

4. Andrew Morgan holds a shared post with Shropshire Community Health NHS Trust, 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.

Remuneration of senior managers 2024/25 (comparison) - **subject to audit**

2024/25							
Name and Title	**Salary £000**	**Other Remuneration £000**	**Expense payments (taxable) £0**	**Performance pay and bonuses £000**	**Long term performance pay and bonuses**	**All pension-related benefits £000**	**TOTAL £000**
Executive Directors:							
Louise Barnett Chief Executive (to 13/09/24) ∞	285-290	-	700	15-20	-	180-185	485-490
Sara Biffen Acting Chief Operating Officer (to 03/11/24) ○	160-165	-	-	-	-	0	160-165
Hayley Flavell Director of Nursing (to 31.12.2024) ◊	160-165	-	-	-	-	15-25	175-180
Dr John Jones Medical Director	270-275	-	-	-	-	60-65	330-335
Nigel Lee Director of Strategy & Partnerships	160-165	-	800	-	-	30-35	190-195
Helen Troalen Director of Finance	165-170	-	-	-	-	20-25	185-190
Inese Robotham Assistant Chief Executive	160-165	-	200	-	-	25-30	185-190
Rhia Boyode Chief People Officer	180-185	-	-	-	-	Opted out of NHS pension scheme	180-185
Anna Milanec Director of Governance	130-135	-	-	-	-	20-25	150-155
Edward Hobbs Chief Operating Officer (from 22/10/24)	70-75	-	-	-	-	60-65	130-135
Joanne Williams Interim Chief Executive Officer (from 14/09/2024)	115-120	-	2,000	-	-	25-30	145-150

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

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

◊ *Whilst Sara Biffen stepped down as Acting COO from 3rd November 2024, she remained employed by the Trust.*

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

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

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

All Pension Related Benefits

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

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

All Pension Related Benefits 2025/26 – **subject to audit**

	2025/26							
Name and Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2026 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2026 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2025	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2026	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Joanne Williams Chief Executive in common	0-2.5	0	60-65	135-140	1,232	13	1,315	0
Joanne Williams Chief Executive	0-2.5	0	60-65	135-140	1,232	22	1,315	0
Dr John Jones Medical Director	10-12.5	20-22.5	90-95	235-240	1,931	230	2,226	0
Adam Winstanley Acting Director of Finance	7.5-10	0-2.5	45-50	15-20	531	100	658	0
Helen Troalen Director of Finance	2.5-5	0	50-55	115-120	940	30	1,006	0
Edward Hobbs Chief Operating Officer	2.5-5	0	45-50	0-5	550	26	604	0

Inese Robotham Assistant Chief Executive	0-2.5	0	50-55	125-130	1,118	28	1,185	0
Anna Milanec Director of Governance	0-2.5	0	35-40	0-5	603	27	657	0
Nigel Lee Director of Strategy & Partnerships	0-2.5	0	30-35	0-5	536	26	592	0

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

	2024/25							
Name and Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2025 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2025 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2024	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2025	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Louise Barnett Chief Executive (to 13/09/2024)	10-12.5	12.5-15	75-80	185—190	1,418	218	1,731	0
Hayley Flavell Director of Nursing (to 01/01/2025)	0-2.5	0	65-70	175-180	1,374	43	1,507	0
Helen Troalen Director of Finance	0-2.5	0	45-50	115-120	847	35	940	0
Dr John Jones Medical Director	2.5-5	0-2.5	80-85	210-215	1,711	105	1,931	0
Sara Biffen Acting Chief Operating Officer	0	0	75-80	200-205	1,770	0	1,849	0

Inese Robotham Assistant Chief Executive	0-2.5	0	50-55	125-130	1,005	45	1,118	0
Anna Milanec Director of Governance	0-2.5	0	30-35	0	526	41	603	0
Nigel Lee, Director of Strategy and Partnerships	2.5-5	0	30-35	0	457	48	536	0
Edward Hobbs Chief Operating Officer (from 22/10/2024)	2.5-5	0	40-45	0	469	50	550	0
Joanne Williams Chief Executive (from 14/09/2024)	2.5-5	0	55-60	135-140	1,106	52	1,232	0
Adam Winstanley Acting Director of Finance (from 20/01/2025)	2-2.5	0-2.5	35-40	10-15	465	35	531	0

Fair Pay Disclosure – **subject to audit**

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

The banded remuneration of the highest paid director at the Shrewsbury and Telford Hospital NHS Trust in the financial year 2025/26 was in the salary banding of £270,000 to £275,000 (2024/25: £270,000 to £275,000). This was 7.21 times (2024/25: 7.49 times) the median remuneration of the workforce, which was £38,002.28 (2024/25, £31,685).

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

The median remuneration ratio of the workforce reduced by 16.28% (2024/25: 12.2%).

	2025/26	2024/25
The yearly percentage change in the highest paid director's remuneration	0.44%	4.15%
The yearly percentage change in the total average employee remuneration	6.83%	1.05%
The ratio between the highest paid director's remuneration and the pay and benefits of the employee on the 25th percentile of pay and benefits of the Trust's employees for the financial year	9.89	10.35
The ratio between the highest paid director's remuneration and the pay and benefits of the employee on the 75th percentile of pay and benefits of the Trust's employees for the financial year	5.28	7.49
25th percentile of pay	£27,690	£25,354
75th percentile of pay	£51,846	£48,725
Average annualised pay	£57,820	£54,125
Range of pay for an FTE of 1	£14,763 – £391,883	£12,514 - £261,844
Number of employees receiving remuneration in excess of the highest paid director	17	17

Year	25th percentile pay ratio	Median pay ratio	75th percentile pay ratio
2025/26	9.89	7.21*	5.28
2024/25	10.35	7.49*	5.60

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

Reporting of compensation schemes - Exit Packages agreed in 2025/26

This section provides an analysis of exit packages agreed with staff during the 2025/26 year (along with a 2024/25 comparison) and is subject to audit. Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme.

Exit Packages 2025/26 **– subject to audit**

Exit packages 2025/26				
Exit package cost band (including any special payment element).	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages	Total cost of exit packages
<£10,000	-	54	54	£223,285
£10,000 - £25,000	1	24	25	£408,256
£25,001 - £50,000	-	21	21	£730,500
£50,001 - £100,000	-	10	10	£651,721
£100,001 - £150,000	-	-	-	-
£150,001 - £200,000	2	-	2	£336,000
>£200,000	-	-	-	-
Total number of exit packages by type	3	109	**112**	
Total cost (£)	£360,843	£1,988,920		£2,349,762

Exit Packages 2024/25 (comparison) **– subject to audit**

Exit packages 2024/25				
Exit package cost band (including any special payment element).	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages	Total cost of exit packages
<£10,000	-	46	46	£133,647
£10,000 - £25,000	-	1	1	£21,057
£25,001 - £50,000	-			
£50,001 - £100,000	-			
£100,001 - £150,000	-			
£150,001 - £200,000	-			
>£200,000	-			
Total number of exit packages by type	-	47	**47**	
Total cost (£)	£0	£154,704	£154,704	£154,704

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

Other non-compulsory departure payments				
	2025/26		2024/25	
Type	Number of payments agreed	Total value of agreements £000	Number of payments agreed	Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	64	1,778	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	45	211	47	155
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**109**	**1,989**	**47**	**155**
Of which, non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

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

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

The Trust has a policy that all substantive staff are paid through the payroll. No executive Board members were engaged on an off-payroll basis in 2025/26. On 6 April 2017, public bodies became responsible for collecting tax from those contractors subject to HMRC's IR35 rules; all contractors are subject to a review to determine whether they are affected by the rules. The number of contractors engaged as of 31 March 2026 is shown in the tables below where daily rates exceed £245 per day and the engagement has lasted longer than six months."

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

For all off-payroll engagements as of 31 March 2026, for more than £245 per day and that last longer than six months:	**Number 2025/26**	Number 2024/25
Number of existing engagements as of 31 March 2026	3	3
Of which, the number that have existed:		
for less than one year at the time of reporting	0	0
for between one and two years at the time of reporting	0	0
for between two and three years at the time of reporting	1	1
for between three and four years at the time of reporting	0	0
for four or more years at the time of reporting	2	1

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 2025/26**	Number 2024/25
Number of new engagements, or those that reached six months in duration, between 1 April 2025 and 31 March 2026	3	3
Of which:	0	0
Number assessed as caught by IR35	3	3
Number assessed as not caught by IR35	0	0
Number engaged directly (via PSC contracted to department) and are on the departmental payroll	0	0
Number of engagements reassessed for consistency/assurance purposes during the year	0	0
Number of engagements that saw a change to IR35 status following the consistency review	0	0

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 2025/26**	Number 2024/25
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0	0
Total number of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure includes both on payroll and off-payroll engagements.	22	24

Staff Report

The Trust employs 8,025 colleagues who collectively support the delivery of high-quality patient care across our hospitals and community services. The majority of our workforce consists of permanently employed clinical staff who are directly involved in caring for patients. In addition, the Trust employs a substantial number of colleagues in non-clinical roles, including technical, and administrative teams, whose expertise and support are essential to the effective running of our services. The table below provides a breakdown of the Trust's workforce:

Average number of employees (WTE basis) – subject to audit				
			2025/26	2024/25
Type	Permanent number (WTE)	Other number (WTE)	**Total number (WTE)**	Total number (WTE)
Medical and dental	945	122	**1,067**	1,018
Ambulance staff	4	0	**4**	7
Administration and estates	1,707	89	**1,796**	1,863
Healthcare assistants and other support staff	1,710	191	**1,901**	1,898
Nursing, midwifery and health visiting staff	2,180	238	**2,418**	2,378

Nursing, midwifery and health visiting learners	0	0	**0**	3
Scientific, therapeutic and technical staff	588	16	**604**	580
Healthcare science staff	201	32	**233**	216
Social care staff	0	0	**0**	0
Other	2	0	**2**	8
Total average numbers	**7,337**	**688**	**8,025**	7,971
Of which: Number of employees (WTE) engaged on capital projects	39	1	**40**	65

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

Communicating with staff

The Trust is committed to ensuring staff remain informed about organisational developments, actively involved in decision-making processes, and engaged in the Trust's performance and future direction. We recognise the strong link between staff engagement and the quality of patient care and therefore place significant importance on maintaining open communication and meaningful involvement across the organisation.

The Trust continues to utilise a broad range of established communication channels to keep staff informed about both internal and external developments affecting the organisation and the wider NHS. These include regular Team Briefings delivered by the Chief Executive and senior leaders, targeted newsletters for specific audiences or topics, daily desktop communications, and comprehensive intranet platforms providing access to policies, guidance, and digital tools.

The Trust's weekly Staff Bulletin continues to be distributed to all employees, and work is ongoing to develop a single, accessible, Trust-wide intranet platform to further improve communication and access to information.

The Trust also produces a well-received staff and patient magazine, Chatterbox, alongside regular electronic newsletters. Strong working relationships continue to be maintained with staff-side representatives for medical, dental, and Agenda for Change colleagues, as well as staff networks and other employee representatives, ensuring staff voices are heard and considered in organisational decision-making.

Hospitals Transformation Programme

The Hospitals Transformation Programme (HTP) represents a significant strategic investment in the future of acute healthcare delivery across Shropshire, Telford & Wrekin, and Powys. The programme outlines a reconfiguration of services at the Royal Shrewsbury Hospital (RSH) and Princess Royal Hospital (PRH), aiming to address longstanding challenges in clinical service delivery, estate suitability, and workforce sustainability. Central to this transformation is the consolidation of emergency and planned care services, which is expected to improve patient outcomes, enhance staff experience, and optimise resource utilisation.

In order to support delivery of HTP there has been substantial work within teams across the Trust. Clinical pathways and workforce plans have been developed to support delivery of HTP by clinicians at a local level. Change Agents are being trained across the Trust to support individuals with the impact of the changes on their terms and conditions, and managers are being offered training to support their teams through change. HTP is a regular item on the Cascade agenda and at a local level, HTP is being discussed regularly through Team Huddles and local discussions. The Group model will further enable an integrated approach to supporting development of the Local Care Transformation Programme which will support with HTP delivery and a better patient experience.

Staff Survey

The NHS Staff Survey is one of the largest annual workforce surveys in the world and has been conducted every year since 2003. The 2025 survey asked staff questions which are aligned to the NHS People Promises and themes. The results are benchmarked against our comparator group which is made up of 121 acute and combined acute and community trusts. The Trust's response rate in 2025 was 46%, with 3,813 responses received from the 8,363 eligible staff at the point of the 2025 fieldwork period. This is a 5% reduction on last year and below the median of 47% for our sector benchmarking group; however, is broadly in line with previous years.

In 2025, the Trust scored above the national average in one area: We work flexibly. At sub-score level the results were above national average in Diversity and Equality, Negative Experiences, Development, Flexible Working and Motivation, with scores marginally above national average for Inclusion and Support for Work-Life Balance.

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

The response rate for our bank staff was 25% and is significantly higher than the median response rate for our sector benchmarking group (15%), with 243 completing the survey. The Trust's scores for this staff group show above national average results for 'We are safe and healthy', 'We are always learning', 'We work flexibly' and 'We are a team'.

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

2025 Staff Survey Question	National average	Trust score
Staff agreeing that the care of patients/ service users is the organisation's top priority	71.63%	64.34%
Staff recommending the Trust to a friend or relative as a place to receive care or treatment	60.83%	45.49%
Staff recommending the Trust to a friend or relative as a place to work	57.77%	47.63%

Staff Survey Results

Staff were asked whether they had experienced unwanted sexual behaviour from patients or from colleagues. This reflects the Trust's commitment to the NHS England Sexual Safety Charter, which aims to protect staff from harassment and inappropriate behaviour. The Trust fully supports this national approach and the ongoing work to prevent and address sexual misconduct in the workplace.

Our score for unwanted behaviours experienced by our staff from patients is 6.96% compared to the national average score of 8.07%. However, staff experiencing unwanted behaviours from staff/colleagues is 3.63% compared to the national average score of 3.39%. This score has seen a decrease from 2024; however, is still above the average. The Trust is committed to cultivating a culture where our staff are protected from all forms of unwanted and harmful behaviours, and we are working on improvement actions to ensure all staff feel safe.

Addressing areas of concern

The results of the 2025 staff survey indicate that the employee experience at The Shrewsbury and Telford Hospital NHS Trust has slightly improved for three out of the seven people promises.

It is important to note that results were expected to be varied this year due to the impact of the overall NHS challenges as well as the number of change programmes and re-structures. These are results that give an indication of a Trust which is continuing to improve experiences of staff.

It is acknowledged that several actions can take longer periods of time to embed before they are felt/experienced by staff. NHS England suggests that the staff survey provides rich and valuable data to support and inform continuous improvement and cultural change for longer term 3 to 5-year planning.

The Trust is committed to working closely with senior leaders and managers to maximise staff participation in the 2026/27 NHS Staff Survey, ensuring colleagues have the opportunity to share their views and experiences. The Board has placed renewed emphasis on responding to staff feedback, addressing areas of concern, and continuing to strengthen the Trust as a welcoming, fair and inclusive place to work.

Culture and Leadership development

During the year, the Trust has continued to strengthen collaboration through its development as part of a wider Group, enabling closer partnership working, shared leadership and greater consistency in people practices across SaTH and Shropshire Community Health NHS Trust. The Trust has also reinforced its commitment to working with families and will soon launch Poppy's Promise, ensuring Compassion, Acknowledgement, Respect, Empathy which is Essential to safe, high-quality care.

We have been measuring our culture using The King's Fund and NHS Improvement dashboard since 2021 to help identify cultural issues. We are now working on a two-year programme to strengthen our actions to develop a culture that enables and sustains safe, high-quality, compassionate care. And, over the last few months we have explored partner experts, to work on a cultural programme and in 2026/27 we will work with A Kind Life, and Advancing Quality Alliance (AQuA), to enhance kindness, leadership and team development.

A new leadership programme for colleagues with disabilities has been developed in partnership with Disability Rights UK, and a review of the Trust's leadership framework is ongoing to ensure alignment with the NHS England Management and Leadership Framework. This review has identified that participation by five or more colleagues in leadership programmes is associated with improved results in relevant areas of the National Staff Survey.

We continue to expand our leadership masterclass offer and enhance our talent and career portal, which provides career planning tools, self-assessments and online learning modules. The introduction of online training design software has enabled the development of more blended and e-learning opportunities.

The Trust continues to explore accredited learning pathways. During the year, 13 colleagues completed Level 5 'Step into Leadership' modules through Telford College. Career and talent conversations remain central to the Striving Towards Excellence Programme (STEP), alongside HR Essentials, supporting the development of management capability and progression towards inclusive leadership behaviours.

The Culture Dashboard continues to be a key tool in measuring progress on the Trust's cultural transformation. Whilst four domains saw a reduction during the year and Health and Wellbeing remained unchanged, Compassion increased by 1%, highlighting that we are maintaining some momentum in how colleagues support one another and patients.

Equality, Diversity and Inclusion (EDI)

The Trust is committed to building a workforce that reflects the diversity of the communities we serve and to designing services in partnership with those communities. This is fundamental to delivering equitable, high-quality and compassionate care.

Equality, Diversity and Inclusion (EDI) is a strategic enabler, embedded across workforce, leadership and service delivery rather than treated as a compliance requirement. This approach helps create an environment in which staff feel valued and supported, and where patients experience care that is personalised, respectful and free from discrimination.

Our EDI priorities are fully aligned to the NHS Long Term Workforce Plan, NHS People Plan, People Promise, NHS Impact and the six High-Impact Actions, ensuring our work delivers measurable improvement against national priorities while responding to local population need.

Impact Areas

Transforming Staff Experience and Leadership Diversity

The Trust continues to strengthen inclusion at every level of the organisation, with a clear focus on staff voice, talent development, leadership diversity and culture:

- Strengthening staff voice and allyship: Four core staff networks now engage more than 500 colleagues, supported by a thriving Armed Forces Network.
- Inclusive leadership pipeline: The Galvanise BAME Leadership Programme continues to accelerate progression, with 40% of alumni promoted and a further 40% actively progressing. In partnership with Disability Rights UK, a new leadership programme has been developed for colleagues with disabilities and long-term health conditions.
- Disability inclusion and retention: The Trust achieved Disability Confident Leader (Level 3) status, supported by improved reasonable adjustment processes, enhanced neurodiversity guidance and refreshed adjustment passports.
- Building leadership capability: Targeted development has been delivered for leaders focused on cultural competence, anti-racism, active bystander behaviours and LGBTQIA+ inclusion.
- Improving organisational culture: The Trust continues to demonstrate a sustained reduction in bullying and harassment, outperforming national comparators,

underpinned by transparency and a zero-tolerance approach to behaviours that do not align with Trust values.

National recognition of this work includes success at the 2025 National BAME Health and Care Awards, where the Trust had a winner in the Midwife of the Year category and two finalists in Future Leader – Next Gen (18–30) and Educator or Workforce Developer of the Year.

The Trust's WRES results show continued improvement in perceptions of fairness and opportunity. In 2025, 51.22% of ethnic minority staff reported that the organisation provides equal opportunities for career progression and promotion - above the national average of 49.11% and a significant improvement from 41.71% in 2021.

Our Gender Pay Gap can be accessed via our website Equality, Diversity & Inclusion – SaTH

We are strengthening our use of insight, partnership and co-design to ensure services are accessible, inclusive and responsive to population need.

Deepening Community and System Partnerships

The Trust continues to strengthen meaningful engagement with diverse communities to improve access, experience and outcomes for both patients and staff. This includes widening participation initiatives, education pathways and strong partnerships with Keele University, local organisations, colleges, and voluntary sector partners.

A range of initiatives are in place to promote equal and inclusive access to learning, employment and progression, including:

- Inclusive learning and development: Interactive workshops and mandatory training addressing bias, micro-aggressions and incivility, authentic allyship, and the development of cultural competence.
- Neurodiversity inclusion: Introduction of guidance to support neurodivergent colleagues, recognising the reasonable adjustments required from recruitment through to ongoing employment.
- Flexible access to learning: Expanded online learning opportunities and use of the Trust's talent portal, accessible via laptops and mobile devices, enabling greater flexibility for a diverse workforce.
- Empowered staff networks: Continued development and support of the Trust's LGBT+, multicultural, disability and Armed Forces staff networks, providing peer-to-peer support on equality, diversity and inclusion issues.
- Leadership accountability: ongoing review and updating of people management processes to eliminate bias and structural barriers.
- The Galvanise leadership programme, now in its fourth cohort, continues to support improved ethnic diversity within senior leadership.

In September 2025, the Trust hosted Embers of Care, a 100-piece art exhibition celebrating the strength, resilience and contributions of migrants working in UK healthcare. The artwork, displayed and designed by Yayen John, a registered nurse originally from the Philippines and now working within the NHS, was funded by the Arts Council and showcased the diversity of colleague experiences and patient care.

Health, Wellbeing and Sustainable Performance

A healthy workforce underpins high performance. We have significantly strengthened our wellbeing offer, including expanded staff psychology services, psychological therapies, menopause support, and wellbeing training for managers. These interventions support retention, resilience and compassionate leadership.

This year we have trained over 22 menopause support advocates. We have supported just over 700 colleagues with the menopause education and support programme, available across the Group.

NHS Staff Survey Results

Comparison of NHS Staff Survey Results for 2022 to 2025 against National Average (Acute and Acute & Community Trusts):

	National Average 2022	Trust Score 2022	National Average 2023	Trust Score 2023	National Average 2024	Trust Score 2024	National Average 2025	Trust Score 2025
Response Rate	44%	49%	45%	45%	49%	51%	47%	46%
People Promise element								
We are compassionate and inclusive	7.18	6.85	7.24	7.06	7.21	7.08	7.28	7.15
We are recognised and rewarded	5,72	5.54	5.94	5.86	5.92	5.81	5.87	5.83

We each have a voice that counts	6.65	6.24	6.70	6.45	6.67	6.47	6.60	6.38
We are safe and healthy	5.88	5.67	6.08	6.02	6.09	6.02	6.07	6.01
We are always learning	5.35	5.09	5.62	5.41	5.64	5.48	5.57	5.45
We work flexibly	6.00	5.75	6.20	6.17	6.24	6.26	6.22	6.30
We are a team	6.64	6.39	6.75	6.63	6.74	6.61	6.75	6.62
Theme								
Staff engagement	6.80	6.32	6.91	6.59	6.84	6.59	6.74	6.50
Morale	5.68	5.42	5.90	5.79	5.93	5.84	5.84	5.74

Next steps

The Staff Survey results are reviewed alongside other feedback gathered throughout the year to provide an understanding of what is working well and where improvement is needed. Across the organisation local action plans are being developed to drive positive and sustainable change.

These include:

- Launched a global communication campaign to acknowledge and learn from areas of improvements, with an ongoing focus in all Trust and Group communications moving forward.
- Dissemination and sharing of divisional and local headlines, shared by respective senior leaders.
- Divisional and local action plans in-place and progress reviewed as part of the Performance Review Meetings.
- 2026 will see the Launch of Poppy's Promise in Maternity and ED, to further embed compassion into all our interactions and what we do.
- Designed and co-produced the Insight disability development programme for 2026, with a focus on supporting colleagues to role-model compassionate and inclusive leadership.
- Continuing with focused work around sexual safety and embedding the NHS Sexual Safety Charter, supported by an ongoing communications campaign and implementation of the national requirements around colleague training.

- A health and wellbeing campaign to raise awareness of the offer and support available, in conjunction with the development of a dedicated Belonging and Wellbeing Plan for the Group.

Temporary and Agency staff

The Trust has maintained its focus on reducing reliance on agency staffing and is now fully compliant with NHS England's agency cap for our Nursing workforce, which sets maximum pay rates for agency workers. Robust monitoring and reporting arrangements are in place to oversee agency expenditure, and significant reductions in agency usage were achieved during 2025/26.

The proportion of agency staffing within the Trust's overall temporary workforce has continued to decline and is now at its lowest level for several years.

Staff Costs – subject to audit				
			2025/26	2024/25
Type	Permanent £000	Other £000	**Total £000**	Total £000
Salaries and wages	393,390	1,869	**395,259**	**378,032**
Social Security Costs	49,081	-	**49,081**	**36,963**
Apprenticeship levy	1,929	-	**1,929**	**1,809**
Employer's contributions to NHS pension scheme	72,539	-	**72,539**	**67,663**
Temporary Staff (agency)		8,075	**8,075**	**19,662**
Total gross staff costs	**516,939**	**9,944**	**526,883**	**504,129**
Recoveries in respect of seconded staff	-	-	**-**	**-**
Total Staff Costs	**516,939**	**9,944**	**526,883**	**504,129**
of which				
Costs capitalised as part of the assets	-	3,638	**3,638**	**4,292**

Expenditure on Consultancy

The Trust spent £772,000 on consultancy during 2025/26 (£746,000 in 2024/25).

Analysis of staff numbers

The figures in the following tables are calculated based on headcount in the organisation as of 31 March 2026, unless otherwise indicated.

The Trust had 310 new starters in medical and dental roles over the last 12 months (up to March 2026) inclusive of 203 Deanery doctors. During the same period, the organisation had 270 leavers, of which 158 were Deanery doctors.

Medical & Dental Starters & Leavers (Headcount)		
Job Role	**New Starters**	**Leavers**
Consultant	50	26
Specialty Doctor	18	15
Salaried General Practitioner	8	2
Deanery Postgraduate Doctor - Foundation Level	80	38
Deanery Postgraduate Doctor (ST1-8)	123	120
Locally Employed Doctor - Foundation Level	0	16
Locally Employed Doctor - Specialty Registrar (ST1-8)	31	53
Total:	**310**	**270**

Staff gender distribution

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

Gender Breakdown (headcount) 2025/26	Male	Female	Total	Percentage of total
Board level directors	4	5	9	0.10%
Non-Executive Directors/Chair	6	5	11	0.13%
Senior Managers	21	47	68	0.82%
All other employees	1945	6554	8499	98.95%
Grand Total	**23.01%**	**76.99%**	**8587**	

Turnover

Staff turnover figures are published by NHS Digital using data drawn from the Electronic Staff Record (ESR) data warehouse. The latest version, which covers the year to 2025, can be found on the NHS Digital website:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

Sickness absence

The Trust's staff sickness absence data for 2025* is provided below:

Staff Sickness Absence 2025	**2025** (Number)	**2024** (Number)
Total days lost	84,050	86,671
Total staff years	7,334	7,143
Average working days lost (per WTE)	**11.5**	**12.1**

*The sickness absence figures are reported on a calendar basis (2025), rather than for the 2025/26 financial year. These statistics are published by NHS Digital, using data drawn for January 2025 to December 2025 from the ESR data warehouse.

Safe Working Environment

As part of its commitment to improving the psychological safety, health, and wellbeing of staff, the Trust's dedicated Staff Psychology Service provides a range of evidence-based psychological interventions for employees experiencing emotional or psychological distress linked to their work.

Support available to individuals includes:

- Specialist psychological assessment and formulation
- A range of therapeutic interventions, including Counselling, Cognitive Behavioural Therapy (CBT), Dialectical Behaviour Therapy (DBT) skills, Acceptance and Commitment Therapy (ACT), Psychodynamic Therapy, Compassion Focused Therapy, and other evidence-based approaches to support work-related mental health concerns
- Support for staff involved in formal processes, including grievances, investigations, and tribunals
- Consultancy support for colleagues, particularly those in leadership or senior roles, who may be managing challenging team situations and would benefit from reflective space to consider appropriate approaches and solutions

A range of interventions is also available to support teams experiencing difficulties or responding to challenging events. These include:

- The development and roll out of a trust Trauma Pathway to ensure an evidence based and consistent approach to supporting teams following traumatic events, including training on understanding trauma, facilitating ‘hot debriefs’ and how and when to access further psychological support
- Post Event Team Reflections (PETRs), formerly known as debriefs, which help teams process the emotional impact of traumatic events
- The ProSocial Framework, designed to strengthen team relationships by supporting shared agreements around values, behaviours, and ways of working
- Reflective practice sessions, offered as a preventative measure to help teams regularly explore the emotional impact of their work and reduce the risk of distress becoming overwhelming

Signed by

Jo Williams
Group Chief Executive

22 June 2026

Annual Governance Statement – 2025/26

1. Scope of Responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of The Shrewsbury and Telford Hospital NHS Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Trust Accountable Officer Memorandum.*

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Shrewsbury and Telford Hospital NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively, and economically. The system of internal control has been in place in the Shrewsbury and Telford Hospital NHS Trust (the Trust) for the year ended 31 March 2026 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

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

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

I am also supported in my role through the assurance committees of the Board of Directors, each under the chairmanship of a Non-Executive Director, with appropriate contribution from members of the Executive Team. These committees comprise the Audit and Risk Assurance Committee, Quality and Safety Assurance Committee, Finance Assurance Committee, Performance Assurance Committee, People and Organisational Development Assurance Committee, the Hospitals Transformation Programme Assurance Committee, and the Group Transition Committee (a joint committee with Shropshire Community Health NHS Trust) which

held its first meeting on 17 July 2025. A statutory Remuneration Committee is in place which has delegated authority from the Board to determine the remuneration and terms of service of the Board Executive Directors and other Very Senior Managers, and to be responsible for identifying and appointing candidates to fill vacant Executive Director positions on the Board.

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

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

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

The Trust has continued its improvement journey, with two conditions previously imposed by the CQC remaining on its Provider Licence at the start of 2025/26. Following a successful application to the CQC, one of these conditions was removed in December 2025 and ongoing actions have continued throughout the year to progress the removal of the remaining condition. There have been improvements and innovation in many services, which has led to improvements in the quality and timeliness of care provided to our patients. These improvements have been recognised by a number of external visits and independent reports. However, the Trust recognises that there are still areas for improvement in some services and these remain a priority for the Trust.

A Chair in Common (across SaTH and Shropshire Community Trust) was appointed on 01 October 2024. An Interim Chief Executive Officer (for SaTH) was appointed on 16 September 2024. During May 2025, the Boards of Shropshire Community Health NHS Trust (SCHT) and The Shrewsbury and Telford Hospital NHS Trust (SaTH) agreed to appoint a shared Group Chief Executive (CEO). This shared role has provided leadership across both organisations working with the Group Chair. The two trusts have also explored opportunities to form a Group Model during 2025/26, with a Group Partnering Agreement approved at March 2026 private

Board of Directors meeting, and a Group Model commencing from 01 April 2026. Working as a Group will mean shared Executives and Non-Executive Directors across both organisations.

There has been a change in several Non-Executive and Executive director posts at SaTH in recent years, leading to a restructure of executive portfolios and bringing in more experience and skills to the Board. The Trust has had some in-year support from an NHSE Improvement Director and an Interim Financial Recovery Director. In-year changes to the directors can be found within the *accountability report* section of the annual report.

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

4. The risk and control framework

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

The Board Assurance Framework provides the Trust with a system to identify and monitor risks which may affect achieving the organisation's strategic objectives. It is reviewed on a quarterly basis by the executive directors and the assurance committees. Each risk is mapped to corresponding controls and assurances, both internal and external.

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

The Audit & Risk Assurance Committee reviewed and agreed the Trust's updated Risk Management Strategy in November 2025, along with the Trust's Risk Appetite Statement for 2025/26 and the Risk Management Policy. All were approved by the Board in January 2026. The Risk Appetite Statement sets out the optimal position in pursuit of the Trust's strategy and vision and the upper tolerances for reporting/escalation of risks.

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

The Risk Management Group Terms of Reference (ToR) were updated during 2024/25 to include representation from Executive Directors and to increase the visibility of risks. These ToR will be reviewed to consider the new Group Model with Shropshire Community Health NHS Trust.

Quarterly risk management reports are presented to Audit & Risk Assurance Committee and Board to ensure appropriate assurance is provided regarding risks on the Trust risk register. Monthly Key Issues reports are produced by the divisions to support this assurance. The Trust's Corporate Risk Register was introduced during December 2023 and continues to be used.

The Board Assurance Framework (BAF) document has continued to be updated during 2025/26 and to be actively considered by the Board, following prior consideration at its assurance committees. Training has continued to be rolled out across the organisation to support the continual development of a robust risk management framework and the Trust's capability to consistently manage and mitigate risk.

The risk management face-to-face and virtual training programme was piloted on 20 September 2023 and has been rolled out across the Trust. Over 300 members of staff have received this training since September 2023. Evening risk management training sessions are provided for night shift workers via Microsoft Teams. The syllabus of the training has been continuously adapted to capture the risk appetite statement and, separately, to cater for neurodivergent staff. Any staff member is able to receive risk management training. However, all staff with 'risk' / 'quality' / 'governance' in their job title are required to complete this training (face to face or virtually). In addition, E-learning risk modules are available to supplement the risk management training. Completion rates for both forms of the training are monitored.

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

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

5. Major risks to the organisation

The Annual Governance Statement for 2024/25 identified a number of risks that were carried forward into 2025/26, some of which continue to remain current. A commentary for each of these risks is provided below.

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

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

Throughout 2025/26, the Trust has continued to focus on several areas of improvement including reducing the number of patient falls resulting in harm, reducing hospital acquired pressure ulcers, and ensuring recognition and timely escalation of the deteriorating patient. The Trust has piloted the Bedside Mobility Assessment Tool focused on early mobilisation of patients and the prevention of patient de-conditioning whilst in hospital with plans to roll this out across the Trust in 2026/27. Work has also progressed with the planning for the implementation of Martha's Rule, a national NHS patient safety initiative that gives patients and families the right to request an urgent clinical review if they are worried about a patient's condition deteriorating and feel they are not being heard.

Another priority for the Trust has been improving the experience of patients discharged from our Trust. To drive the improvements in relation to discharge planning and discharge processes a system-wide Discharge Improvement Group has been established, chaired by our Chief Nurse and attended by all key stakeholders across our system.

The need for the Trust to maintain its continuous improvement journey is vital. The last CQC report published in May 2024, following their inspection October / November 2023, demonstrated improvements in a number of core services including End-of-Life Care (EOLC), Maternity and Children and Young People (CYP), which were both rated as good overall and in all domains. Urgent and Emergency Care remained challenging with the Emergency Department at the Royal Shrewsbury Hospital rated overall as "requires improvement", and at the Princess Royal Hospital the Emergency Department has an "inadequate" rating for the safe and responsive domains, and an overall rating of "inadequate".

The Trust moved from the previous rating of 'Inadequate' to 'Requires Improvement' overall, with the individual ratings for each domain being as follows:

- Safe – Requires Improvement
- Effective – Requires Improvement
- Caring – Good

- Responsive – Requires Improvement
- Well-led – Requires Improvement
- Use of Resources – Requires Improvement

Much improvement work has taken place since 2024 to ensure the timely initial assessment for patients attending our Emergency Departments and reduce the risk of prolonged delays in the urgent and emergency care pathways. There has been a reduction in care on corridors, increased patient observations and reduced waiting times. Following a successful application to the CQC, one of the two remaining CQC conditions both of which relate to our Emergency Departments was removed; this related to all children attending the Emergency Departments being assessed within 15 minutes. Ongoing actions have continued throughout the year to progress the removal of the remaining condition.

The Trust has continued to hold formal quarterly engagement meetings with the CQC to discuss and highlight improvements made in core services provided by the Trust. An ongoing dialogue between the Trust and its local CQC regulators enables timely escalation of any issues, should this be required. There have been regular updates throughout 2025/26 on CQC action plan improvement progress to the Board with "Moving to Excellence" programme updates and to our Quality and Safety Assurance Committee.

A CQC Inspection of our Emergency Departments and Medical Wards took place on the 3rd and 4th March 2026. Initial verbal feedback was positive in relation to the improvements observed, however, we have not yet received the final inspection report.

b) <u>Access and waiting time performance.</u>

Urgent and emergency care demand remained high throughout the year and continues into the current financial year. A&E performance, including ambulance handover delays, continued to be a challenge and, as a result, the Trust remains in Tier 1 monitoring by NHS England. SaTH All-Type 4-hour performance to March 2026 ended the year at 53%, below the agreed operational plan of 60%. During the year, 31.1% of ambulance handovers experienced waits of 60 minutes or longer. Performance against the 12-hour Type 1 standard also fell short of plan, with 19% of patients remaining in the Emergency Department for more than 12 hours, compared with the operational plan target of 83%.

The Trust's Stronger Together campaign — focused on helping patients to be seen more quickly, reducing waits in the Emergency Department (ED), and supporting shorter stays in hospital — has driven significant improvement work across the year within ED, acute medicine, and inpatient ward processes. A major step forward was the opening of 96 additional beds and assessment spaces (56 RSH & 40 PRH) across both sites, largely through the introduction of two new modular wards at RSH, and through capital Estate work to expand capacity within PRH.

These capacity improvements, combined with the reconfiguration of the acute medical floor and a range of flow initiatives, have begun to yield measurable results. The proportion of patients seen within 15 minutes improved from 57.3% in March 2025 to 68.5% in March 2026, and average time to initial assessment (adult) fell from 20.91 minutes to 14.29 minutes over the same period, dropping below the 15-minute target in eight of the last 12 months.

Further system-wide initiatives were implemented throughout the year, particularly in partnership with colleagues from Shropshire Community Health NHS Trust to progress improvement, including: expanding the Care Transfer Hub to 8am–8pm, 7 days a week; establishing an Integrated Front Door team working on both acute sites; and expanding Urgent Community Response to midnight, 7 days a week.

However, despite these efforts, the improvements achieved have not been sufficient to alleviate pressures across the urgent and emergency care pathway to the level required to meet performance standards. The Trust continues to face significant pressures, particularly within its Emergency Departments, and this is impacting on the experience of patients and the wellbeing of colleagues.

Plans are in place for 2026/27 and 2027/28 through the System Transformation Programme. The programme is structured around three pillars — Community Urgent Care, Acute Flow and Care Coordination, and Discharge Transformation and Capacity Release — and reflects the Trust's continued commitment, working alongside system partners, to reduce waiting times and improve the experience of patients and colleagues across the urgent and emergency care pathway.

There are already early signs of significant improvement in April 2026, including in 12-hour performance and average ambulance handover times, which are set to be some of the strongest performance for a number of years.

During 2025/26, the Trust delivered sustained improvement in elective performance, with a strong focus on increasing capacity, improving productivity and reducing long waiting times. A comprehensive programme of actions across theatres, outpatients, diagnostics and elective pathways supported improved access to care and strengthened performance through the year.

Key actions and achievements included:

- **Theatres:** An increased number of core elective theatre lists were delivered, including specialist lists such as children's surgery, supporting higher elective surgical throughput and improved utilisation of capacity.

- **Orthopaedics:** Expansion of elective orthopaedic joint replacement activity, including the successful delivery of day-case hip replacement surgery. This reduced inpatient length of stay and released additional bed capacity to support elective flow.

- **Waiting List Reduction:** Significant progress was made in reducing elective waiting times, with sustained reductions in long waits and continued improvement against the 18-week referral-to-treatment (RTT) standard. By the end of the financial year, the Trust is the most improved in the country for 18-week and 52-week performance, and exceeded its operational plan trajectory for 25/26 for both standards.

- **Day Case Activity:** Strong elective productivity was maintained throughout the year, with high levels of day-case delivery and performance comparing favourably with peer organisations.

- **Diagnostics:** Access to diagnostic services improved further, with strengthened performance across key modalities including MRI, non-obstetric ultrasound, flexible sigmoidoscopy, cystoscopy and gastroscopy. Improved diagnostic access supported both elective and cancer pathways.

By year-end, the Trust had delivered a more stable and improved elective position, providing a solid foundation for continued progress in 2026/27 and supporting improved patient experience through reduced waiting times and timely access to care.

Cancer performance improved significantly during 2025/26, reflecting sustained organisational focus and the impact of targeted improvement actions. Over the course of the year, delivery strengthened across key standards, supported by enhanced diagnostic capacity and continued pathway redesign.

As a result, we not only recovered performance against previously challenged areas but also exceeded our operational plan trajectories for cancer access standards, including the 28-day Faster Diagnosis Standard (FDS) and 62-day pathways. This progress demonstrates the effectiveness of the cancer improvement programme and the commitment of clinical and operational teams to delivering timely, high-quality care for patients. Over the last year, the Trust was the most improved in the country against the 28-day Faster Diagnosis Standard, and second most improved in the country against the 62-day Referral To Treatment standard.

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

c) Financial performance

The Trust set a deficit plan of £45.1m for the financial year (FY) 2025/26. This plan was

converted to a breakeven control total following the provision of £45.1m of non-recurrent Deficit Support Funding (DSF) from NHS England. At the time of finalising the plan, a number of significant risks were identified, including the continued use of additional capacity, the cost of temporary workforce, pay inflation, the scale and deliverability of the efficiency programme, delivery of the activity plan, and the pay settlement for clinical support workers.

Against the breakeven control total, the Trust delivered a full-year retained surplus of £4.9m. This favourable variance was driven by the receipt of additional non-recurrent bonus DSF in-year.

After removing non recurrent DSF, the Trust's underlying retained deficit position at the end of FY2025/26 was £45.1m. The Trust continues to actively monitor and manage its underlying financial position, and the ongoing impact on underlying sustainability is a key consideration in decisions to commit expenditure.

The Trust adopted a risk-based approach to financial planning for FY2025/26. While a number of the identified risks materialised to a greater extent than anticipated, the mitigation actions implemented during the year were sufficient to maintain compliance with the agreed financial plan and breakeven control total.

A key objective for FY2025/26 was to further strengthen budget holder engagement and financial management capability to support delivery of the increased efficiency requirement. As a result, significant improvements were made during the year, contributing to the delivery of £41.5m of efficiencies. This represented an increase of £8.1m compared to FY2024/25 efficiency delivery and reflects improved grip, engagement and financial control.

In FY2024/25, the Trust's agency expenditure for the year was £19.4m; this reduced to £7.9m for FY2025/26, achieving compliance with the required agency reduction targets. Further reductions are planned for FY2026/27, with the agency spend plan set at £5.1m.

During the year, the Trust also delivered its largest capital programme to date, totalling £149.7m. This included £127.2m of nationally funded developments, notably the Hospital Transformation Programme.

For FY2026/27, the Trust has agreed a stretching financial plan reflecting a £30.5m deficit pre-DSF, supported by a planned efficiency programme of £40.0m (5.7%). The Trust remains committed to the delivery of high-quality services and recognises the need to balance patient care, workforce requirements, operational pressures and financial sustainability.

Delivery of the FY2026/27 financial plan is subject to several significant risks, most notably pay inflation in the absence of commensurate income uplift, the delivery of a stretching efficiency

programme, and delivery of the activity and income plan given ongoing limitations in data visibility.

The Trust is committed to strengthening partnership working across the health and care system, noting that several critical actions to improve financial performance are dependent on effective collaborative arrangements with system partners.

The Trust continues to prioritise training, development and engagement within the finance function. Following the achievement of Future-Focused Finance Level Two accreditation in FY2023/24, the department continues to work towards Level Three. In December 2025, three individuals were shortlisted for Healthcare Financial Management Association (HFMA) National Awards, winning in one category and receiving a highly commended award, building on the Trust's success at the HFMA National Awards in December 2024.

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

During the reporting period, Enforcement Notice EN 255 was withdrawn by the Fire Authority in July 2025.

The Trust is currently subjected to four legal notices under the Regulatory Reform (Fire Safety) Order, 2005:

- Enforcement Notice EN 365 (Princes Royal Hospital)
- Enforcement Notice EN 366 (Princes Royal Hospital)
- Alterations Notice No 219
- Alterations Notice No 306

EN 365 (issued 28th January 2026), this Notice has a completion deadline of 30th April 2026. EN 365 focuses on the effectiveness of the Cross Corridor Fire Doors on the Hospital Streets, Fire Doors to corridors off the Hospital Streets and Ward Entrance Fire Doors. The EN also references the requirement for a Fire Compartmentation survey to be completed and the lack of Automatic Fire Detection in areas of PRH, including the Stairwells, Outpatients department and Pathology.

EN 366 (issued 29th January 2026), this Notice has a completion deadline of 30th April 2026. EN 366 focuses on the management of the Trust's Hospital Full Protocol in relation to the space in front of the inter Ward connecting fire doors/escapes being utilised as patient care areas. The Fire Service has withdrawn their support for the ongoing use of these areas, and post 30th April, will enforce robustly if the Fire Exit routes are obstructed. EN 366 also challenges to the Trust to provide evidence that Ward 11 can also be evacuated effectively and within the permitted

timescales due to the large occupancy of the Ward (generally 31 patients) and the restriction of only having two means of escape.

The Trust received an Alterations Notice, Serial No. 219 on 11 March 2020 regarding restriction to use of the Copthorne Building. This notice states:

"You must notify the Fire Authority before you:
Make a change to the premises affecting fire compartmentation between Ward 18, Ward 20 and the lift lobby area outside these Wards".

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

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

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

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

The Board has continued to receive regular direct updates on the position with fire safety during 2025/26. In February 2026, the Board received the Annual Fire Safety Audit Report that was carried out by the Trust's Authorising Engineer (Fire). Delivery of the action plan is overseen by the Fire Audit Action Plan Oversight Group which is chaired by the Group Director of Estates, Facilities, HTP, Capital and MES, and meets monthly.

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

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

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

Since then, the Trust has made major investments to enhance the delivery of maternity services. Increased governance, stronger leadership, improved culture, consistent training, and a supplementary workforce, have all supported making our maternity services more robust.

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

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

Towards the end of 2024/25, the Trust was given the opportunity to work with Mrs Donna Ockenden again, which included reconnection with some of the families who had been affected by the poor care they had received from the organisation. The Trust welcomed this opportunity, which was also supported by NHSE with several of their senior colleagues attending a 'Learning and Improvement Group' alongside members of the Trust's Board of Directors. At the time of writing, the meetings with Mrs Ockenden, families and others, are still taking place on a quarterly basis, and the learning has, and will, continue.

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

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

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

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

f) Political NHS Landscape

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

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

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

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

The Trust continues to comply with its statutory commitments to Emergency Preparedness Resilience and Response (EPRR) and this commitment can be quantified during the completion of the annual NHS EPRR Core Standards Assurance process whereby the trust self-assesses itself against 62 criteria. This is subsequently followed up with a *confirm and challenge* process alongside NHS England and the Integrated Care Board. In 2025, the Trust was assessed as “Substantially Compliant” overall, reflecting that 57 of the Core Standards were assessed as “fully compliant” and 5 of the standards assessed as “partially compliant”. The Trust submitted the required evidence in support of the submission on 31 August 2025 which was rigorously scrutinised by NHS England. The Trust continues to identify areas for improvement as a result of the learning of the NHSE Assurance Process, and the Emergency Planning Team have developed a detailed work programme to support its 2026 submission.

The focus for 2025/26 has been to ensure that all necessary EPRR response plans are reviewed, updated and re-established in line with national guidance best practice. The Trust regularly facilitates and participates in EPRR activities on a local and regional footprint, including testing and exercising of our plans and procedures whilst maintaining a robust training and debriefing to ensure all lessons learned are captured and inform improvements to our processes.

7. NHS Provider Licence section 4 (governance)

The NHS Provider Licence is the main tool for regulating providers of NHS services. NHS England (or precursor bodies) has had undertakings in place with the Trust since June 2019. These were reviewed and refreshed in January 2021, then again in April 2022 and latterly in July 2024. On 06 March 2026, NHS England wrote to the Trust advising that they had assessed the Trust's position and were able to refresh the Trust's then-current Undertakings which led to removing the finance and quality items, confirmed by a Compliance Certificate. Replacement Enforcement Undertakings were put in place which focus largely on improvements to be made regarding Urgent and Emergency Care, and a respective improvement plan which will be jointly developed with STW ICB and WMAS.

Oversight of all NHS trusts, NHS foundation trusts and Integrated Care Boards is undertaken by NHS England using the *NHS Oversight Framework*. A letter dated 02 March 2026 from NHS England provided formal notice of the important milestone of The Shrewsbury and Telford Hospital NHS Trust's transition to NHS Oversight Framework (NOF) segment 3 (from segment 5) and exit from the Recovery Support Programme (RSP). The Trust first entered national intensive support in 2018 following an inadequate CQC rating. Since then, it has been in receipt of significant support and intervention by NHS England (and pre-cursor bodies). However, over the last 18 months, NHS England confirmed that it has seen demonstrable and sustainable improvements across a range of areas, including meeting SaTH's RSP exit criteria. This was a testament to SaTH leadership and the dedication, perseverance and hard work of staff over many years.

Following the publication of the *Code of Governance for NHS Providers* which applied to all NHS Trusts from 1 April 2023, the Trust adheres to the Code on a 'comply or explain' basis.

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

8. Fit and Proper Person Framework and Board effectiveness

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

As part of the directors' appraisal process, the Leadership Competency Framework, which was published in 2024, is also utilised.

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

9. Committees of the Board

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

- The Board of Directors is responsible for establishing principal strategic and corporate objectives and for driving the organisation forward to achieve these. It is also responsible for ensuring that effective systems are in place to identify and manage the risks associated with the achievement of these objectives through the Board Assurance Framework and the Corporate Risk Register. The Board held a public meeting in common with Shropshire Community Health NHS Trust on 23 September 2025 to consider and approve a Group Model Case for Change to form a shared leadership Group model. At a private Board meeting on 12 March 2026, a Group Partnering Agreement was considered and approved. The name of the Group was agreed as Shropshire Telford & Wrekin Community and Hospitals NHS Group and came into effect as a formal Group Model on 01 April 2026.

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

- The Quality and Safety Assurance Committee (QSAC) is established to seek and obtain evidence of assurance on the effectiveness of the Trust's clinical quality and safety governance structure, systems, and processes and the quality and safety of the services provided to achieve consistently high-quality effective care, ensure continuous improvement and to meet legal and regulatory obligations.

- The Finance Assurance Committee (FAC) is responsible on behalf of the Board of Directors for objective scrutiny and seeking evidence of assurance of the Trust's financial performance plans, major investment decisions, capital plans and relevant regulatory compliance. It provides the Board with an objective review of the financial position of the Trust and assurance on the delivery of the Trust's financial objectives, including identifying any significant risks and associated mitigating actions. It also considers processes for the preparation and the content of strategic and operational financial plans, including annual revenue, capital and workforce budgets, and test the key assumptions and risks underpinning such plans.

- The Performance Assurance Committee is responsible for providing independent assurance to the Board of Directors regarding: - the development and delivery of the Trust's annual business plan; performance of the Trust across a range of performance indicators within the Integrated Performance Report; and to ensure appropriate Estates and Digital strategies are in place. It also oversees the development of a long-term strategy that addresses all identified operational business risks and opportunities, including those deriving from partnership work.

- The People & Organisation Development Assurance Committee receives assurances that staffing processes are safe, sustainable, and effective and that the NHS People Promises are being delivered. From November 2025, the committee held its meetings in common with Shropshire Community Health NHS Trust and met as a People Committee in common, as part of the Group Model development.

- The Hospitals Transformation Assurance Committee is responsible for providing independent assurance to the Board of Directors regarding the processes, procedures, and management of the Hospitals Transformation Programme (HTP) and associated work to support the successful achievement of the HTP Investment Objectives and realisation of the stated benefits.

- A Group Transition Committee was established as a joint committee with Shropshire Community Health NHS Trust during the year, with its terms of reference approved at private Board in August and public Board in September 2025. The Group Transition Committee exists to scrutinise the robustness of and provide assurance to each Board on the development and delivery of a group model, the integration agenda and strategic aims and objectives for the benefit of our population.

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

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

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

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

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

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

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

Having the right nurse staffing levels is fundamental to providing safe, high-quality patient care, as well as creating a positive working environment for staff. The Trust undertakes bi-annual nurse staffing reviews, in accordance with the National Quality Board (NBQ, 2016) standards and Developing Workforce Safeguards (2018). This ensures that a systematic approach is applied to determining staffing numbers and the skills required to maintain the safety of patients in our care. The Group Chief Nurse and Group Chief Medical Officer have confirmed that they are satisfied with the safety, effectiveness and current sustainability of staffing levels at the Shrewsbury and Telford Hospital NHS Trust.

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

The Shrewsbury and Telford Hospital NHS Trust is required to register with the Care Quality Commission (CQC). The Trust is not fully compliant with the registration requirements of the CQC with one condition previously imposed on the Trust remaining on its license as described earlier in this statement within its major risks.

The trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the trust with reference to the guidance) within the past twelve months, as required by the ‘Managing Conflicts of Interest in the NHS’ guidance. The Trust has achieved over 80% compliance with declarations of interest within the Electronic Staff Record by those classed as ‘decision makers’, in line with the 80% compliance requirements of the Counter Fraud Authority Standard.

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

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

One of the Trust's key enablers to the organisation objectives in 2025/26 is to live the people promise in our teams through valuing difference and inclusion. However, we recognise that we have more to do which includes:

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

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

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

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

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

In 2025/26, the Audit and Risk Assurance Committee focused on the effectiveness of controls in relation to a number of areas which were the focus of internal audit reviews (as detailed later within this report). The Committee also played a crucial role in overseeing the integrity of financial reporting, and the independence and performance of the external auditors.

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

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

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

The governance structure at Executive level and below provides opportunities for specific divisions, service lines and departments to be challenged on their efficient, effective and economic use of resources within the respective services which they provide. All budget holders are provided with monthly financial information to help them ensure resources are used economically, efficiently and effectively.

12. Information Governance

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

The Trust uses NHSE's Cyber Assessment Framework (CAF)/ aligned Data Security and Protection Toolkit (DSPT) independent assessment framework to measure performance, and improvements over the previous year have been noted, although the Trust continues to work through its agreed improvement plan with NHSE. The Trust aims to submit its 2025/26

submission by the end of June 2026. The Trust submitted its 2024/25 submission in June 2025 (Approaching Standards). We have submitted the latest CAF/aligned DSPT 2025/26 to our internal auditors and have recently received the follow up report.

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

The Trust have had no ICO reportable data incidents/breaches within the reporting period 1 April 2025 to 31 March 2026.

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

13. Data Quality and governance

Data quality remained a key priority for the Trust in 2025/26, particularly as the organisation transitioned into business as usual following the implementation of Careflow and the migration of its data warehousing infrastructure into the Federated Data Platform (FDP) environment.

The Data Quality Group continues to meet on a monthly basis, providing strategic oversight of data quality and ensuring that assurance is both obtained and formally documented for data systems and data items that impact key standards, patient safety, or financial sustainability. The Data Quality Policy has been refreshed to set clear direction for the Trust, outlining key deliverables that support the overall vision and strategic direction for ensuring that data held within the organisation is robust and reliable. This policy was approved by the Policy Approval Group in January 2026 and is available on the Trust website.

The recovery agenda across both elective and emergency pathways remained a central focus throughout 2025/26, with significant improvements achieved in elective performance. A key enabler of this improvement was the availability of fit for purpose, quality assured, and validated data. This has been achieved through targeted validation activity undertaken in collaboration with MBI Health Ltd. and by addressing identified issues at pace through the Data Quality Group. A Data Quality app is now live within the Trust, with a specific focus on maintaining waiting list

data quality, developed in line with key NHS England LUNA metrics for waiting list quality assurance.

The integrated performance report continues to be shared with the Board on a monthly basis and is subject to ongoing development to ensure it meets the evolving requirements of the organisation as we move into a Group model for 2026/27.

The challenges identified in 2024/25 relating to the technical structure of the Trust's internal data warehousing have persisted into 2025/26. While considerable improvements have been made and national submissions to the Secondary Uses Service (SUS) have been reinstated, issues remain regarding the consistency of data quality within these submissions. Service Level Agreement Monitoring (SLAM) is currently in the development and testing phase, which means the Trust is not yet able to produce a fully accurate view of activity and income. This remains a priority for the organisation, with progress closely monitored through the Data Warehouse Project Board and reported monthly to the Performance Assurance Committee.

A structured and actively managed recovery plan is in place to address these issues and ensure delivery at pace. Weekly escalation meetings have been established to provide focused oversight of delivery, unblock technical and operational issues, and maintain momentum against the project plan. These sessions ensure that risks are rapidly identified, clearly owned, and driven through to resolution with defined actions and timelines. In addition, progress is formally governed through the monthly Federated Data Platform (FDP) Board, which includes executive representation. This forum provides robust oversight, ensuring that delivery milestones, risks, and interdependencies are fully understood and that appropriate executive support and challenge is applied. Reporting from this group feeds into wider corporate governance, ensuring continued visibility and accountability.

Looking forward, the Trust has developed a Target Operating Model (TOM) for data engineering and business intelligence. This has been designed to address the underlying causes of the current challenges by ensuring that both the technological architecture and workforce capacity and capability are fit for purpose. The TOM sets out a clear end-state model that will provide a stable, sustainable, and resilient data environment. Implementation is planned for Quarter 3 2026/27, at which point the Trust expects to achieve a consistent, high-quality data flow supporting accurate reporting of activity, performance, and income.

In the interim, while full resolution is being delivered, the combination of strengthened governance, frequent escalation routes, and executive oversight provides assurance that issues are being actively managed, risks are understood, and progress is being maintained at pace. The restoration of SUS submissions demonstrates that improvement is being achieved, and the current focus remains on stabilising data quality and completing SLAM to enable a fully accurate and assured position.

14. Review of effectiveness

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

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

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

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

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Board Assurance Framework and on the controls reviewed as part of the internal audit work. The Head of Internal Audit opinion for 2025/26 gave an overall **Substantial Assurance** opinion on the system of internal control in place during the year:

"The overall opinion for the period 1st April 2025 to 31st March 2026 provides Substantial Assurance, that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently."

Issues relating to the formulation of the opinion included work conducted through the risk based internal audit plan for 2025/26, as can be seen in the following table:

Opinion provided	**Title of core and risk-based reviews issued**
1 **high** assurance opinions:	Risk Management Core Controls
4 **substantial** assurance opinions:	Key Financial Controls. Patient Safety Incident Response Framework (PSIRF) (*carry forward from 24/25*). Grip & Control Review. Fit & Proper Persons.
2 **moderate** assurance opinions:	Data Quality - Waiting List & Performance Review. E Rostering / Roster Management.
1 **limited** assurance opinions:	Waiting List Initiatives & Consultant Job Planning
Nil **no** assurance opinions	-
Nil reviews without an assurance rating	-

The internal auditors during the course of the year have undertaken follow up reviews and have concluded that the organisation has made "good progress" with regards to the implementation of recommendations. They will continue to track and follow up outstanding actions.

The Assurance Framework (AF) internal audit opinion for the period 1st April 2025 to 31st March 2026 was as follows:

"The structure of the AF meets the NHS requirements. Processes in place to update the AF robust. The AF was visibly reviewed by the organisation."

Internal audit undertook work during the year aimed to assess and provide assurance based upon the validity of the organisation's intended final Data Security and Protection Toolkit (DSPT) submission, and consider compliance with the NHS Cyber Assessment Framework (CAF) aligned Data Security and Protection Toolkit profile for 2025/26 for the in-scope security and governance of information control environment outcomes and the level of risk / wider risk associated with weak or failing controls and security and governance of information objectives not being achieved. The findings were as follows:

Overall Assurance Rating	
Across the CAF DSPT our assurance is based on the number of in-scope outcomes rated as not meeting the minimum achievement levels as profiled by NHS England. As a result of this our overall assurance level across the in-scope outcomes and indicators of good practice is rated as:	**High Risk**
Veracity of the organisation's self-assessment	
In our view, the organisation's self-assessment for the in-scope outcomes partially aligned with that of the Independent Assessor and as such, the confidence-level in the veracity of the organisation's CAF DSPT self-assessment is:	**Medium confidence**

A report was produced at the conclusion of each audit assignment and, where scope for improvement was found, recommendations were made, and appropriate action plans agreed with management. 34 recommendations were raised during the year relating to the risk-based audits, all of which were accepted by management. None of the recommendations were critical, but five were high risk recommendations in relation to the reviews of Waiting List Initiatives, E Rostering and a Data Quality - Waiting List and Performance Review. The total number of recommendations yet to be implemented as at end of March 2026 is nil. The remaining seven open recommendations are not yet due.

My review as Accountable Officer is also informed by:

- Opinion and reports from our external auditors
- Financial accounts and systems of internal control
- Matters brought before the Board of Directors, and Board Assurance Committees
- Trust risk registers
- In-year submissions against performance to NHS England
- Department of Health and Social Care performance requirements/ indicators

- Compliance with the Care Quality Commission essential standards for quality and safety for all regulated activities
- Progress against the information governance assurance framework including the Data Security and Protection Toolkit
- Investigation reports and action plans following serious incidents (RALIG)
- The work of the Trust's Anti-Fraud Specialist who carries out a detailed work plan and specialist investigations.

15. Conclusion

As the Accountable Officer, I am reporting that there are **no significant internal control issues** that have been identified for 2025/26 year.

However, as highlighted above, there are several significant risks which may affect delivery of the Trust's objectives, which are reflective of the CQC's 'requires improvement' rating for the Trust.

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

The system of internal control has been in place at the Trust for the year ended 31 March 2026 and up to the date of approval of the Annual Report and Accounts.

Organisation:	**The Shrewsbury and Telford Hospital NHS Trust**
Signed by Accountable Officer/ Group Chief Executive, Jo Williams	
Date:	**22 June 2026**

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

The Chief Executive of NHS England has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the *NHS Trust Accountable Officer Memorandum.* These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance
- value for money is achieved from the resources available to the trust
- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them
- effective and sound financial management systems are in place and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, other items of comprehensive income and cash flows for the year.

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

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

Signed

Jo Williams

Group Chief Executive

22 June 2026

Statement of directors' responsibilities in respect of the accounts

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

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

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

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

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

By order of the Board.

Signed by

Jo Williams
Group Chief Executive
22 June 2026

Adam Winstanley
Acting Chief Finance Officer

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

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of The Shrewsbury and Telford Hospital NHS Trust ("the Trust") for the year ended 31 March 2026 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity and the Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2026 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State for Health and Social Care with the consent of HM Treasury on 23 June 2022 as being relevant to NHS Trusts in England and included in the Department of Health and Social Care Group Accounting Manual 2025/26; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

Basis for opinion

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

Going concern

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

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

Our conclusions based on this work:

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

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

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

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

opportunity to commit fraud. Our risk assessment procedures included:

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

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

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

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

We performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included unexpected account combinations with revenue and cash.
- Inspecting expenditure transactions in the period prior to 31 March 2026 to assess whether expenditure had been recognised in the correct accounting period.

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

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

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

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

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

As described in the section of this report dealing with other legal and regulatory matters, we made a referral to the Secretary of State under section 30 of the Local Audit and Accountability

Act 2014 on 13 May 2026, relating to the Trust's failure to comply with its "breakeven duty" set out in paragraph 2(1) of Schedule 5 to the National Health Service Act 2006.

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

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

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

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The directors are responsible for the other information, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared in all material respects, in accordance with the Department of Health and Social Care Group Accounting Manual 2025/26.

Directors', Accountable Officer's and Audit and Risk Assurance Committee's responsibilities

As explained more fully in the statement set out on page 134, the directors are responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to either cease the services provided by the Trust or dissolve the Trust without the transfer of its services to another public sector entity. As explained more fully in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, on page 133 the Accountable Officer is responsible for ensuring that annual statutory accounts are prepared in a format directed by the Secretary of State.

The Audit and Risk Assurance Committee is responsible for overseeing the Trust's financial reporting process.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained in the statement set out on page 133, the Chief Executive, as the Accountable Officer, is responsible for ensuring that value for money is achieved from the resources available to the Trust. We are required under section 21(2A) of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We are also not required to satisfy ourselves that the Trust has achieved value for money during the year.

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if:

- we issue a report in the public interest under section 24 and Schedule 7 of the Local Audit and Accountability Act 2014; or
- we make written recommendations to the Trust under Section 24 and Schedule 7 of the Local Audit and Accountability Act 2014; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We made a section 30 referral to the Secretary of State on 13 May 2026 in respect of the Trust's breach of its "breakeven duty" set out in paragraph 2(1) of Schedule 5 to the National Health Service Act 2006 for the year ended 31 March 2026.

We have nothing further to report in these respects.

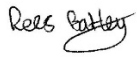
THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Board of Directors of The Shrewsbury and Telford Hospital NHS Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Board of Directors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of Directors of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

DELAY IN CERTIFICATION OF COMPLETION OF THE AUDIT

As at the date of this audit report, we are unable to confirm that we have completed our work in respect of the trust accounts consolidation pack of the Trust for the year ended 31 March 2026 because we have not received confirmation from the NAO that the NAO's audit of the Department of Health and Social Care accounts is complete.

Until we have completed this work, we are unable to certify that we have completed the audit of The Shrewsbury and Telford Hospital NHS Trust for the year ended 31 March 2026 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the NAO Code of Audit Practice.



Rees Batley
for and on behalf of KPMG LLP
Chartered Accountants
66 Queen Square
Bristol
BS1 4BE

25 June 2026

Annual Accounts for the year ending 31 March 2026

The Shrewsbury And Telford Hospital 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	3.1	727,942	675,319
Other operating income	4	50,118	48,746
Operating expenses	6.1	(780,567)	(741,826)
Operating surplus/(deficit) from continuing operations		**(2,507)**	**(17,761)**
Finance income	10	3,189	3,749
Finance expenses	11	(350)	(240)
PDC dividends payable		(9,625)	(9,323)
Net finance costs		**(6,786)**	**(5,814)**
Other gains / (losses)	12	(198)	(399)
Surplus / (deficit) for the year		**(9,491)**	**(23,974)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(10,007)	(5,441)
Revaluations	16	6,340	1,942
Total other comprehensive income for the period		**(3,667)**	**(3,499)**
Total comprehensive income / (expense) for the period		**(13,158)**	**(27,473)**

Statement of Financial Position

	Note	31 March 2026 £000	31 March 2025 £000
Non-current assets			
Intangible assets	13	23,179	24,658
Property, plant and equipment	14.1	500,512	394,007
Right of use assets	17.1	18,623	19,472
Receivables	22.1	1,766	1,828
Total non-current assets		**544,080**	**439,965**
Current assets			
Inventories	21	10,450	10,108
Receivables	22.1	27,113	13,787
Cash and cash equivalents	23.1	72,979	61,518
Total current assets		**110,542**	**85,413**
Current liabilities			
Trade and other payables	24.1	(107,198)	(88,333)
Borrowings	26.1	(3,482)	(3,559)
Provisions	28.1	(292)	(267)
Other liabilities	25	(1,264)	(4,141)
Total current liabilities		**(112,236)**	**(96,300)**
Total assets less current liabilities		**542,386**	**429,078**
Non-current liabilities			
Borrowings	26.1	(15,202)	(15,812)
Provisions	28.1	(553)	(649)
Total non-current liabilities		**(15,755)**	**(16,461)**
Total assets employed		**526,631**	**412,617**
Financed by			
Public dividend capital		763,709	636,537
Revaluation reserve		76,270	79,937
Income and expenditure reserve		(313,348)	(303,857)
Total taxpayers' equity		**526,631**	**412,617**

The accompanying notes form part of these accounts.

Name Jo Williams
Position Group Chief Executive
Date 22 June 2026

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

	Public dividend capital	Revaluation reserve	Financial assets reserve	Other reserves	Merger reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2025 - brought forward	**636,537**	**79,937**	**-**	**-**	**-**	**(303,857)**	**412,617**
Surplus/(deficit) for the year	-	-	-	-	-	(9,491)	**(9,491)**
Impairments	-	(10,007)	-	-	-	-	**(10,007)**
Revaluations	-	6,340	-	-	-	-	**6,340**
Public dividend capital received	127,172	-	-	-	-	-	**127,172**
Taxpayers' equity at 31 March 2026	**763,709**	**76,270**	**-**	**-**	**-**	**(313,348)**	**526,631**

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

	Public dividend capital	Revaluation reserve	Financial assets reserve	Other reserves	Merger reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2024 - brought forward	**584,087**	**83,436**	**-**	**-**	**-**	**(279,883)**	**387,640**
Taxpayers' equity at 1 April 2024 - restated	**584,087**	**83,436**	**-**	**-**	**-**	**(279,883)**	**387,640**
Surplus/(deficit) for the year	-	-	-	-	-	(23,974)	**(23,974)**
Impairments	-	(5,441)	-	-	-	-	**(5,441)**
Revaluations	-	1,942	-	-	-	-	**1,942**
Public dividend capital received	52,450	-	-	-	-	-	**52,450**
Taxpayers' equity at 31 March 2025	**636,537**	**79,937**	**-**	**-**	**-**	**(303,857)**	**412,617**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Financial assets reserve
This reserve comprises changes in the fair value of financial assets measured at fair value through other comprehensive income. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure, unless the assets are equity instruments measured at fair value through other comprehensive income as a result of irrevocable election at recognition.

Merger reserve
This legacy reserve reflects balances formed on previous mergers of NHS bodies.

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

Statement of Cash Flows

	Note	2025/26 £000	2024/25 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(2,507)	(17,761)
Non-cash income and expense:			
Depreciation and amortisation	6.1	28,289	27,380
Net impairments	7	21,984	12,768
Income recognised in respect of capital donations	4	(8,449)	(8,463)
(Increase) / decrease in receivables and other assets		(13,584)	(1,645)
(Increase) / decrease in inventories		(342)	(197)
Increase / (decrease) in payables and other liabilities		(975)	23,950
Increase / (decrease) in provisions		(74)	(63)
Net cash flows from / (used in) operating activities		**24,342**	**35,969**
Cash flows from investing activities			
Interest received		3,189	3,749
Purchase of intangible assets		(4,975)	(4,284)
Purchase of PPE and investment property		(133,550)	(75,088)
Receipt of cash donations to purchase assets		8,449	8,463
Net cash flows from / (used in) investing activities		**(126,887)**	**(67,160)**
Cash flows from financing activities			
Public dividend capital received		127,172	52,450
Capital element of lease rental payments		(3,513)	(3,703)
Interest paid on lease liability repayments		(347)	(235)
PDC dividend (paid) / refunded		(9,306)	(10,484)
Net cash flows from / (used in) financing activities		**114,006**	**38,029**
Increase / (decrease) in cash and cash equivalents		**11,461**	**6,838**
Cash and cash equivalents at 1 April - brought forward		**61,518**	**54,680**
Cash and cash equivalents at 31 March	23.1	**72,979**	**61,518**

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.

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

The Board has carefully considered the principle of 'Going Concern' in the context of the Trust continuing to operate under the HM Treasury's Financial Reporting Guidelines (FReM). For the year ending 31 March 2026, the Trust is reporting a surplus of £4.9m on an adjusted financial performance basis, against a breakeven plan, supported by non-recurrent deficit funding of £45.1m and bonus deficit support funding of £4.9m. The Board has therefore reported that the Trust is a going concern, with no plans for any substantial changes to its portfolio of services.

Since the Trust has neither been notified that its services are no longer required nor received notice of material closure of NHS services currently run by the Trust, and services continue to be commissioned from the Trust by local and specialist commissioners. The Trust has submitted a compliant breakeven plan for 2026/27 underpinned by £30.5m of deficit support funding. The Trust therefore expects to operate as a going concern through to the end of the going concern period of 30 June 2027. The Trust Board has considered the advice in the DHSC’s GAM that the anticipated continuation of the provision of a service in the future, as evidenced by the inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern. The Trust has therefore adopted this approach in preparing these accounts.

The Trust maintained a cash and cash equivalent balance of £73.0m at the end of 2025/26 (March 2025: £61.5m).

The Board of Directors have concluded that whilst the financial position for 2026/27 is very challenging, based upon enquiries with NHSE and the Department of Health and Social Care, they have a reasonable expectation that the Trust will have access to adequate resources (as in previous years) to continue in operational existence for at least 12 months from the date of approval of the financial statements and continue to provide services to its patients. Based on this expected continuation of services, the Trust continues to adopt the going concern basis in preparing the financial statements.

Note 1.3 Interests in other entities

The Trust is the Corporate Trustee to the Shrewsbury and Telford Hospital NHS Trust Charity. The Trust has assessed its relationship to the charitable fund and determined it not to be a subsidiary because the Trust is not exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

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

Note 1.4 Revenue from contracts with customers

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

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

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for healthcare 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. 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. During 2025/26 variable income was received aligned to contracted levels, and additional allocations were made available during Q4 for elective sprint. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

High costs drugs and devices excluded from the calculation of national prices are reimbursed by NHS England based on actual usage or at a fixed baseline in addition to the price of the related service.

The Trust also receives income from commissioners under the Best Practice Tariff (BPT) scheme. Delivery under the 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.

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.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

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

Deficit support funding
The Trust received planned deficit support funding of £45.1m and £4.9m of bonus deficit support funding as a result of its delivery of the 2025/26 financial plan. This funding is recorded under patient care activities and received via the host ICB contract.

Note 1.5 Other forms of income

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

Apprenticeship service income

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

Note 1.6 Expenditure on employee benefits

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

Pension costs

NHS Pension Scheme

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

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

Note 1.7 Expenditure on other goods and services

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

Note 1.8 Discontinued operations

Discontinued operations occur where activities either cease without transfer to another entity, or transfer to an entity outside of the boundary of the Whole of Government Accounts, such as private or voluntary sectors. Such activities are accounted for in accordance with IFRS 5. Activities that are transferred to other bodies within the boundary of the Whole of Government Accounts are ‘machinery of government changes’ and treated as continuing operations.

Note 1.9 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

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

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

Subsequent expenditure

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

Measurement

Valuation

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

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

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current 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. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as ‘held for sale’ cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

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

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

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

Impairments

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

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

De-recognition

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

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

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

Donated and grant funded assets

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

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

Useful lives of property, plant and equipment

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

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	4	70
Dwellings	12	44
Plant & machinery	5	27
Transport equipment	7	10
Information technology	3	10
Furniture & fittings	5	23

Note 1.10 Intangible assets

Recognition

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

Internally generated intangible assets

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

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

Software

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

Measurement

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

Prior to 1 April 2025, intangible assets were held under a revaluation approach reflecting current value in existing use. Revaluation gains and losses and impairments were treated in the same manner as for property, plant and equipment. On 1 April 2025, the carrying value of these assets was carried forward as 'deemed cost' and any related revaluation surpluses in the revaluation reserve were transferred to the I&E reserve.

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
Information technology	3	12
Software licences	3	10

Note 1.11 Inventories
Inventories are valued at the lower of cost and net realisable value using the replacement cost formula. This is considered to be a reasonable approximation to fair value due to high turnover of stocks.

Note 1.12 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 1.13 Financial assets and financial liabilities

Recognition

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

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

Classification and measurement

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

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

Financial assets are classified as subsequently measured at amortised cost, fair value through income and expenditure.

Financial liabilities classified as subsequently measured at amortised cost or fair value through income and expenditure.

Financial assets and financial liabilities at amortised cost
Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense.

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).

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 1.14 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

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

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

Operating leases

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

Note 1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2026:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.64%	4.03%
Medium-term	After 5 years up to 10 years	4.22%	4.07%
Long-term	After 10 years up to 40 years	5.32%	4.81%
Very long-term	Exceeding 40 years	5.07%	4.55%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2026:

	Inflation rate	Prior year rate
Year 1	2.5%	2.60%
Year 2	2.0%	2.30%
Into perpetuity	2.0%	2.00%

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 28.2 but is not recognised in the Trust’s accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in Note 29 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 29.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity’s control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.17 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 1.18 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 1.19 Corporation tax

The Trust is not required to pay corporation tax as it is an NHS trust and has no trading company.

Note 1.20 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.21 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.22 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 1.23 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.24 Early adoption of standards, amendments and interpretations

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

Note 1.25 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 - The Standard is effective for accounting 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. The expected impact of applying the standard in future periods has not yet been assessed.

The following future changes to adaptations and interpretations of IAS 16 for the public sector are also not yet adopted:

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 £254.0m as at 31 March 2026.

The current accounting policy for property assets measures the cost of replacing the service potential using a 'modern equivalent asset'. This policy is not changing. In deriving the modern equivalent asset, the Trust and its valuers currently adopt an 'alternative site' assumption for all of its specialised buildings, meaning the replaced service potential may be in a different location. The option of using this assumption is being withdrawn for NHS bodies from 1 April 2028. Therefore the hypothetical modern equivalent asset will change to be located on current sites in asset valuations from 2028/29. Assets valued on an alternative site basis have a total book value of £242.4m at 31 March 2026. The impact of this change is not able to be quantified at this time.

Note 1.26 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Charitable Funds: Following Treasury's agreement to apply IAS 27 (Consolidation and Separate Financial Statements) to NHS Charities from 1 April 2013, The Shrewsbury and Telford Hospital NHS Trust has established that as the Trust is the Corporate Trustee of the linked NHS charity, it effectively has the power to exercise control so as to obtain economic benefits so therefore may have needed to consolidate its NHS Charity Accounts into its NHS Trust Accounts. The Trust has considered the income, expenditure, assets and liabilities of the NHS Charity to be immaterial in the context of the accounts of the NHS Trust and has not consolidated these into the Trust's accounts.

Note 1.27 Sources of estimation uncertainty

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

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

Revaluation: The Trust commissioned Cushman and Wakefield ('C&W') to undertake a full valuation of the Trust's estate as at 31 March 2026. Specialised buildings are valued at Depreciated Replacement Cost defined as Modern Equivalent Asset.

Valuation of property, plant and equipment is based upon an assessment undertaken by professional property valuers which by its nature includes an element of subjectivity. It is impracticable to disclose the extent of the possible effects of an assumption or another source of estimation uncertainty at the end of the reporting period as there are a number of factors that can affect the valuation.

A 1% movement in the BCIS cost indices or location factor for Shropshire would have an impact of increasing or reducing the valuation of the Trust's estate by £2.24 million based on an overall valuation of building assets of £224.28 million. In order to have a material impact, the movement in BCIS cost indices would need to be c.6%.

Note 2 Operating segments

The Trust has one operating segment, being healthcare services. This is in line with the organisation's 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
Acute services		
Income from commissioners under API contracts - variable element*	125,075	-
Income from commissioners under API contracts - fixed element*	483,339	563,773
High cost drugs income from commissioners	44,900	41,380
Other NHS clinical income	3,802	339
All services		
Private patient income	1,142	1,074
National pay award central funding***	-	1,220
Additional pension contribution central funding**	28,654	26,752
Other clinical income	41,030	40,781
Total income from activities	**727,942**	**675,319**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. During 2024/25 the trust operated on a 'fixed' contract basis with an agreed national variation to the payment system due to ongoing issues resulting from the go live of the EPR. 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. There was no additional funding made available in 2025/26.

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	69,419	63,118
Integrated care boards	615,775	569,464
Other NHS providers	573	339
Non-NHS: private patients	1,142	1,074
Non-NHS: overseas patients (chargeable to patient)	459	569
Injury cost recovery scheme	1,213	1,223
Non NHS: other	39,361	39,532
Total income from activities	**727,942**	**675,319**
Of which:		
Related to continuing operations	727,942	675,319
Related to discontinued operations	-	-

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

	2025/26	2024/25
	£000	£000
Income recognised this year	459	569
Cash payments received in-year	79	105
Amounts added to provision for impairment of receivables	317	468
Amounts written off in-year	-	8

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	2,307	-	**2,307**	1,455	-	**1,455**
Education and training	21,810	-	**21,810**	19,724	-	**19,724**
Non-patient care services to other bodies	1,954	-	**1,954**	1,936	-	**1,936**
Income in respect of employee benefits accounted on a gross basis	-	-	**-**	-	-	**-**
Receipt of capital grants and donations and peppercorn leases	-	8,449	**8,449**	-	8,463	**8,463**
Charitable and other contributions to expenditure	-	-	**-**	-	-	**-**
Support from the Department of Health and Social Care for mergers	-	-	**-**	-	-	**-**
Revenue from finance leases (variable lease receipts)	-	-	**-**	-	-	**-**
Revenue from operating leases	-	-	**-**	-	-	**-**
Other income	15,598	-	**15,598**	17,168	-	**17,168**
Total other operating income	**41,669**	**8,449**	**50,118**	**40,283**	**8,463**	**48,746**
Of which:						
Related to continuing operations			50,118			48,746
Related to discontinued operations			-			-

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

	2025/26	2024/25
	£000	£000
liabilities at the previous period end (i.e. deferred income)	4,434	3,470

Note 6.1 Operating expenses

	2025/26	2024/25
	£000	£000
Purchase of healthcare from non-NHS and non-DHSC bodies	-	222
Staff and executive directors costs	523,245	499,837
Remuneration of non-executive directors	236	180
Supplies and services - clinical (excluding drugs costs)	63,748	55,939
Supplies and services - general	7,834	8,486
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	62,795	61,199
Inventories written down	428	291
Consultancy costs	772	746
Establishment	7,047	6,587
Premises	27,011	32,767
Transport (including patient travel)	1,122	792
Depreciation on property, plant and equipment	23,897	23,184
Amortisation on intangible assets	4,392	4,196
Net impairments	21,984	12,768
Movement in credit loss allowance: contract receivables / contract assets	1,120	892
Increase/(decrease) in other provisions	156	111
Change in provisions discount rate(s)	3	3
Fees payable to the external auditor - statutory audit	225	203
Internal audit costs	159	114
Clinical negligence	20,121	18,378
Legal fees	267	554
Insurance (as a policy holder)	66	102
Education and training	1,896	1,580
Variable lease payments not included in the liability	9,473	9,566
Car parking & security	2,457	1,961
Losses, ex gratia & special payments	19	20
Other	95	1,148
Total	**780,568**	**741,826**
Of which:		
Related to continuing operations	780,568	741,826

Note 6.2 Other auditor remuneration

No other auditor remuneration was paid to the external auditor (2024/25: £nil).

Note 6.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £5.0m (2024/25: £5.0m).

Note 7 Impairment of assets

	2025/26	2024/25
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Abandonment of assets in course of construction	-	5,790
Changes in market price	21,984	6,978
Total net impairments charged to operating surplus / deficit	**21,984**	**12,768**
Impairments charged to the revaluation reserve	10,007	5,441
Total net impairments	**31,991**	**18,209**

Please refer to note 16 for further details relating to the revaluation undertaken.

Note 8 Employee benefits

	2025/26 Total £000	2024/25 Total £000
Salaries and wages	395,259	378,032
Social security costs	49,081	36,963
Apprenticeship levy	1,929	1,809
Employer's contributions to NHS pensions	72,539	67,663
Temporary staff (including agency)	8,075	19,662
Total gross staff costs	**526,883**	**504,129**
Recoveries in respect of seconded staff	-	-
Total staff costs	**526,883**	**504,129**
Of which		
Costs capitalised as part of assets	3,638	4,292

Note 8.1 Retirements due to ill-health

During 2025/26 there were 8 early retirements from the Trust agreed on the grounds of ill-health (9 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £417k (£791k 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 2023, 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 at 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	3,189	3,749
Total finance income	**3,189**	**3,749**

Note 11.1 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	347	235
Total interest expense	**347**	**235**
Unwinding of discount on provisions	3	5
Total finance costs	**350**	**240**

Note 11.2 The late payment of commercial debts (interest) Act 1998

	2025/26	2024/25
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	-	-
Amounts included within interest payable arising from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 12 Other gains / (losses)

	2025/26	2024/25
	£000	£000
Gains on disposal of assets	19	18
Losses on disposal of assets	(217)	(417)
Total other gains / (losses)	**(198)**	**(399)**

Note 13 Intangible assets - 2025/26

	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Cost at 1 April 2025 - brought forward *	**6,476**	**26,470**	**7,352**	**40,298**
Additions	126	281	2,613	**3,020**
Reclassifications	-	-	(107)	**(107)**
Cost at 31 March 2026	**6,602**	**26,751**	**9,858**	**43,211**
Amortisation at 1 April 2025 - brought forward	**2,973**	**12,667**	**-**	**15,640**
Provided during the year	927	3,465	-	**4,392**
Amortisation at 31 March 2026	**3,900**	**16,132**	**-**	**20,032**
Net book value at 31 March 2026	**2,702**	**10,619**	**9,858**	**23,179**
Net book value at 1 April 2025	**3,503**	**13,803**	**7,352**	**24,658**

* From 1 April 2025, the option to apply the revaluation model in IAS 38 to intangible assets has been withdrawn prospectively. Where assets were previously revalued, the carrying value at the transition date was carried forward as 'deemed cost'.

Note 13.1 Intangible assets - 2024/25

	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - as previously stated	**5,443**	**17,484**	**10,513**	**33,440**
Additions	762	2,938	2,949	**6,649**
Reclassifications	271	6,048	(6,110)	**209**
Valuation / gross cost at 31 March 2025	**6,476**	**26,470**	**7,352**	**40,298**
Amortisation at 1 April 2024 - as previously stated	**2,147**	**9,297**	**-**	**11,444**
Provided during the year	826	3,370	-	**4,196**
Amortisation at 31 March 2025	**2,973**	**12,667**	**-**	**15,640**
Net book value at 31 March 2025	**3,503**	**13,803**	**7,352**	**24,658**
Net book value at 1 April 2024	**3,296**	**8,187**	**10,513**	**21,996**

Note 14.1 Property, plant and equipment - 2025/26

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2025 - brought forward	**14,040**	**226,517**	**1,488**	**105,248**	**67,408**	**646**	**29,958**	**2,855**	**448,160**
Additions	-	31,225	-	110,688	9,187	23	1,241	104	**152,468**
Impairments	-	(42,893)	(164)	-	-	-	-	-	**(43,057)**
Reversals of impairments	-	3,952	-	-	-	-	-	-	**3,952**
Revaluations	-	3,749	-	-	-	-	-	-	**3,749**
Reclassifications	-	19,625	-	(22,404)	2,572	-	246	68	**107**
Disposals / derecognition	-	-	-	(2)	(6,345)	(141)	(5,259)	(58)	**(11,805)**
Valuation/gross cost at 31 March 2026	**14,040**	**242,175**	**1,324**	**193,530**	**72,822**	**528**	**26,186**	**2,969**	**553,574**
Accumulated depreciation at 1 April 2025 - brought forward	**-**	**1,708**	**-**	**-**	**33,856**	**413**	**16,976**	**1,200**	**54,153**
Provided during the year	-	9,223	41	-	6,172	40	4,449	278	**20,203**
Impairments	-	(6,091)	(42)	-	-	-	-	-	**(6,133)**
Reversals of impairments	-	(981)	-	-	-	-	-	-	**(981)**
Revaluations	-	(2,591)	-	-	-	-	-	-	**(2,591)**
Reclassifications	-	(1)	1	-	1	(1)	1	(1)	**-**
Disposals / derecognition	-	-	-	-	(6,131)	(141)	(5,259)	(58)	**(11,589)**
Accumulated depreciation at 31 March 2026	**-**	**1,267**	**-**	**-**	**33,898**	**311**	**16,167**	**1,419**	**53,062**
Net book value at 31 March 2026	**14,040**	**240,908**	**1,324**	**193,530**	**38,924**	**217**	**10,019**	**1,550**	**500,512**
Net book value at 1 April 2025	**14,040**	**224,809**	**1,488**	**105,248**	**33,552**	**233**	**12,982**	**1,655**	**394,007**

Note 14.2 Property, plant and equipment - 2024/25

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - as previously stated	**13,500**	**214,686**	**1,514**	**84,472**	**65,160**	**414**	**23,616**	**2,828**	**406,190**
Additions	-	4,926	-	59,755	3,195	-	3,461	85	**71,422**
Impairments	-	(17,204)	-	(5,790)	-	-	-	-	**(22,994)**
Reversals of impairments	540	581	(3)	-	-	-	-	-	**1,118**
Revaluations	-	(2,064)	(23)	-	-	-	-	-	**(2,087)**
Reclassifications	-	25,592	-	(33,189)	3,216	232	3,937	3	**(209)**
Disposals / derecognition	-	-	-	-	(4,163)	-	(1,056)	(61)	**(5,280)**
Valuation/gross cost at 31 March 2025	**14,040**	**226,517**	**1,488**	**105,248**	**67,408**	**646**	**29,958**	**2,855**	**448,160**
Accumulated depreciation at 1 April 2024 - as previously stated	**-**	**761**	**-**	**-**	**31,634**	**376**	**13,563**	**975**	**47,309**
Provided during the year	-	8,602	41	-	5,967	37	4,469	286	**19,402**
Impairments	-	(2,535)	-	-	-	-	-	-	**(2,535)**
Reversals of impairments	-	(1,128)	(4)	-	-	-	-	-	**(1,132)**
Revaluations	-	(3,992)	(37)	-	-	-	-	-	**(4,029)**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(3,745)	-	(1,056)	(61)	**(4,862)**
Accumulated depreciation at 31 March 2025	**-**	**1,708**	**-**	**-**	**33,856**	**413**	**16,976**	**1,200**	**54,153**
Net book value at 31 March 2025	**14,040**	**224,809**	**1,488**	**105,248**	**33,552**	**233**	**12,982**	**1,655**	**394,007**
Net book value at 1 April 2024	**13,500**	**213,925**	**1,514**	**84,472**	**33,526**	**38**	**10,053**	**1,853**	**358,881**

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

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	14,040	233,060	1,017	177,724	36,555	217	10,013	1,500	**474,126**
Owned - donated/granted	-	7,848	307	15,806	2,369	-	6	50	**26,386**
Total net book value at 31 March 2026	**14,040**	**240,908**	**1,324**	**193,530**	**38,924**	**217**	**10,019**	**1,550**	**500,512**

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

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	14,040	216,223	1,166	96,948	31,262	233	12,973	1,593	**374,438**
Owned - donated/granted	-	8,586	322	8,300	2,290	-	9	62	**19,569**
Total net book value at 31 March 2025	**14,040**	**224,809**	**1,488**	**105,248**	**33,552**	**233**	**12,982**	**1,655**	**394,007**

Note 15 Donations of property, plant and equipment

During 2025/26 donations have been received from Royal Shrewsbury Hospital League of Friends, The Shrewsbury and Telford NHS Trust Charitable Funds, Lingen Davies Cancer Fund and a commercial Research and Development partner for the purchase of equipment and building works. In addition, a Public Sector Decarbonisation Scheme grant of £8.1m has been received.

Note 16 Revaluations of property, plant and equipment

The Trust commissioned Cushman and Wakefield to undertake a full valuation of the Trust's Estate as at 31 March 2026. The properties were inspected internally and externally by Alex Fakatou and Lois Duffy during December 2025 and Nick Worthington MRICS during March 2026 (“the Surveyors”). Jonathan Stickells, MRICS, has been signatory of Valuation Reports provided to Shrewsbury and Telford Hospital NHS Trust since 31 March 2025. Stuart Hailey is also a signatory to this years Report.

As a result of these revaluations the net book value of the Estate was valued downwards by £25.7m as follows: Revaluation Reserve - total £3.7m downwards, representing a revaluation upwards of £6.3m and a net decrease of £10.0m relating to upward reversals totalling £2.9m and decrease of £12.9m. The Impairment Charge to SoCI is £22.0m - representing an impairment charge to the value of £24.0m and reversal of previous impairments of £2.0m.

Note 17 Leases - The Shrewsbury And Telford Hospital NHS Trust as a lessee

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

The Trust is a lessee in a number of leases relating to property and equipment. These include property leases for a number of the Trust's services including Diagnostics, Fertility and Maternity Services. In addition, the Trust has several leases for equipment including MRI and CT scanners, X-Ray equipment and Endoscopy and Pathology Services equipment.

Note 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	**19,119**	**10,328**	**309**	**29,756**	**4,597**
Additions	2,001	820	27	**2,848**	-
Remeasurements of the lease liability	314	64	-	**378**	50
Disposals / derecognition	(544)	-	-	**(544)**	(544)
Valuation/gross cost at 31 March 2026	**20,890**	**11,212**	**336**	**32,438**	**4,103**
Accumulated depreciation at 1 April 2025 - brought forward	**4,841**	**5,294**	**149**	**10,284**	**1,280**
At start of period for new FTs	**-**	**-**	**-**	**-**	**-**
Provided during the year	1,757	1,839	98	**3,694**	443
Disposals / derecognition	(163)	-	-	**(163)**	(163)
Accumulated depreciation at 31 March 2026	**6,435**	**7,133**	**247**	**13,815**	**1,560**
Net book value at 31 March 2026	**14,455**	**4,079**	**89**	**18,623**	**2,543**
Net book value at 1 April 2025	**14,278**	**5,034**	**160**	**19,472**	**3,317**

Net book value of right of use assets leased from other NHS providers	1,452
Net book value of right of use assets leased from other DHSC group bodies	1,091

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	**16,853**	**9,238**	**316**	**26,407**	**4,795**
Additions	2,587	1,812	132	**4,531**	143
Remeasurements of the lease liability	(321)	-	-	**(321)**	130
Reclassifications	-	-	-	**-**	(471)
Disposals / derecognition	-	(722)	(139)	**(861)**	-
Valuation/gross cost at 31 March 2025	**19,119**	**10,328**	**309**	**29,756**	**4,597**
Accumulated depreciation at 1 April 2024 - brought forward	3,116	4,046	160	**7,322**	1,150
Provided during the year	1,725	1,970	87	**3,782**	483
Reclassifications	-	-	-	**-**	(353)
Disposals / derecognition	-	(722)	(98)	**(820)**	-
Accumulated depreciation at 31 March 2025	**4,841**	**5,294**	**149**	**10,284**	**1,280**
Net book value at 31 March 2025	**14,278**	**5,034**	**160**	**19,472**	**3,317**
Net book value at 1 April 2024	**13,737**	**5,192**	**156**	**19,085**	**3,645**

Net book value of right of use assets leased from other NHS providers	1,642
Net book value of right of use assets leased from other DHSC group bodies	1,675

Note 17.3 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 26.1.

	2025/26	2024/25
	£000	£000
Carrying value at 1 April	**19,371**	**18,923**
Lease additions	2,848	4,531
Lease liability remeasurements	378	(321)
Interest charge arising in year	347	235
Early terminations	(400)	(59)
Lease payments (cash outflows)	(3,860)	(3,938)
Carrying value at 31 March	**18,684**	**19,371**

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.

Note 17.4 Maturity analysis of future lease payments

	Total 31 March 2026	Of which leased from DHSC group bodies: 31 March 2026	Total 31 March 2025	Of which leased from DHSC group bodies: 31 March 2025
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	3,482	402	3,559	462
- later than one year and not later than five years;	7,725	1,562	11,155	1,712
- later than five years.	7,477	563	4,657	1,136
Total gross future lease payments	**18,684**	**2,527**	**19,371**	**3,310**
Finance charges allocated to future periods	-	-	-	-
Net lease liabilities at 31 March 2026	**18,684**	**2,527**	**19,371**	**3,310**
Of which:				
Leased from other NHS providers		1,463		1,654
Leased from other DHSC group bodies		1,064		1,656

Note 18 Investment Property

The Trust has no investment property that require disclosure within this note (2024/25: £nil).

Note 19 Investments in associates and joint ventures

The Trust has no investments in associates or joint ventures (2024/25: £nil).

Note 20 Disclosure of interests in other entities

The Trust has no interests in unconsolidated subsidiaries, joint ventures, associates or unconsolidated structured entities that require disclosures within this note.

Note 21 Inventories

	31 March 2026 £000	31 March 2025 £000
Drugs	3,484	3,519
Consumables	6,690	6,385
Energy	276	204
Total inventories	**10,450**	**10,108**

Inventories recognised in expenses for the year were £0k (2024/25: £137k). Write-down of inventories recognised as expenses for the year were £428k (2024/25: £291k).

Note 22.1 Receivables

	31 March 2026 £000	31 March 2025 £000
Current		
Contract receivables	21,468	8,910
Allowance for impaired contract receivables / assets	(2,590)	(1,741)
Prepayments (non-PFI)	6,114	4,280
PDC dividend receivable	662	981
VAT receivable	1,375	1,286
Other receivables	84	71
Total current receivables	**27,113**	**13,787**
Non-current		
Contract receivables	1,213	1,223
Other receivables	553	605
Total non-current receivables	**1,766**	**1,828**
Of which receivable from NHS and DHSC group bodies:		
Current	15,861	4,935
Non-current	553	605

Note 22.2 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	**1,741**	**-**	**1,221**	**-**
New allowances arising	1,199	-	1,085	-
Reversals of allowances	(79)	-	(193)	-
Utilisation of allowances (write offs)	(271)	-	(372)	-
Allowances as at 31 Mar 2026	**2,590**	**-**	**1,741**	**-**

Note 22.3 Exposure to credit risk

The majority of the Trust's revenue comes from contracts with other public sector bodies therefore the Trust has low risk, as disclosed in the trade and other receivables note.

Note 23.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2025/26	2024/25
	£000	£000
At 1 April	**61,518**	**54,680**
Net change in year	11,461	6,838
At 31 March	**72,979**	**61,518**
Broken down into:		
Cash at commercial banks and in hand	12	17
Cash with the Government Banking Service	72,967	61,501
Total cash and cash equivalents as in SoFP	**72,979**	**61,518**
Total cash and cash equivalents as in SoCF	**72,979**	**61,518**

Note 23.2 Third party assets held by the trust

The Shrewsbury And Telford Hospital NHS Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the Trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2026	31 March 2025
	£000	£000
Bank balances	1	2
Total third party assets	**1**	**2**

Note 24.1 Trade and other payables

	31 March 2026 £000	31 March 2025 £000
Current		
Trade payables	14,230	9,760
Capital payables	45,033	28,070
Accruals	30,244	34,920
Receipts in advance and payments on account	57	24
Social security costs	5,591	4,474
Other taxes payable	5,957	5,471
Pension contributions payable	5,981	5,490
Other payables	105	124
Total current trade and other payables	**107,198**	**88,333**
Of which payables from NHS and DHSC group bodies:		
Current	1,798	1,830
Non-current	-	-

Note 24.2 Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

	31 March 2026 £000	31 March 2026 Number	31 March 2025 £000	31 March 2025 Number
- to buy out the liability for early retirements over 5 years	-		-	
- number of cases involved		-		-

Note 25 Other liabilities

	31 March 2026 £000	31 March 2025 £000
Current		
Deferred income: contract liabilities	1,264	4,141
Total other current liabilities	**1,264**	**4,141**
Non-current		
Total other non-current liabilities	**-**	**-**

Note 26.1 Borrowings

	31 March 2026 £000	31 March 2025 £000
Current		
Lease liabilities	3,482	3,559
Total current borrowings	**3,482**	**3,559**
Non-current		
Lease liabilities	15,202	15,812
Total non-current borrowings	**15,202**	**15,812**

Note 26.2 Reconciliation of liabilities arising from financing activities

	Lease Liabilities	Total
	£000	£000
Carrying value at 1 April 2025	**19,371**	**19,371**
Cash movements:		
Financing cash flows - payments and receipts of principal	(3,513)	**(3,513)**
Financing cash flows - payments of interest	(347)	**(347)**
Non-cash movements:		
Additions	2,848	**2,848**
Lease liability remeasurements	378	**378**
Application of effective interest rate	347	**347**
Early terminations	(400)	**(400)**
Carrying value at 31 March 2026	**18,684**	**18,684**

	Lease Liabilities	Total
	£000	£000
Carrying value at 1 April 2024	**18,923**	**18,923**
Cash movements:		
Financing cash flows - payments and receipts of principal	(3,703)	**(3,703)**
Financing cash flows - payments of interest	(235)	**(235)**
Non-cash movements:		
Additions	4,531	**4,531**
Lease liability remeasurements	(321)	**(321)**
Application of effective interest rate	235	**235**
Early terminations	(59)	**(59)**
Carrying value at 31 March 2025	**19,371**	**19,371**

Note 27 Other financial liabilities

The Trust has no other financial liabilities (2024/25: £nil).

Note 28.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2025	**45**	**116**	**125**	**630**	**916**
Change in the discount rate	-	3	-	(44)	**(41)**
Arising during the year	44	63	74	(24)	**157**
Utilised during the year	(45)	(74)	(60)	(23)	**(202)**
Reversed unused	-	-	(25)	-	**(25)**
Unwinding of discount	-	3	-	37	**40**
At 31 March 2026	**44**	**111**	**114**	**576**	**845**
Expected timing of cash flows:					
- not later than one year;	44	111	114	23	**292**
- later than one year and not later than five years;	-	-	-	553	**553**
- later than five years.	-	-	-	-	**-**
Total	**44**	**111**	**114**	**576**	**845**

Early departure costs and injury benefits relate to a provision for future payments payable to NHS Pensions Agency in respect of former employees.

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

Clinicians who are members of the NHS Pension Scheme and who as a result of work undertaken face a tax charge in respect of the growth of their NHS pension benefits above their pension savings annual allowance threshold will be able to have this charge paid by the NHS pension scheme. A contra entry has been set up in Receivables.

Note 28.2 Clinical negligence liabilities

At 31 March 2026, £369.4m was included in provisions of NHS Resolution in respect of clinical negligence liabilities of The Shrewsbury And Telford Hospital NHS Trust (31 March 2025: £350.5m).

Note 29 Contingent assets and liabilities

	31 March 2026 £000	31 March 2025 £000
Value of contingent liabilities		
NHS Resolution legal claims	(30)	(43)
Gross value of contingent liabilities	**(30)**	**(43)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(30)**	**(43)**

Note 30 Contractual capital commitments

	31 March 2026 £000	31 March 2025 £000
Property, plant and equipment	168,320	240,914
Intangible assets	-	36
Total	**168,320**	**240,950**

Note 34 Financial instruments

Note 34.1 Financial risk management

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

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

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

Interest rate risk
The borrowings are for 1-25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

The Trust may also borrow from government for revenue financing subject to approval by NHS England.
Interest rates are confirmed by the Department of Health and Social Care (the lender) at the point borrowing is undertaken. The Trust has no revenue or capital loans in place as at 31 March 2026.

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk
Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposure as at 31 March 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 ICBs, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks subject to the availability of temporary revenue support funding and the demonstration of cash requirement.

Note 34.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2026	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
Trade and other receivables excluding non financial assets	20,728	-	-	**20,728**
Cash and cash equivalents	72,979	-	-	**72,979**
Total at 31 March 2026	**93,707**	**-**	**-**	**93,707**

Carrying values of financial assets as at 31 March 2025	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
Trade and other receivables excluding non financial assets	9,068	-	-	**9,068**
Cash and cash equivalents	61,518	-	-	**61,518**
Total at 31 March 2025	**70,586**	**-**	**-**	**70,586**

Note 34.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2026	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Obligations under leases	18,684	-	**18,684**
Trade and other payables excluding non financial liabilities	89,612	-	**89,612**
Provisions under contract	845	-	**845**
Total at 31 March 2026	**109,141**	**-**	**109,141**

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Obligations under leases	19,371	-	**19,371**
Trade and other payables excluding non financial liabilities	72,874	-	**72,874**
Provisions under contract	916	-	**916**
Total at 31 March 2025	**93,161**	**-**	**93,161**

Note 34.4 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	93,387	76,700
In more than one year but not more than five years	7,820	11,289
In more than five years	7,934	5,172
Total	**109,141**	**93,161**

Note 34.5 Fair values of financial assets and liabilities

The book value (carrying value) is a reasonable approximation of fair value for the Trust's financial assets and liabilities.

Note 35 Losses and special payments

	2025/26		2024/25	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	-	-	1	1
Fruitless payments and constructive losses	-	-	-	-
Bad debts and claims abandoned	403	271	690	372
Stores losses and damage to property	49	428	37	291
Total losses	**452**	**699**	**728**	**664**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	-	-
Extra-contractual payments	-	-	-	-
Ex-gratia payments	93	313	93	230
Special severance payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**93**	**313**	**93**	**230**
Total losses and special payments	**545**	**1,012**	**821**	**894**
Compensation payments received				

Note 36 Gifts

	2025/26		2024/25	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Gifts made	-	-	-	-

Note 37 Related parties

The Department of Health and Social Care is regarded as the parent department.
The main entries within the public sector that the trust has had dealings with during the year are listed below.
These are entities where income and/or expenditure has been in excess of £250,000.

NHS Shropshire, Telford and Wrekin ICB
NHS Black Country ICB
NHS Cheshire and Merseyside ICB
NHS Staffordshire and Stoke-on-Trent ICB
NHS Herefordshire and Worcestershire ICB
NHS Birmingham and Solihull ICB
NHS England
NHS Resolution
NHS Property Services
Shropshire Community Health NHS Trust
Midlands Partnership NHS Foundation Trust
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
The Royal Wolverhampton NHS Trust
University Hospitals of North Midlands NHS Trust
University Hospitals Birmingham NHS Foundation Trust
Oxford Health NHS Foundation Trust
Powys Local Health Board
Betsi Cadwaladr University Local Health Board
Cwm Taf Local Health Board
NHS Pension Scheme
HM Revenue and Customs
Shropshire Unitary Authority
Telford & Wrekin Council
UK Health Security Agency
Care Quality Commission

The Trust is linked to the Shrewsbury and Telford Hospital NHS Trust Charity. The Annual Report and Accounts for the Shrewsbury and Telford Hospital NHS Charity are submitted separately to the Charity Commission and are not consolidated into the Trust's Accounts.

The Trust is also linked to Royal Shrewsbury Hospital League of Friends, Friends of Princess Royal Hospital and Lingen Davies Cancer Fund, who donate various pieces of medical equipment to the Trust. The Trust hires facilities from Shropshire Education and Conference Centre.

Note 38 Prior period adjustments

The Trust has made no prior period adjustments where comparative information has been restated due to either a change in accounting policy or material prior period error.

Note 39 Events after the reporting date

The Shrewsbury and Telford Hospital NHS Trust and Shropshire Community Health NHS Trust agreed to establish a Group between the organisations in September 2025. The Group was established on 1 April 2026 with each Trust remaining a separate statutory organisation, with separate reporting.

Note 40 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	108,537	333,686	133,965	279,391
Total non-NHS trade invoices paid within target	106,352	323,210	130,055	268,134
Percentage of non-NHS trade invoices paid within target	98.0%	96.9%	97.1%	96.0%
NHS Payables				
Total NHS trade invoices paid in the year	2,792	13,536	2,295	12,299
Total NHS trade invoices paid within target	2,683	12,358	2,140	11,226
Percentage of NHS trade invoices paid within target	96.1%	91.3%	93.2%	91.3%

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 41 Capital Resource Limit

	2025/26 £000	2024/25 £000
Gross capital expenditure	158,714	82,281
Less: Disposals	(597)	(459)
Less: Donated and granted capital additions	(8,449)	(8,463)
Charge against Capital Resource Limit	**149,668**	**73,359**
Capital Resource Limit	149,668	73,359
Under / (over) spend against CRL	**-**	**-**

Note 42 Adjusted financial performance

	2025/26 £000	2024/25 £000
Surplus / (deficit) for the period per SOCI	(9,491)	(23,974)
Remove net impairments not scoring to the departmental expenditure limit	21,984	6,978
Remove I&E impact of capital grants and donations	(7,572)	(7,494)
Remove net impact of DHSC centrally procured inventories	-	137
Adjusted financial performance surplus / (deficit)	**4,921**	**(24,353)**

Note 43 Breakeven duty financial performance

	2025/26 £000
Adjusted financial performance surplus / (deficit)	4,921
Breakeven duty financial performance surplus / (deficit)	**4,921**

Note 44 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		712	26	59	81	65	(12,130)	(14,649)	(5,631)
Breakeven duty cumulative position	(22,891)	(22,179)	(22,153)	(22,094)	(22,013)	(21,948)	(34,078)	(48,727)	(54,358)
Operating income		262,882	277,980	299,850	309,362	314,106	316,794	326,477	350,244
Cumulative breakeven position as a percentage of operating income		(8.4%)	(8.0%)	(7.4%)	(7.1%)	(7.0%)	(10.8%)	(14.9%)	(15.5%)

	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	(17,400)	(18,743)	(25,715)	(3,752)	(10,890)	(47,206)	(54,582)	(18,563)	4,921
Breakeven duty cumulative position	(71,758)	(90,501)	(116,216)	(119,968)	(130,858)	(178,063)	(232,645)	(251,208)	(246,287)
Operating income	359,041	369,186	421,853	511,443	535,142	556,605	624,322	724,065	778,060
Cumulative breakeven position as a percentage of operating income	(20.0%)	(24.5%)	(27.5%)	(23.5%)	(24.5%)	(32.0%)	(37.3%)	(34.7%)	(31.7%)

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